

Participation of psychologists in Istanbul Protocol based physical examinations: an applied perspective

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Objective

When invited to evaluate a middle-aged male asylum seeker regarding alleged torture, the following question kept coming to my mind: Would it be appropriate, perhaps even vital, for mental health professionals to participate in Istanbul Protocol (IP) based *physical* examinations? The intent is not to *do* the physical examination but to be present, observe, ask relevant questions, and witness with the client's consent. The article elaborates on this question while sharing my perspective as a clinical psychologist and referring to relevant literature.

Keywords: torture and ill-treatment, clinical evaluation, interdisciplinary collaboration, Istanbul Protocol, mental health professionals, Israel.

Introduction

In the last decades, the IP has been the primary medico-legal tool in evaluating victims of alleged torture and ill-treatment and their consequences. The complete IP evaluation requires a multidisciplinary team, which focuses on documentation and witnessing, and is used internationally in courts (UN

Office of the High Commissioner for Human Rights, 2022). The IP evaluation is considered an expertise. The first training course on the IP in Israel took place in Israel in 2014 (Abu Akar et al., 2014). It was facilitated by the International Rehabilitation Council for Torture Victims, partnering with the Public Committee Against Torture in Israel. I joined this course and subsequently completed the training of trainers.

The IP evaluation includes a psychological and a physical examination, often a full body examination, and requires the expertise of both a physician and a mental health professional because torture's consequences are often complex with psychological and physical symptoms. The IP notes that it "may be advisable for the experts in physical evidence and psychological evidence to conduct one evaluation together" (UN Office of the High Commissioner for Human Rights, 2022, p. 76). It adds that in "assessing the health consequences of torture and ill-treatment, it is important to consider and to probe into the interrelationship between the physical, psychological and social consequences of ill-treatment" (UN Office of the High Commissioner for Human Rights, 2022, p. 88)

According to the IP training, a psychologist or other mental health professional and a physician participate in the *psychological* examination, whereas only the physician partic-

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ipates in the *physical* examination. (Sometimes, an interpreter participates as well.) The option of psychologists' participating in the physical part of the IP evaluation – albeit in a secondary role – has until now not been deemed an issue worthy of discussion, whereas the fact that physicians participate in the psychological part is considered obvious. The non-participation of the mental health professional in the IP-based physical examination is a professional asymmetry. This asymmetry may have to do with schooling. Physicians learn about mental health, though much less than clinical psychologists, whereas psychologists (in most branches) learn about physical health issues but do not have medical training. (Psychiatrists are an exception, as they are knowledgeable and trained in both fields.) The asymmetry seems to be also related to the interprofessional hierarchy, in which the physician – appropriately or not – is seen as a higher-status professional (cf. Gergerich et al., 2018; Hoffman & Koocher, 2018).

To demonstrate why it could be advisable for a psychologist or other mental health professional to participate in the physical examination, I will relate to three different facets of the IP-based evaluation, which are a) the holistic approach to the evaluation as a whole, b) the collaboration between psychologist and physician, and c) the concern for privacy and consent and the role of the chaperone.

The holistic approach of the evaluation

Psychological and behavioural processes are closely related to physical health and illness (Richards & Cohen, 2020), and we may view mental health as the health of the whole body (Alessi et al., 2020). When we evaluate the consequences of torture (and not only), we take this holistic approach and relate to the combined and interacting impact of physical and mental aspects of the trauma, which is

multi-faceted and often massive. It is all about integrating the physical and the emotional, while the specific interaction between body and psyche is heavily based on the subjective experience of the particular client.

Physical health may significantly impact one's psychological well-being and is therefore regularly taken into account by mental health professionals. In my practice, clients who are disabled often talk about and show me – on their initiative – their limitations so that I get a better understanding of their difficulties. Thus, one of my elderly clients feels highly distraught by the fact that due to a fall, she cannot raise her arm as she used to, though both her physician and physiotherapist declare she is okay. She displays what she can and cannot do, which gives me a better understanding. Likewise, a torture victim's little scar can be of psychological significance, as it may remind of the experienced trauma, be perceived as disfiguring the body, and impact self-esteem. The observation of the scar could be relevant for the mental health professional to obtain a better understanding of the situation.

I became acutely aware of the professional asymmetry when a physician and I interviewed an African refugee a couple of years ago. This man, who was in his twenties, had found his way to Israel after dreadful experiences in Sinai. He told us an abhorrent story and, at some point, complained that his scars had a negative effect on his self-esteem. As he was fully dressed, I could not see any scars. I also sensed a discrepancy between his words and his sporty appearance. I believed that the impression of the extent of his scars was necessary to understand the psychological dynamics, as would be his reaction to exposing the scars. However, at the time, it did not occur to me to ask to observe the physical examination.

The physician did the physical examination alone and informed me that there was ex-

tensive scar tissue. He initially did not want to show me the pictures for privacy reasons, but I insisted since I considered them highly relevant from a psychological perspective. Only after receiving the images was I able to grasp how our client must have felt, as the scars were large and numerous, with significant changes in skin color. In hindsight, I believe I should have been present during the physical examination. My presence in the physical examination would have given me a fuller picture of the damage to the man's body and the resulting impact on his self-esteem, like the presence of the physician during the psychological examination gave him a fuller picture of our client's state.

For a clinical psychologist and other mental health professionals, there is a difference between receiving pictures from a third person and obtaining a first-hand description. I could compare this with situations concerning my clients, who sometimes ask me to read their writings about traumatic events they experienced. As a psychologist, I want to get as close as possible to their experience. Therefore, I ask them to read the text aloud, as the essence is in how the client relates to the traumatic material, something I would miss if I had only received the written text. Similarly, if I obtain pictures from the torture victims' physical examination, I miss part of the experience.

Collaboration of psychologist and physician

The concept of clinicians meeting clients together is not new. In fact, three decades ago, I participated in a project in which psychologists joined physicians in their regular flow of primary care consultations (Aronzon, Weishut, Unger & Fraenkel, 1995). Primary care models of collaboration between psychologists and physicians described clinicians working jointly with clients and maintained that clients with PTSD respond well to this

arrangement (Holloway & David, 2005). In healthcare services, there nowadays is an emphasis on interdisciplinary teams (Richards & Cohen, 2020). Moreover, a recent publication with best practices and recommendations for psychologists refers to two overarching themes for the future of global mental health: the consideration of cultural/contextual variables and collaboration (Hook & Vera, 2020).

For many tortured clients, there are more psychological than physical signs of trauma. In some places, standard practice is that mental health professionals and physicians independently perform evaluations of alleged torture. Separate evaluations make things easier for psychologists, as they have a line of professional thought in the interview, which will not be interrupted by a sometimes helpful but occasionally side-tracking physician. It also would save the physician time and emotional effort. In contrast, this is not common practice in Israel and other places, where clinicians perform IP evaluations jointly in only one session. Physicians are present during history taking and the examination of psychological symptoms. Thus, they can ask questions regarding possible medical consequences of the victim's experiences. They also may notice things that went unnoticed by the other professional. Moreover, talking to both clinicians together, the client does not need to repeat the story.

Likewise, the mental health professional would be an expert in observing psychological aspects during a physical examination and could have insights to offer. In addition, the IP requires various measures to assure objective and exact reporting of physical findings, which are complex to administer alone. The mental health professional could be instrumental in, for example, the measurement, mapping, or photographing of scars. They also could assist in taking notes of the explanations provided

by the client, comments by the physician, and the situation as a whole. To make it clear, this is not in any way to suggest that the mental health professional will do a physical examination, as this is not part of the psychological expertise.

The presence of a mental health professional during a physical examination might influence the evaluation. For example, it could impact the client's transference toward the clinicians and the relationship between the clinicians. This is comparable to the physician's influence during the psychological examination and the interpreter's presence in both the psychological and the physical examination. Moreover, not all mental health professionals will feel comfortable joining the medical doctor in the physical examination and being exposed to physical symptoms. Similarly, for physicians and interpreters, it may take some effort to become accustomed to the exposure by clients of traumatic material verbatim.

If there are any difficulties in the collaboration, they need to be discussed. After all, communication in the collaboration is essential in the success of the three-way relationship between client, physician, and psychologist, as all parts bring invaluable perspectives on the situation to the benefit of the client (Holloway & David, 2005; Hook & Vera, 2020). A study on the collaboration of physicians and mental health professionals assessing torture victims in Israel elaborates on this issue (Weishut, Gurny, Rokach & Steiner Birmanns, 2022).

Privacy, consent and the chaperone

Privacy, informed consent, and confidentiality are concerns central in ethical codes of conduct for psychologists and physicians, such as the American Psychological Association and the American Medical Association, and the IP refers to these issues. Privacy is as

relevant in the psychological as in the physical examination since the disclosure of details regarding trauma is often experienced as disclosure of an intimate nature, different but still comparable to the display of one's body. Therefore, clients need to consent to any part of the evaluation, including the presence of all individuals, and can opt out at any moment. In addition, all information obtained from the evaluation must be kept private unless the client waives confidentiality.

The privacy issue remains debatable because, during the IP evaluation, there is regularly more than one clinician in the room, often an interpreter and sometimes an observer. We leave for discussion elsewhere the question of whether clients actually feel they can refuse to have someone participate in the examination. For personal and cultural reasons or because of a perceived power differential, they may feel that they should accept the situation as is.

For safety reasons, one may consider that it is better to have the encounter between clinician and client not in private. There is an increasing tendency to make room for medical chaperones to protect both clients and physicians from alleged or actual misconduct during sensitive examinations (Pimienta & Giblon, 2018). The American Medical Association recommends having an authorised health care team member serve as a chaperone during physical examinations and suggests that this may help prevent misunderstandings (American Medical Association, n.d.). Furthermore, there was a recent call for health care institutions to provide trained chaperones to act as "practice monitors" during breast, full-body, skin, genital, and rectal exams (AbuDagga et al., 2019). Also, the University of Michigan Health (2020) provides a clear policy regarding chaperones, stating, among others:

1) *A chaperone is a person who acts as a witness for a patient and a health professional during a medical examination or procedure. A chaperone should stand in a location where he or she is able to assist as needed and observe the examination, therapy or procedure.*

2) *A chaperone may be a health care professional or a trained unlicensed staff member. This may include medical assistants, nurses, technicians, therapists, residents and fellows. [...] (Chapter: Definitions)*

Medical organisations in other parts of the world too recommend using medical chaperones in sensitive examinations (Alameer et al., 2021; Anikwe et al., 2021). Moreover, the lack of availability of a chaperone or the client's decline of their use poses an ethical dilemma, questioning whether the physician could proceed with an intimate examination (Thuraisingham et al., 2017).

There is no doubt that IP evaluations include sensitive physical examinations. They are sensitive not only because of their nature but also on grounds of intersectionality: issues of gender, race, class, legal status, and more. The procedure is all the more delicate in cross-gender examinations, as clients may prefer not to be alone with a physician of the opposite gender for reasons such as those related to their trauma or religion. (In Israel, most torture evaluations are of Muslim men, whereas most physicians are Jewish women.) Consequently, the involvement of a medical chaperone seems appropriate if the client consents. The chaperone could be the mental health professional with whom a relationship was established earlier in the evaluation.

In the case of the middle-aged male asylum seeker, whom I mentioned before, the female physician and I had discussed the issue of participating together in all parts of the examination. We took the anamnesis jointly, and she

stayed with us during my questioning regarding his psychological state. Yet, when asked, the client had not felt the need for a chaperone during the physical examination, and the room was so small that it would be uncomfortable for another person to attend. The client had not spoken about any scars but had mentioned torture-related genital problems. With that said, we considered it less appropriate for me to observe a genital check, which is anyhow delicate. Therefore, I remained outside but close enough to hear their conversation. We agreed that if the physician felt this could help, she would call me.

Conclusion

The article centres on the participation of psychologists (or other mental health professionals) in physical examinations that are part of the Istanbul Protocol evaluation and refers to three different facets: the holistic approach of the evaluation, the collaboration between physician and psychologist, and privacy, consent, and the role of the chaperone. It is not self-evident for the psychologist to have a physician participate in the psychological examination of a client. Likewise, physicians may struggle with having a mental health professional participate in the physical examination. Still, this form of collaboration might be the recommended arrangement for the client's sake. Therefore, let me conclude by reiterating the question: Would it be appropriate, and perhaps even vital, for mental health professionals to participate in Istanbul Protocol-based *physical* examinations? I believe the answer is positive, at least in some cases, with the client's consent.

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References

- Abu Akar, F., Arbel, R., Benninga, Z., Dia, M. A., & Steiner-Birmanns, B. (2014). The Istanbul protocol (manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment): implementation and education in Israel. *The Israel Medical Association Journal*, 16(3), 137–141. <http://europepmc.org/abstract/med/24761699>
- AbuDagga, A., Carome, M., & Wolfe, S. M. (2019). Time to end physician sexual abuse of patients: Calling the U.S. medical Community to action. *Journal of General Internal Medicine* 2019 34:7, 34(7), 1330–1333. <https://doi.org/10.1007/S11606-019-05014-6>
- Alameer, A., Mohammed, A., Elwahab, S. A., Boland, M., Elfadul, A., Tiwary, T., Power, C., Allen, M., Butt, A., & Hill, A. (2021). Documentation of chaperone presence in breast clinic, a complete audit cycle. *Irish Journal of Medical Science*, 1–3. <https://doi.org/10.1007/S11845-021-02634-Y>
- Alessi, M. G., & Bennett, J. M. (2020). Mental health is the health of the whole body: How psychoneuroimmunology & health psychology can inform & improve treatment. *Journal of Evaluation in Clinical Practice*, 26(5), 1539–1547. <https://doi.org/10.1111/JEP.13386>
- American Medical Association. (n.d.). Code of Medical Ethics Opinion 1.2.4: Use of chaperones. American Medical Association. Retrieved September 24, 2021, from <https://www.ama-assn.org/delivering-care/ethics/use-chaperones>
- Anikwe, C. C., Irechukwu, C. J., Ogah, C. O., Ikeoha, C. C., Okorochukwu, B. C., Okoroafor, F. C., & Ndukwe, O. E. (2021). Presence of chaperone during pelvic examination: Women's opinions and preferences in a tertiary hospital in Abakaliki, Ebonyi State, Nigeria. *Journal of Clinical & Diagnostic Research*, 15(4), 1–4. <https://doi.org/10.7860/JCDR/2021/46850.14705>
- Aronzon, R., Weishut, D., Unger, M. & Fraenkel, Y.M. (1995, September). Mental health service in a primary care clinic: A model for integration of mental health services and primary care medicine. Lecture presented at 13th World Congress of Psychosomatic Medicine, Jerusalem, Israel.
- Gergerich, E., Boland, D., & Scott, M. A. (2018). Hierarchies in interprofessional training. *Journal of Interprofessional Care*, 33(5), 528–535. <https://doi.org/10.1080/13561820.2018.1538110>
- Hoffman, J. S., & Koocher, G. P. (2018). Strategies for ethical practice in medical settings. *Practice Innovations*, 3(1), 43–55. <https://doi.org/10.1037/PRI0000062>
- Holloway, R. L., & David, A. K. (2005). The complex of collaboration: An overview of the psychologist-physician relationship. *Clinical Case Studies*, 4(2), 115–125. <https://doi.org/10.1177/1534650103259756>
- Hook, K., & Vera, E. (2020). Best practices in Global Mental Health: An exploratory study of recommendations for psychologists. *International Perspectives in Psychology: Research, Practice, Consultation*, 9(2), 67–83. <https://doi.org/10.1037/IPP0000125>
- Pimienta, A. L., & Giblon, R. (2018). The case for medical chaperones. *Family Practice Management*, 25(5), 6–8. <https://www.aafp.org/fpm/2018/0900/p6.html>
- Richards, C. S., & Cohen, L. M. (2020). Trends in clinical health psychology and behavioral medicine. In *The Wiley Encyclopedia of Health Psychology* (pp. 311–319). John Wiley & Sons, Ltd. <https://doi.org/10.1002/9781119057840.CH165>
- Thuraisingham, C., Nalliah, S., & Sinniah, D. (2017). The chaperone in a therapeutic relationship: A critical discussion. *International Journal of Person Centered Medicine*, 7(1), 53–60. <https://doi.org/10.5750/IJPCM.V7I1.608>
- UN Office of the High Commissioner for Human Rights. (2022). *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Professional Training Series 8/ Rev. 2. https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf
- University of Michigan Health. (2020). The use of chaperones during sensitive examinations and procedures. Retrieved September 23, 2021 from <https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures>
- Weishut, D.J.N., Gurny, D., Rokach, R. & Steiner Birmanns, B. (2022) Complexities of collaboration between physicians and mental health professionals in the assessment of torture victims. In review.