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Refugee Board

Commission de l'immigration
et du statut de réfugié

Refugee Protection Division

TRAINING MANUAL ON VICTIMS OF TORTURE

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INTRODUCTION

About the Training Manual

The Training Manual on Victims of Torture provides guidance to IRB Members and Refugee Protection Officers (RPOs) of the Refugee Protection Division (RPD) on dealing with victims of torture in the context of refugee status determination proceedings. These materials were prepared to accompany a national training workshop on victims of torture and to serve as a resource for Members and RPOs after the workshop. The IRB would like to acknowledge the contribution of the Canadian Centre for Victims of Torture (CCVT) and Réseau d'intervention auprès des personnes ayant subi la violence organisée (RIVO) in the development of this Manual.

The Objectives of the Training Manual

It is a sad fact that some of the refugee claimants who come before the Board have been subjected to torture - a form of treatment that is so shocking and horrible it is almost unimaginable to us. They are walking reminders of the worst ways people can behave to fellow human beings. Yet come they do. And their claims need to be adjudicated. This Manual will make you more aware of, and sensitive to, issues faced by victims of torture, and better able to conduct a hearing involving a victim of torture. It will help you conduct a full and proper examination of the claim when dealing with a victim of torture, while at the same time taking any special needs they may have into account. The Manual also addresses issues relating to credibility, false allegations of torture, and corroborating medical/psychiatric reports.



Here are some of the questions this Manual will address:

- How do I reduce the risk of re-traumatizing the claimant?
- Why do victims of torture all seem to act differently?
- What do I do when the claimant has difficulty answering my questions?
- How does trauma affect memory?
- How can I be most effective in my questioning?
- How do I question the author of a medical/psychiatric report when I suspect the claimant is malingering?
- How do I recognise and address vicarious traumatization?

Scope of the Training Manual

The principles put forward in this Manual apply to all victims of torture who come before the Board, regardless of whether the claim for refugee protection is based on the experience of torture.

The Manual does *not* deal with *legal* issues relating to the definition of torture and the status determination of persons who have been tortured or may be at risk of torture if returned to their country. For further guidance on these legal issues, please refer to the Legal Services publication: “Consolidated Grounds: Persons in Need of Protection” (May 2002).

ABOUT TORTURE

It is a modern paradox that the systemic and widespread use of torture today is unprecedented, at the same time that it is so widely prohibited by international measures.¹

The 1948 UN *Declaration of Human Rights* states clearly that no one should be subjected to torture. Not to be subjected to torture is one of the few rights that may not be derogated: there can be no justification for torture nor mitigating circumstances for its practice. Other international instruments include the 1975 *Declaration Against Torture* and the 1984 *Convention Against Torture*. However, and in spite of this universal condemnation, Amnesty International describes torture as the “twentieth century epidemic.” Today, torture is practised in over 100 countries -- more than half of the world's countries.²

Not surprisingly, many of those countries in which torture has been reported, are refugee-producing. It is believed that a significant number of refugee claimants appearing before the IRB's Refugee Protection Division are victims of torture.

What is torture?³ In its simplest terms, torture is the infliction of severe physical or mental pain or suffering. An important feature of torture is that the torturer has complete physical control over the victim. A feeling of helplessness remains with the victim long after the torture episode is over. Pain and suffering are an integral part of torture, but the main purpose is not really pain and suffering but rather breaking of the will. Torture is directed towards instilling and reinforcing a sense of powerlessness and terror in victims and the societies in which they live. Torture is a purposeful, systematic activity - the *deliberate* infliction of pain by one person on another. This feature makes torture very different from trauma created in other circumstances such as a natural disaster.

¹ Joan Simalchik, “The Politics of Torture: Dispelling the Myths and Understanding the Survivor” excerpted from “Community Support for Survivors of Torture: A Manual” pp. 9-13, edited by Kathy Price Published by the Canadian Centre for Victims of Torture, Toronto, Ontario, 1995

² *Ibid.*

³ The following description has been adapted from: Elena O. Nightingale, “The Problem of Torture and the Response of the Health Professional”, Health Services for the Treatment of Torture and Trauma Survivors, J. Gruschow & K. Hannibal, eds., (Washington, DC: American Association for the Advancement of Science, 1990), p. 8-9 (cited in US Asylum Officer Basic Training Course, Interviewing Part V: Interviewing Survivors (February 1998))

Istanbul Protocol

“One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress than can lead to a deterioration of cognitive, emotional and behavioural functions. Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate physically a victim but also to disintegrate the individual's personality...By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children and other family members and relationships between the victims and their communities.”⁴

⁴ *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. High Commissioner for Human Rights (1999) p. 43

Definitions

Article 1 of the international *Convention Against Torture*⁵

For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

The World Medical Association in its “Declaration of Tokyo” (1975) defines torture as follows:

For the purpose of this declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

⁵ The Canadian *Immigration and Refugee Protection Act (IRPA)* adopts this definition of torture.

Methods of Torture

Following is a list of some common methods of torture. It would be impossible to create an exhaustive list all of methods of torture currently in use in the world. Torturers continue to develop new and more sophisticated methods of torture and ways to hide evidence of the torture.

Physical Torture

- blunt trauma: beating, punching, kicking, slapping, whipping, truncheons, falling down
- positional torture: forced body positions, suspension, stretching limbs, constraint of movement, binding
- crush injuries
- burning: instruments, cigarettes, scalding liquid, caustic substance
- stabbing with knife, cutting with knife
- wires under nails, electric shock
- mutilating body parts, traumatic removal of body parts
- amputation of digits and limbs, removal of organs
- asphyxiations: drowning, smothering, choking, chemicals
- chemical exposures in wounds, body cavities
- attacks by animals, dental torture
- exhaustion, forced labour, starvation

Sexual Torture

- rape, insertion of objects, sexual humiliation
- trauma to sexual organs, forced sexual acts, forced nudity

Psychological Torture

- threatening to harm or kill the victim or the victim's relatives
- forced witnessing or hearing the torture of others
- mock execution, forced to harm others
- denigration and humiliations, threats of attacks by animals
- violations of taboos, violation of religion

Environmental Torture

- sleep, light or hygiene deprivation
- exposure to extremes of temperature, sensory overload - loud noises, lights
- isolation
- denial of privacy, overcrowding

Pharmacological Torture

- hallucinatory drugs, toxic doses of sedatives or muscle-paralyzing drugs

Examples of Specific Types of Torture

Bell: the person's head is placed within a pail or other metal container which is then struck repeatedly, causing sudden loud sounds and reverberations

Buzzer: the person is repeatedly shocked through wires or other conducting objects that are attached to parts of the body (e.g., ears, eyes, eyelids, genitals, gums, soles of feet)

Falanga/Falaka/Basinado: repeated application of blunt trauma to the feet

Necklacing: a tire, filled with gasoline or similar flammable liquid, is placed around the person's neck and set afire; also, a method of psychological torture in which a landmine, grenade, or similar explosive is tied around the person's neck in a way that it is difficult or impossible to remove without detonation

Parrot's perch: hanging the victim from a stick between knees and arms bound tightly together

Submarino: covering the head with plastic bag, closure of the mouth and the nose, pressure or ligature around the neck, or forced aspiration of dusts, cement, hot peppers, etc (“dry submarino”) or forcible immersion of the head into water, often contaminated with urine, feces, vomit, or other impurities (“wet submarino”)

Suspensions: “cross suspension” (spreading arms and tying them to horizontal bar or beam), “butchery suspension” (fixation of hands upwards, together or one by one), “reverse butchery suspension” (fixation of feet upward, head downward), “palestinian suspension” (forearms bound together behind the back with the elbows flexed 90 degrees and the forearms tied to a horizontal bar or beam, or suspending from a ligature tied around the elbows or wrists with the arms behind the back)

Dispelling Myths About Torture

In order to understand torture and its practice, it is important to dispel certain myths about its nature and purpose.⁶

MYTH: *Torture is practiced by “less civilized” societies*

REALITY: There is no solace in the misconception that “others”, that is, people different than ourselves practice torture. Modern torture has occurred on every continent and employed within regimes of both the left and the right.

MYTH: *Torture is used primarily to obtain information or signed confessions.*

REALITY: Obtaining information and confessions is not the primary purpose of torture. Signing such confessions seldom leads to relief or release. Torture is directed towards instilling and reinforcing a sense of powerlessness and terror in victims and the societies in which they live. It is a process which generates a situation designed to destroy the physical and psychological capabilities of survivors to function as viable individuals.

MYTH: *Torture is meant to destroy the body*

REALITY: Torture is not intended to kill the body, but the soul. Doctors and medical personnel often participate during torture sessions so as to ensure that the victim will live long enough for the strategy to be effective.

MYTH: *Torture is practiced randomly*

REALITY: Rarely, if ever, is torture practiced randomly. Rather torture is used as part of a continuum of repressive measures and suppression of rights or as part of state policy in order to deter real or suspected dissidents.

MYTH: *Torture is punishment carried to an extreme*

REALITY: While torture may be utilized for a variety of purposes (for example, to punish, to obtain information, or to coerce a third party), a primary reason for its use is as a means of social control.

⁶ This section was adapted from Joan Simalchik's article, "The Politics of Torture: Dispelling the Myths and Understanding the Survivors", *supra*, note 1.

MYTH: *Torture exists outside of governmental responsibility*

REALITY: The state is often involved in torture, either directly or indirectly. Such involvement provides adequate authorisation and even a measure of justification for the torture.

MYTH: *Torture is performed by psychopaths or sadists*

REALITY: While there is no doubt that there are torturers who are drawn to the trade because they are sadists, most perpetrators are not. They are part of a larger apparatus of terror that can act to shield them from the consequences of their actions.

Compounding the problem of misperceptions about torture is a “wall of sustained disbelief” that prevents full comprehension of the enormity of torture. Most people simply try to avoid the topic entirely.⁷

⁷ *Ibid.*

THE EFFECTS OF TORTURE

“In ten years of conflict 56,000 young Americans were to die in the jungles, river deltas and rice paddies of Southeast Asia. Between 60,000 and 100,000 were subsequently to take their own lives. The conflict in Vietnam was the first war in recorded history whose combat deaths were later to be exceeded by the suicide of its veterans.”⁸

As the above statement reminds us, exposure to extreme trauma can have a devastating effect on a person. Given the extreme nature of the torture experience, it should not be difficult to understand how exposure to torture is likely to have a significant impact on the survivor and on that person's conduct at the Board. *All* victims of torture suffer some physical and/or psychological effects of the torture. It is believed that survivors of torture never fully recover from the experience.

The word “broken” is often used by victims to describe how torture has affected them. Victims of torture will always see the experience of torture as a reference point. Life will be described as “before” or “after I was tortured”. The individual's biography will be perceived as broken at that very point. Statements such as “I am no longer what I used to be” or “I can't seem to find myself any longer” are commonly heard, even years after torture took place.⁹

Some victims of torture will experience profound emotional reactions and psychological symptoms. The main psychiatric disorders associated with torture are post-traumatic stress disorder (PTSD), depression, adjustment disorder, and anxiety disorders. However, while everyone who is tortured is affected by the experience, it is important to recognise that not everyone who has been tortured develops a diagnosable mental illness. Consequently, Members and RPOs should not draw a negative inference from the fact that a person alleging torture does not have PTSD.

Following is an overview of some of the physical and psychological effects of torture.

⁸ Baigent and Leigh (1998), cited in Health Canada, *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* (2001) (Prepared by Jan I. Richardson)

⁹Dr. Paul Berdichevsky, “The Continuing Ordeal: Long Term Needs of Survivors of Torture” (www.ccvv.org/ccvtpublications.html)

Physical and Psychological Effects of Torture

Physical effects of torture may include:

- musculoskeletal aches and pains
- numbing and weakness
- neurological damage (numbing, weakness, motor function, strength or coordination)
- headaches
- fractures to bones
- skin damage (lesions, contusions, bruises, lacerations, burns, sharp trauma wounds)
- head trauma
- damage to internal organs
- gynaecological problems
- vision and hearing loss

Psychological effects of torture may include:

- re-experiencing the trauma (flashback and intrusive memories)
- psychic numbing (showing no or inappropriate emotion)
- detachment and social withdrawal
- impaired memory/loss of concentration/confusion
- anxiety and depression
- panic disorder/panic attacks
- sleep disturbances and nightmares
- somatic complaints (e.g. pains, headaches, stomach aches, nervousness, fainting, sweating, fatigue, weakness, loss of appetite or weight gain)
- fear (especially fear of authority)/phobias
- mistrust/suspiciousness/paranoia
- feelings of helplessness
- feelings of hopelessness/despair
- feelings of isolation/alienation/disorientation
- damaged self concept (feelings of shame, humiliation, worthlessness, loss of confidence)
- rage/outbursts of anger/aggressive behaviour/irritability
- dissociation/detachment and depersonalization
- hyperarousal,
- hypersensitivity
- thoughts of death or suicide

*Effects of Torture on Social Functioning:*¹⁰

- deterioration of the family structure, impaired ability to interact as a family member, impaired parenting skills
- deterioration of community ties
- impaired ability to hold a job and support oneself and one's family.

*Factors that May Compound Effects of Torture:*¹¹

- overwhelming grief or bereavement due to separation from and/or loss of loved ones
- overwhelming sense of guilt (survivor guilt, blaming themselves for their torture or for the torture of others)
- “culture shock”: adjustments problems arising out of resettlement to a new country
- uncertainty over status in Canada

¹⁰ US Asylum Officer Basic Training Course, Interviewing Part V: *Interviewing Survivors* (February 1998)

¹¹ *Ibid.*

DSM-IV Criteria for Posttraumatic Stress Disorder

309.81 Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following have been present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.
- B. The traumatic event is persistently reexperienced in one or more of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers (for the onset and duration of symptoms):

Acute: This specifier should be used when the duration of the symptoms is less than 3 months.

Chronic: This specifier should be used when the symptoms last three months or longer.

With Delayed Onset: This specifier indicates that at least 6 months have passed between the traumatic event and the onset of symptoms.

Associated Features and Disorders

Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job.

The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse), domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics. There may be increased risk of Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder.

Specific Culture and Age Features

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be “omen formation” - that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms such as stomach aches and headaches.

Prevalence

Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58%.

Individuals who have recently emigrated for areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political status. Specific assessments of traumatic experiences are needed for such individuals.

Course

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first three months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently the disturbance initially meets criteria for Acute Stress Disorder (see p. 429) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within three months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Differential Diagnosis

In Posttraumatic Stress Disorder, the stressor must be of extreme (i.e., life-threatening) nature. In contrast, in Adjustment Disorder, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor do not meet criteria for the diagnosis of Posttraumatic Stress

Disorder and require consideration of other diagnoses (e.g., a Mood Disorder or another Anxiety Disorder). Moreover, if the symptom response to pattern to the extreme stressor meets criteria for another mental disorder (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder. Acute Stress Disorder is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1-months and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder.

Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

Working with Survivors¹²

As I walked into the waiting room, I remember being struck by his appearance. Although he was almost exactly my age, I saw an old, tired-looking, white-haired man, his face deeply lined and drawn. I wondered what I had to offer this survivor of torture. Would I be able to help him recover from such a dreadful trauma? How could anyone come to terms with an experience which seemed to threaten some of the most basic human needs?

This was the first of many referrals from my colleagues at the Medical Foundation. I learned a great deal from him. For example, I got to know the real meaning of words which I had only ever come across in books and journal articles. I knew that *falaka* was a term applied to a form of torture in which the soles of the feet are beaten with a cane. I had to be told about the pain this causes, not just the first time as the soles of the feet are reduced to bleeding open wounds, but on each subsequent occasion as the scars (by now probably infected) are opened again and again. Even years later, it is often unbearably painful to walk more than a few hundred yards.

More than this, I learned that the worst aspect of his experience was not the personal suffering, but being forced to witness the torture and the deaths of others. Sham executions were often combined with genuine killings. After facing a firing squad, he would sometimes be the only one they did not kill. And the deaths were usually not accomplished so cleanly. In the dark crowded cells, people would be returned from torture only to die several hours later, without any possibility of relief in their final agonies.

In some ways this man is lucky. He is one of the survivors of torture. He had escaped from his own country and had been granted political asylum. He is relatively safe from further attack. Yet his life could never again be the same. He knew that he had been betrayed by a member of his family, someone to whom he had been particularly close. He would never again be able to trust or to live as freely as before. He would carry the chains of his torture to his death.

¹² Stuart Turner, "Working with Survivors" (1989) *Psychiatric Bulletin*, 13:173-176.

VICTIMS OF TORTURE IN THE HEARING ROOM

Ability to Testify

A refugee hearing, which can be stressful for any claimant, will be even more so for a victim of torture, even if he or she is not questioned directly on the torture experience itself.

It is almost certain that the experience of torture will have a negative impact on the claimant's ability to testify, regardless of whether the claimant is suffering from a psychological disorder. When you combine this with the fact that our hearings are the type of environment that will be uncomfortable for a victim of torture, it is clear that special measures need to be taken when questioning victims of torture. In order to understand these special measures, it is first necessary to have a better understanding of the difficulties a victim of torture may face in a refugee hearing.

It is very common for a victim of torture to feel stressed, vulnerable, powerless, and, even fearful in the setting of a refugee hearing. A victim of torture will probably be reluctant to talk about their experience of torture and other traumatic events. He or she may even be reluctant to talk about non-traumatic matters. It is also very common for a victim of torture to have difficulties with memory and concentration, and to behave emotionally in an unpredictable manner, even when the torture took place years earlier. This should not be surprising, given the extreme nature of the act of torture.

However, while virtually all victims of torture will find the hearing to be quite stressful, and virtually all will have some difficulty testifying, it is very important to understand that *there is no "typical" way a victim of torture will behave in the hearing room:*

“While there are consequences, there is not (and cannot be) a 'typical' profile of a torture survivor. Too many modifying and diverse elements factor into the equation for a viable profile to be constructed. Culture, belief systems, age, gender, social and family support (or lack thereof), and individual personality, all combine to influence the recovery process.”¹³

Thus, it is important that Members and RPOs not have any expectations about how a victim of torture *should* behave in the hearing room.

¹³ Joan Simalchik, *supra*, note 1.

No Obvious Signs

Even if you cannot tell that a claimant is currently experiencing problems, the symptoms of torture can still have an impact on the claimant's ability to testify at the hearing. In most cases there will not be any obvious signs that the claimant is having difficulty testifying. Indeed, the claimant will not usually tell you that she is experiencing a flashback, nor will it always be obvious to an observer. Moreover, the claimant is unlikely, for example, to tell you that he is trying to avoid answering questions that might touch upon the experience of torture. All of these difficulties are most likely to be internally manifested. This makes it all the more critical that Members and RPOs:

- Are aware of the various ways in which the experience of torture can have an impact on the claimant's ability to testify;
- Take steps to minimize the impact; and
- Are cautious in making any assumptions about credibility.

Following is a discussion of the primary ways in which the experience of torture can have an impact on the claimant's ability to testify.

Key Characteristics

FOUR KEY CHARACTERISTICS OF VICTIMS OF TORTURE IN THE HEARING ROOM

DENIAL/AVOIDANCE: A victim may avoid discussing events - using avoidance as a coping mechanism.

DIFFICULTY: A victim may have difficulty remembering events (or details of those events) and/or concentrating on the hearing and questions being asked.

FEAR/MISTRUST: A victim may have an intense fear and mistrust of persons in authority as well as settings that remind him or her of the torture experience.

UNPREDICTABILITY: A victim of torture may respond in emotionally unpredictable ways.

Denial/Avoidance

There are powerful disincentives to testifying about torture and other similar traumatic experiences. A person who has undergone a major traumatic experience may be very reluctant to re-live the emotions by relating events from which he or she has suffered. Being questioned during the hearing can trigger deep emotions and may exacerbate trauma-related symptoms. Denying or avoiding discussion of the torture is a common coping mechanism for a victim of torture and may or may not be conscious. Some victims of torture will also avoid discussing events because they fear not being believed. Indeed, some torture is so horrific it is almost beyond belief. Others may feel humiliated talking about their experiences - especially through an interpreter, and in front of strangers who often do not share the claimant's social and cultural background. Still others may believe that talking about their experiences might dishonour their family or community.

Difficulties Testifying

In addition to disincentives to testifying, it is quite common for victims of torture to have difficulty in relating their story, due to problems with memory, concentration and/or stress and anxiety. During their testimony, they may falter, appear confused, be unresponsive, retreat into prolonged silence, or provide explanations that lack coherence and seem contradictory. It is not unusual for a torture victim to break down and become incapable of coherent expression. These problems are intensified with increased anxiety. The impact of torture on memory is discussed in more detail below.

Fear/Mistrust

Victims of torture may be reluctant to testify because they mistrust or are afraid of the Member, RPO, or interpreter, who they perceive as persons in position of power and authority. Distrust is a common consequence of the torture experience. It is also a common survival technique - the claimant may have found it necessary to distrust everyone in order to make his or her escape.

As well, the enclosed hearing room and long periods of questioning could remind the victim of torture of the torture experience and make him or her feel fearful. Victims of torture may also be afraid of disclosing information that could place themselves or their family at risk. Thus, they may be afraid of what people in the hearing room will do with the information he or she provides.

This fear and mistrust may be manifested in a number of ways, including signs of emotional distress, avoiding eye contact with Members and RPOs, or avoiding answering questions.

Unpredictability

A victim of torture may behave in an emotionally unpredictable manner. He or she may lose composure, show inappropriate emotion, or be unresponsive. Some claimants will feel comfortable with a first-person, emotion-laden account. Others may be emotionally reserved, or show flat affect or may relate the incident in the third person. Some claimants may smile or laugh at what seem to you to be inappropriate times.

Members and RPOs need to be aware that their questioning may trigger an emotional response or the opposite could happen -- the claimant could appear emotionless. It is impossible to predict. As well, Members and RPOS need to be careful not to assume the claimant was not tortured if the claimant talks about the traumatic events with a lack of affect.

QUESTIONING VICTIMS OF TORTURE

Because the job of the Board is to conduct oral hearings and make well-reasoned decisions, victims of torture will most likely need to be questioned at the hearing, and, if considered necessary, have their credibility tested.

Obviously, we need to be very careful when dealing with victims of torture not to draw erroneous conclusions about their credibility.

How best to question a victim a torture? Questioning needs to be specially adapted when dealing with victims of torture (1) in order to try to avoid re-traumatising a victim of torture, and (2) because using standard questioning techniques with a victim of torture may simply be less effective in eliciting testimony that is complete and reliable.

This module sets out an approach to questioning that applies whenever there is an allegation of torture. Because any story of torture could be true, the member and RPO should approach all claims in the same manner.

Not Always Necessary to Question on the Torture Incident

As a basic principle, unless there are *significant* credibility concerns, it will not be necessary to ask for details about the torture incident itself. In most cases, the claim can be examined through questioning on other areas of the claim or by questioning *around* rather than *about* the torture incident. However, even when the questioning is not on the torture incident itself, we must still adapt our questioning style to take into account the difficulty the victims of torture may have in testifying on other aspects of the claim. As discussed in the previous section, a victim of torture may be reluctant to testify about non-traumatic events and may feel stressed and fearful in the hearing room setting.

A Balancing Act

Just because it can be difficult to question a victim of torture this does not mean that the claim should not be thoroughly examined. Legitimate problems of credibility may still arise in claims involving torture, just as in other refugee claims. Moreover, some claimants make false allegations of torture and we need to be able to conduct an effective examination into the claim. However, we do not know at the start of the hearing whether the claim is genuine or not, and when presented with a claimant who is having difficulty testifying, we do not know whether the difficulty is due to the effects of torture or because the claimant is not being truthful. We are then faced with a balancing act: we need to probe the claim but also need to take steps to avoid re-traumatising the legitimate claimant. This balancing act is a necessary condition of our work.

Overcoming Your Inhibitions

If you find yourself having to ask the claimant about the torture, you will need to try to overcome any inhibitions you may have about questioning victims of torture and hearing about the abuse they have suffered. Hearing stories of torture and asking questions about it can be very distressing and uncomfortable. You may feel very uncomfortable asking questions about the very personal matters involved in physical, psychological and sexual abuse. The important thing to remember is that it is a valid part of your job to ask these questions and that as a professional you are expected to be able to overcome your inhibitions so that you are able to conduct an effective examination of a victim of torture.

The Basic Approach

As a starting point, consider the following observation of a psychiatrist who deals with victims of torture on a regular basis:

While certain information may need to be obtained, doing so in a way which is intrusive or insensitive generally leads to less trust and less information.¹⁴

Adapting our style of questioning when dealing with victims of torture serves two main purposes: (1) it elicits more information and (2) reduces the risk of re-traumatizing the claimant.

There are five basic considerations:

1. Have the Right Attitude
2. Put the Claimant at Ease
3. Explain the Reason for Your Questions about Torture
4. Use Recommended Techniques to Elicit Testimony
5. Deal Effectively with Extreme Situations

1 - Have the Right Attitude

- Show respect for the claimant in your tone, language and attitude
- Treat the claimant as a “whole person” not a “victim”
- Treat the claimant with humanity
- Remember that there is no particular way in which victims of torture should be expected to behave in the hearing room
- Remember that a story of torture may sound unbelievable but be true

¹⁴ Dr. Donald Payne, "*Relating to Survivors of Torture in Bureaucratic Settings: Developing Sensitivity in Office Procedures*" (www.ccvv.org).

- Remember that problems with testifying do not mean the story is false - we would expect the legitimate victim of torture to have difficulties testifying
- Remember that you are not the claimant's therapist - you may acknowledge the claimant's pain and distress, but maintain your professional boundary

2 - Put The Claimant At Ease

Remember that a victim of torture probably (and with good reason) has a fear of persons with power and authority. The danger is that this will interfere with the communication process. A refugee hearing can be extremely intimidating, especially to a victim of torture. The risk can be reduced by putting the claimant at ease. Here are some ways to put the claimant at ease:

Before the Hearing

If you know beforehand that the claimant may be a victim of torture, there are a number of steps you can take to ensure the physical environment is as comfortable, informal and non-intimidating as possible and to reduce other possible barriers to communication. Following are a number of suggestions:

- Take steps to avoid creating waiting room anxiety - waiting can remind people of their torture - make sure the hearing will start on time
- While in most cases, the hearing will take place in a regular hearing room, in some cases it may be appropriate to hold the hearing in a less formal interview room with the participants sitting around a table. Even if the hearing is held in a regular hearing room, steps can be taken to make the environment better. For example, you can ensure the claimant has a comfortable chair and plenty of water
- Make sure the interpreter is aware of the sensitive nature of the claim and that there is sufficient opportunity for the claimant to become comfortable with the interpreter
- If an application to change the order of questioning has been made, consider whether there are “exceptional circumstances” for departing from the practice of having the RPO question first¹⁵
- Depending on the alleged facts and socio-cultural considerations, it may be appropriate to ensure that the Member, RPO and/or interpreter are all a particular gender. Cases in which the claimant suffered torture of a sexual nature are the most likely to raise this concern. You may wish to consult with counsel for the claimant on this matter
- In some situations putting the claimant at ease may mean ensuring the interpreter is not from the same ethnic group as the person(s) who tortured the claimant.

¹⁵ IRB Chairperson's *Guidelines Concerning Preparation and Conduct of Hearing in the Refugee Protection Division* (2003).

- If there are other claimants or witnesses expected to be present during the hearing determine whether the claimant is willing to testify in their presence and take appropriate steps as necessary
- Consider creating a less formal environment by having the Member and RPO introduce themselves to the claimant before the hearing starts
- In certain cases where there is evidence the claimant may have an extremely difficult time in the hearing room, it may be a good idea to hold a pre-hearing conference to discuss how to proceed and how to best elicit testimony

During the Hearing

- Establish a good rapport with the claimant at the outset of the hearing to build the claimant's confidence and trust
- Never start the hearing by questioning on the torture experience - question on “easy” topics first
- Consider, where appropriate, asking the claimant if he or she is taking any medication that may impact on his or her ability to testify
- Give the claimant your full attention when you are questioning and make natural eye contact
- Be aware of non-verbal communication. Remembering that power issues are central in torture situations and that victims of torture often have gained a keen ability to read nonverbal signs in order to stay alive, will help you be mindful of the potential impact of gestures you make in the hearing room. For example, you should not: stare, look away while questioning, use large, sweeping and forceful gestures, point, tap your fingers, clench your fists, slouch, sigh, or roll your eyes. Such gestures may be taken as accusatory, intimidating, or suggestive of a lack of interest
- Take steps to ensure the claimant feels a sense of control. A major issue for victims of torture is loss of control, which was a key part of the torture experience - asking open questions at the beginning of the examination can help give the claimant a feeling of control
- Make sure the claimant understands the purpose and nature of the proceedings (especially important if the claimant is unrepresented)
- Emphasize the confidentiality of the proceedings
- Don't rush the pace of the hearing
- Take cues from the claimant about his or her emotional state and adjust your style of communication accordingly - try to match the claimant's tone and volume
- Give the claimant ample opportunity to ask questions throughout the hearing Consider asking, “what questions do you have?” instead of asking “do you have any questions?”
- Tell the claimant that he or she may request a break as necessary, may interrupt in order to ask for clarification or repetition of a question or may ask to stop the hearing if he or she is having difficulty
- Don't be afraid of emotion: if the claimant starts to show a lot of emotion, go with it rather than backing off - strong emotions are a normal consequence of talking about torture

- Understand that a claimant may wish to bring a person to the hearing room to provide him or her with emotional support and take appropriate measures to accommodate such persons

3 *Explain The Reason For Your Questions About Torture*

If it is necessary to go into detail about the torture, the claimant will be more at ease if the claimant understands why he or she is being asked to talk about the torture experience. It is therefore recommended that you begin your examination on the torture by telling the claimant the reason for your questions and by acknowledging that you are aware that it can be difficult to testify on such matters. For example, you could say:

“We need to know a little more about what happened when you were being questioned. We don't expect you to remember every detail but we would like you to describe what happened to you. We know it is difficult for you to testify about this, but it is important for us to understand what happened to you in order to make a decision.”

Then, before you begin questioning, ask the claimant if he or she has any concerns in order to give the claimant the opportunity to voice any concerns, fears or objections to the process. Ask:

“Do you have any concerns before I begin questioning?”

4 - *Use Recommended Techniques to Elicit Testimony*

The Golden Rule

Let the claimants tell their stories in their own words and at their own pace

Start with an Open Question

There are two important reasons why it is important to begin questioning with open questions:

- (1) Open questions may help a victim of torture feel more in control than closed questions and therefore make it easier for the claimant to testify; and
- (2) Open questions will provide the best possible means of assessing the veracity of the claimant's statements. As much as possible, you need to have the story in the claimant's own words, uninterrupted, and at the claimant's own pace.¹⁶

Open questions cannot be answered with “yes,” “no,” or a simple fact. They often begin with “what,” “how” or “why.” Here are a few sample open questions:

- “What happened when you were taken to the interrogation room?”
- “How were you treated in prison?”
- “Can you please describe a typical day in prison?”

Depending on the amount of information provided by the claimant in response to the first open questions, you can decide whether to ask another open question, such as:

- “What happened next?”
- “Please describe the cell/room/etc”
- “Please tell us more about that”
- “Is there anything else you would like to add?”

Once the claimant has provided the basic information in response to these open questions, you can back up and, if necessary, ask closed questions to elicit further details or clarify areas of the testimony.

A good technique in questioning a claimant about a torture experience is to employ the **T-funnel approach**. That is, to begin with open questions and then follow-up with closed questions, gradually narrowing the scope of the inquiry, and eliciting more pertinent details.

Having in-depth knowledge of conditions in the claimant's country will assist you in formulating questions that are relevant and accurate, and will help you avoid asking unnecessary questions or confusing the claimant.

Testing Credibility

Refer to “False Allegations of Torture” below for guidance on questioning when the credibility of the torture story is in issue.

¹⁶ See the discussion below for information about false allegations of torture.

*Maximizing the Reliability of the Testimony*¹⁷

- Let the claimant tell the story in his or her own words: using open questions will help to achieve this
- Check the claimant's understanding of your questions and the proceedings, as necessary
- Avoid leading questions (for example, do not ask, “were you tortured?” but rather “what happened when you were in custody?”)
- Try re-phrasing your questions to see if this resolves inconsistencies

Techniques to Avoid

As is the case with all claimants, the following “interrogation” styles of questioning should be avoided when questioning victims of torture:

- Rapid questions
- Rushing the claimant
- Confrontational style
- Repeating questions
- Strings of closed questions
- Changes in attitude, approach, demeanour
- Loud or aggressive voice, gesturing
- Interrupting or cutting off
- Expressing disbelief
- Attempts to catch or trip up the claimant

Use Minimal Encouragements

Using “minimal encouragements” is a gentle way to persuade the claimant to continue and to convey that you are following the claimant's testimony. Using “minimal encouragements” can help in situations where the claimant is struggling with his or her testimony or where you would like to direct the flow of the testimony. The minimal encouragements technique uses forms of verbal prompting such as “and then,” “go on” “umm humm,” and “right” or the repetition of a few key words from the claimant's previous response. For example:

- Claimant: The warden came into the cell again that evening. I was afraid to even turn around when I heard him enter. (pause)
- RPO: Please continue...
- Claimant: I knew what was coming. I heard screaming from the next cell the hour before and knew the warden had been in there questioning that inmate. (pause)
- RPO: Go on....

¹⁷ Camille Giffard, *The Torture Reporting Handbook* (www.essex.ac.uk/torturehandbook/english.htm)

Dealing with Silence

The general rule is: do not break silences too quickly. Sometimes, an interested and expectant silence from the questioner may encourage a claimant to talk more freely. Breaking a silence too quickly may deprive the claimant of the opportunity to respond effectively. When you encounter silence, don't assume that the claimant is buying time to make up a false answer. Especially in the case of victims of torture, it is more likely that he or she simply needs time to get control of his or her emotions, or collect his or her thoughts. Silences are more likely to occur following a general or open question than a direct or closed question. Avoid the tendency to interrupt the silence with a more specific question. While this second question may produce a quick response, you will be depriving the claimant of the opportunity to reveal the importance he or she attaches to the issues that will emerge in his or her response to the first question.

Acknowledge the Difficulty

After the claimant finishes testifying about the torture experience, it is recommended that you acknowledge that the claimant has had a difficult time testifying. For example, you could say the following:

“I know that was difficult, but it's good that you told me. Do you have anything else to tell me about this”?

Additional Points

- In some cases you may not be able to complete your questioning within the usual time frames.
- A victim of torture may not have told his or her counsel, or anyone else, about the torture, or its details, before the hearing. The refugee hearing may thus be the first time a person ever speaks about his or her experience, resulting in a greater potential for trauma.
- Victims of torture appearing before the Board unrepresented present special difficulties and will require special care to minimise the potential for traumatising the claimant.

5 - Deal Effectively With Extreme Situations

If after trying the techniques described above the claimant remains extremely upset or reluctant to testify, or seems to have severe memory or concentration problems, you can try the following:

- Shift the focus of the questioning to a non-threatening subject until the claimant regains composure
- If the claimant dissociates, speak softly and slowly bring them back to reality
- Offer verbal assurances
- Take a recess
- Hold a mid-hearing conference to decide how to proceed. In some situations, you may need to adjourn the hearing for a medical or psychiatric evaluation - and, depending on the results, it may appropriate to consider alternatives to oral testimony, such as a sworn statement or video-taped evidence or, where the person is considered “unable to appreciate the nature of the proceedings” to designate a representative for that person ¹⁸ Before deciding to take any special measures, the Member will need to take into account any costs that may be involved.
- Remember that, generally speaking, even claimants who are extremely upset will usually prefer to continue the hearing rather than re-schedule to another day
- Consider whether there is enough evidence to make a decision, obviating the need for further testimony from the claimant.

Trauma, Memory and False Allegations

Our assumptions and beliefs about memory can be a key element in assessing the credibility of alleged victims of torture. While some claims are legitimately rejected on the basis that the claimants cannot provide sufficient details about their torture experiences, or omitted important details in earlier statements, there is also a risk that genuine victims of torture may be rejected when decision-makers draw wrong conclusions about their memory difficulties. What then should our expectations be in terms of a victim of torture’s ability to remember? This section provides an overview of how memory works, how trauma can affect memory, and some tools for distinguishing genuine memories from fabricated ones.

Basic Features of Ordinary Memory

As defined by Schactel (1947):

Memory as a function of the living personality can be understood as a capacity for the organization and reconstruction of past

¹⁸*IRPA* s. 167(2)

experiences and impressions in the service of present needs, fears, and interests.

Explicit memory¹⁹ is considered to be “an active and constructive process.”²⁰ Memory does not record an accurate copy of the event, but rather an *interpretation* of the event. Memory tends to be a mixture of real events somewhat accurately recalled and “what the person intuits, hears or infers must have happened.”²¹ It may also be distorted by post event information, and the context and emotional state at the time of recall.

According to this “reconstructive model” of memory, there are three stages of acquisition (1) encoding, (2) retention and (3) retrieval, and there are “threats to the integrity of memory” at all three of these stages.²² For example, a person may not be able to pay attention to everything that is happening, or may encode the information but may forget some of it over time, or may have encoded and retained the memory but later have trouble retrieving the information.

There are four major sets of circumstances under which memory tends to be inaccurate:²³

- Poor environmental conditions at time of event (e.g. low lighting)
- Sub optimal observer states at time of event (e.g. high stress, perceived or directly inflicted violence, diverted attention)
- Memory-distorting problems during the retention interval (e.g. lengthy interval, inaccurate post-event information)
- Errors introduced at the time of retrieval (e.g. leading questions)

Clearly, we need to be mindful of these opportunities for memory distortion when questioning alleged victims of torture and assessing the accuracy of their memory. We need to ask questions that draw out evidence related to the conditions described above in order to get as complete picture as possible.

There are other important characteristics of ordinary memory that need to be taken into account when questioning a person about apparent memory problems and assessing the results. These characteristics include:²⁴

¹⁹ Explicit memory is memory which is verbally accessible. Implicit memory is memory without awareness.

²⁰ Bessel A. van der Kolk & Rita Fisper, “Dissociation and the Fragmentary Nature of Traumatic memories: Overview and Exploratory Study” (1995) (www.trauma-pages.com)

²¹ Goodman, et al., (1999) cited in Mitchell K. Byrne, “Trauma Reactions in the Offender” *International Journal of Forensic Psychology* May 2003, Vol. 1, No. 1 pp. 59-70.

²² Byrne, *supra*, note 21.

²³ Geoffrey R. Loftus, PH.D “Declaration in the case of Javier Suarez Medina” (www.internationaljusticeproject.org/pdfs/jsmedinaLoftus.pdf)

²⁴ Dr. Juliet Cohen, “Errors of Recall and Credibility: Can Omissions and Discrepancies in Successive Statements Reasonably be Said to Undermine Credibility of Testimony?” (2001) The Medico-Legal Society (www.medico-legalsociety.org.uk)

- Over time, memory tends to deteriorate and become less accurate, details tend to be lost, and become generalized, sometimes merging with similar memories
- If little personal significance and meaning is attached to information, recall will be less easy
- Memory for dates and times is “notoriously unreliable”
- People remember more details about personal autobiographical memories over repeated recall sessions, even when they thought they could not recall any further (called “hypermnesia” or the “reminiscence” effect)
- Memory varies significantly from one retelling to the next (facts not the same and new detail added)
- Memories (especially more recent ones) are largely reconstructed on recall, rather than being reproduced

It is clear that there is significant variability in autobiographical memory - even ordinary, non-traumatic memories are not necessarily accurately encoded, retained or retrieved, and often change with each retelling.

Trauma and Memory

While ordinary, non-traumatic memory is highly variable, it is clear that errors in the encoding, retention and retrieval of memories can be compounded in the case of trauma.

“If the reliability of memory is on shaky ground to begin with, it is not surprising that trauma can influence both the completeness and accuracy of the memories with which it is associated.”²⁵

Memory is “especially vulnerable to failure when associated with highly emotionally arousing events - especially the “attentional and perceptual processes.”²⁶ For example, under conditions of high arousal, people experience a significant narrowing of consciousness, and remain focussed on the *central* perceptual details, at the expense of the peripheral details.²⁷ Some information will be never encoded, or, if encoded, will not be stored.

Traumatic memories appear to be *qualitatively* different than memories of ordinary events – emotional and perceptual elements tend to be more prominent than declarative (explicit) components. Van der Kolk & Fisler²⁸ assert that it is the very nature of traumatic memory to be *dissociated*,²⁹ and to be initially stored as sensory fragments without a coherent semantic component. It consists of images, sensations, affective and

²⁵ Byrne, *supra*, note 21.

²⁶ *Ibid.*

²⁷ Christianson and Loftus (1991) cited in Byrne, *supra*, note 21.

²⁸ van der Kolk & Fisler, *supra*, note 20.

²⁹ A disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment – DSM IV

behavioural states that are invariable, do not change over time, are state-dependent, and cannot be evoked at will.

It is recognized that trauma can lead to “extremes of retention and forgetting” the experiences may be remembered with extreme vividness, or totally resist integration, or a combination of both.³⁰

Thus, there may be amnesia for some or all of the traumatic event. Such amnesias, with later return of memories for all or part of the trauma, have been widely noted in the literature on trauma victims.³¹ It may last for hours, weeks, or years, until recall is triggered by exposure to sensory or affective stimuli that match sensory or affective elements associated with the trauma. At that point, the person can begin to construct a narrative of the event. However, in some cases, problems relating to dissociation can cause continuing memory problems. For example, some trauma survivors may only be able to access to their implicit memory of the event and will not be able to provide a narrative account.³²

At the other end of the spectrum are intrusive memories of the trauma. The initial remembering of a traumatic event is believed to consist of intrusive flashback experiences. Even when a person has been able to construct a narrative of the events there is a tendency to still experience these intrusive flashback sensations. Intrusive memories are one of the key characteristics of Post-Traumatic Stress Disorder.

While PTSD is the disorder we most often encounter when dealing with victims of torture at the Board, it is also important to recognise that there are other factors that can have a negative effect on memory functioning such as sleep disorder, anxiety, depression, chronic pain, malnutrition, or severe weight loss³³. Thus, even where the victim of torture does not have a medical report with a diagnosed illness, we should not overlook these other possible reasons for impaired memory function.

Summary

Because of the variable nature of memory and the impact of trauma on memory processing, the presence of credibility problems such as inconsistencies and omissions should not necessarily indicate that the memory is not a genuine reconstruction from autobiographical memory.³⁴

False Allegations of Torture

³⁰ van der Kolk & Fisler, *supra*, note 20.

³¹ *Ibid.*

³² *Ibid.*

³³ Cohen, *supra*, note 24.

³⁴ Cohen, *supra*, note 24.

What is the best approach to take when it is suspected that the claimant is not a genuine victim of torture? This section discusses the importance of getting a “true version” of the alleged events, how to distinguish real memories from fabricated ones, and various methods of questioning to draw out the right kind of evidence for assessment.

Getting the True Version

It is believed that the best way to uncover false allegations is to have the “true version” of the claimant's statement to examine.³⁵ The true version is the statement of the alleged incident made by the claimant in his or her own words and without interruption. If you have a true version of the claimant's statement you will be able to have more confidence in drawing conclusions about the veracity of the claimant's story. Why is this so? A true version will allow the legitimate claimant to demonstrate the credibility of the story – to impress you with his or her credibility. The “feel” of a true story is more likely to come through if the claimant is given freedom in telling his or her story. Conversely, a true version is more likely to expose a false allegation than eliciting the testimony through other means, because it will better enable you to analyze whether the story is being told through real memory. With a false story, the claimant will have memorized details and will be simply recalling them in response to questions. However, a true story will be described using the senses and displaying other characteristics associated with a real memory.

Real Versus Fabricated Memories

It has been found that real memories tend to reflect³⁶:

- greater sensory detail (such as colours, size, shape and sound)
- greater mention of geographic detail
- more mention of cognitive or other internal processing e.g. thoughts, emotions, reactions
- fewer verbal hedges (e.g. I think so, I believe, I'm not sure)

It has also been found that real memories tend to be described in a spontaneous manner.³⁷ On the other hand, an invented or coached memory would tend to be rigid, have an overly strict chronology. As well, with an invented memory, two different accounts of the event might be very similar, not showing signs of the reminiscence effect (that, with an actually experienced event, recall varies with each telling) expected to occur with a real memory.

³⁵ Adapted from a presentation to the IRB by Detective Wendy Leaver, Toronto Police Department.

³⁶ Gudjonnsen (1992) and Schooler, Gerhard and Loftus (1986) cited in Cohen, *supra*, note 24. (note that this list is based on comparisons of real and suggested memories).

³⁷ John C. Yuille, Ph.D. *Fact Finding and the Judiciary: Second Part* (1996)

Questioning

The basic approach is to make sure the claimant is given a full opportunity to describe the story in his or her own words so that the determination of whether or not the memory appears to be “real” can be properly made. Questioning should be directed at eliciting evidence of the characteristics listed above that are associated with real memories.

A person who actually experienced torture will have “a unique, personal memory of the event”³⁸ and in retelling the story will usually describe events referring to one or more of the five senses (sight, hearing, touch, smell, taste) as well as some of the other characteristics listed above. For example, the claimant might say: “I was in a very dark, damp room that smelled like mould...this room was much smaller than the first one I was taken to...I was finding it very difficult to breathe and could hear myself breathing very loudly.”

Asking open questions of the alleged victim of torture is the appropriate strategy for eliciting evidence that can be analyzed for these characteristics. Indeed, it would be difficult to determine the presence or absence of these characteristics if the claimant merely responded to a series of closed questions.

Start your inquiry about the torture incident with one or two very general open questions, such as

- Can you please tell me what happened to you?
- What happened next?

Then, if you are still unsure about the credibility of the torture story, you can continue by asking additional open questions that may draw out answers involving the claimant's senses. For example:

- Please describe the room you were in
- What do you remember hearing?
- How did that make you feel?
- How did you respond?
- What do you remember thinking about?

Remember that there is often a fine line to tread in questioning an alleged victim of torture - one needs to fully examine the claim but one needs to avoid traumatising the legitimate claimant.

Another technique, which can be used where there appears to be a low risk for re-traumatisation (for example, where the claimant has thus far in the questioning appeared relatively comfortable talking about the torture incident), is to ask the person to imagine that he or she is at the scene – and to describe it through his or her own eyes, using the

³⁸ Detective Leaver, *supra* note 35.

present tense to re-enact. This will help draw out evidence to analyze in view of the characteristics listed above.

The presence of “visual cues” that tend to support a real allegation of torture, such as changes in expressions, gesture, body language indicating emotional and re-enactment of posture during torture can enhance the credibility of the claimant’s statements.³⁹ However, Members are cautioned against relying on the claimant’s demeanour in drawing *negative* credibility inferences.

As the testimony unfolds, you may also need to follow-up on inconsistencies and omissions. When doing so, be careful not to confuse the claimant with complicated set ups to your questions. Also, remember to give the claimant ample opportunity to explain. Finally, you should also avoid dwelling on credibility concerns pertaining to peripheral details of the traumatic event because they may not have been properly encoded in the person’s memory. Generally speaking, in the case of an alleged victim of torture we should not have inflated expectations in terms of accuracy and consistency of recall. The following advice given to physicians conducting evaluations of torture is also applicable in our context:

If possible, the clinician should ask for further clarification [when inconsistencies arise]. When this is not possible, the clinician should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person’s story. *Although the individual may not be able to provide the details desired by the clinician such as dates, time, frequencies, and exact identities of perpetrators, overall themes of the traumatic events and torture will emerge and stand up over time.*⁴⁰ [Emphasis added]

Remember that a false allegation can range from a slightly distorted report of an actual event to a complete fabrication of an event. In some cases, the claimant may be fabricating aspects of the story but nonetheless fulfill the criteria for refugee protection.

³⁹ Dr. Juliet Cohen, *supra*, note 24.

⁴⁰ Physicians for Human Rights, *Examining Asylum Seekers: A Health Professional's Guide to Medical and Psychological Evaluations of Torture* (2001) p. 31.

MEDICAL/PSYCHIATRIC REPORTS

A medical and/or psychiatric report can have an impact on the hearing in many ways. For example, a report can:

- Corroborate the claimant's evidence in support of the claim for refugee protection (assess the degree of consistency between the person's account of torture and the findings made during the evaluation)
- Provide an expert opinion about any difficulties the claimant may have in testifying at the hearing or in recalling certain experiences
- Reduce or eliminate the need for questioning on the torture incident itself

It would make our jobs much easier if all victims of torture provided a corroborating medical/psychiatric report prepared by a doctor or psychiatrist familiar with the work of the Board, specialised in dealing with victims of torture, and known to the Board as an expert. Thus, in a perfect world, all legitimate claims would be “pre-certified” by these experts. Often, however, the reality is that either the claimant does not come with a report or does produce a report but the report cannot be given much weight or is not particularly helpful. Reports do vary in quality and reliability. Examples of reports which might not be given much weight include those hastily prepared or resulting from an incomplete examination of the claimant, containing insufficient detail regarding the claimant's ability to testify, or written by someone who lacks special education or training in dealing with refugees who are victims of torture.

In addition to problems with the reports of genuine claimants, claimants who are making false allegations of torture are sometimes able to get a medical or psychiatric report. The issue of the “malingering” claimant is dealt with separately below.

Ultimately, the Member has to decide the case, based on all of the evidence before him or her, of which the medical/psychiatric report is merely one piece.

The purpose of a medical/psychiatric report is not to prove or disprove the allegations of torture, in other words, to draw conclusions about whether the torture did in fact take place. Rather, the health professional provides expert opinions on the *degree* to which his or her findings correlate with the allegations of torture. Such medical evidence can demonstrate that injuries or behaviours presented could have been caused by the torture described. It makes sense not to expect medical professionals to be able to draw definitive conclusions when we consider that⁴¹:

- Many forms of torture leave little trace, and even fewer leave long-term physical signs

⁴¹ Camille Giffard, *supra*, note 17.

- It is possible for injuries or marks to be the product of other causes

Please note that this section provides an overview of issues relating to expert reports. More detailed information can be found in *Principles of Law Regarding Expert Witnesses* (see Appendix) and Chapter 6, section 6.7 of Legal Services Paper *Weighing Evidence* (1999).

Contents of a Medical/Psychiatric Report

While the structure and contents of a medical report will vary from case to case, the following is a list of the basic elements:⁴²

- **Basic Case Information** (date of subject's name, date of birth, gender, date of evaluation, duration of evaluation, whether an interpreter was used, who else was present)
- **Educational and professional qualifications** (education, training, experience with victims of torture and in preparing reports)
- **Background Information** on Victim of Torture (age, occupation, education, family, past medical history, psychosocial history)
- **Allegations of Torture and Ill Treatment** (summary of allegations reported by claimant)
- **Physical Examination**
- **Psychological History/Examination**
- **Photographs**
- **Diagnostic Test Results**
- **Interpretation of Findings**
- **Conclusions and Recommendations** (statement of opinion on the consistency between all sources of evidence cited above and allegations of torture. Reiterate symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse. Provide any recommendations for further evaluation and/or care)
- **Signature**
- **Relevant Appendices** (curriculum vitae, anatomical drawings, test results, etc)

Please Note: It is preferable if the medical professional does not repeat portions of the PIF in the report or present information provided by the claimant at the examination as if

⁴² This section was adapted from Chapter 6 of *Examining Asylum Seekers*, *supra*, note 40.

it were true. The medical professional should be careful to state only that the claimant “stated” or “reported” that X occurred and should only include such statements when necessary to explain a particular finding.

Assessing the Weight of a Medical/Psychiatric Report

Following are a number of questions to consider when assessing the weight of a medical/psychiatric report:

- Is the report recent? If not, could a new one be obtained?
- What are the practitioner's credentials, and specific training/experience? Is the content of the report within the practitioner's area of expertise?
- Did the practitioner meet with the claimant personally or simply refer to medical records? If the practitioner met with the claimant, how long was the interview? Did it take place in one sitting or over several appointments?
- Was malingering considered? If so, what steps were taken to rule it out?
- Were differential diagnoses considered and ruled out? Is there any supporting evidence? (e.g. X-ray, psychometric tests) Were any tests administered culturally sensitive?
- How definitive is the wording of the report? Did the practitioner examine the claimant?
- Was a history of other traumatic events in the individual's life taken?
- Is the claimant a client of a recognized organization for victims of torture?
- Has the claimant followed up on the diagnosis/suggested treatment?
- Is the evidence consistent with the claimant's age, culture, gender, etc?
- Are there any cross-cultural or gender factors that could impact on the reliability of the examination?

It is important to be aware of the difference between therapeutic (treating a patient's symptoms) and forensic (legal) medicine. The objective of forensic medicine is to establish the causes and origins of injuries and is a specialised field.⁴³ For obvious reasons, it would be preferable to have the examination of the claimant performed by a medical professional with special training in forensic medicine.

⁴³ Camille Giffard, *supra*, note 17.

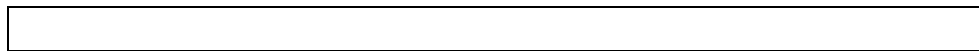
The following legal principles should be considered when weighing expert evidence⁴⁴:

- A Member is not bound to accept and give full weight to an expert report or testimony. It may be weighed in the same manner as any other evidence
- However, when the expertise of a witness is not in doubt, the Member should take particular care in explaining why he or she rejects the evidence of the expert, especially if the evidence supports the claimant's position
- The greater the expertise, the greater the weight, unless there are other reasons to give the evidence less weight
- An expert's opinion is not proof of the truthfulness of the information upon which it is based. Where the member finds the events on which the report was based not to be credible, it may give the expert report no weight
- A Member must take into account an expert's report, and if relevant, explain the reasons for rejecting it. Thus, it is an error to fail to refer to a medical/psychiatric report in the Member's reasons

Questioning an Expert Witness

If you or the claimant decides to call the practitioner who prepared the report as an expert witness, there are a number of things you will need to consider.⁴⁵

What distinguishes an expert witness is that he or she is permitted to express an *opinion* about the evidence: an expert is "characterized as a person possessed of the special skill and knowledge acquired through study or practical observation that entitles him [or her] to give opinion evidence or speak authoritatively concerning his or her area of expertise."⁴⁶ In a court proceeding, before an expert witness is allowed to testify in court, it must be demonstrated that the witness is qualified to testify by having special or peculiar knowledge of the subject-matter of the testimony. Such expertise can be gained through training or experience. While it is not necessary to formally qualify an expert witness at the RPD, it is good practice to ask the witness for his or her qualifications at the start of questioning. The witness's qualifications are relevant to the weight to be given to his/her evidence. Remember that the suitability of the expert will depend upon the precise topic in issue.



⁴⁴ This section was adapted from the Legal Services paper : *Principles of Law Regarding Expert Witnesses* (see Appendix) and Chapter 6, section 6.7 of Legal Services paper *Weighing Evidence* (1999).

⁴⁵ For information about the procedural requirements in calling an expert witness, please refer to Legal Services paper *Principles of Law Regarding Expert Witnesses* (see Appendix)

⁴⁶ Stobo, G. *Expert Evidence*, Legal Services, (1989) p. 3 cited in *Principles of Law Regarding Expert Witnesses* (see Appendix)

Good preparation is the key to effective
questioning of an expert witness

As a starting point, the questions presented above under “Assessing the Weight of a Medical/Psychiatric Report” can be used when questioning an expert in the hearing room. As well, the use of hypotheticals will be an effective method of questioning an expert witness. Thus, you may ask the expert whether his or her opinion would change if “X” fact was changed or introduced, and in this way, determine the precise scope of the expert's opinion and applicability to the case at hand. You should never attack the expert's credentials or knowledge during questioning of the expert (any questions in this regard would have been relevant when the qualifications were being presented at the outset of the testimony). It would, however, be appropriate to question the physician with respect to the method by which the claimant was diagnosed, the level of certainty involved in the diagnosis, and the precise effect of the disorder on the claimant's ability to testify.

Malingering and PTSD

This section concerns the situation where a claimant may have obtained, under false pretences, a psychological report that corroborates his or her story of torture. Having an understanding of the approach of the psychiatric profession to malingering can assist us at the Board in both detecting when a claimant may be malingering, in analyzing a report submitted on behalf of a claimant, and in questioning the author of such a report.

Malingering is defined in the DSM-IV-TR as:

“the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs” (American Psychiatric Association, 2000).

Malingering is a valid concern in the refugee status determination process because there is an external incentive at stake – a diagnosis from a professional can corroborate the story of torture and contribute to a positive decision. However, it is important to understand at the outset that malingering can be very difficult to both detect and to prove. It has been observed that psychiatrists are at a disadvantage compared to other medical specialists when confronted with the possibility of a malingering patient, since they depend more heavily on the accurate self-report of internal mental states by their

patients.⁴⁷ Short of catching the malingerer behaving contrary to their reported symptoms, or where the malingerer confesses to lying, it can be very difficult to confirm that the person is malingering. Nevertheless, there are some methods that have been developed to assist clinicians in the detection and investigation of malingering. Understanding these methods will help us better understand, question and evaluate the psychological reports put in evidence.

While the focus here is on the diagnosis of PTSD, the essential principles can be applied when considering malingering in other psychological diagnoses, such as depression and anxiety disorders.

The description of PTSD contained in the DSM specifically asks practitioners to consider whether malingering is in issue. Likewise, the Physicians for Human Rights Guide states that “it is important to recognize that some people falsely allege torture for a range of reasons and that others may exaggerate a relatively minor experiences in order to make a stronger case for asylum.”⁴⁸ The Guide further states, “the clinician must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication.”

There does seem to be some risk that a claimant could obtain a false diagnosis of PTSD or other psychological illness from a doctor or psychiatrist. There are a number of reasons why a claimant might be able to fool the ordinary professional:

- PTSD is considered relatively easy to fake because it is defined almost completely by subjective criteria and lists of symptoms can be easily found⁴⁹
- Detecting this type of lie is very difficult. It has been observed that “psychiatrists’ ability to detect lies in strangers is little better than chance” and that their confidence in their ability to detect malingering has no relationship to their actual ability⁵⁰
- Psychiatrists are often reluctant to consider the possibility of malingering, even in obvious situations, as an accusation of lying can damage if not destroy the therapeutic relationship between doctor and patient.⁵¹ Psychiatrists do not normally want to approach their patients with a sceptical attitude
- The professional may rely solely on the claimant’s self-reporting rather than any corroborating evidence.⁵² Even where the professional may have adequate

⁴⁷ Michael R. Harris M.D. and Phillip J. Resnick, M.D. “Suspected Malingering: Guidelines for Clinicians” *Psychiatric Times*, December 2003, Vol. XX, Issue 13 (www.psychiatrictimes.com)

⁴⁸ *Examining Asylum Seekers*, *supra*, note 40.

⁴⁹ Harris and Resnick, *supra*, note 47.

⁵⁰ Ekman (1985) as cited in Harris and Resnick, *supra*, note 47.

⁵¹ Harris and Resnick, *supra*, note 47.

⁵² In one study the use of leading questions or symptom checklists allowed malingerers unfamiliar with psychiatric disorders to qualify for diagnoses of major depression and posttraumatic stress disorder (Lees-Haley and Dunn, 1994), cited in Harris and Resnick, *supra*, note 47.

- knowledge and experience, “reliance on clinical interviews alone will not allow the clinician to diagnose malingering in any but the most obvious cases”⁵³
- The professional may not spend enough time with the claimant
 - The professional may be swayed by the “vividness and emotional impact of a trauma story,” although there is in fact no connection between these factors and the truthfulness of the story⁵⁴
 - The professional may ask leading questions about symptoms
 - The professional may not being sufficiently knowledgeable about PTSD and/torture
 - There may be significant language, cross-cultural and gender barriers to communication

Obviously, the ability to detect malingering would be significantly enhanced in the case of a professional who specializes in PTSD (including malingered PTSD), has experience working with refugees and received training in forensic medicine or psychiatry. Moreover, a person playing the role of an *evaluator* rather than a *treatment provider* may be in a better position to assess for malingering. It has been observed that where a clinician plays a dual role of both treatment provider and evaluator it can be more difficult to detect malingering.⁵⁵

Characteristics of Malingered PTSD

Researchers have identified a number of characteristics that are associated with malingered PTSD:⁵⁶

- The true PTSD sufferer generally downplays symptoms while the malingerer overplays them
- Malingerers may report or exhibit bizarre or improbable symptoms
- In true PTSD, the person often denies or has numbed the emotional impact of the trauma. In malingered PTSD, the person will make efforts to convince the clinician how emotionally traumatizing the event was
- Malingerers may exaggerate the severity of the stressor
- Malingerers are also likely to concentrate on reliving the trauma, whereas patients with genuine PTSD focus more on the phenomenon of psychic numbing
- Malingerers may claim repetitive dreams that exactly re-create the trauma night after night without variation, whereas with true posttraumatic dreams the typical pattern is a few dreams that re-enact the traumatic event followed by nightmare

⁵³ Harris and Resnick, *supra*, note 47.

⁵⁴ Judith G. Armstrong, Ph.D. & James R. High, M.D. “Guidelines for Differentiating Malingering from PTSD.” *NC-PTSD Clinical Quarterly*, Vol. 8(3) (1999)

⁵⁵ *Ibid.*

⁵⁶ This is not intended to be a complete list of the characteristics of malingered PTSD. The list was compiled from two sources: Harris and Resnick, *supra*, note 47, and Armstrong & High, *supra*, note 54.

- that are variations on the theme, in which other elements of the patient's daily life are incorporated
- In true PTSD posttraumatic dreams are frequently accompanied by body movements and thrashing in bed and the person may awake suddenly in a state of panic. Moreover, there tends to be middle insomnia as opposed to initial insomnia or early awakening
 - In true PTSD the person may avoid environmental conditions associated with the trauma whereas the malingerer is unlikely to report such reactions to environmental stimuli
 - Malingerers may give a neat recitation of symptoms that appears to be straight out of the diagnostic manual
 - Malingerers may be vague about state of mind aspects of PTSD (criterion A – peritraumatic horror, helplessness, and/or dissociation) Malingerers tend to forget negative symptoms of PTSD (detachment from close relationships, avoidance of trauma-related activities) (criterion C)
 - Malingerers will find it difficult to consistently mimic behavioural cues such as hyperarousal and dissociative “spacing out” (criterion D)
 - Malingerers may be uncooperative
 - Malingerers may call attentions to his or her distress but be evasive about details of symptoms
 - Malingerers may present pre-trauma functioning in an over-idealized light and tend to blame all life problems on the trauma and resultant PTSD

In order to evaluate the genuineness of PTSD, the clinician can:⁵⁷

- Insist on detailed descriptions of the symptoms because while a malingerer may know what to report they may be unable to give a convincing description or examples from their personal life
- Look for behavioural cues to PTSD such as staring, startling, and somatic reactions
- Ask open questions instead of using check off lists of symptoms
- Use multiple sources of data, including interviews, records, collateral sources of information, and psychometric tests.⁵⁸ For example the clinician could interview family members to help clarify inconsistencies, corroborate the person's history and to corroborate behaviours such as the frequency of nighttime awakenings, physical activity during sleep and emotional changes since the trauma
- Be careful to ask open-ended questions and to let patients tell their complete story with few interruptions and to carefully phrase inquiries about symptoms to avoid giving clues about the nature of true symptoms

⁵⁷ List compiled from Harris and Resnick, *supra*, note 47, and Armstrong & High, *supra*, note 54.

⁵⁸ Resnick (1997) as cited in Harris and Resnick, *supra*, note 47. The importance of using multiple sources of data when evaluating malingering is well recognised in the field, and is a key factor to consider when we are evaluating reports. However, regarding tests, it must be understood that there really are no reliable, valid objective measures or tests of malingering, especially in the cross-cultural context of refugee claims.

- Examine the reasonableness of the relationship between the reported symptoms and the stressor, the time elapsed between the stressor and the development of symptoms, and the relationship between current symptoms and psychiatric problems before the stressor

What to do when malingering is suspected

The first course of action when malingering is suspected should be to question the claimant using the techniques described earlier in this section (“False Allegations of Torture”) in order to determine whether or not the claimant can establish that he or she was actually tortured. Other corroborating evidence submitted by the claimant should also be examined. If that finding is not in dispute, it may not ultimately matter if the claimant obtained a false PTSD diagnosis. In other words, the person may have obtained a false report but could still be accepted because the rest of the evidence establishes that there is a valid claim for refugee protection. So first decide if the report is a critical piece of evidence.

If the report is really necessary as corroborative evidence of the torture and the matter isn’t resolved through careful questioning of the claimant, then it may be appropriate to call the author of the report as a witness and to question the author in the hearing room. Other approaches, such as arranging to have an independent expert prepare a second report, could be very costly and time-consuming and would need to be discussed with a Coordinating Member.

VICARIOUS TRAUMATIZATION

Vicarious trauma is the experience of bearing witness to the atrocities committed against another. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by victims searching for a way to release their own pain. It is the instant physical reaction that occurs when a particularly horrific story is told or an event is uncovered. It is the insidious way that the experiences slip under the door, finding ways to permeate the counsellor's life, accumulating in different way, creating changes that are both subtle and pronounced. Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyche react to the profound despair, rage and pain. Personal balance can be lost for a moment or for a long time. The invasive and intrusive horrors infiltrate and make their mark. The waves of agony and pain bombard the spirit and seep in, draining strength, confidence, desire, friendship, calmness, laughter and good health. Confusion, apathy, isolation, anxiety, sadness and illness are often the result.⁵⁹

Thus far, the Manual has focused on difficulties the victim of torture may have in talking about the torture he or she experienced. We now turn our attention to difficulties the Member or RPO may have in listening to claimants' stories of torture. This chapter provides a brief overview of the phenomenon called vicarious traumatization.⁶⁰

Definition of Vicarious Traumatization

Vicarious traumatization has been defined by Saakvitne and Pearlman⁶¹ as:

“the transformation of the therapist's or helper's inner experience as a result of empathetic engagement with victim clients and their trauma material.”

What this means in lay terms is that people who work with victims of torture may themselves become traumatized as a result of listening to the stories of trauma. Saakvitne and Pearlman describe vicarious traumatization as an “occupational hazard, an

⁵⁹ Health Canada, *Guidebook on Vicarious Trauma*, *supra*, note 8.

⁶⁰ This Manual uses the term "vicarious traumatization." Other terms for the same phenomenon include: secondary traumatization, secondary stress disorder, and compassion fatigue.

⁶¹ K. Saakvitne, L. Pearlman, *Transforming the Pain: A Workbook on Vicarious Traumatization* (1996) (W.W. Norton & Company)

inescapable effect of trauma work...a human consequence of knowing, caring, and facing the reality of trauma.”

Applicability to IRB Context

Most of the research and literature on this subject has been based on the experiences of trauma workers such as police, fire fighters emergency workers, and “anti-violence” workers such as persons working with victims of sexual assault, and therapists. While IRB members and RPOs are not trauma workers, therapists, or employed in a caring profession, and certainly do not have the same level of risk of vicarious traumatization, the repeated exposure to the traumatic stories of refugee claimants still puts them at some risk. Vicarious traumatization can have an effect on a Member or RPO’s interactions with others, work performance, and can decrease their objectivity, tolerance, patience and ability to listen dispassionately.⁶² The Member or RPO might react with disbelief or sarcasm to stories of torture. Among the suggestions listed below for preventing and dealing with vicarious traumatization, the importance of communicating -- talking about one’s feelings and experiences needs to be highlighted. It is recommended that Members and RPOs “debrief” with a colleague, close friend, or family member after a hearing involving torture.

Note that vicarious traumatization can also affect family members and other people closely associated with a victim of torture. This may need to be taken into account when dealing with a family member or close associate of a victim of torture in the hearing room.⁶³

Contributing Factors

The specific impact of vicarious traumatization will be determined by the unique interaction between the situation and the person. Saakvitne and Pearlman identify the following factors:

The Situation

- Nature of the work
- Nature of the clientele (type and number of clients and their traumas)
- Cumulative exposure to trauma material
- Organizational context
- Social and cultural context

⁶² U.S. Asylum Officer Basic Training Course, *supra*, note 10.

⁶³ *Ibid.*

The Individual

- Personal history
- Personality and defensive style
- Coping style
- Current life context
- Training and professional identity and history
- Supervision
- Personal therapy

Further, they point out that the empathy - a deep emotional engagement with the victim of trauma - can make a person particularly vulnerable to traumatic stress.⁶⁴

Signs and Symptoms

According to Saakvitne and Pearlman, the basic signs and symptoms of vicarious traumatization are:

General changes

- No time or energy for oneself
- Disconnection from loved ones
- Social withdrawal
- Increased sensitivity to violence
- Cynicism
- Generalised despair and hopelessness
- Nightmares

Specific changes

- Disrupted frame of reference
- Changes in identity, world view, spirituality
- Diminished self capacities
- Impaired ego resources
- Disrupted psychological needs and cognitive schemas
- Alternations in sensory experiences (intrusive imagery, dissociation, depersonalization)

Note that vicarious traumatization may be combined with other stress and burnout. There are very serious consequences of unmanaged stress, particularly when combined with the harmful effects of vicarious trauma.

⁶⁴ A number of self-assessment tools are included in the Saakvitne and Pearlman Workbook to identify vulnerability to, and evidence of, vicarious traumatization.

Preventing and Addressing Vicarious Traumatization

Self-awareness, self-assessment and self-care are the three critical components to preventing a toxic, unhealthy build-up of the negative and invasive effects of dealing with victims of torture.⁶⁵

According to Saakvitne and Pearlman, antidotes to vicarious traumatization must address two fundamental aspects of vicarious traumatization:

- better self-care to address the stress inherent in vicarious traumatization; and
- transformation of negative beliefs, despair and loss of meaning to address the demoralization and loss of hope created by vicarious traumatization.

Strategies for Dealing with Vicarious Traumatization

Saakvitne and Pearlman suggest the following strategies for dealing with vicarious traumatization:

Professional

Supervision/consultation
Scheduling; client load and distribution
Balance and variety of tasks
Education
Work space

Organizational

Collegial support
Forums to address VT
Supervision availability
Resources (mental health benefits, space, time)

Personal

Making personal life a priority
Personal therapy
Leisure activities (physical, creative, spontaneous, relaxation)

⁶⁵ Health Canada, *Guidebook on Vicarious Trauma*, *supra*, note 8.

Spiritual well-being
Self-Nurturing (emotional, physical, spiritual, interpersonal, creative, artistic)
Attention to health

There are three central aspects of all vicarious traumatization interventions, referred to as the “ABCs of vicarious traumatization, which need to be addressed in the 3 ‘realms’- professional, organizational and personal:”

ABCs of Vicarious Traumatization

Awareness - being attuned to one's needs, limits, emotions and resources.

Balance - maintaining balance among activities, especially work, play and rest.

Connection - connections to oneself, to others and to something larger. These connections offset isolation and increase validation and hope. Communication breaks the silence of unacknowledged pain.

In all 3 Realms - professional, organizational, and personal

APPENDIX

PRINCIPLES OF LAW REGARDING EXPERT WITNESSES

1. Definition of an expert.

An expert witness is a person possessed of a special skill and knowledge acquired through *study or experience* that entitles him to give opinion evidence concerning his or her area of expertise. [Emphasis added]

Rice v. Sockett
(1912), 8 D.L.R. 84 (H.C.)

2. The purpose of expert evidence.

With respect to matters calling for special knowledge, an expert in the field may draw inferences and state his opinion. An expert's function is precisely this: to provide the judge and jury with a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate. [...]

An expert witness, like any other witness, may testify as to the veracity of facts of which he has first-hand experience, but this is not the main purpose of his or her testimony.

R. v. Abbey
[1982] 2 S.C.R. 24, at 42

It is my understanding that there are at least two aspects to expert evidence; (1) the adducing of facts through an expert because that individual has a particular knowledge thereof and such evidence can only realistically be obtained in this manner; (2) the drawing of inferences from a defined set of facts in circumstances where the making of such inferences are difficult for a trier of fact because they depend on specialized knowledge, skill or experience.

Fraser River Pile & Dredge Ltd. v. Empire Tug Boats Ltd.
(F.C.T.D., no. T-1631-93), Reed, March 20, 1995

3. Admissibility of expert evidence in courts.

Admissibility of expert evidence depends on the application of the following criteria (a) relevance; (b) necessity in assisting the trier of fact; (c) the absence of any exclusionary rule; and (d) a properly qualified expert.

R. v. Mohan
[1994] 2 S.C.R. 9 (headnote)

The general rule is that expert evidence is admissible to furnish the court with scientific information which is likely to be outside the experience and knowledge of the judge and jury [...]

R. v. Burns
[1994] 1 S.C.R. 656, at 666

4. Admissibility of evidence (including expert evidence) at the RPD.

Section 170 of the *Immigration and Refugee Protection Act* provides that the Refugee Protection Division, in any proceedings before it,

- (g) is not bound by any legal or technical rules of evidence;
- (h) may receive and base a decision on evidence that is adduced in the proceedings and considered credible or trustworthy in the circumstances;

Application in a case:

Despite the hearsay frailties [information provided by unidentified Somalian informants] of professor Samatar's evidence ... the tribunal was entitled to find this evidence credible and trustworthy, and to base its decision upon it ... the tribunal gave reasons to prefer Professor Samatar's evidence to that of the [claimant], as it is required to do. The tribunal was entitled to admit this evidence and to give it the weight that it did.

Siad v. Canada (Secretary of State)(C.A.)
[1997] 1 F.C. 608 at 620

5. Disclosure requirements.

RPD Rule 38 provides that:

- (1) If a party wants to call a witness, the party must provide in writing to any other party and the Division the following witness information:
 - (a) The witness's contact information;
 - (b) The purpose and substance of the witness's testimony or, in the case of an expert witness, the expert witness's signed summary of the testimony to be given;
 - (c) The time needed for the witness's testimony;
 - (d) The party's relationship to the witness;
 - (e) In the case of an expert witness, a description of the expert witness's qualifications; and

- (f) Whether the party wants the witness to testify by videoconference or telephone.
- (2) The witness information must be provided to the Division together with a written statement of how and when it was provided to any other party.
- (3) A document provided under this rule must be received by its recipient no later than 20 days before the hearing.
- (4) If a party does not provide the witness information as required under this rule, the witness may not testify at the hearing unless the Division allows the witness to testify.

The purpose of disclosure is to allow for better preparation of the case and to avoid surprises and possible delays at the hearing. The Rule is procedural and in no way displaces the discretion of the Refugee Protection Division to admit and weigh the evidence as it sees fit in the circumstances of the case.

6. Qualifying an expert and assessment of the evidence.

Mewett, Alan W., in *Witnesses* (Carswell, 1991) explains that there are two aspects to qualifying experts; (1) the field of expertise, and (2) the individual qualifications of the proffered expert.

(1) "... the subject-matter on which the witness is offering his or her opinion must be one recognized as an area of expertise, that is to say, one requiring special study or experience for the drawing of scientifically acceptable conclusions." (at 10-8)

(2) "Qualification as an expert may come from formal training or experience or, most often, a combination of both." (at 10-16)

Excerpt from the Legal Services paper *Weighing Evidence*:

Before the courts, opinion evidence is generally not permitted. The exception to this rule is opinion evidence from an expert, who must be qualified as such before being permitted to testify. However, none of the three Divisions of the IRB is bound by the Rules of Evidence, and experts need not formally be qualified as such in order to give opinion evidence. [...] The qualifications of the witness will have bearing on the weight to be given to the evidence. For this reason, it is still important to establish the domain of the asserted expertise, and to compare the qualifications offered with the domain asserted.

Macaulay, Robert, in *Practice and Procedure Before Administrative Tribunals* (Carswell, 1997) indicates that:

"Very few tribunals require an expert to be qualified and then cross-examined on his qualifications before hearing his evidence. The common practice is to file a c.v. as an exhibit, after which counsel usually highlights the expert's experience followed by the witness' examination. In cross-examination, those opposed in interest may attempt to attack the qualification. On the whole, the attack is a waste of time. What is far more effective is to attack the quality of the evidence directly rather than the qualifications of the donor." (at 17-6)

McLachlin J. puts it thus:

The only requirement for the admissibility of expert opinion is that the “expert witness possesses special knowledge and experience going beyond that of the trier of fact” ... Deficiencies in the expertise go to weight, not admissibility.

R. v. Marquard
[1993] 4. S.C.R. 223, at 243

Macaulay also says that “[t]he failure to qualify an expert will not normally cause the evidence to be inadmissible; it will, however, reduce its persuasiveness in the minds of the members of the tribunal.” (at 17-7) This view, however, should be read cautiously in light of the general proposition accepted by courts that expert evidence is to be assessed like any other evidence.

[...] As a tribunal specializing in the assessment of refugee status claims, the [Refugee] Division must decide the merits of applications before it. *Expert testimony can be very useful in certain areas; however, it is a piece of evidence like any other, and it is up to the Division to decide how much weight it should [be] given.* [emphasis added]

Bula, Ngaliema Zena v. S.S.C.
(F.C.T.D., no. A-794-92), Noël, June 16, 1994, at 2

Experts [...] have no divine immunity from being disbelieved as a result of a negative assessment of their credibility. [...] no tribunal needs to stand in awe of any expert, because, in law, tribunals are free to accept or to reject any expert's evidence as seems reasonable to the tribunal, without committing a reviewable error.

Bains, Iqbal Singh v. M.C.I.
(F.C.T.D., no. IMM-2055-94), Muldoon, August 24, 1995, at 13

The trial judge was entirely correct in advising the jury that they were not bound by the expert psychiatric testimony and that its probative value was to be assessed in the same manner as any other testimony.

R. v. Ratti
[1991] 1 S.C.R. 68, at 81

The acceptance of a witness as qualified to give expert evidence does not operate to suspend the Court's evaluation of that evidence.

Eli Lilly and Co. v. Novopharm Ltd.
(F.C.T.D., no. T-2432-95, T-2433-95, T-2434-95), Reed, April 25, 1997

According to Mewett, in *Witnesses*:

“When a jury is considering whether or not to accept the opinion of an expert, it must, as part of that process, consider what weight it will give the opinion. This is particularly true when there are conflicting experts and the jury must choose between them or neither of them, but it is also no less true even when there is only one expert since the jury, even in that case, is not bound to follow the expert’s opinion.” (At 10-18.3)

As for the parties, this is what he has to say:

“Although in some cases counsel may have no choice, attacking competence on the ground of lack of sufficient expertise (as apposed to attacking competence on the ground that the *area* is not one of admissible scientific expertise) is not always the best tactic to adopt when there is the alternative of accepting the expert as a witness and subsequently seeking to attack the weight to be given to that testimony.” (At 10-30)

7. Factors to consider in weighing the evidence of an expert witness

Excerpt from the Legal Services paper *Weighing Evidence* (footnotes omitted):

- whether an expert would be of assistance regarding the issue to be decided. Counsel should be asked to clarify the purpose of the expert testimony. Before refusing to hear the testimony, the decision-maker must be certain that the evidence would be of no assistance. It may be preferable to hear the testimony and weigh it appropriately later
- whether the testimony is within the expert’s area of expertise
- the manner in which the expertise was acquired, i.e. by education and/or experience
- whether the expert’s opinion was formed with full knowledge of the relevant facts
- the facts and assumptions relied on by the expert
- whether the facts relied on by the expert have been established
- quality of textbooks and other source material relied on by the expert
- whether the methods relied on to form the opinion were reliable. eg. Nature of tests applied, and whether they were culturally sensitive
- whether the expert has relied on hearsay in forming an opinion and how reliable that hearsay information is
- whether the hearsay information relied on by the expert is of the nature generally relied on by experts in the field

- whether there is evidence that other respected experts in the field hold a different opinion on the subject
- any biases or radical views held by the expert
- expert's relationship to the claimant, appellant, or person concerned
- whether a medical expert has examined the claimant personally, or simply referred to medical records.

According to Mewett, in *Witnesses*:

“Part of this weighing will depend upon the credentials of the expert — qualifications, experience, reputation and so on. Part will depend upon the jury’s view of the thoroughness of the expert’s examination or diagnosis or whatever is involved, his or her opportunity to observe the facts properly and, generally, what the jury perceives to be the degree of care taken.” (At 10-18.3)

8. Expert opinion on a witness's credibility cannot replace the credibility assessment of the trier of fact.

A judge or jury who simply accepts an expert's opinion on the credibility of a witness would be abandoning its duty to itself determine the credibility of the witness. Credibility must always be the product of the judge or jury's view of the diverse ingredients it has perceived at trial, combined with experience, logic and an intuitive sense of the matter [...].

R. v. Marquard
[1993] 4 S.C.R. 223, at 248

9. An expert's opinion is not proof of the truthfulness of the information upon which it is based.

[...] While it is not questioned that medical experts are entitled to take into consideration all possible information in forming their opinions, this in no way removes from the party tendering such evidence the obligation of establishing, through properly admissible evidence, the factual basis on which such opinions are based. Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist.

R. v. Abbey
[1982] 2 S.C.R. 24, at 46

In this case, the use of the medical testimony is dependent upon the facts giving rise to the medical opinions. Where, as

in this case, the Board did not find the applicant to be credible, the medical evidence did not persuade the Board that the scars which were present on the applicant necessarily stemmed from persecution in Ghana. If the applicant was found to be credible then the treatment of the medical opinions would of necessity be different. In the latter situation, the medical opinions might assist the Tribunal in clearing up any uncertainties associated with the applicant's testimony. It is not necessary for the Board to speculate as to the origin of the scars but rather it must determine whether the scars and bumps found on the body of the applicant resulted from persecution in Ghana.

Boateng, Nicholas v. M.C.I.
(F.C.T.D., no. A-1027-92), Wetston, March 31, 1995, at 1-2

[..] With respect to the assessment of the doctor's evidence, to find that that opinion evidence is only as valid as the truth of the facts on which it is based, is always a valid way of evaluating opinion evidence.

Danailoff, Vasco (Vassil) Vladimirov Danailov v. M.E.I.
(F.C.T.D., no. T-273-93), Reed, October 6, 1993, at 1-2

When such reports are nothing more than a recitation of the applicant's story, which the Board does not believe, and a conclusion based on symptoms, which the applicant has told the psychiatrist are being experienced, then, Boards cannot be faulted for treating such reports with some degree of scepticism. When they are based on independent and objective testing by a psychiatrist, then, they deserve more consideration.

Gosal Pardeep Singh v. M.C.I.
(F.C.T.D., no. IMM-2316-97), Reed, March 11, 1998, at 5.

The tribunal attributed little weight to the psychologist report in general, principally because it did not believe the information the applicant shared with the expert. [...] The tribunal's obligation was to receive and consider the psychologist report. The tribunal received evidence from the applicant over three days. It is not because the psychologist did not discredit the applicant's allegations concerning "marital rape", as described in the report, that the tribunal itself could not do so. The tribunal's treatment of the psychologist's report was consistent with its appreciation of the applicant's credibility. The decision by the tribunal to

afford “little value” to the psychologist’s report is not a reviewable error.

Wati Phul v. M.C.I.
(F.C.T.D., no. IMM-3932-98), Lutfy, April 16, 1999, at 4-5.

10. Expert testimony on human behaviour may be useful in assessing a witness's credibility.

[...] there is a growing consensus that while expert evidence on the ultimate credibility of a witness is not admissible, expert evidence on human conduct and the psychological and physical factors which may lead to certain behaviour relevant to credibility, is admissible, provided the testimony goes beyond the ordinary experience of the trier of fact. Professor A. Mewett describes the permissible use of this sort of evidence as "putting the witness's testimony in its proper context." He states in the editorial "Credibility and Consistency" (1991), *33 Crim. L.Q.* 385, at p. 386:

The relevance of his testimony is to assist - no more - the jury in determining whether there is an explanation for what might otherwise be regarded as conduct that is inconsistent with that of a truthful witness. It does, of course, bolster the credibility of that witness, but it is evidence of how certain people react to certain experiences.

[...] To accept this approach is not to open the floodgates to expert testimony on whether witnesses are lying or telling the truth. It is rather to recognize that certain aspects of human behaviour which are important to the judge or jury's assessment of credibility may not be understood by the lay person and hence require elucidation by experts in human behaviour.

R. v. Marquard
[1993] 4 S.C.R. 223, at 249-250

11. If relevant, the Refugee Protection Division is required to consider the fact that the expert not only based his or her opinion on what the claimant has told him or her, but also on what he or she has observed as an expert.

[...] the CRDD states that Dr. Payne based his conclusion, his psychiatric opinion “... on what he was told by the male claimant.”

[...] the CRDD ignored the fact that Dr. Payne based his diagnosis, not simply on what he was told by the male applicant, but also on his trained, professional observation of the male applicant. [...]

I conclude that the CRDD erred in its cavalier dismissal of the professional opinion of Dr. Payne.

Zapata, Carlos Alberto Ruiz v. S.G.C. and M.E.I.
(F.C.T.D., no. IMM-4876-93), Gibson, June 29, 1994, at 5-7

12. An expert's report cannot be rejected for the sole reason that it could not specify that torture is the only cause of the claimant's injuries.

With respect to the evidence contained in the medical report submitted by Dr. William Chan relating to injuries sustained by the claimant as a result of torture, the tribunal erred in considering and rejecting it. The tribunal's suggestion that the report needed to indicate that torture was the only possible cause of the injuries places an impossible burden on the refugee claimants.

Thurairajah, Uthayasankar v. M.E.I.
(F.C.T.D., no. IMM-2339-93), Tremblay-Lamer, March 11, 1994, at 5

13. The Refugee Protection Division is not required to accept the opinion of an expert witness regarding the well-foundedness of a claim.

While the Refugee Division accepted the statements of Margaret Atwood and Michael Ondaatje that it was not out of the ordinary for a poet to be unable to recite her work, it accorded no weight to their statements [that] the applicant would be persecuted in Sri Lanka because of her poems. That was a decision entirely within the tribunal's discretion. There are a number of factors which must be considered in the determination of a Convention refugee claim and it is the function of the Refugee Division to assess the likelihood of persecution based on all the evidence before it. It is not incumbent on the tribunal to accept the opinions of third parties concerning the ultimate issue which it has to determine.

Gnanapragasm, Monica v. M.E.I.
(F.C.T.D., no. IMM-3317-93), Jerome, September 14, 1994, at 4

[...] As a tribunal specializing in the assessment of refugee status claims, the [Refugee] Division must decide the merits of applications before it.

Bula, Ngaliema Zena v. S.S.C.
(F.C.T.D., no. A-794-92), Noël, June 16, 1994, at 2

14. Dealing with expert evidence in the reasons.

The Refugee Protection Division must take into account an expert's report and, if relevant, justify the reasons for rejecting it.

[...] Convention Refugee Determination Division decisions have been sent back because they failed to make reference to medical evidence supporting a claim. [...]

In my opinion, in completely ignoring the medical evidence before it, the Board committed an error [...]

Miayuku, Lubanzadio v. M.C.I.
(F.C.T.D., no. IMM-4813-93), Pinard, July 18, 1994, at 2

[...] although three pieces of documentary evidence directly specific to the applicant were introduced, namely, a doctor's certificate, [...] the Refugee Division made no mention of these documents in their decision. Once again, I am concerned that no mention of this documentation is made in the reasons. [...] The Refugee Division, in my view, is obligated, at the very least, to comment on the information. If the documentation is accepted or rejected the applicant should be advised of the reasons why, especially as the documentation supports the applicant's position.

Bains, Iqbal Singh v. M.E.I.
(F.C.T.D., no. 92-A-6905), Cullen, May 26, 1993, at 5

[...] The Tribunal appears to completely ignore evidence before it in the form of written psychiatric report that indicates the Applicant suffers from Post-Traumatic Stress Disorder and Depression with the result that "...he gets very forgetful, loses his train of thoughts, concentration and becomes very afraid, especially when the past is discussed." The Applicant is entitled to an assurance that such evidence was taken into account in the credibility finding against him that apparently was based on the evasiveness and confusion in his testimony.

Sanghera, Bhajan Singh v. M.E.I.
(F.C.T.D., no. T-194-93), Gibson, January 26, 1994, at 3-4

Obviously, it was open to the Board to disregard the medical report. However, having regard to the importance which it placed on the applicant's demeanour in reaching its decision, it had the obligation to indicate why it chose to do so.

[...] the Board never explicitly rejects her allegations of gang-rape, nor does it reject Dr. Spiegel's opinion at least insofar as it is framed by reference to this occurrence.

It is [...] apparent that the Board did not reject the medical opinion of Dr. Spiegel because it did not believe the underlying facts on which it was based. Why then was it rejected? The Board had to confront this evidence and explain why it was to be discarded. It never did.

Sivayoganathan, Maria Rajeswary v. M.C.I.
(F.C.T.D., no. IMM-4979-93), Noël, November 7, 1994, at 7-9