Title: "THE ATLANTA ASYLUM NETWORK: INCORPORATING MEDICAL AND PSYCHOLOGICAL KNOWLEDGE IN THE POLITICAL ASYLUM PROCESS"

Authors:
BRANDON A. KOHRT, Department of Anthropology, Emory University School of Medicine, MD-PhD Candidate, *Atlanta Asylum Network Founding Director*
JULIE L. SELF, Rollins School of Public Health, Emory University, MPH Candidate, *Atlanta Asylum Network Research and Training Coordinator*
ALISA R. GUTMAN, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, MD-PhD Candidate, *Atlanta Asylum Network Member*
JANE E. FARRINGTON, College of Letters, Arts, and Sciences, Emory University, BA Candidate, *Atlanta Asylum Network Student Coordinator*
PHOEBE ALLEMAN, College of Letters, Arts, and Sciences, Emory University, BA Candidate, *Atlanta Asylum Network Member*

Article Summary:
The Atlanta Asylum Network is a student-founded organization employing psycho-medical expertise to assist survivors of torture and persecution seeking political asylum in the United States.

Abstract:
The practice of torture is a gross assault on human health and dignity worldwide. As indicated in the United Nations' Universal Declaration of Human Rights Article 14, torture survivors may seek political asylum in other countries. Asylum seekers arriving in the United States are confronted with the challenge of proving the credibility of their asylum claims or facing deportation. Health professionals can play a key role in assessing the consistency of asylum seekers persecution claims by evaluating psycho-biological sequelae of torture. In 2003 the Atlanta Asylum Network (AAN) was established by students at Emory University, with support from Physicians for Human Rights and Institute of Human Rights at Emory University, to address the need for medical and psychological evaluations of asylum seekers in the Southeastern United States. Between 2003 and 2006, AAN provided training for the medical and psychological evaluation of torture survivors to over two-hundred students and health professionals. During this period, volunteer health professionals from AAN provided evaluations for 67 asylum seekers. Ten cases have been granted asylum. AAN is increasingly aiding torture survivors in their search for health care and other social services. Ethical, financial, and infrastructural challenges have been and continue to be central issues facing AAN.

Background

Torture is one of the grossest assaults on physical health, psychological health, and human dignity worldwide. Torture is defined according to the *Convention Against Torture* as

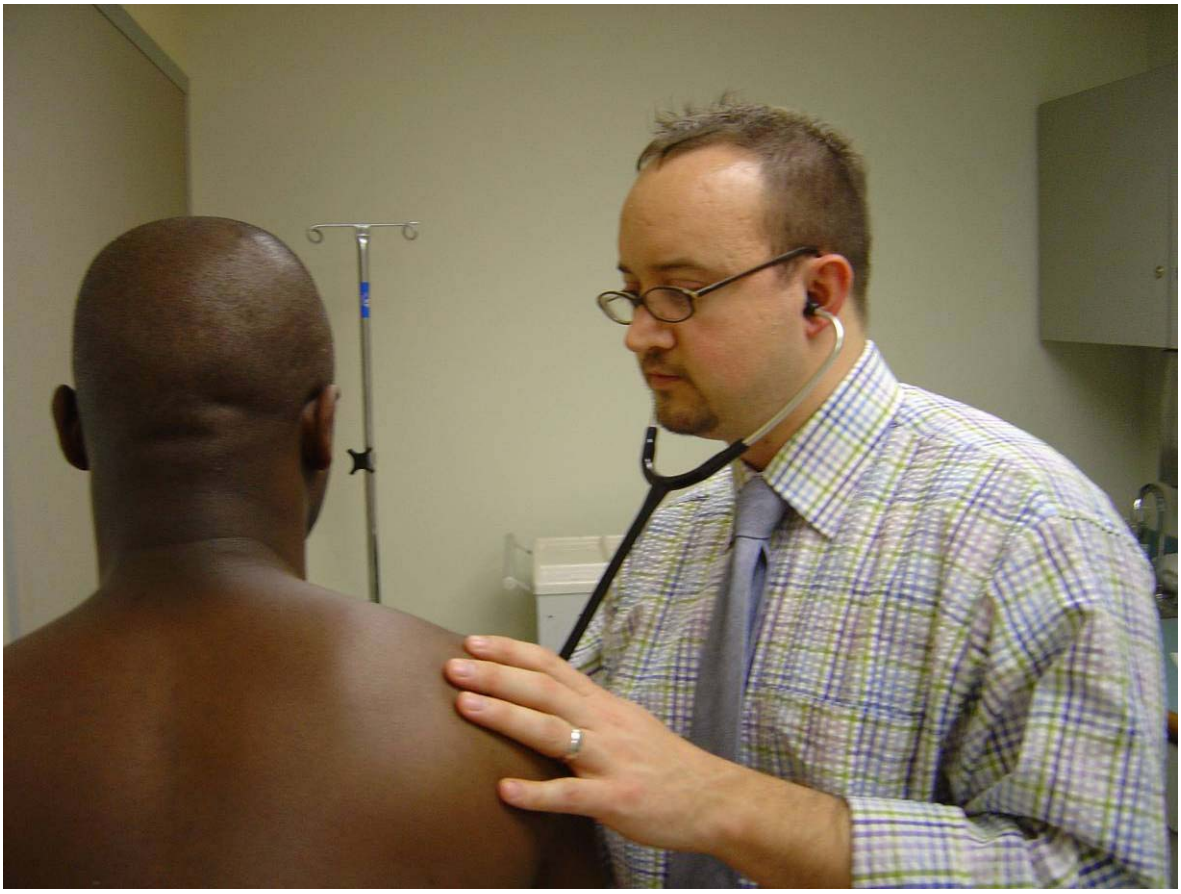
> [A]ny act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. [41]

The Atlanta Asylum Network (AAN) was founded in 2003 to use health expertise to aid the plight of torture survivors in the southeastern United States. Torture survivors from other nations come to Atlanta and other metropolitan US areas seeking political asylum. The mission of AAN is to use medical and psychological expertise to increase the accuracy of the political asylum process. An estimated 400,000 torture survivors live in the United States and 54 percent of foreign born individuals presenting at US community health settings are estimated to have been exposed to political violence including torture [9, 20]. Torture produces a dramatic range of physical and psychiatric sequelae; it is associated with physical disability, particularly with musculoskeletal and neurological damage, as well as a high incidence of posttraumatic stress disorder (PTSD), depression, anxiety, and somatoform disorders [5, 6, 8-10, 15, 22-24, 32, 34-37, 39, 45, 46]. From a health and human rights framework, one of the most effective ways to improve the health and well-being of torture survivors is through protection of their human rights [2-4, 17, 44]. The political asylum system allows for torture survivors to reside in countries with greater human rights protection, less threat of recurring persecution, and increased access to health care.

Article 5 of the Universal Declaration of Human Rights (UDHR) asserts that every individual has the right to be free from torture; whereas Article 14 of the UDHR declares that countries will provide refuge for torture survivors [42]. Additionally, article 33 of the Convention Relating to the Status of Refugees goes on to affirm that states party to it should not deport or otherwise return (*refouler*) an individual to a situation where substantial danger, including torture, exists for him or her, including to countries with known patterns of human rights violations. The spirit of this convention protects anyone fleeing persecution; however, enforcement is greater for refugees than asylum seekers.

The United States passed its own Refugee Act in 1984 and ratified the Convention Against Torture in 1994 [16]. Initially, the United States did not have a political asylum system in place. With the ratification of the Refugee Act in 1984, a political system was formally established for torture survivors and others fleeing persecution to obtain legal residency in the United States [11, 19, 28]. However the U.S. immigration system requires assurance that the individual claims of persecution are credible, and not false depictions, in order to obtain residency in the United States. Documentation of credibility poses a challenge because torture survivors often leave their

home nation with little personal documentation and rarely possess a legal record of torture. Complicity among health professionals in persecution also limits the degree of medical care pursued by torture survivors; physicians in Turkey and Iraq have been involved in torture practices [31, 33], and recently the American Psychological Association has been implicated in aiding US interrogation practices [7, 30]. Furthermore, persecuting governments typically employ methods to prevent disclosure of acts of torture. This practice results in torture survivors seeking asylum in the United States with little or no legally recognized documentation of their persecution.



DR. JEREMY HESS, ATLANTA ASYLUM NETWORK DIRECTOR, EXAMINING AN ASYLUM SEEKER

The human body and psyche can, however, be a form of documentation [29]. Some methods of torture leave characteristic scars and disabilities [29]. Documentation by medical and psychological health professionals can substantiate the consistency of torture claims with an individual's asylum case. For example, various forms of suspension hanging cause damage and consequent disability to the brachial plexus [14, 25-27, 38]. Cigarettes and electrical shock torture may leave characteristic burn marks. The disabilities and scars characteristic of these types of torture can still be observed and documented many years after persecution occurred [29]. Psychologically, torture is associated with re-experiencing (such as flashbacks and nightmares), avoidance and emotional numbing, and increased physiological arousal [6, 8, 10, 21-24, 34-37, 45], which are the three primary domains for PTSD in the Diagnostic and Statistical Manual of Mental Disorders [1]. Due to the unique, scientifically-grounded statements

that health professionals can make with regard to the consistency of psycho-physical signs for asylum claims, Physicians for Human Rights (PHR) and other organizations have increasingly involved health professionals in the asylum process. Compared to the less than 40 percent approval rate for asylum cases, PHR's selection process and medical documentation has contributed to a 90 percent approval rate for cases on which they have worked.

In Georgia, there are an estimated 700 asylum applicants each year (see Figures 1 and 2). Prior to 2003, no organization specifically dedicated to providing affordable medical evaluations for asylum seekers existed in the state. Two principal barriers to providing service were: (I) lack of specific training for torture evaluation and documentation, and (II) lack of infrastructure to connect health professionals, immigration lawyers, and asylum seekers. In 2003, with a joint effort among PHR's national Asylum Network, the Institute of Human Rights at Emory University (IHR), and several Emory students, the Atlanta Asylum Network was founded to address these two needs. The mission of AAN is to facilitate the objective medical and psychological evaluation of asylum seekers in the southeastern U.S. Unlike many programs throughout the country that aid torture survivors, AAN is not a 501c(3) not-for-profit organization; AAN is a student-run organization and a service arm of IHR (humanrights.emory.edu) funded by Emory University.

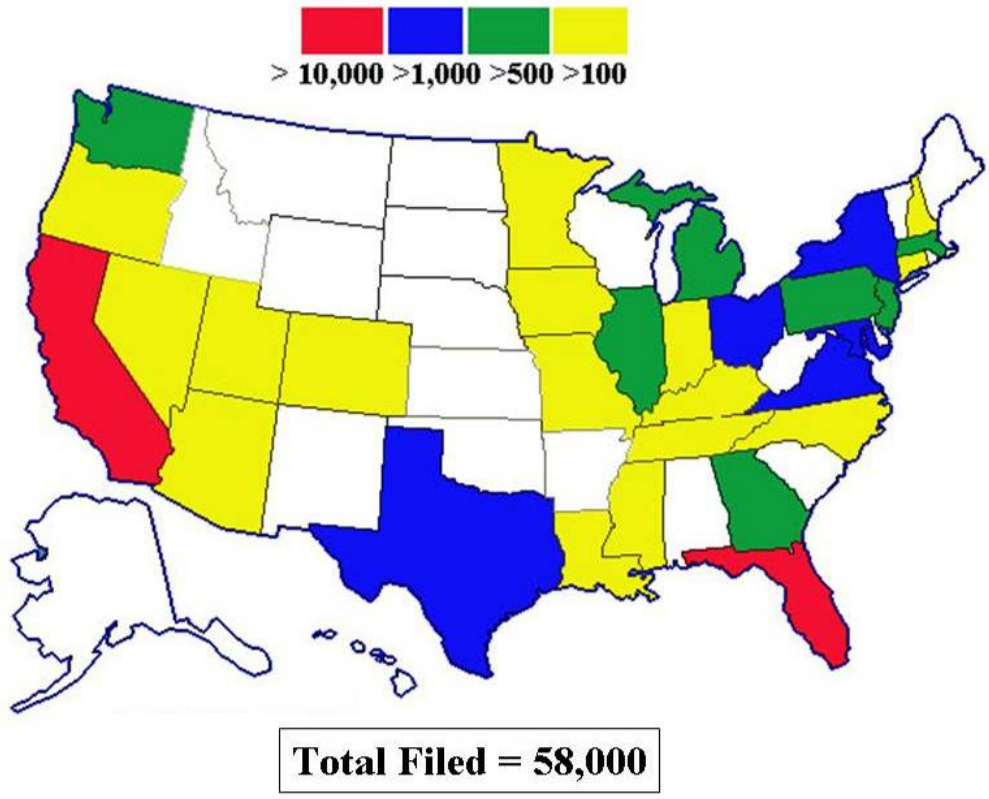


FIGURE 1. ASYLUM CASES FILED IN 2002

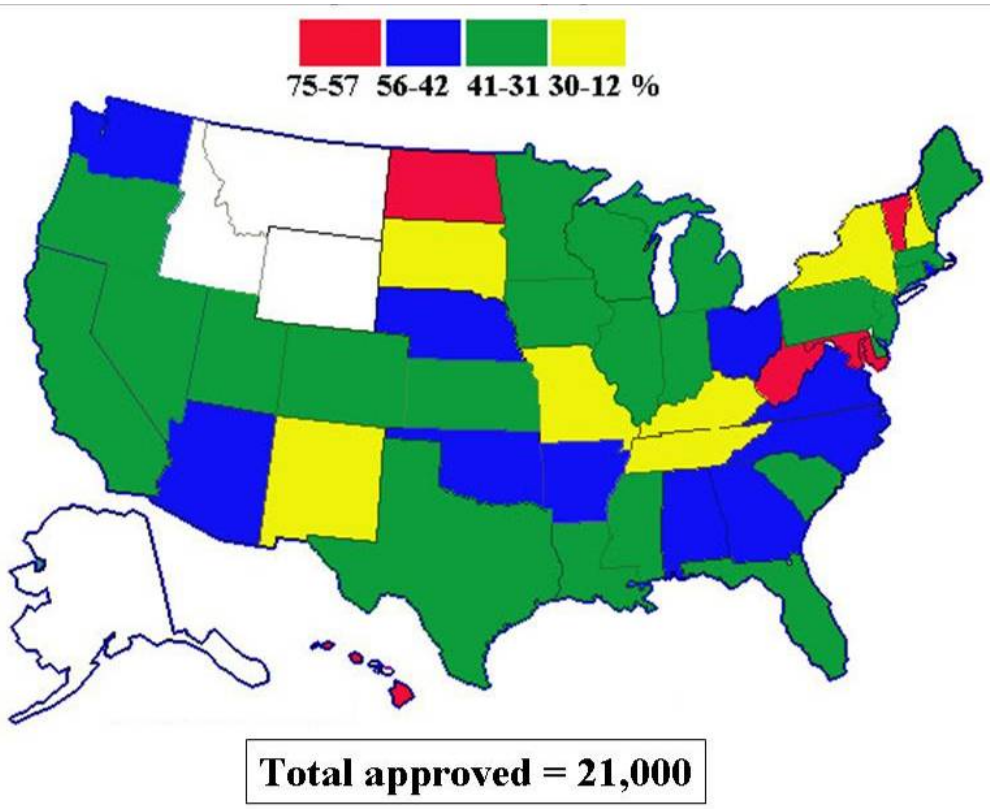


FIGURE 2. PERCENTAGE OF ASYLUM CASES APPROVED IN 2002

AAN is based, in part, on other national programs aiding torture survivors. Four of the largest programs include San Francisco's *Survivors International*, New York's *NYU/Bellevue Program for Survivors of Torture*, Minneapolis' *Center for Victims of Torture*, and Chicago's *Marjorie Kovler Center*. These programs receive funding from a variety of sources including private foundations and government programs, such as the Office of Refugee Resettlement (ORR). In addition to medical and psychological evaluations for torture survivors, these organizations also include treatment programs, legal advocacy, and other social welfare support activities. The number of asylum seekers in Atlanta is lower than that of other cities such as Miami, New York, and San Francisco [43]. However, the federal judges in Atlanta have had the lowest approval rating of asylum cases across the country [12].

Resources

A number of resources were essential for the establishment of AAN. Student volunteers provided the interest, time and manpower to orchestrate the development of the organization. Medical students provided the initial leadership in the program. At inception, the program was supervised by one medical student and one undergraduate coordinator with two additional medical students and seven undergraduates assisting with case management and evaluation. The original group was recruited via a training session organized in conjunction with PHR and IHR. Undergraduates were recruited by visiting classes with a focus on international health, medical anthropology, and human rights. The majority of work is now implemented by undergraduates, medical students,

and public health students. Nursing, law, and graduate students have also provided crucial assistance to the organization. Involvement is not limited to a specific year of training, as freshman undergraduates to fourth year medical students are active participants.

Local health professionals interested in health and human rights provided the necessary backbone of evaluation services. At the first training, 23 physicians received instruction in evaluating torture survivors. Additional training sessions expanded recruitment to psychologists and licensed clinical social workers. All three groups (physicians, psychologists, and licensed clinical social workers) are eligible to testify in court regarding the health status of asylum seekers. Health professionals have been recruited through PHR mailings, medical school faculty and residents in the Atlanta area, faculty in psychology departments, and through professional organizations. The local public broadcasting channel (WPBA) also aired brief community education segments on AAN to raise awareness (http://www.wabe.org/atlanta/community/asylum.html).

National expertise required for capacity building training of local professionals was provided by PHR. Institutional infrastructure was crucial to the success of AAN. IHR provided educational infrastructure in the form of meeting space and training funds. Health infrastructure, including resources and space for evaluations, was provided by the Dekalb County Board of Health and later through the Dekalb Country's Center for Torture and Trauma Survivors (CTTS). Financial resources were provided through the IHR, student interest groups such as the Emory University School of Medicine's chapter of PHR, and nationally through PHR's training funding.

Implementation:

Figure 3 outlines the intersection of the Atlanta Asylum Network with an individual's journey through the asylum system. Individuals enter the country by either legal or illegal means and must begin the asylum process within one year of arrival. Meeting with an immigration officer results in either asylum approval or referral to an immigration judge. AAN intersects with asylum applicants before they reach the immigration judge, arranging for a health professional evaluation which is used as a legal affidavit by the client and his/her lawyer. Figure 4 describes the actions within AAN following contact by the client's lawyer. When AAN was first instituted, immigration lawyers and refugee organizations were contacted to raise awareness about AAN services. Through initial publicity and word-of-mouth, the majority of lawyers taking asylum cases are now aware of AAN. Furthermore, AAN has been involved recently in an asylum consortium of lawyers in Atlanta.

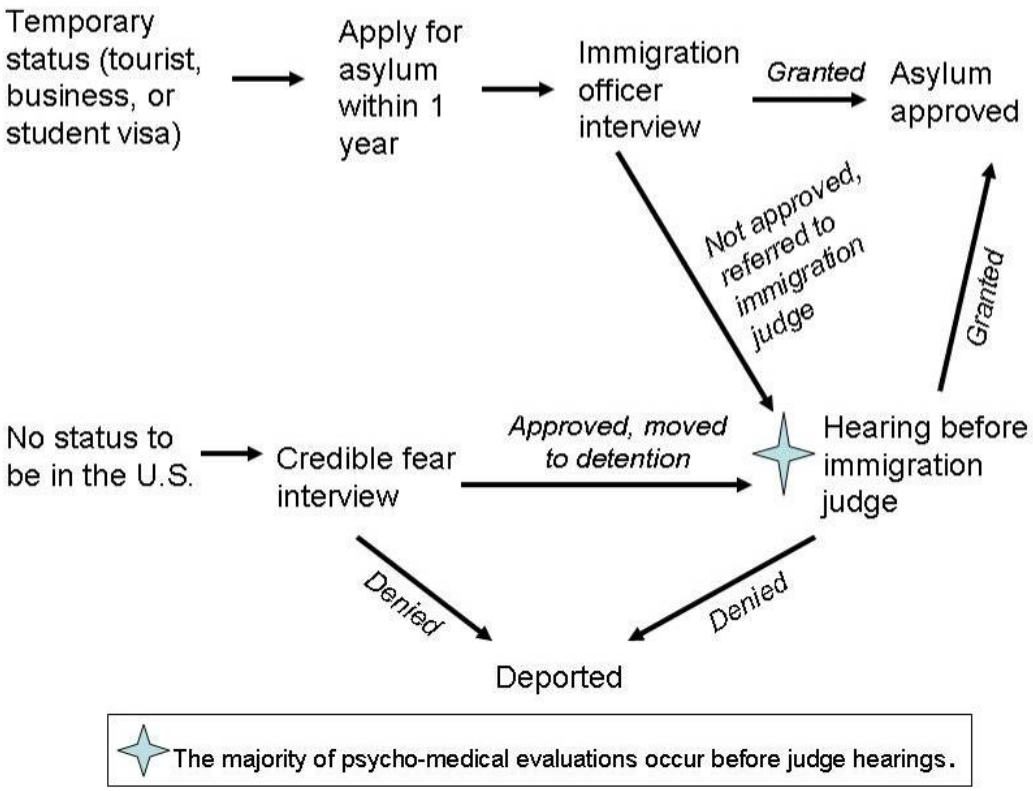


FIGURE 3. THE ASYLUM PROCESS

Once a lawyer has contacted AAN, the student coordinator reviews the case and assigns a student case worker who conducts an initial intake with the client (see appendix with "Intake Form" and "Client Tracking Form"). Then, the student case worker arranges for an evaluation by the appropriate health professional. The evaluation consists of a medical and psychological examination similar to an initial session when a physician or psychologist first meets a patient. However, the primary focus of the interview is to assess the psycho-medical consequences of torture. The psychological component explores the presence of depressive episodes, panic attacks, posttraumatic stress disorder, and other psychological conditions that may result from torture. The medical component explores physical signs of torture such as musculoskeletal damage, dermatologic scars from burns and lacerations, and neurological deficits. Finally, the health professional, along with assistance from AAN, produces a legal affidavit containing documentation of these findings; this is used as expert testimony in court. For a extensive review of conducting evaluations and common psycho-medical signs of torture see the PHR manual *Examining Asylum Seekers [29]* available at the PHR website.

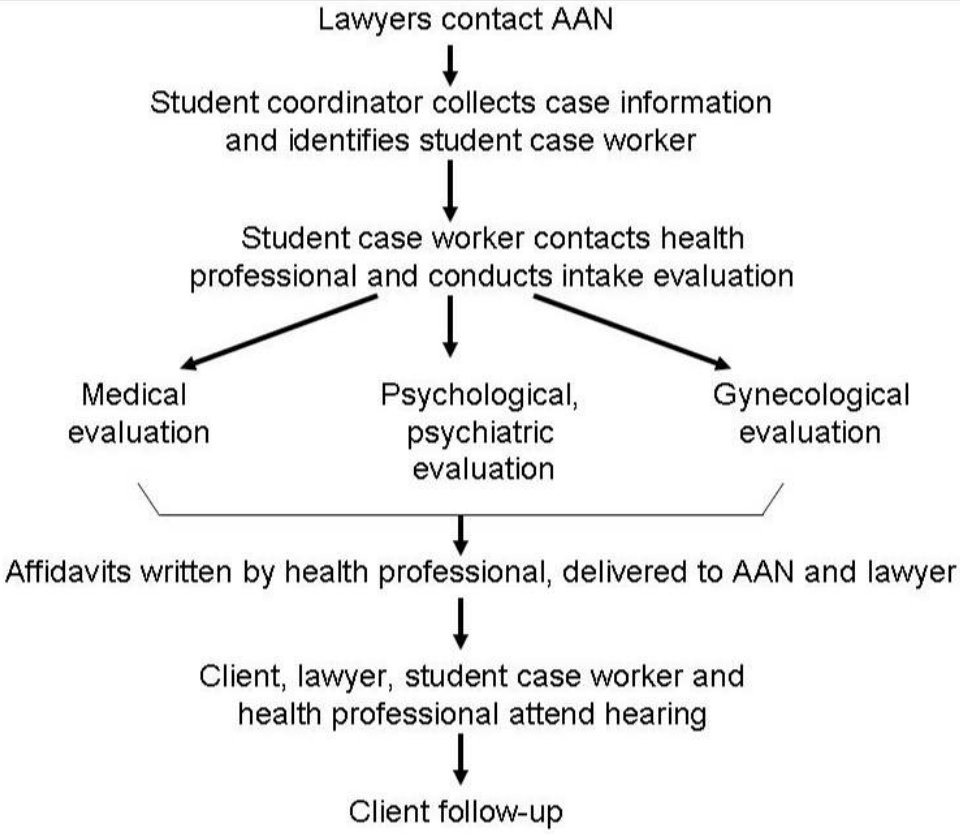


FIGURE 4. PROGRESSION OF A CLIENT THROUGH THE ATLANTA ASYLUM NETWORK

The implementation of AAN has been elaborated over the past three years since its founding. The core roles include a director overseeing the organization, student volunteers coordinating the services, and volunteer health professionals conducting the evaluations (see Figure 5). The additional necessary roles are those of trainers who facilitate capacity building among health professionals and students to conduct this work with torture survivors. Initially, training was provided externally through PHR. With the building of capacity among AAN volunteers, there has been an increasing shift to knowledge transfer within the organization from knowledgeable health professionals to interested groups, and from experienced students to new students. Increased student involvement has made possible the diversification of core leadership roles. Several student group activities have been expanded from the case coordination. Research and training, legal coordination, and student volunteer coordinator are now separate but collaborating positions. Some positions are elected through Emory's affiliated student group, while other positions are appointed by the director. The original director from 2003-2006 was a medical student. However, with expanding scope and student involvement, a faculty member from the medical school in the department of emergency medicine now directs the organization.

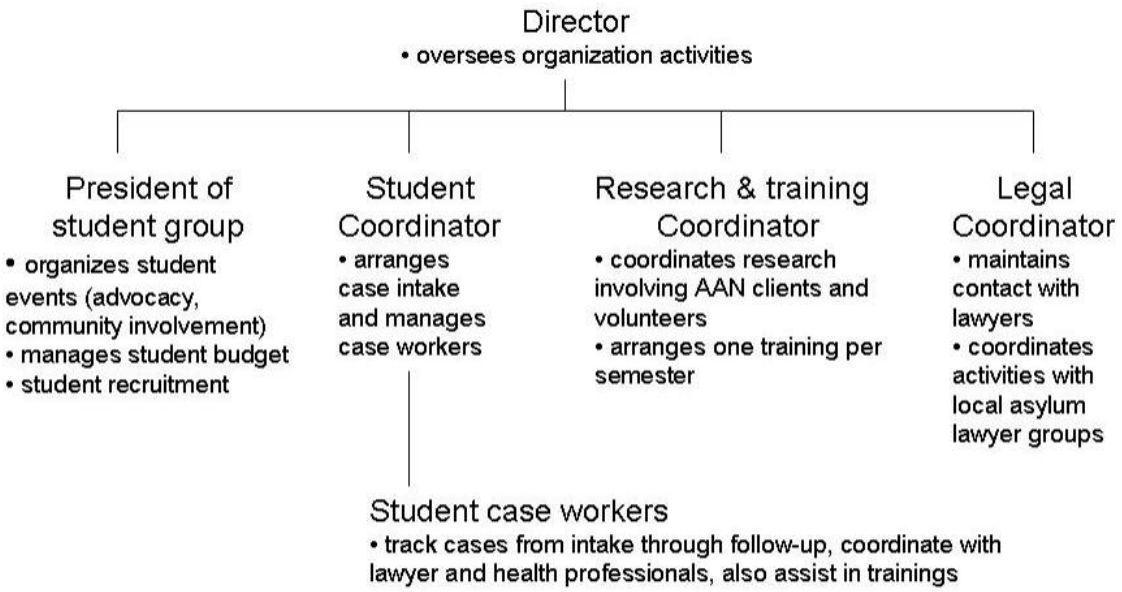


FIGURE 5. ROLES AND RESPONSIBILITIES OF ASYLUM NETWORK MEMBERS

Trainings have been a central part of AAN mission and one training session has been conducted every fall and spring semester since spring 2003. Attendees include health professionals, students in the health professions, students in other fields, and community members working with torture survivors, asylum seekers, and refugees. Trainings include international experts such as representatives of PHR and more recently Survivors International. The general content of trainings follows the original agenda designed by PHR. Trainings include an introduction to the political asylum system, then separate discussions of the medical and psychological evaluation of torture survivors. Trainings generally require three hours with one hour devoted to legal issues, one hour to physical sequelae, and one hour to psychological sequelae. With the need for more detailed skill building, trainings have become increasingly specialized. Separate trainings have recently been conducted devoted entirely to medical or psychological evaluations. This allows for three to four hours of in-depth discussion. Trainings have also expanded to include more discussion of advocacy issues and other public health topics related to torture and asylum.

Although dependent upon students for the daily functioning of the organization, AAN has relied strongly upon coalition building to survive and grow. The Executive Director of IHR has been central to developing AAN's mission and procuring funding. The volunteer health professionals have provided feedback to restructure the organization and to streamline the case coordination process. Through regular contact with immigration lawyers, undergraduates have revised the process of intaking clients. The staff of CTTS, in addition to providing evaluation space, has been both a source of referral and a decision making partner in the evolving mission of the organization. Refugee organizations have also provided support and resources. These relationships have been established informally through student contact with different organizations and professionals. Coalition building has also become increasingly structured through scheduled meetings involving individuals representing different organizations. The weakest aspect of a true coalition has been the absence of asylum seekers themselves in the

organization. Upcoming proposed research aims to obtain more information from asylum seekers directly and to promote their inclusion in AAN executive activities.

AAN has encountered numerous difficulties in fulfilling the mission of providing torture documentation for asylum seekers. The three main challenges have been (I) recruitment of health professionals, (II) access to torture survivors, and (III) interaction with the media. Regarding *recruitment*, the limiting factor initially in conducting evaluations was the number of trained and willing health professionals. This was, in part, overcome through word-of-mouth among physicians, psychologists, and social workers who recruited their colleagues. Trainings conducted every semester have also provided an opportunity to recruit more health professionals. Specific disciplines have been especially difficult to recruit, particularly psychiatrists and gynecologists who are frequently required for evaluations. Recruiting academic physicians in these disciplines who involve their residents has been one approach to overcoming this barrier. Ultimately, AAN continues to be limited in the services and number of evaluations provided because of the limited number of interested and available health professionals.

The increasing use of detention for asylum seekers [28] has created our second challenge, *access to clients.* Detention has been commonly used for asylum seekers beginning in 1996 and its use has been expanded greatly since September 11, 2001. This is problematic because health professionals are rarely allowed entry into detention centers, which are often jails housing U.S. criminal populations. Access to detention centers is necessary for evaluations because asylum seekers are not allowed out of the detention facility until their case is approved, or, if the case is denied, they are sent home. Through extensive communication with lawyers and detention center wardens, AAN has been able to access some cases in detention. In most cases, however, despite pleas from the legal representatives, AAN has not been able to enter detention facilities. Working in detention centers also presents challenges because examination facilities with privacy are difficult to arrange. The amount of examination equipment that can be brought in is also restricted. Additionally, asylum seekers in Atlanta are typically housed with the general criminal population, which exacerbates mental health problems and deteriorates the quality of interviews. Furthermore, many clients require additional testing that can only occur in a medical setting. For example, one client from China in an Atlanta detention center required a hysterosalpingogram, a type of gynecological medical exam which can be used to identify the presence of forced sterilization. Unfortunately, to date no detained clients have been allowed to attend nearby medical facilities for further testing such as a hysterosalpingogram.

Another challenge is the *relationship with popular media*. The press provides an ideal venue to raise awareness about torture, asylum issues, and advocacy for torture survivors. However, press interaction can present a conflict in many areas. AAN is dedicated to maintaining the confidentiality of clients seeking political asylum. Many asylum seekers have illegally fled violent and persecutory regimes. If their status and location of residence were to become public knowledge, this could be a threat to them in the United States and a serious danger should their claim be rejected resulting transport back to their country of persecution. Within AAN, confidentiality is maintained by not including identification in electronic communication and via an understanding among volunteers to not disclose information about clients outside of the network. Despite the importance of confidentiality, some clients wish to share their stories with the public and raise awareness about their causes. AAN continues to search for the best way to

facilitate empowerment and personal agency among clients who might wish to work with the press without unintentionally exposing clients to further persecution through their involvement with the media.

Outcomes

From May 2003 to August 2006, AAN provided services for 67 clients. Below, we provide summary results of client contact. These are summary results rather than a research evaluation program (AAN is currently in the process of initiating an IRB approved research program to track the needs and outcomes of clients). Of the 67 clients, 33 were women. Clients ranged in age from 17-52 years (mean 34.1, SD 10.1). Table 1 details the clients' countries and case status. Of these 67 cases, 10 have been granted asylum. The majority of successful cases have been men (six cases) with most cases from Africa (eight cases) and one successful case each from Europe and Latin America. Of the 10 successful cases, five were imprisoned with torture by police, two cases involved rape by police or army, two cases involved the political assassination of a relative, and one case involved forced female circumcision.

Of the remaining 57 clients, the statuses of eight clients are still pending. Court dates may be repeatedly postponed; some clients have had their dates postponed for greater than one year. Six cases were rejected by AAN. On initial review before referral to a health professional, it was found that the individuals did not have history of persecution or torture, nor threats of torture. Thus, it would not have been possible for health professionals to document any sequealae of torture. One case was rejected because the client was a suspected torturer. Federal judges denied asylum to ten cases and ordered deportation of these clients. The remaining 35 clients were lost to follow-up. Many of these clients fled to other states where judges had higher approval ratings such as California, New York, and Massachusetts. Some clients “disappeared” before their court dates and may have chosen to remain in the country illegally rather than risk deportation after a failed asylum application. Due to a lack of data for many clients, we are unable to conduct statistical analyses nor make a quantitative judgment about the efficacy and impact of AAN services.

TABLE 1. ASYLUM SEEKERS PRESENTING TO THE ASYLUM NETWORK AND CASE STATUS

REGION	COUNTRY	CLIENT TOTAL	ASYLUM GRANTED	ASYLUM DENIED	REJECTED BY AAN	PENDING	LOST TO FOLLOW-UP
AFRICA	Cameroon	6	1	1		1	3
	Congo (DRC)	2	1			1	
	Eritrea	4					4
	Ethiopia	3	2		1		
	Guinea	7	1	1			5
	Ivory Coast	2				2	
	Kenya	3	2			1	
	Liberia	2	1	1			
	Nigeria	3					3
	Rwanda	1					1
	Sierra Leone	1		1			
	The Gambia	3					3
	Togo	4		1			2
	Zimbabwe	7				2	5
	Region total	*48*	*8*	*6*	*1*	*7*	*26*
ASIA	China	2				1	1
	Region total	*2*	*0*	*0*	*0*	*1*	*1*
CARIBBEAN	Haiti	3					3
	Jamaica	1					1
	Region total	*4*	*0*	*0*	*0*	*0*	*4*
EUROPE	Bulgaria	1	1				
	Romania	4		1	3		
	Russia	1					1
	Region total	*6*	*1*	*1*	*3*	*0*	*1*
LATIN AMERICA	Colombia	1			1		
	El Salvador	1			1		
	Guatemala	4	1	1			2
	Venezuela	1					1
	Region Total	*7*	*1*	*1*	*2*	*0*	*3*
TOTAL		***67***	***10***	***8***	***6***	***8***	***35***

Future Directions

AAN is currently undertaking several efforts to improve and expand our activities. The three main areas for development are (I) research, (II) connection with clinical services to expand evaluation and treatment base, and (III) advocacy.

I. A *research program* is currently being developed to assess the long-term needs of torture survivors employing AAN services. To better understand the client population and their needs, AAN recently has implemented a more thorough intake interview. This intake includes more information on the reason for asylum, current living arrangements, current economic status,

violence experienced since coming to the United States, and how the individual found out about both the asylum process and AAN specifically. Mental health surveys in the intake interview include the Hopkins Symptom Checklist-25, the National Center for PTSD Checklist, and the World Health Organization Disability Assessment Scale. The information collected during these interviews have three important uses: provide preliminary information for the health professional conducting the evaluation, guide the development of new services and referrals, and contribute to the small body of research available regarding experiences of asylum populations. AAN is also exploring how to maintain communication with attorneys and clients during and after the asylum process. This promises to be another important area of improvement which will allow AAN to keep better records and observe changes in the efficacy of the asylum system. Potential research questions include the effect of asylum status on mental health. Based on anecdotal experience, the approval of asylum applications can dramatically reduce PTSD and depressive symptoms. Another research question could address the health evaluators rating of consistency with the approval status of claims. Based on guidelines from the Istanbul Protocol, health professionals are to rate cases according to level of consistency. If the asylum system were operating according to objective credibility, it would be expected that cases with higher consistency ratings should be more likely to be approved.

II. *Expanded collaboration with clinical services* is another future direction to increase the base of evaluators as well as provide a direct link to treatment after evaluation. AAN is currently in close collaboration with the Dekalb County Center for Torture and Trauma Survivors which was established in late 2004. AAN has begun to take advantage of the academic medical setting at Emory University School of Medicine to involve both medical students and medical residents in the asylum process. Recently, AAN has established a partnership with the Psychiatry Student Interest Group in the medical school to expand our volunteer pool of case managers to include medical students, who often have a particular interest in medical human rights. Medical students are currently working in concert with undergraduate students to follow asylum seekers through the process. AAN hopes that this will effectively couple the strengths of the undergraduate and graduate student volunteers to provide an overall better experience for the clients. In addition, as mentioned above, medical residents are an important resource in the medical school setting. AAN has used the existing organization of the residents in the Emory Department of Psychiatry and Behavioral Sciences to recruit volunteers to perform psychiatric evaluations for asylum seekers. While residents are generally still unlicensed, they often have the passion, time, and training necessary to assist with asylum seekers. Medical affidavits must be signed be a licensed physician, so psychiatry attending physicians with expertise in trauma have been recruited to oversee the evaluations performed by residents. AAN has received an enthusiastic response from the psychiatry residents, and a training session specific to the psychiatric evaluation is being planned. After training, residents can, therefore, take on the majority of the burden of performing the psychiatric evaluations. While still in an early phase, AAN hopes that the recruitment of young physicians will help establish a more reliable base of volunteers with the skills to perform thorough evaluations of asylum seekers.

III. In addition to improving and expanding services, *advocacy* for persecuted populations worldwide, and specifically in the local Atlanta asylum community, is another future direction of interest. The continued U.S. government violation of the Convention Against Torture and Geneva Convention is producing a devastating toll on psychological and physical well-being of

individuals [13, 18, 40]. The American Psychological Associations involvement with U.S. government torture activities illustrates the need for health professionals to become educated about the psychological, physical, and social costs of torture. An investigative report by Salon.com reported that a task force of the American Psychological Society has supported a policy of psychologists participating in interrogations of enemy combatants as "a valuable and ethical role to assist in protecting our nation, other nations, and innocent civilians from harm," [7] This has resulted in the participation of psychologists in controversial military interrogation practices [30].

Other important future directions include addressing secondary trauma of individuals working with torture survivors, addressing the ethics of working with torture survivors, and replication of asylum network with the cooperation of PHR at other medical universities throughout the country.

How to get involved

The development of AAN illustrates that it is feasible for students interested in working with torture survivors to develop service and advocacy programs. For more information on volunteering with AAN or developing similar programs please email: atlantaasylum@yahoo.com. A number of cities have similar programs already in place which provide student internships and other forms of involvement. Physicians for Humans Rights provides trainings on working with torture survivors and is involved in ongoing research into the policies and impact of torture committed by the United States government and other nations worldwide. PHR also provides resource materials for conducting evaluations and has a link to the Istanbul Protocol which details torture documentation for health professionals. Other advocacy groups involved in torture issues include Amnesty International and Human Rights Watch. Internationally, there are a range of opportunities for students in the health and legal fields to become involved in documentation, treatment, advocacy and research. The International Council for the Rehabilitation of Torture Survivors is an organization addressing the needs of torture survivors worldwide. The IRCT holds international conferences on the subject every other year. Please follow the links below for more information.

National and International Organizations

Amnesty International – www.amnesty.org
Asylum Law Consortium - http://www.asylumlaw.org/
Atlant Asylum Network - http://humanrights.emory.edu/asylum.html
Human Rights Watch – www.hrw.org
Human Rights First – www.humanrightsfirst.org
Institute of Human Rights at Emory University – http://humanrights.emory.edu
Physicians for Human Rights – www.phrusa.org

National and International Torture Survivor Treatment and Intervention Programs

Bellevue/New York University Program for Survivors of Torture - http://www.survivorsoftorture.org/survivors/

Center for Torture and Trauma Survivors (Dekalb County, Georgia) - www.dekalbhealth.net/PDFs/torture.pdf
Center for Victims of Torture (Minneapolis, Minnesota) - http://www.cvt.org/main.php
Center for Victims of Torture (CVICT)–Nepal (Kathmandu, Nepal) – www.cvict.org.np
International Rehabilitation Council for Torture Victims (Copenhagen, Denmark) - www.irct.org
Marjorie Kovler Center - http://www.heartlandalliance.org/kovler/
Survivors International (San Francisco, California) - http://www.survivorsintl.org/

Additional Information

I-589 Application for Asylum and Withholding from Removal - http://www.uscis.gov/graphics/formsfee/forms/files/i-589.pdf
Physicians for Human Rights – Asylum Network: *Guidelines for Evaluations* - http://www.phrusa.org/research/istanbul_protocol/isapdx4.html
Physicians for Human Rights – Asylum Network: *Examining Asylum Seekers* - http://www.phrusa.org/campaigns/asylum_network/manual.html
Physicians for Human Rights – Asylum Network: *Istanbul Protocol* - http://www.phrusa.org/research/istanbul_protocol/index.html
United States Citizenship and Immigration Services – Asylum Program - http://www.uscis.gov/graphics/services/asylum/index.htm

Suggested Readings

BULSTRODE, C. (1996). Asylum seekers who claim to have been tortured should have right to independent medical examination. *BMJ, 313*(7060), 822.

EVANS, D., & KOHRT, B. A. (2004). No refuge for persecuted neighbors: human rights, asylum and the Americas. *Ameriquests: Journal of the Center for the Americas, 1*(1).

HARGREAVES, S. (2002). A body of evidence: torture among asylum seekers to the West. *Lancet, 359*(9308), 793-794.

IACOPINO, V., OZKALIPCI, O., & SCHLAR, C. (1999). The Istanbul Protocol: international standards for the effective investigation and documentation of torture and ill treatment. *Lancet, 354*(9184), 1117.

IACOPINO, V., KELLER, A., & OKSENBERG, D. (2002). Why torture must not be sanctioned by the United States. *Western Journal of Medicine, 176*(3), 148-149.

KELLER, A. S., ROSENFELD, B., TRINH-SHEVRIN, C., MESERVE, C., SACHS, E., LEVISS, J. A., SINGER, E., SMITH, H., WILKINSON, J., KIM, G., ALLDEN, K., & FORD, D. (2003). Mental health of detained asylum seekers. *Lancet, 362*(9397), 1721-1723.

RUBENSTEIN, L., PROSS, C., DAVIDOFF, F., & IACOPINO, V. (2005). Coercive US interrogation policies: a challenge to medical ethics. *JAMA, 294*(12), 1544-1549.

SILOVE, D., STEEL, Z., & MOLLICA, R. (2001). Detention of asylum seekers: assault on health, human rights, and social development.[see comment]. *Lancet, 357*(9266), 1436-1437.

STEEL, Z., & SILOVE, D. (2004). Science and the common good: indefinite, non-reviewable mandatory detention of asylum seekers and the research imperative. *Monash Bioethics Review, 23*(4), 93-103.

WEINSTEIN, H. M., DANSKY, L., & IACOPINO, V. (1996). Torture and war trauma survivors in primary care practice. *Western Journal of Medicine, 165*(3), 112-118.

References

1. American Psychiatric Association (2000) Diagnostic criteria from DSM-IV-TR. The American Psychiatric Association, Washington, D.C.
2. Amowitz LL, Kim G, Reis C, Asher JL, Iacopino V (2004) Human rights abuses and concerns about women's health and human rights in southern Iraq. JAMA-J. Am. Med. Assoc. 291:1471-1479
3. Amowitz LL, Reis C, Lyons KH, Vann B, Mansaray B, Akinsulure-Smith AM, Taylor L, Iacopino V (2002) Prevalence of war-related sexual violence and other human rights abuses among internally displaced persons in Sierra Leone. JAMA-J. Am. Med. Assoc. 287:513-521
4. Basoglu M (1993) Prevention of torture and care of survivors. An integrated approach. Jama 270:606-611
5. Basoglu M, Paker M, Ozmen E, Tasdemir O, Sahin D (1994) Factors related to long-term traumatic stress responses in survivors of torture in Turkey.[see comment]. Jama 272:357-363
6. Basoglu M, Paker M, Paker O, Ozmen E, Marks I, Incesu C, Sahin D, Sarimurat N (1994) Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey. American Journal of Psychiatry 151:76-81
7. Benjamin M (2006) Psychological Warfare. In: Salon.com.
8. de Jong JT, Komproe IH, Van Ommeren M, El Masri M, Araya M, Khaled N, van De Put W, Somasundaram D (2001) Lifetime events and posttraumatic stress disorder in 4 postconflict settings.[see comment]. Jama 286:555-562
9. Eisenman DP, Gelberg L, Liu H, Shapiro MF (2003) Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence.[see comment]. Jama 290:627-634
10. el Sarraj E, Punamaki RL, Salmi S, Summerfield D (1996) Experiences of torture and ill-treatment and posttraumatic stress disorder symptoms among Palestinian political prisoners. Journal of Traumatic Stress 9:595-606
11. Evans D, Kohrt BA (2004) No refuge for persecuted neighbors: human rights, asylum and the Americas. Ameriquests: Journal of the Center for the Americas 1, (http://ejournals.library.vanderbilt.edu/ameriquests)
12. Fennessy S (2004) Insane Asylum. In: Creative Loafing. Atlanta (http://atlanta.creativeloafing.com)
13. Glittenberg J (2003) The tragedy of torture: a global concern for mental health nursing. Issues in Mental Health Nursing 24:627-638
14. Goldfeld AE, Mollica RF, Pesavento BH, Faraone SV (1988) The physical and psychological sequelae of torture. Symptomatology and diagnosis.[erratum appears in JAMA 1988 Jul 22-29;260(4):478]. Jama 259:2725-2729
15. Gorst-Unsworth C (1992) Adaptation after torture: some thoughts on the long-term effects of surviving a repressive regime. Medicine & War 8:164-168
16. Human Rights Watch (2004) The Legal Prohibition Against Torture. In:
17. Iacopino V, Frank MW, Bauer HM, Keller AS, Fink SL, Ford D, Pallin DJ, Waldman R (2001) A population-based assessment of human rights abuses committed against ethnic Albanian refugees from Kosovo. American Journal of Public Health 91:2013-2018

18. Iacopino V, Keller A (2002) Why torture must not be sanctioned by the United States. Western Journal of Medicine 176:148-149
19. INS Asylum Program (1999) History of the United States INS Asylum Officer Corps and Sources of Authority for Asylum Ajudication. In:Immigration & Naturalization Services, Washington, D.C., p 14
20. Jaranson JM (1998) The science and politics of rehabilitating survivors of torture. In: Jaranson JM, Popkin MK (eds) Caring for Victims of Torture. American Psychiatric Press, Washington, DC, p xxxii, 267
21. Kagee A (2004) Do South African former detainees experience post-traumatic stress? Circumventing the demand characteristics of psychological assessment. Transcultural Psychiatry 41:323-336
22. Mollica RF, McInnes K, Pham T, Smith Fawzi MC, Murphy E, Lin L (1998) The dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. Journal of Nervous & Mental Disease 186:543-553
23. Mollica RF, McInnes K, Sarajlic N, Lavelle J, Sarajlic I, Massagli MP (1999) Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia.[see comment]. Jama 282:433-439
24. Momartin S, Silove D, Manicavasagar V, Steel Z (2003) Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia. Social Science & Medicine 57:775-781
25. Moreno A, Heisler M, Keller A, Iacopino V (2003) Documentation of torture and ill treatment in Mexico: A review of medical forensic investigations, 2000 and 2002. J. Gen. Intern. Med. 18:233-233
26. Nice DS, Garland CF, Hilton SM, Baggett JC, Mitchell RE (1996) Long-term health outcomes and medical effects of torture among US Navy prisoners of war in Vietnam.[see comment]. Jama 276:375-381
27. Petersen HD, Jacobsen P (1985) Psychical and physical symptoms after torture. A prospective controlled study. Forensic Science International 29:179-189
28. PHR & Bellevue/NYU Program for Survivors of Torture (2003) From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers. Physicians for Human RIghts, Boston
29. Physicians for Human Rights (2001) Examining asylum seekers: a health professional's guide to medical and psychological evaluations of torture. Physicians for Human Rights, Boston
30. Physicians for Human Rights (2006) PHR Calls for APA to Prohibit Psychologists from Participating in Interrogations In:
31. Physicians for Human Rights (1996) Torture in Turkey and its Unwilling Accomplices. Physicians for Human Rights, Boston
32. Ramsay R, Gorst-Unsworth C, Turner S (1993) Psychiatric morbidity in survivors of organised state violence including torture. A retrospective series. British Journal of Psychiatry 162:55-59
33. Reis C, Ahmed AT, Amowitz LL, Kushner AL, Elahi M, Iacopino V (2004) Physician participation in human rights abuses in southern Iraq. JAMA-J. Am. Med. Assoc. 291:1480-1486

34. Shrestha NM, Sharma B, Van Ommeren M, Regmi S, Makaju R, Komproe I, Shrestha GB, de Jong JT (1998) Impact of torture on refugees displaced within the developing world: symptomatology among Bhutanese refugees in Nepal. Jama 280:443-448
35. Silove D (1999) The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. Journal of Nervous & Mental Disease 187:200-207
36. Silove D, Sinnerbrink I, Field A, Manicavasagar V, Steel Z (1997) Anxiety, depression and PTSD in asylum-seekers: assocations with pre-migration trauma and post-migration stressors.[see comment]. British Journal of Psychiatry 170:351-357
37. Silove D, Steel Z, McGorry P, Miles V, Drobny J (2002) The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants. Comprehensive Psychiatry 43:49-55
38. Skylv G (1992) The physical sequelae of torture. In: Basoglu M (ed) Torture and its consequences : current treatment approaches. Cambridge University Press, Cambridge ; New York, NY, USA, p xxiii, 527
39. Speed N, Engdahl B, Schwartz J, Eberly R (1989) Posttraumatic stress disorder as a consequence of the POW experience. Journal of Nervous & Mental Disease 177:147-153
40. Summerfield D (2003) Fighting "terrorism" with torture. Bmj 326:773-774
41. United Nations (1984) "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of December 1984. Entry into force 26 June 1987, in accordance with article 27 (1). . In:
42. United Nations (1948) Universal Declaration of Human Rights. In, G.A. Res 217A (III), UN GAOR, Res. 71, UN Doc. A/810
43. USCIS (2004) Resource Information Center. In:USCIS
44. Van Ommeren M, Sharma B, Prasain D, Poudyal BN (2002) Addressing Human Rights Violations. In: de Jong JTVM (ed) Trauma, War, and Violence: Public Mental Health in Socio-cultural Context. Kluwer Academic/Plenum Publishers, New York, p 259-282
45. Van Ommeren M, Sharma B, Sharma GK, Komproe I, Cardena E, de Jong JT (2002) The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: examination of comorbidity with anxiety and depression. Journal of Traumatic Stress 15:415-421
46. Van Velsen C, Gorst-Unsworth C, Turner S (1996) Survivors of torture and organized violence: demography and diagnosis. Journal of Traumatic Stress 9:181-193

Contributor section: For all correspondence please contact Brandon Kohrt, Email: brandonkohrt@gmail.com.

Acknowledgements: We greatly acknowledge the support and assistance from individuals who have made the work of the Atlanta Asylum Network possible: Ameena Ahmed, Scott Allen, Laurie Bay, Sarah Bennett, Lauren Carlile, Robert Chlala, Christina Chan, Sue Collusy, Dabney Evans, Ben Guile, Jesse Haskins, Jeremy Hess, Timothy Holtz, Vince Iacopino, Kitty Kelley, Robert Koenig, Supriya Kotagal, Suzanne Merlis, Samantha Morse, Ben Landey, Ben Levy, Jason Prystowsky, Len Rubinstein, Stephen Schiavone, Katherine Tan, Stephanie Weldon.