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Cross-cultural assessments of torture survivors based on the Istanbul Protocol

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Abstract

The text provides an overview of the key considerations for conducting a cross-cultural assessment of a torture survivor. The first part introduces essential concepts in anthropology, medicine, cross-cultural psychology and psychiatry. The second part reviews the most relevant elements concerning a forensic report of a survivor. The text has particular focus on cultural considerations regarding the ethical aspects of the Istanbul Protocol. It also addresses aspects related to the encounter with the survivor and the interview, medical aspects including the physical examination with a focus on transcultural ideas on pain and suffering, and the psychological and psychometric assessment. It also briefly discusses aspects related to consistency and credibility analysis. In the last section, the text provides a global perspective and a checklist of cultural considerations following the outline of the Istanbul Protocol.

An evaluation of a torture survivor would require a cross-cultural perspective when there is a difference between the cultural, linguistic or ethnic background of the survivor and the institution or the person that requires it.

The Istanbul Protocol, in its 2022 revised version, offers some indications on how to take cultural aspects into account in the assessment of torture survivors (see annex 1).

In this editorial, we will try to further elaborate on transcultural aspects of forensic assessments and provide suggestions and guidelines in the framework of the Istanbul Protocol.[1]. The first part of the editorial will review basic anthropological concepts, while the second will focus on specific aspects of the assessment.

Anthropological expertise versus transcultural assessment. Generally speaking, the expert will face two different types of reports (Kirmayer et al., 2007):

1. Those of a more anthropological nature attempt to explain the cultural context in which the events take place and the particular significance they may have in the light of that context. The aim is to understand how the cultural context determines the account of events, including likely causal explanations (IIDH, 2010; Meger, 2010). Table 1 reflects three examples of this type of report. In all them, the anthropological expertise helped the Court to understand the role of culture and context in the framing of rights violations
2. Expert reports of a more clinical nature, related to cross-cultural medicine and psychology, that aim to explain the individual, family and community impacts of torture in the light of the person's worldview including psychosocial, anthropological and cultural perspectives. Table 2 provides four examples. In all these cases the expert report assessed the specific impacts of torture from the light of the identity and cultural background of the victims.

1 The terms cross-cultural and transcultural are often used interchangeably, but they have distinct meanings, especially in fields like psychology, anthropology, and healthcare. Cross-cultural refers to the comparison or interaction between two or more different cultures. It focuses on identifying and understanding the differences and similarities across cultures. Transcultural refers to going beyond individual cultures to find commonalities and shared experiences. It aims to integrate aspects from multiple cultures, transcending boundaries to create a new, inclusive understanding

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Table 1.

Case	Relevance of forensic report – expert witness from a cross-cultural perspective
Yakye Axa Indigenous Community v. Paraguay Interamerican Court of Human Rights (2005)	The Yakye Axa community, part of the Enxet-Lengua people, traditionally inhabited the Chaco region in Paraguay. Over time, their lands were sold to private owners, leading to their displacement and severe living conditions. – An anthropological report showed the community's historical connection to their ancestral lands – A cross-cultural assessment showed the suffering of the community and the impact of displacement on cultural and social life. The Court ruled against the State, among other HR violations, regarding the Right to Life (Article 4) due to the community's precarious living conditions and the inaction of the State[2].
Similar cases in the IACHRT: Xucuru Indigenous People and their Members vs. Brasil (2018); Mayagna Awas Tingni Community v. Nicaragua (2001), Saramaka People v. Suriname Maya Indigenous Communities of the Toledo District v. Belize	
"Street Children" (Villagrán-Morales et al.) v. Guatemala (1999)[3]	The case concerned the kidnapping, torture and murder of four street children in Guatemala City by individuals or groups operating outside the control of the state. Expert reports and expert witnesses provided information on the situation of street children in Guatemala, including marginalisation, stigma, vulnerability to abuse and exploitation. The Court condemned the state for lack of protection of the tortured and murdered children.
Royal Commission into Aboriginal Deaths in Custody (1987-1991)[4]	The Commission made an inquest on the disproportionate number of suicides of Aboriginal people in Australian police stations and prisons. The findings of the expert reports showed the psychological impact of cultural dislocation, racism, and the lack of consideration for the distinctive needs of Aboriginal inmates.

Table 2. *Relevance of forensic report – expert witness from a cross-cultural perspective*

Case	
Prosecutor v. Thomas Lubanga Dyilo (2012) International Criminal Court[5]	Thomas Lubanga Dyilo, a Congolese army leader, was charged with enlisting and conscripting children under the age of 15 and using them in the Patriotic Force for the Liberation of Congo (FPLC). – Many of the witnesses were former child soldiers who testified about their recruitment, training, and participation in hostilities. While the defence often challenged the credibility of witnesses, particularly those who were former child soldiers, the prosecution called upon expert witnesses, including psychologists and child protection specialists, to provide context and explain the psychological impact of the crimes on the child soldiers, supporting the credibility of the statements – There was also a discussion on whether the minors had voluntarily joined the Army. The psychological expert reports discussed the consideration of age, family, community and cultural norms to show the unvoluntary nature of their involvement. The Court ruled the minors suffered cruel and inhumane treatment.

2 https://corteidh.or.cr/docs/casos/articulos/seriec_125_ing.pdf
3 https://corteidh.or.cr/docs/casos/articulos/seriec_77_ing.pdf
4 http://www.austlii.edu.au/au/other/IndigLRes/rciadic
5 'Lubanga (ICC-01/04-01/06) Decision of the Trial Chamber I; 14 March 2012', 2012, pp. 1–624. https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2012_03942.PDF

Case	
Prosecutor v. Bosco Ntaganda International Criminal Court[6]	Bosco Ntaganda was charged with war crimes in the ICC including rape, murder, and torture committed by his troops in the Central African Republic (CAR). – The transcultural forensic reports documented the systematic use of rape and sexual violence as a weapon of war in Congo, the profound trauma inflicted on the victims, many of whom were stigmatized and ostracized in their communities due to the sexual violence they endured. – Expert reports also were essential in determining individual and collective reparation measures
Lonkos and Mapuche Communities v. Chile (2008) Inter-American Court of Human Rights (IACtHR) (Vargas-Forman et al., 2022; Vargas, 2017)	The Court analysed the application of Chile's Anti-Terrorism Law against Mapuche leaders and activists who were advocating for territorial rights. – The forensic reports considered the cultural significance of the Mapuche people's connection to their land and the right to recover their ancestral lands, the role of the Longkos and Machis (traditional healers) within the community and the psychosocial impact of detention on them when being condemned in high security prisons far from the land. The State was condemned to overturn the convictions and ordered individual and collective reparation measures that took into account the cultural elements of trauma.
Ines Fernández vs Mexico[7]. Inter-American Court of Human Rights (IACtHR)	Mrs. Fernández Ortega was an Indigenous Me'phaa woman, resident in Barranca Tecoani, Guerrero state. At the time of the events, on 22 March 2002, she was raped at home in front of her four children by a group of approximately eleven Mexican soldiers, dressed in uniforms and carrying weapons, to obtain information on the whereabouts of her husband. – An expert report, with a psychoasocial and transcultural perspective, assessed the personal and family impact that Mrs. Fernández Ortega and her children suffered as a result of the rape and the years of impunity – A second report assessed the impact that the torture had on the Me'phaa Indigenous community, especially the women and the social fabric.
Similar case: Rosenda Cantú vs Mexico.	

Some basic concepts of Ethnomedicine and Ethnopsychology.

We will here very briefly go through basic concepts in anthropological medicine, relevant to writing forensic reports.

An ethnic group can be defined as a collective of individuals who share a common cultural tradition, symbolised by an identifying name and a collective consciousness of belonging to that group. It is estimated that there are currently approximately 15,000 ethnic groups worldwide, with some comprising only a few surviving individuals.

Ethnicities are *dynamic and heterogeneous structures* that are in constant interaction with the surrounding populations, with frequent insertions, borrowings or exchanges among cultures. It is therefore important to avoid a rigid or essentialist view of cultures and to refrain from assuming the existence of cultural archetypes. For instance, there may be greater similarities between a young Guaraní and a young Mapuche internally displaced in town, than between a young and an older traditional Guaraní person. Furthermore, due to globalization, a significant proportion of survivors can navigate multiple cultural contexts with relative ease.

Cultural relativism posits that all cultural norms are inherently valid and deserving of respect. Nevertheless, in instances where these practices conflict with fundamental human rights, the latter must prevail. Female genital mutilation provides an illustrative example of this tension between cultural norms and the protection of human rights. Nevertheless, the question of where the boundary of what are considered fundamental human rights lies is open to debate, particularly from those who argue that the Universal Declaration of Human Rights was drafted from the perspective of Global North, with markedly individualistic societies (Ramcharan, 1998).

Etic and Emic

The study of culture can be roughly approached from two perspectives: the *emic approach,* which involves the description and

6 https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2019_03568.PDF

7 https://corteidh.or.cr/docs/casos/articulos/seriec_215_esp.pdf

analysis of a culture from the perspective of those who belong to it, and the *etic approach*, related to the description and analysis of a culture from the perspective of an external observer.

To illustrate, in the context of the impact of traumatic events, *susto* can be conceptualised as an ethnic-illness endemic to certain Latin American cultures, that appears mostly in children. It is typically described as a critical bodily response of physical and psychological collapse in response to situations of alarm or crisis. However, it is important to note that there are variations in the descriptions, causal attributions and treatments applied to *susto* by the family or healers in different countries and cultural settings. By contrast, from an etic perspective, *susto* would be labelled, according to Western psychiatric classifications, as an adjustment or an anxiety disorder. The emic approach is more closely aligned with the subjective and experiential perspective of the survivor. In contrast, the etic perspective facilitates the establishment of a shared forensic language, which is crucial in an expert process. Indeed, anthropological expert opinions aim to establish a connection between the two perspectives (Harris, 1976).

Key concepts in cross-cultural psychology relevant to forensic assessment

Self and identity. The concept of person and self is understood differently in Western and non-Western cultures. There are alternative ways of defining what constitutes correct or "normal" behaviour. Furthermore, in collectivistic societies there are interpersonal constructions of personality that extend beyond Western individual traits. A significant number of clinical diagnoses lack adequate cultural translation and personality disorders is one of them (Sökefeld, 1999). Consequently, it is imperative to exercise particular caution when analysing allegedly personality traits or making personality diagnoses in the context of cross-cultural assessments.

Cultural determination of emotions. Although there is a set of emotions that are considered universal (the usual agreement is happiness, sadness, anxiety, anger and disgust), the context in which these emotions are considered normative or expressed varies across culture (Leff, 1988). An understanding of the cultural context in which emotions are experienced is thus required (Kirmayer et al., 2018). The interpersonal emotions of guilt and shame serve to exemplify this cultural dependence, with notable discrepancies observed between, for instance, African, European, and Asian cultures regarding the origins, bodily symptoms, triggering situations, cognitions and behaviours linked to guilt (Leff, 1988).

Cultural analysis of pain. There is no evidence to suggest that cultural differences exist in the perception of physical or psychological pain. However, there are discrepancies in the interpretation of pain (and suffering as its subjective dimension) and in the manner in which its expression is deemed socially acceptable (Alexander et al., 2007). It is contrary to the available evidence to assume that there are cultural contexts in which individuals who suffer ill-treatment or torture are more resilient to (and therefore feel less) physical or psychological pain.

Grief and Bereavement. It is particularly important to consider the impact of culture on forensic reports in the context of bereavement and mourning. In Western societies, the individual is typically regarded as either dead or alive in the biological sense. In contrast, traditional cultures often conceptualise a series of transitional phases between life and death, during which the person is perceived to remain present and interact with the living. This includes, for instance, expressing opinions and engaging in activities that continue to affect friends and loved ones. Consequently, there are numerous avenues of symbolic communication with relatives through pain, dreams or rituals. Accordingly, in Western societies, rituals are directed towards the bereaved and the suffering they are enduring, whereas in traditional societies, rituals are communal social acts that support the deceased and help them on their journey towards other dimensions of life in these different states of transition. The focus is on helping those who leave and not those who remain.

Health and disease

The concept of health and illness varies considerably between different ethnomedicines. There are significant differences in the way disease, its causes and, consequently, the best treatment are conceived.

A dualistic view of mind and body and the significance of disease. The concept of mental illness is linked to a dichotomous view of body and mind that is not shared by all cultures. A holistic view of the human being will only consider illness - which encompasses, in its wholeness, the body and the mind. Bodily pains can be an embodied memory of traumas, losses and crises. (Raingruber & Kent, 2003). In the case of torture victims, physical symptoms, particularly chronic pain, will often be forms of bodily metaphors for the traumatic experiences the person has endured. (Theidon, 2004).

Relationship between body and symptoms. While Western cultures tend to express distress using emotions and cognitions, non-Western cultures tend to have a holistic view of mind and body and express distress through somatic symptoms. Sometimes this is wrongly labelled by Western experts as *alexithymia* or inability to put words to emotions. This can be a Western-colonizing view of misinterpreting body-mind unity. This view can lead to errors by not properly exploring mental

health issues or trauma when they are primarily presented as physical complaints.

Illness

In the Western conception, psychological disturbances are understood to result from a disruption in the individual's functioning, which may be attributed to either biological alterations (i.e. lack of serotonin) or a lack of emotional or cognitive resources (coping mechanisms to navigate the external environment). In contrast, traditional cultures tend to view illness as originating from external agents, whether physical, natural or supernatural, that *penetrate* the body and disrupt its equilibrium. This force is a personification of the illness that has entered the body and which the therapist must therefore expel. In order to extract the disease, a variety of therapeutic techniques are employed, with the central focus being on symbolic healing processes of a secular or religious nature, as described in numerous texts on medical anthropology (Levi-Strauss, 1964). Symbolic healing is combined with a number of other traditional therapeutic elements, including meditation, phytotherapy, ecstasy and catharsis, the use of metaphors and counselling guidelines, the recontextualisation of the problem in accordance with culture, the resignification of the person's role, the restructuring of the family or social environment, and ceremonies that restore balance and reconnection with the environment, social elements, or natural or supernatural forces.

These therapeutic manoeuvres have a biological basis insofar as, through the manipulation of symbols and other techniques, they are able to generate biological changes in the person (Dow, 1982). The physiological bases of these changes are gradually becoming better known with the study of interoceptive receptors and the bi-directional connection between the central brain and these peripheral receptors (Khalsa et al., 2018; Tsakiris & Preester, 2019). These processes are not dissimilar to the biological changes observed in the standard Western psychotherapies (Davies, 2018).

Traditional medicine practitioners can discern these interconnections and offer culturally congruent coping strategies that are beyond those of a Western-trained therapist.. Therefore, collaboration and communication between different medical systems are vital for the benefit of the patient. The input of a traditional healer can be invaluable in providing an outside perspective to offer contrasting views and an alternative perspective when preparing a forensic report..

Culture-bound syndromes and Idioms of Distress in the assessment of torture survivors

Are there non-culture-bound syndromes?

Western classifications have traditionally included a category of the so-called culture-bound syndromes (CBS). The supposition that CBS exist is merely an ethnocentric conceptual distortion and, with time, the concept has declined. There are numerous medical systems globally, each with its own diseases classification system. Regardless of the specific taxonomy employed, culture is a pertinent factor in all of them. Koro and Dhat can be considered culture-bound syndromes in the same way that anorexia, alcoholism or depression are (Leff, 1988). Western classifications tended to group some folkloric syndromes under the label of CBS, collecting some of them from among the hundreds of diagnoses that exist in the different ethnomedical systems and cultures around the world. However, the emphasis in CBS was placed on the anecdotal rather than on the cultural understanding of the symptoms and syndromes. The majority of the so-called culture-bound syndromes (CBS) are somatic, dissociative, or psychotic reactions to overwhelming anxiety and stress. These syndromes possess an inner logic that can be discerned through a process of assessment and dialogue, which is what is relevant in the expert assessment.

It is important to distinguish between the so-called CBS and idioms or cultural concepts of distress.

Cultural concepts of distress

The term cultural concepts of distress (known in the past as *idioms of distress*) is used to describe words or expressions that capture physical or psychological discomfort from a cultural perspective (Kaiser & Weaver, 2022). Such expressions may correspond from simple colloquialisms to symptoms, signs, or even nosological entities. For a cultural concept of distress to be considered a syndrome, it must manifest within a specific cultural context, possess a name that is recognised by local healers, and be accompanied by an aetiological and therapeutic hypothesis that is grounded in that culture.

To list even an approximate list of *Cultural Concepts of distress* that have been used concerning survivors of torture can be an endless task (Simons & Hughes, 2012). Over the last 30 years, more than 100 papers have been published with different proposals for specific terms and symptoms that would reflect psychological or psychosomatic reactions about experiences of war, violence, conflict or torture in almost every geographical location where extreme violence has occurred. Just as an example, there are around ten papers, one review and two chapters that describe cultural concepts of distress for Cambodia survi-

vors, suggesting terms which are, by the way, not always coincident in their meaning and context of application (Kidron & Kirmayer, 2019).

Cultural concepts of distress are not diagnoses. In a way of speaking, "being stressed" is a cultural concept of distress in Western cultures that may or might not correspond to multiple (or any) diagnoses. The cultural concepts of distress that people use in their language bring us closer to the reality in their words and narrative (Kidron & Kirmayer, 2019).

We might find, just to mention some, the *baksbat* (Broken Courage) in Cambodia (Chhim, 2013), *tension* (tension), *bi-shi sinta* (excessive thinking), *feshar* (pressure), *gum zai nofara* (unable to sleep), and *shoit-shoit lagon* (feeling restless and/or trapped) among Rohinya refugees (Trang et al., 2024). *Hozun* and *majnun* have been described Among Darfur refugees (Rasmussen et al., 2011); *child witchcraft* (as a metaphor for family psychosocial and trauma suffering) has been described in Sierra Leone torture survivors (Yoder et al., 2021), *pinsamientuwan* (repetitive thoughts, worries), *ñakary* (collective suffering and distress, collective punishment) or *llaki* (sorrow, embodied grief) among quechua people in Perú (Pedersen et al., 2008, 2010), *reflechi twòp* (thinking too much) in Haiti (Kaiser et al., 2014), although similar cultural concepts around thinking too much are described in many cultures (Kaiser et al., 2015); *huzun*i (deep sadness), *msongo wa mawazo* (stress, too many thoughts), and *hofu* (fear) in refugees from Congo (Greene et al., 2023), *Sakit Hati* (chronic mental distress related to resentment and anger amongst refugees exposed to persecution) in West Papua (Rees & Silove, 2011). In Nepal, Kohrt & Hruschka (2010) described up to sixteen cultural concepts of distress related to trauma and torture.

Some studies show that CCD might be more useful in forensic assessments than Western categories. Chhim (2014) showed, while doing forensic expert reports for the Extraordinary Chambers in the Courts of Cambodia (ECCC), that *Baksbat* (Broken Courage) could capture more trauma symptoms among Khemer Rouge survivors and provide unique information beyond that described by PTSD. More important than a catalogue of terms is the availability of methodologies that help us to understand and properly describe the experiences of severe suffering of survivors in specific cultural contexts (Rechtman, 2000).

The Mapuche people have a complex ethnomedical system with a classification of diseases transmitted orally that combines the physical, psychological, psychosocial and spiritual, with specific treatments attached to each one (Pérez-Sales et al., 2000). Among the Mandinka, Fox (2003) identified four post-trauma syndromes: two were disorders of the heart, one affected the mind, and the last affected the brain. These syndromes operate cumulatively: If the heart problems are severe, this leads to dysfunction in the mind and, ultimately, the brain. At each stage, Mandinka healers had specific treatments. In both cases, there is a medical system that provides a theoretical framework to understand the diagnosis of torture survivors from within the culture.

Williams (2021) has shown how in most contexts torture survivors navigate both systems and often hybridisation between the emic and etic occurs. In his study, in Uganda, the psychiatric notions of suffering brought into the region by humanitarian intervention programs interacted with local concepts of suffering (based on conceptions of the spirit) and people proved a mixture of Western concepts with traditional meanings and causal explanations.

Trauma is a universal experience, but not a universal entity, it is a social construct. Culture shapes the way that torture and trauma are perceived and responded (Nicolas et al., 2014). Forensic experts should, as much as possible, avoid limiting their work to fit the survivor in pre-fixed categories, but try to gain deeper insight into local perceptions of trauma-related distress. and how symptoms are understood, interpreted, expressed and coped with (Bovey et al., 2024).

Although there has been much debate about the cross-cultural validity of the PTSD concept (Marsella, 2005), there is now sufficient accumulated evidence to show its biological basis, shared traits across cultures and usefulness (Hinton & Lewis-Fernández, 2011). Its use not only allows for a common forensic language, but also for comparison of impacts between people from different cultural backgrounds and types of violence, something that would be impossible to address from an emic perspective alone. Preliminary data also partly supports the transcultural validity of Complex PTSD (Heim et al., 2022). Annex 2 shows a selection of comparative epidemiological data on PTSD in the general population and in survivors of war and torture in different countries and cultural settings, showing the usefulness of its use as a shared global concept from an etic perspective.

Interviewing survivors- Some cross-cultural elements

In cross-cultural assessment, some particularly elements require consideration. These include, among others:

– The use of *Western terms* for which a translation is assumed to exist. In some cultures, there are no terms that are equivalent to some folk Western expressions like anxiety or depression. There are, in some cultural settings, certain particular ways of asking about psychological distress. Common questions in Latin America or Africa might be: *How is your heart*

doing? How are you thinking? The interviewer might have answers such as*: My heart is weak or my thoughts do not rest; I keep having brain pain; Since I got out of prison, I have a burning heat that goes up and down my body*, or *At night I feel ants walking inside my body*... As most people are nowadays bicultural, anxiety and depression will likely be understood by all survivors, but it is good practice to be aware how is the usual way to ask.

- Individualistic or Western cultures are more inclined to make *intimate or personal disclosures*. This may result in the forensic expert perceiving individuals from collectivist cultures as lacking trustworthiness, sincerity, or a capacity to convey their thoughts with clarity. Consequently, they may be regarded as exhibiting inconsistency or a lack of credibility (Jubany, 2017).
- Additionally, cultural differences exist concerning the *types of questions or situations that are perceived as embarrassing*. In a Western setting, it may be perceived as socially inappropriate to make out-of-context comments. In traditional cultures, the act of interrupting another individual without allowing them to conclude their utterance or raising one's voice to engage in discourse with new arguments may be perceived as a breach of cultural norms.
- From a Western perspective, the *concept of truth or falsehood* is dichotomous. In collectivist cultures, by contrast, there may be a socially tolerated use of white lies for the sake of maintaining balance in the dialogue or for the well-being of the group.
- There are differences in the *sense of humour* and very rational cultures find it more difficult to find absurd ideas amusing and humour or jokes might not be understood or even misunderstood.
- Finally, in collectivist cultures there is flexible *use of time* to meet the obligations of social reciprocity, whereas in individualistic cultures time is seen as a scarce resource to be rationed and controlled.

The Istanbul Protocol : transcultural perspectives

The Istanbul Protocol (UNHR, 2022) provides advice on cross-cultural aspects of assessing torture survivors. In Annex 1 we have collected the paragraphs where this is reflected, and the advice provided on them. There are aspects related to the interview, use of translators and formulation of diagnosis among others. We will consider here some aspects which are not fully developped and complement the information provided there.

Ethical aspects

The Istanbul Protocol sets out very strict ethical requirements for a report to be compliant with it. Some of these ethical requirements may demand a cross-cultural perspective. Table 3 summarizes these aspects.

Physical examination: cultural norms.

Different cross-cultural elements are of relevance in the medical examination:

There are important cultural differences in patients' expectations of the physician's physical examination. For some people, the fact that the doctor is close to the body, examines, touches and explores gives them confidence and indicates that the doctor has done his or her job properly. For others it may be seen as unnecessary and invasive and that the doctor should trust their account. It is important to ask questions in advance in the informed consent process and to take cultural preferences into account when organising the examination. (Costanzo & Verghese, 2018). It is also important when deciding whether a family member or other trusted person should be present at the physical examination of the person. In Arab cultural settings the husband may want to be present at his wife's examination and it is important, if the examiner is a man, to be able to have female health workers present at the examination in his place.

History taking

The medical examination is based on a thorough medical history similar to what would be done with any other patient seen for the first time in primary care. This includes an anamnesis and a systematic examination by apparatus, including not only the external observation of lesions but also a cardiological, respiratory, abdominal, musculoskeletal and sensory organ examination.

Some notions of tropical medicine will be helpful for patients coming from areas where there are uncommon infectious diseases, especially if the survivor was held in overcrowded prisons or unhealthy premises. Dietary conditions should also be explored.

A cross-cultural perspective will allow a targeted examination with a special emphasis on detecting the methods of torture prevalent in a certain area. Thus, for example, falanga requires a specific physical examination of the sole of the foot and alterations in mobility and standing which are not routinely done. Knowing that falanga is a widely used method of torture in, for instance, Sudan, Egypt or Syria will allow for specific questioning and examination of survivors from these countries. The use of sexual torture with the insertion of objects via the anus against Sahrawi militants by the Moroccan police allows for targeted anamnesis and eventual examination. There

***Table 3**. Transcultural view of ethical aspects in a forensic assessment compliant with the Istanbul Protocol.*

Informed consent	***Individual or collective decision.*** In some cultures, consent might be influenced by family, community or even religious authorities. It is essential to strike a careful balance between respecting individual autonomy and cultural norms, on the one hand, and the flexibility that others might be involved in the process, on the other. ***Language***. The informed consent document should be written in the language that the individual understands best. This entails the utilisation of straightforward and unambiguous terminology, devoid of legal or medical jargon that could prove confusing or intimidating. ***Non-verbal communication*** may be employed to ascertain whether the individual is comprehending the information provided and genuinely consenting to the proposed course of action. It is important to ensure that the individual is indeed understanding the information presented and that the consent is truly informed. ***Power balance***. Some individuals may be more vulnerable to power imbalance, particularly if the subject is from a marginalised or oppressed group. From a reparative perspective, the consent process should be designed to empower the individual and to ensure that they feel in control of their decision to participate. This would entail giving the person a clear right to refuse or withdraw consent at any point. ***Confidentiality Concerns***: In small communities and in contexts where local disputes and conflicts are prevalent, concerns about confidentiality may be particularly pronounced. It is of the utmost importance to address these concerns and to elucidate the manner in which the information will be safeguarded, with a view to preventing any potential harm. ***Culturally Appropriate Documentation***: Furthermore, the method of documenting consent must be culturally appropriate. A verbal agreement may be regarded as more binding than a written one. The process should respect these preferences while also meeting the legal and ethical standards that apply in this context.
Confidentiality and privacy	***Expectations around privacy and confidentiality***. In some cultures, the concept of privacy is highly valued and strictly maintained, whereas in others, the notion of privacy may extend to the community or family unit, rather than being confined to the individual. There is a risk that the forensic expert may breach the collective expectations of communal privacy. The justification for privacy can be based on legal grounds. In some cases, a participatory approach may prove an effective means of circumventing an otherwise challenging situation. One potential solution is to conduct the interview in a manner that allows for a distinction between collective and private aspects. This could entail addressing certain topics, such as the account of events, in a collective manner, while other aspects, such as medical and psychological exploration, are conducted privately.
Security	***Legal Awareness***: It is important to be aware of the local laws and regulations regarding the documentation and reporting of violence. For instance, reflecting sexual violence can have unexpected negative consequences in countries where there are homophobic laws or abortion is legally penalised. ***Global context but also local context.*** In small communities where there is a delicate balance between different ethnic groups or families in conflict, the act of visiting or interviewing residents in a particular house is not neutral. It is necessary to consider the roles and power balance within the community when determining how to conduct the assessment. It is particularly important to avoid singling out individuals in leadership roles, especially empowered women or families who may be at the centre of threats. ***Community Relations and risk of reprisals***: The possibility of backlash or reprisals may be greater in closely-knit communities where speaking out can affect not only the individual but also the wider family or community. Some members of the community might be fearful or vulnerable by others reporting.

are repeated reports of torture against sexual organs in China that will not be reported unless specifically asked.

Knowledge of cultural practices can also help to make a differential diagnosis in cases where some cultural practices can be confused with torture. Thus, for example, Einterz (2018) reported the need to make a differential diagnosis in Central African cultures between skin lesions caused by torture and skin lesions caused by ritual scarification. In children who have studied in Koranic schools in North Africa or Afghanistan are common marks and scars on legs and arms as a result of beating with sticks by teachers.

Biological markers

Biological parameters should be assessed with caution. For example, in certain malaria endemic areas there may be normative baseline levels of haemoglobin in the blood that would be considered indicative of anaemia in other settings. There are some analytical parameters that can be influenced by the area from which the person comes.

Also to consider that, in pharmacological torture, there are differences in the impact of drugs in different geographical areas due to differences in liver metabolisation (Lin & Lin, 2015). The effect of psychotropic drugs may be different from that expected in the assessor's usual environments.

Pain screening

The most important symptom in the medical examination of torture victims is pain. Up to 60% of survivors present with chronic forms of pain associated with torture. (Baird et al., 2017; de C Williams & Baird, 2016)

It is important to understand the difference between pain (as a neurological manifestation of damage) and suffering (as a subjective expression of pain) (Bustan et al., 2015). It is paramount to understand cultural variations in the expression of suffering, social norms and expected behaviour in interpreting the signs of examination (Abd-Elsayed, 2019; Lasch, 2000) and the connections between traumatic events, culture and pain.

Neurological manifestations

Differential diagnosis between some somatic conditions with conversive and dissociative symptoms and underlying neurological disorders can sometimes be challenging. This is especially complex in the case of pseudo-crises. An adequate anamnesis, a cultural understanding of the symptoms, the existence of a cultural perception of the disease and the performance of some complementary tests (such as an EEG or a sleep study) may help in the differential diagnosis (Moreno & Peel, 2004).

Psychological examination: etic and emic

In an expert assessment, the clinician should include an assessment from both the emic and etic perspectives. Regarding the etic approach, the interview corresponds to the standard criteria as developed in the Istanbul Protocol (chapter 4 to 6).
Table 4 summarises the steps for an emic assessment of the survivor.

Cultural formulation interviews.

Different models try to provide guidelines on how to conduct the psychiatric interview. The DSM-5 Cultural Formulation Interview (CFI) includes questions that explore the individual's cultural identity, cultural explanations of the illness, cultural factors related to the psychosocial environment and levels of functioning, and cultural elements of the clinician-patient relationship (Lewis-Fernández et al., 2020)

Kleinman (1988) has developed an extensive and very detailed model on how to explore mental health issues in different cultures. It has four sections that include asking patients about their understanding of the cause, course, and treatment of their illness, as well as their expectations for care.

Transcultural view of psychometric tools. Questionnaires adapted to culture and context

A psychometric analysis is essential when trying to objectify the consequences of ill-treatment or torture. But this entails additional challenges. In the case of large population studies, the development of ad-hoc instruments adapted to the context and culture may be considered. In most cases, however, the forensic expert will have to resort to previously developed and cross-culturally validated instruments. Table 5 provides a list of tools that have been validated in a wide range of cultures

In circumstances where some forensic assessments are required from the same population, an alternative route may be considered. This involves the development of a psychometric instrument based on local cultural concepts of distress. A variety of methodologies have been proposed (Bachem et al., 2024; Bolton et al., 2013; Fabian et al., 2018; Weaver et al., 2022) although all of them require a considerable amount of time (Patel & Hall, 2021)

Credibility analysis

There are some transcultural aspects of credibility in torture survivors, which a forensic expert must be aware:

– **Stereotyping and Bias**: Evaluators may unconsciously apply cultural stereotypes or biases when assessing the credibility of symptoms. For example, certain cultural groups might be un-

***Table 4**. Emic assessment*

1. Description of the symptoms elicited by torture in the person's own words. Clarification of symptoms and expressions
2. Consideration of whether the symptoms could correspond to some cultural concepts of distress according to what exists in the cultural environment to which the person belongs. Try to clarify when this is used and what situations produce it.
3. Whether the person suffered from these symptoms or syndrome earlier in life, and what treatment was prescribed from within the culture. If, at that time, they were brought by themselves or the family to a traditional healer and what kind of treatment they received.
4. Causal attribution of these cultural symptoms. Reasons for the symptoms to appear concerning torture and likely explanations, especially (a) if they can be attributed to some kind of transgression, harm or external influence other than torture. (b) why torture would produce these symptoms
5. Exploration of illness behaviours and the functional and life impact of the symptoms

***Table 5**. Psychotic Tools with a Transcultural Perspective.*

	Posttraumatic Stress Disorder
Harvard Trauma Questionnaire (HTQ) (Berthold et al., 2019; Shoeb et al., 2007)	The HTQ has been translated into over 30 languages and validated and used in around 50 countries. It includes both a trauma event checklist and symptom questions based on DSM criteria. It has been regularly updated to new DSM versions. Transcultural studies have shown very slight differences between the cut-off scores of the English version (2.5) and those in other cultures (Ocuppied Palestine (2,3); Iraq (2.2); Bosnia (2.6).
Postraumatic Stress Disorder Checklist- Civilian version (PCL-C) / PCL-5 (for DSM-V) (Blanchard et al., 1996; Weathers et al., 1991)	The PCL-C has been translated to around 30 languages and used in a similar number of countries. Although based on DSM diagnostics, some of the versions include adjusting the language and slightly modifying items to fit cultural norms and experiences of trauma. Most of the studies just translate the questionnaire but still use the English scores (cut-off 33). In some of the studies, cut-off scores were recalibrated (i.e. China, Japan, Brazil, Mexico) although the results always ranged quite close to the English original validation (range of cut—off scores 30 to 38)
Other alternative PTSD tools translated and/or validated to more than 20 languages around the world	Impact of Event Scale-Revised (IES-R) Clinician-Administered PTSD Scale (CAPS) Trauma History Questionnaire (THQ) Davidson Trauma Scale (DTS) Child PTSD Symptom Scale (CPSS)
	Depression
Tools translated or validated in more than 20 languages around the world	Beck Depression Inventory (BDI) Patient Health Questionnaire-9 (PHQ-9): Center for Epidemiologic Studies Depression Scale (CES-D):
Quality of Life	WHOQOL-BREF (World Health Organization Quality of Life – BREF. assess quality of life across four domains: physical health, psychological health, social relationships, and environment. Specifically designed for cross-cultural use and has been validated in multiple countries and languages (WHO, 1996) SF-36 (Short Form Health Survey) EQ-5D (EuroQol-5 Dimension)

fairly perceived as being untruthful or unreliable, which can influence the assessment process.

- **Cultural Norms Regarding Emotion**: In some cultures, showing emotions like fear, sadness, or anger might be proscribed, which can lead to underreporting or minimization of symptoms. This might be misinterpreted as a lack of credibility due to a supposed dissonance between the account of events and the emotions attached to it. People from cultures with high expression of emotions tend to be considered more credible than those from cultures which are more contained. The same can be applied to non-verbal communication. For instance, avoiding eye contact is usually considered in Western culture as a sign of lack of credibility, while in many cultures might be a sign of respect.
- **Structure of memory and sense of time**. While some cultures tend to recount events in a linear way, others tend to recall key events, without a clear timeline. (Jobson & O'Kearney, 2006). The difficulties in organizing information in time may make the narrative lacking credibility. Furthermore, some cultures emphasize a tendency to suppress traumatic memories while others tend to share and keep them structured in a collective narrative. This will influence the way events are latter reminded.
- **Help-seeking behaviour**. Certain cultures tend to keep traumatic events in private. The forensic expert might be surprised that heavily traumatic experiences have never been shared and find it a sign of lack of credibility.

A short form of a culturally sensitive format for a transcultural forensic report according to the IP

Table 6 summarizes the main points to take into account for doing a cross-cultural assessment of a torture survivor based on the Istanbul Protocol Context

***Table 6**. Points to take account for cross-cultural assesment of a torture survivor.*

Ethical aspects	– Informed consent – individual or collective decision – Language – Non-verbal communication – Attention to power unbalance – confidentiality concerns – culturally appropriate documentation – Confidentiality and privacy. – negotiations of expectations – Security – Legal awareness – Attention to local context – Community relations and risks of reprisals.
Time and space	– Consideration of distance, position of chairs – Careful consideration of interviewing style: open questions, avoiding interruptions or being too directive
Use of translators	– Avoid family members – Discuss beforehand expectations, ethical aspects and ways to talk to survivors (see IP guidance)
Istanbul Protocol	
Psychosocial History	– Focus on community and family – Take into account family in an anthropological wide sense and not in a restricted biological sense. – Expect a non-western sense of time – Likely the survivor normalizing or minimizing attachment problems or vulnerabilities in infancy – Role of ancestors
Account of events	– Attention to verbal and non-verbal expressions of distress. – Expressions of emotions do not need to be culturally congruent with the examinator's expectations, Avoid judging an apparent lack of emotions. Ask beforehand to cultural mediators
History taking	– Anamnesis including cultural concepts of disease and cultural conceptions of health and illness – After the usual interview, consider questions related to an emic perspective (see table 4) – Systematic examination with consideration of prevalent diseases in the geographical area of the survivor – Cultural sensitivity to interrogation about sensitive matters. No answer does not mean it did not happen.
Medical Examination	– Cultural norms and expectations regarding physical examination, including physical contact and persons present in the room (see table on ethical aspects) – Special attention to exploring signs or marks of torture methods prevalent in the area. – Knowledge of religious or cultural practices likely associated with marks or bodily deformities

Psychological examination	– Cultural relativity of symptoms, including hearing voices, visual hallucinations or other classic Western psychotic symptoms – Special attention to pain and suffering as expressions of distress and, the relationship of pain (localization, intensity, triggers, cognitions) to trauma, crisis and loss. – Combine Western Diagnosis (etic) with Cultural conceptions of distress (emic) if they are relevant to the survivor. Try to link both in a map of causal relationships. – Attention to dreams – Use of cross-cultural tested tools. Avoid any intelligence, personality or projective tests. – Careful consideration of neuropsychological tests
Consistence analysis	– Include cultural considerations in deciding the level of consistency
Credibility analysis	– Attention to stereotypes and personal bias – Do not base credibility on emotions unless having experience with the expression of emotions in that cultural environment – Inconsistency in details is a rule and not an exception. Expect that the overall account of events is credible based on the internal coherence, sources of triangulation and analysis of impacts. – Difficulties in organising information in a time-line is not a sign of lack of credibility – Help-seeking behaviour and coping strategies should be according to the culture and not to Western expectations.
Conclusions	– Include cultural aspects in the causal analysis linking events, torture, impacts and sequels. – Include family and community considerations when relevant – Include culture on the analysing impact on life projects and well-being – If the expert proposes reparation measures, discuss with the survivor symbolic and community reparations, besides individual ones.

In this issue

This issue includes a special section with contributions that explore the integration of livelihoods in the rehabilitation of torture survivors. Starting with a paper from *Tania Herbert* examining the intersect between livelihoods loss and torture, the importance of documenting livelihoods losses in torture assessments and the integration of livelihoods into rehabilitation programs. It provides a foundational framework for treatment centres to consider the integration of socio-economic support into rehabilitation programmes, in addition to psychological and medical care, to address the full impact of torture. The author advocates for a survivor-centered, evidence-based approach to restore sustainable livelihoods as part of comprehensive treatment efforts.

Berta Soley and Skyla Parks present a paper which examines the short-term outcomes of five projects that integrate livelihoods support with mental health and psychosocial treatment for survivors of torture. These projects, conducted by IRCT member centers in Uganda, India, Lebanon, Nepal, and Palestine, aimed to enhance rehabilitation outcomes by addressing both socio-economic and psychological needs. The study's preliminary results suggest that integrating livelihoods into rehabilitation improved participants' well-being, social relationships, and community integration. However, limitations such as small sample sizes and short project durations make the results preliminary, highlighting the need for further research.

This is followed by a contribution by *Khanal and colleagues*, from one of the centres included in the study by Soley and Parks, assessing the outcomes of integrating livelihood support into mental health and psychosocial support (MHPSS) programs for survivors of torture in western Nepal. Results show reductions in anxiety, depression, and PTSD, as well as increased self-confidence, social trust, and economic resilience. The study emphasizes the importance of a holistic approach to rehabilitation, integrating livelihood support to enhance the well-being and social reintegration of torture survivors.

Likewise, *Ayesha Mushtaq* explores the integration of livelihood support with MHPSS in the rehabilitation of torture survivors in low- and middle-income countries (LMICs). Using a cross-sectional study, it highlights the negative cycle of poverty and mental health faced by survivors, with 92% of respondents confirming a strong link between the two. The integration of livelihood support is found to improve mental health outcomes, economic stability, and social reintegration. The study further recommends enhancing coordination, securing sustainable funding, and implementing holistic rehabilitation programs to address survivors' needs comprehensively.

The special section concludes with the contribution from *Andreea Lachsz*, which studies the incarcerated populations in Australia and the US, highlighting how many come from marginalized communities with histories of trauma, arguing that imprisonment adds to this trauma and calls for a shift in the criminal legal system from focusing on reducing reoffending to promoting healing. The author also advocates for stronger international legal protections and more research into the effectiveness of prison labour in supporting post-release livelihoods.

This issue also includes a research paper from *Nielsen and colleagues* that assesses the effectiveness of sleep-enhancing treatments, Imagery Rehearsal Therapy (IRT) and mianserin in trauma-affected refugees with PTSD. The study finds that IRT improved well-being six months post-treatment, but neither IRT nor mianserin showed significant benefits in sleep quality or other outcomes compared to TAU.

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Annex 1. Transcultural aspects in the 2022 updated version of the Istanbul Protocol. Where and how is transculturality taken into account

The revised version of the Istanbul Protocol has included some general considerations on transcultural aspects on forensic asssment of torture survivors.

Legal investigation of torture (#210)
The authorities investigating should have cultural competence related to the alleged victim

Use of translators (219, 296-298)
- Avoid family members, specially children; Prefer trained interpreters, previoulsy working in team with the clinician; Avoid co.detainees (#219)
- Rules regarding the use of interpreters
- Brief interpreters before the interview
  - Discuss confidentiality and ethical aspects.
  - Introduce some of the specific language used
  - Interpreters should (a) speak directly to victims and witnesses; (b) only use direct speech ("can you please describe what happened" not "the investigator is asking what happened"); (c) use active listening techniques (posture, nodding and respectful eye contact); (d) be able to control their emotional responses and show empathy and sensitivity; and (e) not editorialize, that is interpret exactly what is said and nothing more (f) help in gaining undertanding of body language, facial expression, silence, tone of voice anbd gestures.

General considerations for interviews (#294-295; 341)
- Clinicians who conduct evaluations of victims of alleged torture should have (...) cultural humility
- The clinician should attempt to understand mental suffering in the context of the interviewee's own experience, circumstances, beliefs and cultural norms
- Idioms of distress can be culturally specific or language-bound methods to express a feeling or experienceCulture and language can also influence how a specific illness, symptom or experience is conceptualized and describedAwareness and constant learning of idioms of distress and culture specific conceptualizations of pain and illness are of paramount importance for conducting the interview and formulating the clinical impression and conclusion
- Interviewers should also be aware of the sociocultural dynamics of their own identity and how implicit and explicit perceptions of power, ethnicity, nationality, gender, age, sexual orientation and socioeconomic status may impact the interview
- Interviewers should make sure to conduct themselves in a manner that does not offend cultural or religious sensibilitiesA lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview
- It is important to remember that different cultures have different concepts of what is normal behaviour in an interview

Sexual and Gender Violence (#282, 600)
- Both sexual and gender-based torture are reliant on the power dynamics involved and can change based on the social, cultural and religious contextEven if no explicit sexual assault is alleged, many forms of torture have sexual or gendered aspects that must be considered in the evaluation
- Be familiar with the specific social, cultural, and political factors that may have influenced the physical and mental health of lesbian, gay, bisexual, transgender and intersex persons

Psychological evaluation (#493, #539)
- Cross-cultural research reveals that phenomenological or descriptive methods are the most useful approaches when attempting to evaluate psychological or psychiatric disorders What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.
- Psychologial tests of personality and neuropsychological assessment lack crosscultural validity

Cross-cultural validity of Western diagnosis (#494)
- The diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violenceHowever, the utility of this diagnosis has been questioned on many grounds, including its universal applicabilityNevertheless, evidence suggests that there are high rates of PTSD and depressive symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds

Cultural relevance of symptoms (#497-498, 509)
- Western cultures suffer from an undue medicalization of psychological processesThe idea that mental suffering represents a disorder that resides in an individual and features a set of

typical symptoms may be unacceptable to many members of non-Western societies As much as possible, the evaluating clinician should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms

– The expression of distress may be nuanced or mediated by culture and social context, for example according to the experience of shame, fear of reprisals and fear of further stigma or ostracization within the family or community The psychological assessment should aim to reach an understanding of the multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification
– Misinterpretation of psychotic symptomsCultural and linguistic differences, as well as flashbacks and anxieties, may cause misinterpretation of psychotic symptomsBefore diagnosing someone as psychotic(suffering from a mental disorder characterized by a distorted perception or processing of reality), the symptoms must be evaluated within the individual's unique cultural contextPsychotic reactions may be brief or prolonged, and the symptoms may occur while the person is detained and tortured or afterwards.

Interpretaton of findings (#525)

– The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context.
– Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

Annex 2. Usefulness of the Etic perspective

***Table 1**. Epidemiological studies - Prevalence of PTSD in survivors of political violence including torture (%: Prevalence of PTSD)*

General Population		**Disasters**	
Brazil[1]	1.5%	India[2] (Mass disasters)	20%
South Africa[3]	2.3%	Nepal[4] (Earthquake)	9.5%
Mexico[5]	3.4%	Haiti[6] (Earthquake)	25%.
Bangladesh[7]	6.2%		
Philippines[8]	6.7%		
Rusia[9]	7-10%		
Pakistan[10]	13-50%		
General Population in areas of political violence, low-intensity armed conflict or social unrest		**Survivors of torture and political violence**	
Laos[11]	6%	Cambodia[12](survivors of genocide)	8-12%
Peru[13]	8%.	Kenya[14](political conflict)	12%.
Colombia[15]	10%.	Myanmar[16](internally displaced)	18%
Nigeria[17]	10%.	Rwanda[18] (10yrs after genocide).	24.8%
Zimbabwe[19]	15%.		
Ethiopia[20]	16%		
Sri-Lanka[21]	28%		
General Population in areas of War or On-Going political conflict			
Israel[22]	8% (higher close to border)		
Occupied Palestine[23],[24]	*Previous to Gaza bombings* 20-30% Adults; 25-40% Children and adolescents *During on-going bombings* 35% Adults; 45% Children and Adolescents		
Ukraine[25]	30%-40% ((higher close to border)		
Venezuela[26]	20-30% (Economic hardship -political instability		
Afghanistan[27]	35-45% - Adults; 50% Children and adolescents.		

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