Assessment of Torture Survivors

Special Competencies for Psychological Assessment of Torture Survivors

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Abstract

In spite of the absolute prohibition against torture in international law, this grave human rights abuse is still practiced systematically and with impunity in the majority of countries around the world. Mental health professionals can play a positive role in the fight against torture and impunity by developing competencies to assess the psychological sequelae of torture. High quality psychological evidence can help to substantiate allegations of torture, thereby increasing the likelihood of success in civil, administrative and criminal proceedings. This article will orient mental health professionals to issues specific to forensic assessment of torture survivors. It provides a brief introduction to the socio-political context of torture, reviews literature on the psychological sequelae of torture, introduces the reader to key competencies, offers information on strategies for producing documentary evidence and expert opinion, highlights ethical considerations and suggests areas for development in the field.

Keywords

forensic assessment, posttraumatic stress disorder, refugees, torture

While torture is absolutely prohibited under international law, this grave human rights abuse is still practiced systematically and with impunity in the majority of countries around the world (Amnesty International, 2010; 2014). The United Nations stipulates

“complaints about ill-treatment must be investigated effectively by competent authorities” (United Nations, 2004; p. 5). Because torture often leaves a lasting legacy of psychological impairment, psychological evaluations can play a forensic role when they are included in submissions in civil, administrative and criminal proceedings (United Nations, 2014). While mental health professionals cannot determine whether or not torture occurred, they can provide documentary evidence and expert opinion as to the causal connection between the alleged events and the psychological findings. Forensic assessments may thus be important in securing rights and reparations for victims, and can also help to substantiate asylum and refugee applications by torture survivors who have fled their countries of origin to seek refugee protection in a safer country. Therefore, mental health professionals with the competencies to produce high quality forensic assessments can be instrumental in the efforts to address impunity for acts of torture and can assist states to fulfill their obligations towards non-refoulement (United Nations, 2014). This article aims to inform mental health professionals about issues specific to forensic assessment of torture survivors, and begins with a discussion of special competencies required to conduct such assessments. Subsequently, information on strategies for producing documentary evidence and expert opinion and a discussion of risks and precautions will be offered. A number of areas for development in research and practice will also be highlighted.

Special Competencies

In order to produce competent and effective forensic assessments for civil, administrative, and criminal proceedings in cases of torture, mental health professionals require specialized knowledge and skills (American Psychological Association, 2013; Pope, 2012). This includes basic knowledge of forensic assessment of torture as well as the relevant legal and sociopolitical contexts.

Torture in Context

Torture, as defined by the United Nations Convention Against Torture, is severe pain or suffering intentionally inflicted or instigated by a person acting in an official capacity for the purpose of punishing, obtaining information, or intimidating the victim or a third person¹. It is notable that this definition identifies two “types” of torture: interrogational torture—that perpetrated with the objective of obtaining information—and terroristic torture, in which torture is intended as punishment or intimidation (Shue, 2004). Though torture is often justified as a method of interrogation, on the basis of its presumed utility for gathering information, the Convention recognizes that it also functions as an instrument of social and political intimidation through which the victim sustains physical, neurological, and psychological damage, and is then sent back into the community as a warning to third persons in order to stifle dissent (Amnesty International, 2014; Gorman, 2001; Hardi & Kroo, 2011; Haritos-Fatouros, 2003; Shue, 2004).

¹ Article 1 of the Convention Against Torture states: “For the purposes of this Convention, the term

Although torture was initially seen as a violation exclusive to political prisoners, the end of the cold war brought a greater awareness of the fact that states may use torture against civilians in armed conflict, and that it is also systematically used against the poor, women, and indigenous peoples, and on the basis of ethnic or sexual identities (Amnesty International, 2003, 2014).

There is a striking discrepancy between the high incidence of torture reported by human rights organizations and the fact that the overwhelming majority of states have officially endorsed a categorical ban on acts of torture (Frewer & Furtmayr, 2010). These gross violations of international law occur with impunity, in large part, because states maintain the sovereign authority to enforce the ban, and no state that systematically practices torture has an interest in investigating or prosecuting its own agents. Nevertheless, “all States have a clear obligation to investigate acts of torture and other cruel, inhuman or degrading treatment or punishment (other ill-treatment)” (United Nations, 2014). In his 2014 report, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment explained the importance of investigation, documentation and denunciation. He stated that “for every single right the victim has—from being free from torture in the first place to the rights after having survived torture, and even for the families of those torture victims who do not survive—documentation and evidence is the most fundamental prerequisite, and, unfortunately, one the attainments of which is too often frustrated” (United Nations, 2014; p. 19). Mental health professionals can provide critical documentation and evidence, which

when submitted as forensic evidence in international and domestic courts and tribunals, can assist in corroborating allegations, ascertaining damages, determining reparations and shaming perpetrators (Kjaerum, 2010; United Nations, 2014).

The Istanbul Protocol and Psychological Evidence

“The Istanbul Protocol: A Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment” was developed under the auspices of the United Nations High Commission for Human Rights in consultation with numerous human rights organizations and is the first comprehensive and multi-disciplinary set of guidelines for investigating and documenting allegations of torture (United Nations, 2004). It outlines numerous investigative procedures, including interviewing victims and witnesses, collecting statements from perpetrators, obtaining physical evidence, establishing an independent commission of inquiry, as well as providing guidelines for physicians and psychologists on conducting clinical examinations (United Nations, 2004).

As described in the Istanbul Protocol, psychological evidence has a number of “advantages” as compared with medical evidence submitted in cases of torture. Methods of torture are increasingly sophisticated and are designed to create the maximum psychological impact while leaving the least physical evidence (Giffard, 2000; Jacobs & Iacopino, 2001; Pokempner, 2005; United Nations, 2004, 2014). Physical evidence may lack specificity or heal before a medical professional can make an assessment, whereas

psychological evidence can often be observed and documented months or even years after a traumatic event (United Nations, 2004). By carefully observing a survivor while they give their testimony, comparing their psychological functioning before and after critical traumatic events, and assessing for the common sequelae of particular forms of political violence, an experienced mental health professional can offer a rigorous evaluation of the likelihood that symptoms are consistent with the allegations (Giffard, 2000; United Nations, 2004).

Psychological Consequences of Torture

The Istanbul Protocol and a large body of research literature recognizes that torture is an extraordinary life experience that carries an extreme risk of severe and lasting mental and emotional sequelae. The following section provides a brief overview of these findings, in order to orient practitioners to this body of research. The Istanbul Protocol and various authors caution, however, that while clusters of symptoms and psychological reactions have been observed with some regularity across cultures and contexts, a great deal of individual variability also exists as a result of personality factors, and the social, cultural and political context in which the traumatic events have occurred (Green, Rasmussen and Rosenfeld, 2010; Hollifield et al. 2011; Miller et al., 2006; United Nations, 2004).

In numerous studies, torture has been found to be an important predictor of post-traumatic stress disorder (Basoglu, Paker, Paker et al., 1994; Basoglu, Paker, Ozmen et

al. 1994; Basoglu and Paker, 1995; de Jong, Komproe, Van Ommeren, et al. 2001; Eisenman et al., 2003; Jaranson et al., 2004; Moisander and Edston, 2003; Mollica, Mcinnes, Pham et al., 1998; Mollica, Mcinnes, Poole et al., 1998; Priebe and Esmaili, 1997; Ramsay et al., 1993; Shrestha, 1998; Silove, Steel, McGorry, Miles, & Drobny, 2002; Steel, Chey, Silove, and Marnane, 2009; Wenzel, 2002). A review article (Johnson and Thompson, 2008) on the development and maintenance of PTSD in survivors of civilian war trauma and torture compared PTSD prevalence in tortured refugee populations (reported prevalence of 14-92%), tortured community samples (18-82%), non-tortured refugee and displaced populations (4- 71%), and non-tortured community samples affected by war (11%- 75%). There is evidence of a dose-response relationship between torture and the development and maintenance of PTSD (Hollifield, Warner and Westermeyer, 2011; Mollica, Mcinnes, Pham et al., 1998; Mollica, Mcinnes, Poole et al., 1998). In refugee populations, variables related to displacement and settlement may exacerbate symptoms and contribute to their maintenance (Jaranson, Butcher, Halcon, Johnson, Robertson, Savik, Spring, et al., 2004; Silove, Sinnerbrink, Field, Manicavasagar, and Steel, 1997). Protective factors have also been highlighted. These include preparedness for torture, social support, camaraderie, religious beliefs and family reunification (Basoglu, 1997). These findings indicate that in any psychological assessment aiming to understand the impact of torture, PTSD symptoms should be investigated thoroughly. However, the potential contributions of migration and refugee trauma, current stressors, and resiliency should also be investigated.

The PTSD construct is not an exhaustive descriptor of the sequelae found in survivors. Even long after the traumatic events, survivors commonly experience intense emotions of distrust, humiliation, helplessness, insecurity, rage and revenge which can deeply disrupt their sense of security, ability to function in relationships, membership in social groups, belief in society, purpose in life, view of human nature, worldview, and religious or spiritual certainty (Allodi, 1991; Gorman, 2001; Hanscom, 2001; Hardi and Kroo, 2011; Jacobs and Iacopino, 2001; Kinzie, 2001; Nickerson and Bryant, 2014; Keatley et al. 2013; United Nations, 2014; Van der Veer, 1992). Significant functional impairments occur as a result of disruptions to core adaptive systems, including physical safety, attachment, identity, and a sense of attachment and existential-meaning (Silove, 1999). Additionally, there are often lasting somatic complaints relating to poorly healed injuries, sleep and digestive problems, headaches and chronic pain, which may have arisen from medical injuries but have a severely exacerbating psychological component (Allodi, 1991; Gorman, 2001; Hanscom, 2001; Jacobs & Iacopino, 2001; Kinzie, 2001; Van der Veer, 1992). In documenting the impact of torture, careful attention must therefore be paid to a wide range of potential sequelae, not limited to PTSD.

Neurological sequelae can also result from the types of torture that affect the brain, which include blunt and penetrating injuries to the head, violent shaking, gunshot wounds, asphyxiation, starvation and electric shock (Grodin & Moreno, 2002; Peel & Moreno, 2004; Weinstein, Fucetola, Mollica, 2001). Brain injury secondary to blunt trauma, the most commonly experienced form of torture, commonly produces symptoms

including memory and attentional deficits, headache, vertigo, loss of consciousness, dizziness, apathy, labile affect, impaired social judgment, impulsivity, and depression (Grodin & Moreno, 2002; Peel & Moreno, 2004). Less frequently reported symptoms include parasthesias, paralysis and seizures (Grodin & Moreno, 2002; Peel & Moreno, 2004). Seizures and subsequent epilepsy conditions are strongly correlated with experiences of electric shock torture, but are also associated with head trauma (Grodin & Moreno, 2002; Peel & Moreno, 2004). These injuries can leave fixed neurological deficits that can be severe, long lasting and have a dramatic negative impact on the survivor's prognosis (Weinstein, et al. 2001). Assessors must carefully consider the interaction between brain injury and psychological sequelae because PTSD, anxiety, and mood disorders can arise spontaneously, can be secondary to traumatic brain injuries, or can co-occur with traumatic brain injury, with each interaction exacerbating and complicating the clinical picture (Keatley et al. 2013; Weinstein, et al. 2001).

While research on the impact of torture frequently finds that it leaves profound and lasting psychological wounds on individual victims, debates have arisen surrounding the definition, salience and potentially reductive nature of the constructs of torture and trauma in health science research, as well as methodological weaknesses, which may impact the interpretation of findings across studies (Green, Rasmussen and Rosenfeld, 2010; Hollifield et al. 2011). For the purposes of a psycho-legal assessment, however, the research findings alert us to the necessity of making a thorough investigation of PTSD,

anxiety, depressive symptoms as well as a wide range of emotional, neurological and functional complaints. Ultimately, these debates in the literature remind us that torture is not a uniform experience resulting in uniform outcomes, and that the severity of psychiatric symptoms are not a measure of the severity of trauma (Prahbu and Baranoski, 2012). Each person's trauma history and response to traumatic stress is unique, and our task as assessors is to describe that particularity as comprehensively and with as much context as possible.

Cultural Competence in Assessment of Torture Survivors

The cultural complexity inherent to the assessment of survivors of torture arises because experiences of torture and the process of seeking human rights remedies are always experienced by particular individuals in specific social, political and cultural contexts. Assessors must therefore strive toward a high degree of cultural competence, which has been described as “the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes” (Davis, 1997, p. 3). A culturally competent assessment will present a detailed, integrative and contextualized narrative of an individual life from a psychological perspective, while avoiding cultural stereotypes (Perlin and McLain, 2009).

Depending on the context, survivors, assessors, and the members of the legal

community who are designated recipients of the report, may be of different cultural backgrounds. In such cases, the need for cultural competence on the part of the assessor is obvious, since there may be linguistic challenges, cultural variations in the expressions of distress and dysfunction, and different cultural meanings attached to types of violence and social practices (Kirmayer, 2007; Prahbu and Baranoski, 2012). These differences may impede understanding, influence interpretation, limit disclosure, and negatively impact credibility determinations (Prahbu and Baranoski, 2012). A culturally competent assessment will thus provide a cultural context for a survivor's actions, experiences and symptoms, without stigmatizing or stereotyping the cultural group to which he or she belongs (Kirmayer, 2007). This can be done through consultations in partnership with culture brokers and interpreters who can identify the salience of culture in the survivor's narrative (Kirmayer, 2007).

Cultural competence is of equal relevance when assessments of torture sequelae are done within the survivor's country of origin, by professionals who share some of the same identifying features of the survivor (such as language, nationality or cultural group), or when culture brokers are employed to make cultural interpretations, as assumptions of similarity can also lead to incomplete understanding. There is a risk of failing to attend to the "culture of the familiar", which can result in interpretations that are blind to the social, political and economic factors that have given rise to the conditions of structural violence in which torture is operational (Kirmayer, 2007).

In every case, therefore, culturally competent assessment includes an analysis of

intersectionality (Crenshaw, 1989), in which the assessor seeks to understand the ways in which culture, class, gender, sexual orientation, group membership, political beliefs and affiliations, disability, and age, shape the survivor's identity and how these may relate to the basis for torture and interactions with the legal context (American Psychological Association, 2013). These facets of identity are of particular and profound significance in any assessment of a torture survivor, as they are often the foci of persecution and the very foundation of the appeal to human rights remedies.

Finally, cultural competence also requires personal and professional self-reflexivity, which is based on self-awareness, open-mindedness, cross-cultural immersion, and which can minimize the likelihood that personal bias will contaminate the assessment process (American Psychological Association, 2013; Perlin and McClain, 2009). In striving for cultural competency an assessor may also examine the cultural foundations of Western psychological constructs and consider whether these constructs, and the tools by which they are measured, adequately describe the culturally salient features of the survivor's narrative (Heinrich, Heine and Norenzayan, 2010). Ultimately, a psychological assessment submitted in a case of torture is itself a cross-cultural product. The forensic utility of such an assessment depends on its capacity to function as a bridge, translating the private, yet culturally mediated suffering of an individual survivor into those psychological constructs which are salient within the context of human rights law and the adjudication of refugee status.

Understanding the Legal Context

For torture allegations to be effectively substantiated by psychological evidence, mental health professionals must have an understanding of the particular legal context of the case (American Psychological Association, 2013; Pope, 2012). As with any forensic evaluation, it is important to work closely with legal counsel in order to understand the legal context for the referral questions as well as relevant legal procedure, criteria for admissibility of evidence, and how probative value is to be assigned to expert witness evaluations. Appropriate social service and non-governmental organizations in the community can often also provide valuable information on the legal and human rights context of the case (Giffard, 2000; Pope, 2012). There is a wide range of domestic and international mechanisms that will respond to allegations of torture (Giffard, 2000). Generally in human rights proceedings, appellants are responsible for providing all documentation establishing the elements of their case (Kjaerum, 2010; United Nations, 2004).

While medical and psychological evidence is usually considered, institutions vary as to whether the Istanbul Protocol is seen to provide the baseline criteria for evaluating this evidence (Kjaerum, 2010; United Nations, 2004). In refugee claims to the Canadian Immigration and Refugee Board, the requirements pertaining to submissions of psychological evidence in cases involving torture allegations can be found in the “Training Manual on Victims of Torture” (IRB, 2004), and “Guideline 8: Guideline on Procedures with Respect to Vulnerable Claimants Appearing Before the IRB” (IRB,

2006). For information pertaining to asylum procedures within the US legal framework, assessors may refer to the Refugee Act of 1980. Asgary and Smith (2013), Cleveland, Rousseau and Guzder (2013), Cleveland and Ruiz-Casares (2013), Melfert et al. (2010), and Prahbu and Baranoski (2012) provide commentary relevant to refugee determination procedures in both nations. Information regarding submission to the European Court of Human Rights, The Inter-American Human Rights System, The African Commission on Human and Peoples Rights, and UN Treaty-based Mechanisms can be found in the Istanbul Protocol (United Nations, 2004) and in Giffard (2000) and Kjaerum (2010).

Producing Psychological Documentary Evidence

This section summarizes information derived from the Istanbul Protocol and subsequent research articles on the use and interpretation of psychological assessment for human rights proceedings. An optimal psychological evaluation of a survivor of torture will take a multi-method data-collection approach comprising a complete pre- and post-torture history, medical and psychiatric history, mental status examination and assessment of current functioning, psychological testing for relevant diagnostic criteria and neuropsychological assessment (United Nations, 2004).

Taking the history of the torture experience is a necessary part of the assessment. It is important, however, to distinguish the psychologically relevant from the legally relevant facts (Cleveland, Rousseau and Guzder, 2013). Forensic assessments are not the appropriate medium for recording precise details of the events alleged in legal

proceedings – this is the responsibility of a human rights worker or legal representative (Cleveland, Rousseau and Guzder, 2013; Giffard, 2000). Rather, by eliciting the torture history, the assessor observes and compares the emotional and psychological reactions with common or expected reactions of torture survivors. Although it is not uncommon for a supportive and empathic mental health professional to be able to draw out relevant details that have not previously been accessed in legal documentation, these should not be documented in the assessment report but should be carefully communicated to the lawyer for further review (Cleveland, Rousseau and Guzder, 2013). In some situations, the full history of the torture experience may be taken in collaboration with a lawyer or a human rights worker (Gangsei and Deutsch, 2007; Perlin and McClain, 2009; Prahbu and Baranoski, 2012). Using a collaborative approach, legal professionals have the task of probing for details and working to resolve inconsistencies, while mental health professionals have the opportunity to observe reactions and interpret these in the light of the legal narrative. In this way, the survivor is also spared the painful and potentially damaging task of narrating his or her traumatic experience on multiple occasions, and a clinician is on hand to offer brief psychological interventions if needed.

The pre-and post-torture history must be assessed in conjunction with medical and psychiatric history in order to evaluate changes to baseline functioning. An assessor should provide as much baseline information as possible. It is important to inquire in detail about changes in occupational, interpersonal, and sexual functioning, as well as

tasks of daily living and habits of substance use - especially to determine whether substances are being used differently to cope with psychological distress (Groth-Marnot, 2009; United Nations, 2004). If possible, this information can be substantiated by medical reports and interviews with family or community members (Groth-Marnot, 2009). The mental status examination will capture observations and data on general appearance and behaviour, affect and mood, perception (including the presence of hallucinations), intellectual functioning, orientation to time and place, cognitive functioning, insight and judgment, and thought content (Groth-Marnot, 2009).

The Istanbul Protocol does not offer guidance on the use of psychological tests, suggesting that they are of unknown utility in cases of torture. Structured and semi-structured diagnostic interviews and brief questionnaires are nevertheless frequently used to assess symptoms and plan treatment interventions in specialized treatment clinics for survivors of torture (Vrana et al. 2012). They have also become standard in research on tortured populations (Wenzel, 2002; Willis and Gonzales, 1998). Brief instruments can be useful adjuncts in forensic assessment of torture survivors, as they provide a supplemental source of data collection and an element of standardization with an empirical research base. However, several cautions have been raised regarding the use of standardized measures with survivors of torture in clinical settings, including basic methodological issues, construct definition, scope of measurement, problems of administration, and interpretation of results (Perlin and McClain, 2009). Notwithstanding

these limitations, legal decision-makers often perceive standardized tests as being more objective and reliable, and are likely to assign greater weight than to opinions based on clinical interviews alone. As in any assessment, testing instruments are chosen after the assessor has carefully considered the how the psychometric properties (reliability, validity, sensitivity, specificity, and other relevant features) of the test relate to an individual from the particular population, as well as the suitability of the instrument for the requirements of the particular assessment (Pope, 2012). When the validity of an assessment technique has not been established in the forensic context in which it is being used, the assessor will need to describe the limitations of test results and explain how to interpret the data in context (American Psychological Association, 2013).

When integrated with data derived from the clinical interview, mental status exam and corroborating sources, brief screening measures may add evidentiary weight to a mental health professional's observations and expert opinions. Highly trained, culturally competent, experienced assessors, with a sound understanding of the psychopathological constructs in question, should be able to produce valid and reliable reports, provided the measures have been carefully adapted with appropriately adjusted cutoff scores for the specific population. Numerous culturally validated and translated versions exist of the Harvard Trauma Questionnaire, the Trauma Symptom Inventory, and the Hopkins Symptom Checklist, and these have been used widely in research on cross-cultural populations with complex trauma experiences. A brief review of each of these measures follows.

The Harvard Trauma Questionnaire – Revised (HTQ-R; Silove et al., 2007) is a simple screening instrument that identifies trauma symptoms related to experiences of political violence and forced migration and is associated with DSM-IV posttraumatic stress criteria. Four sections cover exposure to traumatic events, open ended questions to elicit detail about the most distressing events, specific questions related to head injury, and items derived both from the DSM-III and from clinical experience with particular refugee populations to capture diagnostically relevant information. Mollica et al. (1992) have reported data on the psychometric properties of the HTQ. The HTQ-R was developed to fit the cultural constructs of posttraumatic experiences in specific populations: Vietnamese, Cambodian, Laotian, Japanese, Croatian, Bosnian, and Arabic (Mollica & Caspi-Yavin, 1991; Silove et al., 2007; Oruc et al., 2008; Shoeb, Weinstein, & Mollica, 2007; Truong et al., 1992). Unofficial adaptations have been used in numerous studies but these are not readily available.

The Trauma Symptom Inventory (TSI; Briere, Elliott, Harris, & Cotman, 1995) is a 100-item test used to assess symptoms associated with the diagnostic criteria for acute stress disorder and posttraumatic stress disorder, with additional scales to measure comorbid symptoms commonly experienced in cases of severe or complex trauma. Briere et al. (1995) examined the psychometric properties of the TSI and found the 10 clinical scores had a mean alpha of .87 with alphas ranging from .74 for tension reduction behaviour to .90 for both depression and intrusive experience. A significant benefit of this test in forensic settings is that it contains three validity scales in addition to the 10

clinical scales. It has also been translated and its crosscultural validity researched for use in several cultures outside of the United States (e.g., GutieÅLrrez Wang, Cosden, & Bernal, 2011).

The Hopkins Symptom Checklist (HSCL-25) is a symptom inventory that measures symptoms of anxiety and depression (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). It has demonstrated consistent sensitivity to major depression and can also measure severity of emotional distress of unspecified diagnostic criteria. Ekblad and Roth (1997) reported good psychometric properties in a culturally diverse sample. The HSCL-25 has been widely used in research on a variety of different populations including torture survivors (e.g., Ertl et al., 2010; Kaaya et al., 2002; Lhewa, Banu, Rosenfeld, & Keller, 2007; Ventevogel et al., 2007).

The Neuropsychological Checklist has been suggested as a relatively culture-fair screening tool for survivors of torture (Weinstein et al., 2001). If neurological deficits are flagged, especially cognitive decline or personality change (irritability, aggressiveness, or apathy), a full neuropsychological assessment may be warranted to clarify the potential contributions of PTSD, traumatic brain injury, depression, and possible developmental antecedents to current dysfunction (Weinstein et al., 2001).

In addition to a clinical interview, mental status exam, and psychometric tests, other corroborating information could include media reports, other expert evidence (e.g., medical reports), official reports and statements (e.g., findings from special inquiries or delegations), witness statements, information from family or community members about

a survivor's prior mental functioning, evidence of the practice of torture in the region, and pertinent research literature (Giffard, 2000).

Finally, if an assessment must occur while a survivor is in prison and there is limited security, time or privacy - or if a survivor is profoundly distressed or dysfunctional – only a brief interview, mental status exam, and a detailed description of the assessment conditions and its limitations may be possible. An independent mental health professional conducting a mental status exam will pay particular attention to signs of an acute stress reaction: numbing, detachment or absence of emotional responsiveness, a reduction of awareness of his/her surroundings (“being in a daze”), amnesia (being unable to recall important aspects of events), marked distress, exaggerated startle response, poor concentration, and restlessness (American Psychiatric Association, 2013). If privacy is an issue and direct questions about torture cannot be asked, questions about injuries, pain, eating, sleeping, nightmares, stress, and fear can help the prisoner provide indirect but relevant information (Giffard, 2000). Under such conditions, the resulting assessment report will be limited compared to a full evaluation. Nevertheless, if clinical observations suggest an acute stress reaction and any additional information can be documented about the prisoner's treatment in custody, these can be compared with common findings in the documentation literature to ascertain whether the person presents signs and symptoms consistent with cases of torture.

Producing Expert Opinion

Clinical conclusions will be drawn after weighing the various data sources, analyzing the nature and possible causes of psychological injury and making conclusions about the consistency between the documented symptoms and deficits and the alleged acts of torture. If the individual is expected to testify, assessors may also offer an opinion as to whether the mental health symptoms are likely to adversely affect the individual's ability to present his or her case. Courts will treat clinical analysis, conclusions and recommendations as "expert opinion" and may assign a different probative value to this body of evidence (Kjaerum, 2010). Thus, assessors would be prudent to clearly distinguish documentary evidence from analysis and to make an unambiguous argument for how the documentary evidence leads to the conclusions they have drawn.

As in any forensic report, assessors must address the issue of credibility directly, and evaluatees must be properly informed about this aspect of the forensic role (Cleveland and Ruiz-Casares, 2013). Threats to credibility include malingering, symptom exaggeration, symptom minimization, denial, and response biases (Young & Schultz, 2009) but credibility issues can also arise as a result of psychological and physiological processes of traumatic stress (Mollica & Caspi-Yavin, 1991). With torture survivors, minimization and denial of symptoms is a common credibility issue, perhaps in part due to the shame connected with experiences of torture or stigma attached to mental health problems (Mollica & Caspi-Yavin, 1991). Cognitive deficits, impaired memory and defensive avoidance responses secondary to traumatic head injury or psychological

trauma can also impact the consistency and quality of testimony (Wenzel, 2002). Furthermore, torture practices themselves, such as clandestine locations, hooding, 24-hour light exposure, and sleep deprivation, are designed to confuse and disorient survivors so that they are unable to provide details about their experiences (Wenzel, 2002). Assessors should point out any instance of inconsistency in the narrative, as well as any indication of minimization, denial or response bias. Reference to the research literature can provide a rationale for how the presence of these common symptoms in survivors of torture may actually lend credibility to diagnostic inferences (Wenzel, 2002). Finally, using a well-validated standardized measure that includes validity scales, such as the Trauma Symptom Inventory, can greatly enhance the trustworthiness of an assessor's expert opinion in matters of credibility. Given the aforementioned difficulties posed by cultural differences, linguistic barriers, and the effect of trauma on memory, several authors emphasize the need for extreme caution before concluding that an evaluatee is malingering. (Cleveland and Ruiz-Casares, 2013; Prabhu and Baranoski, 2012). However, if the assessor finds that the clinical presentation is clearly inconsistent with the allegations of torture, he or she is encouraged to obtain consent from the client to discuss any reservations with the lawyer, so that the lawyer can attempt to clarify the situation (Cleveland and Ruiz-Casares, 2013).

Mental health professionals are cautioned against providing an opinion about the veracity of the allegations in the case, as this is the exclusive mandate of the decision maker; however, as expert witnesses they are called upon to make a direct causal

connection between the alleged event and the psychological findings (Cleveland and Ruiz-Casares, 2013). The following five-point model can guide causality decisions (Young, 2007): 1) the index event is the **sole cause** of the resulting condition which would not have occurred without this event; 2) an emotional disorder had been present in latent or potential form, but would not have manifested except for the effects of the **preponderant** event; 3) the event is an **aggravating** factor, adversely affecting some emotional disorder which was clinically evident; 4) the event is a **minor** factor, contributing only a small degree to the intensity of an emotional disorder which had been well developed prior to the event; or finally 5) the event is **unrelated** to any emotional disorder that appeared subsequently, added nothing to an already disturbed claimant, or there is evidence of malingering. There is no definitive way to determine whether a claimant's injuries are actually the result of a specific event changes or are based on preexisting factors (Young, 2007). An expert opinion can only suggest that there is (or is not) a substantial evidentiary basis to conclude that the findings are consistent with the alleged history (Young, 2007).

Ethical Considerations: Risks, Benefits and Precautions

For a survivor of torture, there may be various motivations and perceived benefits for participating in a legal proceeding. The perceived benefits of testifying in a human rights process may include obtaining recognition for the wrongs and compensation for the damages suffered, the satisfaction of holding the perpetrator or the State accountable, and

fulfilling a political commitment to oppose oppression. If the survivor is making an asylum application or refugee claim, he or she will be motivated to testify by the hope of obtaining refugee protection and the right to live in a safer country. Regardless of the motivation, the act of testifying about a torture experience entails risks to a survivor, including persecution or reprisal, psychological (re)traumatization and risks related to professional trust.

Mental health professionals may find themselves struggling to balancing their ethical responsibility to society and the obligation to report torture, against the obligation to protect survivors from the risk of potential serious harm associated with testifying (Giffard, 2000). Assessors can mitigate this dilemma by being fully aware of the potential risks and by taking every precaution to protect against them. They can also establish an interview process in which the survivor is fully informed of the risks and is genuinely empowered to provide consent, maintain control over his or her participation in the interview, and attend to his or her own self-care.

Whether survivors are in custody, they are living in their own communities, or have gone into exile, they may still be experiencing persecution or may fear reprisals towards themselves or their family and community members if they are identified as the complainant in a torture case (United Nations, 2004). The level of confidentiality to which an expert is bound will be determined by the assessment environment, as well as the evidentiary and procedural requirements of the court or tribunal to which the case is

being submitted (United Nations, 2004). For example, if a survivor remains in custody it may be impossible to fully ensure that prison officials do not learn that a complaint is being investigated and the identity of a complainant (Giffard, 2000; United Nations, 2004). If an application is being made to an international body, its procedures will dictate the level of confidentiality that can be ensured. For example, the African Commission on Human and People's Rights makes the provision for an application to be filed without the victim's formal consent, which means that human rights organizations can pursue a case on behalf of a torture survivor who fears reprisals (Kjaerum, 2010). In contrast, the United Nations Committee Against Torture has a strict victim status requirement, meaning that only a named victim may file an application (Kjaerum, 2010). The survivor must be made aware of the specific limits of and risks to confidentiality so that he or she can make a fully informed decision about the security risks that may be involved.

The dynamic between a survivor of torture and an interviewer raises issues of professional trust. Firstly, if the assessor is also in a clinical role, an ethical tension must be resolved between the obligation of professional integrity and the duties of beneficence and non-maleficence to the client (American Psychological Association, 2013; Cleveland and Ruiz-Casares, 2013). Secondly, if the survivor feels coerced or pressured, perceives a lack of control while exposed to distressing and unwanted thoughts, feelings and sensations related to the torture experience, this will mimic the dynamic of interrogation

and elicit strong emotions, defenses or negative responses to the interviewer (Pope, 2012; United Nations, 2004; Wenzel, 2002). Given the fact that doctors and psychologists have been known to be complicit in torture, the professional status of an interviewer may be no guarantee of trustworthiness to a survivor (Pope, 2011; 2012; United Nations, 2004; Wenzel, 2002). Lastly, a survivor who is exposed to traumatic memories during an interview process is at risk for re-traumatization, with a serious exacerbation of symptoms (United Nations, 2004).

To address these issues of professional trust, assessors must first be completely independent and function in awareness of and adherence to their professional codes of conduct (Giffard, 2000; Pope, 2011; 2012; United Nations, 2004; Wenzel, 2002). They must then work to establish genuine rapport with the survivor. If, during the interview, they are able to adopt a warm and supportive attitude toward the survivor, without turning the assessment into therapy, this may help to build trust (Gangsei and Deutsch, 2007; United Nations, 2004). Furthermore, as part of creating a working alliance, assessors can educate survivors about the nature of the legal process, and the level of certainty that is needed for evidence to be accepted, so that when they ask for clarifications or a greater level of detail, survivors understand what is being asked and do not feel they are being disbelieved (Pope, 2012). While in an assessor role, a mental health professional remains clinically skilled at recognizing signs of emotional distress - including the potentially less obvious 'negative' signs such as avoidance, detachment, flat affect, numbing, and dissociative responses. If such symptoms arise during the

assessment process, and the assessor can offer timely interventions, such as redirecting, offering a break, grounding or ending the interview all together in order to assist the survivor to stabilize, he or she will likely be able to prevent a survivor from being re-traumatized (Gangsei and Deutsch, 2007). Finally, assessors must also be aware of common reactions which could impair their own judgment, including avoidance of the most painful or horrific aspects of the testimony, voyeuristic curiosity about the graphic details, lack of awareness of personal biases and assumptions, fear of personal danger, and survivor guilt (Pope, 2012). Assessors must demonstrate a high level of “emotional competence” in order to listen openly, attend to their own emotional reactions, and make an accurate assessment (Pope, 2012; United Nations, 2004). An assessor using these strategies, while maintaining an interview environment that empowers the survivor to act in his or her own best interest, will provide the best degree of protection against these risks.

Areas for Development

There are a number of areas of development in the field of forensic assessment of torture survivors. Given the frequent centrality of psychological distress and dysfunction over time in torture cases, and the important contribution this evidence can make in both substantiating allegations and in determinations about damages, there is a clear need for the psychological community to continue to develop and improve standardized methods

of producing forensic evidence for survivors of torture. This would necessitate adapting more standardized measurement tools that meet rigorous validation criteria to ensure they are appropriate for use with survivors of complex trauma from specific cultures. In addition, there is also a need for qualitative research on the social and cultural meanings of torture in particular contexts, and on the local idioms of distress that survivors and communities use to describe the resulting suffering. There is also need for sufficient numbers of adequately trained and funded local mental health professionals who can produce high quality evidence. Judges and legal professionals within the various legal systems also need training to ensure they have the technical knowledge to properly evaluate and ascribe appropriate probative weight to psychological evidence in cases of torture. Finally, research is needed to understand the psychological impact that participating in legal processes has on survivors of torture, as well as appropriate accommodations and treatment during and after their participation that can mitigate torture's long term effects.

Conclusion

Mental health professionals who work with populations who have had experiences of torture require specific knowledge and competencies to produce effective assessments in forensic and other settings. The Istanbul Protocol and subsequent research articles specify that in order to produce admissible psychological evidence, assessors must understand the distinct psychological sequelae of torture and utilize a multimethod data collection

approach to draw conclusions about the consistency between the documented symptoms and alleged acts of torture. Assessors must also have the ability to guard against retraumatization and protect survivors as well as their family and community members still facing the threat of violence. In most settings, a flexible approach is taken to establishing the facts of a case, including the submission of psychological evidence. However, there are many areas for development within the field that would improve assessment practices and justice for survivors. For example, in areas with ongoing conflict or large numbers of refugees, there is a need for well-trained and funded mental health professionals who can produce high-quality documentary evidence. More standardized measurement tools for complex trauma need to be adapted for specific languages and cultures. Finally, further research is needed to understand and minimize the impact of assessment on survivors of torture.

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