MEDICAL EXAMINATION IN THE ASYLUM PROCEDURE

ARTICLE 18 DIRECTIVE 2013/32/EU.

MANUAL

FOR HEALTH PROFESSIONALS AND LEGAL WORKERS

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iMMO


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FOREWORD

There has been a growing awareness that a medico-legal report (MLR) of an individual requesting international protection in the European Union plays an important role in the asylum decision-making process. In Article 18 of their recast of the Directive on Common Procedures for Granting and Withdrawing International Protection (Asylum Procedure Directive), the European Council and EU Parliament recognized the MLR as a means to provide indications for past persecution or serious harm.

The explicit recognition of the MLR in EU asylum legislation provided the momentum for three partner organizations from the Netherlands, France and Hungary to combine their expertise to create a new, standardized MLR format to suit the requirements of the EU asylum procedure. An additional objective of this joint effort was to develop a programme to deepen the knowledge on physical and psychological signs of past persecution and serious harm, and to train professionals in effectively using MLRs in the asylum procedure.

From 1 January 2016 to 30 June 2017, the Netherlands institute for Human Rights and Medical Assessment (iMMO), the Hungarian Cordelia Foundation for the Rehabilitation of Torture Victims and the French organization Parcours d'Exil, along with several international experts, worked together on developing this manual. Also a separate report on common forensic standards for the medical examination in the asylum procedure, which includes a pilot of 25 examinations, is available.

The three partners hope that this manual will be a genuine contribution to the decision-making process.

A. M. Keunen, iMMO director

INTRODUCTION

The purpose of this manual is to provide health professionals and legal workers with specific information needed to produce and read medico-legal reports (MLRs) in the context of the EU asylum procedure.

It provides the reader with: (1) the legal framework of the asylum procedure in the European Union; (2) an overview of the common signs and symptoms of persecution and serious harm as well as specific acts of persecution and serious harm, and problems associated with recounting the history of violence; (3) a guide on how to perform a medical examination and write an MLR for health professionals; (4) information about the MLR as expert evidence in the asylum procedure; and lastly (5) advice about vicarious trauma and self-care.

This manual has been developed to comply with the latest legislative developments in international and EU asylum law, as well as with the existing international medical guidelines; it takes the Istanbul Protocol standards as its foundation.

The content is aimed at health professionals: medical doctors and psychologists who perform MLRs in the context of an asylum procedure, initiated either by member states' immigration authorities, or by applicants. It is also aimed at legal workers involved in asylum proceedings: immigration officers, as well as lawyers, judges, the judiciary and social workers.

The material may be used both as a training manual, and as a work of reference. For the purpose of it being used as training material, each chapter starts with learning objectives and reading material. These can be used as goals to be met, and as preparation material respectively.

With this manual, the authors aim for increased quality, uniformity, as well as understanding of the Article 18 MLR in the asylum procedure.

I. > LEGAL FRAMEWORK

I.1. INTRODUCTION

In this chapter, the legal framework of the EU asylum procedure is laid down. It includes information about legislative aspects of the Common European Asylum System (CEAS), with a focus on the Article 18 medical examination. It does not include national legislation of the EU member states; that information should be included in national training and teaching material.

This chapter is relevant for legal workers, as well as for health professionals.

For legal workers, the information clarifies the role of the medico-legal report (MLR) in the assessment of asylum claims.

For health professionals, this chapter provides a basic understanding of the legal framework of asylum claims, and clarifies the purpose of the medical examination and the MLR in the asylum procedure.

Learning objectives:

For legal workers, complete understanding, and for health professional basic understanding of the following:

- 1951 UN Refugees convention and the 1967 protocol.
- European convention on Human Rights (ECHR) and European Court of Human Rights (ECtHR), Council of Europe.
- Common European Asylum System.
- Directive 2011/95/EU; 'qualification directive' – refugee status, subsidiary protection status and 'persecution' and 'serious harm' in this context.
- Asylum assessment – credibility, plausibility, coherence and consistency.
- Directive 2013/32/EU; 'procedures directive' – Article 18 in particular.

Reading material:

UN 1951 Convention Relating to the Status of Refugees and the 1967 protocol ('Geneva' convention).

UNHCR Refugee Handbook:
United Nations High Commissioner for Refugees (UNHCR), Handbook on Procedures and Criteria for Determining Refugee Status. Geneva: UNHCR 1979, re-edited in 1992.

Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons or 'qualification directive'.

Directive 2013/32/EU on common procedures for granting and withdrawing international protection or 'procedures directive'.

European Asylum Support Office (EASO) Practical Guide: Evidence Assessment, EASO Practical Guide Series, 2015.
https://www.easo.europa.eu/sites/default/files/public/EASO-Practical-Guide_-Evidence-Assessment.pdf

The national legislation of the relevant member state.

1.2. LEGISLATIVE BACKGROUND OF THE ASYLUM PROCEDURE

The EU legislator has the competence to create legislation regarding asylum procedures. This competence is based on the European Union Treaty provisions, which aim to establish an area of freedom, security and justice (AFSJ) within the EU.[1] Directives regarding asylum procedures set minimum standards for granting and withdrawing international protection, and reserve the right for member states to maintain more favourable standards.[2] Directives need to be transposed into national legislation by a certain date, and they have direct effect after this date is due, even if they are not transposed.[3] This manual covers only the minimum standards that are applicable throughout the EU.

International protection or asylum is granted in the European Union to people who are fleeing persecution or serious harm in their own country.[4] Assessment of an application for asylum is done by establishing the facts of the claimant's accounts and evaluating if there is a legal basis for asylum. If a person has suffered persecution or serious harm, this serves as a strong indication that they are facing new persecution or serious harm when returning to their country of origin.[5]

Directive 2011/95/EU (Qualification Directive) recognizes two kinds of asylum seekers: refugees and persons eligible for subsidiary protection. In short, a refugee is a person who faces persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group.[6] A person eligible for subsidiary protection does not qualify as a refugee but, if returned to their country of origin, would face a real risk of suffering serious harm.[7] The acts of persecution and serious harm are defined as follows.

Persecution:
In order to be regarded as an act of persecution […], an act must: (a) be sufficiently serious by its nature or repetition as to constitute a severe violation of basic human rights […]; or (b) be an accumulation of various measures, including violations of human rights, which is sufficiently severe as to affect an individual in a similar manner as mentioned in point (a).[8]

Examples of persecution are:
Acts of physical or mental violence, including acts of sexual violence; discriminatory legal, administrative, police and/or judicial measures; prosecution or punishment that is disproportionate or discriminatory; denial of judicial redress resulting in a disproportionate or discriminatory punishment; prosecution or punishment for refusal to perform military service in a conflict, where performing military service would include crimes or acts against international law or human rights; acts of a gender-specific or child-specific nature.

Serious harm:
The death penalty or execution; or torture or inhuman or degrading treatment or punishment; or serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of armed conflict.[9]

The actors of persecution and serious harm may be the state and parties or organizations controlling the state or a substantial part of the territory of the state. In addition, non-state actors, such as, for example, the victim's family, may be the actors of persecution or serious harm if the victim cannot be protected by the state or related organizations.[10]
The terms 'persecution' and 'serious harm' have been and will be used henceforth in this legal sense, thus referring to the Qualification Directive.

1.3. ASSESSMENT OF THE ASYLUM CLAIM

It is a general legal principle that the burden of proof lies on the person submitting a claim. It is up to the applicant to show that there is a 'reasonable possibility' of future persecution or that there are substantial grounds for assuming that they face a real risk of serious harm.

Often, however, an applicant may not be able to support their statements by documentary or other proof. [11] The assessment of the applicant's account therefore plays a pivotal role in the determination of the outcome of the asylum application.

In this determination process, the applicant's account needs to appear 'credible'.[12] EU directives and international standards require that the applicant's statements are 'coherent and plausible' as one of the cumulative conditions that must be met,[13] and not run counter to generally known facts.[14]

The UNHCR has further identified five credibility indicators that, when applied appropriately, may be used to guide adjudicators when they are deciding whether to accept an asserted material fact. These are:

- Sufficiency of detail and specificity.
- Internal consistency of the oral and/or written material facts asserted by the applicant (including the applicant's statements and any documentary or other evidence submitted by the applicant).
- Consistency of the applicant's statements with information provided by any family member and/or other witnesses.
- Consistency of the applicant's statements with available specific and general information, including country information, relevant to the applicant's case.
- Plausibility.

Rejection or submission of an asylum claim is done according to the credibility assessment based on all the relevant aspects that need to be considered. If the applicant's account cannot be supported with evidence, but appears credible, they should, unless there are good reasons to conclude otherwise, be given the benefit of the doubt.[15]

The benefit of the doubt principle is outlined in §204 and §205 of the UNHCR Refugee Handbook and acknowledged by the European Court of Human Rights when it comes to assessing the credibility of statements.[16]

1.4. MEDICAL EXAMINATION IN THE ASYLUM PROCEDURE

Asylum applicants may submit documents and other evidence in order to support their asylum claim. Article 4 of the Qualification Directive mentions, in general terms, what elements are relevant for the examination of the asylum claim. However, it leaves some discretion to the member states as to the specific types of evidence that should be taken into account and the weight that should be given to them. The determining authority of the member states may regard certain types of evidence as irrelevant or attach very limited weight to them.[17]

There has been a growing awareness that a medico-legal report (MLR) of an individual requesting international protection in the EU plays an important role in the asylum decision-making process.[18] In Article 18 of the Procedures Directive, the European Council and EU Parliament recognized the MLR as a means to provide indications of past persecution or serious harm.

Article 18
Medical examination

1. Where the determining authority deems it relevant for the assessment of an application for international protection [...], Member States shall, subject to the applicant's consent, arrange for a medical examination of the applicant concerning signs that might indicate past persecution or serious harm. Alternatively, Member States may provide that the applicant arranges for such a medical examination.

The medical examinations referred to in the first subparagraph shall be carried out by qualified medical professionals and the result thereof shall be submitted to the determining authority as soon as possible. Member States may designate the medical professionals who may carry out such medical examinations. An applicant's refusal to undergo such a medical examination shall not prevent the determining authority from taking a decision on the application for international protection.

Medical examinations carried out in accordance with this paragraph shall be paid for out of public funds.

2. When no medical examination is carried out in accordance with paragraph 1, Member States shall inform applicants that they may, on their own initiative and at their own cost, arrange for a medical examination concerning signs that might indicate past persecution or serious harm.

3. The results of the medical examinations referred to in paragraphs 1 and 2 shall be assessed by the determining authority along with the other elements of the application.

At present, there are no guidelines that indicate when an MLR shall be arranged for. Article 18 Procedures Directive leaves it up to the discretion of the determining authority, and alternatively the applicant, to decide that an MLR is relevant for the assessment of an asylum application. It is beyond the scope of this manual to evaluate the factors that may constitute the relevance of an MLR for the assessment of an application. This manual limits itself to providing the information that is required to determine whether there are medically ascertainable indications of past persecution or serious harm.

Medical organizations that already deliver MLRs within the asylum procedure in European countries, as well as organizations outside the EU, all use their own methodology, standards and report formats.[19] The Asylum Procedure Directive states that 'national measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or psychological violence, including acts of sexual violence, in procedures covered by this Directive may, inter alia, be based on the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)'.[20]

As the Istanbul Protocol[21] is presently the only internationally adopted guideline for the investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment,[22] and is used by most of the organizations that deliver MLRs within the asylum procedure, this manual and the presented MLR guideline take the Istanbul Protocol standards as their basis.

The overall purpose of the MLR is to establish the correlation between the physical and psychological signs and symptoms and the alleged persecution or serious harm. This is done by assessing the physical and psychological signs and symptoms through an extensive examination including a detailed interview of the historical accounts. The examination is also designed to acquire insight in the cultural, emotional, psychological and neuropsychiatric processes affecting the ability of the applicant to recount their history. This makes the MLR a potentially valuable source of information in the complex task of the credibility assessment.[23, 24]

1 *In particular outlined in Article 78(2)(d) of the Treaty on the Functioning of the European Union. A few member states have opted out of the AFSJ, with the retention of the right to opt-in. These member states, Denmark, the United Kingdom and Ireland, do not participate in the common European asylum system (CEAS). Yet, the medico-legal report is relevant in asylum procedures in these states too, as Denmark, the United Kingdom and Ireland, as well all states participating in the Council of Europe, are bound by the European Convention on Human Rights (ECHR). Article 3 ECHR (and related case law) obliges those states to abide by the principle of 'non refoulement', which entails that no one shall be sent to a country where they face a real risk of being subjected to torture or inhuman or degrading treatment or punishment.*

2 *For example, Article 5 Directive 2013/32/EU.*

3 *See Court of Justice of the EU case Francovic vs Italy. The due date for the Asylum Procedure Directive (2013/32/EU) was 20 July 2015.*

4 *The duty to grant protection to asylum seekers is based on international law, EU treaty law and EU legislation. Important international conventions are the 1951 Geneva Convention on the Protection of Refugees, the Universal Declaration on Human Rights and the European Convention on Human Rights. EU treaty law, as relevant for the EU asylum system, consists of the Treaty on the European Union, the Treaty on the Functioning of the European Union and the Charter of Fundamental Rights of the European Union. Relevant EU legislation comprises the Asylum Procedure Directive (Directive 2013/32/EU), the Reception Conditions Directive (2013/33/EU), the Qualification Directive (2011/95/EU), the Dublin Regulation (Regulation no. 604/2013) and the Eurodac Regulation (Regulation no. 630/2013).*

5 *Article 4(4) Directive 2011/95/EU.*

6 *Article 2(d) Directive 2011/95/EU.*

7 *Article 2(f) Directive 2011/95/EU.*

8 *Article 9 Directive 2011/95/EU.*

9 *Article 15 Directive 2011/95/EU.*

10 *Articles 6 and 7 Directive 2011/95/EU.*

11 *UNHCR Refugee Handbook §196.*

12 *UNHCR Refugee Handbook §196.*

13 *Article 4(5)(c) Directive 2011/95/EU.*

14 *UNHCR Refugee Handbook §205*

15 *Article 4(5) Directive 2011/95/EU and UNHCR Refugee Handbook §196.*

16 *'Building credibility' supporting EU-wide access to know-how on objective credibility assessment. Credibility Assessment in Asylum Procedures – Expert Roundtable, Budapest, Hungary, 14–15 January 2015.*

17 *European Council on Refugees and Exiles & Dutch Council for Refugees, The application of the EU Charter of Fundamental Rights to asylum procedural law. Europe: ECRE/VWN 2014, p. 134–137.*

18 *Refer to, among others, the International Association of Refugee Law Judges' Guidelines on the Judicial Approach to Expert Medical Evidence. https://www.iarlj.org/images/stories/working_parties/guidelines/medicalevidenceguidelinesfinaljun2010rw.pdf*

19 *Physicians for Human Rights (PHR), Examining asylum seekers. A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment. Second edition. United States of America: PHR, 2012.*

20 *Preamble (31) Directive 2013/32/EU.*

21 *Office of the United Nations High Commissioner for Human Rights. Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations, 2004.*

22 *The term 'persecution or serious harm' in the context of EU legislation as discussed above has a broader scope than the term 'torture and other cruel, inhuman or degrading treatment or punishment' in the context of UN treaties, because in the latter the actors and intentions of the ill treatment are more limitedly defined. On the other hand, the physical and psychological consequences of the ill treatment on which the Istanbul Protocol focusses coincide with the consequences of persecution or serious harm. As a consequence, the standards of the Istanbul Protocol are indeed suitable in the context of the EU asylum procedure.*

23 *Discussed in more detail in chapter II. Medical aspects §4. Credibility.*

24 *Meffert, S.M., Musalo K., McNiel D.E., Binder R.L. The role of mental health professionals in political asylum processing. J Am Acad Psychiatry Law. 2010;38(4):479-89.*

II. > MEDICAL ASPECTS OF PERSECUTION AND SERIOUS HARM

II.1. INTRODUCTION

In this chapter, the physical and psychological effects of violence (section 2 and 3), the common specific acts of persecution and serious harm (section 4), as well as the ability of the applicant to recount the history appropriately (section 5), will be discussed.

This chapter is relevant for health professionals as well as legal workers.

To establish whether an applicant has sustained persecution or serious harm, it is required to be familiar with the most common causing mechanisms, and to be able to recognize the physical and psychological signs that might indicate past persecution or serious harm. Furthermore, the applicant's account is in many cases the pivotal evidence in an asylum procedure, as other sources are usually not, or only limitedly available. Therefore, basic understanding of the working of the memory is required, as well as knowledge of psychological trauma or other medical conditions that may affect the memory. An MLR is a means to acquire legally valid information about the likelihood that an applicant has sustained persecution or serious harm, and information about the extent to which this influences their ability to recount their history.

Learning objectives:

Legal workers (basic), and health professionals (complete) understanding and recognition of the following:

- Physical effects of violence and the principles of physical injury and healing.
- Psychological effects of violence and common signs and symptoms.
- The role of culture and age, and common psychological signs and symptoms.
- The diagnostic criteria (according to DSM-V) of common trauma associated with psychiatric illnesses.
- Specific acts of persecution and serious harm, in particular sexual violence.
- The working of the memory and what aspects may lead to difficulty in recounting the history.

Reading material:

Danielsen, L., Rasmussen, O.V. Dermatological findings after alleged torture. Torture. 2006;16(2):108-127.

American Psychiatric Association, DSM 5 handbook of differential diagnosis. Virginia: American Psychiatric Publishing, 2014.

International Rehabilitation Council for Torture Victims. Model curriculum on the effective medical documentation of torture and ill treatment. Prevention through documentation project (2006–2009) – Module 4: Torture methods and their medical consequences.

Peel, M., Lubell, N., Beynon, J. Medical Investigation and Documentation of Torture: A Handbook for Health Professional, Chapter 2.2.2.6 Forms of torture and other ill-treatment. Colchester, United Kingdom: Human Rights Centre, University of Essex, 2005, pp. 8-9.

Istanbul Protocol (Office of the United Nations High Commissioner for Human Rights. Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations, 2004.):
Chapter IV. § 144, 145.
Chapter V. Physical evidence of torture – Specific forms of torture (§ 187–232).
Chapter VI. Psychological evidence of torture.

Beyond proof, Credibility Assessment in EU Asylum Systems. Brussels: United Nations High Commissioner Refugees, May 2013

The online EASO Tool for Identification of Persons with Special Needs (IPSN), was developed to assist officials involved in the asylum procedure, to identify applicants with special needs, among which persons who have been subjected to torture or rape, or other serious forms of physical or psychological or sexual violence. It provides information about these groups, as well as tailored support measures.
https://ipsn.easo.europa.eu/

II.2. PHYSICAL EFFECTS OF VIOLENCE

In this section, an overview of the effects of trauma on the physical body is given. Basic anatomy and principles of healing of the skin and the two types of skin injury (wounds and bruises) are discussed. The other organs that may be affected and the possible causes of (chronic) pain are also discussed.

II.2.1 SKIN [25, 26, 27]

Basic anatomy [28]

As a simplification, the outer layer of the skin (epidermis) is composed of keratinocytes at the surface and melanocytes or pigment-producing cells at the base: stratum basale (see Figure 1).

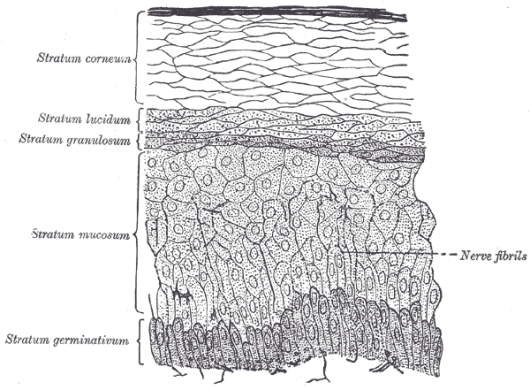

Figure 1. Epidermis [29]

The underlying, inner layer of the skin (dermis) is consists of connective tissue and functions as support for the top layer; this layer contains the appendages (skin-associated structures such as sweat glands and hair follicles). These appendages may even extend into the underlying, mainly fat-containing, subcutaneous tissue (see Figure 2).

The melanocytes and appendages play an important role in the aspect (pigmentation) of the healed skin lesions and in the wound healing, respectively, as will be discussed below.

Wound healing

In wound healing, after blood clot formation, there are three, largely overlapping, phases: inflammation, proliferation, and tissue remodelling. The type of tissue that is formed – neoepithelium ('normal' skin tissue) or connective tissue (scar tissue) – will depend on the depth of the wound.[30]

In partial thickness injury of the skin, re-epithelization will occur from the keratinocytes of the wound edges and/or in partial thickness defects of the basal membrane surrounding the 'appendages' of the skin. The skin may remodel towards an almost normal structure but may have a reduced presence of pores and hairs and melanocytes.

In 'full thickness' injury of the skin (dermis and epidermis), unspecialized connective tissue (scar tissue) will be formed. Since the appendages are lost in full thickness injury of the skin, re-epithelization from the underlying structures cannot take place. The scar-tissue formation involves fibroblast cells and collagen from the initial blood clot that is formed in the wound.

The healing process is influenced by many factors, e.g. size and depth of the wound,

occurrence of infection, surgical care (such as suturing) and general condition of the individual (e.g. nutritional status, vascular disease and diabetes). Furthermore, even in similar circumstances, healing differs from person to person; this includes the time of healing as well as the amount of scar tissue that is formed. The duration of healing thus varies and may take up to 2 years. Dating of scars is therefore very difficult, and no reliable methods to date a scar exist as yet.

Pigmentation [31]
In partial thickness injuries, the wound bed will contain appendages that will be able to provide melanocytes and epithelial cells to the neoepithelium. However, in deep injuries in which all adnexal elements have been destroyed, the only available source for melanocytes is the wound edge. Therefore, hypopigmentation will usually be observed in the centre of a deep scar.

Furthermore, increased inflammation in the wound may lead to hyperpigmentation, caused by the activation of melanocytes. Melanocytes, besides being involved in the production of melanin, also have an active role: the inflammatory response.

The hyperpigmentation may persist for some time after injury. Necrosis of damaged cells at the wound edges will lead to increased inflammation, and therefore hyperpigmentation is often observed at the periphery of scars. Furthermore, infection of the wound and delayed wound healing will lead to increased inflammation and hyperpigmentation.

Increased or decreased pigmentation is an undesired effect of wound healing, as it makes wounds more noticeable and may lead to perceived disfigurement. In the forensic practice, on the contrary, this will help the investigation of scars. Obviously, hyperpigmentation is more easily visible in white skin, whereas hypopigmentation is more easily visible in dark skin. The difference with the surrounding skin may be subtle and should specifically be looked for during careful examination.

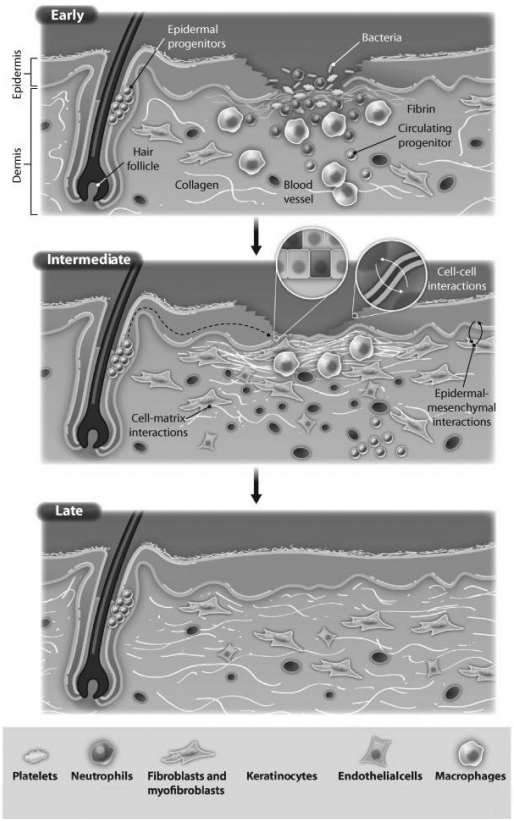

Figure 2. Wound healing [32]

Contraction
Due to the active biological process of reduction of a large area of skin loss, 'contraction of the wound' occurs. In large wounds, this may lead to a 'scar contracture'. This 'shortening of the scar', in turn, affects underlying structures and may cause shortening and deformation of muscles, tendons, nerves, blood vessels and joints.[33] This may lead to discomfort, pain and even loss of function. Adequate treatment, however, may reduce or prevent this process.

Abnormal scarring
Hypertrophic scars and keloid are both forms of an abnormal wound healing. They, by definition, rise above skin level due to an overabundance of collagen.

- Hypertrophic scars develop within several weeks, have a rapid growth for up to 6 months and gradually regress over years, eventually leading to flat scars. Prolonged inflammation and insufficient resurfacing with epithelium may cause hypertrophy.
- Keloids, unlike hypertrophic scars, extend beyond the margins of the original tissue damage, and they may develop years after the injury. The aetiology remains unknown; even after an episode of relative minor trauma to the skin (e.g. folliculitis), extensive keloids may form. The prevalence is higher in dark skin.[34]

Wound type
A specific causing mechanism of trauma usually leads to a specific type of wound. For example, cut wounds due to cleaving of the skin with a sharp object, lacerations due to the impact of blunt force, bullet wound due to a gunshot, burn wounds due to application of heat.

Identification of the causing mechanism and original wound type from a scar or dyspigmentation of the skin can be difficult. When the causing mechanism is indicated by the individual, it is usually possible to establish whether this alleged type of violence could be responsible for the given skin lesion. This is one of the main focusses of the MLR, and will be further explained in chapter 3. It is, however, necessary to keep in mind that there might be other causes, and if there are, a differential diagnosis shall be given. The sooner the examination is done, the better, as the pigmentation and scarring will change and diminish over time.

As we have seen, full thickness injury will lead to more fibrotic tissue formation (scarring). This can usually be observed easily as a distinct skin structure with absent creases, pores, hairs.
In partial thickness injury, with healing due to re-epithelization (from edges and/or appendages), normal skin will be formed. Although the skin structure is normal, hypopigmentation (due to loss of melanocytes), hyperpigmentation (due to the inflammation process) or decreased hairs or pores may point to old injury.

Furthermore, in deep wounds, the underlying tissue might also be affected, and may result in damage to important structures, e.g. muscle, nerves, blood vessels. This may lead to permanent damage and possible disability or chronic pain.

Bruises
When, due to trauma, the skin is not disrupted, bruises may be formed. Bruises (or contusions) are areas of haemorrhage (bleeding) into soft tissue due to rupture of blood vessels. This is a result of blunt trauma, e.g. kicking, falling, beating, etc.[35] Disruption of the small blood vessels in the skin, subcutaneous tissue or

muscle causes blood to go in the interstitial tissues and causes acute swelling and discolouring of the skin. The particular colour of the skin (purple, brown, green, blue, yellow, red, black) depends on the age of the bruise and the depth. Usually, after the healing process, bruises leave no permanent signs on the body. However, it is possible that, for several years or even permanently, hyperpigmentation is seen; this is caused by increased melanin production due to inflammation.[36] Also hypopigmentation may be possible due to inflammation.[37]

Specific patterns can sometimes be distinguished, e.g. tramline bruising, which is typical for beating with a rectangular or round object. Due to the increased pressure in the centre, the blood vessels may have been compressed in such a way that they do not bleed and do not cause haematoma. The bleeding will occur at the edges of the object and leave haematomas (and possibly hyperpigmentation) in a specific pattern (Figure 3).

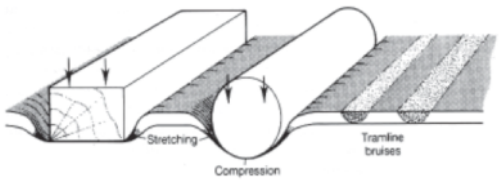

Figure 3.[38]
The formation of 'tramline' bruising from the application of a rectangular or cylindrical object.

Furthermore, there will usually also be bruising of the underlying tissues. This will predominantly heal without any signs; however, possible late signs could include muscle reduction, pain or irregularity of the underlying bone. Furthermore deep bruises tent to track along tissue planes and appear days after the injury, in a different location than the original trauma.

II.2.2 OTHER ORGAN SYSTEMS [39, 40]

Besides causing damage to the skin, other organ systems may be injured; e.g. the muscular system, skeletal system, nervous system, including the brain, blood vessels, reproductive system, digestive system and internal organs.

Examples of this include:
- Disruption of joints and damage to nerves or blood vessels due to suspension techniques.
- Damage to nerves, muscles or tendons of blood vessels due to stab wounds.
- Damage to internal organs due to beating in the abdomen.
- Fractures of bones in severe beating.
- Damage to the reproductive or digestive system due to sexual violence.
- Damage to the musculoskeletal system of the feet due to repeated beating (falanga).
- Brain damage due to severe beating or violent shaking.

Many of these injuries leave no permanent signs, or these signs are subtle.
Specific diagnostic tests or specialized investigations may be indicated. For example, radiological imaging (X-ray, CT or MRI) in the case of fractures, neurological examination in the case of nerve injury due to suspension and urological and/or gynaecological examination in the case of sexual violence. The absence of any signs cannot be regarded as evidence that the events did not take place; positive results on the other hand can corroborate an account.

II.2.3 PAIN

Pain is typically experienced in any injury; it may also be a long-term consequence, but most injuries heal without long term physical symptoms. Yet, there are some exceptions; injuries that cause chronic pain include:
- Chronic muscle pain and increased muscle tone due to beating.
- Joint pain due to damage of the joint, such as cartilage damage or contractures.
- Nerve pain due to disruption of nerves.
- Sexual violence may cause chronic pelvic pain or abdominal pain.
- Pain under the feet after severe beating (falanga).

Furthermore, individuals who have been through traumatizing events often show chronic symptoms of pain and dysfunction in the parts of their body where the trauma took place, without any objective signs of lesion. This seems to be even more prevalent in survivors of torture and prolonged forms of abuse. This phenomenon is called 'somatization': the person experiences pain, discomfort or dysfunction in certain parts of the body, whereas no physiological or organic cause can be found. These medically unexplained symptoms have a complex aetiology that is not yet fully understood.[42] It is thought to involve unconscious memories of trauma and other psychological processes.[43] Cultural factors, feelings of shame and stigma also play an important role in how the symptoms are being expressed and interpreted. Somatisation may be expressed as pain in a particular part of the body, or as clusters of symptoms, e.g. chronic pelvic pain (often observed after sexual violence), irritable bowel syndrome, conversion or somatization disorders.[44]

SUMMARY SKIN LESION

Full thickness injury will lead to fibrotic tissue formation. This will be observed as scar tissue: a changed structure of skin and absence of the normal skin structures (creases, pores, hairs). The centre of the scar usually shows hypopigmentation; the edges are usually hyperpigmented. But this varies significantly depending on the age of the scar, the nature of the injury, the causing mechanism and the absence or presence of infection and/or treatment.

Partial thickness injury will lead to re-epithelization (from the wound edges and/or the appendages). This can be observed as (almost) normal skin tissue with a normal or reduced amount of skin structures. Both hyperpigmentation and hypopigmentation may be observed (due to increased/ reduced production of melanin).

Bruises are haematomas in the skin or underlying tissue. Where the skin remained intact, normal skin structures will be seen after healing. Both hyperpigmentation and hypopigmentation may be observed due to inflammation.

The healing process is influenced by:

- Individual factors; healing is different in each individual, and it is influenced by specific conditions; e.g. nutritional status, diabetes mellitus, vascular disease.
- Healing circumstances; e.g. hygiene, wound and/or surgical care.

II.3. PSYCHOLOGICAL EFFECTS OF VIOLENCE

The effects of trauma on psychological health are discussed in this section.
This includes:

- Psychological consequences of persecution and serious harm.
- Common psychological responses to trauma.
- Diagnostic classification.

II.3.1 PSYCHOLOGICAL CONSEQUENCES OF PERSECUTION AND SERIOUS HARM

Acts of violence or torture are man made, committed in a 'relationship'. There are two parties participating in the traumatic relationship: the perpetrator(s) and the victim. Persecution or serious harm is often inflicted by entities who act in an official capacity of some form or who the state does not stop or punish. In the majority of these cases the victim has nowhere to turn to, has no escape or means of defence – either in the concrete situation when the violence is taking place, or within the given socio-political context altogether. This also means that foreseeing or preventing the traumatic event, or accessing justice afterwards, is often impossible, and this makes the psychological effects of trauma even deeper and act on several levels. Scientific literature underlines that these extreme traumas have an invasive character. They often intrude on the personality and overwrite the coping capacity of the victim, which disrupts the victim's world, leaving it fragmented. The broken reality is a new world far from the previously known, structured world. What used to be reliable and familiar may now appear as hostile or estranged to the survivor.

It is important to recognize that not everyone who has been traumatized or tortured develops symptoms or a diagnosable mental illness. Whether or not an individual develops symptoms or illness is influenced by the coping mechanisms of the individual (i.e. general health, character, belief systems, age, intelligence, social context and support system) and by the severity of the traumatic event (type, duration, perpetrators, other life experiences, etc.).

Thus, the number or seriousness of psychological symptoms is not linked directly to the severity of the traumatic event. Moreover, the absence of psychological symptoms or the absence of a specific diagnosis does not mean that the individual did not sustain traumatizing events. A third important notion, is that often there is a combination of symptoms that fall in different categories of disorders. Comorbidities of different disorders are commonly present, for example PTSD and depression are often co-morbid in asylum seekers and at different times one or the other condition may predominate, for example as a result of the presence of different stressors and/or treatment. Similarly there is a spectrum of presentations between PTSD and psychosis, with psychotic features taking on varying prominence over time depending on the circumstances.

Many victims, however, do experience profound emotional reactions and psychological symptoms. Psychological issues among asylum seekers are more common than in the general population.[45] This is often related to sustained traumatic events.[46] Traumatic events often comprise psychological consequences, and contrary to the physical effects of torture, psychological effects may be more persistent and debilitating.

Persecution and serious harm have consequences not only on an individual level, but also on a family level and social/

community level. Torture may traumatize the whole family, particularly if family members are also threatened or ill treated, e.g. in the case of a politically active family member who has escaped from prison. The threatening systems are particularly efficient to cut off family relations, through the fear, guilt and shame they tend to instal.

If the victim continues to live with family members after the traumatic events, the relationship is often deeply disturbed by behavioural problems of the person concerned; the family members have to face stress, fear, worry, feelings of being terrorized, loss of sense of safety as well. This may lead to a profound change of roles within the family, e.g. adults may lose their capacity to provide safety and assume leadership, while children are forced into the parents' roles.

Asylum seekers furthermore experience additional trauma: e.g. the loss of their home, community, country, culture. For adults, these changes contribute to a further disorganization of their lives and themselves. Children may cope more easily with such changes.

Minors
Cognitive, social and emotional development may be affected as a consequence of trauma, e.g. impairment of autobiographic memory, inability to establish trusting relationships and difficulties in expressing emotions. In an early stage of a person's life, stressors tend to cause more psychological distress and influence the development more. Thus, the earlier in a person's lifetime and the more severe and the longer lasting traumatic events are, the more they tend to cause psychological distress and developmental interference.

II.3.2 COMMON PSYCHOLOGICAL RESPONSES TO TRAUMA

The common psychological responses to traumatic events are discussed below. These include the typical observations that can be made during the interview and examination that may point to underlying psychological problems. [47] As mentioned above, there is a significant overlap of PTSD symptoms with depressive and psychotic disorders; differentiation between these may be difficult. Moreover, survivors of trauma often have comorbidities of different disorders.

Often some features of one or more of the below listed symptoms will be present, but the diagnostic criteria will not always be met. This does not always mean that the person in question does not suffer from a disorder. While it is important for professionals of various backgrounds to gain a basic understanding of the symptoms and signs that can be observed, it goes without saying that a diagnosis can only be made by (mental) health professionals.

RE-EXPERIENCING THE TRAUMA

A person who sustained a traumatic event may have flashbacks and/or intrusive memories; these can include elements of the traumatic event in the original or in a symbolic form. While flashbacks are instantaneous fragments of different sensorial experiences (a smell, a visual or acoustic signal) that do not assume the form of an episodic memory and are thus very difficult to reconstruct verbally, intrusive memories assume the form of complex episodes from the past events. Re-experiencing the trauma in one form or another can happen when the person is awake and conscious, or in the form of recurrent nightmares.

Possible diagnosis: Post-traumatic stress disorder (PTSD), psychotic disorders.

Possible observations: Possible observations are various, non-specific, and may vary in intensity. Falls silent, looking away, displaying emotions, crying often, visibly swallowing, choking while talking, turning the head away, keeping the head in hands, displaying anxiety; not in contact, moments of absence, mistrust, scepticism, distress at exposure to cues to the trauma. However, keep in mind that severe emotional or physical distress may have another etiology, for example a panic attack, an episode of acute pain, a seizure, or a cardiac event.

AVOIDANCE AND EMOTIONAL NUMBING

The person may show avoidance of any thought, conversation, activity, place or person that arouses a recollection of the trauma. This is often accompanied by profound emotional constriction, personal detachment and social withdrawal, as well as the inability to recall important aspects of the trauma. These symptoms overlap with PTSD.

Possible diagnosis: PTSD, depressive disorders, psychotic disorders.

Possible observations: No or poor eye contact; applicant remains stuck in (less) relevant details, wants to go through the events quickly, does not answer the questions in a proper way, avoids telling details or tells other things, looks flat, is apathetic, shows little or no emotion.

Cultural aspects: In some non-Western cultures, personal problems are kept more to oneself; the applicant might not want an interpreter of their own tribe/own country, or will not speak out with the 'wrong' interpreter.

HYPERAROUSAL

Hyperarousal is characterized by an excessive alertness of the mind. This state of arousal is an autonomous reaction of the nervous system and is adaptive in situations where actual danger occurs. If this state becomes permanent even after the life-threatening situation (such as torture) is no longer there, it becomes problematic and can cause considerable distress in everyday life. It will cause high levels of stress, resulting for instance in sleeping disorders or other complaints: headache, shortness of breath, sweating, palpitations, dizziness, gastrointestinal distress or even various pain syndromes can be observed as possible consequences. Possibly this may also result in self-destructive behaviour, such as self-harm.

Possible diagnosis: PTSD, panic disorder.

Possible observations: Overreacting when startled, angry outbursts, difficulty concentrating, hypervigilance, irritable or angry, generalized anxiety, sweating, being tense or nervous in attitude and in voice.

NEGATIVE ALTERATIONS IN MOOD OR COGNITIONS

There are many causes for negative feelings and a depressed mood, including trauma. In case of trauma, a change in the mood pattern or emotional responses is observed, in comparison with the behaviour before the traumatic events. The symptoms include anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance or weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, diminished concentration or memory, thoughts of death and dying and suicidal ideation (thought or plans) or attempted suicide.

Possible diagnosis: PTSD, depressive disorder, trait of a personality disorder.

Possible observations: Flat, morose, tired or sulky facial expressions or posture, soft voice, apathy, poor concentration and attention, lack of emotional display, crying, visibly, swallowing, stammering speech, turning away the head, holding the head in hands.

Cultural aspects:
Different cultures regulate talking about feelings and mood in different ways – while in some openness about emotions and feelings is accepted and encouraged, in others it is more restricted; sometimes languages do not even have the associated vocabulary for certain feelings or states of mind.

DAMAGED SELF-CONCEPT AND A SENSE OF FORESHORTENED FUTURE
Torture aims particularly to break self-confidence, which affects the individual's capacity to think and act independently. The victim has a feeling of having been irreparably damaged, and having undergone an irreversible personality change. The person has a sense of foreshortened future without expectation of a career, marriage, children or normal lifespan. This can be accompanied by avoiding social contacts, feelings of worthlessness and excessive guilt.

Possible diagnosis: PTSD, depression, enduring personality change.

Possible observations: Feelings of shame, guilt or low self esteem, expressed in speech or body language.

DISSOCIATION, DEPERSONALIZATION AND ATYPICAL BEHAVIOUR
Dissociation, depersonalization and atypical behaviour are the results of the victim's unconscious capability to react against overwhelming traumatic events, recalls and flashbacks, through a detachment from themself and reality. Confrontation with an overwhelming event from which physical escape is not possible, causes the individual to find an escape from the external environment as well as their internal distress. States of depersonalization and derealization provide striking examples of how consciousness can be altered to accommodate overwhelming experiences, that allows the person to continue functioning under fierce conditions.[48] While being tortured, they may feel no pain or anxiety: 'it was as if it wasn't happening to me'. If such mechanisms occur, the chance of developing post-traumatic disorders is higher and recovery may be difficult.
These states can furthermore lead to the inability to recall important autobiographical information, the experience of loosing touch with reality or detachment with respect to oneself or one's surroundings, numbing, lowered emotional responsiveness, reduction in awareness and feelings of being in a daze.

The defence mechanism may become pathological when the adapted behaviour leads to the physical or mental health of the individual being adversely affected, as is observed with the disruption of orientation, emotional, affective and cognitive functions.
Dissociation is 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 as if observing themself from a distance. Dissociation describes a wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and

emotional experience. The major characteristic of all dissociative phenomena involves a detachment from reality (rather than a loss of reality, as it happens in a psychosis). Early trauma may increase the likelihood of dissociation.
Depersonalization is the feeling of being detached from oneself or one's body.
Atypical behaviour is experienced by the victim with respect to the pre-trauma personality. This can be a result of impulse control problems. For example, a previously cautious individual may engage in high-risk behaviour.

Possible diagnosis: PTSD subtype, with dissociative traits; psychotic disorder; complex PTSD.

Possible observations: Not in contact, moments of absence, unresponsive, angry, not showing emotion, detached way of speaking, the person complains about loss of concentration or memory (as if he was 'not there' when doing something).

SOMATIC COMPLAINTS
Somatic complaints and pain may arise from psychological problems. Physical causes need to be excluded, and when symptoms cannot be accounted for by a medical condition, it is called 'somatization'. For example, pain in an area of the body that was beaten or traumatized in another way, or headache being caused or exacerbated by tension and stress. In particular, head injuries may cause chronic post-traumatic headaches. Furthermore, other physical complaints are possible, as the result of independent recalls by the body of situations of extreme danger, e.g. highly increased heart rhythm, which represents a recollection of a situation in which the victim had to run for their life.

Possible diagnosis: Somatization disorder, PTSD, depression, etc.

Possible observations: Difficulty concentrating, complaining of pain, difficult posture.

Cultural aspects: Western countries have made a division between physical and psychological complaints. In many other cultures, this division is not clearly made. Therefore the applicant may have no words to express psychological issues, and they may use physical symptoms to describe their level of psychological dysfunctioning.

SEXUAL DYSFUNCTION
Sexual dysfunction includes no or poor libido or desire, no physical pleasure, arousal or orgasm, or pain in sexual intercourse. There may be many causes to this phenomenon, and it is common among survivors of torture, particularly, but not exclusively, among those who have suffered sexual violence or torture. Other consequences of sexual violence are a damaged self-image: often victims blame themselves for what happened; they feel worthless and ashamed. Furthermore, sexual violence may lead to risky, self-destructive or reckless behaviour. It is often very difficult to talk about the sexual violence, due to feelings of worthlessness, shame and guilt, and most victims avoid speaking about the acts of sexual violence. Dissociation and anxiety for men (if the perpetrator was male) are also frequent symptoms.

For male victims, the sense of humiliation after sexual violence is often extra deep, and they might also experience a crisis of the sexual identity (i.e. concerns about being homosexual after being raped). They often experience themselves as being weak, not strong enough to defend themselves, rather than as a victim. For men, it is therefore often even more difficult to disclose their experience with sexual violence.

Possible diagnosis: PTSD, depression, enduring personality change, complex trauma.

Possible observations: Complaints about the sex or ethnic group of the interviewer or interpreter.

Cultural aspects: In some cultures, women will suffer expulsion from their own family or by their husbands after being the victim of sexual violence; sometimes they will even receive physical punishment. This enhances shame, guilt and difficult disclosure.

PSYCHOTIC SYMPTOMS

Psychosis is used to describe conditions that affect the mind where there has been some loss of contact with reality. During a psychotic episode, a person's thoughts and perceptions are disturbed, and the individual has difficulty understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behaviour that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleeping disorders, social withdrawal, lack of motivation and difficulty in overall functioning.

Causes of psychotic thoughts or behaviour include bereavement, sleep deprivation, sensory deprivation, substances abuse and stressful events. Delusional thoughts or hallucinations may be normal reactions to extreme circumstances. They may occur, for example, while an individual is detained and experiences sleep deprivation, extreme stress and/or sensory deprivation (e.g. solitary confinement). This may lead to prolonged experiencing of psychotic symptoms that continue after the causes are not present anymore (e.g. after release from prison) and, in extreme cases of violence, permanent dysfunctioning may be induced; the victim might never recover psychologically.

Possible diagnosis: Psychotic disorder, PTSD (subtype with psychotic traits), major depressive disorder, acute stress disorder, substance abuse disorder.

Possible observations: Incoherent speech, abnormal behaviour, anxious behaviour, talking to perceived others in the room, explaining that they see things that the interviewer is unable to see, anger, distrust, unable to understand the interviewer, unable to keep in contact. Note: psychotic symptoms need to be differentiated from dissociation.

Cultural aspects: Before labelling someone as psychotic, the symptoms must be evaluated within the individual's unique cultural context. In cultures where, for example, witchcraft or voodoo are commonly accepted, certain behaviours regarded as bizarre in the Western cultural context may be labelled as normal. Thus, in such cases the person may seem to exhibit psychotic behaviour, where in fact their behaviour ought to be explained by their cultural beliefs (e.g. being influenced by a spirit). The individual may refuse to talk due to belief in the power of others to harm them if they break their oath, or they may express firm belief in the spiritual powers of voodoo. Determining the difference with psychotic symptoms is not always easy. For example, if the individual is afraid of being poisoned or followed, it is important to investigate the possible 'spiritual power' the perpetrator has on its victim.

SUBSTANCE ABUSE

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

These behaviours represent mostly an effort of the victim to self-medication, a sort of anaesthesia.

Possible diagnosis: Substance abuse disorder, PTSD, depression.

Possible observations: Withdrawal symptoms, erratic or violent behaviour, drowsiness, forgetfulness, concentration problems, agitation, restlessness, trembling hands, smell of alcohol or marihuana.

NEUROPSYCHOLOGICAL IMPAIRMENT

Torture may cause physical trauma that leads to various levels of brain impairment. Blows to the head, lack of oxygen to the brain (for example due to suffocation) or prolonged malnutrition may cause short- or long-term neurological and neuropsychological impairment. Symptoms are dependent on the type of injury (diffuse or focal) and the part of the brain that is affected, they may include: fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning. There is significant overlap with the symptomatology arising from PTSD and major depressive disorder and they may also be caused by organic causes (such as dementia). Making this distinction can be difficult, neuropsychological assessment and awareness of problems in cross-cultural validation of neuropsychological instruments are important when such distinctions are made.

Possible diagnosis: Dementia, traumatic brain injury, substance abuse disorders, intellectual developmental disorders.

Possible observations: Poor understanding, incorrect answers, problems in finding the correct words, forgetfulness, poor orientation in space and time, poor concentration, attention and memory, suggestable answers.

Cultural aspects: Illiterate or low-educated asylum seekers may experience difficulties in reading documents and understanding (Western) administrative systems, for example the administrative steps in the asylum procedure, the importance of a chronological and complete report without ample digression; this may be confused with neuropsychological or cognitive impairment.

FEELINGS OF GUILT AND SHAME

Guilt and shame are self-conscious emotions.

Shame is caused by an internal state of inadequacy, unworthiness, dishonour or regret, which others may or may not be aware of. Another person, a failure, circumstance or situation may trigger shame.

Guilt is a cognitive or an emotional experience that occurs when a person believes or realizes, accurately or not, that he or she has compromised his or her own standards of conduct or has violated a universal moral standard and bears significant responsibility for that violation. It is closely related to the concept of remorse.

Given that feelings of guilt and shame may lead to conclusions that the whole self is flawed, bad, or subject to exclusion, it makes a person want to withdraw or hide themself.

Sexual violence particularly brings about feelings of shame and guilt; usually males suffer from this even more than women.

Possible diagnosis: PTSD, depressive disorder.

Possible observations: Avoidant; no or poor eye contact.

Cultural aspects: Events in a non-Western culture could have another impact than expected in Western countries. Subjects of taboos and stigma differ in various countries, as do concepts around victimization: for example, the victim of sexual violence may feel themself as an offender. In some cultures, it is perceived as embarrassing to talk about (mental health) problems.

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 may change the personality include disasters, prolonged captivity with an imminent possibility of being killed, exposure to life-threatening situations, such as being a victim of terrorism, and torture. The diagnosis of an enduring change in personality should be made only 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 themself, associated with inflexible and maladaptive behaviours not present before the traumatic experience. For example, a husband does not recognize his wife anymore, or children may remark that the parents no longer have any patience and become rough, shouting at them.

SPECIFIC REACTIONS TO TRAUMA IN MINORS

Minors have, according to their development, limited capacity to regulate their affect. They still have to develop sufficient skills in emotional regulation and impulse control. This may result in difficulty managing emotional responses in stressful situations, as well as being unable to answer questions. Common mental health problems of minors include PTSD, depression, anxiety, as well as psychosis, self-harm, risk of suicide, delinquency and aggression. Signs and symptoms of these mental problems are shown in their behaviour, rather than in verbal descriptions as in the case of adults. Children may have a troublesome sleep or eating problems or behave very busily and uncontrolled, and they may auto-mutilate. They may behave withdrawn and appear unemotional. Adolescents are more likely than adults to act impulsively, sometimes in combination with antisocial behaviour and the possible use of alcohol and drugs.

When minors have experienced disrupted attachment to parents or caregivers, their ability to trust, or relate to others, may be severely impaired. This may give problems in disclosing aspects of their story, or they may provide different information to different people.

Minors may believe that disclosure of their experiences would bring shame to their family. Loyalty toward parents and family may hamper full disclosure.

II.3.3 DIAGNOSTIC CLASSIFICATIONS

In psychology and psychiatry, clusters of symptoms will result in a disorder or diagnosis according the international standard of diagnostic classification, the DSM-V.[49] Again, not everyone who has sustained traumatic events develops a diagnosable mental illness. Many will have some features of one or more disorders but will not fulfil all the diagnostic criteria. The absence of a specific diagnosis does by no means indicate that the events did not take place.

Below, the common types of disorders and diagnosis associated with traumatic experiences are discussed. Comorbidity of disorders (multiple disorders at the same time) is a regular occurrence rather than an exception.

PTSD
Several criteria need to be met before the diagnosis of PTSD can be made. These criteria are: exposure to a traumatic event, persistently re-experiencing the event(s), avoidance of trauma-related stimuli and negative thoughts or feelings, as well as trauma-related arousal and reactivity. The symptoms must be present for more than 1 month, and the disturbance must cause significant distress or impairment in functioning and is not caused by medication, substance abuse or other illness.

The definition of PTSD relies heavily on the presence of memory disturbances in relation to the trauma, such as intrusive memories, nightmares and the inability to recall important aspects of the trauma. The individual may be unable to recall central details of the torture events but will be able to recall the major themes of the torture experiences.

Differential diagnoses
Acute stress disorder develops after exposure to one or more traumatic events and lasts for at least 3 days. It has essentially the same symptoms as PTSD but is diagnosed within 1 month of exposure to the traumatic event.

Subtypes
- Chronic: if the duration of symptoms is 3 months or more.
- Late onset: if the onset of the symptoms is at least 6 months after the extreme stress.
- Cumulative PTSD: the result of multiple serious stress-related experiences.
- Complex PTSD: similar to PTSD, but it distorts a person's core identity, especially when prolonged trauma occurs during childhood development.

DEPRESSIVE DISORDERS
Depressive states are frequently observed among survivors of torture. They may be a consequence of the breaking-down of self-esteem. To make this diagnosis, the symptoms must cause significant distress or impaired social or occupational functioning. Some of the most important symptoms are: depressed mood; markedly diminished interest or pleasure in all or almost all activities; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate; and recurrent thoughts of death or suicide.

Subtypes
Major depressive disorder, single episode or major depressive disorder and recurrent depressive disorder (more than one episode).

COMPLICATED BEREAVEMENT

Complicated bereavement can be diagnosed if the individual's ability to resume normal activities and responsibilities is continually disrupted if bereavement lasts longer than 6 months. Symptoms may be maladaptive thoughts and behaviours, continuous emotional dysregulation, social isolation and suicidal ideation. This may occur after exposure to trauma in which a significant loss was sustained.

ADJUSTMENT DISORDERS

Adjustment disorders are states of distress and emotional disturbance that arise in the period of adaptation to a significant life change or stressful life event. Stressors include those that affect the integrity of an individual's social network (e.g. bereavement, separation) or the wider system of social supports and values (e.g. migration, leaving the armed forces), or represent a major developmental transition or crisis (e.g. retirement). Manifestations vary and include depressed mood, anxiety or worry, a feeling of inability to cope, plan ahead or continue in the present situation, as well as some degree of disability in the performance of daily routine. Conduct problems may also occur.

SUBSTANCE USE DISORDER

The DSM-V recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: alcohol, caffeine, cannabis, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco, and other or unknown substances.

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

- Taking the substance in larger amounts or for longer than is meant to.
- Wanting to cut down or stop using the substance but not managing to do so.
- Spending a lot of time getting, using or recovering from the substance.
- Cravings and urges.
- Not managing to do what should be done (work, home or school).
- Continuing to use the substance, even when this causes problems in relationships.
- Giving up important social, occupational or recreational activities.
- Using again and again, even when this puts them in danger.
- Continuing even when this causes or worsens physical or psychological problems.
- Needing more to get the wanted effect (tolerance).
- Development of withdrawal symptoms.

As time passes, persons may need larger doses of the alcohol or drug to get high. Soon the person may need the drug just to feel good. As the drug use increases, they may find that it is increasingly difficult to go without the drug. Attempts to stop drug use may cause intense cravings and make the person feel physically ill (withdrawal symptoms). Possible indications are problems at school or work, changes in behaviour, neglected appearance or lack of energy of motivation.

DISSOCIATIVE DISORDERS
Symptoms include disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour. Dissociative symptoms potentially disrupt every area of psychological functioning. Varieties of these disorders include dissociative identity disorder, dissociative amnesia (gaps in recall, often related to traumatic events) and depersonalization/derealization disorder, as well as other specified and unspecified dissociative disorders. Dissociation may be a symptom of PTSD, or a separate diagnosis if not all PTSD criteria are met, such as avoidance of trauma-related stimuli or hyper-arousal.

PSYCHOTIC DISORDERS
Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against them or that the TV is sending them secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. The psychotic disorders may vary in gravity and duration. The brief psychotic disorder has most in common with PTSD. It is triggered by extreme stress, such as a traumatic accident or loss of a loved one and it is followed by a return to the previous level of functioning. The person may or may not be aware of the strange behaviour.

NEUROCOGNITIVE IMPAIRMENT
Neurocognitive symptoms include memory loss, concentration and attention deficits, problems with learning and language, etc. One of the causes is traumatic brain injury due to the sustained traumatic events (e.g. head trauma or lack of oxygen due to asphyxiation or pharmacological substances). These traumatic events might also trigger symptoms of PTSD, including cognitive impairment, and these need to be differentiated. There are, besides trauma, multiple alternative, medical causes such as Alzheimer's disease, vascular disease, substance, medication use, etc.

ANXIETY DISORDERS
Generalized anxiety disorder
Excessive anxiety and worry about a variety of different events or activity. Symptoms include increased autonomic activity and physical tension.

Panic disorder
Recurrent and unexpected attacks of intense fear or discomfort, including symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes.

Phobias
Conditions such as social phobia and agoraphobia are extensions of the effects of terror and represent defence reactions of the victim in order to avoid further violence.

Obsessive-compulsive disorder
Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e. by performing a compulsion).

Somatization disorders
Recurring, multiple clinically significant complaints about physical symptoms that cannot be accounted for by a medical condition.

OTHER DIAGNOSIS
Below mentioned diagnosis are not specific to trauma but might be exacerbated or serve as a differential diagnosis to trauma specific diagnosis.

Bipolar disorder
This disorder features manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas (abrupt leaps from one topic to another) and psychomotor agitation (restlessness, unintentional and purposeless motions); associated psychotic phenomena may be triggered or exacerbated by trauma.

Personality disorder
A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Prolonged exposure to trauma can result in emotion dysregulation, problems with stable interpersonal relationships, and dissociative symptoms; this should be differentiated from a personality disorder (like a borderline personality disorder for example).

II.4 SPECIFIC ACTS OF PERSECUTION AND SERIOUS HARM

II.4.1 DEFINITIONS

In chapter I.2, the legal definition of 'persecution and serious harm' was presented. A wide variety of abusive acts fall under this definition. When such acts cause (temporary or permanent) physical or psychological trauma, they fall within the realm of the medico-legal report (MLR).

'Torture or inhuman or degrading treatment or punishment' is one of the most important classes of acts of persecution and serious harm,[50] and it is the underlying reason for a substantial portion of the asylum applications within the EU. This term was coined by the UN in 1984.[51] Torture is one of the most traumatic and destructive human experiences possible. Its purpose is to deliberately destroy the physical and emotional well-being of individuals, and even, in some instances, the dignity and will of entire communities.[52] The aim of torturers may be not only to break the person and their family (often, by using one against the other), but also to intimidate third parties by means of fear, inhibition or conformity. Torture may be an attack on the entire community and opens the possibility to terrorize the entire population, as well as create a state of general insecurity and lack of confidence and breaking off social bounds. Torture may also have long-lasting effects on the different forms of collective behaviour.

This chapter is focused largely on these acts of torture, as it may be expected that many of the target audience, living in the relatively safe environment of the European society, are not fully acquainted with the cruelties the human race is capable of. It follows the enumeration of such acts in the Istanbul Protocol, supplemented with other relevant sources and expertise developed by the organizations responsible for this manual.

The enumeration is divided in physical and psychological acts, supplemented with a description of acts of sexual violence as this is a very common form of violence.[53] Yet, one must be aware that almost all forms of violence involve both physical and psychological acts and consequences, directly and indirectly, in any conceivable combination. The division used in this section and elsewhere is, therefore, only an aid to structuring the subject matter [54] and must not be attributed any additional significance.

The acts mentioned below are merely examples, rather than a definitive list, as forms of physical, psychological and sexual violence depend strongly on context; they are invented, developed, reinvented and tailored continuously to their specific circumstances, aims and victims.[55]

II.4.2 PHYSICAL FORMS OF VIOLENCE/ TORTURE

BEATINGS AND OTHER FORMS OF BLUNT TRAUMA (Istanbul Protocol § 189–202)
Beating is a common form of violence and the most common form of physical torture. When the aim is to disguise its effects, beating may be performed with heavy, flexible implements such as sandbags or lead-filled plastic pipes, which may leave short-lived bruising, but no permanent scarring.

BEATINGS TO THE FEET (Istanbul Protocol § 203–205)
Falanga, also referred to as falaka or bastinado, can be defined as the repetitive application of blunt trauma to the soles of the feet. It may be applied by batons, whips or canes to the bare feet or with shoes still on, and the effect will depend on these variables.

SUSPENSION (Istanbul Protocol § 206–209)
Suspension is a common form of torture, that can produce extreme pain and damage to the nerves and joints. One example of such damage is peripheral neurological deficits caused by brachial plexus injury (the nerves running from the spine to the arm). [56] Examples of suspension include:

- Cross suspension or 'crucifixion'. Applied by spreading the arms and tying them to a horizontal bar.
- Butchery suspension. Applied by fixation of hands upwards, either together or one by one.
- Reverse butchery suspension. Applied by fixation of the feet upward and the head downward.
- 'Palestinian' suspension. Applied by suspending the victim with the wrists or forearms bound together behind the back and tied to a horizontal bar or rope.
- 'Parrot perch' suspension. Applied by suspending a victim by the flexed knees from a bar passed below the popliteal region, usually while the wrists are tied to the ankles.

POSITIONAL (Istanbul Protocol § 210 and 211)
This involves prolonged constraint of movement, forced positioning, ligatures or handcuffing. There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels.

ELECTRIC SHOCK (Istanbul Protocol § 212)
Electric shocks have been used commonly by torturers because they cause excruciating pain but rarely leave identifiable physical signs. The equipment can be as basic as the magneto of an old military field telephone, or a couple of bare wires in an electrical socket, to complex stun guns. Often water is thrown over the victim to reduce the electrical resistance of the skin and to increase the effect of the shocks.

ASPHYXIATION (Istanbul Protocol § 214)
Asphyxia or asphyxiation is a condition of severely deficient supply of oxygen to the body as a result of abnormal breathing. Ways of inducing asphyxia to near-death include:

- *Near drowning or submarino* – the head is immersed in water for minutes at a time to the point of drowning, then brought out and immersed again.
- *A variant of submarino* – a plastic bag or similar impervious material filled with liquid is tied over the head. In all these techniques, the water is often contaminated with sewage or chemicals, adding to the immediate distress and increasing the likelihood of permanent ill effects.
- *'Waterboarding'* – victims are strapped to a board or made to lie in a supine position with their heads lower than the rest of their bodies and their faces covered with cloth; water is poured over their mouths to create the sensation of drowning.

- *Dry submarino* – a plastic bag or similar impervious material is placed over the head and tied tightly around the neck. Again, there is often contaminated material or an irritant such as chilli powder inside the bag.

INFLICTION OF OTHER WOUNDS OR INJURIES

- Crushing and stretching.
- Burning (cigarette burns, or burns with other instruments or substances, acid or caustic).
- Violent shaking.
- Cutting, stabbing.
- Whipping, kicking.
- Dragging along the ground.
- Gunshots.

SPECIFIC LOCATIONS

- *Head:* trauma to the head can lead to loss of consciousness and brain damage.
- *Dental* (Istanbul Protocol § 213): breaking or extracting teeth or through application of electrical current to the teeth.
- *Ear trauma* (Istanbul Protocol § 179): especially rupture of the tympanic membrane (eardrum); this is a frequent consequence of harsh beatings or loud sounds such as explosions.
- *Eye trauma* (Istanbul Protocol § 179): common, either incidental to general beating about the head or elsewhere intentionally sought.

II.4.3 PSYCHOLOGICAL FORMS OF VIOLENCE/ TORTURE [57]

DEPRIVATION

- *Social deprivation:*
  - Restriction/coercion of physical space (e.g. prison, psychiatric institutes).
  - Restriction of relationship with relatives/ friends.
  - Coercion of learning, work, cultural, political or religious activities.
- *Psychological debilitation:*
  - Deprivation of food, water, clothes.
  - Deprivation of sleep, the disruption of sleep cycles.
  - Prolonged standing, crouching, or kneeling, forced physical exertion.
  - Exposure to temperatures leading to stifling or hypothermia.
- *Sensory manipulation:*
  - Hooding, blindfolding, cell without windows, restricting movement, use of cuffs, etc.
  - Overstimulation with monotonous noises and lights.
- *Perceptual deprivation:*
  - Restriction of communication with other persons and the outside world; restriction on receiving letters, books, phone calls or media use.
  - R*estriction of the victim's orientation in space:* confinement in small places; small, darkened or otherwise non functional windows.
  - Restriction of the victim's orientation in time: denial of natural light; night-time recreation time; erratic scheduling of meals, showers, or otherwise regular activities.
- *Hygienic, medical care deprivation:*
  - Non-hygienic circumstances, ineffective protection against heat, cold, humidity, microorganisms, insects or dangerous animals.
  - Deprivation from medical care or subjection to incorrect, harmful medical practices.

- *Pharmacological abuse:*
– Toxic doses of sedatives, neuroleptics, paralytics, hallucinogenics, etc.

COERCION

- *Impossible decision situations, non-congruent acts:*
– Signing falsified statements.
– Watching torture without the possibility to intervene.
– Forced to witness torture or atrocities being inflicted on others.
– Forced breach of religious or cultural prohibitions or taboos such as dietary codes.
- *Humiliation:*
– Crawling.
– Belittling, insulting.
- *Induced Desperation:*
– Arbitrary arrest; indefinite detention; random punishment or reward; forced feeding; implanting sense of guilt, abandonment, or 'learned helplessness'.
- *Threats:*
– Towards the victims or their loved ones.
– Threat to the victims' physical/mental integrity or life.
– Misinformation.
– Mock executions and mock amputations.
- *Being forced to obey rules and commands.*

II.4.4 SEXUAL VIOLENCE, GENDER-BASED VIOLENCE AND SEXUAL TORTURE
(Istanbul Protocol § 215–232)

Sexual violence, as defined by the World Health Organization, is any sexual act, attempt to obtain a sexual act or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

Gender-based violence includes those acts that are likely to result in sexual or mental harm or suffering to people based on gender, including threats, coercion and arbitrary deprivation of liberty. Examples include:

- Intimate partner violence.
- Sexual coercion.
- Childhood sexual abuse.
- Rape (in conflict situations).
- Trafficking/forced prostitution.
- Forced marriage.
- Female genital mutilation/female genital cutting.
- Honour killings.
- Virginity testing.
- Dowry deaths.[58]

Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations: an individual is never as vulnerable and helpless as when naked. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse, rape or sodomy. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects, all part and parcel of the procedure.

The groping of women is traumatic in all cases and is considered to be torture.[59] Different forms include:

- Forced nudity.
- Verbal sexual threats, abuse and mocking.
- Sexual humiliation.
- Forced sexual acts on themselves, on/with others or on/with animals.
- Object inserted into the vagina, penis or anus.
- Penis forced into the mouth, anus or vagina.
- Other forms of violence – penile traction, beating of testes, etc.

Throughout history, sexual harassment of women has been a weapon of war and power. In many countries, acts of sexual violence are a common method of torture or inhuman treatment inflicted on women. It is found that female victims of torture are raped more often than men, although men are also frequently subjected to rape. Gender-based and sexual violence inflicted on refugees is frequently a hidden problem.

This kind of violence might have taken place during a conflict, as it is frequently used as 'a weapon of war' to terrorize and undermine communities. Many people hide the trauma they have suffered, and parties to a conflict often try to manipulate or conceal evidence of torture and rape. [60]

Furthermore, en route to Europe and due to human trafficking, there is the risk of forced labour or prostitution. [61]

It must be emphasized that gender-based violence and rape may be only one among many traumas that women have suffered, and that physical consequences are often accompanied by psychological and social consequences; it induces shame and cultural stigma, as well as loss of family and community bonds.

Sexual violence in general and rape in particular are related closely to the exercise of domination and the subjugation of both female and male victims.[62]

See appendix 1 for the medical effects and investigation methods of specific acts of violence.

II.5. RECOUNTING THE HISTORY

II.5.1 INTRODUCTION

Applicants have inherent challenges in recounting their history. There are many factors that play a role (see box 1). In recording the information by the health professional or immigration officer, misinterpretations may also happen, e.g. due to assumptions about the contextual circumstances, culture, gender roles or responses to risk.

BOX 1. FACTORS THAT MAY CAUSE DIFFICULTIES IN RECOUNTING THE HISTORY:

- Conditions during the experience itself (e.g. blindfolding, drugging, lapses of consciousness, disorientation in time and place during torture).
- Psychological impact of torture (e,g. PTSD-related memory disturbances, concentration difficulties; denial, avoidance; confusion, dissociation, amnesia).
- Neuropsychiatric cognitive impairment due to head injury, asphyxiation, etc.
- Emotional/cultural factors (feeling of guilt, shame, fear of stigmatization).
- Interview conditions or communicational barriers (lack of trust, lack of feeling safe, lack of privacy, inadequate time, pain, interview techniques, communication through an interpreter).

II.5.2 FACTORS THAT INFLUENCE THE ABILITY TO RECOUNT THE HISTORY

Communication
As the way in which someone is questioned affects in part the coherence of the answers, the way in which asylum seekers are interviewed plays a role in the outcome of the interview. The interview technique, circumstances, environment and attitude of the attendees (interviewer, interpreter and other[s]), the reaction to display of emotions and the use of open, closed or suggestive questions all influence the ability to recount the history. Additionally, it is important to emphasize that asylum interviews – and evoking traumatic memories there – may have a retraumatizing effect on victims.

Free recollection is where open questions are asked and no cues are given; a person can speak freely about their experiences. This usually means that fewer details will be remembered.

In cued recollection, closed questions containing suggestions as to the target information are used. This may trigger more detailed recollection than open questions. However, this may have a negative effect on the accuracy of the recollection, provoking falsely 'remembered' details ('suggestive questioning'). It has been shown that closed questions may cause shifting responses under repeated questioning, while open-ended questions do not impair accuracy.

Furthermore, working with an interpreter may cause interference – the process by which information is distorted or a different meaning is given to information through translation.

Cognitive functioning
Cognition is defined as 'the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses'. [63] It encompasses processes such as knowledge, attention, concentration, short-term memory and long-term memory, judgement and evaluation, reasoning and computation, problem-solving and decision-making, comprehension and production of language, etc. Human cognition is conscious and unconscious, concrete or abstract, as well as intuitive (such as knowledge of a language) and conceptual (such as a model of a language). Cognitive processes use existing knowledge and generate new knowledge. Cognitive capacities influence the way memories are encoded, stored and recalled.

Trauma to the head, a lack of oxygen to the brain for a sustained period of time or a lack of nutrition may lead to permanent or temporary cognitive impairment. [64]
Examples of such trauma include beatings to the head, asphyxia, starvation and intoxications.[65]

Furthermore, (medical) conditions at the time of interview may play a great role in the ability of the applicant to concentrate and recount the history. Examples of these include use of medication, alcohol or drugs, general illness, degenerative brain disease (dementia), sleep loss, chronic pain, insufficient food intake and general weakness.

Intelligence, educational level and age also determine the level of cognitive functioning.

The amount of schooling and the quality of the education influence the cognitive development of the individual. Some asylum seekers may have had limited access to education. A lack of education does not necessarily mean that a person is not intelligent or has poor mental functioning. Both intelligence and educational level play a role in the ability to recount the history and, for example, whether dates or

numbers will be recounted. It may in some cases be difficult for the examiner to distinguish between lack of education/low intelligence or fabrication. A medical examination and specific psychological assessment may be useful in such cases.

Memory of traumatic events
Autobiographical memory is the basis to recall past events. However, the biological, socio-cultural and psychological processes related to traumatization may obstruct the encoding and storing of traumatic events and the 'consultation' of the autobiographical memory.

Under severe stress, storing of information from the experiences will be diminished. Memories of traumatic events may therefore be incomplete and deformed by omissions. When experiencing a traumatic event, the attention narrows down its focus on the most important – that is, most threatening – element, which then becomes of central importance. The phenomenon 'boundary restriction' refers to the failure to remember information that is on the visual or acoustic periphery of the shocking image or event, such as features of uniforms, number of people present during torture and duration of the traumatic event. This is a direct consequence of such a narrowly focused processing of information surrounding the individual.

In the registration of traumatic events, some 'central' details are therefore more likely to be remembered than others, the 'peripheral details'.[66] The distinction between central and peripheral details, however, is complex. What is central and what is peripheral is different for each person and their experience, as well as in each individual context. As a generalization, central details (i.e. details central to the narrative or emotional gist of the event) make up the core of the story. Peripheral details (dates, number of people, etc.) are less fundamental. Yet, torture victims often develop PTSD, one of the symptoms of which is the inability to recall central details (see Chapter II.3.3). Thus, the distinction between central and peripheral details is of little to no use to determine which details of the traumatic event a victim ought to remember. Also see Box 2.

Memory of traumatic events may entail everything from complete amnesia (e.g. due to avoidance) to intrusive and distressing recollection and reliving the experience. [67]

Examples include:
- Intrusive memories of the traumatic experience in the form of flashbacks, nightmares or reliving the experience in another way.
- A decrease in recollection of neutral information, e.g. the circumstances of torture, peripheral details of the location or other details.
- Fragmentation and partial or total amnesia of the trauma-related information.
- Transposition of 'hotspot' memories (moments of peak emotional distress).

At the level of the implicit, non-verbal accessible memory, it appears that trauma-related information remains strongly locked in one's memory. Trauma is stored in the so-called 'limbic system', which processes emotions and sensations (but not language or speech). This means that traumatized persons may well keep implicit memories of the traumatic experiences (e.g. the fear or terror they felt while being tortured or detained), but not of the exact way their feelings were caused. This may lead to an extreme response (hyperactivity, hypersensitivity) to certain events that resemble the traumatic experience.

BOX 2. FUNCTIONING OF THE MEMORY

Hypotheses about memory have been widely tested, and a number of different models have been proposed to explain the observed phenomena of everyday memory. Full understanding has not been achieved yet.[68] It is, however, known that memory is not a collection of facts. It is reconstructed continuously in order to use it as a tool to live one's life. In time, memories are subject to change; they may improve, deform or deteriorate.[69]

The short-term or working memory deals with the recollection of information after seconds to a minute. Long-term memory will lead to storage of information for up to a whole lifetime.

The limbic system, the structure in the brain that also deals with emotions, is essential in memory. The hippocampus, a part of the limbic system, is essential in consolidating information from short-term to long-term memory.

There are different stages in the creation of a memory: registration and storage of the event or the information, and retrieval at the moment of recollection. All these stages can be influenced or distorted. It is known that the memory is strongly selective: the content changes continuously and is distorted naturally by several factors.[70]
Retrieval requires reconstruction of the memory from units, some may drop out and others may be inserted, hence the recollection may vary somewhat in detail each time the memory is brought up. Memory also tends to deteriorate and become less accurate over time; it is particularly unreliable for dates and times.[71]

Emotions[72]
Emotions play a large role in what information is encoded, stored and labelled, and what is being recalled. High levels of emotion may impair storing of any memory, not just traumatic memories. Moreover, while experiencing levels of emotions or stress, the ability to retrieve information is reduced accordingly.

Defence mechanisms
A defence mechanism is an unconscious psychological mechanism that reduces anxiety arising from unacceptable or potentially harmful stimuli.[73] Defence mechanisms are psychological strategies, brought into play by the unconscious mind. Their purpose is to manipulate, deny or distort reality, in order to defend against feelings of anxiety and unacceptable impulses that threaten one's self-schema. The unconscious strategies to forget painful memories may need to be adopted for the victim to be able to survive or function in daily life. Relevant memories may be blocked for a longer period of time for this reason.

Symptoms of Post-Traumatic Stress Disorder (PTSD)
Symptoms related to PTSD (avoidance, shame, negative thoughts or feelings and dissociation) lead to difficulty in disclosing, especially where there is a history of sexual violence.[74]

Depressive symptoms [75]
Depressive symptoms may be part of the PTSD spectrum or an independent diagnosis. Reduced memory capacity is one of the most frequent and neuropsychologically well-investigated symptoms of depression.

Effects of sexual violence [76]
It is common that women as well as men who experienced sexual violence are unable to disclose the traumatic events they experienced. The setting of the interview and the gender and attitude of the interviewer and the interpreter play a particular role.
Cultural background influences the amount of shame and guilt that is experienced in some cultures. Sexual violence excludes victims socially. This fear of social stigma leads usually to great reluctance to disclose. Due to the especially traumatizing nature of this type of violence, dissociation, reliving memories, avoidance and not remembering details often play a significant role. It is necessary to specifically ask the applicant whether a male or female interviewer/examiner or interpreter is required.

Age
There are specific considerations in working with minors. Disruption of personal ties, such as with parents, or exposure to interpersonal trauma may especially affect their ability to trust others. Also shame or guilt about what a child has done or experienced or their sense of duty or loyalty to their family may play a role. Childhood trauma may lead to parentification: the child taking over the role as a parent and, through caring for their parent(s), neglect their own feelings and emotions. All these factors may make disclosing information more difficult for a child.

Culture
Culture highly influences what is perceived as normal or adequate behaviour, what information is received (e.g. women and children might not be told certain information to protect them) and who is to be trusted. For legal workers, as well as interpreters and health professionals, it is important to have a non-judgemental attitude towards what the applicant is recounting and allow for the individual to explain if things are unclear.

Cultural belief systems may lead to the possibility of 'intuitively' rejecting certain accounts, based on personal assumptions, preconceptions, conjecture, speculation and stereotyping. [77]

If the interpreter is of a different ethnic group than the applicant, this may lead to mistrust and play a negative role in disclosing information. It is important to check this with the applicant, keeping in mind that this check is done via the interpreter, and that therefore a catch-22 situation may arise.

II.5.3 MEDICAL EXAMINATION

The physical and psychological examination will give insight in the aforementioned cultural, emotional, psychological and neuropsychiatric processes affecting the ability of the applicant to recount the history. This is information that the health professional needs, in order to establish a correlation of the history with the medical signs and symptoms.

The factors influencing the applicant's account as discussed above are to be distinguished from indications of fabrication and/or exaggeration of the history.[78] If there is a suspicion that the story is (partly) made up or exaggerated, and this cannot be (completely) attributed to the aforementioned factors, it may be useful to apply the different credibility indicators that are being used by the legal workers in their 'credibility assessment': detail and specificity, coherence, consistency and/or plausibility.

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41 *Istanbul Protocol § 184.*

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50 *As was mentioned in Chapter I, the scope of the term 'persecution and serious harm' within the context of the EU asylum system is wider than that of the term 'torture, cruel, inhumane or degrading treatment and punishment' within the context of the Istanbul Protocol.*

51 *1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment:*
'For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed,

or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.' The concept has been since developed in different legislative instruments and legal cases worldwide, resulting in slight variations in scope.

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III. > MEDICAL EXAMINATION AND THE MLR

III.1. INTRODUCTION

How to perform a medical examination and write an MLR are indicated in this chapter..

It is mandatory that health professionals are sufficiently equipped to perform a medical examination on traumatized individuals. This includes knowledge of the specific injuries caused by acts of violence, how to perform a physical and psychological examination and how to establish the correlation between medical signs and symptoms and the alleged events. The overall goal is to deliver an objective expert evaluation.

This chapter is aimed at health professionals.

LEARNING OBJECTIVES:

General principles:
- Cultural sensitivity, informed consent, ethics, etc.
- How to ensure a safe and comfortable setting.
- Working with translators.

Preparation:
- How to prepare an examination.

Interview:
- Ability to apply different interview techniques.

Physical:
- How to perform a medical examination.
- Knowledge of the physical consequences of specific types of violence.
- How to establish the correlation of physical signs and symptoms with the alleged acts of persecution or serious harm.

Psychological:
- How to perform a psychological examination.
- What tests can be used.
- How to establish the correlation of psychological signs and symptoms with the alleged acts of persecution or serious harm.

Guideline health professionals:
- Ability to use the guideline.

Reading material:

Istanbul Protocol (Office of the United Nations High Commissioner for Human Rights. Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations, 2004.)

International Rehabilitation Council for Torture Victims (IRCT), Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment. Copenhagen: IRCT, 2009.

Physicians for Human Rights (PHR), Examining asylum seekers. *A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment.* Second edition. United States of America: PHR, 2012. http://physiciansforhumanrights.org

III.2. GENERAL CONSIDERATIONS

The factors that need to be considered when performing a medical examination are discussed below. These factors influence how well the applicant is able to disclose information, and help to prevent retraumatization.

The examination must be structured so as to minimize the risk of retraumatization. Two important elements should be balanced: the need to obtain a useful, detailed account, and the well-being of the applicant. Whether or not certain questions can be asked safely will vary considerably and will depend on the degree of confidentiality and security that can be assured.

Any inadequacy of the examination setting should be noted in the report, and notice thereof shall be given to medical authorities or state authorities, if indicated.

The physical and psychological health of the asylum seeker
The applicant should be in reasonably good health to undergo a medical examination. Cognitive capacities, such as memory and concentration, are greatly influenced by physical and mental well-being. If necessary, refer the applicant to treatment first and schedule the examination later. Mental capacity shall be specifically considered in this examination and advice shall be given on whether or not the person can be expected to gain sufficient capacity to take part in their asylum process after treatment.

Privacy, safety and security (Istanbul Protocol § 83, 91, 93, 124, 126, 129, 239 and 264)
Necessary precautions and safeguards should be taken to ensure the safety and security of both the applicant and the examiner, especially in a detention setting.

Adequate and comfortable setting
There should be adequate and comfortable conditions, with enough light, space and ventilation, as well as availability of food, water and sanitation. Sufficient equipment for medical examinations should be at hand.

Presence of others (Istanbul Protocol § 125).
Government officials, police officers or other state authorities, security forces and law enforcement officials in particular should not be present.

Having partners or children present may prevent disclosure of sensitive information, due to shame and other cultural factors. On the other hand, the presence of a person who the applicant trusts may improve the feeling of safety and increase the ability to talk about traumatic events. This should be carefully evaluated. A possibility is to perform parts of the examination with the presence of others and other parts without.

If any other persons are present in the interview room during the interview, the identity, titles and affiliations of these should be indicated in the report

Language barriers/ interpreter
Ideally, the interpreter should be a professional interpreter who has experience in working with asylum seekers. Having a non-professional interpreter can specifically inhibit sensitive disclosures. Although it may sometimes be unavoidable, it is not recommended to use an interpreter from the applicant's own family or social group.

When using an interpreter, the interviewer should remember to talk to the applicant and to maintain eye contact, even if the applicant has a natural tendency to speak to the interpreter. To ensure this, using a triangular set-up of chairs

is helpful, with the examiner directly facing the applicant.

The medical examiner should be aware of interference – the process by which information is distorted or a different meaning is given to information through translation. For example, by asking the meaning in a different wording if there seems to be a misunderstanding.

Gender
Trust and the ability to talk about the traumatic events (especially when this involves sexual violence) can depend on the sex of the interpreter, examiner or immigration officer. Women should be offered a medical examination by an all-female staff, and men should be offered a choice between male or female staff members. This will make it easier for women to express their preference, if they come from a culture where they have not been empowered to do so.

Time
There should be sufficient time for the examination and breaks, and the examiner should be sensitive to the level of exhaustion. It may be necessary to spread the examination over several days.

Examination in detention (Istanbul Protocol § 66, 67, 123, 124, 125)
The examination in detention should take place in private. Police or other law enforcement officials should not be present. The setting should be as comfortable and safe as possible. Medical doctors must ensure that any person in custody has access to any medical examination and treatment required.

Do no harm
Do no harm – the first principle of the ethics code for health professionals – may sometimes take paradoxical forms, as happens when there is a risk of retraumatizing the asylum seeker. It is essential to realize that only careful individual examination makes it possible to respect this principle. An assessment needs to be made by the examiner of whether and to what extent pressing for details is necessary for the effectiveness of the report, considering the well-being of the applicant. This applies especially, if the asylum seeker demonstrates significant signs of distress, dissociation or uncontrolled weeping, or fatigue.

Confidentiality and informed consent (Istanbul Protocol § 149, 165) [79]
Clinicians have a duty to maintain confidentiality of information and to disclose information only with the applicant's informed consent. Informed consent should be obtained, based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical examination; it should be given voluntarily, without coercion by others. The understanding should include the nature of the process, the purpose of the examination, confidentiality, its limits and the legal obligations for disclosure of the information (i.e. how the information will be used and possible consequences).

Note: if a person discloses information that they do not wish their family to find out, it is important that the examiner explains that this information can be included in the report while being kept confidential, e.g. by adding an explanation to the lawyer not to discuss these matters with family members, and that copies of the report and subsequent decision are not sent to the person's home.[80]

The applicant has the right to refuse to cooperate with all or part of the interview and/or evaluation. In such circumstances, the clinician should document this, as well as the reason for

refusal of the interview and/or evaluation and record, if given, and whether there are signs of anxiety or visible lesions. If the applicant is a detainee, the report should be signed by their lawyer and another health official.
Additional consent should be obtained for photographs and genital examination.

Establish trust and rapport (attitude/empathy) (Istanbul Protocol § 129, 164)
The establishment of an effective and trustful relationship is crucial for a complete and adequate history and examination. Creating a climate of trust requires active listening, meticulous communication, courtesy, genuine empathy and honesty.[81]

Empathy opens the way to a real exchange and thus to a mutual understanding. It requires experience of the medical examiner, as the necessity of showing empathy is combined with the indispensable objectivity and impartiality of a medico-legal report (MLR). The clinician needs to be sensitive and empathic in their questioning, while remaining objective in their clinical assessment.

Intercultural competence
Intercultural competence is the ability to effectively communicate and interact with others who have a different cultural, ethnic or social background.[82] Culture is a complex system of values, symbols, rules and categories that are acquired as a member of multiple groups. Cultural sensitivity or competence includes being aware of how culture influences how we think and behave. This requires knowledge, certain attitudes, mastery of interpersonal skills and experience; it is not acquired at once but over a period of learning and practice.

Important aspects include:
- Communication style – both verbal and non-verbal: directness, emotional expressiveness, body language.
- Interpretation of information; this is influenced by ideas (e.g. stereotypes and prejudices), relationship to power, gender-related concepts, etc.

Transference, countertransference or 'resonance' (Istanbul Protocol § 265)
It is important to be aware of the reciprocal feelings that the narration may provoke. This is generally referred to as 'transference', 'countertransference' and 'resonance'.

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

Countertransference, or resonance, is the clinician's emotional response to the torture survivor. It is an important means of understanding the applicant through what their behaviour evokes in the examiner. This may be useful, as it may produce information about the mental state of the applicant. On the other hand, the examiner may misinterpret some attitudes of the applicant, who undergoes dissociative moments, falsely considering these absences as reactions to the examiner. Identification and managing of these processes depends much on the experience of the interviewer.

III.3. MEDICAL EXAMINATION

All investigation and evaluation of persecution and serious harm should preferably include a detailed physical as well as psychological evaluation. All examinations should at least include a psychological examination; the often extreme nature of persecution and serious harm causes a wide range of psychological and mental problems. Physical signs and symptoms are not always present: torture methods are often designed not to leave physical lesions, and lesions heal and become less visible over time. The psychological symptoms of violence and torture are more prevalent and persistent than physical signs and symptoms.

The aim is to perform a medical examination in approximately 4 hours: more or less 2 hours for a psychological examination and 2 hours for a physical examination. Obviously the time required will depend on the situation and type of problems; more time or a second appointment might be needed in some instances. For example when the applicant has great difficulty in relating the history, when there are extensive psychological problems (and psychological tests are needed) or when there are numerous skin lesions and/or other physical complaints.

The following should be available or arranged for:
- Adequate time.
- Interpreter.
- Safe, secure, comfortable and adequate setting.
- Medical equipment, photo camera, ruler with colorimetric scale.

A structured format should be used; this aids the flow of questions and reduces the risk of neglecting key areas of inquiry. In the next section, a structured guideline is given for the examination.

III.4. GUIDELINE FOR HEALTH PROFESSIONALS

Medico-legal report Article 18 Directive 2013/32/EU

Based on the Istanbul Protocol [83]

THE REQUIRED COMPETENCIES FOR THE MEDICAL EXAMINER ARE AS FOLLOWS:

- Clinical experience (preferably at least 5 years of clinical working experience).
- Knowledge of forensic principles and objective reporting.
- Ethical conduct, uncompromising accuracy and impartiality.
- Specific forensic expertise in documenting evidence of persecution and serious harm, in compliance with the Istanbul Protocol.
- Cultural sensitivity; knowledge of and experience with different cultural aspects.
- Experience in working with interpreters
- Sensitive to gender-related issues; sexual orientation, gender identity, sexual- and gender-based violence.

Medical doctor when performing physical examination:

- Knowledge of forensic principles of injury and the common after-effects of violence, torture in particular.

Psychologist/medical doctor when performing psychological examination:

- Knowledge of common psychological problems associated with (severe) trauma.

III.4.1 PREPARATION

The appropriate legal documents and the medical file should be studied as preparation. The legal file includes a detailed narrative of the events from the immigration interview; this information is needed to detect inconsistencies. These need to be clarified, if possible, during the interview. The medical file may contain important information about medical problems, treatments, reports from a psychiatrist, etc. There may also be previous MLRs available, or information from other investigations. Sometimes medical files from the country of origin are available; it is difficult, however, to be certain of the authenticity of these documents; these should therefore be used with care.

Furthermore, it may be useful to review information on current country conditions: information on the patterns of torture or violence that is prevalent for the region or country where events occurred. This should be included only when the examiner has particular experience in assessing individuals from this region/country, as practices might differ substantially from region to region and alter over time. Other sources of information could, for example, be legal documents of a family member's asylum application.

The relevant document should be listed under section **2 File.**

III.4.2 INTRODUCTION

The introduction contributes to reassure the applicant and marks the beginning of the relationship. The interaction ought to build up the trust necessary to go through the different parts of the examination.

- Introduction of the medical professional (name, qualifications, duties, roles).
- Identification of the client (ID provided).
- Explanation of the purpose, context, procedures of the examination.
- The outline of the examination and the possibility of breaks and interruptions.
- Obtaining informed consent.

The details of the applicant, examiner, interpreter, language, location as well as any special remarks (e.g. the number of sessions, any practical difficulties) should be listed under section **1 Examination details.**

1 EXAMINATION DETAILS

1.1 PERSONAL DETAILS OF APPLICANT

Name:

Gender:

Country of origin:

Ethnicity (if relevant):

Date of birth:

1.2 DATA RELATED TO THE MEDICAL EXAMINATION

Circumstances of the interview (Istanbul Protocol 83a)

Time and date:

Location (nature and address of institution):

Name examiner, discipline, affiliation

(CV attached)

1.

2.

Name supervisor, discipline, affiliation (if applicable):

Professional ID number or registration number medical council

1.

2.

Name referrer, designation:

Name interpreter:

Language spoken

Name and affiliation other attendants:

1.3 SPECIAL REMARKS ABOUT THE EXAMINATION

Istanbul Protocol § 83(a)

Any appropriate circumstances and other relevant factors.

2 FILE

The relevant documents should be listed below:

Medical

M1

M2

…

Legal

L1

L2

…

Other (e.g. country information)

O1

O2

…

III.4.3 HISTORY AND MEDICAL HISTORY

The history and medical history should be recorded, from three time periods: (A) before the events, (B) during and (C) after, up to now.

Interview techniques
Health professionals must rely on their experience and expertise and conduct the interview in the way it seems the most suitable and effective.

General principles: [84]

- Start off with general questions and less sensitive issues such as social or childhood history. Continue with more sensitive and deeper issues and seek for more specific details when more trust is established.
- Use simple questions, as complex questions with multiple parts may be confusing to the applicant and the interpreter.
- Maintain good eye contact with the applicant.
- Use reassuring nods and pauses to express empathy.
- Frequently seek clarification and re-state what you have heard.
- Ask for clarification of inconsistencies with other available information (see box below).
- Be aware of pacing; avoid rapid, staccato

type questions, as this may resemble interrogation and torture experiences.
- Make observations – body language, emotions, prolonged silence, memory difficulties; register in which situation(s) these occur.
- When asking about the traumatic events like torture, preferably use open-ended, non-leading questions, in a way that promotes a chronological narrative of the events.

Furthermore: [85]
- Be objective and impartial in the clinical assessment.
- Create a climate of trust, courtesy, honesty, empathy.
- Be sensitive and empathic in questioning; exercise a non-judgmental approach.
- Maintain an attitude that takes the beliefs and cultural norms into consideration.
- Be attentive in tone, phrasing and sequencing of questions.
- Avoid any manner, approach or style that may remind the applicant of the traumatic situation.
- Allow for time, room for the individual's needs; allow for questions.
- Be open to learn and apprehend the applicant's situation.
- Use active listening.
- Before closing the interview, ensure that the emotional arousal has subsided.

Be aware of:
- The risk of retraumatization.
- The potential emotional reactions that evaluations of severe trauma may elicit in the applicant.
- The examiners own potential personal reactions or feelings, which might influence the their perceptions and judgements.

INCONSISTENCIES/ FABRICATION [86, 87]

It is important to be aware that inconsistencies do not necessarily mean that an allegation is false. Victims of persecution or serious harm may have difficulties in recalling and recounting the specific details of the torture experience and other parts of the history, which may cause some inconsistencies and blanks in the history. There are many factors that may cause difficulties in recalling and recounting the history as we have seen in chapter 2 (for a list, see box 1, chapter II.5). It is important to keep in mind that fabrication of medical conditions would require detailed knowledge of trauma-related symptoms (and great acting skills) that individuals rarely possess.

The following consecutive steps should be taken by the health professional:
- Ask for further clarification.
- Look for other evidence. A network of consistent, supporting details may corroborate and clarify the applicant's story.
- Additional interviews should be scheduled to clarify inconsistencies.
- Family or friends may be able to corroborate details of the history (heteroanamnesis).
- Evaluate all factors that may lead to inconsistencies (for a list, see box 1, paragraph II.5).
- Conduct additional examinations (e.g. intelligence, neuropsychiatric assessment)
- Refer the applicant to another interviewer and/or ask for a colleague's opinion.
- The suspicion of fabrication should be documented with the opinion of two clinicians.

Option 1. For instance, at the beginning, the examiner can leave up to the applicant to expose the themes that are the most important for them. – As already indicated, it is important that the applicant feels free to express themselves, and that this method may build up a relationship of trust.
Difficulty: it is important to notice that it is virtually impossible to recount traumatic events with all the physical and psychological consequences without the active assistance of the interviewer. This includes not only active listening, but also a broad knowledge of trauma and torture methods, and their consequences on victims. Moreover, this includes asking increasingly more precise questions on events, on background story and on the mental status of the applicant. A risk of this way of entering the interview is that it may remain quite unstructured, and parts of the interview may be forgotten.

Option 2. Another possibility is to progress chronologically, and ask the applicant to tell about his family story preceding the persecution or serious harm.
Difficulty: this may lead directly into the traumatic events if the applicant has been ill treated by their family.

Option 3. Another possibility for the examiner, particularly for the psychological interview, is to start with the part regarding the mental state of the applicant, i.e. to ask the questions on the state of health of the applicant, and thus check through the list of the current symptoms of post-traumatic stress disorder (PTSD). Experience shows that this is a good way to come into communication with the applicant, who feels understanding and empathy and may tell things about themselves they have not pointed out similarly before. This may lead to a family, school and personal background story and culminate in an account of the traumatic events consequently.
Difficulty: although showing good results, this is a time-consuming way of carrying out the interview. It presupposes a good knowledge of post-traumatic stress symptoms and their effects.

The narration is written down in the applicant's own words. It is important not to go beyond the story of the applicant and your observations here; do not include interpretations. Use direct quotes and put them in between quotation marks.

Observations should be noted in the text, as these are relevant for the reader who was not present during the interview. They demonstrate objectivity as distinct from the subjective report of the applicant. Make sure that there is a distinction between observations and the narration of the applicant, e.g. by using italics. (Example: observation: client is crying when he says this.)

Observations include:
- Eye contact.
- Expression; speech and language use; quality of the verbal expression.
- Random movements, sweating, shaking.
- Portraying of the traumatic events and the way torture was sustained.
- Level of consciousness (e.g. dissociation), orientation, memory.
- Emotional reactions – distress, avoidance, numbness, nervousness, fear, shame, guilt, panic, anxiety, lack of self-confidence.

3 HISTORY & MEDICAL HISTORY

The history and the physical and mental health history as recalled and recounted by the applicant.

3.1 BACKGROUND Istanbul Protocol § 288

3.1a History

The functioning before the traumatic events is an important starting point for identifying changes in functioning thereafter. Talking about family history often sheds a light on the traumatic events that led to the flight out of the country. For many women, family history shows how it came to forced marriage. Family history may show family engagement in political activities, or political engagement after traumatic events affecting the family (e.g. a family member was assassinated, and the applicant joined political activities consequently). The applicant might have suffered a series of traumas, some in childhood, others later on, but all contributing cumulatively to their current state.

Describe the family, education, occupational history,[88] social status, cultural and religious background, political orientation, social functioning and sports. List any past traumatic events.

A questionnaire that may be used is the cultural formulation interview (CFI). [89]

3.1b Medical history

Physical health

Any physical injury before events discussed in 3.2. Any surgery in childhood, any other wounds, illnesses; mention especially those that have led to permanent sign or symptoms (scarring, disability, pain). Furthermore, sports injuries, combat injuries, physical punishment at home or school and domestic violence.

Psychological health

This includes the effects of childhood trauma and a brief developmental history; the medical effects rather than the exact details of the events are necessary.

3.2 ALLEGED PERSECUTION OR SERIOUS HARM [90] Istanbul Protocol §83(b), 137–143, 290

3.2a History

Every effort should be made to document the full history of persecution or serious harm. Record the narration in the applicant's own words and formulate the questions in a non-leading, open-ended manner. After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. A method-listing approach may be counter-productive, as the entire clinical picture produced by torture is much more than the sum of lesions produced by methods on a list. Such an approach might also feel like an interrogation. The applicant might just say 'no' to everything to get it over with, or 'yes' to everything to bolster their claim. For any torture described, it is necessary to explore the details of the events.

Detailed description of the traumatic events:
- General information – date, time, duration.
- Perpetrators.
- Location and conditions – country, size of the room, ventilation, lighting, temperature, toilet facilities, sanitation, food, visits/contact (family members, lawyer, health professionals), conditions of overcrowding or solitary confinement, etc.
- Acts of violence – body position, anatomical location, restraint, duration, frequency.

Furthermore, focus on the social consequences of the events and inconsistencies; clarify and take further steps if malingering is suspected.

Note: always ask about sexual violence; note any relevant changes in demeanour. Be specifically sensitive and make sure no other people are in the room (except for interpreter).

Examples of acts of violence include: sexual violence, blunt trauma, falanga, suspension, electrical shock, immersion, standing for a long time, isolation, threat, mock execution, sound, bright light, sleep deprivation, torture of others, cold, burning, painful positions, dehydration, starvation, pulling out of nails, asphyxiation, deprivations (sleep, food, toilet facilities, sensory stimulation, human contact, motor activities, threats, humiliations, violations of taboos and behavioural coercions.

3.2b Medical history [91] Istanbul Protocol Istanbul Protocol § 83(b), 170, 172
Physical health
This is essential information, and a detailed description is required. It may be useful to make a numbered list of the traumatic events and review for each event the physical consequences.

Injured bodily areas; location, frequency, onset and duration of each symptom, healing processes, treatment or lack of treatment, medication, etc. Much of this information will also be gathered during the physical examination – as each individual lesion or scar will elicit a story and usually brings back more specific memories.

Psychological health
Give a chronological account of the events and the emotional, psychological effects. Try to be as detailed as possible: emergence of symptoms, duration, intensity, frequency, fluctuations over time, etc.

Note: A story of unconsciousness may be a result of a dissociative reaction as well as due to pain or head trauma. Try to clarify this.

3.3 CURRENTLY Istanbul Protocol § 105(e), 287(iv)

3.3a Social situation/ life circumstances

Previous stressors (especially the alleged persecution or serious harm) need to be differentiated from current (coexisting) stressors. Furthermore, what coping strategies are being used and the cultural belief systems as compared with childhood may be reviewed.

- Social support (family, community, different culture, LGBT community, etc.).
- Daily activities (work, study, occupation, ability to take care of themselves).
- Social functioning.
- Religious practice (church, mosque, meditation or praying at home).
- Belief systems (changes since childhood, traditional healing practices, etc.).
- Co-existing stressors (ongoing persecution, forced migration, exile, loss of family and social role).

3.3b Medical history Istanbul Protocol § 171

Physical health

Any current physical problems. Focus on the signs and symptoms that are being attributed to the events under 3.2.

Psychological health

Any current psychological problems. Focus on the signs and symptoms that are being attributed to the events under 3.2, as well as on the way these are influenced by the current social situation as described in 3.3.

4 ADDITIONAL INFORMATION Istanbul Protocol § 161

Additional information regarding the history or medical history e.g. heteroanamnesis, witness accounts.

This includes information from accompanying family members or mentors in case of minors for example. With permission of the applicant, heteroanamnestic information can be obtained from them. This may include information of the history, to clarify inconsistencies, or details of the history, if indicated, and the person's current functioning.

State clearly in the report the source of this information.

III.4.4 PHYSICAL AND PSYCHOLOGICAL EXAMINATION

Each physical sign and symptom is examined in detail, and possible effects of the alleged traumatic events need to be evaluated and searched for. It is the physician's responsibility to discover and report upon any material findings that are considered relevant. Also, lesions that are not caused by the traumatic events or where the aetiology is unknown should be recorded; this yields information about possible exaggeration or fabrication.

Maintain a structured approach (e.g. blood pressure, pulse, listening to heart and lungs, abdomen, skin [from head to toe], musculoskeletal system, neurological, ear, nose and throat examination, genital and anal examination). It is preferable to investigate certain parts of the body and leave other parts covered, so as to avoid that the applicant is fully exposed. Covering the genital area with a towel during the genital examination can cause the individual to feel less exposed.

Note: It should be recorded if any body parts are not examined, with reasons provided.

Note: Also document the absence of injury, e.g. absence of ear drum abnormalities in the case of alleged blows to the region of an ear.

Photographic documentation [92] *and body diagram*
With the informed consent of the applicant, photographs should be taken of all injuries allegedly caused by sustained persecution or serious harm, as well as scars that are not related to the alleged history, as this could support the credibility of the applicant. Use a measuring tape or other scale device on each photograph. It may be helpful to show the photographs to the applicant to help them to explain more specifically about the alleged causing mechanism.

To describe the localization of the lesions, an anatomically correct drawing (body diagram) should be used to note the injuries and scars, in a numbered way and matching the photograph numbering. Photographs can greatly help to illustrate the description of skin lesions and are an important aid for peer-review and training purposes.[93] Photographs should be made of each lesion, including lesions that are not related to the history. Include a ruler with colorimetric scale for reference. A photograph of the applicant's face for identification purposes could be included.

5 PHYSICAL EXAMINATION Istanbul Protocol § 162

5.1 GENERAL EXAMINATION

Physical features: sex, age, body type, skin colour, nutritional status, height, weight. General impression of physical health, posture, gait, movements, self-sanitation, blood pressure, pulse, examination of lungs, heart and abdomen

Note: During the examination, it is important to get additional anamnestic information about the causing mechanism of each lesion that is being examined, as discussed in the previous paragraph. Be as detailed as possible about what method was used, how often, how long, the position of victim and perpetrator, symptoms (such as pain, swelling), medical treatment received, etc. Take sufficient time for this and make clear notes on how each skin lesion or injury was caused. Also note observations, e.g. the individual might portray the exact way in which they were restrained or in which way the perpetrator acted.

5.2 EXAMINATION OF SKIN LESIONS

This entails the examination (inspection and/or palpation) of the entire surface of the skin; be as precise and complete as possible.

Terminology [94]

A standard use of terminology/taxonomy of documentation should be central in the MLR. The use of standard descriptions of physical lesions related in this context is essential to ensure uniformity and proper understanding and to avoid misunderstanding. It is also fundamental for learning, comparison and scientific purposes. A description of a lesion should be its appearance ('as it is seen'); do not go beyond what is observed.

In the forensic description of skin lesions, commonly the skin defect is described using words that are actually types of injuries such as laceration, incision and abrasion (see Table 1). However, such descriptions are to be avoided, as these indicate the mechanism of injury, which prematurely eliminates other potential causes, and thus can lead to faulty conclusions. Thus, instead of describing a skin defect as an abrasion, describe it as a superficial erythematous erosion. Avoid using terms such as laceration, a bite or burn, as those descriptors are all types of injuries implying the causing mechanism.

TABLE 1.

LESION CHARACTERISTICS

- Location (on body diagram: body part, left/right, back/front, inner side/outside).
- Colour, pigmentation (white, yellow, red, brown, blue, black, hyperpigmented [dark], hypopigmented [pale]).
- Size (length, width, depth, diameter).
- Shape (linear, round, oval, rectangular, irregular, patterned).
- Surface (smooth, oedematous, crusty, hypertrophic, atrophic, depressed, raised).
- Margins (smooth, jagged, irregular, pigmented, necrotic).
- Distribution (single or multiple lesions, confluent, widespread, scattered, symmetrical).
- Orientation (with respect to body axis: horizontal, vertical, oblique, diagonal).
- Pattern (round, annular, arcuate, confluent, grouped, irregular, linear, mottled, reticular, oval, serpiginous, stellate, target).
- Normal skin structures (presence or absence of skin appendages [hairs/pores]/presence or absence of normal skin creases/absence of nails).

TYPE OF LESION

Fresh lesions: erosion, ulcer, blister, haematoma, contusion, purpura, petechiae, laceration, incision, excoriation, plaque, papule, eschar, erythema, macule, vesicular, pustular, abrasion, avulsion, amputation, cyst, nodule, abscess, excoriation, wheal, fissure.
Healed lesions: pigmentation (hypo- or hyperpigmentation), scar, hypertrophic scar, keloid

5.3 SPECIFIC EXAMINATION OF PHYSICAL SIGNS AND SYMPTOMS

Indications for specific examination include symptoms such as pain in a particular body part, a reported fracture, disability or neurological deficit. Furthermore, if the type of violence or torture usually causes specific physical signs, this should be investigated, e.g. sensibility of arms and investigation of the shoulders in alleged suspension or examination of the feet in alleged beating on the feet *(falanga)*.

Genital and anal examination

Consent for examination of the genital area should be sought while the person is still seated and dressed. Such an examination is likely to be highly distressing for a person previously subjected to forced nakedness and other sexual violence or torture. The examiner needs to consider the risk of retraumatization against the likelihood of finding any physical evidence at this interval from the event. If specific injury to the area has been described and the person consents, this shall be documented. A chaperone may be required and should be offered.

Besides signs of sustained injuries, examination might reveal signs of dyspareunia (which could be related to sexual violence). Furthermore, confirmation of the nature of female genital mutilation may be required, if this is part of the claim, or should be noted if found incidentally, as women may not be aware that it can be relevant to their claim.

Examination of the hymen ('virginity testing') should not be done, as this does not produce reliable information (except in case of children, shortly after sexual assault or rape).

The absence of any specific findings at the examination is common, as ano-genital violence rarely leaves visible signs. The absence of specific evidence of ano-genital violence can therefore not be taken to indicate it did not occur.

It is necessary that the interpreter remains inside the room, as the explanation of each scar/physical sign will need to be provided by the applicant. Therefore, the room should be equipped with a curtain/division, to keep the applicant out of sight of the interpreter during the examination.

Neurological, musculoskeletal, face/head, chest/abdomen, genital, etc.: see appendix 2.

5.4 ADDITIONAL DIAGNOSTIC TESTS [95]

If your examination warrants further investigation, for example to diagnose an old fracture, this should be noted (e.g. X-ray, MRI, CT scan, ultrasound (US), laboratory, biopsy etc.).

6 PSYCHOLOGICAL EXAMINATION

6.1 MENTAL STATUS

The information for the description of the mental status is gathered throughout the whole interview and examination. It includes observations, direct questions, information from psychological testing, etc. The psychological evaluation thus starts at the beginning of the interview, at the very first contact.
It comprises of the following items:

General appearance:
- Appearance in relation to age.
- Accessibility.
- Body build.
- Hygiene, grooming and clothing.
- Facial expression.
- Eye contact.

Psychomotor behaviour:
- Gait and posture.
- Handshake.
- Abnormal movements.
- Rate and coordination of movements.

Mood and affect:
- Appropriateness of affect.
- Range of affect.
- Stability of affect.
- Attitude toward examiner.
- Specific mood or feelings.
- Anxiety level.
- Assessment of risk of suicide and self-harm, risk to others.

Speech:
- Rate and flow of speech.
- Intensity of volume.
- Clarity.
- Liveliness.
- Quantity.

Cognition:
- Attention and concentration.
- Memory (short term and long term).
- Abstraction.
- Insight into illness.
- Orientation in time, place and person.
- Mental capacity and possible intellectual disability.

Thought patterns
- Clarity and flow.
- Content, relevance and logic.

*Level of Consciousnes*s
- Use of medication, substances and alcohol.
- Lack of sleep.
- Dissociation.
- Freezing (due to fear for example).

Common psychological responses of trauma (Istanbul Protocol § 241–248):
- Intrusive memories/re-experiencing the trauma.
- Avoidance and emotional numbing.
- Hyperarousal.
- Negative changes in thinking and mood/ symptoms of depression.
- Anxiety.
- Damaged self-concept and foreshortened future.
- Dissociation, depersonalization and atypical behaviour.
- Somatic complaints.
- Sexual dysfunction.
- Psychosis.
- Substance abuse.

6.2 SPECIFIC EXAMINATION OF PSYCHOLOGICAL SYMPTOMS

Few published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of survivors of persecution and serious harm. Also, most psychological tests of personality lack cross-cultural validity. These factors combine to limit severely the usefulness of psychological testing in the evaluation of victims of persecution and serious harm.[96]
It may be useful to make use of psychological tests or questionnaires to better understand the problem or improve the validity of your findings. It is important that the tests are validated for people with different cultural backgrounds. In general, non-verbal tests are more suitable for multicultural use. Be very careful interpreting the results; be aware of misinterpretation and especially of cultural bias.

Neuropsychological testing may be helpful in assessing cases of brain injury.
Furthermore, since an individual who has survived persecution and serious harm may have trouble expressing in words their experiences and symptoms, it may be helpful to use trauma event and symptom checklists or questionnaires to gather more specific information about symptoms.

Some suggestions for psychological tests, valid for multicultural use:

Cultural background, adults:	CFI [97]
Trauma	LEC-5 [98]
Concentration and sustained attention	
Adults:	Bourdon–Wiersma [99]
Minors:	Bourdon–Vos [100]
Intelligence test	
Adults:	RAVEN [101]
Minors:	SON-R [102]
Psychopathology	
Adults:	BSI [103]
Minors:	SDQ [104]
PTSD	
Adults:	CAPS [105], PCL 5 [106]
Minors:	RATS [107]
The following tests are sometimes used but not valid for multicultural use:	
Malingering	SIMS [108], TOMM [109]

Ending the examination
Ask if there are any more questions; explain further steps after the examination. Try to make sure there is support after the examination, as the examination may lead to a short-term exacerbation of psychological symptoms. If there is a significant suicide risk take appropriate steps for referral and support.

7 REFERRAL Istanbul Protocol § 83(d), 156, 291

When treatment or therapy is indicated or recommended, a referral should made.
If applicable, indicate which medical conditions found during the examination fall outside of the expertise of the examiner; if possible, further forensic specialist evaluation should be arranged.

This should be noted in the report.

III.4.5 EVALUATION OF FINDINGS
The overall purpose of the examination is to establish the correlation between the physical and psychological findings and the attributed history of persecution or serious harm.
An interpretation of the available information should be made, an expert opinion of the correlation of the individual signs and symptoms with the alleged persecution or serious harm should be given and an overall conclusion of the totality of the findings should be formulated.

In coming to these conclusions, many factors need to be considered. A structured way of working is therefore critical. A standardized methodology is furthermore useful for learning, comparison, scientific and explanation purposes.

In this guideline, a series of steps is presented, based on the Istanbul Protocol, that can be followed in evaluating your findings and the other information required to reach your conclusions.

8 EVALUATION OF FINDINGS

Note: the evaluation of your findings should be presented in such a way that it may be read easily by professionals who are not familiar with medical terms and expressions – such as judges, lawyers or immigration officers. Specialized medical vocabulary must be avoided or explained.

8.1 RELIABILITY OF THE EXAMINATION Istanbul Protocol § 105(f), 287(v), 290
Reflect on the possibility of a false allegation.

Reflect on:
- Information from the interview on inconsistencies (internal and external consistency).
- Any differences between the accounts obtained from the two different examiners (e.g. medical doctor and psychologist).
- Factors that influence the ability to recount the history (the experience itself, psychological factors, neuropsychiatric cognitive impairment, emotional cultural factors, interview conditions).

- Presence of any skin lesion not attributed to the alleged events.
- Observations – emotions, detailed portraying of alleged sustained trauma.
- Information from other sources (e.g. medical file, country information, heteroanamnestic accounts, witness information).
- Information from the interview on cultural belief systems. For example, believing in spirits or witchcraft may be associated with particular ideas about the origin of skin lesions or complaints.

8.2 EVALUATION OF FINDINGS FROM PHYSICAL EXAMINATION

Expert opinion
A detailed description of each physical sign or symptom from the medical history and examination, illustrated with body diagram and photographs, together with a detailed description of the attributed mechanism of injury (the acts of persecution or serious harm) should lead to an evaluation. For each physical sign or symptom111 (skin lesion or physical injury, pain or other symptoms), establish the correlation with the alleged persecution or serious harm, and explain your reasoning.

There are often different causes that may produce similar signs and symptoms (differential diagnosis). These causes should be evaluated (e.g. skin diseases, self-inflicted injury or accidental injury, tribal scars or surgical scars); an opinion should be given as to their relative likelihood.
- Indicators of traumatic aetiology include injuries on body surfaces not commonly prone to injury, patterned injuries from instruments, multiple injuries with different stages of healing, circumferential injuries, and eye, ear, dental, anal or genital injuries).
- Indicators of non-traumatic aetiology, e.g. medical origin of a scar or dermatological lesion.
- Indicators of self-inflicted injuries (in easy reach of the dominant hand; a characteristic pattern of superficial scarring in different healing stages is often seen).

For skin lesion:
The lesion characteristics should lead to a description of the preceding wound type and the most likely causing mechanism. The distribution and location of the lesions should lead to further determination of the correlation with the specific mechanism of injury (position of the victim, perpetrator, the torture methods used, etc.). The extent, number and pattern of skin lesions are relevant to determine the likelihood of accidental injury or other causes.

In your interpretation you may include:
- Results of diagnostic tests (e.g. X-ray) and/or information from the medical file.
- The expected effect of the mechanism of injury (adapted from Istanbul Protocol § 105[c]) [112], as this gives insight in pathophysiology and the possible consequences.
- Historical accounts of the lesions and injuries; the individual's observations of acute lesions and the subsequent healing process. [113]
- Psychological evaluation and observations during the examination. The behaviour during the examination and the psychological signs and symptoms, e.g. signs of shame, avoiding or stress, may be taken into account, if this is relevant.

Note: Surgical procedures use established approaches and are easily recognizable.
Note: Striae distensae should be distinguished from scarring; these are located in the skin lines and parallel on specific areas of the body. Striae distensae are characterized by a symmetrical, atrophic, depigmented pattern, with a linear aspect. (The applicant might have been unaware of such lesions and mistakenly attributes them to sustained trauma on these areas of the body.)

Conclusion
Establish the correlation of each individual physical sign and symptom (acute and chronic) with the alleged causing mechanism.
Use Istanbul Protocol grading [114] (i) not consistent, (ii) consistent, (iii) highly consistent, (iv) typical of or (v) diagnostic of.

Note: If no physical signs and symptoms are present, an evaluation can be made based on the medical history of the physical injury (observations of acute signs and symptoms and the subsequent healing process).
Note: In cases where refugees have been tortured on several occasions, they can often recall what happened to them or when certain lesions were sustained, but not exactly which skin lesion is attributed to what event. If the exact mechanism of each individual skin lesion is not known, it is not possible to attribute the lesions to one or more of the alleged ways of violence or torture according to Istanbul Protocol grading.[115] However a reflection can be given on the likely causing mechanism of the injury (e.g.: 'the lesion has the appearance of a blunt force/sharp force/burn injury [whichever applies] and could be caused by the torture method described in the history of [x], but without a specific attribution it is not assessed in terms from Istanbul Protocol § 187.')
Note: It is important to realize that many acts of violence leave hardly any physical signs and symptoms on the long term:

- Many forms of violence leave no detectable findings (e.g. internal organ trauma, asphyxia tortures, infections, poisoning, some episodes of blunt trauma, suspension, and many forms of sexual violence).
- Some methods of torture are designed in a way to cause maximum pain and suffering but no permanent signs.
- Due to healing, signs and symptoms will disappear over time; skin lesions heal without scars, pain will diminish and functionality will return to normal.

Thus, the absence of physical signs or symptoms does not mean that the events did not take place (Istanbul Protocol § 159, 161). [116]
Note: If the report is used in a criminal case rather than or additional to an asylum procedure, the potential debilitating and lethal consequences of specific acts of violence need to be evaluated. This is, however, outside of the scope of this manual.

8.3 EVALUATION OF FINDINGS FROM PSYCHOLOGICAL EXAMINATION

Expert opinion
A description of the psychological symptoms and/or psychiatric diagnosis is given, including: findings of the examination (medical history - the psychological responses and symptoms in time, mental state and diagnostic testing), supported by information from the medical file (about the care that the individual has received, about the start and duration of symptoms and whether a psychiatric diagnosis has been made) if applicable.
For the psychological symptoms or psychiatric diagnoses, establish the correlation with the alleged persecution, serious harm, and explain your reasoning.

Important aspects:
- Content of memories, flashbacks, nightmares.
- Observations of reactions during interview (e.g. dissociation when talking about certain events).
- Historical accounts (the timeline of the psychological symptoms in relation to the traumatic events).
- Relevant other traumatic events or stressors; childhood trauma (e.g. loss of parents) and current/ concomitant stressors (e.g. lack of support, family, community, meaningful activities).

In your interpretation you may include the following:
- The usual, expected effect of the traumatic events within the cultural and social context of the individual (e.g. shame in sexual violence) should be described, as this gives insight in the possible consequences and pathophysiology in the cultural and social context.
- Cultural belief systems. For example, believing in spirits or witchcraft is associated with particular ideas about the experiencing of psychological symptoms.
- Education and intelligence/mental capacities, possible learning disabilities and include information on possible intelligence testing.
- Age, e.g. developmental issues in minors.
- Gender roles, sexual orientation.
- Relevant (pre-existing) psychological illness, e.g. previous psychiatric conditions.
- Physical condition (e.g. general illness, disability, neurocognitive impairment).

Note: Diagnosis of psychiatric illness can be made if the survivor has symptom levels consistent with a psychiatric diagnosis. Psychiatric diagnostic criteria are often specific for the cultural context and do not always apply to severe trauma. It is therefore indicated to record carefully the psychological symptoms rather than focus on the diagnosis.
Note: The correlation of the diagnosed symptoms with the alleged persecution or serious harm depends on specificity and the content of the specific symptoms, e.g. the content of nightmares. The more specifically related to the experiences, the stronger the correlation is.
Note: If there are multiple traumatic experiences, the interpretation will be more difficult. If the content of symptoms relates to both the persecution or serious harm, and to other experiences, this points to a less specific correlation.

Conclusion
Establish the correlation of the psychological findings with the attributed traumatic events.
Use Istanbul Protocol grading : (i) not consistent, (ii) consistent, (iii) highly consistent, (iv) typical of or (v) diagnostic of.

Note: If no psychological symptoms are present, an evaluation can be made based on the medical history of the psychological symptoms (observations of acute signs and symptoms and the subsequent recovery).

8.4 OVERALL EVALUATION OF THE TOTALITY OF FINDINGS Istanbul Protocol § 188
An evaluation of the physical and psychological findings in its totality. Istanbul Protocol grading should be used to describe the correlation between the totality of the findings and the alleged acts of persecution or serious harm.
For example: an individual lesion is often assessed as no higher than 'consistent with' the attribution of torture given, however the overall evaluation may be much stronger given the number of such lesions, their distribution on the body and the combination with the psychological evidence.

Note: In suspected or alleged sexual violence, the observations of emotions (such as shame or guilt) and behaviour during the examination as well as the findings of physical and psychological examination are important. It is the complete picture, i.e. all the information together, that might point to a correlation with sexual violence.
Note: Where possible, support your opinions with references from literature (see reading material/ literature for important reference articles).

9 SUMMARY

9.1 SUMMARY OF THE HISTORY
Summary of the history (alleged persecution or serious harm), the social consequences, inconsistencies and other stressors if applicable, as recalled and recounted by the applicant. No interpretations or conclusions.

9.2 SUMMARY OF THE PHYSICAL AND PSYCHOLOGICAL SIGNS AND SYMPTOMS
Summary of the medical findings; the medical history, findings of examination, additional information and information from the file if applicable. No interpretations or conclusions.

9.3 SUMMARY OF CONCLUSIONS
Summary of the conclusions of the correlation of the physical and psychological signs and symptoms with the alleged persecution or serious harm.

9.3a Conclusion of evaluation of physical signs and symptoms
9.3b Conclusion of evaluation of psychological signs and symptoms
9.3c Overall conclusion

10 AUTHORSHIP Istanbul Protocol § 83(e)

Each medical examiner signs the document and a resumé of each examiner is attached with qualifications, diplomas, training and experience/activities.

Examiner 1 (CV attached)

Date:

Place:

Name:

Signature:

Examiner 2 (CV attached)

Date:

Place:

Name:

Signature:

79 *Allnutt, S.H., Chaplow, D. General principles of forensic report writing. Aust. N.Z. J. Psychiatry 2000;34:980–7. doi:10.1080/000486700533.*

80 *Information that may incriminate the applicant is in principle confidential. If the applicant expresses the desire that this information be included in the report, it is the duty of the examiner to inform the applicant of the potential consequences thereof, and the right not to cooperate with their prosecution (nemo tenetur principle).*

81 *International Rehabilitation Council for Torture Victims (IRCT), Psychological Evaluation of Torture Allegation, 2007.*

82 *Hungarian Helsinki Committee (HHC), Credibility Assessment in Asylum Procedures –A multidisciplinary training manual. Budapest: HHC 2013.*

83 *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel or Degrading Treatment or Punishment. New York and Geneva: United Nations,1999*

84 *Physicians for Human Rights (PHR), Examining asylum seekers. A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment. Second edition. United States of America: PHR, 2012.*

85 *Medical checklist for effective documentation and investigation on torture and other forms of ill-treatment, 2005 and 2007. Copenhagen: IRCT.*

86 *Medical checklist for effective documentation and investigation on torture and other forms of ill-treatment, 2005 and 2007. Copenhagen: IRCT.*

87 *Istanbul Protocol § 142, § 143.*

88 *The examiner should be aware of possible work related illnesses and injuries. The occupational history should be evaluated to determine whether it may be the cause of any of the observed physical and psychological signs and symptoms.*

89 *DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed. Arlington, VA: American Psychiatric Association, 2013, chapter XX.*

90 *Istanbul Protocol § 137–141. Summary of detention and abuse/Circumstances of detention/Place and conditions of detention/Methods of torture and ill treatment.*

91 *Istanbul Protocol § 172: 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.*

92 *Özkalipci, Ö., Volpellier, M. Photographic documentation, a practical guide for non professional forensic photography. Torture. 2010;20(1): 45-52. http://irct.org/assets/uploads/Photographic+documentation.pdf.*

93 *Photographers should have information on the basics of forensic photography, including chain of custody. See previous footnote. All the individuals examined should be photographed if they provide consent.*

94 *Based on and edited from: Coleen Kivlahan and Christy Fujio, Learning to See, Meeting summary of the International Expert Consortium on an Online Photo Library of torture, Ill Treatment and other forms of abuse, Brussels, July 2015.*

95 *Istanbul Protocol Annex II.*

96 *Istanbul Protocol § 286.*

97 *DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed. Arlington, VA: American Psychiatric Association, 2013, chapter XX.*

98 *Life Events Checklist for DSM-5.*

99 *The dot cancellation test or Bourdon–Wiersma test is a commonly used test of combined visual perception and vigilance.*

100 *Bourdon-Vos test (1998); this measures attention and concentration of children and young people aged 6–17 years.*

101 *RAVEN is a non-verbal IQ test*

102 *SON/R is a non-verbal IQ test for the ages of 6–40 years.*

103 *Brief Symptom Inventory (BSI) is an instrument that evaluates psychological distress and psychiatric disorders in people.*

104 *The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3–16-year-olds.*

105 *The Clinically Administered PTSD Scale (CAPS) is an in-person clinical assessment for measuring post-traumatic stress disorder.*

106 *The PCL-5 or PTSD Checklist for DSM 5 criteria is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD.*

107 *Reactions of Adolescents to Traumatic Stress Questionnaire (RATS) is a multicultural self-report on PTSD for adolescents, available in 19 languages.*

108 *The Structured Inventory of Malingered Symptomatology (SIMS) is a psychometric test that measures neurological and psychiatric symptoms amplification. It can provide presumptive indication of malingering, which must be tested by other assessment tools.*

109 *Test of Memory Malingering (TOMM) is a test that distinguishes between malingered and true memory impairments.*

110 *Istanbul Protocol. § 105: (f)/ 287: (v) Does the clinical picture suggest a false allegation of torture?*
§ 290: Effective documentation of psychological evidence of torture requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report.
111 *For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. Istanbul Protocol § 187.*
112 *Istanbul Protocol 105: (c) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?*
113 *Physicians for Human Rights (PHR), Examining asylum seekers. A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment. Second edition. United States of America: PHR, 2012.*
114 *Istanbul Protocol §187. The following terms are generally used:*
(a) Not consistent: the lesion could not have been caused by the trauma described.
(b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes.
(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes.
(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes.
(e) Diagnostic of: this appearance could not have been caused in any way other than that described.
115 *Istanbul Protocol Chapter IV (D) § 137 and Istanbul Protocol Chapter V (D) § 187.*

IV. > MEDICO-LEGAL REPORT AS EXPERT EVIDENCE

IV.1 INTRODUCTION

In this chapter, the implications of the MLR and the further use in the asylum procedure are discussed. A guide for legal workers on how to read an MLR is included at the end of this chapter.

As was mentioned in chapter I, this manual and the MLR guideline were developed to suit the requirements of Article 18, using the Istanbul Protocol as the foundational resource document.

In this last section of the training manual, the MLR will be discussed in detail. By going through each of its sections, understanding their content and goal, the trainee will get to understand and interpret correctly this important piece of evidence. As a matter of course, self-explanatory chapters of the MLR will be left undiscussed.

This chapter is aimed specifically at legal workers. Yet, it is also relevant for health professionals, as they need to understand how the report is being used in the asylum procedure.

Learning objectives:

For legal workers and health professionals understanding of the following:
- The implications of the MLR.
- What standards the MLR should adhere to in order to be regarded as 'expert evidence' (competencies of the medical examiner as well as the standards for the report).
- The content of the MLR.
- How medical evidence is established, and what information is taken into account in this process.

Reading material:

Istanbul Protocol (Office of the United Nations High Commissioner for Human Rights. Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations, 2004.)

IV.2 EXPERT EVIDENCE

The medical examination in the asylum procedure is part of forensic medicine, the branch of medicine that deals with establishing medical facts within a legal context. It requires objective examination and documenting, under an approach different to therapeutic medicine. While forensic medicine usually deals with criminal law, it is important to stress that, in the asylum procedure, the legal standards are different: [123] the level of evidence has a different value, and in legal terms the 'benefit of the doubt' [124] principle applies. It further requires that medical professionals write their report in such a way that it is understandable for non-medical professionals.

There are several complicating factors concerning the medico-legal report (MLR) in the specific context of the asylum procedure. The application (and examination) often takes place years after the causing event, which makes it particularly challenging and requires specific knowledge and expertise. Furthermore, asylum seekers have different cultural backgrounds, which calls for cultural sensitivity and awareness of possible different expressions of symptoms and signs. Thirdly, asylum seekers are often traumatized, which makes it difficult for them to tell their stories.

This type of examination therefore requires specific expertise,[125] which includes clinical experience, forensic training, as well as a culturally sensitive approach. Medical professionals producing an MLR must have completed specific training and are legally accountable for their actions.

In order for the MLR to be regarded as expert evidence, it should adhere to the internationally recognized standard for this type of investigation according to the principles of the Istanbul Protocol.

IV.3 INTERPRETING MLR CONCLUSIONS

When legal workers interprete a MLR several principles apply::

- Legal experts shall not make their own interpretations about medical findings, as this is not within their area of expertise.
- When conclusions are being questioned by the legal experts, an additional examination (second opinion) is indicated.
- Knowledge of the Istanbul Protocol grading is of great importance. [126]
- The absence of physical or psychological signs and symptoms does not mean that the alleged event did not occur. [127]
- A diagnosis of a trauma-related mental disorder can support the claim of torture, but not meeting criteria for a diagnosis does not mean that the person was not tortured. [128]

IV.4 GUIDELINE FOR LEGAL WORKERS

MEDICO-LEGAL REPORT ARTICLE 18 DIRECTIVE 2013/32/EU

Based on the Istanbul Protocol. [129]

The required competencies for the medical examiner are as follows:
- Clinical experience (preferably at least 5 years of clinical working experience).
- Knowledge of forensic principles and objective reporting.
- Ethical conduct, uncompromising accuracy and impartiality.
- Specific forensic expertise in documenting evidence of persecution and serious harm, in compliance with the Istanbul Protocol.
- Cultural sensitivity; knowledge of and experience with different cultural aspects.
- Knowledge of working with translators.
- Sensitive to gender-related issues; sexual orientation, gender identity, sexual- and gender-based violence.

A medical doctor when performing physical examination requires:
- Knowledge of forensic principles of injury and the common after-effects of violence, torture in particular.

A psychologist/medical doctor when performing psychological examination requires:
- Knowledge of common psychological problems associated with (severe) trauma.

1 EXAMINATION DETAILS

1.1 PERSONAL DETAILS OF APPLICANT
1.2 DATA RELATED TO THE MEDICAL EXAMINATION
1.3 SPECIAL REMARKS ABOUT THE EXAMINATION ISTANBUL PROTOCOL §83(A)
This section provides information regarding the identity and country of origin of the applicant, time of examination, language used, translator, location and details of the examiner. Also any irregularities during the examination are included here.

2 FILE

This section lists the documents that are used in the report.

3 HISTORY & MEDICAL HISTORY

This section describes the history and physical and psychological health history as recalled and recounted by the applicant.

3.1 BACKGROUND
3.1a History
This subsection describes the family of origin, education, occupational history, social status, cultural and religious background, political orientation, social functioning and sports. Any past traumatic events are listed.

3.1b Medical history
This subsection describes any physical injury before the events discussed in 3.2, especially those that have led to permanent signs or symptoms (e.g. scarring, disability, pain), as well as any sustained childhood trauma, and also gives a brief developmental history.

3.2 ALLEGED PERSECUTION OR SERIOUS HARM

3.2a History
This subsection focuses on:
- Detailed description of the traumatic events; describe methods, time, duration, location, country, etc.
- The social consequences of the traumatic events.
- Inconsistencies.

3.2b Medical history
This subsection gives a detailed account of injured bodily areas as well as the emotional and psychological effects of the traumatic events discussed in 3.2a.

3.3 CURRENTLY

3.3a Social situation/life circumstances
This subsection describes the current life circumstances, social support, daily activities, social functioning, religious practice, belief systems and co-existing stressors.

3.3b Medical history
This subsection gives insights in any current physical and psychological problems, with a focus on the signs and symptoms attributed to the events discussed in 3.2a, as well as on the way this is influenced by the current situation.

4 ADDITIONAL INFORMATION

This section includes any additional information that is relevant for the examination, e.g. heteroanamnesis, witness accounts.

5 PHYSICAL EXAMINATION

In this section, a detailed description of skin lesions and (other) physical complaints is given, as well as an evaluation of the findings illustrated with a body diagram and photos.

5.1 GENERAL EXAMINATION

This subsection describes characteristics, physical features, general impression and basic examination such as blood pressure, pulse and examination of lungs, heart and abdomen.

5.2 EXAMINATION OF SKIN LESIONS

This subsection gives a detailed description of the skin lesions.

5.3 SPECIFIC EXAMINATION OF PHYSICAL SIGNS AND SYMPTOMS

This subsection has a focus on specifically indicated examinations: neurological, musculoskeletal, face/head, chest/abdomen, genitals, etc.

5.4 ADDITIONAL DIAGNOSTIC TESTS

This subsection includes additional diagnostic tests (e.g. X-ray).

6 PSYCHOLOGICAL EXAMINATION

In this section, a detailed description of psychological symptoms and/or responses is given, as well as an evaluation of the findings.

6.1 MENTAL STATUS

This subsection gives detailed information about the psychological health; it includes information from observations and direct questions, as well as information from psychological testing.

6.2 SPECIFIC EXAMINATION OF PSYCHOLOGICAL SYMPTOMS

This subsection has a focus on specifically indicated psychological testing. The tests used should be valid for multicultural use.

7 REFERRAL

In this section, it is described whether treatment or therapy was indicated or recommended, and whether any referrals were made. Furthermore, it is stated here whether further forensic investigation of specific medical conditions is necessary, and whether this has been arranged.

8 EVALUATION OF FINDINGS

This section consists of an expert interpretation of the findings.

8.1 RELIABILITY OF THE EXAMINATION

In this subsection, a reflection is made on possible exaggeration or fabrication of symptoms.

8.2 EVALUATION OF FINDINGS FROM PHYSICAL EXAMINATION

This subsection includes the evaluation of the correlation between the physical signs and symptoms and the alleged causing mechanism, using Istanbul Protocol grading.

8.3 EVALUATION OF FINDINGS FROM PSYCHOLOGICAL EXAMINATION

This subsection includes the evaluation of the correlation between the psychological symptoms and the alleged traumatic events, using Istanbul Protocol grading.

8.4 OVERALL EVALUATION OF THE TOTALITY OF FINDINGS

This subsection includes an evaluation of the findings from physical and psychological examination in its totality. The Istanbul Protocol grading is used to describe the level of consistency of the totality of the findings and the alleged acts of persecution or serious harm.

9 SUMMARY

9.1 SUMMARY OF THE HISTORY

In this subsection, a summary of the history as recalled and recounted by the applicant is given.

9.2 SUMMARY OF THE PHYSICAL AND PSYCHOLOGICAL SIGNS AND SYMPTOMS

In this subsection a summary of the medical findings is given, this may include the medical history, findings of examination, additional information and information from the file.

9.3 SUMMARY OF CONCLUSIONS

In this subsection, a summary of the correlation of the physical and psychological signs and symptoms with the alleged persecution or serious harm is given.

9.3a Conclusion of evaluation of physical signs and symptoms
9.3b Conclusion of evaluation of psychological signs and symptoms
9.3c Overall conclusion

10 AUTHORSHIP

This section includes the medical examiner's signature and resumé, with qualifications, diplomas, training and experience/activities.

123 *Istanbul Protocol §92. 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 under 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 needs to provide only a relatively low level of proof of torture.*

124 *The benefit of the doubt principle is outlined in § 196, 204 and 205 of the UNHCR handbook and acknowledged by the European Court of Human Rights and Directive 2011/95/EU when it comes to assessing the credibility of applicants' statements. 'Building credibility' supporting EU-wide access to know-how on objective credibility assessment. Credibility Assessment in Asylum Procedures – Expert Roundtable, Budapest, Hungary, 14–15 January 2015.*

125 *Istanbul Protocol §131. Documentation of medical evidence of torture requires specific knowledge by licensed health practitioners. Knowledge of torture and its physical and psychological consequences can be gained through 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 these. Experience in interviewing and examining individuals for physical and psychological evidence of torture and in documenting findings should be acquired under the supervision of experienced clinicians.*

126 *Istanbul Protocol §187. The following terms are generally used:*
(a) Not consistent: the lesion could not have been caused by the trauma described.
(b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes.
(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes.
(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes.
e) Diagnostic of: this appearance could not have been caused in any way other than that described.
Istanbul Protocol §188. 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.

127 *Istanbul Protocol §159. 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 with a rug, or shoes in the case of falanga, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also forms of torture with the intention of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels are used with electric shocks.*
Istanbul Protocol §161. (…) To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person has been 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.

128 *'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill treatment' prepared by the Society of Forensic Medicine Specialists in 2005, revised for 'Prevention Through Documentation Project' IRCT (2007); by Sebnem Korur Fincanci and Turkcan Baykal in cooperation with the projects training committee.*

129 *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel or Degrading Treatment or Punishment. New York and Geneva: United Nations, 1999.*

V. > SELF-CARE

V.1 INTRODUCTION

This chapter discusses the risks of working with traumatized people. Working with traumatized individuals, and asylum seekers in particular, may be very demanding, and may lead to burnout and vicarious trauma. Therefore, self-care is evidently important.

This chapter is aimed at legal workers, social workers and health professionals.

Learning objectives:

- Understand the psychological consequences of dealing with traumatized individuals, including the concept 'vicarious trauma'.
- Understand what personality characteristics (roles) may lead to burnout.
- Recognize signs and symptoms of burnout.
- Understand how burnout or vicarious trauma may influence the way decisions are being made.
- Come up with solution strategies.

Reading material:

Herman, J., Trauma and Recovery. New York: Basic Books 1992.
http://unityandstruggle.org/wp-content/uploads/2016/04/Herman_Trauma-and-Recovery.pdf

V.2 TRAUMATIZATION AND BURNOUT

It is important to realize that working with traumatized people may be stressful and strenuous. This is equally true for the legal worker as well as for the health professional. Listening to the traumas of another person may be traumatizing, and might eventually even lead to burnout.

Traumatization
Traumatization can be primary for the victim and secondary for the relatives, but also for a caregiver who witnessed the trauma or for any other professional who encounters and deals with the traumatic experience of the victim.

Vicarious traumatization arises from the 'intrusive nature of trauma' invading the listener as well. Active listening is the most important characteristic of empathy, and through the thread of this empathy, the trauma often intrudes into the listener's subconscious mind. It might increase the vulnerability of the professional and evoke the caregiver's own traumatic experiences.

This may lead to mild symptoms of post-traumatic stress disorder: anxiety, depression, helplessness, flashbacks, alienation from normal life, dissociative episodes, paranoid thoughts, cynicism, pessimism, extended helper's role, over-identification with the victim's rage/mourning, identification with the aggressor, feeling of guilt, hypervigilance, social dysfunction, mistrust and/or existential panic.

Burnout
Burnout is defined as a state of fatigue or frustration brought about by long-term stress (due to a devotion to a cause, a way of life or a relationship that failed to produce the expected reward).[130] Burnout is a problem born of good intentions, because it happens when people try to reach unrealistic goals and end up depleting their energy and losing touch with themselves and others.

The onset is usually slow. The early symptoms include a feeling of emotional and physical exhaustion, as well as a sense of alienation, cynicism, impatience, negativism and feelings of detachment, to the point that the individual begins to resent the work involved and the people who are a part of that work. In extreme cases, the individual who once cared very deeply about a project or a group will insulate themself to the point that they no longer care at all.

Other signs and symptoms:
- Emotionality, mental and physical exhaustion.
- Feelings of helplessness and hopelessness.
- Feeling of emptiness.
- Somatic symptoms – headache, weakness, overstretching, pain in the neck and shoulders, gastric pain, increase of weight, weakening of the immune system, sleeping disorders.
- Emotional symptoms – dysthymia, helplessness, hopelessness.
- Mental symptoms – negative attitude, rigidity and distance in human relationships; cynicism instead of empathy.
- Psychological consequences of burnout are depressed feelings with the idea of being worth nothing, helplessness, hopelessness, exhaustion, difficulties to achieve work, over-identification with the applicant, etc.

V.3 SOLUTION STRATEGIES [131]

Solution strategies include active and direct strategies, such as trying to influence and change the stressful situation, speaking about the stressors and gain insight and understanding its elements. A positive attitude and keeping up activities outside of those causing burnout also helps. On the other hand, it has been proven that passive strategies, such as the denial of certain elements of stress or the trivialization of feelings, have a reverse effect. Abandoning the stressful situation also belongs to passive/indirect ways of searching for a solution.

Some advice for the prevention of burnout:

- Follow the ethical rules of your profession.
- Become aware of your reactions in a stressful situation.
- Examine your coping mechanisms and your ability to adapt.
- Prioritize your aims.
- Divide your energy– do not concentrate it solely on the one activity.
- Separate your private life and work.
- Evaluate the situation and your current strength to cope with it.
- Share the result of the work with colleagues, for instance in a formalized conference time; plan time in advance for a debriefing and reflection on the ongoing progress of the interviews immediately after the interview or the day after.
- Organize time for supervision and training in different forms.
- Try to maintain a positive attitude by using humour and looking for delight.
- If necessary, ask for help – there are many forms of psychotherapy or counselling that can help.

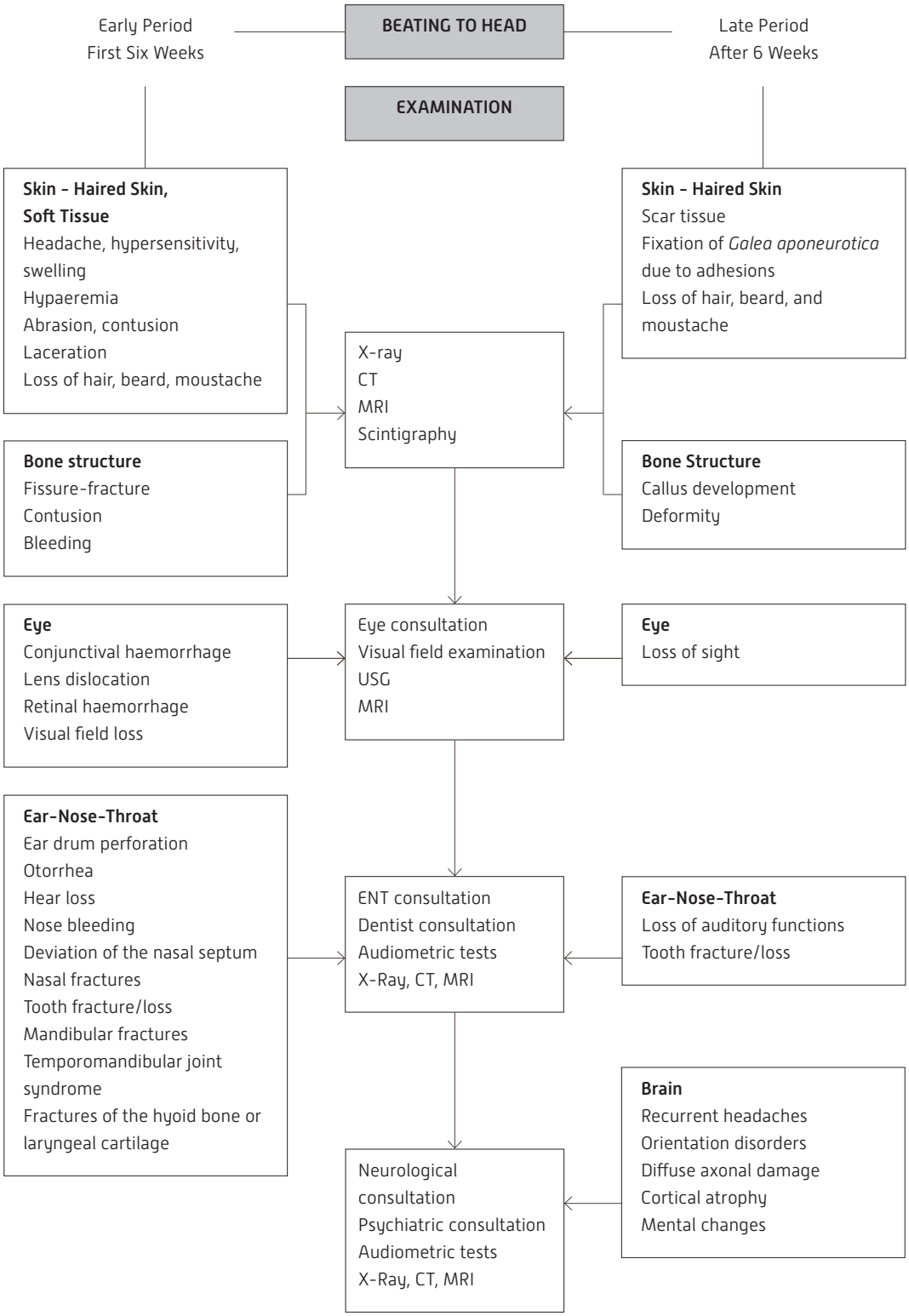
Everybody has to recognize their own trauma filter, their own characteristics, with their background of personal wound or vulnerability, as we know that trauma has an intrusive nature. Vicarious traumatization depends on this filter function as well.

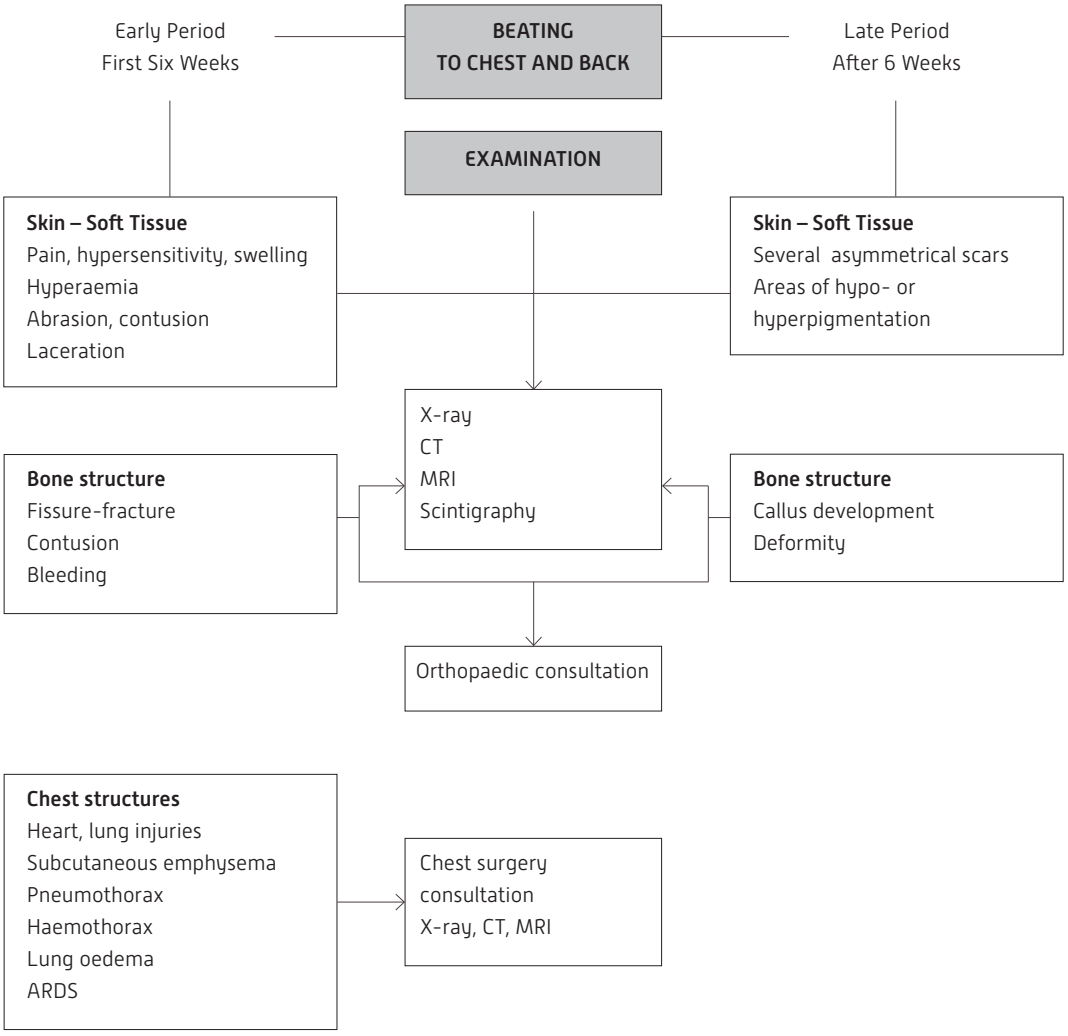
We must always take into account the reality frames: depending upon how much time and energy we have, we must respect the personal, the professional and the environmental boundaries. Having adequate self-esteem and the use of our psychological resources, as well as keeping sufficiently strong and flexible boundaries at the professional empathic levels, are needed to avoid serious problems or conflicts. Belonging to a team is a great help, for its support and criticism. It has a container function, sharing the load of the trauma. Colleagues are the best boundary in the prevention of incompetent acts. Learning and elaborating new methods together increase group cohesion significantly. The group is the best circle in which we can laugh together at our mistakes – as we know that humour is one of the best mature defence mechanisms. And, last but not least, the ability of 'closing the door', taking enough leisure time after the hard working hours, may help to maintain a healthy distance from the problem.

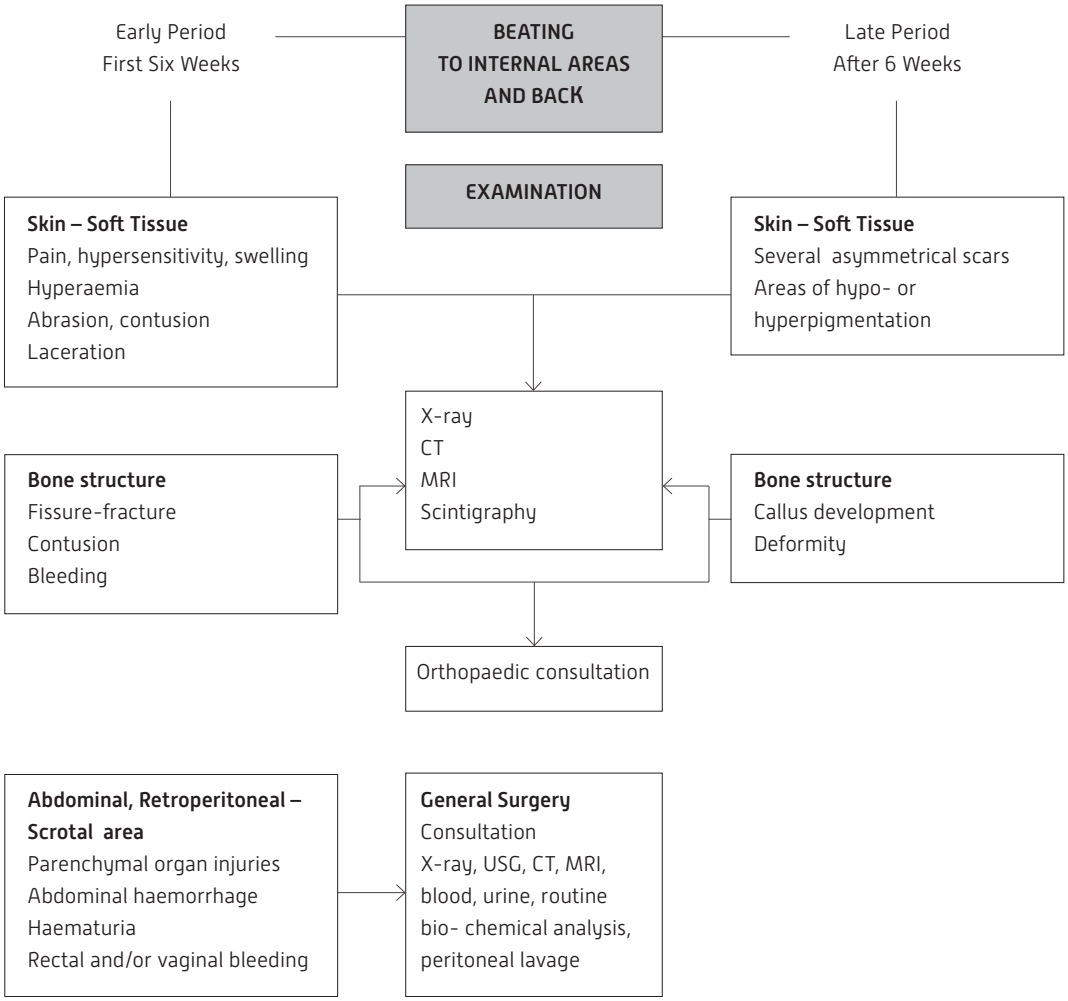
NOTES CHAPTER V. SELF-CARE

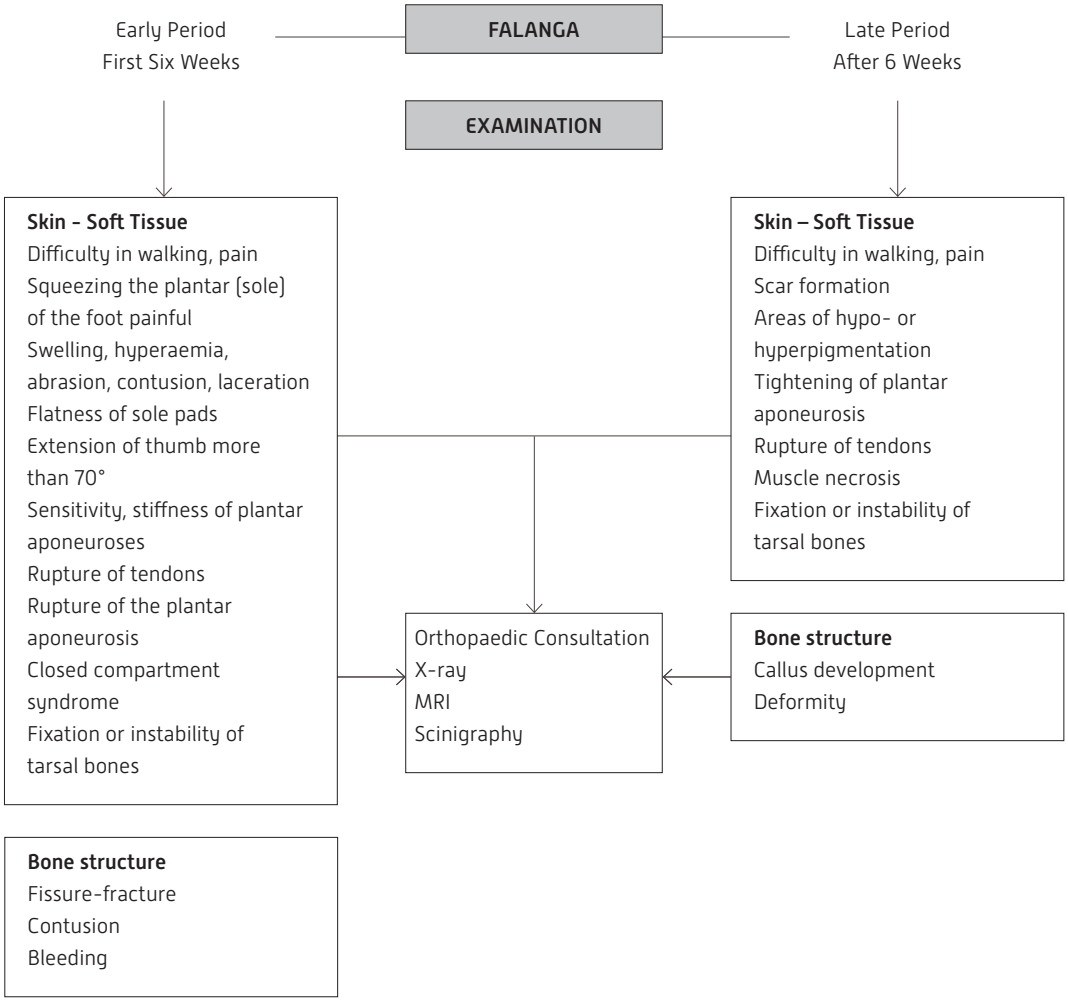
130 *Freudenberger, H., Richelson, G. Burnout: The High Cost of High Achievement. What It Is and How to Survive It. New York, NY: Bantam Books, 1980.*

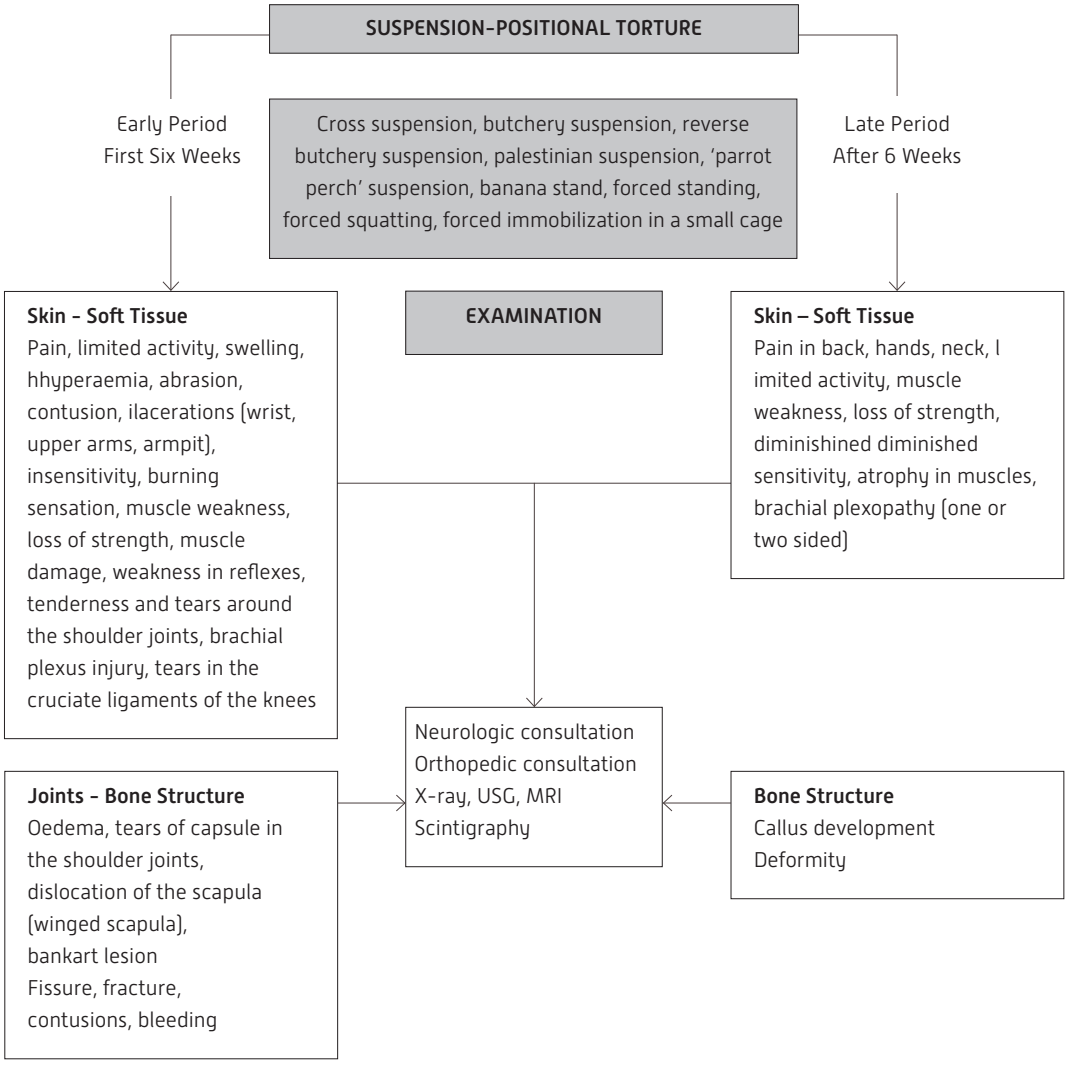
131 *Herman, J., Trauma and Recovery. New York: Basic Books 1992. http://unityandstruggle.org/wp-content/uploads/2016/04/Herman_Trauma-and-Recovery.pdf*


Early Period
First Six Weeks
BEATING TO HEAD
Late Period
After 6 Weeks
EXAMINATION
Skin – Haired Skin,
Soft Tissue
Headache, hypersensitivity, swelling
Hypaeremia
Abrasion, contusion
Laceration
Loss of hair, beard, moustache
Skin – Haired Skin
Scar tissue
Fixation of Galea aponeurotica due to adhesions
Loss of hair, beard, and moustache
X-ray
CT
MRI
Scintigraphy
Bone structure
Fissure-fracture
Contusion
Bleeding
Bone Structure
Callus development
Deformity
Eye
Conjunctival haemorrhage
Lens dislocation
Retinal haemorrhage
Visual field loss
Eye consultation
Visual field examination
USG
MRI
Eye
Loss of sight
Ear-Nose-Throat
Ear drum perforation
Otorrhea
Hear loss
Nose bleeding
Deviation of the nasal septum
Nasal fractures
Tooth fracture/loss
Mandibular fractures
Temporomandibular joint syndrome
Fractures of the hyoid bone or laryngeal cartilage
ENT consultation
Dentist consultation
Audiometric tests
X-Ray, CT, MRI
Ear-Nose-Throat
Loss of auditory functions
Tooth fracture/loss
Brain
Recurrent headaches
Orientation disorders
Diffuse axonal damage
Cortical atrophy
Mental changes
Neurological consultation
Psychiatric consultation
Audiometric tests
X-Ray, CT, MRI


Early Period
First Six Weeks
BEATING
TO CHEST AND BACK
Late Period
After 6 Weeks
EXAMINATION
Skin – Soft Tissue
Pain, hypersensitivity, swelling
Hyperaemia
Abrasion, contusion
Laceration
Skin – Soft Tissue
Several asymmetrical scars
Areas of hypo- or
hyperpigmentation
X-ray
CT
MRI
Scintigraphy
Bone structure
Fissure-fracture
Contusion
Bleeding
Bone structure
Callus development
Deformity
Orthopaedic consultation
Chest structures
Heart, lung injuries
Subcutaneous emphysema
Pneumothorax
Haemothorax
Lung oedema
ARDS
Chest surgery
consultation
X-ray, CT, MRI

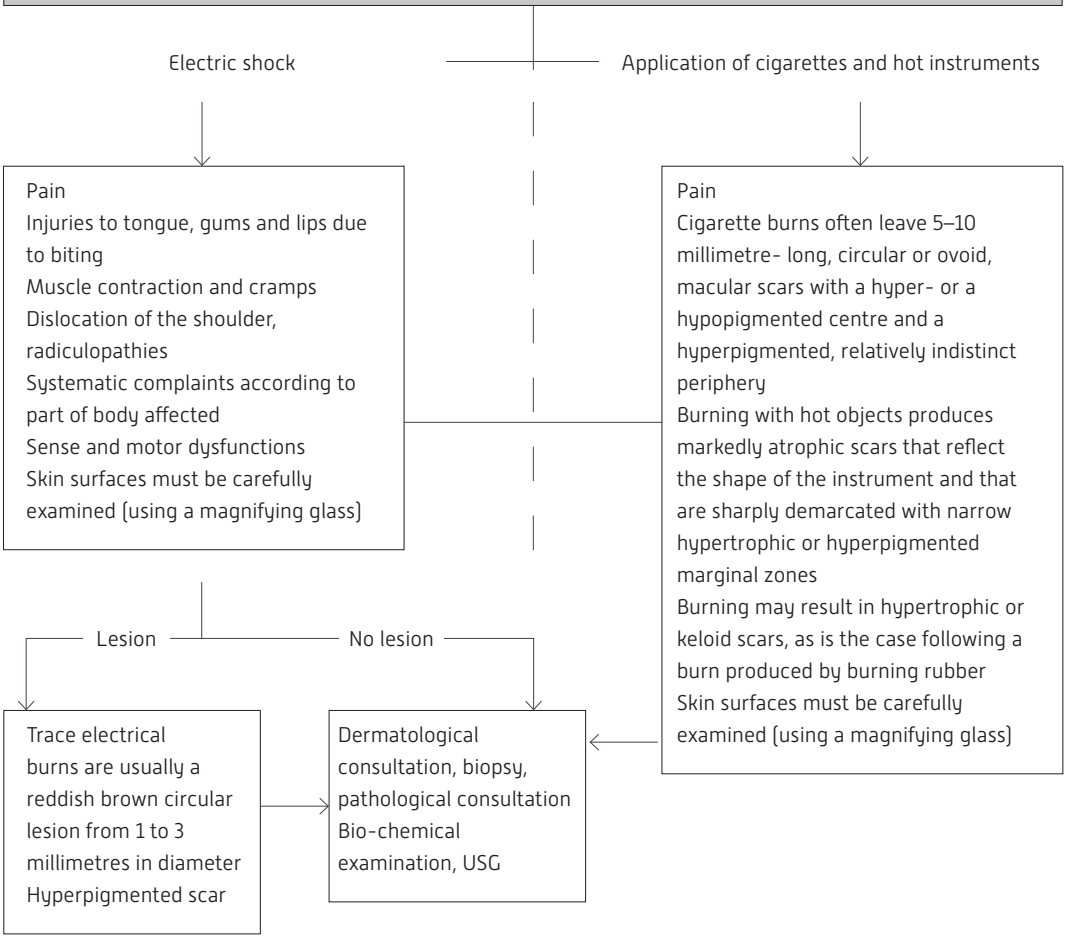

Early Period
First Six Weeks
BEATING
TO INTERNAL AREAS
AND BACK
Late Period
After 6 Weeks
EXAMINATION
Skin – Soft Tissue
Pain, hypersensitivity, swelling
Hyperaemia
Abrasion, contusion
Laceration
Skin – Soft Tissue
Several asymmetrical scars
Areas of hypo- or
hyperpigmentation
X-ray
CT
MRI
Scintigraphy
Bone structure
Fissure-fracture
Contusion
Bleeding
Bone structure
Callus development
Deformity
Orthopaedic consultation
Abdominal, Retroperitoneal –
Scrotal area
Parenchymal organ injuries
Abdominal haemorrhage
Haematuria
Rectal and/or vaginal bleeding
General Surgery
Consultation
X-ray, USG, CT, MRI,
blood, urine, routine
bio- chemical analysis,
peritoneal lavage


FALANGA
Early Period
First Six Weeks
Late Period
After 6 Weeks
EXAMINATION
Skin – Soft Tissue
Difficulty in walking, pain
Squeezing the plantar (sole) of the foot painful
Swelling, hyperaemia, abrasion, contusion, laceration
Flatness of sole pads
Extension of thumb more than 70°
Sensitivity, stiffness of plantar aponeuroses
Rupture of tendons
Rupture of the plantar aponeurosis
Closed compartment syndrome
Fixation or instability of tarsal bones
Skin – Soft Tissue
Difficulty in walking, pain
Scar formation
Areas of hypo- or hyperpigmentation
Tightening of plantar aponeurosis
Rupture of tendons
Muscle necrosis
Fixation or instability of tarsal bones
Orthopaedic Consultation
X-ray
MRI
Scinigraphy
Bone structure
Callus development
Deformity
Bone structure
Fissure-fracture
Contusion
Bleeding


SUSPENSION-POSITIONAL TORTURE
Early Period
First Six Weeks
Cross suspension, butchery suspension, reverse butchery suspension, palestinian suspension, 'parrot perch' suspension, banana stand, forced standing, forced squatting, forced immobilization in a small cage
Late Period
After 6 Weeks
Skin - Soft Tissue
Pain, limited activity, swelling, hhyperaemia, abrasion, contusion, ilacerations (wrist, upper arms, armpit), insensitivity, burning sensation, muscle weakness, loss of strength, muscle damage, weakness in reflexes, tenderness and tears around the shoulder joints, brachial plexus injury, tears in the cruciate ligaments of the knees
EXAMINATION
Skin – Soft Tissue
Pain in back, hands, neck, l imited activity, muscle weakness, loss of strength, diminishined diminished sensitivity, atrophy in muscles, brachial plexopathy (one or two sided)
Neurologic consultation
Orthopedic consultation
X-ray, USG, MRI
Scintigraphy
Joints - Bone Structure
Oedema, tears of capsule in the shoulder joints, dislocation of the scapula (winged scapula), bankart lesion
Fissure, fracture, contusions, bleeding
Bone Structure
Callus development
Deformity

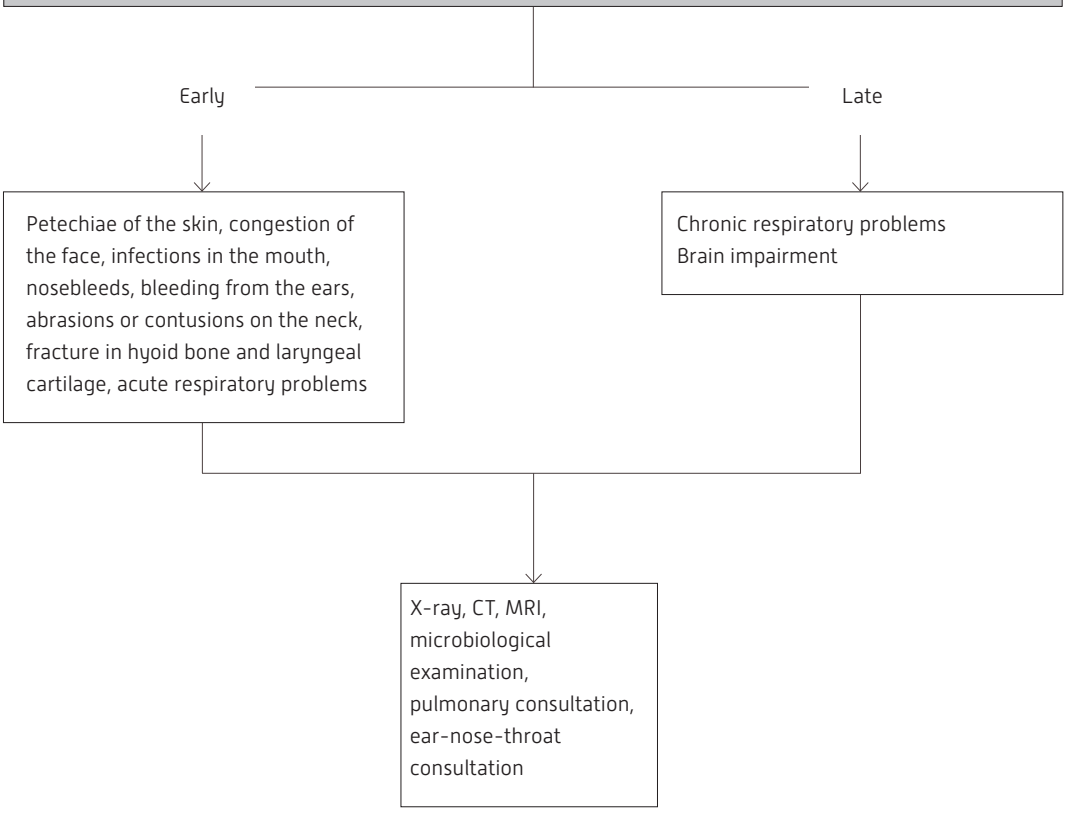
ELECTRIC SHOCK OR BURNIING

Electric shock should be treated taking the following factors into consideration:
Duration, frequency, how and which type of instrument applied; parts of body affected; suffering during exposure; treatment if any following electric shock. Presence of metal devices on the body during electric shock should also be determined (watch, bra hook, bracelet, ring, necklace, etc.), as well as whether water or gels were used in order to increase the efficiency and expand entrance of the electric current on the body, in order to prevent any detectable electric burns.
Application of electric shock should also be evaluated according to the type of current, voltage and ampere.



ASPHYXIATION

Covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, hot peppers
Forcible immersion of the head in water often contaminated with urine, faeces, vomit or other impurities



MUSCULOSKELETAL
Examination: orthopedic examination; posture, walking pattern, examination joints, including spine, muscle strength.

The following signs and symptoms should be recorded:
Pain; difficulty in walking; tendon, joint and muscle injuries; muscle atrophy; fractures and dislocations with or without deformity; mobility of joints, spine and limbs, contractures, stiffness, compartment syndrome.

NEUROLOGICAL[134]
Examination: cranial nerves, sensory organs, peripheral nervous system (motor: strength, muscle atrophy, reflexes; sensory: sensibility).

Cognitive ability and mental status.

Vestibular examination (in a history of dizziness and vomiting). Possible brain imaging (MRI, CT).

The following signs and symptoms should be recorded:
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, temperature sensation, motor function, gait and coordination may all result from trauma associated with torture.

Note: In history of burns, examination of sensibility is necessary.
Note: In history of head trauma, special attention should be paid to signs of brain damage, including cognitive ability and mental status.

FACE/ HEAD
Examination: inspection, palpation, cranial nerves examination, fundoscopy, eye testing, otoscopy, hearing test (test of Rinne and Weber).

The following signs and symptoms should be recorded:
Pain, headache, swelling of face, adhesion of epicranial aponeurosis (the fibrous tissue that covers the upper part of the cranium), crepitation, fracture/depressed skull.

- Eyes – conjunctival haemorrhage, lens dislocation, retinal haemorrhage and visual field loss.
- Oral cavity and teeth – tooth avulsions/ fractures of the teeth, dislocated fillings and broken prostheses.
- Ears – eardrum perforation, bleeding, loss of auditory functions.
- Nose – bleeding, septal deviation, fracture.
- Jaw – mandibular fractures or dislocations, temporomandibular joint syndrome.
- Larynx – fractures of the hyoid bone or laryngeal cartilage.

Note: if there are signs of scarring on the mouth area, investigation of the oral cavity and teeth should be performed

CHEST AND ABDOMEN
Examination: inspection, palpation, auscultation heart, lungs and abdomen.

The following signs and symptoms should be recorded:
Acute problems (e.g. signs of fractures of ribs or vertebrae, injuries to heart, lungs, internal organs).
Chronic problems include signs of constipation, deformities of ribs or spine, signs of previous operations (e.g. laparotomy of ruptured spleen due to blunt abdominal trauma).

GENITAL

Examination: inspection genitalia and anus, palpation testis, palpation vaginal introitus, rectal examination if indicated.

Note: consent and privacy are especially important.

The following signs and symptoms should be recorded:

Acute physical signs and symptoms include:

- Genital bruising, wounding (abrasion, contusion, laceration, bite wounds), petechiae due to sucking, haematocele, testicular torsion.
- Anal bruising, wounding, fissures.
- Vaginal/anal pain, discharge, bleeding, infection (sexual transmitted diseases).
- Constipation, incontinence, bloody stools.
- Urinary frequency, dysuria, bloody urine, UTI (urinary tract infection).
- Irregularity of menstruation.
- Sexual dysfunction.
- Pregnancy, loss of virginity.

Long term signs and symptoms:

- Possible long-term signs and symptoms are especially present in more severe trauma and include:
- Genital scarring or deformity, testis atrophy (Istanbul Protocol §231), genital pain/bleeding
- Vaginal or penile discharge, sexual transmitted diseases.
- Anal scarring, fissures, haemorrhoids, skintags, anal pain/bleeding, reduced anal sphincter function.
- Irregularity of menstrual periods,[135] pregnancy, abortion, subfertility.
- Sexual dysfunction (e.g. arousal problems, dyspareunia, erectile dysfunction) (Istanbul Protocol §158, 226).
- Gastrointestinal complaints; abdominal pain, constipation, incontinence.
- Urinary complaints – urinary frequency, incontinence, dysuria, recurrent UTIs, urethral stricture in case of direct trauma to urethra.[136]
- Vesicovaginal fistulas,[137] rectovaginal fistula.
- Different somatic complaints, [138, 139] – (chronic) abdominal pain, chronic pelvic pain, general non-specific pains, chronic vaginal pain (vulvodynia, vulvar vestibulitis).

Note: Even during examination immediately after rape, injury of vagina and anus is often not present. Most injuries will heal quickly and rarely are any signs seen after 1 week. Damage is most severe in younger girls, after female genital mutilation. (Istanbul Protocol §221, 232.)

Note: It is often difficult for victims to talk about sexual violence (due to feelings of shame, cultural stigma, etc.). Asking for consent to examine the genital area can bring about reactions that might lead to suspicion of sexual violence and a possibility for the person to talk about this. Furthermore, there are other symptoms that can suggest the possibility of non-disclosed sexual violence or support the account of sexual violence, e.g. compulsive washing of the genital area, possibly leading to vulvovaginitis etc.

Note: The medical file might reveal information that can point to sexual violence (i.e. abortion, STD investigation)

Note: Special attention should be paid to the observation of the emotions and expression and possible dissociation.

Note: Photos can be useful; however, specific consent needs to be obtained and they should not be send with the report.

132 *Adapted from: Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill treatment' prepared by the Society of Forensic Medicine Specialists in 2005 revised for 'Prevention Through Documentation Project' IRCT (2007); by Sebnem Korur Fincanci and Turkcan Baykal in cooperation with the projects training committee.*

133 *'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill treatment' prepared by the Society of Forensic Medicine Specialists in 2005 revised for 'Prevention Through Documentation Project' IRCT (2007); by Sebnem Korur Fincanci and Turkcan Baykal in cooperation with the projects training committee.*

134 *Istanbul Protocol §186.*

135 *Golding, J.M. Sexual assault history and women' s reproductive and sexual health. Psychol Women Q. 1996; 20:101-21.*

136 *Norredam, M., Crosby, S., Munarriz, R., Piwowarczyk, L., Grodin, M. Urologic complications of sexual trauma among male survivors of torture. Urology 2005;65(1):28-32.*

137 *Norredam, M., Crosby, S., Munarriz, R., Piwowarczyk, L., Grodin, M. Urologic complications of sexual trauma among male survivors of torture. Urology 2005;65(1):28-32.*

138 *Paras, M.L., Murad, M.H., Chen, L.P., et al. Sexual abuse and lifetime diagnosis of somatic disorders: A systematic review and meta-analysis. JAMA. 2009;302(5):550-61.*

139 *Beck, J.J., Elzevier, H.W., Pelger, R.C., Putter, H., Voorham-van der Zalm, P.J. Multiple pelvic floor complaints are correlated with sexual abuse history. J Sex Med. 2009;6(1):193-8.*

Postma, R., Bicanic, I., van der Vaart, H., Laan, E. Pelvic floor muscle problems mediate sexual problems in young adult rape victims. J Sex Med. 2013;10(8): 1978-87.

Butrick, C.W. Pathophysiology of pelvic floor hypertonic disorders. Obstet Gynecol Clin North Am. 2009;36(3);699-705.

Faubio, S.S., Shuster, L.T., Bharucha, A.E. Recognition and management of nonrelaxing pelvic floor dysfunction. Mayo Clin Proc. 2012; 87(2):187-93.

MEDICO-LEGAL REPORT ARTICLE 18 DIRECTIVE 2013/32/EU

BASED ON THE ISTANBUL PROTOCOL[2]

File number:	XXXXXX

1 EXAMINATION DETAILS

1.1 PERSONAL DETAILS OF APPLICANT

Name:	NNNNNN
Gender:	Man
Country of origin:	XXX -East Africa
Ethnicity (if applicable):	Unknown
Date of birth:	DD-MM-YYYY

1.2 DATA RELATED TO THE MEDICAL EXAMINATION Istanbul Protocol §83(a)

Time and date:	00.00 DD-MM-20XX
Location (nature and address of institution):	XXX

Name examiner, discipline, affiliation (CV attached)

1.:	B, psychologist, iMMO
2:	H, medical doctor, iMMO

Professional ID number or registration number medical council

1:	BBBBBB
2:	HHHHHH

Name referrer, designation:	A, lawyer, law firm XXX
Name interpreter:	IIIIII
Language spoken:	XXX
Name and affiliation other attendants:	None

1.3 SPECIAL REMARKS ABOUT THE EXAMINATION Istanbul Protocol §83(a)
The applicant requested a male examiner for the examination. The psychologist was male but due to the fact that no male medical doctor was available the physical examination was carried out by a female doctor. This was discussed and agreed with by the applicant.
The applicant identified himself with an ID.
The procedure and confidentiality (and its limits) was explained, it was understood by the applicant and informed consent was obtained in writing.
The examination took place on one day, by the psychologist followed by the medical doctor. Duration of the examination was 6 hours, several breaks were taken.

Throughout the examination the applicant had difficulty talking about the traumatic events.
He regularly had tears in his eyes and cried whenever he spoke about traumatic events.

2 FILE

Medical
M1. Immigration services medical advice (MediFirst 'hearing and decision making' advice) (DD-MM-20YY)
M2. Medical file health centre asylum seekers (DD-MM-20YY – DD-MM-20YY)

Legal
L1. First interview Immigration and Naturalisation Service (IND) (DD-MM-20YY)
L2. Corrections first interview lawyer (DD-MM-20YY)
L3. Second interview IND (DD-MM-20YY)
L4. Corrections second interview lawyer (DD-MM-20YY)
L5. Intended decision to reject application IND (DD-MM-20YY)
L6. Viewpoint intended decision lawyer (DD-MM-20YY)

Other
Not applicable

3 HISTORY & MEDICAL HISTORY

3.1 BACKGROUND Istanbul Protocol § 288

3.1a History

The applicant relates as follows.

He grew up in a small town in East Africa. He had a few years of elementary education, up to his 15th year. He experienced school as fun, was a good student and there were no further noteworthy details. He worked together with his father, helping him with the work on the land and as a corn trader. He obeyed his father. If his father told him to do something or to collect something, he did so without question, as is common in his culture. His brother, called NNNN, was killed during a bombardment during fighting between the government and the opposition; he found his brother and saw his injured body.

Observation: he becomes emotional and cries.

In 20XX, his father was arrested by the security services on a false suspicion that his father had ties with members of the opposition. It was a bad year with a poor harvest; thus, their cornmeal storage sheds were empty. The sheds were visited by the authorities, who unjustly accused his father that he had sold corn to opposition members, which his father denied. The applicant was not present; he heard about it through their neighbour, who was present at his father's arrest. The applicant went to the police station to try to get his father released, to no avail. The police told him 'these are the security services; there is nothing we can do'. His mother was afraid that, if he would go through with these attempts, like his father, he would be arrested. The applicant indicates that it was a troubled time and everyone ran the risk of being accused of colluding with the opposition, rightly or wrongly. He explains that his father and he himself were not politically active. He indicates that his own problems (arrest, detention and torture; see section 2.2) have a connection with this, because it was usual that, if someone is accused, it is then assumed that the family members are involved also. After some time, he heard through a neighbour, who they knew well for several years and trusted, that this neighbour had been detained along with his father, but had been released. The neighbour had seen how the father was tortured while being detained and had died of his injuries. The neighbour saw this because the abuse suffered by the father served as an example for the other inmates, to ensure that they would obey the authority of the guards. They accused his father of having collaborated with the opposition. The applicant went to the police and the prison to retrieve his father's body, but to no avail. They have not seen or been able to bury his fathers body.

Observation: the applicant cries as he speaks about his late father and brother. He says: 'he was innocent, me too, you don't know what happens in East Africa.'

After the detention and death of his father, he found work through an acquaintance, named NNNNN, as a seller of phones and call credit, first in ZZZZ, later independently in a small kiosk in ZZZZZ. There, on DD-MM-20XX, he was arrested by government forces. He was accused of working with the opposition.

3.1b Medical history
Psychological:
Until his arrest on DD-MM-20YY, the applicant had no significant psychological complaints. He experienced his upbringing as positive and normal. However, the death of his brother and later of his father were very difficult and sad. Life in XXXX was tough for him, but normal regarding the circumstances of poverty and political unrest.

Physical:
As a child, the applicant was physically healthy. He was rarely sick and never had accidents as a child that led to injury. The work on the field with his father did not cause physical injury. Furthermore there was no physical punishment at home or at school.

3.2 ALLEGED PERSECUTION OR SERIOUS HARM Istanbul Protocol § 83(b), 137–143, 290
3.2a History
The applicant relates as follows.
He worked in the kiosk in ZZZZZ when two men came in. He was beaten and had to walk to a car in which two more men sat. Thus, he was arrested and taken away by four people. In the car, he was blindfolded with a black hood and was shackled with metal handcuffs. Some time later, he had to get out of the car, at a place that was unknown to him at the time; he had to sit on a chair and was questioned regarding his ties with the opposition. He was accused of having collaborated with the opposition because he had sold them chargers and telephone cards/credit. The applicant denied this. . He told them that he couldn't see from the appearance of his customers whether or not they belonged to the opposition and that he sees every customer as a regular customer and sells them products and services. The men who interviewed him did not believe him and continued their interrogation and questions and beat him on his head, for example on his right temple. Because he was blindfolded, he could not see the perpetrators and he did not know where the blows came from.

Observation: the applicant portrays how he was struck; he shows how he was handcuffed with his hands behind his back and how he was beaten on the head. He starts crying, he is sweating and looks agitated.

Then he was taken outside to a hole in the ground, where he had to go down into using a ladder. Then the ladder was taken away, so that he could not go anywhere. The hole could be closed off at the top, making it very dark. Sometimes the hatch was opened, whereby sometimes he could see daylight or moonlight and thereby have a vague idea of the time of day, but often the hatch was shut. He could stand and lie down in the hole. It was made of earth; there were no stones or tiles. There was some straw, a kind of wicker mat, where he could lie down and sleep. There was a small hole in the ground where he could go to the toilet, making the hole very smelly and dirty. He received food once a day, via a bucket on a rope. Sometimes daily, sometimes every few days, he was taken out of this hole to the interrogation room to be interrogated and tortured in various ways. In total, he was detained like this for about 4 months, during which he was regularly interrogated and tortured. This happened so often that he can no longer remember exactly when, how often and what methods were used on which day.

He was asked the same questions over and over; about his ties with members of the opposition and about specific people and names. He denied and continued to deny any connection, because he knew nothing and had nothing to confess. During the interrogations he was tortured with different methods:

- He was often undressed, sometimes wearing only underwear, sometimes completely naked. During the interrogations, he was sometimes blindfolded, with his hands handcuffed at the back to a chair; his legs were free.
- He was made to sit on an iron chair; then electricity was connected to the chair. This resulted in a great deal of pain; he shook all over and afterwards suffered a lot of pain for some days.
- With iron pliers, with ridges on the ends, he was squeezed hard and pulled at his scrotum. He begged them to stop, but they did not. He tried to move backwards to avoid the torture, but that did not work. The pliers made the skin turn white. Due to the intense pain, he sometimes lost consciousness.

Observation: he shows with his hands how his genitals were grabbed and how he was sat shackled on the chair. He says that he would rather not talk about these events and stares out in front of him.

When asked how it is that he had not spoken earlier about this at the IND, he points out that, during the hearing, he indicated that he was also tortured 'there' [he points to his pubic area], but did not go into detail about this because the hearing at the IND took place with both a female IND official and a female interpreter. He was ashamed to discuss it too much, because it is not common within his faith and culture to discuss matters regarding sexuality with people of the opposite sex.

- He was beaten with fists and flat hands, everywhere on his body, on his head, neck, back, shoulders, stomach and legs. They kicked him with heavy military boots. He was beaten with a heavy object, 'a kind of hammer'.
- He was forced to crawl on his hands and feet, in the hallway, next to the interrogation room, with grit and pebbles on the ground.

Observation: he goes on his hands and feet and shows how he had to crawl. When he speaks, he blinks his eyes and stares out in front of himself.

- The skin of his knees was damaged, making them bleed. These wounds were not taken care of and they got bigger. Often he was tortured intentionally on spots where he was wounded, so that these wounds could not heal well. This caused a lot of pain in his knees, and this made it difficult for him to walk.
- The guards lit up, in a kind of basket, charcoal with dried herbs and chilli peppers, called 'shatal', making a very strong-smelling, stinging thick smoke. As a result, he could barely breathe and was nearly suffocated. It irritated his eyes and airway.
- He was several times being threatened to be murdered, while he had to watch how other prisoners were tortured or murdered. He witnessed the execution of others. He describes an event in which he had to sit with some men in a row, with security guards behind him, and some men in front of them were executed. The guards also threatened to kill the applicant if he wouldn't confess to having cooperated with the opposition.

- He was forced to witness how other people were tortured in a gruesome way and ultimately killed, in order to put pressure on him to confess. So he had to watch as two men, almost entirely undressed, were beaten with a hammer and tortured. He heard their cries of pain and fear.

- He was also once handcuffed and blindfolded and brought by armed guards to a place in the desert, where he then had to watch as two other people were tortured. They told him that he would undergo the same fate if he continued to deny his guilt. He had to watch how a man was tied up by his legs to two different cars; then the cars drove in different directions, whereby the man was torn into pieces.

After about 1,5 months in detention, the applicant was so unwell from the pain and injuries that he was brought unconscious to a hospital. According to him, this was a military hospital in ZZZZ, which was known to everyone in the area because it was the only military hospital in the area. Here, both citizens and government soldiers were treated. He recalls that a female doctor or nurse told him that he should cooperate with the security service and tell them what they want to hear, because he otherwise would not survive. He stayed here a few days and, among other things, was placed on a drip. He does not know what sort of liquid was administered. He describes that he had injuries and bruises everywhere and that the medical care he received was bad and inadequate. He was patched up so that he could be interrogated again. After a few days, he was again handcuffed and blindfolded by armed men and brought back to the hole under the ground. The interrogations and torture then resumed in a similar way to before; however, as far as he could tell, this occurred a little less frequently than before.
He gave in, wanted some peace and quiet and said 'make this come to an end'.

Observation: the applicant starts crying, he is sweating, looks agitated and is staring at the table.

A few weeks later, there was a resurgence of fighting in the area. From his hole in the ground, the applicant heard heavy shelling and bombing. This went on for a whole night until the following afternoon. He was taken handcuffed and blindfolded again and thought he was going to be killed. He was physically weakened, despondent and hopeless, and, because of the pain in his knees and body, found it difficult to walk. He was then taken back to the same military hospital, where he had been brought earlier. Under the watchful eye of armed guards, he had to help with the transport of victims and bodies – resulting from the fighting and shelling – to the place where they were buried. There were also a number of wounded people in the hospital. Some doctors checked whether people had actually died, but did so hastily and sometimes barely or not looking at the bodies, said the applicant. With another man, named NNNNNN, he had to lift bodies into an open back of a truck. They would hoist about five bodies into the truck and then drive the bodies to a place in the desert where the bodies were buried. The bodies were sometimes covered with sheets, sometimes not, and he could see blood and mutilated bodies everywhere. They drove several times back and forth, each time, transporting many corpses and bodies from the hospital to the desert; this was over dirt roads with potholes and gaps in the road. At one point, a body moved, because they drove through a pothole. He, NNNNNN and the guards got a huge fright. This person turned out not to be dead. He sat upright and grabbed a guard, who was so startled that he then fainted. The other guard put aside his rifle and

told the driver to stop. The driver got scared and ran away, along with the guard. This created chaos and bustle in and around the truck. NNNNNN said to him, 'this is our chance'. Initially, he didn't want to run away because he was afraid, but then thought better of it, that this might be the only chance that would arise. He jumped out of the truck and ran away, to the north. NNNNNN ran in a different direction. The applicant kept running. He explains that the anxiety and tension were stronger than the pain. He had so much fear of being caught, tortured and murdered that these thoughts prevailed over the physical pain. As a result, he was able to get away. When he was out of sight and kept running, the complaints and the pain got worse, especially in his knees and lower abdomen, but he forced himself to keep walking. He went to an uncle's place. A cousin told him about the fate of his sisters, they had been raped and murdered while he was detained.
Observation: the applicant cries when he speaks of his deceased relatives.

He then fled, through a long and complicated journey, from XXXX to XXXXX. In XXXXX, he was arrested because he did not have the right papers and was interrogated in detention for about 4 months. These were difficult conditions, although he was not tortured or mistreated. They thought at the prison that he came from XXXXXX, but later a senior guard, who apparently had some power, heard that he spoke Arabic and asked him if he was Muslim, which he confirmed. He told that he came from XXXX. This guard said that he had worked in XXXX and would help him. This guard released the applicant and took him to his home, where he was able to stay for some time. In return, the applicant had to work as a shepherd of the officer's sheep and cows. He spent a total of about a year in XXXXX. Then, he crossed over to Italy in a crowded boat. The crossing took a few days; on the way, many became sick, including women and children. He did not quite know where he was when he arrived in Italy. He then travelled through France to Netherlands and asked for asylum here.

Observation: the applicant speaks in detail about the violence and detention He speaks about these events from his own perspective. Sometimes, he seems not to hear or note some of the investigator's questions; he simply wants to complete his sentences and further tell his story in detail. In these moments he seems stuck in his memories of the torture undergone in the past.

3.2b Medical history Istanbul Protocol § 83(b), 170, 172
Psychological:
During the arrest, detention and torture, he felt very frightened. He felt dejected and saw no future perspective any more; he told his guards: 'kill me, then I am done with all this'. He slept badly, felt tired and weakened by inadequate facilities and torture. Since the detention and torture, he feels anxious and is burdened by nasty, oppressive memories of the torture undergone in detention in XXXX.

Physical:
He had various physical symptoms. He had pain everywhere, on the places where he was beaten, kicked and tortured. Especially on his head, back, legs, knees and genitals. The electric chair was very painful, leading to experiencing tingling all over, as well as having a few days of bad vision and stiff muscles. He had bruises and injuries everywhere, whereby regularly he was covered in blood.

The applicant also had blows to the head on the right side against his ear. He has no problems with his hearing. He has no scars on his head.

Both knees were swollen and very painful. The knees were so swollen that he could no longer put on his pants. There was grit from the floor in the wounds. The wounds were red, and the wound on the inside of his left leg became thicker and more painful. Later, he broke open painful swelling himself. Pus came out of the wound. He doesn't know if he also had antibiotics in the hospital. He can still remember that he had a drip, but was so sick and weakened that he does not know which treatment he has had. After fleeing, someone applied 'blue tea' and later also cobwebs to the wound on the knees; this is a local remedy, to allow the wounds to heal. He has various scars resulting from these wounds.

Because of the hammer blows to his knees and lower legs, the applicant also had many wounds on his lower legs. These wounds became larger during detention but then healed spontaneously. His legs were also full of dark spots from bruising.

During his imprisonment, his scrotum was pulled on with a pair of pliers. This yanking occurred for so long that, according to the applicant, one could see white flesh. This created such a painful wound that he could not put on his underpants. The wound produced a lot of fluid, but later healed spontaneously. The applicant also saw blood in his urine and he could produce urine only little by little. Later he could urinate normally.

3.3 CURRENTLY Istanbul Protocol § 105(e), 287(iv)
3.3a Social situation/life circumstances
The applicant relates as follows.
He is currently living in an asylum centre without his family. He has little social support, there are a few people in the asylum centre he can talk to. He prays and reads texts from the Koran but he does not visit a mosque. Since his detention, he has lost contact with his mother, despite an attempt from the Red Cross to find her.

3.3b Medical history Istanbul Protocol § 171
Psychological:
Currently he has sleeping problems. He has nightmares every night, about the torture, and having seen and heard others being tortured. Also the corpses and bodies that he had to transport come back in his dreams. He dreams also that he is being tortured again in the same way as in the past. He awakens screaming and frightened. A roommate in the asylum centre sometimes locked the door so that he could not flee from the room as a result of his nightmares. He experiences these feelings and memories sometimes during the day as well, but less frequently than at night. Then it feels as if he is suddenly back in XXXX and experiences the torture again. He tries in vain not to think about the events in the past. He would prefer not to speak about it again, because this is too painful. He feels wary, on edge, anxious and has trouble concentrating. He eats moderately, drinks sometimes nothing for a long time. He has contact with other people from XXXX in the asylum centre, but avoids talking about the painful events of the past.

He feels very sad and gloomy about what has happened to him. He thinks sometimes about death, but indicates forcefully to that his faith prohibits suicide and that only Allah gives and takes life. 'What to expect after suicide in the hereafter is worse than what you have experienced in life.' He mentions repeatedly that he would rather die here in the Netherlands than return to XXXX. XXXX terrifies him enormously, because of the torture he has undergone. He is afraid of being arrested and again tortured and eventually killed. He feels very lonely and alone and misses his mother: 'I just want to see my mother'. Reading in the Koran, reading certain Suras and meeting up with some friends from XXXX gives him some support.

Physical:
He says he lost weight because he eats less. He eats less because he is too tense and because he's not with his family; he sees food (also) as a social matter.
He sometimes has headaches, but these are recently somewhat reduced. These complaints arise especially if he thinks about his situation. The headache is mainly in his left forehead and temple. His vision is good. Sometimes he also feels nauseas, but doesn't have to vomit.
Since fleeing, the applicant suffers from having to urinate frequently. He has no pain when urinating. These complaints have increased since his arrival in the Netherlands. Also, he sometimes feels pain that radiates from his scrotum in the direction of his belly. These complaints also occur since his imprisonment. If he thinks about what he has gone through, sometimes he feels the pain in the same places as where he was in pain during the torture.

He has problems with his knees. In cold weather, he has pain in his right knee. In warmer weather, he has little complaints. He can then walk without too much difficulty.

Current medication:
He receives medication for his psychological problems prescribed by the GCA. Previously he received Mirtazapine, 15 mg, 1 b.i.d., now he is taking another drug, but he does not know the name of this medication.

4 ADDITIONAL INFORMATION Istanbul Protocol § 161

Not applicable.

5 PHYSICAL EXAMINATION Istanbul Protocol § 162

5.1 GENERAL EXAMINATION

The applicant is a lean young man with a dark-tinted skin colour.

5.2 EXAMINATION OF SKIN LESIONS

The applicant has various scars, spread all over his lower body, that he attributes to the torture he has undergone in prison. These scars are examined and described below. Photos (not shown in this example MLR) and a body diagram are attached.

SCAR 1: Various small and large scars can be seen on both knees (photos 1, 2, 3, 4, 5).

A: On the right knee, three flesh coloured, round-oval, sharp edged scars with a diameter of 0.5 cm to 1.3 cm. The scar tissue is thin and smooth, with an atrophic appearance (red arrows, photos 2, 3).
B: On the inside of the right knee, irregular oval scar of about 4 by 3.5 cm flesh coloured on the edges and hypopigmented centrally, with irregular margins. The surface is smooth, atrophic and shiny and the normal skin structures are not visible. (blue circle, photos 2, 4).
In addition to this, there are various small (approximately 0,5 cm in diameter) scars on the right knee, all of which are not described separately and are not marked on the photos.
C: On the left knee at the top of the kneecap an oval scar of 3 by 1.5 cm, sharp edged. The surface is smooth, shiny and depressed (yellow arrow, photos 2, 5).

In addition to this, there are various small (approximately 0,5 cm in diameter) scars on the left knee, all of which are not described separately and are not marked on the photos.

SCAR 2: On the outside of the right lower leg, a round scar of 3 by 3 cm, hyperpigmented smooth margins. Centrally a hypopigmented discolouration in the shape of a 'plus' sign of approximately 0.5 cm wide (photos 6, 7).

SCAR 3: On the front of the right lower leg above the ankle three similar scars, round-oval in shape, about 1 cm to 3 cm in diameter, hyperpigmented irregular margins and centrally hypopigmented (photos 6, 8).

SCAR 4: On the right lower leg, over the tibia, an elliptical-shaped scar of 4 by 2 cm, hyperpigmented margins, centrally hypopigmented and irregular in colour (photos 9, 10).

SCAR 5: On the left shin, six hypopigmented linear scars. On the outside one scar of 0.5 by 13 cm, irregular in colour (partly hypopigmented, flesh-coloured or hyperpigmented) sharp edged and the

normal skin structures are not visible. The other scars are irregular shaped with a diameter of about 1 cm sharp edged and the normal skin structures are not visible (photo 11).

SCAR 6: On the scrotum, near the base of the penis, hypopigmented, atrophic, scar of approximately 2 by 3 cm, irregular margins, the normal skin structures and hairs are not visible. (photo 12 – due to privacy reasons not attached, available upon request from the office of iMMO).

5.3 SPECIFIC EXAMINATION OF PHYSICAL SIGNS AND SYMPTOMS

Examination of the left and right knee: both knees have full range of flexion (bending) and extension (stretching) which is not painful. Both kneecaps move smoothly but with a creaking sound under the kneecaps when bending. The meniscus tests show no abnormalities. The muscles of the upper legs are thin and atrophied in appearance.

Examination of the scrotum: the applicant finds it difficult and shameful to have to undergo this examination, but in the end he nevertheless agrees. However, he keeps his underwear on and shows the scar on the scrotum from the leg of his underpants. There are beside the scar no further abnormalities, both testicles feel normal. The penis was not examined.

5.4 ADDITIONAL DIAGNOSTIC TESTS

Not applicable.

6 PSYCHOLOGICAL EXAMINATION

6.1 MENTAL STATUS

First impression

The applicant is a XX-year-old man from East Africa, tidy in appearance and in accordance with his calendar age. In contact with others, he is initially reticent and polite. He shows little emotion, until he talks of the traumatic events in the past; then he becomes emotional several times. He gives a depressed, fearful and sombre impression. A high degree of distress is clearly observable and tangible.

Cognitive functions

Consciousness is at first sight clear; at the start of the examination, his attention span and concentration are reasonable. He seems preoccupied with the torture, detention and flight that he experienced. He tells, when asked, in detail about various traumatic events and torture that he underwent. As a result, he seems stuck in his memories of the torture undergone in the past. He indicates to be having trouble with remembering some events and details. In addition, there are also strong feelings of avoidance from certain aspects and details of the torture. He gives the impression of having average intelligence. Currently, he shows good orientation in space, person and time. His sense of reality seems intact. How he presents himself and how he perceives things are undisturbed. How he thinks is, in terms of tempo normal; the content is coloured by fear, sadness and traumatization. His current frequent nightmares, flashbacks and intrusive recollections relate in detail to the undergone torture methods, the bodies/corpses that he has seen and has had to transport, as

well as sounds and images of other people who were tortured and murdered. Following on from this, he also experiences strong physical sensations and stress complaints, such as severe pains related to the undergone violence, trembling, sweating, increased heart rate and hot shivers. This fits in with the flashbacks and intrusive recollections as a result of undergone traumatic events.

Affective functions
His mood is depressed; the applicant is sombre, sad and anxious; during the recollection of the history, at one point, he indicates that it would have been better if he had died, he often cries. The affect is mostly flat and modulating. His fear is accompanied by increased wariness.

Conative functions
His psycho-motor skills are largely undisturbed; the applicant makes an sober impression. He is mostly silent, with his arms folded. His facial expression is lively when he depicts the undergone torture. He has thoughts about death, resulting from the loss of future prospects and gloom; however, currently he has no acute suicidal thoughts or plans. He is motivated to take part in the examination, although he also finds it difficult to talk about the past.

Alcohol and drug use
The applicant reports no substance abuse such as of alcohol, nicotine or drugs.

6.2 SPECIFIC EXAMINATION OF PSYCHOLOGICAL SYMPTOMS
Several cross-cultural validated psychological tests were carried out.

The Bourdon–Wiersma test
The Bourdon–Wiersma test measures the ability to concentrate. It is a non-language test, where the test applicant has to differentiate, as quickly as possible, a certain number of dots.

Results of the Bourdon–Wiersma test
The applicant understands the explanation of the instructions and is motivated to take part. During the try-out, he makes some mistakes. During the actual test, he stops after about 10 lines. With some encouragement, he continues, although it is apparent that his attention waned: he makes various errors, has several omissions and stares out in front of himself. Halfway through the test, he is already well over the standard time (4 min and 10 sec). Therefore, the test is stopped before completion. The outcome of the test gives a clear indication of problems in concentration.

The Harvard Trauma Questionnaire (HTQ)
The HTQ measures if there are symptoms associated with PTSD. Per item, the client indicates, on a four-point scale, to what extent he or she suffers from a particular complaint, ranging from 'no burden' to 'a lot of burden'. The questionnaire gives a score for PTSD as described in the DSM-IV-TR.

Results of the HTQ
The applicant has trouble with some questions, which need extra explanation. He scores very high on all three clusters: intrusive memories, avoidance and increased irritability. The contents of his thoughts, memories and nightmares relate to the recollection of violence in East Africa. Consequently, on the basis of this questionnaire, he conforms to the three criteria that are associated with a PTSD, according to the DSM-IV-TR.

The Brief Symptom Inventory (BSI)
The BSI is a questionnaire to measure symptoms of psychopathology in adults. The list is used to get a first impression of the nature and severity of complaints. Many common complaints are measured, such as depression, anxiety and somatic complaints but also less common symptoms such as hostility, paranoid ideas and complaints that indicate psychotic symptoms. For each item, the person indicates the degree to which they suffer, on a five-point scale, from a certain problem, ranging from 'no difficulty', to 'extreme difficulty'.

Results of the BSI
Due to time constraints, this questionnaire was not carried out.

7 REFERRAL Istanbul Protocol § 83(d), 156, 291

Given the seriousness of the current psychological complaints, the psychologist, according to the professional standards of the examiner, referred the applicant to the mental healthcare consultant at the health centre for treatment and counselling

8 EVALUATION OF FINDINGS

8.1 RELIABILITY OF THE EXAMINATION Istanbul Protocol § 105(f), 287(v), 290
The applicant describes his history with concrete personal examples, he portrays how he was tortured on his hands and knees. Talking about the traumatic events call up physical and psychological responses in the applicant (agitation, sweating, avoidance, shame) that are visible. The applicant is unambiguous in this examination with regard to the complaints and emotions that he shows at different times. Furthermore the applicant is unable to give an attribution to certain scars, this points to that there is no exaggeration of symptoms. It is logical and well known that when tortured multiple times it is highly difficult to give exact attributions to each scar.

The clinical picture is highly similar to how it is described in medical records and legal documents.

Information from the medical file:
During the initial interview at the health centre asylum seekers (GCA) on DD-MM-20YY, it was reported that the applicant indicated to have undergone traumatic experiences but didn't go into any further details. He was described as a very skinny young man who wouldn't look directly at the doctor/nurse.

From DD-MM-20YY, the health centre file (item M2) repeatedly makes mention of a man who has undergone physical violence during captivity. He has been beaten and tortured with sharp objects on, among other parts of his body, the scrotum. He has pain in his knees and in his scrotum. Also, scars are noted on his knee, lower legs and scrotum. He also mentions nightmares, anxiety and flashbacks. Because of these problems as a result of violence, he was referred by the health centre to the mental healthcare consultant, who described the referral as 'very appropriate'. He was immediately referred to a specialized mental healthcare institute. Since then, there have been various contacts with the mental healthcare consultant who has diagnosed PTSD, including fears, nervousness, tension and nightmares as a result of torture in detention in the country of origin. The mental healthcare consultant considered the lawyer's request for a forensic medical examination at iMMO as being 'appropriate'.

Information from the legal file:
During the asylum interviews, the applicant avoids speaking about any of the undergone violence. From the current examination, it becomes evident that the he did not want to speak about the undergone sexual violence, because of the presence of a female interpreter and immigration officer (see also 'second interview' report; file item L3). He indicates that it is not appropriate for him, personally and culturally, to talk about such matters with someone of the opposite sex; this corresponds to what is known in the scientific literature about feelings of shame and avoidance to speak about undergone sexual violence.

From scientific research, it is known that, in cases of sexual violence, there are very strong feelings of shame and avoidance which make it difficult to disclose the traumatic events.[3] Furthermore cultural factors play a role for the applicant in the level of disclosure that is possible with a female present. These feelings of shame and avoidance were also apparent during the examination.

There is therefore no reason to doubt the reliability of the examination or to suggest falsification or aggravation of the clinical picture.

8.2 EVALUATION OF FINDINGS FROM PHYSICAL EXAMINATION Istanbul Protocol § 187 [4]
Assessment of scars
The described scars (under section 5.2) are interpreted below according to the same numbering.

SCAR 1: Various small and large scars can be seen on both knees. The applicant states that these were caused by being forced to crawl on his bare knees through the corridor of the prison complex. The floor was covered with tiles and grit. While crawling he was kicked with heavy soldiers boots against the back of his feet causing the grit to penetrate deep into the skin of his knees (photo 1,2,3,4,5). The atrophic appearance of the scars indicates deep healed wounds. The scar on the inside of the right knee is likely the result of, because of its irregular aspect, a deep infected wound. The location and the size of the scar on the left knee are likely to be caused by the described causing mechanism (maximum bending of the knee and kicking against the feet as portrayed in detail by the applicant). There are few other possible causes for the amount and large size of the scars on this location. A fall on the knees would not likely result in such extensive scarring.

The scars are therefore assessed as **highly consistent** with the alleged causing mechanism.

SCAR 2: The scar on the outside of the right lower leg is, according to the applicant, caused by pinching of the skin with force using tongs by a guard. (photo 6, 7). This created a superficial wound and bruising of the skin. The aspect of the scar; the smooth margins, the hyperpigmentation on the margins and the hypopigmentation in the centre, as well as the visible pattern are likely caused by the mechanism described by the applicant. Due to the force on the skin the margins are likely to be lacerated, in the centre due to the pressure bruising is likely and can cause altered pigmentation of the skin.[5] The shape of the scar as well as the diagonal lines is likely to be caused by a specific object, such as the pinchers the applicant describes. A fall or kick to the lower knee would not give such a specific scar. The scar is therefore assessed as **highly consistent** with the alleged causing mechanism.

SCAR 3: The scars on the front of the lower leg were caused by the abuse according to the applicant, but he cannot remember how exactly. The upper scar shows similarities with the above described scar (scar 2). However, because of the absence of an exact explanation, no assessment is possible according to the Istanbul Protocol regarding the causal relationship between the scar and the alleged abuse (photo 6, 8). The fact that no clear attribution was given is used in the assessment of the reliability of the examination (and possible falsification) see section 8.1.

SCAR 4: Like the scars described above (scar 3) the scars on the right lower leg were caused by the abuse according to the applicant but he cannot remember how exactly.. Because of the absence of an exact explanation, no assessment is possible according to the Istanbul Protocol regarding a causal relationship between the scar and the alleged abuse (photo 9, 10).

SCAR 5: The scars on the front of the left lower leg were caused by being hit with a hammer by a guard according to the applicant. (photo 11) This caused various wounds, the wounds were bleeding and slowly healed without infection. The aspect of the scars, the hypopigmentation and irregular shape, can be caused by the described mechanism. Force from the outside with a hard object can cause lacerations of the skin, damaging all layers of the skin. There is no skin disease which causes this type scarring. The scars are however not specific, there are other possible causes like deep scratching over sharp or hard objects. These scars are therefore assessed as **consistent** with the alleged causing mechanism.

SCAR 6 (including the complaints of the scrotum): the scar on the scrotum is according to the applicant caused by a wound inflicted by pulling with tongs by the guard. This was extremely painful, the applicant resisted which caused even a stronger pull. It created a wound and 'white tissue' came out of the scrotum. The description of the applicant that he saw 'white tissue', points to a wound through the skin and the underlying tissue becoming visible. The skin of a the scrotum is thin and considering the alleged force used this is very well possible. Additionally, the applicant states that he suffers from pain in his scrotum ever since. He also experiences this pain during intrusive memories. It is possible that a nerve was damaged which causes the pain to remain. Persistent pains on the location of torture are documented regularly, this can be referred to as somatisation. [6] Additionally, the applicant suffers from frequent urination, which is seen more often after sexual abuse.[7] The scar

and the remaining pain in the scrotum are also described in the medical file on 24-12-15 (file item M2). The location of the scar is not known for spontaneous injuries nor does it have the aspect of any surgical procedure (photo 12).
The scar as well as the pain- and urination complaints are all together assessed as **typical** with the account of the applicant regarding the torture of his scrotum.

Assessment of physical complaints/symptoms
The applicant suffers from occasional knee pain, he attributes this to the sustained violence on his knees, the hitting as well as the crawling on his knees. Examination of the knees shows besides the scarring (see above) creaking sounds under the kneecap. This can be caused by possible damage of the cartilage under the knee cap due to direct violence to the knees, such as crawling over the floor, as stated by the applicant. These complaints are not specific however and frequently occur due to other causes.
The pain of both knees is therefore assessed as **consistent** with the accounts.

Examination of the scrotum:
see under scar 6 above.

Conclusion physical examination
The correlation between the scars and the physical symptoms and the attributions given by the applicant are assessed, in this investigation, as ranging from consistent to very consistent.
The amount and distribution of scars spread all over his legs and scrotum, the description given by the applicant of the physical symptoms, the details given about the causes and the portraying of the accounts makes the totality of the physical signs and symptoms **highly consistent** with the accounts of the applicant regarding the described torture.

8.3 EVALUATION OF FINDINGS FROM PSYCHOLOGICAL EXAMINATION Istanbul Protocol § 187 [8]
Diagnostic considerations according to history (section 3.3) and examination (section 6.1)
It concerns a XX-year-old man who appears very anxious and sombre. He describes various experiences of loss of family members (father, brother, sisters) due to political turmoil in East Africa. After those events, he was, in 20YY, himself arrested on suspicion of collaborating with the opposition and, during that detention, underwent various traumatic events for about four months. He describes being severely tortured several times; electric shocks, physical torture such as hitting, kicking and choking, being kept in solitary confinement in deplorable conditions, sensory deprivation, being forced to witness severe torture and the murder of other people, as well as undergoing threats and mock executions.

Since these events he describes having various mental and physical problems. He suffers daily from PTSD symptoms; intrusive recollections, in the form of nightmares and flashbacks, of the undergone torture (he experiences again how he was tortured, he sees images and hears sounds of the detention, of his own torture and that of others, he sees images of corpses and bodies); this also leads to experiencing physical symptoms such as increased heart rate, trembling and sweating. He is anxious, wary and suspicious.

He tries in vain to avoid these memories and tries to stay clear of topics that remind him of what he has gone through.

He has a depressed mood, there is loss of perspective about the future, mourning for his deceased relatives and for the absence of his mother. He feels gloomy about what he has endured and about his current situation. He is afraid to be sent back to East Africa and to be tortured and murdered there.

The above complaints correspond to what is described in the medical record of the GCA (file item M2).

The applicant makes contact in a restrained, socially adequate way. The post-traumatic stress complaints and the high degree of distress are clearly visible.

The results of the psychological assessment tests confirm the clinical findings and the symptoms described in the medical file. The results of the two psychological tests (HTQ and Bourdon-Wiersma) show a clear picture, they point to serious mental symptoms that fit with a PTSD according to the criteria of the DSM-IV-TR. Furthermore serious concentration problems were found with the test.

He meets all the criteria that match having a post-traumatic stress disorder (PTSD), in accordance with DSM-IV-TR, with complaints relating to all three clusters: intrusive recollections, avoidance irritability and hyperarousal. Given the frequency, intensity and distress, these complaints are serious in nature. This diagnosis is in accordance with the diagnosis of PTSD of the mental healthcare consultant (file item M2).

Conclusion psychological examination
Because of the nature, content and timeline of the complaints and symptoms the findings are being assessed as typical of the asylum accounts of the applicant.

Specific psychological findings, such as his nightmares, intrusive recollections and flashbacks about detention under the ground and being (sexually) tortured in his country of origin, fit the type and content of the alleged violence in detention, as described in sections 2.2 and 3.3. Furthermore the timeframe of psychological symptoms in relation to the trauma events supports this.

Other symptoms, such as sadness, grief, loneliness and loss of future perspective, relate both to the undergone violence as well as to the other stressful experiences including the current life situation. These coexisting stressors (such as his current situation and the death of his brother, father and sisters) are not likely to have lead to PTSD. PTSD requires specifically experience of severe trauma such as threat to life and would not be expected to arise due to bereavements. These can cause other psychological symptoms like depression and act as co-stressors but the PTSD requires a different cause and none other is apparent than the torture described. (Istanbul Protocol § 287(iv)].

8.4 OVERALL EVALUATION OF THE TOTALITY OF FINDINGS Istanbul Protocol § 188 [9]
The physical and psychological signs and symptoms together are being assessed as **typical** of the history of violence. The amount and specificity of the physical scarring (for example the scar on the scrotum) together with the seriousness and amount of psychological symptoms, the description of the traumatic events, the obvious physical responses (like sweating) and avoidance (especially in relation to the sexual violence) are assessed together in this evaluation.

9 SUMMARY

9.1 SUMMARY OF THE HISTORY

The applicant is a XX-year-old man from East Africa. He worked for years with his father as a farmer and corn merchant. His brother was killed in a bombardment. In 20YY, his father was falsely accused by the security forces of working with the opposition, which led to his arrest and torture, resulting in his death. After the death of his father, he worked in a small phone credit kiosk in ZZZZZ. In 20YY, he was visited there by the security services and arrested. He was falsely accused of collaboration with opposition members, and for about 4 months he was held in detention, without hope of release, in a hole in the ground. Multiple times he was tortured; through electric shocks, physical torture such as being beaten, kicked, choked, placed in solitary confinement in deplorable conditions, forced to witness the serious torture and murder of other people, undergoing psychological threats and mock executions. At one stage, he succumbed to the effects of this torture and was for a short time moved to a hospital, where the medical care was inadequate. He was then brought back to the same captivity, where the interrogations and torture continued. One day he was taken away; he expected to be killed, but had to clear away victims resulting from increased fighting and shelling. He had to transport bodies and corpses to be buried. During this work, an unexpected situation occurred: a body suddenly moved and turned out not to be dead, whereby his fellow prisoner, NNNNNN, and the armed guards got a huge fright. One guard passed out, the other guard and driver ran away in panic, and so he had the opportunity to flee. He describes his fear being more powerful than his physical complaints and weakening. He found shelter and help from his cousin and uncle and fled to XXXXX.

9.2 SUMMARY OF THE PHYSICAL AND PSYCHOLOGICAL SIGNS AND SYMPTOMS

Before the traumatic events he was physically and psychologically healthy. He experienced grief due to the loss of his brother and father.
Since the torture and detention he suffers from various physical and psychological problems.
He had many physical complaints during the detention, weakening of his general condition, pain in his knees and wounds all over his body (especially his knees, lower legs and scrotum). His physical condition got worse in the course of his flight. He currently has scarring on his scrotum, knees and lower legs and occasional pain in his knees. He also is experiencing physical complaints like sweating, agitation and hot flushes when talking about or thinking about the traumatic events as well as pain on his scrotum and urinary symptoms.
He has been diagnosed with PTSD and symptoms of depression, in short he has intense memories of the undergone torture, avoidance and a depressed mood.

9.3 SUMMARY OF CONCLUSIONS

9.3a Conclusion of evaluation of physical signs and symptoms

The correlation of the scars and the physical symptoms and the applicant's accounts are assessed in this examination as ranging from **consistent** (the scars on the left shin and the pain in the knees), **highly consistent** (the scars on both knees and on his right lower leg) to **typical** (the scar on his scrotum).

The amount and distribution of scars spread all over his legs and scrotum, the description given by the applicant of the physical symptoms, the details given about the causes and the portraying of the accounts makes the totality of the physical signs and symptoms **highly consistent** with the accounts of the applicant regarding the described torture (see section 8.2).

9.3b Conclusion of evaluation of psychological signs and symptoms

This correlation of the psychological symptoms and the accounts is being assessed in relation with the manner in which the applicant describes, explains and illustrates his psychological complaints, the visible and perceptible distress, the detailed representation of various methods of torture that he underwent, the findings, both physical and psychological/psychiatric, noted in the current examination, which, because of the nature, content and timeline of the complaints and symptoms, are being assessed as **typical** of the asylum accounts of the applicant (see section 8.3).

9.3c Overall conclusion

In conclusion it can be said that based on this examination there is medical evidence of the applicant's asylum account of the alleged torture. The physical and psychological signs and symptoms together are being assessed as **typica**l of the history of violence (see section 8.4).

To come to these conclusions the evaluation of the reliability of the examination has been taken into account (see section 8.1).

10 AUTHORSHIP Istanbul Protocol § 83(e)

Date:

Place:

Name:

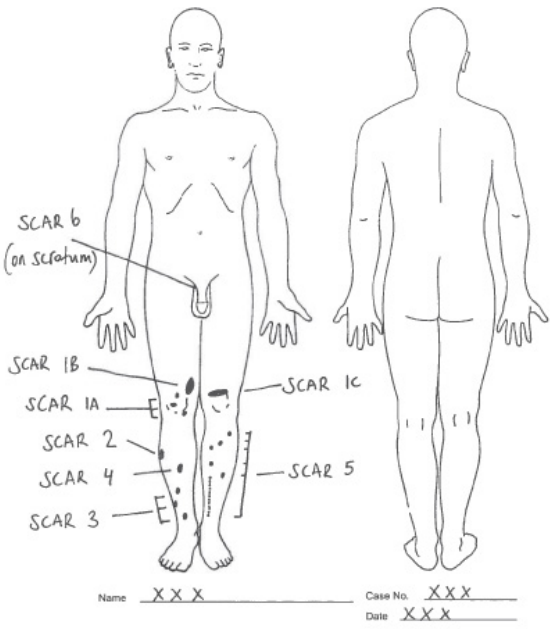
Signature:

Curriculum Vitae B, psychologist, iMMO
Clinical psychologist, 8 year work experience, including 2 years in Africa.
Trained as a forensic examiner by iMMO in December 2013, since then several forensic examinations per year on a volunteer basis. Furthermore follows the regularly held training days and intervisions as organized by iMMO. Also involved in the peer-review of MLRs for iMMO.

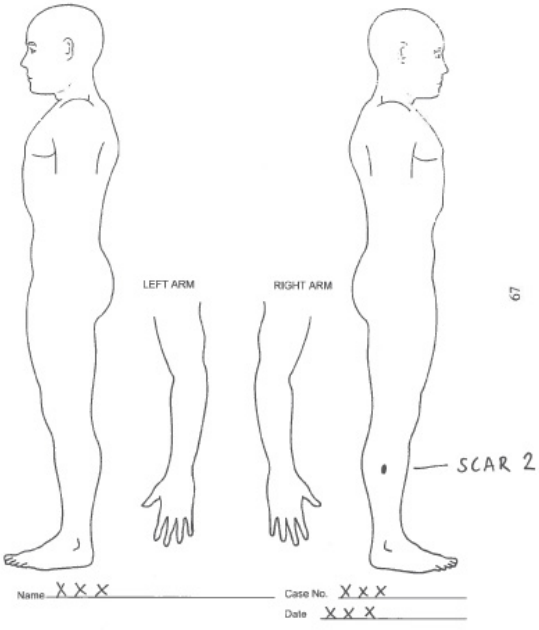
Curriculum Vitae H, medical doctor, iMMO
General practitioner, 12 year work experience in clinical practice, experience with intercultural communication.
Trained as a forensic examiner by iMMO in March 2012, since then several forensic examination per year on a volunteer basis. Furthermore follows the regularly held training days and intervisions as organized by iMMO. Also involved in the peer-review of MLRs for iMMO.

BODY DIAGRAM Istanbul Protocol Annex III

Full body, male
anterior and posterior views (ventral and dorsal)



Full body, male
Lateral view



1 *The information in this MLR has been anonymized and the applicant has given written consent for the information being used for educational purposes.*

2 *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel or Degrading Treatment or Punishment. New York and Geneva: United Nations, 1999.*

3 *Bögner, D., Herlihy, J., Brewing, C.R. Impact of sexual violence on disclosure during Home Office interviews. Br J Psychiatry. 2007;191(1);75-81. https://www.ncbi.nlm.nih.gov/pubmed/17602129*

4 *Istanbul Protocol §187. The following terms are generally used:*
(a) Not consistent: the lesion could not have been caused by the trauma described.
(b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes.
(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes.
(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes.
(e) Diagnostic of: this appearance could not have been caused in any way other than that described.

5 *Peel, M., Hughes, J., Payne-James, J.J. Postinflammatory hyperpigmentation following torture. Journal of Forensic and Legal Medicine 2003;10(3):193-196. http://www.jflmjournal.org/article/S1353-1131%2803%2900078-6/abstract*
Vachiramon, V., Thadanipon, K. Postinflammatory hypopigmentation. Clin Exp Dermatol. 2011 Oct;36(7):708-14. https://doi.org/10.1111/j.1365-2230.2011.04088.x

6 *Rohlof, H.G., Knipscheer, J.W., Kleber, R.J. Somatization in refugees: A review. Soc Psychiatry Pschiatr Epidemiol. 2014;49(11):1793-804.*
Williams, A.C.C., Amris,K. Pain from torture. Pain. 2007;133:5-8. https://doi.org/10.1016/j.pain.2007.10.001
Persistent pain in survivors of torture: a cohort study. Williams AC et al. J Pain Symptom Manage. 2010 Nov;40(5):715-22.

7 *Physical and sexual abuse in patients with overactive bladder: is there an association? Jundt L etal. Int Urogynaecol J Pelvic Floor Dysfunct. 2007 Apr;18(4):449-53.*

8 *See footnote 4*

9 *Istanbul Protocol §188. 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.*

ABOUT THE PARTNERS

IMMO (THE NETHERLANDS INSTITUTE FOR HUMAN RIGHTS AND MEDICAL ASSESSMENT) is an independent organization founded on 14 July 2011. iMMO contributes to the protection of human rights, especially by making forensic medical assessments of suspected victims of torture and inhumane treatment and the transfer of expertise thereof. This is done especially in the context of a procedure for asylum seekers. iMMO works with freelance professionals – especially physicians and psychologists – who have the required knowledge and expertise, who commit themselves on a voluntary basis and who are not bound to iMMO by an employment contract. Every year iMMO receives around 150 applications for a medico-legal report. Besides forensic medical assessments iMMO offers advice and consultation to professionals having questions regarding medical aspects of the asylum procedure. iMMO also provides training and education, e.g. with regard to the early recognition of victims of torture or inhumane treatment. iMMO works not for profit and depends on funding. For more information: *http://www.stichtingimmo.nl*

THE CORDELIA FOUNDATION FOR THE REHABILITATION OF TORTURE VICTIMS is a non-profit medical organization operating in Hungary since 1996, with the aim to provide complex rehabilitation to those asylum seekers and beneficiaries of international protection who survived torture or other forms of inhuman or degrading treatment. Cordelia's team of psychiatrists, psychologists, other therapists and specially trained mothertongue interpreters, works country-wide, providing medical treatment, psychotherapy, counselling, crisis intervention and psycho-social care to more than 1000 patients per year. Cordelia was founded and is still today led by dr. Lilla Hárdi, psychiatrist, psychotherapist and member of the International Forensic Expert Group. The Foundation is the only Hungarian member of the International Rehabilitation Council for Torture Victims and besides the above activities, the only entity in Hungary that issues medico-legal reports based on the Istanbul Protocol for its clients.

Founded in 2001 by Pierre Duterte and accredited as a charitable organization, **PARCOURS D'EXIL** ("a journey of exile") runs a healing center in Paris that provides free medical and psychological services to victims of torture, government-sponsored violence, human rights violations and unaccompanied minors. Each year the center welcomes nearly 750 men, women and children. Parcours d'Exil is one of Europe's leading centers for specialized rehabilitation cares for torture survivors. The majority of the patients are either asylum seekers or refugees who have no other choice but to flee their home country in order to save their own life. The efforts of the multidisciplinary team focus on achieving three primary goals:

- Treating victims of various human rights violations, most notably torture.
- Training the professionals who interact with torture victims;
- Informing professionals, institutions and the public in general.

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