Torture Journal Forensic Case Series

Welcome to the Torture Journal Forensic Case Series, a new section of the Torture Journal. Through this Series, we aim to provide a source of information and continuing education for health and legal practitioners involved in the forensic evaluation of survivors of torture.

Case 1: Chronic Pain and Functional Impairment as Evidence – Case of JN

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Introduction to the Reader:

In this inaugural case study, a survivor of torture presents with a syndrome of chronic pain and functional impairment of their right arm following blunt trauma. Many torture survivors bear no permanent physical signs of abuse, others show marks that would be apparent to any clinician, while some have evidence of abuse only discernable with medical knowledge that may be outside the practice scope of a given examiner's specialty. In this case, the physical record of the individual's torture was not so apparent as a scar or burn, but an observant clinician could establish a clear causative pathway from the torture she experienced to her current symptoms, thus bolstering her asylum claim. However, her specific diagnosis may not be familiar to many forensic medical examiners.

Background:

Patient JN is an approximately 40-year-old female seeking asylum in the United States. In her home country in South Asia, JN worked as a journalist and reported on issues of crime and corruption in the country. Because of her reporting, she was targeted by political operatives who attempted to intimidate her from continuing her work. JN was physically attacked on multiple occasions and threatened with further violence, sexual assault and death against her and her family. During one attack, JN was yanked forcefully from a rickshaw and hit repeatedly with a field hockey stick to her right supra-clavicular area (the area between the neck and shoulder). Immediately following this attack, she struggled to move or feel her right arm. With time and physical therapy in her home country, she recovered use of her arm over the course of several weeks, although she still reports decreased strength, range of motion, and sensation in specific parts of her arm. She later left the country to seek asylum in the United States. She was examined by a physician in the United States several years later as a part of her legal case for asylum.

Ethical considerations:

Verbal informed consent was obtained from the patient for the publication of this case report.

Psychological Signs and Symptoms

On examination, JN was bright and engaging, with a linear thought process and appropriate

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affect for the subject matter discussed. She reported multiple psychological symptoms as a result of her trauma, including intrusive thoughts, distressing nightmares, difficulty with concentration, disrupted sleep, and a general decrease in her enjoyment of life. These symptoms are consistent with the diagnoses of both post-traumatic stress disorder (PTSD) and major depressive disorder given to her by her regular therapist.

Physical Signs and Symptoms

Physical examination of JN found that the right shoulder, right arm, and neck lacked any gross deformity or focal tenderness to palpation, although manipulation of the shoulder in any direction elicited pain. She had decreased strength (4/5) in flexion and extension of the wrist (C5/C6), elbow (C5-C8) and shoulder and decreased strength (4/5) in abduction of the shoulder (C5/C6). She had a limited range of motion in flexion, abduction, and external rotation of her right shoulder. Her left arm had full strength in all movement and a full range of motion. There was a decreased sensation to light touch in the lateral aspect of the right arm, from the shoulder to the hand, in an area consistent with the anatomical distribution of the C5/C6 nerve roots. Performing a Spurling's test of her neck (applying downward pressure to the top of her head while the neck is tilted in one direction) induced pain in the right arm.

Interpretation and Conclusion:

The history and physical examination of JN are diagnostic of a traumatic brachial plexopathy resulting from a high-impact injury to the neck or shoulder, commonly called "Burner and Stinger Syndrome" (BSS). This diagnosis is supported by the initial mechanism of the injury, the description of the initial presentation of pain, and the examination showing decreased sensation and motor functioning in the C5/C6 nerve distributions and a positive Spurling's test. Moreover, her history and physical exam are highly consistent with her described abuse, as is the presence of symptoms of PTSD and major depressive disorder.

Discussion:

Burners and Stinger Syndrome is a diagnosis frequently encountered among athletes in high-contact sports. These injuries result from trauma to the brachial plexus or cervical nerves via either (1) *traction* (when the shoulder is depressed while neck if forced the opposite direction), (2) *compression* (when the neck is simultaneously extended and rotated), or in JN's case, (3) *direct blunt trauma* to the supraclavicular fossa (Ahearn, 2019). The duration and severity of the injury depends on the extent of the injury to the nerve, as classified by Seddon's criteria (Feinberg, 2000). In most cases, symptoms last only moments or resolve within 24-48 hours. However, in 5-10% of cases, symptoms can take several weeks to resolve or persist for a lifetime (Levitz et al, 1997; Speer and Bassee, 1999).

Diagnosis of burners and stingers primarily relies on a clinical history and physical examination (Kuhlman, 2004). As is often the case in evaluating survivors of torture, reconstructing the mechanism of the injury in detail will be helpful. The history typically includes trauma leading to the sudden onset of burning pain in the supraclavicular area with associated pain radiating down the ipsilateral arm in a circumferential, non-dermatomal pattern, potentially with associated numbness and weakness (Feinberg, 2000). These symptoms may immediately self-resolve or persist as previously mentioned. Some patients may not develop symptoms of weakness until several days after the injury (Hershman, 1990).

The physical examination should include a thorough neurological assessment of the sensory and motor function of the C5-T1 nerves. Most burner-related deficits are related to C5-C6. A Spurling or Tinel test (direct percussion of a nerve to illicit neuropathic symptoms) may be helpful. While not necessary for diagnosis of shorter-term symptoms, an MRI should be utilized in the evaluation of patients with persistent or recurring symptoms, as anatomical abnormalities of the cervical spine may predispose an individual to prolonged symptoms (Levitz et al, 1997; Standaert and Herring, 2009).Additionally, the presence of cervical spine tenderness, altered mental status, bilateral neurological symptoms or decreased range of motion of the neck should raise concern for more serious brain or cervical spine injury, warranting further imaging and evaluation.

Management of burners focuses on rest, pain control and physical therapy of the cervical spine and upper extremity with the aim of improving flexibility, strength and posture to decrease symptoms (Ahearn et al, 2019; Weinstein, 1998). In severe cases with permanent complete motor or sensory deficits, surgical interventions may be considered.

As is commonly the case with survivors of torture or physical violence, JN's trauma left no visible scar. However, in this instance a detailed neurological exam identified a specific neurological deficit highly consistent her account of prior blunt trauma, helping to corroborate her asylum claim. After initial evaluation by her primary care doctor, JN was referred to a neurologist for further imaging and treatment.

Case 2: Legal Persecution as Torture in Non-Custodial Settings – Case of AC

Berta Soley[1] and James Lin[2]

Introduction to the Reader:
In this case, a torture survivor who is released from prison to house arrest due to COVID-19 mitigation measures continues to suffer in house arrest from serious physical and psychological symptoms as a consequence of her previous experiences of torture and ill-treatment during prolonged confinement (Amir and Lucas, 2021; Richards and Gelleny, 2021). While release from the custodial setting to house arrest may alleviate a survivor's acute psychological distress, the continued restriction of liberty and attendant challenges in accessing appropriate medical and mental health care may continue to perpetuate the survivor's pain and suffering and pose substantial obstacles to healing. For victims of ongoing legal persecution, legal threat and uncertainty may continue to impart significant psychological distress that may manifest as somatic or psychological symptom, and altogether may qualify as torture or ill-treatment.

Background:
Patient AC is an approximately 40-year-old female living abroad. While visiting her family home in the Middle East and North Africa region, she was detained, accused of espionage, forced to sign a "confession," and was sentenced to several years' imprisonment.

During her incarceration, AC spent many months in solitary confinement. She endured sometimes daily interrogation lasting all day while handcuffed and often blindfolded, repeatedly told that her husband had left her or was unfaithful, that her family would be imprisoned, and that she would never see her infant child again. Interrogators threatened to dig a grave for AC if she did not cooperate or become an informant for them or to launch a new legal case against her. During this period, AC was kept in a small unhygienic cell without windows, where she had to sleep on a mat on the ground with the light continuously on.

After several years in detention, due to Covid-19, AC was released with an ankle monitor to her family's home under house arrest and forbidden from being more than a few hundred meters away. This limited range prevented her from accessing any medical treatment. AC lived under constant fear of being returned to prison or having a new legal case launched against her. A medico-legal evaluation of AC was conducted using remote communication technology by a physician and a psychiatrist while she was in house arrest (Cohen et al, 2021).

Ethical considerations:
Written or verbal informed consent was obtained from the patient for the publication of this case report.

Physical Signs and Symptoms
AC reported that she was healthy before her

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arrest with no physical disabilities except for occasional back and shoulder pain. During her imprisonment, AC developed severe neck stiffness and neck and shoulder pain, which was exacerbated by lying on a hard floor to sleep and being handcuffed for extended periods of time. Her neck pain became so severe she was unable to stand up. Her right hand also became numb and weak to the extent that she would drop things when she was trying to hold them.

During house arrest, AC sought to hide her symptoms from her family. However, she continued to experience physical pain and impairment from her neck, right shoulder and arm, as well as numbness that were not able to be adequately evaluated and treated and was at high risk of becoming chronic and worsening. AC also experienced anxiety from having breast tumors that could be cancer but being unable to access appropriate evaluation despite the growing possibility of metastatic spread.

During the video examination, AC was unable to bend or rotate her head to the right without pain and had limited movement. When AC palpated her right neck, she reported tenderness all along the sternocleidomastoid muscle and some pain to the right trapezius muscle, but no pain on the left side. These symptoms raised concerns about a cervical radiculopathy with nerve compression that required further evaluation. AC also reported a history of breast cancer and the development of painful lumps in her breasts that were growing.

Psychological Signs and Symptoms

Before arrest, AC reported that she lived a balanced and happy life with many social contacts and friends. While she displayed some obsessive manifestations like making the bed a bit more often than average and experienced claustrophobia following a traumatic experience, these symptoms decreased and faded over time and did not require any special treatment. During her imprisonment, she developed serious symptoms of claustrophobia, such as a feeling of being suffocated behind closed cell doors and heart palpitations, and obsessive-compulsive thinking and behaviour. AC also had insomnia and extreme hair-loss due to high levels of anxiety and depressed mood.

While AC did not feel as acute stress as she did when she was in prison, she continued to relive and suffer from the serious and long-lasting traumatising issues that she experienced during her confinement. She continued to experience anguish and fear about the threat of a new trial and the constant danger of being taken back to prison. AC's inability to cope with the previously manifested post-traumatic issues kept her under permanent stress. The ankle monitor also served as a constant reminder of her prison experiences and being deprived from liberty and constantly triggered her traumatic memories and experiences, exacerbating her psychological/psychiatric symptoms.

During the video examination, AC reported frequent headaches and problems with concentration and memory, including an inability to evoke memories from before prison. Her prison experiences were evoked in fragments instead of a linear way. She also reported experiencing mood swings, being easily irritated and becoming angry, losing her religious faith and feeling hopeless about the future. AC's symptoms are altogether characteristic for serious and chronic post-traumatic stress disorder (PTSD) and major depression.

Interpretation and Conclusion:

These physical and psychological findings are highly consistent with the experiences AC

recounted during her time spent imprisoned and under house arrest. AC suffered from serious and chronic PTSD, major depression and obsessive-compulsive disorder due to her years of extremely stressful, traumatising experiences in the prison and her continuous uncertainty about her fate. In addition, she suffered from neurological and skeleto-muscular symptoms from prolonged confinement with inability to move freely, engage in necessary physical activity, have adequate sleeping conditions, and being required to remain in restricted physical conditions for long periods.

Discussion

During the last two years, many survivors of torture who are prisoners or detainees have been released from prison to house arrest as part of COVID-19 mitigation measures. Yet, as in the example of AC, they may continue to suffer from serious physical and psychological trauma even while released to a non-custodial setting such as home.

While house arrest and the presence of family may provide some psychological relief, survivors may continue to experience serious psychological symptoms due to the continued restriction of their liberty and inability to access appropriate medical and mental health treatment. As in the case of AC, their lack of freedom and symbols of this, such as their ankle monitor, may serve as a constant reminder of their torture and prison experience and trigger traumatic memories as well as exacerbate their psychological symptoms. Continued legal uncertainty, including the fear of being sent back to prison, and any legal persecution, such as threats of new legal cases against them, creates a permanent sense of threat leading to constant pain and suffering.

In addition, where the place of house arrest or 'home' is unable to present a safe and non-threatening environment, survivors' physical and psychological conditions may risk becoming chronic and potentially deteriorate. As in the case of AC, she continued to be in need of urgent psychiatric and psychotherapeutic support as well as evaluation and treatment of her physical symptoms. AC's psychological conditions were unable to resolve themselves and risked becoming chronic and worsen. Inadequate evaluation and treatment of her physical conditions also created a high risk that she would experience chronic pain and impairment in the medium to long-term.

AC's case demonstrates how torture and ill-treatment can extend to the non-custodial setting and should be explored as an integral part of the clinical evaluation. Additionally, the deprivation of access to appropriate medical care as well as legal persecution have both been recognised as acts that may qualify as or contribute to situations of torture and ill-treatment whether in custodial or non-custodial settings.

References

Ahearn BM, Starr, HM, Seiler, JG. "Traumatic Brachial Plexopathy in Athletes: Current Concepts for Diagnosis and Management of Stingers." Journal of the American Academic of Orthopedic Surgeons. 2019, Vol 27, No 18. DOI: 10.5435/JAAOS-D-17-00746

Amir, K. and Lucas, A. (2021) Depression and Associated Factors Among Refugees Amidst Covid-19 in Nakivale Refugee Camp in Uganda. Journal of Neurology Research Review & Reports. SRC/JNRRR-145. DOI:10.47363/JNRRR/2021(3)132

Cohen, J., Gregory, B., Newman, K., Rowe, E. J., Thackray, D. (2021) Remote medico-legal assessment by telephone during COVID-19: Monitoring safety and quality when documenting evidence of torture for UK asylum applicants. *Torture Journal, 31(1), 37-52.* DOI: https://doi.org/10.7146/torture.v31i1.121832

Feinberg, JH. (2000) Burners and Stingers. *Phys Med Rehabil Clin N Am,* 11(4), 771-84.

Hershman, ED. (1990) Brachial plexus injuries. *Clin Sports Med*, 9(2), 31. DOI: 10.1016/S0278-5919(20)30734-1

Kuhlman G. (2014) Burners (stingers): Acute Brachial Plexus Injury in the Athlete. *UpToDate,* Post, TW (Ed), UpToDate, Waltham, MA

Levitz CL, Reilly PJ, Torg JS. (1997) The pathomechanics of chronic, recurrent cervical nerve root neurapraxia: The chronic burner syndrome. *Am J Sports Med,* 25, 73-76. DOI: 10.1177/036354659702500114

Richards, David L. and Gelleny, Ronald (2021) Torture in the Time of COVID-19 (February 26, 2021). DOI: DOI: 10.2139/ssrn.3914295

Speer K, Bassee F. (1990) The Prolonged Burner Syndrome. *American Journal of Sports Medicine*, 18(6). DOI: 10.1177/036354659001800606

Standaert CJ, Herring SA (2009) Expert opinion and controversies in musculoskeletal and sports medicine: Stingers. *Arch Phys Med Rehabil*, 90, 402-406. DOI: 10.1016/j.apmr.2008.09.569

Weinstein SM. (1998) Assessment and rehabilitation of the athlete with a »stinger«. A model for the management of non-catastrophic athletic cervical spine injury. *Clin Sports Med*, 17, 127-135. DOI: 10.1016/s0278-5919(05)70067-3