TORTURE NARRATIVES
AND
THE BURDEN OF GIVING EVIDENCE

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Torture narratives and the burden of giving evidence

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Chapter I. Introduction

Problem statement

Torture is unbearable. I want to contribute to the understanding of the victim’s burden by listening to the experience that is buried in the narrative of many asylum seekers. My work as a doctor volunteering for Amnesty International gave me the access and the means of documentation. One peculiar aspect of the asylum procedures is, that the victim is bound to produce evidence of having been tortured. As the local Dutch asylum law defines: ‘at the earliest opportunity’. The narrative has to be presented in a decisive hearing, in which the evidence of torture can be disbelieved. This is not what the victim expects, but it is true. If the evidence is discounted in the decision, the victim loses the claim on asylum and faces extradition, and that can signify re-exposure to torture. In this dramatic setting, the narrative is pivotal.

The position that is taken by Amnesty physicians on the discounted asylum testimony can be characterized as: “Our asylum system did not understand you; please tell your narrative again, but now slowly, coherently and completely”. The medical document, that results from this interview, is an important intervention on behalf of the individual victim. The collective medical experience of the AI medical intervention is a contribution to the understanding of the burden of evidence, connecting torture with truth by following the course of explications through a confusing context. To an unbelieving audience, the torture is a complex and compact riddle that asks for a solution. The core of my thesis is what victims have told during medical examinations in the context of their seeking asylum in the Netherlands. The time span described is a period of 1995 until the present. The period relates to case histories, collected on behalf of AI by a group of volunteer doctors and refugee experts. The task of the doctors can be summarized as to ensure an independent medical documentation of the traumatic aspects in the asylum narrative, to support the search for verification of torture. The evidence in that narrative of torture, as it is told to an empathic doctor, is the objective of this thesis. The following case vignette exemplifies the study objective: ‘A (Table II, case 3, p. 84) is an 31 year old man, who alleged to have been detained and tortured in Iran as a consequence of being homosexual. He escaped and requested asylum 3 years later. In a procedure of 18 months the immigration officials discounted his narrative. The negative decision was sustained in the court of appeal but his solicitor appealed anew and asked AI to search for supportive new evidence. In an extensive report, 6 months later, on the plight of homosexuals in Iran, confirming the torture by a medical examination of his complaints, AI provided documentation of scars and of rape, attested by serious signs of traumatization. AI stated that the trauma, that motivated his request for asylum, had occurred
during imprisonment in his country of origin. In a final reappeal, 9 months later, the State Council reversed the negative decision. The Immigration Department was instructed to reassess A’s request and the officials permitted a temporary asylum for medical reasons, that is to continue the psychiatric treatment.’ This vignette emphasizes the paramount question, to be answered in this thesis: how, in the context of the Dutch asylum procedure, to assert the right of victims to tell their torture narrative to an understanding physician. How is that narrative constructed?

**Methodology**

To describe torture as a burden of evidence, investigational methods will be applied that are used in medical anthropology. The case vignette shows the focus of study to be the moment, when the narrative of torture has become crucial as an allegation. The method of description by AI portrays the asylum seeker primarily as a medical client, experiencing the past trauma as an illness, occupying space and time in life. We will critically reflect on the burden of torture, while it is tested, commented and documented, during confrontations, both judiciary and medical, between many actors in frequently opposing roles: the victims themselves, but also immigration officials, solicitors, non-governmental refugee workers, AI experts, doctors and judges. The burden has to be carried through interactions that are characterized by temporisations. Time elapses between trauma and asylum intake. Between initial decision and final appeal the progress of time is considerable. In that period re-assessments are frequent, while the asylum seeker is alternating between hope for safety, fear of extradition and expectation of asylum.

To retrieve the significance of torture as the causal agent, my study has to retrace many steps in order to cover all the relevant social, physical and psychological contexts of the individual traumatization. For that reason I chose an anthropological revision of the medical observations, done as a participating doctor in the AI examination. The revision will first describe the AI medical examination and then offer an analysis of the observations made on the narratives of asylum seekers during the medical examination. Medical anthropology is a discipline, that engages in conceptualisation of health and disease in society. An advantage of its use is the manifold and multilevel perspectives that search for a focus of concern and help interpret the burden of trauma evidenced by the torture victims. The anthropological methodology opens not one, but many windows, that can be looked through as observer, hoping to arrive without prejudice at interpretations that make sense. Making sense of the evidence is central, because it counsels a fresh retrospective over considerable time, argument and course of event. Estimates of the impact of torture on motivations for asylum migration vary between
observers, but all of the applicants cite a history of mistreatment as the main cause for fleeing the country of origin. The torture narratives are not easily extracted or interpreted. Listening requires, even on the part of the trained examiner, not only empathy, but, in verification, also impartiality, objectivity, consistency and rationality. Tales of torture, by the traumatized victim, are, per definition, delivered through pain and grief. The circumstances of medical examination may motivate the asylum seeker to do so, but at the same time the avoidance to re-enact the trauma is a strong counter current to disclosure. A disadvantage of the medical anthropological methodology can be that the restless search for new perspectives may exhaust the observer. The pitfall of reduction may be avoided at the cost of falling into the trap of relativism. So many different truths may evolve that the argument, what narrative is pivotal, is lost from view. Then, fragmentary findings, established at individual examinations, do not matter much, because their interpretation varies with each new look anyhow. In particular in the arena of conflict, surrounding asylum, limits of understanding are imposed on the narrative by the single-minded mindframes that separate the actors. The victim wants only asylum, the asylum authority restriction first of all, the solicitor merely to appeal on negative decisions, and the physician insists, that support to traumatized victims has to predominate. The purpose defines the approach to the evidence. Purposive language is the key to the questions and the truth obtained. Truth itself is a construction. To escape a paralysing split between opposing problem statements, in this thesis a medical and an anthropological perspective are combined. The medical perspective is to collect, take stock and search for a reduction of the narrative to essentialities, while the anthropological gaze can do its job of criticizing, problematizing and contextualizing.

**Approach**

In the next chapter the method in collecting data, source of observations and the problem statement will be amplified in research questions and diagrams. Observations start with one exemplary case study. This part will detail the structure of the medical investigation and illustrate the reporting process and protocol. Secondly, a literature review is added, to arrange and compare recent publications on the differences between the actors involved. The third step is the juxtaposition of opinions of trusted experts, who have been personally interviewed. The next, fourth, step, is a discussion on making the permanence of torture visible through the scars. Images and visualizations are presented that search for a balance between the need for verification and the possibility of understanding. Lastly, the available source of narrative will be surveyed by a quantitative and qualitative epidemiological approach.
In the conclusion, possibilities and restrictions of all steps, tracing the burden of torture in the narrative, will be discussed, leading towards interpretation with respect to the research question. Finally, literature references to all chapters are brought together and the appendices contain the illustrations, questionnaires, procedures and other tools used.
Chapter II. Data collection, research questions and material

Data collection by the Medical Examination Group of AI Amsterdam

The main original observational contents of this thesis are my work experiences in the group of doctors, who volunteer to perform examinations on behalf of AI. Thus, I will first give careful consideration to that source. Since 1995 I have participated, as an experienced internist, in the Medische Onderzoeksgroep (Medical Examination Group: MEG) of AI in Amsterdam. This group of doctors varied in number over the past decades between 25 and 75 volunteers, with an average of 50 professionals involved at any one time and usually 30 at any one time being attached to one examination in the total caseload. The professional disciplines represented are mixed; ranging from general practice and tropical medicine, psychiatry and neurology, public health, surgery and revalidation medicine, internal medicine, gynaecology, pediatrics and dermatology. Male and female practitioners, differing in age and experience, in various stages of their careers as trainee, consultant or retired, are represented. The prevalent medical occupation in the group is a clinical one. All members are interested in the human rights aspects of medicine. The conscientious search for the proper application of human rights in clinical practice can be seen as the motivation that binds the group together.

Their volunteer work has become a feature of the asylum scene in the Netherlands because AI, as a non-governmental organisation, is the sustaining platform. If indicated by a request of the asylum solicitors, its mandate commits AI to prevent extradition of victims of human rights transgressions. In 1977 AI in the Netherlands decided to make medical reporting available to asylum seekers, as a consequence of the fact that torture victims had no access to such documentation as part of their testimonies. The initial drive to do so was to prove medical reporting to be an obligatory part of the asylum request if a history of torture was part of the claim. In time, the specific task of the MEG amplified into caseloads of testimonies in order to assess medical complaints, as related to the history of torture, of claimants whose request on asylum had been turned down, and who were in fear of extradition.

Approximately half of all solicitors’ annual requests to the AI refugee department are dealing with problems to define the human rights position of their clients vis-à-vis the negative decision on asylum by the Dutch immigration authority. Roughly half of the AI refugee expert’s advice in return includes a referral for a medical examination to be performed by the MEG. In the past decade the MEG produced an average of 150 affidavits to the selected population of victims annually. Each affidavit represents a professional workload of 20 to 50 hours. The interaction between medical examination and AI refugee expertise provides the clients of Dutch solicitors and asylum seekers with the opportunity for medical,
psychological and photographic documentation, targeted at reversing the extradition, if the individual evidence collected through medical examination for signs of torture matches the AI perspective.

Early during my present training in medical anthropology it occurred to me that a retrospective on my participant observation in the MEG might be food for scientific digestion. In April 2004 the count of dossiers personally examined by me passed that of 30 since 1995. (Table II, p. 84) The MEG has reported on approximately 2000 dossiers in the period of 1990-2000. (Fig 9, Annexes) Thus, the quantity of material seemed adequate for an attempt to compare and analyse. In 1998 the MEG introduced an evidence-based protocol to improve the quality of reporting. The protocol facilitates the comparison and evaluation of dossiers and a scientific exploration of their content and effect. So, the quality of data collection too seemed sufficient to base my thesis on. The on-going assessment of medical findings in relation to torture history and asylum claim in the Netherlands is part and parcel of the aims of the local AI and the MEG, and in that way my research effort can contribute to the same goal, that is to expose the consequences of the evil of torture. The possibility for a future application of my research in the fight against torture is a possibility to consider.

During the past decade, in an average year, approximately ten to fifty thousand refugees entered asylum procedures in the Netherlands. The average sample size drawn into the AI intervention from this large population is small: less than 500 cases (1%) each year. To lend my retrospections a general significance requires a thorough study of the background of problems that each case stands for. For that purpose, AI has made the dossiers available through the secretariat of the MEG that is also responsible for the evaluation of progress in the asylum request. All non-medical documents, used in my evaluation, are related to the asylum request and the client’s solicitor’s appeal procedures. Also, AI refugee experts added summaries of the relevant political situation in the country of origin and on the human rights position of each client. With a written permission, each client examined has cooperated to the MEG archive and to my research on the digitalized medical records. All case related medical documents were collected during the administration of MEG-tasks with such written permission of each client. Further significant data were collected from AI’s internal publications and correspondence with the immigration authority. Regular meetings that took place in the MEG, coordinating the actions of the refugee experts and the medical volunteers, provided the professional intevention to my work as an examiner.
Research questions and diagrams

Chapter III shows, in one extended case study, how the narrative of torture by the asylum seekers is represented in the asylum procedure. The story line takes the medical examination by AI for reference, defining the case by ordering the observations according to the diagram:

<table>
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<tr>
<th>Case Definition Diagram</th>
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<td>Query</td>
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Purpose of narrative in hearing on asylum claim

Purpose of narrative in appeal on negative decision in asylum claim

Medical examination of narrative in the claim for asylum

Perception ➔ Effects on Asylum ➔ Coping

The flow diagram 1 is used to outline the account given in the case transcript. Elements of this diagram will return in the subsequent chapters. The main query is: how to assert the right of victims to tell their torture narrative, in the Dutch asylum procedure, to an understanding physician. Related research questions are: what truth is the medical examiner in search of during the interview and physical examination of the client, and what is the examiner’s argument to qualify findings as reliable, consistent and in support of the claim of asylum.

What does it take to qualify that documentation into evidence of torture? The transcript defines the examiner’s role and mode of operation in comparison to that of the other actors involved. At each turn in the process of documenting the evidence of torture, decisive choices have to be made by the examiner. Findings must be argued and physical observations be visualized to connect the torture evidence with the asylum request. How does the victim of torture and the other actors perceive the examination of evidence and how do they cope with the result of examination?

Chapter IV searches the literature concentrating on the narrative of torture as a condition to obtain asylum. The research question is: in what way can a medical examiner contribute to the interpretation of the evidence extracted from the narrative? The rationality of medical strategies is sought in restating torture as a defining agent in the claim for asylum.
The human right to escape torture is a basis, but how solid is that? What relevancy has that basis according to the literature, if we follow different medical and anthropological perspectives, at various levels of interpretations? What individual, social, national or general political and medical forces oppose the disclosure of evident torture? How is the faith of the medical examiner constructed towards receiving and interpreting the evidence? Can the understanding of torture be shared, even standardized, between the opposing actors, if asylum is at stake?

In chapter V the examination of the narrative will be put to eight experts knowledgeable in the setting and procedures for asylum and those for the MEG intervention. Their experience in mediating the torture evidence in the Dutch asylum conditions has been sought to elucidate the local conditions. The following line of questioning structured the interviews: How to tell the narrative of torture in order to inspire trust by the interpreter of the claim for asylum? In what circumstance is that a task for the appropriate asylum authority? Is the risk of refoulement (extradition) an indication for medical examination? If so: is the narrative a ‘tactical use of trauma’? What medical approach is applicable to the narrative of torture? What result can be expected of that medical intervention in the asylum claim? Is the traumatization a constraint on the medical intervention? Is secondary traumatization a possible adversity of that medical intervention? Is the cultural background a constraint on it? How can the individual refugee, involved in this interaction, be best supported?

All interviews were conducted as conversations, and respondents received the research questions in advance. Prior to the interview I studied their publications on the subjects that we would discuss. A transcript of the interview was exchanged for corrections. In the summary I kept their responses in the questioning sequence, contrasting the content for each of the 10 items, to discover the consistency and range of their perceptions. That summary was subjected to a focus group discussion with medical anthropologists, assessing trauma, violence, narrative and memory. The interviews were then re-arranged per interviewee as points of view on the human rights aspect of refugee medicine.

In chapter VI the visualization of physical findings in medical examinations, in particular the scarring from torture, is discussed. The MEG collection of images and descriptions was sent to two expert panels and their responses are reviewed to answer the following questions. How can the narrative of torture be visualized? What meaning lies behind scars? What pictures can contribute to link torture and scar? What medical approach is applicable to the visualization of torture? What support can be expected of the visualization of torture narratives?
Chapter VII surveys the use of quantification and qualification of narratives in relation to the asylum request. The description of ‘an epidemic of torture’ signals another approach of how to deal with the medical and anthropological perspective. The MEG survey of dossiers contributes a statistical assessment of the impact of the reports on the outcome of asylum request in the appeal stage and a qualitative investigation in a representative sample of medical observations.

My participation as a medical examiner spans the period of 1995-2004. The dossiers utilized are part of an archive, which has been addressed frequently by the MEG for evaluation. Their analysis, previously published, discusses two issues: (1) Statistical assessment of the impact of the reports on the outcome of asylum request in the appeal stage (2) Qualitative investigation in a representative sample of medical observations as has been summarized by Geurts, Vervaat and van Rijswijk in 2002. These publications will be interpreted as assets of the medical documentation of torture in the claim on asylum. A comparison is made between the collective effort of examiners, to 30 individual examinations performed by me, moving from the quantitative epidemiological towards the qualitative experience of one participant. (Table II, p. 84)

A SPSS file was used to transcribe the data from the dossiers (Annexes p.121-124). To obtain an insight on the figures and the effects of the medical reports, Fig. 9 shows the trajectory of MEG quantifying the reporting in the period 1990-2000 as recorded in 2003. (Pomstra 2003)

The quality analysis, following research diagram 2, helps to develop an insight into population characteristics, which will not surface by statistical analysis per se. Finally, a general discussion of the survey will precede my conclusions, to demonstrate what the interconnections are, which can help to understand the experience of suffering conveyed by tables, statistics and graphs.

The results will be interpreted as assets of the medical documentation of torture in the claim on asylum. The results are structured by the following questions and research diagram: How is the query about torture responded to in the asylum procedure? How is the query responded to in the medical examination? How do the observations compare between both? What interpretation do both give to the observations? What new observations are made by the medical examiner?

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1 MEG internal publications (De verblijfsrechtelijke positie na medische rapportage i-iv, 1990-2003).
2 Thesis, Sietske Vervaat (Somatische en psychische problemen bij asielzoekers: bevindingen door artsen van de MOG-AI, 2000)
Research Questions and Diagram on the Comparison of Examinations
Chapter III. Case

This chapter summarizes and annotates a case. The dossier is prepared by the AI office to contain (a) the request for medical examination, and the appeal notes, by a solicitor; (b) the clients informed consent and written statements; (c) the results of former proceedings in the Immigration and Naturalization (IND) hearings and decisions; (d) the medical information collected by the solicitor to support a revision, and (e) the review of notes and correspondence by the AI refugee department. The case to be annotated is the following:

A (Time Path., Annexes Table 1, Table II, sub.4, p. 84) is an 40-year old West-African man. He alleges to have been arrested by the state-police in Zaire as a suspect of being involved in the murder of the state president. His story is that he became accidentally mixed-up with the perpetrators as a taxi driver. He remained many months in custody and was frequently tortured. His scars, he states, are the results of that torture. An influential family member helped him to escape detention and the country. In the 1st IND-hearing he was considered to be unable to prove his identity. The story of his escape did not satisfy the interrogator. In the 2d and definitive hearing, the alleged torture during detention was not accepted as a reason to fear refoulement. The decision states “the fact that scars exist is not contested, but these cannot, as a rule, make apparent what injuries caused it, as the possibility exists they result from fights or accidents”.

The key for the solicitor’s request to AI for a medical examination is the IND refusal to accept the narrative and scars as evidence of the alleged torture. AI considers it an essential feature of human rights protection that asylum is available to refugees who have been subjected to torture. In A’s case an allegation of torture appears applicable, that is: ‘deliberate infliction of severe pain or suffering by state agents for which the state bears responsibility through consent or acquiescence’. (UNHCR Handbook 2002) Since 1995 AI and the MEG adhere to, review and improve a protocol as guideline of examining the narrative of torture victims according to international guidelines. (Istanbul Protocol 2001)

The specific purpose of the medical examination protocol is to extend and interpret the information, with the purpose that it can be introduced as new evidence, through the solicitor, in appeal. The topics of medical examination are represented by Annexes, Table 2. The AI refugee department prepares an expert report based on revising the narrative and personal documentation in combination with Presentation to MEG
research of the regional political background in the country of origin. In a minority of cases
the claimant is invited and interviewed by the AI expert in person. The cooperation between
AI experts and legal representatives defines the judicial queries that are to be solved. An
explicit questionnaire is used to pinpoint differences, between the asylum seeker and the IND
in the interpretation of disputed occurrences. During the 2d and definite hearing the asylum
seeker explicates the experienced mistreatment and fear for re-exposure. In the dossiers
studied by AI, at the stage of the definite asylum hearing, the interviews by the IND appear to
be comparable to a cross-examination. The interrogation is conducted according to a strict
program of instructions on the part of the interrogator. The IND maintains, that independent
medical examination cannot, in principle, play a role in verification of allegations. The IND
interrogating and deciding officials have to assess on their own accord to what extent the
narrative of torture, or any actual medical complaints or scars, suit them as part of verification
with respect to the events narrated. The particular episode of arrest, detention and
mistreatment as summarized by A in the 2nd hearing is: “During the night of [date] soldiers
forced entrance to my house and threatened me and my wife. I was unable to send them off
with a bribe and they bound me up, threw me in their jeep and took me to a camp, were I was
kept imprisoned several months. The military officials in charge accused me of being an
accomplice to the president’s murder and did not believe my story. I was tortured and
mistreated in an attempt to make me give particulars of the persons I had carried in my taxi. I
was however unable to do so, because I had no information on that subject whatsoever. A
military doctor, who did not intervene or prescribe treatment, has summarily examined the
injuries. My injuries, that is a fact I am certain of, are partly irreversible.”

The MEG is prompted by the AI refugee expert to initiate a new and independent approach,
taking as its cue the AI-mandate that ‘refugees and asylum seekers, who flee persecution, are
not to be sent back to their country, if they are in danger of becoming prisoners of conscience,
facing torture or the death penalty’. (AI 1996) The dossier is adjudicated by an experienced
MEG member, who reviews the information (1) by considering the origin of the actual
complaints and scars in relation to (2) the medical information, available in files of attending
doctors (mostly on behalf of the asylum medical services: MOA\(^3\)) and complaints such as (a)
physical problems, that can be related to the mistreatment, (b) psychological problems,

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\(^3\) Dutch: Medische Opvang Asielzoekers; offering medical services in asylum centers as institutionalized
part of national and municipal public health services: Gemeentijke Geneeskundige en Gezondheids-diensten
(GG&GD). The services are provided free under a service contract between GG&GD with the Dutch
Government.
mentioned but not investigated previously as related to the trauma. Experience with precedent cases is an important factor in adjudication.

The asylum seeker has to demonstrate the traumatization as judicial evidence. In addition he has to explicate the torture suffered and its consequences as a foundation for his fear of extradition. The solicitor is in the position to offer counsel on what evidence is vital to the procedure. The key to a successful course of appeal is to reconstruct the evidence from the start.

The IND dossier shows the provisional negative decision to be based on several facts, obtained in the 1st hearing: (a) A has no convincing papers documenting identity, manner and route of flight; (b) the allegation, that (false) identity papers were taken away by the travel agent, who left him at the Dutch airport, is discounted by pointing out that the refugee should have asked for on the spot protection by the Dutch police; (c) the argument, that he has never been in the possession of any other valid travel document is not believed. The proof of personal identity being unacceptable, further allegations in the 2d hearing are, by extrapolation, found improbable and insufficiently specified. The allegation that the scars result from mistreatment is considered unsupported. The escape from prison, facilitated by bribing the guarding officers, is equated with having been released from prison. In the definitive negative decision reference is made to news agency reports and dispatches, indicating that the president’s murder has been investigated and that the judicial inquiry is officially closed after a release of suspects from prison. As a consequence, the fear for a further detention is considered unsupported and is discarded as a consideration to be taken into account for the sake of non-refoulement.

Verification (Dutch ‘waarheidsvinding’) of the need for asylum is the client’s burden in the procedure. Each part of evidence is inspected very critically and meets many objections. The IND is reluctant to accept, from the mouth of an uninvited alien, oral proof of mistreatment and torture as evidence, and, both during interviewing and also on interpretation, makes every effort to sift, reduce and invalidate the informational content by connecting to other doubts or unproven statements. The victim can share his burden with few supportive instances. One possible source of assistance is the Refugee Council (VVN), whose workers have helpful contacts in the social network surrounding asylum; e.g. the Red Cross or UNHCR

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4 United Nations High Commissioner for Refugees; a specialized part of the United Nations, in charge of the executive tasks of treaties and conventions on refugee care.
representations in conflict areas. (van Willigen 1998) Relief workers can help sort out the information and seek written documentation from family, acquaintances or non-governmental organisations in the country of origin.

The attitudes of the VVN representatives and MOA caretakers contrasts with the IND approach but that is of no legal significance to the asylum. The confusing pattern of interaction between asylum seeker and asylum officials shows, that the structure of the 2d or later definite IND hearing is of paramount importance. During the interrogation the IND puts emphasis on relating the allegations to information about the actual conditions in the country of origin as reported in dispatches furnished by the Foreign Office (Dutch: Ambtsberichten). Asylum narratives are expected to provide matching evidence of a very detailed nature, factual and documentary, before being accepted as connecting the individual experience with the Dutch governmental interpretation of relevant international obligations with respect to providing protection. (Bruin 2001) The victim’s resources for self-determination in that process are lowest at the very moment that, as a client in the procedure, he is most vulnerable. (van Willigen 1992) In the critical issue of appeal a defence counsel is the last relief. Asylum counsel is available from specialized barristers, acquainted with the maze and shifts of rules, instructions, dispatches and precedence. Leading cases are reported and commented upon in the professional journals. On behalf of clients they collect information to challenge the IND decision. A recurrent problem is, that the IND provisions develop continuously and vary considerably over time as a reflection of intense political pressure to stop the subsumed flood of refugees. One defence counsel, consistently critical, accused the IND of hindering an unprejudiced and systematic assessment of truth in asylum narratives. (Bogaers 1998)

The asylum procedure prescribed by the Aliens Act (2001) is a process of extracting the required information, enumerated by an extensive IND internal handbook, and looking at the evidence obtained, in successive stages of verification. The time path and scenario is illustrated in Tables 1,2,4 and Fig.6. (Annexes) The successive queries, in two hearings, strive to find out, stepwise, what is a proven fact:

(a) Documentation stating identity, age, family, profession, escape route in the 1st hearing.

The IND takes a DNA-test or fingerprints and can solicit expertise on ethnicity, language (dialect test), age (for the under aged by a radiological estimate assessed by a physical anthropologist) and schooling; job qualifications; political activity and military service.
(b) The 2d hearing restates the previous findings and amplifies accounts that correlate with accessible sources on regional backgrounds, matching chronology, location, events, sexual or racial discrimination and related conflicts. Specific points of interest are suggested in the operative IND instructions, which also stipulate margins of reliability or imputability.

(c) Specification is required for all details of alleged incidents, officials involved, accusations, arrests, duration, location and layout of detention sites, injuries and connections with guards, travel agents or escape routes.

(d) Queries are directed at specific anti-governmental actions, such as political involvement in civil or military conflicts or in criminal offences.

(e) The next step is an opportunity for the asylum seeker to react to and correct the provisional decision with the help of a solicitor.

(f) Reactions and corrections can lead to an extension of the 2d hearing. The solicitor is always given a limited time to respond, that is then followed by the definitive decision.

(g) Under the Aliens Act operative since 2001 no appeal to the decision is possible except to the State Council (Dutch: Raad van State). This court will not reconsider the case for its evidence, but appraise the course of justice for errors; a process that is described as a marginal testing (Dutch: marginale toetsing).

(h) If an indication of mistrial is found, the IND is instructed to review and correct the decision accordingly. The representing lawyers act on behalf of asylum seeker in the further interactions with the IND officials and the judges in the process of appeal.

The intervention of AI occurs uses opportunities in the last of the steps (f,g,h). At that stage the relationships between client, interpreters, caretakers and solicitors are complex. The solicitor is the solitary guide that offers a liaison that can make the judicial course intelligible to the asylum seeker. Counsel is available from one personal solicitor for each client, but the arrangement is vulnerable due to time lapses, relocations of asylum centers and many ad hoc changes. The client is extremely dependent on the quality of the solicitor support and any error in timing is attributed to the client. (Bogaers 2001) The national parliamentary commissioner, or ombudsman, has each year acted on a stream of complaints pertaining to virtually every link in the asylum chain, by a series of critical recommendations. (Ombudsman 1999, 2001) Nonetheless, the persistent lining up of complaining asylum seekers
seekers, legal representatives, advocacies and caretakers, resorting to the impartiality of the ombudsman, spells out the frequent occurrences of flaws in the protracted procedure and the sentiment that the justice meted out is unreliable and unfair. (Ombudsman 2001)

AI asylum experts adjudicate on average 100-200 appeal cases annually for medical examination. Apart of accepting, adjudication can result in a refusal to take the case or a reverse query to the solicitor for more material in preparation to reassessment. Once that information is complete, a referral is made effective and the documents are handed to the secretariat of the MEG. (Table 4, Annexes) Screening and selection criteria are:

(a) The narrative has to reflect traumatization as exemplified in the human rights covenants, undersigned by the asylum country, and has to comply with the AI-mandate.  

(b) The requesting claimant has to be motivated for the purpose of an extensive and demanding new expert medical examination.

(c) The medical information, available and supported by attending physicians, can be considered adequate just as it is and cannot be improved by the MEG.

(d) The specific condition of the claimant is such that a medical examination can be considered impractical at this stage, for instance when the asylum seeker is admitted for psychiatric treatment and the re-examination risks a deterioration of psychiatric problems.

(e) The physician responsible must be convinced, that facts, circumstances and findings can be elicited and provided, that justify an interpretation contradicting the IND decision.

The refugee department performs the first part of screening and selection (a) and after an exchange of views, the MEG adjudicates the second part (b, c, d, e). The queries agreed upon with the solicitor can be categorized as:

(f) Is it probable that scars and complaints have their origin in torture, detention or other mistreatment in the country of origin, (and/or)

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5 The AI mandate on behalf of asylum seekers includes all who have been detained anywhere for their beliefs, color, ethnic origin, gender, religion, language, or sexual orientation, provided they have neither used nor advocated violence. For preventive purposes the mandate is extended to ‘non-refoulement’ of individuals, who, when forced to return to their country of origin, risk to be subjected to unfair trials, torture, execution or ‘disappearances’.
(g) To what extent is it possible to connect the present psychological and physical complaints to the events the refugee has gone through in the country of origin.

In the adjudication on the narrative of A the AI refugee expert and the MEG representative are satisfied that the claim is genuine and relevant to the prevailing conditions in the country of origin, as reported by reliable independent observers. Some doubts remain however. A’s solicitor’s request is supported because scars are present, that have not been described in sufficient detail and have not been accounted for in the course of justice. In addition the available medical records mention psychological problems, which as yet have not been examined and correlated with his narrative. It appears that more medical information is frequently readily available, but not included in the assessment by the IND.

The MEG-solicitor cooperation starts with a careful instruction about the purpose and role of AI, MEG and examiners. The essentiality of obtaining all relevant facts during medical examination is emphasized. During the interview, assisted by a knowledgeable interpreter, and caretakers if available, the examining physician will attempt to extract that narrative that is necessary to resolve the solicitor’s queries. It is important to prepare a premeditated route through the thicket of observations, emotions and interests in order to reconcile an appropriate respect for individual suffering, with a neutral and exhaustive re-exploration of consistent and verifiable facts, which should have led to a positive asylum decision in the first place.

The medical examination, as in this case, is a last resort when all other legal means have been tried and have failed to succeed. If the report can convince the judge of appeal, the target is met. A vital part of the premeditation consists of the collecting, sorting, re-assessing and linking of medical information that can be related to the solicitor’s queries. Documents of relevant medical complaints are, almost without exception, available but remain unconnected to the asylum dossier. The reasons behind the reluctance of physicians to share the burden or the responsibility of examining asylum clients and declaring on their findings for the purpose of the claim are manifold. One prevailing attitude in the asylum adversities is the overriding disinclination to be a referee to the acceptability of claims founded on the individual human and medical traumatization. Bloemen, physician staff member of Pharos, suggested that, at the root of these disinclinations lies the fact that ‘a good practice consent’ is lacking amongst professionals being in medical attendance (MOA, attending general or specialized practitioners, or medical advisers to the IND). Part of the reluctance is attributed to the
pressure of the number of asylum related medical claims. For instance in 1999 more than 3000 cases were put to the medical advisers of the IND for advice. In a typical Dutch proverbial expression, the IND advisory consultant stated: “the rising tides have to be put behind dikes, otherwise flooding is inescapable”. (Crommentuyn 1999) The IND medical advisers resist categorically to be enlisted as an instrument of verification of narrative. (Protocol Medische Advisering 2000). Other reasons for the medical professional reluctance are the perceived restrictions and requirements of a medical disciplinary nature and the lack of specialization, training and experience necessary. (Hoogenberk & Pastoors 2003)

A’s complaints have been examined in the Netherlands. The MOA medical journal describes, that A has stated (a) hearing problems, still being examined; (b) scars on leg and arm, resulting from ulcerations, unrelated to the alleged mistreatment; (c) scars, that are allegedly due to mistreatment, on head, hands and back, that have been described in detail and measured; (d) psychological problems, that have not been examined or related to the asylum claim. The MOA doctor advised a full medical examination by the MEG.

Several institutionalised Dutch refugee expertise and psychiatric centres (e.g. Pharos, de Vonk, Phoenix) have inpatient and outpatient services, which are specialized in the psychotraumatology of asylum seekers and refugees. They try to meet the need for clinical and outpatient care in this population, but are not available as a consultancy on behalf of the asylum clients, solicitors or the IND, because that task is judged to conflict with their therapeutic doctor-patient relationship. Consequently, the MEG is referred to by all medical professional organizations as the only agency for an independent medical diagnosis, where the dispersed medical documentation can be collected and assembled into an affidavit.

The strategy of the MEG is to promote a voluntary cooperation from every participant. Questions are invited and it is made clear that the report itself will be a document that can be questioned by the refugee and his solicitor.

The MEG cannot act as a forensic expert or as an invited witness in the procedure itself, because asylum instructions disallow any role for medical testimony in the truth finding. The affidavit is a document, produced on behalf of the asylum seeker. Its aim is to supply the client with an opportunity of stating his or her case, to have the traumatic consequences

Strategies of the MEG

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6 Pharos is a national provider, training and advising on patient care for refugees; de Vonk and Phoenix are supraregional clinical psychiatric centers for traumatized refugees. Several regional centers of mental health care (Instituten voor Geestelijke Gezondheidszorg, IGZ) have outreaching specialized teams to advise the MOA in asylum centers or other providers of psychiatric care on demand.
recorded, expecting, that, for once, the burden will not work against but in favour of an asylum solution. The input of the MEG expertise, being disallowed as direct evidence, has to be routed through the cumbersome means of an individual medical examination, by way of the solicitor’s appeal, to a court that can correct the negative decision on the asylum request. The targets and strategy of adjudications of the MEG are presented by Tables 3-4 in the Annexes. The client is offered space, time, translation, expertise and empathic listening, enabling him to state the narrative in the context of actual complaints, and to demonstrate the physical and mental consequences. The interpretation of complaint-causeality is discussed with the client. The complaints are assessed and scars are measured and sketched according to the Istanbul protocol, attempting to produce a professional codification of the result. Technical assays (e.g. imaging by photographic or radiographic means, laboratory tests) are utilized, if indicated, to illustrate and objectify medical findings. Prior medical findings and assays are not repeated, but, if relevant, the results are discussed and interpreted anew. To obtain the proper records, it is often necessary to correspond and exchange queries and/or findings with the attending physicians. The examining physician performs a routine medical and psychiatric history and examination in such manner that this can be extended into a post-traumatic-stress-disorder (PTSD) oriented interview if there are psychiatric signs.

A is unhappy about the medical attendance he receives. There have been no requests or referrals for psychiatric examination. Also, he has not received any help in getting through the feelings of loss and separation that are dominating his present life. Significantly, he admits that he does not know where his wife and child are. A admits to have taken no steps to find out. He fears that, if he does, he will attract negative attention in his country of origin and that he may affect their future adversely. He is often preoccupied by a sense of obligation, that, having been assisted by his family to escape, he should no longer be a threat to their safety. At other moments, he feels, that by his flight he has admitted to be guilty and that, as a consequence, he has closed the door for repatriation forever.

A careful medical translation and interpretation of the perceived justification of the narrative is crucial. The refugee is stimulated to retell his story as much as possible without interruptions. In the subsequent going over, due attention is paid to the veracity of the telling, the accidentality of events, the interpretation in the clients own frame of mind, the traumatic impact at that time, its development later on and its effects at the present time. A uses analgesic medication on demand, because of the earache in the right ear due to a chronic internal inflammation. The physical history, at this moment of examination, is dominated by
the chronic ear inflammation. From the history it is clear that related complaints have existed for a long time and have been treated also in the country of origin. The inflammatory signs have increased during his period in detention and the pain still causes much discomfort and loss of sleep. It is apparent that he has often requested attention for this problem and during the 2 past years of asylum proceedings it has been slow in deliverance.

From a comparison with his MOA dossier it is apparent that several factors have caused delays: (a) he has only been referred for specialist diagnosis after a course of antibiotic that had no effect; (b) the communication between ENT-specialist and patient has been wanting and the correspondence with the MOA taking months; (c) he has failed check ups, but was not aware of this because language problems have interfered; (d) he has been transferred between centres often, causing constant disruptions and rescheduling. A’s interview becomes difficult when he is asked if sexual harassment has occurred in detention and it perspires that he does not want to go into the details on that subject at the present time and setting i.e. in the presence of the male examiner and his female colleague, the translator and his accompanying friend.

The medical examiner is not to obtain results at any cost. The fact of having been tortured has to be perceived and related to the essential, that is the sharing of the burden of evidence. The shared purpose and the medical experience in, and the art of, taking histories, do afford the opportunity to turn the individual narrative into a window for introspection, remembrance and observation. Apart from contents the expert handling of the interpersonal contact, by eye and speech, between examiner, interpreter, and examinee imparts signs of relevance. Table 5 in Annexes gives a translation of the Dutch MEG protocol into an English version.

The MEG aims at collecting medical observations in order to state a professional opinion that contradicts the IND, where the relevance of the medical approach is contested. The AI protocol provides a conceptual structure to obtain a basis of evidence by means of taking the history, exploring previous (pre- and post-traumatic) coping styles, present functioning, psychiatric history and examination, physical examination and specific documentation of scars or physical consequences of mistreatment. A has a medical history of ear-infections, paracentesis and surgery for appendicitis. He is open and approachable on the account of the arrest, the conditions of detention, the unwarranted charges of being involved in de coup d’état, the ways he has been beaten up by the military servicemen, the military belts used to beat him up and the injuries received. His narrative matches the earlier independent
descriptions to the IND and the MOA. He gives a factual account of the extent, duration and healing of the wounds and he is also quite straightforward in considering that a thing of the past. A is asked prior to the physical examination to draw a schematic representation from memory, assisted by the Istanbul body maps, to locate the scars and describe the acts and conditions (secondary infection, treatment) that are likely to have had an influence on their present appearances. He has no difficulty in the attribution of scars to specific tortures and circumstances now being assisted by images and questions about their effects at the time and subsequently. The residual signs are mostly due to being hit frequently by the metal parts of military belts and shoes; symmetrical scars of burns by cigarettes on both hands and on his back; an irregular scar on his left hand due to a secondary inflammation, affecting the underlying tendon by way of deformations to a finger. The medical examination reveals no other signs except a surgical scar of an appendectomy. The medical correspondence is discussed. All findings are summarized and an affirmation obtained on that revision.

Permission is obtained for copies of the report to be available to the co-examining physician and archive for research purposes. Inviting comments on the translation and an evaluation of the investigation concludes the interview. The manner in which scars are described is extensive and detailed. A non-interpretational approach is used whenever possible: not “a number of almost circular scars caused by burns with cigarette ends” but “6 round atrophic areas with an average diameter of 7 millimetres, in 3 symmetrical locations on the outer surface of the right and left thighs”, is interpreted as ”that could correspond to scars caused by burns…in the narrative attributed to abuse with lighted cigarettes”. Whenever possible photographs are taken for reference and the locations marked on a body map.

The examiner interprets the narrative striving for impartiality and scientific objectivity in whatever way that is acceptable in the prevailing circumstances, by checks on consistency and rationality from a medical perspective. As a conclusion the examiner’s reply to the solicitor: (1) Is it probable that scars and complaints have their origin in torture, during detention, in the country of origin – is: Yes, it is probable that the scars, attributed by him to specific means of torture, are caused in that manner. His narrative is consistent with that explanation. No alternative causes can be demonstrated. The explanation is also consistent with several independent documentations and the published experience on similar acts of torture, showing his narrative to be consistent and reliable over time and in separate lines of questioning. (2) The reply to what extent is it possible to reduce his present psychological and physical complaints to the
events the refugee has gone through in the country of origin is: It has not become evident that all his present complaints can be reduced to the same events. No apparent psychiatric disturbance could be diagnosed with certainty. The difficulty to sleep, the sorrow and physical discomfort he feels for his losses is considered to be a normal response. His physical complaints are mostly due to a chronic inflammation of one ear. While it is certainly acceptable that the perception of that illness is aggravated by the traumatic events, it is not in itself to be considered as due to torture. It is further unfortunate that adequate treatment of the ear appears to have been delayed, due to factors, none of which he should be blamed for. It may be that feelings of shame are involved in the eventuality of disclosure of other possible causes of psychological suffering. It is also possible that he fears disclosure can harm him or affect persons in his country of origin. Nonetheless the examiners consider his narrative to be consistent, reliable and adequate for an unforced positive reply to both queries. A’s solicitor informed AI three months afterwards that his client had obtained an asylum permission for humanitarian reasons. In a medical perspective the reliability of interpretation hinges on those elements that led to the identification of patterns that render their significance recognizable. The interpersonal variations in nuances are accepted if they conform to an overall projection, shared between experienced professionals. Nonverbal signs and the possibility to share accompanying emotions are considered to be of paramount importance in the perception of illness behaviour. That immaterial reading or intuition is an element of medical investigation that is both inevitable but at the same time difficult to standardize.

The emotions intrinsic to the inhumanity of torture are inescapable, as part of a complicated setting, that nevertheless must produce an irreproachable diagnostic result. The dialogue routine of the MEG examination includes unambiguous questioning in all fields, which are related to infliction of torture and the circumstances in which it occurred. It is important to acquire an insight in the scenario of the torturer, the perceived explanations of the victim and other personalities involved. The chronology of the perpetrations of mistreatment; the frequency and setting, the effects, and the reactions of attendants and witnesses – all are illustrative of the torture remembered.

Even if not all material facts can be remembered in detail, the reviewing itself offers a window on the victim’s perspective, the extent of trauma and the dimensions of the fear for re-exposure. (Oomen, 2001) Signs of torture are only rarely obvious in a physical way. As a rule most lesions heal within weeks and leave non-specific scars or no visible scarring at all. So, reconstructing the traumatic sequence requires acumen beyond the normal expertise of
immigration officials. (Jacobs 2001). To ask a patient to give a demonstration of the cause of a severe trauma is uncomfortable to both, and can be unethical, harmful and even counter-productive, even in a therapeutic relationship. The only way out of this dilemma is to combine forces. The examiner has to convince the examinee to lie down on the Procrustes’ bed for the common purpose of verification. The medical interview cannot be an interrogation only, especially when working through an interpreter. The doctor assists the client in the production of evidence, and the patient assists the doctor in reaching a diagnosis, in any such way as is to their mutual advantage.

For a doctor to operate as a forensic fact finder, detached by ‘scientific’ disbelief, is anathema to attitudes considered appropriate in the professional communication with traumatized patients. As in any other medical interpretation the art and craft of finding essentiality is exercised. The comparison to precedents of similar trauma and circumstances, the outcome and experience of previous investigations, is useful expertise.

One important paradigm is the straightforward reduction of observations towards a satisfactory reply on the solicitor’s query, that is taken as the hypothesis to be (dis) proven by any scientific means at hand. This includes an explicit assessment of the accuracy, sensitivity and specificity of data obtained, and the transparency and reproducibility of interpretation. The required factual and detailed account of the consequences of torture covers those abnormalities and symptoms that can be ascertained and correlated to the detailing of events in the narrative. The inclusion of too personal or subjective interpretations is best avoided, if possible, as it will undermine the construction of credibility in court. (Vingerhoets; in AI, 2002) Whenever possible, drawings or photos are taken for reference, locations marked on an anatomical body map, and comparisons made to a digital sourcebook (MOG: Scarring from torture 2001; Oomen 2001)

Trust is the irreplaceable ingredient of the specific relationship necessary to generate a narrative acceptable as the truth.

Care is taken to avoid the disclosure of memories beyond the queries to be answered. Prior to finalizing the text the concept of the report is mailed to the client, to provide room for corrections and additions. This gesture emphasizes that the testimony contained is a product of cooperation between examiner and examinee. Finally, the solicitor is asked by the MEG for feedback on the results of the appeal procedures.
The protocol of investigation that is utilized by the MEG affords a means of intervision. An ordered, detailed and logical narrative is paramount, presenting the refugee experience without partiality, with due medical attention and empathy.

Only in such way will the report be considered as individualized medical documentary evidence of human rights transgressions. The group experience, case evaluations and literature study have resulted in a procedural base for the support of evidence. A combined social, psychiatric and somatic trajectory is considered to be essential. That approach cannot be a typical forensic one, not only because the MEG members lack the appropriate training and instrumental facilities, but also because a strictly physical examination would reduce scars to objects of proof in verification only. Such objectification is not within reach of medical investigation. It can be argued that in the prevailing conditions of truth-finding in the asylum procedures objectification is not a relevant issue. To make sense of the medical involvement on behalf of tortured refugees it can be argued, that what should be provided is an evidence, based on expertise of the context, combined with a focus on the social, political and medical aspects of the individual narrative from the human rights perspective, into one convincing report. The MEG has shown that the course of justice can be significantly altered by that application of the human rights perspective, even if admittedly that cannot always be so in every case. To make even more sense in this arena of contradictions it may be helpful to state a hypothesis that facilitates the medical anthropologist to effectively deconstruct the workings and consequences of torture in the procedures of asylum. Turner assumes that torture essentially turns trust into distrust: “It is no longer possible to assume that the world is a comfortable place. A process of radicalization may follow in which trust will be one of the first casualties. By talking in detail about the trauma story, there is the opportunity for emotional processing; by setting the events within a socio-political context, and the possibility of re-interpreting these experiences, of rewriting the trauma itself” (Turner, 1995: 69). This assumption helps to define the physician’s task in the rewriting of the trauma. Apparently, the fierce repression on trusting torture narratives demands an antidote of forbearance. In the arena of asylum, where trust toward the individual narrative is suppressed, a medical intermediate can be allowed to intervene, in an act as mediator that suffices to accept and return trust, both to the provider and also to the seeker of asylum.
Chapter IV. Review of literature

In search of a perspective

This chapter is a review based on the publications of several actors: investigators of torture victims, asylum authorities, advocates, caretakers of asylum seekers and medical examiners, giving explications and comments based on their personal or professional involvement. An enumeration of the literature is not a satisfactory way of extracting comprehension out of the many explanations of torture. Different perspectives and approaches have to be combined to find answers to the central question of this thesis. That is: how to assert the right of victims to tell their torture narrative, in the Dutch asylum procedure, to an understanding physician. The Dutch arena of asylum, at the present, is a suitable place and time to look for a comparison of perspectives, because differences in opinion abound and, by virtue of a variety in arguments, prevalent strategies are diverse and conflicting.

In the medical anthropological literature, the personal narrative links the medical and the anthropological points of view and connects reductionist and holistic models. The study of narrative contributes “finding out how people in different cultures and social groups explain the causes of ill health”. (Helman 2001:1) As Langellier writes (2001: 699): “Embedded in the lives of the ordinary, the marginalized, and the muted, the personal narrative responds to the disintegration of master narratives as people make sense of experience, claim identities, and ‘get a life’ by telling and writing their stories.” For making the comparison of sources productive, social science offers a methodology of relating rationalities. Mannheim and Weber, as referenced by van Amersfoort (2001; 14, 27) stated, that “institutions, confronted with new developments, tend to respond to the new situation by symbolic actions of relational rationality.” Weber showed, that standards of procedure contribute to orderly government in a rational relation to the new development, but they also foster a bureaucracy, which can become, as Mannheim called it, related but unwanted irrationality. Understanding (ir) rational institutions is important to find a unifying perspective on (1) torture consequences for individual asylum seekers, and (2) the assessment of narratives by means of medical examinations. (Jacobs 2001)

As my review will try to show, all actors, notwithstanding their difference in position as victims, authorities or examiners, adhere, for the purpose of finding evidence in the torture narrative, to rationalities that appear compatible with the Weber-Mannheim dictum. In the confrontation with new developments, characteristic of the asylum arena, accusations between the actors point at the irrationalities of procedural standards in the other. Harassed by that conflict, confusion and contradiction, my review cannot group the accusations together into a
single level of comparison. Looking for solution in the review of literature, I found the multi-
level perspective a helpful construction. (van der Geest et al. 1990, DeWalt 1985) The 
metaphor of levels in organization facilitates to sort out vertical linkages, from macro to 
micro, and horizontal links, where acts and actors conflict with each other. Linkage can 
connect concepts, information, words and institutions. The application of a multi-level 
perspective reveals that meaning changes, when links are examined upward or downward.
For my purpose, moving from macro to micro in the master narrative, the levels will be, from 
top to bottom, (a) the (inter) national, (non) governmental, (b) the local, community, asylum 
centre and advocacy organisation and (c) the asylum seeker, the examining doctor and also 
the supporting actors, that play a role in personal interactions.

A framework for comparison
First I will compare relevant anthropological, political and human rights sources, defining 
torture in the claim for asylum and searching for context in the Dutch asylum conditions 
concerning the traumatized and the position of the actors. Secondly I will review the medical 
examiner’s role in giving an independent expert opinion on the narrative of tortured clients, 
whose asylum claim has been denied. The review tries to consider the consequences of 
asylum strategies also. In the arena are Dutch cultural scenes. A case vignette will be used to 
set the stage.

Within the constraints of this review, I did not find room, other than covertly referring 
to their existence, to encompass cultural comparisons, for instance to those of the country of 
origin of asylum seekers. This medical anthropological review limits itself to the conflict at 
home between social groups in a Dutch variety of a European culture. In the discussion I will 
defend the choice of sources, and in the conclusion gather the main points of practical value 
for application to doctors examining asylum seekers.

Above the local community stands the International Covenant (1966) that ruled: “No 
one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”. 
This reference defines the meaning of the term that is central in this review, positioning 
freedom from torture as a priority. Torture can appear in many connotations, historical in 
societies not outlawing physical coercion, or voluntary as in physical (self-) punishment in 
cultural (ritual, tribal scarring), religious (flagellation) or sexual (sadism, masochism) 
gratification. In my discourse any cultural ambivalence or (non) acceptance of violence is not 
an issue, because it is safe to state without too detailed reference or exploration, that the 
Dutch culturally adhere to the conventions that guarantee freedom from torture both at home

29 Torture Narratives
or anywhere else. A firm intention exists to apply a full, unrestricted non-refoulement guarantee, meaning that no one will be extradited to a country of origin, if threat of torture can be demonstrated. (Justitie 2003) Local governmental policies subscribe to the manifold definitions, actions, declarations and treaties, aiming at the abolition of torture practices. The cultural opposition against torture and organized violence is strong and internalised to the extent that taking an alternative view would cause a public outcry.

Condoning and abetting torture by Dutch civilians and organizations, even if occurring outside the state boundary, is a crime to be persecuted. The law will be enforced on non-Dutch persons if in reach of Dutch justice. At this level expectations are established, which the medical examiner, collecting asylum narrative evidence, must satisfy. At the community level, the scene is set by the fact, that the Dutch consider persons, who have been tortured, to suffer from a self-evident trauma, that affects their health profoundly. (van der Veer 1998) Van der Veer specialized on that posttraumatic issue and is an expert quoted worldwide. He claimed, that if one has read one victim’s story, one has in fact read them all. In the context of an affluent Western democracy, two paramount goals remain to be achieved: the abolition and prevention of cruelty and degradation, and the realization and perfection of Self. (Ramdas 1996, 184) As torture is a violation of both emblematic aspirations, one can understand the public revulsion of the act as if it was a final common pathway of evil. Further commonplace is the assumption that feelings of shame, guilt and culturally imposed taboos contribute to keeping the victims silent. Important and relevant in the issue of torture, both in clinical medicine and in medical anthropology, is the observation that “a feature of externalising explanations is, that they take the form of a narrative.” (Tankink 2000) Telling the story is a way of giving meaning to the torture experience and placing that trauma in the context of the individual’s life history, additionally relating the narrative to wider themes in the society in which the victim must make a life. A narrative is thus a basic strategy, organizing an experience, especially a traumatic one, and making sense and giving meaning. (Helman 2001; 95-98; Greenhalgh 1999; van Dongen 2002) These are the incomputables, that medical anthropology seeks to link: the human right on freedom of torture, the silence of victims, their narrative that would give suffering meaning and the certainty, that they will not be delivered to torture again.

A basic issue is the medical examiners role of obtaining and interpreting the narrative on the request of both victim, solicitor and the defenders of the right on asylum. The review starts by introducing a case vignette and develops the questions, derived from the central query: how to assert the right of victims to tell their torture narrative. What is the focus of the narrative? Are the narratives of torture strategically shaped by the foresight of possible
refoulement? Play cultural differences between actors a role? Can the silence of victims transform into communication in the setting of a medical examination? What medical examinations are to be expected and what is the state-of-the-art on narrative interpretation in the claim for asylum?

**A case vignette**

For a start one narrative, taking place in the arena of the asylum organization, seems the best way to link the micro- with the macro-level (Case 25, p. 84).

'It relates the experiences of Aisha [not her real name] as told during the AI medical examination 11 months after her asylum request. The narrative starts when the victim was a 14-year-old girl in Africa and her father was murdered by rebels, while he was trying to defend her. She was abducted and raped by the perpetrators, whose chief took her as his ‘sex slave wife’ into the bush. Having been a schoolgirl and virgin, when this happened, she became pregnant and gave birth to her first child, a girl. After 3 years of an intense violent character, the killing of ‘her chief’ in battle and a reverse of the political conditions, she was able to leave the bush. She returned to her village, where she was rejected by the neighbours because of being tarnished by her stay in the rebel camp. The one family member left alive was a stepmother, who was a fanatic in a powerful national society, proclaiming female circumcision. Aisha herself had been circumcised as a girl of 12 and hated the custom. A younger sister had died in the same ritual, due to a complicating infection. The narrative now arrives at Aisha’s reasons to escape her country of origin. She was 17 when her stepmother took away Aisha’s daughter for the purpose of circumcision. Aisha responded by burning down the huts in which the ceremony was to be held and ran away, seeking temporary safety in a Red Cross refugee camp. Here she told her story to a Western refugee worker, who advised her to leave the country and helped her to board a ship. She was in hiding during the passage that ended in a Dutch harbour, where she went to see the police to seek asylum. She was transferred to an immigration center where she got a first hearing (establishing identity, route of flight). That hearing was within 48 hours followed by the definite hearing (reasons for asylum) and the provisional decision, refusing the request because (a) she could not show identity (travel papers or boarding ticket) and insufficient indication for asylum, argued as (b) her fear of being returned to home was rejected, by virtue of the fact, that the cause, a conflict on her daughters circumcision, was of a relational character (a family matter) and the setting fire a common crime (mischief). In addition the Dutch Foreign Office Dispatches had declared, that parts of her country of origin were safe to return to in case of extradition. The provisional decision was appealed to by her solicitor; stipulating that she had not yet
explicated for the purpose of asylum (c) the violent loss of her father and the trauma of rape and abduction in sex slavery. In reply the IND refused that for consideration, because in her own allegations the attempt to escape had not been occasioned by that fact. Additionally, if she would have explicated that trauma, its occurrence was too long ago to comply with the prescribed trauma-request interval as stated in the IND-instructions. A definite negative decision was handed to her. The solicitor appealed again, now to the Court, requesting a provision for her to stay for humanitarian reason, arguing that the IND had inadequately examined her reasons for the asylum request, but this protest was turned down, the Courts arguments being in support of the IND decision, in that the prevailing IND instructions had been executed. Within 4 weeks of her asylum request Aisha was ousted from procedure and put on the street, after being told to return to her own country. The Refugee Council, a volunteer agency, remained in contact however, and provided temporary shelter for a short period. After that she ‘became an illegal’ and was taken in by fellow-victims. In return for that favour she had a brief sexual affair with one of them. Shortly after she moved elsewhere again and 6 weeks later she found herself pregnant. The contact with the presumed father of the baby was lost and she turned for help again to the Refugee Council volunteer, who tried to assist her in obtaining an abortion on a social indication. She was then, for the first time since arriving in the Netherlands, medically examined, and declared healthy. Delays and a misunderstanding on the duration of the pregnancy impeded the abortion to be effected. As an expecting mother, she now qualified for renewal of shelter in an immigration centre. She delivered a healthy baby girl, 10 months after having set foot on Dutch soil. The refugee worker assisted her in a renewal of contact with her solicitor and a request to the refugee department of AI, in order to claim asylum for herself and her baby, because she feared that extradition would expose her daughter to circumcision in the country of origin. After due procedure, AI complied with that and requested a medical report to find supportive evidence for her fear of extradition. This brought Aisha and her baby in the doctor’s room to relate her narrative during a medical examination. Nine months later her solicitor confirmed to AI that she obtained an asylum permission.

The narrative continues, but, at this stage, the role, that the history of torture and the asylum request plays can be put forward as defining her life, and a vivid example of the medical anthropologist’s view that “the basic cultural belief that life is a project, which can be controlled and modelled by human beings, is affected by the discrepancies between the power of people and power of culture as human construction.”(van Dongen 2002; 134)
The master narrative

As stated in the introduction, the Dutch situation is taken as the starting point of perspectives. A claim on asylum to be based on the evidence of torture and organized violence can be a motive of medical intervention. The request to perform a medical examination can come from the government, asylum authority, the advocacy, the attending medical services, and lastly, directly or indirectly, from persons on behalf of, or the refugees themselves. That last source of requests is a scarcity. The literature requires a diligent search for finding consensus on the perspective of medical intervention between these different actors. European governments are struggling to support the ban on torture elsewhere, e.g. in Africa, South America and Asia. It appears that the warriors for human rights are bound hand and foot by the limitations, increasingly put on the consequence; i.e. the offer of asylum as protection. Anthropological researchers point at “a marked discrepancy between impressive legislation incorporating internationally accepted human rights versus the denial of asylum to obvious victims of persecution and torture” (Baker 1998) The approach to asylum claims is “entirely judicial, concentrating on extraction of facts, that are indisputable. Its portrayal of mankind is homogenous and laws are assumed to be universal”. (Twint 1990)

The focus of the master narrative moves from the acceptance of the human right principle, to the legislation in asylum procedures how to activate the principle, and to the transformation of personal narrative into indisputable jurisprudential claim. This is not a local Dutch shortsightedness, as Freeman (2002) convincingly argued in a discussion on human rights as a key concept in transactional policies. In most governments the principle is an ideal, but the practice is limited by the cost of implementation. Practicing human rights is mainly dependent on pressure from both international and local democratic, religious or non-governmental associations. The application of human rights goes through several phases of (non) acceptance: repression denial, tactical concessions, negotiated limitations, careful legitimation and, finally, institutionalisation (Freeman 2002: 135) A constriction of human rights and the right on asylum are linked. (Care 2002)

Dutch attitudes on asylum are eloquently portrayed as ‘economical and grumpy’ by van Goudoever (1997), a political analyst of international renown. Whereas the Government defines the asylum policy as ‘tough but fair’, he demonstrated, that during five decades the Netherlands have pursued a practice that he characterizes as “broad, selective, optional, hypothetical and full of paradoxes”. (van Goudoever 1997: 63)

Governmental reasoning is guided by “the consideration, that the grant of asylum may place unduly heavy burdens on certain countries.” The statist policy is particular in its
affirmation that asylum is not available for anyone by right, but a favour, indicated for individual cases. Van Goudoever recounts this master narrative over the past decades, pointing out that Willem Drees Senior can be seen as an opinionated founder of the Dutch asylum system. This highly esteemed statesman is the father of the Dutch welfare state.

The author concludes, that Drees, from 1950 onwards, initiated a train of national policy that opposed hospitality towards uninvited refugees. Reason was a fear, that masses of refugees would cause overpopulation of the country and play havoc with welfare institutions. (van Goudoever 1997: 65-66) Significantly, in each negative decision the asylum seeker meets that specific territorial consideration: “the Netherlands are a small country etc.”

The Thomas’ (1928) theorem says: “If men define situations as real, they are real in their consequences.” The perceived threat of overpopulation being equal to loss of welfare and resulting from uninvited immigration, explains adherence to human rights on the one hand, and the economical application of asylum on the other hand. Van Goudoever argued, that, striving for a safe settlement of that fear, asylum can be offered to individual refugees only, if they can contribute to Dutch society. A contributing individual is well educated, will not be a burden to health services or other welfare provisions, and can be employed and integrated as a valuable citizen in a welfare society. Van Goudoever’s analysis of recent social history was published in a respected journal, linked to the Foreign Office and plots the overall narrative of the asylum spectacle, staged in the arena of Dutch society during the past fifty years.

Hesitancy due to fear is one source of conflict, appeased by lip service to human rights: “talking for the sake of reassurance” (van Goudoever in Dutch: “een praatje voor de vaak”). Medical anthropology is a craft that is interested in plotting worry and fear as powers in social hegemony and agencies that can cause social conflict and raise health issues. (van der Geest and Rienks 1998) The worry-fear complex, as an agent acting on cognitive, emotional, physical and social uneasiness, calls for appeasement. Fear is an emotion that combines rationality and irrationality. Controlling fear is basic in the practice of medicine and in the medical service to society. (Nichter 2003) The asylophobia raises in proportion to the flood of asylum seekers sapping the dikes that defend the welfare nation. Granting asylum can be perceived a dangerous gift: a risk and a worry.

This review will amplify on the importance of that worry, or asylophobia, to make sense of the (non) acceptance of the torture narrative in the context of society. The level of perspective, that concerns the negotiation of asylum in the public arena, is where advocacies confront the immigration authority. The struggle can be visualized as watched over and
commented upon by the community. As to be expected from links to the conventional national interpretation of asylum, the community wants the procedure to be controllable, individual, careful and thorough. Unfortunately, any such procedure is time consuming. If cases have to be processed individually, and unexpected increases of immigration volumes occur, careful procedures will cause arrears that are unpalatable. Asylum must then be granted to unburden the immigration institutions and to pacify the community admonished by advocacies and human right institutions. Equality is undermined because asylum becomes a matter of chance and waiting it out in the crowded temporary shelters, that are a sore sight in the welfare landscape.

In the past decade, asylum proceedings in repelling or removing unwanted immigrants have become prolonged and unsuccessful beyond endurance. The presumed shortsightedness and incompetence of immigration officials causes waves of opposition as more irrationalities become apparent all the time. The extradition of rejected persons fails and communities are burdened with illegals, which are at one time appreciated as refugees with a right to be, then again as an uncontrollable bother to welfare. (Human-Rights-Watch 2004) Rejection leads to harrowing cases (Dutch: schrijnende gevallen), shocking society to such extent that hurried interventions are inevitable. “Why do the asylum procedures fail to proceed according to intentions? The reason is a paradox: Dutch society does not intend the refusal of asylum to cause harrowing cases”. (Van Amersfoort 2001; 22) The renewed intention of the Aliens Act (2002) to aim at a 48 hours interval between request and refusal is one obvious choice for criticism. The promise of a shorter procedure feeds expectations that arrears will disappear, but inconsistencies in the provisions derail that design. Resolute governance is unenforceable and compels authorities to hurried acts of sharpening procedures, without inquiring the real significance. In the arena of asylum, relational rationality has led to an approach that is bureaucratic, symbolic, emotional, irrational and irrelevant to ordering society. Irrelevant because it increases the conflicts instead of contributing to the solutions.

The medical input
As the observed behaviour of officials, advocacies and medical professionals reveal, the paradoxical intentions have direct links to the official standpoint on medical narratives in the claim for asylum. A medical procedure that contributes to an acceptable solution of asylum regulations requires consensus. Essentially, if tortured, the claimant has a genuine reason and will have to be accepted. Admitting that, the former IND director, Nawijn, described the official attitude towards traumatisation as ”offering opportunity for narrative. If medical
complaints are mentioned, or documents put forward regarding mistreatment and torture, this will be indication to invoke the Bureau of Medical Advisers of the Ministry (BMA), to contact medical caretakers (Medical Services: MOA) of the asylum centre.”

AI observed that this policy is not implemented in the IND practice. (Amnesty 1990) It is not in the IND instructions; neither is any implementation apparent in the many dossiers, which are documented by independent advocacies, including AI, in the past three decades. In the first place, the time interval between request, decision and appeal cannot afford the means to realise a medical documentation of torture. Secondly, IND instructions do advise to act upon narrative or sign of organized violence by not requesting medical expertise. The BMA, as will be shown, refuses categorically to be involved. Finally, it is never the victim’s experience, that the narratives are met with any such medical consideration. Torture is approached as that very matter out of place, unverifiable by virtue of the prejudice of opinionated consideration. The governmental strategy is unable “to avoid the tragic conflation and confusion of humanitarian and political solutions”. (Cohen 1998)

Both IND and BMA have consistently defended the denial of medical intervention by statements emphasizing that ”on the basis of medical examination, firm pronouncements cannot be made as to the cause of complaints or scars.” (Crommentuyn 1999; Vreemdelingen-circulaire 2002) Amnesty’s legal pundit Bruin (2002) has suggested, “the true reason for the denial of medical examination is the political anxiety, that asylum will be medicalized. In other words, that the examination on the veracity of asylum claims by medical methods is elaborate, time consuming and risks a considerable medicalization of procedures”. The exact meaning of medicalized, in this context, can be understood as ”alleging that the medical condition is a pressing reason for stay”. (Vrijsen 2000) The presumption of medicalization is confusing, considering the circumstances prior to the asylum request. Persons, who can run away, do not have medical conditions, which are itself reason for asylum, because any serious illness would factually prevent the escape due to the hardships of the flight itself.

In practice, as we have seen, the IND instructions interdict medical examination for the purpose of the verification of the claim, but allow medical professionals to intervene if the asylum seekers’ mental and physical condition is unfit for being interrogated. If illness is a matter of importance and contention at the first hearing, the fact would be a matter of record. Taking the same argument further, many traumatised claimants are referred, by the MOA, for medical, often psychiatric, consequences of traumatisation due to torture. The referral itself is

7 In general, medicalization is viewed as a process by which medicine asserts inappropriate authority over a sphere of life.
also on record in the asylum dossier. Moreover, it is also widely known, that attending physicians complain frequently that they cannot treat trauma-related complaints, if the patient is insecure while the asylum claim is denied. Thus, advocacy experts submit, “the attitude of denial generates secondary trauma and medicalization as a result; it is not a cause of the increasing number of medical claims in asylum requests”. (Hoogenberk and Pastoors 2003)

Compromising to the critics in advocacies and in the medical profession, and to stem the tide of claims based on trauma, the IND has belatedly redefined causes that meet the qualification of a trauma narrative. (Justitie 2002; TBV 2001/2) The renewed instructions state that non-refoulement can be offered to asylum seekers “that are traumatised by events that they have been victim of in the country of origin; while the government of that country offers them no protection against; and if that fact occasioned them to flee the country of origin. They have to make that claim plausible during interrogation. The nature of the traumatic events has to conform with the 1st and one or more of the following stipulations: (1) they occurred within 6 months of the moment they left the country; (2) consisted of the violent death of close family members, friends and relatives; (3) substantial detention without penal cause; (4) torture, mistreatment or rape; (5) having witnessed torture, mistreatment or rape of close relatives.” (TBV 2001/2) However, instructions, that offer detailed criteria about traumatization, are not instructions, that detail the assessment of trauma-related complaints. Neither do the new instructions deliver the means to implement a verification of the causes of trauma-related complaints. The instructions remain adamant, that any intent to measure the narrative by way of calling for medical evidence is beyond the scope of the IND official.

To some, the issue of medicalization seems close to the anthropological construct of ‘hidden transcripts’: weapons of the defenceless. (Scott 1990) Are the narratives of torture strategically shaped by the foresight of possible refoulement? The IND worries on this issue are manifest in their medical advisers’ resistance to be enlisted as an instrument of verification of narrative. (Protocol Medische Advisering 2000) A double contradiction is, that, at the other hand, the medical examiners of AI are invoked for a reliable expertise, while adding that such medical reports have to be presented to the BMA to ”prevent the IND to draw unjustified conclusions.” (Crommentuyn 1999, Justitie 2002)

Clearly, the IND feels in one way able and responsible for interpretation of medical motives in the narrative, but is at the same time unwilling to verify that motive on their own. The medical input of the attending physicians, who are part of the asylum habitat (MOA), is minute in this respect. They are asked for advice only regarding the medical condition, that their client is in, to see if (s) he can participate in the hearing or for circumstances that
necessitate medical attention in the Netherlands. It is certain, that a medical dossier contains a
description of complaints in relationship to violence even if the details may vary in depth. The
question what an attending doctor should do with that report in the context of the claim is
unsolved. If asylum claims are accepted, the reasons behind that decision remain undisclosed.
That gap is significant, as I will show, because the international medical community offers
unequivocal instructions. It suffices to say, for the sake of argument, that the IND has the
required medical information available, at the same time denying using it.

**The personal narrative**

The first account personal narrative largely remains outside the public arena, disclosed to a
small group of medical professionals only. As actors, the medical professionals occupy
themselves informally with the acts of denial, acting as translators and interpreters to the
advocates and judges concerned. The vignette of Aisha illustrates, that essentially only at this
level an individual narrative of torture is voiced and interpreted as a significant part of the
claim for asylum. The experiential worlds of the conflicting parties are vastly separated, as is
illustrated by an asylum seeker, Abdulrahman, who wrote a diary, published by a Dutch daily:
“it is a pitfall, that I had entered of my own free choice. From the very beginning, the
interviewer, for reasons unknown, appeared to find my narrative utterly lacking in credibility
and interest, showing that by interrupts as ‘up till now you haven’t brought anything, that
could justify your asylum claim’ or similar remarks”. (Bruin 2001) The process of distrust is
most emphatic in its approach to traumata. To substantiate the claim, “a credible and
consistent account of all motivations is to be given, eventual contradictory explanations will
be objected to”. Decisions on asylum hinge on this instruction, during the definite hearing, but
also in the judicial follow up. The narrative should produce no contradictions in geography,
chronology and synchronicity of events, which can be checked in the dispatches produced by
the Foreign Office. The same precision is required for describing the trauma, in order to fit it
in with other events in the narrative.

In the sequential turns of the screw to an increasingly and precisely directed tightening,
torture can only be accepted by a court of appeal as a motivation for asylum, if assessed by
the AI medical examiner, and if the medical advisers of the IND find their report reliable. But,
when, in the context described, can that medical report be reliable in court? The victim is the
only witness available for examination. Independent observation of facts and circumstances,
that link the complaints presented, and scars observed, to their causes, is difficult or not at all
feasible. The site and circumstances, pertaining to the torture are far removed from the moment of examination. The flight away from the executioner is difficult to combine with obtaining documentation from the authority that the refugee is fleeing from. The reductionist medical approach to the forensic fact of having been tortured is in many ways illusory. The medical concept of post-traumatic shock and stress corresponds to a physical and mental condition of the victim, that interferes with the ability to produce an uncoloured exposition of the actual facts. Uncoloured can be explicitated as independent of feeling. The client’s memory is impaired; dissociation and repression is a setback on the reproduction of facts. Mutual distrust and unease in the conditions of interrogation and cross-examination is likely and understandable. In many cases the recollection of trauma is traumatic itself and its elicitation can be considered to be unethical, if the advantage for therapeutic purpose is not a pressing indication. So, at the end of the line, the medical interpretation of late posttraumatic response can be the only evidence to a genuine cause for asylum. However, it is not easily rationalized by its own standards of evidence. (Turner 1995)

The medical standard

The MEG examiner’s role is not that of a therapist, but that of an independent advocacy expert. “It is the doctors job to document, not to believe or disbelieve”. (Amnesty 1999: 11) Procedural examination and standards of evidence have been constructed and agreed upon by the international medical community, but the practical problems persist. In the prevailing asylum setting, the doctor cannot promise or produce anything, but a honest and complete evaluation of the actual medical history, supported by observations collected by a mental and physical examination, performed months or years after the trauma is incurred. (Istanbul Protocol, Peel and Iacopino 2002)

What roles do doctors play on hearing the full story? As medical observers, their concern is the immediate personal mental and physical condition of the asylum seekers, in relation to the alleged trauma. Firstly, on the frequency of mental and physical scars: “There are symptoms identifiable after different forms of organized violence, more correctly termed behavioural reactions, affecting most of torture victims”. Secondly, on the official failure in appreciation: “to convince authorities is a process of intense stress”. (Baker 1998) “Doctors should therefore pay attention to record any injuries, they find in a person seeking asylum, and, if the possibility of abuses of human rights comes to their attention, they have an ethical duty to
One purpose of the narrative of torture is, that doctors, being so informed, cooperate in making it a public issue. To be able to do that, they need to listen to the narrative and to make their pronouncements to be flawless. The core of the complaint is “the fear for persecution”. (Twint 1990) The medical standard of notification is not in doubt. In a report, recently commissioned and published on behalf of the Dutch Ministry of Justice, “the inevitable conclusion is, that medical evidence can play an important role in the ascertainment of the actual threat of inhuman treatment (refoulement). This puts the duty to perform medical examinations on the government; particularly so if they contend the evidence that is put forward by claimants.” (van den Bosch et al 2002, Commissie Smeets 2004) It is beyond doubt, that advocacy groups in the Refugee Conventions emphasize the same position (Nederland-AI-Bestuur 2003, Bruin and Wouters 2001)

The contest between principles (medical examination can vs. cannot contribute) is in a seesaw movement, both with respect to procedural content, but also in its development over time. This again causes the medicalization issue to add to a process of delay, postponement and indecision. The delays in processing asylum claims have in the past decade become one of the main occupations of the independent parliamentary commissioner (ombudsman), because they produce one third of all complaints received. In the appeal cases the course of justice takes turns and twists, that show, that individual Dutch judges often disagree with the official procedural result. The courts seem to concur with the theory of human right principles by including medical expertise into its testimonial evidence. (van den Bosch et al 2002) A salient point is the fact, that the IND does not, as a rule, take it that the judicial verdicts are to be executed per se. The ombudsman reaction was that: ”a fundamental rule of our democratic state is at stake”. (Ombudsman Annual Reports 2000-2002)

What then is the opportunity for medical documentation if the official immigration policy states there is none: ‘medical examination cannot contribute to verification’. (Geurts in: Bruin 2001) Comparing that policy closely with its effect on cases studied by AI, it can be shown to be a sequential trap of tightening restrictions, that reduce opportunity for medical documentation to a trickle of exceptions: (1) complaints or scars, can, in principle, not be attributed to torture in the country of origin, because certainty cannot be obtained as to causality; (2) medical expertise from attending physicians, cannot, in principle, be admitted as
evidence because of partiality and as breach of confidentiality of medical information; (3) independent medical expertise is not directly available to the asylum seeker, if not obtained by the solicitor; (4) the solicitor investigates this possibility, if it can be introduced as new evidence only (nova); (5) if introduced in an appeal case, the IND will remonstrate, that it should have been presented at first opportunity in the hearing, and is no longer admissible; (6) the judge of appeal may decide, by marginal testing, on the basis of all arguments, including the medical report, that the IND has not followed their instructions or properly investigated the medical aspect; (7) if the IND accepts, re-examination and revision of their decision follows. Judgment through the needle’s eye is the IND standard for the medical interpretation.

In search of interpretation

The instruction by the asylum authority in hearing the allegations in a torture narrative can be summarized as distrustful, to the point of not taking evidence into consideration. The evidence is anticipated to be tainted, due to lack of reproducible fact, or by virtue of secondary medicalization, or because of the link to the assumption, that expert examination will take too much time and effort. The task of the medical examiner can be defined as falsifying that thesis, by producing reports that contradict, with the assistance of the solicitor, the arguments in the negative decision, in an appeal procedure, that is medically feasible, sound and respectable. Both tasks can be understood as rationally linked, because the report of the medical examiners has to meet the critical approval of the asylum authority and vice versa.

Faith of the asylum authority in the medical interpretation is the paramount prerequisite. Training, routine, and evaluation of the results in beating the system of asylum adjudication bring about respectability and make the medical report a support of verification. (Greenhalgh 1999) My review sketched the context of that medical exercise. I chose to emphasize the governmental fear and worry, facing loss of state welfare, as a dominant motive of asylophobia in the grand narrative. That fear appears to be linked to the rationalization of restrictive procedures, producing an economizing on the admissibility of testimony. On the level of community involvement the procedures are linked to bureaucracies that are no longer appreciated as rational by the public, nor by the affected asylum seekers and their advocates. The medical profession plays a role that is linked to dealing with the denial that ensues, if the politicians cannot make up their minds. In particular the genuine claim of torture victims, deserving protection, is disposed of by suppression and medicalization. The attempted
elimination of the asylum seeker from the public space is a striking feature and it is markedly unsuccessful.

The Dutch medical profession, by keeping silent about the dilemmas of the asylum procedure, does not respond in an appropriate fashion. Reporting on the late consequences of torture is a prime example of narrative based medicine, “upholding the importance of clinical expertise and judgment, an interpretative act, which draws on narrative skills, integrating the overlapping stories told by patients, clinicians and [other documentary] results to reach clinical judgment.“ This quote qualifies the expertise necessary for the medical examination in the context of asylum, the patient being the text to read and interpret. (Greenhalgh 1999) The related interpretational expertise cannot strive for forensic verification, as there are no first hand observations or incontestable tests available of the tortures that occurred far and away. The recognition of truth has to come out of the diagnostic encounter with the traumatized person (Frey in: Peel 2002) To direct recognition towards that focus of truth, the conclusions should concentrate on the eventual consequences of refoulement also.8

Siegfried (2001) tested the minimal standards, laid down by the laws on refoulement, on the Dutch and Swiss procedures, and concluded, “The Dutch Asylum Centre procedure does not offer sufficient guarantee on the non-refoulement issue. It is a frequently heard complaint that in European countries an unduly big burden of proof is often imposed on the applicants as a discouraging practice intended to reduce their number.” An irrational bureaucracy is constructed "inclined to judge the merits of a request only in order to show that it is abusive or unfounded.” (Swart 1988) What medical approach is appropriate to redress the excess of distrust and enable the Dutch asylum procedure to decide between founded and unfounded fear for persecution? I have tried, by comparing differing authors and retracing their thinking in different perspectives, to demonstrate links that enable the construction of judgment as a result of mutual trust.

“Fear is a mental condition and to consider fear founded is a matter of judgment”. (Twint 1990) “The search for an objective golden standard in judgment is a flight from interpretation, that is doomed to fail”. (Leder 1990) That state of mind is presented by a recent report of the Dutch state committee, which rejected the standpoint “that medical

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8 Article 3 of the Convention against Torture declares that “No state party shall expel, return (refouler) or extradite a person to another state where there are substantial grounds for believing that he [or she] would be in danger of being subjected to torture. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence of the state concerned of a consistent pattern of gross, flagrant or mass violations of human rights.”
information cannot contribute to the verification procedure in asylum.” (Commissie Smeets 2004) The argument given is that: “the fact that medical information cannot be 100% conclusive detracts nothing from the significance as supporting evidence. To renounce on medical examinatory procedures has to be viewed as convenient rather than principled. It is an inconsistency to put the burden of proof on the shoulders of the asylum seeker while discarding medical information, relevant to verification, in the narrative. The relevancy of the medical findings to the narrative is a point of departure of international consensus”. 9 To assess and verify the trauma, if indicated, by medical expertise, also means a timely start with treatment; and additionally it facilitates an insight on what medical problems are due to the events in the country of origin and what problems originated during the stay in the Netherlands.”

In conclusion medical anthropology offers a contextual interpretation that can help restoring faith in society towards the narrative of torture. The literature reviewed shows, that the narrative is a focal act in the grant of asylum. The applicable medical approach emerges as an intervention to solve the discrepancies that are generated by denial. The existence of torture is a severe social evil that causes a profound individual illness of traumatization. The restrictions of asylum increase the individual burden and contradict the deeply felt appreciation of a human right of freedom of torture. The escape from the country, that is the source of torture, is only one step towards a remedy. The burden of torture requires further redress, at least by the application of asylum. To silence the narrative amplifies the silence of the victim. The absence of empowerment to the victim of torture is all too obvious in the insularity of asylum housing, the adverse circumstances of hearing the evidence and the uncontrollable elapse of time waiting for the verdict on extradition or not. All of that adds to conditions that invalidate the meaning of the personal suffering and detract from it being an acceptable expectation of finding a cure. If, on top of the adverse conditions, the illness of traumatization is being considered unverifiable, the very fact causes further worsening of the trauma to become insupportable as a stigma of social injustice, unbearable for the individual victim.

The denial present in such adverse conditions forces the tactical use of traumatization as a last resort. The victim’s suppressed narrative halts at a crossroads, leading from silence to extradition, or disclosure and temporisation, possibly asylum. The liminal condition becomes an illness, and the reliability of the physician the most perceptive tool of verification. The

9 References are the treaty of Geneva, the opinions of the UN Anti-Torture Committee and the Dutch General Governance Law (Algemene Wet Bestuursrecht).
mediation of causes and meaning of illness is a basic asset of the relationship between patient and physician. The presentation of a complete and transparent conclusion on what constitutes a personal trauma is a main target in all patient-centered diagnostic effort. The construction of the medical narrative, as a resource of meaningful truth, is a pathway to comprehension, that helps worries about abuse disappear, and faith in understanding be restored. The tortured’s burden of evidence, if met by denial or appeasement, has to be faced by an understanding physician and turned into credibility, trust, and the recovery of humanity. (Turner 1995) Medical anthropology can contribute the basics of how to connect the concrete experience of the tortured with the social construction of human rights, in order to turn rationalities of bureaucratic righteousness into one of principled respect. (Sennet 2003)
Chapter V. Mediating sense

Fundamentally, the task of the medical examiners towards the torture victims is to make sense of their narrative and to communicate the result between the client and the distrusting authority: a mediating performance (Ricoeur 1984: 10) In this chapter I have summarized interviews with eight Dutch experts offering informed opinions on context and procedures of Dutch asylum and MEG intervention. All interviewees are professionally involved and have various experiences with the narratives of torture and asylum. Their opinions has been sought to elucidate and understand all differences in perspective as much as possible.

The Anthropologist

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To make sense, the medical examination of the torture narrative must be constructed in support of the claim for asylum. The narrative has to be listened to, understood, retold and interpreted. Additionally, the way it is presented depends in many aspects on the audience. The delivery of the story has a choice between being objective, intersubjective and critical:

(a) Objective, rendering the remembered as a problem of meaning, susceptible to resolution.

(Geertz 1973; 87)

(b) Intersubjective, reflecting the dialogue between client and examiner, their interactions and circumstances. The outcome has to transcend those distinctions until fusion has occurred.

(Gadamer 1993)

(c) Critical, reflecting the fact, that the truth of representation cannot be a matter of course, since it results from power relationships and context. (Nanda 1998, 286)

At best, the interpreted telling integrates these three hermeneutic perspectives. (Richters 2004, 146-149). The case reports produced by the IND support the assumption, that hearings are ‘a tell-the-truth-once-only’ opportunity in conditions, that appear to be shaped by a decisionistic urge to cut, instead of untie the knots. (Schmitt 1995) The IND interrogation seems further characterized by ’a tell-me-only-what-I-want-to-know’ approach, that skips the feedback.

A comparison between the results of IND-hearings and MEG-reports shows that certain factors repeatedly underlie misrepresentation and misinterpretation. The client, unaware of the premises, is not being enabled to be in control of the narrative and, in
consequence, at present, the contents cannot contribute on the issue to be decided. The criteria have to be clarified to the claimant. Absence of attorney, prior to hearing, is significant to illustrate the tendency of not allowing a full expression of the asylum request. The medical examiners can help if, in the end, the question remains: has truth prevailed? (Care et al 2002). Assuming that the asylum seeker’s culture of origin is making parts of the evidence unspeakable, an appropriate approach must be that an interpreter mediates in such way that the evidence comes out nevertheless.

Doing the asylum request justice requires (a) careful portrayal of the person, (b) careful description of the memory of torture as a cause of fear for extradition and (c) impartial prediction of the conditions upon the return to the country of origin. The translation, by the medical examiner, of post-traumatic symptoms to describe the fear for refoulement, is a proper application of medical expertise and justifies the medical intervention (Care et al. 2002) The medical professional may be of the opinion, for the sake of policy and intervention programs, that the transformation of people, traumatized by political violence, into patients with psychological and medical pathologies, as PTSD, is unwarranted. That opinion can be made into a dilemma because a sociopolitical problem should not be disguised. However, at the same time, the medical professional knows that, for the sake of justice to the individual patient, it may be inevitable to medicalize the problem and present it as PTSD to the authorities, because doing so affects the decision with regard to the refugee status. A positive decision on the asylum request is for the client a medical priority because the consequences, at an individual level, are perceived as a matter of life or death.

In the international forum it has become recognized, that it is imperative that every physician learns how to apply the human rights in actual practice. Simply by doing their job, physicians are often the first to observe abuses. Training in the application of human rights helps and should be on offer in the medical curriculum, as it is for instance at the Leiden Medical School. A variety of documents and guidelines are available. The appropriate approach requires an intercultural perspective, that utilizes acts of meaning and accepts the significance, that the clients themselves attribute to their experiences in the context of their cultural environment. Medical reports should impartial. (Care et al. 2002) Expectations of medical mediation can be tentatively predicted by an evaluation of the various effects of the medical intervention, for instance the outcome of interventions by the MEG in past asylum procedures. Preferably this is done by an external and qualified audit, as that is the proper scientific way to decide on that question.
To return to the research questions of this thesis: the acknowledged purpose, both of the IND and the MEG, is to assess torture as part of the claim. The burden of evidence and the breaking down of the narrative is part of that process. It is certain that the adjudication of truth is not equally distributed between the claimant and the deciding authority. The question on propriety of disclosure can be partly answered by follow up on extraditions. The country reports, by AI and other independent agencies, should be a reference to that. The medical examiner’s re-confronting the torture victim with trauma, raises dilemmas, but that is no alibi to tuck away the uncertainty. A collective search for the answer to - what can be done; what can I do - may take away at least some of the frustration and indecision. An attitude of empowerment towards the victim is helpful for all participants and promotes the giving of testimony. Any adversity depends on expectations between the parties involved. If the asylum seeker does expect release in the medical intervention, a conflict of interest is unlikely. If the asylum seeker meets an empathic attitude towards the problem, the intervention is also unlikely to re-traumatize.

The asylum hearings are crossroads of culture. Both the IND and the MEG apply a protocol of ethnocentric uniformity. Both protocols do an effort towards contextual approximation, but make the interpretation subject to preconceived criteria. Much depends on the individual position, talent and development of the asylum seeker, acquired in her or his own culture and imported to the new one. How are the narrating skills? Is the trauma of torture by rape expressible for women? Is having survived tortured shameful or heroic? How do perceptions differ from that of the Western observer? The interval between examinations can be important, because the IND definite hearing, the provisional decision on asylum and the MEG medical examination - 30 months later, after a negative decision - are set in different circumstances. Much can change by acculturation in the meantime, due to contacts in the expectational and transitional asylum scene. The compromise, to be strived for, is a system that is explicable, available, adequately supported by training and by resources of current knowledge and information.

The Psychiatrist

Annechien Limburg-Okken is psychiatrist, contributing from her special expertise on migrants that was the subject of her PhD thesis in 1989. She practices and teaches in the outpatient department of one of the largest Dutch Mental Health Care institutes, Altrecht in Utrecht. She is member of the MEG and is consulted often by her colleagues in Amnesty International on psychiatric issues and complications.
Viewed from the angle of psychiatric consultation “the client faces a frightening situation. Still traumatized, unaware of the codes of behaviour in the new country, evidence is required in terms, that may not even be conscious to her or him.” The cultural limitations in expressing personal traumatizations may be a hindrance. It is probable that the cultural limitation masks other, stronger mutual mechanisms of denial. At the interpretational side, in the context of Dutch society now, the acceptance of the suffering of forced immigrants is threatened by suspicion. The claim for asylum is judged by negative sentiments and a priori visualized as contaminated with falsehood and selfishness. The IND aims at justification of extradition, according to instructions, and the procedure is absolved as a routine job.

Clearly, it should be possible to approach refugees, who have escaped countries where torture practices are reported, with that fact in mind and to consider them as possible victims, until evidence is given, that they are not. The same attitude implies, that female clients should be interrogated by female officials and interpreters as a matter of course. If the officials wait for the clients to indicate their choice, the victim of rape will interpret that as being suspected of what she wants to remain her secret. In many dispatches and regional reports on conflict areas it is obvious that rape is a systematic tool of terror. The same applies to conditions, which are known to result from atrocities such as genocide and systematic torture. The authorities should be aware and acting on that public information. From a psychiatric point of view the threat of extradition is certainly and severely underestimated by the asylum authorities. To escape that menace the clients have risked all. They can experience the forced return as a sentence of death. PRIME, as a concerned self-help organization active in the Netherlands, has alerted the media to a number of killings, documented after the extradition to the country of origin, and to the increase in suicides, prior to extradition, that appears to be related to it. The psychiatric services in the Netherlands are aware of the fact, that the prevalence of suicide in this group is six times higher than that expected in epidemiological surveillance. (Heijmans 2002) The threat, perceived by the client, both in mental and physical aspects, is of paramount importance. There are clear stipulations on that point in the international agreements and in the conditions, adhered to by the UNHCR.

The medical profession has obligations. The extradition can professionally be assessed for its health hazards and it is wrong that an attending or consulting physician stands by passively. The cooperation between solicitors, advocacy groups and medical profession needs to be strengthened. A dilemma of intentions is real and it is impossible to exclude the misuse of medical arguments completely. The duration of procedures and the escalation of procedural
requirements puts a great strain on the interactions, fostering secondary traumatization in a number of clients, as the AI refugee workers and MEG have observed. However, a thorough study of medical aspects in migration shows, that post-traumatic medical complaints is not an important issue.10 (van den Bosch 2002: 24, 113) That medicalization is used for escaping repatriation - a spectre evoked by politicians in parliament - is an unfounded allegation.

From a psychiatric perspective it benefits the examination if the venue is outside a hospital, in a normal community environment - the usual Dutch general practice setting - during office hours. So, the most rewarding approach is to invest in an environment of safety, positive contact, mutual trust, emotional comfort and empathy. The medical intervention is often experienced as a last station, at the end of a travel that has drained all reserves. It is important to lift the occasion out of the ordinary process of verification. One psychiatric view is, that the political reality should become a concern of the doctor in the relationship with patients. The medical intervention should not stop at dilemmas and get stuck because it cannot make choices between roads that seem to lead to disadvantages only. The fact that results may differ between cases has to be accepted. A solution is the following stepwise approach: Define the main moral problem and constituents; what conflict arises from the tasks, issues, norms involved; what alternatives are possibilities resulting from those considerations; and what final decision offers a way out that fits the individual concerned best. A vignette (case 27, p. 84) for illustration: “A woman from a traditional African background informed her female psychiatrist, that she was not willing to testify about the rape she endured, even if the interpreter was a woman. She saw the interpreter as representative of her own social environment and feared her disapproval. She was certain that she would be expelled from her community once this trauma was disclosed to others with the same ackground.” Subsequently the psychiatrist found out, that not only had she not testified about it before (the unsaid) but also that she had in fact no words or metaphors (the unspeakable) for what had happened to her. That inability to express requires both (a) well-directed treatment to overcome her silence and (b) training to give testimony in the ways a professional would give it: a proto-professionalization. Going by observations in psychiatry, the concept of constraint by culture may well be a consideration of the past. The combination of coercive migration and compulsory inculturation (inburgeren – a law-supported movement to become a typical Dutch citizen) appears to be a stressor and pathogen of more importance.

10 Central Bureau for Statistics (CBS) calculated that 1% of annual residence permits is granted for medical treatment; reference in report of the Center for Migration Rights, Nijmegen University. (van den Bosch 2002)
It fosters the block to admittance and constructs discriminatory attitudes, that prevent assimilation and are a menace to mental health.

**The Refugee Expert**

_Tedros Menelik was born in Asmara, fled the Ethiopia-Eritrea civil war and received, after a procedure of 3 years, asylum in the Netherlands. He obtained successively a masters in rural development as a bursary of the University Asylum Fund (UAF) and in medical anthropology with the assistance of the Amsterdam Medical Anthropological Unit, combining courses with work in governmental immigration institutions. His master’s thesis addressed the asylum motivations and narratives. He is now a senior manager on health issues in the Refugee Council (Vluchtelingen Werk Nederland: VVN)._

Looking back at his own struggle and on his later experience as a refugee worker, Menelik told me, that at present, the asylum seeker faces insurmountable difficulty in telling the true story. The upheaval, while being detained for an assessment of the claim, is exhausting and causes a profound confusion of motivation and identity. Survival is the only perspective. Clients suffer being blamed for being exiled. Rejection precedes judgment. Truth does not seem the issue, because telling the facts does not help to convince. The circumstance, that the claimant has lost all, and asylum is the only course remaining, is not acknowledged. The humiliating top-down approach of the authority is interpreted as a strategy of convenience. If the authority would be interested in the torture, it should be willing to let the victim prepare for the testimony, willing to wait for opportunity to be the the proper one and would support all expertise, that facilitates to render the painful story in a definite hearing. The institutions, which can offer the appropriate assistance are available, but are not allowed to intervene in the decisive processes. The advocacy groups, associated with or employed by the IND itself (Refugee Council, Medical Services), or as independent agents (Pharos, Amnesty International), can advise in retrospect and act in cases of appeal only. That means, that they are positioned to offer at best some compensation to a few of the more fortunate. They cannot prevent misjudgements, nor, on a larger scale, can they correct the procedure in its totality. One possible solution would be to invite them in the reception area and admit their consultation as part of the testimony. The extradition is now more often than not argued on antiquated or wrong information on the country of origin. Many political experts on asylum perceive the Foreign Office Dispatches as a Rip van Winkle institution.¹¹

¹¹  Rip van Winkle, in a short story by Irving (1819), is a legendary character, who fell asleep, waking up 20 years later, and who refused to grow up to the realities of the world surrounding him. Irving prophetically reveals that the prevailing attitude of most “free citizens”, confronted with oppression to others than themselves, is apathy.
Improvement of communication is essential. The asylum seekers have many complaints about the lack of respect they meet. By nature, they expect to be treated as a guest, and as an individual, that needs medical attention, also, as a refugee in need of care and support. The medical approach, exemplified by routine screening, crowded surgeries, delayed appointments, is often experienced as the opposite of the expected. Disappointment can be prevented by better explication. To have the intended result, the aim of intervention should not be restricted to post-traumatic care, separated from the social conditions. The clients experience their future health and their chances on asylum as inexorably intertwined. The medical effort towards the prevention of the stressors of waiting, refusals and uncertainties, is a logical consequence. The question cannot be answered by generalizing, but only in response to individual situations. The trauma and its working through is a personal issue. This PTSD-type of traject is certainly important, as a course of overcoming hindrances, in expressing the details, required for the asylum claim. It should be seen as a contextual transition, however, and part of the struggle for the asylum seeker to maintain identity. In many ways cultural identity is certainly influential in numerous aspects of communication. It should not be forgotten, that many clients have fled their culture for a purpose and that exactly that culture itself can have been the context of the traumatic events. To understand the narrative, the interrogator needs to know that background. The asylum seeker should be seen as the agent, carrying the least of culpability for his or her situation. The checks and balances, now operative in the Dutch procedure, are not attuned to that reality. The future looks black. The advocacy groups should show more energy and originality to redress the downward spiral, and offer more effective resistance to the negative sentiments, that are at the root of the rejection of asylum for those that deserve it.

The Immigration Official

Henk van Ballegooijen, psychologist, worked as a volunteer for AI evaluating the MEG results, and advising on protocol and revising of the internal handbook. He has been working since for the IND as a decisional official and as a consultant and editor of internal instructional handbooks for the immigration and naturalization services.

The IND views the disclosure of torture as only part of the evidence necessary. Its verification is looked upon as a difficult job. The result should fit in the evidence as a whole. Scars by itself are not seen as sufficient proof. Allegations that can be related to political persecution are more to the point. The claimant receives a careful instruction and can ask for independent external help in preparing. (Asielprocedure 2001) In the perception of the IND the following
is proper procedure. Information on mistreatment is collected in the definite hearing and the allegations are assessed in the context of the asylum request as a whole. The official hearing, in contact with the client, and the deciding processes are separate assessments. The officials have received training in the interrogation on the subject of trauma and can consult a handbook, which serves them for reference.

The interrogators try vigilantly to match all narrated elements (background, arrest, detention, accusation, mistreatment, escape, choice of asylum country) in order to see if they are detailed (or vague), acceptable (or improbable), authentic and credible (or inconsistent, contradictory). On the average, at present, the evidence fits in only 5–10 % of decisions, demonstrating the strictness of the procedure. Yet, the IND perceives its performance as a fair hearing, that is, at the same time, attuned to be workable. Time limitations are consistently observed. The asylum seeker is welcome to introduce all documentation, but has to bring that forward within those limits. Within those limitations it is possible to submit medical information from attending physicians. That documentation is assessed on its expert content.

One does not expect a general practitioner to diagnose PTSD because that is expert psychiatry. If the evidence is beyond the scope of the hearing or deciding official, the BMA is asked for comments. PTSD and a history of sexual harassment or rape are considered serious allegations. The asylum seeker is notified of the availability of an official and interpreter of the same gender. The IND perceives its decision, if appeal fails, as final, but if PTSD or other illness, that is being attended to, appears to obviate the extradition, then the BMA will be asked for an advice and extradition can be postponed. The IND views that as quite dependent on the nature of complaints, but it respects the special capabilities of the MOA, MEG and other medical institutions. The IND considers medical observations as useful verification of the allegations if resulting from an unbiased examination and producing results, which match the other parts of the narrative.

The link between scars and allegations is viewed as difficult to ascertain, equivocal and questionable. A significant alteration in the narrative with respect to traumatization, during appeal, is suspect. An alteration of medical complaints is particularly improbable if the person involved has been observed to function normally within the asylum settings and hearings. The proper authority, as the IND views it, to answer those questions, is the attending psychiatrist.

The IND has to rely on the expertise of the Foreign Ministry. Their official dispatches (ambtsberichten) on circumstances, specific to the country of origin, are studied by the interrogators and decision makers. Other on-line IND services are Country Desks and Quests.
The IND stimulates group activities for specific and actualized region-oriented knowledge, which can be transformed into hearing and deciding with more background information. The IND, on the other hand, considers the Dutch and European judiciary traditions as satisfactory for the purpose of asylum assessment.

The asylum seeker is respected and cared for conforming to international and national law. To obtain asylum the claimant is to give evidence as indicated by that law. The IND is not eager, for fear of abuse, to extend its service beyond that, and to provide indications on how the asylum is best achieved.

**The Human Rights Lawyer**

*Diederik Pomstra studied law and specialized in human rights. He worked afterwards for the UAF and as a representative to the European legal network on asylum (ELENA). He advised caretakes for VVN. He works as a staff member of AI, erstwhile coordinating the MEG bureau services, and now in the section of professional action groups. He co-edited the MEG publication and revisions of the publication on visualization, called ‘Scarring from Torture’. He visited Copenhagen and London for the purpose of exchanging experiences with representatives of the international centers for the care of the tortured.*

Credibility depends on details that officials and asylum seekers can share. AI is one actor that actively supports that by information, on request of solicitors or other caretakers, on behalf of the client. Their expertise often attempts a reverse of the negative verdict by going into a dialogue with the IND and solicitor on these decisions. The AI mandate is a statement of rights. The formal approach shares the analytic features with the IND. An important premise is, that asylum is not to be claimed for regular or economic migration. That suspicion has escalated the restrictions of asylum. The intention of the narrative by the asylum seeker should be to give a true account of the trauma and a convincing ground for fear of refoulement. AI independently matches the details by expert critical assessment. AI needs to do that in order to maintain its own respectability. The interpretation of the claim is a function of the immigration authority according to treaties of which the government is a party. AI has in numerous occasions called on governments to differentiate more accurately and without delay between those with a claim well founded and those without.

The decisive moment under Dutch procedure (Aliens Act 2000) is during the definite hearing. The new Act issues only one permit, although grounds, on which asylum is granted, remain the same as in the old Act. According to section 1A\(^{12}\), traumatized people, or those

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\(^{12}\) The EU treaty of Amsterdam harmonized the application of Article 1 in the Geneva Convention
coming from a country to which repatriation would be harsh, because of the general situation, are not extradited. The European Council on Refugees and Exiles (ECRE), of which AI is a member, stipulates that traumatization resulting from torture, inhuman or degrading treatment, or any such threat in the country of origin, must be part of the decision on the asylum request. If for reasons that can be justified, clients delayed mentioning a history of torture in the hearing, a provision must be made until the moment they can express themselves fully.

According to the principles set out in its mandate, AI opposes refoulement when a person can be expected to become prisoner of conscience; be subjected to torture; face ‘disappearance’ or politically motivated extra judicial execution; or face the imprisonment or execution of the judicial death penalty. If this is the case, AI considers an expert medical examination justified. In the lawyer’s perspective the preferable approach is the one straight at the target of verifiable evidence. A clear, short and itemized declaration in reply to the query, stated by the solicitor, is the required product of medical examination. The MEG perception is that in almost 100 percent the MEG reports on the negative decisions of the IND are confirmatory from the point of view of the solicitor. A large majority of cases, which has been taken into consideration, do show, during follow up, that appealing the negative decision is successful. Even taking into account the fact that the IND needs quite some time for to redress negative decisions, the reported MEG cases show a majority to deserve asylum.

The MEG 1999-2004 retrospective results demonstrate, that the percentage being provided with a refugee status also increase over time. An estimate as to what extent the medical reports have contributed is a knotty issue however, because of the multiplicity of intervening factors. By the means of questionnaires the MEG has questioned solicitors on the outcome of the medical intervention (Table I; Fig. 9 Annexes), and the respondents gave as their estimate that for the period 1999-2001 in 65-85 percent of cases a positive outcome was strongly or decisively affected by the medical reporting. (Pomstra 2003) The cases, that AI provides with a medical report are no more than 50% of those requested by solicitors in the first place. A further restriction is, that the AI intervention itself takes several months. The MEG takes care to invite feedback and actively solicits follow up on their reports. At present, all facts taken into consideration, the chance that a report in the long run contributes to a successful appeal is 75-85 percent. It is difficult to see how, in that context, medical examination will be stressor, provided that the MEG trains its members to take care not to initiate questions and examinations, that are not asked for. The results of reporting show that the examination contributes to the intentions of the client. The MEG did not receive complaints, neither from clients, nor from solicitors or attending physicians. Very often, in
cases that are successful, a spontaneous note of gratitude is sent to the office. Occasionally the BMA criticizes the MEG on their conclusions, but just as often the medical advisers of the IND agree on the contents of the report.

As to the constraints of culture and social background: it is a fact to be considered but not a stable factor. The dynamics and appreciation of the cultural perspective changes continuously. Even within the confines of the Netherlands, the individual outcome of the asylum procedure varies considerably, over time, and depending on the locality and on the fluctuations in the political climate. AI believes, holds fast, tries to outlast the opposition and hopes to generate support and trust, that will improve things in the end. Genuine refugees must know that AI keeps doing all it can to stand up for their cause.

**The Asylum Center Physician**

*Mieke Knoppers is a physician, specialized in public health, working in the medical services to asylum seekers (MOA) for more than 10 years. Before that she was a general practitioner and a `Medicin sans Frontières`. She has published on disease and health conditions in the Dutch asylum centers.*

From the point of view of the physician, attending asylum seekers, “the central problem is, that the direction of the procedure moves away from the issue of trauma”. The evidence of trauma is kept out, because decisions are on the political perspective. The clients themselves do not realize that their history of trauma is part of the verification necessitated by their claim. The claim for asylum on the allegation of torture should be in a different category, but at present that category seems to be absent. The attending physicians are in no way part of the asylum proceedings. In the quarters of the medical services, little interest exists for it. The doctor observes that for clients “torture is not a subject that you can talk about in hearings.” The experience is, that clients are grateful however if they find opportunity for disclosure in the medical setting. Doctors advise them emphatically to inform the solicitor, for example about HIV-infection due to rape, in order that these facts are included in the procedures. First medical concern is that the illness remains unattended and not on the impact on asylum.

The approach of the MOA is to instruct the patients on their own responsibility in bringing the matter of torture forward in their asylum claim. The medical caretakers will pay attention to documentation of the trauma and provide the proper circumstances by requesting expert interpretation and removing gender obstacles. They will also give full cooperation to solicitors, with informed consent of their clients. The asylum medical services possess considerable knowledge on social and physical health aspects during the asylum conditions. The local, actual epidemiological background is an important help for interpretation of
narratives. Not all asylum seekers are interviewed and examined by a physician in the medical service: the estimate is that 50% of adults and 100% of the unattended minors and children are. It is preferable and should be possible, that all asylum seekers can meet a doctor, but at the present time a medical indication is necessary. A history of trauma is of course such indication. (Richardus 2003) Traumatization is inherent to torture and all its consequences. An effort to understand can hardly be avoided and must not be delayed.

Ultimately, the will for that originates from the victim. It is likely that the positive – the opportunity to express – and negative influences – the need to forget – neutralize each other. In the practical experience of an attending asylum physician the doctor-patient relationship is a reliable setting for the complete individual account of trauma to be given. Both the physical and the mental consequences are discussed without constraints on either side. Tears may flow, but if the doctor apologizes for that distress, invariably the response is, that the client feels relief. The professional experience of attending physicians, to prevent any adversity, is to wait for the client to be ready for disclosure. Clearly, the agenda of the asylum hearing may be too explicit and the moment out of step for disclosure. If patients are not yet prepared to open up, they will not come to see the doctor about that subject; neither will they raise the subject in the hearing. There is no cultural unity in the medical support systems either. Within the privacy of the doctor-patient relationship, cultural distances are overcome by other priorities: “the need for understanding and the sharing of intention to heal”.

The disagreement experienced by the professionals of the Medical Services, towards the politics and strategies of the IND on the exclusion of medical affidavit, is strong. Yet, the professionals concentrate on their duties towards the individual refugees and try to improve their health as a first priority. They admonish clients earnestly to put forward their traumatic narratives, if that is part of the solution. They help them carry that burden, but stop there and do not take personal action to press authority on their behalf.

The Medical Anthropologist

Rob van Dijk studied social and cultural anthropology in Utrecht before calling himself one of the first dedicated Dutch medical anthropologists. He researched disability of migrants in the Netherlands and managed intercultural projects for several governmental mental health organizations, specializing in asylum and refugee care, now at the Bavo-RNO in Rotterdam. He is one of the founders and a board member of MIKADO, knowledge center for intercultural mental health.

The medical anthropologist views the narrative from a perspective, which is utterly different if compared to the IND. “Context and interaction are constructive forces.”
mother narrative is not intended for testimony, but bits and parts are adapted to the circumstances, even if the questions are bewildering.

As an illustration, a kind of bewildering question, that one meets in the definite hearing, to check the locally acquired knowledge of the interviewee, is: “what colour are taxis in Afghanistan?” Thoughts about the trauma are created and arranged during conversation with the interrogator, doctor, family or other listeners. Content and emphasis rely on the level of like-mindedness of the other. What is communicated should not be taken at face value. Communication is intended to be part of the relationship. If falsification is the main objective of the interrogator, then the response will be to selectively offer that part of the narrative, which is thought the most acceptable and impervious to argument. Depending on the respectability of prevailing stories, this means that many claimants show a tendency to tell the same narrative. (Kleinman 1996) In the medical anthropologist’ opinion: “It is crucial that the party, that listens to the narrative, is equipped for that role. The events narrated are part of an individual reality. It will be difficult to share that content, and its internal consistency, if the realities between narrator and listener are too distant. If the otherness dominates, communication suffers. The settings of the asylum domain are symbolic for creating distance. Locations outside the community and poor basics (work, privacy) emphasize that the asylum seeker does not belong. The policies confuse them by contradictions. The effect is strengthened by the fact that caretakers (IND, MOA, VVN, etc) differ in their approaches. PRIME – Participating Refugees in Multicultural Europe – states that these institutions have lost their autonomy, as they exist by the grace of the government. (PRIME 2002)

An important improvement of circumstances surrounding asylum would be an unambiguous scenario. From the anthropological perspective again, the key factor is to respect the realities of the client. If the explanatory framework behind the asylum request is not taken into account, the extradition will be an irresponsible act and medical intervention may offer a mediation effort. Medical anthropology relativizes however the significance of the doctor mediating sense, warning that medicine can play a minor role in many instances “Some clients may accept the patient role, but what of the many who do not?” The existing system of refugee care tends to place the emphasis upon identifying those individuals, who are the most overtly distressed and who identify with the disabled patient role. (Weine 1999) A less medico-centric, and more culturally sensitive (or emic) approach would invest more effort into facilitating to enable clients to find their own solutions, independent of medical intervention. The solutions, experienced as significant by the asylum seekers, depend on the patterns of their attempt to make sense. They can be (a) stricken by chaos (b) hibernating in
fear (c) fighting their cause, but also (d) making use of chances. Fighting is mainly directed against a context, experienced as discriminatory and unjust.

What physicians have to offer should be supportive to their choices. This may be straightforward on some consequences, which are easily recognized. It may need inquiries for tortures, less overtly demonstrated, as in falaka or sexual violence. For others, it can be necessary to concentrate on behavioural consequences. Do they suffer under their scars, as a stigma, or, the reverse, as signs of individual heroism? Not one standard solution can be formulated for the purpose of medical intervention, but many. One anthropological creed advises to give priority in helping people making sense of their experience by restoring networks essential for negotiating meaning. If that is not accomplished, emotions, originating in the trauma, will persist and continue to obstruct communication and treatment.

Medical anthropology emphasizes the need for more reflection on our own part: “our attitudes are fraught with unspoken anxieties. We consider the asylum seeker as an agent of social awkwardness, whose presence forces us to rethink our culture. This is demonstrated by the sudden, national urgency to demand that migrants become active in the development of citizenship. Through their frightening stories we are induced to a forced awareness of the thin line between our civilization and the barbarities of the dark side of mankind.” The constraints of culture are mainly projections of those fearful images. From the same perspective to support more and better, we should professionalize our efforts, improve the asylum conditions, and cooperate with each other through supervision. That will help to prevent the burnouts and the transmission of trauma, which is now all too apparent in most organizations, involved in refugee care.

**The Amnesty Expert**

Annemarie Busser was a local cultural worker when she became interested in migrants and refugees in the ’70’s. She was involved as a volunteer of the Refugee Council (VVN) in Rotterdam during her study of law. Since then she made it her professional career in the Amsterdam refugee department of AI, which she is now coordinating.

The quality of the construction of narrative in support of the claim has come to depend on the weakest link, is the summing up of AI refugee expertise in the present Dutch proceedings. Many voices and intentions produce a communicative roulette between the client, interpreter, contact official, decision maker, solicitor and also the medical expert and the end result is determined by the lowest stake. Mutual irritations at interferences and miscommunications abound. The past decade has shown a slow but clear deterioration in the intent of government to act according to the principles of human rights. The AI refugee expertise suggests that
provisions should be made for traumatized clients that resemble the conditions met in life insurances or industrial disabilities: a context of safety and independency of medical examination. What escaped scrutiny until now, is that, during hearings, the IND routinely requests consent, from the client, for the eventuality that the IND will seek medical documentation. In reality however, one observes that such information is not solicited or used in the decisions ever. It seems an empty gesture, a relic of old days.13 (Ombudsman 1999) AI and the MEG have a definite role in non-refoulement, according to its refugee expert. 'The MEG examination can bring new facts to the surface: nova, which can help to re-open the procedure. When case records are combined, patterns can emerge demonstrating systematic “disappearances” or extra judicial executions in the countries of origin. By revealing that pattern the human right organization can challenge official denials and break through governmental strategies for avoiding accountability. Well-documented information becomes a weapon. (AI 1994) The AI expertise agrees with refugee caretakes, who have good personal relationships with asylum seekers, in observing, that many clients are severely traumatized, but do not wish to speak about that experience. They feel that they can function only by keeping their trauma hidden for others. They do not want to think back and will try to evade medical treatment in order to keep their personal past silent. The MEG examinations are important to AI, because they present an option, which works in the right direction. The MEG facility is unique in that respect, that it is a volunteer service, organized and facilitated by AI in the Netherlands only. The protracted postponement of disclosure of trauma, now occurring in many asylum procedures, is a negative phenomenon. It is important that the conscious constraints are removed. Being attentive and approachable is best. If that attitude is realized, the risk, that traumatization is a constraint, is minimal. Secondary traumatization is not an adverse possibility if the medical intervention is properly indicated, prepared and executed. The refugee department takes great care to select the dossiers, which will benefit by it. This includes frequent consultation and evaluation between the lawyers, the regional specialists and the coordinating members of the MEG. One success, that AI claims, is, to have succeeded to make the dispatches by the Foreign Office to be more factual and impartial. At the same time, alas, the refugee department has observed, that the positive influences, which dispatches can exert on the IND decisions, has decreased. AI will continue to put all expertise, they can

13 On the urgent request of the national ombudsman, the medical advisory service (BMA) within the IND was reorganized in 2000 due to chaos in that department in which reporting averaged delays of 12 months or more.
mobilize, to support the application of human rights in the asylum claims of individuals deserving and the overall improvement of the system that attempts to judge them.
Chapter VI Visualizations

Introduction

Photographs and drawings can visualize the narrative. The aim of this chapter is to discuss the visual documentation in medical examinations of torture. I will first review an ongoing experiment of picturing the torture scars. The rationale of introducing photography is described and the procedures of visualization as a tool of investigation for medical purposes is analysed. In practice several confounders are met, that diminish the efficacy of photography for the purpose of representing the victim in the context of asylum. The attempt of making an image of the torture victim is fraught with contradictory expectations. In order to understand the conflict a panel of illustrations will be discussed. I will try to analyse the pictorial visualization vis-à-vis the verbal reports. Does medical photography help the tortured to narratize their suffering in any particular way? Finally I will summarize an application of the visualizing tools, striking a balance between verification, representation, and understanding.

Overview of experiences

Since 1996 a ‘scarring from torture’ visualization project was initiated and systematically pursued by the MEG, in cooperation with experts in AI. (MOG 2000) The rationale is that photos can support and extend the evidence of torture by their visual impact. The photographic approach taken by the MEG is a descriptive one, which concentrates on the distinguishing characteristics of scars only. The photo should succeed as an illustration of what the examining physician has seen and considered significant.

The procedure, adhered to, is that each photo is accompanied by a summary, restating the alleged torture, selecting points that relate the image directly to the instrument of injury, or the pattern of torture, that is remembered. All images are described in detail to reveal and improve the medical findings, that correspond with the act of torture and that identify the local pathological results. The medical gaze is structured by a strict sequence. In describing the skin the Dutch acronymic PROVOKE\(^\text{14}\) is used as a helpful mnemonic, to register for each scar first the place, then the bulk, followed by the arrangement, form, circumference, colour, and eventual similarity to a well known visual object such as a specific flower. The description is amplified by a discussion on what makes the image so characteristic of that injury, citing similarities to scars resulting of comparable tortures or pointing out differences if compared to other scars due to skin disease or non-torture related wounds, which were self-

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\(^{14}\) Dutch: Plaats, Rangschikking, Omvang, Vorm, Omtrek, Kleur, Efflorescentie
inflicted or repaired by surgery. Several photos will be used for comparison to demonstrate
the objectification of similarities and differences. In search of quality the MEG has struggled
to achieve a forensic level of expertise. The purpose is that, by the extension of the visual
evidence, the physician will produce an even more compelling narrative.

The MEG routine of medical documentation uses the visualization of external
appearances to amplify the correlation of torture and scar. The image assists in grading
the judicial consistency between evidence and allegation as (a) none (b) slight (c)
moderate (d) high or (e) inescapable proof.

Difficulties
To survey the visual documentation of the medical documentation of torture, the MEG, on its
own initiative, made an inventory of all useful material in the professional visual media.
Several isolated case studies in the medical literature, and a few dedicated dissertations,
monographs or human rights manuals contain pictures, that can comply with the MEG
standards. Other material was collected from internal publications, handbooks or by
courtesy of rehabilitation physicians, surgeons or forensic pathologists, who kept
illustrations for their own purpose of reference and training. (e.g. Peel & Iacopino 2002,
Jacobsen 1997, Basoglu 1992) The result is used for one compact disc edition, that is
updated annually. At first the collection has been distributed only for training of
members of the group. Lately, an English translation has been sent to experts in several
international institutes for the care of the tortured and has been discussed with expert
representatives aiming at further enlargement, improvement and a wider utilization of
the collected material.

The experience of making an inventory has shown, that, dispersed over many archives,
much visual material exists, but also that it is difficult to make an effective use of it,
because of a variety of reasons. Material is often inaccessible due to restrictions for use
by others, because a written permission cannot be obtained from the patient and/or
physician. Other reasons for restraint are, that: (a) the personal identification is
generally avoided; (b) the risk to the victim (refoulement) is considered overriding, (c)
the torture may be seen as too shameful to personalize. It appears that, in the visual
representation of the personal narrative of torture, the propriety of the private domain is
strong and self-evident.

The material problems are manifold. The photo is unclear, the description absent and
the matching medical document unavailable. Effective visual medical representation of torture
is also difficult by virtue of the fact, that many physical traumata leave scars, which are hardly visible after healing. The visual appearance of those scars, that are clearly visible, is mostly inarticulate as to cause and cannot be differentiated from the end result of other injuries. Thus, an approach, that matches medical forensic photography is usually unattainable.

Add to that, that the practical visualization of torture is mixed up in the negative connotations, that the act itself is perverse, uncivilized and forbidden. The probity of abhorrence struggles with the righteousness of exposition. To be reminded is painful to victims and perpetrators alike. The torture scar cannot be made into a neutral image of medical research.

The exposition of torture photographs is used to initiate and orchestrate public outcries in order to shame the perpetrators. The provocative nature of the image of torture is illustrated by the recent media hype on "numerous incidents of sadistic, blatant, and wanton criminal abuses" by the USA Army in Baghdad’s Abu Ghraib prison. (Washington Post 2004). In this incident, the impact of photographic documentation is demonstrated by an immediate worldwide response of disgust, fury and revenge. The amateurish stealthy snapshots shattered the guilty secrecy more effectively than could the informed, steady and professional reporting by the Red Cross or Amnesty representatives.

Recounting torture in images
Translating medical evidence of torture into images is enmeshed in the conflict between concealment and exposition. To find an acceptable application, the medical examiner has to fulfil the expectations of the system it serves, that is the objectification of a medical argument in favour of the allegation. In practice the MEG experience shows, that medical images of torture, however, are in a category different from other professional visual representations. The horrors associated with torture resist to be made into simple objects of examination and recording. To respond appropriately would mean to recognize the essential inhumanity of torture and to make the permanence of trauma visible through the image. A discourse is required that connects the medical and the visual documentation.

The illustrations on the next two pages show several categories of images. The images can be characterized as supporting a document by visualizing –fig I– a medical diagnosis, –fig II– a differential diagnosis, –fig III– an individual narrative, –fig IV– a torture method, –fig V,VI– two patterns of scars, and –fig VII– the evocation of the mental anguish experienced by the victim. The first line of approach in visualization, as in figs I-VI, seems to
emphasize that torture is instrumental. The images tend to present the consequences of torture filtered by the medical and legal perspective of how to objectify. In the medico-legal representation the context is impersonal and the image reduces the suffering to the physical causes and consequences. In contrast, the paintings shown in fig VII, made by the victims themselves, emphasize the feelings that make them suffer and succeed in reproducing the mental effects of torture. Clearly, the really important signs of torture, embodied by scars and handicaps, are due to the mental impact, and do not appear in the medico-legal images. (Kleinman & Kleinman 1997) The medico-legal routine narrows down on the abnormality that can be made into object, and, by doing so isolates the object from the person, from the suffering but also from the perpetrator.

Fig I a,b. Visualization that supplements and clarifies verbal description. Photo of paralysis of the shoulder blade typical of a late effect of the suspension torture shown in drawing.

Fig II a,b. Measurement and visual explanation to show the similarity between the defect that can result of (a) skin Leishmaniasis infection and (b) drawing of a burn of a cigarette and (c) late scar on the forearm due to burn.

Visual diagnosis

Visual differential diagnosis
<table>
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<tr>
<th>Visual documentation of medical narrative</th>
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<tbody>
<tr>
<td><strong>Fig III a,b.</strong> The victim was marked by multiple burns, inflicted by a heated iron in the shape of the crescent moon, powerful nationalistic symbol of the country of origin.</td>
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<tr>
<th>Visual documentation of a torture</th>
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<tr>
<td><strong>Fig IV a,b.</strong> The foot soles of this victim were beaten for two days – falanga. The drawing shows how feet are immobilized in a strap during torture.</td>
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<tr>
<th>Visualizing specific patterns of scars</th>
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<tr>
<td><strong>Fig V.</strong> Asymmetrical scars from a corrosive liquid, thrown on a nude victim who was lying down. Specific circumscriptive scars correspond with burns of the skin in position and chemical agent.</td>
</tr>
<tr>
<td><strong>Fig VI.</strong> Symmetrical scars that correspond with long lasting application of handcuffs, causing skin ulcers and strictures.</td>
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Envisioning

What to search for in a photographical documentation, that should be a routine part of the medical examination of the tortured? (Peel & Iacopino 2002:134, Iacopino 2001). The Istanbul Protocol instructions emphasize the objectification of the physical damage to include (1) all scars (a) anatomically located and related to similar scars, (b) measured (adding a scale, time-indication) and described in detail if considered more specific, (c) high quality techniques (professional, digital) or accurate drawings; (2) supplemented by a photo to identify the patient. The similarity of the impersonal approach with the anthropometrical stage in anthropology is striking. Because the lasting, specific and significant effects of torture are mental and emotional, one of the problems with photography as partial evidence of torture is how to pursue the meaning, which lies behind the scars.

Because the context of the narrative of torture is hard to envision, finding satisfactory comprehensive publications for reference proves to be almost impossible. One medical attempt is ‘A Radiological Atlas of Abuse, Torture, Terrorism, and Inflicted Trauma’. The preface by the first author states: “The radiological images documenting aggression may be less than optimal, often being acquired by inexpert persons under difficult, sometimes even surreptitious, conditions. Hence, we regret that some of the illustrations we present are not better, but we do not apologize for them”. In addition, the acknowledgements by the authors show that they had to travel wide and far, and to dig deep and hard, to collect their imperfect material. (Brogdon et al 2003) In what way can the image enable a vision of the trauma, suffered by the person scarred, and also of the torturer who writes his signature of power on the skin of a victim?

Fig VII. Paintings of (a) female and (b) male victim that portray the late emotional effects of shame and guilt as a consequence of sexual torture. Paintings were made as creative therapy in a torture rehabilitation centre.
In most scars and deformations, examined by the MEG, the trauma is too far removed, by lapse of time and healing of acute effects, to obtain the observation that is desired as verification. The successful image attempts to extract and to sumarize the gruesome reality and enables the onlooker to confront the painful cause. In highlighting the evidence so that it becomes impossible to ignore, the visualization must be political and bolster the case for the rejected asylum seekers. The aim should be met in a compelling way, matching the intensity of the pain produced by torture: “At first occurring only as an appalling but limited internal fact, it eventually occupies the entire body and spills out into the realm beyond the body, takes over all that is inside and outside, makes the two obscenely indistinguishable, and systematically destroys anything like language. Terrifying for its narrowness, it nevertheless exhausts and displaces all else until it seems to become the single broad and omnipresent fact of existence. Its mastery of the body, for example, is suggested by the failure of many surgical attempts to remove pain pathways because the body quickly, effortlessly, and endlessly generates new pathways” (Scarry 1985: 55)

**Producing a visual interpretation**

Whatever the difficulties, medical images can be made into effective supportive evidence of the late sequels of torture. Envisionment adds motivation and sense to observation. The authoritative impact of image can be made strong and convincing. The advantage of a pictorial presentation justifies the attempts to make a proper use of that medical tool and to offer it to the victims for support.

In summary: the ideal photography should bring unique evidence by a configuration, which is immediately recognized or interpreted. Further suggestion is, that a competent photo or drawing produces an independent illustration of the findings at medical examination, facilitating comparison to similar injuries. The photographic narrative is to exemplify the method of expert qualification and quantification in the reporting. The image can combine the scar with a metric scale for an instant comparison. The photo can give a comprehensive view in situations where a description that relies on words only would be confusing. An overall view of the patient is useful for a personal identification, while zooming-in can bring out the number, pattern and distribution of scars. The extent and localisation of scars is eloquent to give a measure of the traumatic impact and the handicaps. Photography can bring out scars of which the patient is unaware, for example on the back. There may be scars of incidents, that the patient has forgotten or repressed and discussing the photo with the victim can help memory or overcome denial to clarify the narrative.
Further links between the photos and the attribution to torture to be looked for are:
(combinations of): (a) correlation between the type of torture and the findings that can be extended by other imaging procedures, such as radiology, (b) correlation between the alleged date of torture and the appearance of the scar or deformation, (c) correlation with the context of torture, such as imprisonment, nutritional deficiency and protracted healing, lack of adequate treatment or inexpert surgery, (d) patterns of late injuries, typical for known types of physical mistreatment in particular settings, geographical and historical events and corresponding with the histories of more victims of the same area and setting, (e) scarring in unusual locations, that cannot be reached or seen by the victim, or that show an asymmetry, suggesting a deliberate cause, and arguing against an accident or auto-mutilation (Brogdon 2003:106, Peel 2002:155) The bizarre can highlight the absurdity of torture fashions, such as ‘petite guillotine’, that was developed in Iran during the times of the Shah, but persisted in the dungeons of the guards of the Islamic Revolution. Brogdon’s atlas contains a photograph of the hand of a 14-year old girl with parts of the 2-4th fingers cut off in prison. Other examples of a highly specific nature are the circular patterns due to ligatures around ankle and wrist, the periosteal reactions as a result of palmatoria (beating on the shins, Guinea Bissau), the degenerative bony and articular changes in the feet (beating on the soles or falaka in Arabic and bastinado in Spanish traditions of torture), the fractured hands and wrists (in Zaire/Congo; of journalists, writers or artists, who were mutilated and whose livelihood was taken away at the same time). The Zairese soldiers use their pointed military buckle for trashing and this leaves a distinctive scar, found in many victims. All are examples of medical attribution, signification, magnification, measurement and comparison that are instructive by providing a vivid visible interpretation of the link between scar and torture.

**Distortion, partiality, exaggeration, denial and unreliability**

The medical aim of objectification calls for specific expertise that is often hard to achieve, and the inexpert use is counter-productive or controversial. An example of the last is the estimation of age by the means of radiology and physical anthropology in the IND procedure. This method entails that the claim of being an underage asylum seeker (Dutch: Alleenstaande Minderjarige Asielzoeker AMA) is verified by a visual assessment of radiological bone maturation. Several authorities, both from the medical and medico legal point of view, have criticized the scientific validity and the ethics of the radiological procedure. (Smeets 2004: 32, Keunen 2004) The scientific criticism is, that the stage of maturation is too variable to obtain certainty in an age dispute.
Other critics pointed out the exceptionality of this medical procedure versus the general IND instruction that medical testimony cannot contribute to verification. Significantly, the radiologists involved in the technical assessment refused to countersign their reports, distancing themselves from any personal relationship with the examined person. This again was unacceptable to medico legal judgment, demanding a personal medical testimonial responsibility as part of the record. (van Es 2003) This example emphasizes that the medical imaging, as a support to the asylum claim, is not by definition a freestanding instrument, suitable for a neutral reproduction.

The medical approach can also be experienced as too narrow, detailed and detached by the emphasis on the abnormality only. An example is the discussion whether skin biopsies should be taken of torture scars with the aim of a histological analysis. The microscopy of the scars, due to electrical torture, can be used to demonstrate tissue calcifications, which have been found to be a typical feature of electrical injury. (Thomsen 1981) The suggested line of investigation is included in the discussion of the Istanbul protocol: “Electric injuries may, but do not necessarily, exhibit microscopic changes that are highly diagnostic and specific for electric current trauma. The absence of these specific changes in a biopsy specimen does not testify against a diagnosis of electric shock torture, and judicial authorities must not be permitted to make such an assumption. Unfortunately, if a court requests that a petitioner alleging electric shock torture submit to a biopsy for confirmation of the allegations, refusal to consent to the procedure, or a 'negative' result is bound to have a prejudicial impact upon the court. Furthermore, clinical experience with biopsy diagnosis of torture-related electrical injury is limited, and the diagnosis can usually be made with confidence from the history and physical examination alone. This procedure is therefore one that should currently be done in a clinical research setting, and not promoted as a diagnostic standard. In giving informed consent for biopsy, the person must be informed of the uncertainty of the results, and permitted to weigh the potential benefit against the impact upon an already traumatized psyche.” (Istanbul Appendix 1999: 88)

In the Dutch asylum procedure, questions are asked about torture, but, apart of the reply being recorded, the signs or scars do not play a role in the decisions. (Oomen 2001) The interrogators do not look at the scars, mentioned during the hearing. The looking away from clearly visible signs of torture can only be explained as wilful denial. Propriety of the private domain is self-evident, but the adverse result that has to be overcome is that the context is removed. The unwillingness to acknowledge the gruesome reality protects the onlooker from confronting the pain, but at the same time excuses us from taking responsibility.
Visual anthropology may help to develop approaches that prevent the objectification of torture, while respecting the sensitivities of the victim. The ultimate aim should be to empower the victims to state their case by images that engage the onlooker, involve the victim, explain better and encourage the visual interaction. That expertise needs images in the professional visual media.

**A portrayal of the torture, torturer and torture victims**

If the effort in visualization is to be representative, it must be sensitive to the distinction between images that support evidence in the individual verification of torture narratives versus a more contextual approach. If scars are objectified for their physical impact only, the connection with the alleged torture becomes too bluntly depersonalised and instrumental. To understand torture, visualization cannot be limited to scars as objects. A more contextual approach towards images is necessary to impart real meaning to the medical knowledge and explication of torture consequences. Important is, in the description, to search for context and attached meanings. The interests of the photographer, the aims of the picture, and the participation of the victim, are signifying ingredients. The photographer shares a vision on a person or event. The expectation of the public is that of a particular significance and exceptionality. Sometimes images may be offered to the intended public as a statement, at other times as a question. Visual anthropology offers ideas for constructing and interpreting images in the context of culture-bound communication, behaviour, or emotion. When looking at human appearances the eye of an anthropologist tries to record embodiment of culture and identity in kinesics and proxemics of gesture, non-verbal sign language, and spatial position. In order to picture personal trauma an empathic view is required. In the representation of torture the photographer can share the imagination of factors, which are critical in the construction of the traumatic experience, the individual perception and the social background. Contextual signifiers to be included are the cultural bereavement and mental fatigue, isolation and loneliness, insecurity and helplessness, loss of personal space and incomprehensibility of rejection. (Collier 1999, Helman 2001) That visual contextualization should be an intention of medical documentation also. Drawings can be used to depict the torture, the doings of the perpetrators and consequences to the victims. Rasmussen (1990) recognized the importance of Eva Forest’ observation (1987): “I believe that the most important factors, those that have been most harmful, are not told. We need another and more sensitive kind of visual communication, another language, one which will go deeper and shock.”
The perceptions, illustrated by an artist in treatment at the Rehabilitation Centre in Copenhagen, were described by Genefke (1986) as revealing: “how ugly he finds himself, his feet grotesquely swollen, his body ugly, he is worth nothing at all”; “without hope, all alone, quite isolated”; “how much she has been humiliated by the sexual torture, everyone stares at her, she feels useless, ugly with a distorted grotesque body”; “long after detention, he feels still behind bars, he fights and cannot escape”.

Many effects of torture are never visualized, because they are out of reach or have disappeared. Images of torture and related imaging studies are scarce in countries, where torture is common, whether in times of peace or war. Mutilation by torture involves a high risk of the victim being killed. Victims who escape their tormentors, and reach a country where they can seek asylum, are likely to have been tortured less severely than the many others, who died or were unable to leave. Their narratives often underscore the accidental character of escape and confirm that numerous others died in similar circumstances. Modes of inflicting pain do not per se result in scars that can be made visible. Torturers often sophisticate deliberately the infliction of physical and psychological pain to prevent future verification. In addition, if scars can be demonstrated, compatible with the narrative, it is necessary to realise that the lasting and main impact of torture is mental and emotional. The reality is far more desperate than one can imagine. (Brogdon 2003: 105)
Chapter IX. Survey

Introduction
“There is an acute tension in human rights reporting between the blurred and constructed nature of the category of human rights violation and the desire to assert the veracity of information.” (Wilson 1997: 142) This quote captures the epidemiologist’s struggle how to define the trauma of torture by the means of describing quantity. Important part of the attempt is, that torture has to be codified, measured, numbered and isolated from other trauma. The traditional and positivist approach to research data is to define, collect and quantify, and then assess by statistical means for significance and variation. To make the trauma of torture count, quantification is necessary, but, at the same time, it is not sufficient to tell the full story: “The texture of dire affliction is best felt in the gritty details”. (Farmer 1997) Thus, a medical anthropological view tries to surpass quantification by the amplification of the qualitative assessment. What quantitative measures are available should be considered for appropriateness, both in a medical and an anthropological sense. In human rights violations in particular the qualitative approach seems better equipped to represent the essentiality of suffering, and to recognize the importance of the subjective and contextual aspect. In order to cover both, quantity and quality, of the torture narrative, this chapter will start by looking at the epidemiological aspect of torture first, but will then enlarge and detail the picture by insights that result from the individual examination of victims.

To connect the questions of quantity with those of quality, the objectives of this survey must clarify the trajectories or the frequencies of observations in order to demonstrate the interconnectedness of the asylum procedure and the torture narrative of Dutch asylum seekers. The suitable information is encountered in the results of the medical examination itself. The advantage of the individual medical interview is, that the personal narrative of asylum seekers can be made into an step of empowerment. The tortured victim and the examining physician meet to construct a relationship of a particular significance, that differs from other medical routines. The client is in need of a way to achieve a new future, which can be built on trust, credibility and the restoration of personal identity. The physician tries to oblige the client’s search, while maintaining the virtues of his profession, requiring a combination of truth, empathy, care, humanity and scientific detachment.

In the second part of this survey I will summarize, then discuss those aspects in the MEG evaluation and in my own series of case observations, aiming at a new perception of data, which can convey the individual experience of suffering.
An epidemic of torture?

A good reason to start the survey as an epidemiologist would have done, is, that Amnesty International and other anti-torture organizations have declared, that torture is becoming an epidemic of our times. Is that a metaphor? Once it is viewed as the causal agent of an epidemic, torture can be constructed also as an illness, that is ‘spreading rapidly and extensively, affecting many individuals in different areas and population at the same time’. (Dictionary 2000) The creation of that image generates the question what resistance there is to counteract the epidemic and how the defence can be improved. Who is responsible, where did this epidemic start, what is its course, and how will it end? Without doubt, the image of an epidemic, chosen by the anti-torture activists, helps to raise the alarm and to produce social awareness, involvement and resistance. By virtue of combining a typical medical concept with the fear of great social complications, the introduction of ‘epidemic’ is certainly a useful rhetoric. In the analysis of how doctors deal with torture, an epidemiological approach enhances the demonstration of the socio-political context of interventions. Finally the rhetoric offers human rights activists encouragement, because it is self-evident, that an epidemic should be stopped.

One important consideration in comparing the medical and the anthropological point of view is: whose persuasion is taken as the key for the analysis and the interpretation of the events that are taking place in the medical arena? How is torture singled out as an agent in the narrative of asylum? What is the contribution by the profession? I will continue using the questions, generated by an assumed torture-epidemic, to examine how epidemiology takes part in the discourse on torture. (Sommerfeld 1994: 280)

Epidemiology is the study of the demographics of disease processes, including epidemics of diseases, that are common enough to allow statistics to be applied. So, besides contagious diseases, it also focuses on disorders, that affect millions, such as diabetes, coronary heart disease, high blood pressure and the effects of organized violence on health. Epidemiology offers a complementary perspective on the understanding of illness and health. (Helman 2001: 218-229) The agent, that causes disease, is never a single hit on humanity. The individual, who is struck, is always part of a community. The strike is staged in the context of politico-socio-cultural circumstances. (Hardon et al. in Manual Applied Health Research 2001: 30) In torture related illness, for reasons to be reviewed, the medical concept lacks a clear and reliable outline. Not only is the reliability of case studies a doubtful issue; the counts also of tortured individuals as a proportion of source population and a population at risk is
uncertain. If and how torture is exposed, as the responsible agent for causing an epidemic, depends on what is acceptable in the public discourse and the political agenda. Medical epidemiology is the gathering and interpreting of evidence on clearly defined health conditions and speaks, pictures and publicizes of what can be categorized in relation to groups and expected frequencies. In the medical model, the case definition itself of torture offers no problems. Literature contains sufficient observations, descriptive criteria and other specifications of time, place, and person. (tables 1-8) It is in the application to epidemiological investigations that a medical model of torture confronts many obstructions of measurement, quantification and comparison.

In the medical model, disease is categorized in ‘entities’, that are reductions of experience and observation by the means of positive or negative criteria on causes, signs and symptoms. (Sackett et al 1985, Kager 1998) The epidemiological perspective introduces quantity, period (incidence, prevalence, frequency, emergence), spatial and population dimension (locality, group), visualizing the overall narrative in numbers, tables or graphs. (Fig. 1, 2) The rate (numerical proportion) is the prime epidemiological unit of measurement, appearing in incidence (new cases per population at risk in a specified period), prevalence (proportion of a specific population at a point in time) or frequency (recurrence in a specific period). The term ‘epidemic’ (‘pandemic’, ‘holoendemic’) is applied when a disease occurs above the average and/or the expected. (Fig. 3) Appropriate investigations are paramount to verify the diagnosis. (Coggon et al. 1997) To diagnose torture, the crucial criteria are: severe pain and suffering, whether physical or mental, that has been intentionally inflicted by a state official or another acting with the acquiescence of the state.

Access to incidents of torture by direct observation is however hardly ever possible. Secrecy is an important part of the scenario of the torturer. In all ‘modern’ states official governmental sources will keep silent as a first line of defence; and if that is ineffective they will state emphatically that none of their employees is involved in applying torture. If presented with undeniable evidence, the responsible authority will deny all complicity. If cornered by further evidence the ultimate solution is either to accuse the torturer to have acted on his own or to have misinterpreted the instructions. The fact that, as a rule, at this time, the responsible authority denies its existence and keeps all related data outside the public view, removes torture from the health registers. A medical counterpart that is classified in ICC and not ICD would be hard to find. Possibly agents of biological or toxic warfare are viewed upon in somewhat similar way.

Torture is a weapon both against individual persons and groups in society. The perpetrators use it to break the mind of opponents and to stamp out all resistance to state
suppression. To wield it as an effective weapon, the perpetrator has to control the publicity concerning torture and its victims. (Rejali 1994) Torture is an indicator of the existence of a pathology of power. It shows that the lack of mutuality in human interaction has reached an extreme, and aggressors have absolute control, victims totally none. (Farmer 1999, 2003) Medical institutions under that extreme state authority have no agency on torture and are forced into participation. (Maio 2001) As a result, ‘normal’ criteria of epidemiological observation cannot be applied. For example, Mexican statistics, that make it appear as if the prevalence of torture is diminishing, could be constructed differently by demonstrating, that people wounded or killed by the authorities are not registered as torture, or, that many victims do not denounce their torturers for fear of reprisals.

Organized violence and torture are not easily separated or reduced into single agents. Both terms qualify as acts against humanity in the Rome statute of the International Criminal Court (ICC) at The Hague. Beyond the boundaries of a state only this one court can deal with the countries accused of torture. The international consensus, that torture is a punishable act, entered into force only recently, in 2002. Contrary to that international consensus, fig.1 (Annexes) illustrates that, at the beginning of this millennium, torture is common in many countries, and all but few are signatories of the treaties of the ICC. Prophetically, in 1965 Camus described torture as an uncontrollable plague. Amnesty International (AI), visualizes torture as a causal agent in an epidemic today and uses the image with the purpose to compare with other medical catastrophes. (Table 6) This representation is supported by many organisations worldwide. (Torture 2004 for the International Medical Volunteer Organizations, Giffard 2000) How does the similitude of a torture epidemic work in epidemiology? (table 6-7 in Annexes)

**Torture in medical epidemiology**

Weinstein et al. (1996) summarized factors that are commonly associated with torture from a wider literature. (Tables 8-13) Unlike entities such as infections, chronic disease conditions and injuries, torture-related illness occupies no code in the international classification of disease (ICD). In an epidemiological perspective, the medical gaze is caught between impartiality, coercion, complicity and loyalty, and this constriction is forbidding. As an example: physicians in Turkey are coerced to ignore torture of detainees (Iacopino et al. 1996) A recent survey in Mexico, amongst state forensic physicians in Mexico, offers a detailed view on structural medical complicity, that prevents reporting on torture. (Heisler et al. 2003)

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15 ICD10 registration of trauma or injury. F43.1 as post-traumatic stress disorder (PTSD specified as being the victim of torture, terrorism, rape, or other crime)
Medical professionals comply, deny, are kept away or protest without much impact, but they do not control the agent, nor the reporting or registration of the so-called epidemic. A further source of paradoxes is, that torture, which leads to the asylum request in one country, is inflicted in another. Local laws and bilateral or international treaties set the boundaries. The paradoxes present in other areas also. In the case definition, the illness, arising from torture, can be ICD-coded — for instance as post-traumatic disorders (PTSD or other: table 12). A torture syndrome has been proposed as an entity. (Jacobsen & Smidt-Nielsen 1997, Network 2003) However, medical experts argue, that “there is no specific post-torture syndrome, and it is impossible to give precise cause for someone suffering from the symptoms of PTSD.”(Peel 1999; Peel and Iacopino 2002) Peel illustrated that by showing the difficulty in pinpointing causal relationships between violence, government actors and illnesses, in one torture outbreak related to detention periods in Algeria. (fig 2: Peel 1999; Burnett and Peel 2001)

One consequence is that the post-torture disease entity cannot match the scientific approach in medical epidemiology, known to work in many other disorders (Table 7: WHO 1992) If it would, results should appear in Medline searches, or other probes on the Internet, and in comparable global publications. The epidemiological literature rarely carries reviews or news on torture epidemics. (Anonymous 2001) Any attempt to a meta-analysis of epidemiological fact reveals, that evidence based publications are limited to a few articles in international medical journals, that have the prime intention to point out the existence, without detailing the extent of torture related illness. One notable exception is Allodi, who wrote: “The concept of post traumatic stress disorder is used to organize literature on psychiatric casualties resulting from massive psychic trauma, e.g. the current world epidemic of torture. Torture is a unique human made stressor resulting in category-specific diagnostic symptoms. Medical assessment can be complemented with photographs, X-rays, electro-encephalograms, and sleep studies. Future research needs to include the conceptualisation of the trauma of torture and its sequel in broader terms, the application of standardized measurements to facilitate international comparisons, and the testing of various approaches to intervention in an experimental design.”(Allodi 1991) In the decade since, screening and examination protocols have become available, tested and validated. (Harvard Trauma Scale, Mollica et al. 2002, Protocol 2001). Recent research on 15000 trauma events concluded, that identification of torture must be maintained in order to develop a public health model. (Mollica et al. 2002)

A study on asylum seekers concluded however: “The prevalence of psychiatric symptoms was high without significant differences in mental health, both in groups of tortured and non-tortured persons”. (Hermansson et al 2003)
The facts are mostly inaccessible. Can ‘conjectural statistics’ support the image of a world plague? Advocacies claim, that, in the year 2000, up to 4.3 million refugees, wandering worldwide, have survived torture. (IRCT 2004) Mortality due to torture is a quantity that is largely unknown, due to the politico-socio-cultural barriers discussed above. The morbidity statistics are derived from accounts of refugees and asylum seekers, outside the grasp of their tormentors. The figures are rough estimates, much affected by the circumstances. Who could escape to testify? Who is there to count? What would be the purpose? A case definition on Allodi’s concept is possible, but it is only rarely put into practice. One practical advantage of the medical examination, as a regulated part of asylum procedures, is, that individuals can be screened and identified as victims of torture.

**The blurring of trauma**

The medical data on torture as an agent are probably less than an informed guess. The estimate is, that, at least, approximately 20 % of the registered UNHCR-refugee population (19 million in 2004) have a verifiable history of torture. This figure is mentioned repeatedly by medical institutions (PHRUSA 2004; Peel and Iacopino 2002) In some countries, as in the Netherlands, the prevalence of morbidity over the past decade, attributed to torture in specified groups of asylum seekers and refugees, matches the above minimal estimate of 20 %. (van Willigen 1992, Hondius et al. 2000) In one recent Norwegian study of 462 refugees 35 % had been subjected to torture. In one nation-wide assessment concerning the post-civil war conditions in East-Timor a population survey showed that 97 % of respondents had experienced at least one traumatic event and 57 % had been subjected to torture. (IRCT 2003)

Nevertheless, in whatever way torture has been reduced to one entity with the intention to enable a report on incidence and prevalence, the suggestion, that it qualifies as a pandemic, (hyper) endemic and epidemic occurrence, has no basis on established and reproducible observation. Only a small number of medical journals picture torture epidemics in the sense that WHO epidemiological reports ordinary deal with. (Silove 1999)

This ‘blurring’ contributes to an image of torture as collateral to world conflicts and human rights violations, and not, at the same time, a specific concern in public health. Organized violence is not linked to a professional medical point of view by medical epidemiology. The medical epidemiologist cannot accommodate post-torture conditions in a disease-centred classification. That denial fails the victims of torture as patients. (Jones 2002) The same lack in engagement is apparent in the Netherlands: “Health problems of migrants only become visible when public health is threatened. The focus is on the risk of the spread of
tuberculosis and other infectious diseases. In this perspective, migrants, especially illegal migrants, are viewed upon as transmission sources of infectious disease. Since 1966, residence permits are connected to tuberculosis-examinations". (van Dijk and van Dongen 2000: 50)

Traumatic events in the narratives of asylum seekers are taken into account, but they are not communicated to the health authority or to the immigration service. The medical professionals agree that the main cause of asylum migration is the pervasive global effects of organized violence, but that interpretation does not contribute to shaping an image of a social epidemic. (Hondius et al. 2000) This image is kept hidden in the arena of health, as is admitted and regretted by the medical professionals involved. Richardus wrote: "Registered asylum seekers are legally living in the Netherlands and receive the same health care as other residents. On arrival all asylum seekers undergo a medical examination. However, apart from the preventive medical examination concerning tuberculosis, there is currently no agreement concerning the extent of this examination."

Due to the lack of epidemiological determinants for torture, the extent of sexual violence in asylum narratives has to be explored by studying incidences of venereal infections in the female population of Dutch asylum centres. (Knoppers 2004)

**Medical anthropology and the epidemic of torture**

Hahn (1995) wrote:"Anthropologists deploy universals to arrive at particulars". One universal that pertains to the image that torture is spreading like an epidemic can be traced to Kleinman (1996: 202): “Suffering can be defined as a universal aspect of human experience. There are routine forms of suffering that are experiences of degradation and oppression that certain categories of individuals (the vulnerable and the defeated) are specially exposed to and others relatively protected from. There is also suffering resulting from extreme conditions. The cultural meanings of suffering may be elaborated in different ways, but the intersubjective experience of suffering, we contend, is itself a defining characteristic of human conditions in all societies”. Medical anthropology offers this perspective as one that is distinct from the medical. Torture survivors express their plight in a specific discourse and use explanatory models that are different from that in any other illness. Anthropology compares that discourse to the epidemiology of other scourges as illustrated by fig.6, 7 (McMichael 1995) Zwi and Ugalde expected in 1989 that increasing recognition of political and man-made violence would become a major public health concern. (Zwi and Ugalde 1989) 15 years later, the reverse has happened. (Zwi 2002, Krug et al. 2002)
Anthropological studies reveal, that state power is behind most human rights violations. Torture is embedded in the structural violence of social and economic inequities. (Farmer 1999) Literature searches in this direction provide a wealth of data, which makes sense. In the shifting paradigms of epidemiological research, medical anthropology differs clearly and in almost every aspect from the classification, according to the medical model, of torture and its sequel, as discussed in the previous paragraph. Paramount to the exposure of the narrative of torture victims is “the information provided by public health professionals and through the media, and prevailing memories, ideas and emotions. On the basis of all this, the imagined epidemic emerges”.

The meaning of torture is determined by cultural and political beliefs. (Holtz 1998) The universal narrative, taken into account by medical anthropology, captures the social image of organized violence. Torture in this context is experienced as the trauma of a whole community. (Rejali 1994) Torture rationality is interpreted to have as its intention to damage the person's self esteem and personality, to destroy trust in fellow humans, and to terrorize the population. The agent can eliminate almost everything that has value in the individual mind, even the language necessary to speak out about it. (Scarry 1985: 48). It produces tales that nobody wants to hear. (Weschler 1990: 242) Victims can be silenced or muted as a consequence of the fear for re-exposure, for instance in refoulement if the asylum request is denied. Their silence can also be due to the mental trauma itself and the abhorrence to relive the experience. Loyalty towards kin or other potential victims may prevent asylum seekers to speak. The unspeakable and the unwillingness to hear is often a combined phenomenon. This silence accompanies the asylum seeker. The medical anthropological literature tends to point that out, but also to respect it. Of course, this is for a good reason. Exposing torture conditions has had negative consequences on the victims, and on anthropologists themselves also with respect to the possibility to do field observations. (Danzig 2004) So, ethnographic information of the occurrence at the source, which can be related to the torture epidemic, is hard to come by. (Agar 2001; Tankink 2000).

In the countries of refuge, the influx of asylum seekers, for instance in European countries, are one reason that immigration authorities try their utmost to palm off asylum seekers onto others. Local law, again, defines the boundaries and thresholds. (Fig 5) In the processing of the claim of asylum seekers, the violence they suffered in their country of origin is removed from the official strategies of admittance. (Fig. 6) In the Netherlands, the immigration authority does not want to accept torture to be investigated from a medical point of view. (Oomen 2001) The disconnection of torture as agent of asylum is confirmed and
extended as shown by recent qualitative studies among groups of asylum inhabitants in the Netherlands, in which the interviewees blamed the lengthy stay in the reception centres and unemployment as cause of their non-specific medical problems. (Logghe 2001)

While few anthropologists oppose the metaphor of a torture epidemic, many would argue for a critical pause before this concept is applied to atrocities committed in other times and places. (Hinton 2002; Asad 1997) That very critical reflection, that is a cornerstone of medical anthropological reasoning, precludes particularity in the epidemiological case definition. (Fig 7,8) It may explain also, why, in the Netherlands, no medical anthropological observations are available on the asylum hearings itself, while the most pertinent publications deal with the narrative of torture after a period of latency. (Driessen 2003)

Finally one question remains: can the rhetoric of an epidemic of torture function as a tactic of resistance? Scott (1990) proposes such ‘hidden transcript’ as “the oppressed groups’ ability to undermine their oppressive ‘official transcript’ to create an underground resistance. The underlying meaning of these hidden transcripts provides the keys which unlock the secrets coded into the public discourse.” In their attempt to expose the worldwide problem of torture, the resisting organisations are helpless and have no other means than the rhetorical. In that respect the anthropological discourse offers a purpose, a promise and an encouragement, but as yet the rhetoric is too weak to succeed.

**Trajectory of reporting**

Having discussed the difficulties of epidemiology to connect torture with illness, this survey will now to turn towards the attempt of a group of doctors, who, by means of their medical examinations, try to offer an organized resistance to the ‘blurring of human rights violation’ in ‘their desire to assert the veracity of information’ according to the Allodi concept. (Wilson 1997) This Medical Examination Group (MEG) grew as an offshoot of the Dutch branch of Amnesty International, that itself was founded in London in 1961 and in the Netherlands in 1968. An increasing preoccupation of the Dutch AI with torture initiated a demand for medical competence, and resulted in a professional group of dedicated medical volunteers in 1975. The participating doctors first studied torture from a theoretical medical point of view, and then decided that too little was known about the consequences, in particular about the physical and mental complications experienced by victims in the Dutch asylum centres. In 1977 the MEG was founded to interview asylum seekers individually.16 Since 1980 medical

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16 Handboek Medische Onderzoeksgroep Amnesty International Nederland 2003
affidavits were produced on behalf of a select sample of asylum seekers, who had been refused asylum in the Netherlands, on the request of their solicitors.

The MEG, which I joined in 1994, has since made follow-up inventories of more than 2000 reports. (Fig 9) In 1994, fifty years after the UN’s universal declaration on human rights, the volunteer action had developed into a medical application, supported by an evidence-based guideline, aiming at averting expulsion from asylum of persons, which had been tortured.\textsuperscript{17} The examinations are a routine that is performed by one member, who has been trained by an experienced colleague. On average, in the past decade the group numbered fifty members, and each reported approximately 4 cases per year.

Analysis of a 5-year span in a consecutive number of 1000 requests (1990-1994) by 200 solicitors showed that 51\% led to a medical examination and a 90\% positive intervention: 31\% asylum status, 59\% temporary status and 10\% unsuccessful or unknown result. Important is, that less than half of requests result in a report. The explanations for not accepting the other half of the requests are: (solicitors) changes in the procedure itself or (client) asylum obtained or claim withdrawn; (asylum seekers) disappearances or inability to cooperate in the examination (often due to psychiatric admission); (adjudication by AI refugee expert) requests that do not conform with the AI mandate or provide insufficient detail for analysis; (adjudication MEG) decision that medical examination cannot add anything significant because (a) sufficient medical information is already available (b) ongoing medical treatment or examination can provide the documentation (c) the expectation of providing evidence cannot be met.

The analysis in more recent annual evaluations shows, that the above explanations are reducing requests reported upon to 44\%. The statistics in the trajectory show that measured with an interval of 2 years after reporting, 65\% of the examined dossiers (30\% of the original requested by solicitors) progress to a positive outcome for the asylum seeker. That assessment relies on information obtained by follow-up through the solicitors’ offices. The extraction of data and their interpretation is uncertain due to a meshwork of circumstances. Even after an appeal period of 2 years 10\% of claimants are still in procedure, more than 6 years after the initiation of the claim. Non-response of the solicitors is 10\% because many of them are no longer responsible for the appeal and do not know where the client is.

To what extent and in what manner the reported medical examinations affect a positive conclusion is even harder to pinpoint. The lack of transparency in the long process of granting

\textsuperscript{17} Data from my poster at the European Association of Psychosomatic Research Manchester 1996
asylum is maintained to the very end and positive decisions are not argued by the IND. Due to the duration of the judicial process itself novel situations constantly affect its outcome. Country conditions change, and claimants disappear or otherwise desist. The Foreign Office assesses the safety conditions in the countries of origin differently to increase or diminish the risk of extradition. Other interceding decisions favour groups of claimants for no other reason than the inability of the bureaucratic apparatus to process their claims: such instances arrived by granting asylum to all, whose claim had waited unprocessed for three consecutive years, or after a new Aliens Law (2001), or been reassessed as smarting (Dutch: ‘schrijnende’) cases. Another restriction is, that a minority of professionals, who offer legal aid to asylum seekers, invoke the AI assistance: one estimate is that 13 % do and is not known what proportion of asylum procedures that percentage represents of the population that could benefit by being assisted. The overall outcome of these incalculable processes is that the lump sum of measured MEG intervention, is estimated as 30 % positive vs. 6 % no effect, or approximately 5:1, but can hardly be statistically evaluated or correlated in the asylum-due-to-torture equation itself. How and by what medical argument the IND is influenced in its decisions remains unclear because data relevant to that question are unavailable.

Victims, tortures and consequences
In a further attempt of connecting the issues of asylum and torture, Vervaat (2000) analysed a representative sample of 52, 41 male and 11 female, out of 157 MEG reports produced in the period 1998-1999. (Tables 10,11; fig. 8). Starting in 1998 the MEG made use of a standard protocol for examination, and that fact facilitated a detailed inventory from, and the comparison between reports. The analysis shows that the average age of clients examined is 33 years (plus/minus 9 years) and the duration of the asylum procedure is 2,3 years (plus/minus 1,4 years). The clients are equally distributed as to high, middle and low social origins. Torture had almost always occurred during extra judicial detention periods. The interval between the last (index) detention period and the moment of medical examination was 4,7 years (SD 4,1). Since the examination took place on average 2,3 years after entry in the Netherlands, that signifies that an interval existed of at least several years distance between index mistreatment and asylum request and another considerable time lapse to the medical examination. All clients examined had suffered more than one torture period or method; the average mode of mistreatment affecting each person, as detailed in table 15 for 20 different methods (conform the Istanbul Protocol) was 6,1 (SD 3,4) Sexual violence, rape in particular, was documented as having been suffered by 73% of women and 32% of men.
Methods of torture were often related to the countries of origin: occurrences on the African continent show emphasis on burns and the deprivation of food or water; the Middle East and Asian continent on blindfolding, threatening, falanga, suspension and isolation. The analysis of the consequences of tortures, assessed during examination according to the protocol, demonstrates a high incidence and broad variety of physical and mental complaints. By making an inventory of the signs and symptoms according to distinctive categories, a semi-quantitative statistical description is facilitated. (Table 16) The pattern of complaints attributed is more often of a mental than a somatic character. Both the psychological and somatic observations appear applicable to a cluster of chronic and continuous signs of distress, which overlap with the criteria of PTSD and/or a depressive disorder. The medical interpretation (table 16) can be summarized by the following semi-quantitative observations:

1. Nearly all clients (96 %) attributed a complex of somatic and mental complaints to torture
2. Incidence of somatic complaints per person was 5.8 (SD 4.1); mental 7.3 (SD 4.0)
3. During physical examination distinct scars and/or disabilities are present in 83 %, equally distributed over all parts of the body.
4. Somatic complications, which were reported often, were loco-motor (joints, muscles, movement: 60 %), motor-sensory (paresis, pain, loss of feeling: 33 %) and teeth (15 %).
5. The emotional and mental functions, which were most often involved, are affective (mood, initiative, impulses: 90 %), cognitive (concentration, memory, intellectual: 58 %)
6. PTSD criteria were diagnosed in 13 %; a further 66 % met several but not all of the criteria of PTSD; in particular because signs in the avoidance-cluster were not apparent.
7. Criteria for the psychiatric diagnosis of depression were met in 21 %; a further 27 % met several but not all criteria of a psychiatric depressive disorder.
8. The quality of reporting was assessed by comparing the subject matter of documentation to the prescriptions of the guideline. In 88 % the manner of observing and interpreting was found to conform to requirements as stated in the protocol.
9. Comparing conclusions to the solicitor’s queries, which initiated the medical examination, assessed the result of documentation. In 83 % of conclusions the request for confirmation could be met fully and satisfactorily and in 17 % part of conclusions was confirmatory.
10. The results confirm the facts suggested by Weinstein’s in tables 4-8. One notable fact is that in a significant proportion of the conclusions, the MEG reports substantiate the presence of medical findings, that have not been previously been taken into consideration in the asylum procedure.

**Medical reporting and individual asylum claims**

The previous sections show that the aims of the MEG have changed direction over the past decades. At the outset in 1977 their action aimed at answering the question: is the issue of torture being considered sufficiently in the Dutch asylum procedure? Since 1990 the stated goal of medical examination has, step-by-step, transformed into the actual documentation of the complaints presented by individual victims, that confirm the allegation of torture and can thus be presented in the court of appeal of asylum. In 1997 AI called on "governments to ensure that they do not obstruct asylum seekers' access to their countries and that they provide asylum procedures that are fair, impartial and thorough.". It is important to dwell on the intricacies of that task, because of the fundamental antithesis between IND and MEG on the issue of medical reporting being a instrument valid for that purpose. Difficult as it is to take apart the chain of evidence, observed between torture and the distance of appeal conditions in asylum cases, the surveillance on cases examined is one method, that provides at least some direction and material to do so. (Fig. 9) Conclusions from the ongoing interpretation of cases and evaluation of the follow-up in appeals, as interpreted by members of the MEG, are:

1. Tortures leave physical scars in almost all victims (96 %) through signs and symptoms that can be observed and interpreted as a consequence of that trauma. In a large majority (83 %) scars and/or disabilities are physical and can be verified by simple inspection, performed by a trained medical professional.

2. Late post-torture symptomatology is by and large of a recognizable pattern determined by multiple signs and discrete complaints of a physical and psychological nature, that is persistent and of long duration.

3. Emotional and cognitive problems, that correlate PTSD (intrusions, sleeping disorders, nightmares, anxiety) and depression (mood, impulse control) are frequent (80 %).

4. The symptomatology as a whole is sufficiently distinct to develop a systematic approach to interpretation, which can help, as a basis of evidence, future medical assistance in other allegations of torture, made by other victims.
These conclusions provide support to the view that medical expertise should be included in the procedural evaluation of asylum seekers, who state as an allegation to have been tortured in their countries of origin. The recent evaluations of the MEG offer some insight in the impact of medical reporting on obtaining asylum. (Pomstra 2003) A sample of 100 consecutive dossiers, reported upon from the start of 1999, was taken to assess the opinions of solicitors. Due to a non-response in 9 cases, data were available in 91. The majority of solicitors involved, questioned on the relevance of the medical report, answered, that it had a decisive or important effect on the outcome of appeals: as to 1999 64 % and as to 2000 85 % of solicitors expressed that assessment. Table I illustrates the results:

<table>
<thead>
<tr>
<th>Table I Effect Medical Report</th>
<th>1999</th>
<th>2000</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number reports assessed</td>
<td>63</td>
<td>28</td>
<td>91 (100 %)</td>
</tr>
<tr>
<td>Decisive</td>
<td>18</td>
<td>12</td>
<td>30 (33 %)</td>
</tr>
<tr>
<td>Important</td>
<td>22</td>
<td>13</td>
<td>35 (38 %)</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
<td>1</td>
<td>5 (5 %)</td>
</tr>
<tr>
<td>Little</td>
<td>3</td>
<td>2</td>
<td>5 (5 %)</td>
</tr>
<tr>
<td>None</td>
<td>16</td>
<td>0</td>
<td>16 (18 %)</td>
</tr>
</tbody>
</table>

Two further aspects must be differentiated: the acquisition of asylum, in the appeal procedure, based on a regular refugee-state or that of a permission on humanitarian grounds, enabling the asylum seeker to stay as a person traumatized according to the European treaties.18 If the result of medical reporting is assessed in 2003, in relation to a five-year period of 1995-2000, those two aspects were documented in 51 % of permissions obtained in total, of the regular type in 19 %, and of the humanitarian type in 32 %.

**The gritty details**

The effect of reporting can be further investigated by an in depth analysis of individual cases and their outcome in the asylum procedure. What differences of interpretation between observations are relevant? Table II details the trajectory between torture and asylum.

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18 The ETHR (European treaty for human rights) articles stipulate the humanitarian conditions that have to be considered.
Table II: The 30 dossiers of my cases and details of their trajectories of asylum as in 2004.

<table>
<thead>
<tr>
<th>Dossiers</th>
<th>Client, year of asylum request</th>
<th>M / F</th>
<th>Country origin</th>
<th>Allegation &amp; months of time lapse total, detailed for (1) trauma to asylum request, (2) asylum request to medical examination (1) (2)</th>
<th>Related medical conclusion (and eventual unrelated but significant diagnosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &gt; 2000</td>
<td>33 M Iran</td>
<td>Detention, torture</td>
<td>56 34 22</td>
<td>Scars, PTSD</td>
<td></td>
</tr>
<tr>
<td>2 * 1998</td>
<td>42 M Irak, Syria</td>
<td>Detention, torture</td>
<td>156 96 60</td>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>3 * 2001</td>
<td>31 M Iran</td>
<td>Detention, sexual assault</td>
<td>54 36 18</td>
<td>Assaulted, PTSD</td>
<td></td>
</tr>
<tr>
<td>4 * 2001</td>
<td>38 M Zaire</td>
<td>Detention, torture</td>
<td>40 24 16</td>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>5 * 1998</td>
<td>50 M Irak</td>
<td>Detention</td>
<td>139 99 40</td>
<td>Amnesia, Brain lesion, diabetes</td>
<td></td>
</tr>
<tr>
<td>6 # 1997</td>
<td>30 M Irak</td>
<td>Detention, torture</td>
<td>120 60 60</td>
<td>Scars, PTSD</td>
<td></td>
</tr>
<tr>
<td>7 * 1995</td>
<td>42 M Ethiopia</td>
<td>Detention, sexual assault</td>
<td>159 99 60</td>
<td>Assaulted, Scars, PTSD</td>
<td></td>
</tr>
<tr>
<td>8 * 2000</td>
<td>35 M Cameroon</td>
<td>Detention, torture</td>
<td>30 30 0,1</td>
<td>Scars, asthma</td>
<td></td>
</tr>
<tr>
<td>9 * 1998</td>
<td>21 M Guinea</td>
<td>Detention, sexual assault</td>
<td>56 36 20</td>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>10 * 1995</td>
<td>52 M Irak</td>
<td>Detention, torture</td>
<td>92 70 22</td>
<td>Scars, endocrinopathy</td>
<td></td>
</tr>
<tr>
<td>11 &gt; 1995</td>
<td>21 M Ethiopia</td>
<td>Torture</td>
<td>126 66 60</td>
<td>Knee deformed, PTSD</td>
<td></td>
</tr>
<tr>
<td>12 * 1995</td>
<td>30 M Iran</td>
<td>Torture, sexual assault</td>
<td>24 18 6</td>
<td>Assaulted, Scars, Testicular lesion</td>
<td></td>
</tr>
<tr>
<td>13 * 1994</td>
<td>25 M Sri Lanka</td>
<td>Torture, sexual assault</td>
<td>84 48 36</td>
<td>Assaulted, Scars</td>
<td></td>
</tr>
<tr>
<td>14 * 1993</td>
<td>23 M Sri Lanka</td>
<td>Detention, torture</td>
<td>76 40 36</td>
<td>Scars, PTSD</td>
<td></td>
</tr>
<tr>
<td>15 # 1994</td>
<td>33 M Ethiopia</td>
<td>Detention, torture</td>
<td>48 36 12</td>
<td>Scars, Vertebral lesion</td>
<td></td>
</tr>
<tr>
<td>16 &gt; 1994</td>
<td>39 M Turkey</td>
<td>Detention, torture</td>
<td>98 50 48</td>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>17 &gt; 1997</td>
<td>29 M Libya</td>
<td>Detention, torture</td>
<td>116 59 57</td>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>18 * 1997</td>
<td>29 M Sri Lanka</td>
<td>Detention, torture</td>
<td>108 72 36</td>
<td>Scars, PTSD, Depression</td>
<td></td>
</tr>
<tr>
<td>19 * 1998</td>
<td>33 M Turkey</td>
<td>Detention, torture</td>
<td>44 36 8</td>
<td>Scars, PTSD, hypertension</td>
<td></td>
</tr>
<tr>
<td>20 * 1998</td>
<td>27 F Turkey</td>
<td>Sexual assault, beating</td>
<td>22 14 8</td>
<td>Assaulted, Lost unborn child</td>
<td></td>
</tr>
<tr>
<td>21 (*) 1999</td>
<td>41 M Syria</td>
<td>Detention, torture</td>
<td>52 40 12</td>
<td>Scars, PTSD</td>
<td></td>
</tr>
</tbody>
</table>

The key observations in these reports were transcribed to a SPSS database (in yes/no/unknown or numerical entries), containing items (age, sex, country of origin, main issue of request, time lapses between trauma and examination, and findings on examination) adapted from Vervaat’s thesis, Weinstein’s criteria (in yes/no/unknown, numerical or annotated entries) and extended with criteria on the previously reported issues in the trajectory of medical evidence.19 (Tables 8-13 Annexes). The listing provides clues:

1. To the analysis of undisclosed trauma in the IND hearings

19 The structured SPSS database is in Annexes p.121–125
2. On the uncovering of new medical facts (‘nova’) in defence to the IND decisions

3. On new medical evidence on the trauma, that came to light during the interval between IND and MEG intervention

4. On medical data that can correlate the trauma to the stated motivation for asylum

5. On MEG evidence suitable to connect the narrative, scars, somatic and/or psychiatric complaints and/or observations.

6. On the chronology of disclosure between the IND hearing and the MEG examination.

7. On the outcome of the asylum request after MEG reporting.

My thick description of the asylum seeking strives to provide details on the fate and the profile of the victim of torture in the Dutch procedure by giving a portrayal of disclosures. An attempt to generalize is made by contrasting the medical evidence to the evidence in the IND hearing and decision. The moment of medical examination follows the IND hearing after a period of months or years and includes the periods of awaiting appeals and thus this retrospect of asylum seekers in the Netherlands, with a history of trauma, provides the qualitative aspect of the sequence of information acquisition. The order of items is conform the MEG protocol of reporting. Items that are correlated *italicised* and cases are numbered as in the table.

- **1-** The *circumstances and historical events* that are associated with to the *escape and asylum request* show that more often than not the clients were unarmed civilians caught in a local conflict, as bystanders and not as active participants. This is even more so with *female* and *young* examinees. Family ties were prominent factors in their arrest: females and children were taken hostage or used as a substitute for other household or community members. The background violence was more often intra-ethnic than between groups of differing *ethnicity* or on issues perceived as *racial* or *religious*.

The ties connecting clients to the cause of *opposition* or suppression in the country of origin were weak and accidental. The *preamble to trauma* was more often gradual than sudden: protracted harassment by discrimination, arrest and detention building towards a breaking point, that can be seen as the final motivation for an escape attempt. The *loss of significant others* was one recurring reason, either by violent or by natural causes. Also important were personal events, that made the client unavoidably an *unwanted person*, whose continuing presence menaces the safety of others, family, group members or even persecutors. The
leaving home was often linked to *bribery or conspiracies* between victim and assisting/persecuting parties. On the issue of *attachments*, that tied the client to a Dutch asylum request, an aspect of note is, that, in a minority of cases, the victim had a partner and/or children in this country, who had or had not obtained an asylum status and were dependent on the client. Case 29 for instance was completely preoccupied by the care for his severely depressed wife, who had followed him into asylum, obtained a refugee status independently, while he himself was still awaiting appeals after a negative decision.

-2- *The escape opportunity* was usually due to a combination of chance and assistance by family and friends, who aimed at removing the exposed relative, but at the same time the dangers of their own exposition. Violence of a more indeterminate and prolonged nature was often as important in the course of events as was the circumscribed trauma of torture itself. Equally influential was the *fear of reoccurrence of trauma* and the clients conviction to be unable to avert it. Another recurrent theme can be constructed as an experience of *profound loss of identity*, apparent in feelings of humiliation and exhausted coping strategies. Expecting a chance of treatment for medical conditions or needs was not apparent at all in the request for asylum, neither were economical or career ambitions. Important to note is that the flight from home was never motivated by any self-awareness of having been traumatized and being in need for care in that respect. The majority of clients had no previous experience in refugee conditions and no attachments to the country they requested asylum from. Their knowledge of asylum requirements and setting in this country was usually non-existent at the start and still poor at the later date of medical examination. The *planning and control of travelling* arrangement was in a majority of clients done by family or another intermediary, such as a non-governmental refugee worker. Financial arrangements varied, but often bribes were handed to persecutors and variable sums to travel agents.

In a minority the flight was possible by help of individuals or humanitarian organizations without recompense. The *remaining links* to home were often to family relatives, who were emotionally near to them, but neutral in the conflict that had occasioned the flight. A minority had family members in exile, but in only in one of these (case 5) there had been contacts to facilitate the search for asylum. A few clients had a network with co-victims, refugees or elsewhere in an asylum procedure. Only three clients (cases 2,21,26) had occupied a leadership position at home. Reported instances of previous attempts of escape were rare. Case 2, a businessman and journalist from Irak, had first requested asylum in Syria, but when threatened with eviction, he again moved on to the Netherlands. He was the only case who
had collected on his *own initiative an extensive documentation, including photographs, documenting his detention and torture.

-3- *The availability of documents* is a major concern of the IND: none of my clients had the expected, and most of them had never possessed a formal identification paper. From others the authority in the country of origin took what they had during detention. Medical records or paper proof of arrests or sentences were also usually unavailable. The exact date of birth, marriage and other administrative milestones are often not available in many cultures and countries of origin. This is a fact well known, but yet neglected in the asylum registration. A minority of clients admitted to have obtained *false travelling identifications* as part of the deal with travel agents and also, that these had been destroyed or retaken by these agents. In particular the male clients with a formal education showed themselves to be annoyed at having no paper identity and did much, even pathetic, effort to reclaim it by the help of relatives, for example writing home to ask for a certificate of a death sentence. It is important to note that the ‘moment of identification’, at the first hearing, and the link to the ‘moment of decision’, after the definite hearing, are literally *momentary events*: if identity is not established then and there, there are no second chances. In several instances, the cases, that I have examined, offered further evidence of their identity later on, for example by the help of relatives staying in the Netherlands. That later verification was however unacceptable to the IND for revision of negative decisions, ruling that the information had to be given at the once only proper time and occasion. The asylum procedure demonstrates a pre-emptive strategy that has to clash with the *realities that force refugees* to flee their countries of origin.

-4- The *general verification of narrative vis-à-vis the IND and the MEG demonstrates a significant difference. It the hearings the IND assessed the facts to find argument for a negative decision on the asylum request: at the definite hearing the interrogative routine checked the narrative in search of contradictions. The search is firmly directed at internal *consistency* and no effort is done in triangulation by linking the information to other sources, other informants or outside expertise. This approach is best illustrated by the fact that the client is required to give written permission to obtain medical information, but the IND never actually used that permission to do so. Reporting by the IND emphasized ascertainable facts by fragmentation, repetition of dates, locations and personal involvement of client; while the MEG emphasised context, correlation between fact and emotion, and the external consistency by comparing to the interpretations of other, in particular medical, observers. The IND
hearing took the *circumstances of flight as point of departure, in contrast to the MEG approach that took as its focus the *trauma that caused the asylum seeker to leave home.

-5- The *trauma is narrated by the victims as a set of events, that has certain aspects in common in most cases. Extra judicial *arrest and detention is a common circumstance; there is no formal charge, no solicitor, or formal publicity surrounding the detention. One notable exception is Iran, where the Islamic Guards maintain a routine of officiality. Relatives are not notified, but later on very often informed through guards parleying between the detained and family. The arrest takes place by a team of persons, in the home environment; the arresting ‘officials’ are armed, and bystanders are threatened, sometimes killed. The arresting team members do not identify themselves, but they are as a rule described by the victims as belonging to government-associated semi-official or secret *institutions with an exception in Sri Lanka and Sierra Leone, where anti-government rebel units in the civil wars were the perpetrators. Most severe *physical abuse occurs in the early part of detention. The victims have difficulty answering, when asked for possible reasons why they have been chosen to be subjected to torture. The explanation that fitted best to the majority: “it was an unfortunate accident of the kind that happened to a lot of people at that time and setting”. Mostly they emphasized as a main cause of *mental abuse the fact, that they had nothing to reveal or to let out. The perceived irrationality of their trauma is often paramount in the rewording during interrogation and medical examination. They relate a large part of their anguish to the inability to understand why it happened. Another amplification of trauma with much impact is to have been part of the torture centre scene and to have witnessed the torture of others, likewise powerless. In effect, the more the torture is devoid of explanation, the more it seems to have been experienced as demeaning and unbearable. In a majority of victims a vital part of humiliation is of *sexual abusive nature, and this part is usually hardest for the examiner to make his examinee recall. The victims, both men and women, who are able to state that they have been *raped, make clear that the sexual acts have been performed by their torturers as a gesture of ultimate *contempt. Several victims referred to the physical torture as restorable, but to the sexual abusive experiences as irreparable.

-6- The *psychiatric history of coping. Only in 2 examinations (cases 3,29) the client told during the medical examination that he had been seen by a psychiatrist/psychologist in the country of origin. This *prior psychiatric history had no link to the traumatic events causing the asylum request. None of the other clients had experienced psychiatric complaints in their personal history. The fact that so few of clients had experienced psychiatric complaints in the
past seems the more relevant, because, prior to their own personal involvement, most clients had witnessed severe traumatic events and violent conflicts involving their beloveds. All cases examined had experienced psychological problems since their arrival in the Netherlands and a majority had been attending outpatient treatment in regional psychiatric services. Actually, the reports of intake and progress of these treatment sessions were an important source of information prior to my medical examination. The main indication for psychiatric referral in this group was the persistent complaints of a post-traumatic stress disorder (PTSD), in particular disturbances in mood, pervasive anxieties, impulsive (auto-) aggressive behaviour and mental exhaustion, due to lack of sufficient sleep, nightmares and other intrusive experiencing signs of traumatization. Depressive and dissociative psychopathology was also often mentioned as an indication for the referrals. At the date that medical examination took place half of my cases were still in ambulatory psychiatric treatment. Of these, a minority of clients interviewed were satisfied with the results. A majority complained that psychological distress had not improved. Usually that fact was attributed to a complex despondency associated with the asylum procedure, the stressors of environment such as the lack of privacy and enforced idleness, and the lack of specific social support assisting integration in their new surroundings. Non-compliance to attend group activities or treatment sessions and/or medication was prevalent and the clients attributed their failures to miscommunication and the frequent occurrence of relocations between asylum centres. In a few male clients the use of drugs or alcohol had a negative effect on compliance.

- The physical examination. Interestingly, none of the IND reports or decisions included facts from the general medical history in their interpretation of the narratives. Two cases are exceptional in this respect. Case 5: a man, aged beyond his years due to diabetes and posttraumatic brain lesion. His relatives stated that the head trauma had occurred in detention. At the time of his definite hearing he was clearly unfit to be interrogated, due to a partial amnesia. Neither the report of definite hearing nor the negative decision made mention of his limitations. The IND has interrogated case 10 while he also had an amnesia and was ill due to an endocrine (parathyroid) disorder. In the report of his definite hearing he is recorded to state: “I am often feeling ill and I should be taking medicine, but forgetting to do so. When I try to go out, I get lost and people have to take me by the hand. If I leave this room, I know I will forget everything that has been said here.” The IND official, who reported the hearing, states the fact that the client is under medical treatment as an argument, that he can be interrogated. In the negative decision on his asylum request no attention is paid to his medical
condition. One young male (case 11) stated, during the IND hearing that he was in pain, due
to an inflamed knee, and that in this condition, he could not talk about what had happened.
The treatment of his knee had been delayed because the attending surgeon did not want to
perform a difficult operation on a person who did not have a prospect of obtaining asylum. In
the written IND reports on the definite hearings of not one of my cases specific individual
attention was paid to the historical particulars of torture. At most, the client is allowed to state
how the arrest and mistreatment had taken place, but *no further questions are asked. Clearly,
for the victim of torture this lack of opportunity and interest is a factor in not being able to
express the full story, in particular if the victim considers the information of a very private
and sensitive nature. This almost always the case after *rape, as for instance in case 26: a man
who had been sexually assaulted during detention. A broken bottle had been inserted into his
anus. At the time he had lost much blood and had been unable to defecate for days. He had
never been able to talk about this trauma other than during my medical examination. He
allowed an inspection of the anal area and a scar was found, that was consistent with his
allegation.

-8- The *psychiatric examination of the client is definitely a part, that cannot be missed in the
evaluation of the narrative of torture. Notwithstanding the considerable lapse of time between
their entry and the occasion of the medical examination a majority of clients were still
mentally affected by their traumatization. In case 29, due to mounting *mental confusion and
exhaustion in the client, we, as medical examiners, were not able to perform a full routine and
had to halt the procedure without reaching a conclusion. Two other clients proved to be
unable to retell their story coherently because of a neuropsychological impairment (case
5,10). due to head trauma in the past and (case 10) a florid endocrine disorder. In both the
*hetero-anamnestic information, given by relatives or persons, who had known them during
the past years in asylum centres, proved to be indispensable. Case 10, for instance, did not
remember that he had been married and could not tell the number of his children. Yet he was
interrogated alone during the definite hearing by the IND. The transcript of his hearing was
clearly that of a confused person. The interpreter repeatedly stated to be unable to translate
what he had said. Nevertheless he was given a negative decision on his asylum request.
Several cases were still in a florid post-traumatic condition: they were on sedative, anti-
psychotic and/or antidepressant medication. In a few instances, *conscious denial was a
severe setback during medical examination. The youngest case (11) was examined by me
when he had been waiting for asylum since 5 years. He stated that “he had decided not to

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speak ever again about the trauma that caused his leaving his country. The only way to be able to enjoy life was not to think about the past”. He used the same argument to explain why he had not been willing to attend psychiatric treatment earlier, when several crises of impulsive and auto-aggressive behaviour had occurred. In comparison to others, who had not suffered sexual insults, clients who had been raped had complaints that emphasized the combination of physical (i.e. constipation, vaginal discomfort, menstrual disorders), sexual (impotence, infertility, loss of libido) and psychiatric complaints.

-9- The *summary* is the strategic part of the medical report, answering the solicitor’s questions and offering expertise that may be used as support of the asylum claim in appeal. In general the pattern of the conclusions in 20 out of 30 dossiers confirm those demonstrated earlier by Vervaat (2000) on a random sample of the MEG population and those of Weinstein (1996) on a primary care practice population. A majority of victims show permanent *physical scars*, that are consistent with their narratives. Of equal importance is the fact that a majority is *mentally traumatized to the extent that, according to Dutch standards, a psychiatric treatment is indicated, and in all except few the torture in the narrative meets the *requirements of human rights* definitions to be designated as the main cause of distress. The exceptions have one fact in common, that affect the narrative: *cultural factors or *mental or physical dysfunctions* can prevent the victim to disclose the trauma during the IND hearing.

Such an exception is case 27, a 30-year-old female, who had been, in the country of origin, abducted, raped and beaten by two unknown perpetrators. Her guilt and shame were such, that she was incapable to admit the trauma to her relatives and made up a story of harassment by state officials. Her family helped her to escape to her husband, who had at the time obtained an asylum status in the Netherlands. In the first asylum hearing she kept the rape secret for fear that her husband, now her only support, would disown her. After a negative decision she discussed the real trauma with her Refugee Council contact and was advised to disclose the rape in a second procedure. Unfortunately, due to the interference, her husband became aware of it and indeed disowned her. In the asylum appeal the Court ruled that she should have disclosed the actual trauma and, having failed to do so, the negative decision remained as it was. The solicitor then did put the problem to AI to obtain supportive evidence for a statement that the client had not been mentally capable to disclose what had necessitated her asylum request at the first opportunity. The MEG complied for humanitarian reasons, notwithstanding the fact that the trauma did not qualify as a state-condoned mistreatment according to international law. In one other instance (case 24) a male victim of rape did not want the fact to
be disclosed in a hearing with the IND. Both cases 24 and 27 are in psychiatric treatment and for that reason, for the time being, they have not been extradited. In cases 19 and 20, a married couple was involved: the husband had been tortured and had gone into hiding. The wife had been persecuted by the police to find out where her husband was hidden. While advanced in the pregnancy of her fourth child, during one session she was beaten and sexually assaulted to the point, that she had lost consciousness and was admitted to hospital where she a dead premature had to be removed with a caesarean section. In her asylum hearing, being afraid of the consequences if her husband would become aware of the facts, she disclosed less than the full story and received a negative decision. In the medical examination she cooperated, and then in the appeal stage she was forced to disclose this during the medical examination, after which in due process of appeal she received a positive decision. However, her husband disowned her and left her and his 3 children once he had understood what had actually happened. In the instances of case 5,10,11,29 *physical or mental incapacities, caused by the prior traumatic events, did produce considerable restrictions in the potential of medical examination to fit the narrative to the solicitor’s queries. In these cases the *triangulation with previous medical information, collected by attending physicians, relatives and contacts, proved to be indispensable.

-10- The *outcome. The data contained by table II augment and detail the previous MEG evaluations. The table shows (column a/b) the year of asylum request, age and gender; (c) country of origin; (d) allegations stated as queries to medical examination; the total of time lapse since the trauma occurred; subdivided over time lapse between trauma, asylum request and medical examination; (e) the finding of medical examination in relation to that allegation and eventual co-incident medical diagnosis. The average age of clients examined was 32,3 years; 24 were male and 6 female: this data and the country of origin parameters are similar to Vervaat’s (2000). In my retrospect in 2004 of a period of ten years examining as a MEG volunteer, 30 dossiers of personally produced reports were available (1994-2004), and 22 cases (73 %) had put all procedures possible behind them, 18 cases (60 %) had obtained an asylum status, 8 cases (28 %) were still awaiting procedures, 2 cases (6 %) postponing appeals due to a florid psychiatric disorder, and 2 (6 %) had received irrevocable negative decisions. Data on time lapse, between trauma and asylum request (average 46 months) and then between asylum request and medical examination (average 24 months) demonstrate the delay to be a significant part of the process. The total interval between trauma and medical examination is on the average 70 months, or more than 5 years. The series illustrates the
difficulty of obtaining an insight on the interaction between medical examination and procedural asylum consequence. It is likely that the confirmation of the medical queries contribute to asylum in the end. Only cases 6 and 15 had a negative decision that was not reverted versus a total of 18 cases in which a ‘definitive’ negative decision had been changed to an asylum permit after appeals. In addition, no one in this population had been extradited. The exact nature of the medical contribution however remains hard to deduce, both due to the delays and also the impossibility to connect essentials of the trauma, findings of medical examination and final outcome in the asylum process.

**The whole story**

This survey addressed the question, what universalities are found, when the asylum procedure of torture victims is evaluated and compared. One quote sums it up best: “Whatever it is, that the law is after, it is not the whole story”. (Geertz 1983: 173) The epidemiological aspect is difficult to ascertain due to an insurmountable obstruction in acquiring the relevant information at its source, at the site of the execution of torture. The absence of this primary information blurs the public image of torture. Other objectives of this survey were to show trajectories and frequencies of observations in order to demonstrate the interconnectedness of the asylum procedure and the torture narrative of Dutch asylum seekers. Relevant information is encountered by comparing the observations during IND hearing and those of MEG examinations. The data show that, when looked at from a medical point of view, the Dutch asylum procedure is an inauspicious border zone, fraught with insecurity and delay. In the verification by the IND hearing asylum seeker has to step on a trapdoor of instant precision. In that practice, only a torture narrative that complies strictly with a set of particularly discerning and judgmental instructions on the nature of the torture can accomplish a positive decision on the issue of asylum.

As the contours of verifiable tortures are blurred, in the overall population of refugees, a minimal number of individuals can furnish verification to include untainted documentation pertaining to their identity, escape and the traumatic period they try to leave behind. The key to asylum, and only way to keep the trapdoor closed, is to answer as required. The hearing, in its rigidity of observational and interpretational attitude, can be characterized as striving for maximum of deniability, and verbal wrestling to find sufficient judicial argument to declare the narrative either lacking in sufficient detail, inconsistent, or unascertainable. That hearing of narrative aims to pinpoint and enlarge the holes in the story. In the second part, the survey
turned towards a summary of narratives as documented by the MEG, which could not meet IND verification, to ascertain the facts anew in an attempt to demonstrate that medical examinations can support an explanation how, in the dossiers that have been selected by the intervention of solicitors and AI as advocates, the required narrative elements are available if individual medical findings are allowed to contribute. The outcome of the Dutch appeal results of MEG dossiers underscore the usefulness of an expert medical examination, independent from the authority on asylum, if:

1. There is clear perspective and consent on purpose and procedures in medical applications, agreed upon by the means of ‘a good practice intention’

2. There is a political support for the relevancy of the result of the medical examinations

3. There is an opportunity for the application of the medical examination at the earliest occasion taking into account the mental, physical and sociocultural capability of the individual asylum seeker for cooperation in the procedures

4. There is a reliable public and scientific accounting of the process, both from legal, anthropological and medical perspectives

The above four considerations would take away part of the burden of evidence by enabling the victims of torture, who give their narratives in a request for asylum, to tell the full story.
Chapter IX. Summary, discussion and conclusions

A burden of evidence

This thesis appraises the torture victim’s burden by giving an account of asylum narratives. By situating the victims in the Dutch context, the thesis gives a critical reflection on perceiving individual traumatization in one arena of asylum. The evidence in the narrative of torture, as told to an empathic doctor, is the source of information. The account takes clues from the experience of a non-governmental organization, Amnesty International (AI), to better understand the grand narrative of tortured people, in the context of Dutch asylum procedure of the past decade. The problem to solve is, how to assert the right of victims to tell their torture narrative to a physician, who can thus support the request for asylum. My work as a volunteer between 1994 and 2004 for AI’s medical examination group gave me access to the documentation, which generated a hypothesis for anthropological research. The hypothesis is, that, essentially, the narrative, stated by tortured asylum seekers, is missed or misrepresented in the Dutch asylum procedures. On the issue of torture one could argue, that the whole story is not even searched. The misrepresentation is connected to the issue of refoulement. (Note 8; Table 4) As a consequence of the negative decision on the request, the asylum seeker becomes an illegal, and is at first emphatically told to leave, and lastly forcibly extradited to the country of origin. If the torture is the event that caused the search for asylum, it is AI’s ambition to play a role in ensuring that the misrepresentation is stopped. By advocacy, which is actively intervening on behalf of the asylum seeking population, both in the debate on policies, but also by acting in support of the individuals affected, AI tries to correct the representation of the torture narrative. (Amnesty 1994: 221) An important contextual element of this thesis is, how the advocacy is turned into pragmatic action, and becomes the key for a local group of medical volunteers to get involved in giving medical interpretations as affidavits in support of appealing negative decisions.

To study the burden of giving evidence about torture in the process of Dutch asylum, misrepresentation is contrasted by advocacy and to do so, this thesis brings in a medical and an anthropological discourse. The medical discourse is primarily that of empathy, contributing an attempt at comprehension, based on observational experience of how traumatized individuals combine illness and misfortune into one narrative, and how the contents can be confirmed by the personal interview, physical examination and the response of the victim in a patient-physician interaction.
The medical research perspective is that of looking at the consequences of misrepresentation as an “illness, sharing the psychological, moral and social dimensions associated with adversity within a particular culture”. (Helman 2001: 84) This perspective explores the asylum seeker’s plight as a pattern that can be interpreted along the lines of explanatory models as Kleinman suggested. (1980: 104-108) The illness is transformed into evidence by investigating the narrative for symptoms, related to causative events, influenced by time scales, and psychological and physical processes. The evidence is reduced to the disclosure of the victim in the interaction between medical examiner facilitated by mutual trust.

The other discourse in this thesis is guided by an anthropological perspective, approaching the interaction between medical examiner and asylum seeker as a social and cultural field of research. The exchange of queries, responses and interpretations, and the construction of evidence for the purpose of asylum, is a performance, that Kristin Langellier (1998: 207-213) typified as: ”bearing witness of narrative, legitimating and emotionally supporting, culturally criticizing, analyzing and observing”. The task of anthropology is to put the human emphasis into the purpose of human rights. (Wilson 1997:1-27,134-160) This approach argues that ”only in the context of social consequences, linking the concept of human rights to cultural understanding of real people in real situations” the medical intervention on behalf of tortured asylum seekers can be productive. (Freeman 2002: 94,178) In the anthropological discourse it becomes clear, that the laws speak but do not act. The international treaties about human rights ring in a clear and certain voice, but the asylum authorities bend their ear to the victim’s whisperings only reluctantly. Even if the article says that everyone has the right to seek asylum from persecution in their country, the refugee experience of human wrongs in reality as a vast blur of persecutions, consequences, uncertainties and paradoxes. (Owen 2003)

Discussion

To present the research observations on the misrepresentation of torture narratives in asylum requests, I chose the following order and strategy: a case description, a review of literature, a series of interviews with experts, a study of visualization, and a survey of the epidemiological, quantitative and qualitative aspects related to the medical examination of torture victims. The first chapters outline the investigational approach, theoretical perspective, sources and research questions. The choice of research questions emphasizes the conceptualisation of the (dis) trust in the narrative of the torture victim, and the role of medical expertise in a mediator position. The topic receives less appraisal of the emic approach, because I cannot demonstrate that the misrepresentation is a culture bound phenomenon.
The asylum sought for in my presentation is a place for fugitives that flee their country of origin and are forsaken by their own. Refuge by a culture different from their own is the atonement; they are seeking, and not reparation by cultural sensitivity. Neither is an etic element found that can be usefully appraised, because the misunderstanding of the evidence of torture cannot realistically be perceived as Dutch, or European, Western-American, or otherwise culturally centred. To state the problem is to find a pathway “to avoid the tragic conflation and confusion of humanitarian and political solutions”. (Cohen 1998) The ethnographic element is not represented in my studies. In my preparation I did not see an inroad to an unbiased ethnographic approach. The observational part of such fieldwork would have to stumble through a density of problems with respect to the necessary independence. A neutral function for an Amnesty-based physician would be inexplicable both to victim and official. Expectations of support and criticism would have dominated the interactions. It is improbable that the real sites of action would have been made accessible, because they are regulated and fortified by strict governmental instructions. The scope of my investigations was therefore scaled down to an in-depth revision of my earlier observations as an examining physician, having the disadvantage of not having been executed with the research purpose in mind, but having the advantage of providing a vast trajectory of well-organized retrospective data, as yet hardly utilized for scientific purposes.

In chapter III a start is made by annotating a transcript of my report in one case (Table II, p. 84, sub 4), selected as an appropriate model from the 30 consecutive examinations, that I performed as a member of the medical examination group (MEG) for AI between 1994 and 2004. This case description portrays the asylum seeker as a victim of torture, sets the scene of the medical examination, and presents the scenario, plot and roles of participants in the performance that is expected by the MEG.

The key to indicate a medical examination by the MEG is the Immigration and Naturalization Department’s (IND) refusal to accept the medical narrative and scars as evidence of the alleged torture. The issue contested is whether medical expertise on mental and/or physical scarring can contribute to verification of narrative by making apparent what signs of injuries can be established as a result of torture. Apart of the role of the examining physician, the transcript describes the stands of the immigration officials, solicitors, refugee workers and Amnesty experts. The proceedings, represented in tables 1-2 in the Annexes, show that the lapse of time is a factor of importance. The positioning of the case in the list of my dossiers, in Table II, p. 84, sub 4. Tables 3,4,5 (Annexes), presents the full MEG procedures and protocol of medical investigation, and compare these to the IND procedures.
In chapter IV the task of the MEG is reviewed in the context of relevant publications. Understanding the trauma of torture and the significance of the narrative of the victim in asylum requires the search for a unifying perspective. All parties in the asylum arena participate in the quest for narrative evidence with different rationalities. My review describes the confrontation between rationalities from a multi-level perspective. Torture is rejected by all, but the involvement in dealing with the consequences differs. Another case (Table II, p. 84, sub 25) is described to make the confrontational situation palpable (‘a harrowing case’). The young woman, victim of organized aggression and rape, hovers for years at a fateful deciding point between finding refuge or being expelled. She has lived 10 years subjected to a powerless expectancy, dependent as she is on the unpredictability of policies, which bear on her human rights. The review describes the obstacles, that interfere with the rationalities of the asylum procedures, in particular the statist attitude of protectionism and the public discord if and how asylum policy is a threat to the internally secure welfare state.

A close reading of the IND instructions and publications show that the obstacles in the medical arena are firmly associated with the public struggle of mind in the Netherlands, that alternates between accepting and restricting asylum facilities. The top medical adviser to the IND is quoted to defend the departmental policy, resisting medical examinations in asylum requests, by saying that ”the rising tides have to be put behind dikes, otherwise flooding is inescapable”. This attitude confronts the human rights activism, proclaimed by the United Nations, non-governmental pro-refugee movements and a number of medical organizations, as is exemplified by the ‘Istanbul Protocol’ (2001), that offers a good practice consent and guideline on the medical involvement with the victims of violence and torture.

Chapter V contributes eight interviews to elucidate both the consensus and the differences in perspective between experts, who share a professional involvement with the asylum conditions specific to the Netherlands. The outcome can be appreciated as a state-of-the-art combining anthropological, legal, psychological and medical expertise on the actual experiences of the victims of torture appealing for asylum in this country. It appears that the policy conditions and individual factors, which underlie misrepresentation and misinterpretation of the victims’ narratives, are manifold. For a collective truth to prevail, mutual trust has to be concerted. All respondents agree that the explication of the trauma due to torture can be supported by medical examination. The distrust of narratives in the IND hearing appears to be closely related to an insufficient intercultural sensitivity, an inequity in sharing the burden of traumatization, and a constriction of the will to adjust verification to the
reality of a violent outside world. The medical anthropologist interviewed, himself an ex-
asylum seeker, speaks about facing insurmountable difficulty in telling the true story.

In the disconcerting atmosphere of distrust, the target to verify and clarify the contents of the narrative by a medical approach irrevocably suffers. The content and emphasis of the medical document, that has to be produced, rely on the level of like-mindedness between examiner and examinee. The constraint of culture is variable as a limiting factor, but can disguise the essential in the narrative, leaving the traumatic incidents unspoken. Also, the conflicting expectations of the parties, between which the medical examiners are mediating, define the validity of interpretations. The IND will point out, that the examinee is enticed to be traumatized and attribute that to medicalization. In the perspective of the law the preferable approach of verification is the one straight on, but the whole story is more often than not too emotional to be disclosed to strangers in a single interrogation.

Chapter VI is an essay on the visual representation of tortured victims from the viewpoint of medical anthropology. To facilitate visual imagery, in 1996 a ‘scarring from torture’ project was initiated and systematically pursued by the MEG. To build the case for asylum, the focus was put on photos that extended the evidence of torture through the impact of expert images. Basic routines in medical documentation essentially reproduce external appearances without consideration for the emotional or psychological aspects of the individual. Torture however is in a category of embodiment different from most medical images. If scars are objectified as due to physical impact only (‘electrical burn’, ‘blunt trauma’) the similarity with medical forensic efforts is too strong, because the lasting, specific and significant effects of torture are not anatomical, but mental and emotional and cannot be adequately visualized in a neutral way.

Because visualization of torture is enmeshed in the negative connotations, that the act itself is perverse, uncivilized and forbidden, the probity of abhorrence struggles with the righteousness of exposition. To be reminded is painful to victims and perpetrators alike. As a consequence, probably, the appropriate visualizing material is difficult to locate, hard to obtain and poor in technical quality. A new discourse is necessary, promoting visualization to aim at empowering the victims to state their case by images that engage the onlooker, involve the victim, explain better and encourage the visual interaction.

Lastly, chapter VII surveys quantitative and qualitative data on torture, torture victims in asylum conditions and epidemiological consequences relevant to the research questions. The first part presents and analyses the rhetoric of a torture ‘epidemic’ to bring into focus the difficulty of a case definition fully and reliably addressing the trauma of torture victims.
Epidemiological research meets nearly insurmountable hindrances when attempting to collect the appropriate facts in the localities where torture takes place. The authority, at least aware, and often responsible for the occurrence of torture, will deny all cooperation, and the local medical agencies are tarnished, powerless or avoid being involved. Medical sources struggle with the adequacy of ‘a torture syndrome’ as a validated case definition of the illness caused by torture for medical statistical purposes. Submerged in the prevailing public view on asylum seekers (as economical migrants, hunters of fortune and ready to try any tale to force entry) the torture victims’ grand narrative is met with misapprehension. Governmental asylum agencies are poorly motivated to provide the necessary data on what is really going on. At the same time, the world shows vast areas in armed or social conflict, expelling millions of victims over their borders. Comparing the blurred phantom of a torture epidemic, the image of ever growing figures of uninvited immigrants is a stronger incentive to fortify the gates instead of an increased support to the afflicted. (Fig. 6) The rhetorical designation of an epidemic seems a weak weapon, wielded by the powerless. (Fig. 7, 8) Improving the epidemiological surveillance is necessary, but, at the same time, will not suffice to reveal the trajectories and frequencies of torture to help conceptualise it as one source of the pathology of power. (Farmer 2003) This is not said to minimize the efforts done by retrospective or prospective research on the distribution, attribution and methodology of torture: an excellent example of a successful forensic investigation is that of Moisander and Edston (2003).

To finalize the structure of argument contained in this thesis, chapter VII turns towards the observations of the MEG in order to demonstrate the interconnectedness of the asylum procedure and the torture narrative of Dutch asylum seekers. Suitable information is encountered in the semi-quantitative and qualitative results of the individual medical examinations. The advantage of the personal medical interview and examination is, that the narrative can be translated into a statement, which can serve a purpose in the asylum request and can lighten the burden of carrying the evidence of torture.

**Distrust and conflation**

Torture stands out as an important and evil source of harm, generated by pathologies of power, that use cruelty, inhumanity and degradation as a weapon against individuals and groups of people. For all the condemnations and covenants, declaring torture unlawful and uncivilized, its practise is widely continued and is recently spreading to new areas and purposes. To trace torture as a source in pathogenesis, the narrative of the individual asylum seeker’s traumatization can be, at least partially, disentangled by an expert physician. At what
stage the handling of the individual in a cruel, inhuman and degrading manner starts to be more than individual traumatization and begins to torment society, is a multidimensional social problem, political, cultural, historical, contemporary, humanitarian and judicial, and so on… to the extent that a definition of that torment is contextual, arbitrary, controversial and needs an anthropologist. The concept of conflation springs to mind; a shrill cacophony of interpretations, blowing on fires in a foundry of conflicting themes, contradictory texts and confused readings. To find a pathogen, and to explore that as a lead on the path of what is the matter, is critical.

The misrepresentation is approached in this thesis by contrasting the official’s disbelief to the physician’s documentation of narrative. Both the governmental disbelief and the medical documentation need to be liberated from the conflation in order to achieve a comparison. Narratives obtained in the asylum procedure of the Netherlands are contrasted to those, obtained in the past decade by one coherent individual medical examination, which has redocumented the torture aspect of narrative in a population of victims, who were disbelieved by the government.

Torture as an agent of illness is shaped in the examiners’ minds as (1) individual application of degrading cruelty, (2) appraised as a maximal traumatic event (atrocity), (3) both by the victim and the examining physician, (4) having occurred within the responsibility of the government in the country of origin, (5) in a context, defined as extra judicial by (inter) national law and the treaties, ratified by the Dutch Government, and by AI as a non-governmental organisation. Both contrasting parties subscribe to the verdict, that if torture, as so defined, is manifest, the plea for asylum is founded. The contrast in views start on the issue of assessing the plea for evidence and foundation. The governmental view, as represented in the Dutch procedures, relies on a strictly prima facie verification of the torture narrative in a ‘now-tell-me-only-what-I-want-to-know’ decionistic processing of the claim for asylum.

For rationality, a decisionistic attitude is not served by documentation of what is the full story. From the same point of view, medical intervention in support of the plea will have the additional disadvantage that the narrative is recognized as potentially of an unresolved traumatic nature, meriting considerations way beyond a routine differentiation between manifestly founded or unfounded, and that the verification is moving away from being controlled by the asylum authority. The rules of hearing and deciding are established by a handbook of detailed instructions, the contents of which are adapted frequently, in accordance
with the political actuality, and the explicit need to restrict asylum to those applicants who
deserve safety, because the government, represented in the persons of the inquiring and
deciding officials, shares the victim’s anxiety on re-exposure to extra judicial violence if
extradited to the country of origin. Anxiety and restriction are the foundation for regulation.

Making it a governmental gift of pacification to be universally accepted in the public arena
solves the dilemma of regulating asylum. It is not an individual universal right in the defence
against persecution. The duality of restriction and pacification explains the context of
dis/belief in the Dutch asylum arena best. Deserving cases are to be designed ‘harrowing’. A
further refusal will spread social distress and cause public outcries. What happened in the
country of origin is of lesser weight than what can be made acceptable here. One will not get
not away with too much disbelief. Other deserving pleas are those that have not been
processed in time, or have accumulated to the point of wrecking the asylum bureaucracy. So,
rationalities have to give way to the practicalities of here and now. Lastly a number of
negative decisions are allowed to be reverted in a procedure of appeal, acceptable as a
correction on the internal standards of procedure. Pacification and practicality are a secondary
foundation for acceptance. It is a mixed bag. For founding modes of operation it is difficult to
strike a balance between anxiety, deniability, pacification and practicality. Saying, that the
Dutch asylum is a gift that cannot be withheld for reasons of national convenience might
summarize it.

**Empathy and mediation**

Whatever the outcome of medical intervention, it detracts from the convenience in giving
asylum, and adds to bureaucracy by being a time and procedure consuming effort. The
interference by the MEG is motivated by virtue of the fact that Amnesty is trying every which
way, that is legal and prudent in a democratic society, to ensure that the human rights treaties
are fully, individually and consistently applied in the asylum procedure. The almost belated
insertion of the medical evidence is deployed to support the judicial appeal in order to revert a
negative decision on the asylum request on legal grounds, but often it is also a step to stall the
procedure in order to bend the flow of time to the advantage of the defence or to search for
resources previously not utilized. To liberate the antithesis between the governmental
approach and the advocacy from the context of conflation means that the neutral observer
tries to contrast a conscientious application of human rights in the Dutch asylum procedure
with the first priority of the government, that is the restriction of unwanted foreigners.
It is the doctor’s job to document, not to believe or disbelieve, but the reproducibility of narrative is of course an essential endeavour of medicine. A perspective, that joins medical and anthropological observations, with respect to the asylum request, is that justice is not served if the traumatic experience is smothered. Medical anthropological research, on what the consequences of asylum policies signify to the torture victims, offers keys to their unresolved story and helps to break the silence which burdens them down. The whole story of traumatization ought to be paramount in the current debate on who qualifies and how to qualify for being saved from torture. Critical medical anthropology, as represented by Farmer, insists that too little is being heard from that submerged zone of humanity, who live far from the centres of power, but near to the centre of suffering, where pathological powers determine the immediate shape of a grand insufferable narrative. In times, when the miserable and distant lands seem to disappear behind the fortified wall, surrounding safe countries, that grand narrative becomes subject to a postponement in the policy of asylum.

Founded on that conviction, to argue this thesis, a combined medical and anthropological perspective is turned towards the socio-political, physical and psychological context of asylophobia and the relationship to individual traumatization, caused by torture. The substance of questions centres on how is it to be done, retelling the torture narrative in such way that the contents, scars and medical complaints can be transformed from traumatization into support. The question is not approached as a medical one only. I try to demonstrate, that the burden of evidence, contained in the narratives of torture, is not fully understood if perceived only as an amount of emotional distress in a number of individuals affected. I argue that torture is also a social, political and economical burden of a considerable magnitude, and a menace to the public conscience. An approach by empathy is rewarding, not only because it is the preferred attitude socially, but also because it recognizes how arbitrary it can be, being victim or protector. There is no permanency in safe places. Neither is lack of safety or justice insignificant in proportions. A few samples from the period researched will help to estimate the impact of asylophobia as previously defined. In 2000 the number of requests received by AI was 202; that is: solicitors wanted a structured advice or support from a NGO, because their clients’ claim on asylum was considered manifestly unfounded, while the solicitor had run out of resources of proving the opposite. In a majority, 110 cases, the human rights experts of AI honoured the request. (Pomstra 2003)
In 86 cases it was decided that a medical affidavit would have to be added – 84 medical reports have been made available. In 45 individuals, who had been at the end of the asylum procedural tether, a positional improvement was achieved; in 43 cases this was a full asylum. In the majority of these, the solicitor confirmed that the medical intervention had been necessary to turn the scales of justice from extradition to asylum.

It is hard to extrapolate these findings to the overall picture of asylum provisions in the Netherlands, but if similar statistics were applied to any significant health intervention, the public and professional response would be one of outrage. For further comparison: the Dutch immigration authority issued during 2002 asylum decisions on 34,300 applications, with an approval rate, that is a positive decision on the request for asylum, of about 11 percent. (World Refugee Survey Country Report 2003) Many of the asylum permits were compulsory, however, due to the circumstance, that arrears in processing claims had exceeded 3 years. The figures show, that, whatever the evidence of their narratives, many claimants obtained a permit for no other reason than that the backlog had to be cleared. This suggests that only a small proportion of asylum requests find approval in the eyes of government and that granting permissions is a Herculean effort of bureaucracy, beset by scrutiny and doubt. Yet, reliable epidemiological surveys estimate that at least 25 percent of asylum seekers in the Netherlands have been traumatized by torture. (van Willigen 1998)

To further illustrate the issue: when I started working at this thesis, at the end of 2002, the Netherlands hosted 17,200 asylum seekers offered protection by the state: 9,400 asylum seekers awaiting initial decisions on their applications, an estimated 4,200 individuals with humanitarian protection, and about 3,600 persons granted asylum. 18,700 asylum seekers filed first-time applications during 2002, about a 42 percent decrease from 2001. The largest numbers of asylum seekers came from Angola (1,900), Sierra Leone (1,600), Afghanistan (1,100), Iraq (1,000), and Iran (660). The following table positions the sample in a range of years.

<table>
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<td>52,570</td>
<td>29,258</td>
<td>22,870</td>
<td>34,476</td>
<td>45,217</td>
<td>39,299</td>
<td>41,306</td>
<td>32,579</td>
<td>18,667</td>
</tr>
</tbody>
</table>

Combining these figures to obtain an insight of the asylum process is impossible: they are simply too unexpected, puzzling, contradictory and blurred. It is no wonder, that, in the

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20 Excluding the number of people from Kosovo who received temporary protection in the Netherlands
21 These numbers have been obtained from the official web page of the Centraal Bureau voor de Statistiek (CBS: www.cbs.nl)
Netherlands, the asylum debate causes widespread dissent, confusion, and a repetition of unanswered public queries.

**Conclusions**

To assert the right of victims to tell their torture narrative requires understanding. For physicians that means, that in the performance of medical examinations the level of the physician’s empathy has to match that of the exposition. The most valuable resource in that respect is an attitude of trust that is mutual. The reliability of the examiner is to be seen as the most perceptive tool. Talking in detail about the trauma story produces opportunity for emotional processing and understanding the events in the appropriate context, and a possibility of re-interpretation. The basic medical imperative of respecting individuality by cure, care and the avoidance of harm, can be offered in mediation. It must achieve that the burden of evidence is less unbearable because it can be shared. The attempt to reach equity between examiner and examinee is crucial.

Indeed, the most rewarding approach is to invest in settings for the examining of the victims, which are attuned to their self-determination and safety. What does it take to qualify the documentation obtained in an empathic setting into evidence of torture? I suggest that the observations presented in this thesis show that to be a question that can be answered with several convincing arguments. In the profiles of the victims of torture there are sufficient criteria to be used for interpretation. The observations collected in my series of observations convinced me, that van der Veer (1998) is on the mark by stating that “if one has read one victim’s story, one has in fact read them all”. The narratives of torture had at least one recognizable scenario of reproducible conditions. The victim is arrested and detained for reasons that are incomprehensible to his or her person as an individual, but that can be explained as ingredients of a pathology of power in the regional socio-political environment. (Farmer 2003) The victim is exposed as a hostage of family or relatives during events that are perceived as provocative by the pathological power. The indications contained in the criteria, listed by Weinstein (1996) give an image that is reproduced by the MEG dossier evaluations. The exposure of the victim is threatening to the family or relatives that are the real aim of the aggressor, but who are as individuals out of reach. In fact, in many situations the victim can be recognized as the person exposed, not by personal behaviour, but by the context. The fact that torture is applied to the exposed victim is a fateful consequence of not being able to exert agency. Having been tortured, but survived, the victim has only one option left, and that option is understood and supported by family and relatives, in part for the purpose of removing the common threat.
The arrest, detention or torture is extra judicial, and the prospect of dire consequences, for all parties involved or in the vicinity, is less if the exposed victim is definitely exiled. This one ingredient in the scenario is also important in the production of the means of escape and the threat of being repatriated. The victims have lost definitely what was their home and what they appraised as their life. The tortured asylum seeker has to reshape an identity consistent with that loss.

The prevailing view expressed by many politicians in our country, tending to categorize asylum seekers as global scavengers of fortune, motivated and self-possessed individuals, is not at all confirmed in the narratives of victims referred for MEG examinations. In my opinion, such prejudice can be implicated in suppressing the credibility of torture in the arena of asylum. Not being able to show a fresh scar, consistent with the method of torture claimed, drastically limits the survivor's chances of citizenship in the country of refuge. Ironically, therefore, the more deeply, the more frequently, and the more visibly one was hurt, the greater one's officially granted chances of asylum and survival. How are scars shown in order to recognize the torture? The personal experience, and the literature presented in this essay, shows that visualization of the narratives has a subservient role. Photographic techniques are used especially in documentation and study of specific sequels that are recognizable in scars and handicaps after a long delay. Its quality is, that it can capture the one visible sign over time of what happened. It fails to record the process and its significance in the inner belief systems of the victim. The medical use is technically advanced but its application limits itself to a one-eyed view by its attempt to produce representations that equal other disorders of the skin, notwithstanding the fact that these are in a completely different category of embodiment. Most and probably the more significant effects of torture are not visualized. It is probable that this is due to the fact that it is now a new, unchallenged and unsystematic procedure. It is possible that much helpful material is put away in archives from where it cannot be retrieved. No doubt, from a medical point of view the photos, to the extent they are compatible with the narrative, can strengthen interpretation. However, the absence of demonstrable scars, if compatible with the narrative, is never an argument against, because the lasting and main impact of torture is mental.

In my review of the literature there are perspectives, at various levels, that help explicate what forces oppose the disclosure of the other evident signs of torture. The query about torture in the asylum request is respected by the IND but is not searched for in the places where individual traumatization can be observed.
The instructions for interrogation aim at achieving verification in the strictly ordered sequence of establishing personal identity, documentation of flight route, position in society and family, which are the usual cares and affairs of a regular Dutch citizen or a temporary visitor from elsewhere. Doing so from the very first moment onwards, the focus of communication and the objectives for verification are being removed from the issue of traumatization. However, in the legal, and also in the emotional sense, the asylum seeker has lost the regulated identity that the interrogator is trying to construct. Being self-expelled from the country of origin, the asylum seeker is by necessity a ‘sans papier’, and even when a passport would be handed over, that document would not tie the exiled to its origin any longer. By insisting on the impossible, on that what has disappeared, the asylum authority forces the asylum seeker to sing an impossible tune. The later part of asylum hearing scenario continues the distancing and the emphasis on the unutterable. In the second hearing, that is decisive for the purpose of asylum, this approach keeps the ears of the interrogator closed and takes away all chance for disclosure. Revealing signs to support these conclusions are the cases in my series, where the interrogator persisted in the hearing even when the asylum seeker was confused or otherwise muted by physical handicaps.

Another argument is the statement, that to obtain asylum the claimant is to give evidence as indicated by law, and the fact that IND is not eager, for fear of abuse, to extend its service beyond that, because that would provide indications on how asylum is best achieved. The conclusion also finds support in the fact, that positive decisions are not argued, and that the asylum authority is involved in a running battle with the Ombudsman on every aspect of the process of asylum. The asylum seeker cannot provide that matching evidence of the very detailed nature, factual and documentary, that can be acceptable to the Dutch governmental in the fulfilment of relevant international obligations. The rationality of guarding the welfare state for intrusion has turned into an irrationality of bureaucratic mechanisms of maximal denial. Medicine as an element of local culture has no other antidote to that denial than to observe, document, proclaim and explicate. The cultural conflict that underlies social and political denial is of a social and political inclination and for that reason the solution must be sought in a social and political context. A concerted effort of medical and anthropological professionals can help the unutterable to be heard and the full story better known.
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Table 1. Case – Time path – month/year

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<td>Coupe d’etat</td>
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<td>Medical examination</td>
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<td>Asylum Permission</td>
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</table>

Table 2. Basics of Asylum Rights in the European Union applicable to the Dutch procedures

Every request for asylum has to be decided upon by means of an individual examination. Against a negative decision factual appeal should be possible. If the State has serious concerns that an individual applies for asylum, who has participated in terrorist activities or other crimes against humanity, the statute must be denied.

The State responsible for the asylum request has the obligation to investigate if extradition exposes the asylum seeker to punishment by death, torture or inhuman or degrading punishment or treatment. The same applies in the case of refoulement (repatriation to the country of origin).

Collective extraditions are not allowed.

The execution of eviction has to take into consideration the respect for physical integrity and dignity of the individual involved and prevent the occurrence of an inhuman or degrading treatment.

In particular, States are obliged to grant a complementary protection status that includes torture or inhuman or degrading treatment or punishment at a minimum as grounds for protection

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Table 2.2. Order of evidence

<table>
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<th>IND Hearing, consequences</th>
<th>IND Decision, consequences</th>
<th>Solicitors interview</th>
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<td>13. 1st provisional decision</td>
<td>28. review of hearing</td>
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<tr>
<td>2. escape, flight route, travel</td>
<td>14. presumptive decision</td>
<td>29. review of decision</td>
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<td>3. 2d hearing: asylum claim</td>
<td>15. motivation</td>
<td>MEG Examination</td>
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<td>4. account of alleged injury</td>
<td>16. credibility</td>
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<td>17. refugee claim, alegations</td>
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<td>6. details of persons involved</td>
<td>18. humanitarian e.o. arguments</td>
<td></td>
</tr>
<tr>
<td>7. chronology</td>
<td>19. chronology</td>
<td></td>
</tr>
<tr>
<td>8. accusations</td>
<td>20. accusations</td>
<td></td>
</tr>
<tr>
<td>9. detention settings</td>
<td>21. 2d and definite decision</td>
<td></td>
</tr>
<tr>
<td>10. specific considerations</td>
<td>22. stated object</td>
<td></td>
</tr>
<tr>
<td>11. supplementary hearing</td>
<td>23. negative decision</td>
<td></td>
</tr>
<tr>
<td>12. forensic investigations (dialect, DNA, age-estimate by radiological technique)</td>
<td>24. initiation and course</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25. motivations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26. consequences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27. measures, extradition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28. &gt; Appeal</td>
<td></td>
</tr>
</tbody>
</table>

118 Torture Narratives
Table 3. Medical report compiled as a basis for legal action requires the use of accurate wording easily understood by people without a medical background.

- Content and conclusion will have far reaching consequences for the future of the asylum applicant. It is also very different from a report on the diagnosis or the treatment of a patient.

- In the MEG protocol for examination of and reporting on asylum applicants a number of simple rules are given. The most important aspects are outlined in a comprehensive overview of the proposed structure of a medical report as well as guidelines to its content.

- An important part of the case history is a description of the torture suffered; this should be detailed, as it is important for the interpretation of the findings during the medical examination. The recording of current symptomatology should be painstakingly accurate and, if possible, its relationship to the torture undergone should be described. Useful are precise anatomical sketches or images following the Istanbul protocol.

- The medical expertise and knowledge of methods of torture should be emphasized. This section is of great importance and will be scrutinized by others in the course of justice. It must be accurate and easily understandable. The description of the wounds/scars should be precise and stated in an objective manner. Subjective statements are to be avoided.

- The conclusion of the report is the crux of the matter and should concentrate on constructing a balanced and logical discourse, providing insight by way of arguments that lead to a conclusion that flows naturally from the preceding objective information. All that has been written on objectivity in earlier paragraphs is of course to be taken into consideration here.

- AI’s reputation for independence and objectivity combined with the professionalism of the physician is to give the report an important position in the asylum application procedure. This imposes a duty on the physician to draw up a report which is accurate, fair and objective and, therefore, of the highest quality. Becoming thoroughly familiar with the MEG handbook and optimising any available knowledge of torture methods and their consequences are an essential prerequisite for maintaining this AI reputation and the trust invested in its expertise by both refugees and the legal establishment.
**Table 4:** Inclusions and exclusions: comparisons on adjudicatory stands on asylum narratives

<table>
<thead>
<tr>
<th>Adjudication of request by AI</th>
<th>Adjudication of request by IND</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Scars/complaints can be related to torture</td>
<td>- In principle scars cannot be related to torture</td>
</tr>
<tr>
<td>- Complaints can relate to events and conditions</td>
<td>- Complaints cannot be correlated to specific events</td>
</tr>
<tr>
<td>- Medical evidence is qualified by HR treaties</td>
<td>- HR are no medical issues</td>
</tr>
<tr>
<td>- Medical history can be obtained</td>
<td>- Medical expertise cannot concretize allegations</td>
</tr>
<tr>
<td>- Client has to be personally examined</td>
<td>- Medical examination is not to be undertaken</td>
</tr>
<tr>
<td>- If expertise is not available it has to be constructed</td>
<td>- Psychiatric expertise is no basis for evidence</td>
</tr>
<tr>
<td>- Other documentation can be part of that investigation</td>
<td>- Professional integrity will be exposed to conflict</td>
</tr>
<tr>
<td>- Expertise for physician-examiner can be made available</td>
<td>- Outside medical expertise is not to be invoked</td>
</tr>
</tbody>
</table>

**Adjudication of relevant trauma by MEG-AI**

- The cause is a deliberate, systematic or wanton infliction of physical or mental suffering (Basoglu, 1998: 1)
- It is instigated with the consent or acquiescence of a public official or other person acting in an official capacity
- It is to be experienced as intentional to make the victim yield
- It must be judged to be an intense and extreme event, surpassing the capacity to individual adjustment
- It can be shown to provoke emotions of complete helplessness and fear for re-exposure (refoulement)
<table>
<thead>
<tr>
<th>Table 5: The MEG protocol for examination and reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong> Circumstances of the report. Date of the examination, framework of the Amnesty International Medical Examination Group’s investigation, others present: counsellor, colleague, interpreter. Phrasing of questions by requesting party. Medical records. Relevant documents studied? E.g.: information from GP/family physician or specialist, laboratory tests, x-rays, psychiatric reports Indicate to whom a copy of the report will be sent with the client’s permission.</td>
</tr>
<tr>
<td><strong>HISTORY</strong> General. Specify source of information obtained – document, hearsay (e.g.: &quot;When asked, the client told me the following&quot;, or &quot;as far as client informs me...&quot;). Social history Description of client’s social functioning prior to traumatic episode with the aim of enabling reader to picture himself in client’s situation. Family of origin. Educational level, occupation, social status and relationships, religion, political orientation. Report on client’s arrest and detention. Explicit and detailed description of events. Circumstances during arrest. Type of prison, size of cell, number of other prisoners (criminals or political prisoners?), light, temperature, humidity, sanitary facilities, food, contact with guards, presence of informers. Permission to receive visitors. Methods of torture: frequency, actors, instruments?</td>
</tr>
<tr>
<td>Type of torture and/ or sexual violence (against men and women), beating, falanga, hanging, electric shocks, submersion, prolonged standing, isolation, threats, mock executions, noise, bright light, sleep deprivation, torture of others, cold, burns, painful positions, dehydration, starvation, dripping water, nail extraction.</td>
</tr>
<tr>
<td>Consequences, past, present.</td>
</tr>
<tr>
<td>a) Present social functioning. Previous and present state of physical and mental health.</td>
</tr>
<tr>
<td>b) Somatic complaints and/or treatments received before, during and after traumatic episode(s).</td>
</tr>
<tr>
<td>c) Specific complaints associated with abuse; acquired injuries and diseases; if indicated: review of systems, (psycho-)sexual history; medical treatment given in relation to possible torture,</td>
</tr>
<tr>
<td>d) Mental/psychiatric complaints or treatment received before, during and after traumatic episode(s); symptoms of:</td>
</tr>
<tr>
<td>e) Depression: moroseness, tiredness, sleeping disorder, lack of appetite, loss of concentration, depression lack of interest; possibly: thoughts of or attempts at suicide, guilt feelings</td>
</tr>
<tr>
<td>f) Anxiety disorders: palpitations, tremor, perspiration, terrifying thoughts, avoidance behaviour</td>
</tr>
<tr>
<td>g) Post-traumatic Stress Disorder (PTSD): (symptoms during more than 2-3 months): (1) Undergoing traumatic experiences anew: recurrent memories; repetitive dreams; triggered by association with a specific stimulus; severe discomfort as a result of a specific stimulus; (2) Decreased sense of involvement: avoidance of emotions and situations; partial amnesia; lack of interest; disengagement; emotional listlessness; no personal vision of the future; (3) Irritability: rapidly irritated or angry; sleep disorders; disorders of memory or concentration; increased or otherwise unaccounted weariness; shock reactions; physical reactions; (4) Relationship between these symptoms and an event outside the pattern of normal human experience, which would cause grief in practically everyone.</td>
</tr>
<tr>
<td>h) Physical examination. General: nutritional status, physique, external abnormalities, dentition. Specific: consequences of torture: Scars: localisation, size (in mm), shape, limitation, colour, mutual arrangement, hypertrophy, functional disorders; include a diagram of the body and possibly photographs on which the scars are indicated. Only if indicated (=relevant to report): pulse rate, blood pressure, body weight, results of a general, exploratory physical and (neuro-) orthopaedic examination, sensation tests, genital/urinary tract examination.</td>
</tr>
<tr>
<td>i) Psychiatric examination. General impression: age, grooming, presentation of complaints, way of making contact, psychomotor behaviour (posture, facial expression, speech, gestures), behaviour of client towards examiner? Consciousness: clear / diminished. Attention span. can the client’s attention be attracted and maintained easily? Orientation in time and place.</td>
</tr>
</tbody>
</table>
Mood. melancholy/dull, exuberant. Affect: modulating normally, abnormally. Discrepancies between the content of the client’s account and the accompanying emotions. Client motivation for examination: good, sufficient, bad.

SUPPLEMENTARY DATA AND INVESTIGATIONS acquired or carried out as part of the examination SUMMARY AND DISCUSSION providing insight into the line of thought, interpretations and considerations of reporting physician. Is the narrative understandable, consistent, and in agreement with the forensic medical findings; is a correlation to a traumatic episode credible or possible. Discuss discrepancies. Admit uncertainties and offer explanations. Give an explicit answer to the question posed by client’s lawyer. In case of difficulties, consult with him/her. Do not phrase answers in dogmatic terms. Restrain yourself when making recommendations for treatment, unless required by extreme severity. Provide a general conclusion, using understandable terminology and preferably without professional jargon such as a DSM IV classification. Do not give absolute conclusions regarding cause and effect, but prefer terminology such as: "could fit in with…, I consider it credible that…, the unconstrained conclusion is…" CONCLUSION in response to the queries formulated by the solicitor.

**Table 6:** Questions to be solved with respect to the torture epidemic? (A.I.- U.K. 2004)
- List all the conditions necessary for the plague/epidemic of torture to begin and to flourish.
- When does the epidemic occur?
- What is the scale of it?
- What does it need to survive?
- Whereabouts exactly does it lurk?
- How does it grow and flourish?
- What are the various forms that this illness takes?
- Who are the victims?
- What are the effects of this disease on its victims?
- What are the effects of this disease on those who inflict it on others?
- Can it be detected? How?
- What do we know about its cause?

**Table 7:** World Health Report (1996): measures in responding to epidemics (Kager 1998: 26)
- Establishing the diagnosis
- Source investigation
- Control implementation: breaking chain of transmission
- Research for means to treat and to prevent spread
- Establishing means for prevention and treatment
- Establishing a surveillance system
- Promoting an international network of control agencies

**Table 8:** Risk Factors for Torture (Weinstein et al. 1996)
- Refugee or political asylee status
- Immigrant from country with totalitarian history
- Member of minority group in country of origin
- Member of minority political party in country of origin
- Civil war in country of origin
- Residence in refugee camp
- Military government in country of origin
- Prisoner of war
- Flash-point country: that is outbreak regions (since 1990: Bosnia, Somalia, Rwanda, Sierra Leone)
- Multiple family members deceased due to trauma
- History of arrest or detention
- Leadership in an antigovernment organization or relative of same

**Table 9:** Examples of Physical Torture (Weinstein et al. 1996)
- Beatings - Hitting, clubbing, kicking (body or specific parts: head, genitalia) with fists, clubs
- Electric shock - Cattle prod, multiple electrodes (to breasts, genitals, anus)
- Burning - Cigarettes, cigars, other hot implements, forced inhalation of chemicals
- Asphyxiation - Wet submerging (near-drowning: ’submarino’), forced inhalation of chemicals
- Stretching - Suspension by limbs, forced abduction of the legs
- Genital torture - Blunt or penetrating trauma, electrical, vaginal or anal rape, animal rape
- Other trauma – Finger-, toenail removal, removal of teeth, prolonged exposure to heat or cold

**Table 10: Common Forms of Psychological Torture (Weinstein et al. 1996)**

- Threats - pain, torture, pseudo-execution
- Isolation and uncertainty about release
- Sensory deprivation
- Mock executions
- Forced witnessing of beatings, rapes, or executions of friends or family
- Sleep deprivation
- Interrogation for hours
- Excessive noise

**Table 11: Key Physical Consequences of Torture (Weinstein et al. 1996)**

- All organ systems may be affected
- Psychosomatic and neurological symptoms are most typical in chronic state
- Musculoskeletal system symptoms are common in acute and chronic states
- Beating (example falanga) may result in subcutaneous fibrosis, compartment syndrome of the feet
- Electricity, burns of cigarettes, chemicals may leave characteristic skin changes
- Whipping may leave a characteristic pattern of (tramiline) scars
- Suspension and stretching may result in characteristic musculoskeletal and nerve injuries
- Beatings to the head with loss of consciousness may contribute to organic brain dysfunction
- Genital trauma (rape) is often associated with urogenital and anorectal complaints

**Table 12: Key Psychological Consequences (DSMIV terms) of Torture (Weinstein et al. 1996)**

- Post-traumatic stress disorder
- Generalized anxiety disorder
- Major depression
- Psychosis or brief psychotic reactions
- Chronic organic brain syndromes (head trauma, asphyxiation); attentional-cognitive difficulties
- Substance and alcohol abuse
- Sexual dysfunction

**Table 13. Interviewing observations on Torture Survivors (Weinstein et al. 1996)**

- Anxiety: examinatory setting gives discomfort
- Heightened awareness: anxiety triggered by seemingly innocent stimuli
- Re-arousal: waiting triggers anxiety reminiscent of expecting torture
- Role uncertainty; inability to adapt to the patient-examiner interactive role
- Reactions at interview or examination, for instance during pelvic examination
- Hypersensitivity to dominating control; relaxation during break or use of washroom
- Muting and unresponsiveness if questioning reaches repressed memory in a less tactful way
- Responsiveness to empathic questioning “I understand that (specific) has happened to you?”
- Acknowledgement and nonverbal expression that disclosure is difficult
- Expressed feeling that the symptoms are indications of mental illness
- Expressed belief that sexual torture does result in impotence or sterility
- Interpreter problems in the presence of (not-neutral) family members, fellow nationals
Prevalence of Torture


Fig 2 (Peel 1999) Detentions in Algeria reported by 70 torture victims to the ICRT, London

Fig 3a Pandemic: occurring over a wide area, affecting a large proportion of the population, endemic is constant presence, hyperendemic is at a high incidence and/or prevalence rate.

Fig 3b Epidemic: occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time. (Health Dictionary 2004)
Fig 4. Seasonal statistics in 2000 of 1097 violations in relation to a local election campaign. (Human Rights NGO Forum Zimbabwe 2004)

Fig 5. EU asylum data showing the relative position of the Netherlands in a five-year span.
Facts on survivors of violence and torture are best known for Western populations of refugees in host countries. These studies generally support the view that PTSD is a frequent consequence of organised violence: high rates of a history of torture were found in a study of Turkish prisoners (85% - 39% showing PTSD, whilst none of the non-tortured group had the disorder). Of those who showed physical sequelae of torture, 71% had PTSD. Since torture survivors will frequently have both physical and psychological sequelae as a consequence of their abuse, this can complicate the clinical picture and research findings.

Q3 WHAT IS THE LINK BETWEEN HEALTH AND HUMAN RIGHTS?

There are complex linkages between health and human rights:

- Violations or lack of attention to human rights can have serious health consequences;
- Health policies and programmes can promote or violate human rights in the ways they are designed or implemented;
- Vulnerability and the impact of ill health can be reduced by taking steps to respect, protect and fulfil human rights.

- Torture: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”
- Violence against children: “All appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse...” shall be taken.
- Harmful traditional practices: “Effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children” shall be taken.
- Participation: The right to “...active, free and meaningful participation.”

**Fig. 8.** WHO Health & Human Rights Publication Series, 1, 2002

**Fig. 9.** Trajectory AI medical examination 1990-2000. (Pomstra 2003)

<table>
<thead>
<tr>
<th>Solicitor ➔ Request ➔ Refugee Department AI</th>
<th>1982 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examination Group</td>
<td>1031 (52%)</td>
</tr>
<tr>
<td>Medical report and effect (positive, none, unknown) on asylum status</td>
<td>865 (44%)</td>
</tr>
<tr>
<td>Improved</td>
<td>584 (30%)</td>
</tr>
</tbody>
</table>

**Fig. 9.** Trajectory AI medical examination 1990-2000. (Pomstra 2003)
Table 14: Representative sample 1998-1999 (out of 157 reports)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male %</th>
<th>Female %</th>
<th>All (N = 52)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>79 %</td>
<td>21 %</td>
<td>100 %</td>
</tr>
</tbody>
</table>

Country of origin

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Male %</th>
<th>Female %</th>
<th>All (N = 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>15 %</td>
<td>5 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>13 %</td>
<td>7 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Irak</td>
<td>7 %</td>
<td>4 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Turkey</td>
<td>7 %</td>
<td>2 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>5 %</td>
<td>-</td>
<td>5 %</td>
</tr>
<tr>
<td>Guinea</td>
<td>5 %</td>
<td>-</td>
<td>5 %</td>
</tr>
<tr>
<td>Sudan</td>
<td>5 %</td>
<td>-</td>
<td>5 %</td>
</tr>
</tbody>
</table>

Table 15: Incidence of torture methods % of sample affected

<table>
<thead>
<tr>
<th>Torture Method</th>
<th>% of sample affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blunt (beating, hitting, kicking)</td>
<td>98</td>
</tr>
<tr>
<td>Threatening (including pseudo-execution)</td>
<td>46</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>40</td>
</tr>
<tr>
<td>Strapping (handcuffs or other means)</td>
<td>40</td>
</tr>
<tr>
<td>Blindfolding</td>
<td>40</td>
</tr>
<tr>
<td>Suspending</td>
<td>37</td>
</tr>
<tr>
<td>Electrical devices</td>
<td>25</td>
</tr>
<tr>
<td>Falanga</td>
<td>25</td>
</tr>
<tr>
<td>Burns</td>
<td>25</td>
</tr>
<tr>
<td>Starvation</td>
<td>23</td>
</tr>
<tr>
<td>Forced positioning</td>
<td>21</td>
</tr>
<tr>
<td>Torturing by sound, light, cold, heat</td>
<td>21</td>
</tr>
<tr>
<td>Deprivation of sleep</td>
<td>21</td>
</tr>
<tr>
<td>Description</td>
<td>% of Sample Affected</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Forced presence at torturing others</td>
<td>19</td>
</tr>
<tr>
<td>Isolation</td>
<td>19</td>
</tr>
<tr>
<td>Sharp (cutting, stabbing)</td>
<td>17</td>
</tr>
<tr>
<td>Desiccation</td>
<td>10</td>
</tr>
<tr>
<td>Chemical injuries</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
</tr>
</tbody>
</table>

**Table 16**: Observed signs and symptoms attributed to torture

<table>
<thead>
<tr>
<th>Description</th>
<th>% of Sample Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disorder (including nightmares)</td>
<td>90</td>
</tr>
<tr>
<td>Headaches</td>
<td>63</td>
</tr>
<tr>
<td>Anxiety (panic)</td>
<td>50</td>
</tr>
<tr>
<td>Depressed mood</td>
<td>48</td>
</tr>
<tr>
<td>Backache</td>
<td>46</td>
</tr>
<tr>
<td>Diffuse pain</td>
<td>44</td>
</tr>
<tr>
<td>Irritability, loss of control</td>
<td>44</td>
</tr>
<tr>
<td>Loss of concentrating ability</td>
<td>44</td>
</tr>
<tr>
<td>Intrusive memories of trauma</td>
<td>40</td>
</tr>
<tr>
<td>Severe loss of appetite and weight</td>
<td>40</td>
</tr>
<tr>
<td>Suicidal ideations</td>
<td>29</td>
</tr>
</tbody>
</table>
Fig 9. Graphic and listing (cf. table 15) on torture data in MEG reports sorted in order of frequency of observations (Vervaat 2000)
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>26. sound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. light</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. sleep deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. forced presence others tortured</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>30. rest/trauma-type reported</strong></td>
<td><strong>3</strong></td>
<td></td>
</tr>
<tr>
<td>31. cold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. burn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. water restriction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. food restriction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. water torture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. nails extraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. sharp objects, cutting, stabbing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. other *-?&gt; add as sign to criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>40. rest/complaints-type reported</strong></td>
<td><strong>4</strong></td>
<td></td>
</tr>
<tr>
<td>41. exhausted*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. transpiration*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. tremor*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. palpitations*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. chest pain*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. dyspnea*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. anorexia*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. weight loss*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49. nausea*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>50. rest/complaints-type reported</strong></td>
<td><strong>5</strong></td>
<td></td>
</tr>
<tr>
<td>51. exhausted*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52. transpiration*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. tremor*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. palpitations*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. chest pain*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56. dyspnea*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57. anorexia*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. weight loss*-&gt;depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. nausea*-&gt;ptsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>60. rest/complaints-type reported</strong></td>
<td><strong>6</strong></td>
<td></td>
</tr>
<tr>
<td>61. abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62. constipation*-&gt;depression</td>
<td></td>
<td></td>
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<td>85. neck pain</td>
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**Physical trauma leaving scars**  
**Complaints in previous history but improved at date of examination**  
**Complaints in previous history and unchanged at date of examination**  
**Complaints recorded in medical journal**  
**Medication target complaints due to trauma**  
**Physical handicaps due to trauma**
<table>
<thead>
<tr>
<th>Number</th>
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<td>trauma recurrences*-&gt;ptsd</td>
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<td>suicidal attempts*-&gt;depression</td>
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<td>trauma at a distance*-&gt;ptsd A</td>
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<td>124.</td>
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<td>reminiscent dreams*-&gt;ptsd B</td>
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<td>133.</td>
<td>diminished interest*-&gt;ptsd C</td>
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<td>134.</td>
<td>detachment / estrangment*-&gt;ptsd C</td>
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<td>overalert*-&gt;ptsd D</td>
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<td>B,C,D longer 1 month*-&gt;ptsd E</td>
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Psychological handicaps due to trauma

Psychiatric treatment due to trauma

Social handicaps due to trauma

PTSD problems

Treatment aimed at PTSD

Psychiatric treatment refused, avoided, noncompliant
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<td>149</td>
<td>and/or loss interest longer 2 weeks</td>
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<td>153</td>
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<td>anergia</td>
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Somatic equivalents of depression

Psychiatric diagnosis confirmed during examination

Scar allegation confirmed during examination

Irreversible lesions during examination

Psychiatric handicap during examination

Psychiatric condition limits interpretation
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Physical condition limits interpretation
Photographic/pictorial documentation of scars