Psychological evidence

Author: Prof. Thomas Wenzel
Medical University of Vienna, Austria

ARTIP: Awareness Raising and Training Measures for the Istanbul Protocol in Europe

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Education and Culture DG
Lifelong Learning Programme

Psychological aspects

A. GENERAL CONSIDERATIONS

Psychological aspects

A. 1. THE CENTRAL ROLE OF THE PSYCHOLOGICAL EVALUATION

Importance of mental health aspects

Immediate treatment needs and secondary prevention - including suicidality

Importance of mental health sequels

- Frequent
- Often long lasting, persisting after physical traces have vanished
- Physical scars often avoided by torturers
- Severe long term impact
- Interact with memory
- Might limit capacity to participate in legal procedures such as by underreporting or apparent contradictions

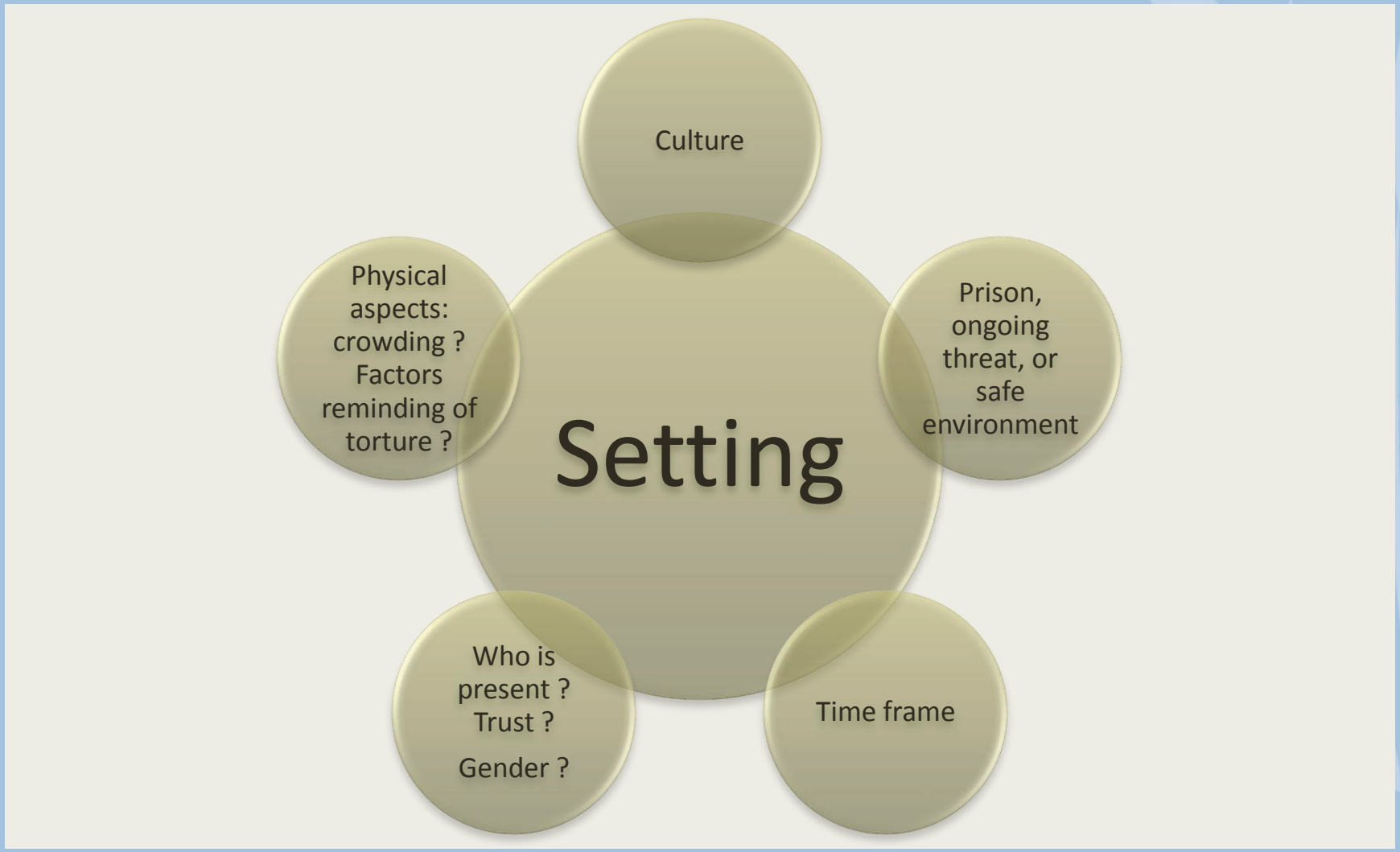
Psychological aspects

A. 2. THE CONTEXT OF THE PSYCHOLOGICAL EVALUATION

A. 2. The context of the psychological evaluation

The setting – all aspects of environment and the context of an examination - must be considered and later described as part of the examination.

A. 2. The context of the psychological evaluation



Psychological aspects

B. PSYCHOLOGICAL CONSEQUENCES OF TORTURE

Psychological aspects

B. 1. CAUTIONARY REMARKS

B. 1. Cautionary remarks

Key points:

- Assessment in the context of culture (see special advanced module)
- PTSD (Posttraumatic Stress Disorder) is an important part, but - only a part of the picture of torture related sequels
- Use an open, careful „informed learning“ attidude – the survivor should feel that he/she has been „heard“

B. 1. Cautionary remarks

Key points:

Be aware of the severe psychological impact of both memory recall and stimuli in the immediate environment
- that might remind of torture or prison.

Psychological aspects

B. 2. COMMON PSYCHOLOGICAL RESPONSES

B. 2. Common psychological responses

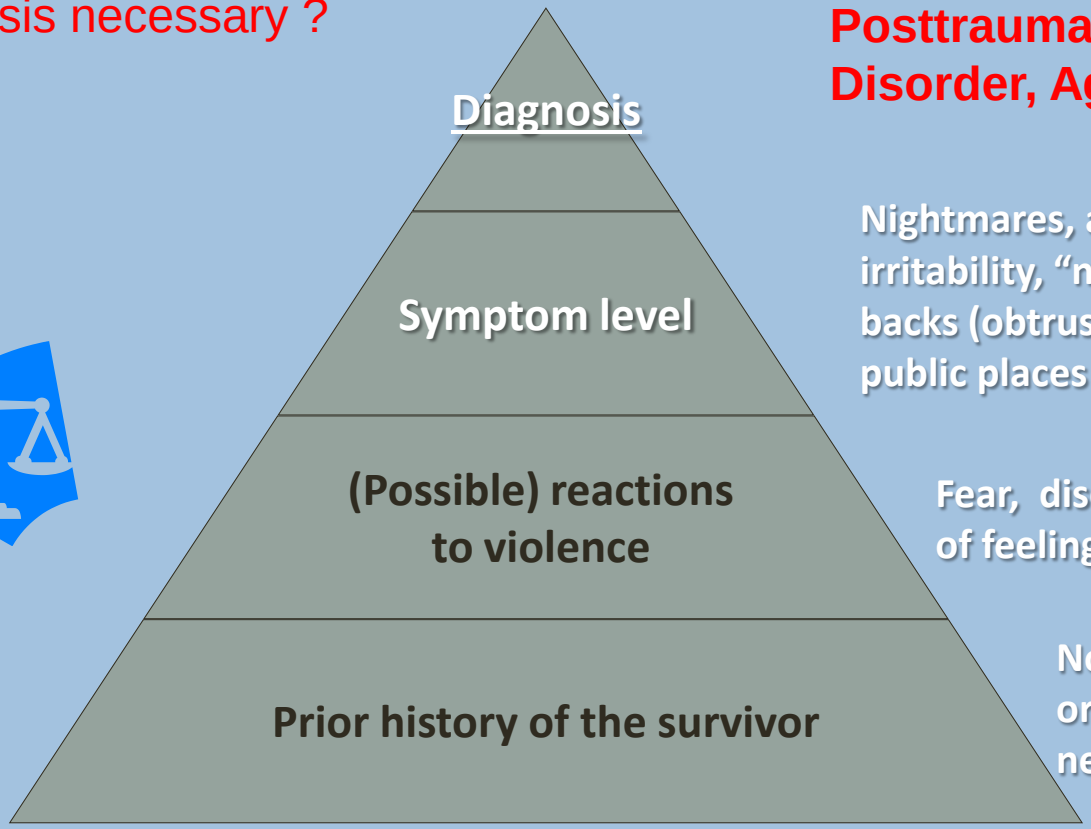
The IP lists a number of responses, that are especially frequent.

It describes psychological changes first on the level of reactions, symptoms, or syndroms (symptom groups) (B.2.) then again on the level of diagnosis (B.3.).

They are part of the assessment, and the steps from noting a normal reaction (such as not trusting authority), pathology = a „symptom“ (such as persistent nightmares), to a diagnosis (Posttraumatic Stress Disorder) should be taken with care.

Documenting psychological sequels: example

Diagnosis necessary ?



Posttraumatic Stress Disorder, Agoraphobia

Nightmares, avoidance of memories, irritability, "no future" feeling, flash-backs (obtrusive memories), avoiding public places not related to torture.

Fear, disorientation, loss of feeling for time, pain.

No psychological symptoms or treatment before torture, negative family history.

B. 2. Common psychological responses

Reexperiencing, avoidance- emotional numbing, and hyperarousal *(usually linked to PTSD)*,

symptoms of depression (like sad mood, loss of interest, energy and appetite)

damaged self-concept and foreshortened future *(usually PTSD/Complex PTSD related or depression related),* **dissociation, depersonalisation and atypical behaviour** *(can be PTSD/Complex PTSD related or depression related),*

somatic complaints (most commonly a way to express distress and suffering in a culture („idiom of distress“) and /or as part of „somatoform“ disorders (disorders where physical symptoms cannot be explained by physical findings alone)

B. 2. Common psychological responses

Sexual dysfunction *(note: common especially after sexual torture, but also as part of depression)*

psychosis: Delusions, hallucinations, bizzare ideation and behaviour, illusions, paranoia
(note: psychotic symptoms can result from many factors, including torture, and occur as part of a wide range of disorders that can also be completely unrelated to torture but appear or get worse under torture - such as schizophenia, severe depression, bipolar (manic-depressiv) disorder, physical illness, or substance abuse).

B. 2. Common psychological responses

Substance abuse (or dependency)
Can be a frequent complication especially as survivors try to self „treat“, sleep problems, hypervigilance or anxiety, or pain. Common in but by no means limited to many prisons, pattern usually culture dependent, including prescribed substances (legal such as (benzodiazepine-type) tranquillizers, alcohol, or illegal substances such as opioids.

Differentiate from the use of drugs during and as part of torture or treatment !

B. 2. Common psychological responses

Neuropsychological impairment like concentration and memory problems, irritability

most commonly through (blunt) brain trauma (can be part of a postcommotional syndrome) caused by falls, blows to the head, but also prolonged asphyxiation (as in the sue of plastic bags, etc.).

Many symptoms can also be caused by PTSD, with partly similar symptoms, a dual diagnosis is a possibility.

Beware:

Negative finding in regard to psychological sequels

- Evaluate and discuss possible reasons
- Additional diagnostic strategies, additional interview, referral
- Good coping or other factors prevent PTSD development or other reactions
  - No diagnosis - does not exclude event (torture)

Psychological aspects

B. 3. DIAGNOSTICAL CLASSIFICATIONS

B. 3. Diagnostical classifications

In the IP, two medical diagnostical systems are mentioned (see following slides):

a) the **ICD** (International Classification of Diseases) of the World Health Organisation and

b) the American **DSM** (Diagnostical and Statistical Manual), the last being most commonly used in the USA and in research.

B. 3. Diagnostical classifications

As ICD and DSM are at times revised - we recommend using the presently valid handbook versions, that give concise definitions and descriptions of all common disorders, usually they even can be accessed online.

Two systems: ICD 10, DSM IV

ICD 10

+

Integrated with somatic diagnostic codes,

used in clinical practice in many countries, official WHO* instrument,

contains helpful categories like (F 62.0), or postconcussional syndrome, for sequels,

open categories for PTSD.

DSM IV (TR)

+

Abundant research data on PTSD in this system,

strict criteria (also limitation, criteria intended originally for research- might be too strict),

many research and diagnostic instruments in multiple languages,

Special “PTSD DESNOES”** category in discussion.

Posttraumatic Stress Disorder

DSM IV 309.81

Acute. Symptoms have lasted less than 3 months

Chronic. Symptoms have lasted 3 months or longer

Specify if:

With Delayed Onset. The symptoms did not appear until at least 6 months after the event

ICD 10 F 43. 1

With Delayed Onset.

A

Evaluation

- *„Specific“ disorders (Posttraumatic stress spectrum disorders) – only caused by severe distress, symptoms might indicate a specific event as cause (example: nightmares reflecting concrete torture events).*
- *Unspecific disorders – can in general be caused by different factors, - that might include but are not limited to distress and violence.*
- Be aware of culture-specific expressions of disorders and culture-specific reaction patterns or disorders (including „idioms of distress“).

B. 3. Diagnostical classifications

PTSD was not included in old versions of the DSM and ICD. The diagnosis was precluded though earlier concepts (such as „war trauma“, „ war neurosis“ or „concentration camp survivor syndrome“) that described some of the symptoms, though they are not identical with the present PTSD definition.

Posttraumatic Stress Disorder

ICD 10: F43.1

Typical symptoms include episodes of **repeated reliving** of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "**numbness**" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and **avoidance** of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Rarely, there may be dramatic, acute **bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction** to it.

There is usually a state of **autonomic hyperarousal** with hypervigilance, an enhanced startle reaction, and insomnia. **Anxiety and depression are commonly associated** with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

Complex PTSD/ PTSD DESNOES

Complex PTSD and PTSD DESNOES (Disorders of Extreme Stress, not otherwise classified) are concepts that have been developed to better include the frequently observed symptoms in survivors of extreme stress, that have not yet been included in the ICD 10 and PTSD concepts.

They are mentioned as **associated symptoms** in the full DSM IV manual, some symptoms are included in the ICD 10 F 62.0 category, and also in the explanatory text of some ICD 10 PTSD descriptions.

Both are similar, but differ in details. Most common symptoms are:

Shame feelings
Guilt feelings
Somatisation tendency

Specific reactions to extreme life events: ICD 10 *

(must not be all present in each case)

Acute stress reaction/ disorder

ICD 10: F 43.0

Hours to days after event

Xan be followed by

Post-traumatic stress disorder (PTSD)

ICD 10: F 43.1

Days to years

Xan be followed by

Personality change after catastrophic experience

ICD 10: F 62.0

2 years or later

*International Classification of Diseases, Rev. 10, WHO

ICD 10 Codes relevant to violence

Z 65. 3: Imprisonment,

Z 65.4: Victim of crime or terrorism including torture,

Z 65.5 Influence of catastrophe, or war,

X 85- Y09: especially other sequels to mistreatment, including Torture

Further codes under S 06.

B. 3. Diagnostical classifications

One relevant disorder, - enduring personality change after catastrophic experiences (ICD 10 F 62.0) – is only listed in the ICD (starting with revision 10), not in the DSM.

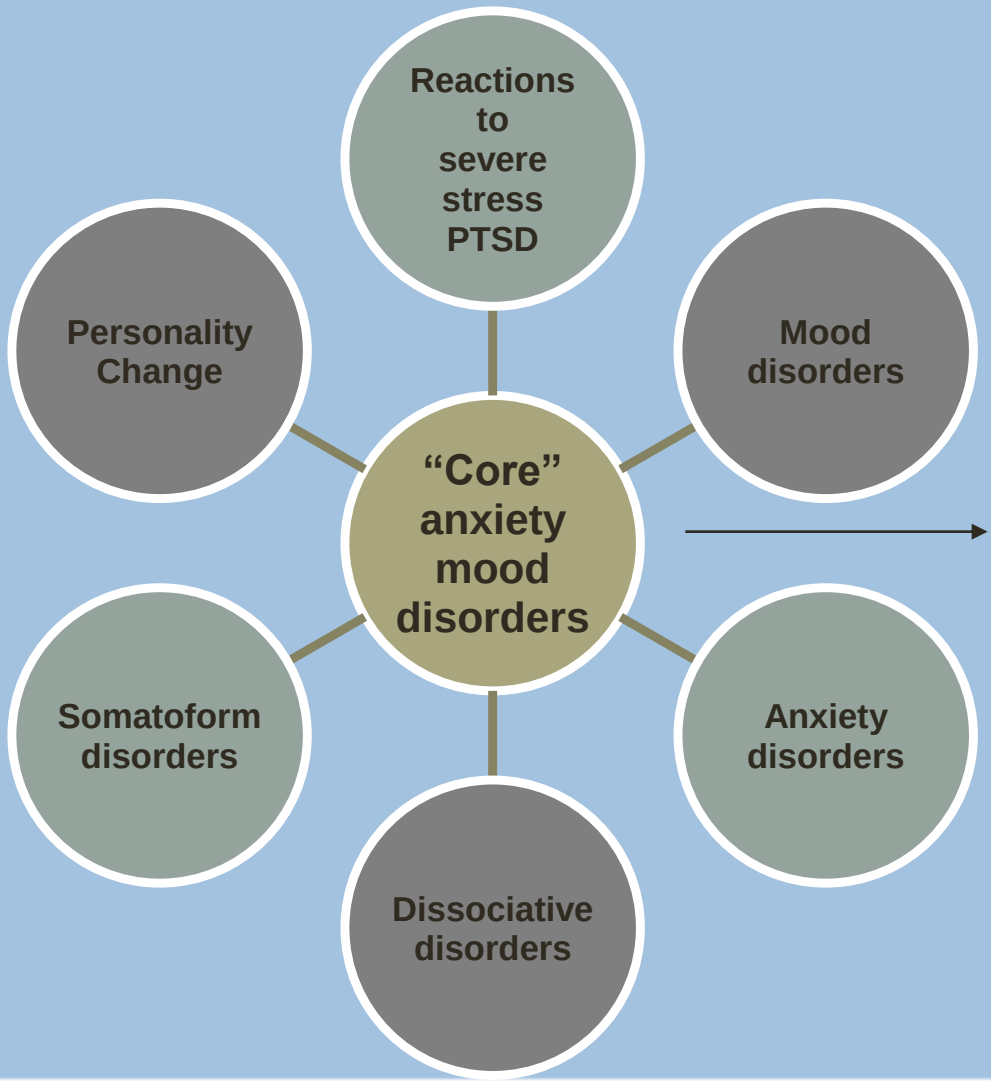
ICD 10: Personality change after extreme life experience

„Enduring personality change, **present for at least two years**, may follow exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a **hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement.**

Post-traumatic stress disorder(F43.1) may precede this type of personality change. .. Personality change after torture

Exclusion : post-traumatic stress disorder(F43.1) „

The ICD 10 system- Chapter V (Mental health)
Most relevant categories



Brief reactive psychosis

Postconcussional syndrome

Adapation disorder

B. 3. Diagnostical classifications

Note: While PTSD is most common, culture can lead to different forms of reaction. Not all are described in detail in the IP but include especially

somatoform disorders (symptoms that resemble a physical problem such as a stomach pain but cannot be explained sufficiently by physical findings)

conversion disorder (symptoms that resemble a neurological problem such as a stroke but again cannot be explained by physical findings) or

culture specific **„idioms of distress“**, a way of reaction commonly observed and named in a specific culture if a person is in distress (such as „fainting“, „or „nerves“.

Psychological aspects

C. THE PSYCHOLOGICAL / PSYCHIATRIC EVALUATION

Psychological aspects

C. 1. ETHICAL AND CLINICAL CONSIDERATIONS

C. 1. Ethical and clinical considerations

Take consideration of the needs of the specific setting, including the aims of the examination, avoding undue distress or even retraumatisation in the victim.

This is relevant for all steps of the investigation and documentation and basic aspects of psychological cnsequences should be known by all involved professionals.

The earlier modules on setting, culture and the importance of a psychological/psychiatric assessment should be included in training.

Psychological aspects

C. 2. THE INTERVIEW PROCESS

Psychological aspects

C. 3. COMPONENTS OF THE PSYCHOLOGICAL PSYCHIATRIC EVALUATION

C. 3. Components of the psychological psychiatric evaluation

- History of torture and ill-treatment history *(might have to be taken together with or in addition to the general medical examinaton history taking)*
- Current complaints
- Post-torture history (including impact on live, current stress factors, support, treatment)
- Pre-torture history (incuding education and occupation)

C. 3. Components of the psychological psychiatric evaluation

- Medical history *(might have to be taken together with or in addition to the general medical examinaton history taking)*
- Psychiatric history (problems might exist before torture, but might increase under torture, a negative history might indicate
- Substance use/abuse/dependency
- Mental status examination

C. 3. Components of the psychological psychiatric evaluation

Psychological testing and the use of checklists and questionnaires:

Note: While a clinical assessment and diagnosis is the key element in the examination, testing, standardised questionnaires and interviews can and in some situations should be included if they are available and validated in the relevant language. They are not explained in more detail in the IP, the psychologist/psychiatrist should be experienced in their application, (see special training modules by WPA).

C. 3. components of the psychological psychiatric evaluation

Psychological testing and the use of checklists and questionnaires-

In forensic testing, special questions such as fabrication of symptoms is sometimes adressed by special tools or questionnaire scales to get a more „objective“ finding.

Results should be handled with care as lnaguage, cultural and trauma specific factors such as shame or brain trauma can influence and distort results. Only a comprehensive assessment can lead to good results, and limitations such as language or culture should be addressed in the conclusions.

C. 3. Components of the psychological psychiatric evaluation

Psychological testing and the use of checklists and questionnaires

Examples: Standardised assessment of Functioning and Quality of Life based on the World Health Organisations BREF instrument, confirmation of a clinical PTSD diagnosis (CAPS interview), standardised indicator of PTSD symptom score to document changes over time or the impact of treatment (Harvard Trauma Questionnaire), neuropsychological testing to identify brain trauma (in addition to radiology (CAT/MRI).

C. 3. components of the psychological psychiatric evaluation

- Assessment of social functioning

- Descriptive or using standard scales (if validated in a culture or language).

Note: this might indicate the impact of torture, and can be relevant also for recompensation.

C. 3. Components of the psychological psychiatric evaluation

- Clinical impression: This includes questions such as consistency, the discussion of possible explanations (or alternatives) for findings, the possible contribution of alleged torture to clinical symptoms, and a discussion of all possible jnfluences.

- It should be considered, if contradictions exist between medical examination results, and reported events (narrative), or when incomplete reporting is suspected this can be explained by psychological or neuropsychological factors.

- Medical and psychological reports if separate should be seen as corresponding and integrated parts of the oeverall findings.

C. 3. components of the psychological psychiatric evaluation

Clinical impression

Note: This part might strongly depend on the medico-legal culture and aspects of the role of the (forensic) expert in the interpretation of findings. Conclusions might either be expected or discouraged by local courts. This should be addressed by local IP country materials.

This applies also to common formulation of results (like (is highly consistent with ..)).

C. 3. Components of the psychological psychiatric evaluation

Recommendations:

.. depend on results, and the examination setting.

Examples: report immediate treatment needs (as for suicidality), need of further assessment, and long term treatment or support needs (such as protection).

Psychological aspects

C. 4. NEUROPSYCHOLOGICAL ASSESSMENT

C. 4. Neuropsychological assessment

Key issues:

- Neuropsychological testing can yield infomation on special questions like indicators or degree of impairment due to brain trauma through force, hypoxia (oxygendeprivation), or toxic substances.
- It cannot exclude brain trauma as impairment can be mild or not recognised by a test due to the unspecific nature of many injuries.

C. 4. Neuropsychological assessment

- To a considerable part dependent on language, though non-verbal tests or neurophysiological tests with „simple to follow“ instructions are available in some areas.
- Similar as in psychiatric diagnostic assessment for depression or PTSD, some tests are also culture dependent and need special culture-based validation.

C. 4. Neuropsychological assessment

- Clinical- especially PTSD diagnosis - is usually reached not immediately through neuropsychological testing, but through clinical diagnostics and interviews.
- that can be supported by psychological testing, though some aspects like the startle response (a reaction to sudden noise) or impairment of concentration can be quantified through neuropsychological assessment.

C. 4. neuropsychological assessment

The IP underlines that special care must be taken again in avoding undue stress or retraumatisation.

Example: Blindfolding in some tests, feeling overwhelmed by questioning, sensors reminding the survivor of electric torture, time pressure, closed spaces.

C. 4. neuropsychological assessment

A new issue not yet covered in IP is that of developing radioimaging techniques (like functional Magnetic Resonance Imaging) in the psychiatric or neuropsychological assessment.

It is standard in the assessment of brain trauma, though a negative finding cannot disprove brain trauma.

It is an up-coming strategy in psychiatric disorders, - but cannot be yet recommended as a standard.

Psychological aspects

C. 5. CHILDREN AND TORTURE

C. 5. Children and torture

- Special care must be taken because of potential harm through inadequate examination.
- Examination should always be embedded in support and treatment.
- Examination strategies must reflect age and should be used only by specialised experts.

C. 5. Children and torture

Pictures can frequently transmit a narrative better then words.

C. 5. Children and torture

While children can suffer from all trauma related problems – like Posttraumatic Stress Disorder – as adults, expression might depend on age and developmental stage and include:

- Changes in behaviour or expression – in play (example: playing torture and being saved with dolls) or actions (example: mutism, agressive behaviour) instead of in conversation,

  or

- regression (emotional reaction leading to loss of skills like bed-wetting reappearing from earlier development)

C. 5. Children and torture

- Assessment depends on biological and psychological (developmental) age, background (literacy), and culture.
- Tools to augment interview and observation include both standardised questionnaires and schedules in elder children, (neuro)psychological testing, but also – especially in younger children - nonverbal instruments, tools and pictorial narratives.

C. 5. Children and torture

- While in many countries, even children and young adults are tortured, children are frequently also indirect victims.
- Suffering can be life long, as documented in studies such as those on the „Second generation syndrome“.
- Impact on children, the family and family functioning in general, should therefore be taken into account when assessing both children and adults.