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Clinical Pearl

Medical Evaluations of Asylum Seekers

Health workers can provide important medical documentation for individuals who are seeking political asylum in the United States.

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Identify important considerations in conducting a medical evaluation of asylum seekers.

Identify physical and psychological evidence of torture and ill treatment.

Each year, thousands of people who have suffered torture and ill treatment at the hands of government officials flee their countries of origin and seek asylum in the United States. Health professionals can provide critical documentation of torture and ill treatment in asylum proceedings. Such evaluations are often conducted through the Asylum Network of Physicians for Human Rights and specialized treatment centers for survivors [1,2].

Purpose of the Medical Evaluation

The purpose of the medical evaluation of asylum applicants is to provide expert opinion on the degree to which medical findings correlate with the applicant's allegation of abuse and to effectively communicate the clinician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials, and the local and international community on the physical and psychological sequelae of torture.

Medical evaluations require a careful and thorough clinical history and examination of physical and psychological evidence by clinicians who are sensitive to cross-cultural issues and interpersonal dynamics between traumatized individuals and persons in positions of authority. Clinicians must be knowledgeable about the medical and psychosocial consequences of torture [3-7] and the established guidelines for effective documentation [3-5].

Torture Definition and Methods

Torture and ill treatment are generally defined as the intentional and systematic infliction of pain and suffering by public officials upon an individual for some purpose [8]. There is no limit to the number of forms that torture and ill treatment can take. This is precisely why all forms of torture and ill treatment are equally prohibited by international human rights law. Further elaboration on possible forms of torture and ill treatment is included in the *United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Istanbul Protocol), which contains international standards for effective investigation and documentation of torture and ill-treatment [3].

Health Consequences

While torture can have devastating health consequences, it is important to recognize that there is individual variability in physical and psychological findings. Individuals respond to and recover from traumatic events, including torture, in a variety of ways. In some cases, physical evidence may not be detectable because most medical evaluations are

conducted after the resolution of acute signs and symptoms of physical injury. Psychological symptoms, on the other hand, are often enduring in nature and also can play a critical role in documenting evidence of torture.

Physical Evidence

Physical manifestations of torture may involve all organ systems. Some effects are typically acute while other may be chronic. Symptoms and physical findings will vary in a given organ system over time, though psychosomatic and neurologic symptoms are typically chronic findings. Musculoskeletal symptoms are commonly present in both acute and chronic phases. A particular method of torture, its severity, and the anatomical location of injury often indicate the likelihood of specific physical findings. For example:

- Beating the soles of the feet (falanga) may result in subcutaneous fibrosis and a compartment syndrome of the feet.
- The use of electricity and various methods of burning may also leave highly characteristic skin changes.
- Whipping may also produce a highly characteristic pattern of scars.
- Different forms of body suspension and stretching of limbs may result in characteristic musculoskeletal and nerve injuries.
- Other forms of torture may not produce physical findings, but are strongly associated with other conditions. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Also, trauma to the genitals is often associated with subsequent sexual dysfunction.

Psychological Evidence
Although there may be considerable variability in psychological effect, torture and ill treatment often result in profound, long-term psychological trauma. According to the Istanbul Protocol, the most common psychological problems are posttraumatic stress disorder (PTSD) and major depression, but may include the following:

- Re-experiencing the trauma
- Avoidance and emotional numbing
- Hyperarousal symptoms
- Symptoms of depression
- Damaged self-concept and foreshortened future
- Dissociation, depersonalization, and atypical behavior
- Somatic complaints
- Sexual dysfunction
- Psychosis
- Substance abuse
- Neuropsychological impairment

Such psychological symptoms and disabilities can last many years or even a lifetime. It is important to realize that the severity of psychological reactions depends on the unique cultural, social, and political meanings that torture and ill treatment have for each individual, and significant ill effects do not require extreme physical harm. Seemingly benign forms of ill treatment can and do have marked, long-term psychological effects.

General Interview Considerations

Clinicians should be aware of the following considerations in the course of conducting their medical evaluations:

Informed Consent: Clinicians must ensure that applicants understand the potential benefits and potential adverse consequences of an evaluation and that the applicant has the right to refuse the evaluation.

Confidentiality: Clinicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the applicant's consent.

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

Control: Let the applicant know it's all right to take a break if needed or to choose not to respond to any question he or she may not wish to.

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

Translators: Professional, bicultural interpreters are often preferred, but may not be available.

Preparation for the Interview: Clinicians should read relevant material in order to understand the context of the alleged abuse and to anticipate regional torture practices.

Interview Techniques: Initially, questions should be open-ended, allowing a narration of the trauma without many interruptions. Closed questions are often used to add clarity to a narrative account or to carefully redirect the interview if the applicant wanders off the subject.

Medical History: Obtain a complete medical history, including prior medical, surgical, or psychiatric problems. Be sure to document any history of injuries before the period of detention or abuse, and note any possible after-effects. Avoid leading questions. Structure inquiries to elicit a chronological account of the events experienced during detention. Specific historical information may be useful in corroborating accounts of abuse. For example, a detailed account of the applicant's observations of acute lesions—and the subsequent healing process—often represents an important source of evidence in corroborating specific allegations of torture or ill treatment. Also, historical information may help to correlate individual accounts of abuse with established regional practices. Useful information may include descriptions of torture devices, body positions, and methods of restraint; descriptions of acute and chronic wounds and disabilities; and information about perpetrators' identities and place(s) of detention.

Pursuit of Inconsistencies: An applicant's testimony may, at first, appear inconsistent unless further information is gathered. Factors that may interfere with an accurate recounting of past events may include: blindfolding, disorientation, lapses in consciousness, organic brain damage, psychological sequelae of abuse, fear of personal risk or risk to others, and lack of trust in the examining clinician.

Nonverbal Information: Include observations of nonverbal information such as affect and emotional reactions in the course of the trauma history and note the significance of such information.

Transference and Countertransference Reactions: Clinicians who conduct medical evaluations should be aware of the potential emotional reactions that evaluations of trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference. For example, mistrust, fear, shame, rage, and guilt are among the typical transference reactions that torture survivors experience, particularly when asked to recount and remember details of their trauma history. In addition, the clinician's emotional responses to the torture survivor, known as countertransference (eg, horror, disbelief, depression, anger, over-identification, nightmares, avoidance, emotional numbing, and feelings of helplessness and hopelessness), may affect the psychological evaluation. Considering survivors' extreme vulnerability and propensity to re-experience their trauma when it is either recognized or treated, it is critical that health professionals maintain a clear perspective of a healing relationship. Such vicarious or secondary trauma to the clinician can be minimized by discussions with other colleagues after the interview. Effective documentation of torture and other forms of ill-treatment requires significant understanding of the motivations for working in this area. It is important that a clinician not use the population to work out unresolved issues in himself or herself, inasmuch as these issues can clearly hamper effectiveness.

Examination

The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and

nature of all injuries. Torture victims may display injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about 6 weeks of torture leaving no scars or nonspecific scars.

Interpretation of Findings and Referrals

The clinician should correlate allegations of abuse with the findings of the medical evaluation and indicate his or her level of confidence in the correlations (eg, inconsistent / consistent with / highly consistent with / pathognomonic). A final statement of opinion regarding all sources of evidence (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 should be included. The clinician also should provide any referrals or recommendations for further evaluation and care for the asylum applicant.

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