REVIEW

THE AMERICAN JOURNAL of MEDICINE®

Torture Survivors and Asylum: Legal, Medical, and Psychological Perspectives

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ABSTRACT

Torture occurs worldwide. Survivors seeking asylum are detained and must complete a complicated legal process to prove a "well-founded fear of persecution" if returned to their home countries. Forensic evaluations guided by the United Nations Istanbul Protocol increase asylum grant rates. Medical evaluation emphasizes skin examination, which can provide strong evidence of torture. Female genital mutilation and cutting, a basis for asylum, is classified according to the World Health Organization. Many resettled refugees and foreign-born immigrants at urban health care facilities have been tortured, but few report it to physicians due to factors affecting both survivors and physicians. Specific torture methods can cause characteristic long-term sequelae. Painful somatic disorders of mind-body interaction and psychological disorders are common. Practices derived from cultural factors and traumatized individuals' feedback enhance management of survivors. Individual and group psychotherapy provide modest proven benefit, but assessment is limited. Physicians and psychotherapists should coordinate care.

Published by Elsevier Inc. • The American Journal of Medicine (2022) 000:1–8

KEYWORDS: Asylum; Forensic; Psychology; Refugees; Somatic; Torture

INTRODUCTION

The United Nations (UN) adopted the Universal Declaration of Human Rights in 1948, introducing human rights into international law. The UN Convention Against Torture (CAT) defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person . . . by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."[1] Since the General Assembly adopted it, 173 countries have signed the CAT. However, torture occurs in 141 countries,[2] and there are about 1.3 million torture survivors in the United States.[3] In 2012 an estimated 513,000 US women and girls had or were at risk for female genital mutilation and cutting.[4] Many traumatized victims immigrate, especially asylum seekers.[5] Most physicians are untrained on forensic medical evaluations and caring for survivors of torture.

LEGAL PERSPECTIVE

Some individuals fleeing persecution are screened outside the United States and gain entry as refugees. Others apply for asylum, which is a complex, lengthy, and highly specialized process.[5]

Asylum Application

Applicants must submit within 1 year after entry: 1) a 10-page application, 2) a detailed declaration in English explaining their asylum claim, 3) identification, 4) corroborating evidence, and 5) information on the home-country context of their claim.

Applicants' legal status determines the process: 1) Individuals lawfully in the United States can file an "affirmative" application with US Citizenship and Immigration Services and have it adjudicated by an asylum officer without losing their visa, if denied. Persons unlawfully in the United States may also file affirmatively but, if denied, are "referred" to immigration court where a judge can grant

Funding: None.

Conflicts of Interest: None.

Authorship: All authors had access to the data and a role in writing this manuscript.

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0002-9343/Published by Elsevier Inc.
https://doi.org/10.1016/j.amjmed.2022.10.014

asylum or deny it and order removal from the United States; 2) Applicants arriving at an airport or border without a visa must request asylum from a Customs and Border Protection officer, be detained, and pass a "credible fear" determination that they have a plausible claim under US law. If the determination is negative, they are removed from the United States to their home countries without the opportunity to file for asylum. If it is positive, they are served with a Notice to Appear in immigration court and returned to detention or released to stay in the United States. They file "defensive" asylum applications. Applicants from either the affirmative or defensive process face a judicial hearing, where they testify and are cross-examined by government counsel.[5] The court often reaches a decision after 1 hearing, but multiple hearings sometimes occur, and completing cases can take several years.

CLINICAL SIGNIFICANCE

- Forensic medical and psychological evaluations aid the complex asylum process.
- Torture occurs widely, and survivors are common among foreign-born US patients.
- Both patient and physician factors hinder obtaining a history of torture.
- Certain practices help health care professionals care for torture survivors.
- Survivors' long-term somatic and psychological disorders require coordinated care.

Asylum Requirements

To obtain asylum, applicants must prove a "well-founded fear of persecution" in their home country. "Well-founded" means a reasonable possibility. "Persecution," conceptionally similar to "hate crime," has two components: 1) severe harm inflicted on the victim, which is 2) motivated by one of five "protected grounds" (the victim's race, religion, nationality, membership in a particular social group, or political opinion[6]—even if falsely attributed). Applicants who prove that they would face severe harm but cannot prove a motivation on protected grounds cannot establish persecution and are denied asylum.[7]

Asylum grantees can sponsor a spouse and children to join them in the United States, travel abroad, work in the United States, receive permanent residence (a "green card"), and ultimately citizenship.

Withholding of Removal

Asylum is denied for various reasons, including applications filed late, prior acquisition of protection in a third country, and criminal activity. However, in those situations individuals who prove that persecution is more likely than not qualify for withholding of removal. "More likely than not" means a greater than 50% chance, a higher standard than "well-founded fear." When granting withholding of removal, the judge first orders removal from the United States but simultaneously "withholds" that order. Those granted withholding are allowed to remain and work in the United States indefinitely but cannot sponsor family members and cannot leave the United States without triggering the removal order that would prevent their return.[8]

Protection Under the Convention Against Torture

Applicants who demonstrate that they have suffered or would face torture in their home countries on account of a protected ground easily qualify for asylum or withholding of removal. If they establish a likelihood of torture without a protected-ground connection, and the feared harm meets the legal definition of "torture," which comes from the CAT,[9] they qualify for protection. Because the prohibition on torture is absolute under international law, any person who is likely to be tortured if removed from the United States must be granted CAT protection. Past torture is considered strong proof of future torture. CAT protection extends to those with serious criminal convictions that prevent even withholding of removal.

When granting CAT protection, the judge orders removal from the United States but then either "withholds" or "defers" that order. Withholding under CAT is functionally identical to withholding of removal described previously and is generally granted to those who establish torture without a protected-ground connection. "Deferral" of removal under CAT is essentially reserved for aggravated felons and terrorists.[10] It protects them from torture without requiring their release from detention and may be reconsidered and withdrawn any time the government shows that torture is no longer likely.

Successful Professional Affidavits

For asylum, proof of torture per se is not required because any type of severe harm suffices. Medical and psychological professionals verify and document the applicant's claimed harms, the applicant's overall health, and the treatment, healing, and complications of injuries and illnesses in the home country and in transit to the United States. We know of no rigorous assessment of the features of successful affidavits, but attorneys generally agree that the most successful affidavits focus exclusively on medical or psychological issues and limit discussion of country conditions and the applicant's demeanor to aspects necessary for analyzing the physical evidence or psychological symptoms and their association with the alleged trauma. Although observations of an applicant's demeanor may reflect truthfulness, affidavits should avoid legal conclusions that are outside the professional's area of expertise, such as whether an applicant has established "persecution" or "torture" or is a "credible" witness.

Rates of granting asylum vary widely based on the assigned judge[11] and are markedly increased by attorney

representation[5] and professional affidavits; a retrospective study of 2584 applicants evaluated by Physicians for Human Rights, mainly in circuits covering the Northeast and South regions, revealed an 82% grant rate versus the national rate of 42% during the same time period. Younger age, African versus South American origin, sexual- or gender-based violence, and lesbian/gay/bisexual orientation were positively associated with grants. Fleeing gang violence and being detained were negatively associated. Few had both medical and psychological affidavits; each increased grant rates, medical evaluations more than psychological evaluations having an impact.[12]

MEDICAL PERSPECTIVE

Physicians provide forensic medical affidavits for asylum seekers, often pro bono.[13] They may also care for tortured immigrants.

Medicolegal Contexts

The UN Istanbul Protocol is a comprehensive medicolegal guide, including international legal standards, ethics, and describing what constitutes physical and psychological evidence of torture and other ill treatment.[14]

Specific knowledge can improve physicians' assessment ability. They should realize that eliciting survivors' memories can retraumatize them.[15] White coats can trigger trauma for those who experienced a physician complicit in their torture.[16,17] They should use interpreters properly to avoid common pitfalls.[18] Interviewers should initially use open-ended questions, be unhurried, and empathetic. Closed-ended questions are needed to obtain details of arrest and detention, fear-producing threats,[19] witnessing others being tortured or killed, type and frequency of torture and weapons used, resulting wounds, treatment, duration and complications of wound healing, and lasting sequelae.[14,20,21] Victims' memory is often incomplete due to posttraumatic amnesia caused by brain injury or emotional arousal, suppression of unpleasant memories, and reduced recall abilities.[14,22,23] Psychological torture lacks physical violence. However, the mind-body interaction leads to psychological and physical torture overlap, either torture causing long-term somatic and mental disorders.[19,24]

Physical findings depend on the torture methods, which vary geographically.[25] In the United States chronic abnormalities greatly exceed acute ones because most survivors present months or years after torture. Victims detained by their torturers typically suffer sensory deprivation and poor diet, sleep, and sanitation that cause no chronic findings on physical examination. Physical violence most commonly comprises beating, but numerous methods include whipping, burning, cutting, suspension, postural stress, shooting, stabbing, dental damage, *teléfono* (ear slapping), sexual violence, and falanga (beating the soles).[14,20,21,25-28] Many victims suffer multiple methods. Among 1249 Danish asylees, men and ethnic minorities suffered more torture methods than women or ethnic majorities.[25]

Well-illuminated skin inspection is paramount. Wide scars without suture marks characterize untreated lacerations. Such wounds often become infected, prolonging healing, and resulting in a larger scar with less defined borders than an uninfected wound.[29] The Figure and other examples[21,27,29-32] show typical scars from some torture methods and treatment. Four types of scars should be distinguished from torture-related scars: 1) surgical scars apart from torture wound treatment (typical location and configuration, often suture marks); 2) self-inflicted lacerations (linear, nondominant forearm)[31,33] and burns (superficial, multiple scars similar);[34] 3) accidental wounds (extremities, sometimes occupation-induced; and 4) traditional healing practices, including cupping (circular, well-defined), coining and spooning (broad, linear, parallel), and moxibustion (circular, target-like), or incisions (thin, linear, multiple, parallel, near joints, symmetrical bilaterally).[32,35,36] Teeth are fractured and limb deformities from untreated bone fractures occur. Importantly, victims of sexual and other trauma may have no relevant physical findings. Measurements, drawings, and photographs[20] strengthen affidavits, which should classify findings according to the Istanbul Protocol (Table 1).

Female genital mutilation and cutting is a basis for granting asylum.[37-39] It is typically performed between infancy and age 15, mainly in Africa, the Middle East, and Asia, without sterility or anesthesia.[4,38,40] Severe pain and bleeding are common, and infection and even death may occur.[38] In such contexts, women without it report disempowerment and social exclusion, and men often abuse women in general.[38,39] Although illegal, it occurs in the United States, but the number is unknown.[4] Many affected women prefer a female examiner. The examiner should classify it according to the World Health Organization (Table 2),[41] which illustrations further clarify.[40]

Clinical Practice Contexts

Geographical origin, armed conflict, and immigrant status affect torture rates. Among US-resettled refugees, 44% of East Africans[42] and 56% of Iraqis[43] reported torture, and 85% of Burmese Karens reported war trauma or torture.[44] A total of 98% of Cambodians who had endured the Khmer Rouge regime had experienced combat, of whom 54% had been tortured.[45] Women more often than men suffer sexual torture.[25,46,47] Lesbian, gay, bisexual, and transgender individuals may be at particularly high risk.[48,49]

Three surveys of foreign-born patients at US urban facilities investigated torture. Of 121 New York City outpatients, 7% had been tortured; none had reported it to their primary physicians.[50] Of 142 Boston primary-care outpatients, 11% had been tortured, and 14% had a personal or family history; only 39% of the latter group had reported it to a health care provider. Of the Boston patients, 6% and 41% of people from the Americas/Caribbean and Africa, respectively, reported torture.[51] Among 342 New York City emergency department patients, 9% reported torture.[52]

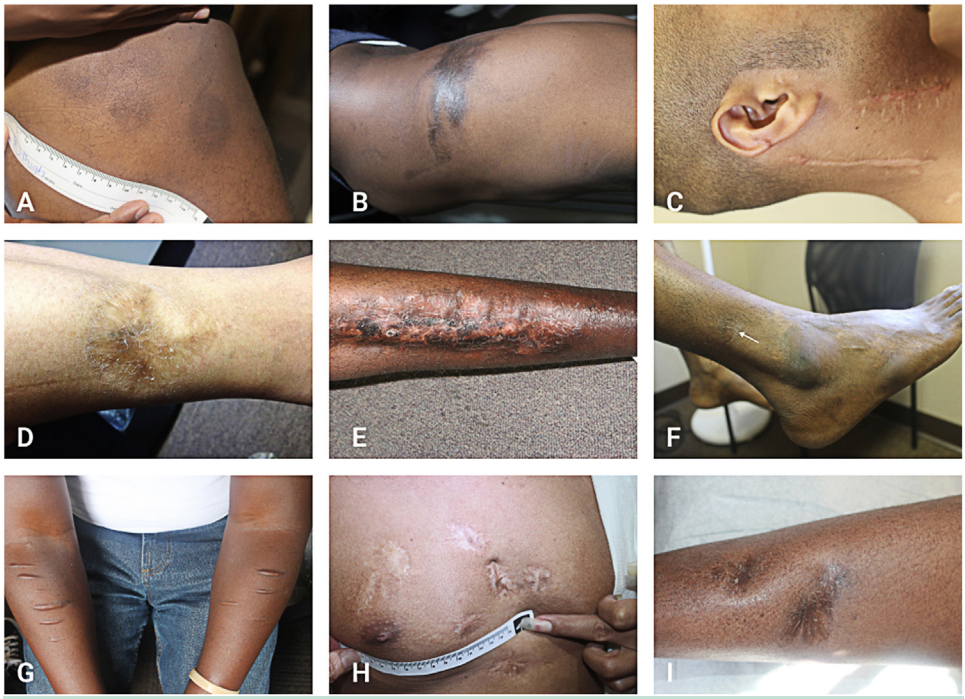

Figure Chronic skin abnormalities caused by torture-induced trauma and treatment (specified if performed): **(A)** Thigh hyperpigmentation due to multiple blunt traumas; **(B)** Posterolateral trunk hyperpigmentation due to burning from poured hot oatmeal; **(C)** Two neck scars from knife lacerations, sutured; **(D)** Lower leg scar from a wound that became infected; **(E)** Anterior tibial scar from injury caused by repeated rolling of a rolling pin over the tibia; **(F)** Lower leg scar (arrow) caused by rope suspension-induced abrasion by a rope tied above the ankles; **(G)** Forearm scars due to binding forearms together behind the back with wires and suspension from the wires; **(H)** Chest scars from multiple stab wounds; **(I)** Two lower calf scars due to blunt traumas, infection debrided. (A, G, H and I courtesy of Dr. Lydia Grypma).

Two-thirds of Minneapolis refugees had not discussed with physicians the effects of conflict, yet 74% wanted to discuss war trauma.[53]

Both physicians and patients may avoid discussing torture: Physicians due to inadequate time or emotional preparation for a disclosure,[54] or implicit bias;[55,56] and patients because of guilt, shame, mistrust, retraumatization avoidance,[50,53] deferring to physicians to initiate discussion, or not considering it health related.[53] These findings, cultural observations[57-62] and traumatized individuals' input[62-64] support best practices to provide care, including eliciting torture experiences (Table 3).

Physicians should routinely ask asylees and refugees if they experienced torture or other violence in their home countries.[50] We suggest a minor modification of a questionnaire with high sensitivity and specificity for eliciting torture experiences compared with psychological assessment.[51] First ask: "Were you ever harmed or threatened by the government, police, military, or rebel soldiers?" If affirmative, ask:

Table 1 Istanbul Protocol Levels of Consistency Between Alleged Harm and Physical Findings[14]

(a) "Not consistent with": the finding could not have been caused by the alleged torture or ill treatment.
(b) "Consistent with": the finding could have been caused by the alleged torture or ill treatment, but it is nonspecific, and there are many other possible causes.
(c) "Highly consistent with": the finding could have been caused by the alleged torture or ill treatment and there are few other possible causes.
(d) "Typical of": the finding is usually observed with this type of alleged torture or ill treatment, but there are other possible causes.
(e) "Diagnostic of": the finding could not have been caused in any way other than that described.

Table 2 World Health Organization Classification of Female Genital Mutilation[41]

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV: All other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

Table 3 Best Practices to Use With Survivors of Torture*

Learn to pronounce their names correctly.
Grant preferences for language- and dialect-matched professional interpretation.
Seek a preferred-gender practitioner and interpreter for trauma-sensitive and female genital mutilation and cutting examinations.
Ensure privacy and assess comfort needs.
Use unbiased, culturally sensitive questions.
Allow adequate time and follow the patient's lead in the order of care needs and treatment preferences, when possible.
Allow attendance by family members if the patient expresses that desire in absence of a family member.
Display compassion, empathy, and interest in their culture, including traditional healing practices.
Ask about their lives in their home country.
Ask about the historical context of their experiences.
Ask about mental health needs and concerns and the effects of torture directly.
Put aside assumptions and explore their experiences and perspectives on health care.
Realize that mental health and psychotherapy may be unfamiliar concepts.
Allow them to control what they disclose at the rate they prefer.
Normalize their physical and mental reactions to trauma and support their needs in a partnering approach.
Expect to build trust gradually.

*Derived from references.[40,50,53,57-64]

"Some people in your experience have experienced torture. Has that ever happened to you or your family?" If affirmative, ask what they feel comfortable sharing.

Although Westerners typically consider female genital mutilation and cutting barbaric, some affected women view it as a cultural tradition and do not regard it negatively. Physicians should avoid implying judgment, pity, discrimination, or undue emphasis; women have inferred these biases. A more neutral term, such as "circumcision," and other communication guidelines may be preferred.[40,64-66]

Certain torture methods cause specific long-term sequelae: wrist/handcuff restraint (de Quervain syndrome, nerve injury),[67] water submersion (chronic sinusitis), *teléfono* (ear injury), neck ligature (laryngeal damage),[68] electrical shocks (epilepsy), head trauma and suffocation (cognitive impairment), traction (brachial plexus injury), stabbing and fracture (nerve and spinal cord injuries),[69] and genital trauma (pain, bladder symptoms, sexual dysfunction).[70] Female genital mutilation and cutting commonly causes urinary disorders, scarring, pain, infection, infertility, sexual dysfunction,[40] and psychological consequences.[20,40] Common torture-unrelated somatic disorders among refugees and asylum seekers are infections, especially tuberculosis and hepatitis B,[71] and noninfectious diseases, especially hypertension, musculoskeletal disease, and diabetes.[72]

There may be no better example of trauma as a chronic condition[73] than torture and its sequelae. Posttraumatic stress disorder (PTSD) and chronic pain, especially fibromyalgia and headache, are strongly linked.[74-77] Many survivors have negative opinions of their pain care, including lack of practitioner interest, dismissal of their pain as psychological,[74] disempowerment, multiple diagnoses and treatments, and lack of service integration.[15,78] Because hospital procedures can resemble enhanced interrogation,[79] hospitalization seems likely to retraumatize some survivors. Many nonimmigrants, who also have painful disorders and negative health care experiences, manifest central sensitization ("increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input"),[80,81] which some torture victims also probably manifest.[74] In addition, depression, pain catastrophizing, and negative trauma-related concepts (beliefs of permanent damage and harm vulnerability) modulate pain in central sensitization and PTSD.[77,82] A validated pain questionnaire[83,84] may assist practice and research.

PSYCHOLOGICAL PERSPECTIVE

Psychopathology identification is complicated in some ethnic groups by varying cultural idioms for distress, including folk attributions, culture-bound syndromes, linguistic issues,[59] and different perceptions of what constitutes trauma.[46] Preferably, therapists with special knowledge of torture sequelae provide trauma-informed therapy and, when appropriate, refer patients for evaluation for pharmacologic treatment.[24,60,85]

Communication and Practice

Ideally, the therapist should be fluent in the patient's native language, although this is often unrealistic.[59] Many survivors do not speak of mental concerns easily; instead, they frequently manifest their mental anguish by reporting painful somatic symptoms.[74-77,82] Communication may be hindered by stigmatization from family and others, sometimes because of rape, pregnancy, disability, or other consequences of torture. Building trust with survivors is essential to elicit unvolunteered mental symptoms and alter the common belief that their trauma is a burden for them to bear alone. Forensic psychological evaluations are covered elsewhere.[20,58]

Mental Sequelae

The long-term mental effects of torture also stem from subsequent trauma, including forced relocation, dangerous transit to the United States, loss of culture or family, financial and housing instability, inadequate health care services, and other life disruptions.[86-88] Survivors can suffer additional trauma in detention, especially transgender individuals.[89] Isolation, hostility, violence, and racism also occur in settings apart from detention.[46]

Among refugees and other conflict-affected groups, torture was the strongest factor associated with PTSD.[90] Twelve studies of refugees, most of whom were tortured, revealed rates of PTSD, depression, and anxiety of 10% to 88%, 28% to 95%, and 23% to 81%, respectively.[47] Among

victims at a US torture treatment center, sex, older age, and unstable housing predicted more severe PTSD, depression, and anxiety. Time in the United States before presenting for services also predicted all three disorders. Multiple torture types predicted greater PTSD and anxiety. Mental health functioning measured psychometrically, lack of basic resources, and victimization risk were the strongest psychosocial predictors of PTSD, depression, and anxiety.[91]

Effectiveness of Psychotherapy

Many forms of psychotherapy have been used, and the patient-therapist relationship often determines efficacy. Trauma-informed therapy includes identifying pretorture mental disorders that may have increased vulnerability to harm. The therapist explores symptoms that often cause survivors to feel uniquely damaged. The therapist points out the cognitive and behavioral resiliency reflected by the survivor, reassures and supports realistic hopes, and jointly identifies treatment goals.

A large systematic review and meta-analysis revealed small improvements in PTSD and functioning posttherapy but not at follow-up. Depression was not improved. However, heterogeneity and biases limited the study.[92] A 10-year longitudinal study was reported on 54 refugees in Norway who had experienced severe trauma, nearly all of whom had PTSD, depression, and anxiety. After a mean of 61 therapy sessions, quality of life and functioning improved more than the mental disorders.[93] The interaction of pain and PTSD is reflected by a Danish study of individualized, multimodal therapy that improved PTSD, depression, and anxiety, but pretreatment pain interference predicted poorer outcomes of all 3 disorders.[94] Group therapy includes storytelling, expressive arts, food sharing, chants, dancing, and rituals. Many reports suggest benefit, but rigorous studies are needed.[95] Some complementary therapies combined with other therapies, including meditation, Ayurveda, and yoga, may be effective but also lack formal assessment.[96]

CONCLUDING COMMENTS

Torture survivors are more common in the United States than many physicians realize. After suffering extreme hardship in their home countries and enduring a complex route to safety, many have subsequent challenges, including chronic somatic and mental disorders. Providing affidavits is valuable for asylum applicants and preparing them and caring for survivors can be rewarding for practitioners. Survivors can consult one of the 34 nationwide, member organizations in the National Consortium of Torture Treatment Programs for specialized advice and care referrals.[97]

ACKNOWLEDGMENTS

We appreciate the helpful comments of Drs. Lydia Grypma and David Gangsei and the technical assistance of Mrs. Lauren Sherby.

References

1. United Nations. *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading. Accessed September 2, 2022.
2. Amnesty International. *Torture*. Available at: www.amnesty.org/en/what-we-do/torture/. Accessed September 2, 2022.
3. The Center for Victims of Torture. *What Is Torture?* Available at: https://www.cvt.org/who-we-are/frequently-asked-questions. Accessed September 2, 2022.
4. Goldberg H, Stupp P, Okoroh E, et al. Female genital mutilation/cutting in the United States: updated estimates of women and girls at risk, 2012. *Public Health Rep* 2016;131:340–7.
5. American Immigration Council. *Asylum in the United States*. Available at: https://www.americanimmigrationcouncil.org/research/asylum-united-states. Accessed September 2, 2022.
6. Office of the Law of Revision Counsel, US Code. 8 U.S.C. § 1101(a)(42)(A).
7. Office of the Law of Revision Counsel, US Code. 8 U.S.C. § 1158, 8 CFR § 208.13.
8. Code of Federal Regulations. 8 CFR § 208.18(a)(1).
9. Code of Federal Regulations. 8 CFR § 208.17.
10. Code of Federal Regulations. 8 CFR § 208.16.
11. Transactional Records Access Clearinghouse, Syracuse University. *Continued Rise in Asylum Denial Rates: Impact of Representation and Nationality*. Available at: https://www.trac.syr.edu/immigration/reports/448/. Accessed September 21, 2022.
12. Atkinson HG, Wyka K, Hampton K, et al. Impact of forensic medical evaluations on immigration relief grant rates and correlates of outcomes in the United States. *J Forensic Leg Med* 2021;84:102272. https://doi.org/10.1016/j.jflm.2021.102272.
13. Mishori R, Hannaford A, Mujawar I, et al. "There stories have changed my life": Clinicians reflections on their experience with and their motivation to conduct asylum evaluations. *J Immigr Minor Health* 2016;18:210–8.
14. Office of the United Nations High Commissioner for Human Rights. Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2022. Professional Training series No. 8/Rev. 2. Available at: https://www.ohchr.org/en/publications/policy-and-methodological-publications/istanbul-protocol-manual-effective-0. Accessed September 2, 2022.
15. Schippert ACSP, Grov EK, Bjørness AK. Uncovering re-traumatization experiencing of torture survivors in somatic healthcare: a qualitative systematic review. *PLoS One* 2021;16(2):e0246074. https://doi.org/10.1371/journal.pone.0246074.
16. McColl H, Bhui K, Jones E. The role of doctors in investigation, prevention and treatment of torture. *J R Soc Med* 2012;105:464–71.
17. Benninga Z, Steiner-Birmanns B, Arbel R, et al. Recognition and treatment of law enforcement violence against detainees and prisoners: A survey among Israeli physicians and medical students. *Torture* 2017;27:42–50.
18. Juckett G, Unger K. Appropriate use of medical interpreters. *Am Fam Physician* 2014;90:476–80.
19. Péres-Sales P. Defining and documenting threats in the context of ill-treatment and torture. Medical and psychological perspectives. *Torture* 2021;31:3–18.
20. Ferdowsian H, McKenzie K, Zeidan A. Asylum medicine: Standard and best practices. *Health Hum Rights* 2019;21:215–25.
21. Herath JC, Pollanen MS. Clinical examination and reporting of a victim of torture. *Acad Forensic Pathol* 2017;7:330–9.
22. Brewin CR. The nature and significance of memory disturbance in posttraumatic stress disorder. *Annu Rev Clin Psychol* 2011;7:203–27.
23. Saadi A, Hampton K, Vassimon de Assis M, et al. Associations between memory loss and trauma in US asylum seekers: a

retrospective review of medical affidavits. *PLoS One* 2021;16(3): e0247033. https://doi.org/10.1371/journal.pone.0247033.
24. El-Khoury J, Haidar R, Barkil-Oteo A. Psychological torture: characteristics and impact on mental health. *Int J Soc Psychiatry* 2021;67:500–6.
25. Dalgaard NT, Bjerre K, Thøgersen MH. Twenty-seven years of treating survivors of torture and organized violence—associations between torture, gender and ethnic minority status among refugees referred for treatment of PTSD. *Eur J Psychotramatol* 2021;12(1):1904712. https://doi.org/10.1080/20008198.2021.1904712.
26. Quiroga J, Modvig J. Torture methods and their health impact. In: Evans MD, Modvig J, eds. *Research Handbook on Torture: Legal and Medical Perspectives on Prohibition and Prevention*, Cheltenham, UK: Edward Elgar Publishing Limited; 2020:395–416.
27. Longstreth GF, Grypma L, Willis BA, Anderson KC. Foot torture (falanga): ten victims with chronic plantar hyperpigmentation. *Am J Med* 2021;134:278–81.
28. McKenzie KC, Bauer J, Reynolds PP. Asylum seekers in a time of record forced global displacement: the role of physicians. *J Gen Intern Med* 2018;34:137–43.
29. Deps PD, Aborghetti HP, Zambon TL, et al. Assessing signs of torture: a review of clinical forensic dermatology. *J Am Acad Dermatol* 2022;87:375–80. https://doi.org/10.1016/j.jaad.2020.09.031.
30. Peel M, Hughes J, Payne-James JJ. Postinflammatory hyperpigmentation following torture. *J Clin Forensic Med* 2003;10:193–6.
31. Clarysse K, Grosber M, Ring J, et al. Skin lesions, differential diagnosis and practical approach to potential survivors of torture. *J Eur Acad Dermatol Venereol* 2019;33:1232–40.
32. Ravanfar P, Dinulos JG. Cultural practices affecting the skin of children. *Curr Opin Pediatr* 2010;22:423–31.
33. Baralla F, Ventura M, Negay N, et al. Clinical correlates of deliberate self-harm among migrant trauma-affected subgroups. *Front Psychiatry* 2021;12:529361. https://doi.org/10.3389/fpsyt.2021.529361.
34. Cohen J, Pettitt J, Wilbourn E. Intentional burn injury: assessment of allegation of self-infliction. *J Forensic Leg Med* 2017;51:9–21.
35. Viero A, Amadasi A, Blandino A, et al. Skin lesions and traditional folk practices: a medico-legal perspective. *Forensic Sci Med Pathol* 2019;15:580–90.
36. Einterz E. Recognizing culturally related findings on refugee physical examinations. *J Am Board Fam Med* 2018;31:653–7.
37. Harivandi ZE. Invisible and involuntary: female genital mutilation as a basis for asylum. *Cornell Law Rev* 2010;95:599–626.
38. Lever H, Baranowski KA, Ottenheimer D, et al. Histories of pervasive gender-based violence in asylum-seeking women who have undergone female genital mutilation or cutting. *J Trauma Stress* 2022;35:839–51.
39. Wikholm K, Mishori R, Ottenheimer D, et al. Female genital mutilation/cutting as grounds for asylum requests in the US: An analysis of more than 100 cases. *J Immigr Minor Health* 2020;22:675–81.
40. Hearst AA, Molnar AM. Female genital cutting: an evidence-based approach to clinical management for the primary care physician. *Mayo Clin Proc* 2013;88:618–29.
41. World Health Organization. *Female Genital Mutilation: Fact Sheet No 241. 2013*. Available at: https://www.who.int/mediacentre/factsheets/fs241/en/. Accessed September 23, 2022.
42. Jaranson JM, Butcher J, Halcon L, et al. Somali and Oromo refugees: correlates of torture and trauma history. *Am J Public Health* 2004;94:591–8.
43. Willard CL, Rabin M, Lawless M. The prevalence of torture and associated symptoms in United States Iraqi refugees. *J Immigr Minor Health* 2014;16:1069–76.
44. Cook TL, Shannon PJ, Vinson GA, et al. War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study. *BMC Int Health Hum Rights* 2015;15:8. https://doi.org/10.1186/s12914-015-0046-y.
45. Marshall GN, Schell TL, Elliott MN, et al. Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA* 2005;294(5):571–9.
46. Abu Suhaiban HA, Grasser LR, Javanbakht A. Mental health of refugees and torture survivors: A critical review of prevalence, predictors, and integrated care. *Int J Environ Res Public Health* 2019;16 (13):2309. https://doi.org/10.3390/ijerph16132309.
47. Burnett A, Peel M. Asylum seekers and refugees in Britain. The health of survivors of torture and organized violence. *BMJ* 2001;322:606–9.
48. Bird C, Bowers G, Piwowarczyk L, Ng LC. Demographic characteristics, torture experiences, and posttraumatic stress disorder symptoms among asylum seekers and refugees persecuted for same-sex behaviors. *J Trauma Stress* 2022;35:1167–76.
49. Budhwani H, Hearld KR, Milner AN, et al. Transgender women's experiences with stigma, trauma, and attempted suicide in the Dominican Republic. *Suicide Life Threat Behav* 2018;48(6):788–96.
50. Eisenman DP, Keller AS, Kim G. Survivors of torture in a general medical setting: how often have patients been tortured, and how often is it missed? *West J Med* 2000;172:301–4.
51. Crosby SS, Norredam M, Paasche-Orlow MK, et al. Prevalence of torture survivors among foreign-born patients presenting to an urban ambulatory care practice. *J Gen Intern Med* 2006;21:764–8.
52. Hexom B, Fernando D, Manini AF, Beattie LK. Survivors of torture: prevalence in an urban emergency department. *Acad Emerg Med* 2012;19:1158–65.
53. Shannon P, O'Dougherty M, Mehta E. Refugees' perspectives on barriers to communication about trauma histories in primary care. *Ment Health Fam Med* 2012;9:47–55.
54. de C Williams AC, Baird E. Special considerations for the treatment of pain from torture and war. *Curr Anesthesiol Rep* 2016;6:319–26.
55. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics* 2017;18(1):19. https://doi.org/10.1186/s12910-017-0179-8.
56. Sabin JA. Tackling implicit bias in health care. *N Engl J Med* 2022;387:105–7.
57. Deps P, Charlier P. Medical approach to refugees: Importance of the caring physician. *Ann Glob Health* 2020;86(1):41. https://doi.org/10.5334/aogh.2779.
58. Baranowski KA, Moses MH, Sundri J. Supporting asylum seekers: Clinician experiences of documenting human rights violations through forensic psychological evaluation. *J Trauma Stress* 2018;31:391–400.
59. Raghavan SS. Cultural considerations in the assessment of survivors of torture. *J Immigr Minor Health* 2019;21:586–95.
60. Wylie L, Van Meyel R, Harder H, et al. Assessing trauma in a transcultural context: challenges in mental health care with immigrants and refugees. *Public Health Rev* 2018;39:22. https://doi.org/10.1186/s40985-018-0102-y.
61. Lurie JM, Pilato P, Kaur G. Female genital mutilation/cutting and birthing: enhanced education and training is critical for health care providers. *J Glob Health* 2022;12:03059. https://doi.org/10.7189/jogh.12.03059.
62. Shannnon PJ. Refugees' advice to physicians: how to ask about mental health. *Fam Pract* 2014;31:462–6.
63. Robertshaw L, Dhesi S, Jones LL. Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum-seekers in high-income countries: a systematic review and thematic synthesis of qualitative research. *BMJ Open* 2017;7:e015981. https://doi.org/10.1136/bmjopen-2017-015981.
64. Upvall MJ, Mohammed K, Dodge PD. Perspectives of Somali Bantu refugee women living with circumcision in the United States. A focus group approach. *Int J Nurs Stud* 2009;46:360–8.
65. Dixon S, Duddy C, Harrison G, et al. Conversations about FGM in primary care: a realist view on how, why and under what circumstances FGM is discussed in general practice consultations. *BMJ Open* 2021;11:e039809. https://doi.org/10.1136/bmjopen-2020-039809.
66. Michlig G, Warren N, Berhe M, et al. Female genital mutilation/cutting among Somali women in the U.S. state of Arizona: Evidence of treatment access, health service use and care experiences. *Int J Environ Res Public Health* 2021;18(7):3733. https://doi.org/10.3390/ijerph18073733.

67. Neufield MY, Kimball S, Stein A, Crosby SS. Forensic evaluation of alleged wrist restraint/handcuff injuries in survivors of torture utilizing the Istanbul Protocol. *Int J Legal Med* 2021;135:583–90.
68. Crosby SS, Mohan S, DiLoreto C, Spiegel JH. Head and neck sequelae of torture. *Laryngoscope* 2010;120:414–9.
69. Moreno A, Grodin MA. Torture and its neurological sequelae. *Spinal Cord* 2002;40:213–23.
70. Norredam M, Crosby S, Munarriz R, et al. Urologic complications of sexual trauma among male survivors of torture. *Urology* 2005;65:28–32.
71. Eiset AH, Wejse C. Review of infectious diseases in refugees and asylum seekers—current status and going forward. *Pub Health Rev* 2017;38:22. https://doi.org/10.1186/s40985-017-0065-4.
72. Amara AH, Aljunid SM. Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: a neglected health care need. *Global Health* 2014;10:24. https://doi.org/10.1186/1744-8603-10-24.
73. Herrera-Escobar JP, Schneider JC. From survival to survivorship—framing traumatic injury as a chronic condition. *N Engl J Med* 2022;387:581–3.
74. Amris K, Jones LE, Williams AC. Pain from torture: assessment and management. *Pain Rep* 2018;4(6):e794. https://doi.org/10.1097/PR9.0000000000000794.
75. Rometsch-Ogioun El Sount C, Windthorst P, Denkinger J, et al. Chronic pain in refugees with posttraumatic stress disorder (PTSD): a systematic review on patients' characteristics and specific interventions. *J Psychosom Res* 2019;118:83–97.
76. Carinci A, Mehta P, Christo PJ. Chronic pain in torture victims. *Curr Pain Headache* 2010;14:73–9.
77. Adams LM, Turk DC. Psychosocial factors and central sensitivity syndromes. *Curr Rheumatol Rev* 2015;11:96–108.
78. Board D, Childs S, Boulton R. Torture-survivors' experiences of healthcare services for pain: a qualitative study. *Brit J Pain* 2021;15:291–301.
79. Mishark KJ, Geyer H, Ubel PA. How hospital stays resemble enhanced interrogation. *Ann Int Med* 2020;173:572–3.
80. Wang XJ, Ebbert JO, Gilman EA, et al. Central sensitization and symptom severity and patient-provider relationships in a community setting. *J Prim Care Community Health* 2021;12:21501327211031767. https://doi.org/10.1177/21501327211031767.
81. International Association for the Study of Pain. *IASP Terminology*. Available at: https://www.iasp-pain.org/terminology?navItemNumber=576. Accessed September 2, 2022.
82. Nordin L, Perrin S. Pain and posttraumatic stress disorder in refugees who survived torture: the role of pain catastrophizing and trauma-related beliefs. *Eur J Pain* 2019;23:1497–506.
83. Kaur G, Weinberg R, Milewski AR, et al. Chronic pain diagnosis in refugee torture survivors: A prospective, blinded diagnostic accuracy study. *PLoS Med* 2020;17(6):e1003108. https://doi.org/10.1371/journal.pmed.1003108.
84. Tan G, Jensen MP, Thornby JL, Shanti BF. Validation of the Brief Pain Inventory for chronic nonmalignant pain. *J Pain* 2004;5:133–7.
85. Haroz EE, Ritchey M, Bass JK, et al. How is depression experienced around the world? A systematic review of qualitative literature. *Soc Sci Med* 2017;183:151–62.
86. Asgary R, Carpentier B, Burnett DC. Socio-medical challenges of asylum seekers prior and after coming to the US. *J Immigr Minor Health* 2013;15:961–8.
87. Namer Y, Razum O. Settling Ulysses: an adapted research agenda for refugee mental health. *Int J Health Policy Manag* 2018;7:294–6.
88. Griswold KS, Vest BM, Lynch-Jiles A, et al. "I just need to be with my family": resettlement experiences of asylum seeker and refugee survivors of torture. *Global Health* 2021;17(1):27. https://doi.org/10.1186/s12992-021-00681-9.
89. Minero LP, Dominguez S Jr, Budge SL, Salcedo B. Latinx trans immigrants' survival of torture in U.S. detention: A qualitative investigation of the psychological impact of abuse and mistreatment. *Int J Transgend Health* 2022;23:36–59.
90. Steel Z, Chey T, Silove D, et al. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. A systematic review and meta-analysis. *JAMA* 2009;302:537–49.
91. Song SJ, Subica A, Kaplan C, et al. Predicting the mental health and functioning of torture survivors. *J Nerv Ment Dis* 2018;206:33–9.
92. Hamid A, Patel N, Williams ACC. Psychological, social, and welfare interventions for torture survivors: A systematic review and meta-analysis of randomized controlled trials. *PLoS Med* 2019;16(9):e1002919. https://doi.org/10.1371/journal.pmed.1002919.
93. Opaas M, Wentzel-Larsen T, Varvin S. The 10-year course of mental health, quality of life, and exile life functioning in traumatized refugees from treatment start. *PLoS One* 2020;15(12):e0244730. https://doi.org/10.1371/journal.pone.0244730.
94. Nordin L, Perrin S. Pre-treatment pain predicts outcomes in multimodal treatment for tortured and traumatized refugees: a pilot investigation. *Eur J Psychotraumatol* 2019;10(1):1686807. https://doi.org/10.1080/20008198.2019.1686807.
95. Bunn M, Goesel C, Kinet M, Ray F. Group treatment for survivors of torture and severe violence: a literature review. *Torture* 2016;26:45–67.
96. Longacre M, Silver-Highfield E, Lama P, Grodin M. Complementary and alternative medicine in the treatment of refugees and survivors of torture: a review and proposal for action. *Torture* 2012;22:38–57.
97. National Consortium of Torture Treatment Programs. *Home Page*. Available at: https://www.ncttp.org. Accessed September 22, 2022.