Guidelines for Instructors
Case #01 and #02

Addendum to Modules 7 & 8 of the

Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment

Educational Resources for Health Professional Students

Prevention through Documentation Project

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International Rehabilitation Council for Torture Victims

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Guidelines for Instructors

Case #01

Module 7

1. Identify sequence of participation among students (5 min). The interview will be divided into 8 sections and each student will have 10 minutes for their component, followed by 5 minutes of group discussion. Ask for volunteers, or make assignments, for each of the components and consider making notes and issues discussed:

	Student/Instructor	Performance Comments	Issues Discussed
1)	_____/_____	_____	_____
2)	_____/_____	_____	_____
3)	_____/_____	_____	_____
4)	_____/_____	_____	_____
5)	_____/_____	_____	_____
6)	_____/_____	_____	_____
7)	_____/_____	_____	_____
8)	_____/_____	_____	_____

2. Notify "detainee" to be brought to the examination room.

3. Begin Interviews: For each component I-VIII below, information is provided for a) objectives, b) relevant case information, c) points for discussion, and d) instructors notes. Timing: 15 min for each component (student = 10 min + discussion = 5 min)

I. Introduction and Identification Information

LEARNING OBJECTIVES:

- Provide clear and effective introduction: identity of examiner, purpose of the interview, who the medical evaluation will be sent to and limitations on confidentiality
- Explain the nature of the evaluation and the simultaneous need for detail and accuracy. Uncertainties should be discussed due to likely adverse effect on credibility.
- Obtain informed consent on Standard Evaluation Form (#1-3).
- Ensure comfortable stetting, respectful interaction.
- Earn trust, establish alleged victim's control over the interview process.
- Ability to accurately record relevant case information on Standard Evaluation Form (#4-5).
- Develop appropriate responses to police coercion.

RELEVANT CASE INFORMATION: (As provided by role-player)

Name: **Mrs. Asha Ali Yousif**

- Date of Birth: dd/mm/yyyy (age 35),
- Citizenship: Sudanese
- Marital Status/Children: Married, widow, 13 year-old daughter
- Place of Birth: A village east of Nyala
- Place of Residence: Kalma IDP Camp, 17 Km. east of Nyala, southern Darfur state
- Highest Level of Education: completed high school
- Occupation: Former teacher, currently unemployed
- Religion: Muslim
- Identification Document Presented: None
- Ethnic Group: Darfurian, Fur Tribe
- Physician Examiner's Name and License #: (To be fill out by the examining physician)
- Individuals Present in the Examination Room and Reason for Presence: (To be fill out by the examining physician)
- Language spoken: Fur
- Name of Interpreter: None (To be fill out by the examining physician)
- Restrictions Noted: (To be fill out by the examining physician)
- Detainee Status: No (To be fill out by the examining physician)

POINTS FOR DISCUSSION:

1. Purpose of the Medical Evaluation:
   - Relate discussions in the plenary sessions with physician attitudes and experiences regarding the purpose of their evaluations
   - Note significant misconceptions of normative practice or legal requirements of expert medical witnesses who provide medical evaluations in cases of alleged torture and/or ill-treatment.
   - Note the Istanbul Protocol states that: "The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient's allegation of abuse and to communicate effectively the physician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture."
   - Please ensure that the students understand, as the Istanbul Protocol makes clear, that "the absence of physical and/or psychological evidence in a medical evaluation does not rule-out the possibility that torture or ill-treatment was inflicted."

2. Informed Consent: Physicians must ensure that detainees understand the potential benefits and adverse consequences of an evaluation to form the basis of informed consent. Physicians have a duty to maintain confidentiality of information and to disclose information only with the detainee's consent. Each detainee should be examined individually, in privacy. The detainee has the right to refuse the examination.

3. Setting: The location of the interview and examination should be as safe and comfortable as possible, including access to toilet facilities. Sufficient time should be allotted to conduct a detailed interview and examination. Discuss potential conflicts between practical limitations and ideal circumstances.

4. Earning Trust: Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires

active listening, meticulous communication, courteousness and genuine empathy and honesty. Consider asking the students to iterate ways of earning trust.

5. Control: Acknowledge the detainee's ability to take a break if needed or to choose not to respond to any question he or she may not wish to.

6. Dealing with Coercion by Law Enforcement and/or Other Officials: Consider the following excerpt from the Istanbul Protocol in your discussions:

> *"Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner's request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place they are not comfortable with."*
>
> *"The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. The presence of police officers, soldiers, prison officials or other law enforcement officials during the examination may be grounds for disregarding a negative medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report."*

Though many clinicians may not examine clients in the presence of law enforcement officials, this issue should be acknowledged for possible future training of forensic clinicians who conduct official evaluations for the government.

INSTRUCTOR'S NOTES:

II. Past Medical and Surgical History and Psychosocial History – Pre-Arrest

LEARNING OBJECTIVES:

- Obtain a complete medical history, including prior medical, surgical and/or psychiatric problems
- Document any history of injuries before the period of detention and any possible after-effects. Knowledge of prior injuries may help to differentiate scars, or other physical evidence, related to torture from those that are not
- Summarise any previous forensic evaluation related to the allegations of torture and/or ill-treatment

RELEVANT CASE INFORMATION:

Past Medical/Surgical History:

- No history of significant medical illness, including psychiatric, no surgeries, broken bones or head injuries or other major injury.
- History of infibulation prior to marriage and reinfibulation after the birth of her child
- Medications: aspirin for headaches and body aches.
- No history of drug use and no history of alcohol or tobacco use.

Psychosocial History- Pre-Arrest:

- Born, in a village east of Nyala, the oldest of 4 children.
- Family poor; parents worked odd jobs to making ends meet.
- Attended school and became a teacher. Husband was also a teacher.
- Husband killed one year ago when the Sudanese Army and Janjaweed militia burned their village to the ground
- Lives in Kalma camp with 13 year-old daughter, Salwa
- Religious

Prior Medical Evaluation:

- Prior medical records were not available for review.
- She went to Nyala Hospital the day after the alleged attack by soldiers, but was refused a medico-legal evaluation. She was told that she needed a special police form (Police Form 8) to receive treatment.
- On the same day, she also visited a clinic in Kalma camp. She was given some aspirin for headaches and body ache, and bandages for the cuts above her left eye and on the back of her left hand. She did not mention any history of trauma as she was afraid of possible reprisals by police.
- The left hand injury became infected and she was treated as an outpatient with antibiotics. She indicated that the doctors incised and drained the wound and packed it with gauze.

POINTS FOR DISCUSSION:

1. Psychosocial History- Pre-Arrest: The student should inquire into the person's daily life, relations with friends and family, work/school, occupation, interests, and use of alcohol (if culturally appropriate) and drugs, prior to the traumatic events. Inquiries into prior political activities and beliefs and opinions are relevant insofar as they help to explain why the person was detained and/or tortured, but such inquiries are best made indirectly by asking the person what accusations were made, or why they think they were detained and

tortured. The psychosocial history is particularly important in understanding the meaning that individuals assign to traumatic experiences.

2. Inconsistencies between prior medical evaluations and the present evaluation should be noted and addressed in the Interpretation of Findings section of the report.

3. In the past, Police Form 8 was required in Sudan for medical treatment of injuries caused by a criminal act. Form 8 is no longer required for medical treatment of such injuries. It may be useful to discuss ways for health professionals to address such relevant country-specific requirements such as Form 8 in Sudan.

INSTRUCTOR'S NOTES:

III. Trauma History

LEARNING OBJECTIVES:

- To understand various techniques of questioning and applying them appropriately
- To elicit a coherent and accurate account of alleged torture/ill-treatment
- To structure inquiries in order to elicit a chronological account of the events experienced
- To understand sources of variability and the effects of such variability on history-taking
- To pursue and clarify possible inconsistencies in the trauma history
- To take note of non-verbal (process) information and links between emotional affect and the content of the trauma history

RELEVANT CASE INFORMATION:

Attacked by Soldiers:

- Note context of antecedent history of trauma about one year ago: home and village burned, witnessed the killing of her husband and father, and displaced to Kalma IDP camp.
- dd/mm/yyyy (4 months prior to the exam date), attacked by "men in military uniforms" while she, her daughter and two other women were fetching firewood
- Stripped naked and insulted
- Threatened at gunpoint
- Witnessed the killing of a woman who tried to flee her attackers
- Unable to protect daughter, heard her daughter scream while they both were being sexually assaulted
- Head trauma: rifle butt to left eyebrow, and kicked on the right side of face, no loss of consciousness
- Sexual assault:
  - Raped by 3 men with vaginal penetration, no anal intercourse
  - Daughter and another woman also raped nearby

- Injury to left hand of unknown cause, which became infected with abscess formation and was subsequently incised and drained.

Police Abuse:
- dd/mm/yyyy (2 days following the alleged assault) visited Nyala police station to make a complaint.
- She reported sexual assault by police officer Omer Mohamed Suliman, i.e. touching breasts and groin with clothes on.
- Slapped on the face and beaten with a hose on the back and arms by police officer Suliman and insulted.
- Suliman reportedly threatened to kill her if she would tell anyone of his actions.

Note: Medical personnel refused to provide treatment citing the need for Form 8 to be completed by police, but this is no longer the case.

POINTS FOR DISCUSSION:

1. Review performance on appropriate use of "open-ended" and "closed" interviewing techniques. Typical open ended question may be phrased as follows:
   - "Can you tell me what happened?"
   - "Tell me more about that."
   - Provide some explanation for traumatic questions: For example, "People who have been detained are sometimes abused sexually, is this something that has happened to you?" Also, such questions should be asked only after a significant level of trust has developed.

2. Discuss how and when to redirect the history when "irrelevant" information is being presented.

3. Consider sources of variability in the history:
   - In the degree of physical and psychological signs, symptoms or consequences that a torture victim will manifest.
   - In the manner in which torture victims conduct themselves in interviews and in recounting the events of their abuse.
   - In the amount and detail of information that an individual will recall with regards to the events of the trauma.

4. Regarding inconsistencies in the history: review student's performance on the pursuit of inconsistencies in the history. Discuss factors that may interfere with an accurate recounting of past events: 1) blindfolding, 2) disorientation, 3) lapses in consciousness, 4) organic brain damage, 5) psychological sequelae of abuse, 6) fear of placing oneself or others at risk, and 7) lack of trust with the examining physician.

5. Non-Verbal Information: Discuss with the students their observations of non-verbal information such as affect and emotional reactions in the course of the trauma history and the significance of such information.

6. Discuss the importance of historical information: Consider the following:

   Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include: descriptions of torture devices, body positions and methods of restraint, descriptions

of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place of detention.

7. Review historical information in this case that may be very useful in corroborating an individual's allegations of torture and/or ill-treatment.
   - Likely abscess formation of the left hand requiring incision and drainage. The injury was noted after the attack. This is not uncommon given the intensity of the experiences reported.
   - See section "V. Physical Symptoms (acute and chronic) and Disabilities" below for additional historical information that corroborates Mrs. Yousef's allegations of abuse.
     - Probable perinephric contusion manifested by hematuria for several days
     - Likely Bell's Palsy due to trauma of the right peripheral facial nerve
     - Description of characteristic "tram-track" marks from police batons
     - Observations of acute injuries and their approximate healing times

8. Identity of perpetrators: Discuss the importance of gathering information on the identity of alleged perpetrators and limitations thereof. Note that it is often helpful to document what the perpetrators reportedly said during the abuse as it may help to establish their identity and/or the imputed intent of the torture/ill-treatment.

9. Considerations regarding sexual assault: It may be helpful to identify and record categories of concern for accountability and prevention of GBV for subsequent discussions on remedial strategies, for example:
   - Camp security
   - Adequate provision for basic needs of internally displaced persons
   - Effective documentation of GBV, particularly rape, in medical settings, including IDP camps.
     - Medical and psychological evaluations using Istanbul Protocol standards
     - Rape kits
     - Photographic documentation
     - Diagnostic testing for pregnancy and sexually transmitted diseases, including HIV
     - DNA evidence
     - Chain of evidence
   - Establishing the identity of perpetrators
   - Current legal norms and evidentiary requirements for rape and sexual assault
   - Prosecution of rape/GBV as torture, ill-treatment, assault, gross indecency, etc
   - Protection of plaintiffs/witnesses.
   - Informed consent
   - Treatment issues

INSTRUCTOR'S NOTES:

IV. Review of Torture Methods

LEARNING OBJECTIVES:

- To understand the advantages and disadvantages of direct questions about specific methods of torture/ill-treatment
- To assess a wider range of possible physical and psychological methods of torture.

RELEVANT CASE INFORMATION:

- Sexual Assault:
  - Condoms were not used by any of the perpetrators.
  - No anal intercourse
  - No menstrual period for the past three months
  - History of infibulation prior to marriage and reinfibulation after the birth of her child.
- Head trauma: Handgun butt to the left side of her face, just above the left eyebrow, no loss of consciousness. There was blood on her face and a cut above her left eyebrow. The area was very tender and swollen for about one to two weeks.
- Laceration injury to the dorsum (backside) of the left hand: She was not sure how or when this happened but she noticed that it had bleeding after the attack. The injury became infected, swollen and drained pus about a week later. She was treated as an outpatient with antibiotics. The doctors opened it and packed it with gauze. Eventually it healed.
- The review of torture methods is negative for the all other torture methods, physical and psychological.

POINTS FOR DISCUSSION:

1. Ensure that students use open ended questions initially in their review of torture methods, i.e. "Were there any other forms of abuse that you experienced?" Did they do or say anything else than what you have already mentioned?"

2. To assess a wider range of possible physical and psychological methods of torture. Consider the following list:

NOTE: Reviewing different forms of torture is especially helpful when: psychological symptoms cloud recollections, the trauma was associated with impaired sensory capabilities (i.e. blindfolding, extreme fear and anxiety, sleep deprivation, loud noises, intense lights or the use of psychotropic drugs), in the case of possible organic brain damage, or when there are mitigating educational and cultural factors. It is important to learn about regional practices of torture and modify the Review of Torture Methods accordingly.

NOTE: This list of torture methods provided below is given to show some of the categories of abuse possible. It is not meant to be used by physicians as a "check list", nor as a model for listing torture methods in a report. A method-listing approach may be counter productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Torture methods to consider include, but are not limited to:

1) Blunt trauma: punch, kick, slap, whips, wires, truncheons, falling down
2) Positional torture: Suspension, Stretching limbs apart, prolonged constraint of movement, forced positioning

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

INSTRUCTOR'S NOTES:

V. Physical Symptoms (acute and chronic) and Disabilities

LEARNING OBJECTIVES:

- To assess relevant physical symptoms (acute and chronic) and disabilities experienced after the alleged torture/ill-treatment
- To anticipate physical symptoms and/or disabilities for specific methods of alleged torture
- To correlate reported physical symptoms (acute and chronic) and disabilities with specific allegations of abuse

RELEVANT CASE INFORMATION:

Acute Symptoms:

- Hematuria for about 3 days following the incident, then resolved completely. No vaginal discharge.
- Bell's Palsy symptoms: Unable to smile on right side or close the right eyelid for about 2 weeks. This was associated with trauma/swelling of the right side of the face just in front of the right ear.
- No menstrual period since the incident – 3 months late.
- She observed bruises where beaten, black and blue marks that resolve after about 2 weeks.
- Description of typical "tram-track" bruises associated with beating with a hose or baton.

Chronic Symptoms:

- Chronic tension headaches (in the front of the head, throbbing, lasts a few hours, once to a few times per day, improved with acetaminophen, similar headaches in the past with stress, but only occasionally.)
- Difficulty concentrating and irritable
- Having problems sleeping (see psychological evaluation below)

Disabilities:

- None noted

POINTS FOR DISCUSSION:

1. Discuss how symptoms (acute and chronic) and disabilities, in this case and other, can be used to corroborate specific allegations of abuse.

2. Discuss how mitigating factors may influence the alleged victim's ability to observe acute (or chronic) symptoms or disabilities.

3. Review historical information in this case that may be very useful in corroborating an individual's allegations of torture and/or ill-treatment.
    - Probable perinephric contusion manifested by hematuria for several days. (See Section V. Symptoms (acute and chronic) and Disabilities below). A urinary tract infection or STI may have been possible, but there were not other urinary, vaginal or systemic symptoms.
    - Likely Bell's Palsy due to trauma of the right peripheral facial nerve.
    - Description of characteristic "tram-track" marks from police beating with a hose.

- Observations of acute injuries and their approximate healing times.

INSTRUCTOR'S NOTES:

VI. Psychological Evaluation and Mental Status

LEARNING OBJECTIVES:

- To be able to conduct a mental status examination
- To be aware of factors that may contribute to psychological outcomes
- To be able to assess symptoms of common psychological conditions associated with torture and ill-treatment.
- To recognise signs and symptoms of possible organic brain dysfunction and how
- To recognise and respond effectively to transference and countertransference reactions
- To recognise
- To respond effectively in court at the qualifications of the physician to conduct a psychological evaluation

RELEVANT CASE INFORMATION:

- Unremarkable mental status examination
- Symptoms of PTSD:
  - -Re-experiencing: intrusive distressing memories, nightmares, flashback/reliving the event,
  - Hyperarousal: insomnia, irritability, difficulty concentrating, exaggerated startle response
  - Avoidance: of stimuli associated with the trauma, foreshortened sense of future
- Symptoms of Major Depression:
  - Depressed mood
  - Anhedonia
  - Appetite disturbance
  - Sleep disturbance
  - Psychomotor retardation
  - Fatigue, poor energy
  - Feelings of worthlessness and excessive guilt
  - Poor attention, concentration and memory

POINTS FOR DISCUSSION:

1. Consider factors that may influence psychological outcomes in this case: Consider the following:
   - Circumstances, severity and duration of the torture
   - Cultural meaning of torture/trauma

- Cultural meaning of symptoms
- Age and developmental phase
- Genetic and biological vulnerabilities
- Interpretation of torture by the victim
- Social context before, during and after the torture
- Community values and attitudes
- Political factors
- Prior history of trauma
- Pre-existing personality

2. What diagnostic categories are supported by the information provided by the detainee in case #01? Do these symptoms constitute Acute Traumatic Stress Disorder or PTSD? If not, why not?
3. What are specific elements of meaning assigned to the alleged torture experience for this individual?
4. Discuss possible causes of psychological symptoms other that torture or ill-treatment? Consider post-torture losses and/or traumatic experiences.
   What evidence, if any, indicates that the psychological symptoms are related to torture?
5. Discuss the use of symptom lists and diagnostic instruments.
6. Discuss the possibility of organic brain dysfunction. Consider evidence that supports/refutes the possibility in Case #01. Are any other tests and/or referrals indicated in Case #01?
7. Discuss the issue of referral for psychological care. When is this indicated and what resources are available?
8. Discuss what criteria may qualify a medical doctor to be an expert on psychological evidence of torture and ill-treatment.
   - Medical school training in psychiatry
   - Clinical experience in the diagnosis of major depression (a common illness among those with chronic diseases)
   - This training course and certification
   - Reading of relevant literature (and attending relevant meeting if applicable)
   - Those cases that require expertise beyond my abilities are referred accordingly

INSTRUCTOR'S NOTES:

VII. Physical Examination

LEARNING OBJECTIVES:

- To be able to recognise physical signs of torture/ill-treatment in acute and chronic settings and understand the sensitivity and specificity of common findings
- To conduct and anticipate pertinent positive and negative findings based on specific allegations of torture and/or descriptions of acute/chronic symptoms or disabilities

following torture or ill-treatment
- To understand the advantages and disadvantages of conducting complete vs. directed physical examinations
- To understand how mitigating factors may affect physical sequelae of torture and ill-treatment; i.e. sequelae of electric shock may be affected by 1) the current applied, 2) the duration of contact, 3) the area of contact, 4) the use of conductors that limit heat production and therefore thermal injury, 5) the thickness (electrical resistance) of skin involved, 6) healing that occurs over time, and 7) variability in the physiological response of victims, among other factors.
- To document photographic evidence where appropriate and make effective use of anatomical drawings

RELEVANT CASE INFORMATION:

NOTE: Images of "virtual physical examination" findings will be presented in a separate room using PPT slides

Slide #1**:** A 1cm x .2cm hyperpigmented, linear scar above the left eyebrow consistent with an old laceration injury

Slide #2: Left hand scar: A large, 4cm x 6cm, atrophic (loss of underlying tissue) scar present on the dorsum (back-side) of the left hand. The scar includes areas of hypo and hyper pigmentation and bands of subcutaneous fibrous tissue are present.

POINTS FOR DISCUSSION:

1. In this case, what pertinent positives and negative findings should the students consider? List them.
2. After viewing the "virtual examination findings," consider possible correlation between the findings and specific allegations of torture.
3. Discuss the advantages and disadvantages of conducting complete vs. directed physical examinations.
4. Consider whether any diagnostic tests and/or referrals may be indicated. If so, list them. Regarding diagnostic tests: pregnancy test, semen analysis of clothing, etc.
5. Under what circumstances is a pelvic or genitourinary examination appropriate for one who has alleged sexual violence? How should the examination be conducted? What should be done?
6. Consider ways in which the physical examination may re-traumatise victims of torture and/or ill-treatment and how this may be avoided.
7. Discuss how the presence or absence of physical findings may be related to specific mitigating factors.
8. Discuss how and when to use photographs and anatomical drawings.

INSTRUCTOR'S NOTES:

VIII. Interpretation and Conclusions

OBJECTIVES: (as stated in the Standard Evaluation Form #13)

- To be able to provide interpretations on physical, psychological and, if relevant, historical evidence of torture/ill-treatment:

Physical Evidence:

- Correlate the degree of consistency between the symptoms (acute and chronic) and the disabilities (acute and chronic) with the alleged history of trauma.
- Correlate the degree of consistency of the physical findings with the alleged history of trauma (the absence of physical findings does not rule out torture or ill-treatment).
- Correlate the degree of consistency of the history of trauma and physical findings with the patterns of torture prevalent for the region where events occurred.

Psychological Evidence:

- Correlate the degree of consistency of the psychological findings with the alleged history of torture.
- Evaluate if the psychological findings noted during the evaluation are expected for extreme stressful situations of individuals with the cultural and social background similar to the examinee.
- Indicate the state of the psychological findings in regards to its natural history and its relation to the alleged history of torture, as well as whether the psychological symptoms and findings are improving.
- Identify any other stressor that coexists and that may play a role in the psychological symptomatology. Describe the extent that these coexistent stressors may have on the individual.
- Mention how the examinee's physical condition may affect the clinical presentation noted during the evaluation, and, in particular, the possible association with cranioencephalic trauma during torture.

Historical Evidence:

- Correlate relevant historical information (descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place of detention) with torture practices alleged in the present case and regionally, if appropriate.

- To state unequivocally in the conclusion the student's opinion on the possibility of torture and/or ill-treatment, and indicate a degree of certainty. Consider the following recommendations in the Istanbul Protocol:
  - Not consistent: The lesion could not have been caused by the trauma described;
  - Consistent with: The lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;
  - Highly consistent: The lesion could have been caused by the trauma described, and there are few other possible causes;

- Typical of: This is an appearance that is usually found with this type of trauma, but there are other possible causes;
- Diagnostic of: This appearance could not have been caused in any way other than that described.

• Be able to provide appropriate recommendations for further evaluations and treatment.

RELEVANT CASE INFORMATION:

As noted above

POINTS FOR DISCUSSION:

1. Discuss any problems that the students anticipate in presenting evidence as suggested above.

2. Discuss the importance of integrating all lines of evidence, and possibly the lack thereof, in the conclusion statement(s).

3. Discuss ways of assessing and reporting the possibility of dissimulation.

4. Consider reviewing with students a list of factors that may account for difficulty recounting the specific details of the torture. Compare student responses with Istanbul Protocol list:
   - Factors during torture itself such as blindfolding, drugging, lapses of consciousness, etc.;
   - Fear of placing oneself or others at risk;
   - Lack of trust for the examining clinician and/or interpreter;
   - Psychological impact of torture and trauma such as high emotional arousal, and impaired memory secondary to trauma-related mental illnesses such as depression and posttraumatic stress disorder;
   - Disorientation and/or lapses in consciousness;
   - Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning, and starvation;
   - Protective coping mechanisms such as denial and avoidance; and
   - Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.[3]

5. Note: the importance of scientific references when appropriate

INSTRUCTOR'S NOTES:

DEBRIEFING:

1. Role-players provide feedback on student performances and process issues.

2. Consider relevant transference and countertransference issues: Physicians who conduct medical evaluations of detainees should be familiar with common transference reactions (i.e., potential reactions of the survivors toward the physician) that victims of trauma experience and the potential impact of such reactions on the evaluation process.

Potential reactions of the survivors toward clinician (transference):

- FEAR, GUILT, SHAME
- REMINDED OF "INTERROGATION"
- SUSPECTS VOYEURISTIC OR SADISTIC MOTIVATIONS
- HOW CAN CLINICIAN UNDERSTAND TORTURE?
- AUTHORITY FIGURE THEREFORE CANNOT TRUST
- INVESTS TOO MUCH TRUST
- FEAR THAT INFORMATION WILL BE SHARED WITH PERSECUTING GOVERNMENT
- FEEL OVERWHELMED WITH MEMORIES
- GENDER ISSUES
- "RE-TRAUMATISATION"

Potential reactions of clinician toward survivor (countertransference):

- AVOIDANCE/WITHDRAWAL
- HELPLESSNESS/HOPELESSNESS
- DEFENSIVE INDIFFERENCE
- VICARIOUS TRAUMATISATION: NIGHTMARES, ANXIETY, AND FEARFULNESS
- OVER-IDENTIFICATION/IDEALISATION OF THE ALLEGED VICTIM
- GRANDIOSITY AS A "SAVIOR"
- INSECURITY IN ONE'S OWN PROFESSIONAL SKILLS
- GUILT
- ANGER

INSTRUCTOR'S NOTES:

Guidelines for Instructors

Case #02

Module 8

4. Identify sequence of participation among students (5 min). The interview will be divided into 8 sections and each student will have 10 minutes for their component, followed by 5 minutes of group discussion. Ask for volunteers, or make assignments, for each of the components and consider making notes and issues discussed:

	Student/Instructor	Performance Comments	Issues Discussed
1)	_____/_____	_____	_____
2)	_____/_____	_____	_____
3)	_____/_____	_____	_____
4)	_____/_____	_____	_____
5)	_____/_____	_____	_____
6)	_____/_____	_____	_____
7)	_____/_____	_____	_____
8)	_____/_____	_____	_____

5. Notify "detainee" to be brought to the examination room.

6. Begin Interviews: For each component I-VIII below, information is provided for a) objectives, b) relevant case information, c) points for discussion, and d) instructors notes. Timing: 15 min for each component (student = 10 min + discussion = 5 min)

I. Introduction and Identification Information

LEARNING OBJECTIVES:

- Provide clear and effective introduction: identity of examiner, purpose of the interview, who the medical evaluation will be sent to and limitations on confidentiality.
- Explain the nature of the evaluation and the simultaneous need for detail and accuracy. Uncertainties should be discussed due to likely adverse effect on credibility.
- Obtain informed consent on Standard Evaluation Form (#1-3).
- Ensure comfortable stetting, respectful interaction.
- Earn trust, establish alleged victim's control over the interview process.
- Ability to accurately record relevant case information on Standard Evaluation Form (# 4-5).
- Develop appropriate responses to police coercion.

RELEVANT CASE INFORMATION: (As provided by role-player)

Name: **Mr. Hassan Bashir Adam**

- Date of Birth: dd/mm/yyyy (age 25)
- Citizenship: Sudanese
- Marital Status/Children: I am single, and I do not have children.
- Place of Birth: Nyala
- Place of Residence: Khartoum
- Highest Level of Education: Currently a student at Khartoum University.
- Occupation: Student
- Religion: Muslim
- Identification: ID confiscated
- Ethnic Group: Darfurian, Zagawa tribe
- Physician Examiner Name and License #: Fill out
- Individuals Present in the Examination Room and Reason for Presence: Fill out
- Language spoken: Zagawa
- Name of Interpreter: None
- Restrictions Noted: This depends on the response of the interviewer.
- Detainee Status: Detained by police and released

POINTS FOR DISCUSSION:

1. Purpose of the Medical Evaluation:
   - Relate discussions in the plenary sessions with physician attitudes and experiences regarding the purpose of their evaluations.
   - Note significant misconceptions of normative practice or legal requirements of expert medical witnesses who provide medical evaluations in cases of alleged torture and/or ill-treatment.
   - Note that the Istanbul Protocol states: "The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient's allegation of abuse and to communicate effectively the physician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture."

2. Informed Consent: Physicians must ensure that detainees understand the potential benefits and adverse consequences of an evaluation to form the basis of informed consent. Physicians have a duty to maintain confidentiality of information and to disclose information only with the detainee's consent. Each detainee should be examined individually, in privacy. The detainee has the right to refuse the examination.

3. Setting: The location of the interview and examination should be as safe and comfortable as possible, including access to toilet facilities. Sufficient time should be allotted to conduct a detailed interview and examination.

4. Earning Trust: Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires active listening, meticulous communication, courteousness and genuine empathy and honesty.

5. Control: Acknowledge the detainee's ability to take a break if needed or to choose not to respond to any question he or she may not wish to.

6. Dealing with Coercion by Law Enforcement and/or Other Officials: Consider the following excerpt from the Istanbul Protocol in your discussions:

> *"Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner's request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place they are not comfortable with".*
>
> *"The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. The presence of police officers, soldiers, prison officials or other law enforcement officials during the examination may be grounds for disregarding a negative medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report. "*

INSTRUCTOR'S NOTES:

II. Past Medical and Surgical History and Psychosocial History – Pre-Arrest

LEARNING OBJECTIVES:

- Obtain a complete medical history, including prior medical, surgical and/or psychiatric problems
- Document any history of injuries before the period of detention and any possible after-effects. Knowledge of prior injuries may help to differentiate scars, or other physical evidence, related to torture from those that are not
- Summarise any previous forensic evaluation related to the allegations of torture and/or

ill-treatment

RELEVANT CASE INFORMATION:

Past Medical/Surgical History:

- No history of significant medical illness, including psychiatric, no surgeries, broken bones or head injuries or other major injury
- Medications: none
- No use of illegal drugs, alcohol or tobacco.

Psychosocial History- Pre-Arrest:

- Born, in Nyala and has 2 younger brothers.
- Father owns small grocery store in Nyala
- Business student at Khartoum University, planned to work with large company before being tortured.
- Active member of SDA (Student Democratic Front) for the past two years. Parents do not approve of his political activities
- One brother killed by security forces in Darfur in dd/mm/yyyy (9 months prior)

Prior Medical Evaluation:

- None

POINTS FOR DISCUSSION:

1. Psychosocial History- Pre-Arrest: The student should inquire into the person's daily life, relations with friends and family, work/school, occupation, interests, and use of alcohol and drugs, prior to the traumatic events. Inquiries into prior political activities and beliefs and opinions are relevant insofar as they help to explain why the person was detained and/or tortured, but such inquiries are best made indirectly by asking the person what accusations were made, or why they think they were detained and tortured. The psychosocial history is particularly important in understanding the meaning that individuals assign to traumatic experiences.

2. Inconsistencies between prior medical evaluations and the present evaluation should be noted and addressed in the Interpretation of Findings section of the report.

INSTRUCTOR'S NOTES:

III. Trauma History

LEARNING OBJECTIVES:

- To understand various techniques of questioning and applying them appropriately

- To elicit a coherent and accurate account of alleged torture/ill-treatment
- To structure inquiries to elicit a chronological account of the events experienced
- To understand sources of variability and the effects of such variability on history-taking
- To pursue and clarify possible inconsistencies in the trauma history
- To take note of non-verbal (process) information and links between emotional affect and the content of the trauma history

RELEVANT CASE INFORMATION:

- Reportedly detained by NSA police on dd/mm/yyyy (7 months prior to the exam date)
- Blindfolded, taken to a police station in Khartoum, ID card and mobile phone confiscated, no legal charges by police and no legal representation permitted
- Striped naked and insulted
- Beatings with punches, kicks, black water hose and electric wires
- Suspension from wrists tied behind the back with rope
- Near suffocation with plastic bag over head about 4 or 5 times resulting in loss of consciousness
- Water forced into oral and nasal cavities causing difficulty breathing
- Electric shock to genitals (wires attached to penis and right foot) 5 or 6 times associated with loss of consciousness
- Multiple cigarette burns to right forearm
- Alleged Perpetrators: Security personnel from the NSA, including Abdel Salih, and Kaleel Rahim, also 2 perpetrators referred to as Rasoul and Mujahid
- Death threats to alleged victim (disappearance)
- Cell conditions: unhygienic, poor ventilation, poor quality food

POINTS FOR DISCUSSION:

1. Review performance on appropriate use of "open-ended" and "closed" interviewing techniques. Typical open ended question may be phrased as follows.
    - "Can you tell me what happened?"
    - "Tell me more about that."
    - Provide some explanation for traumatic questions: For example, "People who have been detained are sometimes abused sexually, is this something that has happened to you?" Also, such questions should be asked only after a significant level of trust has developed.

2. Discuss how and when to redirect the history when "irrelevant" information is being presented.

3. Consider sources of variability in the history:
    - In the degree of physical and psychological signs, symptoms or consequences that a torture victim will manifest.
    - In the manner in which torture victims conduct themselves in interviews and in recounting the events of their abuse.
    - In the amount and detail of information that an individual will recall with regards to the events of the trauma.

4. Regarding inconsistencies in the history: review student's performance on the pursuit of inconsistencies in the history. Discuss factors that may account interfere with an accurate recounting of past events: 1) blindfolding, 2) disorientation, 3) lapses in consciousness, 4) organic brain damage, 5) psychological sequelae of abuse, 6) fear of placing oneself or others at risk, and 7) lack of trust with the examining physician.

4. Non-Verbal Information: Discuss with the students their observations of non-verbal information such as affect and emotional reactions in the course of the trauma history and the significance of such information.

5. Discuss the importance of historical information: Consider the following:

> Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include: descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place of detention.

6. Review historical information in this case that may be very useful in corroborating an individual's allegations of torture and/or ill-treatment.

- Note: The alleged torture reportedly occurred 7 months prior to the medical evaluation.
- Although acute injuries are no long present, observations of acute injuries and their approximate healing times and associated disabilities may be useful in corroborating specific allegations of torture and/or ill-treatment.
- Consider how well allegations of illegal detention practices and allegations of specific torture methods correlated with local/regional practices in Sudan and prior evidence that you have documented, including the identity of perpetrators.

7. Identity of perpetrators: Discuss the importance of gathering information on the identity of alleged perpetrators and limitations thereof. Note that it is often helpful to document what the perpetrators reportedly said during the abuse as it may help to establish their identity and/or the imputed intent of the torture/ill-treatment.

INSTRUCTOR'S NOTES:

IV. Review of Torture Methods

LEARNING OBJECTIVES:

- To understand the advantages and disadvantages of direct questions about specific methods of torture/ill-treatment
- To assess a wider range of possible physical and psychological methods of torture.

RELEVANT CASE INFORMATION:

- The review of torture methods is negative for the all other torture methods, physical and psychological.

POINTS FOR DISCUSSION:

3. Ensure that students use open ended questions initially in their review of torture methods, i.e. "Were there any other forms of abuse that you experienced?" Did they do or say anything else than what you have already mentioned?"

4. To assess a wider range of possible physical and psychological methods of torture. Consider the following list:

NOTE: Reviewing different forms of torture is especially helpful when: psychological symptoms cloud recollections, the trauma was associated with impaired sensory capabilities (i.e. blindfolding, extreme fear and anxiety, sleep deprivation, loud noises, intense lights or the use of psychotropic drugs), in the case of possible organic brain damage, or when there are mitigating educational and cultural factors. It is important to learn about regional practices of torture and modify the Review of Torture Methods accordingly.

NOTE: This list of torture methods provided below is given to show some of the categories of abuse possible. It is not meant to be used by physicians as a "check list", nor as a model for listing torture methods in a report. A method-listing approach may be counter productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Torture methods to consider include, but are not limited to:

1) Blunt trauma: punch, kick, slap, whips, wires, truncheons, falling down
2) Positional torture: Suspension, Stretching limbs apart, prolonged constraint of movement, forced positioning
3) Burns: cigarettes, heated instrument, scalding liquid, caustic substance
4) Electric shock
5) Asphyxiation: wet and dry methods, drowning, smothering, choking, chemicals
6) Crush injuries: smashing fingers, heavy roller to thighs/back
7) Penetrating injuries: stab and gunshot wounds, wires under nails
8) Chemical exposures: salt, chili, gasoline, etc. (in wounds, body cavities)
9) Sexual: violence to genitals, molestation, instrumentation, rape
10) Crush injury or traumatic removal of digits and limbs
11) Medical: amputation of digits or limbs, surgical removal of organs
12) Pharmacologic torture: toxic doses of sedatives, neuroleptics, paralytics, etc.
13) Conditions of detention, e.g.:
    - Small or overcrowded cell
    - Solitary confinement
    - Unhygienic conditions
    - No access to toilet facilities
    - Irregular and/or contaminated food and water
    - Exposure to extremes of temperature
    - Denial of privacy
    - Forced nakedness
14) Deprivations:
    - Of normal sensory stimulation, such as sound, light, sense of time via hooding, isolation, manipulating brightness of the cell
    - Of physiological needs: restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care

- Of social contacts: isolation within prison, loss of contact with outside world - victims often are kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer

15) Humiliations: verbal abuse, performance of humiliating acts
16) Threats: of death, harm to family, further torture and/or imprisonment, mock executions
17) Threats to or arranging conditions for attacks by animals such as dogs, cats, rats, and scorpions
18) Psychological techniques to break down the individual: forced "betrayals," learned helplessness exposure to ambiguous situations and/or contradictory messages, etc.
19) Violation of deeply rooted cultural and religious values
20) Behavioural coercion
- Forced to engage in practices against one's religion (e.g. forcing Muslims to eat pork)
- Forced to harm others: e.g. the torture of others, or other abuses
- Forced to destroy property
- Forced to betray someone placing them at risk for harm

21) Forced to witness torture or atrocities being inflicted on others

INSTRUCTOR'S NOTES:

V. Physical Symptoms (acute and chronic) and Disabilities

LEARNING OBJECTIVES:

- To assess relevant physical symptoms (acute and chronic) and disabilities experienced after the alleged torture/ill-treatment
- To anticipate physical symptoms and/or disabilities for specific methods of alleged torture
- To correlate reported physical symptoms (acute and chronic) and disabilities with specific allegations of abuse

RELEVANT CASE INFORMATION:

Acute Symptoms:
- Multiple bruises over my arms, legs and back, no injuries to the head. The bruises are red and swollen and still visible on my body. (No cuts or bleeding)
- Pain in the shoulders, arms and wrists.
- A number of burn marks on my right forearm, which took about 2-3 weeks to heal.
- I did not observe any lesion on the penis where they shocked me.
- Difficulty lifting objects due to pain in my arms and numbness in my right arm for a few months, but this resolved.

Chronic Symptoms:

- Scars noted on right forearm from cigarette burns.

- Difficulty having erections, i.e. not able to perform sexually but has noted erections upon waking for sleep.

Disabilities:
- None noted

POINTS FOR DISCUSSION:

4. Discuss how symptoms (acute and chronic) and disabilities, in this case and other, can be used to corroborate specific allegations of abuse.

5. Discuss how mitigating factors may influence the alleged victim's ability to observe acute (or chronic) symptoms or disabilities.

INSTRUCTOR'S NOTES:

VI. Psychological Evaluation and Mental Status

LEARNING OBJECTIVES:

- To be able to conduct a mental status examination
- To be aware of factors that may contribute to psychological outcomes
- To be able to assess symptoms of common psychological conditions associated with torture and ill-treatment.
- To recognise signs and symptoms of possible organic brain dysfunction and how
- To recognise and respond effectively to transference and countertransference reactions
- To recognise
- To respond effectively in court at the qualifications of the physician to conduct a psychological evaluation

RELEVANT CASE INFORMATION:

- Unremarkable mental status examination
- Symptoms of PTSD: None
- Symptoms of Major Depression: None
- Though his affect was calm throughout most of the interview, Mr. Adam expressed considerable anger toward those who tortured him and the loss of his brother. Mr. Adam indicated that since being tortured, he is less sure of his future plans. He is now considering altering his career path to become more active politically. His parents have expressed strong disapproval, however; they consider his political activity to be "foolish and dangerous." This has resulted in considerable discord between them. He and his father have not spoken to one another in the past several weeks.

POINTS FOR DISCUSSION:

9. Consider factors that may influence psychological outcomes in this case: Consider the following:
    - Circumstances, severity and duration of the torture
    - Cultural meaning of torture/trauma
    - Cultural meaning of symptoms
    - Age and developmental phase
    - Genetic and biological vulnerabilities
    - Interpretation of torture by the victim
    - Social context before, during and after the torture
    - Community values and attitudes
    - Political factors
    - Prior history of trauma
    - Pre-existing personality

10. What factor may account for the relative paucity of psychological symptoms, despite Mr. Garcia's allegations of significant torture practices.
11. What are specific elements of meaning assigned to the alleged torture experience for this individual?
12. What evidence, if any, indicates that the psychological symptoms are related to torture?
13. Discuss the use of symptom lists and diagnostic instruments.
14. Discuss the issue of referral for psychological care. When is this indicated and what resources are available?
15. Discuss what criteria may qualify a medical doctor to be an expert on psychological evidence of torture and ill-treatment.
    - Medical school training in psychiatry
    - Clinical experience in the diagnosis of major depression (a common illness among those with chronic diseases)
    - This training course and certification
    - Reading of relevant literature (and attending relevant meeting if applicable)
    - Those cases that require expertise beyond my abilities are referred accordingly

INSTRUCTOR'S NOTES:

VII. Physical Examination

LEARNING OBJECTIVES:

- To be able to recognise physical signs of torture/ill-treatment in acute and chronic settings and understand the sensitivity and specificity of common findings
- To conduct and anticipate pertinent positive and negative findings based on specific allegations of torture and/or descriptions of acute/chronic symptoms or disabilities following torture or ill-treatment
- To understand the advantages and disadvantages of conducting complete vs. directed physical examinations

- To understand how mitigating factors may affect physical sequelae of torture and ill-treatment; i.e. sequelae of electric shock may be affected by 1) the current applied, 2) the duration of contact, 3) the area of contact, 4) the use of conductors that limit heat production and therefore thermal injury, 5) the thickness (electrical resistance) of skin involved, 6) healing that occurs over time, and 7) variability in the physiological response of victims, among other factors.
- To document photographic evidence where appropriate and make effective use of anatomical drawings

RELEVANT CASE INFORMATION:

NOTE: Images of "virtual physical examination" findings will be presented in a separate room using PPT slides

Slide #1 and #2 (day of exam): Hyperpigmented, circumferential scars above both wrists, highly consistent with wrist abrasions from alleged restraint with rope and suspension

Slide #3 and #4 (day of exam): Multiple hyperpigmented circular scars (about 1 cm in diameter) with indistinct margins and no central palor or atrophy. The characteristics of the lesions and location on one arm only are highly consistent with the alleged cigarette burns.

Slides #5 and #6 (6 days following alleged torture): Linear "tram-track" lesions with peripheral echymosis and central palor, consistent with acute signs of beating to the back with a water hose.

NOTE: No penile lesions observed

POINTS FOR DISCUSSION:

9. In this case, what pertinent positives and negative findings should the students consider? List them.
10. After viewing the "virtual examination findings," consider possible correlation between the findings and specific allegations of torture
11. Discuss the advantages and disadvantages of conducting complete vs. directed physical examinations.
12. Is the absence of penile lesions on examination inconsistent with the alleged electric shock torture? Describe what you expect from such torture methods and how your expectations apply to this case.
13. Discuss the importance of reviewing the findings of prior medical evaluations of the alleged torture/ill-treatment.
14. Consider whether any diagnostic tests and/or referrals may be indicated. If so, list them. Regarding diagnostic tests: (pregnancy test, semen analysis of clothing,
15. Under what circumstances is a pelvic or genitourinary examination appropriate for one who has alleged sexual violence? How should the examination be conducted? What should be done?
16. Consider ways in which the physical examination may re-traumatise victims of torture and/or ill-treatment and how this may be avoided.
17. Discuss how the presence or absence of physical findings may be related to specific mitigating factors.

18. Discuss how and when to use photographs and anatomical drawings.

INSTRUCTOR'S NOTES:

VIII. Interpretation and Conclusions

OBJECTIVES: (as stated in the Standard Evaluation Form #13)

- To be able to provide interpretations on physical, psychological and, if relevant, historical evidence of torture/ill-treatment:

Physical Evidence:

- Correlate the degree of consistency between the symptoms (acute and chronic) and the disabilities (acute and chronic) with the alleged history of trauma.
- Correlate the degree of consistency of the physical findings with the alleged history of trauma (the absence of physical findings does not rule out torture or ill-treatment).
- Correlate the degree of consistency of the history of trauma and physical findings with the patterns of torture prevalent for the region where events occurred.

Psychological Evidence:

- Correlate the degree of consistency of the psychological findings with the alleged history of torture.
- Evaluate if the psychological findings noted during the evaluation are expected for extreme stressful situations of individuals with the cultural and social background similar to the examinee.
- Indicate the state of the psychological findings in regards to their natural history and their relation to the alleged history of torture, as well as whether the psychological symptoms and findings are improving.
- Identify any other stressor that coexists and that may play a role in the psychological symptomatology. Describe the extent that these coexistent stressors may have on the individual.
- Mention how the examinee's physical condition may affect the clinical presentation noted during the evaluation, in particular the possible association with cranioencephalic trauma during torture.

Historical Evidence:

- Correlate relevant historical information (descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place of

detention) with torture practices alleged in the present case and regionally, if appropriate.

- To state unequivocally in the conclusion the student's opinion on the possibility of torture and/or ill-treatment, and indicate a degree of certainty. Consider the following recommendations in the Istanbul Protocol:
  - Not consistent: The lesion could not have been caused by the trauma described;
  - Consistent with: The lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;
  - Highly consistent: The lesion could have been caused by the trauma described, and there are few other possible causes;
  - Typical of: This is an appearance that is usually found with this type of trauma, but there are other possible causes;
  - Diagnostic of: This appearance could not have been caused in any way other than that described.
- Be able to provide appropriate recommendations for further evaluations and treatment.

RELEVANT CASE INFORMATION:

As noted above

POINTS FOR DISCUSSION:

6. Discuss any problems that the students anticipate in presenting evidence as suggested above.

7. Discuss the importance of integrating all lines of evidence, and possibly the lack thereof, in the conclusion statement(s).

8. Discuss ways of assessing and reporting the possibility of dissimulation.

9. Consider reviewing with students a list of factors that may account for difficulty recounting the specific details of the torture. Compare student responses with Istanbul Protocol list:
   - Factors during torture itself such as blindfolding, drugging, lapses of consciousness, etc.;
   - Fear of placing oneself or others at risk;
   - Lack of trust for the examining clinician and/or interpreter;
   - Psychological impact of torture and trauma such as high emotional arousal, and impaired memory secondary to trauma-related mental illnesses such as depression and posttraumatic stress disorder;
   - Disorientation and/or lapses in consciousness;
   - Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning, and starvation;
   - Protective coping mechanisms such as denial and avoidance; and
   - Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.

10. Note: the importance of scientific references when appropriate

INSTRUCTOR'S NOTES:

DEBRIEFING:

3. Role-players provide feedback on student performances and process issues.

4. Consider relevant transference and countertransference issues: Physicians who conduct medical evaluations of detainees should be familiar with common transference reactions (i.e., potential reactions of the survivors toward the physician) that victims of trauma experience and the potential impact of such reactions on the evaluation process.

Potential reactions of the survivors toward clinician (transference):

- FEAR, GUILT, SHAME
- REMINDED OF "INTERROGATION"
- SUSPECTS VOYEURISTIC OR SADISTIC MOTIVATIONS
- HOW CAN CLINICIAN UNDERSTAND TORTURE?
- AUTHORITY FIGURE THEREFORE CANNOT TRUST
- INVESTS TOO MUCH TRUST
- FEAR THAT INFORMATION WILL BE SHARED WITH PERSECUTING GOVERNMENT
- FEEL OVERWHELMED WITH MEMORIES
- GENDER ISSUES
- "RE-TRAUMATISATION"

Potential reactions of clinician toward survivor (countertransference):

- AVOIDANCE/WITHDRAWAL
- HELPLESSNESS/HOPELESSNESS
- DEFENSIVE INDIFFERENCE
- VICARIOUS TRAUMATISATION: NIGHTMARES, ANXIETY, AND FEARFULNESS
- OVER-IDENTIFICATION/IDEALISATION OF THE ALLEGED VICTIM
- GRANDIOSITY AS A "SAVIOR"
- INSECURITY IN ONE'S OWN PROFESSIONAL SKILLS
- GUILT
- ANGER

INSTRUCTOR'S NOTES: