HUNGARIAN HELSINKI COMMITTEE

SHORT GUIDE on the Support and Care of Asylum Seeking Torture Victims

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1. How can you use this guide?

This short guide offers a framework to enable various professionals working in the context of asylum and refugee assistance **to better respond to the unique needs of asylum seekers who are suffering from trauma or are torture victims**. EU law requires all Member States to ensure that there are early identification procedures and adequate reception conditions for responding to torture victims or traumatized asylum-seekers (among other safeguards). As a majority of the asylum seekers entering the EU are fleeing armed conflicts, it's increasingly important that professionals not only understand their role, but also have some familiarity with the roles of other asylum professionals in order **to create a network of assistance**. The compact guide is not meant to be comprehensive. Rather, it should serve as a useful introduction for professionals offering assistance to asylum seeking torture victims in various fields of work.

2. About torture (definition, methods), how many torture victims are among asylum seekers?

The 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines torture as *"…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."* Based on this definition, **torture** can be understood as the **intentional infliction of physical or mental pain** carried out by state or government officials for a specific purpose. The European Court of Human Rights has extended this definition in its jurisprudence, confirming that **perpetrators**

of torture can be non-state agents as well. In addition, the Court's interpretation does not link torture to an exhaustive list of specific purposes. In a European context, it is therefore the Court's more recent and organically developing interpretation that needs to be primarily considered.

It is not always easy to decide whether a particular set of facts amount to torture or not. There are certain types of treatments, which most people will instinctively recognize as being inhumane or unacceptable and there are others, which are less obvious. The two main **forms of torture are physical and psychological**. Physical torture can take the form of severe beating, electric shocks, burns, mutilation, rape and sexual assault, being buried alive and suffocation. The most common methods of psychological torture include humiliation, isolation, mock executions or amputations, threats and being subject to viewing the torture of others. Most of the psychical methods of torture have also psychological consequences.

Torture is a crime under international law and **there are no conditions under which torture can be justified**. The perpetrators of torture, in most instances, are members of the police, prison guards, military forces or government officials. In some instances the perpetrators of torture can be health professionals including doctors or nurses, or co-detainees, acting with approval or on the orders of a public official. The victims of torture could be anyone – man or woman, young or old. Some of the most frequent victims of torture include human rights defenders, student leaders, politicians, journalists, prisoners, ethnic minorities and religious minorities.

A report published by the International Rehabilitation Council for Torture Victims indicated that up to **35% of refugees are torture victims**.[1] Today, the proportion of torture victims that are asylum seekers is particularly high among people fleeing from armed conflicts and failed states such as Afghanistan, Syria and Somalia. However, identifying victims of torture among refugees or asylum seekers can be a difficult task, because most refugees do not conceptualize their trauma symptoms in terms of Western concepts of mental health. Many refugees or asylum seekers are reluctant to access mental health services because of the social stigma that surrounds mental illness.

3. Physical and psychological effects of torture, what is PTSD?

Psychological trauma is a damage stemming from a severely distressing event (such as torture, inhuman or degrading treatment, natural disaster, sexual assault, etc.). Many asylum-seekers suffer traumatic experiences in their countries of origin, during flight and/or in the host country.

Post-traumatic stress disorder (PTSD) is a condition that might develop as a result of exposure to traumatic events. The symptoms of PTSD include disturbing recurring flashbacks,[2] avoidance or numbing[3] of memories of the event, hyperarousal[4] and changes in the overall patterns of the person's cognitive and emotional responses.[5]

The diagnostic criteria for PTSD can be summarised as follows:[6]

- **Fear** – Exposure to a traumatic event and subjective emotional response of fear, helplessness or horror;
- **Re-experience** – Persistent re-experiencing of the traumatic event (for example in the form of nightmares or flashbacks);
- **Avoidance** – Persistent avoidance of stimuli that remind to the traumatic experience and emotional numbing;
- **Arousal**[7] – Persistent symptoms of increased arousal (or hyperarousal);
- **Distress** – Significant distress or impairment,[8] suffering;
- **Duration of at least 1 month.**

Research has shown that 15–40% of patients suffering of PTSD are survivors of torture, extreme forms of inhuman or degrading treatment, or some extreme trauma. In such cases, especially if the traumatic experience is prolonged and/or repeated, a particularly severe form of PTSD may develop.[9]

4. What are EU members states obliged to do with torture victims or traumatised asylum-seekers?

VULNERABLE PERSONS

Torture victims and traumatised asylum-seekers are vulnerable persons according to the EU legislation.[10]

EARLY IDENTIFICATION

Member States have to identify the applicants with special reception needs and/or in need of special procedural guarantees within a reasonable period of time after an application for international protection is made.[11]

TRAINING

Officials need to be properly trained on how to deal with torture victims/traumatised asylum-seekers.[12]

RECEPTION SAFEGUARDS

- The reception of persons with special reception needs should be a primary concern for national authorities.[13]
- Member States shall ensure that dependent adult applicants with special reception needs are accommodated together with close adult relatives who are already present in the same Member State and who are responsible for them whether by law or by the practice of the Member State concerned.[14]
- Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed.[15]
- Access to rehabilitation services for minor victims and ensure that appropriate mental health care is developed and qualified counselling is provided when needed.[16]

RECEPTION SAFEGUARDS (*continued*)

- Member States shall ensure necessary treatment for the damage caused by acts of torture or inhuman or degrading treatment, in particular access to appropriate medical and psychological treatment or care.[17]
- Personal interview may be omitted, where the applicant is unfit or unable to be interviewed owing to enduring circumstances beyond his/her control. When in doubt, Member States must seek medical advice.[18]
- Member States shall ensure that the person who conducts the interview is competent to take into account the personal or general circumstances surrounding the application, including the applicant's cultural origin or *vulnerability*, insofar as it is possible to do so.[19]
- Where the determining authority deems it relevant, 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. If determining authority does not consider such examination necessary, it should inform the applicant that he can arrange it on his own costs.[20]
- Member States shall in principle not apply accelerated and border procedures.[21]
- Member States shall provide additional guarantees in cases where the appeal does not have automatic suspensive effect.[22]
- Member States may prioritize the applications of vulnerable persons.[23]

PAST PERSECUTION OR SERIOUS HARM

The fact that an applicant has already been subject to persecution or serious harm or to direct threats of such persecution or such harm, is a serious indication of the applicant's well-founded fear of persecution or real risk of suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated.[24]

HEALTH CARE FOR BENEFICIARIES OF INTERNATIONAL PROTECTION

Member States should ensure adequate health care to beneficiaries of refugee or subsidiary protection status who have special needs, under the same eligibility conditions as nationals.[25]

DETENTION SAFEGUARDS

- The health, including mental health, of applicants in detention who are vulnerable persons shall be of primary concern to national authorities.[26]
- Where vulnerable persons are detained, Member States shall ensure regular monitoring and adequate support taking into account their particular situation, including their health.[27]

5. What is early identification and how to identify victim of torture?

According to EU law, Member States already have an obligation to take the situation of vulnerable asylum seekers and refugees having suffered traumatic experiences into account and to accordingly identify these persons. The obligation for the early identification should be clearly defined in national asylum legislation and **Member States should establish a mechanism for early identification**, which should start as soon as an asylum application is received.[28]

The vulnerability of torture and trauma survivors is in most cases invisible – and as such, it passes unnoticed. The involvement of mental health professionals is thus crucial both in developing and adapting a possibly easy-to-use, quick and reliable identification tool and in carrying out identification procedures of trauma survivors.

THE PROTECT TOOL

- As it is often impossible for all asylum seekers to have access to a psychologist or psychiatrist in the early days of their arrival, other caregivers, legal staff and officers have to be trained and be provided with **the tools to be able to make the first steps towards identification**, and look for the possibilities of special medical, legal and social support when needed.
- There is no common EU mechanism for early identification of traumatized asylum-seekers, but a transnational EU project that started in 2010 developed a PROTECT tool exactly for such purposes.[29] This **quick questionnaire** facilitates the early recognition of asylum seekers who have suffered traumatic experiences (e.g. victims of torture, psychological, physical or sexual violence) and was developed for the use of professionals *without* a background in psychology or psychiatry.
- The PROTECT questionnaire is to be **used early on at the reception stage**, but leaving time (a couple of days) for the persons to be screened to rest and adapt, after they arrived to their place of reception. If important decisions about reception and placement conditions (for example detention orders or other measures) cannot be waited with, an interview with the PROTECT tool has to be carried out early enough for the results to be able to influence such decisions. Sometimes psychological symptoms do not appear immediately, thus, it is advised for the PROTECT tool to be used once more at a later stage.[30]
- The PROTECT questionnaire (and similar simple early identification methods) do not identify who the torture victims or traumatized asylum seekers are. Instead, they "pre-identify" those who *may* belong to these groups and **who should therefore be referred to psychological or psychiatric exper**ts (for identification and treatment).

6. How can a psychologist or a psychiatrist help?

a) Early identification

In case asylum-seekers have access to a psychologist or psychiatrist in the early days of their arrival, these professionals should carry out an early identification of asylum-seekers' special needs.

b) Providing therapeutic treatment

Optimal psychiatric and psychological treatment of traumatized persons is often referred to as "**biopsychosocial**", recognizing the fact that trauma affects the whole complexity of the patient's personality: not only the physical and psychological sides that might appear obvious, but the social relationships, and the spiritual self as well, not to mention the legal status (trauma is part of the reasons why the person seeks international protection).[31]

When it comes to the asylum sector and the treatment of traumatized and torture survivor patients, psychosocial and therapeutic aid can be provided at the premises of the refugee shelters or even detention centres (the "**go-model**"), or, for those asylum seekers who are able and permitted to leave their place of stay, outpatient care can be provided (the "**stay-model**").

- Both models have their advantages. Provision of mental healthcare services at the reception facility assures that newly arriving asylum seekers are treated the soonest possible, and they are provided a "first secure place" in the form of a therapeutic relationship that facilitates their adaptation to the new circumstances, helps overcoming the difficulties of "post-migratory trauma" such as the long and uncertain asylum process and at the same time start guiding the patient towards a complex rehabilitation from the after effects of the trauma suffered earlier.
- The "stay-model", on the other hand, facilitates a more independent functioning of the patient, when the time, place, frequency and duration of the therapy is decided in a more active and participatory manner between therapist and patient. This model, more suitable for those who are already somewhat anchored in the

host country and find their way around, is also important as a form of transition for those who move out of the refugee shelter to embark on the integration process in the host country, and will eventually start using state healthcare institutions as local citizens do, instead of being aided by service providers focused on refugees.

The use of an **interpreter** is a quite rare practice in psychotherapy, but the treatment of asylum seekers and refugees is almost unimaginable without it (see Chapter 10 on interpreters).

Non-verbal therapies include expression through movement, dancing and other forms of art (visual art, music, etc.). These often serve as a "softening", preparatory phase of treatment, making the patient ready also for individual and verbal disclosure. In other cases, they stand by themselves, strengthening important forms of self-expression, coping strategies and bringing to the surface underlying emotions, traumas.

Verbal therapies can also be applied individually, in a group (for example by forming groups of the same nationality, women's groups, etc.), or to treat families, couples or other constellations. The phases and methodological tools of different therapies are multiple, but a useful and widespread break-down of the different therapeutic phases is offered by Judith Herman in her classic book, Trauma and Recovery:[32]

Phase 1	**Safety and stability**: this stage is not yet about discussing or "processing" memories of unwanted or abusive experiences, let alone "recovering" them, but about establishing a safe, trustful bond that the therapy is based on.
Phase 2	**Remembrance and mourning**: reviewing and discussing memories, working through grief, redefining their meaning and trying to control and lessen the intensity of emotional responses they evoke.
Phase 3	**Reconnection**: finding again people, meaningful activities and a normal daily functioning in life.[33]

As part of the complex treatment of torture survivor asylum seekers, **psychopharmaceuticals** are needed to complement psychotherapy, or to be given when regular therapy cannot be provided (for example in detention). At the moment antidepressants are used in treating post-traumatic stress disorder, from the first as well as from the second generation. If the only complaint is of nightmares, longer acting benzodiazepines (anxiolytics) can also be recommended. A good matching of pharmacotherapy and psychotherapy is fundamental if negative interaction is to be prevented. Special attention has to be given to compliance: patients with a different cultural background might relate with aversion to taking medication of this sort or might not use it appropriately.

c) Medical and psychological reports

Mental health professionals working with torture survivor asylum seekers from around the world have an internationally recognized, basic tool in their hands for producing reports documenting the physical and psychological consequences of trauma and torture of their patients. This is the **Istanbul Protocol's Manual on Effective Investigation and Documentation of Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment**,[34] the first and most important set of international guidelines for documentation of torture and its consequences. On importance of these reports see Chapter 11.

d) Training, sensitization and supervision to other professionals

Lawyers, case officers, social workers, healthcare professionals and practically anybody who works in direct contact with torture survivor patients can be affected by the phenomenon called "**vicarious trauma**": the emotional residue of exposure that derives from working with trauma survivors, hearing their trauma stories and become witnesses to the pain, fear, and terror that they have endured. It is important not to confuse vicarious trauma with "burnout"; however, in both cases, psychological support of a professional can become necessary.

Besides assisting professionals from other fields dealing with the emotional burden of their work with this extremely vulnerable target group, psychologists and psychiatrist

can provide valuable training and sensitizing education about trauma and PTSD, along with its possible behavioural manifestations (including outbursts of anger, memory problems and sleeping disorders that may affect a persons' behaviour with staff and during the asylum procedure as well). Skills such as effective intercultural communication and conflict resolution or mediation can also be provided by psychologists and psychiatrists.

7. How can social workers help?

The role of the social worker is primarily **to coordinate the different support processes**. It is important that a social worker has time to spend with victims. Additionally, a social worker should have a variety of methods for approaching clients in order to be able to detect torture victims:

- Those assisting asylum seekers and torture victims are best thought of as part of a complex team, in which everyone must work together in order to be effective.
- Social workers mingle among the asylum seekers and initiate conversation with them. In this way, social workers could detect the personal circumstances of asylum seekers and the general mood of their groups.
- Social workers should be able to recognize the real needs of their clients and effectively communicate these needs (i.e. whether the client has special needs as a victim of torture) to the authorities so that the authorities can respond appropriately by providing a psychologist or psychiatrist.
- The community social worker is the best resource for identifying introverted torture victims. Community social workers must facilitate all asylum seekers to participate in different programmes (e.g. language lessons, sport events, workshops, etc.) based on their needs. They must meet with all asylum seekers and they must refer their clients to the appropriate support staff if they appear to be depressed or mentally unstable.
- Social workers must meet with all individuals in need. During pre-integration, the social worker should provide individual counselling and orientation to victims of torture. Social workers must have relevant knowledge about the available psychiatric care and be able to assist clients in translation and in overcoming other special barriers.

- Social workers can supplement the role of the psychologist or psychiatrist through informal counselling. These supportive conversations help foster feelings of normality.
- Social workers should also help all asylum seekers with respect to their official cases by providing advice, concrete administrative as well as non-legal representation. They have intensified responsibility when vulnerable people, such as torture victims are concerned.
- Support must be provided for recognized refugees or beneficiaries of subsidiary protection after they leave reception centres as well. This is very important in the cases of torture victims. There are a lot of difficulties in connection with integration; torture victims can easily feel isolated or alone even when they are with social workers. Special attention must be given to them and they should meet regularly with psychologists or psychiatrists.
- In detention centres, conflicts between security guards or police officers and detained persons are common; therefore social workers are also responsible for mediating between asylum seekers and the personnel of the detention centres, while paying special attention to the mental state of torture victims.

8. How does trauma affect credibility?

Trauma can have very different impacts on a victims' ability to remember the traumatic experiences. Some persons suffering of PTSD show extremes of recalling traumatic circumstances: either continuous, intrusive memories of the event – called **hypermnesia** – or avoidance of thoughts and feelings about the event (**amnesia**). Some victims are constantly haunted by memories of traumatic experiences and this fragmentises their daily life. In other cases, avoiding behaviour might result – in extreme situations – in **dissociative amnesia** or "white spots" in the process of evoking their painful memories, the consequence of which is that they can only present some fragments of them.[35]

Asylum-seekers suffering from PTSD often cannot…	***RECALL***	*details of traumatic memories, or not even the entire traumatic memory itself*
	FOCUS	*their attention on the traumatic memories or the asylum interview*
	TALK	*about traumatic memories freely and in a coherent manner*
	TRUST	*the outside world (including the actors of the asylum procedure) and the future*
	CONTROL	*their emotions, aggressiveness and behaviour*

Even when there is no dissociative amnesia, the symptoms of PTSD seriously limit the victim's capacity to recall and present traumatic memories. Consequently, asylum-seekers suffering from PTSD often cannot be expected to present a coherent, detailed account of their traumatising experiences. In the case of asylum-seekers, traumatic experiences are often a result of persecutory acts. The consistency of an asylum-seeker's account is often a central question in determining asylum status, and so an applicant who gives inconsistent accounts of their experience at different points in the asylum procedure may be treated as not credible. Therefore, recalling and describing these events usually plays a crucial role in credibility assessment and the evaluation of international protection needs.

9. How to provide legal advice to victims of torture (avoiding re-traumatization while gathering the facts)?

Asylum interviews, which often evoke traumatic memories, can result in **re-traumatization** in most victims. Trauma survivors often try to avoid evoking their trauma: "if we do not speak about something it doesn't hurt". This psychological defence mechanism – aiming at protecting the soul from being traumatised again – is seriously challenged by the asylum procedure, which involves an obligation to repeatedly recall the traumatic experiences. However, some victims react in another way. For example, for some

victims, the traumatic experiences are less likely to re-traumatize them if they narrate and repeatedly evoke these episodes in their lives. Some of them are able to do so as they do not feel shame and humiliation tied to the experience or they have already overcome them.

As a lawyer you should pay attention to the following:

- In case there was no early identification performed, you should conduct it yourself, by using the PROTECT tool for example.
- The lawyer shall refer the victim of torture or traumatized asylum-seekers to a psychologist or other relevant experts.
- It is of course important that a lawyer hears all the details of someone's reasons for fleeing her/his country of origin, however in order to avoid re-traumatization, the lawyer should make sure not to request the client to repeat the traumatizing events over and over again.
- The lawyer should explain the importance of credibility in the asylum procedure to the client, and remind her/him of her/his rights: to always have her/his interview read back to her/him and be allowed to correct all potential mistakes or misunderstandings.
- The lawyer should make sure to explain the client that if she/he does not remember something precisely, it is not a problem and she/he is allowed to say that she/he does not remember precisely.
- While speaking to the client, the lawyer must be sure not treat the client as an abnormal, ill person. PTSD is a normal reaction to trauma.
- Medical or psychological expert reports play crucial role in asylum procedure (see Chapter 11), therefore lawyers should obtain this evidence from the relevant expert.
- Once a lawyer obtains a medical/psychological report, she/he should go through and clarify potential contradictions with the client. It is normal that a traumatized asylum seeker tells her/his story in a different way to the authorities and to her/his therapist.
    - It is also common that a traumatized person tells much more information to her/his therapist, whom she/he meets at various therapeutic sessions (while

there is usually only one or two asylum interviews), and with whom usually she/he develops more trust than with the asylum authority.

  - If the report was already submitted to the asylum authority (or court), the lawyer should write an accompanying letter explaining eventual contradictions. If the report was not yet submitted to the authority (court), the lawyer should consult the therapist on how to avoid possible contradictions between the medical/psychological report and the statements made before the authorities (thus avoiding that these are used to undermine the applicant's credibility).

- If the asylum authority or the court asks the traumatized asylum seeker a question that can have a detrimental effect on her/his mental state, the lawyer should ask the officer or judge to formulate the question in a less re-traumatizing way.
  - The lawyer should always pay attention to her/his client during the interview. Traumatized asylum seekers are often not able to, or are too afraid to ask for a break, even when they need one. Therefore, the lawyer should always ask the client if a break is needed or not after 90 minutes.
- If the asylum authority is using language, gestures or clothes/accessories (e.g. belt, uniform), which can seriously re-traumatize and intimidate the victim, the lawyer should ask the asylum authority to change it to avoid such an impact (e.g. a person previously torture by uniformed police officers should not be interviewed by an asylum officer wearing a military uniform).
- Also, the lawyer should ensure that the room where the interview is conducted remains a "safe place" throughout the entire interview. If other persons come into the room, repeatedly open or knock on the door, if there are disturbing noises, etc. the lawyer should signal this as a problem to the proceeding authority.

10. What do interpreters need to know?

Interpreters play a crucial role in the rehabilitation of torture victims in all aspects. Their professionalism and specific training is indispensable for effective and humane asylum interviews, for medical examinations, as well as for psycho-therapeutic sessions (see earlier). Beyond the usual knowledge and skills (language knowledge,

interpreting methodology, ethical and legal obligations, etc.), interpreters working with torture victims and traumatized asylum-seekers – in whichever context – should have **additional competences**:

- They should be trained on what torture and trauma are, and should be aware of post-traumatic symptoms and how they affect communication;
- They should be specifically prepared to face very difficult communication situations (e.g. when traumatized asylum-seekers are not able to talk in smaller "units", such as full sentences, only in continuous speech without breaks) and to avoid collapsing, crying, etc. when obliged to translate shocking memories of torture or trauma;
- They should know the specific vocabulary (e.g. names of specific forms of torture), as well as they should be prepared to deal with symbolic or indirect language often used to describe torture or ill-treatment (e.g. to understand that the sentence "my flower was torn" actually refers to rape);
- They should be specifically skilled to avoid intrusive language when communicating with asylum-seekers;
- They should be trained on how to prevent vicarious (secondary) traumatization, which constitutes a significant risk for them as well. This includes participation in regular supervision sessions (similarly to therapists and other professionals).

Ideally, interpreters working in the **psycho-therapeutic context** should be **independent** – that is, they are not employed by the immigration authorities, courts or other state authorities –, speak the mother-tongue of the patient (or a language similarly well-known) and are specifically trained to interpret in therapeutic settings. In this context, training for interpreters is most often provided by the therapists themselves, and includes specificities such as interpreting gestures, non-verbal or culture-specific communication signs. Moreover, in therapeutic settings which are composed not only by the pair of therapist and patient, but by a "triad" comprising the interpreter as well, both the therapist and the interpreter have to be aware that transference and counter-transference mechanisms[36] in this case include all parties. Dealing with such processes is another skill that the interpreter has to learn. Also, therapeutic sessions should ideally be assisted by the **same interpreter**, to strengthen trust and therefore contribute to the effectiveness of the therapy.

11. Importance of medical/psychological expert reports

Physical evidence (wounds/scars and stated torture) are hard to prove, psychological consequences (PTSD) even harder – this is why medical and psychological expert reports are extremely important. A **medico-legal report** is a report carried out by a **medical expert**, and it includes a **physical and/or psychological evaluation of the victim**, in addition to the expert's **opinion of the probable relation of the physical and/or psychological findings to possible torture or ill-treatment**. According to EU law, Member States already have the obligation where they deem it relevant, subjected to the applicant's consent, to arrange for a medical examination of the applicant concerning signs that might indicate past persecution or serious harm (see Chapter 3).

Medical reporting, according to the internationally recognised standards outlined in the Istanbul Protocol, **is beneficial** to both the asylum seeker and the state assessing the asylum application, **for the following reasons**:

- The purpose of the medical report is the reporting to legal professionals (lawyers, judges) or to the asylum authority, the history of the asylum seeker and the medical-psychological consequences of trauma/torture;
- The use of a medical report as evidence allows an expert opinion to be given on the degree to which medical or psychological findings correlate with the alleged victim's allegation of abuse;
- It decreases the number of procedures and appeals necessary to correct previously incomplete evidence in support of the asylum claim;
- It improves the quality of the decision-making process by ensuring the information provided in support of the allegations is in conformity with internationally recognised standards;
- In countries where detention of unidentified torture survivors is a practice, medical reports can help in proving that the patient's conditions make him/her unfit for detention and can contribute to him/her receiving more appropriate reception conditions.

EXAMPLE OF A STRUCTURE OF A MEDICAL REPORT

Part I **Introductory Statements**	• Statement of foundation • Reference to Istanbul Protocol • Statement of the medical doctor in charge of the case • The aim of the examination
Part II **Background**	• Preceding case history: — Family history — Schooling/education — Personal objectives — Special circumstances • Social background of the applicant: — Current family status and his/her knowledge on family members
Part III **Description**	• Description of the methods of torture and its clinical consequences: — Where? When? What happened? — Sequelae of torture • Reference to other medical specialist(s) • Somatic status — Full somatic description focusing on the somatic after-effects of torture — Other somatic disease(s)
Part IV **Final Statements**	• Declaration — On the consistency of the findings with the narrative and global information on the local situation — Recommendations — Short CV of the medical professional and/or psychologist

Specifically trained psychologists can also provide an expert opinion. In such cases, for the assessment of bodily harms or somatic symptoms, a medical professional needs to be involved. When documenting the sequelae of torture, specific clinical training and expertise are usually indispensable.

Examples from the jurisprudence of the **European Court of Human Rights** regarding the importance of medical reports in assessing or proving the impact of past torture:

TI v. UK[37]	The applicant presented to the Court two medical reports which strongly supported his claims that he was tortured. He also provided photographs of scars of his injuries on his arm, leg and head. The Court emphasized that medical evidence cannot be ignored and that they have an impact on the credibility of the applicant.
Hilal v. UK[38]	The applicant did not mention torture at the first interview and his statements were considered inconsistent, therefore his asylum application was rejected. The Court, turning to the medical reports and his brother's death certificate, highlighted that they were consistent with the applicant's allegations and found violation of Article 3.
RC v. Sweden[39]	The applicant submitted a medical certificate documenting his scars. The Swedish Migration Board rejected his asylum application on the grounds that it was not substantiated. The Court placed special emphasis on the fact that the applicant had initially produced a medical certificate before the Migration Board as evidence of his having been tortured. Although it was not written by an expert specialized in the assessment of torture injuries, it was a good indication and in such circumstances it was for the Migration Board to dispel any doubts that might have persisted as to the cause of such scarring. The Court held that the Migration Board ought to have directed that an expert opinion be obtained as to the probable cause of the Applicant's scars in circumstances where he had made out a prima facie case as to their origin. In such cases, the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture. The medical evidence corroborated the applicant's story.

I v. Sweden[40]	A Chechen asylum-seeker had clearly visible scars on his body. A medical certificate stated that the wounds had "a good relation" with his explanation both of the timing and the extent of the torture. The national authorities did not as such question that the applicant had been subjected to torture. However, he was not found credible in explaining the reasons why he was tortured. The crucial question was whether the isolated fact that a person has been subjected to torture suffices to demonstrate that he or she, if deported to the country where the ill-treatment took place, will face a real risk of being subjected again to treatment contrary to Article 3. The Court agreed with the lack of credibility of the applicant, however in case of a body search of the applicant in connection with possible detention and interrogation by the Federal Security Service or local law-enforcement officials upon return, the latter will immediately see that the applicant has been subjected to ill-treatment for whatever reason, and that those scars occurred in recent years, which could indicate that he took active part in the second war in Chechnya. In the special circumstances of the case the Court finds that that there are substantial grounds for believing that the applicants would be exposed to a real risk of being subjected to treatment contrary to Article 3 of the Convention if deported to the Russian Federation.
R.J. v. France[41]	The Applicant underwent a medical investigation upon arrival. Wounds, pain in the mouth, fresh burning scars were documented. Because of his incomplete and inconsistent statements, French authorities concluded that no further medical investigation was needed. The Court stated that the nature, severity and the recent character of the scars indicate the presence of torture. The Court held that further inquiry into the origin and nature of the applicant's wounds was obligatory.

The increased use and acceptance of medical reports to support allegations of torture or ill-treatment must be accompanied by **training for decision makers** on how to interpret findings in such reports and how evaluate such pieces of evidence as part of wider evidentiary and credibility assessment. Decision makers need to understand the effects torture can have on an asylum seeker's ability to recount past events.

Endnotes

1. IRCT, Recognising victims of torture in national asylum procedures, 2013, http://www.irct.org/files/Filer/publications/MLRweb.pdf
2. A sudden, involuntary, usually powerful, re-experiencing of a past experience or elements of a past experience. In case of PTSD, this means the sudden "re-living" of some of the traumatic experience (e.g. torture), often without any specific stimulus, and the person often not being able to fully realise what is reality and what is only the popping up of a past memory.
3. Difficulty in experiencing positive emotions (such as happiness, attraction, love or trust). Usually includes a loss of interest in previously interesting activities, a feeling of distance from other people and non-responsiveness.
4 A constant state of increased psychological and physiological tension, which usually leads to reduced pain tolerance, anxiety, exaggerated responses to stimuli, insomnia and fatigue.
5. American Psychiatric Association (2013). "Diagnostic and Statistical Manual of Mental Disorders" (5th ed.). Arlington, VA: *American Psychiatric Publishing*. pp. 271–280.
6. Credibility Assessment in Asylum Procedures – A Multidisciplinary Training Manual, http://www.refworld.org/docid/5253bd9a4.html, pp. 90, 91.
7. A physiological and psychological state of being awake and readiness to respond stimuli. It involves increased heart rate and blood pressure, mobility, sensory alertness, etc.
8. Incapacity, inability. In case of PTSD, this means a personality change resulting in a poorly functioning person in the psychological and social meaning.
9. For more information see Credibility Assessment in Asylum Procedures – A Multidisciplinary Training Manual, http://www.refworld.org/docid/5253bd9a4.html, p. 91.
10. Recast Reception Directive, Article 21 and Recast Procedural Directive, Recital 29.
11. Recast Reception Directive, Article 22 and Recast Procedural Directive, Article 24.

12. Recast Reception Directive, Article 25 (2) and Recast Procedural Directive, Article 4 (3).
13. Recast Reception Directive, Recital 14.
14. Recast Reception Directive, Article 18 (5).
15. Recast Reception Directive, Article 19 (2).
16. Recast Reception Directive, Article 23 (4).
17. Recast Reception Directive, Article 25 (1).
18. Recast Procedural Directive, Article 14 (2)(b).
19. Recast Procedural Directive, Article 15 (3).
20. Recast Procedural Directive, Article 18.
21. Recast Procedural Directive, Recital 30 and Article 24 (3).
22. Recast Procedural Directive, Recital 30.
23. Recast Procedural Directive, Article 31 (7) (b).
24. Recast Qualification Directive, Article 4 (4).
25. Recast Qualification Directive, Article 30 (2).
26. Recast Reception Directive, Article 11 (1).
27. Recast Reception Directive, Article 11 (1).
28. See Chapter 3.
29. Protect, Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment, http://protect-able.eu/wp-content/uploads/2013/01/protect-global-eng.pdf
30. More on how to take the questionnaire, instructions and the questionnaire itself are available here: http://protect-able.eu/wp-content/uploads/2013/01/protect-questionnaire-english.pdf
31. Vesti, P., Somnier, F. and Kastrup, M. (1992). "Psychotherapy with torture survivors: A report of practice from the Rehabilitation and Research Centre for Torture Victims (RCT)," Copenhagen, Denmark. Copenhagen: International Rehabilitation Council for Torture Survivors.

32. Judith Herman, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, Basic Books, 2015

33. These processes as illustrated here in an extremely schematic way are in real life much less orderly and sequential.

34. http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

35. For more information see Credibility assessment in asylum procedures, a multi-disciplinary training manual, Chapter VI.2, http://www.refworld.org/docid/5253bd9a4.html

36. Transference, both the main tool and a source of difficulties in psychotherapy, is the unconscious redirection of feelings felt in the past for a person, to another person in the present. For instance, the feelings of fear and submission that the patient felt in the past towards his torturer can appear in his relationship to the therapist in the present. Counter-transference is the opposite-way process: the patient evokes an emotional response in the therapist, and this response is partly shaped by the transference mechanisms themselves.

37. *T.I. v. UK*, Appl. No. 43844/98, 7 March 2000, http://www.refworld.org/docid/3ae6b6dfc.html

38. *Hilal v. UK*, 45276/99, 6 June 2001, http://www.refworld.org/docid/3deb99dfa.html

39. *R.C. v. Sweden*, Application no. 41827/07, 9 March 2010, http://www.refworld.org/docid/4b98e11f2.html

40. *I v. Sweden*, Application no. 61204/09, 5 September 2013, http://www.refworld.org/docid/5229a9c44.html

41. *R.J. v. France*, Application No. 10466/11, 19 September 2013, http://www.asylumlawdatabase.eu/sites/www.asylumlawdatabase.eu/files/aldfiles/AFFAIRE%20R.J.%20c.%20FRANCE.pdf