Identification and health assessment of women survivors of rape and other torture

Handbook for Clinicians

Nimisha Patel and Juliet Cohen
This handbook was authored by Nimisha Patel and Juliet Cohen, International Centre for Health and Human Rights.


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**International Centre for Health and Human Rights**

The International Centre for Health and Human Rights (ICHHR) is a UK-registered charity (No. 1153689). We work to support the implementation of international human rights standards for health and rehabilitation of survivors of torture and other serious human rights violations. Our work includes conducting interdisciplinary research and harnessing available evidence, including practitioner-based evidence and survivors' experiences, to contribute to the development of practice and to inform policy related to the field.
Authors

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Her clinical training included time spent working in general medicine, general surgery, Accident and Emergency, neurology, geriatrics, paediatrics, obstetrics, gynaecology and genito-urinary medicine. She has extensive experience as a GP from work with a wide variety of populations in Hong Kong, Sydney, Canberra, London and Oxfordshire. She has worked in Hong Kong for the British Red Cross at a Vietnamese detention centre and in Sydney for the Royal Australian Navy. In Sydney, she also worked at a sexual assault referral centre, making forensic medical assessments. From 2001 to 2006, she worked as a GP with Specialist Interest to set up a mental health support service in Oxford for asylum seekers and refugees, bridging the gap between primary and secondary care. She is Head of Doctors for the Medical Foundation Medico-Legal Report Service (part of Freedom from Torture), where she has worked part-time since 1997, a forensic physician (specialising in examination of victims of torture, domestic violence and trafficking for servitude and prostitution) and a GP.

Her specialist areas include providing medico-legal reports on evidence of torture, rape, domestic violence and trafficking.
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Contents

1. Introduction

2. Using the handbook
   2.1 What is the purpose of the handbook? 8
   2.2 Who is this handbook for? 8
   2.3 How best to use the handbook? 9

3. Rape, sexual violence and sexual torture
   3.1 Terminology 12
   3.2 Rape in international law 13
   3.3 Rape and other torture 13
   3.4 Sexual violence and exploitation after rape 14

4. Professional, ethical and legal obligations
   4.1 Professional obligations 15
   4.2 Ethical obligations 16
   4.3 Legal obligations 21
   4.4 Key guiding principles 23

5. Aims of health assessments
   5.1 Settings of health assessments 25
   5.2 Key aims of health assessments 25

6. Preparation for the assessment
   6.1 Preparing yourself 31
   6.2 Preparing the setting 34
   6.3 Preparing documentation 36
   6.4 Choosing and preparing an interpreter 37

7. Identification and what to do next
   7.1 Defining identification 39
   7.2 Defining ‘early’ identification 39
   7.3 Improving early identification 40
   7.4 What to do after identification 45

8. Content of health assessment: what to assess?
   8.1 General principles 48
   8.2 Physical health assessment 49
   8.3 Psychological health assessment 57
   8.4 Assessing vulnerability and risk 65
9. **Process of health assessment: how to assess?**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1 Facilitating trust and disclosure</td>
<td>69</td>
</tr>
<tr>
<td>9.2 Interviewing: questions and techniques</td>
<td>90</td>
</tr>
<tr>
<td>9.3 Managing distress arising during assessment</td>
<td>101</td>
</tr>
<tr>
<td>9.4 Transference and countertransference</td>
<td>106</td>
</tr>
</tbody>
</table>

10. **Forming a clinical opinion**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1 Forming a medical opinion</td>
<td>111</td>
</tr>
<tr>
<td>10.2 Forming a psychological opinion</td>
<td>113</td>
</tr>
</tbody>
</table>

11. **Duty of care: follow-up**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>125</td>
</tr>
</tbody>
</table>
1. Introduction

This handbook is aimed at health professionals working in a range of settings and contexts. Although the authors are UK-based, we have sought, as far as possible, to ensure that the guidelines are applicable in different contexts where asylum determination processes and practice may differ.

The guidance in the handbook is intended to enhance health professionals’ ability to better understand and interview their client as a survivor of rape or other forms of sexual violence or torture as core aspects of violence against women and girls. The guidelines are intended to support health professionals in facilitating disclosure of women’s experiences of rape or other sexual violence or torture and to manage distress arising from interview.

Every asylum seeker who alleges rape or other forms of sexual violence or torture is a victim of a crime. Health professionals play a vital role in both ensuring appropriate health care for women survivors, as well as in potentially contributing to their protection under the relevant domestic legal framework and under a wider framework of international protection.

Rape and other forms of sexual violence arise in all forms of human conflict, whether interpersonal, ethnic rivalry, political repression, war, domestic violence, trafficking in human beings or servitude. Rape is also used as form of torture, against women and men, as a form of state-endorsed punishment, for example, against women who themselves or whose family members oppose the regime, women who are viewed as needing ‘correction’ because they are lesbian, women who are from a marginalised ethnic, religious, political or other group etc.

There exist various protocols or training manuals for frontline community workers or helpers and for human rights and legal caseworkers in conflict situations on documenting sexual violence as a crime under international law and for health professionals working with women refugees and internally displaced people in the aftermath of rape or other sexual violence. However, this handbook is aimed specifically at qualified health professionals who may see women survivors of rape or other sexual violence or torture during the course of their work, whether in primary, secondary or specialist health care services or in community or other civil society organisations.

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2. Using the Handbook

This section addresses the questions of who can use the guidance in this handbook and how.

2.1 What is the purpose of this handbook?

Key aim: The guidance in this handbook seeks to facilitate early identification, health assessment and decision-making for clinicians who may come across women survivors of rape or other sexual violence or torture.

Whilst rape or other sexual violence or torture is used against men and boys as well as women and girls, this handbook focuses primarily on women and girls. However, almost all the guidelines are relevant to the identification and health assessment of female and male survivors.

Key goals: The information and guidelines in the handbook are intended to:

- Improve knowledge and understanding of the professional, ethical and legal obligations for health professionals, arising from assessments with those who may have experienced rape or other sexual violence or torture
- Improve knowledge and understanding of the nature of rape or other sexual violence or torture and its impact on physical and psychological health
- Improve knowledge and understanding of the need for early identification of survivors and prompt action to ensure health needs and risks are addressed
- Improve ability of health professionals to prepare for assessments and to conduct thorough health assessments, in keeping with international standards, with those who may have experienced rape or other sexual violence or torture
- Improve skills in conducting interviews of survivors, facilitating disclosure of sensitive and distressing information, including disclosure of rape or other sexual violence or torture
- Improve knowledge and understanding of the obligations to use the assessment information to form a clinical opinion, where appropriate action can be taken. This may include ensuring referrals to other specialists or agencies and other follow-up action.

2.2 Who is this handbook for?

The guidance is written for access by a range of clinicians (e.g. general practitioners, medical specialists, nurses, clinical psychologists) working in a range of settings (e.g. State primary care services, specialist services, non-governmental organisations, detention facilities).

Qualified health professionals: The guidance herein can be used by those who are appropriately qualified and competent to undertake physical and/or psychological assessments, which are complex activities. It is important to recognise that any person in any health and social care service in any setting may identify a girl or woman as having possibly experienced rape or other forms of sexual violence and torture (see section 7 on identification). Nonetheless, the task of conducting an appropriate physical and/or psychological assessment and forming a clinical opinion, in keeping with international standards4, requires appropriate clinical qualifications and a reasonably high level of specialist clinical knowledge and skills.

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Lay practitioners and decision-makers: The guidance is not intended for use by lay practitioners or decision-makers who do not have appropriate formal professional qualifications and clinical competency. Lay practitioners or decision-makers who have identified someone as being a survivor of rape or other sexual violence or torture are advised to seek specialist clinical assessment and opinion wherever necessary.

Managers of clinical services: The guidance may serve to inform them on the professional, legal and ethical obligations of health care staff in early identification and appropriate health assessment. The guidance may also inform them of the complexity of the task of conducting a high quality health assessment and forming a clinical opinion, and of the skills required. Managers will need to ensure adequate resources and protected time to ensure ethical and professional practice in the early identification and health assessment process.

2.3 How best to use the handbook?

The handbook is organised into key sections (see page 10).

The handbook is perhaps most useful if read in its totality, though the format provided makes key information readily accessible whenever needed during clinical practice. The summary boxes and illustrations can be used as aide memoires to complement clinical skills, rather than be seen as a substitute for sound clinical competency. A professional clinical judgement will help guide each practitioner in knowing what is most applicable to them and to the clients they see.

The handbook draws on the extensive clinical experience of both authors. It is also based on research conducted by the first author with women survivors of rape and other forms of sexual torture, health professionals and lawyers who work with women survivors. The research, conducted over three years, focused on how women experienced the process of being interviewed by immigration officials, lawyers and health professionals; and what they see as facilitating in talking about their experiences of sexual violence. Direct quotations from interviews with women survivors and health professionals are provided in the handbook to illustrate some of the guidance herein.

The International Centre for Health and Human Rights also provides bespoke interdisciplinary training and accompanying clinical supervision, elaborating on the guidelines in the Handbook. For further information, please contact us on info@ichhr.org.uk
| Section 3 | Relevant terminology, including: |
| | • Rape, sexual violence and sexual or other torture |
| Section 4 | Professional, ethical and legal obligations arising from conducting a health assessment |
| | • Main implications for health professionals |
| Section 5 | Key aims of all health assessments, regardless of professional background |
| Section 6 | How health professionals can best prepare |
| | • Themselves, the setting, documentation, interpreter |
| | • To facilitate identification and assessment |
| Section 7 | Identification of those who have experienced rape or other sexual violence or torture |
| | • What to do next |
| Section 8 | Content of assessment: what areas to assess |
| | • Content of physical assessment/examination |
| | • Content of psychological assessment |
| Section 9 | Process of assessment: what hinders, what helps? |
| | • Facilitating disclosure of rape or other sexual violence or torture |
| | • Managing distress |
| Section 10 | Forming a clinical opinion based on the assessment |
| | • Forming a medical opinion |
| | • Forming a psychological opinion |
| Section 11 | Ensuring duty of care |
| | • Making referrals and ensuring follow-up |
3. Rape, Sexual Violence and Sexual Torture

Rape is a form of sexual violence against women, girls, boys and men, most often perpetrated by men.

Rape against women and girls is usefully understood as a brutal manifestation of women’s oppression and the discrimination and abuse which they face throughout their lives. Women and girls endure marginalisation, degradation, disadvantage, historical devaluation, oppression, violence, poverty, discrimination in health, education and employment. Violence against women and girls is pervasive globally, endangering their lives5, and globally, women and girls are over-represented amongst those suffering human rights abuses, many suffering systematic human rights violations. Many will have experienced violence in the home, exploitation and sexual harassment; many will go on to suffer rape, forced pregnancy, forced marriage, trafficking and sexual slavery, and enforced prostitution.

All too often, rape and other sexual violence is considered in health, particularly by psychologists, narrowly as ‘sexual trauma’. It is problematically theorised as if it can be understood as an individual problem located within the survivor’s psyche or body alone, rather than to be understood within the social, historical, political and cultural context of all violence against women; and as having an impact beyond the individual, on their family, community and society at large.

Rape and other sexual violence against men and boys is a deeply held taboo in most communities, though historically it has been sanctioned in certain settings and social contexts. Nevertheless, rape against men and boys is a form of sexual violence which breaches one of the most strongly-held social norms, arguably in every culture. It can also be understood as a manifestation of the marginalisation and degradation of women, in that many acts of rape and accompanying sexual threats, taunts and insults, are constructed as the feminisation of the victim, deliberately attacking their masculinity and the status, values and social norms underpinning notions of masculinity. Rape against men and boys is then, an act of disempowerment and an attempt to emasculate the person, forcing them into the apparently inferior social position of a woman, deemed demeaning, degrading and humiliating. As such, it is seen as rendering them the property and under the control of the perpetrator6. The inability to fight off the perpetrators adds to the sense of total disempowerment7 and as an affirmation of their emasculation.

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3.1 Terminology

The terminology used in this handbook is defined as follows:

**Sexual violence** refers to any harmful act of a sexual nature which is perpetrated against a person’s freely given consent. Rape is always sexual violence but not all sexual violence includes rape. Sexual violence includes all forms of sexual assault and also psychological intimidation, coercion, blackmail or other threats. Coercion may also include threats to others. Sexual violence may also amount to torture (see below).

**Gender-based violence** refers to any harmful acts which are perpetrated against a person’s will and which are based on socially-defined gender norms and assumed differences between men and women, or girls and boys. ‘Gender-based violence’ and ‘violence against women’ are often used as interchangeable terms as most gender-based violence is inflicted by men against women and girls. Many forms of gender-based violence are considered as breaches of international human rights and some are criminalised under domestic laws in some countries.

Gender-based violence can include rape, sexual violence, forced marriage of adults and minors, physical assault, dowry and ‘honour’ killings, human trafficking and sexual slavery, trafficking, female genital-cutting, sexual insults, threats and abuse, sexual exploitation by humanitarian aid workers, soldiers or others offering safe passage, intimate partner violence, and many other acts.

**Rape** refers to non-consensual penetration by a body part or an object, of the vagina, anus or mouth. In different countries, rape may be defined differently in domestic legislation.

**Torture** is defined in Article 1 of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions".

For ill-treatment to be torture as defined by Article 1 three cumulative elements must be present:
- the intentional infliction of severe mental or physical suffering
- by a public official, who is directly or indirectly involved
- for a specific purpose

**Rape as torture:** Rape and other sexual violence or other acts of violence against women can constitute torture when they are of the nature and severity envisioned by the concept of torture as defined in international law, and the State has failed in the above standards. There is an absolute prohibition on torture and cruel, inhuman or degrading treatment or punishment (often described as ‘ill-treatment’) in international law. This prohibition is considered of the highest order in international law and does not allow any derogation, whether in peacetime or war.
3.2 Rape in international law

Rape as a form of extreme discrimination: In international law, the United Nations Convention on the Elimination of All Discrimination against Women (1979), its General Recommendation No. 19, and the United Nations Declaration on the Elimination of Violence against Women (1993) recognise rape as a form of discrimination and violence against women – violence which places obligations on the State and state actors (such as state health services) to:

- protect women against rape and other violence within the home
- ensure effective remedies, including adequate health care, to those raped
- ensure prosecution of perpetrators and bringing them to justice in fair proceedings
- take preventive action for future protection.

Rape as a war crime: Rape can also constitute a war crime, a crime against humanity (if systematic and wide-scale) and genocide. The Rome Statute of the International Court of Justice has recognised many forms of gender-based violence as crimes against humanity and as war crimes. These include rape, sexual slavery, trafficking, forced prostitution, forced pregnancy, forced sterilisation and other acts.

3.3 Rape and other torture

Rape as torture is often systematic, deliberate, with a purpose, and state-sanctioned or lacking state protection. Rape like other forms of torture is a political tool of oppression, used to terrorise and control not just individuals but whole populations.

The aims of torture include to:

- destroy psychological and physical resistance, creating debility, injury and harm
- induce loss of control
- maximise helplessness and powerlessness
- create total dependency on the captor
- heighten and maintain a sense of constant fear and vulnerability
- disorientate, create confusion, to ‘break’ the will, physical and emotional resistance
- maximise uncertainty and unpredictability
- dehumanise, humiliate and degrade the individual and their family
- attack the person’s identity (e.g. gender, ethnic, political, religious)
- induce guilt, shame, self-blame and self-disgust.

Rape as a method of torture in repressive regimes and in wartime is used by both the State and by non-state armed forces as a powerful and devastating tool of terror and oppression. Rape in wartime is a brutal and widespread phenomenon, historically and in many of the current armed conflicts globally. It seeks to destroy the trust and social bonds between families and communities, breaking every social taboo; it seeks to destroy women’s procreative powers (seen as a threat of domination by their group), their sexuality and their human worth, where women are seen as subsequently damaged, infected, unclean, contaminated and unfit to bear children – or made to bear children as a result of rape, to ‘dilute’ and attack the ethnicity of the woman. In this sense, rape can be a part of a genocidal strategy and ethnic cleansing to destroy an entire group of people.


3.4 Sexual violence and exploitation after rape

For many women and girls, long after they have experienced rape or other forms of torture, the violence may not stop. Many are subjected to forced marriage with their captor or perpetrator, sexual slavery and exploitation; many will go on to also experience poverty, isolation, ill-health and life-threatening sexually-transmitted infections, pregnancy and intimate partner violence. Others will seek asylum, and face exploitation and rape by agents or others purporting to ‘help’ them.

Whilst rape and sexual violence and sexual and other torture are perpetrated against women and men, girls and boys, this handbook focuses primarily on women and girls. However, much of the handbook is also applicable to men and boys. The focus of the handbook is on health assessments of those who may have experienced rape in detention or armed conflict, by State (e.g. police, army, prison guards) or non-state actors (e.g. opposition armed groups) where rape may amount to torture, and where there are professional, ethical and legal obligations arising for the health professional.\textsuperscript{10}

\footnotesize{\textsuperscript{10} See Section 4.}
4. Professional, Ethical and Legal Obligations

There are several professional, ethical and legal obligations which provide a context and set standards for appropriate identification and health assessment and related activities. These are explored subsequently.

4.1 Professional obligations

All health professionals are guided by the professional guidelines of their particular professional body, which may differ slightly though they all share a common goal – that of the duty of care to clients, or all those who come to the attention of health professionals in whatever professional duty they are undertaking. In some situations, health professionals may hold dual functions, or work in an organisation which gives rise to dual obligations. For example, there may be a professional duty to conduct a health assessment and to assess and to act ethically on identified health needs and concerns, whilst working in certain settings, or with obligations to a third party (e.g. employer) which may preclude a health professional from acting on identified health risks.

Domestic legal frameworks, such as immigration or criminal law and procedures, may vary from country to country, giving rise to particular challenges to health professionals. Nevertheless, it is essential that health professionals always consider their primary duty of care to clients. Clients, in this context, refers to any person, adult or minor, who comes to the attention of a health professional in the course of their professional work (e.g. screening, assessment, therapeutic intervention). The primary duty of care to clients includes addressing health protection needs and concerns which require follow-up or emergency attention and care.

Health professionals should also be aware of their duty to safeguard vulnerable adults and children, which may include women and girls who have experienced rape or other sexual violence and torture. This may include addressing any assessed risk of harm (e.g. suicide, self-harm, harm to others, child-protection concerns) in keeping with established procedures within the particular national context.

Professional obligations of all health professionals are summarised in Box 1.

**Box 1: Professional duties of all health professionals**

In summary, all health professionals have:

- A professional **duty of care** towards the client, whether an adult or a minor, and their family, to address health protection needs and concerns which require follow-up and/or emergency attention and care

- A professional **duty to safeguard children and adults vulnerable to assessed risks**

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11 See Section 8.4 for further discussion.
4.2 Ethical obligations

Each profession in the health and social care fields has its own sets of ethical and professional standards for practice. While they may vary in wording and emphasis, the core ethical principles and standards of professional practice are largely similar.

For all health professionals, wherever they are employed, in whatever setting they work, the ethical principles remain broadly the same. The precise ethical and professional standard and corresponding obligations may vary from country to country, depending on the domestic legislative framework.

The ethical principles and implications for health assessments and related activities are summarised in Box 2 below.

<table>
<thead>
<tr>
<th>Box 2: Ethical principles and implications for working with rape, sexual violence or other torture</th>
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</thead>
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| **Principle 1: Do no harm**  
- Health assessment and rehabilitation services must be provided by those who behave professionally and without coercion, threat, exploitation or harm towards the client or their family  
- All health professionals must endeavour to do no harm in any of their professional activities.  
**Implications**  
- Do no harm when undertaking activities to facilitate early identification and in conducting health assessments with those who have experienced rape or other sexual violence or torture  
- Regularly evaluate the risks and the potential to do harm  
- Where appropriate, ask the client of any anticipated risks or dangers they fear of participating in health assessments and speaking to a health professional – at all times acknowledging and respecting their assessment of the risks they may face and their assessment of their own sense of safety  
- Take all necessary steps to prevent harm to clients, being mindful of additional risks to minors, and to family members. |
| **Principle 2: Non-discrimination**  
- Health services should provide clear criteria for inclusion and exclusion but should not discriminate against clients within the overall remit of the service on any basis other than clinical need, including on grounds of gender, sexuality, ethnicity, ‘race’, age, disability etc. (also as defined within national legislation).  
**Implications**  
- Be aware of national legislation on non-discrimination and equality and related professional obligations  
- Be aware of service or agency protocols, policies and guidance on preventing discrimination  
- Do not discriminate on any grounds other than clinical or health grounds, based on a thorough health assessment and clinical opinion. |
| **Principle 3: Competency**  
- Health services (including health assessments) should be provided by those appropriately qualified, knowledgeable and competent to do so  
- Health professionals should recognise the limitations of their competency; and not give a false impression to clients or colleagues that they have competencies which they do not have  
- Health professionals should not act beyond their level of competency, risking harm to the client and/or their family. |
Implications

- Ensure all professional activities including identification and health assessments are undertaken, and clinical opinions provided, by those who are appropriately qualified and competent
- Competency includes knowledge and understanding of rape and sexual violence and other torture, and their impact on physical and psychological health; knowledge of legislative framework and any relevant national protocols
- Competency includes skills in explaining confidentiality and seeking informed consent, and understanding the cultural, social and political significance of these professional activities for different clients, particularly those who have suffered sexual violence and other torture
- Competency includes skills in facilitating identification, in gender-, age- and culture-appropriate interviewing and in conducting health assessments, avoiding where possible or minimising and managing distress
- Competency includes skills in assessing vulnerability to risks, including risks of harm to self or others and child protection concerns
- Competency includes skills in working with professional interpreters in conducting health assessments.

Principle 4: Confidentiality

- Health professionals should explain confidentiality and its limitations, in accordance with professional and legal obligations, and in a gender-, age- and culturally-appropriate way
- Health professionals should ensure confidentiality, in accordance to professional and legal obligations, by protecting all personal and health information obtained during any health-related professional activity
- Health professionals must ensure that all breaches to confidentiality are dealt with promptly, fairly and without further adverse consequences on the client.

Implications

- Explanations of confidentiality and its limitations must be clear and in a language (with an interpreter wherever necessary) and words (jargon-free) which the client can understand and which are age- and culturally-appropriate
- Explanations of confidentiality should include information on how any health information and personal information, include name and contact details, will be protected from being seen or held by a third party. This should include how information will be recorded, where it will be held or stored, how it will be secured and who will have access to it, under which circumstances and if the client can themselves have access to any information held about them
- Explanations of confidentiality should emphasise that the rule of confidentiality applies to the interpreter, where used, and that the interpreter is also bound to protect the person’s privacy and personal and health information
- Health professionals must have regard to clinical duties and legal duties which arise when there is a risk of suicide, risk of harm to the individual or to others, or child protection concerns and where confidentiality may have to be breached
- Explanations of the limitations to confidentiality should also include information on how and when personal and confidential information may be accessed by third parties if they consent to it being shared (e.g. with other health professionals, a clinical supervisor or manager, police and courts).

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12 See Section 9 for further discussion.
Principle 5: Informed consent

- Health professionals must seek informed consent – such that clients are clearly and fully informed and have the capacity to understand and to consent without coercion, to any health activity, including identification processes, health assessments, interventions and referrals to third parties.
- Informed consent is subject to national legislative frameworks related to age, mental capacity or other factors.

Implications
- Ensure knowledge and understanding of relevant national legislation and protocols on ensuring informed consent.
- Informed consent must include the provision of information on: what the health assessment service is that they are being offered, its limitations, possible consequences and risks to themselves and others, the nature and purpose of the health assessment, the meaning of confidentiality and its limitations, any data collection activities, any photographs or other recordings to be made, any contact details and health records kept and access to those by third parties, any referrals to be made to other agencies or professionals, their right to withdraw consent, to provide feedback, or make a complaint without adverse consequences to them or family members from the organisation.
- Informed consent must be specific, and not be taken as a blank cheque for any activity subsequently undertaken by the health professional or the organisation. For example, where a health professional decides to invite the client to meet a press officer, a lawyer or other non-health professional, informed consent outlining the purpose, risks, legal obligations (or absence of) and likely consequences, must be sought before such meetings are arranged and conducted.
- Informed consent must include the provision of clear information, both verbally and, wherever possible, in writing and in a language which is understandable to the person and age- and culturally-appropriate and jargon-free.
- Informed consent with minors must be sensitively worded and appropriate to the age of the child and assess their capacity to understand and freely consent. Consent on behalf of minors should be obtained from parents or guardians, though different rules may exist in different countries relating to the capacity for adolescents aged 16–18 to provide informed consent.
- Consent must be sought at regular intervals and repeated at different times to ensure that any changes in the context or person’s circumstances are taken into account and that a person is allowed to re-evaluate, and withhold or withdraw consent, if they so decide.

Principle 6: Timeliness

- Identification of health needs and concerns must be prompt14 and timely to reach those most in need, with services and practices designed to ensure minimal delay upon identification of health needs, and health risks.
- Any follow-up services, including emergency investigations and care, should be prompt and responsive to the clinical assessment of urgency.

Implications
- Health professionals should be aware of professional and legislative obligations to ensure timely assessment and care for those with identified health needs and concerns.
- Health professionals should ensure a multidisciplinary response to attend to the assessment and health needs and concerns of clients according to the urgency.

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13 See Section 9 for further discussion.
14 See Istanbul Protocol, para. 104. For further details on identification see also, Section 6.
**Principle 7: Referring on**

- Health assessment services must be provided by those who are competent in making informed clinical opinions and decisions, based on thorough health assessments, on when to sign-post and refer clients on to other relevant services or specialists.
- Clients should be informed of all available services and how to access them directly, or where and how a referral would be made by the clinician.

**Implications**

- Health professionals should ensure they are aware of relevant available services, agencies and informal support networks.
- Health professionals should explain, in jargon-free, gender-, age- and culturally-appropriate language, which services are available.
- Health professionals should explore with clients their views of being referred to another agency or individual specialist and explore any concerns they have.

**Principle 8: Monitoring and addressing ethical breaches**

- Service providers and managers of health services and health professionals should be vigilant to risks to professional and ethical practice in identification and health assessment with girls and women survivors, and address all ethical breaches appropriately, fairly and promptly.

**Implications**

- Health professionals should be aware of the obligation to be alert to and prevent ethical breaches outlined above.
- Health professionals should be aware of the consequences of ethical breaches.
- Health professionals should seek to undertake further training or professional development activities to ensure the ethical principles outlined above are adhered to.

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15 See Section 11 for details.
The key professional and ethical obligations of health professionals in the identification, assessment and response to disclosures of rape or other sexual violence and torture are depicted in Figure 1.

Figure 1. Professional and ethical obligations of health professionals
4.3 Legal obligations

The legal framework relevant to the psychological assessment of rape, other sexual violence which may amount to torture in international law, or other torture includes both domestic and international law. Domestic laws vary according to different countries. In international law, rape and other sexual violence can amount to torture, as well being a crime against humanity and a war crime.

The right to freedom from torture and other cruel, inhuman or degrading treatment or punishment is considered absolute and non-derogable in all circumstances, including war or other public emergency or any form of anti-terrorism measure. The prohibition is provided for in the International Convention on Civil and Political Rights, 1966 (Article 7); in the Convention Against Torture and Other Cruel Degrading and Inhuman Treatment or Punishment, 1984 (UNCAT); in various regional instruments, including the European Convention on Fundamental Freedoms and Human Rights, 1950 (Article 3); and in the domestic legislation of States to the UNCAT.

It is important for health professionals to understand the significance of the legal consequences which arise from the prohibition of torture. These legal consequences have implications for the necessity and conduct of health assessments and follow-up action to ensure appropriate health and social care; and to enable legal protection where a person may be returned to a place where they may face harm (e.g. if they fail an asylum determination process in the country where they are seeking refuge).

The legal consequences which arise from the prohibition of torture (including rape and other sexual torture) are:

**Prevention:** There is a positive obligation on States to prevent torture and ill treatment. This requires States to ensure that general custodial safeguards exist against torture in places of detention, including access to a lawyer and doctor of their choice; informing friends and relatives; access to family; and not holding detainees in incommunicado detention.

**Investigate:** The obligation to effectively investigate allegations of torture includes prompt, impartial investigation; and it includes a guarantee that all allegations of torture are effectively investigated (UNCAT, Article 12). Investigations may include medical and psychological assessments to establish if torture has or is likely to have taken place.

**Criminalise:** States parties to UNCAT are obliged to criminalise torture (both complicity and participation) in criminal codes domestically (Article 4); to make torture an extraditable offence (Article 8) and to provide assistance to other national governments seeking to investigate and/or prosecute persons accused of torture (Article 9); and to ensure alleged perpetrators are subject to criminal proceedings if an investigation establishes that an act of torture appears to have been committed.

**Remedy and reparation:** States parties to UNCAT are also obliged to ensure that victims of torture have a right to an effective remedy and adequate reparation (Article 14) by ensuring that victims have effective procedural remedies to protect their right to be free from torture in law and practice; guaranteeing that domestic law reflects the different forms of reparation recognised under international law. Reparation includes restitution, compensation, rehabilitation (medical and psychological health care and social and legal help), satisfaction and guarantees of non-repetition.

The right to reparation, specifically rehabilitation, is complemented by the right to health as established in Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966. Article 12 provides for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
According to international human rights law, as recently defined in General Comment 3 of the United Nations Convention Against Torture, States parties’ obligations with respect to rehabilitation (defined as health and social care, legal, educational and vocational support), as a form of reparation, are outlined in Box 3.

**Box 3: States’ obligations with regard to the right to rehabilitation**

<table>
<thead>
<tr>
<th>States parties to the Convention Against Torture are obliged, with regard to the right to rehabilitation, as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Available</strong>: to ensure the establishment in the State of &quot;effective services and programmes&quot; (para. 15)</td>
</tr>
<tr>
<td><strong>Accessible</strong>: “without discrimination and regardless of a victim’s identity or status within a marginalised or vulnerable group, including asylum seekers and refugees. Torture victims should be provided access to rehabilitation programmes as soon as possible following an assessment by qualified independent medical professionals. Access to rehabilitation programmes should not depend on the victim pursuing judicial remedies&quot;. (para.13; and see para.15)</td>
</tr>
<tr>
<td><strong>Appropriate</strong>: “tailored to the needs of torture survivors and their families; and available in relevant languages” (para.13)</td>
</tr>
<tr>
<td><strong>Holistic</strong>: “meeting range of needs [of torture survivors and families]” (paras.11 and 13)</td>
</tr>
<tr>
<td><strong>Interdisciplinary</strong>: “providing services including medical, physical, psychological, social, legal, re-integrative services; community and family-oriented assistance and services; vocational training; education” (para.13)</td>
</tr>
<tr>
<td><strong>Specialist</strong>: meeting the specific needs of torture survivors and their families</td>
</tr>
<tr>
<td><strong>Guarantees safety</strong>: Provided in a way that guarantees the safety and personal integrity of the victims and their family</td>
</tr>
<tr>
<td><strong>Time-sensitive</strong>: Care provided as soon as possible in the initial aftermath of torture and within longer-term services (see paras.14 and 15)</td>
</tr>
<tr>
<td><strong>Service provider</strong>: obligation to “provide for the means for as full rehabilitation as possible can be fulfilled through the direct provision of rehabilitative services by the State, or through the funding of private medical, legal and other facilities, including those administered by non-governmental organisations. States obliged to ensure that no reprisals or intimidation are directed at victims; and that the victim’s participation in the selection of the service provider is essential” (para. 15).</td>
</tr>
</tbody>
</table>

**Implications for health professionals:**

Health professionals should be aware that

- Health assessments can contribute to legal processes and State obligations to ensure justice and reparation
- Health assessments can help ensure timely access to appropriate, interdisciplinary, holistic and, where relevant, specialist, health care
- Health assessments can support legal procedures to ensure the safety and protection of survivors who may be at further risk of harm.

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### 4.4 Key guiding principles

There are key guiding principles in any health screening or assessment with women who may have experienced sexual violence or torture, including rape. These are summarised in Box 4 below:

<table>
<thead>
<tr>
<th>Box 4: Key guiding principles in identification and health assessment of rape and other sexual violence or torture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client-centred:</strong> All screening, health assessment and documentation or health record-keeping practices and activities should ensure the best interests of clients as the main priority and uphold the professional duty of care of all health professionals towards clients. They should be respectful to clients, non-intrusive, non-burdensome and acknowledge the impact on clients. They should not hinder therapeutic contact with clients.</td>
</tr>
<tr>
<td><strong>Ethics:</strong> All screening, health assessment and documentation or health record-keeping systems, policies, methods, tools and practices should adhere to ethical principles for health professionals (see figure 1), including the principles to do no harm; to protect survivors from avoidable harm, suffering or exploitation; and to ensure informed consent and confidentiality. Ethical breaches must be avoided and professional integrity maintained throughout.</td>
</tr>
<tr>
<td><strong>Competency:</strong> All screening, health assessment and documentation or health record-keeping systems, practices and activities should be designed and implemented by those qualified and competent to do so, with appropriate qualifications, knowledge and skills.</td>
</tr>
<tr>
<td><strong>Transparency and accountability:</strong> All screening, health assessment and documentation or health record-keeping systems, practices and activities should be transparent and explained to clients in the spirit of seeking informed consent and being respectful and accountable to clients.</td>
</tr>
<tr>
<td><strong>Relevance and appropriateness:</strong> All screening, health assessment and documentation or health record-keeping practices and activities should be meaningful to clients, relevant to their needs, to their experiences and culturally appropriate, and be such that they make sense to them in light of the sexual violence or torture and other hardships and injustices they have experienced, or are still experiencing currently.</td>
</tr>
<tr>
<td><strong>Respectful:</strong> All screening, assessment and documentation or health record-keeping practices and activities should be respectful to torture survivors and their families, and seek to enable them to disclose their experiences as fully as possible, to participate in their rehabilitation, to share their views and to provide feedback on services they receive, without adverse consequences.</td>
</tr>
<tr>
<td><strong>Involving survivors:</strong> All screening, health assessment and documentation or health record-keeping systems, practices and activities should consult survivors and seek their views on those systems and practices and ways to improve them. Torture survivors must not be seen as passive recipients of screening procedures and assessment processes which are ‘done to them’, but as active participants whose views and experiences of those systems and practices are crucial to developing ethical, respectful and meaningful practice and systems.</td>
</tr>
<tr>
<td><strong>Participation and responsibility of all staff and management:</strong> All screening, health assessment and documentation or health record-keeping practices and activities should be viewed as placing a collective responsibility on all staff and all management.</td>
</tr>
</tbody>
</table>

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17 See Section 4.2.
18 See Section 4.2.
Summary
Conducting screening for the purpose of early identification and health assessments with those who may have experienced rape or other sexual violence or torture is a very sensitive and complex task, often carried out within a specific legal framework and socio-political context. It requires sustained and careful attention to professional and ethical practice which keeps at the forefront key principles as outlined in this section and summarised in Figure 2.

Figure 2. Key guiding principles underlying identification and health assessment of rape or other sexual violence or torture
5. Aims of Health Assessments

Health assessments may be conducted at any stage, by any health professional and in a range of settings. In routine health assessments, it is possible that women survivors of rape, sexual violence or other torture will not be identified, and their health needs may not be properly assessed or addressed. This can cause further health complications and intense suffering.

5.1 Settings for health assessments

The range of settings where health assessments may take place are summarised in Box 5. Each setting will have limitations and constraints which may impact on the nature of health assessment undertaken. The time available for the assessment will vary, as will the priorities in the consultation. Inevitably, the setting and service remit will impact on the nature, timing, comprehensiveness and quality of the health assessment.

Box 5: Settings where health assessments may take place

- Initial accommodation or reception centres for asylum seekers
- Removal centres
- Detention facilities
- Emergency health services
- Primary health care services (e.g. GP surgery, community midwifery)
- Secondary health care services (e.g. mental/psychological health services, acute psychiatric wards, obstetric and gynaecology services, sexual health services)
- Tertiary health care services (e.g. specialist pain clinic, psychotherapy service)
- Statutory health and social care services
- Non-statutory/non-governmental services providing health assessments/health care
- Community-based organisations providing health screenings/health assessments
- Private health care services.

5.2 Key aims of health assessments

Regardless of the setting and nature of a health assessment, it is important to recognise the aims of health assessments and the imperative to identify as early as possible those who may be survivors of rape or other sexual violence or torture.

The overall aims of health assessment may be determined by the context in which the assessment is required. This includes:

1. **Health needs**: Conducting health assessments to ensure early identification of health needs and vulnerability; and to evaluate which services are most suitable and their priority, based on clinical need. Early identification and health assessments can greatly facilitate appropriate health care, which can address immediate health care needs, and alleviate distress, as well as diminish the risk of further deterioration in health.

2. **Decision-making in the asylum determination process**: Conducting health assessments to contribute to identifying those who are torture survivors and particularly vulnerable as this may have a bearing on the asylum decision-making process.
3 **Reparation:** Health assessments may be required to establish the impact of torture on a person and their family members in order to determine reparation measures, including compensation, health care and other forms of reparation.

4 **Justice:** Health assessments may be required in judicial proceedings in domestic, regional or international courts to investigate allegations of torture. As such, they may contribute to decision-making with respect to the allegation of torture, and the prosecution of perpetrators.

Key aims common to all health assessments, for all health professionals and for all clients, can be found in Box 6 and are addressed more fully in Section 8.

### Box 6: Key aims of ALL health assessments

<table>
<thead>
<tr>
<th>Key aim</th>
<th>Rationale</th>
<th>See</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create conditions of safety</td>
<td>• When someone feels unsafe and afraid they are less likely to be open and to talk about their experiences, health and other concerns</td>
<td>Section 6 and 9</td>
</tr>
</tbody>
</table>
| Establish and build trust                                              | • Trust between client and the health professional is the foundation of all health assessments  
  • Trust is essential in order to build a therapeutic context and professional relationship to facilitate an assessment  
  • The absence of trust is likely to mean no disclosure of traumatic, violent or distressing experiences or events  
  • Trust of the client has to be earned by the health professional: it cannot be assumed just because they are being interviewed by a health professional or authority figure  
  • Trust takes time, humane effort, genuine warmth, compassion and skill to establish                                                                 | Section 9             |
| Bear witness                                                           | • Listening to the person, as a human being  
  • Listening with openness, respect and compassion to a person’s account of what happened to them, their suffering and their survival  
  • Being human and offering a positive, humane experience of being heard with care                                                                 | Section 9             |
| Enable the client to communicate, with professional interpreters where necessary | • Without professional interpreters, communication is compromised or impossible – without which no health assessment can be conducted meaningfully or ethically                                                                 | Section 9             |
| Assess the understanding of the health system and purpose of assessment | • Clients may not be familiar with the health system: it may differ significantly from health systems they are accustomed to in their home countries  
  • Confusion about the health system and about the purpose of assessment, or the nature of client/patient-health professional confidentiality may cause fear and reluctance to engage in an assessment, and reluctance to disclose traumatic, violent experiences, including torture                                                                 | Section 8 and 9       |
| Provide adequate information and explanations                           | • Enables clients in giving informed consent  
  • Reduces anxiety, confusion and uncertainty  
  • Helps facilitate trust and creates conditions conducive to disclosure  
  • Helps reduce stigma related to sexually-transmitted infections, psychological or mental health problems etc                                                                 | Section 8 and 9       |
<table>
<thead>
<tr>
<th>Key aim</th>
<th>Rationale</th>
<th>See</th>
</tr>
</thead>
</table>
| Gather information to make an appropriate health (physical and psychological) assessment | • Client may not have had previous health screening or any health assessment  
• Enables identification of health needs and concerns, ways of coping, risks and vulnerability                                                  | Section 8 and 9              |
| Facilitate disclosure of difficult experiences and discussion of sensitive areas related to health | • Enables decisions to be made to address health needs  
• Facilitates and supports legal protection – preventing further harm  
• Facilitates reparation – for harm and suffering  
• Facilitates justice – holding perpetrators to account                                                                 | Section 9                     |
| Assess vulnerability and risk (e.g. self-harm, suicide, violence, self-neglect, transmissible disease, health complications) | • Identification of vulnerability and risk can enable preventive interventions:  
• Prevent deterioration in health  
• Prevent harm to self or others  
• Prevent exploitation, abuse, harm by others  
• Minimise/prevent secondary traumas  
• Prevent public health risk                                                                                                   | Section 8.4                   |
| Recognise strengths and resiliency                                      | • Validates a person’s capacity to survive, to make decisions, to find ways to cope  
• Acknowledges how a person can suffer immensely and simultaneously have the capacity to endure and the courage to speak to a health professional who is a stranger | Sections 8 and 9              |
| Identify survivors of rape, sexual violence or other torture           | • Ensures health risks are minimised and health needs can be addressed  
• Establishes any need for referral, for documentation or for reporting obligation  
• Fulfils any legal obligations (as may be set out in domestic legislation or guidance) to report allegations of torture  
• Helps to safeguard the principle of non-refoulement (not returning someone to a place where they may face harm again) | Section 6                     |
| Ensure duty of care                                                    | • Fulfils duty of care to address health and social care needs and related issues which arise out of the assessment                                                                                   | Section 11                    |
| Assess urgency of need                                                 | • Establishes priorities of interventions and follow-up/referrals to other services/colleagues                                                                                                           | Section 11                    |
| Document assessment, clinical opinion, priorities and action taken, as well as where the assessment is incomplete and the opinion is provisional | • Facilitates continuity of care where relevant information is available in case of future need by other health professionals  
• Ensures health risks are addressed and unfinished assessments completed by relevant professionals  
• Ensures accessibility to other health professionals of relevant information about health needs and experiences of rape or other sexual violence or torture | Section 11                    |
| Assess areas which require further assessment, follow-up and referrals to other services/colleagues | • Ensures unfinished assessments are not ignored, to the detriment of the client                                                                                                                            | Section 11                    |
For all adults and minors who are new arrivals as asylum seekers or as internally displaced persons, it is vital important to check whether they have already had a thorough health assessment. Any documentation of previous health assessments will be helpful. Sometimes, documentation may not be available, or it is unclear if any health assessments have been previously conducted. In this case, it is essential and fair to offer a health assessment to everyone.

Some women and girls, for example, may not request a health assessment due to fear, shame or not understanding the need. The issue of consent to further health assessment is very important, particularly when a person fears the consequences for their health and what may emerge (e.g. finding out they are pregnant or that they have a sexually-transmitted infection, fear of revenge ‘honour’ violence if there is disclosure of rape, if psychological health problems are identified fear of being held against their will in a mental health facility), or for their safety.

“I was afraid, I didn’t want to see the doctor. I didn’t know what they would do, I was afraid I was pregnant and infected [with HIV]... I was afraid of my community, my family, what would they say.”

Survivor

Some may not give any indications that a health assessment is warranted. Some may be unfamiliar with available health systems and fear the worst.

“Most patients we deal with […] they see us [in community organisation] as their first contact […]. The health system here is different […] there’s no family doctors, GP services in my country, if you’re ill you go to hospital, you get seen by a specialist who’s also an authoritative figure so you know with a white gown and everything […] they are afraid of the health system, if they don’t understand it.”

Health professional

For others, it is not just that they are unaware of and unfamiliar with how the local health system works, but they fear that the health service is not independent, and therefore deem it unsafe.

“It was something that I didn’t really think of until one of my patients said to me, ‘but you work for the government’, I hadn’t really thought of that, I do […] but someone else looking at it, you work for the government and often that’s been the perpetrator for them so that whole level of mistrust as well, worrying about whether it’s going to affect their [case] in a negative way.”

Health professional

Where health assessments are offered routinely to everyone who is an asylum seeker, refugee or internally-displaced person, the chances are higher of identification of those who are vulnerable and have experienced rape or other sexual violence or torture. It is essential, at minimum, to conduct an initial assessment for everyone and to ensure a full health assessment will take place subsequently.

Sometimes, an assessment must be performed despite the person declining it, for example, by the use of mental health legislation. The fears the person has of such compulsory assessments must be considered sensitively, particularly when, for some, contact with health professionals or other authority figures is related to their past experiences of rape or other torture.

Where limited time or the setting constrain the initial assessment, key aims must be considered and priority areas addressed (see Box 7).
Box 7: Initial health assessment: key priorities

Create conditions of safety conducive to building trust

- Enable the client to communicate, with professional interpreters where necessary
- Inform client on purpose of assessment, provide adequate information and explanations
- Gather information to make an initial and provisional health (physical and psychological) assessment
- Assess vulnerability and risk (e.g. self-harm, suicide, violence, self-neglect, transmissible disease, health complications)
- Assess urgency of need.

Sometimes a specialist health assessment for a medico-legal report may be requested for legal purposes. For example, such reports may be used in domestic courts for asylum determination processes. They may be used in regional or international courts or by United Nations monitoring bodies, for the purposes of seeking reparation and justice. Such health assessments are generally more detailed and their aims are to assess and document the psychological and physical health state or injuries alleged to have resulted from or to be related to torture; and provide a professional or expert opinion based on the health assessment.

Some services may require an additional aim of assessment, such as to identify the most appropriate interventions for the person, specific to their health difficulties, risks, context, ways of coping and resources. Specialist health assessments may also have the aim to explore specific health difficulties (e.g. gynaecological, sexual health, neurological, pain).

Key questions to ask oneself:
- Has an initial health assessment been conducted for this person?
- Is documentation available?
- If there is no previous health assessment, when can an initial assessment be conducted, by whom?
- What are the key aims and priorities for this initial assessment?
- When can a full health assessment be conducted, by whom and why?
- What are the key aims for this full health assessment?
- What additional aims for an assessment need consideration?

Good practice includes:
- Sensitivity to the possible reasons why someone may not request, or why they may fear, a health assessment (physical and/or psychological)
- Being alert to the possibility of sexual violence or other torture in all health assessments
- Offering a health assessment routinely to all women and girls, seeking informed consent, unless an assessment is deemed compulsory under mental health or other national legislation
- Ensuring a full health assessment is conducted, and where necessary, an initial health assessment which at minimum includes an assessment of physical and psychological health, vulnerability, risk and immediacy of needs
- For all health professionals to be clear about the key aims of all health assessments, and for initial health assessments.
6. Preparation: Enabling Identification and Health Assessment of Survivors

There is an imperative for early identification of survivors of sexual violence who may not easily come forward or disclose what happened to them, for health protection and legal protection. Identification is not the sole responsibility of any one agency or profession. Survivors of sexual violence are victims of crime (irrespective of whether that crime took place within the jurisdiction of the country of refuge or elsewhere). There is a duty in domestic and international law to investigate crime, prosecute perpetrators, protect victims and prevent re-victimisation. In the case of refugees and those in need of international protection, this is embodied in the various prohibitions on return to situations of real risk.

The imperative for identification of survivors of rape or other forms of sexual torture by health professionals is essential for three reasons, all preventive and protection-focused:

1. To ensure a prompt and appropriate assessment and documentation of their health needs and torture experienced so that appropriate care and treatment can be assured
2. To ensure all necessary steps have been taken to ensure legal protection as part of the asylum determination process, where relevant
3. To ensure all necessary steps have been taken to protect a person, where the person is held in custody (e.g. detention facilities) or in particular settings (e.g. refugee camps) where the risk of re-traumatisation and deterioration in health and risks to their safety are heightened.

Early identification, as a preventive measure, and health assessments may arise in a number of settings where health professionals work. For example, survivors may be seen in initial accommodation or holding centres, or in immigration detention centres. They may have seen many health professionals, from a nurse
practitioner in a reception centre when they first arrive, seeking asylum, to a midwife in hospital. Some survivors may have come into contact with a general practitioner, or presented in accident and emergency services, or in specialist psychological services – without ever telling anyone what had happened to them, or disclosing the torture they have experienced. Many will have had contact with several health professionals, in different settings, over a period of time, and yet will never have told anyone what happened to them.

The notion of ‘preparation’ is thus important – how best health professionals can be prepared in whatever setting they work in, to enable women to disclose what they experienced and to document this appropriately. In this regard, preparation has three components: preparing yourself, preparing the setting and preparing documentation.

6.1 Preparing yourself

Preparing oneself to be open to recognising indications that someone may have experienced particular sexual violence or other torture is not a one-off action. Rather, it is based on a commitment to maintaining awareness. The awareness can be at several levels:

1 **Self-awareness:** recognising our own anxieties, stresses, personal or work pressures or competing demands and how they may be impacting on our own capacity to listen to others, to take a genuine interest in the client. Self-awareness also requires honest self-reflection about the issues we find hard to hear, or to see or to know more about. Our own assumptions, values and previous personal life experiences can sometimes prevent us from being open to hearing, seeing and listening to others, and in turn clients can sense this from us and may decide they feel too unsafe to share details which they themselves may find very shameful, painful and difficult. This is a two-way process; while you are seeking to facilitate disclosure, the client is consciously or unconsciously making a series of judgements as to what she should (can) or should (can) not tell you. This includes her assessment of your capacity to listen, absorb and process the information that she may disclose. In doing so, your ‘safety’ and capacity to hear the horror of the details of what happened to her may well be one of her concerns, and may inhibit her from speaking to you.

2 **Awareness of person’s culture and background:** Individuals and family members typically present themselves and their difficulties in ways which are shaped by cultural and social norms, as well as by what they believe is the appropriate way to seek help. Demanding medication for particular ailments, or insisting that a particular treatment is all they need etc. may mask many anxieties of other health worries they feel unable to share. On the other hand, as a woman, not speaking or giving monosyllabic responses to a health professional in authority may be culturally appropriate, but may also be shaped by what a woman thinks inappropriate to talk about to a male doctor. Sometimes clients give some signals that they do not feel able to speak openly or fully, but these signals may also be culturally shaped and not so apparent to the health professional.

**Key questions to ask oneself:**

- What do I need to be aware of in terms of this person’s background, culture, language, gendered norms and the social and political context of the country from which this person comes?
- How might the person’s background influence how they present?

**Good practice includes:**

- Making time to be informed of clients’ backgrounds
- Reflecting on how the person’s background may mediate their health presentation and their view of what is expected when meeting a health professional in your given work context or setting
- Reflecting on how gendered norms may dictate what the client feels able to say in the presence of an interviewer and or interpreter who is from the opposite sex
- Considering religious or other norms which may dictate when a client can attend an interview (e.g. prayer times, religious holidays).
3 **Awareness of prevailing attitudes:** recognising wider societal discourses which depict survivors of rape or other sexual violence or torture, including asylum seekers, as untrustworthy, lying about their experiences, or exaggerating their history, or as draining scarce resources and the time of health professionals. For example, in the UK, while a discourse is emerging regarding historical sexual abuse against women and girls, with the accompanying rise of collective moral outrage, there remain lacunae between the reception of claims of sexual abuse by British women and those claims of sexual violence made by asylum seekers coming to Britain.

It is inevitable that such discourses shape our own attitudes, concerns and doubts and this may unfairly influence or distort the assessment process. Often, survivors describe how they can sense that health or legal professionals, or decision-makers, do not believe them and hold negative views about them before they have even properly described what happened to them or what are their difficulties and needs.

**Key questions to ask oneself:**

- What do I need for myself, to help me be present and open to the client, to not be distracted or to feel too rushed and irritated?
- What are my own assumptions about asylum seekers, or women, or people who talk about sexual violence they have experienced?
- What do I do, or convey to clients, which may inhibit them from telling me what happened to them, or what is really worrying them about their health?
- How do these assumptions impact on the way I work, and the way I relate to my clients?

**Good practice includes:**

- **Reflecting on yourself**, your own needs, stresses, pressures and assumptions which could be impacting on your work and your ability to recognise and to be open to hearing about sexual violence and other forms of torture.
- **Approaching each person with an openness** and a view that they may have experienced rape or other sexual violence or torture; and may have particular health, legal and other needs in relation to those experiences.
- **Holding in mind that some women may have seen other professionals before you**, or no one else before you, and that they never felt able to disclose their past experiences of rape or other forms of torture, or to talk about certain health problems, due to embarrassment, shame or fear of being judged or of not being believed or understood.

4 **Awareness that the person may have encountered hostility and disbelief**

Some people, particularly those who have experienced an asylum determination process, may have encountered hostility, indifference and disbelief when they have spoken about their experiences and impact. Furthermore, many survivors will have experienced the same hostility and indifference from their perpetrators, as well as extreme cruelty, brutality and actions which they experience as inhuman, degrading and humiliating. These experiences can prevent a person from trusting anyone who is an authority figure, including health professionals.

> “Most of them, especially the women, I wouldn’t think would ever sort of be able to get rid of this fear, the fear of the authorities. I’ve got clients who literally jump when they hear sirens, or see men and women in uniforms […] there’s still fear of authorities in the UK, in England.”

Health professional
“The whole of the asylum system is almost designed to shut them down even more further than letting them open up and tell, you know, talk about their experiences. [...] it takes a lot of courage to sort of get them to the point where they feel secure enough to start talking about it [...] there’s no empathy, there might be a few [...] more human than others, but mostly not [...] I’ve seen it myself, in court hearings.”

Health professional

“In court, the woman is feeling lost, scared, then she has to talk about the most intimate things to people, the judge, lawyers, interpreters, who don’t want her to feel safe or to really talk.”

Health professional

“I think there is a systemic kind of structural problem in relation to the fact that the asylum system is more adversarial and not positive enough [...] Some of our contexts feel very harsh, they feel very disbelieving, so I think sometimes people’s experiences of having to give statements to lawyers or the [immigration authorities] can set up a culture and expectation of them feeling that they’re going to be disbelieved, that they’re not being treated with respect and with dignity [...] that creates a context when they come to us [in the health service] that they expect to be disbelieved.”

Health professional

**Key question to ask oneself:**

- What other experiences of authority figures might this person have had in the past?

**Good practice includes:**

- Being aware of which health, legal or other systems the person may have already encountered, in this country and previously
- Being aware of any relevant reports of the kinds of experiences of users within these systems.

**Awareness of previous negative experiences with health professionals**

Survivors sometimes describe previous experiences they have had with health professionals and health services, which inhibit them from wanting to see another health professional and trusting them. Some may have been sent from one service to another, and rejected by services who deem the person ‘too complex’ or ‘too ill’ or as having ‘too many problems we can’t deal with in our service’.

Others describe how the interviewer may have little knowledge or understanding of the client’s cultural background or the political context or gravity of the sexual violence the client has been subjected to and how this may come across in their appearing overwhelmed and in their attitude and interviewing as grossly minimising or dismissing the client’s experiences.

“She told me that she had opened up to the health professional, told her in detail how she’d been raped because she wanted to get it all out there with the help of the interpreter, and she said it was very unhelpful because the interpreter was crying, the health professional just looked completely dazed, couldn’t believe what she was hearing, and the health professional said to her ‘when you go home, tell your husband about this, he’ll support you,’ which is complete nonsense in our culture and also, the health professional also told her ‘light a candle, it will help’.”

Health professional
The women told me, ‘you know by the time we explain our position in the Afghani society, first we have to educate them [the health professionals], and then they show us sympathy rather than empathy, and we don’t want the sympathy. We don’t want them to look down on us and think ‘oh poor you’ because no, you know, it is not ‘poor me’.”

Health professional

**Good practice includes:**

- Being aware of which health professionals or services a person may have already encountered, and being open to hearing about the person’s fears and concerns about seeing another health professional.

### 6.2 Preparing the setting

The setting within which clients are asked to wait or where they are seen for a consultation is crucial to the quality of the interview, clinical assessment or examination, and therefore to the quality of the opinion formed of the person and their health and other needs. Sometimes limited funds may constrain the provision of an appropriate environment. Sometimes, the clinician has little control over the environment (e.g. in a detention facility), though mostly there are opportunities to attend to the setting.

It is difficult to anticipate all the circumstances or factors which may cause a client to feel afraid, anxious, mistrustful or distressed. However, a welcoming setting is not just about the physical environment, but the setting in which the client is received and the way they are received.

“Our receptionist is amazing, and I think having that person right at the start, that smiles, that’s, ‘hello’, that’s expecting you, that’s... that person right at the start... very welcoming, the clients feel at ease with her immediately, I think that’s majorly important, instead of getting the grumpy receptionist that doesn’t make eye contact with you that we’ve all seen.”

Health professional

**Key questions to ask oneself:**

- Is the waiting area welcoming and laid out in a way which affords clients privacy and a sense of safety?
- Have I scanned the consultation room to ensure I anticipate any possible triggers of distress or mistrust for the client?
- Is the consultation room welcoming?
- Is the consultation room private? Can conversations be overheard by others?
- Is the consultation setting safe and secure?
- Are there images, pictures or other decorations which may trigger distress or make the client feel uncomfortable or afraid?
- What do I need to do to make the setting appropriate and conducive to a consultation where the client feels as safe and comfortable as possible?
- Is there anything I know about the client, or their previous distressing experiences of seeing health professionals in particular settings, which I should be aware of in preparing the setting?
- Is the client providing any cues or signals that they are finding some aspect of the setting uncomfortable or frightening?
- Is the setting conducive to my own safety?
Good practice includes:

- Taking time to scan the waiting area and consultation room and to think about how to create a setting appropriate and conducive to open communication and disclosure of distress and any difficult experiences of torture
- Take simple steps to create an appropriate setting, such as summarised in Box 8.
- Consultation rooms should be prepared to ensure clients feel comfortable, safe and not as if they are going to be interrogated
- Attend to the layout of furniture in the waiting area and consultation room to facilitate rapport, to minimise the power imbalance and to make the client feel at ease and more able to communicate with you
- In waiting areas, chairs should not be too close together (taking cultural considerations and gender norms into account), or directly facing each other. Waiting areas should be calm as possible, clutter-free, and individual client’s privacy should be respected when they are called or collected for their appointment. In the consultation room, ideally, you should be seated at a comfortable distance from the client and at a slight angle. If an interpreter is present, the chairs should be equidistant, in a triangular arrangement. Chairs should be positioned in a way that the client can make eye contact with you and the interpreter (where present), and see the door, to reduce potential anxiety. You should be able to make eye contact, hear and communicate with the interpreter
- Take time to consider if the room is appropriate. For example, a room with no windows or natural light, or a small room, may remind a person of the cell in which they were detained. Large, sparse rooms may feel cold, exposing and frightening, reminding some people of rooms where they were interrogated and tortured. Bright lights may heighten the feeling of being exposed and evoke the setting in which they were tortured
- Sometimes, a table or an examination couch may be necessary. The position and size of the table can be adjusted to create comfort, and not distance and anxiety. Small tables not positioned between the interviewer and the client, but to the side, can feel less obstructive. Where a table is necessary, round tables may create a setting where the interviewer and the client (and interpreter where present) are not sitting opposite each other as if in an interrogation or in a confrontational style
- Notice any cues from the client or family members about their response to the consultation room or environment of the waiting or consultation area
- Acknowledge to the client or family members that you have noticed their response to the setting or environment, and find ways to adjust the setting as far as possible to help them feel more comfortable and safe
- Avoid conducting an assessment in a setting which is not private. Health professionals are obliged to establish and maintain privacy throughout the interview or, when this is not possible, to make a clinical judgement on whether the assessment venue should be changed, postponed or other measures taken. In some settings and country contexts, it may be extremely difficult to conduct a health assessment without the presence of others. If a health professional is required to still assess the person (e.g. whilst the person is in detention), and others are present (e.g. soldiers, police officers, prison officials) then a clinical judgement must be made on what aspects of the assessment may continue, if the client consents. If others are present, their presence, and impact on the interview, must be noted in the clinical records and in any formal medico-legal report which may arise from the assessment.
- Avoid conducting an assessment where safety and security cannot be guaranteed and where possible consequences of the assessment may be that the person being assessed is in danger of reprisals and further harm (e.g. if they are in detention or other form of captivity) or if you as the health professional may be at risk of harm from the authorities or detention officials.

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19 Istanbul Protocol, paras. 83 and 124.
20 Istanbul Protocol, para 125.
21 See Istanbul Protocol, para. 239.
Box 8: Creating an optimal setting and physical environment

- Avoid cluttered settings with too much furniture and clear away potentially distracting papers and objects
- Remove or store out of sight any medical or other instruments which may cause distress or appear threatening or resemble instruments used in torture
- Ensure there is a ‘do not disturb’ sign and inform others that you don’t wish to be disturbed
- Arrange the furniture: avoid large obstructive tables or desks between you and the client; place chairs at angles, rather than directly facing the client
- Ensure chairs are all at the same level and comfortable
- Ensure the seating allows you, the interpreter (where present) and the client to see each other and have eye contact
- Allow adequate distance, without being too distant, between chairs, allowing the client to move the chair and control the distance to where they feel most safe and comfortable
- Divert office phone and pager and silence mobile phones
- Ensure the consultation room is private and conversations cannot be overheard
- Ensure there is drinking water available for the client
- Ensure there are tissues available, visible and within reach of the client
- Ensure there is adequate ventilation, adequate lighting and the temperature is comfortable
- Ensure you let the client know where the toilet facilities are
- Ensure you are aware of your organisational policy on protecting your own safety, and take action to implement appropriate measures
- Monitor the clients’ cues and acknowledge any signals of discomfort, fear and agitation which may be related to the setting. Make adjustments to the setting, or ask them what could make them feel more comfortable and at ease. Where adjustments cannot be made, acknowledge this to the client, and ask how this impacts on them.

6.3 Preparing and reviewing necessary documentation

Preparing or reviewing relevant documents for any health assessment would be routine practice for all health professionals. In the context of a health assessment where the client may have experienced rape or other sexual violence or torture, it is helpful to consider what additional relevant protocols, guidance or documents may be needed (e.g. national inter-agency protocols for addressing sexual violence, organisational operational policies, professional practice guidelines on working with interpreters).

Key questions to ask oneself:
- What do I need for the interview or examination?
- Is there any indication in the referral letter or other completed assessment forms or from a legal representative of the client that the person may have been raped or subjected to other torture or violence?
- Is there anything in existing documentation which suggests caution about whether the client should be interviewed alone, or with a chaperone, or with/without her partner or family member present?
- Is there any indication in the existing documentation which indicates that the woman needs to be seen with an interpreter, and which language and gender; or if there is concern from the client about being seen by an interpreter from her own community?
- Is there documentation to clarify existing national, local or institutional protocols and guidance I need to be aware of?
Good practice includes:

• Review all available documentation, to see if there is any hint or indication of sexual violence or other forms of torture.
• Review the Istanbul Protocol and other relevant guidance on health assessments with people who may have experienced torture, including rape and sexual violence which may amount to torture.
• Review any national, local and institutional policy guidance or protocols to follow if someone is identified or flagged up as a survivor of rape or other sexual violence or torture.
• Ensure you have paper to take notes, and any diagrams used as protocols to document evidence of injuries which may be related to torture. Avoid interruptions to the interviews.
• Explore the likelihood of the client needing a chaperone during a medical examination.
• Ensure you consider in advance the need for an interpreter, and from what language and ethnic/cultural background and gender. If in doubt, and wherever possible, speak to the referrer, or the client if they are able to communicate this to you adequately (e.g. in limited English or with a friend/person they choose to communicate with you, on their behalf).

6.4 Choosing and preparing the interpreter

Preparation for a health assessment includes giving thought to whether an interpreter is necessary, and in what language, dialect and what gender. Previous health assessments or referrals may not indicate the language of the client, or their proficiency in the language used by the assessor.

Key questions to ask:

• Is there a need for an interpreter?
• Which language and dialect does the client speak, or prefer?
• Are there any considerations with regards to the gender, ethnicity and/or religious background of the client and fears or concerns they may have about the gender, ethnicity and/or religious background of the interpreter?
• If an interpreter was used in previous health assessments, was this a professional interpreter, and one that could be used again to facilitate continuity, or not, if there were any difficulties?
• Where can I access a professional interpreter?

Good practice includes:

• Checking if there is a need for an interpreter, the dialect and any considerations to bear in mind with regards to the gender, ethnicity, age, cultural, religious or political background of the interpreter.
• Ensuring a professional interpreter is used, not a family member or friend.
• Where possible, using an interpreter who is experienced in working with health professionals and familiar with health terminology and process of assessments.
• Giving a choice to the client, wherever possible, on the gender of the interpreter.
• Ensuring the interpreter fully understands their ethical obligations, including of confidentiality, with regards to the health assessment.
• Considering and monitoring any possible risks that may arise for the client (or their family) if a particular interpreter is used (e.g. if from the same community or from a political or ethnic background different to that of the client).

22 See Section 9.1 for further discussion.
• Briefing the interpreter before each interview/consultation about the purpose of assessment, the cultural context of the client and the terminology which may be used in the interview/consultation (including medical or psychology terms, words referring to sexual violence or other sensitive health matters)

• Briefing the interpreter after each interview/consultation to check terminology, cultural reflections on terms used or to reflect on contextual or cultural aspects of the interview which are significant to understanding the client and their situation and health needs and concerns. Briefing after each interview/consultation also allows the interpreter to reflect on the impact of the interview on them (e.g. if they were distressed, disturbed or shocked).
7. Identification and What to do Next

This section focuses on the concept of ‘identification’ and the obligations arising from the need for identification.

7.1 Defining identification

Identification in this context can be defined as the recognition of those adults and minors who may have experienced rape or other sexual violence or torture, either in the context of detention, armed conflict, trafficking or other situations.

Human trafficking has been described as a crime ‘hidden in plain sight.’ Many trafficking victims will be unregulated migrants and may approach legal practitioners for help in that area. They may not see themselves as, or be reluctant to disclose that they are, victims of trafficking, not least because of the ill-treatment and threats they have been subjected to.

7.2 Defining ‘early’ identification

Whilst the term ‘early identification’ is used to ensure prompt action, defining ‘early’ is problematic. Definitions of early identification in the legal context are not available and interpretations of what is considered ‘early’ can vary in different domestic and international courts.

Clinically, early identification can be defined as identifying particular health needs, concerns, vulnerability and risks at the earliest opportunity, whichever health professional assesses the person, for the purpose of ensuring appropriate protection and care.

Despite the imperative to ensure early identification, there are often no clear indicators of rape or sexual torture and a person may not disclose for a number of reasons24. A survivor may see a health professional for a screening health assessment in an initial accommodation centre or what are known in some countries as refugee reception centres. Some may then also see a health professional who is a general practitioner, a hospital doctor, a nurse, midwife, counsellor, clinical psychologist, psychiatrist etc. They may be seen in different settings, sometimes on several occasions, by different health and social care professionals, but never disclose that they have been raped or experienced other sexual violence, or other forms of torture.

Nevertheless, the need for early identification, or identification at the earliest opportunity, arises from three protection concerns and aims (see Box 9):

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24 See Section 9.
Box 9: Protection aims of Early Identification

<table>
<thead>
<tr>
<th>Nature of Protection</th>
<th>Aims of Early Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health protection</td>
<td>To ensure that survivors are able to access the necessary health assessments and health care as early as possible, to:</td>
</tr>
<tr>
<td></td>
<td>1. Address immediate and ongoing health needs and risks</td>
</tr>
<tr>
<td></td>
<td>2. Prevent further health complications and health problems becoming chronic, debilitating and impairing social functioning</td>
</tr>
<tr>
<td></td>
<td>3. Address public health risks</td>
</tr>
<tr>
<td></td>
<td>4. Meet international legal standards for rehabilitation, including accessible, appropriate, specialist, multidisciplinary care and treatment.</td>
</tr>
<tr>
<td>Protection from harm</td>
<td>To ensure appropriate preventive measures can be in place to safeguard adults and minors, to:</td>
</tr>
<tr>
<td></td>
<td>5. Protect adults and minors from risk of harm to self, harm and/or exploitation from others, harm to others</td>
</tr>
<tr>
<td></td>
<td>6. Protect children from neglect, abuse, exploitation and violence.</td>
</tr>
<tr>
<td>Legal protection</td>
<td>To ensure appropriate legal support to:</td>
</tr>
<tr>
<td></td>
<td>7. Protect survivors from being returned to a place where there is a risk of further harm</td>
</tr>
<tr>
<td></td>
<td>8. Help access appropriate rehabilitation and reparation</td>
</tr>
</tbody>
</table>

7.3 Improving early identification

Early identification is the collective responsibility of all those who come into contact with survivors. This may include police, staff at asylum reception centres, staff in refugee camps, frontline workers, interlocutors, immigration officials, legal representatives, health and social care professionals, frontline workers and others.

Where language interpreters are necessary, it is essential to use qualified interpreters who are skilled in working with vulnerable people. Interpreters should be seen not as ‘outsider voice-boxes’ but as professionals integral to effective, multidisciplinary efforts to improve early identification.

For health professionals, the obligation for early identification is crucial to health protection and protection from harm (see Box 9 above). However, many factors, including limited time and multiple competing priorities, may hinder early identification. The conditions of any consultation, however brief, are crucial to how safe and comfortable the person feels and, therefore, how likely they are to disclose any details which may point to rape or other torture.

Sometimes, signs may emerge in a health consultation or a person may give signals which indicate that they have experienced rape or other sexual violence or other forms of torture. There are various ways to improve early identification (see Box 10).

25 See supra note 13.
Box 10: Early identification

What helps?

• Be alert to the possibility of rape or other sexual or other torture

• ‘Listen with knowledge’\textsuperscript{26}: Do your own research and seek background information to inform yourself of the country context, human rights violations and ongoing conflict in countries the person has come from. Listen to their account, being alert to any indication of rape or other torture they may have suffered and any unique aspects to each person’s account

• Be mindful of how difficult it is for survivors to say what happened to them, to loved ones or to professionals even if they seek to help them

• Remember the fears a person may hold about telling someone what happened – fears of reprisal, punishment, rejection or isolation from one’s family; and/or adverse consequences in health and social care or legal system; cultural and social norms about what can and cannot be said to particular people, even if they are health professionals or authority figures

• Observe carefully: What is the general presentation of the person? What is their general health? Do they seem vulnerable (e.g. signs of self-neglect)? What is their general demeanour and are they able to make eye contact with you? Are there visible signs of physical injury, mobility issues? Is the person in pain, anxious, fearful, unable to communicate? What are the non-verbal cues?

• Family: If family members are present, how does the person behave in their presence? Does she seem inhibited, afraid, withdrawn and silent? What do family members say about the person, their health or what the main problem is from their perspective? What words do they use to describe difficulties? Is there a sense that they are not able to speak freely, even if there is an interpreter there?

• Health records: Where available and consent is given, look at the health records and referral letters/forms. See if any indications of ill-treatment/ torture or sexual violence are present

• Be open, be sensitive, notice cues or signs and ask: In your clinical interview or examination, create a sense of safety and ask open-ended questions:

  “How is your health now?”
  “What is troubling/worrying you at the moment?”
  “How is it affecting you (in daily life/everyday functioning)?”
  “What happened?”

Being alert to the different ways in which a person may be vulnerable (see Box 11), and to factors which are related to vulnerability (see Box 12), can help in early identification of those who may have experienced rape, other sexual violence or other torture, and not yet disclosed this to anyone.

Box 11: Types of vulnerability

Vulnerability could include vulnerability to:

• Further harm if returned to the place from where they fled

• Further harm in current context (e.g. domestic violence, sexual violence, slavery, exploitation)

• Harm to self

• Harm to others (including children)

• Serious, life-threatening and/or chronic ill-health (e.g. pain, sexual health problems, addictions to substances)

• Enduring mental health problems

• Self-neglect

• Poor health and social functioning.

\textsuperscript{26} See Section 9.
**Box 12: Factors related to vulnerability**

- Experiences of torture or other ill-treatment (cruel, inhumane, degrading)
- Previous history of experiencing or witnessing violence/abuse
- Lack of knowledge and understanding of systems (e.g. asylum, health, legal systems)
- Limited or minimal resilience and emotional resources
- Limited or lack of social resources and support networks
- Social isolation or withdrawal
- Having no family (e.g. missing, separated or killed, loss of parent at young age, recent losses)
- Prior history of psychological or psychiatric problems
- Poor health or disability (including chronic pain)
- Current psychological health problems
- Difficulty trusting others
- Difficulty in relationships with men, or in intimacy
- Overriding perception and subjective experience of having no control over their life.

Sometimes, legal constraints or proceedings may interfere with appropriate health assessments or follow-up interventions being undertaken. In such instances, it is important to remember professional and ethical obligations and the duty of care to the individual client/patient.

Dual obligations, also referred to as dual loyalty[^27], may arise where health professionals are faced with conflicting demands arising from their obligations to the client (their ethical and professional obligations) and their obligations to a third party (e.g. their employer). For example, health professionals may be required to work with persons who are held in custody (e.g. prisons, detention facilities, health facilities), where institutional policies require them to prioritise their obligations to their employer, raising ethical dilemmas in relation to what is in the best interest of the client. In such instances, professional practice and ethical codes can provide important guidance[^28], and it is advisable to check those, and to consult a senior colleague within the profession.

Where there appear to be no signs that a woman has experienced rape, other sexual violence or torture, a full assessment may still reveal more information to the contrary. It is important not to rule out this possibility and effectively stop noticing or exploring. Attentiveness to alternative explanations for an absence of signs of distress and attentiveness to what is not yet expressed by the client, is important.

“I think health professionals often expect women who’ve been raped or subjected to other kinds of violence to present in a particular way, um, so they might expect them to be very obviously distressed and tearful... and if they are not, they don’t always ask more... it’s one of the things that often gets missed, or misunderstood [...] when people seem very emotionally flat or cut off [it’s] actually a profound expression of distress or [health professionals] may interpret that or misinterpret that as lack of mood, or lack of distress, when it could actually be the opposite.”

Health professional

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[^28]: See also Istanbul Protocol, paras. 66 and 68.
Sometimes, particular screening tools or measures might be used, apparently as ‘identification tools’. It is important to remember that these tools, particularly those which seek to establish psychological vulnerability, have many and serious limitations (see Box 13).

First, these tools are not litmus tests: however easy and fast to administer, they are not universally applicable or reliable. Second, no screening tool can provide a definitive answer to the question of ‘is this woman a survivor of rape or other sexual violence or torture’. At best, screening tools are no more than prompts for the health professional to conduct fuller assessments; at worst, they can be used in a reductionist way which medicalises distress, narrowing the focus to particular symptoms and psychiatric diagnoses.

**Box 13: Summary of limitations of psychological screening tools**

- Reductionist and narrow list of items and focus – to make the screening tool quick and easy to administer
- Assumptions that the items in the psychological symptoms tool are most common in or indicative of survivors of rape or sexual or other torture – rather than of distress which may be related to a range of experiences
- Assumptions that particular items are indicative of the likelihood of particular psychiatric diagnoses, such as post-traumatic stress disorder and that these capture the relevant (or most relevant) signs of someone who has experienced rape or other torture
- Assumptions that those who do not appear to be distressed or meet the threshold of particular diagnosis are not vulnerable; and that they are not survivors of rape or other sexual violence or torture
- Used without a clinical assessment/interview, psychological screening tools or checklists can be dangerous in giving rise to false negatives. Many women survivors may not say anything to indicate their vulnerability or past experiences of rape or other torture, and a screening tool may inadvertently exclude them from further clinical interview or assessment
- Assumptions of universality in human response to particular experiences such as rape or other torture
- Screening tools can also be highly unreliable when applied to women from a range of cultural, linguistic, social and religious backgrounds, without a proper appreciation of how culture, language and social context are relevant. Screening tools ignore social context and how culture shapes (a) the presentation of distress or coping; (b) how a woman understands and expresses her difficulties or health problems; (c) what she chooses to tell or not to tell, to whom and when; and (d) how she interprets and understands the items or questions on a screening tool.

Sometimes there are signs which emerge in a medical or psychological assessment which may indicate rape or other sexual or other torture (see Box 14).
Box 14: Common signs in health assessments indicating vulnerability and possible rape/sexual torture

- Psychological signs of distress (see Sections 8 and 9)
- Distracted, poor concentration, agitated
- Uncommunicative, poor or no eye contact
- Flattened affect, numbness, distant/cut off
- Tearfulness, incoherence when speaks, disoriented/confused
- Unable to elaborate on certain/or details
- Poor memory/poor or no recall of certain events or dates/incoherent account
- Anxiety about who else may know or see health records, or which family members will be told of details of the assessment
- Indifference, detachment, anger or intense ambivalence about being pregnant
- Dates given for pregnancy do not match clinical gestational age estimates – may indicate concealing date of conception from family members
- Poor attachment and difficulty bonding with and feeding the baby, difficulties suggestive of post-natal depression which may be due to the baby conceived as a consequence of rape
- Uncomfortable and fearful in presence of someone from opposite sex
- Inability to relate, or form new friendships or relationships
- Difficulties in intimacy and sexual relationship with partner/spouse
- Complaints related to sexual health but reluctance to attend further assessments/examination
- Physically agitated, in pain or discomfort
- Visible injuries, poor mobility, pain, bruising
- Abdominal/pelvic pain
- Anorexia/nausea (can be a response after oral rape)
- Irregular/painful periods (unclear onset or since assault)
- Recurrent vulvovaginitis in absence of infection – due to stress, obsessive washing of perineum with soap or disinfectants
- Constipation, anal pain, bleeding
- Anal sphincter damage – incontinence of faeces/flatus
- Recurrent prescriptions for medication for piles or thrush
- Altered body image
- Avoids looking in mirror, feels repulsive, ugly
- Paranoid fears e.g. “feel people are looking at me and they can see, like they just know, they know what they did to me”
- Constant cleaning, washing or bathing (e.g. “I feel dirty”, “everything is dirty. I cannot get anything clean”)
- Content of nightmares and intrusive recall related to violence, sexual torture or other aspects of coercion, loss of control or being attacked or running away from men/torturers.

Sometimes, in the course of general health care, there may be indications that a further assessment is warranted. For example, many women who have been raped, and some who are giving birth to a baby conceived from rape, may find it extremely frightening to have a vaginal birth, insisting on a Caesarean section. Gentle exploration of their fears may lead to further information and disclosure of what happened to them.
7.4 What to do after identification?
It is important to know what to do if one suspects that a woman has experienced rape or other forms of sexual violence and torture. Key steps which should be taken may depend in part on the background of the health professional, and the constraints of the setting in which the initial assessment or consultation is conducted. These steps are summarised in Box 15.

Box 15: In all cases, what to do if you suspect rape or other sexual violence or torture

- Ensure a fuller clinical assessment/interview can be conducted promptly by a qualified and experienced health professional
- Ensure there is a medical and psychological assessment
- Ensure risk assessment is conducted
- Ensure documentation in clinical records of your assessment/examination
- Encourage the woman to inform her legal representative, and a doctor (e.g. general practitioner), if she has not already done so, of any violence she has experienced and related injuries or health problems
- Reiterate the importance of informed consent, and repeat the necessary information about what will happen to the information provided, where it will be stored, by whom, who will have access, why and how will this be used etc.) to enable the woman to share details of what happened to her, or not.

Key questions to ask oneself:
- How do I know if someone may have experienced sexual torture/rape as torture?
- What signs should I look out for?
- Is this person vulnerable, how?
- What should I do if I suspect someone has been tortured?

Good practice includes:
- All health professionals should understand the imperative for identification of adults or minors who have experienced rape or other sexual violence or torture
- All health professionals should be aware of the need for early identification for health grounds: to ensure that survivors are able to access the necessary health assessments and health care as early as possible, to prevent further health complications and chronic psychological difficulties
- All health professionals should be aware of their obligations to help ensure the safeguarding of survivors from the risk of harm and exploitation, or harm to others, including children protection concerns
- All health professional should be aware of their role in helping to ensure legal protection for survivors: to protect them from being returned to a place where there is a risk of further harm
- All health professionals should be alert to the possibility that a person may have experienced sexual violence and, in cases where asylum has been sought, the possibility of rape or other forms of torture
- It is helpful to be aware of the country context of the person, as this may give rise to concerns about whether rape or other torture is practised. Rape is often conducted in armed conflicts, but also in countries where there are repressive regimes and rape and other forms of sexual violence are used

29 See Istanbul Protocol (e.g. para. 261) for international standards for specialist health assessments where formal documentation is necessary.
30 See Section 8.4.
31 See Section 10.
to terrorise whole populations, or family members (or the women themselves) who may be political activists, or from a particular tribe, ethnicity, religion etc. In some countries, women may be raped as a punishment and threat, if they are suspected of being lesbian. Rape in many of these contexts can amount to torture in international law

- Always attending to the conditions of the consultation, whatever the nature or setting – making clients feel as safe and comfortable as possible to facilitate disclosure of any relevant information
- Adhering to professional and ethical obligations and remembering the primary duty of care to the individual client
- Always noticing and being open to the possibility that the client may have experienced rape or other sexual violence and torture, even where no signs are apparent immediately
- Recognising that there is no single screening tool or measure which can reliably identify women survivors of rape or other sexual violence or torture. All tools which seek to establish psychological vulnerability have limitations and are no substitute for a clinical assessment and interview.

**In all cases:** if a person is identified as vulnerable; and as having (or possibly) experienced rape or other sexual violence or torture:

- Ensure a fuller health assessment/interview, with informed consent, conducted by a qualified and experienced health professional (both medical and psychological assessments may be warranted)
- Ensure risk assessment is conducted
- Ensure documentation of your assessment/examination with clear clinical records
- Encourage the person to inform her legal representative, and a GP, if they have not already done so, of any violence they have experienced and related injuries or health problems
- Consider the risk to the person if her family members learn about her experiences, or about any hints or disclosure of rape or other sexual violence or torture to the health professional. Wherever possible, speak clearly and directly with the person, in the appropriate language, age-appropriate and culturally sensitive; and acknowledge any anxiety or fear expressed. Wherever possible, explore their fears and discuss with them what course of action they wishes to take, or who they do not wish to know of what happened (e.g. rape). Gaining the person’s trust and respecting their concerns is crucial, though where any risks have been identified, other professional and legal obligations may take precedence.

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33 See Section 8.4.
34 See Section 8.4.
8. Content of Health Assessments: What to Assess?

The content of health assessments may vary to some extent, though an understanding of the nature of rape and other sexual violence or torture and their impact is essential to undertaking a health assessment. This section addresses the impact of rape and other sexual violence or torture and outlines key content areas for physical and psychological assessments.

It is widely understood that torture involves a range of physical and psychological methods, often used in combination, and sexual violence, including rape, may be one of many methods used, often in combination. Rape and other forms of sexual or other torture are used in armed conflict, as a weapon of war, in many conflicts globally. Rape and other forms of torture are also used by State actors (e.g. army, state security and prisons) as well as non-state actors (e.g. organised groups, militias). It is also common knowledge that torture and other ill-treatment are often used repeatedly and over time, with an intention to destroy the psychological functioning of the victim, and that torture methods, including rape and other sexual violence, are designed to leave no lesions despite causing pain, suffering and devastating emotional distress.

For many women, the experience of rape and other sexual violence or torture is perpetrated against a backdrop of the subjugation of women and a continuum of discrimination and violence which they experience throughout their lives, including from family and community members. For some, the violence may include earlier physical abuse within their family, childhood sexual abuse, trafficking, intimate partner violence, female genital cutting, sexual slavery and having to sell sex to survive and to support one’s family. For some, the violence may continue long after they have experienced rape as torture, for example, in detention or during armed conflict – violence from their partner or other men.

“I went through all that in the war [rape] then I am hit and beaten and raped by my own husband, he tells me it is my duty to give him sex when he wants it [...] and, after I left him, I had nowhere to live. This friend told me she knows someone who can offer me a place to stay with him. I stay with him, he thinks I am his property, he knows I have nowhere to go. He rapes me whenever he wants [...], I have nowhere to go. I would rather be raped here every day than be sent back home and be killed.”

Women survivor

According to the Istanbul Protocol, any assessment of physical or psychological harm and suffering needs to consider both psychological and medical assessment by those who have appropriate expertise (trained, qualified and experienced) in assessing the impact, injuries and psychological harm and suffering caused by torture (including rape) and other ill-treatment. Specifically, the Istanbul Protocol makes clear that an assessment should include a medical, a psychiatric (where there may be diagnosable mental illness) and a psychological assessment.

37 Istanbul Protocol, para. 261.
38 Istanbul Protocol, para. 162.
Whilst the guidance below addresses the content of physical and psychological health assessment separately, it is important to note that they are not always so separate. A physical health assessment should also consider psychological health concerns, and at the very least include a mini-mental state examination. Conversely, a clinical psychologist may enquire about a person’s physical health concerns, as described by the person, but without attempting to conduct a physical health assessment. Assessment of chronic pain, for example, will require both physical and psychological evaluation and ideally a multi-disciplinary approach to care.

It is essential that all health professionals consider physical and psychological health together but act within the limitations of their competency.

8.1 General principles on what to assess

Each health assessment and its content will be dictated in part, by four key factors:

- The level of assessment (e.g. if it is an initial health screening assessment or a full medical or psychological assessment);
- The qualifications and competence of the health professional to undertake the relevant assessment;
- The context and setting of the assessment; and
- The key purpose of the assessment.

The interview setting for the assessment may be a constraining factor, although the Istanbul Protocol also insists that, whatever the conditions for interviews for medical and psychological examinations, the Istanbul Protocol standards be adhered to as much as possible. Time may be also a factor, but lack of time must never be an excuse for not conducting at the very least an initial health assessment, outlining areas not addressed (and the provisional nature of an opinion) and the areas which require further assessment, and by whom.

Decisions about which areas, priority of areas and depth of assessment require careful clinical judgement. The professional background of the assessor and the purpose of assessment may be determined by which type and level of service the person is assessed for. For example, a specialist neurological assessment may address specific areas and include particular diagnostic tests relevant to such an assessment, though need not exclude exploration of any other relevant information or a neuropsychological assessment by an appropriately qualified person. An assessment by a General Practitioner may address both health and psychological difficulties but may not allow for an in-depth assessment of all areas.

Factors which will impact on deciding which areas to address are outlined in Box 16.

**Box 16: Deciding priority areas to address in an assessment**

- What is the purpose of the assessment?
- Who is asking for an opinion?
- What are my professional and ethical obligations?
- What is my duty of care to the client/patient?
- What are my legal obligations?
- What am I competent to assess?

40 Istanbul Protocol, para. 239.

41 A survey of health professionals, conducted by ICHHR, showed that the lack of time was cited most often (by 28% of the sample of 32 health professionals) as one the reasons which constrained them in conducting a proper health assessment with women survivors of rape or other sexual violence or torture (Vara, R., Khan, A. and Patel, N. (2014) Survey of health professionals working with women survivors of rape or other sexual violence or torture. London: ICHHR)
• What areas should I include in my assessment?
• Which areas must I prioritise in my assessment?
• To what depth should I consider each area?
• Which areas need further assessment, how urgently and by whom?
• Are other specialist health professionals available and accessible for further assessment for this client/patient?
• If not, what areas can be explored at a basic level, within the limitations of my professional competency?

In all health assessments, core areas for assessment which may help improve the identification of those who have experienced rape or other sexual violence or torture are outlined in subsequent sections.

8.2 Physical health assessment: content
The physical health assessment comprises the clinical history and examination, with the format and extent varying according to the training and qualifications of the clinician, for example, whether doctor or nurse.

Physical health assessment and examination need to consider the range of health problems which can be related to rape or other sexual violence or torture (summarised in Box 17).

**Box 17: Common physical health problems related to rape, other sexual violence or other torture**

<table>
<thead>
<tr>
<th><strong>Physical health problems presented by survivors of rape or other torture</strong></th>
<th></th>
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<tbody>
<tr>
<td><strong>Skin</strong></td>
<td>Wounds inflicted by torture: Contusions, abrasions, incisions, lacerations, burns, branding, avulsed nails, bullet wounds, ligature marks, changes in skin or fat thickness: Also examine for signs of malnutrition/vitamin deficiency/skin infestation, infection or inflammation related to poor conditions of detention/self-harm as a marker of psychological disturbance, related or unrelated to experiences of torture</td>
</tr>
<tr>
<td><strong>Head and Neck</strong></td>
<td>Facial fractures (swelling, tenderness, crepitation, bruising, step in mandible, asymmetry of bite, inability to bite/chew), conjunctival haemorrhage, lens dislocation, nerve damage including infraorbital numbness, retinal haemorrhage, visual loss, tympanic membrane rupture, chronic otitis media secondary to non-healing of TM perforation, hearing loss, nasal misalignment, deviation of septum, gingival haemorrhages, fractured or avulsed teeth, lip lacerations.</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Rib fractures, symptoms of infection including TB [possibly related to poorly ventilated overcrowded cells], shortness of breath related to anxiety or anaemia.</td>
</tr>
<tr>
<td><strong>Genito-urinary</strong></td>
<td><strong>Males:</strong> haematuria, meatal stenoses, scarring from ligation of the penis, atrophic testis, hydrocoele, haematocoele, urethral discharge <strong>Females:</strong> tears, lacerations, bleeding (per vaginal or haematurial), discharge, ecchymoses, incontinence. Dysmenorrhoea, dysfunctional uterine bleeding, vaginismus, vulvo-vaginitis, dyspareunia, pelvic pain, infertility. Perianal region: bleeding, fissures, disruption of the rugal pattern/scarring, haemorrhoids, skin tags, purulent drainage, incontinence.</td>
</tr>
<tr>
<td><strong>Neurological</strong></td>
<td>Traumatic brain injury, post-concussion syndrome, post-traumatic epilepsy, peripheral nerve damage [suspension, handcuffing etc], persistent neuropathic pain, damage to brachial/sacral plexus, headaches.</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Intra-abdominal or intramuscular haematomas, traumatic intra-abdominal organ damage (post-splenectomy, pneumococcal risk), constipation, anorexia, gastro-oesophageal reflux disease, peptic ulcer, chronic abdominal or pelvic pain.</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Fractures and dislocations, malunited or nonunited fractures, osteomyelitis, joint or muscle damage, contractures, compartment syndrome, low back pain, neck pain, generalised muscle pain, headaches.</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Chest pain, palpitations, deep vein thrombosis (prolonged recumbency and dehydration in detention), untreated exacerbated hypertension.</td>
</tr>
</tbody>
</table>

The content of the assessment should be guided by the time available; the context in which it occurs; as well as the training of the clinician; and the facilities for investigation, treatment or referral into secondary care. In general, content areas to address in a physical health assessment are summarised in Box 18 below:

**Box 18: Content areas for a global assessment of physical health**

- Current symptoms: complained of, and on systemic review
- Any likelihood that a woman may be pregnant
- Past medical, surgical, obstetric history (including chronic disease), female genital cutting
- History of past experiences that may have impacted on health (including torture)
- Infectious or parasitic disease
- Sexually-transmitted disease
- Immunisation status
- Nutrition
- Oral health
- Disability, of vision/hearing/mobility/cognition
- Pain state
- Sleep pattern
- Psychological state

General points for consideration in a physical health assessment are summarised in Box 19.

History-taking needs to include past medical history as well as current health concerns and symptoms. Past medical history is important not only in considering current health concerns that may have links to the past, but in understanding and interpreting examination findings attributed to torture or other experiences. For a medico-legal report, the alternative possible causes for any physical findings need to be assessed in the light of what is known about the individual’s past medical history, socio-economic background, past sporting and occupational injuries etc.

Current health concerns may be paramount, particularly where health conditions have gone untreated for a considerable period, for example, during the journey to the country where asylum or refuge is sought. Other delays may mean health conditions are neglected, for example, where there is no access to a general practitioner or any other medical care, whether in a refugee camp, detention etc. Other urgent health needs may be for sexually-transmitted infection screening, pregnancy testing or antenatal care.

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42 See Section 8.3, Boxes 25-27. Note that, even when the role of the health professional is primarily to make a physical health assessment, where rape or other sexual violence or torture has occurred the psychological impact of this cannot be ignored. Unless a psychological assessment has already been made or planned, all physical health assessments should include an assessment of the person’s psychological state, including a risk assessment.
Box 19: General considerations in physical health assessment

- Include current health concerns
- Include current risk factors
- Include past medical history
- For a medico-legal report, consider alternative possible causes for physical findings
- Consider context of the assessment, what is practical and which facilities are available and influence an assessment
- Consider your own competence and seek advice or second opinions where problems are outside this
- Consider facilities for the investigation of physical health concerns, treatment and referral for secondary care to fulfil the duty of care principle.

Specific principles in conducting a physical health assessment are summarised in Box 20.

Box 20: Specific principles in physical health assessment

- Global assessment is essential
- Consider infection risk
- Consider diet and nutritional deficiency
- Be aware of cultural differences
- Be aware of risk of triggering memories of rape or other violence or abuse and possible re-traumatisation
- Rape and other sexual violence and torture are often associated with difficulties in disclosure of those difficulties
- Assessment of physical problems may be complex and subtle as components may be culturally-normative expressions of distress which use physical health language and some may be ‘purely’ physical health problems
- Avoid over-medicalising problems or ordering unnecessary tests
- Explore the person’s beliefs and fears about their symptoms
- Consider carefully practical issues such as gender, chaperones, need for interpreters etc.

**Global assessment is the most useful**

A person may initiate the consultation with their own concerns or may not present any specific health issues, other than relatively non-specific complaints of poor sleep, headache or other bodily pains. The more that is known about their past and recent experiences, the easier it will be for the doctor to identify, assess and prioritise health needs.

A full review of all body systems may reveal symptoms otherwise not disclosed, sometimes because the person did not themselves rate those symptoms as important compared to their other concerns, sometimes because of shame and embarrassment at describing symptoms regarding bodily functions, and sometimes because disclosure of the symptoms evokes recall of the experiences, such as sexual violence, that caused them and the person is trying to avoid this.

Such assessments can be time-consuming and a pragmatic approach may be needed to identify the most urgent presenting needs, addressing others in more detail at a later date.
Consider infection risk

Living in cramped overcrowded conditions, especially in a tropical climate, predisposes to a range of infections. Detention conditions in particular are associated with overcrowding, heat, dehydration, poor diet and malnutrition, Helicobacter pylori infection, tuberculosis and skin infestation such as scabies. Sexual violence increases the risk of sexually-transmitted infections including HIV. Infections such as these may present atypically and a person may have more than one concurrently. For example, a person may have anaemia, recurrent malaria and hookworm or schistosomiasis. If an assessor has limited experience of any of these infections, then early referral to a specialist is indicated for any unexplained symptoms or conditions not resolving as expected after treatment.

Consider diet and nutritional deficiency

Conditions of detention, flight and poverty may mean that a person becomes chronically undernourished or develops specific dietary deficiencies. Vitamin D deficiency is an important cause of non-specific ill-health and bodily pains. Iron deficiency is also common. Asylum seekers, for example, may be housed in shared accommodation with minimal cooking facilities and young adults may be unused to cooking for themselves. Living on very low income, their diet may quickly become nutritionally compromised. This is of particular relevance where pregnant women and young children are involved.

Cultural differences

When examining people from many different parts of the world and especially where they have undergone experiences that specifically impact on their health, attention needs to be paid to the findings and the meaning they hold for the person. For example, it is important to identify female genital cutting where it has occurred – this can take a range of different forms and the person themselves may have been too young at the time to know exactly what was done. The female genital cutting may seem almost undetectable or may be having a significant impact on their daily life. Female genital cutting may have an effect on their sexual function, on their urogenital system, their fertility, and their fears and expectations for present or future children.

Signs of traditional medical practice in the form of ritual cuts made with a razor blade or similar implement are common. Sometimes a particular illness or condition may be identified as a reason why the cuts were made; at other times they are made for spiritual purposes or to enforce good behaviour in a child, or obedience in a trafficking victim or as ‘treatment’ of a person accused of witchcraft. No assumptions should therefore be made as to how they may relate to the person’s past, present and future health.

Other conditions may not be regarded as physical illnesses but hold different meanings: for example, epilepsy may be regarded as due to spirit possession and have been treated as such in the person’s home country. A person who has been accused of witchcraft may have suffered intense psychological trauma with victimisation, physical and sexual violence performed in the name of exorcism.

Re-traumatisation

Sometimes the physical examination can itself trigger distressing memories of past abuse. Torture often involves being forced to be naked or partially naked, and a physical examination can remind the survivor of this. Care needs to be taken with a clear explanation of what will happen in the examination before the person is asked to undress, so that consent is sought and obtained before they make themselves vulnerable.

Some may only be able to cope with exposing limited parts of their body at a time for examination. Intimate examination in particular may be too overwhelming to cope with, and can be postponed to a later occasion, so that control over what happens is returned to the patient.

Gender of the examiner and the interpreter may be critical in a person’s feelings about consenting to intimate examination. A chaperone should always be offered.
Some investigations or treatment may also be traumatic and the patient may need reassurance and explanations before being able to cope with them. A person who has been subjected to electric shocks as a form of torture, for example, may find it difficult to cope with an ECG or EEG examination or some physiotherapy treatments involving electrical stimulation. Someone who has been subjected to confinement in extremely cramped conditions may find the MRI scanner impossible to cope with.

A person’s response to such stimuli is unpredictable, and therefore the assessor must at all times remain alert to verbal and non-verbal cues of distress. When the assessor has identified that the person seems uncomfortable, they should discontinue the procedure and gently ask the person to explain what was happening for them at that time. For example, “You seemed to become quite frightened and uncomfortable when I started to examine you. What was happening? What were you feeling?”

The assessor needs to decide if there is a clinical imperative to continue with an investigation, and discuss this with the patient so they can make an informed pragmatic decision. Sometimes deferment is the best course, but the consequences of so doing should be explained to the person and the doctor needs to record this decision in the notes.

Reactions to certain examinations can, in themselves, provide important clues as to the past experiences of the person being assessed. If, for example, the aim of the examination was to assess for evidence of a rape that occurred some months ago, and there are symptoms of sexually-transmitted infection, the doctor and patient might conclude that any direct evidence of genital trauma hitherto unknown to the patient is unlikely to be found this long after the assault, and that blood and urine tests can be done to investigate for some of the possible infections, pending the patient’s feeling able to be examined at a later date.

**Reluctance to disclose sexual violence**

It may be very difficult for a person to disclose, or disclosure may emerge during the first physical health assessment, or later in a health investigation, or to a legal representative. Disclosure may be partial or may never occur.

Some physical symptoms may be clues to past sexual violence: pelvic pain, irregular or heavy periods, vaginal discharge, vulvo-vaginitis, constipation, rectal bleeding, piles, abdominal pain, nausea or vomiting on eating. Even though these are not uncommon in the general population, they should be explored carefully with a view to their being cues that may prompt disclosure. Questions about when the symptoms arose, what the person believes to be their cause, or how they feel when they experience the symptoms, may elicit important information.

**Facilitation of disclosure**

This requires the development of a good relationship, with trust and rapport and a clear explanation of confidentiality and how this can be maintained. Interpreters used for this work need to be experienced professionals – members of the person’s family or community used as interpreters will inhibit full disclosure, with potentially serious consequences.

**Impact of disclosure**

Assessors need to be aware of the consequences of disclosure for the individual – sometimes not admitting to what happened is their major coping strategy – and, once another person knows about the sexual violence the person feels, they have to face up to what happened and its meaning for them. This may relate to the shame and guilt attached to the experience itself, their relationship difficulties with their family and marriage partner, and their fears of stigmatisation and ostracism from their community. They may be pregnant or have had a termination after being raped and disclosure forces them to confront their feelings about this. Hence, disclosure can trigger an intensification of their psychological symptoms and the assessor needs to consider this and what support is needed.

43 See Section 9 for further discussion.
44 See Section 9 for details.
That said, sometimes, when a person is able to share what has happened to them, in the context of a safe, professional and trusting relationship, they can feel relieved, heard, and their distress validated; and they can feel reassured by having some of their health concerns allayed.

**Culturally-acceptable expressions of distress in physical complaints or specific physical problems**

Bodily pain and headaches are very common symptoms with women who have suffered rape or other sexual violence or torture and may be due to both physical and psychological causes. Headaches may relate to stress, anxiety and sleep problems, brain injury or infections. Body pains may persist for years in those parts of the body injured during rape or under other torture, and again there may be a specific underlying physical reason for this or it may represent the person’s psychological response to the rape or other torture and the meaning it holds for them (for example that they have been damaged for ever, that no recovery is possible, that it is an expression of their emotional pain). The pain may also, of course, be due to a mix of both physical and psychological causes and, as with chronic pain in the general population, a multi-disciplinary approach is the most useful, involving careful assessment of the possible physical causes, the person’s ideas and beliefs about their pain and how they currently manage it.

While over-medicalising and over-investigating a person’s pain may be ultimately unhelpful to them if the related psychological issues have not been addressed, it can be intensely reassuring to a person to know that the physical injury has now healed, that rehabilitation can begin, that they can for example hope to have an active life and bear children in the future.

Other common physical symptoms besides pain that may have either physical causes, psychological causes or a mix of both include:

- chest pain, chest tightness, palpitations and shortness of breath, which may be due to asthma, infection, angina or anxiety
- gastritis, heartburn and abdominal pain, which may be due to anxiety and stress or a Helicobacter pylori infection or duodenal ulcer
- faints, fits and loss of consciousness episodes can be especially difficult to interpret as there is often no eyewitness account to help distinguish if the episode was epileptic or not. These episodes often occur only when the person is alone and becomes overwhelmed with distressing recall of their traumatic experiences, leading to an assumption that they are purely psychologically-mediated but, where there is a history of head trauma or other cues suggestive of epilepsy, this needs investigation.

There may be physical health concerns raised by the person, which require further exploration since many physical health concerns may indicate other psychological or physical health problems (for examples, see Box 21).

<table>
<thead>
<tr>
<th>Box 21: Common physical health concerns with related psychological and/or other physical problems</th>
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<tbody>
<tr>
<td><strong>Common physical health concerns</strong></td>
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<tr>
<td>Headaches</td>
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</table>
For example, a woman undergoing therapy for psychological trauma and sleep problems after being raped repeatedly and tortured, repeatedly complained of severe frontal headaches and these were thought to be due to ‘stress’. Her headaches did not respond to therapy until one day she had an epileptic fit and was found to have schistocerciasis with a cyst in her frontal lobe.

**Chest pain**

Chest pain may be related to:
- Anxiety and stress
- Musculoskeletal injury to ribs, collarbone, sternum
- Chest infection
- Angina

For example, a young person, aged 32 had four myocardial infarctions in the 12 months following a one month detention and experience of brutal torture. He needed six stents inserted into his coronary arteries.

**Abdominal pain**

- Abdominal pain and gastritis or indigestion may relate to stress or organic problems such as ulceration or H. pylori infection.
- Abdominal pain and menstrual irregularity may relate to a history of sexual violence, even in the absence of other symptoms or signs of pelvic infection.

For example, a woman who believed her womb had been torn open when she haemorrhaged during a rape just four weeks after she had had a caesarean section, continued to have irregular bleeding and low abdominal pain for years after. She thought she would never be able to conceive again.

**Sexual violence and the ‘unsayable’**

Sometimes as an assessor you may have a strong intuition that the person has been subjected to sexual violence, but they may not say this or raise any health concerns which might mean they have to disclose that the problem or injury arose when they were raped, for example.

Where rape or other sexual violence or torture is suspected, it is helpful to simply acknowledge that some things are hard to put into words. You may explore concerns about the pregnancy, or the relationship with the baby, or provide information.

For example, you may describe how a person who might have been a victim of rape can access sexually-transmitted infection screening confidentially, how common symptoms such as vaginal discharge, irregular bleeding or anal pain and bleeding may be eminently treatable, how HIV is now treatable and they will not have to pay for such tests and treatment and that psychological support and therapy can be accessed. For men, it can also be very helpful to specify that being raped does not mean a person has ‘become’ gay, even if they had an erection or ejaculated during the assault.

Other clues to the ‘unsayable’ may be that a woman says that she feels damaged, or has no sexual desire, or she may suggest there are difficulties in her intimate partner relations. She may raise concerns about her fertility and fear that she cannot conceive. Sometimes a person may show indifference or emotional detachment to her baby, whilst pregnant, or when the baby is born. She may say nothing or express hostility or ambivalence towards the relationship with the father. Sometimes women may become pregnant to counter feelings of being irreparably damaged (by rape), and stay in relationships which are exploitative or abusive.

A pregnancy where a person who has previously been raped may thus have many meanings and implications for the mother and the baby.

**Excessive washing**

Excessive washing may be related to:
- Anxiety and fear
- Self-disgust

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45 See Section 8.3 on psychological assessment, including for doctors; and Section 9.1 on facilitating disclosure.
Many women who feel they can never get clean again after being raped may wash their genitals repeatedly through the day with strong disinfectants, causing irritation, recurrent Candida infection and discharge, causing them to continue the excessive washing.

**Body pain**

Body pain could be related to:
- Muscular tension
- Illness
- Injuries sustained during rape or other sexual violence or torture

When a normal x-ray report or repeated prescriptions of painkillers does not resolve complaints of pain, a full review of the history and physical and psychological symptoms and signs is indicated.

Chronic pain impacts on a person’s daily functioning in carrying out daily tasks at home, and impacts adversely on other aspects of social functioning. Pain can also impact on roles and dynamics with the family. It can be valuable to ask how the pain impacts on family life, what activities the person avoids as a result, and what would it mean for them to be pain-free.

For example, a woman who had been repeatedly subjected to strappado/Palestinian hanging had pain in both shoulders and marked weakness in her hands due to the brachial plexus injury it caused. She could not chop food for cooking or brush her hair or wash it in the shower. She felt devastated by her inability to maintain her own appearance as she would wish or fulfil her role as provider of meals for her family.

**Consideration of gender**

Gender matching of the assessor and interpreter may be very important. In some situations, there is no choice available but, where possible, the person should be asked their preference. While women usually prefer to see a female health professional and interpreter, it should not be assumed that a man will choose a male health professional, as some, depending on their experiences, may prefer to see a woman.

For examination, a chaperone should always be offered but, while this is standard practice, for example, in the UK’s National Health Service, it is not common in other countries and some survivors of sexual violence may feel it preferable to have as few witnesses to their examination as possible. Best practice is simply not to make assumptions but to offer choice and a clear explanation.

**Key issues to consider include:**
- What are current physical health concerns, risks and needs?
- What content areas do I need to consider and prioritise in the assessment?
- What are common health concerns related to rape or other sexual violence or torture that I should consider in the assessment?
- What might be the significance of cultural expressions of distress presented as physical problems by the person?
- What is the significance of cultural practices (e.g. ritual scarring), cultural meanings related to particular health problems the person complains of (e.g. epilepsy as spirit possession)?
- How can I be attentive to the risk of causing distress to the patient during the physical health assessment and examination?
- Is there a need for a chaperone for this assessment?

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46 A method of torture where the victim’s hands are tied behind their back and they are then suspended by a rope in the air, often with a jerk, whilst their wrists are tied by the rope.

47 See Section 9.1 for further discussion.

48 See Section 8.1, Box 16 and Section 8.2, Box 18.
• Is there a need for an interpreter for this assessment and which gender?
• Is there a need for a follow-up appointment (e.g. where risks are identified, or disclosures of sexual violence or other traumatic experiences made)

**Good practice in medical investigation of rape or other sexual violence or torture includes:**
• Considering the range of health problems which may be related to rape or other sexual violence or torture (see Boxes 17 and 21)
• Conducting a global health assessment
• Adhering to specific principles in physical health assessment and examination
• Recognising that, even if no sexual assault has taken place, most torture has sexual aspects
• Recognising that sexual violence in torture begins with forced nudity, causing vulnerability and helplessness, fear, humiliation, shame and degradation, and breaking cultural boundaries
• Recognising that acute signs are rarely found due to the time interval, but lesions found on other parts of the body may still provide evidence of the assault, for example cigarette burns on the thighs, bite marks on the breasts. Even immediately after rape, <50% of women have identifiable genital injury and <30% of victims of anal rape
• Recognising that physical consequences of rape can include pregnancy, sexually-transmitted infection, loss of virginity, infertility, sexual dysfunction, menstrual dysfunction, anal fissure, piles, constipation and anal sphincter damage
• Recognising that psychological consequences of rape or other sexual violence or torture can include sexual dysfunction, dyspareunia, loss of libido, aversion to opposite sex, loss of ability to enjoy or permit intimate relationships, post-natal depression, and difficulty bonding to a child born of rape
• Acknowledging that full disclosure may be difficult for the person but there may be clues to a history of sexual violence in other physical symptoms
• Where there are disclosures of sexual violence or other highly traumatic experiences, recognising that the person may have many questions and a follow-up session may need to be arranged shortly after the assessment, to monitor how they are coping and to discuss issues raised by the full assessment
• Recognising the importance of following deeply sensitive aspects of an assessment (e.g. risk of suicide) with an area which allows the person to feel more contained (e.g. asking about less emotive areas; discussing how they will travel home, who will be there when they get home, is there someone they can speak to etc.)
• Recognising the importance of ending the assessment in such a way as to leave both the person and the assessor feeling that the person will be as ‘safe’ as they can be.

**8.3 Psychological health assessment: Content**

A psychological assessment is essential in investigating any allegation of torture or other ill-treatment, including rape or other sexual violence. As noted earlier, psychological assessments should be a component of all medical assessments and documentation of sexual violence, rape and other forms of torture and ill-treatment. Sometimes, it may be necessary to ensure formal psychological assessments by those appropriately qualified and competent to carry out such assessments in order to produce medico-legal reports for the purposes of judicial proceedings.

Psychological assessments are often very useful in enabling the identification of those who are vulnerable to a range of risk factors, including those who have experienced sexual or torture or ill-treatment.

49 Istanbul Protocol, para. 154.
50 Istanbul Protocol, para. 220-221.
51 See section 8.3 for further details.
52 Istanbul Protocol, para. 261.
53 See section 8.4.
Psychological assessments are particularly important, for several reasons:

- The impact and evidence of torture is not always visible and torture is often designed to not leave physical signs or conclusive physical lesions, despite causing severe pain, suffering and emotional distress.

- All detention and sexual violence, rape and other forms of torture have psychological features, in the methods used (e.g. use of sexual taunts, threats, insults) and in their psychological impact.

- Psychological difficulties arising from sexual violence, rape and other torture may be severe, enduring, and cause significant impairment in social functioning and overall wellbeing. A psychological assessment may identify psychological difficulties and their impact on everyday life, including parenting and couple relationships, which can help identify and address any risks (e.g. child protection, self-harm).

- The inability to trust is a common effect of torture and particularly common for those who have experienced sexual violence and torture. A psychological assessment can help build trust, facilitating disclosure of what has happened to the person.

Understanding the wide and often profound psychological impact of sexual violence/torture and other forms of torture/ill-treatment is crucial to determining what content area to explore in a psychological assessment (see Boxes 22-24 for impact on individual, family and community).

All torture attacks the integrity, dignity, security and wellbeing of individuals. Sexual torture, including rape, can have severe and enduring consequences on the person and on their relationships, family life and daily functioning. For some, the fear of reprisals may come in the form of violence from one’s own community or family, and so-called ‘honour’ killings. For some, sexual torture and rape can lead to problems in sexual functioning, sexual ill-health, pregnancy, infertility, other health problems and difficulties in relating to those from the opposite sex and in intimate partner relationships. Some girls and women who have been raped may then be forced to become sex-slaves, held in captivity, or forcibly married to their captors. In some cultural contexts, the rape or sexual assault of a woman may lead to her being ostracised and deemed unmarriageable, with some becoming outcaste and rejected as worthless or a source of shame for the family or community.

The impact of sexual violence/torture is not easy to assess. Cultural stigma, intense fear and suspicion of others and authority figures, shame, guilt and other health problems can conspire to make it difficult to disclose what happened, or to discuss health consequences. The expression of psychological difficulties which may be related to the sexual torture can vary, and depend on the meaning of the experience to the individual (shaped by cultural, religious, political or other beliefs) and the cultural idioms and language available to talk about such experiences and difficulties. The nature and context of the torture and other traumatic experiences and losses can also all shape the psychological impact on survivors.

**Box 22: Impact of rape, sexual violence or other torture on the individual**

**Psychological (emotional, behavioural, cognitive) responses:**

- **Heightened arousal – aggression:** Irritability, anger, aggressive behaviour

- **Heightened arousal – fear and anxiety:** Intense fear, acute and chronic anxiety and fearfulness, commonly presented as nervousness, excessive worrying, restlessness, fidgeting, tension headaches, inability to relax, light-headedness, palpitations, dizziness, panic attacks

- **Hypersensitivity to noise, exaggerated startle response** to an external stimulus, commonly acoustic, such as a door slamming or a bell ringing

- **Hypervigilance:** A state of extreme psychological arousal in which the sufferer is constantly on the alert for and anticipates further danger or harm

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54 Istanbul Protocol, para. 260.
• **Numbness**: emotional blunting, restricted affect

• **Dissociation, detachment from others**

• **Loss of control** with a profound sense of being helpless and powerless – to not have any control over their environment or the impact on their health and body, leading to learned helplessness and hopelessness

• **Loss of trust in others**, including family members, friends, physician, authority figures

• **Withdrawal**: diminished or no communication, withdrawal and isolating self from others or any social contact

• **Guilt**: at not being able to stop torture, to protect family members or others, having survived, escaped etc.

• **Shame, self-disgust, humiliation**: as a result of nature of torture (e.g. sexual torture), scars, burns, disability etc.

• **Pain**: general pain, aches, headaches, musculoskeletal or pain specific to physical torture and injuries or disability, or pelvic pain.

• **Depression or depressive functioning** (where the diagnosis of depression is not appropriate): sadness, low mood, insomnia or hypersomnia, despair, hopelessness, worthlessness, helplessness, poor appetite and weight loss, anhedonia, poor concentration, suicidal ideation, history of self-harm, guilt and a variety of similar complaints such as headaches, general aches and pains, fatigue and apathy. Often co-exists with post-trauma reactions and persistent pain.

• **Post-trauma stress responses**: many will present with a range of trauma responses. These include intrusive phenomena (flashbacks, nightmares); numbness (emotional numbing or blunting, dissociation); avoidance behaviour (avoiding people, places or situations which remind them of what happened); hyperarousal (can manifest in agitation, general anxiety, restlessness, startled response, irritability, including aggressive outbursts, insomnia and frequent waking); inability to function in everyday life: (e.g. work, study, cook, clean, take care of the home or children, go shopping, attend to paying bills, taking children to school etc.).

• **Grief reactions**: shock, numbness, despair, anger, withdrawal, guilt, searching behaviour, depressive functioning

• **Ruminative thoughts, obsessive compulsive behaviours**, e.g. washing, checking rituals

• **Sexual difficulties**: fear of intimacy and of sexual relationships, inability to trust partner, no or diminished sexual arousal, loss of desire, loss of sexual enjoyment, pain during sex and avoidance of any sexual contact, self-disgust and shame, fear of disgust and rejection by sexual partner, fear of permanent damage to sexual organs, vaginismus or, for men, erectile dysfunction or premature ejaculation.

• **Substance misuse**: misuse of illegal substances, alcohol or prescribed medication as a way of coping with the impact of torture, pain, sleep disturbance, anxiety, fear and despair

• **Neuropsychological difficulties**: brain injury as a result of torture (e.g. suffocation, blows to head). May be related to injury, disease, malnutrition, psychological trauma response or depressive functioning.

• **Hearing voices, unusual auditory or visual experiences, as part of psychoses or not.**
**Psychological aspects of physical injury, illness, debility or from rape/other sexual violence or torture:**

- **Acute and persistent pain** specific to injury, debility, disease
- **Grief and despair** at debility, loss of function and chronic pain
- **Poor self-esteem**, poor body image, shame and self-disgust at scars and injuries
- **Helplessness**, hopelessness, depressive functioning, anger, irritability, despair at illness or diseases as a result of torture (e.g. HIV+)
- **Ambivalent feelings**, anger, shame and disgust towards pregnancy or child conceived from rape.

**Spiritual**

- **Loss of faith**
- **Despair** where spiritual beliefs and faith were previously central and a personal resource, but no longer

**Existential**

- **Loss of sense of self/identity** (e.g. cultural, ethnic, sexual, religious)
- **Sense of worthlessness** and despair at not being able to make sense of torture and its impact and of life, feeling ‘not human’
- **Loss of sense of future**, purpose and meaning of life
- **Loss of faith in humanity**

**Interpersonal**

- **Inability to trust** significant others, partners, spouse
- **Isolation**, withdrawal
- **Interpersonal conflict**, verbal and physical aggression
- **Shame** (e.g. when raped, sexual torture) and intense fear of rejection or harm by others
- **Difficulties forming or maintaining intimate relationships**
- **Difficulties establishing new relationships**, friends, social networks, friends due to heightened suspiciousness and lack of trust

**Psychological aspects of impact of the social context on survivors**

- **Inability to work**, post/ongoing conflict conditions which can result in poverty and homelessness and continued lack of security, with depressive functioning, persistent fear and helplessness
- **Discrimination** in conditions of asylum/ongoing or post-conflict situations resulting in helplessness, hopelessness, irritability, anger and fear responses
- **Social isolation** – because of withdrawal (e.g. as a result of chronic pain, loss of functioning, emotional problems, racism, dislocation and cultural alienation from host population) or because of rejection (e.g. stigma and ostracism related to rape, torture, gender-specific persecution and violence, mental health problems).
Familial relationships are often affected by rape, sexual violence or other torture, characterised by secrets about what happened to whom, guilt, intense fear, uncertainty, loss of hope of any sense of normality in family life, family security and economic security, and loss of social support, which can lead to:

- **Familial conflict, intimate partner violence, neglect, sexual, emotional or physical harm of children, parenting difficulties** as a result of loss of confidence, fear, sleep disturbance, fatigue, shame, depressive functioning, anger etc.

- **Family roles:** Impact of rape, sexual violence or other torture (physical and psychological) on an individual may impact on their relationships with, withdrawal from and trust of other family members, as well as impair their ability to fulfil their former role in the family or family obligations and duties

- **Intergenerational effects** may also be evident, as trauma responses in children and young people

- **Other family members:** Assessments need to consider the impact of rape, sexual violence or other torture on the individual but also the impact of this on their family members, as well as who else in the family may have been suffered similar violence, who is adversely affected by the impact on the survivor (e.g. main carer(s), children), and who is at risk of harm and protection (e.g. children, women). A careful exploration of family relationships can provide vital information, including disclosures of domestic violence, aggression or violence towards children, experiences not unusual in families where one or more members have experienced torture or ill-treatment.

**Targeting communities, using individuals:** Whilst rape, sexual violence or torture are inflicted on individuals, whether in detention or during armed conflict, they commonly target communities, using individuals as a vehicle to create a state of constant and intense fear, threat, helplessness and passivity/conformity. Sexual violence and other torture impacts on communities, affecting the social milieu within which survivors live, which can exacerbate or maintain their psychological difficulties, impeding recovery. Common responses of communities affected by sexual violence and other torture include:

- **Collective threat and trauma:** The impact of rape or other sexual violence or torture can include pervasive and heightened fear of impending threat or actual harm within whole communities. Collective trauma includes continuous anxiety and sense of threat, a sense of living continuously with uncertainty, death, destruction, violence leading to deep mutual suspicion and mistrust of one another, secrecy, social fragmentation, silencing, isolation and rupture of social bonds within and between communities.

- **Loss and transition:** The impact of multiple losses and transitions, in relationships, homes, livelihood, health, social structures etc. can lead to grief and a sense of instability and lack of safety. These multiple losses can also include disruption of social networks, social identity, support systems, places of gathering and places of worship, work, education. This in turn can make social support absent (e.g. in exile) or destroyed (e.g. in conflict), leading to a disruption in social bonds, leading to isolation and intense grief.

- **Perpetual grief:** The impact of repeated acts of violence, armed conflict and torture can lead to multiple and repeated losses, separations, disappearances of loved ones etc., such that there is continuous grief and a sense of uncertainty and lack of trust in the future, or in the capacity of individuals and communities to develop mutual trust and to form new social bonds.
The specific content and depth of a psychological assessment will depend on the professional background, competence and remit of the health practitioner.

**Key questions to ask:**

- What is the impact of rape or other sexual violence or torture on individuals, families and their communities?
- What should be included in the psychological assessment?
- What are priority areas to be considered in a psychological assessment?
- What sources of information are available?
- Is this person a survivor of rape or other sexual violence or torture?
- Can this person be considered psychologically vulnerable, how and why?
- Are there risk factors present and which need to be assessed and monitored?
- Is a further assessment required, for what, by whom, how urgent?

**Good practice includes:**

- **For all health professionals, in all settings**, understanding the psychological impact of sexual violence/torture and other forms of torture/ill-treatment on the individual, family and communities (see Boxes 22-24)
- **For all health professionals, in all settings**, being clear about one’s own competency, limitations and ethical and professional duty of care to the person
- **For all health professionals, in all settings**, considering a range of sources of information (see Box 25)
- **For all health professionals**, in all settings, recognising that an assessment begins from the first encounter. Indications of rape or other sexual violence, torture or ill-treatment may emerge at any stage of an assessment, whether physical or psychological. It is important to remain attentive to any indications or relevant information which may suggest rape or other sexual violence or torture and which may necessitate a fuller assessment.
- **For all health professionals**, balancing the assessment by also focusing on areas where the person has strengths and is coping or functioning well
- **For all health professionals**, ensuring that assessments are culturally-informed and sensitive and that clinical information is understood within the context of the person’s cultural, religious and political background, in order to make sensitive, meaningful and appropriate clinical decisions.
- **For medical professionals**, psychological assessments should be integral to their examinations (see Box 26) and should include a mental state assessment (Box 27), though important to note that mental state assessments do not suffice as psychological assessments
- **For clinical psychologists**, a psychological assessment should be comprehensive (see Box 28), including key areas as established in the Istanbul Protocol
- **For all health professionals, always recording the outcome of the assessment** and whether you consider the assessment to be ongoing or completed and whether you have referred the person to other health professionals for further specialist assessment.
- **For all health professionals, including an assessment of vulnerability and risk and monitoring regularly** (see section 8.4).
Box 25: Sources of information for psychological assessment

- Observation of the person’s behaviour and psychological presentation
- Clinical interview
- Self-reports from the person
- Reports by significant others (family, friends, carer etc.)
- Where culturally appropriate and available, use of formal psychological assessment tools and checklists only where they are professionally translated into the relevant language and where reliability and validity have been established for the client population.

Box 26: Content of psychological assessment by medical practitioner

- Current psychological difficulties and cultural context
- Mental state assessment and cultural context (see Box 27)
- History and context of any detention and torture and other ill-treatment and psychological significance to person
- Personal history (developmental history, cultural, religious context, educational and/or employment history as relevant etc.)
- History of past trauma, torture or significant events in a person’s life
- Family history (impact of torture of individual on other family members, other family members who have been tortured)
- Psychological impact of physical injury, debility, pain or illness as a result of torture
- Coping (personal and social resources, patterns of coping, social support network availability and use)
- History of substance use/misuse
- Medical, surgical and obstetric history and psychological impact
- Previous assessments or examinations by health professionals (medical, psychiatric, psychological)
- Medication and side-effects, impact on individual and family
- Social functioning (education, employment, everyday living, social and family roles etc.)
- Risk assessment (risk of suicide, self-harm, harm to others, child-protection concerns)
- Social context: housing conditions, food, clothing, living conditions, safety.

Where a mental state assessment is conducted, it is important that it is not seen as the psychological assessment itself, nor as a short-cut or a substitute for a psychological assessment.

Box 27: Summary of Mental State Assessment

<table>
<thead>
<tr>
<th>Mental State Assessment</th>
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<tbody>
<tr>
<td><strong>Area</strong></td>
</tr>
<tr>
<td>Appearance</td>
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<tr>
<td>Behaviour</td>
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<tr>
<td><strong>Speech</strong></td>
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<td>---</td>
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<tr>
<td><strong>Mood</strong></td>
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<tr>
<td><strong>Thought form and content</strong></td>
</tr>
<tr>
<td><strong>Perceptions</strong></td>
</tr>
<tr>
<td><strong>Cognitive function</strong></td>
</tr>
<tr>
<td><strong>Person’s views on their symptoms / difficulties</strong></td>
</tr>
<tr>
<td><strong>Risk</strong></td>
</tr>
</tbody>
</table>

**Box 28: Content of psychological assessment by clinical psychologist**

**Current**
- Current presentation (demeanour, self-care, mobility, mood etc.)
- General health concerns
- Current psychological difficulties and cultural context (emotional, behavioural, interpersonal, cognitive, self/body image, sexual identity, sexual/intimate relationships, including any unusual beliefs, thoughts or sensations (visual, auditory, physical))
- Current social functioning (education, employment, everyday living, social and family roles etc.)
- Coping (personal and social resources, resilience, patterns of coping, social support network – perception of, availability and use, sources of support – religious, political, other community support, secondary problems related to attempts to cope, such as alcohol or substance misuse)
- Current relationships (nature and quality of the person’s relationships with family members, partner/spouse, children, friends; capacity to form new relationships – e.g. at school, college, work)
- Current physical health (main complaints, illness, disease, injuries, disability, functioning, pregnancy) and psychological impact
- Beliefs about health (beliefs about causes of symptoms and health difficulties, including relation to experiences of ill treatment, beliefs about how best to manage the problem, fears of the long-term/future consequences of injuries, health problems)
- Current medication and side-effects, impact on individual and family
- Current risk assessment (risk of suicide, self-harm, harm to others, child-protection concerns) (see section 8.4)
- Current social context: housing conditions, food, clothing, living conditions, safety and threats to personal safety and integrity
- Exile context (where relevant): stage in legal asylum process/other litigation, discrimination, poverty – and impact on current psychological functioning
- Socio-cultural context: stigma related to sexual violence/torture, stigma related to mental health problems, stigma related to child born from rape, stigma related to HIV; experience or fears of marginalisation, reprisals, isolation from family or one’s community
- Political context: events and context in country the person may have fled from, how they make sense of what happened to them, fears and ongoing concerns for loved ones left behind.
Past psychiatric/psychological history
Past medical, surgical, gynaecological and obstetric history and psychological impact
History of substance use/misuse
Developmental history
Personal history (cultural, religious context)
Educational history: brief account of number of years at school, relevant experiences at school, literacy
Employment history: brief account of paid or other employment, previous functioning, skills etc.
Family history (family structure, nature and quality of relationships, family conflicts, difficulties, whereabouts, disappearances, losses, children or other family members left behind or separated from, impact of ill-treatment/torture of individual on other family members, other family members who have been tortured, and social functioning and how they manage their roles in the family)
History and context of any experiences of detention and all sexual violence and sexual and other torture/ill-treatment
History of immediate impact (health and social) of all sexual violence and sexual and other torture/ill-treatment, progression of any health impact, and coping
History of past trauma, earlier experiences of sexual abuse or other significant events in a person’s life, coping
History of exile: how and when left, with whom, how, hardships endured
Social, cultural and other aspects context relevant to experiences of sexual violence, sexual or other torture/ill-treatment.

8.4 Assessing vulnerability and risk

The assessment of vulnerability and risk is an essential aspect of any health assessment and can arise at any stage in an assessment. An assessment of vulnerability and risk aims to identify those in need of further specialist health assessment, monitoring, care or treatment or protection.

Vulnerability refers to factors which place a person at particular risk. These factors may relate to the person, their environment, the social context or nature of the health assessment.

In the health context, assessing risk within a health assessment involves making an informed, professional judgement of the probability of specific behaviour, such as suicide, self-harm or violence towards others, and the priority of identified risks.

For some women, they may have experienced previous childhood sexual abuse, violence and attempted suicide in the past, and they may be considered vulnerable and at risk on several grounds.

“I was 15 years old then and nobody spoke to me to ask me why I had taken overdoses [...] all I had just wanted was just to have relief from all this abuse [...] the verbal abuse from my mum and the physical abuse, I had verbal, sexual and physical abuse from my dad and it was just like there was nowhere... I was just like a trapped animal [...] then again here I am in the same situation, again.”
Survivor

A woman may have experienced hostile questioning by immigration and other authorities and fear she may encounter the same by a health professional, sometimes evoking suicidal feelings which may not be expressed. One survivor described the experiences of being disbelieved by immigration, a housing officer and then by a doctor:
“I had never met people who were so unempathetic, who were so... they [immigration officer] treated you like dirt. They disbelieved anything, even if you told them ‘this is my name, this is my birth certificate’ they told you you’re telling lies. And it was just so dehumanising, and with every interview it made me feel less of a person, and to be honest if they hadn’t taken my medication and everything off me I would have taken another overdose when I was there [...]. I then went to housing [...] and this woman kept telling me ‘oh, you’re telling lies! Oh, you’re telling lies!’ And I said ‘look, I’m not telling lies. Why do I need to tell lies?’ And then when she was talking it brought up a lot of stuff for me and I just started crying. [...] I said ‘I’ve had this where I’ve been abused, and the same way you are treating me is the way I was treated [...] and the doctor made me feel the same [...] I wanted to die. I really wanted to die. [...] If it wasn’t incompetence, it was just sheer inhumanity, sheer disrespect, where they grind you in to the ground, and I can see why people end up taking such desperate measures. And in the time that I’ve been going through this, so many people have lost their lives. I knew a lady who went to... there’s a bridge near Heathrow, and she threw herself off the bridge and she died.”

Survivor

For some, the experiences of racism within society is compounded by experiences they have with health professionals, which can also prevent them from coming forward, leaving their vulnerability to various risks neglected.

“\text{I was absolutely desperate. And I went to the doctor and I told him how I was feeling, and the doctor said to me, he was of the same ethnicity as the neighbours who were giving me problems, and he said to me [...] ‘oh, if you don’t like it so much in this country and you think people are treating you like that, why don’t you go back to your country?’ [...] It was just... life just wasn’t worth living. I was having so many problems.”}

Survivor

**Key questions to ask:**

- Is this person vulnerable on health grounds?
- Is the person vulnerable to particular risks and if so which risks?
- What is the nature, likelihood and urgency of the risk?
- Who needs to conduct an assessment of vulnerability and risks?
- How can the person be protected from further threats, harm or risk to their health or life, including from risks which may arise from health consultations?
- Are there any other people (e.g. children, spouse, elderly relatives) who are at risk of harm or neglect? How can they be protected?
- Are there any risks involved for the health professional conducting the health assessments (e.g. risk of infection, harm, intimidation by perpetrators and risk of secondary trauma or chronic work-related stress)?

**Good practice includes:**

- Being aware of common factors which increase a person’s vulnerability (Box 29) and of the range of risk factors (Box 30) which may vary depending on when a person is assessed and on the setting and country context
- Conducting an assessment of vulnerability and to which risks, as well as of protective factors, as routine practice in all physical and psychological health assessments
- Recognising that an informed clinical judgement of vulnerability and risk can be made only in the context of a proper, skilled health assessment, and not in one or two questions or by the use of checklists
• Recognising that, though a person may present as coping well, in the context of a skilled, sensitive and thorough assessment it may become apparent that there are potential risks and that the person is psychologically vulnerable and not coping.

• Monitoring risk on a regular basis and repeating assessments of vulnerability to particular risks, especially when there are known changes in a person’s circumstances or external factors in their social context. The nature, severity and urgency of risk can also change, sometimes rapidly. Where possible, you should document in clinical records the circumstances in which any particular/known risk might be expected to escalate (e.g. a negative decision on an asylum application, loss of housing, loss of welfare support, news of the death or capture of a family member).

• Recognising that risk factors can be cumulative and may interact in their impacts in different ways, at different times, unique to each person.

• Being alert to cues that may indicate risk of harm, exploitation or deterioration in the person’s wellbeing.

• Interviewing significant others or carers, wherever possible and practical, as part of an assessment of vulnerability, though this must be only with the person’s consent.

• Recording your clinical judgement of:
  (a) vulnerability and risk;
  (b) the severity and urgency of the risk; and
  (c) the rationale for this judgement.

• Monitoring and managing risk within a multidisciplinary, inter-agency approach wherever possible.

• Monitoring risk to your own health and wellbeing and taking appropriate action to ensure self-care and protection in keeping with agency protocols.

**Box 29: Factors relating to increased vulnerability to health problems**

- Experiences of rape, sexual violence or other torture or other ill-treatment
- Previous history of experiencing or witnessing violence/abuse
- Lack of knowledge and understanding of systems (e.g. asylum, health, legal systems)
- Limited or minimal resilience and emotional resources
- Limited or lack of social resources and support networks
- Social isolation or withdrawal
- Having no family (e.g. missing, separated or killed, loss of parent at young age, recent losses)
- Prior history of psychological or psychiatric problems
- History of self-harm and suicide attempts
- Poor health or disability (including chronic pain)
- Current psychological health problems and severity
- Overriding perception and subjective experience of having no control over their life
- Youth
- Old age
- Adverse or negative asylum decision/protracted and complex legal proceedings
- Poverty
- Poor housing conditions or homelessness
- Ongoing threats, intimidation or retaliatory acts by perpetrators
- Inability to communicate effectively/in the language of host country
- Experiences of racism, exploitation and verbal and or physical violence when seeking asylum and safety in another country, or in a refugee camp or neighbouring country
- Being held in detention in countries where a person has sought asylum and safety from further harm.
Box 30: Risk factors to assess

- Risk of self-neglect
- Risk of self-harm, self-destructive behaviours, suicide
- Risk of harm to others through violence
- Risk of exploitation by others
- Risk of intimate partner violence, sexual exploitation, prostitution, sexual slavery and further sexual assault, with related health consequences
- Risk of neglect, harm to or inability to care for dependent children and relatives
- Risk of deterioration of health (physical and/or psychological), including risk of acute health problems or chronic disease requiring urgent treatment
- Risk of substance misuse and addictions and related health consequences
- Risk to public health through transmission of disease
- Risk of sexually-transmitted infections/HIV and need for treatment
- Risk of discrimination, marginalisation, exclusion from health and social care services and impact on health
- Risk of deterioration in physical and/or psychological health related to inability to access health and social care services
- Risk of racist verbal and physical abuse and impact on health
- Risk of homelessness, poverty and related risks to health
- Risk of further traumatic experiences such as detention in country where the person has sought safety
- Risk of deportation to a country where they may face risk of further harm
- Risk of disclosure of rape or other sexual violence or torture, leading to adverse consequences including:
  - threats, harm, exploitation, ostracism or other cruel or inhumane treatment or punishment by family or community members
  - abandonment and isolation by family members, including of children left behind or children born of rape
  - feeling fearful, guilty or ashamed at causing hurt or burden to family members
  - threats of harm or retaliatory acts against other family members or loved ones by perpetrators
  - threats or harm from family members towards the survivor (e.g. “honour” killing) or towards the perpetrators
  - threats, criticisms or harm from community members who see them as betraying others or the community
  - threats of being forced to marry perpetrators or live with them
  - threat of loss of access to financial support, livelihood or access to education or work opportunities
  - threat of further detention, torture or other punishment.
9. Process of Health Assessments: How to Assess?

Conducting health assessments with those who have experienced rape, sexual or other torture is a complex task which requires sensitivity, empathy, patience and skill. Whether it is a medical examination or a psychological or other health assessment, the way a clinical interview is carried out is crucial to the quality of the assessment and subsequent clinical opinion.

Ultimately, the goal in a health assessment is to create a safe, supportive and empathic environment, optimising the conditions necessary to facilitate the interview and disclosure of sensitive or difficult information. The following sections address ways to facilitate the process of assessment, and hence ensure a quality health assessment.

9.1 Facilitating trust and disclosure

Trust

Trust is fundamental to ensuring an optimal process of interviewing and information gathering. A health assessment where there is little or no rapport and trust will likely be superficial and not fulfil the key aims of an assessment\(^5\), possibly leaving the person being assessed feeling more mistrustful and fearful in future health assessments. An absence of trust between the interviewer and the interviewee is likely to lead to poor or incomplete information, which can also have adverse consequences for the interviewee. Further, an interview without trust is likely to hinder the identification of vulnerability, health problems and of experiences of rape or other torture, and can leave the person being interviewed feeling more mistrustful and fearful in future meetings with those they perceive as authority figures and officials.

Disclosure

Disclosure is a term often used and has become an established discourse in the context of work with survivors of rape or other sexual violence or torture.

To disclose something is to make known previously secret or hidden information. It is a term familiar to lawyers because of the duty to disclose information when required to do so by the court. The word is used throughout the Istanbul Protocol, but the context there is the investigation of matters which detaining authorities are likely to wish to keep hidden.

Disclosure is a term not used very often in health practice. When used, it similarly refers to information being provided and entrusted to the health professional – not because they are duty-bound to share this information with the health professional, but because they trust the health professional and the context in which the information is shared. In the sense that it concerns information given on trust and kept confidential unless permission is given to reveal it to a third party, there is perhaps a unified understanding between health and legal practice.

However, the notion of disclosure and its usage in the context of survivors (or potential survivors) of rape or other sexual violence or torture rests on the assumption that if the client has information important and relevant to a case that they would and should share this with the lawyer, health professional or other officials. This is problematic on several grounds.

\(^5\) See Section 5.
Firstly, people who have experienced sexual violence or other forms of torture rarely spontaneously give detailed accounts of what they experienced, and seldom answer all questions asked of them. Questions asked of anyone, about their employment or educational history, or their diet or general family routines, would also not be answered unequivocally and in detail – since context shapes what a person feels able to say at any given time. Some people may feel able to give detailed narratives of their lives, including experiences of sexual violence, torture or other abuses and ill-treatment, but many factors conspire to make it very difficult for most survivors. Shame, embarrassment and cultural mores will pay a critical part in if, when and how experiences are shared.

Secondly, even if asked directly, many people who have suffered sexual violence, torture or other abuses, and those who also suffer from psychological or mental health difficulties, do not share in the first instance, first interview or necessarily to the first person who interviews them. Sensitive information, for example, relating to experiences of sexual violence/torture, may never come up spontaneously and may take time to be shared.

Thirdly, the legitimacy given to the term ‘late disclosure’ by its frequent usage in asylum determination and other legal proceedings, is problematic. Like the use of the term disclosure, ‘late disclosure’ may have a legal root; for example, documents are required to be disclosed in order to comply with court procedure rules and lawyers will know that penalties are attracted if disclosure is late. This concept seems to have translated into the asylum lexicon, thus ‘late disclosure’ is used denote disclosure of particular information (e.g. rape or other torture) which was not disclosed to the relevant authority figure at the earliest opportunity the person was given to say what had happened to them. An underlying assumption is that the ‘reasonable person’ would disclose what happened to them to the first authority/official person they come into contact with; and that if they do not, and if they disclose later, unless an explanation can be given it may be concluded that they are fabricating, embellishing or exaggerating what happened to them. The inference drawn is that the person cannot be trusted or relied upon to tell the truth, unless there are clear underlying factors and explanations.

However, the term ‘late’ disclosure is not used in clinical practice and has no validity or scientific basis. Arguably, it is a legal construct based on assumptions about how ‘the reasonable survivor’ might be expected to behave. It is not grounded in knowledge of psychological processes. The use of the notion of disclosure being ‘late’ implies that an inference can be made that there is a ‘correct’ or ‘early’ or ‘timely’ disclosure – there is not. There is no psychological basis for the notion of ‘early’ or ‘timely’ disclosure.

A person discloses sensitive information when they feel safe to do so; and to a person they feel they can trust. The context of assessment, the nature of the assessment, the assessor and their manner, style and approach to interviewing, their attitude towards the person and their capacity for empathy in an assessment all impact on the extent to which a person feels safe and that they can trust the interviewer. Safety is never a given, and trust can never be assumed to be there, simply because the interviewer is kind, pleasant, an expert, or an official, or a health or legal professional. Trust has to be earned, so that disclosure can be facilitated.

Health assessments will vary depending on the professional background and remit of the health professional, the specific context or setting of the assessment. Nevertheless, all health assessments share a common goal: to develop trust and to foster the conditions that are conducive to the disclosure of relevant information. Disclosure is often thought of as the sharing of critical information, of one particular event or incident of rape or torture.

Disclosure is not about one event, but about the unfolding of a person’s narrative about what happened to them. Within this narrative, sensitive information may emerge, including details of experiences of rape.

56 The Istanbul protocol states “Torture, particularly sexual torture, is a very intimate subject and may not come up before a follow-up visit or even later. Individuals should not be forced to talk about any form of torture if they feel uncomfortable about it” (IP, para. 135).
or other sexual violence or torture. The narrative may contain other relevant, contextual information, including information which has a bearing on the person’s current health and legal protection needs. This includes information about health problems and concerns, difficult experiences of losses, family difficulties, previous and current abuse and violence, experiences of rape or other sexual violence or torture, ways of coping (including sensitive topics such as misuse of alcohol or drugs, or having to sell sex to survive and support one’s children), and current vulnerability to particular risks. Relevant information may include fears about their sexual health status or their sexuality, as a result of sexual violence. Disclosure then must be thought about not as the revelation of one critical incident, but as the sharing of a person’s narrative of the past and the present which allows sensitive and deeply personal information to emerge which may be pivotal in ensuring health and legal protection for that person and their family or dependents.

Facilitating disclosure is a skilled task which requires great sensitivity, compassion and ability to listen and observe carefully, and cultural competency. That said, some people may never disclose experiences or health difficulties because of the fear of the consequences, or intense feelings of guilt, shame, or disgust. Some may vow to never tell another person – and the person’s autonomy and need to feel in control of the pace and level of disclosure they make must be respected, recognising that they may choose to not tell you or another person anything, or only to tell when they feel safe and ready enough to do so.

Conducting health assessments with people who have experienced rape or other sexual violence or torture requires awareness of the professional, ethical, legal and institutional obligations which arise when someone does disclose such experiences. An awareness and understanding of the national, local and institutional protocols and mechanisms is essential – to know what action a health professional is obliged to take, legally and/or professionally. For example, if a person discloses that they have been raped and tortured, this information may need to be drawn to the attention of relevant personnel, if the client consents or chooses to raise this themselves, with the legal representative and/or specialist health services. The obligations require meticulous and accurate health records to be kept, detailing the history and assessment/examination findings.

As noted earlier, a person will only disclose sensitive information when they feel safe to tell. For most, the feeling of safety comes from feeling first respected as a human being and from being able to trust the person to whom they are speaking.

“…especially where people are dealing with institutions and organisations […] you need to treat us with empathy, you need to respect us, you need to treat us with dignity. We have right as fellow human beings to be treated like a human being. And yes you’ve got systems and procedures and all that, but, at the end of the day, you’re dealing with people. And you need to put yourself in that situation. How would you feel, how would you want to be treated? If I was your family, how would you treat me if I was your family?”
Survivor

“Who knows what the truth is? You weren’t there, and why would I want to tell lies anyway […] not many people would tell lies about something that is so much to the core and that is so horrifying and people don’t open up just like that” […] for me also, it helps me to be able to trust someone else, and even if it’s trusting you with what I’ve said.”
Survivor

57 See Section 3.
Some women feel ashamed about their experiences of rape and other sexual violence and torture. They may believe that this only happened to them, and that they are somehow to blame. These feelings of shame and self-blame can stop them from trusting another person to listen to them and to believe them.

“I’m talking on my personal experience, because we most of the time we are ashamed of what is done to us. After that sort of experience you get detached from your body, you start even hating yourself, you start maybe thinking, is it me who is the wrong way, this thing that had to happen to me, and secondly, you are not sure whether the people that you’re talking to would believe you, and it’s something very, very dirty to talk about, you don’t want to be portrayed as somebody who you’d rather, many women are shy, many women are ashamed to talk about those experiences, just because too many people would not give them the chance or the benefit of the doubt, they would be judged very harshly, they would not care, so you have to think fast, you have to know somebody before you start relaying those very secret things to them.”

Survivor

Some women may feel that stigma related to rape prevents trust.

“There’s a lot of stigma, being stigmatised by the community or family and there’s also self-stigmatisation as well […]. And I don’t believe the asylum process has got enough checks and balances within it to enable people to open up about such hard, gut-wrenching things. Because you open up to this person, the next time you’re being interviewed by somebody else. You know, it’s like being raped all over again.”

Survivor

The stigma within one’s community can also prevent women from even mentioning the word rape or sexual violence to a family member or a health professional.

“It’s a taboo, talking about that thing, for my background […]. The rape, you even die, you even rotting, and they will… no one will, even the doctors from my country, they will not come closer to you. […] Even though you are being raped, because speaking that you’ve been raped it was a taboo, it is a taboo.”

Survivor

The fear of further negative consequences such as being rejected from one’s family and judged by one’s community can also be a deterrent to telling anyone about rape or other sexual torture.

“There’s a lot of women who leave the country but their husbands and kids are left back home […] something bad happens on the way when they come to this country, some of them become pregnant, having babies from other men, they don’t know them, some of them got lot of infection problems from that. Then they go to the health professionals to treat the problem. If I’m interpreter, I know these problems and I breach this to the other people in the community… immediately when the husband come here to this country he will hear about it, so this is really a big shame to her, she believe that, we believe that, because we brought up like that, you know, like close-minded society, close-minded family […] it is really difficult for woman in my country, really difficult. He has to divorce her after that, if people knew about it, won’t live with her, whatever, even if she was forced, because of what happened to her.”

Survivor
For many, the experience of being repeatedly asked about their account, and then not feeling listened to, can inhibit them from speaking when meeting a health professional.

“I begin to meet other women who have gone through this sort of thing like me... most of the women believe that nobody cares, nobody would believe them, and nobody would take them seriously about these things, and no one, or very few people, the people you are narrating to, the people we expect to help us, those few, very few would understand us, they would never understand any degree of the pain we are living with or the damage which is done to us so sometimes women just prefer to shut up or maybe just keep quiet and suffer in silence.”
Survivor

“At least try to dig slowly in their own ways what really they’ve been through before just writing them off, they should try to learn what their, where they’re coming from [...]. They should first learn to know the route of the stories of the women whose faces are in front of them because I see, when you hear the stories you see people just have three, five minute for you and they’re not ready for you, nobody can learn about anybody within that limited amount of time, if they can just have pity and listen to some of the stories...”
Survivor

For some women, experiences with health professionals who treat them in ways that are experienced as indifferent, sexist and deeply insensitive can further reinforce the belief that no one can be trusted to listen, let alone to understand the enormity of the experience of rape and other torture.

“I saw a psychologist, so he said sit down, so he’s sitting like he’s in the house, crossing his legs, like we are friends, with his hands at the back of his head, and he’s like, um, ‘what can I do for you, what’s your name again’, and he just bent on his desk to look on the form, yeah, can I call you [name], where do you come from again?’. I said Rwanda, he asked ‘where is it?’ [...] it was a nightmare, I was so fed up with everything. He said, ‘why are you stressed then’, he said ‘you’re too young, you’re pretty, life is too short, go and find, do you have a boyfriend?’ [...]. I realised that maybe this is a sign to never talk to anyone, I just left and I never talked to anyone again [...] for seven or eight years... I didn’t speak to anyone. I was like a dead person walking.”
Survivor

“This [health professional] I met, he was talking about the ethnic minority groups and that they shouldn’t be, they shouldn’t be, they shouldn’t be having any stress, and that they should go back, um, back to where they’re from [...] I never forget that conversation. I said, how could somebody who works with, you’re supposed to be compassionate, you are supposed to help people, how can you, so I started saying to myself, does that mean I have to go back and be raped again, and be abused and go back to where I run from? I just could not, and that give me more fear about going to ask for help, I said, if a professional person speaks like this, maybe that’s how they talk between them”.
Survivor

For some, having tried to tell others of their stories, and being disbelieved, compounds their mistrust and angst, making it harder to speak to health professionals, even when their health is in danger. For example, a woman who was infected with HIV when raped was interviewed by immigration officers:
"They treated me like a what? Like a garbage. You should investigate from the bottom, ask who is this person? Why can’t we get time to sit – see her and even listen to what she’s talking about [...]. They never gave me a chance. And when you can’t speak out for yourself, nothing, you die silently."

Survivor

For some, experiences of what they regard as ignorance and racism can cause further distress and reinforce their belief that they cannot trust the interviewer.

"We are from Rwanda, we came to London, but I didn’t know what is London [...]. They ask me, why do you come to this country, you speak French why didn’t you go to France? We came here because I didn’t want anything to do with, we were so angry the way, with French abandon us during the war so I didn’t want to go anywhere near France or anyway, I mean, already you come to a country, you come from a country where you experienced war and a lot of horrible things happened [...] then you are faced with that."

Survivor

Sometimes, women have experienced other violence subsequent to being raped and felt as if no one would believe them, not even the police. The ongoing experience of violence and feeling unsafe and as if no one would listen to you or believe you can also prevent a person from disclosing what happened to them. For some, they may attribute the disbelief and apparent absence of interest from authority figures, such as the police, as racism, which creates fear of how others, including health professionals may disbelieve them.

"I called the police, when he was beating me, but they came and just left [...]. Maybe because I’m black. Maybe because I’m black? They didn’t care maybe because I’m black? They didn’t care? Because many times we see when two white people are fighting or they have a problem at home, they say, ‘oh domestic violence’, that’s what they call it, domestic violence, when they came, they protect the lady. They have those houses where they put domestic violence women, but why not me? Why they didn’t protect me? Why?"

Survivor

What may seem like harmless interaction as part of professional rapport-building can have a profound impact on women who have experienced sexual violence they are afraid to talk about.

"This consultant asked me why I moved from Uganda to this place. He said to me ‘Why? I’ve been to Uganda, the people are very nice, it’s a lovely country, the food is nice.’ I said ‘yeah but I prefer being here’ to me, because when I’m here I feel at peace, when I’m there I’m scared. It’s like the memories of war, gunshots all the time, being raped, it comes back… when I’m here, at least even if I dream I wake up in my dream. It’s a bad dream [...] you need to get to know people better [...] I’ve seen that whenever I go to see a consultant, they look at the way I dress and say ‘unsmart,’ but that is not what is inside, inside of me I’m dying. You got to ask what’s going on inside? Ask what happened to me, why am I in this country?"

Survivor

For some women there is a fear that if they were to tell someone who is in authority, even if this may lead to some legal protection or health care, the person will have to ‘prove’ what happened to them. This can deter them from speaking about their suffering and what happened to them, even to a health professional.
“Sometimes, here what I’ve discovered is that you have to provide evidence, which is the hardest thing, no matter what you do, provide proof [...] it’s hard, you know you just think ‘okay, if I could just open my heart and open my mind and you could just see how tortured or psychologically I’ve been affected,’ but I can’t do it. The best thing you can do is just talk about it, I know this. But I can’t. I can’t, I can’t.”

Survivor

Perpetrators may hold particular beliefs which they tell their victims, beliefs that bring added horror which endures long beyond the rape, silencing the person.

“He raped me really bad and he told me that he had infected me [with HIV]. He wanted to attack my younger sister too because he had this conception that raping a child will, he would be clean [...] he left us there half dead. So, you have no time to cry, no time to be sad. I have a younger sister that I have to look after, you just have to put the face on and keep going, but inside you, you finished, you dead, you just wish somebody could come and kill you [...]. I was a child, and he said, ‘I’m not going to kill you but I want you to remember me, I’ve left you a souvenir, every time you have a pain, you think of me’. How are you going to speak to anyone about this?”

Survivor

Negative experiences with immigration services can compound fear of disclosing, when women feel momentarily relieved at reaching an apparent place of safety, to be treated with cruel indifference and hostility.

“I remember asking her [immigration officer] for water, a glass of water, she didn’t give me water, so I was like [...] if we get killed here, I don’t mind, you know, maybe they can shoot us, you know, all this ideas going on in my head, if they shoot me, maybe you die quickly. So, she’s talking to me really loud, rude, shouting, in front of other people I prayed, I wished, I wished, that maybe she could just take me somewhere private so I don’t have to feel embarrassed, I can’t, you know, I can’t say in front of people. At that point, you just wish you had that small question: ‘what happened to you’, a simple question that can make something, someone feel, just ask the question, just ask me the question, but they didn’t ask. The simple question would have made me feel... you lived in a genocide [...]. ‘What happened?’ It’s you know, it’s a small question, but it goes a long way, it will save people. But nobody cares, I wanted somebody to speak to, to ask me, this is why it took twelve years for me to trust anyone, to speak to anyone.”

Survivor

There are many factors impeding disclosure of rape or other sexual violence or torture, which also compromise a health assessment. These reasons are related to (a) the person’s subjective experience and physical and psychological health; (b) the context of assessment; (c) the interviewer and the interpreter, where present; (d) past experiences with authority figures, including health professionals; and (e) the wider social, cultural, economic and political context (see Figure 3).
Broadly, the reasons why disclosure can be hindered are summarised below and further discussed in Box 31, with examples of how to facilitate disclosure of rape or other sexual violence or torture.

1. **The person’s physical and psychological health and subjective experience**
   - Absence of safety
   - Absence of trust
   - Heightened arousal
   - Poor concentration
   - Pain
   - Memory problems
   - Avoidance behaviour
   - Intrusive recollections
   - Fatigue
   - Fear of changed sexuality/sexual health
   - Fear of harm to foetus
   - Fear of not being believed
   - Guilt and shame
   - Social stigma
   - Fear of further harm
   - Fear of discrimination
   - Risk of harm
2. The context of assessment

- Absence of privacy and confidentiality
- Informed consent
- Narrow biomedical focus
- Time

3. The interviewer and the interpreter, where present

- Background of assessor and/or interpreter
- Absence of an interpreter/interpreting style
- Prejudice and discrimination
- Reactions of assessor
- Past experiences with authority figures, including health professionals

4. Wider social, cultural, economic and political context

- Ignoring social context and basic needs
- Ignoring strengths and coping

It is important to note that it is widely recognised that, even if no rape or sexual assault takes place, most torture methods have sexual aspects. The Istanbul Protocol also stresses that the absence of disclosure or the level of signs of psychological symptoms or diagnoses does not mean that torture (including rape and other sexual violence) did not occur. In other words, absence of signs and disclosure does not equate to absence of torture or ill-treatment.

Box 31: Disclosure of rape or other sexual violence or torture

<table>
<thead>
<tr>
<th>Factors impeding disclosure</th>
<th>Facilitating disclosure</th>
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<tbody>
<tr>
<td>Absence of safety(^{60})</td>
<td>Ensure:</td>
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<tr>
<td></td>
<td>• Therapeutic interview settings to enable safety(^{61})</td>
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<td></td>
<td>• Good listening and interview skills which display sincerity, genuine positive regard for the person, empathy and sensitivity</td>
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<td></td>
<td>• A collaborative style of interview, advancing at a pace the person can manage and where anxieties about the interview process and distress arising during the interview are acknowledged and breaks provided where needed</td>
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<td></td>
<td>• The person is not required to speak about their health or experiences in front of others (relatives) or children.</td>
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\(^{58}\) Istanbul Protocol, para. 154.

\(^{59}\) Istanbul Protocol, paras. 289, 277.

\(^{60}\) Istanbul Protocol, paras. 93 (referring to asylum setting), 91 (referring to prison setting), 126, 129, 239, 264 (referring to detention settings).

\(^{61}\) See Section 6.
Avoid:

- Coercive environments (e.g. detention settings) wherever possible, to conduct health assessments
- Settings or interview conditions where conversations may be overheard and there is no privacy
- Rushing an assessment
- Asking too many closed questions, in succession, and without listening to the person’s verbal and non-verbal responses
- Not listening, being distracted
- Being or appearing judgemental, conveying disbelief, lack of interest or indifference
- Aggressive and cold interview style
- Ignoring their requests for a break or to not talk about certain topics
- Ignoring their distress, fearfulness or suspiciousness, and conducting the interview in a detached, cold and uncaring manner.

Absence of trust

Ensure:

- Time, to establish trust and rapport
- Empathy and compassion
- Use of active listening skills
- Range of open and closed interview questions, phrased with sensitivity, and at a pace the person feels able to answer
- Consideration of the background of the interviewer (age, culture, ethnicity, gender, professional background etc.) and what that may mean to the person, and their doubts, fears, and questions about the interviewer, the interview process and outcome
- Introductions – of you as an interviewer, your professional role, position and parameters of independence, remit, affiliation, why you are there to see them, how long the appointment will take, how and when breaks can be taken etc., who the interpreter is and their role
- Consideration of differences between you/the interpreter and the person being interviewed. Differences in gender, ethnicity, political, religious or other aspects of an interviewee’s background, and those of an interpreter, may create suspicion, mistrust and fear, impeding communication and therefore adversely impacting on the quality of an assessment
- Explanations: of purpose and context of the interview and possible outcomes; confidentiality and limits (see below)
- Explanations: of the nature of health assessments and examinations, what to expect, why certain questions are being asked, which health impacts or related experiences may be hard to speak about, because of stigma or feared consequences – acknowledging that you are aware that there may be fears related to what a person chooses to talk about, what health complaints they raise or not (e.g. pelvic pain, vaginal infections, psychological problems) and what they may avoid showing to the health professional (e.g. particular scars or injuries related to being raped).

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62 Istanbul Protocol, paras. 129 and 164. In a survey conducted by ICHHR, 73% (out of 32 health professionals) said the lack of trust in the health professional by the client was a significant factor in hindering disclosure of rape or other sexual violence or torture [Patel, N., Vara, R. & Khan, A. (2014). Survey of health professionals working with women survivors of rape or other sexual violence or torture. London: ICHHR].

63 Istanbul Protocol, describes the importance of this explanation, relevant to legal practitioners too, as “The evaluator may be suspected of having voyeuristic or sadistic motivations, and the interviewee may ask him or herself questions such as: “Why does he or she make me reveal every last terrible detail of what happened to me? Why would a normal person choose to listen to stories like mine in order to make a living? The evaluator must have some strange kind of motivation” (para. 267); and that the interviewer may be seen as in a position of authority and not trusted (para. 268). The perceived independence, or lack of, from the authorities is also crucial to clarify at the outset, in terms of the professional role.
<table>
<thead>
<tr>
<th><strong>Heightened arousal</strong></th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>• Consideration of the anxiety and fear the person may be feeling. Heightened arousal and anxiety can affect concentration, attention, listening to and comprehension of questions as well as impairing a person’s ability to recall. What may seem like reluctance or inability to give a coherent account or to answer questions may be related to heightened arousal, anxiety and fear. Sometimes, the person may ask for questions to be repeated, or not understand the questions, or give monosyllabic or disjointed responses – all of which can also be related to arousal.</td>
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<tr>
<td>• The person is given time to respond or to ask questions or to ask for questions to be repeated, if they did not hear or understand them or remember what was asked.</td>
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<tr>
<td>• Reassurance – normalise the anxiety and fear, reassuring the person that this is normal, and being asked to talk about difficult experiences can be very unsettling and frightening.</td>
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<thead>
<tr>
<th><strong>Poor concentration</strong></th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>• Consideration of poor concentration, which may be related to fear, exhaustion, pain, distressing memories, noises and distractions in the setting, lack of sense of safety, depressive mood or other factors.</td>
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<tr>
<td>• Acknowledge to the person when they seem to have trouble concentrating, exploring the possible reasons.</td>
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<td>• Enable the person to ask for breaks, or for questions to be repeated simply, or explanations to be provided in short sentences.</td>
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<tr>
<td>• Take time and be patient with the person but also use your clinical judgement to know when stopping the interview is necessary and consider rescheduling where possible.</td>
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<thead>
<tr>
<th><strong>Pain</strong></th>
<th>Ensure:</th>
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<tr>
<td>• Consideration of pain or discomfort the person may be feeling.</td>
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<tr>
<td>Pain can be very distressing and can cause irritability and contribute to poor attention and concentration, impeding disclosure. Persistent pain can also lead to poor short-term memory.</td>
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<tr>
<td>Pain may be related to the violence and torture endured, it may be related to injuries or illness, or it may be related to muscular tension from being in a state of constant alertness/hyper vigilance and anxiety.</td>
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<tr>
<td>Pain can serve as a reminder of experiences of rape or other torture, and a person may feel deeply ambivalent even acknowledging or talking about the pain and its onset and causes. Persistent pain can also impact on sleep and lead to short term memory difficulties, as well as fatigue and mood changes. Sometimes people misuse a range of substances, including prescribed and non-prescribed, illegal drugs, alcohol or other substances to cope with pain. These substances can also impact on attention, concentration, orientation and memory. The persistent misuse of certain substances may lead to more serious and chronic memory problems, all of which can impact on the person’s ability to disclose what happened to them.</td>
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<tr>
<td>• Acknowledgement that the person may be in discomfort or pain, asking how the pain is affecting them and how they are coping with it.</td>
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<tr>
<td>• Exploring what the pain means to the person can also facilitate disclosure of possible causes, onset and progression.</td>
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<tr>
<td>• Enabling a person to ask for breaks, or to move around or to stand up in the session.</td>
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<tr>
<td>• Offering breaks or the choice to end the session, or making a clinical judgement as to when it would be better for the person to stop and to reschedule where appropriate.</td>
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<tr>
<td>Memory impairments</td>
<td>Ensure:</td>
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<tr>
<td>• Consideration of possible memory impairments which can affect a person’s ability to engage in a health assessment, and which can impact adversely on the quality of the assessment</td>
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<tr>
<td>• Identification of any gaps in the narrative or where the interviewee is unable to recall what happened to them, when, and other details</td>
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<tr>
<td>• Consideration of possible causes of memory impairment.</td>
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<tr>
<td>Memory impairments may arise from:</td>
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<tr>
<td>° Neurological complications related to beatings to the head, suffocation, near drowning and starvation</td>
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<tr>
<td>° Factors related to specific torture methods (e.g. hooding, use of specific drugs, alternations of sensory stimulation such as total darkness with bright lights, intentionally disrupting sleep and inducing confusion, disorientation and prolonged fatigue) can also impact on recall of certain details of torture</td>
<td></td>
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<tr>
<td>° Other organic causes</td>
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<tr>
<td>° Head injury, lapses in consciousness during rape or other torture</td>
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<tr>
<td>° Psychological distress (anxiety, post-trauma stress, depression). Cognitive functioning can be limited, for example in depression, attention, concentration and short-term memory may be affected. Psychological trauma (or post-trauma stress) can also impact adversely on recall and lead to accounts which are vague in parts, lacking detail on particularly traumatic experiences, incoherent and incomplete narratives</td>
<td></td>
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<tr>
<td>° Sleep disturbance can also lead to poor attention, lack of concentration and short-term memory problems</td>
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<tr>
<td>° Malnutrition can impact on memory functioning, and may be related to poverty, poor living conditions, poor prison conditions, hunger strikes in captivity and a result of poor appetite related to depression and grief</td>
<td></td>
</tr>
<tr>
<td>° Cultural factors may also impact on recollections and memory impairment (e.g. not being able to remember precise dates, but recalling the season, where the interviewee had a rural livelihood and lifestyle).</td>
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<tr>
<td>• Questions are simply stated and in short sentences, not several questions embedded in one</td>
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</tr>
<tr>
<td>• Questions are repeated as necessary and answers repeated to confirm accuracy</td>
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<tr>
<td>• Allow for a free narrative, “Tell me what happened?” ”What happened next?”</td>
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<tr>
<td>• Ask questions in different order (e.g. from beginning to next, “then what happened?”; backwards, “what happened just before that...and before that...?”)</td>
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<tr>
<td>• Ask the interviewee to describe a situation from the perspective of an onlooker, “what would somebody watching have seen?”</td>
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<tr>
<td>• When the narrative pauses use closed questions to support the interviewee and to obtain detail e.g. “Do you remember how many men there were?” ”Where there any windows in the room?”</td>
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<tr>
<td>• However, avoid pressing for detail when the person seems</td>
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</tr>
<tr>
<td>° in a state of confusion (there may be health reasons, or effects of medication, head injury or learning disability)</td>
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<tr>
<td>° anxious (since they may feel the need to please the interviewer)</td>
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<tr>
<td>° unable to concentrate or recall</td>
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</tbody>
</table>
| For example, by asking ”How many men were there?” “I don’t remember.” “Well was it three, or five, or ten?” ”There were five.” – since there is a danger of inadvertently coercing them or asking questions which can be suggestive and which interfere with recall, particularly when the person suffers from poor memory and emotional distress.
- Acknowledge to the person that the interview process can feel onerous and distressing in itself, especially when it is hard to remember, or concentrate on the questions or discussion
- Avoid interruptions if possible
- Allow breaks, agreeing with the client, to minimise fatigue and distress at not being able to recall
- Take time, and avoid rushing the person or the interview
- Recognise that emotional and cognitive processing of distressing experiences can take time, and often stops and starts, and that this process is unique to each person and unpredictable. A person may be able to give more detail in subsequent appointments, or where psychological and social support is available and used, when they feel safe and able to think about and talk about their experiences
- Accept answers such as “I do not know” and “I do not remember.” These may give insight into the interviewee’s psychological state and can be explored or re-visited later.

<table>
<thead>
<tr>
<th>Avoidance</th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>Consideration of avoidance behaviour common to trauma reactions</td>
<td>Consideration of avoidance behaviour common to trauma reactions</td>
</tr>
<tr>
<td>Traumatic memories of torture and related experiences may lead to avoidance behaviour, which can include avoiding feeling, thinking or talking about anything that reminds them of torture they have experienced and which may trigger intrusive phenomena [e.g. nightmares, flashbacks], intense fear, grief and emotional pain and suffering. A person may avoid any reminder of the traumatic experience(s), including people, places, conversations, activities, objects, or situations that bring up distressing memories. Even when a person knows the important of sharing what happened to them or related health concerns, they may avoid talking about this, for fear of triggering more intense distress; or fear of judgement, criticism or other negative consequences [detailed in this table].</td>
<td>Consideration of avoidance behaviour common to trauma reactions</td>
</tr>
<tr>
<td>Acknowledgement to the person that you recognise it is very difficult to talk about distressing events or memories, and that they may fear that talking or remembering those details will cause them distress etc.</td>
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</tr>
<tr>
<td>A note is made of those areas the person avoids thinking or talking about, or areas they may skate over, returning to those areas at a later stage, when the person seems less distressed, to explore further and ascertain what their fears are about talking about certain topics</td>
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</tr>
<tr>
<td>A clinical judgement is made on when it is better to not press ahead with questioning on areas the person finds distressing to talk about, and judge when they feel better supported and that they feel they have choice and control as to what they say, when and how much</td>
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</tr>
<tr>
<td>A clinical judgement is made on when it is essential that areas being avoided by the person be addressed [and considering consequences of delay], perhaps with more direct questions [e.g. where physical conditions may deteriorate and become chronic, such as sexually-transmitted infections that may progress to pelvic infection and cause infertility; or where medical evidence is essential for a medico-legal report to support an asylum claim, or a claim for reparation]</td>
<td>A clinical judgement is made on when it is essential that areas being avoided by the person be addressed [and considering consequences of delay], perhaps with more direct questions [e.g. where physical conditions may deteriorate and become chronic, such as sexually-transmitted infections that may progress to pelvic infection and cause infertility; or where medical evidence is essential for a medico-legal report to support an asylum claim, or a claim for reparation]</td>
</tr>
<tr>
<td>A balance is struck between encouraging, supporting and questioning a person and taking time to help them feel at ease, and to build trust. Sometimes, ‘taking time’ with a person may become a source of “stuckness” where there is a combination of the person avoiding talking about what happened to them, and the assessor feeling afraid to ‘push’ the person, or explore areas they too feel uncomfortable to explore64</td>
<td>A balance is struck between encouraging, supporting and questioning a person and taking time to help them feel at ease, and to build trust. Sometimes, ‘taking time’ with a person may become a source of “stuckness” where there is a combination of the person avoiding talking about what happened to them, and the assessor feeling afraid to ‘push’ the person, or explore areas they too feel uncomfortable to explore64</td>
</tr>
<tr>
<td>There is a recognition that, whilst asking questions is important in an assessment, listening to the person and where they are at emotionally and what they are communicating is more important65</td>
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</tr>
</tbody>
</table>

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64 See Section 9.4 on counter transference.
65 Istanbul Protocol, paras.135, 149.
**Intrusive recollections**

Ensure:
- Consideration of how the fear or ongoing experiences of intrusive recollections may impact adversely on a person’s ability to disclose what happened to them.

Intrusive recollections include:
- Unexpected or expected reoccurring, involuntary, and intrusive upsetting/distressing memories of the traumatic event(s).
- Repeated upsetting dreams/nightmares related to the traumatic event(s).
- Experience of re-living (e.g. flashbacks) where the person feels as though any traumatic event they experienced is happening again.
- Strong and persistent/prolonged distress upon exposure to cues either inside or outside of a person’s body that are connected to the traumatic event(s).
- Marked physiological reactions upon exposure to a reminder of the traumatic event(s) (internal/external cue resembling/symbolising the traumatic event(s)).

- Acknowledgement in the interview that the person may be afraid to recall or talk about what happened to them because they are afraid that they may become extremely distressed, feel as if they are ‘losing control’ or cannot predict how they will react or how it may affect their sleep or nightmares later.

- Recognise that sometimes a person may spontaneously talk about what happened to them and still experience intrusive phenomena, or they may be asked a question with a particular word which in itself triggers an intrusive recollection, preventing them from talking about the very issues they fear and try to avoid.

- Recognise that sometimes a person may remain guarded and fearful and not respond to interview questions, for fear of intrusive memories of their traumatic experiences.

- Recognise that assessments must not push a person or the pace at which they disclose, but encourage, facilitate and note those aspects of their histories or experiences which they find particularly difficult to think or talk about.

**Fatigue**

Ensure:
- Sensitivity to a person’s fatigue and distress, acknowledging their fatigue and distress, and offering a break or another appointment, as appropriate.

Fatigue may be related to chronic pain, sleeping problems, enduring anxiety, physical illness, malnutrition etc.

Sometimes a person may feel exhausted, emotionally and physically, though feel unable to say. They may also be unable to talk about what happened to them. Sensitivity and compassion are required in acknowledging fatigue and offering breaks when the person feels unable to ask, or even giving them the option to stop and reschedule the interview where appropriate.

**Fatigue from repetition of story**

Ensure:
- Acknowledgement that often a person has been required to tell their story, and give details of what they endured, to many people, many times, with immense emotional cost to themselves.

Survivors who have told their story to other authority figures may have given considerable details, but may have given less detail to another person who has subsequently interviewed them and so on. The emotional burden and trauma of having to repeat one’s story, without adequate support or protection subsequently, or without any acknowledgment that they may have been asked the same questions many times, can be paralysing. Some women say they simply cannot utter another word about what happened to them, or the details, feeling an intense psychological propensity for self-preservation – by not speaking.
Letting the person know that you are aware they may have been asked the same questions, and they may have told aspects of their experiences to others, can help if it is also clearly explained why it is necessary to ask again, and to know the details of what happened to them. Allowing them time, and choice as to what they feel able to share, in the context of a supportive interview, can often lead to a fuller disclosure of experiences of sexual violence or other torture.

<table>
<thead>
<tr>
<th>Fear of changed sexuality/sexual health</th>
<th>Ensure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consideration of fears related to one’s sexuality or sexual health.</td>
<td></td>
</tr>
<tr>
<td>Sexual violence/torture may lead to injuries and pain and sexual difficulties, including dyspareunia, impotence and loss of libido. Some may believe that these changes are permanent, and fears and shame may prevent them from seeking or attending sexual health assessments, or any physical examination.</td>
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<tr>
<td>Some may experience and intense fear and aversion to those from the opposite sex. They may also find it extremely difficult to express this, for fear they will be asked to disclose reasons why.</td>
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<tr>
<td>Some may fear that sexual violence/torture has changed their sexuality, and permanently so. This may be related to sexual threats and taunts made during torture, for example at men who fear they have ‘become’ homosexual66, who may have heard threats during torture such as “You like women? We will show you how to walk like a woman, when we finish with you, you will walk like a woman… you will be a woman” (survivor).</td>
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</table>

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<thead>
<tr>
<th>Fear of harming the foetus</th>
<th>Ensure:</th>
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</thead>
<tbody>
<tr>
<td>• Consideration of fears related to pregnancy.</td>
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<tr>
<td>Where pregnant, a woman may be unwilling to talk about what happened to her for fear of harming her foetus, or her distress causing hurt to her other children. Sensitivity is required to acknowledge such fears where present and to support the person to speak when they feel more able and safe to speak.</td>
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<thead>
<tr>
<th>Fear of not being believed</th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>• Consideration and acknowledgment that a person may fear no one will believe them if they say what happened to them, or that they will be judged or diminished in other ways.</td>
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<tr>
<td>A person may have told their account to others, including in a judicial process (e.g. asylum determination), and felt they were not believed, judged adversely, patronised and treated inhumanely and without care. This may hinder the person from wanting to talk to anyone, for fear of the same experiences.</td>
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<table>
<thead>
<tr>
<th>Language and labels for rape</th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>• Consideration of the immense power of labels of ‘victim of rape’ social taboos around rape and sexual violence.</td>
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<tr>
<td>The nature of sexual violence is often such that it feels unspeakable for the survivor but, more so, the language to describe the nature and brutality of experiences of rape and other sexual violence or torture simply may not exist. Women sometimes say it is not just unspeakable, but that they have no words, and know no words that can be used to describe what happened to them.</td>
<td></td>
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<tr>
<td>To be labelled as a survivor, or victim, of rape can also give rise to complex feelings, for example, on the one hand, of recognition of what the person experienced and, on the other hand, feeling problematised and labelled, as if forever, as a ‘rape victim’. Stigma associated with such labels, as well as fearing that their lives and identity will only be narrowly defined by their experiences of sexual violence or other torture, can prevent women from disclosing what happened to them.</td>
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</table>

**Guilt and shame**

Ensure:

- Consideration of the impact of social and cultural context leading to feelings of guilt, shame and self-blame.

The context of assessment, or social and cultural context of the person, and prevailing cultural and gender norms, can impact on the extent or willingness of the person to disclose what they have experienced, or to go beyond minimal reporting of symptoms, pains, scars etc. They may feel that they were somehow responsible for what happened to them, that they should have been able to stop the perpetrators, or that they should have anticipated what was going to happen and to protect themselves, or others, such as family members from the same harm, or death. These beliefs can evoke and maintain powerful feelings of self-blame and guilt, which in turn hinder any disclosure, for fear of being judged as to blame and criticised by others.

They may fear that talking about what they experienced would arouse intense feelings of shame (e.g. with rape or other sexual torture). These feelings of shame are strongly related to the social and cultural context and gendered norms and notions of morality against which women may be judged, or feel as if they will be judged, by others.

They may be frightened of their spouse or partner knowing, in case the relationship is ended, with fears of loss, abandonment, loneliness, or domestic violence, judgement, criticism or blame directed at them by loved ones.

Some may fear their families would be destroyed if they learnt of what happened, and that this would destroy the honour of their family and any hope of a 'normal' family life. The fear of losing one’s children can also be profound, where family members reject the woman and remove her children or prevent access to them.

They may be afraid of ostracism by family or community members.

Cultural, religious and political values may influence when a person feels it is appropriate to disclose, to whom, what and how. For some, cultural norms and/or religious values may make them resolve not to tell anyone of what they experienced. For some, political values which enable them to understand their experience of rape and/or other torture as a form of political punishment or oppression may help them to not feel guilt, even if they feel shame at the degradation, and this may enable them to disclose what they experienced.

- Exploration of fears about what would happen if the spouse/partner or other family members or others knew what had happened to the person.
- Acknowledgement to the interviewee feelings of shame and/or guilt they may have, and normalise them (e.g. ‘I understand this is very difficult for you to talk about, and with a stranger, and it seems to make you feel shame/guilt’).
- Adoption of a human rights, non-neutral stance (e.g. ‘It seems you feel shame and/or guilt because of what happened to you, but this is not your fault and what happened was wrong’) to challenge the internalisation of responsibility, guilt and shame and to challenge any beliefs that rape or other torture they experienced was their fault.

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67 A survey conducted by ICHHR, showed that 100% (of 32 health professionals) thought that shame was a factor hindering disclosure by survivors of rape or other sexual violence or torture; 100% thought that the fear of consequences from the family or community knowing; and 97% thought societal stigma related to sexual violence, all accounted for non-disclosure (Patel, N., Vara, R. & Khan, A. (2014) Survey of health professionals working with women survivors of rape or other sexual violence or torture. London: ICHHR).

<table>
<thead>
<tr>
<th>Social stigma</th>
<th>Ensure:</th>
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<tbody>
<tr>
<td>• Consideration, acknowledgement and challenging of the different social stigmas which can prevent a person from disclosing rape or other torture, or any related physical or psychological health problems. Social stigmas against mental health problems, against sexual violence (including rape and other sexual torture) and against torture may all prevent a person from disclosing what they experienced. The person may see these topics as taboo and any disclosure of them as admitting failure, personal 'damage' or personal responsibility for what happened to them. For some women, social and cultural norms may inhibit any discussion of sexual violence or difficulties in intimate partner relationships (for example, after a woman has been raped). Further, social stigma against women discussing any kind of violence against women, especially sexual violence, may be a powerful deterrent against disclosure.</td>
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<tr>
<td>Fear of further harm to self and others</td>
<td>Ensure:</td>
</tr>
<tr>
<td>• Consideration of and sensitivity in questions exploring fears a person has about reprisals against them and fears of further harm, including rape or other sexual violence or torture, to themselves or family members. Many who are tortured may be told by their perpetrators that everyone will know what happened to them. Sometimes they are filmed during the rape or other torture and threatened that the recording will be released on social media ‘so that everyone will see what we did to you’. Threats of similar harm to the person’s relatives, some who may still be left behind, may also be a source of constant fear, and guilt that they are responsible for bringing harm to loved ones by their political actions, or by fleeing. They may intensely fear that if they talk to anyone about what happened, even if a health professional, then somehow the perpetrators will learn of this and carry out their threats. • Consideration of and sensitivity in questions exploring beliefs and fears a person holds about what may befall them or loved ones if they disclose what happened to them Sometimes, a person may hold beliefs, reinforced by what the perpetrators told them, that, if they tell anyone, no one will believe them and harm will come to loved ones. Some of those beliefs may be the cause of intense fear, and some beliefs may relate to witchcraft and the fear that something harmful will happen to one’s children, or that the person, or their loved ones may become seriously ill. Such fears may not be easily expressed, especially to a health professional, but may deter the person from sharing anything which may even hint at rape or other sexual violence or torture they experienced. • Consideration of fears of being punished and/or being subjected violence or of being killed by family members. They may be afraid of recriminations, punishment, death (‘honour’ killing or violence) from family members.</td>
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<tr>
<td>Fear of discrimination</td>
<td>Ensure:</td>
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<tr>
<td>• Consideration of fears of discrimination and related physical and/or verbal abuse or punishment. Survivors may fear that if they disclose rape or other sexual torture, for example, because of their gender, sexuality, ethnicity, religion etc., that they may be subjected to homophobic discrimination, racism etc. by the police, health professionals and others in an official capacity. They may have also previously avoided disclosing their experiences where the police or law enforcement officials were themselves the perpetrators, which would have likely placed them in greater danger and exposed them to further discrimination.</td>
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</table>
Fear of discriminatory practices and laws which discriminate against women (e.g. where spousal rape is not recognised as a crime; or where the woman is outcasted by the family or divorced if they learn of her being raped, and the custody of children from the marriage is given automatically to the father; or where formal legal rules may exempt a perpetrator from punishment where he marries the survivor), whether in the survivor’s country of origin or in their current context, may also dissuade survivors from disclosing what happened to them.

### Risk of harm

**Ensure:**
- A risk assessment is carried out (see section 8.4) to establish if there are any immediate concerns or health risks, which may also impact on the person’s ability to participate and disclose experiences of sexual violence/other torture, in the clinical interview.

The assessment of vulnerability and risk is an essential aspect of any health assessment and can arise at any stage in an assessment. Central to facilitating the process of a health assessment is staying alert to vulnerability and risk – a failure to do so may result in being narrowly driven by the interviewer’s needs to collect information at the expense of what may be of most concern or danger to the client, and what may lead to significant harm to the client.

Where there is a risk of harm to self or others, including child protection concerns, interviewees may be afraid to speak openly about what they are feeling or what happened to them. Common fears relate to possible interventions which they fear will exacerbate their situation (e.g. being medicated or hospitalised against their will, having their children removed, their spouse or a relative being informed).

### Factors related to the context of health assessment

<table>
<thead>
<tr>
<th>Factors impeding disclosure</th>
<th>Facilitating disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absence of confidentiality and privacy</strong></td>
<td><strong>Ensure:</strong></td>
</tr>
<tr>
<td>Privacy and confidentiality. Where privacy is lacking and discussions risk being overheard (e.g. in detention, at home, in a clinic etc.), safety and confidentiality can be compromised and hinder disclosure</td>
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</tr>
<tr>
<td>Discussion of privacy and confidentiality – what the person fears or feels comfortable with (e.g. particularly where they may feel they/you have no control over the lack of privacy in a detention facility, refugee camp clinic)</td>
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</tr>
<tr>
<td>Discussion of who they would like to be present or not in the interview (e.g. relative) and when it would be inappropriate to conduct a health assessment and examination in front of others (e.g. children)</td>
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</tr>
<tr>
<td>Explanations of confidentiality and its limitations</td>
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</tr>
<tr>
<td>Explanation of who the interpreter is (where one is present), their own ethical code, including confidentiality. Provide opportunities for the person to ask any questions relating to the interviewer or interview process, including concerns about whether the interpreter will disclose information to others in their community.</td>
<td>• Explanation of who the interpreter is (where one is present), their own ethical code, including confidentiality. Provide opportunities for the person to ask any questions relating to the interviewer or interview process, including concerns about whether the interpreter will disclose information to others in their community.</td>
</tr>
</tbody>
</table>

| **Inadequate informed consent** | **Ensure:** |
| Adequate information is provided, in a language understood by the person, and in language which is jargon-free | • Adequate information is provided, in a language understood by the person, and in language which is jargon-free |
| Information about the interviewer, the purpose of the interview, the possible outcomes, where notes are recorded, what happens to the records, where they will be stored, who will have access, parameters of confidentiality etc. | • Information about the interviewer, the purpose of the interview, the possible outcomes, where notes are recorded, what happens to the records, where they will be stored, who will have access, parameters of confidentiality etc. |

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69 Istanbul Protocol, paras. 83, 124, 149 and 165.
• Informed consent is taken at different times, particularly if the assessment is conducted over time. Often when a person is anxious, in pain, or frightened, they may not fully hear or understand information being given to them, and may need it to be repeated, and opportunity given to be able to ask questions of the interviewer.

In the absence of informed consent, an interview may proceed, and may later lead to a person learning something which makes them fearful and mistrustful of the interviewer or interview process, hinder disclosure and a full assessment.

### Narrow biomedical focus

**Ensure:**

• A health assessment, in whatever service a client presents, is broad and does not narrowly focus on particular symptoms and diagnoses at the expense of exploring other difficulties, strengths, coping and other areas. Certain services may be organised in such a way as to only assess in detail any health difficulties arising from a particular diagnosis (e.g. HIV positive), or narrowly focusing on one aspect of a person’s presentation using a biomedical model and diagnosis (e.g. PTSD). It is easy to overlook important aspects of the person’s health which may also give indications of previous experiences of rape or other sexual violence or torture that they have not talked about. Attention to the context of a person’s health difficulties and a commitment to both physical and psychological assessment can facilitate disclosure of such experiences.

### Lack of time

**Ensure:**

• Adequate time for a clinical interview.

Rushing can make the interviewee feel pressured, frightened, mistrustful and less likely to feel safe to share details of experiences they find deeply distressing, shameful or stigmatising of them.

Inadequate time for an interview can also prevent a thorough health assessment, and one which is compliant with standards specified by the UN Istanbul Protocol.

### Factors related to the assessor and/or interpreter

#### Factors impeding disclosure

<table>
<thead>
<tr>
<th>Gender, ethnicity, age and background of interviewer and/or interpreter</th>
<th>Ensure</th>
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<tbody>
<tr>
<td>• Consideration of the significance of the gender, ethnicity, age, cultural, religious or political background of the interviewer and where present, the interpreter, and what this may mean for the interviewee. Some differences may be assumed by the client, who may fear that the interviewer and/or the interpreter are biased and judging them, or that certain information may be disclosed to others in their community or used against them for political motives</td>
<td></td>
</tr>
<tr>
<td>• Where an interpreter is used, that he/she is appropriately qualified and skilled in working with health professionals, and, wherever possible, with survivors of rape or other sexual violence or torture</td>
<td></td>
</tr>
<tr>
<td>• The interpreter abides by ethical principles in all their work with health professionals, particularly the principles of ensuring informed consent, confidentiality, working within their competency and adhering to the principle of doing no harm</td>
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</tbody>
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70 See Section 8.


72 See Istanbul Protocol, paras. 150-153 on use of interpreters; and paras. 154-155 on gender considerations.

73 See supra note 23.
• The interpreter is adequately briefed before and after each interview/consultation and understands the context of the assessment/examination, the cultural context of the client and the terminology which may be used in the interview/consultation (e.g. medical or psychology terms, words referring to sexual violence or other sensitive health matters)

• Give a choice to the interviewee, wherever possible, on the gender of the medical examiner/health professional

• Where the interviewer is male, ensure that the interpreter is female, particularly for female clients.

However, there are no hard and fast rules about the gender of the interviewer or interpreter: for some people, this may be a significant hindrance to being able to fully participate and disclose relevant details in an interview. For example, for some women who have been raped, having to talk about intimate details of what they experienced, their health problems and fears may feel extremely overwhelming and frightening, even re-traumatising, when the interviewer and/or the interpreter is male.

However, it is not unusual for female survivors of rape/other sexual torture to say nothing in interviews with females (e.g. legal case-workers, or other non-health professionals), but to disclose to a male doctor.74

For others, the gender of the health professional may feel less of an obstacle than the gender of the interpreter, with whom they feel ashamed and who they may fear will breach confidentiality to members of their (assumed) shared community. Cultural norms may also shape expectations and fears for the person, about what can be spoken of in the presence of others from a different gender.

Absence of an appropriate interpreter/interpreting

Ensure:

• There is a professional interpreter where needed, not relying on family members, children, friends or other lay persons to provide interpreting.

In some settings, and in emergency situations, a lay person may be used for interpreting. The absence of trust, fear of being betrayed, shamed and breaches of confidentiality can prevent a person from speaking of rape or other torture.

In some services, the use of language-lines, interpretation provided by telephone, can severely heighten the fear of a faceless stranger hearing intimate details about one’s life and experiences, inhibiting disclosure of rape or other torture.

Prejudice and discrimination

Ensure:

• You are aware of your own prejudices and attitudes (e.g. towards asylum seekers, refugee people, women who have been raped) and that these do not impact adversely on your clinical interview, rapport-building and clinical opinion.

• You are aware of the different forms of discrimination, and that you actively scrutinise your behaviour, language and clinical judgements and actions to prevent or address discrimination.

• You are aware that the interpreter may harbour prejudices towards the person, which the interviewee can sense or notice (e.g. in the comments made, language used, tone of voice and other non-verbal signals) but you may not.

Everyone has assumptions based on stereotypes and prejudices, many of which remain unexamined, even in professional activities. Often, these prejudices lie unchecked and can unconsciously, or unintentionally, impact adversely on the way an interview is conducted, the clinical judgements that are made, and clinical actions arising from an interview.

Sometimes, interviewees can sense prejudice and recognise discrimination. Women survivors describe comments made to them such as “if you are Rwandese and you speak French, why didn’t you go to France, why did you come to this country?”.

74 Istanbul Protocol, para. 270.
Sometimes, the racism is more direct, for example, a woman described being told by a health professional: “I don’t know why you came for testing [HIV], you must know, most people who come from Africa are HIV positive anyway.”

Women may feel diminished, attacked, disempowered, helpless and too afraid to say or do anything. This can be the case in relation to the interviewer, as well as the interpreter on whom the person relies to communicate on their behalf.

The interviewee may fear that the interpreter will not translate everything, or accurately, to the interviewer. They may also fear that the interpreter will make derogatory or cynical comments to the interviewer, biasing their opinion. The interviewee may also fear that the interviewer will use their authority to be punitive or dismissive towards them, or make clinical judgements based on their irritation or anger at being challenged by the interviewee. For many, the experiences of prejudice and discrimination, and associated fear, are reminiscent of experiences of sexual violence, torture and other ill-treatment, experiences which are themselves acts of extreme discrimination and disempowerment.

Reactions of the interviewer

Ensure:

- Reflection on your own anxieties, concerns and feelings which may impact on the interview process and inhibit the person from disclosing (or giving more details) about experiences of rape or other sexual violence or torture.

The interviewer’s anxieties about what the person is saying, and their reactions to emerging details of sexual violence, can be easily felt and noticed by a person who is being interviewed. Sometimes, what is intended as a display of empathy by the interviewer (e.g. exaggerated expression of shock) may be experienced by the interviewee as evidence that the interviewer cannot tolerate hearing the details of sexual violence or other details. Other reactions (e.g. an absence of any display of human warmth, or of being distracted, can be experienced as indifference, disbelief or negative judgement by the interviewer.

These reactions can inhibit disclosure altogether, or stop a person who has started to share their story.

Past experiences with health professionals and health system

Ensure:

- Consideration of how a survivor’s past experiences with health professionals, or interpreters, may impact on how they see you, their fears and expectations.

- Questions are asked about their previous experiences with health professionals and the health system (e.g. in country of origin, in detention, in current country setting), and with interpreters where relevant, and respond to any cues which indicate that they feel unsafe or uncomfortable with you.

Factors related to wider social, economic, cultural and political context

Factors impeding disclosure

Ignoring social context and basic needs

Ensure:

- An assessment which takes into consideration current and immediate worries and concerns about basic needs (food, housing, clothing) the person has which may be impacting on their health and sense of safety.

A person who is preoccupied with being cold, being homeless, sleeping rough, being unable to feed themselves etc. is unlikely to be able to engage in a health assessment and readily talk about past experiences of rape or other sexual violence or torture.

Acknowledging and attending to these immediate needs, wherever possible, is essential to enabling a person to feel safe and to be open to a more exploratory assessment and discussion.

75 See Section 9.4 on counter-transference.
Ignoring strengths, coping and methods of survival

Ensure:

- A balanced assessment where a positive, humane communication where the person feels heard, validated and seen and treated as a human being, not as an object, or 'victim' and as someone with lots of problems, but as someone who has struggled to survive and to draw on whatever resources were available to them to cope.

When exploring a person’s way and level of coping an account may emerge of different ways a person has tried to deal with traumatic experiences, including violence, losses, poverty etc. Sometimes it is in the telling of how a person navigated and coped with these experiences, and the genuine compassion, respect and openness by the listener, that they may also feel able to also disclose those events which are particularly difficult to talk about, such as rape or other torture.

Recognising and acknowledging how a person’s social and political context may have forced them to make very difficult choices and decisions (e.g. leaving their children behind, or a younger sibling, or elderly parents) can enable them to disclose more, perhaps of what happened, the cultural significance, their ambivalence, sacrifices they made and the ongoing consequences for them or family members within the family’s social context.

Often rape and other torture are perpetrated in front of others, including children, parents and partners. The humiliation is directed not just at the survivor, but at those who are forced to witness what can seem like the annihilation of a loved one and of the very fabric of human relationships. Many women may not speak about the violence, as an act of defiance, as a determined effort to reassure oneself and loved ones that they can resume everyday relationships, trust and bonds. Not speaking about the sexual violence then becomes both a survival strategy for oneself, and a strategy to protect significant relationships and loved ones from having to acknowledge their own despair, helplessness, anger and powerlessness in not being able to protect them from harm.

For women who may have been raped and tortured themselves, some in front of a parent, or older sibling, or husband and then experienced their loved ones being killed, the not speaking about what sexual violence or other torture they experienced is a survival strategy. It can be a strategy to resume or construct the role of protector or parent for younger siblings or other family members, and in some cases, a subjugation of their own needs, and need for health care and protection.

Women who have babies born from rape may struggle with enormously complex and ambivalent feelings of love, disgust, hatred, rejection etc. Some may have rejected or abandoned their baby, some may have given birth but concealed the circumstances of the conception from family members and from health professionals and others. They may feel the need to never speak of what happened to them, but instead to prioritise their baby and the bonding with the baby and building a relationship which feels uncontaminated by the circumstances of the conception. This can create intensely conflicting feelings, including of profound suffering and at the same time the psychological need to ‘put aside’ what happened to them, so that they may nurture and protect the baby.

Acknowledging a person’s ways of surviving and coping can be validating of them as a person. It can also help a person to know that you acknowledge that there may be costs attached to their way of coping, which may be related to feelings of guilt, shame and a sense of a burden, which have hindered disclosure of what happened to them.

9.2 Interviewing: questions and techniques

To effectively cover the key content areas necessary to complete a health assessment, it is important to consider process factors in the style of interviewing which can hinder, or facilitate, disclosure of relevant information and a full assessment.

It is vital that clinicians are adequately prepared and informed themselves, to improve the interviewing process. Examples of good practice for preparation to be informed are described in Box 32.
Box 32: Being informed

- **Acquire a basic knowledge** of the nature of sexual violence, including rape, sexual torture and other torture methods which are often used in combination (see Section 2)
- **Learn about the context and prevalence** of sexual violence, rape and other sexual torture or sexual aspects of torture methods used in the country context of the person being assessed and the circumstances in which such violence is perpetrated (e.g. armed conflict, political repression, ethnic cleansing) and by whom
- **Learn about common psychological and physical health difficulties** related to sexual violence and other forms of torture (see Section 8).

Fundamental to all health assessments is the need to **be human** – relating to the person not as an object from which to extract information, but as a human being. A health assessment is most likely to avoid harm and to be facilitated if the person is treated with genuine respect, dignity, empathy, warmth, compassion and openness. Key principles to consider in facilitating the process of health assessments are illustrated in Figure 4 and summarised subsequently.

**Figure 4. Principles in facilitating the process of health assessment**

**Principle 1: Being human**

- **Relationship-building:** Interviewing is not about firing a list of questions as if by a machine or extracting information as if from an object. An interview is a process which begins not with questions but with the creation of trust and a therapeutic professional relationship with another human being in a way which validates their humanity and dignity and where the client is treated with genuine respect, compassion and openness and warmth. As noted earlier, you cannot assume that trust exists, simply because you are a health professional and an authority figure. Nor can it be assumed that trust can be easily and quickly established. Establishing rapport and a therapeutic relationship requires great care, sensitivity, listening and time.
For example, a woman describing what would have helped her speak about what happened to her stated:

"Like doctors, I will ask them to try to listen, not to listen to just the word but to listen the whole person, not to listen the word, because as I say there are some words which gets stuck there [...]. So I will say that really it’s good to listen the whole person, if they can do that it can help. Listen with love and care [...] how you listen to your child.”

Survivor

- **Being open and alert**: Throughout the interview, it is important to be alert to verbal and non-verbal communication, and observing, noticing distress, discomfort, tiredness or other difficulties the person may be experiencing in the interview or examination. Sometimes simply acknowledging in a sensitive and non-intrusive or pushy way can help trust-building and facilitate the process of the interview.

- **Being attentive to your own expectations, blind spots and biases**: It is inevitable that as health professionals, as human beings, we bring our own expectations of how a person should or should not present if they have experienced rape or other sexual violence or torture. We may also have our blind spots and prejudices, all of which can prevent us from seeing, and being open and attentive to the person in front of us. It is helpful to remember that there is no one pattern or common presentation for people who have experienced rape or other sexual violence or torture – everyone varies, their ways of experiencing and expressing distress will vary. Some may present as frightened, others as agitated and tearful, others as disengaged, indifferent, withdrawn. Some may complain of one symptom only, such as back pain, but be unwilling to talk about anything else. Another person may disclose rape, but appear uncommunicative, show no emotion and provide no details and seem unwilling to respond to close questioning.

It is also important to remain sensitive and alert to your own expectations, biases, prejudice and not knowing. Being genuine and allowing yourself to reflect on your expectations and blind spots can enable respectful curiosity and enquiry in an assessment.

"A lot of women were very much ‘it’s happened, I expected it to happen and I don’t want to deal with that.’ And it’s ‘I want to move on from it, I don’t want to think about it, I don’t want to deal with it, I just want to move on, and I knew it was going to happen anyway’… a lot of the women expected it to happen… That leaving their country of origin and on that horrific journey that they’ve gone through, that they had expected that to happen… but to actually leave and kind of prepare yourself that this is going to happen, that really shocked and surprised me… and then thought about it a lot, with my team.”

Health professional

**Principle 2: Set the scene**

- **Put the person at ease**: A primary task in any health assessment is how to begin to put the person at ease, to enable trust to be built. A simple acknowledgement of how difficult a journey may have been for the person to get to the venue, or how strange it may feel to see a health professional can help the person feel more at ease.

- **Acknowledge how anxiety-provoking the assessment process may be**: Statements acknowledging how frightening the setting or assessment may feel for the person are also important (e.g. “I know this must be very difficult to talk about this in this setting – and with a stranger like me...”; or “I am aware you have seen other professionals before me, and it must be difficult to trust someone new, again”).

- **Explain the purpose of the assessment, the nature of the setting, context and limitations**, all of which can help the person to feel more oriented and more at ease.

- **Explain what the assessment will involve**: In starting out, it is helpful to explain what the assessment will involve, and in what order (e.g. “I will ask you a few questions first, then perhaps ask you to lie there so I can examine you and then maybe we will talk a little more so I can better understand what your health concerns are”).
Principle 3: Provide information

- **Providing information:** Starting the assessment process, after setting the scene, by providing information helps orientate a client as to what to expect in the assessment, what the context is and facilitates the seeking of informed consent. Providing information can help to address any confusion and uncertainty, to allay some anxieties, to address any misconceptions the client may have about your role and authority to make or influence decisions (e.g. asylum determination or other legal proceedings). Providing information also helps increase a sense of predictability and control for the client and it helps to establish trust and create a context of safety.

- **Information must be age-appropriate, jargon-free, clear and accessible.**

- **Explore a client’s understanding and expectations of the assessment:** Clients may not be familiar with the health system which may differ significantly from health systems they are accustomed to in their own countries. They may not understand the reason why they were referred to you, or why they have to see a health professional or the purpose and limitations of your health assessment. They may have no idea about what to expect, or why they should trust you or speak to you, which would increase anxiety and reluctance to engage in an assessment; and to disclose sensitive information relating to any experiences of rape or other sexual violence or torture or related to their health concerns.

- **Explain your professional background, purpose and nature of assessment** and related administrative procedures.

- **Explain confidentiality and its limits:** Take care and time to clearly explain, with an interpreter wherever required, the nature of confidentiality. This requires a discussion of what confidentiality means (not a simple statement that ‘what we talk about will be confidential’) and an exploration of what the term means to the client and any cultural beliefs about who can and should know what and why. Explanations of confidentiality must include the limitations to confidentiality and the circumstances in which confidentiality would be breached (e.g. where there is risk of suicide).

- **Explain the parameters of the interview:** Explain how long the interview may last, what areas you will cover and what the assessment will entail, who will be present (e.g. interpreter, chaperone if requested).

- **Explain the protection of information:** how the information collected will be recorded (e.g. written clinical records, photographs and audio-recordings, both the latter requiring specific consent), where the records will be held, how secured, accessed by whom and under what circumstances, and what will happen to the information in the future.

- **Explain possible outcomes:** Reduce unpredictability and uncertainty and related anxiety, by explaining potential outcomes of the assessment. Explain what decisions or interventions may follow. Provide an opportunity for the interviewee to ask questions.

- **Take time:** Rushing the process of providing information only serves to raise anxiety levels for the client, and they are less likely to retain what is said to them, compromising the validity of any informed consent subsequently give. It may be necessary to repeat some information at different stages. Clients may find it helpful to be told that they can ask questions and they can ask for information to be clarified or repeated.

Principle 4: Seek informed consent

- **Informed consent** refers to consent provided freely and without coercion of the person, required to participate in a health assessment (unless compulsory, for example under specific domestic mental health legislation). Consent without the person being adequately informed of what they are consenting to does not constitute consent.

- **Use clear, specific and jargon-free language** to seek informed consent.

- **Provisioning both verbal and written information** (with an interpreter, or translated if the person is literate) is crucial to obtaining informed consent.

- **Explaining the parameters of the assessment.** confidentiality and its limitations and what would happen to the information collected, where it will be held, in what format and accessed by whom etc. are all basic ways of ensuring informed consent.
• **Seeking consent from minors** needs to be age-appropriate and considerate of the person’s capacity to give informed consent. Consent for those under 18 should be obtained from a parent or guardian who is an adult, though in some country contexts informed consent may be obtained from older adolescents.

• **Assessments requested by client’s legal representative**, such as for medical/psychological reports used for legal purposes, need discussion. The client must be informed of this and specific consent must be obtained, clarifying with the client your legal duty to the court. Any implications for the clinician-client relationship and the process of building trust and conducting the assessment should be discussed with the client. Explanations must be given about how health records will be made and kept, and that they may be used as evidence.

• **Consent can be withdrawn** at any stage, and the person’s wishes must be honoured, although there is a duty to explain any likely consequences at the outset or any statutory obligations and powers and the precise circumstances in which they can be invoked which may override a person’s wishes.

**Principle 5: Questioning AND listening**

• **Nature and style of questions**: Balance nature and style of questions to avoid evoking experiences of being interrogated and re-traumatising the interviewee. Phrase questions and statements sensitively, avoiding pejorative, offensive or culturally inappropriate language and jargon.

• **Listen carefully**: Active listening requires close attention to what is said, in words, body language and manner. Active listening means maintaining appropriate eye contact, and conveying that you are listening, and interested. For some people, they may have experienced others being dismissive of them and judging them, which may make them more vigilant to how the health professional listens to them, or not.

For example, a woman who had several interactions with immigration officers and in court, describes this as:

“He was saying ‘Well, you can still...you can still go back and get a job.’ Why did I leave [my country] in the first place? And he was not convinced.... His attitude was let’s just finish this and go home, you know, you can tell the person who is [un]interested, he was [un]interested like that. He wasn’t even interested to hear what I was saying, he wasn’t even looking at me, he was busy writing whatever he was writing. And this is the person from the [immigration authority] who is supposed to be assessing the truth from the lies ... He’s not even looking at me! How do you know I’m lying when you’re not looking at me...look at me when I am speaking to you.”

Survivor

• **Noticing hesitations** before someone responds, noticing someone’s anxiety or fear and silence is part of listening. It is important to not draw premature conclusions, to judge or to make unsubstantiated assumptions, but to use what you notice as a way to connect with the person and build trust by acknowledging what you notice, perhaps by using empathic statements and prompts (see below).

• **Use a mixture of statements, open and closed questions and prompts** which are informed by background knowledge of sexual violence and other forms of torture and ill-treatment used in combination.

• **Ask what happened**: For many women, the experience of being asked, with compassion, what happened to them can be a powerful acknowledgement to them that the interviewer is genuinely interested to know and to understand.
“I want to say to health professionals, and others, just try, you know, just try to be compassionate, to give one minute of compassion, because these people, they are coming from somewhere where people are being barbaric to them, so a little bit of compassion, and the simple question, ‘why’, ‘what happened to you’, ‘why are you here’, that will go a long way, it will go a long way [...] for you it don’t mean anything, but for the person, it’s a big time, it’s a lottery time, it’s a question of a lifetime that you never had [...] it’s like winning the lottery. You came to this country with that fear, you never had any opportunity, nobody ever cared to ask you, so you have this I don’t care too, nobody cares. Nobody asks me what happened to you.”

Survivor

“A lot of people seem to be surprised that we ask the question because nobody’s ever asked them before and don’t really know what to expect from that. There’s lots of people who’ve said that nobody’s ever, it’s maybe happened 10 years ago and nobody’s ever asked them that before.”

Health professional

**Empathic statements** are statements said in a way that convey empathy, but also invite the sharing of further information from the person.

- Empathic statements can lead to questions, aimed at making the person feel at ease, but also acknowledging that you are aware of the type of violence and torture the person may have experienced. For example, “many women in your situation, from your country have spoken about the type of violence and assaults they experienced. Some of them are sexual in nature... I know this is often very difficult to talk about”.
- Empathic statements can convey to the person that you recognise the nature of the difficulties or health problems described, and how difficult it is to talk to a stranger about them.
- Empathic statements can also normalise their experiences, as well as their ways of trying to cope (e.g. “I know what I am asking must be very difficult and upsetting, and perhaps it is the last thing you want to think or talk about”).
- Empathic statements may lead to further disclosure, for example, during a physical examination (e.g. “it must be worrying for you to have pain in your pelvis” or “it can be worrying for women when there are unexplained changes in their menstrual cycle...”).
- Empathic statements also sow a seed for the person, letting them know that you are aware there may be very traumatic or difficult experiences they are afraid to mention. For example, if a person talks about general aches and pains and then about poor sleep and being easily frightened a statement can help convey openness to hearing more (e.g. “yes, these problems are common and normal when people have suffered a lot...or something very frightening has happened to them.”)
- Empathic statements can lead to further health complaints being shared, or disclosure of worries about pregnancy, or sexual health problems, or experiences of rape or other forms of sexual violence not otherwise mentioned. Such statements can also help a person feel that you are genuinely interested and concerned about the impact of say, poor sleep, on their general wellbeing (e.g. “it sounds like you are having trouble sleeping and that something is really troubling you, especially at night time” or “I imagine if you are getting such little sleep you feel exhausted during the daytime”).
- Empathic statements can also help a person to speak about sensitive coping behaviours which they are afraid to talk about, or feel there is stigma (e.g. where you suspect the person may be using substances to cope with intrusive thoughts or to cope with insomnia, you may say “sometimes people feel they have to take things they don’t feel happy about, like tablets or alcohol, just to help them sleep, but that can make them feel worse in other ways. This is often difficult to talk about”).
Open questions are questions which open up areas for further exploration, inviting and encouraging the person to respond as freely and fully or as briefly as they wish.

- Open-ended questions usually include ‘what’, ‘how’, ‘why’.
- It is helpful to generally start with open questions. For example, “How is your health?” or “what’s worrying you at the moment?”
- At some stage in the assessment it may become apparent that the person is skirting around or hinting at something but unable to say. An open question which can enable a person to say what they feel comfortable sharing, at that point, is “What happened to you?”
- Sometimes prefacing such a question with an acknowledgement that the person is finding it hard to talk can also help, such as “it seems several things are troubling you about your health, and perhaps other matters... I know it is not easy to talk here, to a stranger like me... can you say what happened to you?”
- A person may share that they lost consciousness, perhaps to avoid further discussion of what happened to them. A gentle, open question can encourage them to say more, for example “So what happened when you lost consciousness... before/after?”

Closed questions tend to be specific and seek particular detail. It is important that they are not fired at the person as if subjecting them to questioning which feels cold, ruthless, insensitive and like an interrogation. Great care must be taken in the tone and style of closed questions used.

- Closed questions usually include ‘when’, ‘where’, ‘who’, ‘did you...’ – which invite often a brief response or a yes/no response.
- Closed questions can be used to gently follow up on responses to open questions. For example, a general enquiry on how a person’s health is could be followed by more closed questions such as “do you have any pain anywhere?”. This might lead to a report of headaches, which can be followed up by more specific questions about onset. The person may respond that the headaches started around two years ago. This can be followed up with a more open question (e.g. “I wonder what happened at that time, when your headaches started?”). They may reply that it was “during the war”, which may be followed up with a “can you tell me what happened to you?” or an empathic statement and a more open question again, such as: “I imagine many terrible things happened in the war. What was going on for you and your family?”
- Closed questions can also follow up an open question, but also allow room for more details to emerge. For example, following up “what happened to you” with questions that seek more detail, such as “when/where was that” and “were you alone”, “who said that/did that?”, “what did they say/do?”, “what happened after that?” etc. An example of the use of closed questions is where there is a loss of consciousness, and the person says little when asked an open question – and there can be follow-up closed questions, which are often more direct, such as “what was it like when you awoke... were you clothed or naked... did you notice any bleeding from anywhere... or any pain... in genitals/ anus”. These closed questions should be balanced with open questions, but they can take a particular line to explore more in detail, for example “when you awoke, were you fully clothed?... was there anyone else there (e.g. guards, soldiers, prison officers)?... Were they fully clothed, or naked?”. Where a person explains that they were detained but says very little, or moves on to the next part of their account, a closed question can help open up the discussion. For example, “you said you were detained, I wanted to ask you more about this....did anyone come into your cell, at night?... who... then what happened...?”
- Closed questions can be useful when open questions have failed to elicit relevant information about, for example, experiences of domestic violence, or sexual torture or suicidal ideation. Closed questions should be carefully and sensitively worded, sometimes prefacing with empathic statements (e.g. “remembering your family left behind must be very, very hard. Can you say why you left or how you became separated from them?”), or “It seems that all you went through must have had an impact on your family life/relationship. How/is this affecting your relationship?”)
Closed questions can also be general, encouraging further details to be shared “Did anything else happen to you while you were in prison?” or “you used the word ‘embarrassing’... did they do anything to make you feel embarrassed or ashamed?”

Preceding a closed question with a statement to convey some understanding and background knowledge can facilitate disclosure. For example, “many people who have had been in prison in [country] have told me that they have been physically or sexually assaulted; while this may be a very difficult thing to talk about, it is important that I ask you, were you ill-treated in any such way?”

Closed questions can clarify the significance of the disclosure. For example, when a person describes experiences of sexual torture it can be helpful to ask “have you ever told this to anyone else before?” or “does anyone in your family know what happened to you?”. The non-disclosure to significant others may signal fear about the consequences of disclosure, within their family, community or for their health, including sexual health.

Closed questions may be used to seek specific information. For example, “when you said you were raped, can you say what exactly happened... how were you raped?”, “what did they use to rape you?”, “which part of your body did they do this to you?”, “can you recall how many people there were who raped you?”, “who were they?”, “what were they saying to you when you were being beaten and raped?”, “when you said they took you to the commander every night, who took you? Where were they taking you... who do you mean when you say ‘the commander’?…”

Closed questions may be necessary in a physical health examination to seek specific information, for example, “do you have vaginal discharge which is unusual to you?”, “do you have bleeding from the anus or pain in that area?”

Closed questions may be used to seek specific information. For example, “when you said you were raped, can you say what exactly happened... how were you raped?”, “what did they use to rape you?”, “which part of your body did they do this to you?”, “can you recall how many people there were who raped you?”, “who were they?”, “what were they saying to you when you were being beaten and raped?”, “when you said they took you to the commander every night, who took you? Where were they taking you... who do you mean when you say ‘the commander’?…”

Closed questions may be necessary in a physical health examination to seek specific information, for example, “do you have vaginal discharge which is unusual to you?”, “do you have bleeding from the anus or pain in that area?”

Closed and direct questions can benefit from some explanation, to fully inform the person of the reasons and context for such direct questioning (e.g. where there is an urgency to conduct the assessment to prepare a medicolegal report within a specific time-frame where there is a date for a hearing in court, or impending threat of removal). In such situations, it is helpful to explain to the person what information you are seeking, why, and what the potential consequences of both sharing and not sharing the relevant information might be. If the person is afraid of their spouse learning of their experience of rape, you can discuss carefully how to ensure confidentiality, particularly in how such disclosure may be made to the court in a way where their spouse is not informed, and the person does not feel exposed and vulnerable. Explanation is both respectful and ensures that the person can make an informed decision as to how much they disclose, to whom and when.

Closed questions can draw on knowledge of rape or other sexual violence and torture and its effects, to facilitate disclosure and to elicit more detail, particularly by using a skilful mix of closed and open questions and empathetic statements and prompts. For example where there may be experiences of sexual torture, asking specifically about the verbal insults that accompanied the rape, or whether there was enforced nudity, or threats of rape to other members of their family.

Closed questions can draw on knowledge of detention settings and circumstances in particular countries. For example, asking questions during history-taking of where someone was held, the surroundings, setting, the conditions of detention settings, including overcrowding, poor ventilation, inadequate nutrition, extreme cold, concrete floors without bedding, lack of sanitary facilities etc.

Closed questions can draw on knowledge of various ways in which rape, sexual violence and torture can be inflicted. For example, sexual slavery during armed conflict may mean a person has experienced multiple rapes and pregnancy. Examples of close questions could be “Were you ever pregnant when you were being held there?”, which can be followed up with more open-ended questions such as “what did the perpetrator/commander say to you about what would happen to you, or the baby?” , “what did you believe would happen to you and/the baby?”.

Prompts can be a few words, or a question, aimed at clarifying details, and inviting the person to say more.

Prompts can be used to facilitate flow in an interview (e.g. “you mean your family? Can you say more about them?”)
• Prompts can acknowledge the distress a person feels during interview (e.g. “my question is making you think of things that are painful/upsetting?” or “you seem very sad”).

• Prompts can help establish more detail. For example, “can you tell me more about that?”, “you were afraid about what they would do to your sister?”, “you seem afraid when I asked you this, what is this making you think about?”, “you seem worried, can you say what’s troubling you right now?”, “you’re worried about pregnancy...?”

• Prompts can sometimes be probing, to establish specific detail. They may be experienced as intrusive, or rushing the person and explaining the reason for the probing can help build trust and facilitate disclosure. For example, “I know this is difficult to talk about, but I need to ask what exactly happened to you in detention – it is important that I understand your experiences, how they affected you, your life and specifically your health, because this can help us make the best decisions about what might be useful/helpful to you now.”

• **Be flexible in the questions asked and the structure of the interview**, to promote flow in the interview. Rigidly following a set of questions can feel like an interrogation and evoke intense fear and distress, and can sacrifice trust for otherwise sparse information lacking in detail. Being flexible in interviewing can enable the establishment of trust and rapport, crucial to facilitating disclosure and conducting a more comprehensive assessment. Sometimes, you may judge in the assessment that you need to be more directive and focused in the questioning. Though it is generally good practice to observe what the person chooses to focus on and how they present when they talk about their experiences, and judge the timing and appropriateness of follow-up and more probing questions. Flexibility is helpful in enabling the person to talk and sometimes it may be best to return to topics the person finds difficult, perhaps when the person seems less anxious, or when there is more trust.

• **Follow the lead of the interviewee**: In clinical interviewing it is important to follow the lead of the interviewee as to what is tolerable for them. This means allowing the person to give a free narrative and their account in their own way. That also means to try only to prompt when they are hesitant, or reluctant. Prompts can also help the person to say more, where for example more details are required. But it is important to give the person space and to respect moments when they feel unable to speak and do not want to speak. Following their lead allows them to build trust and to feel more in control, not as if they are being hurried and forced into talking about issues which they may find deeply distressing.

• **Allow the person to set the pace** at which they feel able to talk as this can feel respectful and enable a person to feel they have some control over what they say, to whom and when. Rushing an interview can be experienced as uncaring, dismissive, disinterested and sometimes abusive and even like an interrogation – all of which are highly likely to impede the development of trust and disclosure.

• **Remain open to hearing other information**: You may focus on key areas for your assessment, or on the main reasons for referral, but avoid rigidly following an interview script with only specific questions routinely asked. Sometimes, where there is trust or rapport forming between you and the person, they may disclose relevant information, such as other aspects of their health or social functioning, which may indicate rape or other torture which the person had not disclosed to the referrer.

• **Allow time for areas causing anxiety or problems for the person**: Wherever possible, allow more time and listen with openness to topics which are anxiety-provoking, distressing and difficult for the person, even at first they seem not central to the interview. This can be experienced as validating and respectful. Allowing the person to speak more about the areas they find most distressing may lead to disclosure of what happened to them, or to vital information which indicates risk or which elaborates on their health difficulties and concerns. The person’s willingness to engage with the assessment may be thwarted if they feel that you are ignoring what is, to them, of most immediate concern. Sometimes a person may bring issues which they feel overwhelmed by, but you feel are outside your expertise. It is important to acknowledge their concerns, and explain why you cannot address or solve those particular problems. You may judge that a referral to another colleague is warranted. Listening carefully to the way the person speaks of their anxieties can lead to further open-ended questions which facilitate disclosure (e.g. when a person complains of problems with their housing and neighbours, exploratory questions may lead to disclosures of racist abuse or sexual harassment the person is being subjected
to). Empathic statements may also facilitate disclosure of relevant further information (e.g. I can see this is really troubling you and affecting your sleep).

- **Show interest and ‘Listen with knowledge’**: Use questions which may indicate relevant background knowledge or experience (e.g. “I have worked with many people from X country and I am aware of some of the conflict there and what kinds of things happened...”), thereby building trust and allowing client to share more details about torture or other related distressing experiences. Showing genuine interest and ‘listening with knowledge requires the use of questions or prompts which are exploratory, without leading the person (e.g. ‘you said your sister was molested in front of you, and that they ‘did things to her’. Can you say more about what that means?... I wonder if this also happened to you?’). Avoid only listening to what you expect to hear. Stay alert to the unique details of each detainee’s experiences.

- **Attend to verbal and non-verbal responses**, and to silences and to what is not said. These give vital indications of when to be more careful, sensitive and empathic with what the person, who may be avoiding telling something, or who may be testing to see if you understand, and if can hear and tolerate what they may feel is too difficult or horrific to talk about.

- **Accept that details don’t emerge exactly when asked**: Sometimes a range of open and specific, closed questions fail to elicit the detail you expect. However, you may suspect that the person is trying to convey something, but not answering fully questions on a sensitive topic. Clinical judgement may be required to decide whether it may be more harmful to pursue closed questions and prompts, or whether it is better to acknowledge that they have shared what they feel able to, at that point in time. You may revisit the topic at a later stage, when further trust has been established, and you may leave the door open for the person to disclose when they feel ready (e.g. “I appreciate you don’t want to say more at the moment, but I am interested and willing to hear, whenever you feel able to say more”). Sometimes, when asked specific questions (e.g. “were you sexually violated in any way during detention?”) the person may display distress, avoid eye contact, become tearful and yet respond “no”. Clinical judgement may be helpful in deciding how far to explore and probe, when and how. In such situations, it is important to note in the clinical records your observations (e.g. the person is tearful, agitated), and if the person said “no, nothing happened to me, but to other people”. Also, it is good practice to record that you view the assessment as incomplete, or that you felt it inappropriate to push further, but that further assessment may be necessary.

- **Repeat questions in different ways**: When necessary, questions may need to be repeated and phrased simply and differently. This can help ensure understanding, as well as taking account of the fact that poor concentration and psychological distress may interfere with their ability to understand the questions. Avoid questioning as if an interrogation or making the person feel as if they have no choice and they must answer all questions, or that there is a ‘right’ answer and they are ‘getting it wrong’ or being obstructive.

- **Clear questions, simply stated**: Avoid long sentences and pre-ambles, and avoid embedding several questions in one question or a monologue.

- **Being questioned can feel onerous, exhausting and distressing**: Be mindful of fatigue, loss of concentration and distress, taking pauses, changing the pace of the interview, or taking breaks. For some, the process of having to tell their story, or to talk about their health problems, may be an exhaustive and repetitive experience, leading them to be anxious about the likely consequences after the interview (e.g. nightmares, extreme fatigue, migraines, intrusive memories etc.).

- **Order of questions can be changed**, and give the interviewee opportunity to provide a narrative. Changing the order of questions, as noted earlier, can enhance recall (e.g. from beginning to next, “then what happened?”; backwards, “what happened just before that... and before that...?”)

- **Attention to responses to questions**: Showing that you are paying close attention to the person’s responses can help build rapport and facilitate disclosure. However distressed, people are usually very aware of how the other person is responding, or not, to them. Listening requires attending both to what is said and the details given; and what is unsaid; as well as paying attention to non-verbal communications. For example, the person may tell you about a ‘bad’ husband or about being detained for a few days, but not share further details. Using their words in a gentle exploratory way can help the person to disclose more (e.g. “you said ‘bad’, I am wondering what you meant by that?” or “you told me you were detained for a few days – can you say more about that... or perhaps later?”
• **Take time:** Ensure you have sufficient time. Rushing questions to complete an interview can make the interviewee anxious, mistrustful of you and the interview process and can lead to an incomplete and poor quality interview. Rushing can also risk re-traumatising the interviewee, and appearing aggressive, uncaring and insensitive. Take time to establish trust and rapport, and an environment of safety throughout the interview. Record the time taken to conduct the assessment, and indicate, both to the person and in clinical records, that a further appointment may be required and explain why.

• **Recognise resilience and survival:** Sometimes a person may appear as if, and indeed be coping and functioning reasonably well. They may not appear to be overtly distressed, but composed and emotionally robust. It is important to acknowledge this, but not to assume that the absence of distress means they did not experience any rape, torture or other traumatic events. It is also important to acknowledge that not everyone will want to or feel able to talk easily and that some may want to tell their story, for others to hear and to validate the injustices they have experienced.

An important aspect of attending to the process of health assessments is first ensuring that an interpreter is available and second, considering the role of an interpreter, and how best to work with interpreters with clients who do not share the culture and language of the interviewer. It is essential that the interviewer is knowledgeable and appropriately skilled in conducting inter-cultural health assessments with people who may be highly vulnerable and who have experienced sexual violence or other torture.

Good practice in conducting health assessments with interpreters is summarised in Box 33.

**Box 33: Conducting health assessment with an interpreter**

- **Use professional face-to-face interpreting** wherever possible (never use children, family or friends to translate during assessments)
- **Ensure briefing time** with the interpreter before the assessment. This can help clarify terminology and words which may be slang, euphemisms or cultural metaphors (for example, in referring to rape or other sexual violence), expectations, the structure of assessment, cultural context and any considerations relating to differences in religion, ethnicity, gender etc. between interpreter and the interviewee
- **Ensure interpreter fully understands and adheres to ethical principles** in all their conduct, avoiding any harm to the client or family members
- **Use the same interpreter** during repeat assessment sessions with that person, wherever possible
- **Establish rapport** directly with the person being assessed, maintain culturally appropriate eye contact and address the person directly
- **Explain to the client the interpreter’s role and professional and ethical duties**, including the duty of confidentiality
- **Consider gender, age, ethnicity and other factors** (of interpreter and of interviewee) which may impact on the assessment
- **Respond promptly** to manage problematic communication (e.g. stop session, clarify expectations with interpreter and where necessary change interpreter).

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76 A survey of 32 health professionals, conducted by ICHHR, showed that the reasons most cited as constraining factors in conducting proper health assessments with asylum seeker/refugee survivors of rape or other sexual violence or torture, were lack of time (50%), lack of resources for an interpreter (20%), a lack of availability of appropriately qualified interpreters and lack of availability of female gender interpreters (28%) [Patel, N., Vara, R. & Khan, A. (2014). Survey of health professionals working with women survivors of rape or other sexual violence or torture. London: ICHHR].


78 For fuller discussion see supra note 23.
Given the range of factors which can hinder the interview process, sometimes it is inevitable that an assessment cannot be properly completed. An incomplete or poor quality assessment can compromise or prevent adequate legal protection (e.g. for a torture survivor) and/or health protection (e.g. a vulnerable young woman). Thus, it is essential that caution is taken in making health records and in providing clinical opinions or reports (see Box 34).

**Box 34: Good practice in incomplete assessments**

- **Acknowledge and record the factors which have constrained or compromised** the quality of the assessment: There may be many reasons why a health assessment could not be completed or conducted thoroughly, such as factors inhibiting the person from disclosing what has happened to them, factors related to the interview setting, the interpreter, or other factors. These must be recorded in the relevant health record and/or formal report.

- **State clearly when the assessment is incomplete** and specify the reasons why and outstanding areas for assessment.

- **State clearly that the clinical opinion is provisional, or not conclusive**. It is considered unethical to form a conclusive clinical judgement on whether someone is vulnerable, and/or whether the person is a survivor of torture or ill-treatment.

- **Make an honest clinical judgement about whether further appointments are needed** to ensure adequate time or a different setting where possible, to enable the establishment of trust and rapport, to ensure appropriate and a comprehensive assessment. Information about sexual violence, torture and other ill-treatment and the effects do not emerge spontaneously or in detail during initial assessments but, with time, a fuller assessment may be possible.

- **Recognising the limitations to competency**: Clearly state if further assessment appointments, or further assessment by another specialist, are necessary for a more comprehensive assessment, for example, when a psychological assessment could not be carried out within a medical examination or where the psychological aspects of the interview were very basic.

### 9.3 Managing distress during assessment

It is highly likely that a medical/physical and a psychological assessment with those who are survivors of sexual assault, sexual torture or other forms of torture or ill-treatment, and/or vulnerable will evoke distress. Common reactions and indications of distress during such assessments are summarised in Box 35, followed with suggestions for good practice in managing distress.

**Box 35: Common indications of distress during assessment**

- Heightened arousal (agitation, anxiety and fearfulness, irritability)
- Hypervigilance
- Intrusive phenomena (e.g. flashbacks/re-living aspects of a traumatic event)
- Avoidance
- Dissociation
- Sadness
- Tearfulness
- Silence
- Lapses in concentration
- Seizures
There are many indications that a person is distressed during an interview, and some may require more skilled assessment and management. More common indications are described below, with suggestions on how to manage distress.

- **Heightened arousal**

  Heightened arousal is common, particularly for those who are experiencing post-trauma stress. Physical and psychological assessments can evoke many painful and distressing memories, and lead to heightened arousal. Indications include sitting on edge, agitation, pressured and fast speech, physiological signs of acute anxiety (dilated pupils, shortness of breath, trembling, shaking, perspiration, dizziness etc.). Sometimes heightened arousal may be indicated by irritability, aggressive tone and posture, threats of or attempts at aggressive behaviour.

  - It is important to note these observations, without making the person feel more self-conscious.
  - It can help to acknowledge that they seem ‘on edge’, or that the interview experience seems very unsettling and uncomfortable for them.
  - Where appropriate, it is helpful to normalise these reactions, explaining that they are common when feeling anxious or afraid, and often also common for people who have experienced very difficult and frightening events.
  - Where appropriate, explain the fight, flight, freeze reaction and normalise these reactions.
  - Offer reassurance and reiterate the purpose of the interview and that you will try to go at the pace at which they can manage, and allow breaks if needed.
  - Give them the option of a break, to have a moment, or to take their time (where possible) in answering questions.
  - Ask more open-ended questions on areas which are less likely to be experienced as distressing, enabling the person to build trust.
  - Where appropriate, it is helpful to use guided breathing, to help the person become calmer and manage their anxiety levels.
  - Using grounding techniques can also help a person focus on the here-and-now and minimise and manage the heightened arousal (e.g. focusing on breathing for 10 seconds, focus on hands, how they feel, noticing an object in the room, focus on what it looks like, describing it, noticing a cup the person is holding, ask them to describe what it looks like, what it feels like (sensations) etc.

- **Agitation**

  A person may fidget or show other non-verbal responses to indicate distress, such as wringing their hands, tapping their feet, standing up, pacing, twitching, tics.

  - It is important to note these observations, and without making the person feel more self-conscious.
  - It can be helpful to acknowledge that the interview experience seems to be anxiety-provoking and uncomfortable for them.
  - Offer reassurance and reiterate the purpose of the interview and that you will try to go at the pace at which they can manage, and allow breaks if needed.

- **Anxiety and fearfulness**

  Anxiety is common, and sometimes there are visible indications, including shortness of breath, perspiration, sudden appearance of flushing or a rash, trembling, shaking, dizziness, agitation. For some, the anxiety may become acute and the person may appear very frightened and on edge.

  - It can be helpful to acknowledge how anxiety-provoking the interview experience may be for them, without making the person feel more self-conscious and anxious.
  - Offer reassurance, attending to the tone of your communication and body language, and reiterate the purpose of the interview and that you will try to go at the pace at which they can manage, and allow breaks if needed.
Ask more open-ended questions on areas which are less likely to be experienced as distressing, and on areas of strength and where the person may be functioning well, enabling the person to relax and build trust.

In some situations, it may be necessary to help the person focus on breathing exercises to manage their anxiety. Where anxiety levels and fear are heightened it may be useful to use grounding techniques to help them feel in the present (e.g. notice your feet on the ground, what it feels like, notice the weight of your legs in the chair, what it feels like, stamp your feet slowly from left to right, notice what it feels like... combined with guided breathing; and with statements to help them stay in the present, reminding them of where they are “you are in the office now, you are sitting with me, you are in a safe place in this room...”).

Hypervigilance

Hypervigilance refers to a state of alertness, as if in readiness for imminent danger. Interviews can evoke extreme fear and in some settings, such as in detention settings, a person may be very afraid of who might enter the room, where there may be any threat of harm, or being overheard. Common indications include constant looking around, or towards the door, or window, or sudden movement at any movement within sight (e.g. someone passing by, even when their shadow or only an outline is visible – from an opaque window/door), or any sound (e.g. door opening, creaking of floor, voices in the corridor or outside or nearby the room).

It can be helpful to acknowledge how anxiety-provoking the interview experience may be for them, without making the person feel more self-conscious and anxious.

Acknowledge if you notice that something (e.g. the sound of a door slamming, or the size of the room, or lack of natural light etc.) is making them feel uncomfortable or fearful.

Offer reassurance, attending to the tone of your communication and body language, and if necessary, make adjustments to the physical environment of the interview setting.

Ask open-ended questions on areas which are less likely to be experienced as distressing, and areas where they appear to be functioning well, enabling the person to relax and build trust.

Arrange meetings where possible, at times when the person is less likely to be faced with distressing and distracting noises etc.

Limit the length of the interview, and offer additional appointment times, to enable trust to be built and for the person to feel at more ease in the interview setting.

In some situations, it may be necessary to help the person focus on breathing exercises to manage their anxiety.

Intrusive phenomena

Intrusive phenomena are common features of post-traumatic stress reactions. They include what are more commonly referred to as ‘flashbacks’ – involuntary, intrusive memories, thoughts and feelings related to aspects of the trauma (e.g. memories of being beaten, or of being raped, images of the instruments used, or the smell of the perpetrators). These memories feel as if the person is ‘re-living’ their traumatic experiences. These memories can trigger physiological reactions of extreme anxiety and fear, and can make a person feel as if they are in the place and situation where they were tortured before.

These flashbacks can be triggered by any sound, smell, thought or feeling, or person, place or situation which reminds them of what they experienced. Particular questions, or the tone of voice of an interviewer, or style of questioning – can all trigger flashbacks, and hence it is not easy to predict during the interview process.

During interview, a person may show indications of re-living aspects of previous experiences of trauma. Signs of intense and sudden fear response, uncontrollable crying, screaming or movements as if they are trying to defend themselves or to get away, or shut out sounds, noises, voices or images may be seen. Sometimes a person may appear distracted or display rapid, involuntary eye movements.
- Ensure that there is trust and safety.
- Ensure that the setting is secure and experienced as therapeutic and non-threatening, which can help a person manage their feeling under threat.
- Ensure that the manner of interviewing is empathic, sensitive, respectful, gentle and that your communications are calm in tone.
- Ensure the interview proceeds only at a pace the person can manage, to help minimise the risk of triggering flashbacks or dissociation.
- Not pushing forth with the interview or line of questioning, when a person seems to be becoming distressed, but slowing down or taking a break if the person wants to, can help them feel more in control.
- When a person seems very tired or increasingly agitated, anxious or fearful, slow down the pace of questioning, observe carefully any indications of escalating distress.
- If a flashback is triggered, stop the questioning. Stay calm, with no sudden movements or questions.
- Help the person to ‘come back’ to the present – by gentle empathic statements reminding them where they are: “you are in [my office], it is [x place], we are sitting here together”.
- When the person seems calmer, do not rush to end the interview. Ask if they want close the interview, rearrange or take a break.
- Allow breaks if the person requires.
- If the person chooses to continue, move to more neutral areas of questioning, noting that you may have to return to what you were asking earlier, but another time – acknowledging that you recognise it has caused them considerable distress.
- Try to balance the need to obtain relevant information, with the need to listen to all verbal and non-verbal cues, and to not cause further distress and avoidable harm to the person. This is difficult, and it requires a clinical judgement on what the person can manage, and professional vigilance during the interview process which keeps central the humanity and dignity of the interviewee.

• Avoidance

Questions during medical or psychological assessments can evoke intense distress, and trigger intrusive phenomena. Sometimes, the interviewee may avoid answering a question, or give little detail, or simply not respond to open-ended questions, when they may be avoiding talking about anything that may trigger flashbacks and intense anxiety and fear.
- Acknowledging this is helpful in facilitating the process of interview, for example “it seems hard for you to answer that question, perhaps it’s making you anxious to have to think and talk about difficult experiences?”
- Where a person continues to avoid talking about certain topics which are key to your assessment, it is helpful to explain why you need to ask those questions and enable the person to set their own pace, which feels more comfortable.
- It is also important to note in their health records their psychological reactions and the topics/questions they found difficult to address.
- Attend to times when you may be avoiding asking particular questions, for fear that the person is also avoiding and not wanting to discuss sensitive or potentially distressing matters. A person may sense that you don’t want to hear, or that you are avoiding talking about a sensitive area, and they may seek cues to ascertain if you want to know, that you are willing to listen – or if they should simply not tell.
- Show openness and that you are willing to listen.

79 See also Istanbul Protocol, paras. 135, 149, 264.
• **Dissociation**

Involuntarily or unconsciously detaching oneself from a situation causing intense, overwhelming feelings can be seen as a functional defence – a way of coping by removing oneself psychologically from the situation which is causing distress. Interviewees may appear as if they have disengaged, as if they are not present in the room, they may stare into space, or at you, or at any fixed object, as if they cannot hear or see you. Interviewees often describe this as an out-of-body experience, “like for a moment, I’m not here, like my body was here but I was not” or as “being outside myself, looking down at myself”.

- It is helpful to slow down, and attend to the process in the interview, noting what was being asked or talked about in the interview when this happened.
- It is important to stop the questions.
- Take time to gently re-orientate and help the person be aware of their surroundings again, and being in the present moment. For example, saying “I’m not sure where you’ve gone, but I’m still here, take your time, look at your feet, your shoes, you are sitting down, look at your legs, your chair, notice your hands...” and so on and to re-orientate them in terms of time, day, location etc. “We’re in [an office], sitting together with me [your lawyer]... I’m here, take your time”.
- Grounding techniques can also be very useful, though usually they have to be taught unless already familiar to a person. Grounding techniques aim to help the person be in the here-and-now. For example, using objects (e.g. a stone, keys) or music which the person associates with the present, and which is associated with a feeling of being safe and calm. Other examples of grounding techniques include asking the person to name and list things they associate with the present. Facilitating a person to describe in detail and to make a mental note of a safe place or activity, which they can be reminded of when they are experiencing extreme distress or dissociating, can also be helpful.

• **Sadness and tearfulness**

Each person may present as being sad at different stages of an interview. The expression of sadness is culturally-mediated and influenced by gender and culture norms. Both medical and psychological assessments can evoke sadness, sometimes profound sadness and tearfulness during interview or examination.

- It is important to allow the person to express their sadness, and to cry, which is also a form of communication and may indicate more the person is remembering, or afraid to tell you.
- It is also important to not prematurely shut down such communication, for example, by hastily offering tissues, or water, without acknowledging the sadness, for example “what I’ve asked has made you very sad, perhaps it’s reminded you of something or someone...”.
- It is good practice to have tissues nearby, within sight and reach of the person, but not thrusting them at the person when they may be trying to compose themselves to speak more.
- Where appropriate, a gentle “there are tissues/water there if you want” may suffice.
- Use appropriate non-verbal communication (e.g. with an open posture, being attentive, maintaining eye contact but dimming the intensity of the gaze).
- Strike a balance between appearing empathic, interested, willing and able to hear more about distressing aspects of the person’s experiences, but not appearing intense, intrusive, threatening or voyeuristic.
- Acknowledge that the interview process is very difficult, ask “I am wondering what was it I said that made you particularly sad/distressed?”, encouraging the person to say, if they feel able.

• **Silence**

Sometimes a person may become silent, for long periods in the interview or examination. Silence can mean many things, including distress, feeling overwhelmed, fear, anxiety about what to say or what might be asked next, or what they may have to talk about but do not wish to recall or tell for fear of triggering flashbacks and further intense distress. Silence is a form of communication, and it is important to not rush to fill the vacuum, with more questions.
• Being attentive to the person’s presentation, their non-verbal cues. Listening with empathy and conveying compassion and concern can all facilitate trust and relationship-building, which in turn can facilitate the interview process.

• Sometimes, a gentle acknowledgement and encouragement may help, for example “perhaps all the questions I’m asking feel very overwhelming and upsetting…sometimes it’s hard to talk, when you may be feeling and perhaps remembering many things. Take your time, it’s all right.”

• The pressure of interview contexts may sometimes limit time, and feeling rushed and pressured can come across to the interviewee, adding to their anxiety and distress. In such situations, it is helpful to explain “I know this is very difficult for you, and unfortunately time is limited so it must feel like a lot of pressure. But it would help if I can understand your situation better, and if we could continue with the interview, if you feel able?”

• Sometimes it is important to acknowledge that silence is acceptable, and that even in their silence, the person is communicating something to you. It is helpful to allow periods of silence as they convey to the person who is silent, that you are able to be patient and willing to hear whatever they choose to share, when they feel able to share.

• **Lapses of concentration**
  
  Distress and exhaustion often leads to lapses of concentration during interview. The interviewee may seem distracted or as if they are not following or understanding your questions.

  • It can help to acknowledge this, and repeat questions where necessary.

  • Ask the person if they wish to take a break.

• **Seizures or other complications**
  
  Medical or psychological assessments can cause severe stress and, on rare occasions, this may trigger a seizure, which can be due to a number of causes, including organic brain damage as a result of head injury, epilepsy, or other medical causes or psychological stress. If a person has a seizure within the assessment/examination:

  • Move them away from anything that may cause injury, including furniture, medical equipment; cushion their head; loosen any tight clothing, especially clothing which restricts the airways. When the convulsions stop, turn them so that they are lying on their side. Note when the seizure starts and ends.

  • Contact emergency health care services if it is the first time a person has had a seizure; if the seizure lasts more than five minutes; or the person does not regain full consciousness; or has a series of seizures without regaining consciousness.

9.4 **Transference and countertransference**

Conducting a physical or psychological assessment can evoke many emotional responses, some unconscious and difficult for the interviewer and for the interviewee. These reactions can impact adversely on the interview process.

The Istanbul Protocol refers to potential transference and counter-transference, psychological terms for these emotional reactions, which may impact on the health assessment80.

**Transference** refers to “feelings a survivor has towards the clinician that relate to the past experiences but are misunderstood as directed towards the clinician personally [...]”81. For example, the interviewee may experience the interviewer as an authority figure and respond in the interview towards the interviewer in particular ways, related to their past experiences. They may experience the authority figure in a negative way, and feel as if they are being taunted, threatened, disbelieved, judged or interrogated.


81 Istanbul Protocol, para. 265.
They may experience the interviewer as a caring and protective parental figure, and relate to the interviewer in a compliant, submissive way as if needing their approval, reassurance, protection and comfort. They may experience the interviewer as their saviour, or ally. Others may experience the interviewer as being voyeuristic or punitive.

These feelings may have some bearing on the interviewer’s behaviour or manner, which requires some self-reflection and change in approach by the interviewer. Though, sometimes, these feelings may have no bearing at all on the interviewer, they are experienced by the interviewee as if the feelings relate to the interviewer. The interviewee may experience further fear, distress, disappointment and anger (e.g. if the interviewer is not able to ‘rescue’ them or to protect them), or shame and guilt. These feelings, including mistrust, fear, suspicion may then affect the interview process, and hence the quality of the assessment. Sometimes, the interviewee may respond to the interviewer with an expectation that they will (and should) ‘make things better’ for them, and experience deep hurt, a sense of betrayal and abandonment, or rage when this is not the case.

**Counter-transference** refers to the interviewer’s emotional responses to the interviewee, which can also impact adversely on the interview process and the quality of the assessment. There are many emotional responses interviewers may experience, as well as many reasons why they may not be aware of their own emotional responses. The reasons may be to do with the interviewer’s own personal history, previous experiences in their own life, patterns in their past relationships and ways of coping which also recur and influence current relationships and ways of relating to others.

Sometimes, exhaustion, being emotionally overwhelmed, stressed and traumatised by one’s work and hearing stories of horror over and over again, can also make one feel depleted and less able to notice and reflect on counter-transference reactions which arise during the interview process. Sometimes, interviewers may fear that the details of the person’s account or distress will create overwhelming distress and paralyse both the client and the interviewer, and can lead the interviewer to change the interview questions and direction, thereby signalling ‘stop’ to the person, as well as inhibiting any further disclosure.

“I think it’s important for us not to be fearful about what disclosure might be, or what people might say, because it’s not you, it’s not happening to you, it’s happened to the person [...] it’s the other person’s distress: it’s not your distress.”

Health professional

Feeling overwhelmed and helpless can make interviewers either prematurely shut down the interview, perhaps by ending it, by offering medication or referring the person to another colleague or mental health professional. This can be experienced by the client as a rejection, or as a signal ‘don’t tell me more, I don’t need to or want to hear it’.

“[Health professionals] putting barriers up, not wanting to see people who have been traumatised through [rape], and that’s how so often that the antidepressants are over-prescribed everywhere, because people think that if you don’t give something tangible, then I haven’t done anything. And a pill becomes a tangible thing. Makes them feel less helpless.”

Health professional

82 Istanbul Protocol, paras. 265 and 268.
83 Istanbul Protocol, para. 265.
Common feelings of being overwhelmed can lead to stress, irritation, helplessness and a limited capacity to hear a person’s story.

“This work, it’s really quite heart-breaking, it’s quite, you go out and you do your day job and a lot of the things that people are disclosing to you are beyond your imagination so it’s quite hard to just walk away and be able to forget about that [...] it doesn’t matter whether you’ve heard it once or whether you’ve heard it 100 times, it can be quite exhausting on you to hear such horrendous things a lot of the time [...] stress, stress and it’s not a job and topic you can that you can draw a line under and go home and get on with your day-to-day business and forget about the things that you’ve heard so it occupies your mind quite a lot [...] It’s horrendous the things that you listen to [...] so you do come away and think, a bit helpless I suppose because you can’t do anything about it apart from just trying your best to be there for somebody.”

Health professional

Examples of counter-transference reactions may include feeling guilt about what the interviewee experienced, and feeling angry or extreme outrage towards the torturers/perpetrators and angry at perceived betrayals and injustices experienced by the interviewee. Sometimes feelings of irritation or excessive rage can also be a response to an interviewee, which may be a defence reaction to being ‘made’ to feel guilty or overwhelmed by the interviewee’s story, for example, or a reaction in response to an earlier personal experience being evoked by listening to the account by the interviewee. Other reactions include withdrawal, emotional detachment and indifference towards the interviewee. Common reactions also include feelings of helplessness and hopelessness, and feelings of omnipotence, as if one is able to be heroic and ‘rescue’ or save the interviewee – from the cruelty of others.

All these emotional reactions are difficult to notice, reflect on and to admit to, and often lead to an embarrassment when the interviewee becomes aware of them, or anger if someone else points them out. Unfortunately, unexamined counter-transference can be deleterious to the interview process (see Box 36).

Unexamined counter-transference, alongside vast workload, long working hours, intense time pressures and deadlines which have a bearing on the safety and protection of human beings can take their toll. This, with the demands of hearing traumatic stories, can lead to emotional exhaustion and stress-related psychological and physical health problems. Where the professional context disallows the expression of role overload and role strain (when work demands outstrip resources), emotional distress and feelings of incompetence and lack of confidence, the negative impact of the health professional’s psychological responses is potentially higher, with the added risk of adverse consequences for the client, and the practitioner.

Box 36: Negative impact of counter-transference

- **Not seeing the interviewee as a person, a human being**
- **Not listening to the interviewee**
- **Being detached, disinterested and indifferent**, making the interviewee feel unsafe and mistrustful of the interview process
- **Not believing the interviewee**, being cynical, distant and critical, all counterproductive to developing empathy and compassionate and respectful communication
- **Over-critical and rigidly maintaining doubts** of malingering or embellishment by the interviewee, in the absence of sound evidence, or a thorough health assessment
- **Not paying attention to detail, forgetting details** given by the interviewee or not recording them, which can adversely impact on any legal and health protection processes as well as making the interviewee feel like a nuisance, irritant or worthless. This can also make the interviewee less likely to open up, to talk and to disclose difficult experiences such as rape
Not being able to complete a full health assessment which meets adequate standards, as specified by the Istanbul Protocol, because of indifference, critical judgement, anger, guilt and other uncomfortable feelings the interviewer has.

Minimising the account of the person, diminishing the gravity of what they say, making the interviewee feel judged, misunderstood or not understood.

Exaggerating the account of the person, inflating the gravity of what they say.

Not being able to complete a clinical opinion, or prepare adequate health records or a report where needed, perhaps due to above-mentioned emotional reactions, leading to adverse consequences for the interviewee — in terms of their safety and wellbeing.

Key questions to ask:

• What do we, as health professionals, bring to the interview process?
  What are our own personal histories and our emotional reactions of hope/hopelessness, anger, omnipotence, desire to save/rescue others and to be a ‘saviour’, cynicism etc.?

• What does client bring to the interview process?
  Fears and experiences from past relationships and experiences. These can lead to them feeling as if interrogated, abused again, disempowered, disbelieved. They may see you as a saviour, protector or sadistic, voyeuristic, judgemental, diminishing and patronising, for example.

• How does this influence how we feel and interact with detainees?
  Am I switching off, not really listening to this person. Is it hard to concentrate for me, and to take a story? Why am I irritable with this person, not really able to be empathic with them? Am I being irritable, angry and dismissive with the client? What is the reason for me being disbelieving? What is it stopping me from listening to them?

• How does this impact on the ability to carry out your work?
  How is this affecting the interview process? How is it impacting on the assessment, and my clinical opinion?

Good practice includes:

• Understanding transference and counter-transference.

• Being aware of transference and counter-transference, and different ways they may arise and manifest.

• Self-reflection and attending to the psychological dynamics in the relationship between the interviewer and the interviewee, during the assessment.

• Scrutinising the interview process and outcome, reflecting on how the psychological dynamics of transference and counter-transference may have compromised the assessment.

• Using peer support or formal clinical supervision to reflect on these dynamics, to facilitate your own professional and personal development.

• Identify personal support, professional supervision or personal, formal counselling or therapy that may be beneficial to you and to your work with those who have experienced sexual or other torture or ill-treatment.
10. Forming a Clinical Opinion

Forming a clinical opinion based on a health assessment is a complex process which requires clinical competency and a sound understanding of a number of key factors (summarised in Box 37).

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rationale</th>
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| **Understanding nature, purpose and context of rape, sexual or other torture for the particular client** | To understand the specific health consequences of specific forms of torture such as rape, sexual threats, humiliation and degradation – and what it means to the person, in their particular context.  
To understand the health impact of rape, sexual and other torture in combination with other forms of torture and conditions of detention and in the context of the pre-existing health problems.  
To interpret the findings/outcome of a physical or psychological assessment, or both, in combination where necessary.  
To ensure that an opinion can be made on the consistency between the findings/outcome of the assessment and the account of the experiences reported by the client. |
| **Understanding the context in which the clinical opinion is sought and by whom** | To ensure clarity on the clinical and legal obligations of the health professional in forming their clinical opinion.  
To ensure that where a clinical opinion is required to ensure appropriate health and social care for the client that this is properly noted in clinical records and appropriate referrals are made as a duty of care to the client (see Section 11).  
To ensure that where a clinical opinion is required for the purposes of preparing formal documentation (medico-legal report) to inform decision-making process (asylum or other jurisdictions) that it is clear that the duty of the expert witness is to the court. |
| **Understanding the importance of the UN Istanbul Protocol for the identification, assessment and documentation of torture** | To ensure that the clinical opinion and the assessment on which it is based meet international standards. |

The process of interpreting physical and/or psychological information established in health assessments is a complex task requiring not just knowledge of different types of torture, including rape and other sexual torture, and their impact, but an understanding of the social, cultural and political context of torture.

The overall aim of both physical and psychological health assessment is:

- To form a clinical opinion based on an assessment of the health needs and concerns of the person; on priorities; and on the evidence of rape or other sexual violence or torture in light of the account given by the person.\(^85\)

When a more formal assessment is required, as in situations where medico-legal reports are required:

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85 Istanbul Protocol, para. 261.
86 See also key aims of a health assessment, Section 5.
- The overall aim of a **physical health assessment** is to "assess the degree of consistency between an individual’s account of torture and the physical findings during the course of the evaluation"\(^\text{87}\);
- The overall aim of a **psychological health assessment** is to "assess the degree of consistency between an individual’s account of torture and the psychological findings during the course of the evaluation"\(^\text{88}\).

### 10.1 Clinical opinion based on outcome of physical assessment

The clinical opinion is formed from all the information gathered in the history and examination, including past medical history and current health concerns. The primary aim is to arrive at a thorough assessment of the person’s present health care needs, a summary considering their relative urgency, and recommendations for further investigations, referrals and treatment. Secondarily, there may be a specific need to communicate the opinion beyond health care, for example, to the client’s legal representative, where requested to do so and where consent has been given by the client.

The clinical opinion should consider\(^\text{89}\):

- If the physical and psychological findings are consistent with the report of the experiences reported by the person, which may include rape, other sexual violence or torture
- What physical conditions contribute to the clinical picture
- If the clinical picture suggests a false allegation (e.g. of rape or torture), where relevant to consider for a medico-legal report.

Key factors to consider in forming a medical opinion are shown in Figure 5 and outlined in Box 38.

![Figure 5. Factors to consider in forming a physical health/medical opinion](image-url)

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\(^{87}\) Istanbul Protocol, para. 261.
\(^{88}\) Istanbul Protocol, para. 261.
\(^{89}\) Istanbul Protocol, para. 105.
Where the legal representative has asked specific questions, such as the impact of return to their home country or of homelessness on their health conditions, these should be addressed in the opinion within the assessor’s expertise and experience, and the assessor should indicate any health issues that lie outside their competence for the purpose of giving such an opinion.

**Box 38: Factors to consider in forming a medical opinion**

- Note the past medical history
- Trauma history – the more detailed the history of events obtained, the easier it will be to make sense of the examination findings and to address all health needs
- The history of the specific sexual violence or other torture or other traumatic experiences, and how they link to current symptoms, psychological conditions and examination findings
- Current physical health: Note that the person’s immediate health condition may impinge on the quality of your assessment: are they currently very distressed, in a lot of pain, had no sleep the night before or had a long journey, have they missed a meal, are they concerned about childcare and the time this assessment has taken?
- Any physical evidence of rape, or other sexual violence or torture
- Medication – including ability to access medication, compliance and side effects
- The role, skill and experience of the interpreter can influence the relationship with the client – the impact of which on the assessment must be considered in the opinion
- The exact form and detail of the clinical opinion will depend on the context and purpose for which it is intended. If a medico-legal report is required, close attention to specific aspects as per the Istanbul Protocol will be required, particularly with reference to consideration of other possible causes of the physical lesions found and their relative likelihood and the possibility of exaggeration or fabrication of the physical evidence.

**Key questions to ask:**

- What current priorities in terms of health care needs and concerns can be identified?
- What are likely explanations for the health needs and concerns identified in the health assessment?
- Are past injuries, lifestyle (e.g. work or sports) or medical history pertinent to current injuries or health care concerns?
- Have I discussed with the client my opinion?

**Good practice includes:**

Writing clinical opinions which:

- Explain the context of assessment
- Explain if an interpreter was used and any problems encountered
- State where the assessment is incomplete and why, especially if the person did not consent to an intimate physical examination
- Address the degree of consistency between findings and account given
- Provide a narrative of the experiences and the course of any clinical conditions identified, including for example treatment accessed in the acute phase and currently

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90 Not all torture, including sexual violence, leaves physical evidence and lack of this cannot be taken to mean that torture or sexual violence did not occur [see Istanbul Protocol, para. 16].

91 See Section 9.1.

92 Istanbul Protocol, para. 191.

93 Istanbul Protocol, para. 105(f).
• Consider the impact of conditions such as head injury and psychological conditions on memory and other cognitive functions
• Summarise findings with diagnoses or differential diagnoses where possible, but recognise that not all survivors will have a specific diagnosis, especially for the psychological impact of their experiences^4
• Review the risk assessment, addressing any risks of harm to the person themselves or others; if there are child protection issues; if the person or someone with whom they live is a vulnerable adult with safeguarding issues^5
• Recognise that the ethical duty in the provision of a clinical opinion is to ensure informed consent was taken from the client; that confidentiality is adhered to (subject to statutory obligations to disclose without consent in the event of risk); that no harm is done to the client; and that clinical opinion is provided within the limitations of one’s professional competency
• Recognise that the professional duty of health care professionals in providing a clinical opinion is to ensure the safety and wellbeing of clients^6
• Recognise that in the provision of a clinical opinion for medico-legal reports the legal duty of the health professional is to the court
• Summarise and explain your clinical opinion to the client
• Avoid jargon, or when technical terms are used ensure they are explained
• Check with the client if they have any questions or wish to add anything
• Discuss implications of the clinical opinion, including any recommendations for further assessment, investigation, specialist evaluation and care and follow-up as necessary^7
• Record your clinical opinion and justifications, storing information according to best practice and statutory regulations regarding data protection
• Ensure that written communications of the clinical opinion are appropriate in terms of the detail they contain for the recipient: bear in mind the specific consent of the person who may for example not wish a particular recipient to know all aspects of their experiences in a letter, due to fears about confidentiality, preferring when they feel able to tell them in person^8.

10.2 Clinical opinion based on outcome of psychological assessment

Understanding the psychological impact of rape and other sexual violence or other torture is complex because such violence affects people in different ways. The psychological impact can be immediate and long-term, affecting all aspects of wellbeing, such as physical health, emotional health, social functioning, interpersonal relationships and existential beliefs. The psychological impact may also be at different levels of the individual, their relationships and family, their community and society at large^9.

However, not all survivors will suffer enduring psychological health problems. Some may suffer chronic and debilitating psychological problems; others may suffer in many ways, but never present as having psychological problems or come to the attention of professional services. For some, the impact may be intense and far-reaching in terms of other family members; for others, their silence may serve to isolate them, and maintain a secret, which in itself may have severe health consequences.

^4 See Section 10.2 on clinical opinion based on outcome of psychological assessment.
^5 See Section 8.4 on risk assessment.
^6 See Section 11 on duty of care and follow-up.
^7 See Section 11.
^8 See Section 11.
Key questions:

- **Can we predict the psychological response to rape or other sexual violence or torture?**

  It is impossible to predict the impact of rape or other sexual violence or torture on a person and on their family members. The reasons for this are complex, and relate to the various factors which mediate the impact of torture, the disclosure of rape and other torture, and the presentation of psychological distress (see summary in Box 22 and Box 31).

- **What are the implications for a clinical opinion of non-disclosure of rape or other torture or the absence of physical or psychological evidence?**

  The absence of disclosure of rape or other sexual violence or torture or the absence of evidence of psychological difficulties or specific symptoms should not be taken to mean that the person has not experienced torture. This is well-established in the United Nations Istanbul Protocol\(^{100}\) and in the literature\(^{101}\).

  There are many reasons why a person may not disclose rape or other sexual violence or torture\(^{102}\). These reasons need careful consideration in interpreting the outcome of a psychological assessment and careful explication in forming and stating a clinical opinion. It is important to not dismiss presenting psychological difficulties as general distress, or to dismiss the absence of psychological difficulties as indicating that nothing has happened to the person, just because the person has not disclosed what happened, or fully explained what they experienced. A clinical opinion must be based on a full assessment and consideration of all relevant factors.

  It is also important to not dismiss as fabrication, embellishment or exaggeration any account given in an assessment of what happened, without careful analysis of all available information and an understanding of the reasons and context which may dictate what a person chooses to tell you or others, or what they can recall, or not\(^{103}\).

- **Can we adequately capture the impact of rape or other sexual violence and torture in psychiatric diagnoses?**

  It is impossible, as well as theoretically and ethically deeply problematic, to attempt to capture the impact of rape or other sexual violence and torture in the reductionist use of psychiatric diagnoses. The over-reliance and use of psychiatric diagnoses as a simplistic way of representing the nature, severity and complexity of psychological health problems experienced by survivors has been criticised in many ways. In particular, the use of psychiatric diagnoses, such as post-traumatic stress disorder, has come under increasing scrutiny and critique over the last two decades, particularly for individualising, medicalising or psychologising the sociopolitical problem of torture\(^{104}\), including rape, and for their cultural specificity and Eurocentric biases.

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100 Istanbul Protocol, paras. 236, 289.
101 For example, see Peel (2007) at supra note 7.
102 See Section 9, Box 31.
103 Ibid.
The theoretical, scientific and ethical basis of psychiatric diagnoses has also been rigorously critiqued with growing recognition of their limitations and their being scientifically inadequate. The range of traumatic experiences which many asylum seeker and refugee survivors of rape and other torture endure in the countries in which they seek refuge can also impact on their psychological difficulties. A narrow use of and reliance on psychiatric diagnoses can ignore the role of such experiences as discrimination which may involve verbal and physical abuse and violence, poverty, homelessness or poor housing, inadequate or no welfare, legal and other support, the absence of social networks, the lack of permission to work, to be productive and to look forward to re-building a life. All these factors can impact on psychological wellbeing of survivors and all require careful and thorough assessment and interpretation.

- **How can the diversity and complexity of psychological presentations be explained?**

  The diversity of psychological responses, difficulties and their presentation depend partly on the events themselves – the nature, frequency, severity and duration of rape or other sexual violence or torture. These are further discussed below:

  (a) **Nature of violence**

  - **Rape** is a violent act in its own right, but the way in which a person is raped may impact on the particular health consequences for each person. For example, rape can be penile or with an object (such as truncheon, stick, broken glass bottle); it can be anal, vaginal or oral. The psychological impact depends not just on the nature of the act, but the way in which the person psychologically interprets this violence, and the physical pain, injuries, debility and physical health consequences.

  For example, a woman may believe that as a result of rape her womb is permanently damaged and that she may never conceive. In some situations the physical injuries as a result of rape may mean this, but not always. The psychological impact of being violated is compounded by a sense of being permanently damaged and robbed of a future – a future to have a family, to find a partner, to function in everyday life.

  For women who are infected, for example, learning that they are HIV positive as a result of rape, the sense of injury can be profound and enduring.

  "He told me when he finished raping me that he had infected me and given me something to remember him by [...]. He told me that I will never forget this, every time I have pain, I am ill, that I will remember this [...] he did not want me to live, but wanted me to live like a dead person alive, waiting to die". Survivor

  - **Sexual torture other than rape** may include electric shock applied to genital areas, burns, cutting and other harm inflicted to genital areas and breasts. All these can have specific health impact, physically and psychologically.

  For example, being burned with cigarette burns or branded by an iron rod on a woman’s breasts may have specific meaning to the person, leaving her feeling damaged, married and violated; whilst also serving as a signal to other men, that she has been sexually violated. Being scarred and branded in this way

can induce intense and unbearable shame, self-disgust and guilt, all of which can impede disclosure, not only to the health professional, but also to legal professionals and other authority figures, family members and partners/spouses. Evidence of such sexual torture can also adversely impact on intimate partner relations for fear of ‘being found out’ and subsequent relationship/marital discord, separation or violence. All such considerations need to be taken into account and carefully explained in a clinical opinion.

- **Sexual degradation, threats and verbal abuse** often used in combination with the above violence can also have particular health implications, often intensifying vulnerability, fear, shame, humiliation and feelings of being degraded.

For example, forced nudity and being held or tied in positions where the woman feels exposed, degraded and highly vulnerable can cause intense distress and unbearable fear and shame. Sometimes women are stripped naked and/or raped in front of their children or family members, which can also lead to profound consequences in family relationships subsequently, leading to secrets, collective shame, confusion, blame, counter-blame and guilt.

Rape and other torture can be accompanied by threats that they will be killed, or that the relatives of the woman, or her children, will also be raped or harmed in other ways – all of which can also intensify the woman’s sense of vulnerability and the fear of impending or imminent death.

- **Combination of acts**

The specific combination of the acts of rape, sexual violence or other forms of torture which are used in combination can have a unique impact on each person’s health.

For example, rape and other sexual violence may be one of many other forms of torture to which a woman is subjected, including beatings, solitary confinement, sleep deprivation and deprivation of sanitary supplies, food and fluids. Additionally, the conditions in which she is held may also have a bearing on the health impact, for example, where she is held in overcrowded conditions, with poor sanitation, poor ventilation, damp and cold cells etc.

The multiplicity of the acts of rape or other torture and ill-treatment, including the conditions and context of this violence can all have a profound and complex impact, unique to each person.

- **Frequency**

The number of periods of detention, and the number and frequency of rape or other sexual violence and torture can impact on different people in different ways.

The repeated acts of violence can reinforce the belief that the person has no control over what happens to them and that they cannot ever be safe or protect themselves, or be protected, from harm. This can lead to helplessness, emotional and physical exhaustion and despair and a pervasive feeling of having loss of control and no agency in their lives. They may feel hopeless, believing that nothing or no one can help and that there is nothing to gain from telling partially or fully what happened to them.

Some women may have been subjected to rape in different periods of detention, or in the context of armed conflict. Some may then be subjected to violence, including rape by those who purport to ensure them safe passage. They may suffer intimate partner violence or other violence within the family. The impact of each of these experiences may differ, depending on the circumstances and context of each, leading to what has been described as sequential traumatisation,106 where each ‘episode’ or traumatic experience can be understood within its own distinct historical period, with its unique contextual features and phases defining and shaping the nature of each specific trauma for the person.

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Furthermore, several experiences of rape, multiple rape or other sexual violence or torture can be understood in terms of the cumulative psychological impact of these.

For example, a woman may come to believe that she is a ‘bad person’, or ‘cursed’ or ‘spoilt’ which is why she is subjected again and again to such violence. Her beliefs may contribute to the way in which she responds psychologically and on whether she chooses to disclose all the events, or just one or two, or none, to family members, a health or other professional or authority figure. Living with the constant threat of further harm can also prevent the person from beginning any recovery process, or from trusting others.

- **Duration**
  The duration of the period of detention, and harm, can also have a particular impact on each person. Duration applies not just to the period of detention and assault, but also the course of time during which a person may experience multiple, repeated and prolonged harm and be exposed to constant threat.

  For example, some women may have experienced multiple rapes over many months in detention or captivity, some may have subsequently also experienced repeated domestic violence over a period of time. Some women may experience further sexual assault, exploitation and harm, for example by an agent supposedly helping them to escape. Other women may also experience further exploitation and sexual assault in the country where they have sought asylum.

- **(b) Meaning-making**
  The psychological impact of rape and other sexual violence or torture depends on the subjective psychological appraisal of those experiences. The way in which people make meaning in relation to such experiences is crucial to understanding the significance of what and how a person presents psychologically in an assessment. Understanding the nature and process of meaning-making for each person is then central to interpreting information obtained in an assessment and to forming a clinical opinion.

  Many factors influence the process of meaning-making (see Figure 6). For example, the nature and context of torture (outlined above), as well as belief systems, previous significant experiences, personal and collective histories and the current context, all addressed subsequently, influence how a person makes sense of what has happened to them. As such, no act, event or behaviour will necessarily have the same impact on different individuals, families or communities.
Figure 6. Influences on meaning-making

- **Cultural, religious and political belief systems**
  The process of psychological appraisal and giving meaning to these experiences varies with each person, who may draw on a range of meaning-making and belief systems. These include cultural, religious and political belief systems.

- **Previous significant experiences**
  Other factors may contribute to meaning-making, such as a person’s previous significant life events, experiences of abuse, violence, losses etc.

  For example, a woman who has experienced child sexual abuse earlier in her life, and/or a violent adult relationship, may appraise the experience of rape as further punishment, or as ‘deserved’ because she sees herself as worthless.

- **Collective meaning-making**
  The person’s family history (see below) may influence how a family collectively makes meaning of the experience of rape or other sexual torture of a family member. For example, a family where the parents were forced to witness their young adult daughter being raped and tortured may themselves be deeply distraught at the experience and they may believe that the shame and dishonour is brought not just on their daughter, but on the whole family. For a family whose cultural and religious background may lead

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them to believe that the honour of a family resides in the virtue and ‘purity’ of the body of their daughter, the rape can be experienced as an assault on the whole family’s honour, on the ability of parents to protect their children, and an assault on the future prospects of marriage and forming a new family by the daughter. In such a situation, the rape may come to be understood as a weapon aimed at the whole family, and the impact as collective trauma experienced by all (or some) family members. The family’s need to protect one another from this being known more widely in the extended family and in the community may then become a collective secret, and suffering, each colluding to not disclose what happened in order to protect one another from the psychological and social consequences which arise from their cultural meaning-making belief system.

Individuals and families who share a history of persecution, violence, conflict, marginalisation and torture against their community (e.g. people from ethnic or religious minority backgrounds) may have a way to make meaning of their suffering collectively. It may be that acts of rape and sexual violence aimed at women and girls from their community are understood as political weapons of terror, subjugation and control. Such collective-meaning-making can both help and hinder a woman from disclosing what happened to her, for example to a health professional. For example, a woman whose political activities and beliefs are shared within her community may be less able to express her psychological distress, fearing that this would be somehow a betrayal of her community, or reflect a weakness in her as an individual. Her way of making sense of her experiences may lead her to say very little about what happened, or to appear dismissive, flat or un-emotive in her presentation. Understanding her way of making sense of her experiences, in the context of her community and collective-meaning-making beliefs (e.g. political) would then be extremely important in developing a clinical opinion.

**Creativity and survival**

For some, the urge to seek meaning through creative methods can mediate the impact and presentation (or absence of) psychological distress. For example, an artist, poet or writer may use their creative resources and skills to make sense of what has happened to them, and to transform meanings in a way which makes it bearable, and enables them to be resilient. Similarly, those who use entrepreneurial skills and beliefs may also be able to transform their suffering into forming new enterprises, businesses and building meaning into their life, with a vision, hope, determination and investment in a life beyond rape and violence. They may give an account of rape, but not necessarily present as psychologically deeply troubled by this experience – which does not mean the account is untrue, nor that the person has not suffered, or is not suffering.

What may appear to be an absence of psychological suffering and visible signs of distress, may be masked or balanced by a drive to survive, through whatever means available. Survival must then be recognised for its multifaceted nature, a combination of pain and suffering, with hope and endurance.

The way the person draws on personal resources and their own meaning-making systems and creativity is essential to forming a clinical opinion and extremely important to explain in the opinion.

(c) Pre-torture history

- **The person’s previous life experiences** of rape, sexual violence, previous torture, detention and different significant life events and traumatic experiences can all impact on their psychological distress and presentation. These earlier experiences may also be psychologically unresolved and can re-emerge, intensifying the impact of the more recent distressing life events and experiences of violence.

- **The person’s previous ways of coping** can also influence how the person is able to cope with the recent life events and experiences of rape or other violence or torture. Some people may have developed many internal and social resources to cope with life’s adversities and with previous experiences of rape or other torture, whilst others may have struggled to cope throughout their lives. Some may have used their religious beliefs to cope with hardship and previous traumatic life experiences. Some may have used their political beliefs, activities and networks to anticipate violence and to develop ways to withstand torture. However, some of those ways of coping may no
longer feel enough and the last act of rape, or other torture, may be the ‘straw that broke the camel’s back’. How a person makes sense of how they have previously coped and how they feel they are coping or not now and why, is crucial to address in forming a clinical opinion.

- **Any experiences of earlier psychological or psychiatric problems** are also important to consider in forming a clinical opinion about their current psychological health and vulnerability, and on the consistency of the current presentation with the account of rape or other sexual violence or torture. Earlier psychological problems and how the person coped with them, if and what nature of treatment or care they had and response to treatment may all help in the formulation of the reasons for the current psychological difficulties. Carefully delineating other factors and pre-existing or ongoing health difficulties which may account partly or wholly for the current distress is also important.

Again, it is crucial to remember that the absence of psychological difficulties cannot be assumed to indicate that rape or other sexual violence or torture did not take place. Additionally, the psychological distress evident in an assessment may be partly related to other significant life events or traumatic experiences, and/or to a prior history of psychological or psychiatric difficulties. A clinical opinion would seek to address the relative significance of all these issues for each person.

**(d) Post-torture history**

- **The experiences following** rape or other sexual violence or torture are significant to understanding the impact and presenting psychological difficulties. A clinical opinion should consider what happened after the rape or other torture and whether the person was released, left somewhere to fend for themselves, whether they were detained for further periods. It is also important to understand if any medical care was provided in or after detention, and how the person was treated and if they were returned to detention to face further harm and abuse.

- **Ongoing separation** from loved ones, including one’s children or partner, or hearing of the loss or rape of another family member or friend, can all impact on how the person coped or deteriorated and why.

**(e) Age and developmental history**

- The impact of rape or other sexual violence or torture can vary according to the person’s age at the time or the period during which they experienced these acts, and their previous developmental history.

- For example, a young woman with mild learning difficulties who, when she was 16 years old witnessed her mother being raped and killed, and was then herself raped, may give a partial account of what happened and present her distress to a health professional in a particular way. The health professional may assume that as the woman is in her early twenties, her inability to recount what happened in any detail, or to present clear dates of what happened when, casts doubt on the veracity of what she says happened. The health professional may assume that her uncontrollable sobbing and calling out for her mother during the assessment are exaggerated or pretence. The impact of her experiences may have profound consequences for her emotional development and the development of her sexuality as a young woman, possibly contributing to her difficulty in trusting adults or, in particular, male adults.

An assessment and interpretation of presenting psychological difficulties in the context of the person’s developmental history and the age at which they experienced rape or other sexual or torture is important in forming a clinical opinion.

**(f) Cultural context and health presentation**

- **Culture influences how a person and family members:**
  - Make sense of their experiences;
  - Express their difficulties or not;
  - Choose language, idioms, metaphors and words to refer to their distress or experiences (e.g. rape);
  - Present to health or legal professionals and authority figures; and
Disclose or choose to omit in recounting the extent and detail of their experiences;
Respond to stigma within their own communities related to rape, sexual violence, mental health
problems, pregnancies as a result of rape, and sexual health problems.

All these factors need to be carefully explored in an assessment and considered in a clinical opinion.

- **The importance of intersectionality:** The different axes along which a person may be disadvantaged
  (e.g. gender, age, class, religion, disability) and which contribute to power imbalances and dynamics
  between the health professional, and interpreter where present, and the client, in an assessment can
  influence what is said or not, and how. This must also be considered in a clinical opinion.

For example, a woman in her 50s who is interviewed by a young male health professional and a young
female interpreter who speaks her language (but not as a mother tongue, and who is from a different
and cultural background from that of the client) creates a unique situation and dynamics. The
client may feel able to speak very frankly about what happened to her, but may edit some of the detail,
unconsciously wishing to protect the interpreter, concerned that she may not understand, or may find the
detail too graphic, distressing or embarrassing.

108 Statement of Louise Arbour, UN High Commissioner for Human Rights, 8th Session of the Human Rights Council, Meeting on the
For women, this context of inequalities and discrimination provides a backdrop and context within which to understand the use of gender-specific torture (e.g. rape, burns or cuts on breasts, sexual threats) and its impact on the woman. It also provides a background to understand aspects of the current context, for example in a country where the person is seeking asylum, where women and girls may experience covert and intentional or unintentional discrimination and prejudices in health and legal systems where they seek support and protection.

**Good practice includes:**

- Explaining the context of assessment (e.g. why the assessment was conducted, and in what setting – if in detention, hospital, unsafe conditions etc.)
- Explain if an interpreter was used to conduct the assessment and explain, where relevant, if/how this influenced the assessment on which the clinical opinion is based
- In forming a psychological opinion based on an assessment, it is essential to carefully consider and evaluate the different factors and considerations which mediate how a person responds to and manages the impact of rape or other sexual violence and torture and how they present psychologically (see Box 39)
- Noting in clinical records and in a clinical opinion when an assessment is incomplete, with reasons provided. It is essential that a conclusive opinion based on a partial assessment is avoided
- Ensuring that the clinical opinion addresses the information obtained in the psychological assessment and the degree of consistency between an individual’s account of what happened to them (e.g. rape, sexual violence, torture) and the psychological assessment findings
- Providing a narrative of the experiences reported by the person
- Explaining the course of psychological difficulties and ways of coping, and reasons where possible – in context. Explaining the social, cultural, political, linguistic and current context, as relevant to each person
- Identifying and explaining co-existing stressors (e.g. ongoing persecution, forced migration, exile, loss of family and social role, poverty etc.) and their impact on current psychological distress
- Explaining the consistency or inconsistency in the narrative of the client, where possible, drawing on understanding of factors which impact on disclosure, including factors contributing to the impairment of memory, particularly where these contribute to any apparent lack of congruence between the account given to different people
- Avoiding jargon, or when technical terms are used to ensure they are explained
- Provide a psychological formulation as a basis for a clinical opinion, not as a summary but to provide explanations and comment on consistency between all assessment information and the account of rape, sexual violence or other torture and coherence
- Avoiding providing psychiatric diagnoses as an apparent summary or crude substitute for a psychological formulation and considered clinical opinion
- Providing recommendations for further assessment and/or care for the individual where deemed necessary
- Recognising in the provision of a clinical opinion that the legal duty of the health professional is to the court
- Recognising that the ethical duty in the provision of a clinical opinion is ensure informed consent was taken from the client; that confidentiality is adhered to (subject to statutory obligations to disclose without consent in the event of risk); that no harm is done to the client; and that clinical opinion is provided within the limitations of one’s professional competency
- Recognising the professional duty of health care professionals in providing a clinical opinion is to ensure the safety and wellbeing of clients.

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110 See Section 9, Box 31.
111 Istanbul Protocol para. 261.
### Box 39: Forming a clinical opinion: Summary of factors to consider

<table>
<thead>
<tr>
<th>Relevant factors/considerations</th>
<th>How is this relevant?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. The nature of torture and detention(s)</strong></td>
<td><strong>Rape, sexual violence, sexual threats and verbal abuse:</strong></td>
</tr>
<tr>
<td></td>
<td>- Rape is a violent act in its own right, but the way in which a person is raped may impact on the particular health consequences for each person</td>
</tr>
<tr>
<td></td>
<td>- Sexual torture other than rape may include electric shock applied to genital areas, burns, cutting and other harm inflicted to genital areas and breasts. All these can have specific health impacts, physically and psychologically</td>
</tr>
<tr>
<td></td>
<td>- Sexual threats and verbal abuse often used in combination with the above violence can intensify sense of vulnerability, fear, shame, humiliation and feelings of being degraded.</td>
</tr>
<tr>
<td></td>
<td><strong>Combination of acts of torture</strong></td>
</tr>
<tr>
<td></td>
<td>- Additional methods of torture used alongside any of the above, and the specific combination, can have a bearing on the unique health consequences for the person.</td>
</tr>
<tr>
<td></td>
<td><strong>Frequency</strong></td>
</tr>
<tr>
<td></td>
<td>- The number of periods of detention, and the number and frequency of rape or other sexual violence and torture, can impact on different people in different ways</td>
</tr>
<tr>
<td></td>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td></td>
<td>- The duration of the period of detention, and harm, can also have a particular impact on each person. Duration applies not just to the period of detention and assault, but also the course of time during which a person may experience multiple, repeated and prolonged harm.</td>
</tr>
<tr>
<td></td>
<td><strong>Nature and conditions of detention(s)</strong></td>
</tr>
<tr>
<td></td>
<td>- Circumstances of detention, dates, location, type of detention facility, duration</td>
</tr>
<tr>
<td></td>
<td>- Conditions (lighting, windows, ventilation, access to toilet, bedding, food, water etc.)</td>
</tr>
<tr>
<td></td>
<td>- Detailed account of client’s experiences of detention and their beliefs about why they were detained.</td>
</tr>
<tr>
<td><strong>2. Meaning-making</strong></td>
<td><strong>Cultural, religious and political belief systems</strong></td>
</tr>
<tr>
<td></td>
<td>- Cultural, religious and political belief systems can all influence the way a person makes sense of their experience(s) of rape or other sexual violence or torture; and this can influence their psychological difficulties.</td>
</tr>
<tr>
<td></td>
<td><strong>Previous significant experiences</strong></td>
</tr>
<tr>
<td></td>
<td>- Previous significant life events, experiences of abuse, violence, losses etc. can also influence meaning-making and thereby influence the psychological difficulties.</td>
</tr>
<tr>
<td></td>
<td><strong>Collective meaning-making</strong></td>
</tr>
<tr>
<td></td>
<td>- Collective meaning-making by a family, or a community, can influence how a person responds to rape or other sexual violence or torture and the way they present their psychological difficulties or whether they choose to not disclose fully what happened to them.</td>
</tr>
<tr>
<td></td>
<td><strong>Creativity and survival</strong></td>
</tr>
<tr>
<td></td>
<td>- Creativity in ways of coping, resilience and different ways in which people survive may be misunderstood as fabrication or embellishment of the account of rape or other sexual violence or torture.</td>
</tr>
</tbody>
</table>
### 3. Pre-torture history
- The person’s previous experience of rape, sexual violence, previous torture, detention and different significant life events and traumatic experiences can all impact on their psychological distress and presentation.
- The person’s previous ways of coping and related belief systems.
- Experiences of earlier psychological or psychiatric problems, and ways of coping and previous care or treatment, are also important considerations in forming a clinical opinion about their current psychological health and vulnerability; and on the consistency of the current presentation with the account of rape or other sexual violence or torture.

### 4. Post-torture history
- The experiences following rape or other sexual violence or torture (including further harm, hardship, medical or psychological treatment) are significant to understanding the impact and presenting psychological difficulties.

### 5. Age and developmental history
- The impact of rape or other sexual violence or torture can vary according to the person’s age at the time or the period during which they experienced these acts, and their previous developmental history.

### 6. Health presentation and cultural context
- Health presentation and current health difficulties.
- Culture influences how a person makes sense of their experiences; how they express their difficulties or not; how they present to health or legal professionals and authority figures; and the extent to which and what details they disclose or choose to omit in recounting their experiences; how they respond to stigma within their own communities related to rape, sexual violence, mental health problems, pregnancies as a result of rape, and sexual health problems.
- All these factors need to be considered in a clinical opinion.
- The importance of intersectionality, the different axes along which a person may be disadvantaged (e.g. gender, age, class, religion, disability) and which contribute to power imbalances and dynamics between the health professional, and interpreter where present, and the client, in an assessment can influence what is said or not, and how. This must also be considered in a clinical opinion.

### 7. Current context
- The clinical opinion should consider ongoing factors in the current context, their contribution to the current psychological difficulties and the extent to which the context is conducive to recovery. Factors relevant to any ongoing risks or vulnerability to further harm or exploitation should also be explained in a clinical opinion.

### 8. Social context of violence against women and girls
- Violence against women, including rape and other forms of torture, does not exist in a vacuum but in a specific social, economic and political context dominated by patriarchal biases and in a context of marginalisation and discrimination – an important context to consider in forming a clinical opinion.

Where a psychological opinion is required for the purposes of preparing a formal assessment report (e.g. medico-legal report), it is important that the above considerations are taken into account and that the clinical opinion addresses international standards as set out in the Istanbul Protocol. \[112\]

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\[112\] Istanbul Protocol, para. 287.
Every health assessment requires attention to the ethical and professional obligations for health professionals and their duty of care to the client. This duty of care requires that (a) any identified health needs or (b) concerns about vulnerability and risk are followed up appropriately and effectively.

The validity of any clinical decision for follow-up investigation, assessment, care and treatment depends on the quality of the assessment. The quality of the assessment depends on two key factors, amongst others:

- the competency of the assessor
- the adequacy of time allocated for assessment.

Whilst there may be constraints (e.g. nature of the setting, as in detention facilities) to ensuring adequate time for an assessment, certain essential areas must be addressed during the assessment to reach an adequate clinical judgement on whether and what type of follow-up is required (see Box 40).

**Box 40: Deciding on follow-up and priority: Essential areas for assessment**

- Current psychological and physical health
- Immediate health needs and concerns and urgency
- Current concerns about vulnerability and risk and urgency
- Current social circumstances (e.g. basic needs, concerns, other stressors)
- Availability and use of support network
- Current social functioning and level of coping
- Ability and means to access support from other services (e.g. availability and affordability of transport, safety concerns, stigma related to certain services, cultural appropriateness of services etc.)
- Ability to use health care or support from other agencies (e.g. taking into account cultural beliefs, norms, stigma, previous experience of discrimination, family restrictions or concerns, factors in social context and basic needs requiring more urgent attention)
- The person’s own views on health needs, available services (e.g. suitable, culturally appropriate, accessible?) and referral to other services.

Where a referral to another service, agency or colleague is required, the quality of the referral can help inform the recipient in making a decision about what can be offered or not. Whilst many services require a referral letter or a general referral form to be completed, particular agencies and services may require more detailed information or service-specific referral forms and patient questionnaires to be completed and submitted. For many clients, their psychological state may be such that any additional requirements to complete health questionnaires before being accepted for a further assessment may be a deterrent and cause further anxiety, fear and stress, and lead them to not pursue any referral made by the health professional who originally assessed them.

It is also important to recognise the added burden placed on clients when a referral is made to another agency, after they have just disclosed rape during armed conflict, for example, or other torture. The person may feel rejected, and shunted to another service, as if without care for the anxieties and distress such disclosure may have evoked. They may also fear that a referral to another colleague or service will require them to repeat their story, or be subjected to further physical examination. These concerns must be acknowledged and explored with the person, and the recipient of the referral informed.
Key questions to ask:

- Is the assessment complete?

- If not, has the assessment considered the essential areas to make an adequate clinical judgement on follow-up and priority?

- Which health needs and concerns require follow-up, by whom and with what urgency?

- Are there concerns about vulnerability and risk, and what is the level of urgency?

- Are there concerns about the person's security (e.g. if they have disclosed sensitive information in an assessment, whether they fear repercussions from family, community or others?)

- Is a formal referral letter required, or are other formats or methods required?

- What are the person's views and concerns about:
  
  (a) a referral being made (fears of consequences, cultural beliefs, having to repeat their story, having to undergo another physical examination etc.);

  (b) access to another service (location, distance, transport availability and affordability, safety and risks involved in information which may be shared with others without consent, risks foreseen if family or community members find out about their health problems, use of services, disclosure of sensitive information etc.); and

  (c) any adverse consequences, including risks to their own safety?

- Has the person given consent for a referral to be made, or made some requests in relation to what can be disclosed in a referral?

- Are there statutory responsibilities which require you to refer to another service/colleague in the absence of client consent (e.g. if the client is a minor, risk of harm)?

- Are there other services, organisations or other informal support structures and networks the person could access?

- Are there established referral pathways, mechanisms and national standards and protocols already in place (e.g. for particular services such as sexual assault services, for between services, for between local community organisations and health services, for between international and national support agencies, or hotlines and self-referral routes?)

- Has the referrer been informed of the client’s anxieties about the referral?

- Is there scope for follow-up, after a referral is made, so that the person does not fall through the net, for example if they miss an appointment (e.g. due to fear) with the service to which they have been referred.

Good practice includes:

- Being aware and forming professional links with other support services and agencies to which referrals could be made

- Being aware of established referral pathways and mechanisms, including national standards and protocols for such referrals and referral criteria for the relevant services or agencies

- Ensuring a clinical judgment on whether follow-up assessment, investigation, care or treatment is based on a thorough assessment

- Ensuring good practice in fulfilling health professionals’ duty of care to the person assessed (see Box 41)

- Ensuring the client is informed of all available services and support networks

- Ensuring the views and concerns of the client in relation to possible referral to other agencies or specialists are always explored and taken into careful consideration; and the referrer is informed as appropriate

- Ensuring that there is careful consideration of any risk factors arising or escalating if a referral is made to another agency (e.g. where this becomes known to a family or community member, or where the agency is a government agency not independent from authorities responsible for rape, sexual violence or other torture)
- Ensuring that, where referrals are made to other services or agencies, they are accessible (e.g. transport availability and cost and time involved) and appropriate (e.g. culturally)
- Ensuring referrals in the case of minors guarantee the best interests of the child and take a holistic view of their social, welfare, health, educational and other needs, and the need for a coordinated response in meeting their needs
- Ensuring referrals in the case of minors and their families adequately inform and include their parents/guardians in discussing what is in the best interest of the person
- Ensuring good practice in making referrals (see Box 41)
- Ensuring follow-up after a referral has been made, to ensure the client does not fall through the net if they fail to attend and further risks arise.

**Box 41: Good practice in ensuring duty of care**

<table>
<thead>
<tr>
<th>Duty of care</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify health needs or concerns</strong></td>
<td>• Ensure appropriate procedures and practices to facilitate early identification of those with health concerns and needs, those who may be vulnerable, at risk of exploitation, or otherwise at risk.</td>
</tr>
<tr>
<td></td>
<td>• Ensure adequate assessment (physical and psychological).</td>
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<tr>
<td><strong>Inform client of your clinical opinion and its implications</strong></td>
<td>• Inform and explain to the client in terms, and in culturally and age-appropriate language they can understand, the clinical opinion and any decisions or recommendations for further assessment/investigation and care.</td>
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<tr>
<td></td>
<td>• Provide information, with an interpreter where necessary, on any specific instructions or compliance with medication. The person may not be literate and may not be able to read instructions for medication, or recall what to take when. They may not be familiar with the health care system, how to obtain medication, whether they have to provide medication, how to complete relevant forms for medication fee exemptions, how to contact the relevant clinician, when etc.</td>
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<tr>
<td></td>
<td>• Provide adequate and clear information about availability of other relevant services and the options for future health care investigations and possible implications. Explain what the referral process is likely to entail, particularly to limit unpredictability and potential anxiety.</td>
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<tr>
<td></td>
<td>• Provide information about how to access those services, including health care, social care and legal support services. Clients may have many health concerns and legal and social welfare problems which impact on their ability to understand and navigate the services available to them. Health professionals may be the first to be alerted to these difficulties and can play a key role in referring and facilitating access to the appropriate services.</td>
</tr>
<tr>
<td><strong>Check with the client</strong></td>
<td>• Note that discussion with the client on a clinical opinion and need for referral or follow-up care and their views and concerns can help the person feel less uncertain, less frightened, more aware and more in control.</td>
</tr>
<tr>
<td></td>
<td>• Discuss with client which health or other professionals may need to be informed about the identified health needs and concerns, but note that a legal representative cannot be contacted about health concerns which may be relevant to an asylum application unless the client chooses to inform the legal representative themselves; or if the client has consented to the legal representative seeking such a view from the health professional.</td>
</tr>
<tr>
<td></td>
<td>• Explore client’s expectations and view of accessing particular services (e.g. “Who would you go to for help with these health problems in your country?”, “What do you think about the services I just described?”)</td>
</tr>
<tr>
<td></td>
<td>• Explore the client’s views and any concerns they have about a referral to any health and social care services (e.g. stigma, fears of being subjected to medical/other interventions without consent, fears of discrimination, location and accessibility of service etc.)</td>
</tr>
</tbody>
</table>
| Provide or ensure care | Where emergency care is needed, to provide or ensure such care  
|                       | Where care and treatment are deemed necessary, to provide or to ensure such care can be accessed.  
| Referral to others for protection of the client/others | Where the assessment conducted indicates concerns about vulnerability and safeguarding or identified risks to self or others, to take appropriate action to ensure the protection of the client and others  
|                       | Ensure sensitive and respectful dialogue with clients before such action is taken, taking particular care to discuss with clients assessed as being vulnerable and/or at risk of exploitation, harm to self or others etc.  
|                       | Ensure compliance with statutory duties arising from information shared during the assessment, including where the client is a minor, to protect their best interests.  
| Referral to others for specialist assessment/investigations/interventions | Where the assessment conducted indicates a need for further specialist assessments, investigations or interventions, a referral should be made to relevant services/colleagues  
|                       | Decisions on referral to other health or social care specialists should be taken collaboratively, with informed consent, as noted above.  
| Note in clinical records | Ensure there are clear notes of the clinical opinion in the clinical record to justify referral to another colleague/specialist  
|                       | Note in the clinical opinion, and clearly within clinical records:   
|                       | o all health needs and concerns and priorities;  
|                       | o all identified vulnerability and risks and priorities;  
|                       | o where the risk is considered ongoing and requires re-evaluation and monitoring over time;  
|                       | o all concerns and fears raised by the client about referral to other agencies or about disclosures of sexual violence made during the health assessment;  
|                       | o all care/treatment provided and rationale;  
|                       | o all decisions made to refer to other specialists, agencies or bodies and related consent from the client;  
|                       | o all referrals made to others and priorities, with justifications;  
|                       | o when an assessment is incomplete (and which areas have not been assessed); and when the clinical judgement is based on an incomplete assessment.  

- Explore with client any fears or concerns they have about family or community members, or others, finding out about their health needs or disclosures of sexual violence  
- Discuss with client the information which will be sent in a referral, and to whom and for what purpose. Check that they understand and encourage them to share their doubts or concerns  
- Check with the client if it is safe for letters to be addressed to them and where they should be sent, or if they prefer to have their correspondence regarding health care and referrals sent to another address [e.g. a friend’s or legal representative’s address]  
- Seek informed consent to send relevant documentation in the referral to a third party for further health assessments, investigations, or treatment  
- Note that in some situations there is a statutory duty to act in the best interests of the person or others [e.g. where risk or child protection issues are raised] without consent.
### Box 42: Good practice in making referrals

<table>
<thead>
<tr>
<th>Good practice</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language</strong></td>
<td>• Use professional language</td>
</tr>
<tr>
<td></td>
<td>• Avoid vagueness in your clinical opinion and on what you are requesting:</td>
</tr>
<tr>
<td></td>
<td>Be specific, detailed and clear</td>
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<tr>
<td></td>
<td>• Inform the recipient if a professional interpreter is needed, in which language/</td>
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<td></td>
<td>dialect and if the gender of the interpreter has been specified by the client/</td>
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<td></td>
<td>and where not, your opinion on this</td>
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<tr>
<td></td>
<td>• Avoid judgemental comments or discriminatory language.</td>
</tr>
<tr>
<td><strong>Assessor/referrer context</strong></td>
<td>• Provide your professional qualifications and current job title</td>
</tr>
<tr>
<td></td>
<td>• Explain the context in which you have assessed the person</td>
</tr>
<tr>
<td></td>
<td>• Provide your contact details</td>
</tr>
<tr>
<td></td>
<td>• Provide the date(s) on which you assessed the person</td>
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<tr>
<td></td>
<td>• Note if plan to continue seeing the person for monitoring, care etc., or not</td>
</tr>
<tr>
<td></td>
<td>• Explain what you have told the person being referred about the referral.</td>
</tr>
<tr>
<td><strong>Reasons for referral</strong></td>
<td>• State specific reasons for referral</td>
</tr>
<tr>
<td></td>
<td>• Provide your clinical opinion.</td>
</tr>
<tr>
<td><strong>Urgency</strong></td>
<td>• Provide your opinion on the urgency and the reasons for this</td>
</tr>
<tr>
<td></td>
<td>• Highlight any relevant factors in the person’s social, economic or legal context which may impact on the urgency of the referral (e.g. impending homelessness, deportation, changes in family circumstances)</td>
</tr>
<tr>
<td></td>
<td>• Explain the circumstances in which the urgency may change, if known, and your opinion on likely impact on urgency.</td>
</tr>
<tr>
<td><strong>Provide adequate information</strong></td>
<td>• Include information on health needs and concerns, social context, social support (availability and use), vulnerability, risks and current coping</td>
</tr>
<tr>
<td></td>
<td>• Enclose any relevant investigation results, medical notes or other relevant documentation</td>
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<tr>
<td></td>
<td>• Include details of any previous treatment and outcome if known, and the person’s experience of that treatment</td>
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<td></td>
<td>• Include your clinical opinion and any suggestions for management, where discussed with the person</td>
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<tr>
<td></td>
<td>• Provide a copy of your full assessment or inform the recipient of the referral that this has been completed (e.g. if a medico-legal or psychological report has been completed) but only with the consent of person assessed (or with the legal representative’s consent, if they instructed the assessment).</td>
</tr>
<tr>
<td><strong>Note sensitivities</strong></td>
<td>• Explore with the person any concerns or fears they may have about possible further medical or psychological assessment, investigation or interventions that may be related to or trigger distress related to previous experiences of rape or other sexual violence or torture</td>
</tr>
<tr>
<td></td>
<td>• Highlight any particular issues with the client, for example, sensitivities such as phobias (e.g. needles), and fears of being forced to lie in certain positions, or of a physical examination</td>
</tr>
<tr>
<td></td>
<td>• Highlight with sensitivity any risks which may arise or escalate as a result of the referral (e.g. risk of family or community members finding out, with adverse consequences for the client).</td>
</tr>
</tbody>
</table>
| **Other information** | • Provide client’s written consent where applicable  
• Provide client’s contact details  
• Inform client who to contact if their contact details (address, phone etc.) change  
• Alert recipient service to make additional arrangements required to ensure that the person can access and utilise the service to which they have been referred (e.g. booking transport, escorts, interpreter, enquiring about availability of health advocate). |
| **Where formal referral letters are not used** | • Provide information about ongoing health needs, concerns and risks in a way which is easily clearly accessible (e.g. write an entry in the clinical notes shared by clinical team, and inform the general practitioner (or relevant health professional), where further attention or action is needed and urgency  
• Comply with duties to clearly and adequately record and to report allegations of torture (including rape and sexual violence) which emerge during a health assessment (e.g. in immigration detention settings or immigration removal centres). Where these duties have not been specified or related mechanisms established within a particular organisational setting, assessors must seek guidance from their management. |
| **Sending referral letters** | • Send directly to the receiving health professional/service where possible  
• Place a copy in the client’s files  
• Inform the client’s doctor/general practitioner and, where necessary, contact the doctor/general practitioner if information needs to be relayed immediately or is deemed too sensitive to be communicated in writing and the person has only consented to the information being shared without being recorded in detail in clinical records/referrals  
• Provide a copy to the person being referred, unless service policies dictate otherwise  
• Provide written summaries of their verbal explanations to the person where required, as they may be unable to retain all information given to them due to anxiety, psychological distress and other health problems. |
| **Waiting lists of recipient service/agency** | • Take adequate steps to ensure the monitoring of any risk of a significant deterioration or complications in physical and/or psychological health, as well other risks  
• Take adequate steps to ensure any changes in health needs, concerns, risk and urgency are conveyed to the recipient service where the person is held on a waiting list. Where consent is provided, the person’s legal representative should also be informed. |
The International Centre for Health and Human Rights provides bespoke interdisciplinary training and accompanying clinical supervision, elaborating on the guidelines in this Handbook.

For further information, please contact us on info@ichhr.org.uk

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