

Expert medico-legal reports: The relationship between levels of consistency and judicial outcomes in asylum seekers in the Netherlands

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Key points of interest

- Symptom-story consistency in medico-legal reports is associated with several factors such as gender, history of trauma and receipt of mental health care.
- Presence of physical signs and symptoms and their consistency with the refugee's story was positively associated with being granted asylum, but the presence of psychological symptoms and their consistency with the refugee's story was not.

Abstract

Introduction: If asylum applicants need to prove that they have been persecuted in their home country, expert judgment of the psychological and physical consequences of torture may support the judicial process. Expert medico-legal reports can be used to assess whether the medical complaints of the asylum seeker are consistent with their asylum account. It is unclear which factors influence medical expert judgement about the consistency between an asylum seeker's symptoms and story, and to what extent expert medico-legal reports are associated with judicial outcomes. *Methods:* We analysed 97 medico-legal reports on traumatised asylum seekers in the Netherlands. First, we evaluated the impact of trauma-related and other variables on experts' judgments of the consistency of symptoms and story. Second, we evaluated the effect of experts' judgments of symptom-story consistency on subsequent judicial outcomes. *Results:* Gender, receipt of mental health care and trauma-related variables were associated with symptom-story consistency. Positive asylum decisions were predicted by expert judgments about the presence of physical signs and symptoms of torture, and ill-treatment and their consistency with the refugee's story, but not

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psychological symptoms. *Conclusion:* These results suggest that standardised procedures for the documenting of medical evidence by independent experts can improve judicial decision quality and the need to improve psychological and psychiatric assessments.

Keywords: Asylum seekers, refugees, torture, legal medicine, post-traumatic stress disorder, Istanbul Protocol

Introduction

Forced migration has been a global phenomenon in recent decades and the Netherlands has received considerable numbers (30,000 in 2018) of asylum seekers looking for protection (Ingleby, 2005; Jennissen, 2009). The decision to grant asylum status depends on numerous factors, including the consistency and credibility of the asylum seeker's story, availability of objective evidence, host country policies, and the emotions of both asylum seeker and decision maker (Herlihy & Turner, 2013). Disturbances of emotion and memory can influence the consistency of an asylum seeker's story; discrepancies in an account are often considered as evidence of fabrication and therefore reduce the probability of obtaining asylum (Herlihy & Turner, 2006; Schulz, 2008). History of torture or ill-treatment and the medical consequences thereof are often overlooked during the asylum procedure (Bruin, Reneman, & Bloemen, 2006). Several authors have argued that medico-legal reports should play a greater role in the procedure on this very basis. Medical evidence should consist of a standardised, written expert opinion about psychological and physical signs and symptoms of torture and other forms of ill-treatment (Cathcart, Berger, & Knazan, 1979; Jane Herlihy & Turner, 2007; Oomen, 2007).

Physical scars and content of intrusive recollections in post-traumatic stress disorder (PTSD) can provide an indication of their cause and may consequently be used as medical evidence. Evaluating physical scars after traumatic events can prove difficult and requires careful physical and psychological examination. A history of intrusive recollections, in combination with observable behavioural reactions to specific 'triggers', can also be supportive (OHCHR, 2004). The relationship between torture, ill-treatment and the medical consequences, such as scars or PTSD, plays a central role in experts' judgments of the consistency between an asylum seeker's physical and psychological state and their story. Asylum authorities normally have no medical background, lack medical understanding, and focus mainly on legal aspects. This explains why consistency between symptoms and story plays only a marginal role in the final decision regarding an asylum seeker's status (Lustig, Kureshi, Delucchi, Iacopino, & Morse, 2008; Wilson-Shaw, Pistrang, & Herlihy, 2012).

Since 1999, the Istanbul Protocol has set the standard for medico-legal investigations of asylum seekers and other victims of torture and ill-treatment (UN, office of the High Commissioner for Human Rights, 2004). Research into the practical application of the Istanbul Protocol indicates that there is room for improvement (Keten, Akcan, Karacaoglu, Odabasi, & Tumer, 2013). Several authors have also emphasised the importance of the Istanbul Protocol as a potentially effective approach to documenting torture, in order to build medical evidence, and secure justice for torture victims (Furtmayr & Frewer, 2010; Haagensen, 2007; McColl, Bhui, & Jones, 2012).

Asylum lawyers can request an expert medico-legal report if physical and psychological signs and symptoms are accompanied by a history of torture or ill-treatment (iMMO, 2017; Wilson-Shaw et al., 2012). European laws also imply that medical evidence in the asylum procedure is becoming increasingly important (European Court of Human Rights, 2010; Migration & Affairs (ACVZ), 2014). In asylum law, the granting of a residence permit by the authorities responsible for decisions on asylum applications is referred to as a 'status decision positive', whereas the denial of a residence permit is referred to as a 'status decision negative'. In 2015 the new European Asylum Procedure Directive was implemented, which requires asylum authorities to commission a medical examination if there are medical signs that torture or ill-treatment may have occurred (EP, council of the EU, 2013).

The factors influencing judgements on the consistency between an asylum seeker's psychological or physical state and their story remain unclear. The extent to which expert medical judgments influence the judicial outcome of asylum applications is also unknown. We analysed 97 medico-legal reports on asylum seekers in the Netherlands to investigate the variables associated with experts' judgments on the consistency between the asylum seeker's psychological and physical state and their story. The second aim was to compare the expert judgments on consistency with the subsequent judicial outcome. We defined the following specific research questions. Firstly, what trauma-related and other variables play a role in expert opinions about the degree of consistency of an asylum seeker's psychological and physical state and their story? Secondly, how do expert judgments about consistency in

the medico-legal report relate to decisions about asylum applications?

We hypothesised, firstly, that symptom-story consistency would be associated with reported exposure to trauma, female gender and receipt of mental health care. Our second hypothesis was that symptom-story consistency would be associated with a positive judicial outcome.

Methods

Data Sources

This descriptive quantitative study of medico-legal reports used in the asylum procedure in the Netherlands used data from 97 reports written by independent experts working for the Institute for Human Rights and Medical Assessment (iMMO). All the reports were written between the foundation of iMMO in 2012 and the start of this study in June 2013. All experts are clinicians who have received training from iMMO. Whereas some experts may have a background in psychology, others may be medical doctors. Some of the reports are co-authored by two people with different backgrounds; for example, a physician and a psychologist.

iMMO is an independent, neutral and non-governmental organisation carrying out expert medico-legal reports for asylum seekers in the Netherlands. iMMO thereby contributes to the protection of human rights by facilitating timely and accurate identification of victims of torture and ill-treatment, in accordance with European asylum law and regulations (EP, council of the EU, 2013; iMMO, 2017). Asylum lawyers can request a medico-legal report in cases where they suspect that the individual is experiencing the physical or psychological consequences of torture and ill-treatment and that this has not been properly considered in the asylum procedure. These medico-legal reports include an expert judgment on the

consistency between the psychological and physical findings and the refugee's story. The medico-legal examination consists of a full mental and physical health assessment in a neutral environment. The examination usually takes several hours and can be extended if necessary. Where appropriate, a professional interpreter is present. Specific psychometric evaluations can also be performed, as well as specific parts of the physical examination. The reports produced by iMMO experts are written in accordance with Istanbul Protocol guidelines and include a joint evaluation of medical and psychological symptoms and global conclusions (iMMO, 2017; OHCHR, 2004).¹ iMMO office staff systematically review the experts' reports, which go through an extended process of peer review and feedback before they are used by the asylum lawyer to support a claim for asylum status. The peer review process focuses on adherence to the Istanbul Protocol, consistency of the report, and substantiation of the conclusions and language. We included in our dataset all finalised peer-reviewed iMMO reports produced up to June 2013. The degree to which the asylum seeker's story was deemed consistent with their physical and psychological symptoms of trauma was rated on a scale from 1 to 5, where: 1 = 'not consistent'; 2 = 'consistent'; 3 = 'highly consistent'; 4 = 'typical of'; and 5 = 'diagnostic' (OHCHR, 2004).

Data Extraction and Coding

Demographic and clinical data on asylum seekers, trauma characteristics, judicial

outcomes, and symptom-story consistency were coded. We analysed the following trauma-related variables: history of detention, history of physical violence, and history of sexual violence.² Information about whether an asylum seeker was receiving mental health care was taken from available medical documents. Data extraction was performed by the authors, with any differences in interpretation of the reports being resolved by discussion, after which the consensus decision was recorded. Asylum lawyers provided written information about the judicial outcome of asylum claims as part of their routine feedback to iMMO. Outcomes were coded as 'status decision positive', 'status decision negative' or 'status decision still unknown'. Those asylum seekers, whose reports appear in this study, gave their consent to have their data included in an anonymised form for educational purposes. All asylum seekers were assured that their data would remain confidential.

Analyses

The influence of gender, history of detention, sexual violence, physical violence and receipt of mental health care on physical symptom-story consistency and on psychological symptom-story consistency was analysed using bivariate correlations. Judgments of the degree of physical and psychological consistency were cross-tabulated and their correlation was calculated to evaluate possible risk of multi-collinearity in the logistic regression analysis (see below). Associations between psychological consistency and

¹ The number of reports that systematically reported on the consistency between verbal and non-verbal expression and consistency of the description of events was low, so this was unable to be analysed.

² Note that 'history of physical violence' and 'history of sexual violence' refer to being subject to physical and sexual violence respectively. These terms are used in this sense throughout the paper.

refugee status decision, and physical consistency and refugee status decision, were also calculated using bivariate correlations. In addition, the influence of expert judgments on asylum decisions was analysed using a logistic regression analysis. The analysis was conducted with judicial outcome (0 = 'negative decision'; 1 = 'positive decision') as the binary dependent variable. Expert judgments of physical symptom-story consistency and psychological symptom-story consistency were the independent predictors. No other covariates were included. Cases for which refugee status decision was still unknown (N = 8) were excluded from the analyses.

Results

The reports concerned asylum seekers from 25 different countries, most often from Iran (N = 16), Uganda (N = 11), Sri Lanka (N = 10), Guinea (N = 8), and Afghanistan (N = 8). Table 1 summarises the demographic and clinical characteristics of the sample. The majority of the asylum seekers were male. The experts diagnosed almost all subjects with clinically significant PTSD. The vast majority of asylum seekers reported physical violence and over half reported sexual violence.

Data on the degree of consistency between the psychological and physical state of the asylum seeker and their story

Table 1: Summary of demographic and clinical characteristics (N = 97)

Variable	N (%)	mean ± SD, range
Age in years		28.6 ± 7.5, 13 - 61
Male	70 (72.2)	
Clinical diagnosis of PTSD	90 (92.8)	
Receiving mental health care in host country	51 (52.6)	
Number of months spent in asylum procedure		24.0 ± 27.4, 0 - 138
History of physical violence	92 (94.8)	
History of sexual violence	61 (62.9)	
History of detention or hostage-taking in country of origin	69 (71.0)	
Detention or hostage-taking in country of origin in weeks		21.5 ± 52.1, 0 - 225
Refugee status decision positive	67 (69.1)	
Refugee status decision (still) unknown	8 (8.2)	
Refugee status decision negative	22 (22.7)	
Consistency psychological symptoms ¹		3.71 ± 0.50, 2 - 5
Consistency physical scars ¹		2.76 ± 0.56, 1 - 5

¹Scale Istanbul Protocol (1: not consistent,..., 5: diagnostic).

Table 2a: Descriptive statistics of expert judgment on the presence of psychological and physical symptoms/scars and the degree of consistency with the refugee’s story (N = 97)

Symptom-story consistency scale	Explanation of symptom-story consistency scale	Psychological Symptoms N (%)	Physical Symptoms/ Scars N (%)
No symptoms present or not able to judge consistency	The expert was not able to judge the degree of consistency between the condition of the subject and the trauma described.	4 (4.1) ¹	27 (27.8) ²
Not consistent	The condition could not have been caused by the trauma described.	0 (0.0)	0 (0.0)
Consistent	The condition could have been caused by the trauma described, but it is non-specific and there are many other possible causes.	1 (1.0)	6 (6.2)
Highly consistent	The condition could have been caused by the trauma described, and there are few other possible causes.	26 (26.8)	27 (27.8)
Typical	This is a condition that is usually found with this type of trauma, but there are other possible causes.	65 (67.0)	31 (32.0)
Diagnostic	The condition could not have been caused in any way other than that described.	1 (1.0)	6 (6.2)

¹ No psychological symptoms present or not able to judge psychological symptoms (N=4)

² Not able to judge physical scars (N=1), no physical scars present (N=26)

is shown in Table 2a. The vast majority of expert reports (N = 93, 95.9%) included a rating of psychological symptom-story consistency using the interval scale stipulated in the Istanbul Protocol. In most cases the asylum seeker’s psychological state was rated ‘typical of’ someone who had experienced the reported type of trauma (N = 65, 67%). 71 reports included a physical examination of scars, 26 subjects did not have scars and, in one subject, physical examination was undertaken but the expert was not able to judge the degree of consistency. Most expert reports rated the physical scars as ‘highly consistent’

(N=27) or ‘typical of’ (N=31) someone who had experienced the reported type of physical trauma.

Table 2b presents a cross-tabulation with the consistency judgments of psychological symptoms and the consistency judgments of physical symptoms/scars. We found an inverse association between physical symptom-story and psychological symptom-story consistency ($r = -0.27$ $p = .009$).

The hypothesised variables and their influence on symptom-story consistency are shown in Table 3. Being female, presenting a history of sexual violence,

Table 2b: Cross table with expert judgments on psychological symptoms and physical scars

Expert judgment physical symptoms (N)	Expert judgment psychological symptoms (N)					
	0	1	2	3	4	5
0 No symptoms present or not able to judge consistency ¹	1	0	0	4	21	1
1 Not consistent with story	0	0	0	0	0	0
2 Consistent with story	1	0	0	2	3	0
3 Highly consistent with story	2	0	0	4	21	0
4 Typical	0	0	0	15	16	0
5 Diagnostic	0	0	1	1	4	0

¹ Not able to judge physical scars (N=1), no physical scars present (N=26), no psychological symptoms pre-

Table 3: Associations between gender, trauma-related and clinical variables, and expert judgments of symptom-story consistency

Associations with psychological symptom-story consistency	Pearson correlation	P-value
Male (vs. female) gender	0.23	0.011
History of detention	-0.14	0.447
History of sexual violence	0.27	0.004
History of physical violence	0.06	0.294
Receipt of mental health care	0.34	0.000
Associations with physical symptom presence and their consistency with the refugee's story	Pearson correlation	P-value
Male (vs. female) gender	-0.39	0.000
History of detention	0.34	0.000
History of sexual violence	-0.17	0.052
History of physical violence	0.35	0.000
Receipt of mental health care	0.10	0.460

and being in receipt of mental health care were significantly associated with expert judgments of higher psychological symptom-story consistency. The receipt of mental health care was most strongly associated with expert judgments of psychological symptom-story consistency. Being male, presenting a history of detention and presenting a history of physical violence were significantly associated with the presence of physical symptoms and a higher physical symptom-story consistency.

The association between the expert judgments of symptoms and asylum status decisions is shown in Table 4. About two-thirds of the asylum seekers in our sample were granted asylum (N = 67, 69.1%), several requests were denied (N = 22, 22.7%), and eight (8.2%) cases were excluded from the analysis because the refugee status was still unknown. Physical symptom presence and consistency with the refugee’s story and refugee status decision were significantly correlated ($r = 0.40, p < .000$), but psychological symptom-story consistency and refugee status decision were not ($r = 0.00, p = .972$). Similarly, physical symptom presence and consistency with the refugee’s story significantly predicted a positive refugee status decision (OR=1.96, $p < .001$), but psychological symptom-story consistency did not (see Table 4).

Table 4: Logistic regression of expert judgments as predictors of positive (vs. negative) refugee status decisions

	OR	95 % CI	P
Expert judgment psychological symptoms	1.96	0.61—6.29	0.260
Expert judgment physical scars	1.92	1.37—2.70	0.000

Discussion

As hypothesised, the results indicate that receiving mental health care, being female, and having a history of sexual violence may influence experts’ judgments about psychological symptom-story consistency. Also, our results indicate that 93% of the subjects were diagnosed with PTSD, which is a higher percentage than usually found in the literature. This finding may be related to the observation described in the literature that severely traumatised and thus psychologically disturbed asylum seekers tend to give inconsistent accounts during the first asylum hearings, thereby lowering their chance of obtaining asylum (Herlihy & Turner, 2006).

Male gender and a history of detention and physical violence play a critical role in experts’ judgments about physical symptom-story consistency. This may indicate that experts become more convinced by reports on potentially traumatic situations when this involves physical violence, and by special details of the symptomatology that fit to the reported situations, when there is written proof of treatment history.

Regarding our second hypothesis, positive asylum decisions were significantly associated with expert judgments regarding the presence of physical signs and symptoms of torture and ill-treatment and their consistency with the asylum seeker’s story, but not with psychological symptoms. The probability of obtaining asylum was higher if experts indicated the presence of physical signs and symptoms and rated a higher degree of consistency of these signs and symptoms with the refugee’s story. This indicates that expert medical evidence influences the outcome of decisions regarding asylum in this population. The mean expert symptom-story consistency

rating was higher for psychological symptoms (3.71) than physical signs and symptoms (2.76). Subjectivity of the interpretation of intrusive psychological symptoms, compared with physical scars, may therefore play a role and help explain this finding. Asylum procedures are often complex and lengthy, which explains why, at the time of the study, the outcome remained still unknown in 8 cases (8.2%). The data used suggests that decision makers are more influenced by experts' assessments of physical symptoms their consistency with the refugee's story than by psychological symptom-story consistency. This suggests that asylum decision makers consider experts' judgments about the physical signs and symptoms of trauma, and their consistency with the asylum seeker's account, more objective or more reliable than comparable judgments about consistency between story and psychological symptoms. This may be because indices of psychological symptoms are perceived to be more subjective than physical signs and symptoms (i.e., they are dependent on the individual's account rather than being based on direct measurement or observation). Further training for decision makers should be delivered to inform them about the possibilities (and limits) of medico-legal expertise evaluations.

Expert judgments in medico-legal reports stating that physical signs and symptoms are present and consistent with the asylum seeker's story are associated with a higher probability of obtaining asylum. However, at present, many asylum seekers with physical and psychological signs and symptoms of trauma lack access to medical and psychological examination and documentation by specially trained experts as established

in the Istanbul Protocol (Bruin et al., 2006; Keten et al., 2013; Migration & Affairs, 2014; Wallace & Wylie, 2013). Our results have implications for the way medico-legal reports are prepared and used in asylum procedures. Earlier access to the documenting of medical evidence by independent experts could improve decision quality. Signs, symptoms and medical evidence of torture should be documented according to the Istanbul Protocol guidelines. Placing more medical professionals in asylum centres, and giving them a specific task in the early identification of signs and symptoms of torture, might facilitate earlier identification of torture survivors, thereby leading to more medico-legal reports being requested. An increase in requests by the asylum authorities and judges, following the implementation of Article 18 of the new European Asylum Procedure Directive, which requires asylum authorities to obtain a medical examination where there is an indication of trauma or a reported history of trauma, will result in an increased use of medical evidence in procedures for making decisions about asylum.

Limitations

Our study contains a number of limitations that must be acknowledged. Data on judicial outcomes in eight (8.2%) of the cases analysed was unavailable, which reflects the length of asylum procedures. Refugee status was known for 89 out of 97 subjects (February 2017). The decision was positive in 67 cases, and negative in 22 cases. The eight subjects for whom refugee status decision was still unknown at the time of analysis did not differ from the analysed group regarding gender, age or other demographic

variables.³ Because outcome data was not available in all cases, it is possible that our analysis under-estimated the judicial impact of expert medical reports.

Another limitation is that we were not able to analyse the rationale behind the decision-making after the medico-legal report was used in the asylum procedure. Lawyers provided iMMO with routine outcomes regarding the result of the claims, but no rationale was provided for positive decisions. Therefore, if one were to analyse how decision makers judge the provided medico-legal report, further research, which takes into account the socio-cultural judicial context in which medico-legal reports are used, would be required. After the medico-legal report was used in the asylum procedure, 69% of the asylum seekers obtained asylum. This percentage may not be comparable to other countries and may not generalise to other time periods. For example, it is possible that the increase in asylum applicants following the Syrian crisis may have led to a different percentage. This is another limitation that should be acknowledged.

However, the relatively large sample size of medico-legal reports and the availability of data on judicial outcomes of the asylum procedures are key strengths of the study. To the best of our knowledge no other studies quantitatively evaluated medico-legal report in the asylum context. Furthermore, the majority of reports (71%) include expert judgment about both psychological and physical consequences

of torture, reflecting the medical and psychological expertise of iMMO.

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³ In terms of variables related to the asylum history, it appeared that suicidality was mentioned more often in reports for those whose status decision was still unknown compared to those whose decision had already turned out to be negative or positive ($X^2(1) = 4.77, p < .05$). Actual presence of suicidality was similar in both groups.

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