Medically assessing refugees who may have been victims of torture

A Martin F Reeve

The current issue of the Journal contains an article written by experts describing the prevalence and effects of torture on refugees in New Zealand. However, often a non-expert may be called upon to assess the effects of torture on a refugee or someone in a similar situation, and should not be afraid to do so.

Usually an expert is not available, and any clinician who has had experience in general practice and/or emergency medicine in one capacity or another is capable of assessing a person who has been mistreated, providing a forensic report, and managing any follow-up needed.

Written guidelines are available, perhaps the best being the manual produced by the United Nations High Commission for Human Rights. Training is also available, and the Forum of Australian Services for the Survivors of Torture and Trauma (FASTT) network is a good starting point.

The clinician may not be used to dealing with people from refugee background, especially those who have been tortured, but their assessment follows the same principles as those for any one else who has suffered from trauma in the past. One important difference from usual examinations is that in most cases an interpreter will be needed.

A full assessment may take some time; it should take the usual course of asking for presenting complaints, taking a social history, including travel; past medical history and medications; family history; allergies; lifestyle history such as smoking, and asking set questions about each system, e.g. chest pain, dyspepsia. It is usually best to leave until last to ask about the causation of the presenting complaints; that is, the torture history, and their physical and psychological effects.

A routine physical examination follows, focussing on the areas which have been affected by torture, recording any findings. The recording can be written, diagrammatic, and if possible, photographic.

A vital difference between the assessment of a torture victim and most other assessments is the psychological dimension. The main aim of torture is to affect the victim psychologically in order, as the authors note, to obtain information, punish or to pursue political ends by terror and coercion.

Torture victims will often therefore present with overt psychological symptoms, but as the authors again note, present with symptoms which are often atypical and predominantly psychosomatic, particularly in those cultures where psychological symptoms are not recognised or accepted.
It can be a difficult clinical decision whether to investigate some ill-defined symptom intensively and hence reinforce the belief that it is physical in origin in the victim’s mind, or not investigate and perhaps miss a physical problem.

Another vital difference between torture assessment and others is the traumatic effect of obtaining and recording the torture history itself. This can affect:

- The victim, by recollection of traumatic events, particularly sexual abuse.
- The translator, who may have experienced similar mistreatment.
- The clinician.
- Third parties such as the victim’s lawyer, immigration officers and so on.

The “vicarious trauma” experienced by those hearing or reading the torture history can be difficult to deal with. Traumatic events in a person’s life, professional or personal, are commonly dealt with informally by interactions with colleagues, friends or family, but the nature of a torture history usually makes it impossible to share it with any one else except a professional counsellor. Hence, those involved with victims of torture should themselves have access to counselling services.

The management of a torture victim involves organising appropriate investigations and referral to appropriate specialist services, especially psychological; in some areas the clinician will be fortunate in being able to refer to specialist torture/trauma counselling services. Management may also involve prescribing, and dealing with non-torture related conditions, including disease prevention such as vaccination, contraception, diabetes screening and so on. Finally, follow-up care should be undertaken or arranged.

A clinician may be requested to provide a forensic report, for example to support the victim’s application for asylum. In general, the clinician preparing a forensic report should:

- Use commonsense
- Be conscious of the limitations of physical assessment.
- Keep an open mind

Training in assessment and report preparation would be a great asset, but is not available to most people, but the effects of say, whipping, are predictable and the clinician may have had similar experience, for example in the assessment of child abuse.

The body’s tissues have a limited repertoire in response to trauma, and so it may be impossible to distinguish between an entrance bullet wound, a cigarette burn, or a localised skin infection. Often there is little or nothing to see, especially if time has passed since the events.

The true sequence of events may be difficult to obtain, due to misunderstandings, involuntary deceit such as memory lapse caused by the event itself, or deliberate deceit for personal gain.

The clinician may feel great sympathy for the victim, but the report should be dispassionate, and contain such phrases as “consistent with”, “typical of”—see the
Istanbul Protocol Manual. Other incidental findings such as those caused by accidental trauma should be recorded as they may support the victim’s credibility. The absence of any findings should be commented on and explained, as this is common, but non-professionals might take such absence as a sign that the victim is being deceitful.

If the report is for non-professionals, it should be in plain language, and any diagrams or photos attached, subject to the victim’s consent.

A recent conference in Auckland concerned with the Investigation and Documentation of torture, which was facilitated by visiting experts from the International Rehabilitation Council for Torture Victims (IRCT), was unfortunately poorly attended by doctors. It is hoped that in the future that clinicians who are or may be involved with victims of torture will have the opportunity to hear and learn from experts in the field.

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**References:**
