



Physicians for  
Human Rights

# Conducting Istanbul Protocol Clinical Evaluations of Alleged Torture and Ill-Treatment in Conflict Settings

# Section 1: Preliminary Considerations



# Purpose of this Training Document

- The purpose of this training document is to enable independent, non-forensic clinicians with limited or no prior Istanbul Protocol training to conduct clinical evaluations of alleged or suspected torture and ill-treatment in conflict settings where comprehensive medico-legal evaluations are not possible, and there is a considerable risk of reprisals to alleged victims and clinical evaluators.
- Under these circumstances, the abridged guidance in this training document will enable clinicians to conduct clinical evaluations of alleged torture and ill-treatment that comply with the required elements of the Istanbul Protocol Principles contained in Annex I of the Istanbul Protocol.
- Such clinical evaluations will be critical in informing human rights investigations by NGOs and international legal bodies, the media and public, and future criminal proceedings to hold perpetrators accountable.

Note: Clinicians in non-conflict settings should use other, more comprehensive training materials to conduct clinical evaluations of alleged torture and ill-treatment in accordance with Istanbul Protocol guidance (see: [https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol\\_Rev2\\_EN.pdf](https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf)).



# How to Use this Training Document

- These slides are intended to convey essential Istanbul Protocol knowledge to individual clinicians rather than serve as an outline for a presentation to clinical trainees.
- This training document should be used in conjunction with PHR's **“Istanbul Protocol Clinical Evaluation Short Form for Conflict Settings”**
- Clinicians should also refer to other PHR documents that are relevant to clinicians conducting Istanbul Protocol clinical assessments in conflict settings including:

PHR - Digital Security

PHR - Vicarious Trauma, Professional Wellness & Self-Care



# What is Torture?

- The Istanbul Protocol uses the UN Convention against Torture (CAT) definition of torture:

“...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**.”
- Clinicians who conduct clinical evaluations of alleged torture and ill-treatment should apply the CAT definition in formulating their opinions on the possibility of torture.



## What is the Difference Between Torture and Ill-Treatment (Cruel, Inhuman and Degrading Treatment or CIDT)?

- Torture requires intent and a purpose whereas ill-treatment does not
- Torture is more severe in terms of:
  - Duration of treatment
  - Physical effects of treatment
  - Mental effects of treatment
  - Gender, age and state of health of the victim
- Powerlessness of the victim may also be a factor



# What is the Istanbul Protocol?

- UN Standards for the effective investigation and documentation of torture and ill-treatment – developed in 1999 and updated in 2022, The Istanbul Protocol standards are endorsed by international, regional, and national human rights bodies and legal mechanisms.
- They have informed states' treaty obligations to investigate, prosecute, and punish torture under the UN Convention against Torture and international and national law.
- They have underpinned health professionals' global efforts to end torture, hold perpetrators accountable, and afford victims the redress and rehabilitation they are entitled to.





# What are the Essential Principles for an Istanbul Protocol Clinical Evaluation? (See Annex I, Istanbul Protocol, 2022 edition)

- Clinical evaluators must always behave in conformity with the highest ethical standards and obtain informed consent before any examination is conducted.
- Clinical evaluations must:
  - Conform to established standards of medical practice
  - Be under the control of medical experts, **not** security personnel
  - Be conducted promptly
- Written reports must be accurate and include the following:
  - Identification of the alleged victim and conditions of the evaluation
  - A detailed account of allegations including torture or ill-treatment methods and physical and psychological symptoms
  - A record of physical and psychological findings
  - Interpretation of all findings, an opinion on the possibility of torture and/or ill-treatment, and clinical recommendations
  - Identification and the signature of the medical expert(s)





# What are the Relevant Ethical Obligations of Clinicians?

- The Istanbul Protocol 2022 refers to 4 basic ethical principles:
  - Beneficence – acting in the best interests of one’s patient
  - Non-maleficence – “do no harm”
  - Autonomy – respect the decisions of one’s patient, e.g. informed consent
  - Confidentiality – maintaining confidentiality of information
- The primary ethical obligation of health professionals is to act in the best interest of their patients & alleged victims regardless of employment considerations or third-party interests.
- Physicians have a duty to document and report torture and ill-treatment (WMA, 2006).
- Clinicians who evaluate alleged victims who fear reprisals and refuse to consent to a clinical evaluation must never breach the primary ethical duties of "do no harm" and respect for autonomy over the obligation to document and report.
- Informed consent is imperative and requires clear disclosure of all material information including the purpose of the evaluation, potential risks and benefits, the nature of the evaluation, including the possibility of taking photographs, and limits on confidentiality including any mandatory reporting requirements of the clinician.
- In conflict settings, clinicians should take steps to ensure digital security and only share the findings of their clinical assessments with the full and informed consent of the alleged victim.

## Section 2: Interview Considerations



# Interview Considerations

- Interview Settings
- Ensure Safety of the alleged victim
- Earn Trust & Build Rapport
- Obtain informed consent
- Maintain confidentiality
- Mitigate the risk of retraumatisation
- Understand important gender issues
- Recognize the special needs of children
- Work effectively with interpreters
- Understand emotional reactions and their potential effects
- Prepare for the Interview
- Use effective interview techniques
- Pursue inconsistencies and potential reasons for them



# Interview Settings

- Clinical evaluations of persons alleging torture or ill-treatment should be conducted at a location that the clinician and interviewee deem most suitable.
- Clinicians should document any adverse effects of the setting in their clinical evaluation.
- The room should have appropriate physical conditions (light, ventilation, size, and temperature).
- There should be access to toilet facilities and refreshment opportunities.
- The seating arrangement should allow the interviewer and interviewee to be equally comfortable and at an appropriate distance to establish eye contact and see each other's faces clearly.
- Neither the interviewer nor the interviewee should sit in a position that blocks access to the door.
- Attention should be paid to arranging the room in a way that it is not reminiscent of official surroundings or the interrogation process.



# Ensure Safety of the Alleged Victim

- Consider the possibility of reprisals, especially among alleged victims. Do not conduct an evaluation if reprisals are very likely or certain.
- Check premises to ensure there is privacy
- Prepare emergency response plans including changing sites if privacy is compromised
- Do not promise a level of security that cannot be achieved
- Safeguard identifying information
- Police or other law enforcement officials should never be present in the examination room
- Police presence during the interview and exam should be noted in the medical report and may be grounds for disregarding a “negative” report
- Under no circumstances should a copy of the medical report be transferred to the law enforcement officials



# Earn Trust & Build Rapport

Trust is an essential component of eliciting an accurate account of abuse and requires.

- Active listening and communication
- Genuine empathy
- Objectivity: maintaining professional boundaries
- Creating a safe and comfortable setting
- Allowing the interviewee to have control over the process (e.g. stopping or taking breaks)

Build rapport with the interviewee from the moment you first meet:

- Introduce yourself and provide information about yourself
- Start the interview by discussing neutral topics (family, things they enjoy and value)
- Be mindful and respectful of the interviewee's cultural and religious background



# Informed Consent in Conflict Settings

- Clinicians must receive the informed consent of the patient at the beginning and end of the clinical evaluation.
- Informed consent requires that the consenting individual:
  - Is competent
  - Receives full disclosure of information, including risks, benefits, and clarification of the limits of confidentiality that may be imposed by State or judicial authorities.
  - Understands the information provided
  - Gives their consent voluntarily
  - Provides authorization for their consent
- Submission of independent clinical assessments of torture and ill-treatment in legal proceedings typically is typically not possible in conflict settings.
- In such settings, the purpose of a clinical evaluation is often limited to human rights reports, advocacy and media reports, investigations by international legal bodies, and, possibly, future criminal prosecution of alleged perpetrators.



# Documentation of Informed Consent in the Istanbul Protocol Clinical Assessment - Short Form for Conflict Settings

As indicated in the **Istanbul Protocol Clinical Evaluation Short Form for Conflict Settings**, clinicians should identify themselves and inform the individual of the purpose and content of the clinical evaluation, how the information may be used, the potential benefits and risks, the steps that will be taken to ensure confidentiality such as data storage and encryption, and that they can stop participation at any time.

Clinicians should complete each component of informed consent at both the beginning and end of the interview.

**Informed Consent** (Obtain at onset of clinical evaluation and review alleged victim at the conclusion of the evaluation for any changes)

Identify yourself the purpose and content of the evaluation, how the information may be used, the potential benefits and risks, the steps that will be taken to ensure confidentiality such as data storage and encryption, and that the individual can stop participation at any time.

- Obtain consent for the clinical assessment any photographs of alleged injuries:

Clinical evaluation findings  Yes  No

Photographs of alleged injuries  Yes  No

- Obtain consent for specific purposes:

Human rights reports  Yes  No

Advocacy, media reports  Yes  No

Investigations by international legal bodies  Yes  No

Future criminal prosecution of alleged perpetrators  Yes  No

- Ask the alleged victim if they want their evaluation to be anonymous (no name or identifying information disclosed) or to disclose their name and identifying information:

Consent to USE ONLY ANONYMOUS information  Yes  No

Consent to USE NAME AND OTHER IDENTIFYING INFORMATION  Yes  No





# Maintain Confidentiality

- Clinicians have a duty to maintain confidentiality of information and to disclose information only with the individual's informed consent.
- The individual should be clearly informed of any limits to the confidentiality of the evaluation and of any legal obligations for disclosure of the information.
- Police or other law enforcement officials should never be present in the examination room.
- Police presence should be noted in the medical report and may be grounds for disregarding a "negative" report.



# Mitigate the Risk of Re-traumatisation

- Clinical evaluations and diagnostic tests can re-traumatize victims of torture and symptoms may manifest during or after the clinical evaluation.
- Retraumatized individuals may mobilize strong defenses that result in profound withdrawal and affective flattening during examination or interview; alternatively, they may express hostility and anger.
- Examiners can prevent and mitigate re-traumatisation and psychological sequelae with effective communication, empathy and by allowing individuals control over their narrative account of the alleged events.
- When the interviewer suspects that re-traumatisation has occurred, it is important to acknowledge the concern, mitigate re-traumatisation (such as with breaks, breathing exercises and redirection to less emotional topics), offer psychological support, and refer the individual to appropriate follow-up care.



# Understand the Importance of Gender Issues

- Sexual abuse is common among torture survivors, and this may influence the clinical evaluation.
- Same-sex interviewing is generally preferable. Individual choices should be respected whenever possible.
- Male survivors may be even more reluctant to disclose sexual abuse than women, a problem that is often not considered.
- Cultural and individual factors must be weighed in determining the appropriate interviewing strategy.



# Recognize the Special Needs of Children

- Medical evaluations should be carried out in a child-friendly setting by trained clinicians with experience in assessing and documenting physical injury in children including sexual assault.
- Consent should be obtained from the child's guardian and as appropriate from the child.
- Take time to build rapport using clear and age-appropriate language; give breaks and opportunities for questions.
- Short attention spans may require frequent breaks.
- Understand that trauma & parental separation may adversely affect memory formation.
- Understand age-related effects of trauma & potential beneficial and adverse role of parents/guardians in the interview.
- Use age-appropriate questioning techniques.



# Work Effectively With Interpreters

- When interpreters are needed, they have similar professional obligations to the examiner (confidentiality, impartiality).
- Friends or relatives may not be impartial but may function as important witnesses.
- The interpreter should not be a law enforcement official or government employee.
- The examiner should maintain contact with and talk to the examinee, not the interpreter, in order to maintain rapport and gather observations.



# Understand Emotional Reactions and their Potential Effects

- Clinicians who conduct physical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and counter-transference.

## Transference

- The feelings a survivor has towards the clinician that relate to past experiences, which may be misunderstood as directed towards the clinician personally.
- The evaluator's questions may be experienced as an interrogation or a sign of mistrust or doubt on the part of the examiner.
- The evaluator may be perceived as having voyeuristic and sadistic motivations, as a person in a position of authority (in a positive or negative sense), or on the side of the enemy.



# Understand Emotional Reactions and their Potential Effects

## Counter-transference

- Defined as the clinician's personal reactions and feelings to the interview, which may influence the clinician's perceptions and judgments.
- Common counter-transference reactions include:
  - Avoidance, withdrawal, defensive indifference
  - Disillusionment, helplessness, hopelessness, and over-identification
  - Omnipotence and grandiosity in the form of feeling like a savior, the great expert on trauma, or the last hope of the survivor
  - Feelings of insecurity, feelings of guilt, or excessive rage toward torturers, persecutors or the individual



# Understand Emotional Reactions and their Potential Effects

## Counter-transference

- Possible effects of counter-transference reactions include:
  - Underestimating the severity of the consequences of torture
  - Forgetting some details
  - Leading to disbelief regarding the veracity of the alleged torture
  - Failure to establish the necessary empathic approach
  - Over-identification with the torture survivor
  - Vicarious traumatisation, burn-out
  - Difficulty in maintaining objectivity





# Prepare for the Interview

- Clinicians should prepare for the interview by:

Familiarizing themselves with the case and potential topic areas to focus on

Building in flexibility for discussing other topic areas as they arise in the interview

Reviewing appropriate documents/affidavits prepared by the individual's legal counsel

Note: Information in legal documents/affidavits should be independently verified and all information relevant to a clinical evaluation should be gathered by the clinician.



# Use Effective Interview Techniques

- Listening is more important than asking questions.
- Utilize open-ended questions:
  - “Can you tell me what happened?”
  - “Tell me more about that.”
- A free narrative in the interviewee’s own words may be followed by a direct question to clarify and understand the chronological order of events.
- Improve accuracy of information by:
  - Clarifying details
  - Summarize key points periodically
  - Consider a follow-up interview to address outstanding questions or any inconsistencies
  - Inquire about inconsistencies in their narrative and potential reasons for them



## Pursue Inconsistencies and Potential Reasons for Them

Variability and inconsistencies in the history should be expected in clinical evaluations of torture and ill-treatment. Clinicians should understand that:

- Variability and inconsistencies in the history do not necessarily indicate that the narrator is providing false or unreliable information, since memory may be affected by the physical and psychological effects of torture and ill-treatment such as head trauma, disorientation to time and place, PTSD symptoms such as avoidance of painful thoughts.
- Clinicians should use judgment about how much specific detail is needed to document the alleged abuse.
- Clinicians have a duty to pursue possible explanations for inconsistencies by asking for further clarification and seeking other evidence that supports or refutes the account of events.
- Clinicians should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess.



## Pursue Inconsistencies and Potential Reasons for Them

If the clinician suspects fabrication:

- The clinician should try to identify potential reasons for exaggeration or fabrication.
- Additional interviews should be scheduled to help clarify inconsistencies in the report.
- Family or friends may be able to corroborate details of the history.
- The clinician should refer the individual to another clinician and ask for the colleague's opinion.
- The suspicion of fabrication should be documented with the opinion of two clinicians.



# Record Case Information

I. Case Information	
Clinical Examination Date: _____, Place: _____	
Patient/ Name: _____	Patient ID #: _____
Person Requesting Clinical Evaluation (Name): _____	Position/Relationship: _____
Reason For Request:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical harm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological harm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Others Present During Examination:</b> (law enforcement & prosecutors should be barred from the exam room as they are rarely necessary for security purposes)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name _____	Relationship: _____
Name _____	Relationship: _____
<b>Note any of the following limitations on the clinical evaluation:</b>	
Detainee Restrained (Describe): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inadequate Time for Evaluation (Explain): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inappropriate Location (Explain): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lack of Privacy (Explain): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No



# Record Relevant Clinical History, Allegations of Abuse, and Alleged Perpetrators

II. Relevant Clinical History	
Clinical Records/Forensic Report Available for Review: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Findings & Conclusions
1. _____	_____
2. _____	_____
3. _____	_____
Past medical, Psychiatric history: _____	

Record significant prior illnesses, surgeries, and accidents/physical traumas. Be sure to enquire about and document any scars/lesions prior to the alleged trauma.

## III. Allegations of Abuse: (open-ended, chronological inquiry followed by direct questions as indicated - include circumstances of detention, place and conditions of detention, and allegations of abuse, and be sure to ask about the possibility of sexual assault.)

“Please describe to me in detail what happened to you:”

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- For each form of abuse: ask about body position, restraints, type of object used, the duration and frequency, and the area of the body affected.
- Was there any bleeding, head trauma, or loss of consciousness?
- Description of torture instruments
- Clothing/Disrobing
- What was said during the abuse?
- Sexual Assault?
- What was the condition of the person at the end of the torture?

**List Alleged Perpetrators:**

Name _____	Institution: _____	Position: _____
Alleged Abuses: _____		
Name _____	Institution: _____	Position: _____
Alleged Abuses: _____		
Name _____	Institution: _____	Position: _____
Alleged Abuses: _____		



# Be Aware of Common Methods of Torture

- Blunt trauma, such as a punch, kick, slap, whipping, a beating with wires or truncheons, or forced contact with hard surfaces, such as floors and walls
- Positional torture, using suspension, stretching limbs apart, prolonged constraint of movement, and forced positioning
- Burns with cigarettes, heated instruments, scalding liquids, or caustic substances
- Electric shocks
- Asphyxiation, such as wet and dry methods, near drowning, smothering, confinement in small or coffin like boxes, choking or use of chemicals
- Crush injuries, such as smashing fingers or using a heavy roller to injure the thighs or back
- Penetrating injuries, such as stab and gunshot wounds, or wires under nails
- Chemical exposure to salt, chili pepper, gasoline, etc. (in wounds or body cavities)
- Sexual violence to genitals, molestation, instrumentation, or rape
- Traumatic or surgical amputation of body parts, such as ears, digits, or limbs
- Surgical removal of organs
- Pharmacological torture using toxic doses of sedatives, neuroleptics or paralytics, hallucinogens or other substances
- Conditions of detention, such as small or overcrowded cells, unhygienic conditions, no access to toilet facilities, irregular or contaminated food and water, exposure to extremes of temperature, denial of privacy, and forced nakedness



# Be Aware of Common Methods of Torture

- Deprivation of normal sensory stimulation, such as sound, light, sense of time, and physical, and social contacts
- Denial of medical and mental health care and treatment
- Incommunicado detention and denial of social contacts in detention and/or with the outside world
- Prolonged use of restraint devices, such as handcuffs, chains, irons, and straitjackets
- Solitary confinement and other forms of isolation
- Sensory overload, such as loud music, bright lights, and prolonged interrogations
- Exhaustion from prolonged, forced exercise often in combination with sleep deprivation
- Humiliation, guilt and shame, often resulting from verbal abuse and the performance of humiliating acts on the basis of one's identity, gender, and/or (actual or presumed) sexual orientation
- Threats of death, harm to family, further torture, imprisonment and mock executions; or attacks by animals, such as dogs, cats, rats, or scorpions
- Psychological techniques to break down the individual, including forced betrayals, amplifying feelings of helplessness, exposure to ambiguous situations, or contradictory messages and violation of taboos
- Behavioural coercion, such as forced engagement in practices against the religion of the victim (e.g. forcing Muslims to eat pork), forced harm to others through torture or other abuses, forced destruction of property, and forced betrayal of someone placing them at risk of harm
- Manipulation of affect and emotions
- Forcing victims to witness torture or atrocities being inflicted on others, including members of their families



# Section 3: Evaluation of Physical Evidence



## Record Acute and Chronic Physical Symptoms and Disabilities Related to the Alleged Abuse

**IV. Physical Symptoms and/or Disabilities Related to Alleged Abuse (Describe acute and chronic symptoms and disabilities including location, intensity, frequency, duration, potentiating and alleviating factors, and subsequent healing processes)**

Acute Symptoms and Disabilities:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Chronic Symptoms and Disabilities:

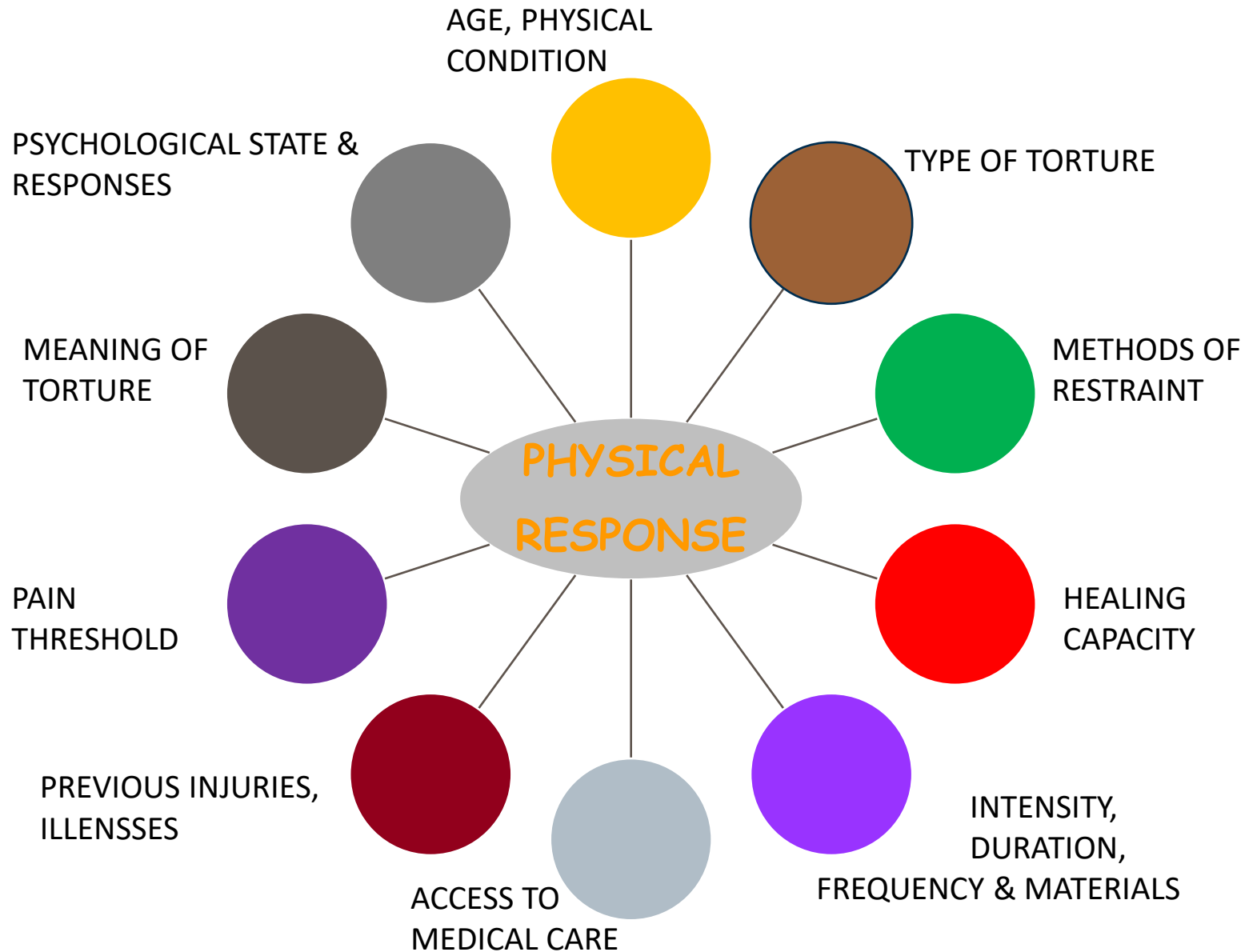
1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_



# Physical Health Consequences

- May involve all organ systems. Dermatologic findings and musculoskeletal symptoms are commonly present in both acute and chronic phases.
- Physical and psychological symptoms often overlap.
- Some effects are typically acute while others may be chronic.
- Expect individual variability in injuries and recovery/healing.
- Symptoms & physical findings will vary in a given organ system over time.
- A particular method of torture, its severity, and the anatomical location of injury often indicate the likelihood of specific physical findings.
- **The absence of such physical evidence should not be construed to suggest that torture did not occur.**

# Many Factors May Affect Physical Responses





# Dermatologic Evaluation

- Scarring is the most common late physical finding
- Healing is influenced / impaired by many factors:
  - Persistent, untreated infection
  - Repeated trauma to the same area
  - Malnutrition
  - Healing by primary vs secondary intention
- Healing of lacerations and incisions may be by:
  - Primary intention: top down, leaving a narrow, linear scar
  - Secondary intention: from below leaving a wide “biconvex” scar, gaping edges, and tissue bridges, that are prone to infection
- Self-inflicted injuries: usually made with the dominant hand to accessible parts of the body and are not severe



# Dermatologic Evaluation

- Common injuries to the skin can be classified as:
  - Abrasions (or grazes)
  - Contusions (commonly known as bruises)
  - Lacerations (commonly known as cuts)
  - Incisions (including stab wounds)
  - Burns and scalds
- Some injuries/scars may be highly consistent with specific allegations of torture

1

**Abrasion:** superficial layer of skin/tissue (epidermis) is removed resulting from direct trauma or friction against a rough surface

2

**Contusions/Bruises:** hemorrhage due to forceful blow to the skin and soft tissue, leaving the outer layer of skin intact (e.g. ecchymoses, hematomas)

3

**Lacerations:** tissue is crushed, split, torn (avulsion); may be linear (regular) or stellate (irregular)



Partial avulsion: tissue is elevated but remains attached to body

Total avulsion: tissue is completely torn off from the body with no attachment



# Dermatologic Evaluation

- Description of skin lesions should include:
  - Localization (use body diagram): symmetrical, asymmetrical
  - Shape: round, oval, linear, circumferential, etc.
  - Size (use ruler)
  - Colour
  - Surface: scaly, crusty, ulcerative, bullous, necrotic
  - Periphery: regular or irregular, zone in the periphery
  - Demarcation: sharply, poorly
  - Level in relation to surrounding skin: atrophic, hypertrophic, macular



# Abrasions

- Circumferential loss of hair (cicatricial alopecia) following prolonged application of a tight cord around the leg six years prior to the examination.
- An abrasion is a scraping away of the superficial portions of the epidermis or destruction of the superficial layers by tangential application of force against the rough surface of the blunt object. Abrasions are more commonly observed over bony prominences or where a thin layer of skin overlies bone.
- Linear abrasions may be referred to as scratches.
- Abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Identifiable patterns of scratches can be seen, for example, from fingernails. Elongated broad abrasions can be caused by friction on the skin from objects such as ropes and cords. When the blunt force is directed perpendicular to the skin over the bony prominences, it will generally crush the skin at that point. Sometimes if there is anything between the object and the skin, its imprint may be observed on the skin, such as a shoe print. In hanging and other asphyxiations by ligature, patterned abrasions can often be found on the neck.

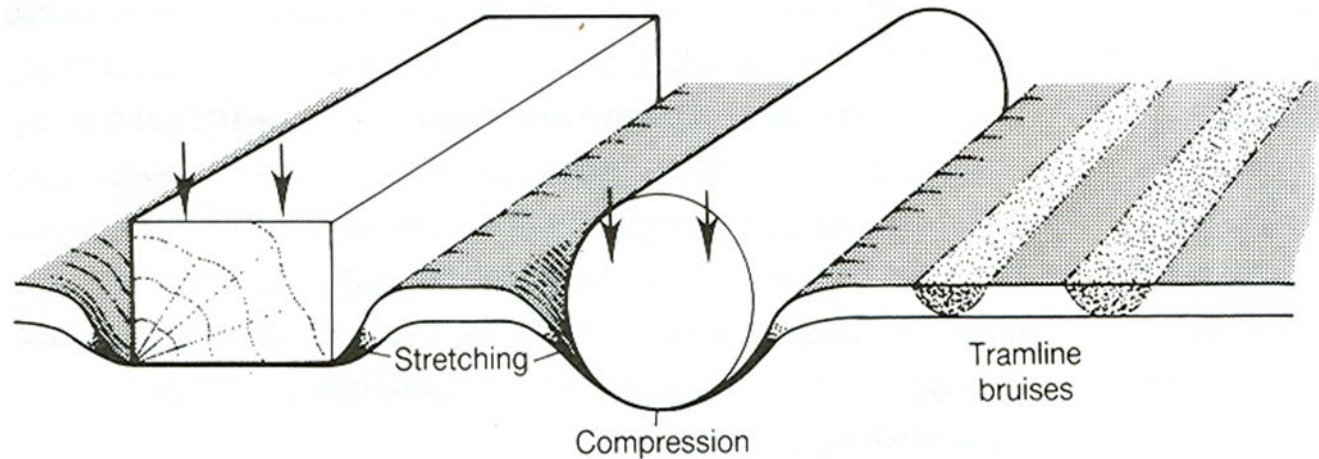






# Contusions

- A contusion or bruise is caused when blunt trauma occurs to the subcutaneous tissue resulting in the rupture of blood vessels with extravasation into the neighbouring soft tissue. The continuity of the skin surface is unbroken. Contusions may be present not only in skin but also in muscles and internal organs. A haematoma is a focal collection of blood in the area of a bruise.
- Sometimes the shape of the bruise helps to identify the shape of the blunt instrument that caused the injury. For example, a blow from a baton or heavy stick often leaves two parallel lines of bruising (tramline bruising) caused by the blood being pushed sideways by the contact. Ideally bruises should be photographed as soon as possible, before they spread or fade.





# Contusions

- Contusions with a typical “tramline” appearance after alleged torture involving beating with a broom handle.
- When the bruise is deep the blood tracks slowly to the surface, and it may be several hours or even days before anything is visible. It is often helpful in such cases to re-examine the patient a day or two later. In such cases, the extravasated blood (blood that has been lost from the vessels) follows tissue planes and may emerge some distance from the original injury, and is unlikely to be tender. For example, bruising of any part of the face may appear below the eye. Thus the site of the bruise is not the site of the injury, but the size of the bruise could be evidence of the force of the blow. This should be made clear in any report.
- Bruises change colour and fade over a period of hours and days as the blood pigments are metabolised and absorbed, but this takes a variable period of time in different parts of the body following a single incident. However, if there are bruises at different stages of resolution in the same place, this could support allegations of repeated assaults over several days.



“Tram-track” bruises after beating with wooden baton



# Lacerations

- Lacerations are a pattern of injury in which skin and underlying tissues are cut or torn. Unlike an abrasion, none of the skin is missing.
- Lacerations injuries may be caused by blunt trauma, crush injuries, and sharp objects.
- The clinical presentation of lacerations can be highly variable based on location, depth, width, and length. Due to this highly variable presentation, the healthcare team must have a strong understanding of the critical history and physical exam items each laceration requires.



Laceration injury following blunt head trauma



# Incisions

- Incisions are caused by sharp objects like a knife, bayonet, or broken glass that produce a more or less deep, sharp, and well-demarcated skin wound. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations.
- Incisional wounds have clearly defined edges and, on close inspection, it may be possible to see that hairs have been cut. There are no tissue bridges. Sometimes the wound can be jagged, suggesting that it was not caused by a single stroke. However, because the skin stretches as it is cut, the size of the wound is not necessarily related to the size of the implement used.
- Small wounds and those that are supported by surrounding tissues heal at the surface, and they may be difficult to see after only a few days. If the wound is in a part of the skin that is not supported, it will gape. Unless it is sutured or otherwise closed, it will heal from inside.
- Stab wounds are incisions that are deeper than they are wide. They should be examined carefully because of the risk of damage to deeper structures.



Alleged torture two years previously in Africa involving the use of razor blades and the application of pepper to the open incised wounds.



# Burns

- Burns are usually caused by dry heat, but the skin can also be scalded with very hot liquids or burnt with chemicals. Burning is a form of torture that frequently leaves permanent changes in the skin. The shape of the lesion can sometimes, but not always, reveal the shape of the object that caused the burn. The damage caused by heat is proportional to the temperature and the duration of exposure. Burns are classified into three degrees, according to severity.
- In superficial (first-degree) burns, there is no permanent damage to the epidermis. They present as a reddening of the skin.
- In partial thickness (second degree) burns, some of the epidermis is destroyed and there may also be damage to deeper tissues. They present as moist, red, blistered lesions and are normally very painful.
- In full thickness (third degree) burns, there is complete destruction of the epidermis and significant damage to deeper tissues. Sometimes third-degree burns are seen with complete destruction of all layers of the skin. The shape of the lesions may or may not reflect the shape of the object that caused the thermal injury. They may not be as painful as partial thickness burns. If the burns are widespread, there is usually death from shock and fluid loss.



# Burns

- Alleged torture involving burning with a cigarette four weeks previously. There are 5 to 10 mm, circular, macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery noted on the back of the hand.
- Cigarettes are commonly used by torturers to inflict pain. Most cigarette burns are superficial and fade over a few hours to a few days. They tend to be circular, and have a diameter of up to 1 cm. They cause an erythematous (reddening of the skin) and an oedematous circle that can blister. Deeper burns are caused when the lit cigarette is pressed against the skin for a longer time. When this happens, the lesion is deeper and there might be a full thickness burn in the centre surrounded by blisters. Macular scars are typically circular with a depigmented centre and a hyperpigmented, relatively indistinct periphery. If the cigarette is rubbed in it leaves a larger and more irregular lesion.





# Burns

- Alleged torture involving burning several areas of the skin with a heated, circular metal rod, the size of a cigarette, one year previously. Circular scars with an atrophic centre and a regular, narrow, hyperpigmented zone in the periphery are seen. (The patient had 35, mostly circular, scars distributed on several areas of the skin, some of them with a hypertrophic zone in the periphery. Their diameter varied from below 1 cm to around 2 cm).
- Burns from hot objects tend to take the shape of the surface that caused the burn. The wound contracts as it heals, so the lesion may be smaller than the object. Scars often demonstrate an atrophic centre and a regular, narrow, hyperpigmented zone in the periphery with well demarcated borders.



Burns from a hot circular rod



# Striae Distensae

- Striae distensae (stretch marks) are most common on the abdomen (especially after pregnancy), the lower back, the upper thighs, and around the axillae. They are hypopigmented lines in which the skin might be folded. **They must not be confused with scars from whipping.** In striae, the skin is intact. They can be evidence of significant weight loss, for example in detention.







# Musculoskeletal System

- Musculoskeletal complaints are very common.
- May result from beatings, suspension, or other positional torture or may also be psychosomatic.
- If the individual has musculoskeletal pain and/or a limited range of motion, have the individual engage in movement and note what movements increase or alleviate the pain and any restriction in range of motion.
- Physical examination of the skeleton should include:
  - Testing for the mobility of joints, the spine, and the extremities
  - Observing pain with motion
  - Testing muscle strength
  - Assessments of compartment syndromes
  - Detecting fractures by palpating callus bone formation, with or without deformity
  - Observing dislocations or contractures



# Neurological Evaluation

- Torture may cause central nervous system injuries such as traumatic brain injury (contusions and concussions), life-threatening hematomas, and injuries to the peripheral nervous system such as peripheral nerve injuries.
- Clinicians should enquire about any head trauma and asphyxiation associated with the loss of consciousness, symptoms of headache, numbness, weakness, dizziness, vertigo, and problems with memory or cognitive function.
- Clinicians should evaluate neurological complaints with a thorough neurologic examination including a mental status examination (using the Montreal Cognitive Assessment (MoCA) or other, equivalent instrument).



# MoCA

## Montreal Cognitive Assessment (MoCA)

## آزمون شناختی مونترال

نام و نام خانوادگی: \_\_\_\_\_ جنس: \_\_\_\_\_ میزان تحصیل: \_\_\_\_\_ تاریخ انجام آزمون: \_\_\_\_\_

امتیاز	ساعت را بکشید (یازده و ده دقیقه) (به امتیاز)		مکعب یا بکشید		دیداری - فضایی / اجرایی	
	[ ] [ ] [ ]		[ ]		[ ]	
۵۱	[ ] [ ] [ ]		[ ]		[ ]	
نام ببرید						
۷۱	[ ] [ ] [ ]		[ ] [ ] [ ]		[ ] [ ] [ ]	
حافظه						
بدون امتیاز	فرغز	انتابگردان	بیمارستان	مخمل	صورت	فهرست کلمات را بخوانید ، فرد باید آنها را تکرار کند. دوبار این کار را انجام دهید. حتی اگر بار اول موفقیت آمیز باشد. پس از ۵ دقیقه یادآوری را انجام درخواست کنید.
۷۲	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
توجه						
۷۳	۴ ۵ ۸ ۱ ۲ [ ]		۲ ۳ ۷ [ ]		فهرست شماره ها را بخوانید (یک شماره هر ثانیه) فرد باید به همان ترتیب تکرار کند فرد باید برعکس تکرار کند	
۷۴	فهرست حروف را بخوانید. فرد باید با شنیدن هر حرف ب شریه ای یا دهنش بزند. دو بار یا بیشتر اشتباه، امتیازی نمی گیرد. <b>ف ج چ بی می من ن پ ز گ ل چ پ ف ب گ د ر ب ب پ ز ب م و ف ب ب چ</b> [ ]					
۷۵	از صد ۵۷ تا ۷۰ کم کنید <b>۶۵ [ ] ۷۲ [ ] ۷۹ [ ] ۸۶ [ ] ۷۳ [ ]</b> <b>۴ یا ۵ مرحله درست : ۳ امتیاز ، ۲ یا ۳ مرحله درست : ۲ امتیاز ، ۱ مرحله درست : ۱ امتیاز ، صفر مرحله درست : صفر امتیاز</b>					
۷۶	تکرار : من قضا می دهم رضا کسی است که امروز کمک می کند. [ ] وقتی سگها در اتاق بودند گریه همیشه زود جیل پنهان می شد. [ ]					
۷۷	روایی کلام / هر تعداد کلماتی را که با حرف م شروع می شود در یک دقیقه بگویند. [ ] (تعداد کلمات درست ۱۱ و بیشتر)					
۷۸	شاهت بین موز و پرتقال چیست؟ هر دو میوه اند. [ ] قشار - دوچرخه [ ] ساعت - خط کش [ ]					
یادآوری یا تاخیر						
۵۱	فرد باید کلمات یا بدون هیچ راهنمایی یا با راهنمایی یادآوری		فرغز	انتابگردان	بیمارستان	مخمل
اختیاری		راهنمایی یا گروه	[ ]	[ ]	[ ]	[ ]
		راهنمایی یا چند جواب	[ ]	[ ]	[ ]	[ ]
اتمامی به زمان و مکان						
۵۶	[ ] چندمین روز ماه [ ] ماه [ ] سال [ ] روز هفته [ ] مکان [ ] شهر					



# Head Trauma & Traumatic Brain Injury

- Head trauma is one of the most common forms of torture.
- Estimates of a period of loss of consciousness following head injury are unlikely to be accurate as a person may suffer a period of peri-traumatic amnesia.
- Acute symptoms may include pain, dizziness, nausea, vomiting, and visual disturbance. Headaches may be the initial symptom of an expanding subdural haematoma. They may be associated with the acute onset of mental status changes and a CT scan must be performed urgently.
- Soft tissue swelling or haemorrhage will usually be detected by CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessments.
- Scars can be observed in cases in which there have been lacerations of the scalp.
- Chronically, there may be persistent headaches, dizziness, and memory or other cognitive deficits. There may be seizure disorders. The pain may be somatic or may be referred from the neck.
- Late effects of brain injury can be detected with specialized radiological techniques.
- Minor traumatic brain injury, even without loss of consciousness, may affect memory and concentration in the short and long term. Brain injury from asphyxia torture may also lead to cognitive deficit.



# Neurologic – Winged Scapula

- Demonstration of “winged” scapula in a torture victim subsequent to prolonged suspension.
- “Reverse suspension” occasionally causes winging of the scapulae (prominent vertebral border of the scapula) caused by traction on the long thoracic nerve, easily missed unless specifically looked for by asking the subject to press against a wall with outstretched arms, and there may be permanent deficit of the lower roots of the brachial plexus, as shown by sensory deficit in an ulnar distribution.





# Sexual Violence & Rape

- There is considerable variability in the recall of events by victims and disclosure of sexual torture may be difficult and delayed.
- The absence of physical injuries should not be considered evidence of consent.
- A full review of symptoms may aid in the disclosure of sexual violence.
- Violent and repeated rape or sexual assault by anal penetration with an object can cause significant physical damage with long-lasting effects.
- Examinations of ano-rectal injuries may need to be performed under sedation.
- Examinations should proceed at a pace dictated by the alleged victim and stopped if too stressful.
- Most injuries heal within a few days and are not present at the time of examination.
- Sexually transmitted infection may be detected but does not necessarily confirm torture as the cause.
- Sexual dysfunction may occur in those who have not suffered sexual torture, or it may be that they have not yet disclosed sexual torture.



# Sexual Violence & Rape

- Men who experience sexual arousal during anal rape should be reassured that this is a physiological reaction that does not reflect their sexual orientation.
- Symptoms of sexual dysfunction include profound effects on the psyche.
- Small lacerations or tears of the vulva normally heal completely but can scar.
- Genital examination findings may include scarring from cigarette burns or cutting injuries.
- Clinical evaluations of alleged sexual assault & rape should include:
  - A complete history including reproductive & OB/GYN and urogenital history
  - A “head-to-toe” physical examination including genito-anal examination, if indicated
  - Documentation (written/photos) of all injuries
  - Collection of indicated forensic (hair, semen) specimens (maintain chain of custody)
  - Diagnostic tests (pregnancy, STDs)
  - Offer indicated interventions such as follow-up physical and mental health care
- Clinicians may be requested to a medico-legal report and testify in court.



# Evaluations of Physical Evidence in Children

- Medical examination should be carried out in a child-friendly setting by trained clinicians with experience in assessing and documenting physical injury in children including sexual assault.
- Consent should be obtained from the child's guardian and as appropriate from the child.
- Clinicians may need to seek additional information from other children, young people, and their caretakers.
- Children victims must have access to trained, competent pediatric examiners, whenever possible, who can provide medical assessments and recommendations for care.
- The evaluation must safeguard individuals to prevent further torture and ill-treatment, recommend resources for recovery and reintegration, and reduce exposure to experiencing or witnessing violence.
- Examination of the genital and anal areas should be conducted only when necessary, and by experienced clinicians & under general anaesthesia.
- Scar formation in children may be different from that in adults as wounds might heal faster. Bony injuries, depending on their position related to the growth plate, may not be apparent on initial x-rays or months after a fracture has healed.
- Radiological techniques should be used scrupulously in children given the anxiety they may cause and potential after-effects of childhood radiation.





# Conduct a Directed Physical Examination

**V. Examination of Physical Evidence** (Include all pertinent positive and negative findings; for skin lesions include: size, pattern, elevation, color, location, shape, consistency and border; for reported head trauma, loss of consciousness or asphyxiation, conduct a complete neurologic exam including mental status using the attached MoCA form; for acute vaginal or anal rape, obtain indicated tests and forensic evidence for analysis. Use attached body diagrams and/or take photographs of all relevant physical findings)

General Appearance & vital signs: \_\_\_\_\_

Skin: \_\_\_\_\_

Face/Head: \_\_\_\_\_

Eyes/Ears/Nose/Throat \_\_\_\_\_

Oral Cavity/Teeth: \_\_\_\_\_

Chest/Abdomen (including vital signs) \_\_\_\_\_

Genitourinary System \_\_\_\_\_

Musculoskeletal System \_\_\_\_\_

Nervous System (including Mental Status Exam): \_\_\_\_\_



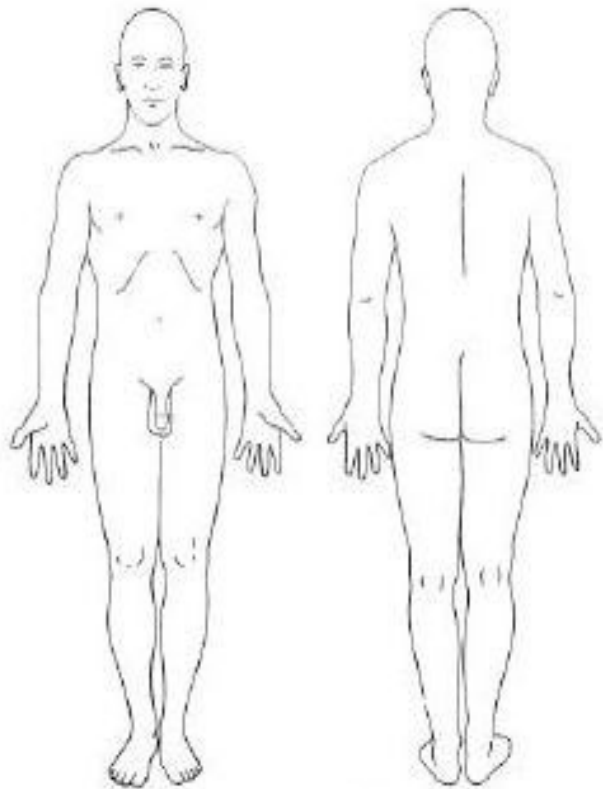
# Document Physical Evidence Using Body Diagrams & Photographs

- Use body diagrams to describe injuries and their location. (see Istanbul Protocol Clinical Evaluation Short Form for Conflict Situations or Istanbul Protocol Annex IV: [https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol\\_Rev2\\_EN.pdf](https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf)).
- Take photographs of all injuries/lesions, identify them with numbers, and refer to them in your written report.
- Photographs should be taken using a digital camera that records the date and time. If a film camera is used, it should have a date & time function. Also, the chain of custody of the film, negatives, and prints must be fully documented.
- Document injuries as quickly as possible, before changes occur.
- Any photographic equipment can be used initially, and more professional photographs can be taken later.
- Take photos of each injury/scar/wound (far away, medium, close-up).
- Photographs should include:
  - Current date (digital or newspaper in photo)
  - Identity of the alleged victim (face or label)
  - Scale (ruler or common object)
  - Use natural lighting instead of flash
  - Follow chain of custody
- Prior photographs: record who took them, and when they were taken; describe the image quality and your ability to identify the person evaluated.



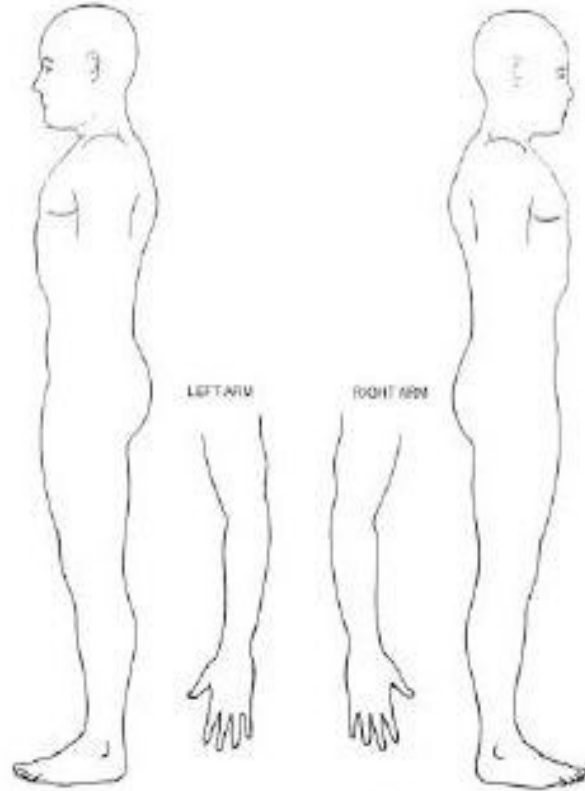
# Examples of Body Diagrams

FULL BODY MALE—ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)



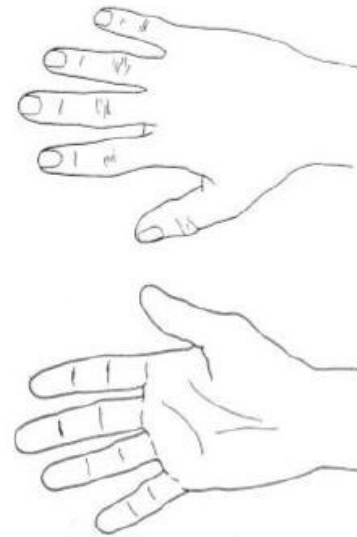
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

FULL BODY MALE—LATERAL VIEW



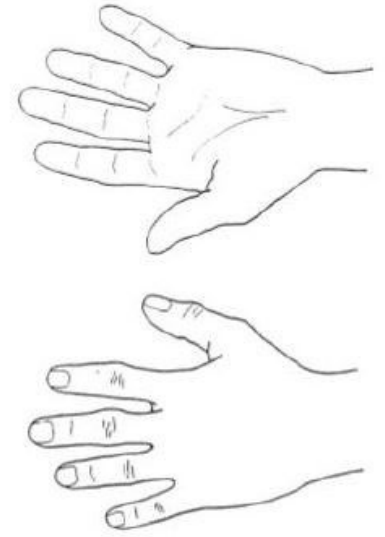
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

RIGHT HAND—PALMAR AND DORSAL



Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

LEFT HAND—PALMAR AND DORSAL



Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_



# Chain of Custody

- Clinical Reports (electronic and hardcopy), photographs, diagnostic test results, and any other evaluation-related documents should follow chain of custody guidance.
- Each person in possession of case material must record:
  - Date of access
  - Location
  - Name of person in possession
  - Reason for taking possession
  - Any damage to evidence while in possession
- If the evidence packet is opened, the new person must also sign and date under seal.
- Store evidence with the chain of custody form.
- Store evidence in a space safe from theft and/or damaging elements.



# Example Chain of Custody Forms

**EVIDENCE COLLECTION  
CHAIN OF CUSTODY FORM**

Case #: \_\_\_\_\_  
Exhibit Reference #: \_\_\_\_\_  
Date Collected: \_\_\_\_\_  
Time Collected: \_\_\_\_\_  
Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Location Where Found/Seized/Produced: \_\_\_\_\_  
Collected By: \_\_\_\_\_  
[PRINT FULL NAME(S) IN BLOCK LETTERS]  
\_\_\_\_\_  
[SIGNATURE]  
\_\_\_\_\_  
[TITLE AND AGENCY]

**Transferred From:**  
\_\_\_\_\_  
[PRINT FULL NAME(S) IN BLOCK LETTERS]  
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[SIGNATURE]  
\_\_\_\_\_  
[TITLE AND AGENCY]

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**CONTINUITY**

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[TITLE AND AGENCY]

**Date of Transfer:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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[TITLE AND AGENCY]

**Date of Transfer:** \_\_\_\_\_ **Time:** \_\_\_\_\_

# Section 4: Evaluation of Psychological Evidence



# Psychological Evaluations in Conflict Settings

Note: For the purposes of this training, the psychological evaluation consists of two basic questions and two diagnostic tools, one for depression and the other for PTSD

- Psychological reactions to torture and ill-treatment are variable, but often profound and result in long-term symptoms & disabilities.
- The severity of psychological reactions depends on the unique, individual cultural, social, and political meanings.
- Significant psychological symptoms and disabilities do not require extreme physical harm.
- **The absence of psychological symptoms and disabilities should not be construed to suggest that torture did not occur.**
- **Also, the absence of diagnostic criteria for a psychiatric diagnosis does not mean the person was not tortured. Sub-threshold symptoms are typically significant psychological findings.**



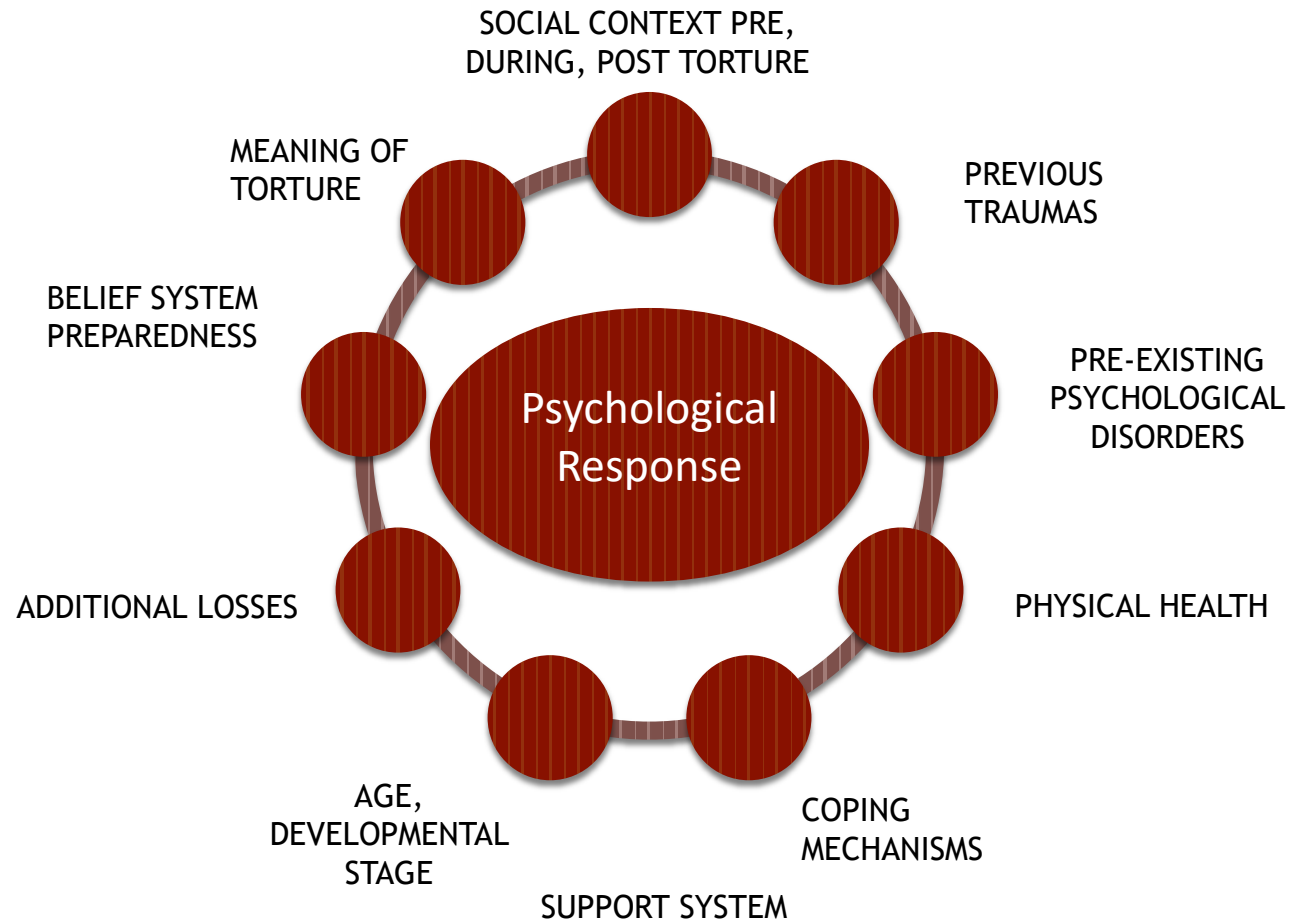
# Psychological Evaluations in Conflict Settings

- Symptoms and/or diagnostic criteria for posttraumatic stress disorder (PTSD) and major depression are most common, but other diagnostic categories may be observed including:
  - Anxiety disorders
  - Damaged self-concept and foreshortened future
  - Dissociation, depersonalization, and atypical behavior
  - Somatic complaints
  - Sexual dysfunction
  - Psychosis
  - Substance abuse
  - Neuropsychological impairment
- Note: Psychological reactions to torture and ill-treatment in a child depend on the child's age, development, and experiences. Clinical evaluations should be conducted by experienced, pediatric clinicians.





# Many Factors May Affect Psychological Responses





# Record Psychological Symptoms & Assessments of Depression and PTSD

## VI. Psychological Symptoms and Assessment of Depression and PTSD

Ask the following:

*“Do you feel that your mental state (thoughts and emotions) has been significantly affected by the abuse that you reported?”*

Detainee’s Response       Yes       No [If “Yes,” complete attached PHQ-9 & PC-PTSD-5]

*“To what extent has the change in your mental state affected your life or your ability to function?”*

Detainee’s Response       None       Mild       Moderate       Extreme

PHQ-9 completed:       Yes     No      Total Score: \_\_\_\_\_ Depression Diagnosis: \_\_\_\_\_  
Depression Severity: \_\_\_\_\_  
PC-PTSD-5 completed     Yes     No      Total Score: \_\_\_\_\_ (Note, a score of 4-5 indicates PTSD)  
(Note, a score of 3 indicates possible PTSD)



# Complete the Patient Health Questionnaire (PHQ-9) to Assess Depression and its Severity

First, read each of the 9 questions and circle one response (0 to 3) for each question.

Next, tally how many answers were circled in the shaded section. Based on this number, you can provide the initial diagnosis:

- **Depressive Disorder:** If there are at least 4 answers circled in the shaded section (including Questions #1 and #2). Add score to determine severity.
- **Major Depressive Disorder:** If there are 5 answers circled in the shaded section (one of which includes Questions #1 and #2).
- **Other Depressive Disorder:** If there are 2-4 answers circles in the shaded section.

Finally, add up the values of all the values you circled. This is the "Total Score" listed at the bottom of the chart. Based on this number, you can determine the severity of the diagnosis:

- 1–4: minimal depression
- 5–9: mild depression
- 10–14: moderate depression
- 15–19: moderately severe depression,
- 20–27: severe depression

PHQ-9				
Over the last two weeks, how often have you been bothered by the following problems? (Circle your response.)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<b>Scoring:</b> Part A. Diagnosis <b>Depressive Disorder:</b> If there are at least 4 answers circled in the shaded section (including Questions #1 and #2). Add score to determine severity. <b>Major Depressive Disorder:</b> If there are 5 answers circled in the shaded section (one of which includes Questions #1 and #2). <b>Other Depressive Disorder:</b> If there are 2-4 answers circles in the shaded section.  Part B. Severity: Add up all of the scores in each section. This is the final "Total" number. 1-4: minimal depression 5-9: mild depression 10-14: moderate depression 15-19: moderately severe depression, 20-27: severe depression		Add: <input type="text"/> <input type="text"/> <input type="text"/>  Total Score: <input type="text"/>  Diagnosis: <input type="text"/>  Severity: <input type="text"/>		
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Check one the boxes to the right)	Not at all <input type="checkbox"/>	Somewhat Difficult <input type="checkbox"/>	Very Difficult <input type="checkbox"/>	Extremely Difficult <input type="checkbox"/>



# Complete the Primary Care PTSD Screen DSM-5 (PC-PTSD-5) to Assess PTSD

Read the initial prompt and record “Yes” or “No” for each of the 5 questions. Then provide a Total Score of all “Yes” responses.

PC PTSD-5	
<b>In the past month, have you...</b>	
1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Been constantly on guard, watchful, or easily startled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Felt numb or detached from people, activities, or your surroundings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Felt guilty or unable to stop blaming yourself or others for the events(s) or any problems the event(s) may have caused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The Total Score is the sum of all “Yes” answers:</b>	<b>Score: ___ / 5</b>
(Note, a score of 4-5 indicates PTSD)	
(Note, a score of 3 indicates possible PTSD)	

A Total Score of 4 or 5 is an indication of PTSD

A Total Score of 3 indicates possible PTSD



# Specialized Diagnostic Tests

- Specialized diagnostic tests are not essential for clinical evaluation of torture or ill-treatment and are usually not warranted unless they are likely to make a significant difference to a medico-legal case.
- Such tests have limitations in specificity and reliability that clinicians should be aware of and may not be useful following the healing of acute injuries.
- Plain radiographs are readily available and may be useful when searching for fractures, fissures, deformities, and foreign bodies in osseous structures and may detect acute soft tissue changes and foreign bodies.
- When periosteal damage or minimal fractures are suspected, MRI, CT, or bone scintigraphy are more sensitive.
- An MRI may detect bone contusion and stress or occult fractures before it can be imaged by x-rays, CT, or scintigraphy.
- In the acute phase of injury, various imaging modalities may be useful in providing additional documentation of skeletal and soft tissue injury. Once the physical injuries of torture or ill-treatment have healed, however, the residual sequelae are generally no longer detectable by the same imaging methods.
- Open scanners and sedation may be helpful in alleviating anxiety and claustrophobia.



# Record Diagnostic Tests or Referrals Ordered

## VII. Diagnostic Tests and Referrals:

**Diagnostic Tests / Studies Ordered:**  Yes  No

1. \_\_\_\_\_ Date: \_\_\_\_\_ Ref #: \_\_\_\_\_ Findings: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_ Ref #: \_\_\_\_\_ Findings: \_\_\_\_\_

**Referrals/Consultations Requested:**  Yes (Explain): \_\_\_\_\_  No

# Section 5: Interpretations & Conclusions



# Consider Inconsistencies

- Clarify all inconsistencies prior to interpreting the findings and forming an opinion.
- Explain whether inconsistencies are related to the alleged torture and ill-treatment:
  - Overstimulation, sensory deprivation, and lapses of consciousness
  - Neurological or psychological memory disturbances
  - Feelings of guilt or shame
  - Lack of trust in the examining clinician and/or interpreter
  - Fear of reprisals
  - Lack of privacy during the interview
  - Cultural differences in the perception of time
- Persecution-related inconsistencies may be considered corroborating material medical evidence that is central to the case (e.g. failure to disclose sexual abuse initially).





# Interpretation of Physical Findings

- Clinicians should provide an interpretation as to the level of consistency between each physical finding and the method of injury reported.
- Note photograph number(s) for each finding.
- Levels of consistency are defined as follows..

**Not Consistent With:** lesion could not have been caused by the trauma described

**Consistent With:** symptoms or lesion could have been caused by the trauma described, but is non-specific and there are many other possible causes

**Highly Consistent With:** symptoms or lesion could have been caused by the trauma described, and there are few other possible causes

**Typical of:** this is an appearance usually found with this type of trauma, but there are other possible causes

**Diagnostic Of:** the symptom or lesion could not have been caused in any way other than that described

**Not Related To:** for lesions that the individual themselves reports are not related to alleged torture/ill treatment



# Interpretation of Physical Findings

- The highest level of consistency of an individual finding often determines the level of consistency for all the clinical evidence.
- In some cases, the overall evaluation will report a higher level of consistency than each individual finding, especially when taken together.
- Factors that may increase the level of consistency for physical evidence include:

Consistency between the description of physical injuries and the alleged victim's account of subsequent acute and chronic symptoms and/or disabilities, as well as the healing of injuries.

Consistency between alleged torture methods and prevailing local/regional torture practices.

Consistency between body positions/methods of restraint with the presence and absence of injuries.



# Interpretation of Psychological Findings

- Depression and PTSD are not specific to torture and/or ill-treatment. Symptoms and/or diagnoses of depression and/or PTSD may be “Consistent With” or “Highly Consistent With” allegations of torture and ill-treatment.
- Note: “Typical of” and “Diagnostic of” levels of consistency are not usually appropriate correlations for psychological findings.
- Factors that may increase the level of consistency for psychological evidence include:
  - The temporal relationship between the alleged abuse and onset of psychological symptoms.
  - Fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors.
  - Congruency between an alleged victim’s observed affect (emotional state) during the interview and the content of the evaluation.
  - PTSD symptoms that corroborate specific allegations of torture and ill-treatment such as the content of nightmares, triggers for intrusive recollections & reliving experiences, as well as avoidance thoughts and behaviours.
- In some cases, the absence of psychological symptoms and disabilities may be explained by individual mitigating factors such as the meaning of the experience, effective coping, social supports, and symptom reduction over time.



# Record Consistency Between Physical Findings and Alleged Methods of Torture

For each physical finding, note the alleged method of injury; indicate the level of consistency and whether photographs were taken and, if so, the photograph number(s).

<b>VIII. Assessment of Correlation Between Physical Findings and Alleged Methods of Injury</b>									
<b>*(NC=Not Consistent With; C=Consistent With; HC=Highly Consistent With; TO=Typical of; DO=Diagnostic Of)</b>									
<b>Physical Finding(s)</b>	<b>Alleged Method of Injury</b>	<b>*Correlation (check one for each finding)</b>					<b>Photograph #s (attach to report)</b>		
1.		<input type="checkbox"/> NC	<input type="checkbox"/> C	<input type="checkbox"/> HC	<input type="checkbox"/> TO	<input type="checkbox"/> DO	<input type="checkbox"/> Yes #	<input type="checkbox"/> No	
2.		<input type="checkbox"/> NC	<input type="checkbox"/> C	<input type="checkbox"/> HC	<input type="checkbox"/> TO	<input type="checkbox"/> DO	<input type="checkbox"/> Yes #	<input type="checkbox"/> No	
3.		<input type="checkbox"/> NC	<input type="checkbox"/> C	<input type="checkbox"/> HC	<input type="checkbox"/> TO	<input type="checkbox"/> DO	<input type="checkbox"/> Yes #	<input type="checkbox"/> No	
4.		<input type="checkbox"/> NC	<input type="checkbox"/> C	<input type="checkbox"/> HC	<input type="checkbox"/> TO	<input type="checkbox"/> DO	<input type="checkbox"/> Yes #	<input type="checkbox"/> No	
5.		<input type="checkbox"/> NC	<input type="checkbox"/> C	<input type="checkbox"/> HC	<input type="checkbox"/> TO	<input type="checkbox"/> DO	<input type="checkbox"/> Yes #	<input type="checkbox"/> No	



# Record Consistency Between Psychological Symptoms/Diagnoses and Alleged Abuse

Indicate the level of consistency between the alleged victim's psychological symptoms and/or disabilities with the allegations of abuse.

Note, "Typical of" and "Diagnostic of" are not usually appropriate correlations for psychological findings.

## **IX. Assessment of psychological findings**

The alleged victim's psychological symptoms and/or disabilities are (**check one**)

**Not Consistent With**       **Consistent With**       **Highly Consistent With ...**

**the allegations of abuse reported.** (Note, "Typical of" and "Diagnostic of" are not usually appropriate correlations for psychological findings)



# Conclusion and Recommendations

- Clinicians should provide a clinical opinion on the overall possibility of torture considering all relevant clinical evidence including, “physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.” as stated in Annex IV of the Istanbul Protocol.
- A conclusion on all clinical evidence should be based on the highest level of consistency reported in evaluations of physical and psychological evidence.
- Clinical opinions on the possibility of torture are based on the probability that the totality of clinical evidence was caused by the alleged torture or ill-treatment as defined by the UN Convention against Torture or other applicable legal definitions.
- Causation is expressed in terms of consistency rather than judicial standards of proof to avoid the conflation of clinical opinions with judicial determinations.
- Conclusions on torture in children should take into account relevant legal thresholds, which may be lower for children, particularly those deprived of their liberty.



## Referrals and Follow-up Care

- Take steps to ensure safety and basic human necessities (food, shelter)
- Be aware of local clinical and social support resources and make appropriate referrals for medical and mental health care.



# Record Conclusion and Recommendations

- Provide your opinion on the level of consistency between all clinical findings (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and the possibility of torture as defined by the UN Convention against Torture (The intentional infliction of severe physical and/or mental pain by State officials gathering information, punishment or for any reason based on discrimination of any kind).
- Review and confirm all informed consent responses provided at the start of the clinical evaluation.
- Indicate any relevant referrals for medical and/or mental health care.

<b>X. Conclusion and Recommendations</b>	
Based on my qualifications, knowledge and experience, it is my opinion that the alleged victim's clinical findings (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc.) are <b>(check one)</b>	
<input type="checkbox"/> Not Consistent With <input type="checkbox"/> Consistent With <input type="checkbox"/> Highly Consistent With <input type="checkbox"/> Typical of <input type="checkbox"/> Diagnostic Of ...	
<b>Torture as defined by the UN Convention against Torture</b> (The intentional infliction of severe physical and/or mental pain by State officials gathering information, punishment or for any reason based on discrimination of any kind.)	
I have reviewed and confirmed all informed consent responses above: <input type="checkbox"/> Yes <input type="checkbox"/> No	
I have provided relevant referrals for medical and mental health care. <input type="checkbox"/> Yes (Explain): _____ <input type="checkbox"/> No	



## Section 6: Case Examples



# Interpretation of Physical Evidence: Case 1

A 41-year-old man alleges being slashed with a knife twice on his right upper arm. On physical examination, you observe the following:

How would you describe the level of consistency between the allegation of abuse and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of



*[Courtesy of Alejandro Moreno MD, MPH, JD.]*



# Interpretation of Physical Evidence: Case 1

Answer: B Consistent With

The photograph shows 2 linear scars “consistent with” with a biconvex appearance, which suggests that they healed by secondary intention. These scars are most consistent with incisions because of the sharp, well-demarcated appearance of the scars.

*Note, the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes*



*[Courtesy of Alejandro Moreno MD, MPH, JD.]*



## Interpretation of Physical Evidence: Case 2

A 24 -year-old man who alleges that he was kicked in the right side with a military boot 4 days ago.

How would you describe the level of consistency between the allegation of abuse and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of





## Interpretation of Physical Evidence: Case 2

Answer: C or D “Highly Consistent With” or “Typical of”

On physical examination, you observe a contusion pattern consistent with the shape of a boot and a small hypopigmented abrasion scar forming at the tip of the “boot mark”.

These physical findings should be considered “Highly Consistent With” or “Typical of” the alleged injury since it is very unlikely that they were caused by any other mode of injury or pathophysiological process.





## Interpretation of Physical Evidence: Case 3

A 33-year-old man alleges multiple cigarette burns 7 days prior to your physical examination. On physical examination, you observe the following:

How would you describe the level of consistency between the allegation of abuse and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of



*[Courtesy of the Human Rights Foundation of Turkey.]*



## Interpretation of Physical Evidence: Case 3

Answer: D or E “Typical of” or “Diagnostic of”

Multiple 0.5-1.0 cm lesions with indistinct hyperemic borders and central blister and/or eschar (scar) formation consistent with recent second-degree burns from alleged cigarette burns.

These physical findings should be considered “Typical of” or “Diagnostic of” the alleged injury since it is very unlikely they were caused by any other mode of injury or pathophysiological process.



*[Courtesy of the Human Rights Foundation of Turkey.]*



## Interpretation of Physical Evidence: Case 4

A 32-year-old man alleges that he was beaten with a police baton. On physical examination, you observe the following:

How would you describe the level of consistency between the allegation of abuse and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of



*[Courtesy of Amnesty International, The Netherlands.]*





## Interpretation of Physical Evidence: Case 4

Answer: D or E

The photograph shows a large 4 cm x 6 cm contusion with underlying edema and/or hematoma formation and a series of parallel linear abrasions that correspond to the ridges of a police baton.

These physical findings should be considered “Typical of” or “Diagnostic of” the alleged injury since it is very unlikely that they were caused by any other mode of injury or pathophysiological process.



*[Courtesy of Amnesty International, The Netherlands.]*



## Interpretation of Physical Evidence: Case 5

A 14-year-old man who fell to the ground after being shot with a tear gas canister during a peaceful protest.

How would you describe the level of consistency between the alleged instrument and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of

Answer:

E. Diagnostic of



[Courtesy of Sondra Crosby, MD]



## Interpretation of Physical Evidence: Case 6

A 26-year-old man alleges that he was whipped on his back with an electrical wire. On physical examination, you observe the following:

How would you describe the level of consistency between the allegation of abuse and the findings on physical examination?

- A. Not Consistent With
- B. Consistent With
- C. Highly Consistent With
- D. Typical of
- E. Diagnostic of



*[Courtesy of the Human Rights Foundation of Turkey.]*



## Interpretation of Physical Evidence: Case 6

Answer: E “Diagnostic of”

The location and distribution of multiple linear scars on the back corroborate repetitive injury and are “Diagnostic of” the alleged injury since it is very unlikely that they were caused by any other mode of injury or pathophysiological process.



[Courtesy of the Human Rights Foundation of Turkey.]



## Interpretation of Physical Evidence: Case 7

In the course of presenting the following evidence in court, the opposing attorney states that the alleged injuries were, instead, “self-inflicted.”

Which of the following may help to explain why the findings are not likely to be self-inflicted?

- A. The “tram-track” marks are characteristic of blunt trauma from a cylindrical object, such as police batons
- B. The location of the lesions suggests a protective posture
- C. The direction/angle of the lesions indicates a person other than the alleged victim produced the injuries
- D. All of the above

**Answer:**

**D. All of the above**



*[Courtesy of the Human Rights Foundation of Turkey.]*



## Interpretation of Psychological Evidence: Case 8

- A 36-year-old woman reports being detained 6 months ago, beaten for two days, and sexually molested by police.
- She has no significant physical findings on physical examination, but has a PHQ-9 Total Score of 15 with 5 in the shaded boxes and a PC PTSD-5 Total Score of 3.

How would you interpret the psychological evidence?

**Answer: Moderately Severe Depression and PTSD**

How would you describe the level of consistency between the allegation of abuse and the psychological findings?

Answer: "Consistent With" or possibly "Highly Consistent With" if there are factors that increase the level of consistency, for example:

- A temporal relationship between the alleged abuse and onset of psychological symptoms.
- Fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors.
- Congruency between an alleged victim's observed affect (emotional state) during the interview and the content of the evaluation.



## Conclusion: Case 9

A 30-year-old man alleges being detained 5 months ago by police and subjected to beatings, suspension, and electric shock. He noted bleeding from his head after being kicked in the head.

Physical examination reveals only a linear scar with irregular wound edges and tissue bridges typical of a laceration injury, a lesion that is “Consistent With” the alleged kick to the head.

His psychological evaluation indicates mild depression and PTSD (PC PTSD-5 Total Score of 5) with a temporal relationship between psychological symptoms and the alleged abuse.

In your opinion, what is the level of consistency between the allegations of abuse and all clinical findings?

Answer: “Consistent With” or “Highly Consistent With”

Note: A conclusion on all clinical evidence should be based on the highest level of consistency reported in evaluations of physical and psychological evidence.



• [Courtesy of Alejandro Moreno MD, MPH, JD.]