

# **The Mental Health Consequences of Torture in Somaliland**

*In the case of Warfaa v. Ali (Col. Tukeh)*

Expert Report Produced by:

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## **I. Introduction**

This report was created by Dr. Daryn Reicherter, with the support of the Human Rights in Trauma Mental Health Program (HRTMHP), an interdisciplinary program based at Stanford University and comprising members of the Department of Psychiatry and Behavioral Sciences, the School of Law, the WSD Handa Center for Human Rights and International Justice, and the Palo Alto University Clinical Psychology graduate program. The program faculty and staff include clinical-academic psychiatrists, professors of medicine, private treating psychotherapists and social workers, human rights lawyers, law professors, and graduate and undergraduate students. The members of this program have amassed considerable expertise in trauma mental health from a range of disciplinary perspectives that render us qualified to submit this report.

This submission is based on HRTMHP's review of the evidence in the case of *Warfaa v. Ali (Col. Tukeh)*, along with a comprehensive and comparative literature review on the psycho-social impact of torture on individuals, their families, and their communities. The report also relies on the professional opinions of health and mental health experts from Somaliland.

This report relies upon our deep knowledge of empirical research that links trauma exposure with psychophysiological and neurobiological outcomes, thereby elucidating the mechanisms by which torture gives rise to the psychosocial outcomes documented in the record. This report is also informed by our long experience treating, representing, and working with victims of severe trauma in communities impacted by massive human rights violations. Dr. Reicherter is a Clinical Professor at Stanford University, School of Medicine's Department of Psychiatry and Behavioral Sciences and the Medical Director of the Center for Survivors of Torture in San Jose California. A full *curricula vitae*, including publications and relevant court activities is attached.

Within this report, we inform the reader of the mental health consequences of physical and psychological torture in the context of the Siad Barre regime's engagement in torture practices on the people of Northern Somalia (Somaliland). This includes the targeting of civilians, primarily from the Isaaq clan in northern Somalia, now Somaliland, between 1987-1989. An

estimated 50,000-100,000 people lost their lives, and even more were displaced (Aideed, 2004). The human rights abuses committed under the leadership of former Colonel Yusuf Abdi Ali [hereinafter Defendant Ali] of the Somali Army's Fifth Brigade created multiple mental health harms, physical harms, and social harms to the people of Somaliland such as Mr. Warfaa. The mental health harms include, but are not limited to, Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), and Traumatic Brain Injury (Basoglu et al., 1994). Other than psychological harms, torture creates maladaptive neurobiological and psychophysiological responses, essentially injuring the stress response system from the overactivation of the sympathetic nervous system and the dysregulation of the central nervous system (Van Der Kolk, 1988). The long-term psychological and physical consequences of torture include higher risk for metabolic disease, cardiovascular disease, and mental illness. Within the onset of mental illness derived from torture practices, a person's economic capabilities are diminished. They also experience social ostracism due to stigma associated with mental illness that, at the worst end, can result in adverse interventions such as being chained or being physically beaten (Im, Ferguson, & Hunter, 2017).

Torture can also have an intergenerational impact as clinicians and researchers are seeing heightened levels of distress and psychopathology in children of torture survivors who have not been exposed to traumatic events themselves (Yehuda, Halligan, & Bierer, 2001). Torture practices can cause displacement, disintegrating communities that are dependent on their historical affiliation to their clan. The disintegration of the community and other psychosocial consequences of torture can lead to distrust in government, in their communities, and in their family. In terms of recovery, cognitive-behavior therapy and narrative exposure have been shown to be the best evidence-based therapeutic interventions with a need for support services (Kinzie, 2011). Cultural expressions of distress are different from western culture, and it has been suggested that Somalis believe mental illness is a disconnection from God. There is a lack of reporting of mental illness within the Somali culture as it can bring shame upon their families. They believe it is the will of God to experience difficulty for a greater purpose (Jimale et al., 2002).

## **II. Methodology**

In addition to our members' abundant clinical and professional experience with survivors' psychology, the HRTMHP relied upon the vast scientific literature in psychology to reach the major conclusions of this report. Other data specifically relevant to Somaliland, Somalia, and to the case in question have been cited throughout the report with great weight. First, we performed a comprehensive search of peer-reviewed psychological and medical journals using keywords such as "physical torture," "psychological torture," "torture outcomes," "posttraumatic stress disorder," etc. The results included single studies, meta-analyses (wherein multiple studies are

statistically combined to determine the effect of a particular subject matter), and review articles (wherein multiple studies are combined in narrative form to draw conclusions on a specific subject matter) that have all been reviewed by experts within their respected fields. Interviews were conducted with local experts, Drs Hussein Bulhan and Yusuf Garaw. This enabled the HRTMHP to better understand how studies published in peer-reviewed literature and global reports can be accurately applied to the specific situation of this case. Lastly, this report connects the vast empirical literature that exists with actual victim statements. The HRTMHP conducted an interview with Dr. Allen Keller and reviewed his expert report of Mr. Warfaa's harms from torture. By making this direct connection, we have provided strong evidence of the mental impacts of physical and psychological torture on survivors. To readily identify exactly where information was obtained, we have cited all of our referenced sources throughout the entirety of this report.

No financial compensation was received for the development of this Expert Report.

### **III. Torture in Somaliland throughout Somali Civil War**

Mohamed Siad Barre established dictatorial rule over unified Somalia beginning in 1969. The Barre regime oversaw two tumultuous decades of internal civil war in addition to periodic conflict with Ethiopia. Eventually exiled to Nigeria in 1991 by factions of his own party, in his years of power, Barre exerted authoritarian control using repressive and violent methods (Carroll & Rajagopal, 1993). As the leader of the Somali Revolutionary Socialist Party, Barre targeted the Somalia National Movement (SNM), an opposing party. Barre used anti-SNM rhetoric to justify his brutal policies toward the Isaaq clan, some of whose members originally founded the political party (Bradbury, 2001). The Barre regime authorized looting and burning of towns, shelling of cities, and the laying of over a million unmarked land mines which resulted in approximately 50,000 deaths between May 1988 and March 1989 (Carroll & Rajagopal, 1993; Africa Watch, 1990). Under the military dictatorship of the Somali National Army, the Isaaq clan in northern Somalia was subjected to human rights violations including rape, torture, imprisonment, detainment without trial, and summary executions at the hands of the military.

The Convention against Torture, and Other Cruel, Degrading, or Inhuman or Degrading Treatment or Punishment as adopted by the General Assembly of the United Nations, and to which Somalia and the U.S. are both State Parties, in 1984 defines torture as follows:

“...any 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 acquiesce of a public official or other person acting in an official capacity.”

At the Canadian Centre for Victims of Torture (CCVT) where Somali victims were treated, Dr. Wendell Block reported “the most common visible, physical scars were those of abrasions and lacerations, entirely consistent with whippings, kicks, bayonet cuts and other methods of beatings described” (Simalchik, 1992). These scars were located on “faces, chests, backs, abdomens, arms, legs and feet” (Simalchik, 1992). Dr. Donald Payne who also treated victims at CCVT discusses the methods and effects of psychological abuse. He reports that “almost all the individuals reported threats to their lives” and the resulting terror was an outgrowth of the perception “that their death could result from a whim of the guards rather than requiring any order from a higher authority” (Simalchik, 1992). Some victims described cells as “roughly three paces square, including the toilet.” (Africa Watch, 1990) Once a day the outside door would be opened for air, and sometimes a little sunshine to enter the cell.”

Another doctor describes torture administered to a 13-year old Somali boy who was repeatedly “stabbed with bayonets to his chest, back, and buttocks,” hung from a tree by his legs, and burned with lit cigarettes on his face. The boy’s scars were “strongly suggestive of injury with a sharp object occurring in a similar fashion to different areas of his body” (Simalchik, 1992).

Collective effects of trauma are generated by experiences such as separation from family, uncertainty relating to immigration decisions, and direct and radiating effects of torture, persecution, and imprisonment (Simalchik, 1992).

In addition to physical abuse, the Barre regime performed psychological torture. An Africa Committee Report describes the guards’ process preceding torture. First, they would “extinguish the lights every night at the same time” (Africa Watch, 1990). This use of light is consistent with acts classified as psychological torture. (Leach, 2016) Prisoners reported subsequently hearing keys rattle and thinking, “Is it me tonight?” Finally, the guards would drive the victim in a Landcruiser to a place 3 miles away to perform the torture acts. (Africa Watch, 1990)

#### **IV. Mental Health Harms Caused by Torture**

Torture has been repeatedly correlated with PTSD, major depressive disorder, and organic brain damage across cultures (Basoglu et al., 1994; Bradley & Tawfiq, 2006; Burnett & Peel, 2001; Shrestha, Sharma, Van Ommeren, and de Jong, 1998). Steel and colleagues (2009) conducted a systematic review of over 5,900 articles related to refugee and post-conflict populations and PTSD and depression prevalence rates. Their final analysis included 81,866 individuals from 40 countries. Results revealed torture to be the strongest predictor of PTSD, accounting for the greatest portion of statistical variance across studies. Torture was also associated with higher

rates of depression, accounting for a moderate portion of variance across studies. These results emphasize the debilitating nature of particular purposeful pain inflicted by torture.

In a male focused sample, Carlsson, Mortenson, and Kastrup (2005) found torture to be a significant predictor of PTSD, depression, and anxiety symptoms. In a sample of torture survivors from both Bosnia and Colombia, Alexander, Blake, and Bernstein (2007) found that 100% of Bosnians and 35% of Colombians endorsed clinically significant levels of depression. Similarly, Bradley and Tawfiq (2006) identified significant rates of PTSD, anxiety, and depression in Kurdish survivors of torture. The psychological effects of torture can persist long after the incidences have ceased. Momartin, Silove, Manicavasagar, and Steel (2004), found human rights violations to be associated with complicated grief (a disorder involving prolonged grief coupled with significant functional impairment) in a sample of Bosnian refugees residing in Australia. Experiencing complicated or unresolved grief was also predictive of depression in this sample (Momartin et al., 2004).

The physical and psychological consequences of torture are not completely independent. In a study on chronic physical pain and psychological outcomes in Punjabi Sikh survivors of torture, Rasmussen, Rosenfeld, Reeves, and Keller (2007) found a relationship between physical pain severity and PTSD symptoms. Specifically, the results indicate that eleven-years post-trauma, the relationship between torture and PTSD was exacerbated by chronic injury. The mediating effect was most pronounced for the relationship with one of the criteria for PTSD: emotional numbing. The authors suggest that chronic pain serves as a lasting reminder of the trauma inflicted by the act of torture.

Perceived controllability of torture mediates the relationship between torture and negative psychological outcomes (Le et al., 2018). Retrospective feelings of helplessness and lack of control over one's environment contribute to greater emotional harm and dysregulation post-trauma. Conversely, "psychological preparedness" can serve as a protective factor against trauma-related psychopathology. Psychological preparedness refers to prior knowledge and experience of torture methods, as well as willingness to endure torture for political or religious reasons. Civilians who suffer unexpected torture are more likely to report having felt angry, fearful, and helpless during the traumatic event. This increased negative emotional activation contributes to the development and maintenance of PTSD and depressive symptoms (Le et al., 2018). Numerous human and animal research studies have examined the construct of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Flannery & Harvey, 1991; Miller & Seligman, 1975; Seligman, Rosellini, & Kozak, 1975). The literature describes learned helplessness as a state of passivity and loss of control that results from repeated exposure to inescapable stress or trauma. Learned helplessness serves to maintain symptoms of depression maladaptive behavior by reducing confidence, self-esteem, and self-efficacy.

In regard to Somali-specific negative mental health outcomes and rates of prevalence: “Common issues include persistent impacts of war trauma (Mollica et al., 2001), torture (Jaranson et al., 2004), post-resettlement stress and acculturative challenges (Ellis, McDonald, Lincoln, & Cabral, 2008; Pernice & Brook, 1996), substance abuse (Sowey, 2005), gender-based violence (Crisp, Morris, & Refstie, 2012; Pittaway & Bartolomei, 2001), and social discrimination in the host community (Ellis, Miller, Baldwin, & Abdi, 2011). Due to tremendous trauma and adversity, rates of common mental disorders among Somalis are consistently high regardless of setting, though numbers may vary across samples and measures. Previous studies have reported PTSD prevalence rates among Somalis ranging from 14% to 37% (J. T. de Jong et al., 2001). In refugee camp settings, some studies found a 48% prevalence of PTSD in Uganda (Onyut et al., 2009) and a 38% prevalence of depression in Ethiopia (Feyera, Mihretie, Bedaso, Gedle, & Kumera, 2015). In a study in Somalia, a third of women reported significant PTSD symptoms (K. de Jong et al., 2011). In an inner city community clinic in Minnesota, almost 60% of Somali women had comorbid depression and PTSD, while 80% of males and 32% of females under 30 presented with psychotic disorders (Kroll, Yusuf, & Fujiwara, 2011). Such mental disorders are often exacerbated by the use of substances, including khat (Bhui et al., 2006; Ellis et al., 2008; Odenwald et al., 2005).” (Im et al., 2017).

Specific expected outcomes and diagnoses is discussed below in greater detail.

### ***1. Posttraumatic Stress Disorder***

Posttraumatic stress disorder (PTSD) is a chronic and debilitating mental illness. It is also one of the most commonly reported psychiatric consequences of torture and other traumatic events. PTSD is the only diagnosis listed in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual Fifth Edition (DSM-5) that can be causally traced back to an event or series of events. The disorder develops in some individuals as a result of “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association [APA], 2013). Forms of exposure include direct experience, witnessing the event, learning that the event occurred to a close friend or family member, or repeated exposure to the adverse details of the traumatic event (i.e. first responders, etc.) (APA, 2013). Symptoms of PTSD include re-experiencing the event in the form of dreams or memories, intense/ prolonged psychological distress, feelings of detachment or estrangement, irritability, anhedonia, hypervigilance, reckless or self-destructive behavior, sleep disturbance, inability to remember important aspects of the event, and negative changes in beliefs or cognitions (APA, 2013).

Prisoners subjected to torture are much more likely to develop PTSD in comparison to non-tortured prisoners. In an analysis of Tibetan political prisoners Paker et al. (1992) discovered that torture survivors experienced an average of 291 separate exposures and 23 different forms of torture. Forms of torture included verbal abuse, threats of death, rape and additional torture, threats of harm to family, being made to witness torture, being stripped naked, electric torture,

hanging by wrists, isolation, and beating the soles of the feet. Paker et al. (1992) compared tortured and non-tortured prisoners of similar demographic backgrounds, duration of imprisonment, and exposure to other types of traumatic stressors inflicted by a repressive regime. While both groups reported experiencing harassment and persecution, the death of loved ones, detention/threats of arrest, job loss, and social or political violence, survivors of torture endorsed significantly higher rates of PTSD (33% vs 11%). Perceived severity of torture and family history of psychiatric illness compounded this cohort's risk of developing PTSD (Başoğlu, Paker, Ozmen, Taşdemir & Sahin, 1994).

Post-conflict populations have been shown to have extraordinarily high rates of PTSD, depression, anxiety, and somatization (De Jong et al., 2001; Ibrahim & Hassan, 2017). However, survivors of torture appear to be at a higher risk for ongoing psychiatric problems (De Jong et al., 2001; Paker et al., 1992; Steel et al., 2009). De Jong et al. (2001) surveyed random samples of survivors of war and mass trauma in four post-conflict settings and found PTSD prevalence rates of 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17.8% in Gaza. Torture was a significant risk factor for the development of PTSD in Algerian, Ethiopian, and Gazian individuals. For Ethiopian individuals in particular, PTSD rates were 16% higher in survivors of torture (De Jong et al., 2001). Jaranson et al. (2004) noted a significant difference in PTSD Checklist Civilian Version (PCL-C) scores between tortured and non-tortured Somali and Oromo survivors of trauma. Among this sample 25% of tortured individuals met criteria for PTSD, compared to 4% of non-tortured individuals. Jaranson et al. (2004) concluded that the greatest additive effect of PTSD symptomology was attributed to torture history.

## ***2. Other Comorbid Mental Health Disorders***

Many other psychological problems are associated with trauma and often occur comorbidly (simultaneously) with PTSD. In fact, the comorbidity of mental health disorders is thought to be the rule rather than the exception in cases of interpersonal trauma and abuse. For example, forty percent of children experience traumatic events and suffer from PTSD symptoms are subsequently diagnosed with two additional mental health disorders (Copeland, Keeler, Angold & Costello, 2007). Mood disorders including depressive and bipolar disorders, obsessive compulsive disorder, and anxiety disorders including generalized anxiety disorder, agoraphobia, social anxiety disorder, and specific phobia have all been associated with PTSD (Creamer, Burgess & McFarlane, 2001). The National Comorbidity Study of 1995 established a historical precedent for understanding PTSD and co-occurring disorders: PTSD was found to be comorbid in 47.9% of individuals with a history of major depression, 21.4% with dysthymia, 16.8% with generalized anxiety disorder, 31.4% with specific phobia, and 27.6% with social phobia (Kessler et al., 1995).

Substance use disorders are also highly comorbid with PTSD (Kessler et al., 1995). Using drugs and alcohol is a common coping mechanism among individuals experiencing posttraumatic

stress. These substances often serve as a form of self-medication intended to reduce intrusive thoughts and memories, aid sleep, and alleviate anxiety. As many as 51.9% of individuals diagnosed with PTSD meet criteria for a substance use disorder. In fact, substance use disorders and PTSD are so correlated that there are specific therapeutic protocols designed to address them simultaneously (Morgan-Lopez et al., 2014).

Psychosocial problems including lack of confidence and self-esteem, fear of intimacy, feelings of shame and humiliation, feelings of despair, interpersonal aggression, sleep difficulties and emotional lability have been reported by survivors of torture (Chester & Holtan, 1992; Molsa et al., 2014; Shrestha et al., 1998). Although these difficulties do not fall into a particular diagnostic category they may exacerbate existing psychological problems. Issues with relating to and trusting others can lead to increased isolation and lack of social support. Self-esteem, for example, is a risk factor for developing depression and unhealthy coping strategies (Johnson, Galambos, Finn, Neyer, & Home, 2017; Yildirim, Sevincer, Kandeger, & Afacan, 2018). Similarly, while sleep problems are often manifestations of existing syndromes, they can also maintain/ exacerbate additional mental health disorders.

### ***3. Anxiety Disorders***

Current research suggests that there is a significant overlap between PTSD symptoms and anxiety symptoms (Ellis, Atkeson, & Calhoun, 1981; Kilpatrick, Resick & Veronen, 1981). Until recently, PTSD was classified as an anxiety disorder in the DSM. Survivors of torture report experiencing a disproportionate amount of anxiety and panic symptoms (Brouwer & Stein, 1999). For example, studies of Cambodian refugee survivors of torture have revealed prevalence rates of social anxiety disorder and generalized anxiety disorder as high as 27% and 14%, respectively (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Blair, 2001). Twelve-month prevalence rates of anxiety disorders within the general population vary widely between cultures. A cross-cultural systematic review of global anxiety prevalence rates estimated ranges of 5.3 (3.6–7.9%) in Asian cultures (Baxter, Scott, Vos, & Whiteford, 2013).

Anxiety symptoms can be severely limiting and often debilitating. Physiological and psychological symptoms of anxiety disorders include uncontrollable worry, nervousness, increased heart rate and respiration, dysphoria, muscle tension, difficulty concentrating, sleep problems, irritability, fear of dying, avoidance of feared situations, and fear of losing control (APA, 2013). The ramifications of anxiety disorders directly impact an individual's family and the larger community. Like most mental health disorders, anxiety disorders are highly heritable. For example, Merikangas and Pine (2002) found that children of mothers diagnosed with panic disorder were 6.8 times more likely to develop the disorder. Similarly, children of mothers with phobic disorders were found to be 3.1 times more likely to develop the disorder at some point during their lifetime.

#### ***4. Mood Disorders***

Mood disorders are another common response to torture (Alexander, Blake, & Bernstein, 2007; Carlsson, Mortenson, & Kastrup, 2005; Paker et al., 1992). Among survivors of torture prevalence rates of major depressive disorder range from 28% to 100%, compared to global prevalence rates of 4.7% (4.4-5.0%) (Alexander et al., 2007; Bradley & Tawfiq, 2006; Carlsson et al., 2005; Ferrari et al., 2013; Kroll et al., 2011; Sack, et al., 1993). Cultural factors such as age, gender and nation of origin influence the expression of depressive symptoms in response to torture and trauma. Women are more commonly diagnosed with depressive disorders cross-culturally (Andrade et al., 2003). As noted above, 60% of Somali women living in the US report experiencing symptoms of both depression and PTSD (Kroll et al., 2011). Within the same sample 58.3% of men and 79.4% of women over the age of 50 endorsed PTSD and depression symptoms.

DSM-5 symptoms of major depression include depressed mood, suicidal thinking, loss of appetite, weight loss or gain, difficulty concentrating, anhedonia, and feelings of intense guilt or hopelessness (APA, 2013). Associated outcomes may include impaired occupational or academic functioning and social withdrawal. Cultural expressions of depression can also encompass irritability and somatic symptoms. As with anxiety disorders, the presence of depressive disorders extends beyond the individual victim; research suggests that children of depressed mothers have a lifetime prevalence rate of depression between 20% and 41% (Goodman, 2007). Children of depressed mothers also experience mental and motor developmental issues, self-regulation problems, and increased negative affect (Goodman & Gotlib, 1999). Spontaneous recovery from depression and PTSD associated with torture is uncommon; unfortunately, refugee and impoverished communities are severely underserved with regards to mental health services (Chester & Holtan, 1992; Kieling et al., 2011).

#### ***5. Suicidality***

Thoughts of suicide are increased among individuals who have experienced traumatic events such as torture, sexual violence, mock executions, imprisonment and isolation, and being forced to witness atrocities (Ferrada-Noli, Asberg, Ormstad, Lundin, & Sundbom, 1998). Lerner, Bonanno, Keatley, Joscelyne, and Keller (2016) found that threats and/or harm to one's family resulted in significant increases in suicidal ideation. Refugee and post-conflict populations present a heightened risk of attempting and completing suicide (Cochran et al., 2013). The annual suicide rate of Bhutanese refugees living in the United States from 2009-2012 was estimated to be 24.4 per 100,000 people, compared to an annual global estimate of 16 per 100,000. Within this sample, post-migration difficulties (e.g. family stress or lack of employment) were associated with mental health symptoms and expressed suicidal ideation (Cochran et al., 2013). Diagnoses of PTSD and depression are risk factors for suicidal behavior. Ferrada-Noli et al. (1998) indicate that suicidal thoughts are most frequently reported by

individuals with a dual diagnosis of PTSD and depression. However, they also assert that suicide is attempted more often by non-depressed people with PTSD.

## **6. *Dissociation***

Dissociative symptoms are another common response to trauma that are not fully captured in PTSD diagnostic criteria (DSM-5; Freyd, 1996; van der Kolk, Pelcovitz, Roth, et al., 1996). Previous research indicates that approximately half of individuals who develop PTSD experience significant dissociative symptoms (Briere, Scott, & Weathers, 2005) compared to only 4.4% of adults with no diagnosis. Dissociative symptoms include an unawareness of one's present state, flashbacks, out-of-body experiences (depersonalization), or feeling as if the world around one is surreal or artificial in some way (derealization). The DSM-5 also defines a dissociative amnesia wherein an individual is unable to remember events from the trauma. Dissociative responses during experiences of trauma can be viewed as evolutionarily adaptive as they create cognitive and emotional distance from the horror, terror, and pain of the trauma; however, the same dissociative experiences that are protective during the moment of trauma are maladaptive when they resurface in individuals' subsequent daily lives and can cause significant impairment in functioning when they become pathological (Freyd, 1996). Carlson, Dalenberg & McDade-Montez (2012) concluded that dissociative symptoms are related to traumatic experiences and their severity, effects can be long lasting, and high dissociative symptoms increase the likelihood and severity levels of PTSD symptoms.

Cultural groups vary in frequency and intensity of dissociative symptom expression. For example, survivors of torture perpetuated by the Pol Pot regime in Cambodia have reported suffering from "khyal attacks." Khyal attacks comprise a combination of anxiety and dissociative symptoms. In severe forms known as "Khsaoy Beh Doung" or "weak heart syndrome" fainting can occur (Hinton, Pich, Marques, Nickerson, Pollack, 2010). Fainting is most common in individuals who have previously suffered from loss of consciousness. Cultural idioms of psychological distress in Somaliland are identified in Section X of this report below.

## **V. Neurobiological and Psychophysiological Responses to Torture**

Experiences of extreme stress, trauma, and victimization—such as torture—essentially injure the stress response system, resulting in lasting neurobiological, physiological, and psychological consequences. That is, extreme stress and trauma impact the brain and central nervous system with an array of physical, psychological, social, and functional impairments that drive the psychiatric disorders described above. These neurobiological injuries to the stress response system are now known to be part of a universal biological response consistent across individuals, cultures, and mammalian species (Bale & Epperson, 2015).

The body responds to traumatic stress by activating the sympathetic nervous system (McEwen, 1998). Sympathetic nervous system activation prepares the body to respond to crisis by releasing a cascade of stress hormones. These hormones suppress necessary resting functions in order to prioritize activities that are adaptive for survival (i.e. increased heart rate and respiration). In acute and innocuous non-traumatic instances, once the stressor is removed the parasympathetic nervous system becomes activated. The parasympathetic nervous system restores resting functions and helps the body regain stability. Under traumatic and life-threatening conditions, the central nervous system can become chronically dysregulated (Van der Kolk, 1998). The body struggles to return to a pre-trauma state of balance and stability, and the individual's subjective experience of safety and well-being is compromised. Individual expressions of posttraumatic dysregulation vary between dissociation, hyperarousal, aggression, avoidance, and/or dependence based on environmental and other neurobiological factors.

The brain is a complex of interconnected regions working in concert, each performing specialized functions to keep an organism alive. Especially relevant to human functioning and the stress response, are the prefrontal cortex (PFC) and the limbic system. The PFC commands oversight, regulation, and executive control. It is our source of rational thought, logic, problem-solving, impulse control, self-regulation, and self-awareness. In contrast, the limbic system handles emotional responses and processing. Structures in the limbic system (i.e. the amygdala, hippocampus, and thalamus) participate in the experiences of emotions, reward, motivation, and memory formation. Known as the “fear circuit,” the limbic system detects threats and activates when potential environmental dangers are perceived, to enable safety and survival responses (such as ‘fight,’ ‘flight,’ or ‘freeze’).

The PFC and limbic system communicate constantly with one another via neural pathways that form a regulatory feedback loop in which cognitive processes (from the PFC) influence emotional responses (in the limbic system), and vice versa. Patterns of activation and communication between the PFC and limbic system are shaped by experience. Hebb's rule, a primary neuroscientific principle, is commonly paraphrased as “neurons that fire together, wire together,” meaning that patterns of activation become mutually reinforced (Hebb, 1949). That is, the connective networks and pathways of two brain regions in regular communication or co-activation become strengthened in order to facilitate learning and adaptation. Through repetition (and by way of Hebb's rule) our life experiences shape patterns of activity and interaction among neural systems. Exposure to trauma and traumatic stress results in prioritization of emotional and instinctual responses from the limbic system, over the regulatory and intentional process stemming from the PFC.

With limited resources to achieve the goal of survival, any perceived environmental stressor requires a reallocation of resources in order to address the threat. The brain—which demands a constant supply of blood and oxygen—responds to perceived stress, threat, or trauma by

“shutting down” the PFC (literally reducing activity in this region) and allocating resources to regions coordinating instinctual survival responses (i.e., the limbic system, in order to trigger the “fight or flight” response), as well as regions regulating basic functions of respiration, body temperature, and heart rate. Shutting down the PFC in times of danger preserves resources, but it also leaves lower order neural structures (such as the limbic system) unregulated and disorganized (Damasio, Grabowski, Bechara, et al., 2000). The limbic system essentially “hijacks” the brain as the alarm response is triggered and PFC shuts down. A useful analogy is a rider on a horse, where the rider (PFC) exerts control and regulates the system, and the horse (limbic system) responds emotionally and instinctively (van der Kolk, 2014). When the horse (limbic system) is triggered by a threat, the rider (PFC) gets temporarily thrown off, as does the capacity for oversight, regulation, and executive control. Thus, the limbic system becomes the primary determinant of behavior and function, consisting of “fight, flight, or freeze” survival reactions: automatic emotional, cognitive, and physiological responses that prepare an organism to respond to threats with aggression, self-defense, escape, or paralysis. Such responses to threat generally prove adaptive by eliminating the PFC’s slower and deliberative processes of evaluation. Even the ‘freeze’ response (also known as “tonic immobility,” as discussed above), common in experiences of torture, is an adaptive automatic response (seen across all mammals) circumventing increased risks of fight or flight (i.e. when escape is impossible, or when flight may incite chase; Fuse et al., 2007; Heidt et al., 2005). However, these patterns of neurological and physiological response (where a hyperactive limbic system subdues the PFC) can become maladaptive outside of genuine danger, and turn pervasive after extreme trauma.

The brain’s response to stress interacts with the body’s physiological functioning via the hypothalamic-pituitary-adrenal (HPA) axis (Southwick, Vythilingam, & Charney, 2005). Activation of the limbic alarm response releases stress hormones (adrenaline and cortisol) in the brain and body that prepare an organism for both short-term and long-term stress exposure. The release of stress hormones activates the sympathetic nervous system (SNS) and triggers the “fight or flight” response: increased heart rate, dilated blood vessels in skeletal muscles, dilated airways in the lungs, and other reactions ensuring an individual’s readiness to face imminent threats. The parasympathetic nervous system (PNS) performs opposing functions: decreasing heart rate, constricting lung airways, and constricting blood vessels. The parasympathetic (PNS) response counteracts the sympathetic (SNS) response once danger subsides. Rhythmic, regular fluctuation in SNS and PNS activation helps maintain physiological allostasis (i.e., regulated physiological balance). Prolonged SNS activation in times of extreme stress (i.e. during and after psychological and physical torture) disrupts this allostatic balance, leading to pathophysiological states and negative physical and mental health outcomes (McEwen, 1998; McEwen & Wingfield, 2003; Sapolsky et al., 2000; Boyce & Ellis, 2005; Herbert et al., 2006).

Our perceived loss of control during extreme stress becomes a critical factor leading to negative psychological, physical and functional outcomes. Principles of neuroscience (e.g., Hebb’s rule)

illustrate how psychological, physiological, and behavioral responses become engrained through repeated exposure to threat or threat reminders. Our reactions to trauma have lasting impacts on neurobiological structure and function, exemplified through specific ‘injuries’ to the stress response system and the individual (Bale, 2015; Teicher & Samson, 2013; Van der Kolk, 2006).

### ***1. Sensitization of the Alarm Response***

A sensitized alarm response is a central example of long-term consequences to chronic trauma exposure. Activation of the alarm response during trauma exposure results in subsequent strengthening of neural pathways associated with responses to danger and insecurity, resulting in higher baseline levels of limbic activation (Yan et al., 2013) that indicate a chronic state of alert (hypervigilance). The threat detection system and HPA axis stress response become chronically active, primed to identify potential threats and trigger the alarm response. Chronic hypervigilance persistently drains neurological and physiological resources. In addition, the amygdala—a central emotion processing region in the limbic system—shows greater activation (exaggerated startle) in response to emotional and ambiguous information in individuals with trauma histories (Teicher & Samson, 2013; Teicher et al., 2016). These findings are paired with decreased structural volume (indicating under-development) and reduced activation of the PFC in individuals suffering from posttraumatic stress (Teicher & Samson, 2013).

As a result, individuals exposed to trauma and traumatic stress have a significantly lower threshold for triggering the alarm response (i.e., the limbic system more easily “hijacks” the higher order pre-frontal executive control systems, and the PFC is less adept at re-regulating and dampening the alarm response). This is due to the long-term neurological consequences of trauma exposure that result in strengthened bottom-up pathways from an overactive limbic system to the PFC, and weakened top-down pathways from the (underactive) PFC to the limbic system (Yan et al., 2013; Teicher et al., 2016). These structural changes affect the ability to regulate cognitive, emotional, and physiological reactions to perceived or potential threat. Essentially, it becomes natural and automatic for the system to enter ‘fight, flight, or freeze’ survival mode, where executive control and rational decision-making are largely absent. An overactive alarm system may promote survival in a dangerous world, but proves maladaptive in other contexts, as the “fight, flight, or freeze” alarm response is frequently summoned by innocuous environmental stimuli, compromising the ability to re-regulate.

### ***2. Physiological Consequences***

As with the short-term stress response, long-term neurological consequences of trauma exposure mirror long-term physiological consequences to the body’s systems. Long term traumatic stress on physiological systems alters both acute responses to stressors, as well as general function (see Teicher & Samson, 2013, for review). Ongoing perceptions of danger, helplessness, or loss of control result in chronic hyper-activation of the stress response, stimulating increased and prolonged release of stress hormones, which are toxic to psychological and physiological

systems when released in excess (Bremner, 2006; Gunnar & Vasquez, 2001, 2006; McEwen, 2007; Sapolsky, 2005, 2012). For example, adrenaline release puts the organism in “fight, flight, or freeze” mode for survival but disrupts homeostasis as the system as it attempts to maintain a regulated balance.

Furthermore, the PNS, or our physiological “brake,” can either atrophy from underuse or deteriorate with overuse, in response to extreme trauma or chronic perceived threat. Individuals with trauma exposure have demonstrated dysregulated cortisol responses to acute stress, showing hypersensitive stress hormone responses in some cases, and dampened responses (Teicher & Samson, 2013) in others. In terms of general functioning, two-thirds of children and adults exposed to trauma show increased adrenal activity (DeBellis, Keshavan & Clark, 1999; DeBellis, Lefter & Trickett, 1994), but low levels of baseline cortisol (Gunnar & Vasquez, 2001; 2006; Meewise, 2007; Trickett et al., 2010; Walsh et al., 2013). This implies these individuals are hypersensitive to threat (more easily triggered into “fight or flight” reactions), but otherwise operating at low levels of general activation (i.e., the system operates in a chronically depressed state, often fatigued from compensating for multiple alarm reactions).

Trauma exposure has also been shown to relatively increase cortisol levels at bedtime (Carrion et al., 2010); individuals are prepared for danger even when the body should be settling down for rest, negatively impacting sleep quality. Such research is consistent with findings that stress and trauma exposure disrupts circadian rhythmicity (Lupien et al., 2009). This means that individuals with a history of traumatic exposure and stress often struggle with attention, memory, and emotion regulation.

The lasting and pervasive neurobiological responses to extreme stress and trauma described above set the foundation for numerous psychiatric, psychological, social, occupational, and health impairments for victims of torture.

## **VI. Physical Consequences of Torture and Imprisonment in the Context of Torture**

### ***1. Physical Effects of Mechanical Torture***

In addition to the psychological and psychophysiological effects of torture, torture victims also experience identifiable physical consequences. “Mechanical Torture: includes physical assaults; including beatings, prolonged enforced standing, hanging, suffocation, burnings, electric shock, and exposure to extreme heat or cold. It also includes deprivation of humane conditions; including deprivation of food and water, being held in isolation, restricted movement, blindfolding, sleep deprivation and withholding of medical care. Sensory over-stimulation, including exposure to constant noise, screams and voices, powerful lights and forced ingestion of drugs. (Center for Victims of Torture, 2015) The immediate physical consequences of these

insults correspond to the mechanism of torture and may include but are not limited to; broken bones, cuts, burns, traumatic brain injury, nerve damage, and death.

Long-term physical effects of torture include scars, headaches, musculoskeletal pains, foot pains, hearing loss, dental pain, visual problems, abdominal pains, cardiovascular/respiratory problems, sexual difficulties, and neurological damage. (Center for Victims of Torture, 2015)

Multiple studies have been conducted across global populations that found higher prevalence of disease and somatic symptoms amongst torture and trauma survivors. Correlations of diabetes and cardiovascular disease in survivors of torture are especially prevalent (Egede & Dismuke, 2011; Goodwin & Davidson, 2004; Sawchuck et al., 2005). A 2016 study found participants with comorbidities of stroke, joint pain, arthritis and asthma had a higher likelihood of having been exposed to trauma (Dismuke et al., 2017). Another study of trauma survivors found higher rates of chronic fatigue syndrome, widespread pain, and fibromyalgia (Afari et al., 2014). In a study of refugees with likely exposure to torture, evidence of hypertension, coronary vascular disease, metabolic syndrome, and diabetes mellitus was found (Crosby, 2013).

Hoffman et al. (2017) conducted a survey of Karen refugees from Burma who experienced torture and recorded diagnoses of tuberculosis, HIV/AIDS, diabetes, renal disease, cancer, and Hepatitis B. The authors cite the lack of facilities and disruption of health services linked to systemic government abuse as contributing to negative health outcomes, thereby inferring a radiating effect of abusive regimes that compounds illness and somatic distress. In primary and secondary effects, literature suggests exposure to torture and trauma has discernible physical consequences (Kanninen, Punamaki, & Qouta, 2002; Emmelkamp et al., 2002).

## ***2. Physical Effects of Imprisonment in the Context of Torture***

Forced imprisonment and torture during detainment result in marked somatic injury with often long-lasting effects. In a study of Tibetan refugees in India, Crescenzi et al. (2002) compared health surveys of non-imprisoned refugees with those who had been detained prior to migration. Participants were given a list of eight somatic complaints and 27 traumatic experiences and the results were compared between imprisoned and non-imprisoned refugees.

Imprisoned refugees were statistically more likely to undergo specific forms of physical torture and deprivation and, as a result, articulate correlated somatic symptoms (Crescenzi et al., 2002). 92% of imprisoned refugees reported being beaten or kicked as opposed to 16% of those non-imprisoned. Imprisoned refugees were 75% more likely to experience electrical torture, 64% more likely to undergo forced sleep deprivation, 51% more likely to not have needed medication when ill, and 3-11% more likely to be burned, suffocated, immersed in water, cut with a blade or

knife, or shot. The effects of imprisonment showed disparate physical effects when compared to refugees who had not been forcibly detained (Crescenzi et al., 2002). To reduce the likelihood of chance occurrence, the level of significance was set at .01.

Psychological torture has physical effects, as well. In addition to a reported correlation between interrogation techniques performed during imprisonment and PTSD, depression, and anxiety, studies have also reported prevalence of somatic complaints and chronic fatigue (Basoglu, Livanou, & Crnobaric, 2007; Tol et al., 2007; El Sarraj, Punamaki, Salmi, & Summerfield, 1996; Ehlers, Maercker, & Boos, 2000). A study of 275 Palestinian male ex-prisoners who had been detained found that psychological torture was significantly associated with somatic symptoms and noted recurrence of weight loss, hypertension, and body ache (Punamaki, Qouta, & El Sarraj, 2010).

Physical effects of torture have marked impact. Studies have shown that exposure to torture increases the likelihood of a multitude of ailments that have identifiable consequences for affected populations.

## **VII. Effects of Social Disruption on Civilians in Armed Conflict**

In exerting control over Somaliland, the Barre regime maintained power through repressive and abusive means (Carroll & Rajagopal, 1992). Two methods of exerting control - torture and the disruption and reorganization of social networks - inflicted psychological and physical pain onto members of the Isaaq clan and other Somalis. With the prevalence of the armed forces and widespread abuses in the region, civilians were acutely aware of the possibility of imminent detention and torture without cause or charge. Such fear and exposure includes additional psycho-social harms on the victim community.

Studies have found evidence that threat of harm is a primary motivator for individual behavior in the experience of armed conflict (Bohra-Mishra & Massey, 2011; Davenport et al., 2003, Engel & Ibanez, 2007; Spilerman & Stecklov, 2009). Civilians in armed conflict suffer psychological consequences due to the “intimate exposure to brutality and subsequent displacement and civil disorder” according to a 2002 study by the Feinstein International Famine Center (McDonald, 2002). In a longitudinal study, Somali and Ethiopian refugees cited instances of “war violence” or “fear or intimidation” in 47% of their responses in a psychological evaluation (Perera et al., 2013). None of these articulated “premigration events” constituted violence inflicted directly upon the participants or their families but the environmental stressors of armed conflict predicted presence of PTSD symptoms (Perera et al., 2013). Previous research supports this claim (Bhui et al., 2003; Ellis et al., 2008; Fenta et al., 2004). These environmental stressors can have marked

impact. In a sample of approximately 300 Somalis living in Helsinki, 43% of men and 27% of women reported suicidal thinking (Kuittinen et al., 2014). The trauma of living in fear and rending of social networks persist within and frequently beyond refugee camps (Hoeffler, 2003). Findings show “that international migration is a common response to the threat of harm” (Williams et al., 2012).

Beyond the individual, collective effects of trauma are evident in communities and triggered by separation from family, uncertainty relating to immigration decisions, and direct and radiating effects of torture, persecution, and imprisonment (Simalchik, 1992). Urie Bronfenbrenner’s Ecological Systems Theory delineates five environmental systems with which an individual interacts including the microsystem (family, clan, school), exosystem (local politics, businesses, non-familial community members), macrosystem (social and cultural norms), and the chronosystem (changes within an historical continuum) (Dryden-Peterson, Dahya, & Adelman, 2017). Bronfenbrenner (1992) describes these systems as “a pattern of activities, roles, and interpersonal relations experienced by a developing person in a given face-to-face setting” (p. 227). Evidence supports that armed conflict and psychological warfare disrupt these patterns of social and interpersonal arrangements.

## **IX. Psychosocial Effects of Torture on Victims**

### ***1. The Destruction of the Survivor’s Role in the Community***

One of the core symptoms of PTSD is avoidance of places where the trauma occurred or other reminders of the trauma (DSM-5). This can lead to the disintegration of the community as survivors flee the area where they were assaulted (Bastick et al., 2007). Therefore, the territory in which the victims once lived is taken from them psychologically as well as physically (UN Security Council Resolution 1820). This, in turn, can lead to a loss of resources as a campaign of terror prevents people from gathering their possessions and basic items before they leave. This is a direct insult to the individual’s sense of safety and comfort. In Bosnia-Herzegovina, for example, where mass rape and assault in public areas led to mass relocation following the disintegration of the former Yugoslavia (Boose, 2002; Reid-Cunningham, 2008), there was an observed reluctance after the conflict ended to return to the geographic locations where the insults occurred, even though such locations were once considered home (Zalihic-Kaurin, 1994).

### ***2. Intergenerational Transmission of Trauma***

Clinicians and physicians have long noted the presence of heightened levels of distress and psychopathology in the children of victims of trauma, even when the children themselves were not exposed to traumatic stress. Research has confirmed that parental trauma exposure corresponds with increased risk for PTSD, mood disorders, and anxiety disorders in children

(Yehuda, Halligan, & Bierer, 2001; Yehuda et al., 2015). These observations led scientists to investigate the mechanisms by which traumatic distress is transmitted intergenerationally from a traumatized (or trauma-exposed) individual to their children. Intergenerational (or trans-generational) trauma is trauma that has been directly or indirectly passed down from one generation to another generation (Dass-Brailsford, 2007).

The concept of intergenerational trauma originally developed from the study of the Jewish Holocaust survivors and their families, resulting in a testable and verified model of the mechanisms by which the traumas experienced by Holocaust survivors' impacted the functioning and well-being of future generations of offspring (Danieli, Norris & Engdahl, 2016). Research has shown that intergenerational trauma transmission not only presents in the second generation (Grunberg & Markert, 2012) but also the third generation (Winship & Knowles, 1996). Besides the study of Holocaust survivors and their family, the study of intergenerational trauma has expanded to the experiences of other groups, such as Asian-Pacific Islanders who experienced cultural trauma (De Vinar, 2012) and survivors of South American Political Violence (Bith-Melander et al., 2017), among others.

In addition to the impact of trauma on parenting and family relationships (discussed above), intergenerational transmission of trauma is now also attributed to the trauma-related neurobiological and psychophysiological alterations that are passed from one generation to the next. The neurobiological alterations associated with PTSD and traumatic distress experienced by individual survivors of trauma have also been observed in their children, a finding which has been attributed to the impact of trauma exposure on the expression of an individual's genetic code (i.e., epigenetics; Yehuda et al., 2015). Past research has demonstrated that environmental influences such as stress exposure can “reprogram” the genetic blueprint for the development of neural and biological systems in rats and mice; these changes in the blueprint are subsequently passed on to the offspring (Bale et al., 2010; Bale, 2015). These findings have more recently been translated to humans, as parental trauma exposure has been found to alter how the genes that code for the psychophysiological stress response (e.g., release of glucocorticoids) are regulated both in the trauma-exposed individuals and in their children. These findings reveal how exposure to trauma such as torture can alter the biology both of the individual victim and their children, providing a biological explanation for the intergenerational transmission of trauma and traumatic stress.

## **X. Cultural Idioms of Psychological Distress in Somaliland**

Highly-educated Somalis are generally trusting of psychiatry but many other Somalis have had no contact with Western psychiatric concepts. As a result, many Somalis would not use psychiatric frameworks to describe experiences of trauma. For example, many Somali individuals would view post-traumatic stress disorder (PTSD) symptoms from rape or murder, as

something to be dealt with primarily as an insult to the family, requiring a *Diya*, a compensation paid by or on behalf of a person who has injured or killed another person (Costello, 2002). In general, mental health issues are not acknowledged openly.

The Somali culture is largely clan-based with a patriarchal family structure. There is a stigma present in regard to mental health that is intertwined with the nation's dominant Muslim religion and family status. Mental health issues are routinely communicated as somatic symptoms such as headaches, general pain, lethargy, etc., which can be associated with the stigmatization of mental illness towards the family unit. Suicidal ideation, whether active or passive, would most likely be denied due to suicide being regarded negatively in accordance with the Quran. Instead, they believe that whatever may happen is "God's Will (Jimale et al., 2002; Scuglik et al., 2007)."

There are seven suggested cultural idioms of distress within Somali culture (Im, Ferguson, & Hunter, 2017). *Buufis* can be related to anxiety that's generated by harsh living conditions that cause resettlement to an affluent foreign country. Those who have *buufis* describe lack of resources and opportunities for economic growth as the cause (Im et al., 2017). *Buqsanaan* can be described as emotional and cognitive reaction to sudden, severe stressors. *Buufis* can be a cause of *buqsanaan*, and symptoms can be characterized by isolation, rumination, and a change in behavior (Im et al., 2017). *Welwel* is similar to *Buqsanaan* and *Buufis* in the characterization of a chronic state of worry, anxious cognitions, and anxious behavior. The distinction is that *Welwel* is perceived as a more stable form of an anxiety disorder (Im et al., 2017). Common symptoms of *Welwel* include physical symptoms such as back pain, chest pain, headache, sweating, fatigue, dizziness, etc., and psychological symptoms crying paranoia, and excessive worrying (Im et al., 2017).

*Murug* is utilized to express symptoms analogous to major depression, which conveys sorrow, grief, and mental health concerns related to such (Im et al., 2017). *Murug* can also be described as a state of emotional difficulty in the sense of emotional numbness (Im et al., 2017). The expression of *Qaracon* holds similarities to Post Traumatic Stress Disorder, which literally means "trauma/shock" in Somali. The causes of *qaracon* have been suggested to be associated with egregious violence such as war, and the loss of loved ones (Im et al., 2017). *Jinn* is another cultural idiom of distress which refers to a type of spirit possession in which an observed change in personality or behavior occurs such as isolation, anger outbursts, aggression, and violent behavior. Various unknown symptoms are described, but a common initial symptom is fainting (Im et al., 2017).

*Wali* is the most stigmatized cultural idiom of distress and is considered the most severe form of mental illness (Im et al., 2017). *Wali* is usually designated for expression of psychotic features akin to the western diagnosis of psychosis, schizophrenia, or dementia (Im et al., 2017). Persons with *wali* are considered to have no spiritual connections and certain interventions include

beating the person with *waali* as they recite Quran scripture, and chaining the person with *waali* to the wall. The onset of *waali* has been suggested to be an exacerbation of less severe symptoms that were left untreated, in which *qaracon* left untreated can become *waali*, and met with more locally stigmatizing interventions (Im et al., 2017).

Despite these cultural nuances, American Psychiatric Association ideas are used as the standard of assessment and measure in Somaliland. DSM IV is the assessment tool most commonly used by mental health professionals, health-care professionals, and psychosocial professionals.

## **XI. Discussions Between HRTMHP and Trauma Health Specialists**

### ***1. Interview with Dr. Allen Keller from 4<sup>th</sup> January 2019 and Review of Expert Report***

Dr. Allen Keller is Associate Professor of Medicine at New York University School of Medicine, Director of the Bellevue/NYU Program for Survivors of Torture (PSOT) and Director of the NYU School of Medicine Center for Health and Human Rights. Dr. Keller is recognized internationally as an expert in the documentation, evaluation and treatment of victims of torture and other human rights abuses.

On January 4<sup>th</sup>, 2019, Dr. Reicherter from the HRTMHP had a one-hour conversation by phone about Dr. Keller's assessment of the Mr. Warfaa. The HRTMHP has reviewed Dr. Keller's expert report. Dr. Keller used standard evaluation techniques (Istanbul Protocol) in his evaluation of Mr. Warfaa. His conclusions are detailed in his report and are consistent with the common findings of survivors of torture. During the interview Dr. Keller highlighted the long-standing physical consequences of Mr. Warfaa's injuries and the long lasting psychiatric consequences.

Dr. Keller emphasized physical injuries that continue to cause functional problems in Mr. Warfaa's life. For instance, Mr. Warfaa has chronic arthritic pain that has caused suffering throughout his adult life. It also makes daily functioning (like prayers) difficult and painful. He is functionally blind in his right eye as a result of blunt trauma to the head. The physical damage and pain exacerbates his mental health symptoms. (Keller Interview, 2019)

*"When I am praying and I feel the pain, I am reminded of what happened to me. But what can I do about it?"* ...from Expert Report of Allen Keller M.D. (Keller, 2019)

Dr. Keller diagnosed chronic Post-Traumatic Stress Disorder and Major Depressive Disorder. Per our interview, Dr. Keller was particularly impressed with the avoidance symptoms observed in his evaluation of Mr. Warfaa. The avoidance symptoms had caused and continue to cause social isolation. The diagnosis and symptoms identified are also consistent with the common findings of torture survivors. Other classic symptoms of PTSD remain problematic in Mr. Warfaa's life. (Keller Interview, 2019)

*“I have dreams and nightmares a lot. I can’t count how many times I have them. Sometimes I can go a couple of days without them, but not more than 1 week.” “This week was every night. The story keeps coming back.”* ...from Expert Report of Allen Keller M.D.

*“I’m not able to feel emotions, but I think about death a lot. It’s like I got used to death.”*  
...from Expert Report of allen Keller M.D. (Keller, 2019)

Mr. Warfaa is not able to sleep in the same room with his wife because his sleep is so disturbed and he is so dysregulated that his distress through the night makes it impossible for his wife to have normal sleep. Dr. Keller also diagnosed cognitive disorder as a consequence of head trauma sustained in the context of torture. (Keller, 2019)

### ***2. Interview with Dr. Yusuf Garaw from 4<sup>th</sup> January 2019***

Dr. Yusuf Garaw is a Doctor of Internal Medicine with special expertise with survivors of torture. He evaluated Mr. Warfaa on three different occasions. Dr. Reicherter from the HRTMHP interviewed Dr. Garaw for approximately one hour on 1/4/2019.

Dr. Garaw’s assessment of Mr. Warfaa was completely consistent with the Expert Report of Dr. Keller. In our interview, Dr. Garaw described the functional limitations and ongoing suffering of Mr. Warfaa since the torture event. Dr. Garaw commented on the deformation of Mr. Warfaa’s joints and the ongoing arthritic pain. (Garaw, 2019)

Dr. Garaw confirmed that the DSM IV is the standard tool for mental health assessment in Somaliland and that Somali torture survivors are similar to global samples in presentation. He also lamented the lack of mental health treatment resources for survivors of torture in Somaliland. (Garaw, 2019)

### ***3. Discussion with Dr. Hussein Bulhan on 6<sup>th</sup> July 2018***

Dr. Hussein A. Bulhan is a graduate of Wesleyan University, Boston University, and Harvard University. He is the author of several major publications and numerous articles, including Frantz Fanon and Psychology of Oppression; Politics of Cain—One Hundred Years of Crises in Somali Politics and Society. Dr. Bulhan is a former tenured professor at Boston University and the President of Hargeisa University. He is now the President and Professor of Frantz Fanon University which he founded. A specialist in the treatment of PTSD and other psychological problems, his primary residence is in Hargeisa, Somaliland.

Dr. Reicherter and Michael Hamilton from the HRTMHP had a discussion by phone with Dr. Bullhan to better understand the nuanced differences between trauma psychiatry outcomes in Somaliland as compared to other parts of the world. HRTMHP spoke with Dr. Bulhan for approximately one hour. Dr. Bulhan confirmed that the general mental health pathology seen in survivors from the torture campaigns in Somaliland is identical to global samples. American

Psychiatric Association's DSM IV is the commonly used instrument to assess mental health trauma in Somaliland. (Bulhan, 2008)

While Dr. Bulhan discussed cultural differences in the interpretation of trauma mental health he was clear that the basic pathology observed in Somaliland is consistent with global samples. (Bulhan, 2018)

## **XII. Prospects for Healing**

Psychological treatment of torture victims are chronically understudied as survivors have multiple, persistent symptoms that constellate Post Traumatic Stress Disorder (PTSD), complex trauma, Major Depressive Disorder (MDD), psychosomatic symptoms, anxiety disorders, and even personality changes (Basoglu, 1997). Beyond formal diagnoses, survivors experience symptoms such as impaired memory, suicidal ideation, conduct issues, substance abuse issues, physical impairments, disturbances in value-processing systems, social stressors, and economic stressors that overall decreases their quality of life (Basoglu, 1997). While treatment becomes more multi-modal by prevalence of symptoms, there are generally 11 principles that should be adhered to regardless of treatment approach. These principles consist of 1) doing no harm, 2) conducting a functional analysis of the client's primary issue and focus treatment on needs, 3) allowing the clients to tell their stories at their own rate 4) having a single person in charge of treatment, 5) using pharmacotherapy to reduce intrusive symptoms, 6) maintaining regular and predictable meetings, 7) supporting the physical, social, and medical needs of clients, 8) recognizing cultural differences and intersectionality, 9) considering group therapy for social support, 10) supporting the client's traditional religious beliefs, and 11) understanding that clients may need to maintain a therapeutic relationship for extended time periods (Campbell, 2007).

Although torture is not only an individual harm, the aim of therapeutic intervention is to accelerate the capacity and flexibility of one's coping mechanisms to resolve trauma-related problems. Suitability of treatment is assessed where more suitable clients are those who are capable of learning about their condition. There are generally four different types of psychotherapeutic interventions that are evidence-based from random-controlled trials that target PTSD symptoms (McFarlane & Kaplan, 2012). Two of them are cognitive-behavioral therapy (CBT) and narrative exposure therapy (NET). Within the cognitive-behavioral approach, there is an emphasis on cognitive restructuring and prolonged exposure. One powerful mechanism of therapeutic intervention is found within the ability for the survivor to describe their experience of torture (Ginzburg & Neria, 2011). Narrative Exposure Therapy is a brief form of cognitive behavior therapy where patients are encouraged to construct the narrative of their entire life from birth to present with emphasis on the chronicity of their traumatic experiences (Gwozdziwycz

& Mehl-Madrona, 2013). Anxiety management is also commonly utilized, which consist of strategies that implement stress management, relaxation training, breathing techniques, social skills training, and distraction techniques.

Medication is also utilized to assist in symptom management. In a study of approximately 239 Somali and Bosnian patients, 65% met criteria for PTSD and 60% met criteria for Major Depressive Disorder (Kinzie, 2011). Most medications that are used for PTSD symptom management are also used for Major Depression symptom management (Kinzie, 2011). Selective Serotonin Reuptake Inhibitors such as paroxetine have been approved for the comorbidity of PTSD and MDD (Kinzie, 2011). Other medications that are commonly prescribed are fluoxetine, citalopram, and imipramine. Alpha-adrenergic blocking agents such as clonidine and prazosin have shown to be helpful for nightmares and agitation (Kinzie, 2011).

Along with medications, other contextual elements need to be addressed such as being displaced, which occurred during the Siyad Barre regime. Torture rehabilitation is not done in a vacuum and one needs to consider the economic loss of the torture survivor during their rehabilitation. This is commonly assessed utilizing the Disability Adjusted Life Years (DALY) methodology, used internationally by the World Health Organization, quantifying the burden of disease from mortality and morbidity (Murray & Lopez, 1996).

The major obstacle for torture survivors in Somaliland is the lack of mental health treatment resources. Drs Yusuf Garaw and Hussein Bulhan were clear that there are no realistic mechanisms to acquire adequate (or any) mental health services for survivors of torture.

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**Daryn Reicherter, M.D.**  
**Clinical Professor**  
**Director, Human Rights in Trauma Mental Health Program**  
**Department of Psychiatry and Behavioral Sciences**  
**Stanford University School of Medicine**  
**401 Quarry Road, Stanford, CA 94305**  
**Phone: (650) 269-7035; Email: dreicherter@stanford.edu**

Daryn Reicherter, M.D., is the director of the Human Rights in Trauma Mental Health Program and a Clinical Professor at Stanford University, School of Medicine's Department of Psychiatry and Behavioral Sciences. He is an expert in the area of cross-cultural trauma psychiatry, having spent more than a decade dedicated to providing a combination of administrative and clinical services in trauma mental health locally and internationally. Dr. Reicherter is an expert on the effects of trauma on human psychology throughout the lifespan. He is on the List of Experts and has provided Expert Report and Expert Testimony for the Extraordinary Chambers in the Courts of Cambodia and for the United Nations' International Criminal Court. He is on the Fulbright Specialists Roster for his work in international trauma mental health. He is a Senior Fellow at the Center for Innovations in Global Health at Stanford University. He has developed new methods for using the mental health outcomes of human rights violations to produce advocacy, policy changes, and treatment for survivors. He has created and cultivated new clinical rotations for residency, medical school, and undergraduate education in Global Mental Health.

**CURRENT CLINICAL AND ADMINISTRATIVE POSITIONS:**

- |                |  |
|----------------|--|
| 2015 - Present | Medical Director, Center for the Treatment of Survivors of Torture<br>Asian Americans for Community Involvement, San Jose, CA<br>Stanford Psychiatry Training Program  |
| 2014 - Present | Director, Program for Human Rights in Trauma Mental Health<br>Department of Psychiatry and Behavioral Sciences<br>Stanford University School of Medicine<br><i>Created and Directs an interdisciplinary program that applies mental health outcomes from human rights violations to international, transitional justices processes.</i><br><a href="http://med.stanford.edu/psychiatry/research/HumanRightsinTraumaMH.html">http://med.stanford.edu/psychiatry/research/HumanRightsinTraumaMH.html</a> |
| 2014 - Present | Leadership Council and Senior Fellow:<br>Center for Innovation in Global Health, Stanford University, School of Medicine   |
| 2005 - Present | Attending Physician, Clinical Professor,<br>Stanford Hospital and Clinics  |

## PROFESSIONAL CONSULTATION IN TRAUMA PSYCHIATRY

- 2005 – 2009                      Volunteers in Asia and the Stanford University Tsunami Relief Program  
*Provided psychiatric consultation and mental health aid to orphans with post-traumatic stress disorder in Indonesia*
- 2009 - 2012                      Documentation Center of Cambodia  
Phnom Penh, Cambodia  
*Consulted on a United States Institute of Peace-funded project to link the witness/victims of the International Criminal Court special tribunal for Cambodia (Extraordinary Chambers of Criminal Court) to mental health services*
- 2011 – Present                    United States Federal Immigration Courts and International Immigration Courts  
Consultations with US Attorneys or International Attorneys  
**More than 40 Interviews and Reports completed for Asylum Seekers surviving political persecution and/or torture.**
- 2010 - 2015                      Haiti Legal/Medical Project and Reed Smith, LLP  
*Providing psychiatric consultation and assessments for this multi-disciplinary humanitarian parole project for vulnerable earthquake survivors. Psychiatric evaluations of Haitian rape survivors leading to the first ever protection paroles on the basis of psychiatric diagnoses.*  
**More than 60 humanitarian parole cases won in federal courts in the USA, Canada, and France based on forensic reports.**
- 2013                                Extraordinary Chambers of Criminal Court’s Khmer Rouge Tribunal  
Phnom Penh, Cambodia  
*Consulted with the civil party attorney on the use of mental health outcomes as evidence against the Khmer Rouge defendants. Book: “Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge.”*  
**Accepted as evidence in the Khmer Rouge Tribunal Case 002/01**
- 2014 – 2016                      International Criminal Court, The Hague Netherlands  
*Consultation with the Office of the Prosecutor on the mental health consequences of mass rape in human rights crime for*  
**ICC Prosecutor vs Jean Pierre Bemba Gombo.**
- 2015 - Present                    Middle East Legal/Medical Project and Reed Smith, LLP  
*Providing psychiatric consultation and assessments for this multi-disciplinary resettlement project for survivors of the Syrian war. Psychiatric evaluations of Syrian and Iraqi rape survivors leading to protection paroles.*  
**More than 50 asylum/humanitarian cases won in international immigration courts based lab assessments and reports.**
- 2016 – Present                    Extraordinary Chambers of Criminal Court’s Khmer Rouge Tribunal  
Phnom Penh, Cambodia  
*Consultation with the civil party attorney on the use of mental health*

*outcomes as evidence against the Khmer Rouge defendants.*

***Expert Report on the mental health outcomes of charges in Khmer Rouge Tribunal Case 002/02 accepted as evidence.***

- 2016 International Criminal Court, The Hague Netherlands  
***Expert Testimony Provided for ICC Prosecutor vs Jean Pierre Bemba Gombo.***  
***Expert Report Provided for ICC Prosecutor vs Jean Pierre Bemba Gombo.***
- 2016 – 2017 United States; Federal Court, Northern District of California, Oakland, California  
***Expert Report on the Outcomes of Long-Term Solitary Confinement of Prisoners at Pelican Bay State Prison (40 class members interviewed) Ashker vs. the Governor of the State of California (Document in Evidence, Case in Progress)***
- 2017 Superior Court of Sierra Leone, Freetown, Sierra Leone  
***Expert Report on the Mental Health Outcomes of Human Rights Violations Caused by ECOMOG Occupation in Sierra Leone (Document Submitted, Case Pending)***
- 2018 United States; Federal District Court for the eastern district of Michigan  
***Expert Report on Community Trauma in the Context of the Flint, Michigan Water Crisis (Document in Evidence, Case in Mediation)***
- 2018 International Criminal Court, The Hague Netherlands  
***Expert Testimony Provided for the case of ICC Prosecutor vs. Dominic Ongwen***  
***Expert Report has been Accepted and Used as evidence for the Civil Party Attorney in ICC Prosecutor vs. Dominic Ongwen***
- 2018 United States; Federal Court, terms of settlement  
***Expert Report submitted on the issue of the mental health of immigrant minors separated from their parents in the case of Reno v. Flores (Document is being considered in evidence)***
- 2018 High Court of Fiji, Suva, Fiji  
***Expert Report used as Evidence in the case of State v Peni Vukici***  
***Expert Testimony Provided on the outcomes of Rape and Child Rape***
- 2018 Supreme Court of Fiji, Suva, Fiji  
***Expert Report Used as Evidence by the Office of Public Prosecutions***

## **ACADEMIC EMPLOYMENT**

- 2005 – 2006 Clinical Assistant Professor

Assistant Director, Medical Student Well Being Program  
University of California, San Francisco

- 2006 – 2009      Clinical Instructor  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2009-2012      Clinical Assistant Professor  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2012 – 2018      Clinical Associate Professor  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2018              Full Clinical Professor  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine

## **EDUCATION**

- 1994              Bachelor of Arts in Psychobiology and Philosophy  
*Suma Cum Laude*  
University of California, Santa Cruz
- 2001              Doctor of Medicine  
New York Medical College
- 2001-2002      Internship  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2002-2004      Residency in Psychiatry  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2004-2005      Chief Psychiatry Resident  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine

## **HONORS AND AWARDS**

- 1994              Phi Beta Kappa, University of California, Santa Cruz
- 1994              Cassias Ellis Award for Scholastic Achievement and Community Service  
University California, Santa Cruz

2001	Greta M. Das M.D. Memorial Award for Child Abuse and Suicide Prevention New York Medical College
2005	Resident of the Year Award, Stanford University Hospitals and Clinics
2006	Tier One Award for Outstanding Performance University of California, San Francisco
2011	Silent Hero in Health Care Award The County of Santa and Gardner Mental Health
2015	Stanford University Faculty Award, Chairman's Award: Community Engagement and Commitment
2016	Moonbeam Children's Book Award Silver Medal for Non-Fiction Picture Book (Cambodian Dancer)
2016	Stanford University Faculty Award, Chairman's Award: Community Engagement and Commitment

#### **LICENSURE AND CERTIFICATION**

2002 - Present	Licensed Physician and Surgeon, #A80353 Medical Board of California
2007 - Present	Diplomate, American Board of Psychiatry and Neurology

#### **COMMUNITY ENGAGEMENT FOR VULNERABLE POPULATIONS**

2005 – 2012	Director of Mental Health Services Palo Alto's Opportunity Health Center (Agency providing mental health services to Palo Alto Homeless)
2006 – 2010	Senior Psychiatrist Eastern European Service Agency (Agency providing mental health services to Bosnian War Survivors)
2006 - 2015	Psychiatrist, Center for the Treatment of Survivors of Torture Asian Americans for Community Involvement, San Jose, CA
2007 - 2016	Clinical Director Integrated Behavioral Health Ravenswood Family Health Clinic, East Palo Alto and Bellview, CA
2007 - 2017	Faculty Advisor and Attending Physician, Arbor Free Clinic Stanford Cardinal Free Clinics, Menlo Park, CA

2013 - Present            Co-director of the Embedded Mental Health Clinician Project  
*Tipping Point* funded project to provide assessment, referral, and intervention  
in selected NGO anti-poverty projects.  
JobTrain and EPACS, East Palo Alto, CA

## **PHILANTHROPIC SERVICE**

2007 - 2015            Board of Advisors  
Khmer Krom Federation,  
*Non-profit human rights group supporting religious freedom and human  
rights issues for Khmer Krom Buddhist monks*

2005 – 2009            Vice President and Founding Member of the Board of Directors Opportunity  
Health Partners, Inc. (Now called Peninsula Healthcare Connections)  
*Non-profit group providing free health care to the homeless*

2008 – 2012            President, Board of Directors  
Survivors International, San Francisco, CA  
*Non-profit group providing mental health care for survivors of torture*

2009 – 2015            Coach, Player Agent, Board of Directors  
Palo Alto Little League, Palo Alto  
*Non-profit group encouraging child development through sports*

## **SCHOLARSHIP**

### ***Research***

2000 – 2001            Research Psychiatrist, Group Psychiatry for PTSD (Drs. Catherine Classen  
and David Spiegel, Psychosocial Research Laboratory, Stanford University)

2006 – 2007            Co-Recipient, Stanford Presidential International Initiative Fund Grant for  
Global Health  
*Funding to develop trans-cultural psychosocial interventions for Indonesian  
orphan survivors of the 2004 Indian Ocean Tsunami*

2006 – 2012            Project Leader, Cambodian Trauma Protocol  
*Developed protocol to develop culturally-specific, trans-cultural mental health  
for Khmer patients with PTSD, based on Khmer Buddhist Mindfulness  
Meditation taught by monks for the relief of PTSD symptoms suffered by  
“Killing Fields” survivors; study sites at Gardner Clinic and Wat Khemara  
Rangsey Buddhist Temple in San Jose, CA*

- 2007 – 2009            Member, Freeman Spogli Institute’s Working Group  
Stanford University International Initiative  
*Developed research protocol in collaboration with UNICEF Zimbabwe and six major NGOs involved with children’s welfare in Sub-Saharan Africa for a large, comprehensive assessment of best practices for the psychosocial outcomes for orphans and vulnerable children*
- 2009 – 2010            Co-Recipient, Stanford Presidential International Initiative Fund Grant for Global Health  
*Funding to support a project focused on psychosocial interventions for HIV-related orphans and vulnerable children in sub-Saharan Africa*
- 2011 – 2012            Co-Recipient, Stanford School of Medicine Office of Community Health Seed Grant for Community Health Development  
*Funding to improve mental health access to children in East Palo Alto via a partnership between the Ravenswood Clinic and the Boys and Girls Club of East Palo Alto*
- 2013 – 2015            Visiting Scholar, Documentation Center of Cambodia/Sleuk Rith Institute, PhnomPenh, Cambodia *Conducted data collection for the production of a book on Mental Health in regard to International Criminal Court functions*
- 2014 -2019            Fulbright Specialist Roster, Fulbright Program Washington DC  
*To Promote work in Post-Conflict Trauma Mental Health*

### **Books**

**Reicherter D**, Khmer Krom Federation Research Team (Eds.) (2008). *The Khmer Krom: The Indigenous People of Kampuchea Krom*, Printed in the USA for the 60<sup>th</sup> Anniversary of the Universal Declaration of Human Rights.

**Reicherter D**, Cooper J (Eds.)(2009). *The Khmer Krom Journey to Self Determination*. Khmer Krom Federation, Pennsauken, NJ.

**Reicherter D**, Van Schaack B, Chhang Y (Eds.)(2011). *Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*. Documentation Center of Cambodia, Phnom Penh, Cambodia.

Roberts L, **Reicherter D** (Eds.)(2014). *Ethics and Professionalism and Ethics in Medicine: A Study Guide for Physicians and Physicians in Training*. Springer Publishing, New York, NY.

Roberts L, **Reicherter D**, Joshi S, Adelsheim S (Eds.)(2015). *Partnering for Mental Health: Stories of Community and Academic Collaboration*. Springer Publishing, New York, NY.

**Reicherter D**, (Author) Hale C. (Illustrator) (2015) *The Cambodian Dancer: Sophany’s Gift of Hope*. Tuttle Publishing, North Clarendon, VT.

Patel S, **Reicherter D**, (Eds.)(2016). *Psychotherapy for Immigrant Youth*. Springer Publishing, New York, NY.

**Reicherter D**, Van Schaack B, (Eds.)(2017). *Cambodia's Hidden Scars: Trauma Psychology and the Extraordinary Chambers in the Courts of Cambodia*. Documentation Center of Cambodia, Phnom Penh, Cambodia.

### **Book Chapters**

**Reicherter D**, Alyward A (2009). The Psychology of Oppression: Human Rights Abuses in the Mekong Delta. In *Khmer Krom Journey to Self Determination*, Khmer Krom Federation, Pennsauken, NJ.

**Reicherter D**, Rong V (2009). Mindfulness Meditation After Trauma. In *Khmer Krom Journey to Self Determination*, Khmer Krom Federation, Pennsauken, NJ.

**Reicherter D**, Alyward A, Student A, Koopman C (2010). The Psychology of Denial in the Political Context: The Case of Torture. In *The Psychology of Denial*, SK Ogden and AD Biebers (Eds.), Nova Science Publishers, Inc., Hauppauge, NY.

**Reicherter D**, Alyward A (2011). The Impact of War and Genocide on Psychiatry and Social Psychology. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang (Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

**Reicherter D**, Eng X (2011). Cambodian Perspectives on the Resources for Trauma Related Mental Health. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang (Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

**Reicherter D**, Boehnlein J, Stewart J(2011). Analysis of Trauma Related Mental Health Resources in Cambodia: Consensus Ideas for an Improved Method. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang (Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

**Reicherter D**, van Schaack B, Chhang Y (2011). Mental Health Reform: Toward a National Program for Trauma Related Mental Health in Cambodia. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang (Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

**Reicherter D**, Sugarbaker R (2013). Mental Health Consequences of War and Political Conflict. In *The International Handbook of Psychiatry: A Concise Guide for Medical Students, Residents, and Medical Practitioners*, LW Roberts (Ed.), World Scientific Publishing, Hackensack, NJ.

Mascola A, Bandstra B, **Reicherter D** (2013). International Perspectives on Homelessness. In *The International Handbook of Psychiatry: A Concise Guide for Medical Students, Residents, and Medical Practitioners*, LW Roberts (Ed.), World Scientific Publishing, Hackensack, NJ.

**Reicherter D** (2014). Personality Disorders. In *Diagnostic and Statistical Manual of Mental Disorders, Study Guide*, LW Roberts and A Louie (Eds). American Psychiatric Association Press, Arlington, VA.

**Reicherter D** (2014). Gender Dysphoria. In *Diagnostic and Statistical Manual of Mental Disorders, Study Guide*, LW Roberts and A Louie (Eds). American Psychiatric Association Press, Arlington, VA.

Aboujaoude E, Roberts L, **Reicherter D**, (2014) Introduction to Ethics in Clinical Medicine. In *Ethics and Professionalism and Ethics in Medicine: A Study Guide for Physicians and Physicians in Training*. Springer Publishing, Roberts L, New York, NY.

Joshi S, **Reicherter D**, Pumariega A, Roberts L, (2014) Multicultural and Ethical Considerations in American Medicine. In *Ethics and Professionalism and Ethics in Medicine: A Study Guide for Physicians and Physicians in Training*. Springer Publishing, Roberts L, New York, NY.

Fleming J., **Reicherter D** (2015) The Earthquake: Creating Legal Access for Haitian Rape Survivors. In *Partnering for Mental Health: Stories of Community and Academic Collaboration*. Roberts L, Reicherter D, Joshi S, Adelsheim S (2015). Springer Publishing, New York, NY.

**Reicherter D**, Bay S, Phen B, Chan T, Lee Y (2015) The Cambodian Lotus Thrives Under a California Sun: How a Mental Health Clinic Partnered with a Khmer Buddhist Temple to Reach Killing Fields Refugees Living in California. In *Partnering for Mental Health: Stories of Community and Academic Collaboration*. Roberts L, Reicherter D, Joshi S, Adelsheim S (2015). Springer Publishing, New York, NY.

**Reicherter D**, (2015) Laughin' in thenRain. In *Partnering for Mental Health: Stories of Community and Academic Collaboration*. Roberts L, Reicherter D, Joshi S, Adelsheim S (2015). Springer Publishing, New York, NY.

Awaad R, **Reicherter D** (2016) Psychological Mind-sets: The Need for Cultural Sensitivity in the Mental Health of Immigrant Youth. In *Psychotherapy for Immigrant Youth*. Patel S, Reicherter D, Springer Publishing, New York, NY.

**Reicherter D**, Yang E, Roberts L, (2016) People from Culturally Distinct Populations. In *A Clinical Guide to Psychiatric Ethics*. Roberts L, American Psychiatric Association Press, Arlington, VA.

**Reicherter D**, Matlow R, Reed D, Williamson R, (2017). Creating Lab Reports on Psychological Outcomes of Political Violence in Human Rights Criminal Cases: Human Rights in Trauma Mental Health Laboratory at Stanford University. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang (Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

**Reicherter D**, the Stanford University Human Rights in Trauma Mental Health Laboratory (2017). Mental Health Outcomes Resulting from Crimes Committed by the Khmer Rouge Regime Before the Extraordinary Chambers in the Courts of Cambodia in Case 002/2. In *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*, D Reicherter, B Van Schaack, and Y Chang

(Eds.), Documentation Center of Cambodia, Phnom Penh, Cambodia.

### **Other Textbook Contributions**

Preface: Dharma Talks Under Three Moons, In *Community Based Participatory Research: Working Together to Improve Mental Health*, LW Roberts. (Ed.), Springer Publishing, New York, NY. 2012.

100 study questions. In *Diagnostic and Statistical Manual of Mental Disorders, Study Guide*, LW Roberts, A Louie (Eds.), American Psychiatric Association Press, Arlington, VA. 2014.

Preface: When the Middle Path Intersects the Way of the Cross, In *Ethics and Professionalism and Ethics in Medicine: A Study Guide for Physicians and Physicians in Training*. LW Roberts, D Reicherter (Eds.), Springer Publishing, New York, NY. 2014.

### **Articles**

Wanat S, Whisnant J, **Reicherter D**, Solvason B, Juul S, Penrose B, Koopman C (2010). Coping with the challenges of living in an Indonesian residential institution. *Health Policy*, 96(1):45-50.

Saechao F, Sharrock S, **Reicherter D**, Livingston JD, Aylward A, Whisnant J, Koopman C, Kohli S (2011). Stressors and Barriers to utilizing mental health services among diverse groups of first generation immigrants to the United States. *Community Mental Health Journal*, 48(1), 98-106.

**Reicherter D**, Carrion V, Aylward A (2012). Building an effective medico-legal intervention model in post-earthquake Haiti. *Revista de AEPNYA*, October.

**Reicherter D**, Gray G (2012). Reconciliation in Cambodia. *Journal on Rehabilitation of Torture Victims and Prevention of Torture*, 22(1), 58-59.

Kletter H, Rialon E, Laor N, Brom D, Pat-Horenczyk R, Shaheen M, Hamiel D, Chemtom C, Weems C, Feinstein C, Leiberman A, **Reicherter D**, Song S, Carrion V (2013). Helping children exposed to war and violence: perspectives from an international work group on interventions for youth and families. *Child Youth Care Forum*, August.

Frenlach A, **Reicherter D**, (2015) The Treatment of VIP Patients in Academic Teaching Settings: Applying the “Difficult Patient Framework” to Guide Therapeutic Response. [Academic Psychiatry](#), 05/2015;

Khan CT, Louie AK, **Reicherter D**, Roberts LW. (2016) What Is the Role of Academic Departments of Psychiatry in Advancing Global Mental Health? *Academic Psychiatry*. 2016 Mar 14

### **Journal Peer Reviewer**

*Academic Psychiatry*

*Annals of Internal Medicine*

*Culture, Medicine, and Psychiatry*  
*Journal of Trauma and Dissociation*  
*Journal of Traumatic Stress*  
*Torture Journal*

## **TEACHING**

### ***Supervision and Mentorship***

- 2005 - Present      Clinical Supervisor, Psychiatry Residency Program  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2008 – Present      Faculty Adviser and Affiliated Faculty  
Human Biology Program, Stanford University
- 2009 - Present      Psychiatry Resident Adviser, Residency Training Program  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2013 - 2016      Site Training Director, Ravenswood  
Created training site and provide oversight/supervision of psychiatry residents rotating through this satellite clinical community psychiatry requirement
- 2013 - Present      Site Training Director, Center for Survivors of Torture  
Created training site and provide oversight/supervision of psychiatry residents rotating through this satellite clinical community psychiatry requirement
- 2014 - Present      Training and Education, Program for Human Rights in Trauma Mental Health  
  
Department of Psychiatry and Behavioral Sciences  
Interdisciplinary students (Medicine, Law, Psychology, Psychiatry, undergrad) integrated into lab functions  
Stanford University School of Medicine
- 2016 - Present      Research Adviser, Palo Alto University/Stanford Consortium  
Research adviser for PsyD and PhD candidates/ dissertation committee member

### ***Stanford Undergraduate Classes Created and Instructed***

- Winter 2008 – 2015 *Psychiatry 81Q, Fate of Orphans and Vulnerable Children in Sub-Saharan Africa: The HIV/AIDS Pandemic*  
Winter Quarters, Stanford University, Sophomore Seminar
- Fall 2014 - 2015 *Psychiatry 52Q: Public Mental Health and Community Psychiatry*  
Fall Quarters, Stanford University, Sophomore Seminar
- Spring 2015 - 2017 *Psychiatry 51Q: Culture, Psychology, and Mental Health Treatment*  
Spring Quarters, Stanford University, Sophomore Seminar
- Summer 2015 *OSPGEN 56: Food, Water and War: Life in the Mekong*  
*Bing Overseas, Stanford in Cambodia*  
Phenom Phen, Siam Reap, Battambang, Kingdom of Cambodia
- Winter 2016 - 2017 *Psychiatry 60N: The Psychology of Stoked!: The Economics of Happiness*  
Freshman Seminar Series, Stanford University
- Fall 2017 *Human Biology 165: Frontiers in Global Mental Health*  
Stanford Undergraduate Course

### ***Regular Lecture Series***

- 2005 - Present Guest lectures on Cross-cultural trauma psychiatry  
Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine
- 2007 – 2012 Guest Lecturer, Stanford University School of Law  
Mental Health and the Law; Forensic Evaluation of Survivors of Trauma
- 2008 – 2009 Trauma Mental Health in Orphans and Vulnerable Children  
Psychiatry 72Q: Traumatic Stress  
Stanford School of Medicine
- April-May 2009 Global Mental Health and Political Trauma  
Human Biology 129: Global Public Health  
Stanford University
- 2010 - 2016 Torture and Forensic Psychiatry  
Med 242: Physicians and Human Rights  
Stanford School of Medicine Course
- October 2012 - 2016 Working with Psychiatrists as Expert Witnesses  
Stanford Law Pro-Bono Social Security Disability Clinic

### ***Selected Invited Lectures and Speaking Engagements***

- Spring 2006, 2007      *The Mental Health of Children Orphaned by the Tsunami*  
Lecture Series for As Syafi-ia University, Jakarta, Indonesia
- April 2007              *International Trauma Mental Health*  
Medical Student Seminar  
Tokyo Women's Medical School
- January 2009            *The Torturer's Motive and International Law*  
Conference on the Interface of Politics and Psychology  
International Society of Political Psychology
- January 2009            Key Note Speaker, *Reaching Underserved Populations: Three Cases of Mental Health Outreach for the Underserved of Santa Clara County*  
PEI Health Care Sector Forum, Santa Clara County Mental Health
- February 2009          *Torture: A Multi-disciplinary Perspective*  
Conference on Global Social Justice Lawyering  
Stanford University, School of Law
- April 2009              *Trauma and Mental Health in Disaster Settings*  
Seoul University, School of Medicine, Korea
- May 2009                *Human Rights Abuses in the Mekong Delta: Crimes Against the Khmer Krom*  
United Nations Permanent Forum on Indigenous Issues, New York, NY
- September 2009        *Moderator, Gender Based Violence Conference*  
Sponsored by Survivors International  
University California, San Francisco
- November 2009         *Moderator, Symposium on the Development of a Protocol for the Clinical and Forensic Assessment of Immigrant Juvenile Survivors of Torture and Gang Violence*  
Sponsored by Survivors International  
University California, San Francisco
- February 2010          *Psychological Scars of War*  
Health After Conflict in Developing Nations Conference  
Stanford Association for International Development
- October 2010            *Psychiatry and Law "Shaking the Foundations" Conference*

Stanford University, School of Law

June 2011      *International Psychiatry in Haiti in the Aftermath of the Earthquake*  
Grand Rounds, Department of Psychiatry and Behavioral Sciences  
Stanford University School of Medicine

July 2011      *PTSD Among Cambodian Refugees*  
Podcast for “Inside Stanford Medicine” Magazine  
Stanford University

August 2011      *Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*  
Palo Alto University

November 2011      *Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*  
Trauma Recovery Program  
University of California, San Francisco

November 2012      *Aftermath of Trauma Psychology: Trauma’s Relation to Economic Decision Making in Cambodia*  
Stanford University, School of Business

November 2012      *Cambodia’s Hidden Scars: Trauma Psychology in the Wake of the Khmer Rouge*  
International Society of Traumatic Stress Studies Annual Meeting  
Los Angeles, CA

March 2013      *Victim Psychology in International Criminal Court: The Case Study of the Khmer Rouge Tribunal*  
Conference on Human Rights and Genocide  
University of California, Davis

June 2013      *Victim Psychology in International Criminal Courts,*  
Documentation Center of Cambodia, Phnom Penh, Cambodia

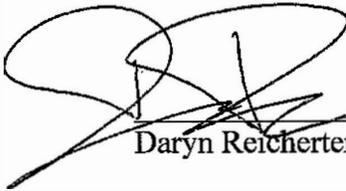
September 2013      *Post Traumatic Stress Disorder and Global Health*  
Stanford Medical School Course on Global Health

October 2013      *Integration of Behavioral Health into the Patient Centered Health Home*  
Learning Collaborative Series

June 2014	<i>Use of Trauma Psychology Statistics in International Criminal Prosecutions</i> International Criminal Court, The Hague, Netherlands
August 2014	<i>Use of Trauma Psychology Statistics in International Criminal Prosecutions</i> Stanford Medical School, Stanford California
September 2014	<i>Psychological Trauma and Resilience: Victim Rehabilitation &amp; Trauma</i> Psychiatry Café Scientifique, Stanford California
February 2015	<i>Mental Health Outcomes and the Transitional Justice System: Test Case with the Khmer Rouge Tribunal</i> Grand Rounds Department of Psychiatry, Stanford California
April 2015	<i>Mental Health Outcomes of Rape Across Cultures</i> Intergenerational Trauma and Healing Workshop, Palo Alto California
August 2015	<i>Mental Health Outcomes and the Khmer Rouge Tribunal</i> Sleuk Rith Institute, Phnom Penh Cambodia
January 2016	<i>Mental Health Outcomes in the Justice Process</i> Physicians for Social Responsibility, Palo Alto California
January 2016	<i>Book Release: The Cambodian Dancer</i> California Book tour
December 2016	Conference: <i>Fifth Meeting of the Global Consortium for Depression Prevention</i> Daryn Reicherter; Master of Ceremonies and Host, Stanford California
August 2017	<i>Mental Health and Resilience in Survivors of Human Rights Violations</i> Webinar for Santa Clara County Health Care, San Jose California
September 2017	<i>Stigma and Children of War Rape: The Psychiatric Consequences</i> Conference at London School of Economics and Political Science, London U.K.
October 2017	<i>Prosecuting "Rape as a Weapon of War" with Psychiatric Outcomes</i> Grand Rounds; Department of Obstetrics and Gynecology, Stanford California

I have agreed to contribute my services for the purpose of preparing this report pro bono. Should I be called to testify, I will be compensated for expenses incurred in connection with my testimony only.

I swear under penalty of perjury, under the laws of the United States, that the statements I have made are true and correct to the best of my knowledge.

 *Reicherter*  
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Daryn Reicherter, M.D.

1/9/2019  
Date