Chapter 7

Medical Evaluation and Care for Survivors of Torture/Refugee Trauma – Summary

Medical Evaluation and Care for Survivors of Torture/Refugee Trauma

Allen Keller, MD, Jonathan Leviss, MD, Nancy Levy, B.A.
Deborah Dyson, PA, MS

Introduction

Medical care providers, including primary care physicians, are often unaware that there are survivors of torture and refugee trauma in their immigrant patient population. Although such patients are often silent about their past, they can be in profound need of medical care and other health services to address the suffering they have endured. Survivors of torture and refugee trauma have had to flee their homes and countries because of persecution and or war. They have been subjected to and witnessed horrific events, such as a Tibetan monk imprisoned and tortured, including being beaten and shocked with electric cattle prods, because of advocating for greater freedom, or the Kosovar refugee who witnessed her home set on fire as she was forced to flee her village by Serbian soldiers, or the young adult male from Sierra Leone, who had been kidnapped by rebel forces after seeing his family murdered. After leaving their countries, traumatic events may continue. In refugee camps, individuals may have experienced overcrowded unsanitary conditions, and continuing fears of attacks. Torture victims seeking political asylum in host countries, such as the United States, who arrive without visas, may face long periods of imprisonment while awaiting decisions on their asylum claims.

By recognizing and treating patients with a history of torture/refugee trauma, health professionals in medical settings, including primary care clinics or emergency rooms, can provide much-needed care and appropriate

referrals to a marginalized group. The general medical/primary care clinic may be the first or only health care setting to which a survivor of torture/refugee trauma presents. Such individuals may present with a known history of abuse, and be referred for general medical care or may never have been identified.

Health professionals have a unique opportunity to identify and begin to address the medical, psychological and social health consequences from which survivors of torture and refugee trauma may suffer. Thus, it is essential for health professionals working in these settings to be aware of the health consequences of such traumatic experiences, as well as effective interviewing skills for effectively caring for such vulnerable populations. Additionally, medical professionals can fill a unique role in the patient's life, one that expands to include doctor, confidante, and advocate.

Prevalence of Torture and Refugee Trauma in the Primary Care Setting

The most recent United Nations statistics on refugees indicate that there are an estimated 8.4 million refugees worldwide (UNHCR, 2006). It is estimated that 5-35% of refugees and asylum seekers were victims of torture (Baker, 1992; Eisenman, Keller, & Kim, 2000; Montgomery & Foldspang, 1994). In certain communities, particularly individuals from post-conflict countries or those known to have widespread human rights abuses, the prevalence is even higher (Jaranson et al., 2004).

Common forms of torture and mistreatment include beatings, sexual assault, forced nakedness or other humiliations, burns with hot objects, being restrained or suspended in painful positions, mock executions, sleep deprivation, witnessing others tortured. Individuals fleeing war-torn

countries may have witnessed horrific acts of violence or their after effects. The physical, psychological and social health consequences of such trauma can be profound.

More than 400,000 torture survivors are estimated to live in the United States (Office of Refugee Resettlement [ORR], 2006). Many more have been victims of political violence/traumatic events that would not necessarily meet international definitions of torture, but can nonetheless have devastating health consequences. Such individuals are by no means a rarity.

The prevalence of survivors of torture in primary care settings in the United States found in 3 studies ranged from 7-11% (Crosby et al., 2006; Eisenman, Gelberg, Liu, & Shapiro, 2003; Eisenman, Keller, & Kim, 2000). In one of these studies conducted in clinics serving the Latino population, 54% of individuals surveyed reported suffering some form of political violence in addition to torture (Eisenman, Gelberg, Liu, & Shapiro, 2003). The studies also found that few if any of the individuals had reported their history of torture/trauma to their physician despite having visited the clinic several times. For individuals coming from war torn countries such as Iraq, the former Yugoslavia or the Sudan, it is unlikely they have not witnessed or experienced traumatic events potentially impacting on their health.

Why do physicians fail to identify their immigrant patients' torture/trauma histories? There are confounding factors on the part of both the physician and the patient. Physicians may not be aware of the prevalence of torture and other traumatic events refugees may have endured. They may also feel uncertain or powerless in determining how to help such individuals. Traumatized patients, on the other hand, may not volunteer the information to a physician who doesn't explicitly ask. They may be silenced by shame,

guilt, or a mistrust of others. They also may feel that their past trauma history has nothing to do with their current medical complaints.

Whenever seeing a patient who is a refugee, asylum seeker, or comes from a war-torn country or one known to have political violence, the possibility that the patient has experienced torture and other traumatic events should be considered. Initial inquiries may focus on why the individual left his or her country before more directly asking about trauma including torture they may have experienced.

The Medical Interview

General Interview Considerations

The medical interview can be challenging with any patient, even more so with a recently immigrated patient with language and cultural barriers, and still more difficult with a survivor of torture/refugee trauma. Such individuals may have had little or no previous contact with health professionals, and if they did any previous medical records may well not be available.

In the context of the medical interview, it is crucial for the medical provider to establish rapport and trust with the torture/refugee trauma survivor. This process begins with the physician understanding the many fears and apprehensions that the survivor brings into the examination room. For example, in some cases, health professionals were involved in the patient's torture experience (Annas, 2005; Miles, 2006). Individuals may also have had substantial difficulties accessing adequate health services both in their countries of origin as well as in refugee camps or detention facilities in their countries of exile (Human Rights Watch, 2002; Keller et al., 2003).

By asking about this, the physician can make sure to take extra steps to gain the trust of the patient.

Additionally, the interview process itself may remind the survivor of being interrogated. In order to avoid re-traumatizing the patient, questions should be asked as much as possible in an open ended manner, rather than in a rapid-fire fashion. Let the patient tell his/her story with as few interruptions as possible, rather than initially trying to get a chronological, detailed history of each event. At the outset of the interview, the care provider should explain the purpose and process of the medical evaluation.

The medical care provider should demonstrate active listening at all times, keeping in mind that the patient may be revealing details that he/she has never told anyone before. Genuine empathy can be expressed by letting the patient talk about what is most important to them—for example, a person who is separated from their family may talk about that more than their actual torture or refugee experience. The physician should allow time for such matters to be discussed so that he/she can get a picture of the "whole" patient.

There are many other ways for the physician to establish trust, such as reassuring the patient of the confidentiality of the medical interview. Physicians must also take care to refrain from forcing the patient to discuss any form of torture or trauma that they do not wish to talk about. Several visits may be required for the patient to feel comfortable enough to fully disclose their experience.

The Need for Interpreters

For many patients, even those with some command of English, interpreters may be necessary for a detailed, nuanced medical history (See

Chapter 4 in this volume). Again, the confidentiality of the interview must be stressed to the patient. Clinicians must work to ensure that the match between the interpreter and the client is appropriate. Both the physician and the interpreter should be aware that the interpreter's ethnic, cultural, tribal, or religious identity may potentially be viewed as threatening by the patient; especially if the patient's torture was administered by a member of that particular group. Additionally, health professionals may have been complicit in the individual's torture and mistreatment; potentially causing more anxiety and fear.

Issues of the interpreter and care provider's gender must also be considered. Gender issues may impact, for example, on a patient's willingness to discuss a history of sexual assault. When possible, patients should be asked in advance if they have a gender preference for the clinician and interpreter, and such requests accommodated. Using family members or friends is discouraged for reasons of privacy/confidentiality, and the impact it may have on a family system.

The physician can reinforce the doctor-patient relationship by showing that he/she is listening even when the interpreter or patient is speaking in their own language. Again, remember that the patient may be revealing very traumatic experiences for the first time, and that the physician should do everything possible to show genuine empathy and interest.

Eliciting the Trauma History

As noted above, health professionals may be reluctant to inquire about traumatic events patients have experienced for a variety of reasons. The trauma history is an important component of the medical interview and may well help the physician better understand the patient and their health

problems. For example, head trauma may result in neurological damage or memory deficits. Musculoskeletal pains from beatings, or being suspended/restrained in particular positions, can help guide the clinical evaluation.

Eliciting a history of sexual assault may signal the need for specialized gynecologic/urologic evaluation including testing for sexually transmitted diseases. Unless a history of sexual assault is specifically inquired about, both for men and women, this vital information may not be offered.

Witnessing individuals killed or seeing dead bodies while fleeing from war can leave haunting memories. These psychological issues are but one aspect of the health concerns brought about by refugee trauma. Individuals who have not had access to medical care as they have lived in exile, or in the unsanitary conditions in refugee camps, may bear the consequences of this through untreated maladies and exposure to pathogens. Adjusting to the new climate, frequently with insufficient resources (i.e. lack of heating or proper winter clothing) also poses health risks. It is our clinical experience that illness, is one major factor that serves to keep clients' traumatic experiences alive in their psyches, as the medical and mental health issues feed off of one another.

Explaining the purpose for inquiring about the trauma history to the patient, acknowledging the difficulty of sharing this information as well as acknowledging that the individual may not want to discuss certain things are useful in rapport building and eliciting important information. However, the physician must keep in mind that there may be strong issues of shame, humiliation, or stigma, especially in the case of sexual assault. The clinician should use his/her judgment as to when to inquire about the trauma history.

It may naturally follow from when the individual has reported complaints such as muscle aches or neurological symptoms that may be directly related to the trauma, or the clinician may choose to wait until later in the interview; for example, while eliciting the social history.

The physician should determine what level of detail is necessary. If, for example, the physician intends to write an affidavit for an asylum-seeker, he or she will need much greater detail, ideally collected over several visits. For someone solely seeking medical care, the physician should not feel the need to "extract" information, but rather to let the patient reveal the level of detail that makes him or her comfortable.

Elements of the Medical Interview

Identifying Current Health Problems (History of Present Illness)

The physician should address the immediate concerns of the survivor of torture/refugee trauma. For the first-time visitor, the medical history should be comprehensive both pre- and post-torture/trauma. The history should include inquiries about possible exposure to tuberculosis, such as time spent in an overcrowded space (i.e. a prison or refugee camp).

After explaining the purpose and process of the medical evaluation, the health professional may begin by asking about the individual's general health and current health concerns (i.e. "How may I be of service?" Or "Can you tell me about your health and any problems currently bothering you?"). Such a patient centered approach is important in establishing rapport and giving the individual a sense of control. The chronology of any current health complaints should be noted. It is important to appreciate that individuals imprisoned for extended periods, or who came from refugee

settings with limited access to health care, may have problems for which they received little or no care.

The health professionals should inquire about any injuries/health problems that may have resulted from reported abuse. The frequency, intensity and duration of persistent symptoms, such as musculoskeletal pain or headaches, as well as factors that improve or exacerbate the symptoms should be noted. Residual physical limitations, such as difficulty ambulating should be noted. The development of any subsequent skin lesions, including scars should be noted.

Past Medical History

Health problems, both before and after traumatic events, should be noted. Survivors of torture and refugee trauma, as with all patients, need primary care providers to identify and address their general health needs. They have common health problems seen in a general medical clinic population, including diabetes, hypertension and asthma. In fact, geographic factors and stress may make the occurrence of such illnesses even more common among refugee populations. Medical health professionals should take a full history as they would for any first-time visitor to a medicine clinic. This includes a detailed family history.

Medications

Any medications the patient is currently taking should be noted. One should also inquire about medications the patient was using before leaving his or her country, including for chronic medical conditions. It is not uncommon that such individuals may present having gone weeks or months without taking their medications. For example, in our clinic, individuals

regularly present with poorly controlled hypertension or diabetes for which they were previously taking medications, but ran out of and had no way to obtain since fleeing their country.

Social History

The physician should elicit a complete social history from the patient, both about their life in their home country, as well as in the United States. Understanding what the patient's life was like before the traumatic events of torture may help engender a greater sense of empathy. For example, many survivors of torture were singled out by their tormentors for their intellectual or political activities. For these professors, poets, or journalists, coming to the United States as a refugee and having to work as an unskilled, manual laborer may be a significant stressor. Other torture survivors may enjoy the chance to talk at length about their children, who may still be in their home country.

Physicians should also inquire about the client's current employment and living situation. Living in isolation, for example, may be a significant cause of distress, and is compounded for patients who don't speak English. Overcrowded living conditions, common among asylum seekers, may contribute to the risk of exposure to tuberculosis. Additional social service needs, including need for English classes, legal assistance (such as applying for political asylum or work authorization), should be identified and appropriate referrals made. Identifying and addressing such needs can be central to promoting the health and well being of survivors of torture and refugee trauma. Evaluation in the primary care setting is an invaluable and in fact may be the first opportunity for identifying such needs.

As with all patients, physicians should inquire about smoking, alcohol use, and drug use (including herbal remedies). Patients may be at risk for self-medicating their depression or anxiety (D'Avanzo, Frye, & Froman, 1994).

Review of Systems

For the first-time visitor, a comprehensive review of systems/symptoms is essential. This includes specific inquiries about urologic and gynecologic symptoms. As noted previously, sexual assault is common and often unreported (Hynes & Cardozo, 2000).

A review of psychological symptoms should also be elicited. This includes screening for depression, anxiety and symptoms of posttraumatic stress disorder (PTSD). The primary care provider may well be the first and only opportunity to screen for such symptoms. Furthermore, while specialized mental health services may be available, individuals may be reluctant initially to agree to such referrals.

A number of psychological screening tools are available. Two screening tools, the Harvard Trauma Questionnaire (Mollica et al., 1992) and the Brief Symptom Inventory (Derogatis, 1983) , are frequently used in assessing refugees and torture survivors. The Harvard Trauma Questionnaire (HTQ) is a brief self-report inventory. It elicits a history of the patient's traumatic experiences and assesses their PTSD. The HTQ has been extensively translated and is highly associated with the clinical diagnosis of PTSD (Kleijn, Hovens, & Rodenburg, 2001). The Brief Symptom Inventory (BSI) is a self-report inventory of 53 questions that provides an overview of psychological status on nine primary symptom dimensions and three global indices of distress. Each of these screening tools takes about 10 minutes to

complete, and they can reveal important information about the mental health of the torture survivor.

An important component of the review of psychological symptoms is a detailed sleep history, given that sleep disruptions are common. For example, Blight, Ekblad, Persson, and Ekberg (2006) found that approximately 49% of their sample of refugees from Bosnia-Herzegovina reported sleep difficulties. Keller et al. (2006) found that 66% of their sample of survivors of torture/refugee trauma reported problems sleeping. As part of the sleep history, it is important to inquire about how many hours the individual sleeps on average, as well as note any difficulties falling asleep, staying asleep, or experiencing nightmares.

Physical Examination

A thorough physical examination is important in addressing health needs of victims of torture/refugee trauma as well as providing documentation (see below). While there may be lasting physical signs of torture/mistreatment, including scars, perforated ear drums or neurological findings, it is important to note that there is often a substantial gap in time between when the individual experienced mistreatment/traumatic events, and when they present for evaluation. Thus physical findings characteristic of injuries previously suffered, including dermatologic and musculoskeletal findings, may have already resolved at the time of evaluation. While physical findings may still be present, a "normal physical examination" does not necessarily negate allegations of torture, and in fact, might well be expected given the passage of time.

As with all patients, the physician should start with the less intrusive parts of the medical exam, such as checking vital signs. This is especially important for survivors of traumatic events who may feel particularly vulnerable in a doctor's office. Explaining each step to the patient will help to put him/her at ease.

The physician should also take care to avoid having the patient naked for an extended period of time. Uncovering each body part as needed, and then re-covering it promptly, will help the patient avoid feelings of humiliation. A chaperone may be helpful in some cases, such as for a female patient who is uncomfortable being examined alone by a male physician.

Ancillary Tests

When ordering ancillary tests, such as blood tests or radiographic studies, the clinician should be mindful of cultural issues as well as the potential for retraumatization. For example, in our Program, several patients from Tibet have reported being forced to have their blood drawn as a punishment and being told by their captors that essential components of their "spiritual essence" were being taken from them. Electrocardiograms may be particularly stressful for individuals subjected to electric shock torture. CT scans and MRI's may result in significant anxiety as a result of a sensation of being in an enclosed space. Appropriate explanations about why the tests are being ordered, and what the patient can expect, can alleviate stress. Pre-medication with anxiolytics for studies such as MRI's should be considered.

Common Health Problems among Torture Survivors/Refugee Trauma Survivors

Survivors of torture and refugee trauma may present with multiple medical, psychological, and social health concerns; all of which are interdependent and impact on one another. For example, a torture victim repeatedly beaten and subsequently held in an overcrowded cell may have medical/physical problems including musculoskeletal pains and exposure to tuberculosis. They may also have depression or PTSD as a result of this abuse which may worsen as a result of physical symptoms or vice versa. Similarly, such traumatic experiences may result in social isolation or substance abuse including self-medication.

The health problems that survivors of torture and refugee trauma encounter, and the evaluation and treatment of these health problems, are not necessarily unique to this population. However, the frequency of certain health concerns, such as musculoskeletal pain, infectious diseases, such as tuberculosis, and psychological symptoms of anxiety and depression, is likely higher than the general primary care population, and higher than even other immigrant groups. Furthermore, the context in which many of these health problems arose is unique. Traumatic events such as torture, forced migration because of war and violence have potentially devastating effects for survivors. The context in which these problems are experienced by individuals from diverse cultures, for whom concerns of trust and safety may be paramount, must also be considered. Empathy, effective communication and sensitivity to cultural norms are essential in rapport building and providing effective care.

Musculoskeletal

Musculoskeletal pain is one of the most common complaints among survivors of torture/refugee trauma. One study of Bhutanese refugees found that 59% of refugees who had been tortured complained of musculoskeletal pain (Shrestha et al., 1998). A recent study of 116 Iraqi refugees resettled in the U.S. and seeking mental health services found that nearly 70% complained of lower back pain (Jamil et al., 2005). The pain may be the result of beatings, various forms of positional torture, conditions of detention, or difficult travel conditions when fleeing their countries. They may also be somatic in nature. The physician should document the complaints even if he/she suspects the pain is somatic (Iacopino, Allden, & Keller, 2001).

Falanga, which consists of beatings on the soles of the feet, is a common form of torture throughout the Middle East, India, and certain African countries. Falanga can result in chronic pain on walking, as a result of damage to the underlying soft tissue. More serious complications include closed compartment syndrome, fractures and permanent deformities of the feet (Iacopino et al., 2001).

Musculoskeletal physical examination should include evaluating joint, spine and extremity mobility. Pain with motion, muscle strength, signs of fractures with or without deformity should be noted.

If fractures, dislocations or osteomyelitis are suspected, radiographs should be performed. Bone scintigraphy is particularly sensitive in demonstrating bone tissue lesions, even years after the trauma (Mirzaei et al., 1998; Peel & Iacopino, 2002). CT Scans are also useful in evaluating injuries to bone and soft tissues, with MRI's being even more sensitive, particularly for soft tissue injuries (Iacopino et al., 2001).

Pain medications, including acetaminophen or non-steroidals may be beneficial, although as with all patients, individuals should be counseled about potential side effects. Physical and Occupational therapy may provide relief of symptoms as well. In individuals suffering from depression or posttraumatic stress disorder, body oriented therapeutic approaches, coupled with treatment of the underlying psychological problem may also help to improve pain symptoms (Berliner, Mikkelsen, Bovbjerg, & Wiking, 2004).

In our program, several individuals presenting with chronic leg ulcers as a result of beatings they had suffered were ultimately diagnosed with chronic osteomyelitis, and required chronic antibiotics and in some instances amputation of the lower extremity. Two other individuals who had required amputations in their countries of origin after suffering beatings and chronic infections, presented to our Program in need of prosthetic devices, which when provided, profoundly enhanced their general functioning.

Several individuals cared for in our Program have also suffered deep vein thromboses, as a result of beatings and being forced to stand for prolonged periods. A number of these individuals have required long-term anticoagulation.

Neurological

Neurological symptoms and injury, both central and peripheral, can result from many types of torture and ill-treatment, including beatings, positional torture such as suspension, and vitamin deficiencies or un-treated disease. For example, damage to the brachial plexus is common in patients who have suffered suspension, even if the suspension lasted only a short while. Cranial nerve deficits and changes in mental status and cognitive ability can result from beatings.

Torture victims may experience vertigo and dizziness. A history of head trauma and loss of consciousness should be specifically inquired about. Additionally, patients may present with paresthesias and paralysis of a limb. In rare cases, patients may present with seizures. Asphyxiation may leave the patient with permanent memory loss or cognitive deficits, which may in turn compound the problem of eliciting an accurate trauma history (Moreno & Grodin, 2002).

The most common chronic neurological complaint reported by torture survivors is headache. Rasmussen et al. (1990) found a prevalence rate of 64%. Mollica et al. (1993) found that 74% of Cambodians living in a refugee camp, whom they interviewed, reported having frequent headaches. Torture survivors who suffered blows to the head often complain of headaches. These may be somatic, or they may be referred pain from the neck (Iacopino, Allden, & Keller, 2001). Visual changes may also result from head trauma.

Violent shaking may result in symptoms similar to "Shaken Baby Syndrome." (The condition is sometimes called "*Shaken Adult Syndrome.*") The chronic manifestations of this include recurrent headaches, disorientation, and mental status changes. Retinal hemorrhages, cerebral edema, and subdural hematoma are more severe sequelae (Iacopino et al., 2001).

Other manifestations of head trauma include dental problems (tooth loosening or loss), ruptured eardrums, retinal detachment or traumatic cataract, and skull fractures. Frontal lobe dysfunction is detectable with neuropsychological testing.

Neurological examination should include evaluation of the cranial nerves, peripheral nervous system, motor and sensory neuropathies. For

individuals who are suspended, for example, torn ligaments of the shoulder joints may result. It is sometimes possible to identify a "winged scapula," which results from nerve damage and dislocation of the scapula (Iacopino et al., 2001).

Cognitive ability and mental status should also be evaluated. Referral for neurology or ophthalmology consultation or neuropsychological evaluation should be considered as appropriate. CT scans and MRI's can help to delineate neurological lesions. Patients undergoing these and other studies should be educated in advance about them so as to avoid retraumatization such as from being in an enclosed space.

Chronic pain is common among torture survivors (Quiroga & Jaranson, 2005). It is under diagnosed and under treated. Chronic pain may be a result of musculoskeletal injury, as described above, or neurological disorders including peripheral neuropathies, such as from falanga. Psychological factors can also play a role, but organic etiologies need to be ruled out. A thorough description of each site of pain should be elicited including location, severity, frequency, timing, radiation, and factors that precipitate or improve the pain. It is important to inquire as to whether the pain began before or after the torture/trauma. Effective management of pain may require a multidisciplinary approach including primary care physicians, neurologists, pain specialists, and mental health care providers.

Dermatological

Many forms of torture can result in dermatologic manifestations, both acute and chronic (Iacopino et al., 2001; Peel & Iacopino, 2002). For example, burns can leave characteristic scars/imprints from hot objects, such as a cigarette or metal rod. Beatings with fists, sticks, or other objects may

also result in dermatologic lesions and scarring. Prolonged, tight shackling of extremities can result in characteristic linear scarring encircling the arm or legs.

Objects with mixed components leave mixed scars: belts have buckles that cut jagged areas and straps that leave linear scars. Scars may contain fragments of the object used to beat a survivor, such as glass or wire shards which have been surgically removed from survivors treated at our program.

Traditional medicine treatments, vaccinations, and surgical scars are usually distinguishable due to symmetry, repetitious patterns or location. Infection can exacerbate any scarring, even in a superficial injury.

It is equally important to note, however, that many forms of torture, such as a mock execution where a gun is held to someone's head and the trigger pulled may leave no physical marks, but the ensuing psychological symptoms can be profound. Other forms of torture, including electric shocks, depending on their severity, may or may not leave any physical marks. Some have hypothesized that torturers are becoming increasingly sophisticated so as to leave no physical marks (Moreno & Grodin, 2000).

For primary care providers working in developing countries, it is often months or even years since the reported torture occurred. Thus it is entirely consistent that many forms of abuse, including beatings, which may have resulted in soft tissue injuries/bruises or abrasions, will have entirely resolved by the time that an individual presents for evaluation. Furthermore, there is variability with regards to how individuals scar and heal. For example, vitamin deficiency and older age are risk factors for easy bruisability, while younger, fitter individuals tend to bruise less easily. Darker skinned individuals are more likely to develop keloid scars, which

are raised lesions that can be firm or rubbery. Keloids are the result of an overgrowth of tissue at the site of a healed skin. For documentation purposes health care providers can record a description from the individual of how the injury appeared immediately after the alleged torture and in the subsequent weeks and months.

In our program, we work closely with dermatologists who provide documentation, including photographs of lesions, when feasible and appropriate, as well as for treatment. Dermatological lesions, such as keloid scar formation may benefit from intradermal steroid injections. Severe burns with thickened scars may best be addressed through plastic surgery, which provides both cosmetic and functional benefits. For example, one patient cared for in our program, who was a prominent painter in his country, suffered severe burns to his hands when they were thrust by his interrogators into a coal burning oven. When he was seen in our Program, it was several years since his torture had occurred. He had severe deformities of his hands, including multiple fibrous bands, resulting in marked range of motion limitation of his hands. Furthermore, when he would hold a pencil, his hand would tremble and he would experience flashbacks of his torture. As part of his treatment, he was referred to plastic surgery. Fortunately, the underlying musculature and bones were intact. Following plastic surgery he regained substantial increased range of motion and ability to draw, as well as a marked improvement in his psychological symptoms.

Infectious Disease

Survivors of torture and refugee trauma are at risk for a number of infectious diseases including tuberculosis or parasitic infections, which may result from overcrowded dirty detention conditions, osteomyelitis as a result

of trauma/beatings (see musculoskeletal section above), or sexually transmitted diseases from sexual assault, including syphilis, gonorrhea, chlamydia, Hepatitis B and HIV. Additionally, individuals may be arriving from countries where diseases such as tuberculosis, HIV and Hepatitis B are endemic (independent of their trauma history). Appropriate screening (see below) and treatment of these conditions are essential. Health professionals should also have a low threshold for screening for Hepatitis C, and screen for this malady in the presence of other blood born infections or abnormal liver function tests. Again, this may result from individuals coming from countries with poor access to clean needles.

Genitourinary/Gynecologic

Sexual abuse and humiliations including rape, forced nakedness, beatings/electric shocks to the genitals, and instrumentation are common among men and women survivors of torture and refugee trauma. A study conducted by the Bellevue/NYU Program for Survivors of Torture found roughly 30% of all clients reported rape or other sexual assault (Keller et al., 2006.) A study conducted by the Boston Center for Refugee Health and Human Rights at Boston Medical Center found that 28% of male clients seen over a one year period reported sexual trauma (Norredam, Crosby, Munarriz, Piwowarczyk, & Grodin, 2005). Reports of rape against women as an act of war are well documented in several conflicts/civil wars including in the former Yugoslavia and Sierra Leone (Amowitz et al., 2002; Swiss & Giller, 1994). For example in a community household survey conducted in Sierra Leone in 2001, 9% of women reported having been a victim of war-related sexual violence (Amowitz et al., 2002).

Given profound shame and humiliation, which may be even more common in certain cultures, it is likely that there is substantial underreporting of the incidence of sexual abuse by both men and women (Quiroga & Jaranson, 2005; Swiss & Giller, 1993). Care providers must be respectful, empathic, and should consider asking specifically about sexual assault.

Sexual assault in women can result in sexually transmitted diseases, including syphilis, gonorrhea, chlamydia, hepatitis and HIV, chronic pelvic pain, pelvic inflammatory disease, papilloma virus, which in turn can lead to cervical cancer. Unwanted pregnancies, as well as subsequent infertility, are also considerable concerns. Irregular menses, sexual dysfunctions such as loss of libido, fear of intercourse for fear of triggering memories of the abuse and dysparania or pain upon intercourse are often expressed by female survivors of rape (Lifson, 2004; Yehuda & McFarlane, 1995). A thorough history and appropriate and gynecologic evaluation and treatment should be provided. Clinicians should be sensitive to the potential for retraumatization by conducting a pelvic examination.

Female Genital Cutting (or Female Genital Mutilation-FGM) is frequently practiced in several countries, particularly in Africa, and refers to procedures involving partial or total removal of the external female genitalia for cultural or other non-therapeutic reasons. Worldwide, more than 100 million women and girls are estimated to have had FGM. The World Health Organization (2000) has developed a classification system for the type of procedure from least to most severe. Type I refers to excision of the prepuce with or without excision of part, or all, of the clitoris. Type II refers to the excision of the clitoris with partial or total removal of the labia minora; Type

III refers to the excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation).

FGM, particularly with the more extensive procedures, can result in increased risk of health concerns including infections, obstetric complications, sexual dysfunction and psychological symptoms. Given the prevalence of this procedure, it is important for health professionals, particularly those providing gynecologic care, to be familiar with the various forms of this procedure and the potential health consequences (Toubia, 1994).

Sexual assault in men can result in similar problems, including sexually transmitted diseases, chronic dysuria, chronic genital and erectile pain, and sexual dysfunction. Diagnostic workup includes history, physical examination, appropriate laboratory studies and ultrasonography, if indicated. Oral erectogenic agents should be considered for sexual dysfunction (Norredam et al., 2005).

Victims of sexual assault are at high risk, for profound psychological sequelae including depression and PTSD (Arcel, 2002). Within our program, we have found higher rates of depression and PTSD among victims of torture/refugee trauma who were sexually assaulted compared to those who were not (Keller et al., 2006).

Ears Nose and Throat

Beatings over the ears, including a hard slap over one or both of the ears with the palm of the hands (known in Latin American countries as 'telefono') is a common form of torture, and can result in rupture of the tympanic membranes (Iacopino et al., 2001; Peel & Iacopino, 2002) Examination with an otoscope can document rupture or signs of scarring.

Hearing loss can be assessed by simple screening. Audiometric testing can demonstrate with more precision the extent of hearing loss and guide further treatment.

Dental

Poor dentition is a common problem among survivors of torture and refugee trauma, and may result from beatings, malnutrition, and inadequate prior access to appropriate dental evaluation and treatment. Signs of poor dentition, including missing/fractured teeth should be documented and appropriate referral for dental care provided.

Gastrointestinal

Abdominal symptoms, which are common in the primary care setting, may be even more prevalent in refugee populations. Etiologies are multifold and can include infections (i.e. parasitic infections, hepatitis), and peptic ulcer disease/gastro-esophogeal reflux. Individuals imprisoned or in refugee camps are likely to have been exposed to overcrowding and extremely unsanitary conditions, making the risk of parasitic disease even greater. Hepatitis B, which is endemic in many countries, may be even higher among torture survivors given the frequency of sexual assault.

Gastrointestinal symptoms as a somatic complaint are also a consideration. As evident from literature in domestic violence populations, traumatized populations often manifest abdominal discomfort as a somatic manifestation. This, however, is a diagnosis of exclusion.

A thorough history of the course of abdominal symptoms, describing symptoms of reflux, dyspepsia (loose stool/diarrhea, including noting presence or absence of blood) should be elicited. Given a high prevalence of

parasitic infections among immigrant refugee populations, routine screening of stool for ova and parasites is often encouraged.

For dyspeptic symptoms a trial of H2 blockers pr proton pump inhibitors should be considered, as well as screening for Helicobacter Pylori. Persistent symptoms should evoke further evaluation including upper/lower endoscopy. It is important to keep in mind the higher prevalence of gastric cancer in certain immigrant populations (Marcus et al., 1999).

Constipation may also be a frequent complaint, often resulting from individuals who previously ate a higher fiber/less processed diet than now being eaten in the United States. This may also be a manifestation of stress. Structural abnormalities, requiring a
colonoscopy should be considered as well if symptoms persist.

Psychiatric Symptoms

For many torture survivors, the only scars they are left with are emotional, and these can be the most devastating and debilitating. (See Chapters 1, 6, 8, and 10). Psychological symptoms commonly occurring in survivors of torture include memory and concentration impairment, nightmares, intrusive memories, increased startle response, amnesia, flashbacks, sleep disturbance, irritability, and avoidance (Keller & Gold, 2005). General feelings of shame and humiliation, especially in light of sexual assault, often plague the torture survivor.

Many survivors will manifest somatic physical symptoms in lieu of addressing their underlying depression or anxiety. Several studies have shown that those suffering from PTSD tend to be more likely to report nonspecific somatic complaints than do those without PTSD. One study found that the number of PTSD symptoms predicts the number of organ

systems involved in the patient's complaints (Van Ommerren et al., 2002). However, physicians must avoid the temptation to write off physical complaints as psychosomatic, taking care to remember that survivors of torture suffer from the same gamut of health problems that affects the general population.

The most common psychological diagnoses among survivors of torture/refugee trauma are posttraumatic stress disorder and depression. Co-morbidity of these two illnesses is common (Momartin, Silove, Manicavasagar, & Steel, 2004; Quiroga & Jaranson, 2005). Anxiety and suicidal ideation are also significant concerns.

Post-Traumatic Stress Disorder (PTSD)

This disorder is defined by the following symptoms persisting for more than four weeks in a manner that impairs normal functioning: 1) re-experiencing the trauma in nightmares, intrusive thoughts, or flashbacks; 2) general "numbing" and avoidance of situations that symbolize the trauma; 3) excessive arousal (Breslau, 2002).

The prevalence of PTSD is markedly higher among survivors of torture/refugee trauma than in the general population In the U.S. the estimated lifetime prevalence of PTSD in the general population is approximately 8% (Kessler et al., 1995). In countries exposed to mass conflict, the prevalence rate is higher-between 16% and 37%.

Among survivors of torture/refugee trauma presenting to our program for care, the prevalence of PTSD was 46% (Keller et al., 2006). Several studies have documented higher prevalence rates of PTSD among refugees who have experienced torture compared to those who have not (Iacopino et al., 2001).

As mentioned above, many patients' PTSD manifests itself as general somatic pain complaints. While it is recommended that all survivors of torture/refugee trauma be screened for PTSD, particular attention should be paid to screening those who present with medically unexplainable pain.

Depression

This disorder is also significantly elevated among refugees and torture survivors (Gerritsen et al., 2006; Keller et al., 2006). A study of Cambodian refugee women in the United States showed levels of depression three times as high as the national average for women (D'Avanzo & Barab, 1998).

Among Latino patients in primary care settings identified as having experienced political violence, 36% had depressive symptoms and 18% posttraumatic stress symptoms (Eisenman, Gelberg, Liu, & Shapiro, 2003). Among clients referred to our Program, 85% had clinically significant depressive symptoms (Keller et al., 2006).

Anxiety symptoms, in addition to full diagnostic criteria, are common among refugees and torture survivors. Additionally, physicians should be aware of the warning signs of possible suicidality. Depression, loss, feelings of meaninglessness, rage, and guilt are all risk factors. The physician should inquire about previous attempts or current thoughts of suicide. Acute inpatient psychiatric hospitalization may be necessary and life-saving.

As noted above, screening for psychological symptoms should be a part of the initial health screening. Many refugees and asylum seekers may not be familiar with the concept of clinical depression or post-traumatic stress disorder (PTSD), or they may be from a culture that stigmatizes mental health problems. Primary care providers have a crucial role to play in recognizing such problems, providing basic psycho education about

symptoms and treatment, including encouraging appropriate referral for counseling and psychopharmacologic treatment.

At the Bellevue/NYU Program for Survivors of Torture, multidisciplinary care is enhanced through effective communication and working relationships between primary care physicians and mental health care providers including psychiatrists, psychologists, and clinical social workers. Services offered by mental health care providers working with our program include psychopharmacological consultation and treatment, as well as individual and group psychotherapy. Communication is facilitated by having multidisciplinary case conferences on a regular basis.

Early targeting of the most troublesome symptoms, such as insomnia, eases suffering, and can enhance the therapeutic alliance. We have found great utility in psychoeducation provided at initial intake into our program, and by primary care providers, about the importance and value of referral to psychiatrists and other mental health care providers for medications and psychotherapy. Such information helps to educate clients about the need and benefit of services, as well as de-stigmatize and in fact normalize referral to mental health professionals.

Primary care providers in our program often will start medications in symptomatic patients, for anxiety, depression and PTSD, particularly if individuals are not willing to be referred for evaluation by a mental health professional. Patients who are experiencing myriad depressive and PTSD symptoms are treated initially with an SSRI and a brief trial of a benzodiazepine or other sleep aid such as trazodone (Desyrel). When prescribing psychotropic medication to survivors of torture from varied ethnic backgrounds, it is important to consider a variety of factors, including that individuals from some cultures may not be used to taking any

medications. Thus starting with lower doses, so as to minimize side effects may be appropriate. A variety of psychopharmacologic interventions are used in our Program (See Chapter 8).

Health Screening

While the above clinical entities require directed treatment, survivors of torture also require primary medical care similar to other immigrants from underdeveloped regions of the world. Immigrant health care is too broad a topic to address in this text, but primary care for survivors of torture often includes the following: serology testing for evidence of immunity to diseases for which vaccines are available, tuberculosis screening, testing for ova and parasite infections, and general primary care screenings according to accepted guidelines.

Torture survivors should be screened for infectious disease and parasitic infections according to the guidelines for all refugees. Physicians should not only ask about present, apparent health problems, but also about diseases that are prevalent in their country of origin (or countries they have passed through en route to the U.S.). Thus, physicians should have access to country-specific health information.

Epidemiological studies of immigrants and refugees show consistently high prevalence of tuberculosis and other infections when compared to the general population. A 2004 study in the New England Journal of Medicine presents the startling statistic that the rate of tuberculosis among newly arrived refugees was 80 times higher than the U.S. national rate (Thorpe et al., 2004).

A prevalence study among refugees in Minnesota showed that 49% of refugees had a reactive tuberculin test. Prevalence was even higher among male patients and those over 18 years of age (Lifson, Thai, O'Fallon, Mills, & Hang, 2002). Seven percent of these refugees tested positive for Hepatitis B surface antigen (HbsAg), with prevalence being the highest among refugees from Sub-Saharan Africa (at 22%) They also found that 30% of African refugees younger than 18 years old—had at least one intestinal parasite (Lifson, Dzung, O'Fallon, Mills, & Kaying, 2002). Another study of African refugees in Massachusetts reported that 56% had ova or parasites. This study of 1,254 refugees found 17 different parasites among them (Geltman, Cochran & Hedgecok, 2003). The prevalence rates among children and adolescents were even higher (Geltman et al., 2003).

With such high prevalence rates among refugees, it is imperative for the primary care physician to thoroughly screen his/her immigrant patients. Physicians should routinely run the following battery of tests:

- CBC with differential
- General chemistry profile including electrolyte and liver function
- Stool for ova and parasites
- Urinalysis
- Serology for Hepatitis
- HIV and syphilis
- Tuberculin skin test (PPD)
- Chest radiograph for any patient with TB symptoms, or a positive PPD

Antibody titers for measles, mumps, rubella and varicella are commonly checked as well, to confirm immunity. Documentation of immunity to these diseases is often needed for employment and other purposes, and individuals commonly do not have records of prior vaccinations. Vaccinations are provided as needed.

Medical Documentation of Torture

Documentation of torture/refugee trauma is important for any patient seen by the physician, but especially so for those applying for political asylum. By providing such documentation, including preparation of a medical report or affidavit, a health professional can provide invaluable assistance to asylum seekers. Objectivity is paramount when evaluating an asylum seeker. Clinicians should not include any opinions that cannot be defended under oath, or during cross-examination in a courtroom. Embellishing the evidence of torture/trauma in order to help the client gain asylum will not only hurt that client's chances in court, but it will also undermine the credibility of the physician for future asylum applications.

International guidelines for documenting torture, particularly the Istanbul Protocol (Istanbul Protocol, 1999) have been established. The Istanbul Protocol is available on the Physicians for Human Rights (PHR) website (www.phrusa.org). Also available on this website is the manual "Examining Asylum Seekers," adapted from the Istanbul Protocol, specifically for application in the U.S. for evaluating individuals applying for political asylum. Sample affidavits are included in "Examining Asylum Seekers."

Multidisciplinary Medical Clinic

An important source of medical care for patients in our program is a multidisciplinary medical clinic, which meets one evening a week. This clinic is particularly helpful for individuals who work during the daytime. Health professionals including primary care physicians, nurses, psychiatrists, and social service providers are present. Trained interpreters in a variety of languages spoken by our clients (particularly French and Tibetan) are also present. The clinic allows for immediate communication and "real time" collaboration between the different disciplines. Additionally, the clinic serves as an invaluable teaching environment for medical students and residents from a variety of disciplines, who have the opportunity to participate in longitudinal care electives with our program.

Primary Care is available at other times of the week as well, by general internists and pediatricians affiliated with our program. Patients are instructed to go to the Emergency Room for urgent medical needs after regular hours or on weekends and instructed to inform our Care Coordinator. Our program has conducted trainings with the Emergency Department and other service providers throughout the hospital in order to educate them about the health needs and complexities of our patients. Additionally, service providers from a variety of subspecialties have been identified and serve as point persons within their departments for patients in our program. This includes neurologists, dermatologists, pulmonologists, and rehabilitative medicine specialists.

Case Examples

Case #1: KD

KD is a 45 year old male from the former Yugoslavia where he worked as an engineer. During the civil war, KD's neighborhood was turned to rubble by frequent shelling and gunfire, and several family friends, including children, were killed in cross-fire. KD and his family subsequently fled and eventually came to New York City where they had relatives. He was referred to our Program by a local refugee resettlement organization.

KD has a history of hypertension, but ran out of his blood pressure medication several weeks before his initial evaluation. He had an empty packet of his medication, which was a kind of beta blocker not available in the United States.

On initial medical evaluation, KD described frequent frontal headaches. He denied blurry vision or a history of head trauma. On further history, he described the headaches as worsening when he was nervous. He also described difficulty sleeping, irritability, and being easily startled when he'd hear a sudden noise like a car backfiring.

Physical examination was significant for a blood pressure of 160/110. The remainder of his physical examination was unremarkable. Routine laboratory testing was normal, including negative hepatitis serologies, and a negative skin test for tuberculosis.

KD was prescribed an alternative Beta blocker (atenolol) that was available. Subsequently, hydrochlorothiazide was added for improved blood pressure control. KD initially refused referral to a mental health provider saying he wasn't crazy. He did, however, acknowledge his psychological symptoms were causing him significant distress and agreed to medication for this. KD was started on a serotonin reuptake inhibitor, as well as on trazodone at bedtime for sleep. Subsequently, the dosage of the sertraline was gradually increased, and KD no longer required the trazodone to sleep. KD, along with his wife and children, subsequently agreed to speak with psychologists associated with our Program. KD was seen by our Program's social service provider who, in coordination with staff at the refugee resettlement agency, arranged for KD to attend English and computer classes, and subsequently assistance with finding a job as a maintenance worker.

Case #2: MB

MB is a 32 year old French speaking female from a West African country. She was referred to our program by a pro bono attorney representing her in her application for political asylum. She reportedly had been imprisoned several times in overcrowded cells for organizing peaceful political demonstrations. She was subjected to a number of forms of torture and mistreatment including beatings with a whip on her back and being burned with a lit cigarette while being interrogated.

MB was asked if she was comfortable seeing a male physician and she said that she was. A French speaking interpreter, who was female, assisted in the interview. At the time of her initial medical evaluation, MB complained of chronic lower back pain, stomach aches, and a chronic cough. She denied fevers or night sweats. She described the pain in her stomach as a "burning sensation going up into her throat." She reported being seen in different emergency rooms on several occasions and given "stomach pills," which she said helped a little. She stated that she had not informed doctors there of her prior trauma history because "they didn't ask" and she was "ashamed."

On further history, MB acknowledged that during her imprisonment she was raped on 2 occasions. While talking about this she became tearful. She said that she had not told anyone else about this.

On physical examination, she had multiple circular scars on her arms consistent with cigarette burns. She had linear scars on her back consistent with her report of having been whipped. The remainder of her physical examination was normal. Gynecological examination performed by a female clinician associated with our Program was normal. A pregnancy test was negative.

MB described difficulty sleeping and feelings of extreme sadness since her imprisonment and rape more than 3 years before. She described frequent suicidal thoughts but denied ever having tried to kill herself or planning to do so. In consultation and subsequent follow up with a psychiatrist associated with our program she was started on

antidepressant medication. She also subsequently participated in a support group for French speaking African torture survivors.

Routine Blood tests were negative, including tests for hepatitis and syphilis. HIV testing was negative as were tests for gonorrhea and chlamydia. Stool examinations for ova and parasites were negative. Skin testing (PPD) for tuberculosis was positive. Her chest x ray was normal.

MB was treated with acetaminophen for her back aches and ranitidine for her gastrointestinal symptoms with subsequent improvement. She was started on isoniazid for 9 months for exposure to Tuberculosis. Her psychological symptoms also significantly improved. Health providers prepared affidavits documenting her trauma history and findings on physical and psychological evaluation. Subsequently, she was granted political asylum.

These cases demonstrate the myriad of health concerns individuals such as KD and MB may present with. Eliciting a trauma history is crucial in identifying and addressing important health concerns. As illustrated by the case of MR, health professionals frequently fail to inquire about a trauma history. Thorough medical evaluation and treatment, in collaboration with mental health and social service providers, is invaluable in promoting the health and well-being of survivors of torture and refugee trauma.

APPENDIX A

Sample Medical Affidavit

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE OF IMMIGRATION REVIEW
----------x

In the Matter of the Application of

XXXXXXX
A# xxxxxx
----------x

AFFIDAVIT OF ALLEN S. KELLER, M.D.

1. I am an American physician licensed to practice medicine in the State of New York. I am a graduate of New York University School of Medicine and completed my residency in Primary Care Internal Medicine at NYU/Bellevue Medical Center. The residency program provided me intensive training on the psychosocial aspects of care including effective doctor-patient communications and the evaluation and treatment of common psychiatric problems including depression, anxiety, and somatization. I am board certified in Internal Medicine and am an Assistant Professor of Clinical Medicine at NYU School of Medicine, and an Attending Physician at Bellevue Hospital in New York City.

2. I have received specialized post-graduate training from Physicians for Human Rights in the use of medical skills for the documentation and treatment of torture victims. I have been conducting medical evaluations of survivors of torture since 1990. In 1993, I worked in Cambodia where I helped develop a program to train Cambodian health professionals in the evaluation and treatment of survivors of torture. In November and December of 1996, I led a fact-finding mission to Dharamsala, India on behalf of Physicians for Human Rights to examine Tibetan refugee survivors of torture and to evaluate and document the continued use of torture of Tibetans by Chinese officials. I am the author or coauthor of multiple publications on the evaluation and treatment of survivors of torture.

3. I have also trained several health professionals in this country in the evaluation of torture survivors. I have participated in training staff of the Immigration and Naturalization Services concerning the physical, psychological, and social consequences of torture. In June of 2001, at the invitation of the Office of Chief Immigration Judge, I was invited to make a presentation concerning the evaluation of torture survivors at the annual conference of immigration judges. I am on the International Advisory Board of Physicians for Human Rights. Most recently, I have developed a program at Bellevue Hospital and NYU Medical Center in New York City to provide medical, psychological, and rehabilitative services to survivors of torture and refugee trauma. Currently, I am director of this program- The Bellevue/NYU Program for Survivors of Torture. I have been previously qualified in Federal Immigration Court as an expert witness in evaluating and treating survivors of torture.

4. Ms. X is a xx year old female from Tibet. Since xxx she has been a patient in the Bellevue/NYU Program for Survivors of Torture. She has been seen many times since then (approximately 20 clinical visits to our program), most recently on March xxx. I have conducted a detailed clinical interview and physical examination of Ms. X in order to evaluate the effects of torture and maltreatment that she reports occurred in Tibet and India prior to her entry into the United States.

5. Ms. X reports that in xxx her father and grandfather, who were volunteer soldiers, were killed by the Chinese military when they invaded Tibet. Until xxx, she reports that she lived in Tibet with family members. She reports being repeatedly harassed and mistreated by Chinese authorities. She reports that she was not allowed to attend school nor practice Tibetan Buddhism. She reports being publicly humiliated by Chinese authorities on a number of occasions because her grandfather and father had fought against the Chinese. On several occasions, she reports being forced to stand in a public square with other Tibetans whose family members had fought against the Chinese. Chinese authorities would say these are examples of troublemakers and then would force the other villagers to throw stones at them. She reports suffering some minor injuries but denies being seriously physically injured during any of these episodes. She reports however, having found the experiences to be very humiliating.

6. On one occasion in 1972, Ms. X reports again being forced to go to the town square with approximately 15 other Tibetans, including her sister in

front of the rest of the village. She reports being forced to sing communist songs. When she did not sing the song completely, she reports that the local Chinese leader hit her on the mouth and then ordered the people to beat her and the others. She reports being punched and kicked all over her body, and subsequently lost consciousness. When she woke up, she reports that she was back in bed in her house. She reports that she felt very weak and sore for many weeks after that.

7. In xxxx, Ms. X reports that she left Tibet for India and lived in xxxx, India. She reports that she became active in a number of Tibetan organizations there. She reports being arrested and tortured on three occasions by the Indian authorities.

8. In March, xxx, she reports being arrested after attending a peaceful demonstration supporting Tibetan independence. She reports being detained for 2 days at a police station in Darjeeling. She reports being kept in a cell with approximately 6 other women. On the first night, she reports that approximately 3 Indian police officers, whom she believes were drunk, came to the cell and started beating her and the other women with sticks, while being verbally abusive. She reports the police threatened to punish them even worse or return them to Tibet if they continued to protest. Before being arrested, while trying to run away from the police, in the midst of the crowd she reports that she fell on a metal fence on the side of the road and injured her left buttocks. She reports the wound subsequently became infected with a purulent discharge. She did not seek medical care for this because she felt ashamed. She used traditional, topical ointments and the wound gradually healed.

9. In April of xxx, Ms. X reports that she was again arrested after having helped organize and then attend another demonstration in New Delhi in front of the Chinese embassy. She reports being held at a police station in New Delhi for three days. On the first day, she was brought into an interrogation room with 2 Indian police who began to question her about her activities. She reports that she was beaten, knocked to the ground and kicked. One of the policemen started undressing her. Subsequently, the other police officer came with a cigarette and repeatedly burned her with a lit cigarette on her left knee. She reports that she was subsequently vaginally raped. She reports the police shouted “You deserve this, and if you keep protesting then you will be sent back to Tibet.”

10. After three days, she reports that she was released. She reports feeling very sore all over her body and experiencing some vaginal bleeding. She reports that she did not seek medical care because she felt ashamed. She reports the wounds from the cigarette burns developed blisters, which subsequently burst. She reports that subsequently her husband divorced her, she believes, because of shame associated with the rape.

11. In March of xxxx, she reports that she was again arrested after attending a demonstration in Darjeeling. She reports that she was detained for 5 days. On the morning after her arrest, she reports being interrogated by Indian police. When she refused to sign a piece of paper that she would no longer protest, she reports being beaten by police officers, including being smacked in the mouth, and subsequently bleeding from her mouth. In order to stop the beating, she subsequently signed the paper.

12. In June xxxx, Ms. X reports that she left India for the United States.

13. Ms. X reports suffering from a number of psychological symptoms, particularly since her rape in India. These symptoms include significant feelings of sadness, hopelessness, decreased energy, and difficulty sleeping. She also reports frequently experiencing recurrent memories and nightmares of her abuse, though she tries not to think about what happened. She reports that when she has the nightmares, she wakes up with palpitations and then has difficulty falling back to sleep. She also reports being easily startled, and experiencing physical reactions, such as palpitations, when reminded of the events. Since being referred to the Bellevue/NYU Program she has received psychiatric care including antidepressant/anti anxiety medication with marked improvement in symptoms.

14. On physical examination, Ms. X is a well developed, well nourished female. She has multiple scars on her body consistent with her accounts of physical abuse. She has a linear scar approximately 2 cm in length on her right pinky and another linear scar on the back of her hand, approximately 3 and ½ cm in length, which she reports resulted from injuries when she raised her arm to block being beaten. There are several scars which she does not recall how she got including a 3 cm linear scar on her right upper arm, two linear scars at the base of the right thumb, and another ½ centimeter scar on the back of her left wrist. She has a scar on her left buttock approximately 2-3 centimeters in diameter, with a central indentation, c/w her report of the injury she suffered in 1984. On her left knee are approximately 5 smooth

hypo-pigmented scars, (ie. lighter than the surrounding tissue) approximately 1 centimeter in diameter consistent with her report of having been burned there.

15. It is my clinical assessment that Ms. X has been a victim of torture. Torture, according to the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment means "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."

16. Ms. X demonstrates clear historical, physical, and psychological evidence of torture. Ms. X provides great detail and consistency with the events of her abuse. Although torture may not always leave physical evidence of abuse, Ms. X clearly has multiple scars that support her allegations of abuse and are consistent with the events she describes.

17. The psychological evidence of Ms. X's abuse is also compelling. The psychological symptoms described above are consistent with diagnosis of depression and post traumatic stress disorder (PTSD), which is a form of anxiety.

18. The detail and consistency with which Ms. X describes her mistreatment, including imprisonment and torture, as well as the findings on physical and psychological examination persuade me that she is very credible and telling the truth. It is my impression that she continues to suffer from the physical and psychological effects of her abuse.

19. Ms. X will continue to receive care through the Bellevue/NYU Program for Survivors of Torture. It is my assessment that she has benefited from this care and will continue to do so.

20. It is my assessment that to force Ms. X to leave the United States and return to India or Tibet would pose a serious threat to her physical and mental health.

I declare under penalty of perjury that to the best of my knowledge, the foregoing is true and correct.

_____

Allen S. Keller, M.D.
March 28, 2003