PSYCHOLOGICAL INVESTIGATION STANDARD

FOR TORTURE, AND CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

IN THE UNITED STATES OF AMERICA

Version 1.5 | March 2026

Institute for the Advancement of Justice & Human Rights

Document Control Number `IAJ-STD-20260324-001-PUB`

RELATED IAJ DOCUMENTS

UNCAT and jus cogens: a contemporary perspective
Harmonizing the Architecture of Disability Rights
IAJ Amicus Curiae, Texas Supreme Court (Cause No. 24-0881)

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Module 1: Legal & Normative Framework

IAJ Framework Reference Architecture

The following table anchors each IAJ framework term to its external legal grounding and companion document. In adversarial proceedings, evaluators should be prepared to cite the external authority column rather than the IAJ designation alone.

V87 Term / Doctrine	External Legal Grounding	IAJ Companion Document
Distress-Induced Harm "Battery Without Touching"	ECHR Art. 3; IP §§6–10; CAT GC No. 2 §21	Lin Memo v9, Dim. V Disability Thesis v49, §6.1–6.3
Biological Assault (physiological harm pathway)	State-created danger doctrine; CRPD Art. 15; UNCAT Art. 1	Disability Thesis v49, §6.2–6.3 Lin Memo v9, Dim. V.B
Forum Nullus	Exhaustion of domestic remedies; VCLT Art. 53; CRPD Art. 13	Lin Memo v9, Dim. VI.D Disability Thesis v49, §6.7
Aggravated Suppression	U.S. RUD equivalence failure; CAT/C/USA/CO/3-5; VCLT Art. 19(c)	Lin Memo v9, Dim. IV Amicus Curiae (Texas SC)
IAJ Clinical Attribution Framework (Forensic Probability Standard)	IP §§417, 524; FRE 702; SPJ literature	V87 Appendix V Lin Memo v9, Dim. VI.A
Dual-Track Rule (Two Legal Planes)	Medellín v. Texas (plane b only); UNCAT Art. 1 & 16 (plane a)	Lin Memo v9, Prefatory Note & Dim. IV.B
Sovereign Withdrawal	Judicial immunity limits; VCLT Art. 53 jus cogens	Disability Thesis v49, §6.5 Lin Memo v9, Dim. III

PREFACE

Conventional scenarios of torture and cruel, inhuman or degrading treatment or punishment (CIDT)[1] are discussed by standards, guidance and publications. However, these conventional scenarios do not provide sufficient insights, guidance and methodology for the psychological investigation of torture and CIDT in the United States of America.

The IAJ observes a material divergence between the documented U.S. institutional conduct and the standards established by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) and the 2022 Istanbul Protocol (IP). Stated in lay terms, the USA is 'not compliant' with international torture law, and existing texts do not provide for the systemic absence of prevention, relief, remedy and punishment despite assurance of the State's full compliance with the treaty. For example:

- The existing domestic procedural framework in matters under investigation by the IAJ, and elsewhere, does not currently recognize the specific treaty-based individual remedies established under UNCAT Articles 13 and 14.

[1] The word "ill-treatment" is used in the Istanbul Protocol interchangeably with Cruel, Inhuman or Degrading Treatment or Punishment (CIDT)

- Certain categories of prohibited acts that may constitute torture and CIDT have no domestic remedy, relief or punishment by design[2], and institutions and courts systemically prevent exhaustion of remedies that the U.S. assures the international community are available in the USA[3].

The non-compliance extends to scenarios of prohibited acts that are not considered by existing standards, guidance and publications, leading to the creation of this standard by the IAJ.

Because of the manner in which the USA ratified the Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment, a standard of psychological investigation that is specifically tailored to the United States must be established by the IAJ. To understand why the USA requires a uniquely tailored standard please read the chapter "Important clarifications about torture and CIDT in the USA" (below) and also refer to other IAJ publications listed by the resources page of the IAJ website.

IAJ investigations have identified a pattern of apparent deviations from UNCAT and 2022 Istanbul Protocol standards across documented cases, suggesting that domestic *fora* are unable to provide the procedural modifications required to prevent, for example, foreseeable neurological decompensation. The resulting harm is attributed to a documented sequence of policy-driven practices and multi-actor institutional interactions rather than isolated individual incidents. A structural inversion is observed where the institutional actors responsible for maintaining **safe harbor**[4] have, in specific instances, knowingly maintained stressors resulting in documented biological injury via coercive procedure, because this is structurally possible by virtue of institutional and judicial policies. Contemporaneous records indicate a systemic divergence from international clinical documentation standards, necessitating an independent forensic framework to preserve the record for subsequent review.

Contemporaneous records support a finding of systematic institutional refusal to integrate internationally mandated clinical documentation standards. The restriction of forensic documentation to specific care-credential tiers creates a barrier to the timely recording of ongoing physiological deterioration, particularly in underserved or indigent populations. Thus, a non-traditional dual-track

[2] For example, a disabled indigent litigant in civil litigation is systemically deprived of essential disability accommodation that insures repetitive physical and psychological injuries, and deprivation of constitutional due process and any test of merits. For example, a parent is permanently separated from their child despite the violations of non-derogable human rights of the parent through systemic institutional and judicial conduct

[3] For example, jurisdictional and procedural obstruction by courts, selective reviews by appellate courts including the U.S. Supreme Court, all of which are asserted as lawful sanctions or legally correct

[4] In the IAJ Psychological Investigation Standard, the term "safe harbor" is utilized in two distinct but related contexts: institutional/legal protections and the psychological effect of forensic documentation. 1. Institutional and Legal Safe Harbor In the legal and normative framework, "safe harbor" refers to the system of "equivalent" constitutional and procedural protections that the United States represented as being in place to fulfill its obligations under the UNCAT. The Collapsed Pathway: It represents the domestic judicial and administrative mechanisms—such as ADA/CRPD modifications, medical stays, and procedural modifications—that are mandated to prevent foreseeable harm, such as neurological decompensation. Structural Inversion: The IAJ observes a "structural inversion" where the institutional actors (judges, clerks, and agencies) who are responsible for maintaining this safe harbor instead knowingly facilitate a biological assault through coercive procedures. Forum Nullus: When these domestic safe harbors are systematically denied, the venue is designated as a forum nullus—a vacuum where human rights protections are functionally suspended. 2. Psychological Safe Harbor Within the ethical and clinical framework, "Psychological Safe Harbor" is defined as a specific forensic function of the documentation process. Evidentiary Validation: It is the act of a care provider fulfilling their Universal Duty to Document torture or CIDT. Affirmation of Dignity: This process provides the victim with a "safe harbor" by formally affirming their dignity and reality as a human being under the Law of Nations, serving as a counter-measure to the "institutional gaslighting" and erasure experienced in hostile domestic forums. In summary, a safe harbor is the intended protective environment of the law which, when it fails at the domestic level, must be reconstructed through independent clinical witness to protect the victim's biological and psychological integrity.

structure is identified so as to ensure that clinical findings remain intelligible under domestic rules while preserving the integrity of the original international-law analysis.

To establish the U.S. standard, the IAJ has incorporated the Istanbul Protocol[5] (IP) for the psychological investigation of UNCAT[6] violations, IRCT publications[7] and IFEG guidance[8], as well as the guidance published by Physicians for Human Rights (PHR)[9], and combined this information for specialized application to the United States of America. These IAJ adaptations are designed for applicability to potential scenarios of individual and systemic prohibited conduct by judicial, institutional, and other actors in the USA, which are not 'stereotypical' according to the mass consciousness, and are underestimated within prevalent coverage of prohibited acts and therefore lacking sufficient depth within existing standards, guidance and publications for application to the USA.

Like the IP and PHR, the IAJ's goal in producing this publication is to enable independent, non-forensic clinicians with limited or no prior Istanbul Protocol knowledge to achieve rapid familiarization and training to participate in, and ultimately conduct forensic clinical evaluations of alleged or suspected torture and ill treatment, particularly when historically underestimated processes are implicated in systemic violations.

To support this goal, quick-reference decision trees are integrated at each major decision point in the evaluation process, including initial screening, instrument selection, credibility assessment, diagnosis determination, causation analysis, severity rating, and report formulation, with additional simplified tools in the appendices.

CULTURAL CONTEXT DOCUMENTATION — IAJ RULE (IP-Aligned, 2022 IP Chapter IV): Every IAJ evaluation must document cultural context as a core methodological component, consistent with the Istanbul Protocol's requirements to assess and report cultural, linguistic, and contextual factors that affect interview process, symptom expression, and interpretation of findings — regardless of the subject's national origin. This is an **IAJ mandatory requirement** grounded in but not verbatim from IP Chapter IV; evaluators should cite the specific IP paragraph that most closely applies to the cultural issue being documented. Western-oriented instruments (PCL-5, PHQ-9, GAD-7, and equivalent DSM-anchored tools) are adjuncts only and must not be used as the primary or sole basis for clinical conclusions. For all subjects, the evaluator must:

- document culturally specific idioms of distress in the subject's own framework;

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[5] https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf -- Published in 1999 and updated in 2022, the Istanbul Protocol standards are endorsed by international, regional, and national human rights bodies and legal mechanisms. As the PHR reports, the Istanbul Protocol provides the UN Standards for the effective investigation and documentation of torture and ill treatment. They have informed states' treaty obligations to investigate, prosecute, and punish torture under the UN Convention against Torture and international and national law. They have underpinned health professionals' global efforts to end torture, hold perpetrators accountable, and afford victims the redress and rehabilitation they are entitled to.

[6] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

[7] International Rehabilitation Council for Torture Victims. See for example, IRCT Journal on Torture -- https://irct.org/torture-journal/, and IRCT YouTube channel: https://www.youtube.com/@IRCT

[8] Independent Forensic Expert Group https://irct.org/ifeg/

[9] Although the material was developed using an older version of the Istanbul Protocol, the PHR website toolkit is comprehensive and very educational – see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf and https://phrtoolkits.org/toolkits/istanbul-protocol-model-medical-curriculum/module-6-psychological-evidence-of-torture-and-ill-treatment/

- complete the IAJ Cultural Validation Checklist (Appendix P);
- include a Methodological Note (Appendix Q) specifying what cultural adaptations were made and why; and
- explain how cultural factors affected interpretation of standardized instrument scores.

The Methodological Note is a required report section. Failure to complete these steps constitutes a methodological limitation that must be explicitly documented in the Methodological Note section of the report. Evaluators should complete all steps unless safety, access, interpreter failure, or feasibility constraints make full completion impossible in the circumstances — in which case the constraint, its effect on the evaluation, and any compensatory measures taken must be documented. A constrained evaluation with transparent documentation of its limitations is more defensible than a non-transparent claim of full compliance.

The evaluator must apply a **trauma-informed, context-sensitive, and culturally responsive methodology** rather than relying uncritically on Western-oriented assumptions, standardized instruments, or interview habits that can distort the record. In torture and CIDT investigations, the evaluator's task is not simply to administer tests, but to understand how power, trauma, culture, language, disability, fear, and institutional coercion shape disclosure, symptom presentation, and apparent inconsistency.

Three methodological cautions are especially important:

1. Scientific Neutrality Mandate

The evaluator should recognize that implicit and explicit bias can affect questioning, interpretation, credibility judgments, and the weight given to symptom reports. Bias may arise from cultural assumptions, diagnostic overconfidence, stereotypes about how "genuine" trauma should appear, or overreliance on familiar clinical frameworks.

Core citations: IP **§279**; IP **§295**.

See also: IP **§278**; IP **§294**.

2. Power dynamics shape the interview itself

Torture and CIDT interviews do not occur in a neutral space. The survivor may experience the evaluator, setting, questioning style, or institutional context as an extension of prior coercion. For that reason, the evaluator must remain attentive to perceived authority, fear, shame, dependency, and the risk that the interview process itself may inhibit disclosure or trigger distress.

Core citations: IP **§295**; IP **§§299–302**.

See also: IP **§272**; IP **§§310–311**.

3. Western-oriented tests and structured tools are only adjuncts

Standardized measures may contribute useful information, but they should not override contextual clinical judgment where cultural mismatch, language barriers, disability, trauma effects, or coercive history affect the meaning of the score. Numerical results must be interpreted as one part of a broader forensic analysis, not as a substitute for it.

Core citations: IP **§§294–298**; IP **§511**.

See also: IP **§325**; IP **§§491–494**; IP **Annex IV**.

Operational rule

The evaluator should integrate:

- narrative interviewing,
- behavioral observation,
- collateral information,
- culturally informed interpretation, and
- careful attention to trauma-related fragmentation, fear, and power imbalance.

No single instrument, score, or interview style should be treated as dispositive where the broader evidence points to a more complex or culturally mediated presentation.

Reporting rule

When these issues are relevant, the report should state:

- what methodological risks were present (bias, power imbalance, cultural mismatch, translation limits, disability-related communication issues, etc.);
- what steps were taken to reduce those risks; and
- how the evaluator adjusted interpretation to avoid overstatement, false negatives, or culturally distorted conclusions.

Multi-tier forensic evaluation

Note that forensic psychological evaluations are distinct from the "practice of psychotherapy" in the treatment sense, as the evaluator does not enter into a therapeutic relationship and provides no clinical care. While this role is fundamentally evaluative and investigator-led, the IAJ recognizes that non-compliant domestic authorities may attempt to weaponize local licensing laws to obstruct human rights documentation. To ensure nationwide torture documentation is feasible and legally defensible, and where domestically obstructed, the IAJ intends to operate through a tiered national model:

- A small number of Forensic Leads (Level 4 Experts) who set standards, train personnel, and shape final conclusions based on the 2022 Istanbul Protocol;
- a network of Locally Authorized Clinicians who conduct direct examinations where specific jurisdictional laws require local licensure; and
- an Intake and Documentation Layer that gathers chronologies, records, and institutional facts without issuing final forensic opinions.

This structure preserves methodological consistency, utilizes interstate mechanisms like PSYPACT where available, and avoids reliance on the premise that non-therapeutic work is automatically exempt from regulation. Clinicians should refer to the IAJ Advisory Opinion for jurisdiction-specific guidance on licensure, compact pathways (e.g., PSYPACT where applicable), temporary practice rules, and lawful role allocation in interstate forensic work. The IAJ does not assume a blanket

exemption from state licensure laws. See IAJ–IRCT Lin Memorandum v9, Dimension IV.B on domestic enforceability as distinct from the international legal obligation.[10]

Cautionary note: We draw your attention to the fact a few English language terms and specific words have legal meanings that are very different from our ordinary use in normal communications. This document points those out and asks you to pay particular attention to how you use them in your reports and in providing testimony. For example, "Credibility" in this Standard refers to the clinically assessed internal consistency, contextual plausibility, and reliability of reported information across multiple data sources. It is not a lie-truth judgment, does not adjudicate whether torture legally occurred, and is assessed under the Istanbul Protocol's "consistency" framework (IP §§388–389) rather than the broader colloquial meaning of the term. Evaluators who frame credibility as a truthfulness determination expose themselves to cross-examination as de facto human polygraphs, which the IP consistency framework was specifically designed to prevent.

Forensic Probability and the Rule of Clinical Attribution

To satisfy U.S. admissibility requirements for "reliable principles and methods," IAJ evaluators shall frame conclusions using the **IAJ Clinical Attribution Framework** (also referred to as the Forensic Probability Standard). This is an IAJ-developed **structured professional judgment framework** — a systematic, documented approach to clinical reasoning about the probable relationship between documented stressors and documented harm — and must never be presented as a legal judgment of liability or guilt. It is not a statistical instrument with published sensitivity/specificity properties. It is designed to provide the transparency and documented reasoning that FRE 702 and Daubert require of reliable methodology. Whether it satisfies Daubert in any particular proceeding is a question for the court; this framework is designed to provide the materials necessary for that determination. See Appendix V for the full Daubert analysis.

Warning: the IAJ draws attention to vicarious trauma, and compassion fatigue, especially in conflict settings where comprehensive medico-legal evaluations are not possible, and where there is a considerable risk of reprisals to alleged victims and clinical evaluators, including risk of disclosure of investigation findings that may lead to reprisals against others.[11] Evaluator wellbeing is not ancillary to forensic rigor; it is a component of it. Fatigue, cumulative exposure to traumatic narratives, moral injury, hypervigilance, rescue impulses, irritability, emotional numbing, over-identification, and haste can all degrade interview quality, distort credibility assessment, weaken differential reasoning, and increase the risk of both overstatement and false minimization. For that reason, self-monitoring, structured breaks, workload pacing, and referral when the evaluator's functioning is materially compromised are part of the evaluation protocol itself, not merely matters of personal wellness. See **Appendix T** for the full self-care protocol.

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[10] Article VI of the U.S. Constitution: "…This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding."

[11] In the event of reprisals, clinicians should immediately report incidents to the IAJ, to UN bodies such as the Committee Against Torture (CAT) and the Special Rapporteur on Torture via urgent appeals or communications. Additionally, collaborate with NGOs like Physicians for Human Rights (PHR) or the International Rehabilitation Council for Torture Victims (IRCT) for peer review of documentation, joint advocacy, and additional protection. This ensures systemic accountability and leverages external oversight to deter further interference, as per Istanbul Protocol §679. IP §679 supports whistle-blower protection for medico-legal and health personnel who report findings. The additional recommendation to report to the IAJ, CAT, the Special Rapporteur, or partner NGOs is an IAJ escalation protocol, not a direct IP requirement. The PHR provides guidance on Digital Security, Vicarious Trauma, Professional Wellness & Self-Care.

What is being investigated?

The 2022 Istanbul Protocol[12] (IP) should be followed for the investigation of "torture" and "cruel, inhuman or degrading treatment or punishment", which are terms defined by the UNCAT Articles 1 and 16. Conventional investigations focus on the elements of Articles 1 and 16 of the UNCAT as causation for psychological pain and suffering, and cruelty, inhumanity and degradation of the individual. The psychological effects of Article 1 and 16 violations are recognized as being potentially long term and outlasting the cessation of the direct violations of those two Articles. The IAJ extends the conventional investigation scope by also considering the psychological effects of the violations of UNCAT Articles 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 20.

As a foundational step, please familiarize yourself with the UNCAT by reading the official text published by the United Nations Office of the High Commissioner for Human Rights.[13] Please try to commit to memory the definitions in Article 1 and 16, which are as follows:

__Article 1__

1. For the purposes of this Convention, the term "torture" means 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 acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.[14]

__Article 16__

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official

[12] The Istanbul Protocol was developed to establish specific United Nations standards on how effective legal and clinical investigations into allegations of torture or ill-treatment should be conducted. Since 1999, a number of legal and health professionals, and other human rights defenders have worked to implement Istanbul Protocol standards in approximately 40 countries. This extensive practical experience has provided insight into the needs and challenges associated with State implementation of the Istanbul Protocol.528 In 2012, four partner organizations (Physicians for Human Rights, the International Rehabilitation Council for Torture Victims, the Human Rights Foundation of Turkey and the Redress Trust) developed a series of practical guidelines – known as the "Istanbul Protocol Plan of Action" – for State implementation of the Istanbul Protocol. The Istanbul Protocol Plan of Action was recognized and supported by the United Nations High Commissioner for Human Rights in 2012 and the Special Rapporteur on torture in 2014. See IP §642,643 for the Protocol's purpose and implementation history. IP §646 establishes that States should officially recognize and institutionalize Istanbul Protocol standards. As demonstrated by the CAT Concluding Observations, the United States does not implement the Istanbul Protocol. The IAJ assesses that the United States has not done so.

[13] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading

[14] Explained simplistically, this second paragraph of Article states that a country can legislate 'stronger' laws than UNCAT to achieve the same purpose and objectives as UNCAT as long as they are 'better' than UNCAT at prevention, relief, remedy and punishment of torture and CIDT. The USA has done the opposite: implemented a 'lesser', 'weaker' version of the UNCAT

capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.[15]

The IAJ Psychological Investigation Standard is developed in response to significant gaps in existing frameworks for documenting psychological consequences of torture and CIDT, particularly as applied to U.S. institutional contexts and potential systemic institutional abuse.

Limitations of Existing Methodologies

Existing frameworks developed for documenting physical and psychological consequences of torture exhibit critical limitations when applied to U.S. cases involving alleged systemic institutional abuse:

- Physical emphasis that inadequately addresses psychological devastation from institutional control methods designed to leave no physical marks;
- Acute event focus rather than cumulative environmental psychological harm;
- International context limitations lacking adequate adaptation for U.S. institutional settings where torture operates through due process violations, ADA violations, and systematic deprivation;
- Access barriers including requirements for attorney representation that create barriers for indigent victims.

Istanbul Protocol Adaptations Required

The Istanbul Protocol (2022) requires adaptation for U.S. systemic institutional abuse:

- no adequate U.S. adaptation for institutional torture through courts and administrative agencies;
- systemic versus event focus needed;
- absence of an institutional and judicial full accountability ecosystem;
- absence of independent monitoring, no process for independent recommendations and guidance
- evidentiary framework mismatch with U.S. adversarial requirements.

The IAJ Enhancement

The IAJ Psychological Investigation Standard provides enhanced psychological documentation that prioritizes psychological sequelae from institutional control methods, addresses cumulative environmental harm, adapts international standards to U.S. constitutional and statutory requirements, provides methodology suitable for systemic institutional abuse across multiple institutional contexts, and addresses documentation needs of indigent pro se litigants.

1. Addressing U.S. Non-Compliance and "Aggravated Suppression"

The primary driver for the IAJ Standard is the documented divergence between U.S. institutional conduct and international law — and the systematic failure of domestic mechanisms to hold accountable those who inflict psychological torture and CIDT under institutional cover. Courts have

[15] See supra: the country may implement 'stronger' and 'better' prohibitions on CIDT, not the opposite

treated the absence of physical contact as a shield. Institutions have treated the invisibility of psychological harm as a license. This Standard exists to dismantle those shields — clinically, methodologically, and evidentiary — by training investigators to see, name, and document what institutional actors have relied upon remaining unseen.

- **The Equivalent Pathway Failure (Structural Accountability Gap)**[16]**:** The U.S. ratified the UN Convention Against Torture (UNCAT) with Reservations, Understandings, and Declarations (RUDs), claiming domestic law provided "equivalent" protections. In reality, victims are often barred from bringing treaty-level actions, creating a state of **Aggravated Suppression**[17]. The IAJ Standard prevents this **Aggravated Suppression** by conducting substantive international-law analysis under the full UNCAT standard first.
- **Judicial branch Impunity:** The Standard specifically identifies how "Separation of Powers" and self-conferred judicial immunities prevent legislated encroachment into court operations, often fostering judicial impunity.
- **Filling the Accountability Gap:** Unlike other nations, the U.S. lacks an effective National Human Rights Institution (NHRI), making the IAJ's independent framework necessary to prevent the erasure of evidence.

2. Technical Differences from the Istanbul Protocol

While the Istanbul Protocol is the foundational global standard, the IAJ Standard introduces several technical enhancements required for the U.S. legal environment:

Feature	Istanbul Protocol (IP)	IAJ Psych Standard
Primary Intent Standard	Purpose-based intent.	Purpose-based intent, but utilizes the Dual-Track Rule to convert findings for U.S. domestic "specific intent" or "deliberate indifference" requirements.
Biological Harm Proof	General clinical correlation.	Causation Synthesis using structured literature-informed clinical attribution frameworks, including event anchoring and differential analysis — grounded in published statistical evidence demonstrating that severe stress causes measurable biological injury in susceptible individuals (e.g., Ackerman et al. 2002: $p < .0001$; Buljevac et al. 2003: RR = 2.2) — to determine whether institutional stressors plausibly precipitated, materially aggravated, or substantially contributed to documented biological deterioration. Where disease-specific literature exists, the relationship between severe stress and biological injury is empirically established, not

[16] This is an IAJ analytical category, not an established legal doctrine in the USA

[17] Aggravated Suppressions is an IAJ analytical category — it not an established legal doctrine in the USA. It is used to describe the investigative pattern of systematic foreclosure of treaty-based remedies.

		speculative.
Mechanism of Harm	Focus on direct physical/psychological torture.	Focus on Distress-Induced Harm ("Battery Without Touching")—physical injury (e.g., MS relapses, cardiac events) caused by non-physical procedural coercion.
Systemic Investigation	Incident-focused.	Systemic Harm Mapping Tool to visualize the "interconnected web of systems" (Courts, CPS, Police) that together inflict harm.

3. Specialized Procedural Innovations

The IAJ Standard introduces unique protocols to protect the integrity of the investigation in hostile domestic environments:

- **The "Witness Obligation":** It establishes a non-discretionary **Universal Duty to Document** for all care providers (Levels 1–4), regardless of their specialty or fear of legal summons. *This duty is ethical and professional rather than independently legal; it means documenting observed signs and reported allegations within licensed scope, and escalating to appropriately qualified personnel for forensic conclusions beyond the documenting clinician's competence.*.
- **Anti-Erasure Mechanisms:** Evaluators use the **Clinician's Incident Report Form (CIRF)** to document acts of institutional silencing or weaponized subpoenas as independent human rights violations.
- **Forum Nullus Determination:** The Standard defines specific data points to formally designate a domestic venue as a ***forum nullus***[18]—an area where the venue appears functionally non-remedial for the specific person and claims with respect to torture/CIDT prevention, investigation, protection, or redress. Example indicators include, but are not limited to, uniform rejection of ADA accommodation motions without individualized analysis, or systematic denial of procedural rights documented across multiple cases.

Important clarifications about torture and CIDT in the USA

Freedom from torture and CIDT[19] are recognized internationally as two of the few ABSOLUTE RIGHTS, meaning that no restrictions are allowed on these rights under any circumstances. A country does not even need to ratify the UNCAT treaty for these absolute prohibitions to be binding upon it.

[18] Forum Nullus is an IAJ analytical category, not an established legal doctrine in the USA. A valid Forum Nullus determination requires: (a) a documented pattern of adverse outcomes across a minimum of 3 similarly-situated cases, or a statistically significant sample with stated confidence interval; (b) documentation that adverse outcomes are not explicable by case-specific factors on individual review; and (c) notation in the Chronological Map with supporting case data. A Forum Nullus determination is an investigative finding subject to Level 4 Supervisory Falsification Pass review before inclusion in any report — it should not be a presumption and may not be asserted without the foregoing evidentiary support.

[19] CIDT = cruel, inhuman or degrading treatment or punishment

The psychological investigation of torture and CIDT in the United States requires considerations that differ from other contexts, because the U.S. implementation of UNCAT includes certain reservations, understandings, and declarations (RUDs) that affect domestic application. Stated simplistically, the IAJ observes that the USA falls short of compliance with international torture law, despite assurance to the world that it fully complies.

The United States has significantly deviated from standard international practice[20] by ratifying the Convention Against Torture (a human rights treaty) in 1994 using Reservations, Understandings and Declarations (RUDs)[21]. In so doing, the USA insisted that it fully complies with the Convention[22], but also represented to the world that it does so without fully implementing the treaty into domestic law. It proclaimed to the world that this is not necessary because its federal Constitution is so advanced that it already includes protections, relief, remedies and punishment for all prohibited acts under the Convention. Congress and the Executive branch both justified not creating domestic laws to implement the UNCAT by insisting that the USA does not wish to complexify domestic legal and other long-established mechanisms that already implement the Convention, and that Congress does not want to create two "**equivalent**" and parallel pathways[23] to accessing protections, relief, remedies and punishment for the prohibited acts, but only hold to the one established constitutional pathway.[24]

International critiques, including from the Netherlands[25] and Finland[26], have highlighted this as a fundamental error. Upon US ratification in 1994, the Netherlands objected to the US reservation to

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[20] Some consequences of the US 'misinterpretation' of the UNCAT include: Failure to criminalize torture consistent with Article 4 Failure to investigate under Articles 12 and 13 Failure to provide redress under Article 14 Admission of coerced evidence in violation of Article 15 Impunity for psychological torture Impunity for discriminatory torture Impunity for systemic torture in detention Policy-based judicial and institutional torture and CIDT

[21] https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4 – search the web page for "United States of America"

[22] See paragraphs 5 and 6 of the U.S. Department of State Initial Report of the United States of America to the UN Committee Against Torture -- https://1997-2001.state.gov/www/global/human_rights/torture_intro.html

[23] One under the US Constitution, and one under the direct enforcement ("self-execution") of the UNCAT

[24] When the UN treaty body finds issue with the ratification by Congress and the Executive, and the U.S. has removed any political question by assuring full compliance with the UNCAT, then under established precedent, the judicial process is constitutionally EXPECTED to correct any legal error by the other branches of government. Article VI of the U.S. Constitution states that treaties are part of the "supreme Law of the Land." However, the interaction is shaped by the nonselfexecuting declaration. A. Treaties are supreme law — but only if selfexecuting UNCAT is supreme law in principle, but: The nonselfexecuting declaration blocks judicial enforcement Courts treat UNCAT as binding on the political branches, not the judiciary B. CAT findings are authoritative interpretations of U.S. treaty obligations Under international law: CAT findings define what the treaty requires The U.S. is obligated to take corrective action Under domestic law: Courts treat CAT findings as nonbinding They may cite them as persuasive authority, but rarely do C. Executive and legislative branches remain bound Even with nonselfexecution: The Executive must implement the treaty Congress must legislate to fulfill obligations The U.S. must report back to the Committee D. Judicial avoidance creates a constitutional paradox The treaty is supreme law The Committee interprets the treaty The U.S. accepted the Committee's authority But courts refuse to apply the treaty This is the core structural contradiction the IAJ is documenting.

[25] From https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&clang=_en#EndDec - section entitled "Objections" subtitled "Netherlands (Kingdom of the)": With regard to the reservations, understandings and declarations made by the United States of America upon ratification: "The Government of the Netherlands considers the reservation made by the United States of America regarding the article 16 of [the Convention] to be incompatible with the object and purpose of the Convention, to which the obligation laid down in article 16 is essential. Moreover, it is not clear how the provisions of the Constitution of the United States of America relate to the obligations under the Convention. The Government of the Kingdom of the Netherlands therefore objects to the said reservation. This objection shall not preclude the entry into force of the Convention between the Kingdom of the Netherlands and the United States of America. The Government of the Kingdom of the Netherlands considers the following understandings to have no impact on the obligations of the United States of America under the Convention: II. 1 a This understanding appears to restrict the scope of the definition of torture under article 1 of the Convention. 1 d This understanding diminishes the continuous responsibility of public officials

Article 16, stating: "The Government of the Netherlands considers the reservation made by the United States of America regarding Article 16 of the Convention to be incompatible with the object and purpose of the Convention, to which the obligation laid down in Article 16 is essential." Similarly, Finland objected: "The Government of Finland therefore objects to the reservation made by the United States to Article 16 of the Convention." These objections, echoed by the UN Committee Against Torture (CAT) in its 2006 and 2014 reviews, assert that the US RUDs violate the Vienna Convention on the Law of Treaties by undermining UNCAT's core aim of absolute prohibition of torture and CIDT without derogation. The CAT's critiques of U.S. compliance are more extensive than country objections.

The United States' ratification of the UNCAT via Reservations, Understandings, and Declarations (RUDs) combined with the existing U.S. procedural framework yield the non-recognition of specific treaty-based individual remedies established under UNCAT Articles 13 and 14, and require diligent investigation into the nullification of inalienable personal rights to freedom from torture and CIDT. While the State Party represents to the world that its federal Constitution provides 'equivalent' protections, the reality is a documented absence of individual enforcement mechanisms: victims cannot personally bring actions for protection, relief, or remedy for treaty-level violations.

Because U.S. prosecutors routinely decline to prosecute these serious alleged violations of the 'supreme Law of the Land' (treaty obligations that may lack domestic enforcement mechanisms), a victim is forced into a state of 'Aggravated Suppression.' Under the current RUD framework, enforcement is only possible if another signatory nation petitions the U.S. on the victim's behalf—an insurmountable procedural hurdle that requires independent investigation and international reporting of the deviation of each state and federal court as potential *__forum nullus__* for human rights victims, and documentation of prosecutorial and legislative inaction and institutional limitations that perpetuate rather than prevent torture and CIDT. Since ratification of the UNCAT in 1994, the United States has not provided the necessary domestic mechanism of independent investigation as required by international law and treaty obligations, requiring the IAJ to be established by the People.

Beyond the UN Committee Against Torture (CAT), investigators must understand the broader international machinery that monitors the absolute prohibition of torture:

- **The Human Rights Committee (HRC) and the ICCPR:** The Human Rights Committee is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights (ICCPR) by its State parties. Because the absolute prohibition of torture is enshrined in Article 7 of the ICCPR, the HRC's General Comments and case law

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for behaviour of their subordinates. The Government of the Kingdom of the Netherlands reserves its position with regard to the understandings II. 1b, 1c and 2 as the contents thereof are insufficiently clear.

[26] From https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&clang=_en#EndDec - section entitled "Objections" subtitled "Finland": With regard to the reservations, understandings and declarations made by the United States of America upon ratification: "A reservation which consists of a general reference to national law without specifying its contents does not clearly define to the other Parties of the Convention the extent to which the reserving State commits itself to the Convention and therefore may cast doubts about the commitment of the reserving State to fulfil its obligations under the Convention. Such a reservation is also, in the view of the Government of Finland, subject to the general principle to treaty interpretation according to which a party may not invoke the provisions of its internal law as justification for failure to perform a treaty. The Government of Finland therefore objects to the reservation made by the United States to article 16 of the Convention [(cf. Reservation I.(1)]. In this connection the Government of Finland would also like to refer to its objection to the reservation entered by the United States with regard to article 7 of the International Covenant on Civil and Political Rights. [For the text of the objection see under "Objections" in chapter IV.4].

provide critical normative guidance for IAJ investigations. Evaluators should document where institutional conduct violates not only the UNCAT[27] but also the ICCPR's mandates regarding:

- Article 9: Protection against arbitrary arrest or detention.
- Article 10: The right of all persons deprived of their liberty to be treated with humanity and with respect for the inherent dignity of the human person.
- Article 14: The right to a fair trial and the provision of procedural accommodations, particularly for those with disabilities.
- **Regional Mechanisms:** The Inter-American System: For investigations within the Americas, the Inter-American Commission on Human Rights (IACHR) and the Inter-American Court of Human Rights represent the primary regional machinery.
- The Commission: IAJ utilizes the IACHR's specialized rapporteurships (e.g., on the Rights of Persons Deprived of Liberty) to benchmark U.S. institutional failures.
- The Court: While the U.S. has not accepted the contentious jurisdiction of the Inter-American Court, the Court's jurisprudence on "psychological integrity" and "forced disappearances" provides a robust legal framework for the IAJ's Biological Assault and Sovereign Withdrawal doctrines.
- **International Criminal Courts (ICC):** The International Criminal Court has the mandate to prosecute individuals for the most serious international crimes, including torture when committed as part of a war crime or a crime against humanity.
- Crime Against Humanity: Torture qualifies under Article 7 of the Rome Statute when committed as part of a widespread or systematic attack directed against any civilian population.[28]
- War Crimes: Under Article 8, torture or inhuman treatment of persons protected under the provisions of the relevant Geneva Convention is strictly prohibited.
- Forensic Significance: IAJ documentation of "systemic institutional patterns" is specifically designed to meet the evidentiary threshold required by international criminal bodies to demonstrate the "systematic" nature of the prohibited acts .
- **The International Committee of the Red Cross (ICRC):** The ICRC holds a unique international mandate under the Geneva Conventions to visit and monitor the treatment of persons deprived of their liberty.
- **Confidential Monitoring: Unlike the public reporting of the UN, the ICRC uses a system of confidential bilateral dialogue with authorities to prevent torture and improve detention conditions.**

[27] Note ICCPR Article 7 prohibits torture and cruel, inhuman, or degrading treatment or punishment

[28] The prohibition against torture and cruel, inhuman or degrading treatment constitutes a peremptory norm of international law from which no derogation is permitted. As the U.S. federal Second Circuit declared in Filártiga v. Peña-Irala, 630 F.2d 876, 890 (2d Cir. 1980), "the torturer has become, like the pirate and slave trader before him, hostis humani generis, an enemy of all mankind." This ancient designation—rooted in the law of nations that the Constitution itself empowers Congress to "define and punish" under Article I, Section 8, Clause 10—carries profound implications: those who commit torture stand outside the protection of ordinary legal process, subject to universal jurisdiction and prosecution. The IAJ observes that systemic violations of the UNCAT are taking place throughout the United States and are not reported or actioned internationally or domestically.

- **Technical Benchmarks: The IAJ incorporates ICRC technical standards for "humane conditions of detention" (e.g., minimum space, light, and ventilation) as clinical markers for Article 16 (CIDT) investigations .**
- **UN Special Rapporteur on Torture:** A "Special Procedure" that can issue urgent appeals and communications to the State Department regarding individual cases of ongoing biological assault. > *International Criminal Court (ICC) and Red Cross (ICRC): While primarily applicable in armed conflict, their definitions of "inhumane treatment" inform the global consensus on what constitutes a breach of* jus cogens* norms.

The United States' compliance with the United Nations Convention Against Torture (UNCAT) has been repeatedly criticized in authoritative international materials, including the CAT's Concluding Observations, and also formalized by the persistent objections of signatory nations such as the Netherlands and Finland[29]. These State parties have officially declared the U.S. reservation to Article 16 incompatible with the object and purpose of the treaty, asserting that the prohibition against cruel, inhuman, or degrading treatment is non-derogable . As the treaty body—whose authority the U.S. voluntarily accepted under Article 21[30]—the **Committee Against Torture**[31] has repeatedly found that the RUDs hinder full compliance[32] (e.g., CAT/C/USA/CO/3-5) [33]. Under **Article 19(c) of the**

[29] The Netherlands stated in its 1996 objection: "This reservation is contrary to the prohibition of cruel, inhuman or degrading treatment or punishment, which is not subject to derogation." Finland similarly objected in 1996: "In the view of the Government of Finland, the reservation to Article 16 is incompatible with the object and purpose of the Convention." These views align with the UN Committee Against Torture's repeated findings (e.g., CAT/C/USA/CO/3-5 in 2014) that the US RUDs hinder full compliance, potentially rendering them null under Article 19(c) of the Vienna Convention on the Law of Treaties.

[30] The U.S. sends high-level delegations (State Department, DOJ, DOD) to appear before the Committee, answer questions, and accept the Committee's findings. Together, these actions bind the U.S. to the CAT's oversight and findings as a matter of treaty law, and therefore require conformant implementation action by the USA. The Committee Against Torture is not a court, so its 'findings' are not judicially enforceable judgments within the United States. However, under international law, the U.S. has binding obligations to: A. Consider and respond to the Committee's findings (Article 19) The U.S. must: Receive the Committee's Concluding Observations Address each finding Report back on corrective measures This is a treaty obligation, not optional. B. Take "effective legislative, administrative, judicial or other measures" to comply (Article 2) UNCAT requires States Parties to prevent torture through: Legislation Judicial remedies Administrative safeguards Investigations Training Oversight mechanisms These obligations are binding, regardless of domestic political preferences. C. Conduct prompt, impartial investigations into violations (Article 12) The Committee's 2014 findings emphasized that the U.S. had failed to adequately investigate torture and illtreatment. Under Article 12, the U.S. must: Investigate Prosecute Provide redress Failure to do so is itself a treaty violation. D. Provide redress and compensation to victims (Article 14) The Committee found in 2014 that U.S. doctrines such as state secrecy and immunity prevented victims from obtaining remedies. Under Article 14, the U.S. must: Ensure enforceable remedies Provide rehabilitation Compensate victims This is a mandatory obligation. E. Prevent refoulement (Article 3) The Committee found U.S. violations of the prohibition on returning individuals to countries where they face torture. The U.S. must correct these practices. F. Establish independent investigative mechanisms (Istanbul Protocol) The Committee requires States to have independent, impartial, and effective mechanisms for investigating torture. The U.S. does not have such a mechanism, and this was a major point of criticism in 2014.

[31] The Committee Against Torture -- https://www.ohchr.org/en/treaty-bodies/cat

[32] The Committee Against Torture's 2014 Concluding Observations identify violations or serious concerns under the following Articles: Article 2 — General obligation to prevent torture Violations included: Lack of effective safeguards in police custody Widespread excessive force Solitary confinement Juvenile lifewithoutparole Systemic failures in detention oversight Article 3 — Nonrefoulement Violations included: Deportations and transfers to countries where torture was likely Inadequate individualized risk assessments Overreliance on diplomatic assurances Article 4 — Criminalization of torture Concerns included: No standalone federal crime of torture fully aligned with UNCAT Gaps in criminal liability for psychological torture and CIDT Article 10 — Training Violations included: Insufficient training for law enforcement, immigration officers, and medical personnel Lack of Istanbul Protocol implementation Article 11 — Systematic review of interrogation and detention Violations included: Use of prolonged solitary confinement Abusive conditions in immigration detention Lack of oversight of private prisons Article 12 — Prompt and impartial investigations Violations included: Failure to investigate CIA torture Failure to investigate police killings Failure to investigate deaths in custody Article 13 — Right to complain and be protected Violations included: Retaliation against detainees Barriers to filing complaints Lack of independent complaint mechanisms Article 14 — Redress and compensation Violations included: No effective remedies for victims of torture State secrets doctrine blocking civil suits No rehabilitation programs Article 15 — Exclusion of evidence obtained by torture Violations included: Use of coerced statements in immigration proceedings Lack of safeguards in national security cases Article 16 — Cruel, inhuman, or degrading treatment Violations included: Police brutality Excessive use of Tasers Shackling of pregnant women Juvenile solitary confinement Death penalty conditions In

Vienna Convention on the Law of Treaties, such incompatible reservations are, under the doctrine established in Article 19(c) of the Vienna Convention on the Law of Treaties — a document reflecting customary international law — subject to severability analysis by international tribunals to uphold treaty integrity[34]. Importantly, no U.S. court has yet adjudicated this international law question on the merits. The VCLT, while not ratified by the United States, reflects customary international law on treaty interpretation. The UN Committee Against Torture has formally concluded (CAT/C/USA/CO/3-5, ¶¶4–6) that these RUDs are inconsistent with the Convention's object and purpose and has recommended their withdrawal. No U.S. court has yet adjudicated this international law question.

Pending domestic adjudication of this question, IAJ investigators apply the unabridged UNCAT standard on the Substantive Truth Track — that is, the substantive international-law characterization of documented facts under UNCAT/IP; not a lie–truth judgment about the examinee and not a domestic legal verdict — while preserving domestic-track compatibility under the Dual-Track Rule (Module 2). Evaluators should present this as an international law position with strong authoritative support, not as settled domestic law, ensuring that the absolute prohibitions of *jus cogens* remain binding regardless of domestic attempts at limitation. [35][36]

That is why **the IAJ, when investigating torture and CIDT,** IAJ anchors its substantive analysis in the **textual interpretation of the UNCAT**[37], supplemented by guidance from the Committee

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short: the Committee found U.S. violations across nearly the entire treaty. The Committee's 2006 and 2014 reviews all document the same failures.

[33] In 2014, the CAT issued CAT/C/USA/CO/3-5: Concluding observations on the combined third to fifth periodic reports of the United States of America -- https://www.ohchr.org/en/documents/concluding-observations/catcusaco3-5-concluding-observations-combined-third-fifth

[34] The Concluding Observations by the CAT ('findings') are authoritative interpretations of U.S. treaty obligations. The U.S. is bound to take corrective action under Articles 2, 12, 13, 14, and 16. The U.S. must report back on progress. Failure to comply constitutes ongoing breach of an international treaty. Because the U.S. declared UNCAT nonselfexecuting, courts do not directly enforce CAT findings. However: (a) The Executive Branch is obligated to implement the treaty. (b) Congress is obligated to legislate to fulfill treaty commitments. (c) The U.S. must answer to the international community for noncompliance.

[35] Under binding treaty law, the United States must: Acknowledge the Concluding Observations by the CAT ('findings') Take corrective measures (legislative, judicial, administrative) Investigate and prosecute violations Provide redress to victims Prevent recurrence Report back to the Committee The U.S. has not fulfilled these obligations since 2006, which the Committee continues to note in subsequent sessions.

[36] In essence the Dual-Track Rule preserves the Substantive Truth Track (international) while acknowledging the Domestic Presentation Track (procedural) .

[37] How this supports the IAJ's institutional analysis of systemic noncompliance: The IAJ's analysis identifies a recurring U.S. pattern: Step 1 — Ratify a human rights treaty The U.S. ratifies UNCAT and accepts the Committee's oversight. Step 2 — Attach RUDs to block domestic enforceability The nonselfexecuting declaration ensures courts cannot apply the treaty. Step 3 — Claim compliance internationally The U.S. asserts that existing law is sufficient, but this assertion has drawn sharp international criticism: The Netherlands and Finland formally objected to the US RUDs upon ratification, viewing them as incompatible with UNCAT's purpose. The Netherlands objection noted that the US reservation to Article 16 "has the effect of lowering the protection against torture which the Convention aims to provide" Finland argued it "undermines the very essence of the prohibition of cruel, inhuman or degrading treatment." These critiques reinforce the UN Committee Against Torture's observations that US domestic laws fall short of UNCAT standards, particularly in addressing psychological torture and systemic CIDT without requiring "specific intent." Step 4 — Ignore or minimize Committee findings The 2014 findings documented widespread violations, but: No structural reforms followed No independent investigative mechanism was created No victims received redress No judicial doctrine changed Step 5 — Judicial behavior maintains the noncompliance Courts: Decline to cite UNCAT Uphold immunities that contradict Article 2 and 12 Allow evidence obtained by coercion in immigration cases Avoid reviewing national security abuses Treat CAT findings as irrelevant Step 6 — Systemic violations persist Because: No independent investigative mechanism exists No judicial remedy exists No legislative action occurs No executive enforcement occurs Step 7 — International bodies repeatedly find the same violations The Committee's 2006 and 2014 reviews all document the same failures. Why this matters for the People of the United States of America: The IAJ's work exposes the structural reality: The U.S. is bound internationally but unbound domestically. Judicial doctrine is the primary barrier to compliance. Behavioral biases and institutional culture drive the avoidance. Independent investigation is required under Articles 12 and 16 — and absent. The IAJ fills a treatymandated vacuum the U.S. refuses to

Against Torture and its Concluding Observations[38], rather than adopting narrower domestic reinterpretations that may under-protect against torture or ill-treatment (through RUDs) because, as the IAJ observes, RUDs inconsistent with the object and purpose of the treaty are vulnerable under international law and implicate **peremptory norms** (see 'treaty law').[39]

As an IAJ-appointed forensic psychological investigator you should follow the UNCAT definition of torture and CIDT, and assess torture and CIDT under the substantive standards reflected in UNCAT, the Istanbul Protocol, and related authoritative guidance, while separately documenting any divergence between those standards and narrower domestic doctrines or reservations that may affect legal uptake in a U.S. forum. This is important in the documentation of systemic violations of the UNCAT.

There is no exception allowed under any circumstances for Cruel, Inhuman, or Degrading Treatment or Punishment (CIDT). The same is true in the case of torture, except where the prohibited act is strictly required as a lawful sanction; however, an exception only exempts a perpetrator from a finding of torture if the sanction itself does not violate non-derogable human rights. Crucially, under *jus cogens*, no sanction can be deemed "lawful" if its implementation violates absolute human rights, irrespective of the domestic laws used to characterize the act. No derogation is permitted from the **UNCAT** or peremptory norms of customary international law (latin: "*jus cogens*") because torture and CIDT are **absolutely prohibited** worldwide.

In the United States, investigators encounter a unique obstacle in torture law. While **Article VI of the U.S. Constitution** establishes treaties as the "supreme Law of the Land," they sit co-equally with federal statutes. Domestic interpretation is further complicated by the doctrine of "self-execution" and the "last-in-time" rule. Current judicial interpretations frequently overlook the critical analysis provided in the **IAJ Amicus Curiae brief (IAJ-AMI-20260217-001-LEG)**, which identifies that international torture law must be applied by state and federal governments as a matter of constitutional necessity. Failure to do so creates a deep discordance with the roots of the Constitution and the Articles of Confederation's respect for the Law of Nations.

The American judiciary often holds that treaties are not automatically enforceable without implementing legislation. The U.S. Supreme Court has held that a treaty's status depends on its specific language and intent (*Whitney v. Robertson*, 124 U.S. 190; *Air France v. Saks*, 470 U.S. 392). Because Congress has not enacted comprehensive implementing legislation for UNCAT, many courts essentially ignore its mandates.[40] This practice has drawn sustained international criticism and is in tension with the United States' obligations under UNCAT on the international legal plane (plane a). In domestic litigation, however, many courts treat UNCAT as non-self-executing absent

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fill. This forensic mapping strengthens the IAJ's legitimacy and demonstrates the necessity of an independent investigative mechanism within the United States.

[38] UN Committee Against Torture (CAT) Concluding Observations on the USA (2006): In its 2006 review (CAT/C/USA/CO/2), the Committee expressed concerns over US RUDs, including the narrow interpretation of torture and CIDT, and recommended withdrawal or modification to ensure full compliance. Full document (PDF): https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Download.aspx?symbolno=CAT/C/USA/CO/2&Lang=En UN Committee Against Torture (CAT) Concluding Observations on the USA (2014): In its 2014 review (CAT/C/USA/CO/3-5), the Committee reiterated incompatibility concerns, urging the US to withdraw RUDs, ensure specific intent does not shield perpetrators, and align domestic law with UNCAT's absolute prohibitions. Full document (PDF): https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Download.aspx?symbolno=CAT/C/USA/CO/3-5&Lang=En

[39] See statement of 'treaty law' under the Vienna Convention on the Law of Treaties

[40] lending credence to the doctrine of forum nullus as a barrier to UNCAT compliance in the United States

implementing legislation; evaluators should therefore present UNCAT/IP conclusions on the Substantive Truth Track, while documenting how those conclusions are translated for domestic admissibility and remedy doctrines under the Dual-Track Rule.[41]

Despite these domestic limitations, the absolute prohibition on torture remains binding as customary international law. The IAJ recognizes that even if a treaty is non-self-executing, its application must be **equivalent and proportional** to the U.S. Constitution's protections. When courts fail to provide this equivalence, they facilitate **Aggravated Suppression**. IAJ investigators must therefore document the truth under the correct international standard—emphasizing **purpose-based intent** rather than domestic "specific intent"—while ensuring that findings of **Distress-Induced Harm** are supported by clear physiological pathways and clinical markers to satisfy *__Daubert__ *(see Appendix V) and FRE 702** reliability standards.

While U.S. domestic criminal statutes often require 'specific intent', IAJ forensic findings must be determined under the **UNCAT purpose-based standard**. For domestic legal proceedings, the evaluator must utilize the **Dual-Track Rule**[^40]: first determining if the institutional acts were *purposeful* under UNCAT, and then documenting if those acts fulfill domestic 'deliberate indifference' or 'reckless disregard' criteria. However, a much larger problem presents itself in the United States: the absence of necessary domestic criminal statutes as observed by the CAT. Therefore, while other guides on the psychological evaluation of torture may educate the investigator on legal testimony, the potential exists for the investigator's testimony not to be admitted at all because no domestic mechanism for prevention, relief, remedy or punishment of the prohibited acts may be available.

A forensic investigator therefore needs to be mindful that, contrary to international law, the USA RUDs significantly narrow domestic enforceability of torture treaty law[42] to such an extent that, potentially, if a psychological investigation follows the proper interpretation of the UNCAT (i.e. the IAJ approach), then the investigation may arrive at a psychological finding of torture and/or CIDT while official records and the government positions[43] and even expert testimonies recorded against the alleged or suspected victim may definitively proclaim the prohibited acts as being lawful, and warranted or justified[44]. Stated another way, if a psychological investigation follows the U.S. version of torture law, UNCAT Article 1 and 16 violations may be clinically determined, but not be

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[41] Although UNCAT remains an international obligation of the United States, U.S. courts may treat treaty provisions as not directly enforceable absent implementing legislation. The evaluator's treaty-based consistency analysis should be preserved as an international-law finding while being presented in a domestically admissible form consistent with Medellin v. Texas, 552 U.S. 491 (2008).

[42] When the U.S. ratified UNCAT, it attached RUDs that significantly narrow domestic enforceability. A. Nonselfexecuting declaration The U.S. declared UNCAT nonselfexecuting, meaning: It creates no directly enforceable rights in U.S. courts Individuals cannot sue under UNCAT Courts cannot apply UNCAT unless Congress passes implementing legislation This is the single most important limitation. B. Narrow definition of "torture" The U.S. added an "understanding" that: Torture requires specific intent Severe mental pain must involve prolonged mental harm CIDT (Article 16) does not require criminalization This narrows liability dramatically. C. Limitation on Article 16 (CIDT) The U.S. declared that Article 16 obligations apply only: "To the extent that the Constitution permits" And only to conduct within U.S. territory This excludes: Extraterritorial conduct Many national security operations CIA black sites (pre2009) D. No acceptance of individual complaints (Article 22) The U.S. did not accept the Committee's competence to hear individual petitions. E. Acceptance of Article 21 (interstate complaints) The U.S. accepted interstate complaints — but no state has ever filed one. Effect of RUDs RUDs allow the U.S. to: Ratify the treaty Claim compliance internationally Avoid domestic judicial enforcement Avoid accountability for systemic violations This is the core of the "ratify but do not implement" pattern.

[43] Note that the UN Special Rapporteur on the Independence of Judges reminded us in 2023 that all judgments and findings at law may be set aside under an investigation of human rights violations. Therefore the IAJ investigator must not yield to institutional, judicial or other governmental of official pressure and procedural momenta, but act as an exemplary and steadfast anchor for truth, while using confidentiality (to the extent possible) to precisely and completely establish the truth

[44] i.e. NOT torture or CIDT under domestic law

determinable as torture or CIDT under domestic law. In such a situation, the independence and the veracity of the investigation under the Istanbul Protocol is domestically undermined.

Noting this potential, the correct approach is for the investigator to follow the UNCAT and the Istanbul Protocol and the IAJ guidance. *The investigator should pay close attention to the guidance in the next chapter (Operational Rule: Navigating Domestic Proceedings While Preserving International Standards) which prioritizes UNCAT definitions over U.S. RUD distortions, and informs practitioners on how to navigate legal proceedings where domestic standards apply. This includes: how to present findings when courts apply narrower definitions; how to address conflicts between international and domestic standards in testimony; and how to preserve international law arguments while satisfying domestic procedural requirements.*

In synthesizing the RUDs, Congress identified the judicial process as the 'final safeguard'[45] against torture and CIDT if domestic mechanisms fail to prevent, remedy, relieve and punish torture and CIDT. But, as noted by the IAJ, the judicial process does not recognize the UNCAT as "self-executing"[46], and does not provide equivalent mechanisms under domestic laws for prevention, relief, remedy or punishment[47]. The IAJ observes that the judicial process systemically fails the safeguard of proportionality, discussed in other IAJ publications. Since courts ascribe finality to their judgments and precedents as the rule of law, court rulings may present challenges for investigation findings, and may affect how findings are weighted in legal proceedings.

No judicial influence or outcome must prevent or influence an independent investigation of torture or CIDT.

Investigation-independence requires independent and impartial determination of the facts by each investigator based on the most trustworthy data and reduction of information to the most self-integral and verified components. The IAJ investigator must recognize the contradictory environment in which the independent investigation of torture and CIDT is performed in the United States, but under no circumstances must the IAJ investigator approach the investigation with any implicit or explicit bias against any actor. The investigation is a pursuit of the truth without permitting influence by these identified factors that arise by virtue of US non-compliance with the UNCAT.

The forensic psychological investigation of torture and CIDT is further complicated in the United States. IAJ Investigators must follow the IAJ guidance on "intent" as follows.

UNCAT uses **two different mentalstate regimes**:

- **Article 1 (Torture)** → requires **intent**
- **Article 16 (CIDT)** → requires **no prohibited purpose element** (State responsibility still required — see Module 1 §B)

[45] Following, in part, the spirit of Marbury v. Madison (1803)

[46] i.e. no one can file a lawsuit or criminal prosecution for torture or CIDT if it occurs within the USA

[47] Judges do not: Treat UNCAT as binding international law Interpret ambiguous facts in light of Articles 1, 12, and 16 Recognize that intent can be inferred Understand that CIDT requires no intent Ensure access to complaints Ensure protection from retaliation Exclude evidence obtained through coercion Avoid intimidation and coercion to produce compliance with prohibited judicial policies

The U.S. RUDs distort this distinction by importing **specific intent** into Article 1 and treating Article 16 as optional. The USA also inappropriately included 'prolonged mental harm'[48] in its interpretation of Article 1, whereas the UNCAT text does not specify a duration requirement.

The IAJ follows what UNCAT Actually Requires:

A. "Intent" under Article 1 (Torture)

UNCAT Article 1 requires that the perpetrator **intentionally inflict** severe pain or suffering **for a prohibited purpose** (e.g., punishment, intimidation, discrimination).

This is **purpose-based intent** (the intent to achieve a prohibited goal such as punishment or intimidation), which is distinct from the higher "specific intent" standard found in U.S. domestic criminal law.

Under UNCAT, "intent" includes:

- **Knowledge** that pain will result
- **Willful blindness**
- **Deliberate indifference**
- **Reckless disregard** when combined with a prohibited purpose
- **Foreseeability** of harm

The U.S. RUD improperly attempts to replace the UNCAT's purpose-based standard with a domestic "specific intent" requirement, which creates a higher evidentiary barrier not found in the original treaty.

The United States has interpreted Article 1's intent requirement to require proof of 'specific intent'—that is, that the perpetrator must act with the conscious objective of causing severe pain or suffering for a prohibited purpose. This interpretation imposes a more demanding mental state standard than the UNCAT's text requires, which looks to whether the perpetrator 'intentionally' inflicted suffering for a prohibited purpose without mandating that this be the sole or primary purpose. The Committee Against Torture has consistently held that **intent can be inferred from the circumstances**, including from the nature of the act, its execution, and the foreseeable consequences, rather than requiring direct proof of the perpetrator's subjective mental state. The IAJ investigation follows the interpretation articulated by the Committee Against Torture as the authoritative construction of the treaty's requirements[49].

B. Article 16 (CIDT): No "prohibited purpose" element; State responsibility still required

Article 16 covers **cruel, inhuman, or degrading treatment** that does not amount to Article 1 torture. Unlike Article 1, Article 16 does not require proof that severe suffering was inflicted **for a prohibited purpose** (e.g., punishment, intimidation, coercion, discrimination). However, Article 16 still requires **State responsibility** — acts committed by, at the instigation of, or with the consent or

[48] This document uses "prolonged", "persistent" and "protracted" interchangeably to describe the same sequelae

[49] In fact, the U.S. Constitution agrees with the expectations of the CAT, and its 'findings' of USA's non-compliance with the treaty. The analysis was presented to the U.S. Supreme Court under the PAG's analyses of Article VI treaty supremacy. Note (v89): The U.S. Constitution operates on the domestic legal plane (plane b). Whether domestic courts give effect to UNCAT obligations is distinct from whether those obligations exist on the international legal plane (plane a). See IAJ-IRCT Lin Memorandum v9, Dimension IV.B.

acquiescence of a public official or other person acting in an official capacity — and the evaluation should document the institutional pathway by which harmful conditions were created, maintained, tolerated, or not prevented. The five Article 1 elements (any act; intentional infliction; severe pain or suffering; public official in official capacity; prohibited purpose) are reduced to four under Article 16: the prohibited-purpose element drops out, but the remaining elements including State responsibility remain. See IAJ–IRCT Lin Memorandum v9, Dimension I.C.

Under Article 16:

- Harmful treatment is prohibited **even if unintentional**
- Negligence, systemic conditions, and institutional practices qualify
- Discrimination, humiliation, or degrading conditions do not require purpose
- Structural failures (e.g., solitary confinement, shackling pregnant women) qualify regardless of intent

This is why Article 16 captures:

- Police brutality
- Prison conditions
- Juvenile solitary confinement
- Immigrationdetention abuses
- Medical neglect
- Discriminatory treatment

The focus is on the **effect and nature of the treatment** and the State's responsibility for it; the Article 1 "prohibited purpose" element is not required for Article 16 analysis, but the report should still document **knowledge, foreseeability, acquiescence, and institutional maintenance** of harmful conditions where supported by the record.

What the United States Did Through RUDs was to improperly narrow UNCAT's mentalstate requirements.[50]

A. U.S. RUD: Torture requires "specific intent"

The U.S. declared that torture requires: "Specific intent to inflict severe pain or suffering." This is **not** what UNCAT requires.

U.S. "specific intent" means:

- The perpetrator must have the **conscious objective** to cause severe pain
- Knowledge or recklessness is not enough

[50] This narrowing has been widely critiqued internationally as incompatible with UNCAT's object and purpose. Objections from the Netherlands and Finland exemplify this: The Netherlands declared the US understanding on intent and reservation to Article 16 as "incompatible with the object and purpose of the Convention," arguing it allows derogation from non-derogable norms. Finland echoed this, stating the reservation "is subject to the general principle of treaty law according to which a party may not invoke internal law as justification for failure to perform its treaty obligations." Such views, supported by the UN Committee Against Torture, underscore that UNCAT requires purpose-based intent (including knowledge and willful blindness), not the higher US "specific intent" threshold, to prevent impunity for psychological harm.

- Foreseeability is not enough
- Willful blindness is not enough

This is a **higher bar than UNCAT**, and it excludes many forms of torture recognized internationally.

B. U.S. RUD: Article 16 applies only "to the extent the Constitution permits"

This effectively guts Article 16.

Consequences:

- CIDT becomes optional
- No prohibited purpose element required (but State responsibility/acquiescence remains)
- Structural abuses (solitary confinement, police brutality, degrading detention) are not treated as treaty violations
- Courts treat Article 16 as nonbinding

This is one of the core U.S. violations identified by the Committee Against Torture.

U.S. Violations flow from these RUDs as follows:

Violation 1 — Failure to criminalize torture consistent with Article 1

The U.S. definition is narrower than the treaty definition.

Violation 2 — Failure to prevent CIDT under Article 16

The U.S. treats CIDT as discretionary.

Violation 3 — Failure to investigate under Articles 12 and 13

Because the U.S. narrows intent, many acts that UNCAT considers torture are not investigated.

Violation 4 — Failure to provide redress under Article 14

Victims cannot meet the U.S. "specific intent" threshold.

Violation 5 — Failure to exclude coerced evidence under Article 15

Immigration courts admit statements obtained through coercion because they do not meet the U.S. definition of "torture."

There are alternate Methods of Ascertaining Intent Under Article 1. Even with the U.S. RUDs, intent can be inferred using **international standards**, **criminallaw analogues**, and **Model Penal Code mental states**.

A. Internationally accepted indicators of intent

The Committee Against Torture recognizes:

- **Willfulness**
- **Knowledge**
- **Deliberateness**

- **Purpose inferred from circumstances**
- **Pattern of conduct**
- **Foreseeability of harm**
- **Failure to intervene**
- **Institutionalized practices**

Intent is rarely proven through direct statements — it is inferred.

B. Model Penal Code mental states (useful for Article 1 analysis)

1. Purpose

The actor's conscious objective is to cause harm. (Equivalent to U.S. "specific intent.")

2. Knowledge

The actor is aware that harm is practically certain. **UNCAT accepts this as intent.**

3. Recklessness

The actor consciously disregards a substantial risk. **UNCAT accepts this when combined with a prohibited purpose.**

4. Negligence

Failure to perceive a substantial risk. (Not enough for Article 1, but relevant for Article 16.)

C. Practical indicators of intent (used by CAT investigators)

- Use of restraints known to cause pain
- Prolonged solitary confinement
- Denial of medical care
- Threats, humiliation, or discrimination
- Coercive interrogation
- Systemic patterns of abuse
- Institutional policies that foreseeably cause suffering

These are recognized in the **Istanbul Protocol**, which the U.S. has not implemented.

Conceptualizing the "No Prohibited Purpose" Element of Article 16 may be done as follows:
Article 16 prohibits CIDT **regardless of intent**.

A. Key principle

If the treatment is degrading, humiliating, or causes severe suffering, **the prohibited purpose element is not required, but State responsibility remains**.

B. Examples of CIDT with no intent requirement

- A jail that routinely denies medical care
- A prison that uses solitary confinement for administrative convenience

- Shackling pregnant women during labor
- Juvenile isolation
- Overcrowded immigration detention
- Police using Tasers on restrained individuals
- Discriminatory treatment based on race or disability
- Conditions that cause psychological deterioration
- Institutional and judicial policies that are cruel, inhuman, degrading, and discriminatory

C. Why intent is irrelevant

Because CIDT focuses on:

- **Effect on the victim**
- **Nature of the treatment**
- **Power imbalance**
- **State responsibility**

The Committee has repeatedly held that **systemic conditions** constitute CIDT even without malicious purpose.

In summary:

Concept	UNCAT Standard	U.S. RUD Standard	Result
Intent (Art. 1)	Purpose, knowledge, willfulness, foreseeability	Specific intent only	Many acts of torture excluded
CIDT (Art. 16)	No prohibited purpose element required (State responsibility still required)	Only applies “as Constitution permits”	CIDT largely unenforced
Investigations	Mandatory	Discretionary	Systemic noninvestigation
Redress	Mandatory	Blocked by immunities	Victims denied remedies
International Critiques	Objections from States Parties (e.g., Netherlands/Finland) view RUDs as incompatible with UNCAT's object and purpose under Vienna Convention Article 19(c); no derogation allowed from absolute prohibitions	US maintains RUDs are valid and sufficient for compliance	Reinforces global consensus on US non-compliance; strengthens IAJ's use of full UNCAT standards over narrowed US interpretations, potentially influencing international accountability mechanisms

Why this matters for an IAJ psychological investigation is because this structure warrants **heightened methodological caution** when relying on institutional or judicial characterizations that

label severe suffering as "lawful" or "warranted."[51] The evaluator's task is not to treat such characterizations as dispositive, but to independently document clinical findings, institutional pathways, and the degree of consistency between alleged stressors and observed harm, while transparently stating limitations and alternative explanations. Specifically:

- The U.S. narrows intent to avoid liability.
- The U.S. treats CIDT as optional.
- Courts refuse to apply UNCAT because of RUDs.
- Investigations and redress are systematically blocked.
- The Committee Against Torture repeatedly finds violations.
- Independent investigation (IAJ) becomes necessary under Articles 12 and 16.

This is the pattern of systemic noncompliance that appears to be indicated nationwide by the volume of cases incoming to the IAJ, and which the IAJ seeks to investigate and document, and thereby provide education for any necessary national reform. The implication is that an IAJ psychological investigation must not give full faith and credit to any institutional or judicial findings of facts that may in any way influence the independence of the psychological investigation. On the contrary, the IAJ investigator must consider that policy-based torture may be in effect and therefore the psychological investigation must also evaluate signs of policy-driven conduct that is beyond the conventional considerations of intent and actor-driven harm. The investigator must retain notes, if any, about such observations for confidential reporting to the IAJ for other investigators to evaluate potential policy-based torture.

The USA also systemically undermines the investigation of torture and CIDT. Not only does the USA and its 50 states not provide "equivalent" remedy, relief and punishment for UNCAT violations, but they also fail the requirement of "proportionality"[52], and prompt, impartial and effective independent investigation.[53] IP **§661** provides that States should develop a strong legal framework for reparation:

"States should develop a strong legal framework to provide reparation for torture and ill-treatment, including civil proceedings that are independent of the outcome of any criminal proceedings, and the right of victims to rehabilitation. This should include effective procedural remedies, both judicial and non-judicial, to protect the right of victims to be free from torture and ill-treatment in law and practice and to provide reparation and rehabilitation for torture and ill-treatment committed against them. Domestic law should provide for the different forms of reparation recognized under international law and the reparations afforded should reflect the gravity of the violation(s)."

The IAJ concludes that current U.S. law and practice do not satisfy this standard.

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[51] Including the absence of cultural humility in judicial decision-making. In general, judges appear not to recognize: Implicit bias affects credibility assessments Trauma affects memory and presentation Disability cues can trigger cognitive shortcuts Cultural norms influence perceptions of "reasonable behavior" Cultural humility requires: Selfreflection Awareness of power dynamics Recognition of systemic patterns Accountability for impact, not intent

[52] See discussion of equivalence and proportionality in other IAJ publications, for example the February Amicus Curiae brief by the IAJ to the Texas Supreme Court, document ID IAJ-AMI-20260217-001-LEG.pdf - see https://iaj.institute/publications/IAJ-AMI-20260217-001-LEG.pdf

[53] Legal investigation IP §186, Prosecutors IP §256, judges IP §259, prompt, impartial and effective independent investigation (see IP §660, plus §§186, 256, 259, 177)

Additionally systemic violations of ethics undermine the UNCAT. For example, many common scenarios of U.S. non-compliance with IP §664-673 test the boundaries of ethics because the USA will not build forensic and clinical systems capable of documenting torture credibly, independently, and ethically, or supporting independent clinicians. This is one of the most important structural parts of the Istanbul Protocol because it defines how a State must reorganize itself to meet its legal obligations.

IP §664 — *States must build forensic and clinical systems capable of documenting torture, and they must support independent clinicians*

Core meaning

- International law requires States to **effectively investigate torture**.
- To do that, States must ensure:
- proper policies,
- proper practices,
- and sufficient institutional capacity for forensic and clinical documentation.
- This obligation **extends to supporting nongovernmental clinicians**, because:
- independence is essential for accountability,
- victims often do not trust State clinicians (since torture is a State crime),
- survivors have a **right** to independent health professionals.

Implications

- States cannot rely solely on their own forensic services.
- Independent clinicians are not optional—they are part of the State's compliance architecture.
- Trust and independence are treated as legal requirements, not preferences.

IP §665 — *State clinicians have a duty to document torture, and State institutions must reform to enable this*[54]

Core meaning

- State-employed clinicians encounter victims in many settings (prisons, hospitals, police custody).
- In *all* settings, they have a **duty** to investigate and document torture according to Istanbul Protocol standards.
- Therefore, State forensic institutions must:
- review and reform policies,
- ensure safeguards for proper evaluations,
- provide adequate training,
- uphold ethical principles.

Implications

[54] Note: IP §535 As such evaluations are an obligation of States, the cost of mandatory health evaluations should be borne by them.

- "I was just doing my job" is not a defense for failing to document torture.
- Institutions must change their internal rules to align with the Protocol.

IP §666 — *Independence from law enforcement is essential; lack of independence is a major barrier*

Core meaning

- One of the biggest obstacles to implementation is that State clinicians are **not independent**.
- Because torture is a State crime, clinicians under State authority may feel pressured to:
- ignore evidence,
- misrepresent findings,
- or avoid reporting.
- This is considered **complicity** under medical ethics (WMA).
- States must create an environment where evaluations are:
- independent,
- scientific,
- ethical.
- Forensic and clinical services must be **structurally independent** from:
- police,
- prosecutors,
- military authorities.

Implications

- Independence is not a "best practice"—it is a **legal requirement**.
- Structural reforms may be large, but they are nonnegotiable.
- This paragraph is a direct challenge to systems where police control forensic medicine.

IP §667 — *Independent forensic institutions must be properly resourced, and States must not obstruct NGO forensic services*

Core meaning

Independent State forensic institutions must have:

- authority,
- funding,
- qualified personnel,
- interpreters,
- equipment,
- diagnostic tools,

- and adequate time to conduct proper evaluations.

States must **not**:

- block the creation of NGO forensic services,
- or control who counts as a "qualified" NGO expert.

Implications

- Independence without resources is meaningless.
- States cannot monopolize forensic expertise.
- NGO clinicians must be free to operate without State interference.

IP §668 — *Evaluations must be prompt, objective, and standardized*

Core meaning

- Evaluations must occur **immediately**, and no later than **48 hours** after the allegation or initial documentation.
- Evaluations must be done by **qualified, independent governmental experts**.
- Clinicians must investigate **all** allegations or suspicions of torture—even without a formal complaint.
- Evaluations must follow Istanbul Protocol standards.
- States should consider **standardized report forms** based on the Protocol.

Implications

- Delay is treated as a form of obstruction.
- The duty to investigate is proactive, not complaintdriven.
- Standardization prevents manipulation and ensures quality.

IP §669 — *Procedural safeguards must be embedded in law and SOPs*

Core meaning

States must ensure that:

- domestic law,
- regulations,
- and standard operating procedures include the procedural safeguards required for effective medicolegal documentation.

Implications

- Safeguards cannot be informal or discretionary.
- They must be legally binding and operationalized.

IP §670 — *Victims have the right to independent evaluations, and States must inform them*

Core meaning

- Individuals have the right to be evaluated by **nongovernmental clinicians** of their choosing.
- This applies **during custody and after release**.
- States must:
- inform victims of this right,
- and provide referral information.

Implications

- Access to independent clinicians is a legal right, not a privilege.
- Failure to inform victims violates the Protocol.

IP §671 — *States must provide comprehensive training to all relevant health professionals*

Core meaning

Training must cover:

- interview conditions and skills,
- clinical qualifications,
- procedural safeguards,
- physical and psychological evidence,
- interpretation of findings,
- limitations and potential misuse of the Protocol,
- ethical obligations,
- resisting institutional pressure,
- and reporting pathways.

Training must include:

- forensic experts,
- all clinicians who may encounter victims (even in nonforensic settings).

Implications

- Training is not limited to forensic specialists.
- Ethical resistance to pressure is a formal training requirement.
- States must create support systems for clinicians who uphold ethics.

IP §672 — *Effective training requires interactive, mentored, multidisciplinary, and civilsocietyinclusive approaches*

Core meaning

Effective training involves:

- interactive classroom work,
- mentoring in real cases,

- "training of trainers" programs,
- joint training of health and legal professionals,
- participation of civilsociety clinicians.

Implications

- Training must be practical, not theoretical.
- Crossprofessional training builds shared understanding.
- Civil society enriches training and builds trust.

IP §673 — *Independent clinicians are essential partners, and States must support them*

Core meaning

- Independent clinicians are crucial for documenting torture.
- Their work is often essential for the State to meet its obligations.
- States should:
- support their training,
- facilitate their evaluations,
- ensure their reports receive **equal weight** in court,
- and support capacitybuilding and networking.

Implications

- NGO clinicians are not "secondary" or "optional"—they are central.
- Courts must treat NGO forensic reports as equally valid.
- States must actively support, not merely tolerate, independent forensic capacity.

Synthesis: What IP §664–673 collectively establish, which the USA does not comply with**:**

These paragraphs create the **State reform blueprint** for credible torture documentation:

- **Independence is the cornerstone:** Forensic and clinical services must be structurally independent from police, prosecutors, and military authorities.
- **Both State and nonState clinicians are essential:** The Protocol treats NGO clinicians as indispensable partners.
- **Prompt, standardized, ethical evaluations are mandatory:** Delays, interference, or lack of training violate international obligations.
- **States must reform laws, institutions, and procedures:** Compliance requires legal, administrative, and operational changes.
- **Training must be deep, multidisciplinary, and ongoing:** Ethics, skills, and resistance to pressure are part of the curriculum.
- **Victims have a right to independent evaluations:** And States must inform them of this right.

- **Independent clinicians' reports must carry equal weight in court:** This is a major safeguard against State manipulation.

The observed non-compliance of the United States with the United Nations Convention Against Torture (UNCAT) creates unique complications that are often overlooked. Based on reports to the IAJ, U.S. state and federal courts and institutions frequently operate in a "human rights vacuum" where treaty compliance is treated as optional or irrelevant. In this environment, institutional systems exhibit systemic human rights violations through rigid, invariant policies and procedures that lack any internal mechanism to correct themselves or align with international standards.

The Normalization of Prohibited Acts

Because some U.S. institutions may not fully integrate UNCAT as a binding authority, the evaluator must be alert to fact patterns in which prohibited acts may be recharacterized as lawful, including through the following mechanisms which have been observed across IAJ case investigations:

- "The Rule of Law": Violations are framed as standard judicial outcomes.
- "Administrative Correctness": Procedural harms are excused as necessary bureaucratic functions.
- "Lawful Sanctions": Cruel or degrading treatments are labeled as valid punishments, even when they violate the absolute prohibitions of UNCAT Article 1 and 16.

By labeling these acts as "lawful," the system can conceal their character as potential violations of international prohibitions against torture and ill-treatment and can impede recognition of the resulting harm. This normalization may obstruct prevention, relief, accountability, and evidence preservation. In domestic proceedings, evaluators should document the underlying facts and clinical consequences in neutral terms and separately state any international-law consistency analysis under the Dual-Track Rule.

The Failure of the "Equivalent Pathway"

The United States has asserted that domestic constitutional and statutory safeguards provide protections "equivalent" to the treaty's prohibitions. In practice, however, reports to the IAJ describe recurring gaps between (a) the protections and investigative duties contemplated by UNCAT and Istanbul Protocol-consistent practice and (b) the remedies, procedures, and accountability mechanisms that are realistically available or applied in certain domestic institutional and judicial settings. The evaluator should treat "equivalence" as an empirical and procedural question: document what protective pathway was purportedly available, whether it was accessible in practice, and whether the outcome prevented, mitigated, or redressed clinically documented harm. Where the record supports a pattern of functional non-remedial conditions, the report may describe the pathway as operationally ineffective for the specific person and claims, while preserving the treaty-based analysis under the Dual-Track Rule.

The Barrier of "Exhaustion of Remedies"

The requirement to "exhaust domestic remedies" before seeking help from international bodies (like the UN) becomes an insurmountable hurdle when those domestic remedies are:

- Ineffectual: The system is incapable of providing a meaningful fix.
- Inaccessible: The victim is procedurally blocked or lacks the resources (such as an attorney) to engage.

- Irreparable Harm: Pursuing domestic relief would subject the victim to further irreparable harm or Biological Assault.

When these conditions are met, the venue functions as a *forum nullus* — a venue that appears functionally non-remedial for the specific person and claims with respect to torture/CIDT prevention, investigation, protection, or redress. When these conditions are supported by the record, the IAJ may recommend parallel evidence-preservation and external review options. Any referral recommendation should be framed as an **investigative triage and preservation step**, not as a legal conclusion about jurisdiction, admissibility, or merits.

Legal Character of This Determination: A forum nullus designation is an IAJ analytical and legal triage conclusion about the practical adequacy of domestic remedies in the specific case; it is not a clinical diagnosis. It must be: (i) documented separately from clinical findings and labeled as legal/institutional analysis; (ii) reviewed by a Level 4 expert with relevant competence before inclusion in any report; and (iii) framed as operating on the international accountability plane, not as a claim that will be directly enforced in the domestic proceeding in which the evaluation is filed. Among its uses, this designation preserves a record of barriers, risk, and non-remedial conditions for later review, and — where the record supports it — may satisfy the exhaustion-of-domestic-remedies threshold for engagement with international mechanisms under applicable treaty procedures. See IAJ–IRCT Lin Memorandum v9, Dimension VI.D (exhaustion analysis); IAJ Disability Rights Thesis v49, §6.7 (remedies taxonomy).

The observed U.S. non-compliance with UNCAT and gaps in Istanbul-Protocol-consistent practices in some U.S. settings may leave survivors without timely, independent, clinically rigorous documentation. The IAJ framework is designed to preserve and standardize medico-legal evidence using Istanbul Protocol methods for subsequent domestic or international review, as applicable. See discussion referenced in the 2022 Istanbul Protocol chapter VIII.

The present state of torture and CIDT investigation in the USA is described in Appendix U. This Appendix provides important contextual background on the systemic factors affecting torture and CIDT investigations in the United States. Understanding this context prepares practitioners for the challenges they may encounter in conducting investigations.

Understanding these contextual factors enables practitioners to approach investigations with realistic expectations and appropriate strategies. The methodological guidance provided in subsequent sections addresses how to conduct thorough, ethically sound investigations within this environment.

The IAJ framework recognizes that while systemic challenges exist, rigorous documentation remains both possible and essential. The following sections provide step-by-step guidance for conducting psychological investigations that meet international standards despite these contextual constraints.

Application of UNCAT Definitions to Systemic Institutional Torture

The UN Convention Against Torture (UNCAT) Article 1 defines torture as intentional infliction of severe pain or suffering for specific purposes. The IAJ Standard requires explicit application of this definition to systemic stressors causing Distress-Induced Harm and operating through institutional processes.

Unlike acute physical assault, systemic torture derives its severity from accumulation. Individual acts viewed in isolation may appear benign— such as extended isolation, denial of recreation or rehabilitation, restricted diet, sleep interruption, absence of procedural adaptations etc.. The evaluation must demonstrate that the cumulative effect of these stressors fulfills the UNCAT threshold of severity. Severity under UNCAT Article 1 must be assessed contextually, not isolated to individual incidents.

In the context of systemic torture and CIDT that are not stereotypical (i.e. effected under some form of physical custody via detention or imprisonment) the investigator must avoid bias and apply the same investigative principles as would be applied in conventional scenarios to other forms of control by a public official or other person acting in an official capacity that may include constructive or jurisdictional custody (e.g. in a civil setting) by a court. Note the absence of any requirement of control in the textual definitions of Article 1 and 16 of the UNCAT, and evaluate all relevant conduct by a public official or other person acting in an official capacity.

UNCAT Article 1 requires intentional infliction. In systemic institutional contexts, intent may be demonstrated through administrative orders perpetuating harmful conditions despite knowledge of psychological deterioration, policy decisions that systematically deprive individuals of basic psychological needs, and continuation of procedures known to cause severe psychological harm despite alternative methodologies available. Consider in your own mind what other factors in institutional contexts and policy-based systems could indicate intent, and investigate them for potential determination of intent.

Definition of Terms

Based on scrutiny of the Nowak Commentary[55], collected Travaux Préparatoires[56], and authoritative UN/ECHR sources, the derived definitions of the terms used in Articles 1 and 16 of the UNCAT are as follows:

1. CRUEL TREATMENT

Definition: Treatment involving the **intentional infliction of severe suffering**. The European Court of Human Rights has assessed "cruel" on the **same standards as "inhuman"** treatment - the key distinction is the **intensity of suffering**.

Key Elements:

- Intentional infliction of severe suffering
- High threshold of severity
- Does not require a specific purpose (unlike torture)

2. INHUMAN TREATMENT

Definition: Treatment that causes **"intense physical or mental suffering"** (Equality and Human Rights Commission).

Key Elements:

[55] The United Nations Convention Against Torture and its Optional Protocol, Nowak et al., Oxford Press 2nd Ed.

[56] See Yale Law School Lilian Goldman Law Library Collected Travaux Préparatoires at https://library.law.yale.edu/research-guides/collected-travaux-preparatoires

- Causes intense physical OR mental suffering
- Does not require specific purpose
- Falls between "degrading" and "torture" in severity

3. DEGRADING TREATMENT

Definition: Treatment that is **"extremely humiliating and undignified"** and **"arouses in the victim feelings of fear, anguish and inferiority capable of humiliating or debasing them"** (EUAA, eachother.org.uk).

Key Elements:

- **Humiliation** of the victim
- **Dignity** is compromised
- Causes feelings of **fear, anguish, and inferiority**
- **Lowest threshold** of the three categories

4. The Hierarchy (Intensity Spectrum)

Level	Term	Threshold	Key Element
1	Degrading	Lowest	Humiliation, dignity, feelings of inferiority
2	Inhuman	Middle	Intense physical/mental suffering
3	Cruel	High	Severe intentional suffering
4	Torture	Highest	Severe suffering + specific purpose

KEY SOURCE: Ireland v. UK (1978)

This landmark ECtHR case established the framework. The Court found that the "five techniques" (wall-standing, hooding, noise, deprivation of sleep, food) constituted **"inhuman and degrading treatment"** but **not torture** - because they did not reach the highest intensity threshold.

CRITICAL POINT: CAT Does NOT Define These Terms

UNCAT itself does not provide precise definitions - they come from:

- **European Court of Human Rights Article 3 jurisprudence**
- **Ireland v. UK (1978)** - foundational case
- **Subsequent CAT Committee interpretations**

5. Key Analysis Incorporating Systemic Practices

1. DEGRADING

- Document this through pattern evidence
- e.g. Disability discrimination in proceedings creates feelings of fear, anguish, inferiority

- e.g. Parental separation is inherently humiliating

2. INHUMAN - depends on documentation

- IAJ's psychological evaluations can establish "intense mental suffering"
- Individual vulnerability assessment helps show heightened impact
- Need to demonstrate severity

3. CRUEL - depends on severity

- Must show "severe" suffering, not just "intense" (see below)
- IAJ's medical/psychological evidence can support this

4. TORTURE - Most difficult

- Requires **both**: severe suffering + specific purpose
- Article 1 explicitly includes "discrimination of any kind" as prohibited purpose
- **But**: Must prove discrimination was the PURPOSE, not just the effect
- This is the highest barrier

5. IAJ's methodology is designed to assess these thresholds:

- **Vulnerability Assessment** → Shows heightened impact → supports "intense" or "severe" findings
- **Psychological Evaluation** → Documents mental suffering → supports "inhuman" or "cruel"
- **Pattern Analysis** → Shows systemic discrimination → supports "purpose" element for torture
- **Note:**
- For **degrading/inhuman/cruel**: A stronger case is present if evidence is documented
- For **torture**: Must prove discrimination was the **purpose**, not just an effect - this is meant to be the highest barrier

6. Distinction between INTENSE and SEVERE suffering

This distinction matters because different legal regimes use these terms differently, and the threshold for **torture** versus **CIDT** often turns on the *degree* of suffering.

A. Core Distinction in International Law

Although the terms sound similar, they are not interchangeable.

Severe suffering

- This is the **legal threshold for torture** under the UN Convention Against Torture (UNCAT).
- It refers to **a high degree of physical or mental pain** that crosses a qualitative threshold recognized in international jurisprudence.
- "Severe" is a **term of art**: it is the *minimum* level of suffering required for conduct to constitute **torture** rather than CIDT.

Intense suffering

- This is a **descriptive term**, not a legal threshold.
- It refers to suffering that is **strong, acute, or overwhelming**, but **not necessarily severe enough** to meet the legal definition of torture.
- It is often used in psychological or clinical contexts to describe the *experience* of suffering, not its legal classification.

B. How the Istanbul Protocol Treats These Terms

The Istanbul Protocol uses **"severe pain or suffering"** as the operative phrase for torture. It does **not** use "intense suffering" as a legal threshold.

- **Severe** = legally required threshold for torture
- **Intense** = may describe the subjective experience, but does not determine legal classification

Thus, a person may experience **intense suffering** that does **not** reach the level of **severe suffering** required for torture.

C. Jurisprudential Interpretation

International courts and treaty bodies (CAT, HRC, ECtHR, IACtHR) consistently treat:

Severe suffering

As a **juridical threshold**, assessed by:

- duration
- physical or psychological impact
- vulnerability of the victim
- intentionality
- context (custody, coercion, discrimination)
- cumulative effects

Intense suffering

As a **descriptive qualifier**, relevant to:

- psychological evaluations
- trauma assessments
- credibility analysis
- CIDT determinations

But it does **not** independently establish torture.

E. The Cleanest Academic Distillation

Here is the distinction in one sentence:

"Intense suffering" describes the subjective magnitude of pain, while "severe suffering" is a legal threshold that must be met for conduct to constitute torture under international law.

7. Guide for psychological assessment

Here is guidance that a psychologist can actually *use* in a report, while staying within professional boundaries and avoiding legal determinations (which belong to adjudicators).

A. The psychologist does *not* label suffering as "intense" or "severe" as a legal threshold

Under the Istanbul Protocol, a psychologist:

- **documents** the nature, duration, and impact of suffering
- **does not classify** it as "severe" (the legal threshold for torture)
- **does not determine** whether conduct meets the definition of torture

Instead, the psychologist provides **clinical descriptions** that allow legal bodies to make the classification.

So the question becomes: **How does a psychologist document suffering in a way that allows others to determine whether it is intense or severe?**

B. The psychologist documents *observable and reportable indicators*, not labels

A psychologist should describe:

1. Intensity of subjective experience

- "The individual reported overwhelming fear…"
- "The distress was described as unmanageable…"
- "The individual experienced intrusive memories multiple times per day…"

2. Duration

- "Symptoms persisted for X months/years…"
- "The distress was continuous during the event…"
- "The individual reports no periods of relief…"

3. Functional impairment

- "Unable to sleep more than 2 hours per night…"
- "Unable to perform daily tasks…"
- "Marked impairment in concentration, decisionmaking, or selfcare…"

4. Physiological and psychological manifestations

- panic attacks
- dissociation
- hyperarousal
- somatic symptoms

- crying spells
- cognitive disorganization

5. Vulnerability factors

- age
- disability
- powerlessness
- dependency
- isolation

These are the elements that allow adjudicators to infer whether suffering is "intense" or "severe."

C. How to document "intense suffering"

"Intense" is a **clinical descriptor**, not a legal threshold.

A psychologist documents it by describing:

Indicators of intense suffering

- acute emotional overwhelm
- marked distress during or immediately after events
- strong physiological arousal (trembling, sweating, heart rate increase)
- crying, panic, or visible fear
- shortterm functional disruption

Example documentation language

"During the described events, the individual experienced overwhelming fear, crying uncontrollably, and reported feeling unable to breathe. These reactions indicate intense psychological suffering at the time."

This is **descriptive**, not legal.

D. How to document "severe suffering"

"Severe suffering" is a **legal threshold for torture**, so the psychologist must avoid declaring it. But they *can* document the **clinical indicators** that adjudicators use to determine severity.

Indicators of severe suffering

- longterm psychological injury
- persistent trauma symptoms
- major functional impairment
- enduring fear, humiliation, or helplessness
- cumulative or escalating harm
- symptoms consistent with traumarelated disorders

- inability to recover without treatment

Example documentation language

"The individual reports persistent intrusive memories, chronic hypervigilance, and significant impairment in daily functioning for more than 12 months. These findings indicate profound and enduring psychological harm."

This allows the legal body to determine whether the suffering meets the **severity threshold**.

E. The Istanbul Protocol's preferred structure

A psychologist should document suffering using the IP's four pillars:

1. Consistency of the account

- Does the psychological presentation align with the described events?

2. Clinical findings

- Symptoms, behaviors, affect, cognitive patterns.

3. Functional impact

- How the suffering affects daily life.

4. Limitations

- What cannot be concluded; what alternative explanations exist.

This structure avoids legal conclusions while providing the necessary forensic detail.

F. The cleanest rule for psychologists

Here is the academically precise formulation:

Psychologists do not classify suffering as "intense" or "severe." They document the nature, intensity, duration, and functional impact of suffering using clinical descriptors, allowing adjudicators to determine whether the legal threshold of "severe suffering" is met.

Navigating U.S. Treaty Reservations and Domestic Legal Requirements

The United States ratified UNCAT subject to significant Reservations, Understandings, and Declarations (RUDs) that substantially narrow the treaty's applicability in U.S. proceedings. The IAJ Psychological Investigation Standard provides guidance on navigating these limitations **while maintaining fidelity to international standards**.

The U.S. reservation to UNCAT Article 1 requires that torture involve "severe pain or suffering" inflicted "specifically" for prohibited purposes (obtaining information, punishment, intimidation, or discrimination). To satisfy the specific intent requirement under U.S. domestic law (18 U.S.C. § 2340), the psychological evaluation must identify distinct administrative choices that demonstrate knowledge and intent, document perpetrator awareness of the severe psychological consequences of their actions and establish that the harm was inflicted for a prohibited purpose.

Under the U.S. understanding of "mental pain or suffering" as codified in 18 U.S.C. § 2340A, the psychological evaluation in international proceedings must demonstrate "prolonged mental harm caused by or resulting from" the threatened or actual application of severe physical pain or mind-altering procedures. Important limitation: 18 U.S.C. § 2340A applies only to acts of torture committed outside the United States (see § 2340A(a): "outside the United States"). For conduct occurring on U.S. soil, the directly applicable domestic standards are: (a) the Eighth and Fourteenth Amendment "deliberate indifference" framework (Estelle v. Gamble, 429 U.S. 97 (1976)); (b) 42 U.S.C. § 1983 (civil rights claims for constitutional violations under color of state law); and (c) the Americans with Disabilities Act and Rehabilitation Act for disability-based institutional harm. Documentation must establish symptom duration meeting the "prolonged" threshold for international proceedings (DSM-5 criteria: one month duration), while also being mapped to the applicable domestic standard on the Domestic Presentation Track.

The U.S. declaration that UNCAT Articles 1 and 16 are not self-executing **does NOT eliminate the relevance of Istanbul Protocol standards, preclude psychological evaluations from citing international standards as authoritative guidance, or prevent courts from considering IP-compliant evaluations as evidence of professional standards**.

The critical consideration is that under international scrutiny, the reported non-compliance of the USA with the UNCAT requires every IAJ investigation to strictly establish an IP-based evaluation first, and then 'translate' under equivalence to determine reporting requirements for RUD-compliant expression of findings.

Mandated Safeguards Against Ill-Treatment

Mandate: Effective prevention of torture and CIDT requires strict adherence to specific procedural safeguards. IAJ investigations shall document the presence or absence of the following in any setting of **constructive**[57] **or physical custody**, treating the failure of any single safeguard as a clinical indicator of a high-risk environment:

- **Right of Notification:** The State must provide immediate notification of the reason for any detention, the specific nature of rights violations, and the non-derogable rights of the individual under both the U.S. Constitution and UNCAT.
- **Maintenance of Custody Records, Communications, and Records of Proceedings:** Authorities must maintain accurate, time-stamped logs of all movements, communications, and "handoffs" between officials across all agencies (e.g., Police to CPS to Court). The **absence or tampering** of these logs is a primary indicator of structural opacity used to facilitate prohibited acts.
- **Limits on Interrogation:** Questioning must adhere to ethical and legal boundaries, avoiding the use of "Procedural Force" or "Complexity Overload" to extract consent or confessions or coerced/intimidated compliance.

[57] Including jurisdictional custody by a court, including civil proceedings

- **Access to Counsel:** Prompt and confidential access to a lawyer is a recognized anti-torture safeguard. Any **institutional obstruction** of legal counsel—including the "Attorney-Representation Barrier" for indigent victims—shall be documented as an intentional facilitator of harm.
- **Right to Challenge Detention and Rights Violations:** This includes the use of *habeas corpus* and the affirmative right to challenge compliance with the **"supreme Law of the Land" (UNCAT)** without retaliation.
- **The Right to Medical Examination:** Litigants must have access to an **independent clinician (Level 3 or 4)** immediately upon entry into a system and following any reported use of force, coercion, or intimidation to prevent unmonitored **Biological Assault** (documented physiological harm pathway).
- **Mandatory Independent Investigation and Oversight:** In accordance with **IP §664**, every person alleging torture or ill-treatment has the right to a prompt and impartial examination by competent domestic authorities.

The absence of independent investigation and oversight becomes a critical factor for safeguarding against systemic torture and CIDT:

- **The Facilitator Role:** The IAJ identifies the **absence of a functional, independent domestic mechanism** (such as a National Human Rights Institution) as a structural **facilitator of torture**. Without external oversight, courts and institutions operate in a "human rights vacuum" where "invariant policies and procedures" can systematically violate rights with no internal self-corrective mechanism.
- **Absence as Evidence:** The persistent refusal to build forensic systems capable of independent documentation is characterized by the IAJ as **evidentiary of systemic non-compliance**. When those mandated to prevent torture (judges and prosecutors) obstruct independent inquiry, this constitutes **State Acquiescence** under **UNCAT Article 1**, transforming the venue into a *__forum nullus__*.
- **The NGO Necessity:** Because independence is essential for accountability and victims often do not trust State-affiliated clinicians, the right to an **independent health professional** is a legal requirement, not a preference.
- **Logical Consistency:** If the State is the alleged perpetrator, it cannot also be the sole investigator. The absence of an independent buffer (the mechanism) makes the continuation of **Distress-Induced Harm** mathematically predictable.
- **Legal Precision:** Under the **Law of Nations**, the duty to investigate is non-derogable. Using "Administrative Correctness" to block independent forensic documentation is a breach of **Article VI treaty supremacy**.
- **Forensic Probability:** During a **Supervisory Falsification Pass**, the Level 4 Expert uses the absence of independent oversight to increase the **Forensic Probability Rating** that institutional stressors were "knowingly maintained" for a prohibited purpose.

Supervisory Falsification Pass (SFP) — Operational Protocol: The SFP is a mandatory quality control process performed by a Level 4 Expert on every IAJ report before finalization. The SFP must:

- Be performed by a Level 4 Expert who did not conduct the primary evaluation;
- Produce a written SFP Record documenting: (i) what contradicting evidence was sought; (ii) what alternative explanations were considered; (iii) what revisions, if any, were required; and (iv) the reviewer's attestation that the report meets IP standards;
- Result in either: approval without modification; approval with required modifications documented; or rejection requiring full re-evaluation;
- Be attached to or incorporated by reference into the final report.

SFP Jurisdictional Scope: Licensure Considerations

Whether an SFP reviewer must be licensed in the same state as the primary evaluator or the subject is a **jurisdiction-specific legal question**. Because the SFP is limited to document review and methodological quality control — no contact with the subject, no treatment relationship, no clinical care — many jurisdictions may not treat it as in-state practice. However, the IAJ does not assume a blanket exemption from state licensure laws. This follows directly from the principle already established in this Standard (§ 3.2, § 3.3, Part G): forensic evaluation is not clinical practice, and the SFP is a methodological quality-control review — the reviewer reads a written report, applies bias-detection and IP-compliance criteria, and issues a written attestation. The reviewer has no contact with the subject, forms no therapeutic relationship, provides no diagnosis for treatment purposes, and renders no clinical care. The SFP is therefore even further removed from the regulated practice of psychology than the primary evaluation itself.

Accordingly, a Level 4 Expert licensed in any U.S. state, territory, or foreign jurisdiction — or credentialed by the IAJ, the UN Committee Against Torture, the IFEG, or an equivalent international body — may perform the SFP for any IAJ report regardless of where the primary evaluation was conducted. The SFP reviewer's home-jurisdiction license authorizes their professional practice; the document-review nature of the SFP is what permits them to operate across state lines without triggering any additional state licensing requirement.

IAJ Central SFP Panel

Because the SFP reviewer need not be co-located with, or licensed in the same state as, the primary evaluator, the IAJ can operate an IAJ Central SFP Panel: a nationally-distributed pool of Level 4 Experts who perform SFP reviews remotely and asynchronously for IAJ reports from any state. The Panel functions as a shared national resource, eliminating the need for a separately-licensed Level 4 reviewer in each of the 50 states. These experts may be licensed across a representative range of jurisdictions and/or credentialed internationally, and can service a national caseload operating on, for example, a rotating-assignment model.

The SFP Panel assignment process is as follows: (i) the primary evaluator submits the draft report and SFP package to the IAJ SFP Coordinator; (ii) the Coordinator assigns the report to a Panel member who did not participate in the primary evaluation; (iii) the Panel member completes the SFP Record (items (b)(i)–(iv) above) within a defined turnaround window; (iv) the completed SFP Record is returned to the primary evaluator for attachment to the final report.

Tiered SFP for Routine Cases

To further reduce the burden on Level 4 Panel capacity, the IAJ recognizes a Tiered SFP for routine, lower-complexity reports (typically Template A cases with no Article 1 torture elements and no *Forum Nullus* determination):

- Peer Attestation SFP: A qualified Level 3 clinician (or Level 4 clinician who is not the primary evaluator) completes the SFP checklist and issues a written Peer Attestation confirming review of contradicting evidence and alternative explanations.
- Panel Co-Signature: The Peer Attestation is submitted to the IAJ Central SFP Panel, where a Level 4 Panel member reviews the attestation and the report summary and issues a brief Panel Co-Signature. The Panel Co-Signature satisfies the Level 4 SFP requirement without requiring the Panel member to conduct a full independent SFP of the entire report.
- Escalation Trigger: Tiered SFP is not available where the report includes an Article 1 torture finding, a *Forum Nullus* determination, a Biological Assault finding, or any finding the primary evaluator designates as high-stakes or novel. Those cases require a full independent SFP by a Level 4 Panel member.

This tiered model means that a single Level 4 Panel member can co-sign multiple Peer Attestation SFPs in the time it would take to perform one full independent SFP, materially multiplying Panel capacity without any reduction in quality-control coverage for high-stakes reports.

Daubert Sufficiency of the SFP Panel Model

For Daubert purposes, the SFP Panel model is designed to be consistent with the peer-review and quality-control standards that support FRE 702 reliability arguments. Whether the model satisfies Daubert in any particular proceeding is a question for the court; no court has yet been asked to adjudicate this question directly. The SFP Record is designed to provide the materials necessary for that determination. The features that support a Daubert reliability argument include: (i) the reviewer is independent of the primary evaluator; (ii) the review is documented in writing and is discoverable; (iii) the review applies explicit, pre-defined criteria (Items (b)(i)–(iv) above); and (iv) the reviewer's professional credentials and jurisdiction of licensure are disclosed in the SFP Record. No court has ever held that a peer-review function must be performed by a reviewer licensed in the same state as the expert whose work is being reviewed. Peer review in medicine, psychiatry, and forensic psychology is routinely performed across institutional and state lines as a matter of standard practice.

The SFP Record is a discoverable document in U.S. proceedings and should be prepared accordingly. The existence of the SFP Record constitutes the primary response to Daubert's error-rate and standards-and-controls factors.

Strategic Enhancement: The Reporting Rule

To strengthen forensic admissibility under **FRE 702**, investigators should not merely list these safeguards but apply the **Systemic Pattern Analysis**:

- **Documentation of Default:** If a court or institution uses "Administrative Correctness" to bypass these safeguards, document it as **Acquiescence** in a prohibited act.
- **Quantified Risk:** Document where the denial of prompt access to counsel or medical review resulted in a measurable "14-day window" of clinical decompensation [Note: Any statistical claim attached to this window must be traced to its primary source, properly attributed, and contextualized as supporting temporal association, not sole causation. Where the Ackerman et

al. (2002) MS exacerbation study is cited, the footnote must specify: "Ackerman et al. (2002) reported stressful life events occurred an average of 14 days before MS exacerbations vs. 33 days before a control date ($p < .0001$). This supports temporal association, not deterministic causation."].

Digital Evidence Protocol

Digital evidence is frequently the most significant evidence category in U.S. institutional abuse cases. Pursuant to 2022 IP Chapter III, the evaluator must seek to identify and document the following categories of digital evidence where available:

- Court records and transcripts (including audio/video recordings of proceedings);
- Electronic health records and medical documentation;
- Email and written communications between institutional actors;
- CCTV or video recordings;
- Social media posts relevant to the subject or institutional actors;
- Metadata (creation dates, modification dates) on key documents;
- Electronic filing system records establishing timing of institutional actions. All digital evidence must be documented with chain-of-custody information: source, date obtained, format, and custodian.

Where digital evidence is collected from open sources, the Berkeley Protocol on Digital Open Source Investigations (OHCHR, 2022) governs collection methodology. The Chronological Map (Template C, Appendix D) must incorporate digital evidence timestamps where available, as these provide independent temporal anchoring for causation analysis.

Constitutional Standards for Psychological Evidence Correlation

Conventionally, consideration of torture and CIDT focuses on detainees and prisoners, omitting entire demographics which are 'covered' under UNCAT and other human rights treaty protections . In particular, when "equivalence" and "proportionality" fail, then the psychological standard must ensure Constitutional mapping **as well as treaty mapping**.

Mandate: To establish actionable claims within U.S. judicial and administrative proceedings, clinical findings must be systematically correlated with specific Constitutional benchmarks. This "Constitutional Mapping" ensures that evidence of **Biological Assault** (documented physiological harm pathway) and **Distress-Induced Harm** is recognized not only as a treaty violation but as a breach of the "supreme Law of the Land" under the **Supremacy Clause** (Article VI of the U.S. Constitution).

I. Primary Constitutional Anchors

Evaluators must identify how documented psychological and physiological injuries intersect with the following protections:

- **Eighth Amendment:** Documentation of "Cruel and Unusual Punishment," specifically focusing on the "wantonness" of institutional stressors and the "Severity Floor" of resulting objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization) or clinical crisis.
- **Fifth and Fourteenth Amendments:** Violations of "Substantive and Procedural Due Process," the "Right to Life and Liberty," and "Equal Protection". Documentation must show how the denial of **ADA/CRPD** safe harbor constitutes **State Action** that knowingly facilitates a biological injury.
- **First and Fourth Amendments:** Correlating psychological sequelae with "Retaliatory Conduct" for protected speech or "Unreasonable Seizures" (including constructive or jurisdictional custody in civil settings).

II. The "Equivalency Gap" and the Incompleteness of RUDs

When formulating Reservations, Understandings, and Declarations (RUDs), Congress failed to map **UNCAT** equivalently to the Fifth, Eighth, and Fourteenth Amendments because those domestic frameworks lack an express prohibition against **"inhumane treatment"**. While conventional domestic focus is limited to the physical treatment of detainees and prisoners, international law covers entire demographics—including civil litigants and persons with disabilities—who are systemically omitted from U.S. domestic protections.

The Forensic Rule: When domestic "equivalence" and "proportionality" fail, the evaluator must perform a dual-track mapping:

- **Treaty Mapping:** Aligning harm with the **UNCAT Article 1 and 16** purpose-based standards, and incorporating consideration of other UNCAT Articles.
- **Constitutional Mapping:** Aligning that same harm with domestic criteria like **"Deliberate Indifference"** to establish admissibility and legal standing.

III. The Mandate for Specialized Competence

Achieving this correlation requires a level of legal and neurobiological education exceeding that of the mainstream legal profession, current model guidance, or conventional AI engines that rely on superficial treatises. The **IAJ** provides specialized training on the interplay between State/Federal Constitutions and *jus cogens* norms to ensure evaluators can defend the scientific and legal validity of their truthful findings.

IV. Judicial Duties Under the 2022 Istanbul Protocol (IP Chapter III, §§257–261):

The 2022 Istanbul Protocol establishes affirmative duties for judges that are directly relevant to IAJ investigations involving judicial actors. Under the IP:

- Judges must be provided with requisite independence, training, resources, and protection to adequately discharge their duties in accordance with the IP and its Principles (IP §257).
- Judges have judicial authority to order that suspects and detainees are not arbitrarily detained or transferred to places where they could be tortured (IP §258).

- Judges should be held responsible for failing to investigate, prosecute, and punish torture (IP §258).
- A judge must not admit evidence alleged to have been obtained through torture or ill-treatment in any proceeding (IP §259).
- If a judge suspects torture, they should initiate investigations or inform prosecutors (IP §259).
- The outcome of legal procedures should not be dependent on a prior full investigation of allegations of torture or ill-treatment (IP §261). Where an IAJ investigation documents judicial conduct, the evaluator should assess that conduct against these IP standards and document any deviations as part of the systemic analysis.

V. Determination of State Action

Because UNCAT applies to conduct by or with the acquiescence of **public officials**, the evaluation must explicitly document:

- the **identity and authority** of perpetrators, including judicial officers, administrative agents, court-appointed professionals, and private actors operating under state contract or color of state authority;
- whether nominally private actors (e.g., court-appointed evaluators, CPS contractors, guardian ad litem appointees) were acting pursuant to state-conferred authority, state policy, or state acquiescence — in which case state responsibility may attach under 2022 IP Chapter I §4 and UNCAT Article 1's 'acquiescence' standard;
- whether state officials with authority to prevent harm failed to do so, which may itself constitute acquiescence under Understanding II(1)(d) of the U.S. instrument of ratification; and
- Whether the harm was inflicted under **color of law** involving the use of "invariant policies" and "Procedural Force" to knowingly maintain harmful conditions.

Physical Documentation in Psychological Investigation

The IAJ Psychological Investigation Standard prioritizes the detection of psychological sequelae from systemic torture—including methods designed to leave no somatic markers. However, this psychological focus must function as a complement to, not a substitute for, physical examination findings. The investigator shall proceed under the presumption that psychological and physical evidence are interrelated in systemic torture scenarios, particularly where physical findings may be absent by design.

Where physical scarring or injury is absent, the investigator must explicitly document this absence not as a lack of evidence, but as potentially characteristic indicator of modern systemic torture methodologies.

Techniques including sensory deprivation, stress positions, prolonged isolation, temperature manipulation, and systematic sleep deprivation are specifically designed to leave no visible somatic markers while inflicting severe psychological harm. The absence of physical findings therefore

constitutes evidence of methodology—a finding that must be integrated into the psychological formulation.

The adaptation of this principle to distress-induced harm requires chronological accounting of physical symptoms and evaluation of correspondence with known etiologies and pathologies. With internal injuries that may only be discernible by medical imaging or other scientific testing, the medical history documenting every physical and mental symptom is paramount.

Equivalence of Psychological and Physical Evidence (2022 IP, Chapter IV — mandatory rule): Pursuant to the 2022 Istanbul Protocol, psychological evidence carries equal evidentiary weight to physical evidence. Where psychological evidence alone strongly supports the allegations of torture or CIDT, the forensic report must reflect that there is strong overall evidence of prohibited treatment. The evaluator must not characterize findings as inconclusive or insufficient solely because physical evidence is absent, inconclusive, or not examined. The 2022 IP explicitly states that it is erroneous to require both physical and psychological evidence to be positive before concluding strong support exists. A deliberate misrepresentation of the absence of physical evidence as proof that no torture occurred may itself constitute collusion with perpetrators (2022 IP, Chapter IV). This principle must be stated explicitly in every IAJ report where physical evidence is absent or limited.

Who may perform the psychological evaluations

Part A: Foundational Distinctions

1. Diagnostic Impressions vs. Psychological Assessment

Understanding this distinction is critical to the IAJ framework:

Element	Diagnostic Impression	Psychological Assessment
Nature	Tentative, preliminary, interpretive	Structured, formal, comprehensive
Basis	Limited information (interview, brief observation)	Multi-method: interviews, standardized tests, behavioral observations, collateral information, record review
Character	Hypothesis-driven ("consistent with…")	Objective, validated instruments, integrative
Status	Provisional, can change	Produces formal report with findings and conclusions
Evidentiary value	Not strong evidence	Forensic-grade evidence—structured, validated, methodologically defensible

Critical Point: A diagnostic impression does **not** satisfy the Istanbul Protocol's requirements for documenting severe pain and suffering. Only a full psychological assessment meets the standard.

2. Forensic Evaluation Is Not Clinical Practice

This distinction is the foundation of the IAJ's approach to evaluator qualifications:

- **Clinical practice** (treatment, therapy, diagnosis for care) = regulated by state/national licensing boards
- **Forensic or evaluative work** (assessment for courts, human rights bodies, investigations) = **not** the "practice of psychotherapy" or "practice of psychology" as defined by licensing statutes

A clinician performing a forensic evaluation is **not** entering into a therapeutic relationship and is **not** providing treatment. This is why:

- Out-of-state psychologists
- Out-of-state psychiatrists
- Out-of-state trauma experts
- **International experts**

are routinely brought into other jurisdictions to conduct forensic evaluations, including torture documentation.

3. The Istanbul Protocol Does Not Require Jurisdiction-Specific Licensure

The Protocol requires:

- Training in trauma
- Training in forensic documentation
- Competence in psychological assessment
- Independence
- Ability to testify to methodology

It does **not** require state-specific or country-specific licensure where the survivor resides. International human rights documentation is not regulated by state therapy boards or national licensing authorities.

4. Training for Non-Specialists:

Non-forensic clinicians with limited Istanbul Protocol experience may perform evaluations after completing the IAJ Basic Training Module (Appendix K). This module provides:

- Step-by-step guidance on core components
- Common pitfalls and how to avoid them
- Practice scenarios with feedback
- Awareness of Western test conflicts: Avoid over-reliance on DSM-5 tools in non-Western contexts to prevent misdiagnosis and align with IP cultural adaptations
- training module for the strategic use of the CIRF is provided in Appendix I.
- Practice cultural humility: Incorporate idioms of distress and avoid pathologizing coping mechanisms.

Part B: What the Istanbul Protocol Actually Requires

A diagnostic impression—or any single instrument—cannot satisfy Istanbul Protocol requirements. The Protocol mandates:

1. Detailed Trauma History

Including chronology, methods, perpetrators, and contextual factors.

2. Behavioral and Affective Observations

The evaluator must document demeanor, affect, psychomotor activity, dissociation, avoidance, hyperarousal, etc.

3. Structured Psychological Assessment

This may include:

- Validated trauma instruments
- Cognitive screening
- Personality structure assessment
- Symptom inventories
- Functional impairment measures

4. Consistency Analysis

A core requirement: Are the psychological findings consistent with the alleged torture?

5. Severity of Pain and Suffering

The evaluator must describe:

- Intensity
- Duration
- Persistence
- Functional impact
- Cumulative effects
- Exacerbation by ongoing threats or judicial actions

6. Clinical Formulation

A structured explanation of how the symptoms relate to the alleged acts.

7. Diagnostic Conclusions (If Appropriate)

These are **formal diagnoses**, not impressions.

8. Mandatory Causality Opinion (2022 IP, Chapter IV — required)

The report must include an explicit opinion on the possibility of torture or ill-treatment based on all available evidence. A report that documents symptoms, history, and findings but does not express a causality opinion — i.e., an opinion on whether the findings are consistent with (or higher on the consistency scale) torture or CIDT — is non-compliant with the 2022 Istanbul Protocol and is considered deficient under that standard. This causality opinion must use the IP's five-level

consistency language (Not Consistent With / Consistent With / Highly Consistent With / Typical Of / Highly Consistent (IP §543(e))). The evaluator must also produce a causality analysis that links evidence, symptoms, and conclusions as a coherent narrative, not merely a list of findings.

Part C: Psychological Tests Are Components, Not Assessments

A common error is treating a single instrument as equivalent to a full assessment. The IAJ framework recognizes this distinction:

Example: The PCL-5 (PTSD Checklist for DSM-5)

The PCL-5 is:

- A self-report measure of PTSD symptoms
- Based on DSM-5 criteria
- 20 items
- Used to screen, monitor, or contribute to diagnosis
- Requires interpretation by a trained clinician

The PCL-5 is **not** a psychological assessment. It **cannot**:

- Provide a diagnosis by itself
- Evaluate cognitive functioning
- Assess personality structure
- Document functional impairment comprehensively
- Conduct consistency analysis
- Meet forensic standards alone
- Satisfy Istanbul Protocol requirements

The PCL-5 is one data point within a larger evaluation process. The same applies to the IES-R, DASS-42, SCL-90-R, and other instruments. They **support** the assessment; they do not **replace** it.

Part D: Qualified Evaluators Under the IAJ Framework

IAJ Level Designations and External Credential Requirements

IAJ Level designations are internal workflow roles. They do not constitute independent professional credentials and do not supersede state licensure requirements.

IAJ Level	External Credential Minimum	Scope
Level 1	Licensed clinician, any mental health discipline	Documentation, observation, triage
Level 2	Licensed clinician with documented forensic training	Primary interview and testing under Level 3 supervision
Level 3	Doctoral-level licensed psychologist or psychiatrist	Full evaluation, attribution analysis, primary report

Level 4	Doctoral-level, board-certified or forensic fellowship-trained; international law competence required	SFP review, forum nullus analysis, high-stakes reports

The IAJ recognizes the following categories of qualified forensic evaluators:

1. International Human Rights Experts, for example

- **Former and current members of the UN Committee Against Torture** who hold credentials as clinical psychologists, psychiatrists, or physicians
- **Members of the UN Subcommittee on Prevention of Torture (SPT)**
- Experts who have served on **UN Special Procedures** related to torture, cruel treatment, or detention conditions
- Members of the IFEG
- Physicians for Human Rights: appointed experts
- Professionals with demonstrated expertise in **Istanbul Protocol** methodology, regardless of country of licensure

2. Academic Experts

- Professors of psychology, psychiatry, medicine, or related disciplines at accredited universities worldwide who have published peer-reviewed scholarship on:
- Torture and its psychological sequelae
- Trauma assessment methodology
- Human rights documentation
- The Istanbul Protocol or comparable forensic frameworks

3. Physicians and Mental Health Professionals with Relevant Expertise

- Clinical psychologists, psychiatrists, and physicians **licensed in any jurisdiction** who have:
- Training in trauma-informed assessment
- Familiarity with the Istanbul Protocol
- Experience documenting torture, CIDT, or severe trauma for legal or humanitarian purposes

4. IAJ-Credentialed Evaluators

- Professionals who have completed IAJ training in forensic torture/CIDT documentation and have been credentialed by the Institute for Advancement of Justice

5. No Geographic Limitation on Licensure

The IAJ explicitly rejects any requirement that forensic evaluators hold licensure in the United States or any particular jurisdiction. The relevant qualifications are:

- **Professional credentials** (doctoral-level training in psychology, psychiatry, or medicine)
- **Substantive expertise** in torture, trauma, and human rights documentation

- **Methodological competence** in Istanbul Protocol or equivalent forensic assessment frameworks
- **Ethical commitment** to objectivity, thoroughness, and human dignity principles

For example: A former member of the Committee Against Torture who is a citizen of another State and a professor and clinical psychologist or psychiatrist—regardless of where that person is licensed—possesses precisely the qualifications the IAJ framework requires. The same applies to members of the IFEG.

Part E: Who May NOT Independently Perform the Evaluation

Certain categories of practitioners **cannot** independently author an Istanbul Protocol-compliant psychological assessment:

1. Unlicensed or Pre-Licensed Practitioners

Category	Limitation
AMFT (Associate Marriage and Family Therapist)	Unlicensed; must practice under supervision; cannot independently diagnose; cannot conduct psychological testing; cannot issue forensic opinions
MFT Interns, Psychology Trainees	Same limitations as AMFTs
Students	Cannot perform independent forensic evaluations

These practitioners **may assist** under supervision:

- Gathering history
- Conducting interviews
- Providing supportive services
- Assisting in data collection
- Contributing observations to a supervising clinician

But they **cannot**:

- Author the report
- Sign the report
- Conduct psychological testing independently
- Provide diagnostic conclusions
- Provide forensic opinions
- Testify as the evaluator

Part F: The Mainstream Bias and How to Overcome It

1. The Problem: Gatekeeping Favors Domestic Licensure

U.S. courts and opposing counsel routinely challenge experts who do not fit the conventional mold. The **mainstream expectation** is that testimony regarding psychological harm will come from:

- Ph.D. or Psy.D. (or equivalently credentialed) clinical psychologists licensed in the forum state
- Psychiatrists (M.D. or D.O.) licensed in the forum state
- Licensed Clinical Social Workers (LCSW) in limited circumstances

This gatekeeping reflects several biases:

2. The Legal Basis for Cross-Jurisdictional Forensic Work

Bias	Description
Jurisdictional parochialism	Courts are more comfortable with local credentials
Conflation of forensic and clinical roles	Assumption that only someone who could treat the subject is qualified to evaluate them
Credentialing hierarchies	Ph.D. > Psy.D. > Master's-level; domestic > international
Unfamiliarity with human rights frameworks	Most U.S. attorneys, judges, and juries have no exposure to the Istanbul Protocol, UNCAT, or UN treaty body work

Forensic evaluators routinely cross state and national lines. This is standard practice in:

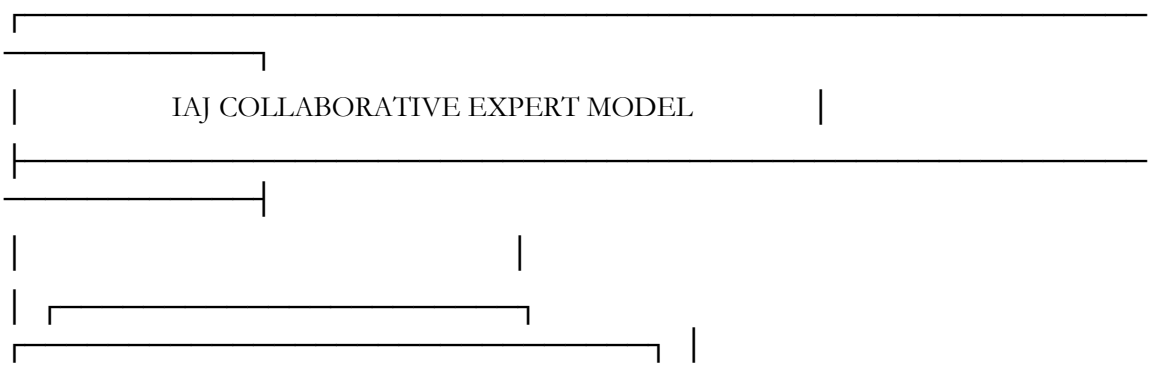
- Asylum evaluations
- Torture documentation
- Death-penalty mitigation
- Competency evaluations
- Civil rights investigations
- Police-violence cases

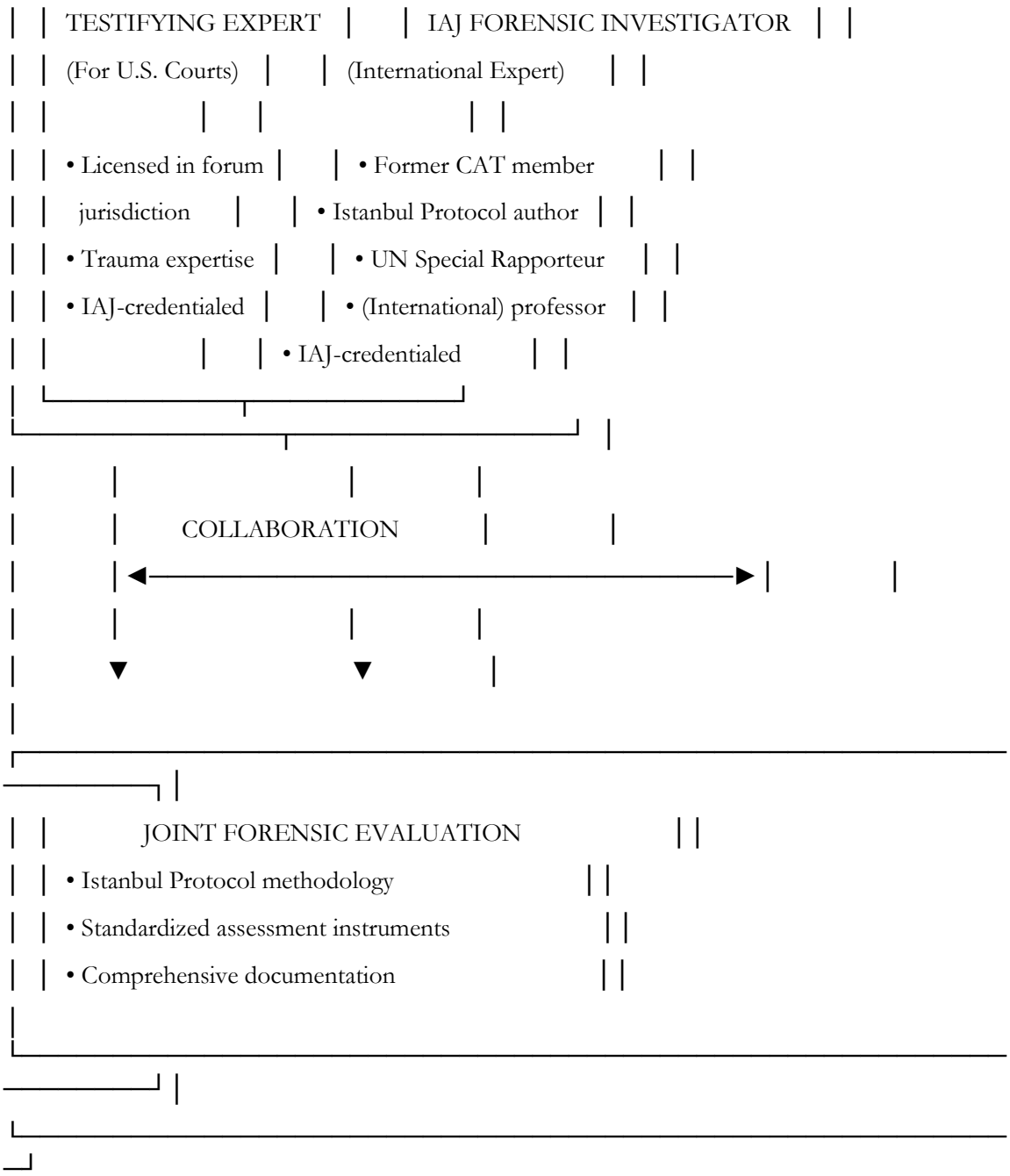
The evaluator's **home-jurisdiction license** is what authorizes them to practice their profession. The **forensic nature** of the work is what allows them to perform the evaluation in another jurisdiction.

The Istanbul Protocol does not require the evaluator to be licensed where the survivor resides.

Part G: The IAJ Collaborative Expert Model

To overcome structural barriers while ensuring the highest quality documentation, the IAJ employs a **Collaborative Expert Model**:





Evaluators should consider this model as a mandatory peer-review process . This allows a Level 3 clinician to "anchor" their findings to a Level 4 international expert, making it harder for domestic courts to dismiss the testimony as "unqualified".

Legal Basis: Federal Rule of Evidence 703

An expert may base an opinion on facts or data in the case that the expert has been made aware of or personally observed. **If experts in the particular field would reasonably rely on those kinds of facts or data in forming an opinion on the subject, they need not be admissible for the opinion to be admitted.**

This permits the Testifying Expert to:

- Rely on evaluations conducted by the IAJ Forensic Investigator
- Incorporate specialized knowledge of international experts
- Present testimony informed by expertise that might not independently satisfy U.S. credentialing expectations

Part H: Expert Witness Qualification in U.S. Courts

Federal Standard: FRE 702 and Daubert

Under **Federal Rule of Evidence 702**, an expert may testify if:

- Their specialized knowledge will help the trier of fact
- The testimony is based on sufficient facts or data
- The testimony is the product of reliable principles and methods
- The expert reliably applied the principles to the facts

The *Daubert* factors include:

- **Testability** of the theory/technique
- **Peer review and publication**
- **Known error rate**
- **Standards and controls**
- **General acceptance** in the relevant scientific community

The Istanbul Protocol satisfies the primary Daubert criteria as follows. Evaluators should be prepared to articulate each factor under cross-examination:

- Peer-reviewed (published by UN OHCHR)
- Generally accepted (international standard for torture documentation)
- Testable and replicable (detailed methodology)
- Subject to standards (explicit protocols)
- Known error rate mitigation: the IP requires malingering analysis and validity testing (Chapter IV), requires supervisory peer review (IAJ Supervisory Falsification Pass), and requires that inconsistencies be documented rather than resolved in the subject's favor. These procedural controls constitute the error-rate mitigation that satisfies Daubert Factor 3 as applied to structured clinical methodology. See Appendix V for extended Daubert analysis and model proffer language.

State Standards

Maxims for Objective Forensic Testimony

Standard	Test
Daubert (Texas, federal)	Reliability + relevance gatekeeping

Frye (CA, NY, IL)	"General acceptance"
Hybrid	Combination

While the truth and a high quality of diligent and ethical investigation under scientific neutrality should suffice to establish the presence or absence of torture and CIDT, the adversarial due process of law practiced in state and federal courts presents significant obstacles to the determination of the truth if institutions and courts have the potential to be non-conformant with the UNCAT in their policies and procedures.

Over decades, the adversarial nature of litigation has departed from the expectations of the People from their courts, reflected in part by the ABA report in 2023[58] of the perceived legitimacy of the judicial branch. Since domestic mechanisms for prevention, remedy, relief and punishment must be exhausted before referral for international action, the IAJ notes the materials provided by Physicians for Human Rights under their Module 9 of the Istanbul Protocol Model Medical Curriculum, which may be found on their website at https://phrtoolkits.org/toolkits/istanbul-protocol-model-medical-curriculum/module-9-report-writing-and-testifying-in-court/. These materials educate the investigator on:

- **Court Testimony Guidelines**: A "dos and don'ts" list for forensic experts under cross-examination.
- **Maxims for Medical Testimony**: Foundational rules for maintaining scientific objectivity while testifying.

To survive adversarial challenge and satisfy the *Daubert* standard, medical experts should adhere to these core maxims:

- **Maintain Scientific Neutrality:** The evaluator is a neutral forensic evaluator providing structured professional judgment, not an advocate for any party.
- **Explicitly Separate Roles:** Clearly distinguish between what the examinee *reported* and what the clinician *observed*.
- **Address Alternative Etiologies:** Proactively explain why common life stressors (e.g., poverty, divorce) do not better account for the documented brain lesion activity than the index institutional stressor.
- **Avoid Legal Conclusions:** Testify that findings are "Consistent with Torture" (a clinical finding) rather than "The defendant is guilty of Torture" (a legal finding).
- **Do Not Overstep Expert Qualifications:** The evaluator must not be drawn into making comments on subjects about which they are not qualified to offer an opinion. Do not offer any opinion on whether torture actually occurred versus limiting testimony to psychological symptoms and diagnoses.

[58] ABA President Mary Smith recently warned that "trust and confidence in the Supreme Court is at a historic low," citing national polling showing that "only 37% of respondents have a great deal or quite a lot of confidence in the Supreme Court—the lowest level recorded in the five years Marist has been asking the question." Mary Smith, President's Letter: A Code of Ethics Is Necessary to Restore Trust in the Supreme Court, ABA Journal (Oct. 1, 2023).

Cautionary note: We draw your attention to the fact a few English language terms and specific words have legal meanings that are very different from our ordinary use in normal communications. This document points those out and asks you to pay particular attention to how you use them in your reports and in providing testimony. For example, the word '**credibility**' as used in this text refers to the clinically assessed reliability, internal consistency, and contextual plausibility of reported information; it should not be used as a direct lie-truth judgment about the person under evaluation, and it does not by itself determine whether torture or CIDT legally occurred. If an evaluator opines in the courtroom or under deposition that torture credibly occurred versus opining that the examinee was credible in their testimony to the evaluator, the evaluator is making a legal determination which courts frown upon because they reserve the legal determination only to themselves. The evaluator is present in legal proceedings to **assist the court** in determining the truth of the matter (whether or not torture or CIDT occurred) based on their expertise. Therefore, your testimony should serve justice without advocacy.

Prohibition on Ultimate Legal Conclusions

IAJ clinicians are prohibited from testifying that 'torture occurred' or that a specific actor is 'guilty'. Following **PHR Module 9 Maxim 38**[59], the expert's scope is strictly limited to:

- documenting symptoms,
- providing clinical diagnoses, and
- offering a clinical opinion on the **degree of consistency** between the findings and the reported history.

The determination of whether those findings satisfy the legal definition of 'torture' is the exclusive province of the trier of fact.

Self-awareness of bias

IAJ evaluates "consistency" between psychological findings and torture allegations. This must only be performed subject to scientific neutrality. If clinicians expect to find consistency, they may, but this approach would in principle invalidate an important and essential investigation by virtue of confirmation bias. Remind yourself at all times that you must seek accurate, evidence-bounded findings without any conflict of interest or bias.

Malingering Protocol (2022 IP Chapter IV — mandatory): Where the evaluator suspects simulation, malingering, or self-inflicted injury, the following protocol applies:

- Validity instruments (SIRS-2, embedded PCL-5 validity scales, or equivalent) must be administered and results documented.
- Pursuant to 2022 Istanbul Protocol Chapter IV, if suspicion of simulation persists after validity instrument review, a second independent clinician — independent of the first evaluator and without access to the first evaluator's conclusions — must give a concurrent opinion before any malingering finding is included in the report. Both evaluators must give concurrent judgment and their reasoning must be documented.

[59] PHR Toolkits, Module 9, Appendix: Court Testimony Guidelines and Maxims: https://phrtoolkits.org/toolkits/istanbul-protocol-model-medical-curriculum/module-9-report-writing-and-testifying-in-court/appendix/

- A malingering determination based solely on one evaluator's clinical impression, without validity instrument support and without independent second review, does not satisfy IP standards and is vulnerable to Daubert exclusion.
- Where evidence is ambiguous, the report must document the ambiguity rather than resolve it against the subject.

Part I: Overcoming Challenges

Overcoming the Ziskin & Faust Adversarial Attack

Challenge	Response
"The evaluator is not licensed here."	Forensic evaluation is not "practice of psychology/medicine." The evaluator is not treating the subject. Under FRE 703, experts may rely on qualified professionals even if those professionals would not independently qualify to testify.
"The Istanbul Protocol is not accepted in the U.S."	The Protocol is published by UN OHCHR, endorsed worldwide, recognized as the international standard, and satisfies Daubert reliability requirements.
"This expert has never testified in a U.S. court."	Prior testimony is not a requirement. A former CAT member has more relevant expertise than a domestically-licensed psychologist with no torture experience.

Adversarial counsel may utilize the critiques of **Ziskin and Faust** to argue that psychological expertise is too subjective, lacks empirical validity, or possesses an unacceptably high error rate to satisfy **FRE 702/Daubert**. This undermines the applicability of the Istanbul Protocol and radically limits the investigation and presentation of the truth by use of psychological evaluation. The IAJ Forensic Standard can neutralize this attack by anchoring the evaluation in the **2022 Istanbul Protocol** and the **Integrated Findings Matrix**, shifting the focus from subjective intuition to **Causation Synthesis** and **Integrated Findings**.

1. Acknowledge and Anchor to Scientific Progress

- **Adversarial Question:** "Isn't it true, as Ziskin and Faust argue, that psychologists cannot agree on diagnoses and have no better than a 50/50 chance of being right?"
- **IAJ Expert Response example:** "While older critiques (such as Ziskin and Faust reviews) highlighted historical inconsistencies in unstructured clinical judgment—which helped the field become more accountable—their critique predates the global consensus established by the **2022 Istanbul Protocol** which includes use of validated instruments like the **PCL-5** and **WHODAS 2.0**."
- **IAJ Expert Response example:** "While older critiques highlighted the limits of unstructured clinical judgment, my findings are not based on unsupported intuition. They are based on structured professional judgment, documented chronology, collateral records, symptom-pattern analysis, differential consideration of alternative explanations, and review under the IAJ collaborative supervision model. Where I reference physiological stress pathways, I do so as part of a clinically reasoned explanatory framework, not as a claim of precise mathematical proof. My

conclusions are therefore grounded in transparent forensic method rather than in unsupported subjective impression."

- **IAJ Expert Response example:** "My findings utilize **Structured Professional Judgment** which are not based on unstructured clinical intuition, but on a **Functional Analysis of Behavior** and structured, peer-reviewed clinical attribution methods, including event anchoring, differential analysis, and—where disease-specific evidence exists—stress-mediated biological injury frameworks discussed in the medical literature[60]. These methods support a reasoned clinical attribution opinion; they do not substitute for records, chronology, or differential analysis. By using the **Collaborative Expert Model**, my findings were anchored to a **Level 4 Expert review**, a peer-review process that eliminates the idiosyncratic errors Ziskin warns about ".

2. Contrast "Subjectivity" with "Factual Primacy"

- **Adversarial Question:** "Isn't it true that psychological findings are purely subjective and based on self-reports from a person with an incentive to lie?".
- **Adversarial Question:** "Isn't it true that psychologists' diagnoses are notoriously unreliable and frequently contradicted by other experts?"
- **IAJ Expert Response example:** "While historical clinical judgment was less structured, my findings utilize **Structured Professional Judgment** and structured clinical attribution methods that produce documented, transparent, and reproducible reasoning rather than subjective impressions. These methods are structured professional judgment tools, not statistical models with published error rates, and are presented as such."
- **IAJ Expert Response example:** "By using the **IAJ Collaborative Expert Model**, these findings have undergone a mandatory peer-review process that neutralizes the idiosyncratic errors you are referring to. The findings explicitly address alternative causation and document malingering considerations."
- **IAJ Expert Response example:** "This evaluation adheres to the Dual-Track Rule and Factual Primacy. We do not rely solely on self-report; we utilize the **Integrated Findings Matrix** to anchor the examinee's statements in objective biological markers, such as MRI-documented lesion progression or cardiovascular markers anchored to the documented clinical timeline following identified stressors (note: the 14-day window $p < .0001$ cited here is one disease-specific example from the MS relapse literature; it is not a required window for other conditions or cases)".
- **IAJ Expert Response example:** "The **Dual-Track Rule** ensures that we don't rely on self-report alone; we map the **Biological Force** of institutional stressors through the documented neuroendocrine pathway. We acknowledge methodological limitations proactively."

3. Demonstrate known Error Rate Mitigation

- **Adversarial Question:** "How do you know you aren't just biased toward your client?"
- **IAJ Expert Response example:** "To eliminate the very biases Ziskin warns about, this report underwent a mandatory **Supervisory Falsification Pass** by a Level 4 Expert. This process

[60] including the 14-day statistical window ($p < .0001$)

requires the reviewer to actively seek evidence that *contradicts* the consistency finding to ensure a neutral, evidence-driven synthesis rather than a circular narrative".

4. The "Common Sense" Attack

- **Adversarial Question:** "Psychologists tell the jury nothing they don't already know through common sense, right?"
- **Adversarial Question**: "Don't you agree that a jury can figure out if a person is stressed without needing an expensive expert to tell them?"
- **IAJ Expert Response example**: "While a layperson can recognize distress, the neuroendocrine cascade triggered by institutional stressors requires specialized expertise to map. Lay common sense cannot determine whether a documented institutional stressor precipitated or materially aggravated biological deterioration in a susceptible individual, or identify how a Biological Assault leads to objective or clinically reliable biological deterioration (including, where applicable, medically documented injury or relapse activity) in distress-sensitive conditions"
- **IAJ Rebuttal:** "While a layperson can recognize distress, specialized expertise is required to map the internal **Biological Assault** (documented physiological harm pathway) and document the physiological harm pathway through which institutional procedure caused documented biological injury — including, where applicable, progressive neurological deterioration, cardiac events, or other medically documented harm with established stress-physiology mechanisms. See Appendix V for the causation framework and Daubert analysis."

5. Addressing the "Known Error Rate" (Daubert Factor 3)

- **Adversarial Question**: "There is no known error rate for this type of clinical speculation, is there?".
- **IAJ Expert Response example**: "The IAJ Standard mitigates the error rate through a mandatory **Supervisory Falsification Pass**. This protocol requires a neutral Level 4 Expert to actively seek evidence that *contradicts* the clinical consistency finding. Furthermore, our use of **Event Anchoring** and **Differential Etiology** ensures that alternative causes are systematically considered and addressed with documented reasoning (including differential analysis and explicit limitations), supporting the reliability of the evaluator's structured method; whether FRE 702 is satisfied in a given proceeding is a determination for the court**FRE 702**"

6. Addressing the "Junk Science" Attack

- **Adversarial Question**: " You are relying on a stress-mediated injury framework that is not a standard psychological test, correct?"
- **IAJ Expert Response example**: "The Solomon paper is a peer-reviewed statistical analysis that provides a literature-supported framework for examining stress-mediated disease activity in Relapsing-Remitting MS that may be used for examining stress-mediated disease activity in a susceptible individual. In this evaluation, it is used only as supportive background to event anchoring and clinical attribution, not as a stand-alone proof of causation."
- **IAJ Expert Response example**: " This methodology is consistent with published findings (e.g., Ackerman et al. 2002) reporting a statistically significant prospective association between stressful life events and MS exacerbation — events occurred an average of 14 days before

relapse vs. 33 days before control dates ($p < .0001$) — independently replicated by Buljevac et al. (2003; RR = 2.2; 95% CI 1.2–4.2). These are not preliminary findings. They are prospective, peer-reviewed, replicated results establishing that severe stress causes biological injury in susceptible individuals. Solomon et al. (2023) developed a case-level longitudinal attribution model for individual event anchoring. The evaluator's method draws on this literature; the court determines whether the method satisfies FRE 702."

7. The "Hired Gun" Attack

- **Adversarial Question:** "Isn't it true you only found 'consistency with torture' because that's what the IAJ Standard instructed you to find?"
- **IAJ Expert Response example:** "On the contrary, the IAJ Standard mandates a **Supervisory Falsification Pass**, where a Level 4 Expert must actively seek evidence that *contradicts* my consistency findings before the report is finalized."
- **IAJ Expert Response example:** "My professional duty is to the **Substantive Truth Track**; I provide a clinical consistency analysis based on the evidence, not a legal verdict for the court."

Note for Counsel: Legal Sufficiency Standards in Biological Harm Claims

The following note is addressed to supervising counsel, not to the evaluator. The evaluator documents clinical findings and provides a structured clinical attribution opinion. Counsel advances the legal theory: where institutional actors, with notice of a person's biological vulnerability, maintained conditions they knew or should have known would trigger documented physiological harm, the resulting injury is legally cognizable regardless of whether physical contact was made. The IAJ framework makes this argument evidentiary. The IAJ Standard distinguishes between the evidentiary thresholds of the laboratory and the courtroom. As noted in foundational jurisprudence: *"In a courtroom, the test... is not scientific certainty but legal sufficiency... the fact that science would require more evidence... is irrelevant"*.

1. Evidentiary Thresholds and Human Rights

- **Scientific Certainty:** Requires exhaustive exclusion of variables and high mathematical proof.
- **Legal Sufficiency:** Satisfied by the **"Preponderance of Evidence"**—the standard that a specific institutional stressor was "more likely than not" a **substantial contributing factor** to the harm.
- **Admissibility Rule:** Counsel may argue that relief should not be denied solely because a clinical trial for a specific stressor is unavailable; where the record supports a causal link via **Event Anchoring** and differential analysis, that argument may satisfy applicable legal burdens. The evaluator states the clinical attribution opinion; the legal sufficiency argument is counsel's to make.

2. Application to Distress-Induced Harm ("Biological Assault")

The IAJ framework operationalizes this principle through **Causation Synthesis**:

- **Mechanism over Biomarker:** An evaluator does not require a specific "laboratory biomarker" if they document a **Physiological Mechanism (the documented biological pathway: HPA axis activation → cortisol dysregulation → condition-specific pathophysiology →**

documented biological deterioration). This is the physical conduit of harm — how coercive procedure causes measurable injury without physical contact. The evaluator establishes the mechanism; counsel advances accountability anchored to a documented institutional trigger.

- **Material Contribution:** Counsel may argue that legal sufficiency can be satisfied where the record supports that institutional conduct materially contributed to documented deterioration, even if other multifactorial stressors were present.
- **Foreseeability as Force:** If a system was on notice that denying an accommodation (e.g., a medical stay) would likely trigger a relapse, the resulting biological deterioration may be clinically attributed to that documented chain of institutional stressors; how that clinical attribution translates to legal liability is a determination for counsel and the court.

3. Strategic Forensic Significance

This distinction neutralizes "gatekeeping" challenges during cross-examination :

- **Nullifying Procedural Defaults:** If a judgment was obtained via the physical incapacitation of a litigant (**"Fruit of the Poisonous Procedure"**), that judgment may be subject to challenge on international law grounds regardless of whether the science of stress is fully resolved in every medical journal. Whether a domestic court will give effect to that challenge is a question of domestic enforceability addressed under the Dual-Track Rule (plane b).
- **Preserving the Substantive Truth:** By focusing on legal sufficiency, the Standard preserves a clear evidentiary record that enables domestic or international reviewers to evaluate the clinical findings and institutional chronology.

Model Daubert Proffer for Distress-Induced Harm Testimony

Where the evaluator is called to testify regarding a Distress-Induced Harm finding, the following model proffer language should be used or adapted:

'My testimony regarding stress-mediated physiological harm is based on the following: (1) a clinical finding of [specific condition] with documented onset on [date], supported by [medical records/treating clinician records]; (2) a plausible biological mechanism — the HPA axis stress-response pathway — supported by peer-reviewed literature specific to [condition], including [cite studies]; (3) temporal anchoring — the onset/exacerbation is chronologically linked to the identified stressor(s) within a clinically coherent timeframe; disease-specific literature (e.g., [cite study]) may be cited as supportive plausibility background rather than as a determinative window; (4) individual vulnerability established by [subject's pre-existing diagnosis/baseline records]; and (5) differential analysis ruling out [alternative causes] as primary causes. My opinion is that institutional conduct was a substantial contributing factor to the documented harm to a reasonable degree of medical/psychological certainty. I am not offering a legal opinion on whether this constitutes torture or CIDT — that determination is for the court.'

Principle of Forum Neutrality and Investigative Independence

The IAJ Standard explicitly rejects the presumption that domestic judicial outcomes or findings of fact are inherently consistent with the **UNCAT** or the **Istanbul Protocol** . IAJ investigators must maintain independent clinical judgment and must not treat domestic adjudicative findings as dispositive of clinical conclusions for the following reasons:

- **Documented Pattern of Concern**: Based on documented patterns of **Aggravated Suppression** and judicial impunity, domestic forums are often unable to provide the procedural modifications required to prevent neurological decompensation.
- **Independent Clinical Assessment Principle**: An IAJ psychological investigation must not treat institutional findings as dispositive of clinical conclusions. Domestic findings are treated as one collateral data source; the evaluator independently documents clinical findings and notes any methodological divergence from institutional characterizations.
- **Structural Inversion**: Evaluators shall recognize that institutional actors responsible for maintaining "Safe Harbor" may, through invariant policies, knowingly facilitate a biological assault.

Part J: Conclusion

The IAJ framework brings the **most qualified expertise** to bear on torture and CIDT documentation by:

- **Rejecting parochial credentialing limitations** that exclude international experts
- **Recognizing the forensic-clinical distinction** that distinguishes forensic evaluation from clinical treatment, but does not assume a blanket exemption from state licensure laws; interstate forensic work must be structured through jurisdiction-specific rules, compact pathways where available (e.g., PSYPACT), and locally authorized clinicians where required
- **Employing collaborative models** that strategically position international expertise within legal proceedings
- **Ensuring evaluations meet Istanbul Protocol standards** through comprehensive, multi-method assessment—not diagnostic impressions or single instruments

The ultimate goal is ensuring survivors receive evaluations from **genuinely qualified experts**—those with deep knowledge of torture, trauma, the Istanbul Protocol, and international human rights law—regardless of where those experts are licensed.

Operational Rule: Navigating Domestic Proceedings While Preserving International Standards

The IAJ recognizes a practical reality in the United States: **domestic courts often do not apply the full UNCAT framework**, may use narrower domestic definitions, and may resist or exclude treaty-based characterization even where the underlying facts and harms are fully documented. This does **not** alter the evaluator's duty. The evaluator must continue to determine findings under the **correct international standard**—that is, the text of UNCAT, the Istanbul Protocol, and authoritative treaty interpretation—while also preparing the report so it can function inside a domestic forum that may apply narrower rules.

Accordingly, in U.S. proceedings, the evaluator should follow a **dual-track documentation rule**:

- **Substantive truth track (international standard):**

The evaluator determines whether the documented facts and clinical findings are consistent with torture and/or CIDT under **UNCAT Articles 1 and 16**, as interpreted through the Istanbul Protocol and the Committee Against Torture.

- **Domestic presentation track (procedural compatibility):**

The evaluator presents the same underlying facts, chronology, symptoms, impairment, causation, and risk in language that remains admissible, understandable, and useful even if the tribunal refuses the full treaty characterization.

Dual-Track Requirement: Evaluators must present the UNCAT conclusion explicitly in its own labeled section ('Substantive Truth Track — UNCAT/Istanbul Protocol Standard'), while utilizing the "Neutral Forensic Equivalent" (domestically accessible language) in a separately labeled section ('Domestic Presentation Track') intended for domestic adjudicative review.

MANDATORY PRESERVATION RULE: The Substantive Truth Track document must be independently preserved by the IAJ in its evidence database regardless of the outcome of domestic proceedings. The evaluator must label the Substantive Truth Track section: "Substantive Truth Track — UNCAT/Istanbul Protocol Standard" and the domestic section: "Domestic Presentation Track." This dual preservation creates the international accountability record required under UNCAT Article 20 and the CAT's Article 20 inquiry procedures. The evaluator must inform the subject of this preservation function as part of informed consent.

Preservation of Severity: Neutralizing the language does not permit the evaluator to lower the definition of harm or omit supportable treaty-based findings.

Factual Primacy: All converted statements must be supported by the specific chronology, symptom patterns, and functional impairments documented in the case file.

This dual-track method safeguards against potential domestic distortion. It is a method of preserving the integrity of the investigation while ensuring that domestic proceedings generate an evidentiary record that can later demonstrate **systemic noncompliance**, obstruction, minimization, or refusal to apply international standards.

A. How to Present Findings When Courts Apply Narrower Domestic Standards Domestic refusal to apply the international standard is anticipated. This Standard does not ask permission from domestic courts; it builds an evidentiary record that survives domestic non-engagement. The domestic refusal is itself documented as evidence: it is relevant to an acquiescence analysis, to the forum nullus determination, and to the international accountability record. Courts that ignore the international characterization do not extinguish it — they add to the documented pattern of systemic noncompliance.

When a court or agency applies a narrower domestic definition than UNCAT, the evaluator should **not alter the underlying factual findings** to fit the domestic standard. Instead, the evaluator should separate:

- **Observed / documented facts**
- **Clinical findings**
- **International-law consistency conclusions**

- **Domestic-law implications (if any), stated cautiously and only as framing, not as ultimate legal conclusions**

In practice, this means the evaluator should document:

- the alleged acts or conditions with specificity;
- the symptom pattern and functional consequences;
- the clinical severity of suffering;
- the role of institutional actors, public officials, or acquiescence;
- any evidence of intent, knowledge, foreseeability, deliberate indifference, or structural maintenance;
- whether the findings are consistent with **Article 1** and/or **Article 16** standards; and
- how the same facts may also be described in narrower domestic terms such as coercion, retaliation, abuse, discrimination, deliberate indifference, denial of accommodation, excessive force, medical neglect, unsafe conditions, or foreseeable psychological harm.

Required framing rule:

The evaluator should never dilute a supportable UNCAT conclusion merely because a domestic court may reject it. Instead, the evaluator should make the UNCAT conclusion explicit **and** provide a parallel factual/clinical formulation that remains usable in domestic proceedings.

Model phrasing:

- "Under the UNCAT / Istanbul Protocol framework, the findings are highly consistent with cruel, inhuman, or degrading treatment, and the Article 1 analysis is discussed separately below."
- "Even if the forum applies a narrower domestic standard, the documented facts independently establish severe psychological harm, functional impairment, and foreseeable institutional causation."
- "The clinical findings do not depend on whether the tribunal adopts the treaty terminology."

B. How to Address Conflicts Between International and Domestic Standards in Testimony

When testifying in a U.S. proceeding, the evaluator should be prepared for the possibility that opposing counsel or the tribunal will attempt to force a false choice between the **international standard** and the **domestic standard**. The correct response is not to abandon the treaty framework, but to explain the difference in scope.

The evaluator should make the following distinctions clear:

- **Clinical / forensic opinion vs. legal adjudication**

The evaluator may testify that the findings are consistent with torture or CIDT under internationally recognized clinical-investigative standards. The evaluator should also clarify that the court will decide what domestic legal label, if any, it assigns.

- **Wider international standard vs. narrower domestic standard**

The evaluator may explain that UNCAT and the Istanbul Protocol use broader and more protective definitions than some domestic doctrines, especially where U.S. law imposes heightened intent requirements or treats treaty obligations as non-self-executing.

- **Same facts, different legal uptake**

The evaluator should explain that identical clinical facts can support a conclusion of torture/CIDT under international law even if a domestic tribunal refuses to apply that label.

Recommended testimony formulation:

"My opinion is offered under internationally recognized torture-documentation standards, including the Istanbul Protocol and the Convention Against Torture. The underlying clinical findings—symptom pattern, severity, functional impact, chronology, and causation—remain the same regardless of whether this tribunal adopts the full treaty framework."

If pressed on domestic law:

The evaluator should not attempt to argue law beyond competence, but may state:

"I am not offering the court a binding legal conclusion under domestic law. I am explaining the clinical and forensic significance of the findings under the recognized international standard for torture and ill-treatment documentation, while also describing the same findings in factual and clinical terms the court may evaluate under its own framework."

Rule against forced collapse:

The evaluator should not allow cross-examination to collapse:

- torture/CIDT documentation into mere advocacy,
- treaty-based consistency findings into forbidden legal conclusions,
- or domestic nonrecognition into supposed clinical invalidity.

Domestic resistance to the treaty framework does not invalidate the evaluation.

C. How to Preserve International-Law Arguments While Satisfying Domestic Procedural Requirements

Where the report will be filed in a domestic court, the evaluator should ensure that the report is procedurally usable **without sacrificing the international framework**.

At minimum, the report should:

- comply with ordinary domestic procedural expectations for expert or forensic reports (clear methodology, sources reviewed, factual basis, reasoning, scope limits, and calibrated conclusions);
- distinguish clearly between:
- factual history,
- clinical observations,
- testing (if any),
- consistency assessment,

- causation analysis,
- and legal-framework discussion;
- present the treaty-based conclusion in a separate, clearly labeled section (for example: **"Consistency with UNCAT / Article 1 / Article 16 Framework"**);
- provide an alternative fact-based formulation that remains intelligible even if the court excludes or disregards treaty terminology;
- identify any narrower domestic doctrines that may affect legal uptake (for example, heightened intent rules, immunity doctrines, non-self-execution, or restrictive admissibility rules), without allowing those doctrines to redefine the clinical findings; and
- preserve the record by making the international-law basis explicit enough that later reviewers—including international bodies, NGOs, and foreign states—can see what standard was applied and how the domestic forum responded.

Preservation rule:

In hostile or narrow forums, the evaluator should not ask the court's permission to apply the correct investigative standard. The evaluator should apply it, disclose it, and also provide the factual and clinical analysis in a form that survives even if the court refuses the legal characterization.

D. Domestic Filing as Part of International Evidence Preservation

In the U.S. context, filing a torture/CIDT evaluation in domestic proceedings serves **two simultaneous functions**:

- **Immediate domestic function:**

to support whatever protection, accommodation, evidentiary correction, relief, or defensive use may still be possible in the present forum; and

- **International accountability function:**

to create a traceable record showing that torture/CIDT allegations were specifically presented to domestic institutions, together with clinically grounded evidence, and that the institutions either responded appropriately or failed to do so.

Where courts ignore, narrow, exclude, distort, or refuse to meaningfully engage the IAJ report, the evaluator must document that response using the following protocol:

- CIRF Entry: File a Clinician's Incident Report Form (Appendix H) documenting the specific court action (order, ruling, or conduct) that constitutes non-engagement with the treaty-based findings.
- Verbatim Record: Attach the relevant portion of the court record (transcript, order, or ruling) verbatim, not summarized.
- Analysis: Note in the CIRF whether the court's response constitutes: (i) procedural exclusion of treaty-based evidence; (ii) substantive rejection of IP-standard findings without analytical engagement; or (iii) implicit non-engagement (treating the findings as if they were conventional psychological testimony and omitting treaty analysis entirely).

- Preservation: The CIRF and attached record are transmitted to the IAJ evidence database and may be reported to the UN Special Rapporteur on Torture under IP Chapter VIII implementation procedures.

This documentation protocol creates the exhaustion-of-domestic-remedies record required for international human rights mechanisms, and transforms each instance of domestic non-engagement into affirmative evidence of structural non-compliance.[61]

E. Required Documentation of Domestic-International Tension

When domestic standards materially diverge from the UNCAT framework, the evaluator should document that tension in neutral forensic language.

The report may include a brief statement such as:

"This report applies internationally recognized torture-documentation standards under the Istanbul Protocol and the Convention Against Torture. The evaluator recognizes that domestic legal standards in some U.S. proceedings may be narrower than the applicable international standard. Accordingly, the report presents both (a) the treaty-based consistency analysis and (b) the underlying factual and clinical findings in a form usable under narrower domestic frameworks. Any refusal by a tribunal to adopt the treaty characterization does not alter the underlying clinical findings."

This preserves the international framework, protects forensic clarity, and strengthens the value of the report for later accountability review.

F. Non-Derogation Rule for Evaluators

The evaluator may adapt **presentation**, but not **substantive standard**.

- The evaluator may change organization, phrasing, emphasis, and level of legal exposition depending on audience.
- The evaluator may not lower the definition of torture or CIDT to match domestic under-enforcement.
- The evaluator may not omit a supportable treaty-based conclusion solely because it is unwelcome.
- The evaluator may, however, include a narrower domestic-facing description alongside the treaty-based conclusion to preserve admissibility and practical usability.

Core principle:

In the United States, the evaluator's task is to document the truth under the correct international standard, present it in a procedurally usable form domestically, and preserve the institutional response as part of the broader record of compliance or noncompliance.

[61] Where courts ignore, narrow, exclude, distort, or refuse to meaningfully engage the report, that response should itself be understood as potentially relevant evidence of systemic noncompliance with obligations of prevention, investigation, protection, redress, and non-repetition. For this reason, repeated domestic presentation of properly prepared torture/CIDT reports is not futile; it is part of the evidentiary architecture through which patterns of institutional refusal may be documented for international review, including Article 20-type systemic analysis.

IAJ Training Infrastructure: Capacity-Building in Hostile Environments

The IAJ identifies the development of trauma-informed psychological expertise as a critical "priority area" for international human rights implementation. This infrastructure is specifically designed for "hostile environments" where the State is unwilling to cooperate or is actively complicit in violations. By building independent, professionalized systems that operate autonomously from state permission, the IAJ fulfills the practical gap in the U.S. "accountability ecosystem". The training module in Appendix I ensures that clinicians can fulfill their "Universal Duty to Document" without succumbing to institutional suppression or personal professional risk.

Additional training modules for non-specialists include:

- Basic Istanbul Protocol Application: Covers core evaluation components for clinicians new to forensic work – Appendix K
- Systemic Torture Recognition: Identifying institutional patterns in U.S. contexts – Appendix M
- - Cultural Adaptations in Assessments: Recognizing conflicts between Western tests (e.g., PCL-5) and IP best practices, including scenarios of mismatch, bias, and re-traumatization – Appendix N
- Recognizing Dissociation and Related Symptoms: Covers IP §506 on dissociation, depersonalization, and atypical behaviour, with guidance on documenting these without undermining credibility – Appendix O

The IAJ **can issue a NOTICE OF HUMAN RIGHTS DEFENDER STATUS & ETHICAL SHIELD** (Appendix J) to protect clinicians facing termination or professional sanctions after filing a **Clinician's Incident Report Form (CIRF)**. This protocol operationalizes a degree of protection for human rights defenders established in the **Istanbul Protocol** and the **IAJ Ethical Standards**.

Strategic Mandate for Independent Capacity

The IAJ Training Infrastructure is not merely a pedagogical program; it is a **Forensic Safe Harbor** designed to maintain documentation integrity when domestic state boards or judicial authorities attempt to suppress evidence of **Biological Assault**.

- **Standardization of the "Witness Obligation":** Training ensures that all Level 1–4 providers apply the **Dual-Track Rule** identically, preventing "Methodological Drift" that adversarial counsel could exploit during *Daubert* hearings.
- **Protection of the Human Rights Defender:** By integrating local clinicians into the **IAJ Collaborative Expert Model**, the infrastructure shifts the professional liability for high-stakes torture findings from the individual provider to the **Forensic Lead Council (Level 4)**.
- **Correctness of Methodology:** Training explicitly addresses the **"Qualification Myth"**[62]**,** certifying that the authority to document a human rights violation is conferred by the **Law of Nations** and transcends state-specific therapeutic licensing.

[62] to better protect clinicians from "Weaponized Subpoenas" and "Credential Harassment."

Module 2: Investigation Methodology & Intent Analysis

Systemic Torture and CIDT: A Framework for Investigation

The IAJ defines systemic torture and CIDT as prohibited conduct that arises from the coordinated or cumulative actions of multiple actors, entities, institutions, and policies, wherein the victim is enmeshed in an interconnected web of systems that together inflict cruel, inhuman, or degrading treatment—treatment that may graduate to torture as the victim attempts to escape or resist, or as a natural consequence of progression along systemic pathways.

Characteristics of Systemic Torture/CIDT:

1. **Multi-Actor Involvement** — No single perpetrator bears sole responsibility; instead, harm results from:

- Sequential actions by different officials across agencies
- Parallel processes in different systems (e.g., child welfare and criminal justice)
- Institutional handoffs that compound harm at each transition
- Bureaucratic indifference distributed across personnel that accumulatively meet the "floor of severity" required for a finding under UNCAT

2. **Policy-Driven Conduct** — The harmful acts are not aberrations but predictable outcomes of:
    - Written policies and procedures that violate human rights
    - Unwritten institutional norms and practices
    - Incentive structures that reward harmful conduct
    - Accountability gaps that permit harm without consequence
3. **Institutional Entrapment** — The victim cannot escape because:
    - Multiple systems act simultaneously
    - Exit from one system triggers intervention by another
    - Legal processes prolong exposure to harm
    - Appeals and remedies require continued engagement with harmful systems
    - Economic or social circumstances preclude geographic escape
4. **Cumulative Harm Escalation** — Severity increases over time as:
    - Initial CIDT is compounded by additional violations
    - Psychological resources are depleted by sustained exposure
    - Attempts at resistance are met with intensified responses
    - What begins as degrading treatment escalates to inhuman treatment
    - What begins as inhuman treatment may escalate to torture

5. **Diffusion of Responsibility** — Accountability is obscured because:
    - Each actor believes they are "just following policy"
    - No individual actor intends the cumulative harm
    - Responsibility is shifted between agencies and officials
    - The system itself becomes the perpetrator, not any individual

Evaluating Systemic Torture/CIDT:

The evaluator must adapt the standard Istanbul Protocol approach when investigating systemic violations:

(a) **Expanded Timeline Construction:**

Create a comprehensive timeline documenting:

- All institutional contacts across all systems
- Actions by each official, agency, and institution
- Cumulative impact on the individual at each stage
- Escalation points where harm intensified
- Attempts at remedy and system responses

(b) **Multi-System Harm Mapping:**

Document the involvement of each system:

- Child welfare (CPS, DFPS, foster care)
- Criminal justice (police, prosecutors, courts, corrections)
- Civil courts (family court, dependency proceedings)
- Administrative agencies (licensing, benefits, housing)
- Healthcare systems (hospitals, mental health, mandated treatment)
- Educational systems (schools, special education)
- Immigration systems (detention, removal proceedings)

(c) **Policy Analysis:**

Identify policies and practices that enabled harm:

- Explicit written policies
- Implicit institutional norms
- Standard operating procedures
- Training materials
- Incentive structures
- Accountability mechanisms (or their absence)

(d) **Actor-by-Actor Analysis:**

For each official involved, document:

- Their role and actions
- Their knowledge of harm
- Their authority to prevent or mitigate harm
- Their failure to act when action was possible
- Their contribution to the cumulative harm

(e) **Cumulative Impact Assessment:**

Assess how the combined effect exceeded the sum of individual acts:

- Psychological compounding
- Loss of resilience and coping capacity
- Impossibility of recovery while harm continues
- Distinguishing systemic harm from individual incidents

To distinguish routine institutional stress from actionable harm, the evaluator shall only apply the Distress-Induced Harm framework where the injury meets the UNCAT Severity Floor: the documentation of permanent objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization) (e.g., MS relapse) or clinical crisis (e.g., acute cardiac event) or complex PTSD following an institutional trigger.

Distress-Induced Harm Causation Protocol — Daubert-Compliant Sequential Analysis: To distinguish routine institutional stress from actionable harm under the Distress-Induced Harm ("Battery Without Touching") doctrine, the evaluator must complete five analytically independent steps. This doctrine holds that where: (i) a person has a documented biological vulnerability; (ii) institutional actors had notice of that vulnerability; (iii) a documented coercive institutional act triggered physiological harm through a published biological pathway; and (iv) the resulting biological deterioration is documented in contemporaneous clinical records — Whether this mechanism satisfies a domestic legal doctrine (battery, deliberate indifference, ADA, UNCAT Art. 1) is a question for counsel — see Note for Counsel: Legal Sufficiency Standards. The evaluator establishes the mechanism; the legal label is counsel's. The five steps are, each documented separately in the report. A DIH finding is only warranted when all five steps are independently supported.[63]

- Step 1 — CLINICAL DOCUMENTATION: Document the specific physiological or psychological harm with clinical specificity (diagnosis, onset date, severity, treating clinician records where available). This step establishes that harm exists independent of causation analysis.
- Step 2 — BIOLOGICAL MECHANISM: Identify the plausible biological pathway linking the institutional stressor to the documented harm (typically the HPA axis activation pathway:

[63] For conceptual simplicity, we retain use of the term "Battery Without Touching" while officially referring to it as "Distress-Induced Harm". The retained term is for "internal IAJ shorthand" only, with "Distress-Induced Harm" mandatory in external reports or submissions

cortisol dysregulation → condition-specific pathophysiology). Cite the specific peer-reviewed literature supporting the mechanism for the subject's diagnosed condition. Condition-specific evidence is preferable to general stress-disease literature.

- Step 3 — TEMPORAL ANCHORING: Document that harm onset or exacerbation occurred within the statistically established temporal window following the identified stressor. For each condition, cite the specific study establishing the window (MS relapse: Ackerman et al. 2002/2003; Buljevac et al. 2003; Solomon et al. 2023, 14-day window, $p<.0001$). Absence of condition-specific temporal data requires explicit notation and limits the certainty rating.
- Step 4 — INDIVIDUAL VULNERABILITY: Document the subject's pre-existing condition, baseline status, and treating history establishing susceptibility to the harm pathway identified in Step 2. This step must be based on medical records, not solely on subject report.
- Step 5 — DIFFERENTIAL ANALYSIS: Address and rule out or quantify alternative causes of the documented harm. Where alternative causes exist, document their relative contribution. The conclusion must state the degree of confidence (High / Moderate / Low Certainty) with basis stated. Where any step lacks adequate evidentiary support, the finding must be qualified or withheld.

Essential Principles for the psychological evaluation

In alignment with the references identified herein, the psychological investigation under the 2022 Istanbul Protocol must:

- conform to high ethical standards
- including confidentiality, impartiality
- conform to high standards of medical practice[64]
- be conducted as soon as possible
- be under the control of the medical experts, not security personnel, court officials, public officials or institutional actors
- obtain voluntary informed consent prior to commencement of examination[65]
- identify specific purpose:
- Human rights reports
- Advocacy
- Media reports
- Investigation by international legal bodies

[64] Including standards applicable to psychotherapy and neuropsychology

[65] Per the PHR guidance (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf), informed consent requires that the consenting individual: Is competent Receives full disclosure of information, including risks, benefits, and clarification of the limits of confidentiality that may be imposed by State or judicial authorities. Understands the information provided Gives their consent voluntarily Provides authorization for their consent

- Future criminal prosecution of alleged perpetrators
- Education and systemic reform
- Any combination of the above
- photographs, recordings for clinical assessment
- Use of information
- Anonymous versus personal identification
- diligently attend to:
- Interview Settings[66]
- Safety of the alleged victim[67]
- Earning Trust & Building Rapport[68]
- Maintaining confidentiality[69]

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[66] The use of telemedicine may be practically necessary for conducting certain evaluations. For in-person evaluations, the PHR provides the following guidance (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Clinical evaluations of persons alleging torture or ill-treatment should be conducted at a location that the clinician and interviewee deem most suitable. Clinicians should document any adverse effects of the setting in their clinical evaluation. The room should have appropriate physical conditions (light, ventilation, size, and temperature). There should be access to toilet facilities and refreshment opportunities. The seating arrangement should allow the interviewer and interviewee to be equally comfortable and at an appropriate distance to establish eye contact and see each other's faces clearly. Neither the interviewer nor the interviewee should sit in a position that blocks access to the door. Attention should be paid to arranging the room in a way that it is not reminiscent of official surroundings or the interrogation process For telemedicine-conducted evaluations, the IAJ provides the following guidelines: Time, place and manner considerations that minimize harmful effects and stress on the alleged victim. Clinicians should document any adverse effects of the setting (and time, place and manner) in their clinical evaluation. Scheduling, rescheduling or continuing the investigation to keep the alleged victim as comfortable, stress-free and trauma-free as possible. Maintain visibility of as much of the interviewee's body in the field of view as possible for the purpose of observing non-verbal conduct and reactions in addition to facial expressions.

[67] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Consider the possibility of reprisals, especially among alleged victims. Do not conduct an evaluation if reprisals are very likely or certain. Check premises to ensure there is privacy Prepare emergency response plans including changing sites if privacy is compromised Do not promise a level of security that cannot be achieved If reprisals occur post-evaluation, document via the IAJ Clinician's Incident Report Form (CIRF) and escalate to UN bodies (e.g., CAT, Special Rapporteur on Torture) for protection under IP §679. Collaborate with NGOs (e.g., PHR, IRCT) for peer review of the evaluation and joint submission to international mechanisms to ensure accountability and deter future threats Safeguard identifying information Avoid Western-oriented tests (e.g., MMPI or structured interviews) that may re-traumatize through power dynamics or cultural mismatch; prioritize narrative approaches per IP §289, 329, 339, 368, 371 If using standardized tools, ensure cross-cultural validation to prevent ethnocentric bias and over-pathologization of cultural coping mechanisms (IP §287) Police or other law enforcement officials should never be present in the examination room Police presence during the interview and exam should be noted in the medical report and may be grounds for disregarding a "negative" report Under no circumstances should a copy of the medical report be transferred to the law enforcement official

[68] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Trust is an essential component of eliciting an accurate account of abuse and requires. Active listening and communication Genuine empathy Objectivity: maintaining professional boundaries Creating a safe and comfortable setting Allowing the interviewee to have control over the process (e.g. stopping or taking breaks) Build rapport with the interviewee from the moment you first meet: Introduce yourself and provide information about yourself Start the interview by discussing neutral topics (family, things they enjoy and value) Be mindful and respectful of the interviewee's cultural and religious background The IAJ observes that some alleged victims appear to be so traumatized that, upon sensing rapport and receptivity of the investigator, they will begin uncontrollably communicating information and their grievances with such momentum and energy that it is best to provide them with uninterrupted audience and a very patient and attentive demeanor. In such circumstances, the alleged victim is receptive and appreciative of relevant questions from the investigator within the context of the stream of information which should remain under the victim's control. The energy and momentum of the alleged victim dissipates, and a very information evaluation may be conducted by continuously providing the victim with opportunity to 'vent' as revisiting trauma occurs while increasingly asking clarifying questions. By flexibility in approach and proceeding from the points of greatest interest to the alleged victim, the disciplined investigator can create a map of the facts and the experiences of the victim.

- Mitigating the risk of retraumatisation as much as possible[70]
- Demonstrating cultural humility and sensitivity[71]
- Understanding important gender issues[72]
- Recognizing the special needs of children[73]
- Working effectively with interpreters[74]
- Appropriate demeanor[75]
- Understanding emotional reactions and their potential effects[76]

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[69] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Clinicians have a duty to maintain confidentiality of information and to disclose information only with the individual's informed consent. The individual should be clearly informed of any limits to the confidentiality of the evaluation and of any legal obligations for disclosure of the information. Police or other law enforcement officials should never be present in the examination room. Police presence should be noted in the medical report and may be grounds for disregarding a "negative" report

[70] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Clinical evaluations and diagnostic tests can re-traumatize victims of torture and symptoms may manifest during or after the clinical evaluation. Retraumatized individuals may mobilize strong defenses that result in profound withdrawal and affective flattening during examination or interview; alternatively, they may express hostility and anger. Examiners can prevent and mitigate re-traumatisation and psychological sequelae with effective communication, empathy and by allowing individuals control over their narrative account of the alleged events. When the interviewer suspects that re-traumatisation has occurred, it is important to acknowledge the concern, mitigate re-traumatisation (such as with breaks, breathing exercises and redirection to less emotional topics), offer psychological support, and refer the individual to appropriate follow-up care

[71] IP §525 notes that "The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of how the cultural background and language of the survivor shape the individual psychological expression of distress is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge of the alleged victim's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the alleged victim's country knows the language, customs, religious traditions and other beliefs that must be taken into account during the evaluation. Interviews may induce fear and mistrust on the part of victims and possibly remind them of previous interrogations. To reduce the risk of retraumatization, the clinician should communicate a sense of understanding of the individual's experiences and cultural background. It is inappropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy, during which the clinician is inactive and says little. The clinician should communicate in a transparent and empathic way and adopt a supportive, non-judgmental approach."

[72] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Sexual abuse is common among torture survivors, and this may influence the clinical evaluation. Same-sex interviewing is generally preferable. Individual choices should be respected whenever possible. Male survivors may be even more reluctant to disclose sexual abuse than women, a problem that is often not considered. Cultural and individual factors must be weighed in determining the appropriate interviewing strategy.

[73] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Medical evaluations should be carried out in a child-friendly setting by trained clinicians with experience in assessing and documenting physical injury in children including sexual assault. Consent should be obtained from the child's guardian and as appropriate from the child. Take time to build rapport using clear and age-appropriate language; give breaks and opportunities for questions. Short attention spans may require frequent breaks. Understand that trauma & parental separation may adversely affect memory formation. Understand age-related effects of trauma & potential beneficial and adverse role of parents/guardians in the interview. Use age-appropriate questioning techniques Additionally, refer to IAJ-INV-20251020-001-PLM.pdf -- "Constitutional Analysis -- Attorney-Only Access to Evidence in Child Welfare Proceedings: A preliminary investigation based on the 2024 Texas case of the parent-child separation of Crystal Salazar"

[74] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) When interpreters are needed, they have similar professional obligations to the examiner (confidentiality, impartiality). Friends or relatives may not be impartial but may function as important witnesses. The interpreter should not be a law enforcement official or government employee. The examiner should maintain contact with and talk to the examinee, not the interpreter, in order to maintain rapport and gather observations.

[75] The IAJ emphasizes that traditional 'rigid' candor in psychological assessment may not be conducive to truth finding and psychological evaluation of torture victims. IP §525 notes that "It is inappropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy, during which the clinician is inactive and says little. The clinician should communicate in a transparent and empathic way and adopt a supportive, non-judgmental approach."

- Preparing for the Interview[77]
- Using effective interview techniques[78]
- Pursuing inconsistencies and potential reasons for them[79]
- document psychological findings
- formulate clinical impressions and conclusions
- review transference[80], counter-transference[81], re-traumatisation issues
- apply diagnostic classifications (ICD-10 and DSM) in the evaluation of psychological evidence of torture and ill-treatment, with understanding of their value and limitations

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[76] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf): Clinicians who conduct physical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and counter-transference.

[77] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Clinicians should prepare for the interview by familiarizing themselves with the case and potential topic areas to focus on Building in flexibility for discussing other topic areas as they arise in the interview Reviewing appropriate documents/affidavits prepared by the individual's legal counsel. Note: Information in legal documents/affidavits should be independently verified and all information relevant to a clinical evaluation should be gathered by the clinician

[78] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Listening is more important than asking questions. Utilize open-ended questions: "Can you tell me what happened?" "Tell me more about that." A free narrative in the interviewee's own words may be followed by a direct question to clarify and understand the chronological order of events. Improve accuracy of information by: Clarifying details Summarize key points periodically Consider a follow-up interview to address outstanding questions or any inconsistencies Inquire about inconsistencies in their narrative and potential reasons for them

[79] The PHR guidance is as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Variability and inconsistencies in the history should be expected in clinical evaluations of torture and ill treatment. Clinicians should understand that: Variability and inconsistencies in the history do not necessarily indicate that the narrator is providing false or unreliable information, since memory may be affected by the physical and psychological effects of torture and ill-treatment such as head trauma, disorientation to time and place, PTSD symptoms such as avoidance of painful thoughts. Clinicians should use judgment about how much specific detail is needed to document the alleged abuse. Clinicians have a duty to pursue possible explanations for inconsistencies by asking for further clarification and seeking other evidence that supports or refutes the account of events. Clinicians should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess If the clinician suspects fabrication: The clinician should try to identify potential reasons for exaggeration or fabrication. Additional interviews should be scheduled to help clarify inconsistencies in the report. Family or friends may be able to corroborate details of the history. The clinician should refer the individual to another clinician and ask for the colleague's opinion. The suspicion of fabrication should be documented with the opinion of two clinicians The IAJ observes that one of the most effective methods of gauging variabilities and inconsistencies is to repeat questions out of order and at different interviews. Also effective is to recount the facts as reported by the narrator while focusing on particular details and asking clarifying questions about them, and measure consistency with prior related information provided by the narrator.

[80] The PHR guidance defines "transference" as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) The feelings a survivor has towards the clinician that relate to past experiences, which may be misunderstood as directed towards the clinician personally. The evaluator's questions may be experienced as an interrogation or a sign of mistrust or doubt on the part of the examiner. The evaluator may be perceived as having voyeuristic and sadistic motivations, as a person in a position of authority (in a positive or negative sense), or on the side of the enemy

[81] The PHR guidance defines "transference" as follows (see https://phr.org/wp-content/uploads/2022/11/PHR-Istanbul-Protocol-Clinical-Evaluations-in-Conflict-Settings-2022.pdf) Defined as the clinician's personal reactions and feelings to the interview, which may influence the clinician's perceptions and judgments. Common counter-transference reactions include: Avoidance, withdrawal, defensive indifference Disillusionment, helplessness, hopelessness, and over-identification Omnipotence and grandiosity in the form of feeling like a savior, the great expert on trauma, or the last hope of the survivor Feelings of insecurity, feelings of guilt, or excessive rage toward torturers, persecutors or the individual Possible effects of counter-transference reactions include: Underestimating the severity of the consequences of torture Forgetting some details Leading to disbelief regarding the veracity of the alleged torture Failure to establish the necessary empathic approach Over-identification with the torture survivor Vicarious traumatisation, burn-out Difficulty in maintaining objectivity

- appropriately apply psychometric instruments (questionnaires, scales, etc) during the psychological evaluation, with understanding of their value and limitations
- develop interpretations of the psychological findings and conclusions and recommendations using Istanbul Protocol standards
- provide accurate written reports containing, at a minimum:
- identification of the alleged victim
- description of the conditions of the evaluation[82]
- a detailed account of allegations including:
- torture or ill-treatment methods
- physical symptoms
- psychological symptoms
- a record of:
- physical findings[83]
- psychological findings
- interpretation of all findings
- an opinion on the possibility of torture and/or ill-treatment
- clinical recommendations
- identification and the signature of the medical expert(s)

Pursuant to 2022 Istanbul Protocol Chapter II §171, the autonomy of individuals who refuse to provide consent for evaluation must be respected unconditionally. Forced, compelled, or coerced evaluations — including court-ordered psychological examinations conducted without adequate procedural safeguards — may themselves constitute ill-treatment under the IP. Where an IAJ evaluator is aware that a subject has been compelled to undergo psychological evaluation without meaningful consent, this fact must be documented in the CIRF (Appendix H) as a potential independent CIDT indicator. The evaluator must never conduct or report on a coerced evaluation as if it were a voluntary one.

Note carefully that, in the same way that physical torture assessment requires psychological assessment as well as physical assessment, psychological torture assessment should also include physical assessment because distress is medically confirmed as capable of directly causing physical harm. For example, a victim of torture who has Multiple Sclerosis will suffer permanent brain and spine injury when subjected to distress.[84]

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[82] E.g. the alleged victim was placed inside an interview room in the prison, with a police officer inside the room during the entire duration of the evaluation

[83] Please refer to the Istanbul Protocol https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf

[84] The disease model described in The Multiple Sclerosis Stress Equation, supra

The Istanbul Protocol cautions the psychological investigator to be culturally humble and sensitive (IP §497). It adds: "*As much as possible, the evaluating clinician should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms. This includes respect for the political context, as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, an attitude of informed learning should be adopted rather than one of rushing to diagnose and classify. Ideally, this attitude will communicate to victims that their complaints and suffering are being recognized as real and understandable under the circumstances. In this sense, an empathic attitude may offer the victim some relief from the experience of alienation*."

With the legal framework established, the psychological consequences understood, the evaluation's role defined, and the guiding principles articulated, we now turn to the practical methodology for conducting the evaluation itself. This section provides step-by-step guidance on the interview process, the components of the evaluation, and the clinical skills required to elicit and document evidence of torture and CIDT. Theory meets practice in what follows.

Intent Analysis for Systemic Violations:

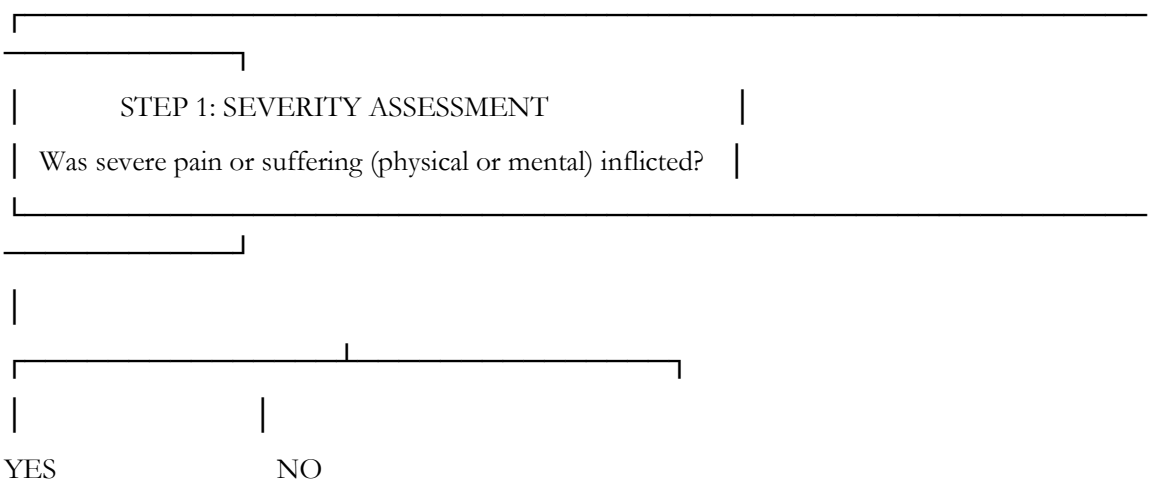
Under Article 1 (Torture), intent in systemic violations may be established through:

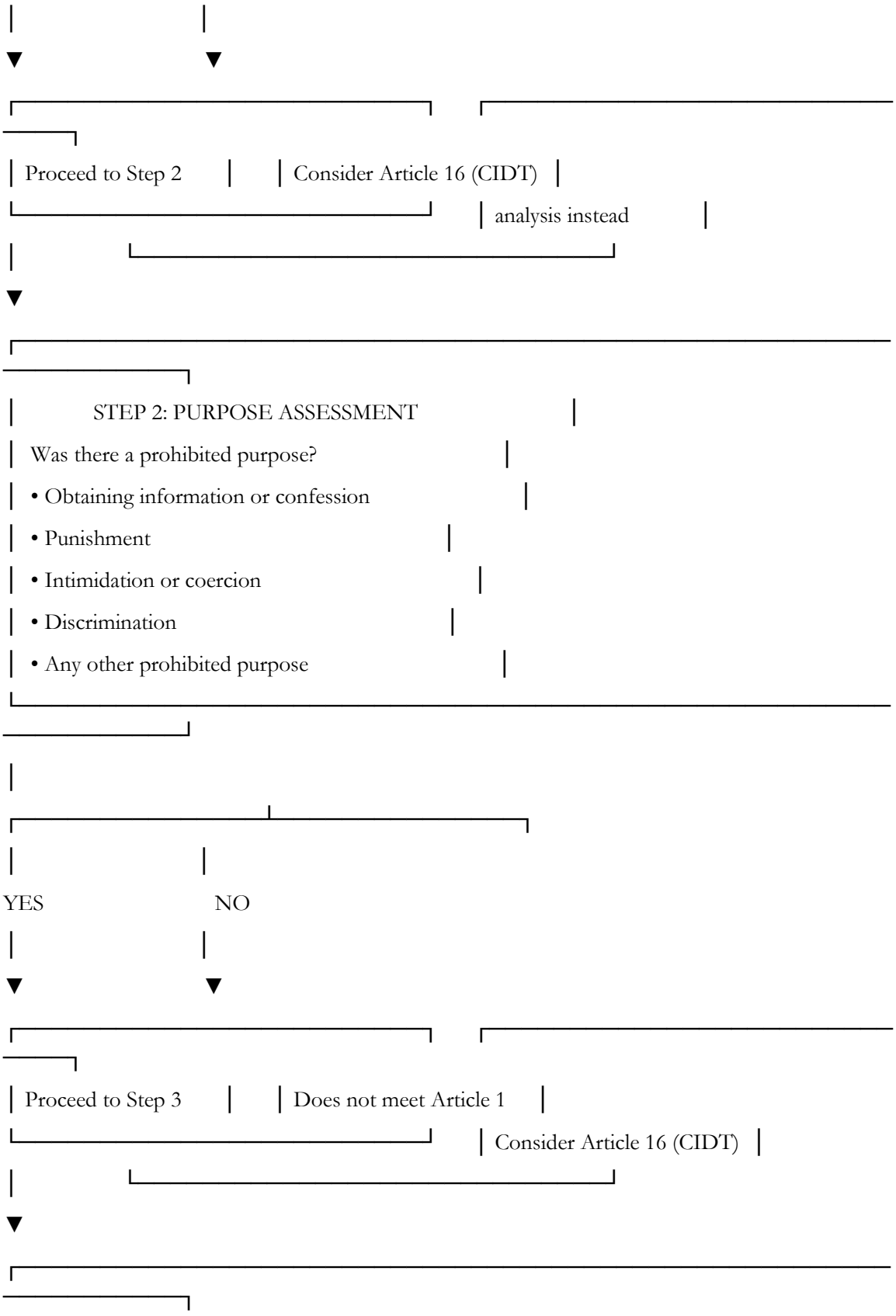
- Policy adoption with knowledge of harmful consequences
- Continuation of policies after harm is documented
- Failure to reform despite complaints and evidence
- Pattern of similar violations across multiple victims
- Institutional benefit from the harmful practices (e.g., cost savings, case closure rates)

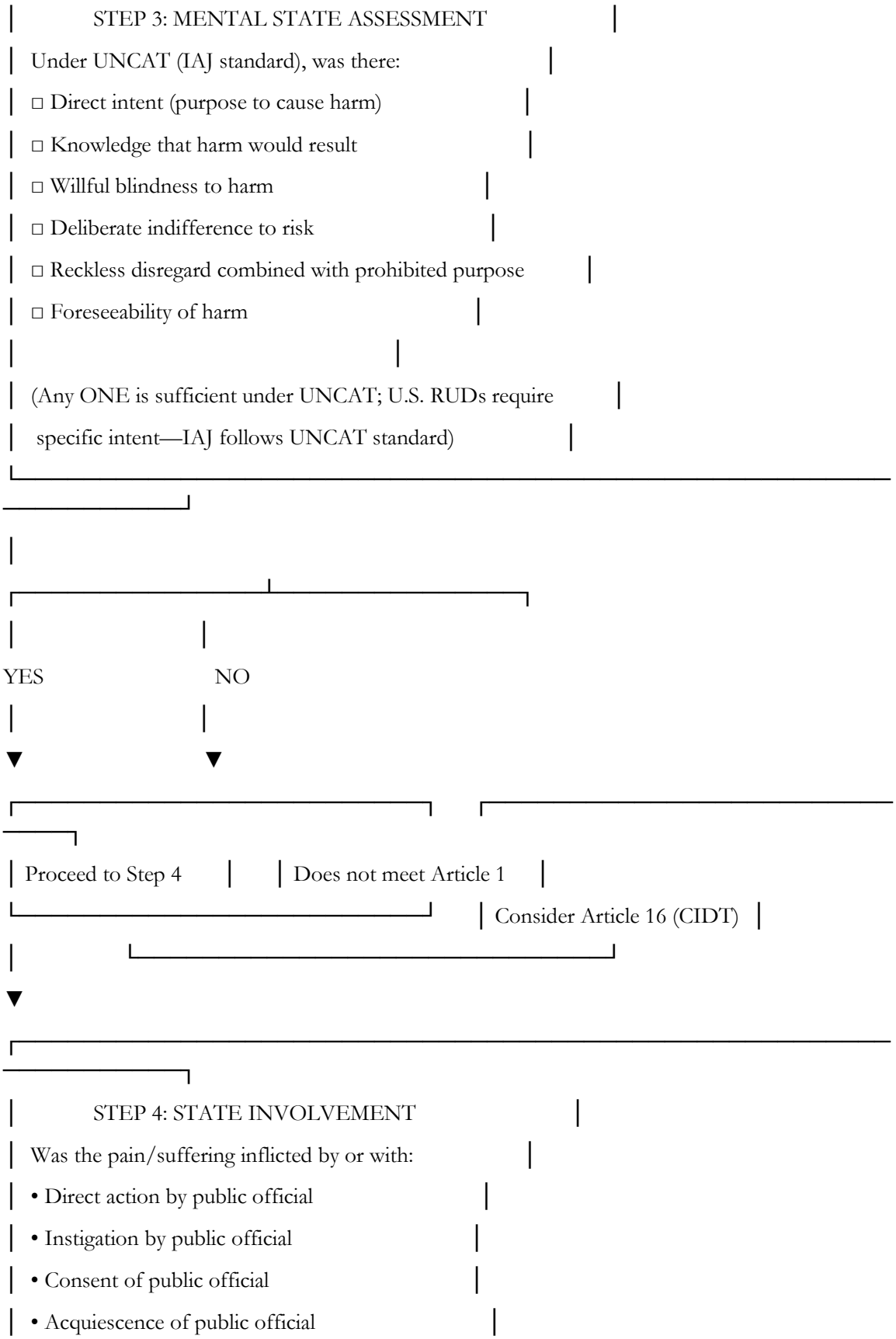
Under Article 16 (CIDT), no intent is required. The evaluator need only document:

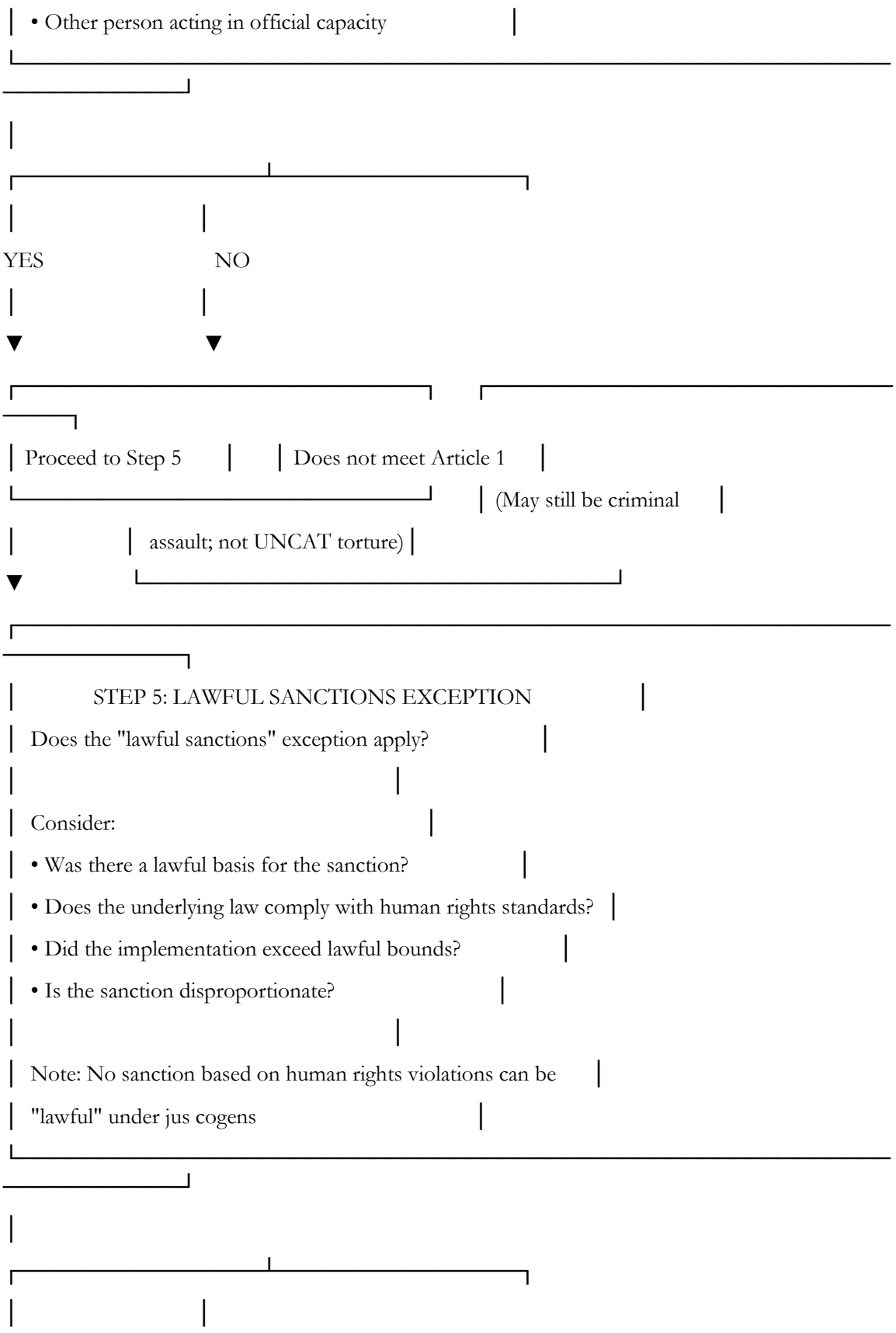
- The nature of the treatment
- The effect on the victim
- The involvement of public officials or official systems

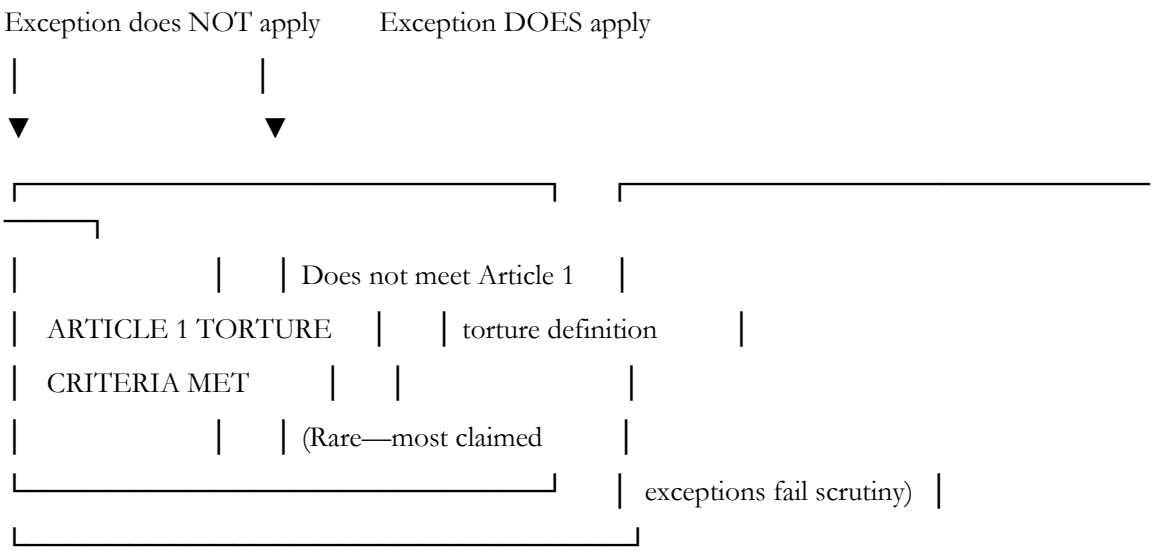
Flowchart for Article 1 (Torture) Analysis:



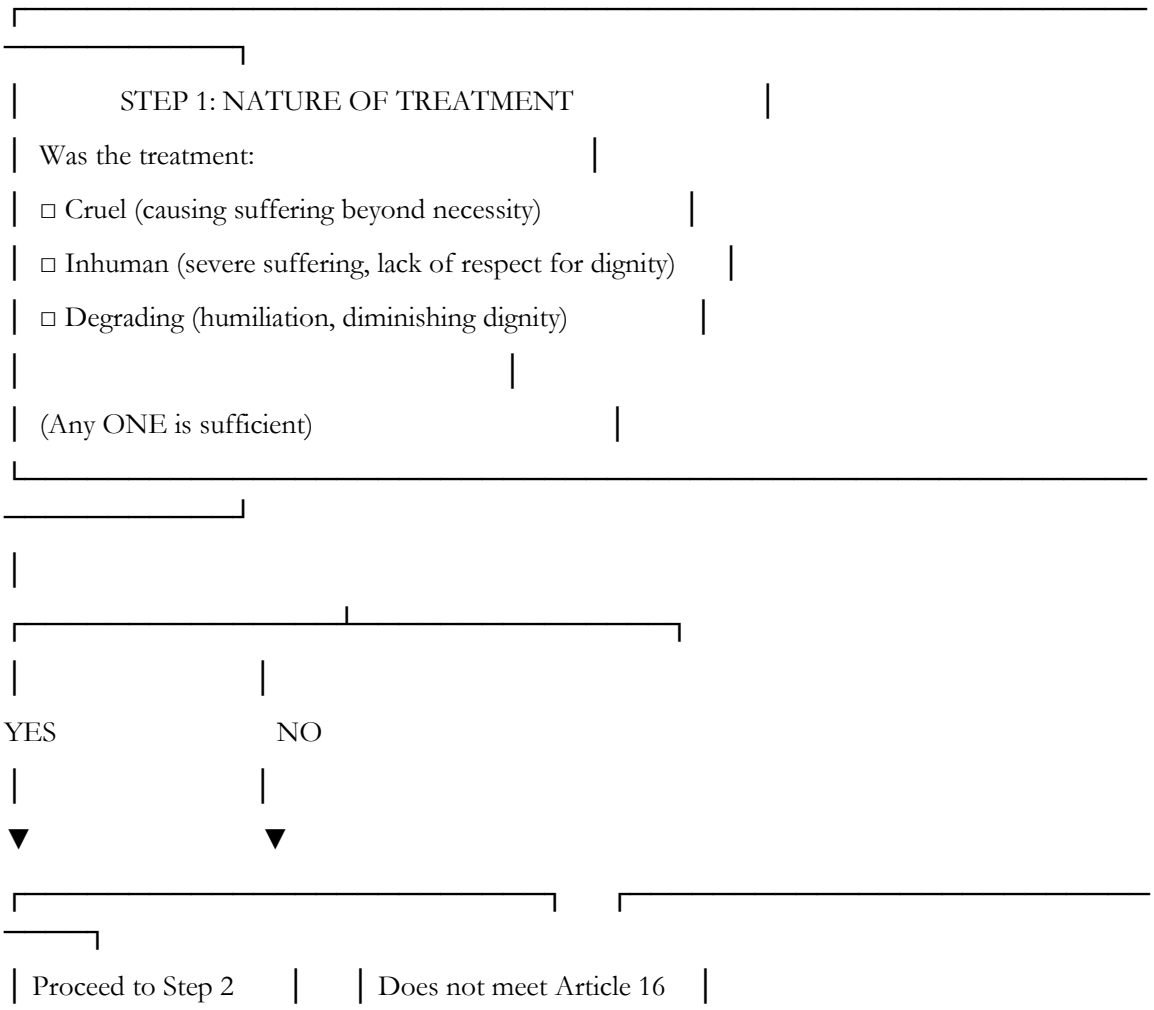

Proceed to Step 2
Consider Article 16 (CIDT) analysis instead
STEP 2: PURPOSE ASSESSMENT
Was there a prohibited purpose?
• Obtaining information or confession
• Punishment
• Intimidation or coercion
• Discrimination
• Any other prohibited purpose
YES
NO
Proceed to Step 3
Does not meet Article 1 Consider Article 16 (CIDT)

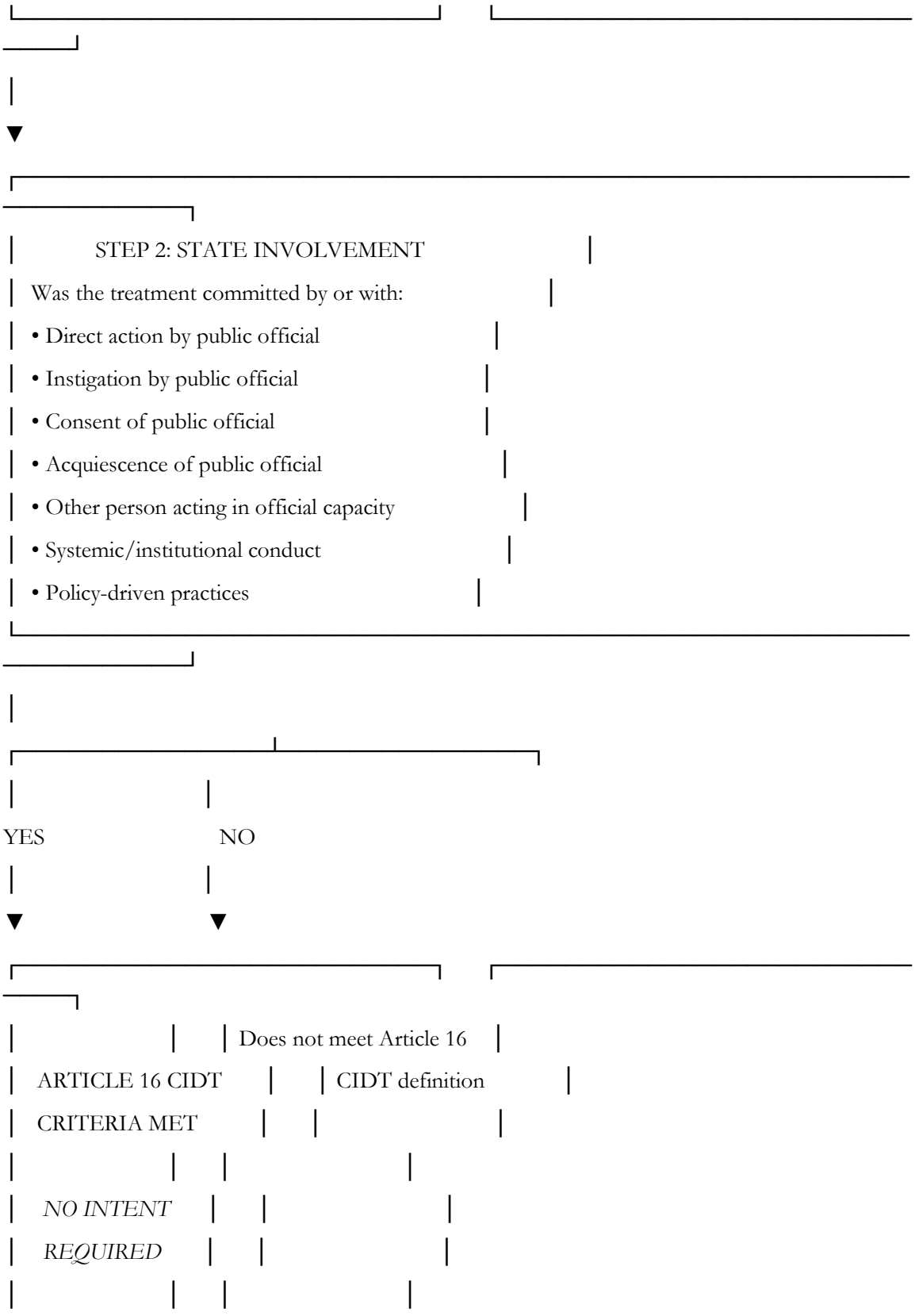

STEP 3: MENTAL STATE ASSESSMENT
Under UNCAT (IAJ standard), was there:
□ Direct intent (purpose to cause harm)
□ Knowledge that harm would result
□ Willful blindness to harm
□ Deliberate indifference to risk
□ Reckless disregard combined with prohibited purpose
□ Foreseeability of harm
(Any ONE is sufficient under UNCAT; U.S. RUDs require specific intent—IAJ follows UNCAT standard)
YES
NO
Proceed to Step 4
Does not meet Article 1
Consider Article 16 (CIDT)
STEP 4: STATE INVOLVEMENT
Was the pain/suffering inflicted by or with:
• Direct action by public official
• Instigation by public official
• Consent of public official
• Acquiescence of public official


• Other person acting in official capacity
YES
NO
Proceed to Step 5
Does not meet Article 1
(May still be criminal
assault; not UNCAT torture)
STEP 5: LAWFUL SANCTIONS EXCEPTION
Does the "lawful sanctions" exception apply?
Consider:
• Was there a lawful basis for the sanction?
• Does the underlying law comply with human rights standards?
• Did the implementation exceed lawful bounds?
• Is the sanction disproportionate?
Note: No sanction based on human rights violations can be
"lawful" under jus cogens



Flowchart for Article 16 (CIDT) Analysis:




STEP 2: STATE INVOLVEMENT
Was the treatment committed by or with:
• Direct action by public official
• Instigation by public official
• Consent of public official
• Acquiescence of public official
• Other person acting in official capacity
• Systemic/institutional conduct
• Policy-driven practices
YES
NO
ARTICLE 16 CIDT CRITERIA MET
NO INTENT REQUIRED
Does not meet Article 16 CIDT definition

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Intent Analysis Decision Tree for Systemic Violations

This decision tree provides a quick reference for evaluating intent in systemic cases, supplementing the Article 1 and 16 flowcharts.

STEP 1: Is there direct evidence of intent?

├── Yes: Document explicit statements, policies, or actions showing purpose to cause harm

│ └── Classify as Article 1 Torture if other elements met

├── No: Proceed to STEP 2

STEP 2: Is there inferred intent?

├── Knowledge of harm: Perpetrators knew or should have known of consequences

│ ├── Yes: Document evidence (e.g., prior warnings, medical records)

│ └── Proceed to STEP 3

├── No: Consider Article 16 CIDT

STEP 3: Is there deliberate indifference?

├── Failure to act despite knowledge: e.g., ignored accommodation requests

│ ├── Yes: Classify as Article 1 if discriminatory purpose present

│ └── Proceed to STEP 4

├── No: Consider Article 16

STEP 4: Pattern evidence?

├── Systemic pattern: Similar harm across multiple victims

│ ├── Yes: Infer institutional intent

│ └── Classify as Article 1 Torture

├── No: Reassess as Article 16 CIDT

Applied Case Guidance: Systemic Intent Determination

Because intent in systemic cases is rarely admitted directly, evaluators must be trained to infer, limit, and qualify intent findings through patterns, notice, foreseeability, repetition, and institutional design. The following examples illustrate when a strong inference is justified, when it is not, and how to document borderline cases.

Case Example A - Strong Inference of Systemic Intent

Scenario: A disabled litigant repeatedly submits treating-provider letters explaining that unmodified deadlines will predictably cause decompensation. Multiple judges, clerks, and opposing counsel

receive the same information over a multi-year period. Accommodation requests are denied in near-identical language across different proceedings. The litigant is then sanctioned for inability to comply with the very conditions the institution refused to accommodate. Internal communications and repeated rulings show that decision-makers were aware of the harm and continued the same approach.

Why intent may be inferred strongly:

- **Notice** was repeated and explicit.
- The conduct persisted after notice.
- The same harmful outcome recurred predictably.
- The pattern is not isolated to one actor.
- Institutional behavior shows **purposeful maintenance of a harmful regime**, not mere error.

Evaluator approach:

- For **Article 1 analysis**, document that prohibited purpose may be inferred from repeated conduct after notice, especially where the conduct functions as intimidation, punishment, or coercion.
- For **Article 16 analysis**, note that the same facts independently support CIDT even if Article 1 intent remains contested.
- Use wording such as: *"Repeated continuation of the same harmful measures after clear notice supports an inference that the suffering was not incidental, but knowingly maintained and foreseeably produced."*

Case Example B - Weak Inference / Likely Administrative Failure Rather Than Intent

Scenario: A hospital unit mishandles a detention referral, resulting in a delayed mental-health assessment and poor communication with the patient. There is distress and humiliation, but the delay appears linked to staffing breakdown, inconsistent documentation, and an isolated supervisor error. There is no evidence of targeted punishment, discriminatory motive, repeat conduct after notice, or institutional persistence in the same harmful act.

Why intent is weak:

- Harm exists, but the record primarily supports **incompetence or disorganization**.
- There is no meaningful evidence of prohibited purpose.
- There is no repeated pattern after warning.
- The facts may support negligence, not Article 1 intent.

Evaluator approach:

- Do not force an intent finding.
- Document that the conduct may still support **Article 16 / CIDT** if degrading or severe, even without intent.
- Use wording such as: *"The available evidence supports serious harmful treatment, but does not presently support a reliable inference of purposeful infliction for a prohibited aim."*

Case Example C - Ambiguous / Borderline Systemic Intent Case

Scenario: An immigration detainee reports that repeated housing decisions, protective isolation, and denial of affirming care caused severe deterioration. Staff were informed that the placement was causing distress. Some officials attempted limited interventions, but the institution repeatedly returned the detainee to the same harmful conditions because "no alternative bed existed." The result was foreseeable and recurrent, but the record mixes resource constraint, bureaucratic indifference, and possible discriminatory disregard.

Why this is ambiguous:

- The suffering is severe and repeated.
- The institution had at least partial notice.
- Some actions suggest indifference rather than overt punitive purpose.
- Structural constraints may explain part, but not all, of the continuation.

Evaluator approach:

- Train evaluators to separate three levels of conclusion:
- **Purposeful intent established**
- **Knowing maintenance / deliberate indifference strongly indicated**
- **Severe harmful conditions established, but prohibited purpose not yet reliably inferable**
- This case often supports a firm **Article 16** conclusion and a qualified **Article 1** discussion.
- Use wording such as: *"The evidence strongly supports knowing maintenance of harmful conditions and resulting severe suffering; whether the record establishes a prohibited purpose for Article 1 should be treated as a qualified inference rather than a definitive conclusion."*

Training rule:

In systemic cases, evaluators should be instructed that the strongest indicators of intent are:

- repeated notice,
- repeated continuation after notice,
- uniformity across actors,
- punishment for disability-linked noncompliance,
- inability of the victim to withdraw, and
- institutional advantage gained from the suffering imposed.

Where these are absent, the evaluator should still document harm full, but must reduce certainty as to Article 1 intent.

Intent in Technology-Facilitated Torture and Psychological Abuse

A: Introduction

Advances in technology have created new mechanisms for torture, surveillance, and control that leave no physical marks but inflict severe psychological harm.

Under the IAJ Psychological Investigation Standard, establishing **intent** is one of the four critical criteria for documenting Distress-Induced Harm ("Battery Without Touching"). The Standard provides specific guidance for analyzing intent in technology-facilitated contexts, which differs from traditional physical torture documentation due to the unique characteristics of digital harm.

B: Forms of Technology-Facilitated Torture

- Electronic Surveillance and Harassment: Hidden cameras, GPS tracking, cyberstalking, online harassment.
- Digital Intrusion: Hacking, account takeovers, identity theft, invasion of private digital spaces.
- Technology-Based Control: Smart home technology used for control, financial control, monitoring of communications.
- Government Technology Abuse: Mass surveillance, internet shutdowns, digital censorship.

C: Psychological Impact

Trauma presentation including hypervigilance, intrusive thoughts about monitoring, avoidance of technology, trust violations, and phantom phone vibration syndrome.

D: Legal Framework for Intent Analysis

The IAJ Standard recognizes that intent can be established through multiple pathways in technology-facilitated contexts. Under UNCAT Article 1, intent requires that the perpetrator acted "for such purposes as" obtaining information, punishment, intimidation, coercion, or discrimination. In digital contexts, this intent can be inferred from the nature of the technology used, the pattern of deployment, the identity and authority of the perpetrator, and the cumulative impact on the victim.

The Standard establishes that intent may be demonstrated through **direct evidence** such as explicit statements, written policies, or communications ordering or authorizing the conduct. When direct evidence is unavailable, **circumstantial evidence** becomes critical, including patterns of conduct, selective targeting, failure to intervene despite knowledge, and the systematic nature of the technology deployment. Additionally, **constructive knowledge** may be established where institutional actors knew or should have known about the technology abuse and failed to prevent or stop it.

E. Intent Determination by Scenario Category

Electronic Surveillance and Harassment

For hidden cameras, GPS tracking, cyberstalking, and online harassment, intent determination follows a layered analysis approach. The first layer examines the **identity of the perpetrator**: government actors, law enforcement, institutional employees, or private individuals with apparent access to surveillance capabilities each carry different evidentiary weight. The second layer analyzes the **targeting pattern**: whether the surveillance was directed at a specific individual or group

suggests purposeful selection rather than random monitoring. The third layer considers the **awareness of the victim**: when victims know they are being watched, the psychological impact differs qualitatively from incidental surveillance, and this awareness often indicates intentional psychological effect.

In cases of cyberstalking and online harassment, intent can be established through the **repetitive and targeted nature** of the conduct. Single incidents may suggest opportunistic behavior, but patterns of sustained harassment directed at a specific victim demonstrate purposeful intimidation. Documentation should capture the frequency, duration, and escalation of harassment, as these patterns reveal the perpetrator's objective. Additionally, **content analysis** of communications can reveal explicit threats, humiliation tactics, or attempts to control behavior, all of which demonstrate intentional psychological harm.

Digital Intrusion

Hacking, account takeovers, identity theft, and invasion of private digital spaces present unique intent challenges because the victim may not immediately realize the intrusion has occurred. The Standard addresses this through what might be termed the **"knowledge with substantial certainty"** doctrine: even if a perpetrator did not specifically intend to cause psychological distress, intent can be established if the perpetrator knew with substantial certainty that psychological harm would result from the intrusion.

The intent analysis for digital intrusion examines several factors. First, the **sophistication of the intrusion** suggests premeditation: automated attacks may indicate general malicious intent, while targeted intrusions suggest specific purpose. Second, the **use of obtained information** reveals motive: if the perpetrator used access to gather information for leverage, intimidation, or public exposure, this demonstrates instrumental intent. Third, **post-intrusion conduct** is instructive: whether the perpetrator threatened to disclose information, actually disclosed it, or used access for ongoing harassment shows the perpetrator's objective. Finally, **failure to notify** of the breach can demonstrate intent to maintain psychological uncertainty and hypervigilance in the victim.

Technology-Based Control

Smart home technology abuse, financial control, and communication monitoring represent forms of technological coercion that require intent analysis focused on the **control dynamic**. The perpetrator's intent is often evident in the **asymmetry of control**: the victim has limited ability to escape or modify the technological environment, while the perpetrator retains override capabilities. This power imbalance itself demonstrates intentional subjugation.

For smart home technology used as control mechanisms, documentation should establish that the perpetrator had **exclusive or primary control** over the technology, that the victim had **limited ability to modify or disable** the systems, and that the technology was **deployed in ways inconsistent with normal use**. For financial control through technology, intent can be shown through the perpetrator's **knowledge of the victim's dependence** on electronic systems and the **deliberate exploitation** of that dependence. Communication monitoring intent is demonstrated through the **willful interception** of communications and the **use of obtained information** to manipulate, coerce, or punish the victim.

Government Technology Abuse

Mass surveillance, internet shutdowns, and digital censorship present the most complex intent determination because the conduct may be formally authorized and publicly justified as security measures. The Standard provides specific guidance for navigating this complexity through analysis of **disproportionality**, **discriminatory targeting**, and **knowledge of harm**.

Disproportionality analysis examines whether the technology measure was **excessive relative to the stated purpose**. Mass surveillance of an entire population for a localized security concern, or complete internet shutdowns for minor disturbances, demonstrate intent that exceeds legitimate security objectives. Discriminatory targeting analysis looks at whether the technology was **selectively deployed against specific groups** without legitimate differentiation, which reveals purpose beyond security. Knowledge of harm analysis considers whether authorities **knew or should have known** that the technology would cause psychological harm to affected populations and **failed to implement mitigations**, demonstrating constructive intent.

Practical Documentation Protocol

For each technology-facilitated scenario, the psychologist should document specific indicators that support intent determination. This documentation should include the **identity and authority** of the perpetrator, the **technical capabilities** deployed, the **pattern and duration** of the conduct, the **victim's awareness** of surveillance or control, the **psychological impact** observed, and any **direct or circumstantial evidence** of purpose.

The IAJ Forensic Certainty Scale applies to intent determination just as it applies to causation: the psychologist should rate the level of certainty that the perpetrator intended to cause psychological harm or knew with substantial certainty that such harm would result. This qualification provides appropriate epistemic humility while still offering the court useful guidance on the strength of the intent inference.

This framework allows psychologists to systematically evaluate intent in technology-facilitated contexts while maintaining the rigor required for forensic documentation and court testimony.

Module 3: Psychological Evaluation Procedure & Applied Forensic Workflow

Performing the psychological evaluation

Before beginning this module, ensure that you have read the chapter in Module 1 entitled "Application of UNCAT Definitions to Systemic Institutional Torture".

IP §524 draws your attention to the fact that the "*overall goal of a psychological evaluation for a medico-legal report in accordance with the Istanbul Protocol is to assess the degree of consistency between an individual's account of torture and the psychological findings obtained in the course of the evaluation and to provide an opinion on the probable relationship between the psychological findings and the possible torture or ill-treatment.*" The IAJ extends this focus to the requirement of also noting any potential signs of systemic or policy-based mechanisms of torture as opposed to merely identification of individual actors by the alleged or suspected victim.

IP §524 notes that "*Psychological evidence comprises not only the alleged victim's statement, but a variety of information, including observations on verbal and non-verbal communication, emotional reactions, affective resonance and behaviour. To this end, the evaluation should provide a detailed description of the methods of assessment, current psychological complaints, pre- and post-torture history, history of torture and ill-treatment, past psychological/psychiatric history, substance use/misuse history, mental status examination, assessment of social functioning, results of psychological/neuropsychological testing if indicated and the formulation of clinical impressions. A psychiatric diagnosis should be made, if appropriate.*"

The investigator is reminded that cultural humility and sensitivity is essential to performing a valid investigation.

The IAJ follows the Istanbul Protocol with enhancements identified in bold font.

Quick-Reference Decision Tree: Diagnosis Determination

This decision tree helps the evaluator determine whether a formal diagnosis is supported, whether only a provisional formulation is appropriate, or whether the report should remain at the level of symptom pattern and consistency without diagnostic overreach.

STEP 1: Is there sufficient clinical data for diagnosis?

├── **No** → Do not force diagnosis; document symptoms, functional impact, and consistency only

└── **Yes** → Proceed to STEP 2

STEP 2: Are the symptoms better explained by a trauma-related condition, another psychiatric condition, neurocognitive factors, substance effects, or a medical condition?

├── **Trauma-related condition likely** → Proceed to STEP 3

├── **Non-trauma condition likely** → Diagnose accordingly, if within competence

├── **Mixed / overlapping** → Use differential formulation

└── **Unclear** → Use provisional or deferred diagnosis

STEP 3: Are diagnostic criteria substantially met using culturally and clinically appropriate interpretation?

├── **Yes** → Record diagnosis with any cultural / contextual qualifications

└── **No / unclear** → Use trauma-consistent symptom formulation rather than over-pathologizing

STEP 4: Are there barriers to valid diagnosis?

├── Inadequate data, severe dissociation, acute crisis, language barriers, cultural mismatch, developmental limits

│ └── Use provisional, deferred, or descriptive formulation

└── None significant

└── Finalize diagnosis if supported

STEP 5: What is the appropriate output?

├── **Formal diagnosis supported**

├── **Provisional diagnosis / rule-out**

└── **No formal diagnosis; symptom-based forensic formulation only**

Diagnostic rule:

A psychological evaluation may be highly probative even when a formal DSM diagnosis is deferred. Absence of diagnosis is not absence of harm.

Interview Process

IP §526. *Clinicians should present themselves and introduce the purpose and process of the interview in a manner that explains in detail the procedures to be followed and the topics to be addressed and that prepares the individual for the difficult emotional reactions that the questions may provoke. Clinicians need to be sensitive and empathetic in their questioning, while remaining objective in their clinical assessment. At all times they have to balance their need to obtain detailed information and the needs of the alleged victims to maintain or regain their emotional balance. Interviews must be conducted in a way that reduces the risk of retraumatization and, at all times, allows the alleged victim to maintain a sense of control. Chapter IV describes comprehensive guidelines for conducting clinical interviews.*

IP §527. *An appropriate structuring of the clinical interview is fundamental in building adequate rapport and trust. Generally, it is advisable to start the interview with less sensitive issues and then proceed to more difficult or stressful content. In many cases, it might be useful to start with the pre-torture history and follow a chronological order. In other cases, especially when the person is under a high level of emotional distress, it may be better to start with the current psychological complaints and current social functioning. The clinician is advised to use a flexible approach instead of following a predetermined order. The following description of the components of the psychological/psychiatric evaluation follows the suggested order for the written report (see annex IV), but not for the clinical interview.*

Pacing, Breaks, and Session Integrity

The evaluator should treat pacing and rest as part of the forensic method. In torture and CIDT evaluations, breaks are not merely accommodations for the examinee; they are also safeguards against evaluator fatigue, desensitization, reactive over-involvement, and cognitive error.

Break protocol

- At the outset, the evaluator should advise that breaks may be taken whenever needed by either the examinee or the evaluator.
- In lengthy or emotionally intense interviews, the evaluator should plan brief pauses at natural transition points, even if neither party has yet requested one.
- The evaluator should take a break immediately if concentration is declining, irritability is increasing, chronology is becoming difficult to track, or the evaluator notices drift toward either emotional flooding or emotional shutdown.
- During breaks, the evaluator should avoid substantive discussion of disputed facts and should instead use brief grounding, hydration, movement, breathing regulation, and note review.
- If the break does not restore adequate concentration and neutrality, the evaluator should shorten, reschedule, or terminate the session rather than continue in compromised form.

Indicators that a break is required

- repeated need to ask the same question because of poor concentration;
- missed details that would ordinarily trigger follow-up;
- diminished ability to distinguish core facts from peripheral details;
- unusual impatience, irritability, or emotional blunting;
- strong somatic activation, dissociation-like detachment, or intrusive reactions;
- a rising impulse to force closure, hurry, or "get through" the material.

Methodological rule

A shorter but well-regulated evaluation is more reliable than a longer interview completed after the evaluator's attention, neutrality, or reasoning has materially deteriorated.

The evaluator should refer, transfer, or seek co-evaluation when:

- repeated breaks do not restore adequate concentration or neutrality;
- the evaluator notices persistent over-identification, rescue urgency, or adversarial anger;
- intrusive imagery, emotional flooding, or numbing continues across sessions;
- the evaluator cannot reliably track chronology, contradictions, or differential explanations;
- the subject matter falls outside the evaluator's competence or requires specialized expertise;
- the evaluator's current caseload or cumulative exposure makes additional trauma work unsafe or methodologically unsound;
- supervisory consultation indicates that continued solo evaluation would create avoidable risk of error.

The goal is not abandonment of the case, but protection of the examinee, the evaluator, and the integrity of the findings.

Components of the psychological/psychiatric evaluation

IP §528. *The introduction should contain mention of the referral source, a summary of collateral sources (such as medical, legal and psychiatric records) and a description of the methods of assessment used (e.g. interviews, symptom inventories, checklists and neuropsychological testing).*

Before proceeding through the components of the evaluation, the evaluator should consider whether the case is appropriate to retain personally. **Referral, co-evaluation, supervisory involvement, or transfer** should be considered when the evaluator's trauma exposure load is already high, when the case involves triggers likely to compromise neutrality, when specialized expertise is needed beyond the evaluator's competence, or when the evaluator cannot maintain adequate analytic functioning despite breaks and regulation strategies.

(a) History of torture and ill-treatment

IP §529. *Every effort should be made to document the full history of the alleged torture or ill-treatment and other relevant traumatic experiences as stated by the alleged victim (see paras. 364–372 above). This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions. The interview should start with a general summary of events before eliciting the details of the alleged torture or ill-treatment experience. The interviewer needs to know the legal issues at hand because that will determine the nature and amount of information necessary to achieve a comprehensive documentation of alleged torture or ill-treatment.*

The IAJ elaborates on this requirement as follows:

- identify, and obtain official records, and personal records and any statements that can be used to investigate the torture and ill-treatment during the period alleged
- including if any documents contain any information that may relate to the physical or mental results of torture or ill-treatment
- including any reports of torture or ill-treatment or equivalent complaint of any form by anyone about the prohibited acts
- was the victim protected upon making the report(s)
- Structure the investigation by identifying distinct incidents, events, or acts to create a timeline of torture or ill-treatment. If this is not possible at the start of your interaction, then build a timeline through patient (repeated) interactions with the alleged victim, which you organize into "time intervals" which delineate the start and end of each **distinguishable episode** of torture or ill-treatment. Then, if possible, within each time interval, identify each distinct incident, event, or act that might indicate torture or ill-treatment
- For each distinct incident, event, or act, identify the following:
- The location where the act occurred
- detailed description of alleged the torture or ill-treatment (cruelty, inhumanity, degradation of the person), including the method(s) used, the context, and the resulting harm

- including coercion/Intimidation tactics
- including discrimination
- identify any other purpose
- if the same act occurred repeatedly, document the frequency[85] if the alleged victim is not clear about the dates. But it is important to identify the duration and difference in nature/characteristics of the repeated acts if they were not identical
- the torture or ill-treatment tactic(s)
- description of any physical torture or ill-treatment resulting in physical harm, including any distress-induced physical injury, or induced self-harm
- description of any psychological torture or ill-treatment resulting in psychological harm, including details and effects of any:
- manipulation/deception[86]
- Humiliation/Degradation Tactics[87]
- Procedural Violations[88]
- Coercion/Intimidation Tactics[89]
- Discrimination, including discrimination based on disability[90]
- Applicable ethics violations
- detailed description of the causation, any motive[91], and any triggering event that led to the alleged torture or ill-treatment, and any documentation or record produced specifically about that act
- Specifically ask if the act may occurred by mistake
- Specifically ask if the alleged victim believes that the act was discriminatory and how
- every complicit actor (perpetrator), and each act by that actor, and the authority for that act
- actor(s) primarily responsible
- actor(s) secondarily responsible
- actor(s) indirectly involved
- each threat and identity of the person(s) making the threat

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[85] e.g., daily during hearings, sporadically over months, every time a specific individual was present, continuously through legal correspondence

[86] E.g. False accusations/self-incrimination, False accusations, exploiting disability, Gaslighting, Evidence fabrication or distortion, Deception in legal proceedings, Manipulation of proceedings

[87] E.g. Public mocking or ridicule, Public humiliation, Degrading treatment, Trivialization of concerns, Denial of human dignity

[88] E.g. Denied access to counsel, Denied proper investigation, Denied access to legal resources, Denied necessary services, Language barriers imposed, Prohibited from speaking/testifying, Due Process Denial, Arbitrary decisions

[89] E.g. Threats against self, Verbal abuse Intimidation tactics, Threats exploiting disability, Forced compliance, Threats of sanctions

[90] E.g. Denial of reasonable accommodations, Exploitation of impairment, Disability stereotyping, Questioning competence due to disability, Discriminatory application of rules

[91] E.g. silencing, punishing, coercing, discrimination, retaliation, control, extracting information, other

- was the alleged victim threatened if they did not comply?
- Was a third party threatened if the alleged victim did not comply?
- Was any third party tortured or ill-treated?
- any and every formal medical or mental health diagnoses made as a result of the torture or ill-treatment
- did the alleged victim freely consent to any formal medical or mental health treatment?
- all existing evidence, including recordings, pictures, videos, notes, documents, emails, text messages, electronic data, medical records
- all percipient witnesses, and any other witness or persons who may have knowledge of the act, particularly if the alleged victim reported the act to the 'witness' immediately following its occurrence
- Was the causation associated with the presence or involvement of the same person(s), and identify them
- Were there any discernible patterns or escalations[92] over time?
- Does the alleged victim believe that the act constitutes torture or ill-treatment and why
- Does the alleged victim believe that the act is SYSTEMIC[93] (very important)
- Did the alleged victim report/complain about the act to anyone?[94]
- Did any other person report/complain about the act to anyone?
- Identify to whom, with date and manner of every report, and obtain a copy of any documents or electronic data or recording about the report/complaint
- Ask the alleged victim to recall in detail what he/she stated in the complaint
- Was there any interference or obstruction with the report/complaint?
- Was there any evaluation of the report/complaint?
- The result(s)
- The victim's perception of the process for handling the report/complaint
- The familiarity of the recipients of the report/complaint with such reports/complaints, and their qualifications, competence and their interest in properly handling them
- Identify the outcome of the report/complaint
- Was there any redress or compensation for the incidents(s)?
- Was anyone punished for the incidents?
- Was the incident every reported to any human rights bodies?

[92] e.g., worsening after a certain event, increasing in intensity, shifting methods

[93] Is also perpetrated against others

[94] E.g. Medical Board, Bar Association, Court Administration, Civil Rights Agency, Disability Rights Organization, Human Rights Commission

- Perform each medical assessment that can be made about the alleged torture and ill-treatment if they are in progress, or retroactively if they occurred in the past, by distinguishable episode (time interval) identifying:
- Dates, times, nature and frequency of injuries
- Symptoms list with dates of onset, exacerbation(s) and remission(s)
- If physical injuries are indicated
- carefully examine the injuries, sites, nature and scars/marks, perform a basic neurological evaluation, and document with pictures and video[95]
- Establish a relative scale of pain and suffering compared to other episodes, and document the pain and suffering of this episode:
- Biological/physiological
- Psychological
- Distress rating
- Physical
- Emotional
- Cognitive
- If psychological injuries are indicated
- Use the IAJ modified HTQ as a checklist to applying structured diagnostic questionnaires as described in Appendix A
- Establish a pre-torture baseline
- Evaluate the effects and injuries from the episode of torture or ill-treatment
- Catalog effects and injuries and to facilitate sensitivity and coping analysis, invite the alleged victim to explain effects and injuries by further time breakdown within each episode of torture or ill-treatment:
- Immediate impact when the act was committed (up to 48 hours)
- Short-term impact (48 hours to 3 weeks)
- Ongoing impact
- Functional assessment
- Use the checklist in Appendix B, or construct an alternate uniquely tailored checklist for evaluation
- Emotional well-being impact assessment

[95] Follow the protocol by Physicians for Human Rights for documenting and evaluating physical torture. Except, the case of distress-induced physical injuries, such as in Multiple Sclerosis, document the distress of the alleged victim, and then ask about any physiological consequences (e.g. MS relapse symptoms) and their duration and severity, and their remission. Update your documentation at each encounter, if appropriate to track the evolution of injuries and symptoms

- Physical well-being impact assessment
- Cognitive health impact assessment
- Behavioral impact assessment
- Psychological diagnoses and symptoms
- Trauma assessment (Exercise caution: risk of retraumatization is elevated when assessing trauma):
- Identify factors/acts that caused the alleged victim to perceive and experience trauma
- Catalog the occurrence and frequency of each traumatic factor/act:
- Document each retrauma
- Distinguish between the nature of the trauma, to the extent that the alleged victim perceives them as distinct and separate types of trauma which do not cross-activate
- Identify factors and acts that the alleged victim associates with trauma:
- Identify triggers
- For example, association with a location, individual, sound, action, situation, emails, deadlines, legal proceedings, phrases, obstruction, liberty, phone call, legal documents, courthouse, police, smell, etc.
- Identify patterns of thought adopted by the alleged victim that reliably lead the victim to re-experience the trauma
- Identify each reinforcement of the anticipation of trauma
- Disability assessment (perform episodic evaluation if appropriate, e.g. changing/accumulative disabilities)
- Causes of each disability
- Accommodation requested or provided for each disability
- To whom was the request made, or who initiated the accommodation request, with date
- Accommodation provided for each disability with dates
- Alleged victim's assessment of the impact of the disability on the torture and ill-treatment
- Alleged victim's assessment of the effectiveness of the accommodation
- Social and family impact assessment
- Employment and financial impact assessment
- Sense of safety/security assessment
- Impact on ability to access services, including courts
- If the episode ended in the past, evaluate residual effects and injuries
- Establish a relative scale of pain and suffering compared to other episodes, and document the pain and suffering of this episode:

- Biological/physiological[96]
- Psychological
- Distress rating
- Physical
- Emotional
- Cognitive
- any medical care provided:
- who requested or initiated the medical care
- at what facility, identify care providers
- dates
- nature, manner
- procedures, treatments, therapy, rehabilitation, alternative therapies
- medicines
- imaging
- transportation
- supervision
- effectiveness
- description of any recovery
- complications
- barriers to treatment, recovery or rehabilitation
- locations/facilities of care provided
- identify of each person who provided care with dates and nature and location
- identify of each witness to the medical care, with dates and description of injury and/or medical treatment
- duration of recovery and rehabilitation, and if permitted, or if obstructed obtain a detailed account of how obstructed, and what experience the obstruction caused
- past assessments of torture and ill-treatment (with dates and identity of investigators)
- Perform fact-gathering about any other alleged victim
- Assess the alleged victim's sensitivities and vulnerabilities to further experience of torture and ill-treatment, and retraumatization, and use the information to:
- Identify safeguards, preventive measures
- Estimate evolution of sensitivities and vulnerabilities based on the episodic facts

[96] Psychological trauma and distress can cause physical symptoms

- Feedback into the episodic diagnoses and evaluations
- Assess the risks and safety of the alleged victim (including episodic evaluations if appropriate the determining the severity of pain and suffering and contributing factors):
- What steps were taken to ensure their safety 1) by them, 2) by any other person(s)
- Were they safe or not?
- What was or is needed to ensure their safety and manage the risk of harm to them?
- Identify risks or harm to other alleged victim(s) (including episodic evaluation if indicated)
- Identify each 'other person' and date and location, and perpetrators, and acts
- What steps have been taken, and by whom, to ensure the safety and management of the risk of torture and ill-treatment of other alleged victim(s)
- Are they safe?
- What was or is needed to ensure their safety and manage the risk of harm to them?

(b) Current psychological complaints

IP §530. *An assessment of the current psychological condition and complaints constitutes the core of the evaluation. In addition to the spontaneous description of the interviewee, specific questions regarding common psychological responses to torture (as described in paras. 499–522) should be asked. All affective, cognitive and behavioural symptoms should be described in detail, including their severity, frequency, onset and evolution over time, regardless of whether they amount to a specific diagnosis. It is important to give a detailed description of the specific symptom presentation as this helps to substantiate the level of consistency between the alleged torture or ill-treatment and the psychological findings at a later stage. This may include the description of the content of nightmares, recurrent thoughts or memories, f lashbacks or hallucinations. Triggers for emotional distress, sadness, fear or reliving experiences should also be explored and described. Questions about sleep (how many hours, what interrupts sleep, feelings when waking up from a nightmare), of how the day is spent (in social isolation, trying to keep busy at all costs, obsessive/compulsive behaviours and the ability to carry out the activities involved in daily living), as well as questions to identify avoidance behaviour related to triggers for re-experience should be asked. An absence or subthreshold level of symptoms at the time of assessment can be due to the episodic nature or delayed onset of specific symptoms or to denial of symptoms because of shame. Therefore, the exploration and assessment of the symptom evolution since the alleged torture is of paramount importance.*

The IAJ refers the reader to Section (a) "History of torture and ill-treatment" Points 2, 3, 4.

(c) Post-torture history

IP §531. *This component of the psychological evaluation seeks information about current life circumstances. It is important to enquire about current sources of stress, such as separation or loss of loved ones, flight from the home country and life in exile. Interviewers should also enquire about the ability of individuals to be productive, earn a living, care for their families, engage in social interactions, form trusting relationships and the availability of social supports. Furthermore, the possible impact of past sexual torture on sexual orientation, gender identity, the ability to enjoy sexual intimacy and partnership should be considered.*

(d) Pre-torture history

IP §532. *The pre-torture history should include information regarding the alleged victims' childhood, adolescence, early adulthood, their family backgrounds, family illnesses and family composition. There should also be a description of the alleged victim's educational and occupational history. It should also include a description of any history of past trauma, such as childhood abuse, war trauma or domestic violence, as well as the alleged victim's cultural and religious background.*

IP §533. *The description of pre-trauma history is important to assess the mental health status and level of psychosocial functioning of the alleged victim prior to the traumatic events reported. In this way, the interviewer can compare the current psychological status with the one the individual reports for the time before the alleged torture or ill-treatment and assess the relative contribution of different experiences, including the alleged torture or ill-treatment. In evaluating background information, the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the circumstances of the torture, the perception and interpretation of torture by the victim, the social context before, during and after torture, community and peer resources, personal values and attitudes about traumatic experiences, political and cultural factors, severity and duration of the traumatic events, genetic and biological vulnerabilities, developmental phase and age of the victim, prior history of trauma and coping mechanisms. In many interview situations, because of time limitations and other problems, it may be difficult to obtain this information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to form an impression of the degree to which the alleged torture or ill-treatment has contributed to the psychological condition.*

(e) Medical history

IP §534. *The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and its side effects, relevant sexual history, past surgical procedures and other medical data (see paras. 394–399 [of the Istanbul Protocol]).*

(f) Psychiatric history

IP §535. *Inquiries should be made about a history of mental or psychological conditions, the nature of such conditions and whether the alleged victims received treatment or required psychiatric hospitalization. The inquiry should also cover prior therapeutic use of psychotropic medication.*

(g) Substance use and misuse history

IP §536. *The clinician should enquire about substance use and misuse, including the route of use, frequency, amount and time periods of use, before and after the alleged torture, changes and evolution of the pattern of use and whether substances are being used to cope with insomnia, pain or psychological/psychiatric problems. Such substances include alcohol, cannabis and opium but also prescribed medication and regional substances of abuse, such as betel nut and many others.*

(h) Mental status examination

IP §537. *The mental status examination begins the moment the clinician meets the individual. The interviewer should make note of the person's appearance, such as signs of malnutrition, lack of cleanliness, changes in motor activity during the interview, mood, concentration, occurrence of dissociative reactions or flashbacks, intercurrent reactions on triggers, use of language, presence of eye contact, ability to relate to the interviewer and the means the individual uses to establish communication. The following components should be covered and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as general appearance, motor activity, speech, concentration, mood (subjective and objective assessment) and affect, sleep, appetite disturbance, thought content, thought*

process, suicidal and homicidal ideation and a cognitive examination (orientation, long-term memory, intermediate recall and immediate recall).

(i) Assessment of social function

IP §538. *Trauma and torture can directly and indirectly affect a person's ability to function. Torture can also indirectly cause impairment or loss of functioning and disability, if the psychological consequences of the experiences impair the ability of individuals to care for themselves, earn a living, support a family and pursue an education. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role (e.g. student, worker or parent), social and recreational activities and perception of health status. The interviewer should ask individuals to assess their own health conditions, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning. Because social function, by definition, encompasses an individual's behaviour, social skills, feelings and overall well-being, it is important to assess social function through multiple dimensions. Changes in social function could stem from the physical consequences of torture (such as the inability to lift weights due to shoulder joint dysfunction) or be related to the psychological consequences of torture. For example, an individual's activity level (including one's willingness to engage in previously enjoyable activities), as well as an individual's participatory level (including involvement in family reunions or engagement in society), could be detrimentally affected. Thus, the interviewer should take these dimensions into consideration during the interview.*

(j) Psychological testing and the use of checklists and questionnaires

IP §539. *Individuals who have survived torture may have trouble expressing in words their experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires.*[97] *If the clinician believes that it may be helpful to use these, there are numerous questionnaires available, although none are specific to torture victims. Before using psychological tests/ questionnaires, the clinician must take special care to evaluate their cultural appropriateness and potential negative impact on torture survivors in specific situations. The lack of standardization for the specific group of reference, the lack of cross-cultural validity, and linguistic differences can severely limit the meaningfulness and reliability of the results. Little published data exist on the use of projective and objective personality tests in the assessment of torture survivors and their use should therefore be evaluated with special care. There is no evidence that specific personality traits as measured in these tests typically result from the experience of torture or that certain personality traits are inconsistent with having been tortured. Also, psychological tests of personality lack cross-cultural validity. Personality tests have frequently been misused to stigmatize alleged victims, question their overall credibility or ascribe the emotional state to personality traits. In any case, psychological testing can only complement the clinical interview, it can never be a substitute for a comprehensive psychological evaluation as described in the present chapter. The use of psychological tests should not be considered as an imperative, nor as generally more objective or more evidentiary than the clinician's evaluation. Nevertheless, they can be an important source of additional information and, when inconsistent with the clinical impression, this should cause further exploration of the phenomena in question. Neuropsychological testing may, however, be helpful in assessing cases of brain injury resulting from torture, although issues of reliability, validity and cultural relevance must be considered seriously (see paras. 549–565 [Istanbul Protocol]).*

Refer to Appendix C (Assessment Administration Protocol).

(k) Interpretation of findings: Psychological Consistency Analysis

[97] Joseph Westermeyer and others, "Comparison of two methods of inquiry for torture with East African refugees: single query versus checklist", Torture, vol. 21, No. 3 (2011), pp. 155–172.

Consistent with international medico-legal standards, IAJ evaluators do not make "credibility determinations" (i.e. whether or not torture or CIDT credibly occurred) as these are legal matters reserved for a court. Instead, clinicians perform a **Consistency Analysis**: determining if the clinical presentation, behavioral observations, and symptom trajectory are clinically consistent with the alleged stressors. Any observed inconsistencies—such as memory gaps or emotional numbing—must be documented as potential trauma sequelae (e.g., dissociative amnesia) rather than indicators of untruthfulness.

IP §540. *The psychological findings resulting from the evaluation include all self-reported information offered by the alleged victim as well as objective findings observed or recollected by the clinician during the evaluation. In order to interpret the psychological findings for the purpose of delivering an opinion on the possibility of torture, the following important questions should be considered by the evaluator:*

(a) Are the psychological findings consistent with the alleged report of torture?

(b) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(c) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?

(d) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

(e) Which physical conditions may contribute to the clinical picture? Special attention should be paid to possible evidence of head injury sustained during torture or detention.

IP §541. *Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged torture or ill-treatment. To this end, the emotional state and expression of the person during the interview, the reported psychological, psychosocial and social impact of the alleged torture, clinical observations, the alleged history of detention and torture and the personal history prior to torture, the onset and evolution of specific symptoms related to the alleged torture, the specificity of any particular psychological findings and patterns of psychological functioning, as well as possible interactions, should be taken into consideration. Likewise, possible reasons for inconsistencies (e.g. memory gaps, cognitive impairment, dissociation, distrust, feelings of shame or guilt or other factors that may hinder disclosure) should be described and discussed (see paras. 343–353 above). Physical conditions, such as head trauma or brain injury, and additional factors should be considered, such as ongoing persecution, forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, and family and social status. The relationship and consistency between events and symptoms should be evaluated and described.*

IP §542. *If the person has symptom levels that correspond with a DSM or ICD diagnosis, the diagnosis should be stated. More than one diagnosis may be applicable. Again, it must be stressed that, even though a diagnosis of a trauma-related mental disorder can support the claim of torture, not meeting the criteria for a psychiatric diagnosis does not mean that the person was not tortured. A survivor of torture may not have the level of symptoms required to meet diagnostic criteria for a DSM or ICD diagnosis fully. In these cases, as with all others, the symptoms that the survivor has and the alleged torture, as well as protective factors and coping mechanisms, should be considered as a whole. The degree of consistency between the alleged torture or ill-treatment and the entirety of the psychological findings should be evaluated and described in the report.* **The IAJ reminds the reader that, consistent with this Cautionary note, evaluators must remember that the finding of legal credibility is the sole responsibility of a court. The IAJ investigator's assessment of "credibility" is strictly limited to the clinical consistency of the statements made by the person under evaluation.**

IP §543. *Depending on the legal and jurisdictional context and requirements under which clinicians prepare a medico-legal report, the consistency of psychological findings with the alleged torture and/or ill-treatment could be described as follows:*

(a) "Not consistent with": the psychological findings could not have been caused by the alleged torture or ill-treatment;

(b) "Consistent with": the psychological findings could have been caused by the alleged torture or ill-treatment, but they are non-specific and there are many other possible causes;

(c) "Highly consistent with": the psychological findings could have been caused by the alleged torture or ill-treatment and there are few other possible causes;

(d) "Typical of": the psychological findings are typically found as a consequence of the alleged torture or ill-treatment and there are few other possible causes;

(e) "Highly Consistent (IP §543(e))": the psychological findings could not have been caused in almost any way other than the alleged torture or ill-treatment.

The IAJ notes the **Rule of Non-Legal Attribution:** When a report uses the term "directly attributable" or "highly consistent with" under the **IAJ Clinical Attribution Framework**, it refers to a clinical consistency judgment—the degree of scientific fit between the documented stressor and the biological outcome. Evaluators are cautioned that "attribution" in a forensic report does not imply a legal finding of liability, which remains the sole province of a court.

IP §544. *Specifying the degree of consistency is common in evaluating physical evidence of torture or ill-treatment and can be useful for psychological evidence as well. However, the underlying logic differs as consistency between psychological findings and alleged torture or ill-treatment does not refer to the connection between a specific symptom and a specific torture or ill-treatment method. Instead it refers to the connections between a set of traumatic experiences and the overall psychological, psychosocial and psychiatric presentation of the person. The primary question is whether these connections make sense and the extent to which they are explained by the abuse the person alleges to have suffered. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed (see paras. 343–353 above).*

IP §545. *Clinicians should note that the level of consistency denoted by "typical of" refers to expected or typical reactions to extreme stress within the cultural and social context of the individual. It is not commonly used to assess psychological evidence of torture or ill-treatment as the psychological consequences tend to depend on individual factors. The presence or absence of a "typical psychological reaction" should not be considered any more or less meaningful or corroborative than the level of consistency denoted by "highly consistent". Also, the level of consistency denoted by "diagnostic of" is used more frequently in the interpretation of physical evidence of torture or ill-treatment and is rarely used in the interpretation of psychological evidence.*

(I) Supplemental Forensic Multi-Axial Framework

While the IAJ utilizes DSM-5/ICD-11 diagnostic criteria, evaluators are encouraged to utilize the **DSM-IV Multiaxial System** as a descriptive forensic tool to capture the "web of systems" involved in systemic torture. This framework promotes a holistic view of the individual's mental, medical, and psychosocial functioning:

- **Axis I – Clinical Disorders:** Primary psychiatric outcomes of torture (e.g., PTSD, EPCACE).
- **Axis II – Enduring Patterns:** Personality changes or developmental regressions triggered by **"Shattering"**.

- **Axis III – General Medical Conditions:** Documents physical tissue injury, MS relapses, or cardiac events resulting from **Biological Assault**.
- **Axis IV – Psychosocial and Environmental Problems:** Identifies institutional stressors such as **Institutional Entrapment**, housing instability, or family conflict.
- **Axis V – Global Assessment of Functioning (GAF) [LEGACY TOOL: GAF was removed from DSM-5 due to reliability and psychometric limitations. It is retained here as a legacy descriptive approximation only. Modern practice should prefer WHODAS 2.0 (WHO Disability Assessment Schedule) or equivalent validated functional assessment instrument where available.] (GAF):** Provides a numerical rating (0–100) of overall psychological, social, and occupational functioning to approximate **Severity and Functional Impact**.

(m) Beyond Standard PTSD: Comprehensive Diagnostic Frameworks for Systemic Torture

IP §546. *Clinicians should formulate a clinical opinion on the possibility of torture or ill-treatment based on all relevant clinical evidence, including, "physical*[98] *and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc." as stated in paragraph 382 [Istanbul Protocol] and annex IV. The clinician's opinion on the possibility of torture or ill-treatment should be expressed using the same levels of consistency as that used for interpretation of findings: not consistent with, consistent with, highly consistent with, typical of and diagnostic of. Ultimately, it is the overall evaluation of all the clinical findings, and not the consistency of each lesion or symptom with a particular form of torture or ill-treatment, that is important in assessing the allegations of torture or ill-treatment.*

IP §547. *In addition to providing a conclusion on the possibility of torture or ill-treatment, clinicians should reiterate current symptoms and disabilities and likely effects on social functioning and provide any recommendations for further evaluations and care for the individual.*

IP §548. *The recommendations resulting from the psychological evaluation can vary and depend on the question posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement, the need for treatment or reparation. Recommendations can be for further assessment, such as neuropsychological testing, medical, psychological or psychiatric treatment, custody conditions or the need for security or asylum. Whenever the clinician detects a need 471 for psychological or medical treatment, a referral should be made, independently of the question posed at the time the evaluation was requested.*

I. The Limitation of Standard PTSD

Conventional diagnostic categories (PTSD, Adjustment Disorder, Major Depressive Disorder MDD) are frequently insufficient to capture the erosion of personality and functional "shattering" characteristic of systemic institutional torture. In U.S. judicial contexts, standard PTSD often fails to account for **Distress-Induced Harm** where the stressor is a prolonged procedural mechanism rather than a single kinetic event.

II. Complex PTSD (ICD-11: 6B41)

[98] Clinical evaluations that are conducted specifically to assess "psychological evidence" may include some "physical findings", for example complaints of physical injuries and symptoms or observations of physical signs during the interview.

Where the clinical presentation supports it, the evaluator must assess for **Complex PTSD (CPTSD)**. This diagnosis is specifically indicated for "prolonged or repeated" exposure to stressors from which "escape is difficult or impossible"—a hallmark of **Institutional Entrapment**.

- **Affective Dysregulation**: Documenting "emotional flooding" or "shutdown" triggered by court-imposed terminal deadlines.
- **Negative Self-Concept**: Persistent feelings of worthlessness and "institutional betrayal" resulting from the **Accommodation-Punishment Cycle** .
- **Disturbed Relationships**: Pervasive hypervigilance and loss of trust in all institutional and social safeguards.

III. Enduring Personality Change After Catastrophic Experience (EPCACE, ICD-10: F62.0)[99]

The IAJ Standard identifies EPCACE as a primary diagnostic framework for survivors of systemic U.S. institutional harm. Key features include:

- **Shattering of the Self**: The systematic dismantling of individual autonomy through total institutional control and the weaponization of procedure.
- **Hostile or Mistrustful Attitude**: A documented shift in personality resulting from the experience of a *__forum nullus__*.
- **Chronic Helplessness**: Transitioning from proactive self-advocacy to a state of **Learned Helplessness**.

IV. The "Shattering" Standard and Forensic Probability

The IAJ introduces **"Shattering"** not as a symptom, but as a diagnostic threshold for systemic torture and CIDT. To satisfy the **Forensic Probability Standard**, the evaluation must document:

- **Baseline Contrast**: A complete loss of pre-existing coping mechanisms compared to documented baseline functioning.
- **Biological Progression**: Where supported by disease-specific evidence, documenting whether severe distress was temporally and clinically associated with objective or clinically reliable physical deterioration (for example, relapse activity, inflammatory flare, infection susceptibility, or other stress-mediated worsening) following institutional triggers.
- **Prognosis**: A determination of whether the injury is permanent due to the **"Substantial Contributing Factor"** of unaccommodated institutional stress.

(n) Correlating Psychological Sequelae with Physical Methods

I. Foundational Principle: The Somatic-Psychological Bridge

While this Standard prioritizes neuroendocrine and stress-mediated harm, evaluators must document traditional physical methods to identify the **totality of cumulative harm**. In systemic institutional

[99] The IAJ has documented the likelihood of death, or catastrophic injury from the psychological impact of torture and CIDT. The disease model by Solomon et al. confirms physical injury may be produced through distress – see The Multiple Sclerosis Stress Equation, Journal of Medical Statistics and Informatics, ISSN 2053-7662, Volume 11, Article 1

investigations, physical evidence often serves as the "Somatic Anchor" for findings of **Complex PTSD** or **EPCACE**.

II. Clinical Correlation Table for Traditional Methods

The following methods must be documented with specific attention to their psychological sequelae:

III. Integration into the Forensic Probability Standard

Physical Method	Primary Clinical Signs	Psychological Correlation
Falanga (Bastinado)	Chronic pain, gait disturbance, orthopedic damage to the feet.	Extreme fear of movement; inability to flee institutional triggers.
Suspension (Positional)	Brachial plexus injuries, joint dislocations, long-term nerve damage.	Induced helplessness; sense of "biological entrapment".
Asphyxiation (Submarino)	Petechiae (broken capillaries), chronic respiratory distress.	Acute panic; "shattering" of the survival instinct.
Electrical Injuries	Characteristic 1–5 mm "punched-out" lesions or skin burns.	Anticipatory terror; hyper-dependence on the oppressor.

To satisfy the requirement for **Diagnostic Certainty**, evaluators must not merely list these findings but perform a **Causation Synthesis**:[100]

- **Factual Primacy:** Correlate documented stun-gun lesions or positional nerve damage with specific psychological indicators of **Shattering**.
- **Biological Anchoring:** Use physical examination findings (e.g., musculoskeletal fractures) to corroborate the severity of **Distress-Induced Harm** reported by the examinee.
- **Differential Analysis:** Proactively document why these physical sequelae are "Typical Of" the alleged torture and cannot be explained by routine domestic stressors.

IV. Mandatory Documentation Protocols

Evaluators shall integrate specialized physical examination protocols as supportive data:

- **Dermatologic Evaluation:** Systematic mapping of scars and lesions to establish methodological consistency with regional torture patterns.
- **Musculoskeletal Review:** Identifying gait or joint impairments that contribute to the examinee's **Functional Impact** scores.
- **Genital & Perianal Examination:** Required where sexual torture is alleged to identify the physiological conduit of the **Biological Assault**.

Physicians for Human Rights provides training on physical methods and evidence, including picture-based training. See the PHR website Tools & Resources at https://phrtoolkits.org/.

[100] Strengthens Admissibility: Judges often find physical markers (scars/nerve damage) more "tangible" than psychological symptoms. This chapter forces the court to recognize the psychological injury attached to those physical markers. Prevents Fragmentation: It prevents the evaluation from being split into separate "physical" and "mental" tracks, which defense counsel often use to minimize the overall severity of harm. Standard Alignment: It ensures the IAJ Standard remains fully compatible with the physical examination requirements of IP Annex IV while focusing on the U.S. context of systemic harm.

Neuropsychological assessment

IP §549. *Clinical neuropsychology is an applied science concerned with the behavioural expression of brain dysfunction. Neuropsychological assessment, in particular, is concerned with the measurement and classification of behavioural disturbances associated with organic brain impairment and neuropsychological tests are designed to assess deficits in cognitive performance. Understanding the nature, the severity and the modality of cognitive complaints is best served by a neuropsychological assessment performed by a qualified psychologist with relevant competencies in neuropsychological assessments. Such an assessment provides useful information about the patient's cognitive functioning, something that is not easy to obtain otherwise. Neuropsychological evaluations of alleged torture victims are performed infrequently but may be helpful in identifying and quantifying some form of cognitive impairment. The following remarks are limited to a discussion of general principles to guide clinicians in understanding the utility of, and indications for, neuropsychological assessments of persons alleging torture. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessments in this population.*

(a) Limitations of neuropsychological assessments

IP §550. *There are a number of common factors complicating the assessment of torture survivors in general that are outlined elsewhere in this manual. These factors apply to neuropsychological assessments in the same way as to medical or psychological examinations. Neuropsychological assessments may be limited by a number of additional factors, including lack of research on torture survivors, reliance on population-based norms, cultural and linguistic differences and the risk of retraumatization of those who have experienced torture.*

IP §551. *As mentioned above, very few references exist in the literature concerning the neuropsychological assessment of torture survivors. The pertinent body of literature concerns various types of head trauma and the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on the application of general principles used with other subject populations.*

IP §552. *Neuropsychological assessments as they have been developed and practised in Western countries rely heavily on an actuarial approach. This approach typically involves comparing the results of a battery of standardized tests to population-based norms. Although norm-referenced interpretations of neuropsychological assessments may be supplemented by a Lurian approach of qualitative analysis, particularly when the clinical situation demands it, a reliance on the actuarial approach predominates.*[101] *Moreover, a reliance on test scores is greatest when brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder.*

IP §553. *Cultural and linguistic differences may significantly limit the utility and applicability of neuropsychological assessments among alleged torture victims. There are many neuropsychological tests available but the majority of them have been developed and "normed" in a Western/European context. The examiner should be aware of these limitations and should adapt the selection of methods and instruments to the specific background of the person, including education, language, culture and familiarity with testing.*[102] *Neuropsychological assessments are of questionable validity when standard translations of tests are unavailable and the clinical examiner is not fluent in the subject's language. Unless standardized translations of tests are available and examiners are fluent in the subject's language, verbal tasks cannot*

[101] Alexander Romanovich Luria and Lawrance V. Majovski, "Basic approaches used in American and Soviet clinical neuropsychology", American Psychologist, vol. 32, No. 11 (1977), pp. 959–968. See also Robert J. Ivnik, "Overstatement of differences", American Psychologist, vol. 33, No. 8 (1978), pp. 766–767; and Uwe Jacobs and Vincent Iacopino, "Torture and its consequences: a challenge to clinical neuropsychology", Professional Psychology Research and Practice, vol. 32, No. 5 (2001), pp. 458–464.

[102] Bahrie Veliu and Janet Leathem, "Neuropsychological assessment of refugees: methodological and cross-cultural barriers", Applied Neuropsychology: Adult, vol. 24, No. 6 (2017), pp. 481–492.

be administered at all and cannot be interpreted in a meaningful way. This means that only non-verbal tests can be used and this precludes comparison between verbal and non-verbal faculties. In addition, an analysis of the lateralization (or localization) of deficits is more difficult. This analysis is often useful, however, because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech. If population-based norms are unavailable for the subject's cultural and linguistic group, neuropsychological assessments are also of questionable validity. An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the population of the United States of America, for example, these estimates are often derived from verbal subsets using the Wechsler scales, particularly the information subscale, because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than other tasks and be more representative of past learning ability than other measures. Measurement may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations apply to subjects for whom population based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

IP §554. *Neuropsychological assessments may retraumatize those who have experienced torture. Great care must be taken in order to minimize any potential retraumatization of the alleged victim in any form of diagnostic procedure (see paras. 277–280 above). To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Neuropsychological Battery, in particular the Tactual Performance Test, and routinely blindfold the subject. For most torture survivors who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the instrument used. Being observed, timed with a stopwatch and asked to give maximum effort on an unfamiliar task, in addition to being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of the torture experience.*

(b) Indications for neuropsychological assessment

IP §555. *In evaluating behavioural deficits in alleged torture victims, there are two primary indications for neuropsychological assessment: brain injury and PTSD plus related diagnoses. While both sets of conditions overlap in some aspects, and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic. A typical neuropsychological assessment will include a clinical interview with the patient to determine: highest level of formal education obtained, the presence of pre-existing learning difficulties, medical and psychological history, previous head injuries, including ones from childhood, and a more detailed review of the patient's cognitive complaints and emotional status. Based on the information gathered during the interview and from the documentation and referral questions, the neuropsychologist then decides which cognitive and emotional domains need to be assessed and may identify tests that are validated, reliable and culturally appropriate for the person, or choose not to use tests but rely on a detailed clinical interview. Most neuropsychologists now use a flexible battery approach, in which the tests are chosen based on the information gathered, systematic hypotheses testing and an understanding of the underlying medical condition that is purportedly responsible for the cognitive and emotional difficulties.*

IP §556. *Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances inflicted during periods of torture or ill-treatment. This may include gunshot wounds, the effects of poisoning, malnutrition as a result of starvation or forced ingestion of harmful substances, the effects of hypoxia or anoxia resulting from asphyxiation or near drowning and, most commonly, from blows to the head suffered during beatings. Blows to the head are frequently inflicted during periods of detention and torture. For example, in one sample*

of torture survivors, 91 per cent reported beating of the head.[103] *The potential for resulting brain damage is high among torture survivors.*

IP §557. *Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. The cognitive and emotional domains that are typically assessed in a comprehensive neuropsychological assessment are: intellect; higher cognitive abilities (executive functioning); attention; memory; visual-spatial abilities; motor and sensory abilities; and emotional status. Signs of injury may include scars on the head, but absence of scars does not exclude significant brain injury. Brain lesions sometimes cannot be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by mental health professionals because symptoms of depression and PTSD are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short-term memory, which can either be the result of brain impairment or reflect the psychological consequences of torture. Since these complaints are common in survivors suffering from PTSD or depression, the question whether they are actually due to head injury may not even be asked.*

IP §558. *The diagnostician must rely, in an initial phase of the examination, on reported history of head trauma and the course of symptomatology. Deciding when to refer for a neuropsychological assessment needs to be done on a case-by-case basis. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, may prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, "inside" the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic, lacks fluctuation and is confirmed by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.*

IP §559. *Once there is a suspicion of organic brain impairment, the first step for a mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation are among the possibilities to be considered. The use of neuropsychological evaluation procedures is usually indicated if there is a lack of gross neurological disturbance, reported symptoms are predominantly cognitive in nature or a differential diagnosis between brain impairment and PTSD has to be made.*

IP §560. *The selection of neuropsychological tests and procedures is subject to the limitations specified above and, therefore, cannot follow a standard battery format, but rather must be case specific and sensitive to individual characteristics. The flexibility required in the selection of tests and procedures demands considerable experience, knowledge and caution on the part of the examiner. As has been pointed out above, the range of instruments to be used will often be limited to non-verbal tasks, and the psychometric characteristics of any standardized tests will most likely suffer when population-based norms do not apply to an individual subject. An absence of verbal measures represents a very serious limitation. Many areas of cognitive functioning are mediated through language and systematic comparisons between various verbal and non-verbal measures are typically used in order to arrive at conclusions regarding the nature of deficits.*

IP §561. *The choice of instruments and procedures in neuropsychological assessments of alleged torture victims must be left to the individual clinician, who will have to select them in accordance with the demands and possibilities of the*

[103] Dorte Reff Olsen and others, "Prevalent pain and pain level among torture survivors: a follow up study", Danish Medical Bulletin, vol. 53, No. 2 (2006), pp. 210–214.

situation. Neuropsychological tests cannot be used properly without extensive training and knowledge in brain-behaviour relations. Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references.[104]

(c) Post-traumatic stress disorder

IP §562. *The considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in alleged torture victims. This must be even more strongly the case in attempting to document PTSD in alleged victims through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider. PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have been invoked more frequently than in the past. However, the findings so far are diverse and thus not applicable for diagnostic purposes.*

IP §563. *There is great variability among the samples used for the study of neuropsychological measures in post-traumatic stress. This may account for the variability of the cognitive problems reported from these studies. It was pointed out that "clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning".*[105] *This is consistent with complaints heard frequently from torture survivors. Subjects describing difficulties in concentrating and feeling unable to retain information and engage in planned, goal-directed activity.*

IP §564. *Neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared with normal controls but they have failed to discriminate these subjects from matched psychiatric controls.*[106] *In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD, but insufficient for diagnosing it. As in many other types of assessment, the interpretation of test results must be integrated into a larger context of interview information. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they do for other psychiatric disorders associated with known neurocognitive deficits.*

IP §565. *Despite significant limitations, neuropsychological assessment may be useful in evaluating individuals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment may also be used to evaluate specific symptoms, such as problems with memory and quantify actual impairment and resulting considerations for redress and rehabilitation. The assessment of cognitive capacities can also be useful in determining barriers to participate in adjudicative processes. Assessment of memory difficulties may inform judges and other decision makers about the weight to be given to discrepancies in the evidence. A person may lack the mental capacity*[107] *to*

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[104] Esther Strauss, Elisabeth M.S. Sherman and Otfried Spreen, A Compendium of Neuropsychological Tests: Administration, Norms and Commentary, 3rd ed. (New York, Oxford University Press, 2006).

[105] Jeffrey A. Knight, "Neuropsychological assessment in posttraumatic stress disorder", in Assessing Psychological Trauma and PTSD, John P. Wilson and Terence M. Keane, eds. (New York, Guilford Press, 1997), pp. 448–492.

[106] John E. Dalton, Sanford L. Pederson and Joseph J. Ryan, "Effects of post-traumatic stress disorder on neuropsychological test performance", International Journal of Clinical Neuropsychology, vol. 11, No. 3 (1989), pp. 121–124; and Tzvi Gil and others, "Cognitive functioning in post-traumatic stress disorder", Journal of Traumatic Stress, vol. 3, No. 1 (1990), pp. 29–45

[107] Mental capacity refers to the capacity to understand the information relevant for a decision, as well as retaining and weighing up the information and communicating the decision effectively. In torture survivors, these capacities may be affected as mood and psychotic disorders are likely to affect the ability to weigh and balance information and cognitive deficits may affect the ability to understand and retain relevant information.

instruct a legal representative, to consent to an examination, to be interviewed or to give evidence. Assessment of impairments in cognition might find a person with basic decision-making capacity has a lack of insight into how their memory and concentration difficulties affect their ability to give evidence and be interviewed or cross-examined. Their ability to understand the inferences others may draw from the ways in which these difficulties affect their evidence may be compromised.

The preceding sections have established the general methodology for psychological evaluations of torture and CIDT. However, certain populations require adapted approaches that account for developmental, cultural, or identity-specific factors. The following sections address these special populations, beginning with children—who require developmentally appropriate methods—and continuing with LGBTQI+ individuals—who face unique forms of persecution and require culturally competent evaluation approaches. Evaluators must be familiar with these adaptations before working with these populations.

Children and torture

IP §566. *Torture can affect a child directly or indirectly. The impact can be due to the child having been tortured or detained, the torture of parents or close family members, or witnessing torture and violence or learning that it occurred to meaningful others. Torture is a significant risk factor for disrupting children's psychological, physical, emotional and social development and negatively affecting children's mental and physical health. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this manual. Nevertheless, several important points can be summarized.*

IP §567. *First, when evaluating a child who is suspected of having undergone torture, the clinician needs to be informed and adhere to the Istanbul Protocol and its Principles. The clinician must make sure that children receive support from caring individuals and that they feel secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation or parts of it. Second, the clinician must keep in mind that children do not often express their thoughts and emotions regarding trauma verbally, but rather behaviourally. The degree to which children are able to put feelings, thoughts and memories into words depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics, cultural norms and psychosocial context. There are several guidelines regarding how to best interview a child that clinicians can use to support their work (see paras. 284–293 above).*

IP §568. *If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse and by using appropriate guides.*[108]

(a) Developmental considerations

IP §569. *Developmental factors affect the capacity of children and adolescents to perform tasks that are relevant to the assessment.*[109] *Research on forensic interviewing notes that children begin to manifest the capacity to recall events*

[108] Royal College of Paediatrics and Child Health, The Physical Signs of Child Sexual Abuse: An Evidence-Based Review and Guidance for Best Practice (Lavenham, United Kingdom, Lavenham Press, 2015). See also Astrid Heger, S. Jean Means and David Muram, eds., Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas, 2nd ed. (New York, Oxford University Press, 2000).

[109] Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128.

accurately between the ages of 3 and 6, but there is high variability.[110] *Nonetheless, information that is valuable and truthful can be obtained from children. This will require careful interviewing procedures and an awareness of children's capacities.*[111]

IP §570. *Infants can be evaluated and observed although they cannot be verbally interviewed. The clinician can comment on the level of activity, the nature of interaction and relationships with others, affect and state of regulation, general mood and involvement in play. The reports of parents or caregivers on the behaviour of their infant (eating, sleeping and temperament) may be useful, particularly in relation to changes in developmental milestones or noteworthy regressions or loss of previously held capabilities. Assessments using infant development scales may provide an indication of the infant's level of functioning in relation to age group.*

IP §571. *Preschool children generally have high levels of suggestibility and social compliance with adults' requests and their cognition is characterized by prelogical, magical and egocentric thinking that might be confused with factual events. They construct reality on their observable world, tend to think in absolute terms and experience rapid changes of emotional states. However, language develops rapidly between the ages of 3 and 5 and children can talk about their concerns and feelings and give truthful descriptions of events. They respond best to short, concrete, probing questions designed to expand on their ideas and clarify them.*

IP §572. *Between the ages of 6 and 12, children can think more planfully and perform different mental tasks. However, thinking remains concrete, rigid and literal. They tend to think in terms of factual rather than logical relationships and cannot reflect on possible outcomes. At the same time, they do understand cause and effect relationships, have social consciousness and can comprehend inconsistencies in social behaviour. Capacity to discuss abstract issues is limited and there is vulnerability to negative feedback and misleading questions.*

IP §573. *Adolescents are less concrete in their thinking and are capable of symbolic and rational thinking. They place a high value on peer influence and may hold an attitude of invincibility and be more likely to engage in risk-taking behaviour. But they are also more capable than younger children in recognizing the boundaries and ethical requirements of an evaluation, as well as the reason for an examination related to experiences of torture or ill-treatment. Researchers note that adolescents can accurately report symptoms, events and experiences with a proper sense of time and setting.*[112] *The clinician should let the adolescent know that their opinions and inputs are valued. Privacy can be of special concern to adolescents and confidentiality limitations should be reviewed carefully. It is advisable to begin with a focus on neutral issues and address sensitive issues later.*[113]

IP §574. *There are important differences between autobiographical memory retrieval strategies and the capacities of preschool and older children: younger children tend to remember less information, provide briefer accounts of their experiences than older children do and are more likely than older children to respond erroneously to suggestive questions. Furthermore, the younger the children, the more their experience and understanding of the traumatic event will be*

[110] Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128.

[111] Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128.

[112] Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128. See also: Zoe Given-Wilson, Jane Herlihy and Matthew Hodes, "Telling the story: a psychological review on assessing adolescents' asylum claims", Canadian Psychology, vol. 57, No. 4 (2016), pp. 265–273.

[113] Sayer Gudas and Sattler, "Forensic interviewing of children and adolescents".

influenced by the immediate reactions and attitudes of caregivers following the event.[114] *Nevertheless, it is important to note that younger children's reports are no less accurate than those of older children.*[115]

Autobiographical Memory and Recall: There are significant differences between the memory retrieval strategies of preschool and older children. Younger children tend to provide briefer accounts and remember less information than older children. Per **IP §574**, younger children are also more likely to respond erroneously to suggestive questions. Furthermore, the younger the child, the more their experience and understanding of the traumatic event will be influenced by the immediate reactions and attitudes of caregivers following the event. Despite these differences, it is a critical forensic principle that younger children's reports are no less accurate than those of older children.

IP §575. *A child's reactions to torture depend on age, developmental stage and cognitive skills.*[116] *For children under the age of 3 who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.*[117] *The reactions of very young children to traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance of people, places, physical reminders, interpersonal situations or conversations (such as a clinical interview) that arouse recollections of the trauma. Children older than 3 often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8–9 years old), when children develop the ability to provide a reliable chronology of events.*[118] *These new skills are still fragile and it is not usually until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a robust developmental period when the effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents resulting in chronically dysregulated emotional functioning, and behavioural and relational problems. Alternatively, the effects of torture on adolescents may be similar to those seen in younger children, with regression and diminishment of functioning.*

Cognitive and Operational Stages: A child's reactions to torture depend on age, developmental stage, and cognitive skills. The ability for verbal expression increases significantly during development. A marked increase occurs around the **concrete operational stage (8–9 years old)**, when children first develop the ability to provide a reliable chronology of events. These skills remain fragile, and per **IP §575**, children are not usually consistently able to construct a coherent narrative until the beginning of the **formal operational stage (12 years old)**. Adolescence follows as a robust developmental period where the effects of torture can vary widely, sometimes causing profound personality changes and chronically dysregulated emotional functioning.

(b) Considerations for conducting the evaluation

IP §576. *As a preparation for the evaluation, clinicians need to consider the individual and contextual circumstances that require an adjustment of the complexity of language and the expectations for the level of detail that the child will be*

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[114] Saskia von Overbeck Ottino, "Familles victimes de violences collectives et en exil: quelle urgence, quel modèle de soins? Le point de vue d'une pédopsychiatre", Revue française de psychiatrie et de psychologie médicale, vol. 14 (1998), pp. 35–39.

[115] Michael E. Lamb and others. "Structured forensic interview protocols improve the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol", Child Abuse & Neglect, vol. 31, No. 11–12 (2007), pp. 1201–1231.

[116] Australian Child and Adolescent Trauma, Loss and Grief Network, "How children and young people experience and react to traumatic events" (2010), p. 4.

[117] Michel Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", in Psychiatrie humanitaire en ex-Yougoslavie et en Arménie: face au traumatisme, Marie Rose Moro and Serge Lebovici, eds. (Paris, Presses universitaires de France, 1995), pp. 89–106.

[118] Jean Piaget, La naissance de l'intelligence chez l'enfant, 9th ed. (Neuchâtel, Delachaux et Niestlé, 1977).

able to provide.[119] *Wherever possible, it is recommended to gather information from parents, teachers and others about the child's developmental history, special needs, psychiatric and medical history, social and school functioning, and behavioural adjustment.*[120] *Caregivers can also provide information about the child's emotions and alterations in mood and behaviour. If the child or adolescent is not accompanied by parents, or parental substitutes, as occurs in the case of unaccompanied minors in asylum cases, special attention should be given to establishing a trustful and welcoming atmosphere. It is also important to make sure that the unaccompanied minor is taken care of after the interview.*

IP §577. *The clinician should be aware of and consider the potential risks and threats to the child, e.g. by the perpetrators of torture. It is strongly recommended that clinicians plan for an evaluation that can be longer than that of adults, considering the time that might be required to establish rapport with a child or allow them the time that might be required to share important and sensitive information.*[121] *This could mean scheduling the evaluation over several days of meetings and including time for breaks and conversations and activities unrelated to the torture or ill-treatment experience. The level of communication with the child needs to be appropriate to their age, level of development, communication skills and other individual and contextual circumstances.*[122] *The child should be provided with information and explanations about the evaluation that will enable them to make decisions on whether and how they wish to participate in the procedure in a way that is comprehensible to them and appropriate to their age and level of maturity. Potential and actual risks should be considered with the child. To the degree that it is possible and in the best interests of children, it is a good practice to include their parents or guardians in the assessment process and to arrive at a clear, mutual understanding regarding the nature and degree of their participation and of the information that will be given to them.*

IP §578. *The establishment of trust can be challenging, as the child may experience the interview situation or conditions as reminiscent of the torture or ill-treatment. Trust may be undermined due to age and power imbalances or if clinicians or interpreters are perceived as representative of the political, ethnic or social group whose authorities executed the torture. These factors may affect the trust and comfort of the parents and guardians with the evaluation as well. It may be impossible to achieve the establishment of trust within the limited time frame of the evaluation. The UNCHR guidelines for interviewing children in the context of applications for asylum in the European Union state that: "Good practice in building trust was evidenced at the beginning of many interviews at which the interviewers introduced the interpreters, explained their role, the meaning of confidentiality, that they would speak in the first person and interpret verbatim."*[123]

IP §579. *It is recommended to greet the child appropriately and to begin the assessment with neutral subjects on matters related to the child's everyday life, such as school, friendships and favoured activities. Another factor that can potentially facilitate the establishment of trust is a reduction of psychological distance and formality; for example, by using a round or oval table and avoiding having a computer screen in front of the clinician and interpreter. It is recommended that the clinician provide ample opportunity for breaks and notice the child's presentation with special care taken to not overwhelm the child. If there are indications that the child is becoming anxious, dissociated or in notable*

[119] UNHCR, The Heart of the Matter: Assessing Credibility when Children Apply for Asylum in the European Union (Brussels, 2014), p. 107.

[120] Kathryn Kuehnle and Steven N. Sparta, "Assessing child sexual abuse allegations in a legal context", in Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 129–148.

[121] Kathryn Kuehnle and Steven N. Sparta, "Assessing child sexual abuse allegations in a legal context", in Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 129–148.

[122] UNHCR, The Heart of the Matter, p. 107.

[123] UNHCR, The Heart of the Matter: Assessing Credibility when Children Apply for Asylum in the European Union (Brussels, UNHCR, 2014). p. 126.

distress, the evaluator should make note of these clinical indicators and take all steps to relieve the child and/or provide psychosocial support. The evaluation can be recorded with the consent of the child and possibly that of the parent or guardian to enable the interviewers to maintain direct communication with the child without the interruptions of note-taking.[124] *If the assessment is recorded, extra caution should be given to keeping the recording confidential, with limited access given only to the assessment team and to protecting the child's identity. If there are any other local legal requirements regarding data protection, these should be adhered to.*

IP §580. *It can be useful and provide additional support for the evaluation's conclusions to use assessment instruments. It is recommended that clinicians use instruments the validity and reliability of which have been established for the particular population that is assessed. When such instruments are not available, great caution should be taken in the interpretation of test results. Any adaptation in administration and interpretation procedures should be documented and the potential impact on the findings should be noted.*[125]

(c) Clinical considerations

IP §581. *An assessment of the psychological effects of torture and ill-treatment on children and young persons should include information regarding the following: (a) the child's age, developmental status, as well as current and past psychological and medical functioning (including cognitive, communication and language abilities, special needs, social and school functioning, behavioural adjustment and emotional disorders); (b) chronological personal and family history of life events, residences etc.; (c) description of the alleged torture or ill-treatment, its frequency and duration; (d) information regarding whether the child witnessed the death and/or torture of others, especially meaningful others, or learned that it had occurred to meaningful others; (e) the alleged torturer's identity and what it represents for the child in their particular social and political context; (f) protective factors and indicators of resilience; (g) the availability of family and other caregivers to provide psychosocial support; (h) the legal status of the child; and (i) the provisions in place for treatment and support.*

IP §582. *While symptoms may appear in children and can be similar to those observed in adults, manifestation of symptoms can be very different from adults and the clinician must rely more heavily on observations of the child's behaviour than on verbal expression, consider the child's behaviour before the alleged torture or ill-treatment and use developmental milestones to identify any potential impact on normal behaviour.*[126] *Collecting information from caregivers, teachers or other adults in the child's environment is advised and might be necessary. Research has delineated the effects of trauma on children's mental and physical health. For example, it has been found that trauma significantly compromises cognitive development,*[127] *and that exposure to traumatic experiences increases the risk of learning and behavioural problems, obesity*[128] *and psychotic symptoms in childhood.*[129] *Neurobehavioural development research shows*

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[124] UNHCR, The Heart of the Matter: Assessing Credibility when Children Apply for Asylum in the European Union (Brussels, UNHCR, 2014). p. 107.

[125] Gerald P. Koocher, "Ethical issues in forensic assessment of children and adolescents", in Forensic Mental Health Assessment of Children and Adolescents, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 46–63.

[126] See Lenore C. Terr, "Childhood traumas: an outline and overview", American Journal of Psychiatry, vol. 148, No. 1 (1991), pp. 10–20; Zero to Three, DC:0–5: Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, version 2.0 (Washington, D.C., 2021); Françoise Sironi, "'On torture un enfant', ou les avatars de l'ethnocentrisme psychologique", Sud/Nord – Folies et Cultures, No. 4 (Enfances) (1995), pp. 205–215; and Lionel Bailly, Les catastrophes et leurs conséquences psychotraumatiques chez l'enfant (Paris, ESF, 1996).

[127] Michelle Bosquet Enlow and others, "Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study", Journal of Epidemiology and Community Health, vol. 66, No. 11 (2012), pp. 1005–1010.

[128] Nadine J. Burke and others, "The impact of adverse childhood experiences on an urban paediatric population", Child Abuse & Neglect, vol. 35, No. 6 (2011), pp. 408–413.

[129] Louise Arseneault and others, "Childhood trauma and children's emerging psychotic symptoms: a genetically sensitive longitudinal cohort study", American Journal of Psychiatry, vol. 168, No. 1 (2011), pp. 65–72.

that children's brain development is affected by the environment in which they grow up. Although they may not be able to recall, the memory of torture can have a traumatic effect on babies and toddlers with potential long term impact on their attachment, regulation and experience of trust.[130] *The environment and trauma will influence an adolescent's identity, brain maturation and thought functions, such as abstract thought and the ability to consider multiple perspectives, as well as the regulation of emotions and emotional processing, which are still developing at this age.*[131]

Manifestation of Symptoms: While symptoms in children can be similar to those in adults, their manifestation is often unique. Clinicians must rely more heavily on observations of the child's behavior than on verbal expression alone. This requires comparing the child's current behavior to their status before the alleged torture and using **developmental milestones** to identify impacts on normal behavior. Per **IP §582**, collecting information from teachers, caregivers, or other adults in the child's environment is not only advised but often necessary for a complete clinical picture.

IP §583. *Symptoms of PTSD may appear in children. The symptoms can be similar to those observed in adults, but the clinician must rely more heavily on observations of the child's behaviour than on verbal expression.*[132] *For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and recurrent nightmares that for younger children in particular (e.g. those aged 6 and less) may not have recognizable content. Children may also articulate repetitive concerns that the torture will occur again or that the perpetrators will hurt them or their loved ones again in spite of reassurances that they are safe. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes towards self and others and feelings that there is no future. The child may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. The child may complain about bodily aches, such as stomach aches, or other physical problems. Fears and aggressive behaviour that were non-existent before the traumatic event may appear as aggressiveness towards peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. Children may demonstrate sexual behaviour that is inappropriate for their ages. Post-traumatic behavioural changes can also include risk-taking behaviour, self-harm and suicide attempts. The child may become avoidant and/or clingy around parents or caregivers, exhibit explosive outbursts or tantrums, or exhibit a trance like state, lapses in attention, confusion, forgetfulness and unresponsiveness. Anxiety symptoms, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying may appear. Distress can be manifest in other behaviours, such as nail-biting and thumb-sucking, and changes in the use of language. The child may also develop eating problems. Teenagers may present very differently, initially denying any symptoms and insisting that their level of function is good and that they have no need of help. Peer pressure to fit in with others and fear of the stigma of mental illness can be particularly evident. Teenagers may have particular difficulty in managing features of PTSD, such as angry outbursts and irritability, directing violence at others or themselves. The examiner needs to take additional time to build trust and rapport and assess carefully for indirect indicators of mental distress, including, for example, appetite, sleep pattern, ability to form friendships and confide in others, self-harming behaviour, risk-taking behaviour and anger management.*

(d) Diagnostic classification

[130] Atilgan Erozkan, "The link between types of attachment and childhood trauma", Universal Journal of Educational Research, vol. 4, No. 5 (2016), pp. 1071–1079.

[131] UNHCR, The Heart of the Matter, pp. 58–60.

[132] See Terr, "Childhood traumas"; Zero to Three, DC:0–5 Diagnostic Classification; Sironi, "'On torture un enfant'"; and Bailly, Les catastrophes et leurs conséquences

IP §584. *When assessing children's mental health, behaviours and emotions that are consistent with a child's developmental age should be differentiated from those that are cause for concern. The same diagnostic categories can be viewed problematic in some ages and be part of normal behaviour in younger ages. Thus, behaviour and symptoms need to be assessed and considered within the expected range in a particular age and developmental stage, as well as within the child's cultural context. Furthermore, torture can worsen pre-existing problems in all domains of functioning and can cause a loss or regression of functioning that has already been attained.*

IP §585. *The following list complements the information on the diagnostic classification in adults above. It is non-exhaustive and enumerates diagnoses or criteria that are particular to children and adolescents.*

(i) Post-traumatic stress disorder

IP §586. *Traumatic events that occurred to a caregiver or other trusted adult are often experienced by children as seriously disturbing and distressing, even indirectly when the child hears about the events. Because children need relationships with their parents and caregivers to feel safe, such events may be experienced as a threat to the child's physical and psychological survival.*[133] *Indeed, criterion A in the DSM-5 diagnosis of PTSD in children aged 6 or younger includes in the definition of trauma witnessing the event(s) as it occurred to others, especially primary caregivers, or learning that the traumatic event has occurred to a parent or caregiver. PTSD can develop at any age after 1 year of age.*[134] *The diagnosis of PTSD in children younger than 6 excludes symptoms that are dependent on the ability to verbalize cognitive constructs and complex emotional states, such as negative self-belief and blame. Therefore, the threshold of avoidance and negative cognitions symptoms (criterion C) is lowered from three to one symptom.*[135]

IP §587. *The re-experiencing of trauma can vary according to the child's age. In young children, symptoms are more likely to be expressed through play, and fearful reactions at the time of exposure or re-experiencing of trauma may be lacking. Young children's frightening dreams may not be specific to the trauma. Parents may report a wide range of emotional and behavioural changes, including changes in play.*[136]

(ii) Separation anxiety disorder

IP §588. *Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the child is attached, as evidenced by three of the following: (a) recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures; (b) persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters or death; (c) persistent and excessive worry about experiencing an untoward event (e.g. getting lost, being kidnapped, having an accident or becoming ill) that causes separation from a major attachment figure; (d) persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation; (e) persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings; (f) persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure; (g) repeated nightmares involving the theme of separation; and (h) repeated complaints of physical symptoms (such as headaches, stomach aches, nausea or vomiting) when separation from major attachment figures occurs or is anticipated.*

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[133] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

[134] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

[135] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

[136] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

(iii) Specific phobia

IP §589. *A marked fear or anxiety about a specific object or situation that is out of proportion to the actual danger posed by the object. The anxiety or fear may be expressed by crying, tantrums, freezing or clinging. The phobic object or situation almost always provokes this reaction, is actively avoided or endured with intense fear.*

IP §590. *It is considered developmentally appropriate for young children to experience fear of specific objects (real or imaginary) or situations (e.g. animals, witches, monsters or the dark), and commonly these are transient and have only a mildly impairing effect. Therefore, in diagnosing specific phobia, it is important to consider the duration of the fear, anxiety or avoidance, the degree of impairment and the child's developmental stage.*

(iv) Disorders of social functioning with onset specific to childhood and adolescence

IP §591. *ICD-11 lists disorders of social functioning with onset specific to childhood and adolescence that are associated with gross environmental distortions and privations. Among these are elective mutism, reactive attachment disorder of childhood and disinhibited attachment disorder of childhood. Elective mutism is a condition characterized by a marked, emotionally determined selectivity in speaking and is most frequently manifest in early childhood. Reactive attachment disorder of childhood is characterized by persistent abnormalities in the child's pattern of social relationships and relationships with parents that is reactive to changes in environmental circumstances, before the age of 5. Disinhibited attachment disorder of childhood is characterized by a diffuse attachment at around the age of 2 and a clinging behaviour in infancy, and/or indiscriminately friendly, attention seeking behaviour in early or middle childhood. This pattern is associated with marked discontinuities in caregivers or multiple changes in family placements.*

(v) Conduct disorder

IP §592. *The DSM-5 diagnostic criteria for conduct disorder are violation of social norms or rules or the rights of others in a persistent and repetitive manner, including aggression towards people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. There are two specifiers to the diagnosis, regarding onset and degree of social emotionality. It has been suggested that trauma plays a key role in the development and persistence of conduct disorder and it has been found that young persons who are diagnosed with conduct disorder often have an experience of trauma.*[137] *Environmental risk factors listed in DSM-5 include physical and sexual abuse and environmental exposure to violence. A cautionary note in DSM-5 states that the context of the undesirable behaviours associated with conduct disorder should be considered and that the diagnosis may potentially be misapplied to individuals in settings in which the behaviour is viewed as near normative, such as war zones and threatening and dangerous, high-crime areas.*

(vi) Oppositional conduct disorder

IP §593. *The diagnostic features of oppositional conduct disorder include a frequent and persistent pattern of angry/irritable mood, argumentative/defiant behaviour or vindictiveness (criterion A). Environmental factors play an important role in causal theories of the disorder. First symptoms usually appear during preschool years and rarely later than early adolescence.*

(vii) Disruptive mood dysregulation disorder

IP §594. *The diagnostic criteria of disruptive mood dysregulation disorder include severe and recurrent temper outbursts, expressed verbally and/or behaviourally, that are intense and prolonged relative to the situation or provocation. They are inconsistent with the developmental level and occur three or four times a week on average. Between outbursts the mood is persistently irritable most of the day, for at least 12 months, in at least two or three settings (i.e.*

[137] Ricky Greenwald, "The role of trauma in conduct disorder", Journal of Aggression, Maltreatment & Trauma, vol. 6, No. 1 (2002), pp. 5–23; Pratibha Reebye and others, "Symptoms of posttraumatic stress disorder in adolescents with conduct disorder: sex differences and onset patterns", Canadian Journal of Psychiatry, vol. 45, No. 8 (2000), pp. 746–751.

school, home and with peers). While there is no consensus on the causes of disruptive mood dysregulation disorder, dysregulation in childhood has been linked to interpersonal trauma and abuse.[138] *Validity for the diagnosis has been established for children between the ages of 7 and 18 and its use should be restricted to this age group.*

(e) Family context

IP §595. *Families are profoundly affected by an experience of torture of a child as well as by torture of other family members. Torture of parents, as well as living in social and political contexts of violence and oppression, can have a serious impact on parental functioning and mental health. It is therefore important to consider the environmental and contextual factors that affect the family and the child, such as separation between family members and the circumstances of these separations, communication routes during separation, threats to family members, the circumstances of reunification, stress factors in resettlement processes (such as loss of social and economic status), the impact of acculturation, racism, social supports, and experiences and beliefs related to seeking support (such as fear of bringing the attention of the authorities to the family), to name but a few.*

IP §596. *As parents, many torture survivors fear that the intensity of their own feelings could overwhelm them and they may feel shame and guilt.*[139] *Coping with the expressed or unexpressed feelings of their children might also raise difficulties for parents, who may feel guilty about the circumstances their children endured and continue to endure.*[140] *Parents of children who were tortured may also experience guilt over their inability to protect their children and their parenting may be affected by feelings of helplessness. Parents' experience of helplessness can be reinforced in violent and oppressive environments that expose children and adolescents to multiple risk factors. Such environments may also damage adolescents' perceptions of their parents' authority.*

IP §597. *The effects of torture on individuals' abilities to function as parents can take on many forms. It is beyond the scope of this chapter to describe these effects, yet it is important to note that these should be considered with regard to the child's age, culture and development. Safeguarding issues related to general considerations of parental functioning, including child neglect and physical, sexual and emotional abuse, should also be considered and addressed within the appropriate local legal and social frameworks.*

(f) Role of the family

IP §598. *The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents, which can hamper the development and result in a depressive symptomatology or else in aggressive behaviour. In the frame of post-traumatic disorders, parents may show outbursts of anger and violence against a child, as well as other forms of domestic violence, which the child might experience and witness and process in a traumatic way. When the child is not the direct victim of torture but only indirectly affected, adults often tend to underestimate the impact on the child's psyche and development. When loved ones around children have been persecuted, raped and tortured or the children have witnessed severe trauma or torture, they may develop dysfunctional beliefs, such as believing that they are responsible for the bad events or that they have to bear the burdens of their parents. This type of belief can lead to long term problems with guilt, loyalty conflicts, personal development and maturing into an independent adult.*

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[138] Yael Dvir and others, "Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities", Harvard Review of Psychiatry, vol. 22, No. 3 (2014), pp. 149–161.

[139] Center for Victims of Torture, Healing the Hurt: A Guide for Developing Services for Torture Survivors (Minneapolis, 2005), chap. 2.

[140] Center for Victims of Torture, Healing the Hurt: A Guide for Developing Services for Torture Survivors (Minneapolis, Center for Victims of Torture, 2005), chap. 2.

(g) Special Considerations for Assessment of Sexual Assault in Children

I. Identifying Sexual Assault in Children

Investigators must be sensitive to the fact that children and young persons might not comprehend the concept of sexual assault or be able to identify it verbally. Behavioral cues are often more prominent than verbal expression. Fear of bringing shame or stigmatization on themselves or their families often inhibits disclosure, as children may feel responsible for the distress the disclosure would cause their parents. In accordance with the **2022 Istanbul Protocol**, it is essential that the child be seen by an expert in child abuse and sexual assault whenever possible.

II. Mitigating Retraumatization During Evaluation

Evaluators should be aware that the examination process[141] itself can be highly reminiscent of the original assault. Therefore, assessments must be carried out with extreme sensitivity, providing appropriate explanations to both the child and their accompanying guardian.

- **Presence of Trusted Adults**: Children should be supported by persons they trust; the presence of a parent or supportive adult can provide comfort and facilitate cooperation.
- **Privacy and Choice**: If a child feels uncomfortable disclosing in the presence of a parent—due to fear of distressing them or feelings of guilt—clinicians must exercise judgment and support the child when being interviewed alone.
- **Non-Threatening Environment**: Using a child-friendly setting, informal tone, and avoiding formal barriers like computer screens can reduce psychological distance.

III. Investigative and Clinical Techniques

- **Communication Style**: Use child-appropriate language and local terminology while avoiding leading or closed-ended questions that suggest desirable responses.
- **Alternative Disclosure Methods**: Techniques such as timelines, drawings, or "practice narratives" about neutral topics can help children generate memory cues and feel at ease before progressing to sensitive topics.
- **Medical Examination Protocols**: Physical examinations of the genital and anal areas should ideally be performed by pediatric specialists and may utilize video recording (with specific consent) to prevent the need for repeated invasive examinations.
- **Assessing Non-Verbal Indicators**: Clinicians should document behaviors such as repetitive "traumatic play," social withdrawal, or regressions like bedwetting as clinical indicators of potential abuse.

IV. Safeguarding and Ethical Duties

- **Best Interests Standard**: Parental consent is required but is invalid if it is given against the child's best interests; the child's well-being must remain paramount at all times.
- **Mandatory Reporting**: Clinicians must be aware of local legal obligations to report violence against children, noting that failure to do so may result in professional or criminal sanctions.

[141] See Pediatric Consent and Assent Form in Appendix R, the Pediatric Decompensation Protocol in Appendix S, and the Clinician's Self-Care Protocol in Appendix T

- **Rehabilitation Entitlement**: Children who have endured sexual torture have a basic right to recovery measures and confidential, long-term psychological follow-up care.

Male Survivors of Torture and CIDT

Section A: Prevalence and Context

Male survivors represent a significant population in torture and CIDT cases. Male survivors may experience torture in contexts including political detention, military service, conflict zones, immigration detention, and law enforcement encounters.

Section B: Forms of Torture Specific to Male Victims

- Sexual and Genital Torture: Testicular torture, forced nakedness, sexual humiliation, rape.
- Physical Torture in Detention: Beatings, stress positions, burnings, blunt force trauma.
- Psychological Torture: Threats, forced participation in executions, sensory deprivation.

Section C: Psychological Presentations

PTSD presentations, complex trauma, masculinity and identity issues, and physical health concerns must be assessed.

Elderly Persons and Torture/CIDT

Section A: Introduction

Elderly individuals may face unique forms of torture and CIDT, and present unique evaluation challenges.

Section B: Contexts of Abuse

Institutional settings (nursing homes, assisted living), community-based abuse (financial exploitation, caregiver neglect), and historical trauma.

Section C: Unique Presentation Considerations

Cognitive factors (dementia, memory impairment), physical factors (comorbidities, medication effects), and psychological factors (lifelong trauma adaptation).

Lesbian, gay, bisexual, transgender and intersex persons and torture and ill-treatment

Lesbian, gay, bisexual, transgender, and intersex persons are frequently targeted for persecution, criminalization, and dehumanization. Per **IP §599**, these individuals are at increased risk of severe physical and psychological abuse, with profound impacts on mental health. Evaluators must avoid **pathologizing identity**. As required by **IP §600**, clinicians must: (a) recognize that diversity in sexual orientation and gender identity is normal; (b) use preferred names and pronouns ; and (c) apply an **intersectional approach** to identify barriers faced by those with multiple marginalized

identities, such as HIV-positive status or physical disabilities. Clinicians should also be aware of their own implicit biases to ensure an impartial evaluation.

IP §599. *Based on their sexual orientation, gender identity, gender expression or sex characteristics, lesbian, gay, bisexual, transgender and intersex persons are frequently stigmatized and dehumanized, leaving them particularly vulnerable to human rights violations, including persecution, criminalization, imprisonment, torture and ill-treatment. Research on lesbian, gay, bisexual and transgender children and young persons shows that they are at risk of experiencing severe and prolonged physical and psychological abuse, with a potentially severe impact on their mental health.*[142] *Lesbian, gay, bisexual and transgender adult asylum seekers also have particular persecution experiences, with consequences for mental health.*[143] *Depending on the different levels of stigma and pathologization, lesbian, gay, bisexual, transgender and intersex persons have experienced in their lives, including health care, they can develop great difficulty in revealing their identity, including to the examining clinician.*

IP §600. *When examining an alleged torture victim from the lesbian, gay, bisexual and transgender community, specific considerations should be taken into account to avoid pathologizing or retraumatizing them. Some of the basic principles and keynotes that should be taken into account by clinicians in order to create a sense of safety and respect and thus help individuals reveal all the aspects of their torture history and help the clinician better understand their current needs (medically, psychosocially and legally) include:*

(a) Recognize that diversity in sexual orientation, gender identity, gender expression and sexual characteristics is normal and is not a mental illness;

(b) Understand how the persecution experiences of lesbian, gay, bisexual, transgender and intersex children, youth and adults affect their mental and physical health;[144]

(c) Be familiar with the specific social, cultural and political factors that may have influenced the physical and mental health of lesbian, gay, bisexual, transgender and intersex persons;[145]

(d) Ask about persecution and abuse that target sexual orientation and gender identity during childhood and adolescence;[146]

(e) Create a supportive environment in which lesbian, gay, bisexual, transgender and intersex individuals are able to explore, discuss and reveal their sexual orientation and gender identity as much as possible at the time;

(f) Recognize that lesbian, gay, bisexual and transgender and intersex persons may not have disclosed their sexual orientation, gender identity, sex characteristics, chosen name or gender pronouns in previous interactions with authorities out of fear based on past experience and other factors;

(g) Use whenever possible the proper names and gender pronouns chosen by the individual, compatible with the individual's self-identification;

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[142] Edward J. Alessi, Sarilee Kahn and Sangeeta Chatterji, "'The darkest times of my life': recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity", Child Abuse & Neglect, vol. 51 (2016), pp. 93–105.

[143] Rebecca A. Hopkinson and others, "Persecution experiences and mental health of LGBT asylum seekers", Journal of Homosexuality, vol. 64, No. 12 (2017), pp. 1650–1666.

[144] Alessi and others, "'The darkest times of my life'" supra

[145] Edward J. Alessi, Sarilee Kahn and Sangeeta Chatterji, "'The darkest times of my life': recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity", Child Abuse & Neglect, vol. 51 (2016), pp. 93–105.

[146] Edward J. Alessi, Sarilee Kahn and Sangeeta Chatterji, "'The darkest times of my life': recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity", Child Abuse & Neglect, vol. 51 (2016), pp. 93–105.

(h) Be aware of their own attitudes, perceptions and prejudices and how they might affect the quality of interaction with lesbian, gay, bisexual, transgender and intersex persons;

(i) Apply an intersectional, intercultural and interreligious approach and strive to understand the specific barriers that lesbian, gay, bisexual, transgender and intersex persons face when they have additional stigmatized and/or minority identities (e.g. HIV positive person, refugee, sex worker or person with physical disabilities);

(j) Do not attempt to change the interviewee's sexual orientation or gender identity;

(k) Do not interpret or seek specific elements that "explain" the sexual orientation and gender identity of lesbian, gay, bisexual and transgender persons;

(l) Do not assume a person's sexual orientation and/or gender identity based on appearance or gender expression.

IP §601. *Further useful information and references on issues of identity, intervention and assessment can be found in the guidelines of the American Psychological Association*[147] *and other references.*

A. Specific Forms of Persecution and Torture Targeting LGBTQI+ Individuals

LGBTQI+ individuals face unique forms of torture and CIDT that evaluators must understand:

1. "Conversion" Practices:

- So-called "conversion therapy" or "reparative therapy"
- Aversive conditioning (electric shocks, nausea-inducing drugs paired with same-sex stimuli)
- Religious-based interventions involving shame, isolation, or exorcism
- Forced institutionalization for "treatment" of sexual orientation or gender identity
- These practices constitute torture or CIDT when conducted by or with State acquiescence

2. Sexual Violence:

- "Corrective rape" targeting lesbian women
- Sexual assault of gay men and transgender individuals
- Forced sexual acts as "proof" of heterosexuality
- Sexual humiliation and degradation based on LGBTQI+ status
- Forced nudity and sexualized searches

3. Physical Violence:

- Beatings by police, corrections officers, or other State actors
- Violence by non-State actors with State acquiescence
- Targeted violence in detention settings
- Medical violence (forced surgeries on intersex individuals, forced sterilization of transgender persons)

4. Psychological Torture:

[147] American Psychological Association, Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2011).

- Threats to "out" individuals to family, employers, or community
- Threats of deportation to countries where LGBTQI+ status is criminalized
- Isolation from LGBTQI+ community and support systems
- Forced separation from same-sex partners or children
- Denial of gender-affirming care
- Deliberate misgendering and deadnaming by officials

5. Institutional CIDT:

- Housing transgender individuals according to sex assigned at birth rather than gender identity
- Denial of appropriate medical care (hormone therapy, HIV treatment)
- Solitary confinement "for protection" that constitutes punishment
- Strip searches conducted by officers of inappropriate gender
- Denial of gender-appropriate clothing, grooming, or hygiene products

6. Family-Based Persecution with State Acquiescence:

- "Honor" violence by family members
- Forced marriage to "correct" sexual orientation
- Familial imprisonment or confinement
- State failure to investigate or prosecute family violence against LGBTQI+ individuals

B. Cultural Competency Requirements for Evaluators

Required Knowledge:

Evaluators working with LGBTQI+ individuals must demonstrate:

1. Terminology Competency:

- Understanding of sexual orientation, gender identity, and gender expression distinctions
- Familiarity with terminology used within LGBTQI+ communities
- Awareness that terminology varies across cultures and generations
- Commitment to using language preferred by the individual

2. Non-Pathologizing Framework:

- Recognition that LGBTQI+ identities are not disorders
- Awareness of historical pathologization and its ongoing effects
- Understanding of minority stress as a framework for LGBTQI+ mental health
- Commitment to affirmative practice

3. Cultural Humility:

- Awareness of the types of bias and how to look for them in oneself and in others

- A keen eye to discern systemic versus individual bias
- Openness to learning from the individual about their experience
- Patience and due diligence in evaluating every individual with respect for their inherent dignity and value as a human being
- Special care when dealing with marginalized and disadvantaged individuals and social categories
- Recognition of diversity within LGBTQI+ communities
- Understanding of intersectionality (LGBTQI+ status combined with race, ethnicity, disability, immigration status)
- Awareness of cultural variations in LGBTQI+ identity and expression

4. Legal and Social Context:

- Knowledge of laws and practices criminalizing LGBTQI+ status or conduct
- Understanding of asylum claims based on LGBTQI+ persecution
- Awareness of barriers LGBTQI+ individuals face in accessing services
- Recognition of institutional discrimination in healthcare, housing, employment

Required Training:

Before conducting evaluations with LGBTQI+ individuals, evaluators must complete:

- Minimum 8 hours of LGBTQI+ cultural competency training
- Training specific to LGBTQI+ trauma and persecution
- Training on gender-affirming interview practices

C. Evaluation Considerations for LGBTQI+ Individuals

1. Pre-Evaluation:

- Inquire about pronouns and name preferences before the evaluation
- Ensure intake forms allow for accurate self-identification
- Offer choice of evaluator gender when possible
- Confirm that the evaluation space is safe and private
- Assess whether interpreter (if needed) is LGBTQI+-affirming

2. Building Rapport:

- Use affirming language consistently
- Acknowledge the courage required to disclose LGBTQI+ status
- Recognize that the individual may have experienced rejection from previous providers
- Allow additional time for trust-building if needed
- Be aware that disclosure of LGBTQI+ status may be traumatic itself

3. History-Taking:

- Ask about sexual orientation and gender identity in open-ended, non-assuming ways
- Inquire about the individual's understanding of their own identity and its development
- Document experiences of discrimination, rejection, and violence related to LGBTQI+ status
- Assess family and community reactions to LGBTQI+ identity
- Explore history of "conversion" attempts or pressure

4. Trauma Assessment:

- Assess for LGBTQI+-specific trauma (see Section A above)
- Recognize that minority stress contributes to psychological distress
- Distinguish between trauma from persecution and distress from minority stress
- Assess for internalized stigma and shame
- Evaluate impact on identity development and self-concept

5. Physical Examination Considerations:

- For transgender individuals, physical examination may be particularly sensitive
- Discuss examination procedures in advance and obtain specific consent
- Allow individual to determine how their body is discussed and examined
- Be aware that physical findings may relate to gender-affirming procedures vs. torture
- For intersex individuals, distinguish between consensual medical interventions and forced surgeries

D. Intersectionality Considerations

LGBTQI+ status often intersects with other marginalized identities, compounding vulnerability:

LGBTQI+ and Immigration Status:

- LGBTQI+ asylum seekers face unique challenges
- Detention conditions may be particularly harmful
- Fear of deportation to countries where LGBTQI+ status is criminalized
- Documentation of persecution may support asylum claims

LGBTQI+ and Race/Ethnicity:

- LGBTQI+ people of color face compounded discrimination
- Cultural factors may affect disclosure and help-seeking
- Experiences of racism within LGBTQI+ communities
- Experiences of LGBTQI+ stigma within racial/ethnic communities

LGBTQI+ and Disability:

- LGBTQI+ individuals with disabilities face multiple barriers
- Disability may affect ability to flee persecution
- Intersecting stigmas compound isolation
- Accessibility needs must be addressed in evaluations

LGBTQI+ and Age:

- LGBTQI+ youth face family rejection, homelessness, school-based harassment
- LGBTQI+ elders may have experienced decades of persecution and concealment
- Generational differences in terminology and identity
- Age-specific vulnerabilities in institutions (juvenile detention, nursing facilities)

E. Report Writing for LGBTQI+ Evaluations

When documenting evaluations of LGBTQI+ individuals:

1. Use Affirming Language:

- Use the individual's stated name and pronouns throughout
- Refer to partners and relationships in non-heteronormative language
- Avoid pathologizing language about LGBTQI+ identity

2. Document LGBTQI+-Specific Persecution:

- Clearly describe the nexus between LGBTQI+ status and persecution
- Document specific acts targeting LGBTQI+ identity
- Explain the context of LGBTQI+ persecution in the relevant jurisdiction

3. Explain Cultural Context:

- Provide context for readers unfamiliar with LGBTQI+ issues
- Explain why certain acts constitute persecution (not universally understood)
- Document legal and social status of LGBTQI+ individuals in relevant jurisdictions

4. Protect Privacy:

- Be aware that the report may be disclosed in legal proceedings
- Discuss with the individual how their LGBTQI+ status will be documented
- Consider safety implications of documentation
- Redact or limit disclosure where appropriate

Immigration Detention and Immigrant Populations

Section A: Scope and Relevance

Immigrants and asylum seekers face unique forms of torture and CIDT within the U.S. immigration detention system. This section provides guidance for psychological evaluators assessing immigrant individuals.

Section B: Forms of Persecution Targeting Immigrants

- Country-of-Origin Persecution: Political, religious, ethnic, and persecution based on membership in particular social groups.
- Persecution During Migration: Human trafficking, extortion, sexual violence, kidnapping.
- U.S. Immigration Detention Conditions: Prolonged detention, inadequate medical care, solitary confinement, family separation.

Section C: Evaluation Considerations

Language access, cultural context, immigration status implications, and confidentiality concerns must be addressed.

Section D: Documentation Requirements

Country conditions evidence, immigration-specific documentation, and psychological documentation required.

Evaluating Persons with Disabilities in Torture and CIDT Investigations

A. Introduction and Scope

Persons with disabilities face unique vulnerabilities in torture and CIDT contexts, both as targets of torture and as survivors navigating legal and institutional systems that may compound their suffering. This section addresses the specialized considerations required when investigating allegations of torture and CIDT involving persons with disabilities, with particular emphasis on:

- Pre-existing disabilities that may be targeted or exploited by perpetrators
- Disabilities acquired or exacerbated as a consequence of torture
- Systemic discrimination against persons with disabilities within legal and institutional processes as a form of ongoing torture or CIDT
- The intersection of disability rights frameworks with torture investigation standards

The investigator must recognize that disability-based torture operates through mechanisms distinct from conventional physical torture, often exploiting institutional processes, medical dependencies, and cognitive/physical vulnerabilities to inflict severe suffering. The denial of reasonable accommodation to a person with a known disability, when combined with coercion and deliberate indifference to predictable harm, may itself constitute torture or CIDT under international law.

B. Legal and Normative Framework

The investigation of disability-based torture must align with the **Convention on the Rights of Persons with Disabilities (CRPD)** and the updated **2022 Istanbul Protocol (IP) §§51-53**. Per **IP**

§52, persons with disabilities are at heightened risk of torture, including forced medication, use of restraints, and solitary confinement. The denial of **reasonable accommodation**—such as accessible communication or medical extensions—may constitute CIDT under **UNCAT Article 16** when it causes severe suffering, and may escalate to torture under persistent discrimination and harm when intent is established. Evaluators must recognize that "powerlessness" (UNCAT Article 1) is amplified when a disabled person cannot withdraw from harmful institutional processes. Furthermore, **IP §147** mandates that health personnel protect the physical and mental health of all detainees without discrimination, specifically prohibiting the certification of "fitness" for harmful punishments like solitary confinement.

1. Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD provides the foundational framework for understanding disability rights in torture contexts:

Article 15 - Freedom from Torture:

"States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment."

Article 13 - Access to Justice:

"States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations."

Article 2 - Definitions:

"Discrimination on the basis of disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms.

2. UNCAT and Disability

The UN Committee Against Torture has recognized that:

- Persons with disabilities are at heightened risk of torture and CIDT
- Denial of reasonable accommodation may constitute CIDT when it causes severe suffering
- Institutional processes that systematically harm persons with disabilities may constitute prohibited conduct
- The "powerlessness" element of torture (Article 1 UNCAT) is particularly relevant when disabled persons cannot withdraw from harmful institutional processes

3. Istanbul Protocol and Disability

The investigation of disability-based torture must align with the updated **2022 Istanbul Protocol**, which address vulnerable populations but require expansion for disability-specific considerations:

- Cognitive impairments affecting testimony and documentation
- Physical disabilities affecting examination procedures
- Psychosocial disabilities requiring trauma-informed approaches

- Sensory disabilities requiring accessible communication

Per **IP §§51–53**, persons with disabilities face unique barriers and are at a higher risk of being subjected to torture or ill-treatment, including forced medication and restraints.

4. Domestic Disability Rights Law

Americans with Disabilities Act (ADA) - United States:

- Title II applies to state and local government services, including courts
- Requires reasonable modifications to policies, practices, and procedures
- The treating provider's determination of necessary accommodation is entitled to deference
- Failure to accommodate, when combined with coercion, may cross threshold to CIDT

Key ADA Principle for Investigators:

The person with a disability's viewpoint should be the dominant perspective on what constitutes reasonable accommodation. Courts and institutions may not substitute their judgment for that of qualified medical providers regarding accommodation necessity.

C. Disability as a Target and Mechanism of Torture

1. Exploitation of Medical Dependencies

Perpetrators may exploit disability-related medical dependencies to inflict suffering:

Case Pattern - Medical Treatment Denial:

When a person with a serious illness (e.g., Multiple Sclerosis, autoimmune conditions, cardiac conditions) requires specific treatment protocols, institutional actors may:

- Deprive essential treatment: Ordering participation in processes known to interfere with necessary medical care
- Create impossible choices: Forcing the person to choose between treatment and constitutional rights
- Weaponize scheduling: Timing proceedings to conflict with medical appointments or treatment windows
- Override medical authority: Substituting judicial or administrative judgment for medical expertise

Investigative Finding (Documented Pattern):

In documented cases, courts have acknowledged 10 or more times over periods exceeding five years that a litigant's medical treatment was "essential to his health and well-being and to his recovery and rehabilitation," yet subsequently ordered unaccommodated participation causing documented harm. This pattern—initial acknowledgment followed by deliberate reversal—demonstrates the intentionality element required under Article 1 UNCAT.

2. Cognitive Disability Exploitation

Perpetrators may exploit cognitive impairments through:

- 1.Complexity overload: Imposing procedural requirements beyond cognitive capacity

- 2.Deadline manipulation: Setting timeframes incompatible with processing limitations
- 3.Documentation demands: Requiring written output that exceeds functional capacity
- 4.Conflating ability with capacity: Treating demonstrated ability to perform an act as evidence of capacity to perform it safely and sustainably

Critical Distinction:

Ability refers to superficial capability to perform isolated acts. Capacity refers to the ability to participate "meaningfully and safely without undue risk or harm." Investigators must document when institutional actors deliberately conflate these concepts to justify harmful treatment.

3. Distress-Sensitive Conditions

Certain disabilities are exacerbated by psychological distress, creating a mechanism for "torture without touching":

Multiple Sclerosis (MS) Example:

Medical evidence establishes that:

- Psychological stress applied deliberately and knowing that it will cause distress can trigger MS relapses
- Distress-induced relapses cause objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization) in brain and spinal cord
- These effects are documented, predictable, and irreversible
- Court-induced distress has been documented in peer-reviewed literature to cause MS relapse and exacerbation, including inducing and exacerbating comorbidities

Investigative Documentation Requirements:

When the alleged victim has a distress-sensitive condition:

- Baseline documentation: Medical records establishing the condition and its stress-sensitivity
- Stressor identification: Documentation of institutional acts causing distress
- Temporal correlation: Timeline showing relationship between stressors and symptoms
- Medical causation: Expert opinion linking specific acts to specific harm
- Perpetrator knowledge: Evidence that institutional actors knew or should have known of the distress-sensitivity

4. The Distress-Induced Harm ("Battery Without Touching") Mechanism

When institutional actors with control over a person with a distress-sensitive disability knowingly cause severe psychological distress through:

- Denial of accommodation
- Coercive orders
- Intimidation by prospective punishment for being disabled
- Deliberate indifference to documented harm

- Override of medical recommendations

The resulting physical harm (neurological damage, cardiac events, immune dysfunction) constitutes physical injury inflicted through psychological means. This mechanism should be documented as:

__Distress-Induced Physical Injury: Physical harm to the body caused by severe psychological distress inflicted through institutional processes, where the perpetrator had knowledge of the victim's vulnerability and the predictable consequences of their actions.__

D. Systemic Discrimination as Ongoing Torture

1. Institutional Patterns Constituting CIDT

When disability discrimination is not isolated but systemic, it may constitute ongoing CIDT. Investigators should document:

Pattern Elements:

- Uniformity: Same discriminatory conduct across multiple decision-makers
- Policy basis: Evidence of formal or informal policies producing discrimination
- Predictability: Statistical likelihood that any disabled person will experience prohibited conduct
- Cumulative harm: Compounding effects of serial discrimination across institutions
- Impossibility of escape: Structural barriers preventing withdrawal from harmful systems
- Documented Finding:

In documented cases, disabled litigants have encountered discriminatory treatment from "100%" of judges tested across multiple state and federal courts over periods exceeding eight years. When discrimination is this uniform, it evidences systemic policy rather than individual misconduct, shifting analysis from individual perpetrator to institutional torture.

2. The Accommodation-Punishment Cycle

A particularly insidious pattern occurs when:

- Person with disability requests accommodation
- Request is denied or inadequately addressed
- Person cannot comply with unaccommodated requirements
- Person is punished for non-compliance
- Punishment is characterized as "lawful sanctions" rather than discrimination
- Person requests accommodation from punishment
- Cycle repeats with escalating harm

Case Example - Documented Pattern:

A person with MS and associated cognitive impairments requested accommodation for discovery obligations in civil litigation. When accommodation was denied, they could not comply with discovery demands due to their disability. The court imposed discovery sanctions exceeding $600,000 in a case that had identically been won by the same plaintiff over a decade earlier, explicitly

characterized as punishment for non-compliance. Medical evidence established the non-compliance resulted directly from unaccommodated disability. The sanctions were later described by the victim as "punishment for disability."

3. Forum Nullus

When systemic discrimination renders an entire court system or circuit inaccessible to persons with disabilities, this constitutes *forum n*ullus—the absence of any forum capable of providing justice. Investigators should document:

- Number of judges/decision-makers encountered
- Accommodation outcomes with each
- Cumulative effect on access to justice
- Whether any effective remedy was available
- Whether the person could withdraw from the system

Investigative Standard:

When a person with disability demonstrates that NO judge or decision-maker within an entire system provided adequate accommodation, the system itself becomes the perpetrator. Individual judge misconduct transforms into institutional torture.

E. Documentation Protocols for Disability-Related Torture

1. Medical Documentation Authority

IP 2022 Principle Applied to Disability:

All healthcare providers treating the person with disability have authority to document:

- The disability: Diagnosis, functional limitations, accommodation needs
- Treatment requirements: Medical protocols that must not be interrupted
- Harm documentation: Physical and psychological injuries from accommodation denial
- Causation opinions: Connection between institutional acts and documented harm
- Prognosis: Expected outcomes with and without accommodation

Treating Provider Authority (ADA Principle):

The treating provider's determination of necessary accommodation is entitled to greater weight than the opinions of institutional actors, adverse parties, or non-treating evaluators. When a treating provider states that a patient requires specific accommodation, courts and institutions may not substitute their lay judgment for medical expertise. The investigator must document if such substitution occurred.

2. Contemporaneous Documentation

Given the ongoing nature of disability-related torture, documentation should be:

- Real-time: Recording events as they occur rather than retrospectively
- Comprehensive: Capturing all accommodation requests and responses

- Multi-source: Including medical records, court filings, correspondence
- Chronological: Establishing clear timelines of requests, denials, and harms
- Quantified: Documenting measurable harm (medical costs, symptom scores, functional decline)

3. The Accommodation Request Record

Investigators should compile a complete record of:

Date	Request Made To	Accommodation Requested	Response	Outcome
[Date]	[Decision-maker]	[Specific accommodation]	[Granted/Denied/Ignored]	[Resulting harm]

Documented Example:

In one documented case, the victim filed accommodation requests over 8+ years with:

- 100+ ADA motions for accommodation in state courts (all systematically denied or inadequately addressed)
- Multiple ADA motions in federal district court (pattern of initial grant followed by withdrawal)
- Appeals to Ninth Circuit (uniformly denied) with ADA motions for accommodation (all evaded or denied)
- Petitions to US Supreme Court (denied or procedurally obstructed)

This comprehensive record demonstrates the systemic nature of the discrimination and the impossibility of securing accommodation through normal channels.

4. Documenting the "Bright Line" Abandonment

A particularly important pattern to document is when an institutional actor:

- Establishes an accommodation standard (the "Bright Line")
- Applies it consistently over extended period
- Abruptly abandons it
- Denies having established it
- Characterizes victim's reliance on it as unreasonable

Case Documentation:

Judge established accommodation standard ("Freeman Bright Line") providing one-year stays for life-saving medical treatment. This standard was applied approximately 10 times over nearly six years. The standard was then "recanted and condemned" without explanation, but appeared to support the CIDT and torture by peers. The abrupt reversal, after years of consistent application, evidences intentionality rather than good-faith legal interpretation.

F. Psychological Impact Assessment

1. Compounded Trauma

Persons with disabilities experiencing torture and CIDT face compounded trauma:

- Primary trauma: The torture itself
- Secondary trauma: Institutional betrayal through accommodation denial
- Tertiary trauma: Social disbelief and victim-blaming
- Quaternary trauma: Re-traumatization through legal processes seeking remedy

Assessment Protocol:

Evaluators should assess trauma at each level, recognizing that:

- Each level compounds the others
- Disability may affect coping capacity
- Previous trauma history (including disability-related) affects vulnerability
- The person may be simultaneously experiencing ongoing torture while seeking investigation

2. Cognitive Impact Documentation

For persons with cognitive disabilities (including MS-related cognitive impairment):

Neuropsychological Assessment Components:

- Baseline cognitive function: Premorbid functioning estimate
- Current cognitive status: Formal neuropsychological testing
- Functional impact: How cognitive changes affect daily activities
- Litigation-specific impact: How cognitive changes affect ability to participate in legal processes
- Temporal changes: Documentation of cognitive decline correlated with institutional stress

Documented Finding:

Neuropsychological testing documented significant impairments in processing speed, attention, and executive function. These impairments were directly relevant to the person's inability to meet court-imposed deadlines and documentation requirements. The court's continued imposition of these requirements, with knowledge of the documented cognitive impairments, evidences intentional exploitation of disability.

3. Physical Impact of Psychological Torture

For distress-sensitive conditions, document:

- Disease activity markers: MRI findings, laboratory values, clinical symptoms
- Temporal correlation: Disease flares correlated with institutional stressors
- Treatment disruption: Medical appointments missed due to litigation demands
- Medication adherence: Impact of stress on treatment compliance
- Secondary conditions: Cardiac events, immune dysfunction, pain exacerbation

Case Documentation:

Medical records documented:

- Three end-stage MS symptoms induced by extreme distress in 2018
- Two reported heart attacks linked to litigation stress
- Confinement to one room for seven years under full-time care
- Doctors declared potential imminent death, stroke, or heart attack
- Peer-reviewed publication documenting the MS-stress-court nexus

G. Special Considerations by Disability Type

1. Multiple Sclerosis and Autoimmune Conditions

Unique Considerations:

- Invisible disability: MS may not be apparent, leading to disbelief
- Variable symptoms: Functioning varies day-to-day, leading to accusations of malingering
- Cognitive involvement: "MS fog" affects processing, memory, and expression
- Fatigue: Pathological fatigue is distinct from ordinary tiredness
- Heat sensitivity: Environmental factors affect functioning
- Stress sensitivity: Documented mechanism for stress-induced exacerbation

Investigation Protocol:

- Obtain complete neurology records including MRI series showing lesion progression
- Document correlation between stressors and documented relapses
- Obtain treating neurologist's opinion on stress-disease relationship
- Document any peer-reviewed literature specific to the person's case
- Assess cognitive function through formal neuropsychological testing
- Document functional impact on litigation capacity

2. Cardiac and Cardiovascular Conditions

Unique Considerations:

- Life-threatening nature: Stress-induced cardiac events can be fatal
- Documented mechanism: Takotsubo cardiomyopathy ("broken heart syndrome") is medically recognized
- Cumulative risk: Each stress exposure increases future risk
- Irreversibility: Cardiac damage is often permanent

Investigation Protocol:

- Document cardiac history and current status
- Obtain cardiology records including stress test results

- Document any cardiac events temporally correlated with institutional stressors
- Assess ongoing cardiac risk from continued institutional involvement
- Consider whether continued litigation participation is medically contraindicated

3. Psychiatric and Psychosocial Disabilities

Unique Considerations:

- Stigma and disbelief: Psychiatric disabilities face heightened skepticism
- Condition exploitation: Perpetrators may deliberately trigger psychiatric symptoms
- Medication interference: Stress may interfere with psychiatric medication efficacy
- Dual diagnosis: Many torture survivors have both psychiatric and physical conditions
- Capacity questions: Psychiatric conditions may affect legal capacity determinations

Investigation Protocol:

- Obtain complete psychiatric treatment history
- Document relationship between institutional stressors and symptom exacerbation
- Assess current functional capacity with appropriate accommodation
- Distinguish between disability-related limitations and torture-induced impairment
- Ensure evaluation environment is accessible and non-triggering

4. Sensory Disabilities

Unique Considerations:

- Communication barriers: May affect testimony and documentation
- Information access: Legal documents may be inaccessible
- Interpreter needs: May require specialized interpretation services
- Environmental factors: Lighting, acoustics, physical accessibility

Investigation Protocol:

- Assess communication needs and preferences
- Provide documents in accessible formats
- Ensure interpreter services are qualified and neutral
- Document any barriers encountered in legal processes
- Assess whether communication barriers contributed to adverse outcomes

H. The Treating Provider's Role

1. Authority to Document

Under ADA principles and human rights standards, the treating provider has authority to:

- Diagnose: Establish the existence and nature of disability

- Prescribe accommodation: Specify what accommodations are medically necessary
- Document harm: Record injuries resulting from accommodation denial
- Opine on causation: Connect institutional acts to documented harm
- Recommend limitations: Specify what the patient cannot safely do without accommodation

Critical Principle:

The treating provider need not be a torture investigation specialist to document disability-related torture. Any qualified healthcare provider treating the person can and should document the disability, the accommodation needs, the institutional denials, and the resulting harm. This documentation has evidentiary value regardless of the provider's torture investigation expertise.

2. Documentation Templates

Provider Documentation for Accommodation Denial:

MEDICAL DOCUMENTATION OF ACCOMMODATION DENIAL HARM

Patient: [Name]

Date: [Date]

Provider: [Name, Credentials]

DISABILITY DIAGNOSIS:

[Diagnosis, ICD-10 code, date of diagnosis, treating specialists]

ACCOMMODATION REQUIREMENTS:

[Specific accommodations medically necessary for this patient]

INSTITUTIONAL DENIAL:

[Description of accommodation request and institutional response]

DOCUMENTED HARM:

[Physical and/or psychological injuries observed following denial]

CAUSATION OPINION:

[Medical opinion on relationship between denial and harm]

ONGOING RISK:

[Assessment of risk from continued unaccommodated participation]

RECOMMENDATION:

[Specific accommodation recommendation]

Signature: _____

Date: _____

3. Multi-Provider Coordination

When the person has multiple providers (neurologist, cardiologist, psychiatrist, primary care), documentation should be coordinated to present:

- Unified accommodation picture: Consistent accommodation recommendations
- Comprehensive harm documentation: Each provider documents harm within their specialty
- Collective causation opinion: Providers agree on institutional causation
- Coordinated treatment plan: Treatment requirements that must be protected

I. Investigation Strategy: Disability Discrimination as Systemic Torture

1. From Individual Incident to Systemic Pattern

When investigating disability-related torture, the investigator should:

- Document individual incidents: Each accommodation denial and resulting harm
- Identify patterns: Common features across incidents
- Aggregate perpetrators: Number of institutional actors involved
- Assess uniformity: Whether discrimination was consistent across actors
- Evaluate policy basis: Whether conduct reflects institutional policy
- Determine systemic nature: Whether the pattern constitutes systemic torture

2. Evidentiary Standards for Systemic Claims

Individual Level:

- Specific accommodation request
- Specific denial or inadequate response
- Specific resulting harm
- Specific perpetrator conduct

Systemic Level:

- Multiple accommodation requests across multiple decision-makers
- Uniform pattern of denial or inadequate response
- Cumulative harm exceeding sum of individual incidents
- Evidence of policy, training, or coordination producing uniformity
- Impossibility of remedy through normal channels

3. Constructing the Systemic Case

Timeline Construction:

Date	Court/Agency	Request	Response	Perpetrator(s)	Harm
[Date]	[Venue]	[Request]	[Response]	[Names/Titles]	[Documented harm]

Pattern Analysis:

After compiling complete timeline:

- Calculate accommodation grant rate (if 0%, this evidences systemic policy)
- Identify common justifications for denial
- Document escalating severity of harm
- Assess whether any effective remedy was available
- Determine whether victim could withdraw from system

4. Recommendations for Action

When investigation reveals systemic disability discrimination constituting torture:

- Individual remedies: Compensation, treatment, accommodation
- Institutional reform: Policy changes, training requirements
- Accountability: Individual and institutional accountability mechanisms
- Monitoring: Ongoing oversight to prevent recurrence
- Systemic change: Legislative or judicial reform to address structural barriers

J. Ethical Obligations in Disability Investigations

1. Non-Discrimination in Investigation

Investigators must ensure their own processes do not discriminate:

- Accessible facilities: Physical accessibility of evaluation locations
- Accessible communication: Documents and communication in accessible formats
- Flexible scheduling: Accommodation for fatigue, medical appointments
- Extended time: Additional time for processing and responding
- Support persons: Allowing disability support persons during evaluation

2. Avoiding Re-traumatization

The investigation process itself can re-traumatize:

- Minimize repetition: Do not require repeated telling of traumatic events
- Control pacing: Allow breaks and accommodate fatigue
- Validate experience: Recognize the reality of disability discrimination
- Provide information: Explain process and empower informed participation
- Respect autonomy: Do not override the person's choices about participation

3. Treating Provider Involvement

The treating provider may serve dual roles:

- Treatment provider: Ongoing clinical care

- Documentation source: Recording accommodation needs and harm
- Expert witness: Providing opinions on causation and harm

Ethical Considerations:

- Treating relationship takes priority over forensic role
- Provider should not compromise treatment for documentation purposes
- Separate forensic evaluation may be appropriate for complex cases
- Provider should document within scope of expertise

K. Conclusion: Disability Rights as Human Rights

The investigation of torture and CIDT involving persons with disabilities requires recognition that:

- Disability discrimination can constitute torture when it involves severe suffering, intentionality, purposeful infliction, and powerlessness
- Systemic discrimination against persons with disabilities in legal and institutional processes may constitute ongoing CIDT
- All healthcare providers have authority to document disability-related torture
- The treating provider's determination of necessary accommodation is entitled to deference
- Accommodation denial combined with coercion and deliberate indifference to predictable harm crosses the threshold from discrimination to prohibited conduct

Core Principle:

The denial of reasonable accommodation to a person with a known disability, when that person is under institutional control, cannot withdraw, and when denial causes severe suffering, is not merely discrimination—it is torture or CIDT. Investigators must document it as such.

L. Appendix

See Appendix E for Disability Accommodation Documentation Checklist, Key Legal Standards, and a case vignette (Systemic judicial disability discrimination).

This section prepared in accordance with the Istanbul Protocol 2022, CRPD, UNCAT, and ADA principles. All healthcare providers treating persons with disabilities experiencing institutional discrimination are encouraged to document their observations using the frameworks provided herein.

Summary Checklist for Specialized Populations

Disability

Does the report document the **denial of reasonable accommodation** as a specific stressor causing **distress-induced physical harm**?

LGBTQI+

Has the evaluator used **non-pathologizing language** and preferred pronouns to mitigate **re-traumatization**?

Intersectionality

Does the clinical formulation address how **multiple vulnerabilities** (e.g., race, disability, and poverty) compound the **cumulative harm**?

Credibility and Reliability Assessment

A. Purpose and Framework

A central function of the forensic psychological evaluation is to assess the credibility and reliability of the individual's account of torture or CIDT. This assessment must be conducted with scientific rigor while maintaining trauma-informed sensitivity.

AN IMPORTANT WARNING TO ALL INVESTIGATORS: We use the term "**credibility**" in this text only to ease the reader's understanding of the task to be performed. **However, you MUST REMEMBER that IAJ evaluators do not make 'credibility determinations' that violations of human rights occurred or did not occur, as these are legal matters reserved for a court.** Instead, clinicians perform a **Consistency Analysis**: determining if the clinical presentation, behavioral observations, and symptom trajectory are clinically consistent with the alleged stressors. Any observed inconsistencies (e.g., memory gaps or emotional numbing) should be documented as potential trauma sequelae rather than indicators of untruthfulness.

Key Principles:

- Credibility assessment is clinical, not legal. The evaluator offers an opinion on the psychological consistency and reliability of the account; ultimate credibility determinations are for legal decision-makers.
- Trauma affects memory. Traumatic memory is often fragmented, non-linear, and may contain apparent inconsistencies that are actually consistent with genuine trauma.
- Absence of perfect recall is not evidence of fabrication. Torture survivors commonly have difficulty recalling exact details, sequences, or timeframes.
- Cultural factors affect presentation. What appears evasive or inconsistent may reflect cultural communication norms.
- The burden is not on the survivor to prove torture. The evaluator's role is to assess consistency, not to require proof beyond reasonable doubt.

Quick-Reference Decision Tree: Credibility Assessment

This decision tree is a rapid guide for distinguishing strong, qualified, and unresolved credibility conclusions without collapsing trauma-related inconsistency into disbelief.

STEP 1: Is the account sufficiently coherent to identify the core allegation?

├── **No** → Determine whether disorganization is due to trauma, dissociation, developmental status, cognitive impairment, translation limits, or psychosis; proceed cautiously

└── **Yes** → Proceed to STEP 2

STEP 2: Are the core allegations stable across retellings?

├── **Yes** → Proceed to STEP 3

└── **No** → Distinguish peripheral inconsistency from core contradiction; proceed to STEP 2A

STEP 2A: Are the inconsistencies trauma-consistent or otherwise explainable?

├── **Yes** → Do not downgrade credibility automatically; proceed to STEP 3

└── **No** → Mark as requiring careful qualification and stronger collateral review

STEP 3: Is there corroboration from records, witnesses, physical findings, chronology, or symptom pattern?

├── **Strong corroboration** → Proceed toward stronger reliability conclusion

├── **Partial corroboration** → Proceed toward qualified reliability conclusion

└── **Little / no corroboration** → Continue with caution; absence of corroboration is not automatic disproof

STEP 4: Are there major contradictions that directly undermine core facts?

├── **Yes** → Consider limited or weak reliability as to those specific facts

└── **No** → Proceed to STEP 5

STEP 5: Are there factors that may distort presentation without implying fabrication?

├── Trauma effects, shame, fear, dissociation, cultural differences, disability, cognitive limits, power imbalance

│ └── Integrate these as explanatory variables, not as reasons to dismiss the account

└── None clearly present

└── Proceed on the available record

STEP 6: What is the correct credibility conclusion?

├── **Strongly supported** → Core account reliable despite normal trauma-related variability

├── **Qualified** → General pattern reliable, but some details remain unresolved

└── **Insufficient / unresolved** → Additional investigation needed before firm conclusion

Credibility rule:

The evaluator should grade credibility by component rather than force a single global verdict where the evidence supports a mixed finding.

B. Istanbul Protocol Consistency Framework

The Istanbul Protocol[148] establishes a framework for assessing the consistency between alleged torture and clinical findings, categorized as Not Consistent, Consistent With, Highly Consistent, Typical Of, or Diagnostic Of. The IAJ adopts this framework with the following interpretation:

Degrees of Consistency:

1. Not Consistent: The clinical findings are not consistent with the alleged torture. The findings:

- Could not have been caused by the alleged torture
- Are better explained by other causes
- Contradict the allegation

2. Consistent With: The clinical findings could have resulted from the alleged torture, but:

- Are non-specific
- Could have other causes
- Do not specifically support the allegation

3. Highly Consistent With: The clinical findings:

- Could have been caused by the alleged torture
- Are common findings in similar cases
- Are not easily explained by other causes
- Specifically support the allegation

4. Typical Of: The clinical findings:

- Are usually found in cases of this type of torture
- Would be expected given the allegation
- Are strong evidence for the allegation

5. Diagnostic Of: The clinical findings:

- Could only have been caused by the alleged torture
- Could not have been caused in almost any way other than the alleged torture or ill-treatment (IP §543(e))
- (Note: This level is rare for psychological findings; more common for specific physical injuries)

When assessing consistency, clinicians should consider symptoms like dissociation, depersonalization, and atypical behaviour, which may fragment narratives without indicating malingering. As detailed in IP §506, dissociation disrupts memory integration, leading to incomplete recollections or emotional incongruence during evaluations. This is common in trauma survivors and should not undermine credibility; instead, document it as evidence of peritraumatic effects.

Quick-Reference Guide: Consistency Assessment Decision Tree

[148] IP §§379–381 for the interpretation of findings and consistency levels or §§540–545 for psychological consistency specific to Chapter VI

This decision tree provides a step-by-step guide for applying the IP consistency framework, ideal for non-specialists conducting initial assessments.

STEP 1: Evaluate overall psychological presentation

├── Consistent with genuine trauma (e.g., dissociation, hypervigilance)?

│ ├── Yes: Proceed to STEP 2

│ ├── No: Document inconsistencies; consider "Not Consistent"

├── Proceed to STEP 2

STEP 2: Assess symptom-allegation fit

├── Symptoms match known torture effects?

│ ├── Yes: Rate as "Consistent With" or higher

│ ├── No: Document alternative explanations; rate "Not Consistent"

├── Proceed to STEP 3

STEP 3: Consider specificity

├── Findings common in similar torture cases with few other causes?

│ ├── Yes: Rate "Highly Consistent" or "Typical Of"

│ ├── No: Maintain "Consistent With"

├── Proceed to STEP 4

STEP 4: Evaluate diagnostic certainty

├── Findings could only result from alleged torture?

│ ├── Yes: Rate "Highly Consistent (IP §543(e))" (rare for psychological evidence)

│ ├── No: Finalize rating from prior steps

├── Document full rationale in report

Application:

The evaluator should assess consistency at multiple levels:

- Overall consistency of psychological presentation with alleged torture
- Consistency of specific symptoms with specific alleged acts
- Consistency of functional impairment with severity of alleged torture
- Consistency of trauma narrative across interviews
- Internal consistency of the individual's account

C. Applied Case Guidance: Credibility Assessment in Strong, Weak, and Ambiguous Presentations

Credibility assessment in torture and CIDT investigations is not a character judgment. It is an evidence-integrative process that examines consistency, plausibility, symptom pattern, corroboration, and known trauma effects. The evaluator must be trained to distinguish between unreliability, incompleteness, dissociation, shame, cultural variance, cognitive impairment, and deliberate fabrication. The following examples illustrate proper application.

Case Example A - Strong Credibility Despite Imperfect Recall

Scenario: An examinee provides an account of prolonged legal and institutional abuse but struggles with exact dates and sequence. During the interview, the examinee becomes dissociative when discussing key events, requires breaks, and shows autonomic arousal, shame, and fragmented memory. Medical records, emails, and court notices corroborate the general timeline. Symptom development tracks the alleged events.

Why credibility is strong:

- Trauma-consistent fragmentation is expected.
- Core facts remain stable across retellings.
- External records corroborate the central sequence.
- Behavioral presentation is consistent with severe distress.
- Minor inconsistencies involve peripheral details, not the core allegation.

Evaluator approach:

- State clearly that fragmented recall does **not** undermine credibility where fragmentation is trauma-consistent.
- Use wording such as: *"The examinee's limited precision regarding dates and sequence is consistent with trauma-related encoding and retrieval disruption and does not materially reduce the reliability of the core account."*
- Train evaluators to distinguish "incomplete" from "inconsistent."

Case Example B - Weak Credibility / Record-Level Reliability Problems

Scenario: An examinee offers a highly dramatic account, but the account shifts materially across interviews on core facts: different institutions, different perpetrators, and different claimed outcomes. Available records directly contradict several central assertions. The examinee denies obvious contrary documentation without explanation. No trauma-related explanation adequately accounts for the scope of contradiction.

Why credibility is weak:

- Contradictions involve **core facts**, not peripheral details.
- External records materially conflict with the account.
- The changes are not explained by dissociation, shame, translation difficulty, or cognitive impairment.
- The presentation does not support a reliable synthesis.

Evaluator approach:

- Do not make moralistic findings.
- Use neutral forensic language: *"The present record contains material inconsistencies concerning central elements of the allegation, and these inconsistencies are not adequately resolved by the currently available clinical or collateral data."*
- Separate this from any diagnosis; a person may be symptomatic and still be unreliable on particular facts.

Case Example C - Ambiguous Credibility / Trauma, Cognitive Impairment, and Collateral Conflict

Scenario: An examinee with significant PTSD symptoms, sleep deprivation, and possible neurocognitive impairment gives a partially coherent account of repeated coercive proceedings. Some records support the broad narrative, but other collateral sources conflict on timing, and the examinee confuses order, sequence, and who said what. There is no evidence of clear fabrication, but there is also no clean corroborative record.

Why this is ambiguous:

- Trauma and impairment plausibly affect recall.
- Some corroboration exists, but it is incomplete.
- The core narrative may be true even if details are unstable.
- The evaluator cannot fully resolve all factual disputes.

Evaluator approach:

- Break the account into **high-confidence**, **moderate-confidence**, and **unresolved** components.
- Example structure:
- **High-confidence:** repeated coercive hearings occurred; distress increased afterward.
- **Moderate-confidence:** certain threats or punitive comments were made, but wording is uncertain.
- **Unresolved:** exact sequence and attribution of some acts.
- Use wording such as: *"The examinee's presentation supports the reliability of the general pattern alleged, while certain event-specific details remain unresolved because of memory fragmentation, competing collateral accounts, and incomplete records."*

Training rule:

Evaluators must be instructed that:

- **Trauma-consistent inconsistency** is not the same as fabrication.
- **Confident presentation** is not the same as reliability.
- **Emotional flatness** is not evidence of falsity.
- **Strong symptoms** do not prove every factual allegation.
- The correct response to ambiguity is **graded conclusion**, not false certainty.

D. Conflicts with Western-Oriented Tests and Methodologies

Standardized instruments such as the **PCL-5**, **PHQ-9**, and similar Western-developed tools may be useful as **adjuncts**, but they should not control the evaluation where their assumptions conflict with the **Istanbul Protocol's contextual, trauma-informed, and culturally responsive approach**. The evaluator should treat these tools as supportive data points rather than as dispositive measures of credibility, diagnosis, severity, or causation.

The principal risks are as follows:

1. Cultural mismatch and false negatives

Western instruments often assume symptom expressions that do not map cleanly onto the survivor's idioms of distress. A survivor may describe suffering somatically, relationally, spiritually, or behaviorally rather than in the categories presupposed by Western symptom checklists. This can produce **false negatives, undercounting, or misclassification** if the evaluator treats the instrument as primary rather than contextualized.

Core citations: IP **§§294–295**; IP **§§491–494**.

See also: IP **§497**; IP **§270**; IP **Annex IV**.

2. Language and interpretation distortion

Translation, interpretation, and cross-linguistic mismatch can materially affect the meaning of questionnaire items, the emotional weight of key terms, and the survivor's responses. Scores derived from poorly translated or culturally misaligned instruments may appear precise while resting on compromised meaning.

Core citations: IP **§§296–298**; IP **§325**.

See also: IP **§576**.

3. Re-traumatization and coercive interview dynamics

Highly structured or repetitive formats can resemble interrogation, reduce the survivor's sense of control, and intensify power imbalance—especially in those with prior detention, custodial abuse, coercive legal exposure, or childhood trauma. The evaluator must therefore consider whether the instrument format itself may worsen distress or impair disclosure.

Core citations: IP **§295**; IP **§§299–302**; IP **§§310–311**.

See also: IP **§272**; IP **§§277–280**; IP **§400**; IP **§§525–526**; IP **Annex II**.

4. Ethnocentric bias and over-pathologization

A response pattern that is culturally normative, situationally adaptive, or trauma-consistent may be mislabeled as pathology when the evaluator applies Western interpretive assumptions too rigidly. This can produce stigmatizing conclusions, under-recognition of resilience, or mistaken credibility judgments.

Core citations: IP **§148**; IP **§§278–279**; IP **§§493–496**.

See also: IP **§498**; IP **§398**; IP **§414**; IP **§§584–585**.

5. Limited cross-cultural validation

Some instruments lack adequate validation across the populations, languages, developmental stages, or coercive settings in which torture and CIDT investigations occur. For that reason, numerical scores should not be treated as self-authenticating evidence.

Core citation: IP **§511**.

See also: IP **Annex IV**.

Operational rule

Where a standardized instrument conflicts with the survivor's cultural context, communication style, developmental status, disability profile, or trauma presentation, the evaluator should prioritize:

- narrative and contextual interviewing,
- culturally informed interpretation,
- collateral information,
- behavioral observation, and
- clinically reasoned formulation.

The evaluator may use culturally adapted measures or modified administration where appropriate, but must explain any such adaptation and must not present a score as more reliable than the conditions of its administration allow.

Reporting rule

If standardized instruments are used, the report should briefly state:

- what tool was used;
- why it was chosen;
- any language, cultural, disability, or trauma-related limits on interpretation; and
- how the evaluator integrated the score into a broader, non-reductive clinical and forensic analysis.

E. Factors Supporting Credibility

The following factors tend to support the credibility of torture allegations:

1. Consistency Factors:

- Internal consistency of the narrative (allowing for trauma-related fragmentation)
- Consistency across multiple interviews or evaluations
- Consistency with known patterns of torture in the relevant context
- Consistency between psychological symptoms and alleged torture methods
- Consistency between physical findings (if any) and psychological presentation

2. Detail and Specificity:

- Provision of specific details that would be difficult to fabricate
- Idiosyncratic details consistent with genuine experience

- Sensory details (smells, sounds, textures) characteristic of memory
- Emotional details accompanying factual recounting
- Peripheral details consistent with alleged setting

3. Psychological Presentation:

- Emotional responses consistent with recounting genuine trauma
- Physiological responses (trembling, sweating, changes in breathing) during recounting
- Dissociative responses during trauma narrative
- Re-experiencing symptoms triggered by evaluation
- Avoidance behaviors during evaluation

4. Corroboration:

- Consistency with documentary evidence
- Consistency with accounts from other witnesses
- Consistency with known practices in the alleged setting
- Medical records consistent with alleged timeline
- Prior disclosures consistent with current account

F. Factors Requiring Careful Assessment

The following factors require careful evaluation but do not necessarily indicate fabrication:

1. Inconsistencies:

- Minor inconsistencies are common in genuine trauma accounts
- Assess whether inconsistencies involve core elements or peripheral details
- Consider whether inconsistencies are explained by trauma, time passage, or repeated questioning
- Distinguish between inconsistency and elaboration over time
- Consider cultural and linguistic factors

2. Delayed Disclosure:

- Delayed disclosure is common among torture survivors
- Assess reasons for delay (fear, shame, lack of opportunity, distrust)
- Delayed disclosure does not indicate fabrication
- Sudden disclosure may be triggered by safety, trust, or external events

3. Flat or Incongruent Affect:

- Some survivors present with emotional numbing
- Cultural factors may suppress emotional expression
- Repeated recounting may result in rehearsed, less emotional presentation

- Incongruent affect (e.g., laughing while describing torture) may indicate dissociation

4. Limited Detail:

- Trauma may impair encoding and retrieval of details
- Dissociation during torture may limit memory formation
- Cultural factors may affect narrative style
- Distinguish between inability and unwillingness to provide details

G. Secondary Gain Assessment

The evaluator should consider whether secondary gain might motivate fabrication or exaggeration, while recognizing that:

- The existence of potential secondary gain does not establish fabrication
- Genuine torture survivors often have legitimate claims (asylum, compensation)
- The presence of secondary gain should heighten scrutiny, not create presumption of fabrication
- The evaluator should document potential secondary gain and explain how it was considered

Assessment Approach:

- Identify potential secondary gains (legal status, compensation, attention)
- Assess whether the presentation is consistent with feigning (see below)
- Consider the individual's history of honesty and reliability
- Evaluate the proportion of claimed symptoms to potential gain
- Document the assessment transparently in the report

H. Response Validity, Feigning, and Misclassification Risk

IMPORTANT: Use With Caution — Symmetric Error Framework

Definition (Narrow, Forensic)

Feigning (including malingering) refers to the **intentional** production or gross exaggeration of symptoms for external incentive. The IAJ distinguishes intentional feigning from: (i) trauma-related fragmentation; (ii) dissociation; (iii) cultural idioms of distress; (iv) disability- or neurocognitive-related communication differences; (v) misunderstanding due to language or interpretation; and (vi) genuine symptom fluctuation under ongoing stress.

Core Principle: Symmetric Error

This Standard is designed to protect against two symmetric errors:

- **False positive** misclassification (labeling a genuine survivor as feigning), which can retraumatize, corrupt the investigation record, and constitute a secondary harm under UNCAT Article 16; and
- **False negative** misclassification (failing to identify intentional fabrication where the evidence supports it), which can undermine the credibility of the overall evidence record.

Evaluators must not use global character judgments. When validity concerns exist, they must be documented as evidence-bounded findings in specific domains.

When Response-Validity Analysis Is Required (Istanbul Protocol Aligned)

The evaluator does **not** have a duty to raise simulation or feigning in the absence of an evidentiary foundation. The Istanbul Protocol (IP §386) establishes that documentation of possible self-infliction or simulation is appropriate only where the evaluator has specific clinical grounds for suspicion — not as a blanket requirement in every report.

Note: Any determination of possible simulation or feigning must be reviewed under the IP two-clinician requirement described in the Protocol section below before inclusion in a final report.

Indicators Suggesting Possible Feigning (Domain-Specific, Non-Exhaustive)

- Endorsement of improbable or impossible symptoms, or symptom combinations inconsistent with known trauma presentations
- Marked inconsistencies on core facts or symptom domains not plausibly explained by trauma effects, disability, language, or context
- Dramatic discrepancy between reported incapacity and observed functioning that persists across settings and over time
- Strong inconsistencies between test performance and observed behavior after considering fatigue, pain, medication effects, literacy, cultural factors, and translation quality
- Patterns on response-validity measures suggesting overreporting, non-credible responding, or performance invalidity (when appropriately administered and interpreted)
- Clear evidence of prior fabrication in similar forensic contexts, if reliably documented

Important caution: These indicators are not proof of intentional feigning. They are triggers for further investigation, structured evaluation, and careful differential explanation.

Assessment Approach (Stepwise; Least-to-Most Intrusive)

1. **Clarify domain and mechanism.** Specify what is being evaluated: symptom report, exposure narrative, functional limits, timing, or test performance.
2. **Check internal and external consistency.** Compare self-report with behavioral observation, longitudinal history, collateral records, and medical documentation. Document contradictions by domain, not globally.
3. **Consider high-risk false-positive explanations first.** Explicitly consider and document whether apparent invalidity could reflect: dissociation, shame, fear, hypervigilance, cultural idioms, neurocognitive impairment, sleep deprivation, pain or fatigue syndromes, medication effects, literacy or translation problems, or disability-related communication differences.
4. **Use validated response-validity methods when indicated and feasible.** When validity is genuinely in question and the setting permits, use validated symptom-validity and performance-validity methods appropriate to the examinee's language, education, culture, disability status, and clinical condition.

- If the PCL-5 is used, the evaluator may consider published embedded symptom-validity indices developed for detecting overreported PTSD symptomatology. These indices are not part of the original scale's official instructions and must be used cautiously and transparently, with documented acknowledgment of their sensitivity/specificity tradeoffs and the population on which they were validated.[149]
- When indicated, structured instruments may be used (e.g., SIRS-2 for symptom feigning; TOMM for performance validity), but must never be treated as dispositive proof of intentional malingering.

5. **Escalate when suspicion persists (Istanbul Protocol mandatory procedure).** If, after the steps above, the evaluator still suspects fabrication, a second clinician must conduct additional interviews. The second clinician must not have access to the first evaluator's written conclusions or attribution opinions before forming an independent clinical judgment. General knowledge of the case's existence does not disqualify the second clinician; receipt of the first evaluator's clinical findings or attribution opinions does. Documentation of possible simulation or feigning may be included in the final report only with the agreement of both clinicians. Both evaluators' reasoning must be independently documented.

Reporting (Court-Safe Language; Avoid Overreach)

If response-validity concerns are present, the evaluator should:

- Document specific indicators observed and the domain affected
- Describe the assessment approach used and its limitations (language, culture, disability, interpretation, fatigue, setting constraints)
- Prefer graduated conclusions: "response validity concerns were observed in domain X"; "inconsistencies were noted that were not fully resolved"; "the evidence is insufficient to determine intentional feigning"; or "findings in domain X are not reliably interpretable without further investigation"
- Distinguish: (a) complete fabrication; (b) exaggeration or overreporting; and (c) confusion, miscommunication, or trauma-related effects
- Where evidence remains ambiguous, document the ambiguity and specify what additional information would resolve it, rather than resolving it against the examinee

Prohibited shortcut: A feigning determination based solely on one evaluator's clinical impression, without evidence-bounded documentation and without the Istanbul Protocol's additional-interview safeguard, does not satisfy IP standards and is vulnerable to cross-examination.

[^PCL5note]: Published embedded indices derived from PCL-5 item patterns — such as the PCL-5 Symptom Severity (PSS), PCL-5 Exaggeration Scale (PES), and PCL-5 Response Inconsistency (PRI) indices — may help flag potential overreporting or inconsistent responding, but they have sensitivity/specificity tradeoffs and were validated on populations that may differ from torture

[149] Published embedded indices derived from PCL-5 item patterns may help flag potential overreporting or inconsistent responding, but have sensitivity/specificity tradeoffs and were validated on populations that may differ from torture survivors. Use with explicit acknowledgment of limitations.

survivors in cultural background, disability status, and trauma exposure. Use with documented caution and explicit acknowledgment of limitations.

I. Documentation in the Report

The credibility assessment section of the report should include:

- Methodology: How credibility was assessed (interviews, testing, collateral)
- Consistency Analysis: Assessment of internal and external consistency
- Supporting Factors: Factors that support credibility
- Factors Requiring Explanation: Any inconsistencies or concerns, with analysis
- Secondary Gain Assessment: Consideration of potential motivations
- Malingering Assessment: Whether assessed, how, and findings
- Overall Opinion: The evaluator's clinical opinion on credibility
- Limitations: Any limitations on the credibility assessment

Sample Language:

"Based on the psychological evaluation, the internal consistency of [Name]'s account, the consistency between reported symptoms and alleged torture, the presentation during the evaluation, and the absence of indicators suggesting fabrication, it is my clinical opinion that [Name]'s account of torture is credible and reliable. The psychological findings are [highly **consistent** with / typical of] the alleged torture."

Cultural Humility: A Transcultural Framework for Torture Investigation

I. Foundational Principles

Cultural humility in the context of the IAJ standard is more than a set of competencies; it is a prerequisite for a valid investigation. Per **IP §497**, clinicians must adopt an attitude of "informed learning" rather than rushing to diagnose or classify survivors according to Western psychiatric paradigms.

The purpose of cultural humility is threefold:

- **To Prevent Ethnocentric Misinterpretation**: Avoiding the dismissal of genuine suffering because it does not fit Western clinical molds.
- **To Build Trauma-Informed Rapport**: Establishing the trust necessary for disclosure in a manner that respects the political, religious, and cultural background of the survivor.
- **To Ensure Evidentiary Validity**: Ensuring that findings of consistency are based on a nuanced understanding of how trauma is processed and expressed within the survivor's specific community.

As a general guide, apply:

- Awareness of the types of bias and how to look for them in oneself and in others

- A keen eye to discern systemic versus individual bias
- Openness to learning from the individual about their experience
- Patience and due diligence in evaluating every individual with respect for their inherent dignity and value as a human being
- Special care when dealing with marginalized and disadvantaged individuals and social categories

II. Idioms of Distress: Beyond Western Symptomatology

Western clinical tools (e.g., DSM-5 or PCL-5) often assume universal symptom expressions. Cultural humility requires recognizing **Idioms of Distress**—culturally specific ways of experiencing and communicating suffering.[150]

- **Somatic Manifestations**: Many cultures express severe psychological pain through physical symptoms, such as "heart pain," "soul loss," or "burning sensations," which may not be captured by psychological checklists.
- **Cultural Taboos**: Questions about psychological distress, sexual violence, or family honor may be considered taboo or insulting in certain societies, requiring clinicians to lead into these topics with extreme sensitivity.
- **Adaptive vs. Pathological**: Clinicians must distinguish between symptoms and adaptive behaviors. For example, hypervigilance or social withdrawal may be necessary survival mechanisms for those living in repressive societies or under systemic institutional threat.

III. Intersectional Frameworks in the U.S. Context

Cultural humility requires an **intersectional approach**. Investigating systemic torture in the USA involves understanding how multiple marginalized identities compound vulnerability and harm.

IV. Clinical Guidelines for Culturally Humble Evaluations

Identity Intersection	Compounding Effect in Systemic Harm
Race & Poverty	Increases the risk of "Emergency Removal" in child welfare proceedings and reduces access to legal evidence.
Disability & Status	Denial of reasonable accommodation becomes a primary mechanism of "Distress-Induced Harm" ("Battery Without Touching").
LGBTQI+ & Culture	Survivors may face "Conversion" practices or targeted sexual violence that carry unique stigmas, preventing early disclosure .
Indigenous Status	Historical trauma and lack of cultural accommodations in judicial proceedings exacerbate psychological decompensation.

To operationalize cultural humility, IAJ evaluators must:

[150] Includes U.S.-specific subcultures (e.g., the intersection of race, poverty, and disability in the "Child Welfare" systemic context)

- **Acknowledge Power Dynamics**: Recognize that the survivor may perceive the evaluator as a representative of the same institutional authority that perpetrated the harm.
- **Prioritize Qualitative Narrative**: Use open-ended, non-leading questions that allow the survivor to define their experience in their own language and cultural context.
- **Utilize Independent Interpreters**: Brief interpreters on the IP standards of confidentiality and ensure they do not "editorialize" or pathologize the survivor's words.
- **Consult Cultural Experts**: When working with unfamiliar populations, seek peer review or consultation with experts from that community to validate clinical interpretations.
- **Complete the IAJ Cultural Validation Checklist**: to complete the investigation record (see Appendix P).

V. Integration of Cultural Humility into Consistency Assessments

Findings of "Highly Consistent" or "Typical Of" must be justified through a cultural lens.

- **Example**: "The survivor's report of [cultural idiom] is highly consistent with the alleged torture, as this expression of distress is typical for individuals of [specific culture] who have undergone [specific form of harm]".

Final Instruction: This chapter replaces the previous placeholder at Source 7354. All IAJ investigators are required to complete this module to maintain Level 2 or Level 3 credentialing status.

VI. Enhanced Cultural Humility Framework

I. Decision Tree: Instrument Modification and Replacement

Evaluators must determine if standard Western instruments (e.g., PCL-5, PHQ-9) are forensically valid for the specific examinee or if they require modification or replacement to avoid "ethnocentric misinterpretation".

STEP 1: Cultural and Linguistic Screening

- Is the examinee from a non-Western background or a marginalized subculture with distinct idioms of distress?
- If **NO**: Proceed with standard instruments, monitoring for subtle cultural variations .
- If **YES**: Proceed to STEP 2.

STEP 2: Validation Check

- Does the instrument have validated norms and a reliable translation for the examinee's specific population?
- If **YES**: Administer with "Semantic Humility," acknowledging that translation may still distort nuanced emotional meanings .
- If **NO**: Proceed to STEP 3.

STEP 3: Determination of Replacement

- Is the examinee presenting primarily with somatic complaints (e.g., "heart pain," "soul loss") rather than psychological categories?
- **ACTION**: Replace or supplement Western tools with the **Harvard Torture Questionnaire (HTQ)** or **Hopkins Symptom Checklist**, which are designed for refugee populations and incorporate cross-cultural idioms .

II. Specific Cultural Formulations in the U.S. Context

Evaluators should utilize the following templates for common populations encountered in U.S. human rights investigations:

III. Protocol for Consulting Cultural Experts

Population Group	Typical Idiom of Distress	Forensic Formulation Approach
Indigenous/Native American	"Soul Loss" or "Historical Grief"	Frame symptoms within the context of Generational Trauma and systemic institutional betrayal.
Latin American Refugees	"Ataque de nervios" (intense emotional upset)	Distinguish these episodes from Western "Panic Attacks" by documenting the social and familial triggers .
East/Southeast Asian	Somatization (e.g., "stomach fire," "weak nerves")	Prioritize the medical record of physical ailments as primary indicators of the Biological Assault .
LGBTQI+ Immigrants	"Identity Erasure" or specific taboos	Document how the trauma of "Conversion" practices or targeted sexual violence prevents early verbal disclosure .

When the evaluator lacks relevant expertise in the examinee's cultural or religious background, they must invoke the following protocol to preserve forensic integrity:

- **Identify the Knowledge Gap**: Explicitly document in the "Methodological Note" that the examiner's background may lead to bias in interpreting the examinee's behavior or narrative.
- **Select an Independent Expert**: Engage a cultural consultant or a **Level 4 International Expert** who is not affiliated with the institutional authorities accused of harm.
- **Conduct a Blind Review**: Provide the expert with anonymized behavioral observations and idioms of distress to determine if the examinee's presentation is "Typical Of" or "Highly Consistent With" trauma within that specific culture.
- **Integrate Expert Findings**: Incorporate the consultant's analysis into the final **Consistency Assessment**, citing the expert as a secondary source of reliability to satisfy **Daubert/FRE 702** requirements.

Role of the Psychological Evaluation

I. Foundational Purpose

The psychological evaluation serves as the central evidentiary pillar in torture and CIDT investigation because:

"*Torture methods are often designed to maximize pain while minimizing traceable physical evidence. Psychological symptoms are frequently the most enduring and often the only lasting evidence of torture.*" — Istanbul Protocol §523

The psychological evaluation exists to:

- Document the psychological consequences of alleged torture/CIDT
- Establish the relationship between alleged acts and observed sequelae
- Assess consistency between the account and clinical findings
- Provide evidence for legal, humanitarian, and medical purposes
- Support the survivor's access to protection, remedy, and rehabilitation
- Contribute to accountability and prevention

II. The Five Functions of Psychological Evaluation

Drawing from the Istanbul Protocol, IRCT guidance, and Physicians for Human Rights standards, the psychological evaluation serves five distinct but interrelated functions:

Function 1: EVIDENTIARY

Providing proof for legal and administrative proceedings

Application	Purpose
Criminal prosecution	Evidence of torture for prosecuting perpetrators
Civil litigation	Documentation of harm for compensation claims
Asylum proceedings	Corroboration of persecution claims
Immigration cases	Evidence supporting protection from refoulement
Administrative hearings	Documentation for disability, benefits, custody
International bodies	Submissions to UN, regional human rights courts

The psychological evaluation provides evidence that may be:

- The sole evidence when physical findings are absent
- Corroborating evidence when physical findings exist
- Explanatory evidence regarding survivor behavior or credibility

Function 2: DIAGNOSTIC

Identifying and characterizing psychological harm

The evaluation systematically assesses:

- Trauma-related disorders: PTSD, acute stress disorder, complex PTSD
- Mood disorders: Depression, persistent depressive disorder, adjustment disorders

- Anxiety disorders: Generalized anxiety, panic, phobias related to torture
- Dissociative disorders: Depersonalization, derealization, dissociative amnesia
- Somatic presentations: Physical symptoms with psychological origin
- Neurocognitive effects: Memory, concentration, executive function impairment
- Substance use: Coping-related substance disorders
- Personality changes: Enduring personality change after catastrophic experience

Function 3: CAUSATIVE

Establishing the relationship between torture and harm

The Istanbul Protocol establishes the consistency framework for causation assessment:

Level	Meaning	Application
Not consistent	Findings cannot be explained by alleged torture	Counter-evidence
Consistent with	Findings could have been caused by torture but are non-specific	Supportive but weak
Highly consistent	Findings commonly seen in such torture; hard to explain otherwise	Strong support
Typical of	Findings usually found in this type of torture	Very strong support
Highly Consistent (IP §543(e))	Findings could only result from this torture	Definitive (rare for psychological evidence)

This framework allows the evaluator to express scientific uncertainty while still providing meaningful evidence.

For rapid causation screening in stress-mediated harm cases, see the **Quick-Reference Decision Tree** in the chapter "The Doctrine of Distress-Induced Harm", Section IV (B).

Function 4: THERAPEUTIC

Supporting healing and recovery

The evaluation itself has therapeutic value:

"*Documentation is not merely forensic—it is a therapeutic act. The survivor's experience is validated, witnessed, and preserved.*" — IRCT, Principles of Documentation

Therapeutic functions include:

- Validation: Affirming the survivor's experience as real and significant
- Witness: Providing an independent witness to atrocity
- Empowerment: Giving the survivor agency through documented evidence
- Narrative construction: Helping organize fragmented trauma memories
- Treatment planning: Identifying needs for rehabilitation

- Hope: Demonstrating that accountability may be possible

Function 5: PREVENTIVE

Contributing to systemic accountability and prevention

Beyond the individual case, psychological evaluations:

- Build pattern evidence across cases
- Document systemic practices for reform advocacy
- Support accountability mechanisms that deter future torture
- Educate courts, policymakers, and the public
- Fulfill State obligations under UNCAT Articles 12-13 (investigation)

III. The Scope of Psychological Evaluation

What the Psychological Evaluation Assesses

Drawing from the Istanbul Protocol §§523-609, IRCT standards, and academic literature:

- Trauma History
- Detailed account of alleged torture/CIDT
- Chronology and context
- Methods, perpetrators, settings
- Immediate and subsequent responses
- Current Psychological Symptoms
- Re-experiencing (flashbacks, nightmares, intrusions)
- Avoidance (of reminders, numbing, withdrawal)
- Hyperarousal (startle, hypervigilance, sleep disturbance)
- Negative cognitions (guilt, shame, altered worldview)
- Dissociation (depersonalization, derealization, amnesia)
- Mood disturbance (depression, anhedonia, hopelessness)
- Anxiety symptoms (panic, phobias, generalized worry)
- Somatic complaints (pain, conversion symptoms)
- Pre-Torture History
- Baseline functioning and mental health
- Prior trauma exposure
- Personality and coping style
- Cultural and social context
- Resilience factors

- Post-Torture History
- Course of symptoms since torture
- Treatment received and response
- Ongoing stressors and re-traumatization
- Protective and risk factors
- Current functional status
- Mental Status Examination
- Appearance, behavior, speech
- Mood and affect
- Thought process and content
- Perception
- Cognition
- Insight and judgment
- Psychological Testing
- Standardized trauma measures (PCL-5, IES-R, HTQ)
- Depression and anxiety measures (PHQ-9, GAD-7, DASS)
- Functional assessment (WHODAS 2.0)
- Validity assessment
- Culturally appropriate instruments[151]

Quick-Reference Decision Tree: Initial Screening and Scope Determination

This decision tree provides a rapid front-end screen to determine whether a full IAJ psychological evaluation is indicated, whether urgent safety measures are needed, and whether the matter should proceed as an Article 1, Article 16, or preliminary documentation case.

STEP 1: Is there an allegation, suspicion, or observable indicator of torture, CIDT, or serious coercive institutional harm?

├── **No** → Routine clinical documentation may suffice; monitor for emerging indicators

└── **Yes** → Proceed to STEP 2

STEP 2: Is there immediate safety risk or acute decompensation?

├── **Yes** → Prioritize crisis response, stabilization, emergency referral, and urgent protective documentation

[151] The standard acknowledges that many psychological tests lack cross-cultural validity and can be misused to stigmatize victims. Since psychological evaluations in the USA rely heavily on Western-normed instruments like the PCL-5 and PHQ-9, the IAJ recommends developing a deep understanding of cultural humility before performing psychological testing of potential victims using Western-normed instruments.

└── **No** → Proceed to STEP 3

STEP 3: Is the reported harm linked to a public official, institutional actor, or official acquiescence?

├── **Yes** → Proceed to STEP 4

└── **Unclear** → Continue documentation; flag for factual development and cautious legal characterization

STEP 4: Is the apparent harm severe enough to raise possible Article 1 or Article 16 issues?

├── **Yes** → Proceed to STEP 5

└── **Unclear / lower-severity but degrading or coercive** → Document as possible Article 16 / coercive abuse pending fuller assessment

STEP 5: Is there a need for a full forensic psychological evaluation?

├── **Yes** → Continue with full evaluation protocol

├── **Partial / uncertain** → Use preliminary documentation plus collateral gathering

└── **No** → Record observations, refer as appropriate, and preserve a path for escalation if new information emerges

STEP 6: Does the case involve special complexity?

├── Child, disability, dissociation, psychosis, severe retaliation risk, major cultural barriers, or systemic/policy allegations

│ └── Apply specialized modules and consider supervision / co-evaluation

└── None of the above

└── Proceed under the standard protocol

Screening rule:

A case need not be fully "proven" at intake to justify evaluation. The purpose of initial screening is to determine whether sufficient indicators exist to begin disciplined documentation, not to prematurely exclude complex or unconventional claims.

IV. The Principles Governing Psychological Evaluation

Core Principles

Istanbul Protocol §§267–273, §§523–545: The psychological evaluation is governed by principles of independence, impartiality, competence, informed consent, and confidentiality.

Principle	Meaning
Independence	Evaluator must be free from pressure by any party
Impartiality	Evaluator must not prejudge; must follow evidence
Competence	Evaluator must have appropriate qualifications and training
Consent	Informed, voluntary consent required
Confidentiality	Information protected except by consent or legal

	obligation
Non-maleficence	Evaluation must not cause harm
Documentation integrity	Accurate, contemporaneous, secure records
Cultural sensitivity	Awareness of cultural context and idioms of distress
Gender sensitivity	Awareness of gender-specific torture and responses
Trauma-informed approach	Methods that minimize re-traumatization

__Evaluator Self-Monitoring as a Condition of Reliable Assessment__

Forensic reliability depends not only on the examinee's presentation and the quality of the collateral record, but also on the evaluator's capacity to remain attentive, emotionally regulated, impartial, and cognitively precise throughout the assessment. Exposure to graphic, cumulative, or morally injurious material can impair concentration, reduce tolerance for ambiguity, distort threat perception, narrow interpretive range, and increase reliance on heuristics. Accordingly, **evaluator self-monitoring is part of methodological integrity**.

The evaluator should actively monitor for signs that fatigue or vicarious trauma may be affecting judgment, including:

- unusual irritability, impatience, or pressure to "rush to conclusion";
- emotional numbing or mechanical interviewing;
- over-identification, rescue fantasies, or loss of analytic distance;
- excessive skepticism or defensive detachment;
- difficulty tracking chronology, details, or differential explanations;
- impaired listening, repeated missed clarifications, or shallow follow-up;
- premature certainty, binary thinking, or collapse of nuance;
- intrusive imagery, somatic stress reactions, or marked autonomic arousal during the interview;
- inability to tolerate additional trauma content without clear decline in concentration.

Where these indicators are present, the evaluator should pause, use structured regulation measures, shorten or split the session, obtain supervision or peer consultation, or transfer the case if necessary. Continuing a compromised evaluation without adjustment can undermine neutrality, accuracy, and defensibility.

The Standard of Proof

The psychological evaluation does not require certainty. The Istanbul Protocol establishes:

"*The clinician's role is to provide an expert opinion on the degree to which clinical findings correlate with the alleged torture. It is not necessary to determine with certainty what occurred—this is for legal decision-makers.*" — Istanbul Protocol §600

For structured guidance on causation thresholds, evidentiary sufficiency, competing etiologies, and graded conclusions in stress-mediated harm claims, see the Chapter "The Doctrine of Distress-Induced Harm", Section IV (B) **“Evidentiary Standards for Distress-Induced Harm Claims”**

The evaluator provides:

- Clinical observations (facts)
- Diagnostic formulation (clinical judgment)
- Consistency assessment (correlation between allegations and findings)
- Degree of confidence (using the consistency framework)

Where the evaluation addresses alleged distress-induced physical or psychological harm, the evaluator should expressly distinguish clinical causation, forensic consistency, and legal causation as set out in the chapter "The Doctrine of Distress-Induced Harm", Section IV (B).

The evaluator also provides a **methodologically sound process**, which includes pacing the evaluation, using breaks when needed, and suspending or transferring the assessment if evaluator fatigue or vicarious trauma would materially reduce reliability.

V. Why Psychological Evaluation Is Essential

The Unique Contribution of Psychological Evidence

From academic literature and clinical experience:

- Permanence of Psychological Harm

"*Physical wounds heal; psychological wounds persist. Torture is designed to destroy the person, not merely the body. The psychological evaluation documents the success or failure of this design.*"

— Metin Başoğlu, Torture and Its Definition in International Law (2017)

- Absence of Physical Evidence

Many torture methods leave no physical trace:

- Psychological torture (threats, humiliation, witnessing others' torture)
- Positional torture (prolonged standing, suspension)
- Asphyxiation methods
- Temperature extremes
- Sleep deprivation
- Sensory manipulation
- Resolution of Physical Evidence

Physical injuries heal; psychological consequences do not:

- Scars fade or become non-specific
- Fractures heal without trace
- Soft tissue injuries resolve

- But PTSD, depression, and personality changes persist
- Behavioral Corroboration

Psychological findings explain behaviors that might otherwise damage credibility

- Memory gaps (dissociative amnesia)
- Inconsistent accounts (trauma-related fragmentation)
- Delayed disclosure (shame, fear, distrust)
- Emotional presentation (numbing vs. expected distress)
- Suffering as the Harm

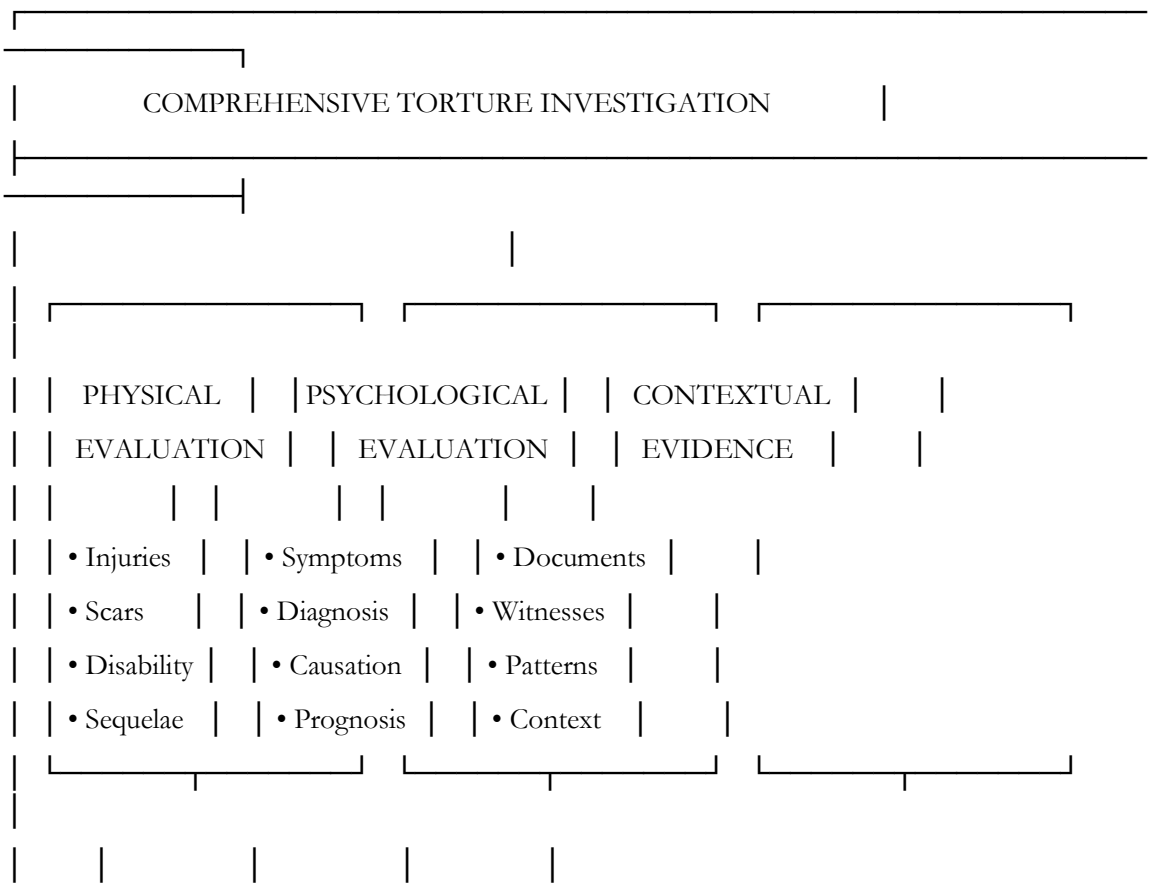
Under UNCAT, torture is defined by severe pain or suffering. Psychological evaluation:

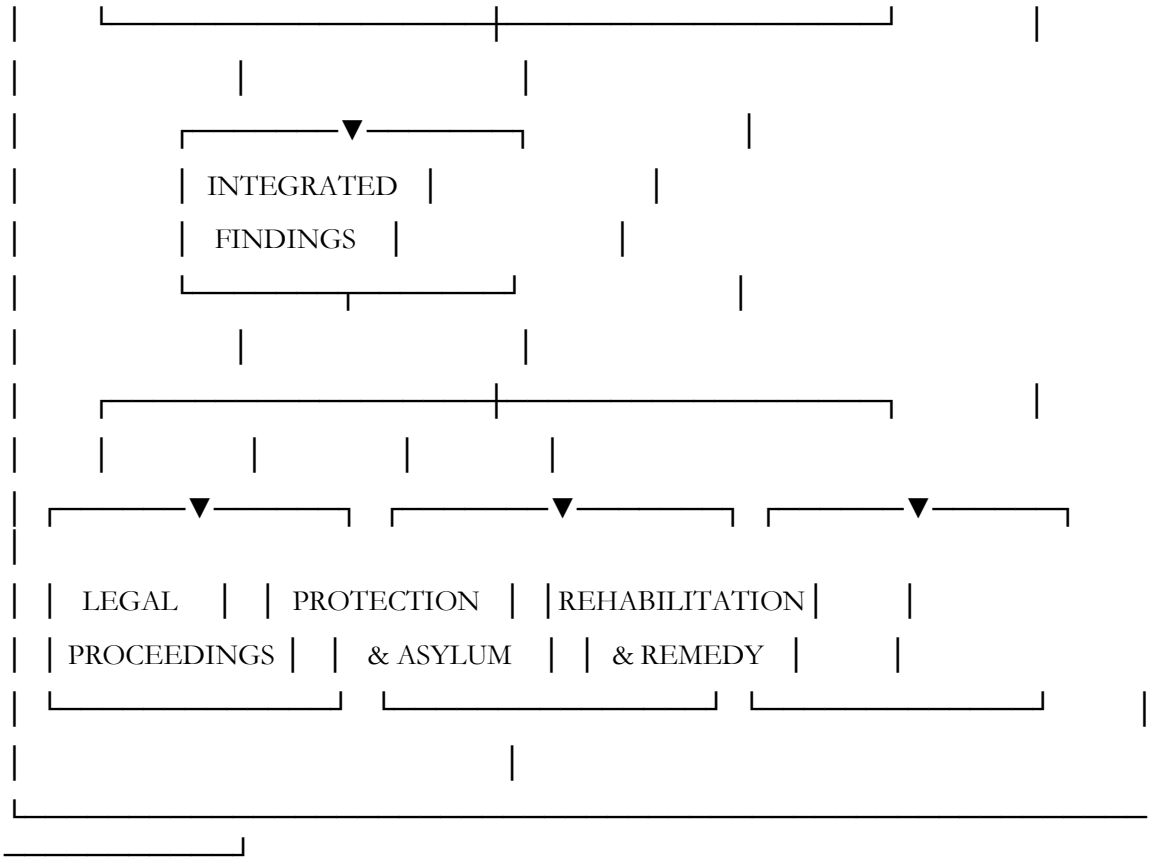
- Documents the suffering directly
- Establishes severity
- Provides evidence consistent with a human rights violation having occurred

VI. The Psychological Evaluation in Context

Within the Investigation Framework

The psychological evaluation is one component of comprehensive torture investigation:





Primacy of Psychological Evidence

"*When physical findings are absent, non-specific, or have resolved, the psychological evaluation often provides the only medical evidence of torture. In many cases, it is the most important component of the investigation.*"

— Istanbul Protocol §524

VII. Synthesis: The Role Defined

The Role of Psychological Evaluation in Torture and CIDT Investigation

The psychological evaluation is the systematic clinical assessment of an individual who alleges or is suspected of having experienced torture or cruel, inhuman or degrading treatment, conducted for the purpose of:

- Documenting the psychological consequences of the alleged acts with scientific rigor and clinical precision;
- Diagnosing mental disorders and psychological conditions resulting from the alleged torture;
- Assessing the degree of consistency between the clinical findings and the account of torture, using established international frameworks;
- Providing admissible evidence for legal proceedings, asylum claims, administrative matters, and international human rights mechanisms;

- Supporting the survivor's access to protection from further harm, remedy for violations suffered, and rehabilitation for injuries sustained;
- Contributing to accountability by documenting violations, identifying perpetrators, and establishing patterns of abuse;
- Serving therapeutic functions through validation, witnessing, narrative construction, and treatment planning;
- Fulfilling State obligations under international law to investigate allegations, provide remedy, and prevent recurrence.

The psychological evaluation recognizes that:

- Torture targets the mind as much as the body
- Psychological harm is often the most enduring and disabling consequence
- Psychological evidence may be the only evidence when torture is designed to leave no trace
- The survivor's credibility depends on understanding trauma's effects on memory and behavior
- Documentation itself is an act of resistance against impunity
- **Every care provider who encounters a torture survivor shares the duty to document**

The psychological evaluation is governed by:

- The Istanbul Protocol (2022 edition) as the international standard
- Professional ethics of the evaluator's discipline
- Human rights principles including dignity, non-discrimination, and non-maleficence
- Scientific standards of reliability, validity, and replicability
- The primacy of the survivor's wellbeing and autonomy

The psychological evaluation ultimately exists because:

"The torturer's goal is to break the person—to destroy their sense of self, their connection to others, their belief in a just world, their capacity for hope. The psychological evaluation documents this destruction. But in documenting it, in witnessing it, in refusing to let it remain invisible, the evaluation becomes an act of reconstruction. The survivor is seen. The truth is preserved. Accountability becomes possible. And the torturer's goal is, in some measure, defeated."

VIII. Integration of Istanbul Protocol Chapter IV: General Considerations for Interviews

The Istanbul Protocol Chapter IV establishes foundational principles for conducting interviews in torture investigations. The IAJ incorporates these standards with adaptations for the U.S. context.

IP Chapter IV Core Principles:

- Purpose of the Interview (IP §§121-122)

The interview serves multiple functions:

- Documentation of alleged torture and ill-treatment for potential legal proceedings

- Identification of physical and psychological evidence
- Assessment of the need for medical, psychological, or social support
- Development of facts for potential prosecution or civil litigation
- Contribution to broader human rights documentation

In the U.S. context, the interview must also anticipate:

- The evidentiary requirements of federal and state courts
- The heightened standard of proof courts may apply given U.S. RUDs
- The need to address alternative explanations that may be raised
- Documentation sufficient for international bodies should domestic remedies fail
- Procedural Safeguards (IP §§123-135)

The following safeguards must be maintained:

(a) Informed Consent — The individual must understand:

- The purpose of the evaluation
- How findings will be used
- Who will have access to the report
- The right to decline participation or limit disclosure
- That participation is voluntary
- The evaluator's role and limitations

(b) Confidentiality — The evaluator must explain:

- What information will be kept confidential
- Exceptions to confidentiality (mandatory reporting, legal compulsion)
- How records will be secured
- Who may access the evaluation
- The individual's control over disclosure

(c) Privacy — Interviews must be conducted:

- In private, without unauthorized observers
- Without surveillance or recording by authorities (unless consented by examinee)
- In a location where the individual feels safe
- With interpreter present only if necessary and trusted

(d) Documentation — The evaluator must:

- Record contemporaneous notes
- Preserve physical evidence according to chain-of-custody requirements

- Create secure backup of all documentation
- Maintain records for appropriate retention periods
- Interview Setting and Conditions (IP §§136-145)

(a) Physical Environment:

- Comfortable, non-threatening space
- Adequate lighting, temperature, and ventilation
- Seating arranged to minimize power differential
- Private, secure location
- Accessible for individuals with disabilities
- Culturally appropriate setting where possible

(b) Timing Considerations:

- Sufficient time allocated (minimum 90-120 minutes for initial interview)
- Breaks offered proactively, not only on request
- Multiple sessions scheduled if needed
- Avoidance of time pressure that could compromise thoroughness
- Awareness of optimal times of day for trauma survivors (avoiding fatigue)

(c) Interviewer Demeanor:

- Calm, patient, non-judgmental
- Professional but warm
- Culturally sensitive
- Trauma-informed
- Prepared for emotional responses
- Willing to pause or stop if needed
- Interview Techniques (IP §§146-159)

(a) Establishing Rapport:

- Begin with non-threatening topics
- Explain process thoroughly before starting
- Acknowledge the difficulty of recounting trauma
- Affirm the individual's courage in coming forward
- Establish the evaluator's independence and purpose

(b) Questioning Approach:

- Use open-ended questions initially

- Progress to more specific questions
- Avoid leading questions that suggest answers
- Do not challenge or express disbelief
- Allow silence and processing time
- Return to topics gently if needed

(c) Trauma-Sensitive Techniques:

- Monitor for signs of distress or dissociation
- Offer grounding techniques if needed
- Respect the individual's pace
- Do not press for details the individual cannot provide
- Acknowledge emotional responses as normal
- Provide closure at the end of each session

(d) Documentation During Interview:

- Take notes without disrupting rapport
- Avoid extensive writing during emotionally intense moments
- Request permission to record if appropriate
- Document direct quotations where possible
- Note non-verbal responses and emotional presentation
- Use of Interpreters (IP §§160-165)

See "Interpreter Protocols for Forensic Evaluations"

- Special Considerations (IP §§166-175)

(a) Gender-Sensitive Approaches:

- Offer choice of evaluator gender when possible
- Be aware of culturally-specific gender dynamics
- Recognize that sexual torture may require same-gender evaluation
- Do not assume comfort based on apparent gender matching

(b) Cultural Considerations:

- Understand cultural expressions of distress
- Recognize culturally-bound syndromes
- Adapt interview style to cultural norms
- Avoid imposing Western psychological frameworks
- Use culturally appropriate idioms of distress

(c) Safety Considerations:

- Assess ongoing risk to the individual
- Develop safety plans if needed
- Consider risks of disclosure to third parties
- Protect identity in documentation where necessary
- Be aware of potential surveillance or retaliation

IX. Adaptations of the Istanbul Protocol to scenarios of torture and CIDT in the USA

IP §524 notes that "[a]s the emotional impact of torture is profound and resulting psychological symptoms are so prevalent among torture survivors, it is highly advisable for any evaluation of alleged torture victims to include a comprehensive psychological assessment."

IP §523 reminds us that "[p]sychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms; torture methods are often designed to leave no physical lesions; and physical methods of torture may result in physical findings that either resolve or lack specificity." The IAJ adds that psychological harm suffered during torture and CIDT can manifest as physical harm.

We describe the role of the psychological evaluation by quoting the Istanbul Protocol, Chapter VI, for simplicity of your reference, with some enhancements and guidance by the IAJ (in bold):

IP §491. *It is a widely held view that torture is an extraordinary life experience capable of causing a broad range of physical and psychological suffering. Research and clinical experience have shown that psychological sequelae*[152] *of torture are often more persistent and protracted than physical sequelae*[153] *and*

documentation of torture frequently takes place when the physical lesions have already disappeared. These circumstances confer upon the psychological evaluation a central role in evidencing torture, holding perpetrators responsible and claiming redress. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, vary according to the nature of the harm inflicted and the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same consequences in every individual. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault. ***And solitary confinement and isolation, or deprivation of rights in the course of access to justice or 'weaponization' of the judicial process or infliction of prohibited acts **through institutional processes are **customarily** considered to be unlikely to produce the same effects as physical acts of torture, but must not be presumed so**. Likewise, the effects of detention, **parent-child separation and torture on an adult will usually not be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity. The IAJ is**

[152] José Quiroga and James M. Jaranson, "Politically-motivated torture and its survivors. A desk review of the literature", Torture, vol. 15, No. 2–3 (2005).

[153] José Quiroga and James M. Jaranson, "Politically-motivated torture and its survivors. A desk review of the literature", Torture, vol. 15, No. 2–3 (2005).

expanding this pool of observations and documentation to previously uncharted areas, including the judicial process, legislated and institutionalized prohibited acts, discrimination based on disability and parent-child separation.*

IP §492. *Perpetrators often attempt to justify their acts of torture or ill-treatment,* ***such as by the need to gather information or the alleged operation of laws or procedures, including derogation of non-derogable rights****. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions*[154]*.* ***However, it must not be under-estimated that a central aim may also be to knowingly and deliberately induce trauma or promote distress-induced injury by use of authority including, e.g., (a) the requirement of compliance with a demand issued for a prohibited purpose or (b) by the derogation of a non-derogable right, or (c) by the application of a process that, by design, causes severe pain and suffering that is avoidable. Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate a victim physically or psychologically**** *but also to disintegrate the individual's personality.*[155] *The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims**, **torturers instill generational trauma and terror in their victims as well as offering a horrific warning for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities and generations****. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and between the victims and their communities.*

IP §493. *It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness*[156]*.However, most victims experience profound emotional reactions and psychological symptoms often also including serious cognitive and behavioural changes.* ***Under the conventional view, the main psychiatric disorders associated with torture are PTSD and depression. However, the IAJ observes that the spectrum of psychiatric disorders associated with torture extend to other debilitating symptoms and conditions that require renormalization of what constitutes "main" psychiatric disorders. While these conventional disorders are present in the general population, their prevalence, though varying among studies, is much higher among torture survivors. The IAJ is expected to advance research in this area. Per the Istanbul Protocol****, epidemiological studies with torture survivors and refugees show prevalence rates of 23–88 per cent for PTSD and 28–95 per cent for depression.*[157] *The high variability among studies is likely due to different population samples (including studies with torture survivors seeking treatment), different assessment methods, coexisting stressors and other factors. However, the unique cultural, social and political implications that torture has for each individual influence the ability of that person to describe and speak about it.* ***The IAJ observes that in the domain of judicial and**

[154] José A. Saporta and Bessel A. van der Kolk, "Psychobiological consequences of severe trauma", in Torture and its Consequences: Current Treatment Approaches, Metin Başoğlu, ed. (Cambridge, United Kingdom, Cambridge University Press, 1998), pp. 151–181.

[155] Almerindo E. Ojeda, ed., The Trauma of Psychological Torture (Westport, Praeger, 2008); and Pau Pérez-Sales, Psychological Torture: Definition, Evaluation and Measurement (Routledge, 2016).

[156] It should be kept in mind that the qualification of an act as torture is not dependent on the existence of subsequent prolonged mental harm. See, in this respect, Manfred Nowak, "What practices constitute torture?: US and UN standards", Human Rights Quarterly, vol. 28, No. 4 (2006), pp. 809–841.

[157] Hiba Abu Suhaiban, Lana Ruvolo Grasser and Arash Javanbakht, "Mental health of refugees and torture survivors: a critical review of prevalence, predictors and integrated care", International Journal on Environmental Research and Public Health, vol. 16, No. 13 (2019)

institutional torture and CIDT, the description and speech by the person has been found to be explicitly prohibited, and if the prohibition is challenged, the person is subjected to retaliation and aggravated suppression, thus magnifying the adverse influence on the ability of that person to describe and speak about it.* *Such effects on the victim's ability to make sense of and describe the experience of torture must be considered especially when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most useful approaches when attempting to evaluate psychological or psychiatric disorders. What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.*[158]

IP §494. *In recent years, the diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. However, the utility of this diagnosis has been questioned on many grounds, including its universal applicability. Nevertheless, evidence suggests that there are high rates of PTSD and depressive symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds.*[159] *A cross-cultural study of depression provides helpful information.*[160] *While some symptoms may be present across different cultures, it is important to consider culture-specific ways of experiencing, expressing and describing psychological distress in order to recognize and document the broad range of suffering that may remain invisible if the PTSD concept is uncritically applied. Such expressions of distress shaped by culture might be more relevant to the survivor than PTSD symptoms.* ***The IAJ observes that within the domain of judicial and institutional torture and CIDT, the types of violence are radically narrowed compared to the conventionally considered broad array of violence types in the population data, providing a new perspective on the significance of PTSD in judicial and institutional settings.***

Note the guidance provided by the Part 2 of the General Considerations of the Istanbul Protocol under Section VI. Within the context of the psychological evaluation, please carefully consider the following two passages:

From IP *§495. Psychological evaluations can help to identify post-traumatic conditions (e.g. memory problems, flashbacks, avoidance and dissociation),*[161] *which may cause victims to act unconsciously or unintentionally and are likely to affect or alter the victims' ability and capacity to recall and present what they have experienced, which in turn may affect their ability to participate and testify in various forms of legal proceedings, including adjudication related to the investigation of torture.*[162] *Assessment and documentation of these barriers to full participation in legal proceedings as a consequence of the sequelae of torture can help prevent inaccurate conclusions being drawn in legal proceedings by*

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[158] H. Tristram Engelhardt, Jr., "The concepts of health and disease", in Evaluation and Explanation in the Biomedical Sciences, H. Tristram Engelhardt, Jr. and Stuart F. Spicker, eds. (Dordrecht, D. Reidel Publishing Co., 1975), pp. 125–141. See also Joseph Westermeyer, "Psychiatric diagnosis across cultural boundaries", American Journal of Psychiatry, vol. 142, No. 7 (1985), pp. 798–805.

[159] See Richard F. Mollica and others, "The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps", Journal of the American Medical Association, vol. 270, No. 5 (1993), pp. 581–586; Kathleen Allden and others, "Burmese political dissidents in Thailand: trauma and survival among young adults in exile", American Journal of Public Health, vol. 86, No. 11 (1996), pp. 1561–1569; J. David Kinzie and others, "The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees", American Journal of Psychiatry, vol. 147, No. 7 (1990), pp. 913–917.

[160] Norman Sartorius, "Cross-cultural research on depression", Psychopathology, vol. 19, No. 2 (1986), pp. 6–11.

[161] Andrea R. Ashbaugh, Julia Marinos and Brad Bujaki, "The impact of depression and PTSD symptom severity on trauma memory", Memory, vol. 26, No. 1 (2018), pp. 106–116.

[162] Karen E. Krinsley and others, "Consistency of retrospective reporting about exposure to traumatic events", Journal of Traumatic Stress, vol. 16, No. 4 (2003), pp. 399–409; Amina Memon, "Credibility of asylum claims: consistency and accuracy of autobiographical memory reports following trauma", Applied Cognitive Psychology, vol. 26, No. 5 (2012), pp. 677–679; Hannah Rogers, Simone Fox and Jane Herlihy, "The importance of looking credible: the impact of the behavioural sequelae of post-traumatic stress disorder on the credibility of asylum seekers", Psychology, Crime & Law, vol. 21, No. 2 (2015), pp. 139–155.

lawyers and judges.[163]* **The IAJ observes the aggravating effect of the perception of imminent danger and further harm on post-traumatic conditions within judicial and institutional processes that control relief, remedy and punishment of torture and CIDT and protection from them***.

From IP *§496. Additional problems arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in detention* ***or subjected to violative institutional or judicial processes or living under considerable threat or oppression, some symptoms may be adaptive. For example, diminished interest in activities and feelings of detachment or estrangement would be understandable in a person in solitary confinement. For example, in institutional and judicial contexts, involuntary consent and conformity, or radically impaired or conflicted self-advocacy, leading to prejudice and harm would be understandable****. *Likewise, hypervigilance and avoidance behaviours may be necessary for persons living in repressive societies.*[164]

The PHR guidance reminds the IAJ investigator that psychological evaluation plays a central role in medical evaluations of torture and ill-treatment. We quote from the PHR Toolkits' Istanbul Protocol Model Medical Curriculum, Module 6 "Psychological Evidence of Torture and Ill-Treatment":

Psychological evaluations can provide critical evidence of abuse among torture victims. It has a central role in the medical investigation and documentation of torture allegations. All medical investigations and documentation of torture should include a detailed psychological evaluation because:

- *One of the main aims of torture is to destroy the psychological, social integrity and functioning of the victim.*

Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualisations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions. Torture is a means of attacking the individual's fundamental modes of psychological and social functioning. The torturer strives not only to incapacitate a victim physically, but also to disintegrate the individual's personality: The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future.

— (IP, §235)

Internationally accepted definitions of torture acknowledge that provoking mental suffering is often the intention of the torturer.[165]

- *All kinds of torture inevitably comprise psychological processes.*
- *Torture often causes psychological/psychiatric symptoms at various levels.*

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[163] Belinda Graham, Jane Herlihy and Chris R. Brewin, "Overgeneral memory in asylum seekers and refugees", Journal of Behavior Therapy and Experimental Psychiatry, vol. 45, No. 3 (2014), pp. 375–380; Urs Hepp and others, "Inconsistency in reporting potentially traumatic events", British Journal of Psychiatry, vol. 188, No. 3 (2006), pp. 278–283; Jane Herlihy, Peter Scragg and Stuart Turner, "Discrepancies in autobiographical memories – implications for the assessment of asylum seekers: repeated interviews study", British Medical Journal, vol. 324 (2002), pp. 324–327; and Cohen, "Errors of recall and credibility" (see footnote 412).

[164] Michael A. Simpson, "What went wrong?: Diagnostic and ethical problems in dealing with the effects of torture and repression in South Africa", in Beyond Trauma: Cultural and Societal Dynamics, Rolf J. Kleber, Charles R. Figley and Berthold P.R. Gersons, eds. (New York, Plenum Press, 1995), pp. 187–212

[165] The IAJ observes that systemic torture includes intention by policy. Policies that are applied invariantly without consideration of the ensuing severe pain and suffering or cruelty or inhumanity or degradation of the individual, with the actors knowing the prohibited harm that will be caused, and deliberately proceeding according to the policy, demonstrate the intent to violate the UNCAT.

- *Torture methods are often designed not to leave physical lesions, and physical methods of torture may result in physical findings that either disappear quickly or lack specificity.*

The improvement in the methods of detecting and providing evidence of physical torture has paradoxically led to more sophisticated methods of torture that do not to leave visible evidence on the victim's body. Most physical symptoms and signs of torture, if there are any, rapidly disappear.

It is important to realise that torturers may attempt to conceal their acts. To avoid physical evidence of torture, precautions are taken with the intention of producing maximal pain and suffering with minimal evidence. Especially under conditions of raised awareness in society, torture applied with these precautions and sophisticated methods may leave almost no physical signs.

Torturers know that by not leaving permanent physical scars, they help their cause and make the work of their counterparts in the human rights arena more difficult. For this reason, in the Istanbul Protocol it is underscored that, "the absence of such physical evidence should not be construed to suggest that torture did not occur."

- *Psychological symptoms are often more prevalent and long-lasting than physical symptoms.*

Contrary to the physical effects of torture, the psychological consequences of torture are often more persistent and troublesome than physical disability. Several aspects of psychological functioning may continue to be impaired long-term. If not treated, victims may still suffer from the psychological consequences of torture even months or years following the event, sometimes for life, with varying degrees of severity.

Having defined what the psychological evaluation seeks to accomplish, we must now establish the principles that guide how it is conducted. These principles—drawn from the Istanbul Protocol, medical ethics, and human rights standards—ensure that evaluations are reliable, valid, and protective of the individual being evaluated. Adherence to these principles distinguishes a legitimate forensic evaluation from one that could be challenged or dismissed. The following section articulates the essential principles that every IAJ-appointed evaluator must observe.

Module 4: Harm Documentation & Causation Synthesis

Psychological consequences of torture and ill-treatment

The Istanbul Protocol (IP) notes (IP §498) that in "most cases, the intensity of trauma-related psychological symptoms changes over time depending on personal trauma processing, the effectiveness of available coping strategies, as well as external factors. There might be subthreshold symptoms at the time of assessment or reported for phases since the traumatic event that do not amount to a diagnosable mental disorder. The expression of distress may be nuanced or mediated by culture and social context, for example according to the experience of shame, fear of reprisals and fear of further stigma or ostracization within the family or community. It is important to recognize that the absence of a formal diagnosis does not exclude the presence of severe mental suffering and disability and is not inconsistent with torture or ill-treatment having taken place. The psychological assessment should aim to reach an understanding of the multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification.

While the IP does not provide an exhaustive list of psychological responses to torture and CIDT, it acknowledges a list of **common** psychological responses (IP §499-522):

- Re-experiencing the trauma (IP §500)
- Avoidance (IP §501)
- Hyperarousal (IP §502)
- Damaged self-concept and negative changes in cognition and mood (IP §503)
- Feelings of guilt and shame (IP §504)
- Symptoms of depression (IP §505)
- Dissociation, depersonalization and atypical behaviour (IP §506)
- Physical complaints (somatic symptoms) (IP §507)
- Sexual problems (IP §508)
- Psychotic symptoms (IP §509)
- Substance misuse (IP §510)
- Neuropsychological and neurocognitive impairment (IP §511)

IP §512 notes that "*it is more common than not for more than one mental disorder to be present, as there is considerable co-morbidity among trauma related mental disorders. Various manifestations of depression, anxiety and trauma-related syndromes are the most common consequences resulting from torture.*"

The Protocol invites the investigator to develop, at a minimum, familiarity with:

- Depressive disorders (IP §513)
- Post-traumatic stress disorder (IP §514-518)
- Acute stress disorder (IP §519)

- Substance use disorder (IP §520)
- Other diagnoses (IP §521) including:
- Anxiety disorders
- Dissociative disorders
- Somatic symptoms disorders
- Bipolar disorder
- Disorders due to a general medical condition
- Psychotic disorders
- Sexual dysfunction

IP §522 notes that non-torture-specific, pre-torture disorders (e.g. recurrent depressive episodes) can worsen or resurface as a result of torture.

The IAJ observes that psychological decompensation is a critical indicator in torture and CIDT evaluations. Decompensation refers to the deterioration of mental functioning in an individual who had previously maintained psychological equilibrium, either through natural coping mechanisms or with the aid of treatment.

Quick-Reference Decision Tree: Severity Rating

This decision tree supports rapid classification of the seriousness of psychological impact for purposes of urgency, documentation depth, and formulation.

STEP 1: Is there acute risk or profound destabilization?

├── Suicide risk, psychosis, inability to care for self, severe dissociation, medical decompensation

│ └── **Classify as Severe / Urgent**; prioritize safety and immediate documentation

└── None of the above → Proceed to STEP 2

STEP 2: Is there marked functional impairment?

├── Major occupational, educational, social, or daily-living impairment

│ └── Proceed toward **Moderate-to-Severe** range

└── Mild or intermittent impairment → Proceed to STEP 3

STEP 3: Are symptoms persistent, escalating, or recurrent after institutional triggers?

├── **Yes** → Increases severity rating

└── **No / transient only** → Continue to STEP 4

STEP 4: Is there evidence of broad multi-domain impact?

├── Affective, cognitive, somatic, relational, and functional domains affected

│ └── Raise severity level

└── Narrow-domain impact only

└── Maintain proportionate rating

STEP 5: Final severity classification

├── **Mild** → Distress present, limited functional disruption

├── **Moderate** → Clinically significant symptoms with meaningful impairment

├── **Severe** → Major impairment, recurrent decompensation, or serious destabilization

└── **Severe / Urgent** → Immediate protection or intervention required

Severity rule:

Severity should be based on the **combined weight of symptom intensity, persistence, functional impact, and risk**, not on symptom count alone.

Decompensation in Torture Contexts:

- **Acute Decompensation** occurs during or immediately following torture/CIDT, manifesting as:
- Sudden onset of psychotic symptoms in individuals with no prior psychotic history
- Acute dissociative episodes
- Complete functional breakdown
- Catatonic responses
- Severe regression
- **Delayed Decompensation** may occur weeks, months, or years after torture/CIDT, often triggered by:
- Anniversary dates of traumatic events
- Encounters with authority figures resembling perpetrators
- Legal proceedings requiring trauma recounting
- Media coverage of similar events
- Loss of support systems
- Secondary victimization through institutional responses
- **Progressive Decompensation** reflects cumulative harm from systemic torture, where
- Initial resilience gradually erodes under sustained mistreatment
- Each additional violation builds upon previous psychological injury
- The victim's coping resources become exhausted
- What might otherwise be survivable stressors become overwhelming
- The trajectory moves from manageable distress to clinical crisis

Evaluator Guidance on Decompensation:

When assessing decompensation, the evaluator should document:

(a) **Pre-torture baseline functioning** — What was the individual's psychological status before the alleged torture/CIDT? This includes occupational functioning, relationships, prior psychiatric history, and general adaptive capacity.

(b) **Decompensation trajectory** — Map the deterioration of functioning over time, correlating changes with specific acts of torture/CIDT. Create a timeline showing:

- Date/period of alleged torture/CIDT
- Onset of specific symptoms
- Progression or fluctuation of symptoms
- Functional impairments at each stage

(c) **Triggering events** — Identify what precipitated acute decompensation episodes, noting whether triggers are thematically related to the torture experience.

(d) **Recovery attempts and obstacles** — Document efforts at treatment and recovery, and barriers encountered, including institutional obstruction, lack of access to care, or re-traumatization.

(e) **Current functional status** — Assess present-day functioning across domains (occupational, social, self-care, cognitive) as compared to pre-torture baseline.

Evidentiary Significance:

Decompensation patterns provide critical evidence because:

- The correlation between torture/CIDT and psychological deterioration establishes causation
- The specificity of triggers to torture themes supports the credibility of allegations
- The trajectory of decline demonstrates the severity and persistence of harm
- Failed recovery attempts may indicate ongoing harm or inadequate remedy
- The degree of functional impairment quantifies damages for reparation purposes

The evaluator should apply the IP consistency framework (§ 601-614) to decompensation evidence, assessing whether the pattern of psychological deterioration is:

- **Consistent with** the alleged torture/CIDT
- **Highly consistent with** the alleged torture/CIDT
- **Typical of** torture/CIDT of the type alleged
- **Highly Consistent (IP §543(e))** a specific form of torture/CIDT (rare for psychological evidence alone)

Understanding the wide range of psychological consequences that torture and CIDT may produce is essential, but this knowledge must be applied within a structured evaluation methodology. The symptoms and conditions described above—from PTSD and depression to dissociation and neurocognitive impairment—are what we seek to identify, document, and relate to alleged torture.

The following section defines the role of the psychological evaluation in this process: what purpose it serves, what questions it answers, and how it fits within the broader Istanbul Protocol framework.

Dissociation, depersonalization and atypical behaviour

IP §506. *Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. Individuals may be cut off or unaware of certain actions and may feel detached from themselves or their bodies as if observing themselves from a distance (depersonalization). Derealization describes the subjective experience of the unreality or distortion of the outside world or environment. Dissociative phenomena can be present during traumatic events as a result of the extreme physical and psychological stress, leading to changes in perception and information processing with a feeling of distance and detachment from the traumatic event and the accompanying emotions. Certain sensory impressions are not registered whereas others might be perceived very intensely. Peritraumatic dissociation, as well as repression and avoidance of traumatic memories, may cause incomplete or fragmented memories of the traumatic event and may impede a coherent and complete narration of it. Dissociation can also occur when the victim is confronted with the traumatic event during the evaluation. In this case, individuals frequently appear to be distant, cut off from their emotions, showing indifference or other emotional states incongruent with the trauma narrative. Survivors may also exhibit impulse control problems resulting in behaviours that they consider highly atypical with respect to their pre-trauma personality. For example, a previously cautious individual may engage in high-risk behaviour.*

The Doctrine of Distress-Induced Harm

I. Introduction

The doctrine of "Distress-Induced Harm," refined from the "Battery Without Touching"[166] analysis in the original IAJ Psychological Investigation Standard (Part B of the Systemic Harm Mapping Tool), provides a rigorous framework for assessing non-physical institutional or judicial actions that cause severe physical harm through psychological stress mechanisms. This refinement addresses potential conceptual overreach by emphasizing physiological causation rather than analogizing to traditional battery torts, which could dilute legal precision or invite dismissal.

The doctrine of **Distress-Induced Harm** serves as a clinical documentation of "**Biological Assault"**. It establishes that institutional psychological stressors, which transition to significant distress episodes, function as the 'force' that triggers internal physiological mechanisms to inflict severe physical pain and objective biological deterioration or injury, meeting the definition of torture or CIDT under the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) when those outcomes are foreseeable and knowingly maintained.

The core premise is that actions such as denial of disability accommodations, procedural exclusions, or retaliatory deadlines can trigger measurable physical decompensation (e.g., autoimmune flares, infections, or neurological exacerbations) in vulnerable individuals, qualifying as torture or CIDT if intentional or deliberately indifferent.

[166] For conceptual simplicity, we retain use of the term "Battery Without Touching" while officially referring to it as "Distress-Induced Harm". The retained term is for "internal IAJ shorthand" only, with "Distress-Induced Harm" mandatory in external reports or submissions

This doctrine aligns with UNCAT's inclusion of "mental" suffering leading to physical outcomes (Article 1) and CIDT (Article 16), as interpreted in the Istanbul Protocol (2022 Rev. 2). To ensure irrefutability and respectability, application is limited to cases with objective medical evidence, clear causation, foreseeability, and proportionality safeguards. This prevents overexpansion (e.g., equating routine stress with torture) while compelling jurists to engage substantively, as evasion would contravene jus cogens norms and U.S. obligations under the Supremacy Clause (Article VI).

II. Legal Foundations

The doctrine is grounded in international and domestic precedents recognizing indirect psychological harm as torture or CIDT without direct physical contact.

A. International Human Rights Law

- UNCAT Article 1 defines torture as intentional infliction of "severe pain or suffering, whether physical or mental," without requiring contact. The UN Committee Against Torture (CAT) in General Comment No. 2 (CAT/C/GC/2) interprets this to include psychological methods (e.g., isolation, threats) causing physical effects, emphasizing case-by-case severity assessment. The Méndez Principles (A/HRC/43/49) warn against "crossing the line to psychological torture," defining it as methods inducing severe mental suffering without physical conduits, such as debility, dependency, and dread. The Special Rapporteur on Torture (A/63/175) classifies solitary confinement as psychological torture if prolonged and foreseeable in harm.
- Landmark cases: The European Court of Human Rights (ECtHR) in El-Masri v. Macedonia (2012) found rendition and secret detention constituted torture via mental violence causing severe suffering, without primary physical acts. In Ireland v. UK (1978), non-physical techniques (hooding, noise) were ill-treatment under ECHR Article 3. The Inter-American Court in Velásquez Rodríguez v. Honduras (1988) held enforced disappearances—inducing psychological anguish—as torture. The UN Special Rapporteur (A/HRC/22/53) deems prolonged isolation psychological torture, especially for vulnerable groups.
- Jus cogens status: Torture prohibitions are peremptory, with indirect methods qualifying if severe (e.g., CAT views on "no-touch" techniques in CIA programs).

B. U.S. Domestic Law

- Eighth Amendment: Hudson v. McMillian (1992) recognizes psychological harm as "cruel and unusual" if wanton; Hope v. Pelzer (2002) includes stress positions inducing mental suffering. In Madrid v. Gomez (1995), supermax isolation was likened to environmental harm (e.g., depriving asthmatics of air), acknowledging psychological triggers for physical effects without contact. Wilkinson v. Austin (2005) upheld isolation but noted severe mental risks, requiring vulnerability proof.
- Federal Anti-Torture Statute (18 U.S.C. § 2340A): Prohibits torture by U.S. officials, defining mental harm as "prolonged" from specific acts (e.g., threats of death), but U.S. reservations to UNCAT are critiqued internationally (e.g., by Netherlands/Finland) as incompatible with the treaty's purpose. Section 1983 claims succeed on "deliberate indifference" to risks (Farmer v. Brennan, 1994), including stress-induced harm.

- Tort Analogies: While avoiding direct "battery" framing, indirect contact precedents (e.g., Fisher v. Carrousel Motor Hotel, 1967: offensive plate-grabbing) inform causation, as do "truth serum" bans (Townsend v. Sain, 1963: involuntary confessions inadmissible due to mental coercion).

C. Academic and Human Rights Authorities

- Pérez-Sales (2017)[167] classifies "no-touch" methods (e.g., environmental manipulation) as inducing personality disruption via stress, using the Torturing Environment Scale (TES) for profiling.
- Research by Başoğlu et al. (2007)[168] demonstrates that the traumatic impact of torture—whether physical or non-physical—is primarily determined by the victim's perceived controllability and predictability of the stressors. The study found that while physical torture is devastating, it showed no significant independent predictive value for the severity of PTSD compared to non-physical methods when levels of perceived distress were equal.
- Leach (2016)[169] documented how psychological factors in extreme environments—including isolation, sensory overload, and cognitive overload—produce verifiable somatic symptoms.
- Multiple prospective studies establish that stressful life events precede MS exacerbations. Specifically, Ackerman et al. (2003)[170] found that stressful events occurred an average of 14 days before MS exacerbations compared with 33 days before control dates ($p < .0001$), documenting a clear temporal window for distress-induced harm.
- Cakal (2018)[171] on "debility, dependency, dread" emphasizes relational dynamics in non-physical torture.
- ACLU cases (e.g., Salim v. Mitchell, 2016) against CIA psychologists highlight designed psychological harm (e.g., waterboarding simulations) as torture.
- Human Rights Watch (2003) states that forcibly administering "truth serums" to compel disclosure is prohibited under international law and is at least inhuman or degrading treatment.

III. Medical and Scientific Basis

Stress as a harm conduit is supported by empirical evidence[172] establishing that severe stress causes measurable physiological injury in susceptible individuals. In multiple sclerosis, prospective studies demonstrate a statistically significant causal relationship. For example, Ackerman et al. (2002) found stressful events occurred on average 14 days before exacerbations vs. 33 days before control dates

[167] Pérez-Sales, P. Psychological Torture: Evaluation, Detection and Evidence. Routledge, 2017

[168] Başoğlu, M., Livanou, M., & Crnobarić, C. "Torture vs Other Cruel, Inhuman, and Degrading Treatment: Is the Distinction Real or Apparent?" Archives of General Psychiatry, 64(3), 277-285, 2007

[169] Leach, J. "Psychological Factors in Exceptional, Extreme, and Torturous Environments." Somatic Medicine and Human Rights Review, 2016

[170] Buljevac, D., et al. "Self-reported Stressful Life Events and Exacerbations in Multiple Sclerosis: Prospective Study." BMJ, 327(7416), 646, 2003

[171] Cakal, E. Debility, Dependency and Dread: On the Conceptual and Evidentiary Aspects of Psychological Torture. Torture Journal, 2018

[172] e.g. The Multiple Sclerosis Stress Equation" by Solomon et al. (Journal of Medical Statistics and Informatics, ISSN 2053-7662, Vol.11, Art.1). Research establishes how acute distress can cause statistically significant increases in lesion activity in specific neurological conditions, which may lead to the death of brain and spine tissues over time.

($p < .0001$); Buljevac et al. (2003) confirmed doubling of exacerbation risk (RR = 2.2). These are replicated foundational findings[173]. These authorities support a structured forensic analysis of distress-induced harm in susceptible individuals, and may be adapted to distinct diseases.

Chronic stress involves the prolonged activation of the HPA axis; however, the resulting physiological changes (such as cortisol alterations) must be **documented through contemporaneous clinical markers** rather than assumed.

Hierarchy of Evidence for Distress-Induced Harm:

- **Level A (Direct Proof) — Quantitative modeling applicable when data density permits: ■ QUANTITATIVE EVIDENCE RULE: Quantitative or statistical modeling of the stress-injury relationship is appropriate ONLY when ALL four data conditions are met: (i) high-frequency time-stamped exposure data (documented institutional stressors with dates); (ii) objective biological outcome markers with timestamps (e.g., MRI lesion dates, cardiac event records, lab values); (iii) repeated episodes sufficient to establish a temporal pattern; and (iv) a documented pre-incident biological baseline. When these conditions are met, the evaluator may apply published disease-specific models (Ackerman/Buljevac for MS; equivalent published evidence for other conditions) and must state the model's scope, data inputs, and known limitations. When these conditions are NOT fully met, the evaluator must use structured qualitative attribution: event anchoring, mechanism documentation, differential analysis, and explicit limitation notation. Neither method fabricates precision beyond what the data supports; both document what the data does support.** Requires contemporaneous medical records (e.g., MRI lesion activity, cardiac biomarkers, blood glucose spikes, or inflammatory markers) with onset or worsening anchored to a documented institutional stressor; where disease-specific temporal association literature exists (Ackerman 2002; $p < .0001$; Buljevac 2003; RR = 2.2 for MS), cite it explicitly following identified institutional stressors (disease-specific temporal association literature, e.g., Ackerman et al. 2002 reporting $p < .0001$ for MS exacerbations, may support plausibility where applicable) of an institutional stressor.
- **Level B (Clinical Correlation):** Utilizes longitudinal treatment records showing a marked shift from a stable baseline to acute decompensation following a documented coercive event.
- **Level C (Circumstantial Pattern):** Based on a documented **Accommodation-Punishment Cycle** where repeated denials are followed by reproducible symptom exacerbations (e.g., tremors, cognitive fog) noted by Level 1 or 2 observers.

*A. **Psychosomatic Effects***

Chronic stress involves the prolonged activation of the **hypothalamic-pituitary-adrenal (HPA) axis**, resulting in elevated cortisol levels that lead to physical harm through immune suppression and systemic inflammation. Consistent with the broader stress-and-disease literature, this biochemical cascade provides a mechanism by which distress may contribute to immune suppression, inflammatory change, or disease aggravation in susceptible individuals. Research documents the stress-disease pathway:

[173] e.g. Ackerman et al. 2002, Buljevac et al. 2003, Solomon et al. 2023

- MS Relapse Research: Multiple studies establish that stressful life events precede MS exacerbations. Ackerman et al. (2003) found stressful events occurred an average of 14 days before MS exacerbations compared with 33 days before control dates ($p < .0001$). Solomon et al. (2023) have developed a case-level longitudinal model that can support event anchoring and structured clinical attribution in susceptible individuals.
- Immune Suppression: Chronic stress causes increased cortisol levels through the HPA axis, ultimately suppressing the immune response. See: "Enhancing versus Suppressive Effects of Stress on Immune Function" (Dhabhar FS. Brain, Behavior, and Immunity. 2009;23(2):159-165).
- Torture Impact: Başoğlu et al. (2007) demonstrated that the traumatic impact of torture—whether physical or non-physical— is primarily determined by the victim's perceived **controllability and predictability** of the stressors. The study found that while physical torture is devastating, it showed no significant independent predictive value for the severity of PTSD compared to non-physical methods when levels of perceived distress and lack of control were equal (odds ratio 1.41, 95% CI 0.89-2.25). This finding supports the IAJ framework that psychological distress is the primary harm mechanism.
- Extreme Environments: Leach (2016) documented how psychological factors in extreme environments—including isolation, sensory overload, and cognitive overload—produce somatic symptoms.

B. Distress-Induced Tissue Injury

The IAJ recognizes that severe psychological distress can, in susceptible individuals, **precipitate, aggravate, or accelerate physical disease expression**. This is particularly important in torture and CIDT investigations because the harm inflicted by institutional actors may often not be confined to emotional suffering; in vulnerable persons, coercive or inescapable stress can contribute to measurable biological destruction (physical injury).

In the multiple sclerosis literature, stressful life events have been linked to relapse timing and increased relapse risk. **Ackerman et al. (2002)** reported that stressful life events occurred an average of **14 days** before MS exacerbations ($p < .0001$). **Buljevac et al. (2003)** prospectively documented that stressful events were associated with a doubling of the exacerbation rate in the subsequent four weeks (**relative risk 2.2, 95% confidence interval 1.2–4.0, p = 0.014**).

The Solomon et al. framework adds an individualized longitudinal model to this literature, proposing a **Stress–Disease Meta Model**: **Stressors → Distress → Effectors → Tissue Injury → Disease Responses**. This framework may be used as a structured forensic aid in **Event Anchoring**, allowing the evaluator to demonstrate whether institutional conduct was a **substantial contributing factor** to objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization).

Evidentiary Rule

A claim of distress-induced tissue injury should be treated as **supported** only when the evaluator can document:

- **An identifiable institutional stressor**

A specific act, omission, threat, coercive proceeding, deprivation, denial of accommodation, or other state-linked stressor is identified with sufficient precision.

- **A clinically plausible stress pathway**

There is a medically and psychologically plausible mechanism by which the stressor could precipitate or aggravate the observed deterioration in this individual (e.g. HPA axis activation).

- **Event anchoring / temporal coupling**

The deterioration is temporally linked to the index stressor or to a repeated pattern of similar stressors, within a clinically coherent window (e.g., the 14-day window ($p < .0001$) for MS).

- **Objective or clinically reliable evidence of injury**

The deterioration is supported by objective findings (e.g. documentation of tissue death, MRI lesions), clinical crisis (e.g. cardiac event), contemporaneous records, documented functional decline, credible symptom evolution, or other clinically reliable indicators.

- **Known vulnerability or foreseeable risk**

The individual had a known susceptibility, stress-sensitive condition, or other documented vulnerability, or the harmful effect was otherwise foreseeable.

- **Differential analysis**

Alternative explanations have been considered and addressed. The evaluator should identify whether the institutional stressor is best understood as a substantial contributing factor, a material aggravating factor, or one plausible contributor among several unresolved factors.

Reporting Rule

When supported, the evaluator should use **measured, non-conclusory attribution language**, such as:

- "The available evidence supports the conclusion that the identified institutional stressors were a **substantial contributing factor** in the observed stress-mediated deterioration."
- "The available evidence supports the conclusion that the reported conditions **materially aggravated** a pre-existing stress-sensitive condition."
- "The available evidence supports a **clinically meaningful temporal and physiological association** between the identified stressors and the documented deterioration."

Scope and Limits

The Solomon framework may be used as a **structured forensic aid** in distress-induced harm analysis, especially where repeated institutional triggers are followed by repeated objective deterioration in a stress-sensitive condition. It should be presented as:

- a framework for **event anchoring**,
- a framework for **stress-mediated disease aggravation**,
- and a framework for **clinical attribution in susceptible individuals**.

It should **not** be presented as:

- a universally adopted medico-legal formula without disease-specific consideration,
- a substitute for disease-specific evidence,
- or a stand-alone mathematical proof of legal responsibility.

Practical Application

In torture and CIDT investigations, this framework is most useful where state action is repeatedly followed by:

- MS relapse or worsening neurological symptoms,
- infection susceptibility or immunocompromise,
- marked glycemic destabilization,
- hypertensive or cardiovascular destabilization,
- stress-triggered inflammatory flares,
- or similar documented biological deterioration.

In such cases, the evaluator should explicitly separate:

- the **institutional stressor**,
- the **stress response**,
- the **objective or clinically reliable injury**, and
- the **attribution conclusion**,

so that the report remains medically disciplined and legally defensible.

*C. **Causation Standards***

- Require temporal proximity, objective metrics (WHODAS 2.0, PCL-5, PHQ-9), and differential diagnosis to exclude alternatives.
- Disease-specific stress models may strengthen a causation analysis where used in conjunction with event anchoring, objective or clinically reliable markers, and differential analysis. They support a structured attribution framework.

IV. Barriers in American Jurisprudence: Navigating the Gap Between International Standards and U.S. Jurisprudence

"Battery Without Touching" effectively communicates how psychological harm can induce physical injury, which is why the IAJ continues to use this term in training materials. However, this terminology faces significant challenges in American judicial proceedings due to doctrinal constraints that differ from international human rights frameworks.

Despite robust international and scientific foundations, the doctrine of Distress-Induced Harm (and its IAJ predecessor, "Battery Without Touching") encounters limited recognition in U.S. jurisprudence. This section analyzes the doctrinal factors contributing to this gap and provides strategic guidance for practitioners.

A. Historical and Doctrinal Framework

American tort law has historically required some form of physical contact for battery claims. This requirement reflects the origin of battery as a protection of bodily integrity—freedom from unwanted physical intrusion. The distress-induced harm doctrine extends battery to scenarios where no physical contact occurs, relying on psychological causation chains to connect institutional conduct with physical injury. This extension represents a doctrinal innovation that lacks direct precedent in traditional battery jurisprudence.

U.S. courts have traditionally privileged direct physical evidence over indirect psychological harm, reflecting doctrinal foundations traceable to common-law origins where battery required tangible contact (Restatement (Second) of Torts § 18). This framework persists in modern applications: courts interpreting constitutional protections have applied "de minimis" physical injury thresholds, requiring visible evidence of harm.

Judicial reliance on established precedent affects how novel theories are evaluated. Cases such as *Chappell v. City of Cleveland* (1984) (requiring "physical force" for excessive force claims) illustrate doctrinal constraints that predate contemporary understanding of psychological harm. Scholarly analysis, such as Luban's examination of torture and power in legal frameworks, addresses the relationship between domestic precedents and international norms.

Doctrinal Harmonization: Rather than dismissing the kinetic requirement of traditional battery law, the IAJ framework identifies the **HPA axis pathway** as a physical conduit of the 'touch'. By leveraging the **Charming Betsy Canon**, counsel may argue that domestic battery statutes should be construed in harmony with **UNCAT Article 1**. Just as 'truth serums' are prohibited as mental torture despite the absence of a kinetic blow, the systematic weaponization of a victim's neurobiology via coercive procedure is a recognizable intrusion upon bodily integrity under the Law of Nations.

B. Evidentiary Standards for Distress-Induced Harm Claims

The establishment of causation in distress-induced harm claims requires a structured evidentiary analysis that is clinically rigorous, transparent, and adaptable to the burden of proof applicable in the forum where the findings may be used. The evaluator's task is not to prove legal liability, but to determine whether the available data support a reliable clinical inference that identified institutional conduct caused, materially contributed to, aggravated, or predictably accelerated the documented harm.

This section is intended to help evaluators answer four practical questions:

- What is the minimum evidentiary basis required to support a causation opinion?
- How should documentation change depending on the applicable burden of proof?
- How should evaluators respond to defense attacks on causation?
- When is the evidence sufficient for a supported finding, and when must the evaluator defer or request additional investigation?

The evaluator should distinguish clearly between:

- Clinical causation (whether the conduct was a medically and psychologically meaningful causal factor),
- Forensic consistency (whether the presentation is consistent with the alleged mechanism of harm), and

- Legal causation (whether a tribunal will ultimately attribute responsibility under its own doctrine).

The evaluator may opine on the first two, but should avoid substituting clinical opinion for legal adjudication.

B.1 Quick-Reference Decision Tree: Causation Analysis for Distress-Induced Harm

This decision tree provides a rapid method for determining whether the available record supports a causation opinion, a qualified aggravation opinion, or the need for additional investigation.

STEP 1: Is there an identifiable institutional stressor, act, omission, or coercive sequence?

├── No → Causation opinion not yet supportable

└── Yes → Proceed to STEP 2

STEP 2: Is there a clinically plausible mechanism linking the stressor to the reported harm?

├── No → Do not force causation; continue factual development

└── Yes → Proceed to STEP 3

STEP 3: Is there meaningful temporal anchoring between the event(s) and deterioration?

├── Yes → Proceed to STEP 4

└── No / weakly documented → Consider qualified or deferred conclusion

STEP 4: Is there evidence of known vulnerability or foreseeable harm?

├── Yes → Strengthens causation inference; proceed to STEP 5

└── No / unclear → Continue; causation may still be supportable depending on the mechanism

STEP 5: Have alternative causes been considered?

├── Yes, and less likely / co-contributors only → Proceed to STEP 6

└── No / unresolved → Use qualified or deferred causation language

STEP 6: What is the correct causation conclusion?

├── Strong support → "Substantial contributing factor" / "clinically significant precipitating factor"

├── Moderate support → "Likely aggravated" / "materially contributed"

└── Insufficient support → "Plausible but requires further investigation"

Causation rule:

The question is not always whether the conduct was the sole cause, but whether it was a substantial, material, or clinically meaningful contributor to the harm.

B.2 Core Causation Standard

A causation opinion in a Distress-Induced Harm case is sufficiently grounded when the evidence supports the following five elements:

- Identifiable Stressor

A specific institutional act, omission, policy, or sequence of coercive acts is identified with enough specificity to permit evaluation.

- Physiological Mechanism (the documented biological pathway: HPA axis activation → cortisol dysregulation → condition-specific pathophysiology → documented biological deterioration). This is the physical conduit of harm — how coercive procedure causes measurable injury without physical contact. The evaluator establishes the mechanism; counsel advances accountability

There is a clinically and scientifically plausible pathway by which the identified stressor could produce the alleged psychological and/or physical harm.

- Temporal Relationship

The timing of symptom onset, exacerbation, decompensation, or functional decline is sufficiently linked to the identified stressor.

- Individualized Vulnerability or Predictable Harm

The evidence shows either:

- a known vulnerability in this examinee, or
- that the harmful effect was foreseeable even without individualized notice because the conduct is generally known to cause such harm.
- Causation Synthesis

To satisfy FRE 702 and *Daubert*, evaluators must establish more than a temporal coincidence. The report must synthesize:

(1) the specific institutional stressor;

(2) the documented **physiological pathway** (e.g., neuroendocrine or cardiovascular);

(3) **differential diagnosis** that considers and excludes competing life stressors; and

(4) the **clinical plausibility** of the harm relative to the victim's known vulnerability.

- Reasoned Differential Analysis

Competing causes have been considered and addressed, with alternative explanations either:

- reasonably excluded,
- shown to be less likely, or
- acknowledged as co-contributors.

A strong causation opinion does not require proof that the institutional conduct was the sole cause. In many torture and CIDT investigations, the correct formulation is that the conduct was a substantial contributing factor, a material aggravating factor, or a clinically significant precipitating factor.

B.3 Temporal Correlation and Event Anchoring

Temporal correlation forms the evidentiary backbone of Distress-Induced Harm analysis, but it must be documented carefully and not treated as sufficient by itself.

a) Minimum Temporal Requirements

- Acute reactions (e.g., panic attacks, dissociative episodes, acute stress reactions): document onset within 0-72 hours where possible.
- Subacute reactions (e.g., depressive episodes, anxiety exacerbation, PTSD symptom emergence): document onset within 1-4 weeks.
- Progressive or delayed sequelae (e.g., PTSD chronification, autoimmune flares, cardiovascular destabilization, functional collapse): document a clinically coherent progression within days to months, with clear event anchoring.

b) Event Anchoring Requirements

The evaluator should document:

- Exact or approximate date of the institutional act.
- Exact or approximate date of symptom onset or deterioration.
- Whether symptoms appeared:
- immediately,
- after cumulative exposure,
- after a threshold event, or
- after repeated reactivation.
- Whether there were additional stressors in the same interval.
- Whether the pattern repeated after subsequent similar institutional events.

c) Temporal Weighting Rule

Temporal proximity strengthens causation, but the evaluator should not overstate it:

- Close temporal proximity supports but does not prove causation.
- Disease-Specific Validation: Where applicable (for example, in stress-sensitive neurological disease[174]), evaluators may cite disease-specific literature to support the plausibility of a temporally coherent stress-to-deterioration relationship. Such literature should be used to support event anchoring, and combined with clinical judgment or differential analysis.
- Delayed onset does not defeat causation if the mechanism is clinically plausible.
- Repeated recurrence after repeated stressors can be stronger than one isolated close-in-time event.

d) Repetition as Evidence

When the same category of institutional conduct is followed by similar deterioration across multiple episodes, the evaluator should expressly identify the pattern as recurrent temporal coupling. Repetition materially strengthens the inference of causation.

[174] Solomon et al. metrics allow the use of mathematical validation in Multiple Sclerosis to establish that the observed relapse fell within a statistically significant window following the stressor, distinguishing it from routine disease fluctuation through Weibull-modeled event anchoring.

B.4 Foreseeability and Knowledge

Foreseeability is especially important where the evaluator is asked to address whether the suffering was knowingly produced or maintained.

a) Foreseeability Categories

- Documented Knowledge

The actor had actual notice of the examinee's vulnerability.

Examples:

- accommodation requests,
- medical letters,
- prior complaints,
- prior decompensation after similar conduct.
- Constructive Foreseeability

The actor should have known because the risk is obvious or well recognized.

Examples:

- coercive deprivation known to produce distress,
- prolonged isolation,
- denial of critical care,
- policies widely known to destabilize vulnerable persons.
- Policy-Based Foreseeability

The conduct is built into an institutional pattern or policy that predictably causes harm.

Examples:

- repeated denial of accommodations,
- recurring punitive deadlines despite known disability barriers,
- formal or informal practices that rely on coercive attrition.

b) Required Documentation

For each foreseeability theory, document:

- Source of knowledge
- Date knowledge existed
- How specifically the knowledge related to this examinee
- Whether the conduct continued after that knowledge arose
- Whether the same harmful result had occurred before

c) Evidentiary Function of Foreseeability

Foreseeability should be used to support:

- causation,
- aggravation,
- deliberate indifference,
- or the inference that suffering was knowingly maintained.

It should not be overstated as automatic proof of intent. The evaluator should link foreseeability to the facts, not to a conclusory legal label.

B.5 Documentation Requirements by Burden of Proof

Different forums require different levels of evidentiary completeness. The evaluator should maintain one core factual record, but calibrate the strength and phrasing of conclusions to the likely burden of proof.

a) Baseline Documentation Required in All Contexts

At minimum, the evaluator should document:

- The alleged institutional conduct
- The claimed harm
- The timeline connecting conduct and harm
- Pre-event baseline functioning or condition
- Post-event deterioration or symptom emergence
- Alternative causes considered
- Basis for any causal conclusion
- Level of confidence and any limitations

b) Context-Specific Evidentiary Thresholds

1. Istanbul Protocol / Human Rights Documentation

The core question is whether the findings are consistent, highly consistent, or otherwise support the account under international documentation standards.

Minimum expected support:

- coherent history,
- clinically plausible mechanism,
- documented symptom pattern,
- no major unresolved contradiction that defeats the inference.

2. Administrative / Immigration / Civil Preponderance Contexts

Where the practical burden is closer to balance of probabilities, the evaluator should show that the institutional conduct is more likely than not a substantial contributing factor.

Best practice:

- clear timeline,
- corroborating records,
- reasoned differential analysis,
- restrained but affirmative causation language.

3. Criminal / High-Stakes Adversarial Contexts

Where the evidence may be scrutinized against a beyond reasonable doubt framework, the evaluator should expect aggressive challenge.

The report should therefore include:

- tighter event chronology,
- stronger baseline documentation,
- objective records,
- explicit handling of alternatives,
- conservative wording,
- no avoidable overstatement.

4. Protective / Emergency / Interim Relief Contexts

Where the immediate goal is protection rather than final adjudication, the evaluator may rely on a lower threshold for urgent action if there is:

- credible risk,
- documented vulnerability,
- clinically plausible ongoing harm,
- and a substantial risk of worsening if the conduct continues.

c) Burden-of-Proof Guidance for Wording

- Lower-support but still usable:

"The available information is consistent with the reported causal relationship, but further corroboration would strengthen the conclusion."

- Preponderance-level support:

"The documented timeline, clinical presentation, and available records support the conclusion that the institutional conduct was a substantial contributing factor."

- High-confidence support:

"The repeated temporal association, documented vulnerability, objective clinical evidence, and differential analysis provide strong support for a causal relationship."

The evaluator should align the wording with the evidence actually available, not with the forum's desired outcome.

B.6 Responding to Defense Challenges on Causation

Defense experts will often challenge causation by emphasizing uncertainty, multiplicity of causes, or lack of absolute proof. The evaluator should address these challenges proactively.

a) Common Defense Challenge: Pre-existing Conditions

Defense argument: the examinee was already ill, fragile, or symptomatic.

Evaluator response: pre-existing conditions do not defeat causation if the institutional conduct:

- worsened the condition,
- precipitated decompensation,
- accelerated deterioration,
- or converted a manageable condition into a disabling one.

Required documentation:

- pre-event severity,
- pre-event stability or instability,
- post-event change in frequency, intensity, or function,
- distinction between baseline symptoms and new deterioration.

b) Common Defense Challenge: Intervening Events

Defense argument: another event caused the deterioration.

Evaluator response: identify intervening events directly and assess whether they:

- fully explain the deterioration,
- partially contribute,
- or are less persuasive than the index stressor.

Do not conceal competing explanations. Acknowledge them and explain the relative weight of each.

c) Common Defense Challenge: Correlation Is Not Causation

Defense argument: timing alone proves nothing.

Evaluator response: agree in principle, then show that the opinion does not rest on timing alone, but on:

- temporal correlation,
- plausible mechanism,
- individualized vulnerability or predictable risk,
- repetition,
- and differential analysis.

d) Common Defense Challenge: Multifactorial Etiology

Defense argument: the condition has many possible causes.

Evaluator response: most real-world psychiatric and stress-mediated medical conditions are multifactorial. The proper question is not whether the institutional conduct was the only cause, but whether it was a material causal factor.

e) Common Defense Challenge: Lack of Laboratory Certainty

Defense argument: there is no biomarker proving causation.

Evaluator response: many clinically valid forensic opinions rely on converging evidence rather than a single laboratory marker. Where objective markers exist, use them. Where they do not, rely on structured clinical documentation, collateral records, and differential reasoning.

f) Common Defense Challenge: Symptom Exaggeration / Secondary Gain

Defense argument: the examinee is exaggerating for strategic advantage.

Evaluator response: address credibility separately from causation. Even where some incentive exists, that fact alone does not defeat a clinically supported causal inference. If credibility concerns are present, specify whether they affect:

- all findings,
- only certain factual allegations,
- or only the degree of certainty.

B.7 Differential Analysis Framework

Differential analysis is the disciplined method by which the evaluator avoids both overstatement and false skepticism.

The evaluator should:

- Identify all plausible causes of the documented symptoms or deterioration.
- Compare each cause against the chronology and symptom pattern.
- Determine whether each cause is:
- primary,
- contributory,
- aggravating,
- remote,
- or unsupported.
- State whether alternative causes are:
- reasonably excluded,
- less likely,
- equally plausible,
- or unresolved.
- Match the final wording to that level of certainty.

Mandatory Differential Etiology

Because PTSD and MDD are not cause-specific, the evaluator must explicitly address alternative life stressors (e.g., poverty, pre-existing conditions). Forensic evaluators document consistency, not causation. The expert must document why the index institutional stressor is a **substantial contributing factor** to the deterioration, distinguishing it from routine disease fluctuation through **Event Anchoring,** review of contemporaneous records, objective or clinically reliable markers, and disease-specific literature where appropriate..

Important rule:

If multiple causes remain plausible, the evaluator should not abandon causation. Instead, the evaluator should identify whether the institutional conduct remains:

- a substantial contributing factor,
- a meaningful aggravating factor,
- or one plausible contributor among several unresolved factors.

That is a stronger and more defensible forensic approach than forcing a binary all-or-nothing conclusion.

B.8 Sufficiency of Evidence vs. Need for Additional Investigation

The evaluator should explicitly classify the evidentiary record into one of four levels:

Level 1 - Sufficient for Supported Causation Finding

Use when the record includes:

- identifiable stressor,
- plausible mechanism,
- anchored timeline,
- meaningful corroboration,
- and no major unresolved competing cause that defeats the inference.

Level 2 - Sufficient for Qualified Causation Finding

Use when the evidence supports a clinically meaningful inference, but important limitations remain.

Appropriate language:

- “supports a substantial contributing role,”
- “likely aggravated,”
- “consistent with causative contribution.”

Level 3 - Insufficient for Firm Causation; Additional Investigation Needed

Use when there is a plausible claim, but the record lacks enough support for a reliable conclusion.

Common gaps:

- no baseline,

- poor chronology,
- missing records,
- unresolved alternative causes,
- no documentation of vulnerability.

The evaluator should then specify what additional information is needed, such as:

- pre-event treatment records,
- emergency or hospitalization records,
- court, detention, employment, or institutional logs,
- collateral witness statements,
- specialist review,
- repeat evaluation after additional data collection.

Level 4 - Insufficient and Too Speculative for Causation Opinion

Use when the claim cannot be responsibly evaluated on the available data.

The evaluator should document the allegation, explain the limits, and decline to overstate.

Training rule:

The correct response to evidentiary weakness is not silence and not exaggeration. It is graded conclusion plus explicit next steps.

B.9 Model Causation Language for Reports

When support is strong:

"Based on the documented pre-event baseline, the chronology of symptom emergence, the known stress-related vulnerability, the objective post-event deterioration, and the differential consideration of alternative causes, it is my professional opinion that the identified institutional conduct was a substantial contributing factor to the observed harm."

When support is qualified:

"The available evidence supports the conclusion that the institutional conduct likely aggravated and materially contributed to the deterioration described, although additional records would strengthen the precision of causal attribution."

When more investigation is needed:

"The reported causal relationship is clinically plausible and not contradicted by the presently available information; however, the current record is insufficient for a firm causation opinion without additional documentation regarding baseline status, timing, and competing explanations."

Language to avoid:

- "The institutional conduct caused the symptoms."
- "There is no other explanation."

- "The defendant is responsible."

These statements either overstate certainty or collapse clinical analysis into legal conclusion.

B.10 Practical Evidentiary Checklist

Before finalizing a causation opinion, the evaluator should confirm that the report identifies:

- the specific institutional act(s),
- the alleged mechanism of harm,
- the date or sequence of the act(s),
- the date or sequence of symptom onset,
- the pre-event baseline,
- the post-event deterioration,
- any intervening events,
- any competing causes,
- whether the conduct caused, aggravated, or accelerated harm,
- the level of confidence,
- and whether additional investigation is required.

A causation opinion that does not transparently show this reasoning is vulnerable to avoidable attack.

B.11 Report Language for Causation Conclusions

The evaluator should use precise language when describing causation:

Appropriate formulations:

- "The documented temporal relationship between [institutional stressor] and [symptom onset], combined with the absence of alternative explanations documented in the clinical record, is consistent with the causal pathway described in [citation]."
- "Based on the pre-event baseline documentation, the documented symptom emergence within [timeframe], and the absence of intervening factors that would explain these findings, it is my professional opinion that the institutional conduct is a significant contributing factor to the observed deterioration."
- "While multiple factors may contribute to [diagnosis], the temporal correlation with [specific institutional conduct] and the absence of alternative explanations during the relevant period support causation to a reasonable degree of medical certainty."

Language to avoid:

- "The institutional conduct caused the symptoms" (absolute causation language)
- "There is no other explanation" (overstating certainty)
- "The defendant is responsible" (legal conclusion, not clinical finding)

Mandatory Alignment Rule: All causation conclusions in the final report must be synchronized with the Forensic Multiaxial Synthesis in Section XII of the Skeleton Report (Appendix D). An evaluator may assign a "High Certainty" rating where chronological anchoring and clinical evidence support it if the Axis III biological flare is anchored to an Axis IV stressor using chronological anchoring and case-specific evidence; disease-specific temporal association literature (e.g., Ackerman et al. 2002, $p < .0001$) may support plausibility where applicable.

B.12 Evidentiary Handling of Judicial Obstruction

An IAJ evaluator in a courtroom is not functioning only as an expert witness.

When a court or institutional actor ignores medical evidence or denies documented accommodation needs (e.g., medical stays), the evaluator shall document this conduct as **independent forensic evidence**:

- **Clinical Indicator of State Acquiescence**: The refusal to meaningfully engage with the **Substantive Truth Track** is documented as a facts relevant to an acquiescence analysis: document the refusal, dates, notice given, and resulting deterioration as evidence of knowledge, foreseeability, and institutional tolerance of harm under UNCAT Article 1.
- **Verification of forum nullus**: If 100% of judges within a tested system reject life-critical modifications, the venue is designated as a ***forum nullus*** — a venue that appears functionally non-remedial for the specific person and claims with respect to torture/CIDT prevention, investigation, protection, or redress.
- **Preservation for International Review**: Domestic presentation of forensic reports serves to create a traceable record of institutional failure for subsequent review by the **UN Committee Against Torture**.

C. Strategic Considerations for Practitioners

Given these doctrinal and evidentiary challenges, medical practitioners should:

- Document thoroughly all temporal correlations between institutional actions and symptom onset.
- Correlate and document each psychological event with any resulting physical symptom, only where causative correlation is indicated.
- Determine and document the likely mechanism of physical harm induced or promoted by the psychological event.

Legal practitioners should then:

- Obtain expert medical testimony establishing physiological pathways by which psychological stress can produce physical harm.
- Present findings within the UNCAT framework while acknowledging domestic legal distinctions.
- Frame conclusions appropriately for the intended audience—international human rights bodies or domestic courts.

D. Relationship to Established Legal Categories

Today, the distress-induced harm doctrine may find greater traction when framed as indirect institutional harm cognizable under international human rights frameworks, rather than as an

extension of domestic battery law. This framing avoids direct conflict with traditional tort categories while capturing substantive harm from institutional psychological maltreatment. Legal practitioners should consider engaging international human rights bodies and comparative jurisprudence from jurisdictions that have recognized similar claims.

V. Limitations to Ensure Responsible Application

To maintain professional credibility and prevent misuse, the following limitations govern application of the Distress-Induced Harm framework:

- Severity Threshold: Harm must meet the "severe" threshold under UNCAT Article 1—debilitating effects such as chronic PTSD, not transient discomfort. Routine institutional stressors are excluded.
- Intent/Deliberate Indifference: Proof must establish purpose (e.g., retaliation) or foreseeability (knowledge of vulnerability). Simple negligence is insufficient under the Farmer v. Brennan standard.
- Causation Proof: Objective medical evidence required, including pre/post treatment records. Findings should be "highly consistent" under Istanbul Protocol standards. Rebuttable presumption applies only when victim vulnerability is documented.
- Official Involvement: Claims limited to conduct by public officials or state acquiescence, per UNCAT Article 1.
- Proportionality Test: Harm must be disproportionate to any legitimate governmental aims (e.g., procedural efficiency). Incidental stress from lawful processes is excluded.
- Ethical Guidelines: Clinicians must avoid misuse, mandate peer review, and follow international standards to ensure professional integrity.

These align with ECtHR's "minimum severity" and U.S. "wantonness," addressing U.S. reservations via global critiques.

Severity Categorization Rule:

- **CIDT (Article 16):** Documented when institutional distress induces significant suffering or humiliating physiological responses (e.g., forced observed incontinence or sub-acute MS fatigue) without a proven intent to destroy personality.
- **Torture (Article 1):** Documented when the **Biological Assault** is knowingly maintained after the actor is on notice that the stressor is causing **objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization)** or life-threatening events (e.g., heart attacks), fulfilling the 'purposeful' element via deliberate indifference to foreseeable destruction.

VI. Application in U.S. Contexts

Applies to isolation (Wilkinson), separations causing decompensation (IAJ reports), or renditions (El-Masri). Jurists must evaluate claims under CAT General Comment 2.

VII. Conclusion

This refined doctrine, as "Distress-Induced Harm," ensures compelling recognition of indirect harms as torture/CIDT, fortified by authoritative sources, without overreach. It challenges U.S. judicial prejudices, urging adaptation to international norms.

Enhanced Causation Analysis and Documentation Methodology

The Istanbul Protocol's degrees of consistency ("consistent with," "highly consistent with," "typical of") are frequently inadequate for U.S. adversarial proceedings. The IAJ Standard requires enhanced methodology.

Functional Analysis of Behavior Approach

The psychological evaluation report must not merely list symptoms but construct a Functional Analysis demonstrating causal relationships between institutional conditions and psychological deterioration. This approach creates a causal timeline linking specific environmental variables with specific decompensation markers, establishes baseline functioning using available records prior to institutional involvement, documents trajectory of deterioration demonstrating progressive psychological decline correlated with escalating institutional restrictions, and rules out alternative explanations

By utilizing this Functional Analysis, the clinician satisfies the **Factual Primacy** requirement of the Dual-Track Rule. This approach anchors the **Forensic Probability Rating** in objective behavior-environment sequences, neutralizing adversarial attacks regarding diagnostic non-specificity by demonstrating why the institutional stressor is a **substantial contributing factor** to the harm.

The IAJ Forensic Certainty Scale (Reconciliation with IP Standards)

While the Istanbul Protocol utilizes "degrees of consistency", the U.S. legal system often demands a "reasonable degree of medical/psychological certainty" to satisfy Daubert and admissibility. To reconcile this conflict, IAJ evaluators shall provide a **Forensic Certainty Rating** using an IAJ Clinical Attribution Framework derived from functional analysis, event anchoring, differential analysis, and disease-specific literature where appropriate, only after completing the **mandatory Differential Etiology**. This is a structured clinical judgment regarding the degree to which available evidence supports attribution, aggravation, or clinically meaningful contribution, based on chronology, plausibility, objective markers, and differential analysis. It that a specific institutional stressor caused a documented biological or psychological injury.

This rating does not evaluate legal guilt. It expresses the evaluator's structured clinical judgment regarding the degree to which the available evidence supports attribution, aggravation, or clinically meaningful contribution by the index stressor. Thus, the certainty rating is strictly a forensic consistency rating following elimination and ranking of potentially competing etiologies.

- **High Certainty** (Clinical Attribution): The findings are "Typical of" the alleged stressor, and the chronology, objective or clinically reliable findings, disease-specific literature where relevant, and differential analysis strongly support a clinically meaningful attribution to the index stressor.
- **Moderate Certainty** (Likely Attribution): The findings are "Highly Consistent with" the alleged stressor, and alternative life stressors are secondary.

- **Low Certainty** (Plausible Attribution): The findings are "Consistent with" the stressor, but multifactorial etiologies remain unresolved.

Mandatory Rule: This scale must be preceded by the Cautionary Note found in Module 1 to ensure the court understands this is a clinical consistency finding, not a determination that the crime of torture occurred.

Chronological Mapping

The report shall include a chronological map documenting date of first and subsequent contacts with the institutional system, documented institutional interventions with dates, first and subsequent observable changes in psychological functioning, progression of symptoms correlated with institutional events, and current presentation compared to documented baseline.

See the Tiered Model Report Templates and Fillable Skeleton Report in Module 5.

Systemic Harm Mapping Tool

This tool is designed to help the investigator move beyond "actor-driven" harm to "policy-driven" harm, documenting the "interconnected web of systems" described in the standard.

It serves as a mandatory component of the **Integrated Findings** within a comprehensive investigation . It should be used to:

- **Map the Web**: Visualize the "interconnected web of systems" that together inflict harm.
- **Establish Causation**: Use the Distress-Induced Harm ("Battery Without Touching") analysis to link judicial or institutional stressors to objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization) or cardiac events.
- **Document the Cycle**: Explicitly trace the "Accommodation-Punishment Cycle" where a victim is sanctioned for non-compliance resulting from their disability.

Part A: Multi-System Interaction Matrix

Evaluators should fill out this table to identify how different systems "compound harm" at each transition .

Part B: "Battery Without Touching" -- Analysis of Distress-induced Harm

System/Institution	Specific Policy or Order	Knowledge of Harm	Cumulative Effect on Victim
Judiciary (Court)	[e.g., Denial of ADA Motion]	[e.g., 10+ medical warnings]	[e.g., "Forum Nullus" / Desperation]
Child Welfare	[e.g., Forced Separation]	[e.g., Documented PTSD]	[e.g., Psych. Decompensation]
Police / Detention	[e.g., Solitary Confinement]	[e.g., Known MS Disability]	[e.g., Physical Brain Lesions]

The doctrine of "**Distress-Induced Harm**" is a renaming of the "Battery Without Touching" analysis in the original IAJ Psychological Investigation Standard, provides a rigorous framework for assessing non-physical institutional or judicial actions that cause severe physical harm through psychological stress mechanisms.

"**Unified Terminology Rule:** To ensure irrefutability in formal proceedings, the term **Distress-Induced Harm** is hereby adopted as the primary technical designation for this doctrine. The term '**Battery Without Touching**' is retained exclusively as a conceptual bridge to established tort law to illustrate the mechanism of 'biological force'—the internal physiological cascade triggered by external institutional stressors. Forensic reports must utilize 'Distress-Induced Harm' as the diagnostic label while citing the battery analogy only to challenge domestic requirements for kinetic contact ."

Application requires documented elements: a specific institutional stressor, temporal proximity to symptom onset, foreseeability based on known vulnerabilities, and severity via validated tools like the IAJ-modified Harvard Torture Questionnaire. For conceptual simplicity, we retain use of the term "Battery Without Touching" while officially referring to it as "Distress-Induced Harm". The retained term is for "internal IAJ shorthand" only, with "Distress-Induced Harm" mandatory in external reports or submissions.[175] This avoids mixed messaging and strengthens irrefutability.

Use this section to document physical harm caused by institutional psychological distress.

- **Stressor Identification:** Identify the specific judicial or administrative act (e.g., a "Bright Line" reversal).
- **Temporal Correlation:** Record the time between the stressor and the physical symptom (e.g., MS flare, cardiac event, or dysphagia) .
- **Perpetrator Foreseeability:** Document evidence that the actor knew the victim was "distress-sensitive" (e.g., treating provider letters on file).
- **Severity Rating:** Use the IAJ modified HTQ to rate the resulting biological and psychological pain.

Part C: Applied Case Guidance: Distress-Induced Harm

In practice, the Distress-Induced Harm analysis must be taught through contrasting examples. The evaluator should not use this framework merely because institutional stress is present. The framework applies only when the evidentiary chain is documented with sufficient rigor. The following examples illustrate a strong case, a weak case, and an ambiguous case requiring caution.

Case Example A - Strong Distress-Induced Harm Case

Scenario: An examinee with a documented stress-sensitive neurological disorder provides treatment records showing repeated physician warnings that acute psychological stress predictably triggers

[175] This renaming addresses potential conceptual overreach by emphasizing physiological causation rather than analogizing to traditional battery torts, which could dilute legal precision or invite dismissal by deviation from traditional restrictions on the use of the term "battery" in legal proceedings (e.g., "as seen in cases like Leatherman v. Tarrant County Narcotics Intelligence & Coordination Unit, 507 U.S. 163 (1993), where novel analogies risk heightened pleading standards"). This refinement ensures compatibility with UNCAT's expansive view of mental suffering, countering U.S. reservations critiqued as incompatible by international bodies (e.g., CAT/C/USA/CO/2). For conceptual simplicity, we retain use of the term "Battery Without Touching" while officially referring to it as "Distress-Induced Harm". The retained term is for "internal IAJ shorthand" only, with "Distress-Induced Harm" mandatory in external reports or submissions. This avoids mixed messaging and strengthens irrefutability.

relapse. The court and opposing counsel received multiple accommodation letters explaining this vulnerability. Despite that notice, the court denied requested scheduling accommodation, issued coercive deadlines, threatened terminating sanctions, and rejected motions supported by updated medical records. Within days of each escalation, the examinee experienced objectively documented neurological worsening, infection, and functional decline, confirmed in contemporaneous medical records.

Why this is strong:

- A **specific institutional stressor** is identifiable.
- **Temporal proximity** is tight and repeated across multiple episodes.
- **Foreseeability** is strong because the vulnerability was documented and known.
- **Severity** is supported by objective medical records, functional decline, and standardized symptom instruments.
- The pattern is **reproducible**, not a single speculative event.

Evaluator approach:

- State that the findings are **highly consistent** with distress-induced physical and psychological harm.
- Separate the medical causation opinion from the legal conclusion.
- Use precise language: *"The available evidence supports a repeated temporal and clinical association between identified institutional stressors and documented deterioration."*
- Note alternative contributors only if supported, but explain why they do not better account for the repeated pattern.

Case Example B - Weak Distress-Induced Harm Case

Scenario: An examinee reports that a single upsetting hearing "caused permanent immune collapse," but supplies no pre-event baseline, no medical documentation close in time to the event, no evidence that the institutional actors knew of any special vulnerability, and no objective testing showing material deterioration. The examinee has significant preexisting instability, but there is no timeline distinguishing ordinary fluctuation from event-linked change.

Why this is weak:

- The **stressor** is described, but not well documented.
- **Temporal correlation** is vague.
- **Foreseeability** is not established.
- **Severity** is asserted, not corroborated.
- Differential causes remain equally or more plausible.

Evaluator approach:

- Do **not** overstate.
- Document the allegation, but conclude only that distress may have contributed.

- Use restrained language: *"The examinee reports a perceived association between the hearing and subsequent decline; however, the current record is insufficient to determine whether the identified event was a substantial causal factor."*
- Recommend additional records, timeline reconstruction, and collateral review before adopting the Distress-Induced Harm framework.

Case Example C - Ambiguous / Mixed Case

Scenario: An examinee with hypertension, diabetes, and chronic pain reports worsening after a campaign of legal harassment, repeated summonses, and threats of jail. There are some contemporaneous urgent-care visits and elevated blood pressure readings near major legal events, but the medical record also reflects preexisting poor disease control, intermittent medication nonadherence, and external stressors unrelated to the legal process. Institutional actors had notice of distress but not necessarily of the full medical risk.

Why this is ambiguous:

- There is a plausible **institutional stress pathway**.
- Some **temporal association** exists.
- Foreseeability is partial, not definitive.
- There are substantial **competing explanations**.
- The evidence may support **contribution**, but not sole causation.

Evaluator approach:

- Frame the opinion around **contributory causation** rather than exclusivity.
- Use language such as: *"The institutional stressors plausibly aggravated preexisting conditions and likely contributed to deterioration, but the present record does not support attribution of all observed decline to those stressors alone."*
- Explicitly identify the additional evidence that would strengthen or weaken the inference.
- This is the model for handling ambiguity: neither dismissing the claim because it is complex nor overstating certainty because the allegation is serious.

Training rule:

The Distress-Induced Harm framework should only be used where the evaluator can specify:

- the stressor,
- the physiological or psychological pathway,
- the timing,
- the known vulnerability, and
- the evidentiary basis for excluding or qualifying alternative explanations.

If any of these are missing, the evaluator should downgrade certainty rather than abandon documentation.

Part D: Narrative of Institutional Entrapment

Describe how the victim's attempts at resistance were met with intensified systemic responses, leading to "Cumulative Harm Escalation".

- *Example:* Documentation of an "Accommodation-Punishment Cycle" where the denial of a disability request leads to judicial sanctions, which further deteriorates the victim's health

Confidential Reporting:

As noted in the primary text, evaluators who observe evidence of policy-based torture should retain confidential notes for reporting to the IAJ. These observations contribute to:

- Pattern identification across cases
- Systemic reform advocacy
- Educational materials for future evaluators
- Submissions to UN bodies (e.g., UN Committee Against Torture, Special Rapporteur on Torture) and NGOs (e.g., PHR, IRCT, Amnesty International) for peer review and joint reporting. NGOs can provide independent validation, amplify findings through advocacy campaigns, and facilitate aggregated reporting to highlight systemic patterns

Such observations should be documented separately from the individual evaluation report and transmitted to IAJ through secure channels.

Assessment Administration Protocol

Purpose

This protocol provides guidance on selecting, administering, and interpreting psychological assessment instruments in Istanbul Protocol evaluations. The goal is to ensure standardized, reliable, and valid assessment practices that produce evidence meeting legal and clinical standards.

A. Instrument Selection Decision Tree

The evaluator should follow this decision process when selecting assessment instruments:

STEP 1: What is the primary presentation?

├── Trauma symptoms (PTSD, acute stress)
│ └── Administer: PCL-5, IES-R
├── Depressive symptoms
│ └── Administer: PHQ-9, BDI-II, CES-D
├── Anxiety symptoms
│ └── Administer: GAD-7, BAI, HAM-A

├── Mixed presentation
│ └── Administer: DASS-42, SCL-90-R
├── Functional impairment focus
│ └── Administer: WHODAS 2.0, SF-36
└── Suicide risk indicators
└── Administer: C-SSRS, BHS

STEP 2: Are there complicating factors?

├── Substance use concerns
│ └── Add: AUDIT, DAST
├── Dissociative symptoms
│ └── Add: DES-II
├── Sleep disturbance
│ └── Add: PSQI
├── Somatic symptoms
│ └── Add: PHQ-15
└── Cognitive complaints
└── Consider neuropsychological screening

STEP 3: Are there cultural considerations?

├── Non-Western background
│ └── Consider culturally adapted instruments
├── Limited literacy
│ └── Use interviewer-administered versions
├── Language barriers
│ └── Use validated translations where available
└── Cultural idioms of distress
└── Supplement with cultural consultation

STEP 4: What is the legal context?

├── U.S. federal court
│ └── Ensure instruments have U.S. validation data
├── U.S. state court
│ └── Check state-specific admissibility requirements
├── International body (UN, regional)

│ └── Use internationally recognized instruments

└── Documentation only (no litigation)

└── Broader flexibility in instrument selection

B. Core Instrument Protocols

1. PTSD Checklist (PCL-5)

- **Purpose:** Assess DSM-5 PTSD symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 5-10 minutes
- **Scoring:**
- Total score range: 0-80
- Clinical cutoff: 31-33 (provisional PTSD diagnosis)
- Severity: 0-20 (minimal), 21-40 (moderate), 41-60 (severe), 61-80 (extreme)
- **Interpretation Guidance:**
- Scores above 33 strongly suggest PTSD diagnosis warranting clinical interview
- Examine cluster scores (re-experiencing, avoidance, cognition/mood, arousal)
- High scores with recent trauma may indicate acute stress rather than PTSD
- **Limitations:**
- Self-report may be affected by recall bias
- Not diagnostic alone; requires clinical interview
- May underestimate symptoms in individuals with alexithymia or cultural suppression of distress

2. Impact of Event Scale-Revised (IES-R)

- **Purpose:** Assess subjective distress from specific traumatic event
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 5-10 minutes
- **Scoring:**
- Total score range: 0-88
- Subscales: Intrusion (0-32), Avoidance (0-32), Hyperarousal (0-24)
- Clinical concern: Total score ≥ 33
- Probable PTSD: Total score ≥ 37
- **Interpretation Guidance:**
- Event-specific: references "the event" so must specify index trauma
- Useful for comparing distress across multiple traumatic events

- Subscale profile can inform treatment planning
- **Limitations:**
- Older instrument; not mapped to DSM-5 criteria
- May not capture full range of complex trauma responses

3. Patient Health Questionnaire-9 (PHQ-9)

- **Purpose:** Screen for depressive symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 2-5 minutes
- **Scoring:**
- Total score range: 0-27
- Severity: 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-19 (moderately severe), 20-27 (severe)
- Clinical cutoff: ≥ 10 for major depression screening
- **Interpretation Guidance:**
- Item 9 (suicidal ideation) requires follow-up regardless of total score
- High scores warrant comprehensive mood disorder assessment
- Consider cultural factors in endorsement patterns
- **Limitations:**
- Screening tool only; not diagnostic
- May conflate depression with trauma-related symptoms
- Somatic symptoms may reflect physical sequelae rather than depression

4. Generalized Anxiety Disorder-7 (GAD-7)

- **Purpose:** Screen for anxiety symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 2-3 minutes
- **Scoring:**
- Total score range: 0-21
- Severity: 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-21 (severe)
- Clinical cutoff: ≥ 10 for GAD screening
- **Interpretation Guidance:**
- High scores may reflect PTSD arousal symptoms rather than primary GAD
- Distinguish between generalized anxiety and trauma-specific fear
- Consider chronicity and functional impairment

- **Limitations:**
- Focused on GAD; may miss other anxiety disorders
- Brief; may not capture full anxiety presentation

5. Depression Anxiety Stress Scale (DASS-42)

- **Purpose:** Comprehensive assessment of depression, anxiety, and stress
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 10-15 minutes
- **Scoring:**
- Three subscales with separate severity ratings
- **Depression:** 0-9 (normal), 10-13 (mild), 14-20 (moderate), 21-27 (severe), 28+ (extremely severe)
- **Anxiety:** 0-7 (normal), 8-9 (mild), 10-14 (moderate), 15-19 (severe), 20+ (extremely severe)
- **Stress:** 0-14 (normal), 15-18 (mild), 19-25 (moderate), 26-33 (severe), 34+ (extremely severe)
- **Interpretation Guidance:**
- Particularly useful for distinguishing depression from anxiety
- Stress subscale captures tension and agitation
- Profile analysis informs diagnostic formulation
- **Limitations:**
- Longer administration time
- May produce response fatigue

6. World Health Organization Disability Assessment Schedule (WHODAS 2.0)

- **Purpose:** Assess functional impairment across domains
- **Administration:** Self-report or interviewer-administered; 12-item or 36-item versions
- **Time:** 5 minutes (12-item) to 20 minutes (36-item)
- **Scoring:**
- Domain scores and overall disability score
- Simple scoring: sum of item scores
- Complex scoring: IRT-based algorithm (recommended)
- Higher scores = greater disability
- **Interpretation Guidance:**
- Assesses functioning independent of diagnosis
- Useful for documenting functional impact for reparations
- Compare to population norms

- **Limitations:**
- Not trauma-specific
- May not capture episodic impairment

C. Assessment Sequencing

Recommended Administration Order:

- **Rapport-building and orientation** (not scored)
- **Broad screening instrument** (DASS-42 or SCL-90-R)
- **Trauma-specific measure** (PCL-5, IES-R)
- **Functional assessment** (WHODAS 2.0)
- **Supplemental instruments** based on presentation
- **Risk assessment** (C-SSRS) if indicated
- **Break** — offer rest period
- **Clinical interview** — comprehensive history-taking

Rationale:

- Begin with broader assessment to identify areas requiring deeper exploration
- Trauma-specific measures administered after rapport is established
- Functional assessment provides context for symptom severity
- Risk assessment conducted when individual is engaged but before fatigue
- Clinical interview benefits from prior instrument data to guide questioning

Sequencing should also account for evaluator load. When multiple high-intensity instruments, prolonged trauma narratives, or repeated dissociative material are expected, the evaluator should distribute the assessment across manageable segments rather than compress all high-burden material into a single sitting. The protocol should be sequenced to preserve attention, reduce reactivity, and maintain interpretive quality. Where fatigue emerges, lower-burden tasks, collateral review, or rescheduling may be preferable to forcing completion.

D. Cultural Adaptation Considerations

Available Translations:

Many standard instruments have validated translations. Evaluators should:

- Use validated translations when available
- Document the translation version used
- Note any concerns about translation adequacy
- Supplement with cultural consultation when needed

Cultural Interpretation:

When interpreting scores for individuals from non-Western backgrounds:

- Consider cultural norms for symptom expression
- Be aware that some cultures suppress emotional expression
- Recognize culturally-bound syndromes that may not map to Western categories
- Note cultural factors that may affect score interpretation
- Document cultural considerations in the report

Instruments with Strong Cross-Cultural Validation:

- WHODAS 2.0 (developed by WHO for international use)
- PHQ-9 (extensive international validation)
- PCL-5 (validated in multiple languages and cultures)
- Hopkins Symptom Checklist (designed for refugee populations)

E. Documentation Requirements

For each instrument administered, the report must document:

- **Instrument name and version**
- **Date of administration**
- **Administration method** (self-report, interviewer-administered, interpreter-assisted)
- **Language of administration**
- **Raw scores** for all subscales
- **Interpretation** of scores with reference to clinical cutoffs
- **Behavioral observations** during administration
- **Validity considerations** (e.g., response style, engagement, comprehension)
- **Integration** with clinical interview findings

Where evaluator fatigue, vicarious trauma, or the need for pacing materially affected administration, the evaluator should document that fact in neutral procedural terms. Examples include: the need to split the session across dates, the use of additional breaks, the deferral of certain instruments, or the decision to seek consultation or transfer. This is not a sign of weakness; it is a transparency safeguard that helps explain scope, limits, and methodological choices.

Module 5: Documentation Standards & Forensic Credibility

Report Writing Standards

A. Purpose of the Report

The forensic psychological evaluation report serves multiple purposes:

- **Documentation:** Creating a permanent record of alleged torture/CIDT and its psychological effects
- **Evidence:** Providing admissible evidence for legal proceedings
- **Protection/Relief Support:** Providing clinically grounded documentation that may support protection, accommodation, asylum/immigration relief, or compensation claims (without adopting a partisan or ultimate-issue posture)
- **Accountability:** Contributing to documentation that may support prosecution or sanctions
- **Education:** Informing decision-makers about torture and its effects

B. Quick-Reference Decision Tree: Report Formulation

This decision tree helps the evaluator determine what kind of conclusion language is justified and what level of report structure is necessary.

STEP 1: Is the report intended for clinical use, legal use, administrative use, advocacy, or mixed use?

├── **Clinical only** → Emphasize symptom description, diagnosis, care implications

├── **Legal / administrative / international** → Use fuller forensic structure and calibrated certainty language

└── **Mixed** → Use a hybrid structure with explicit audience clarity

STEP 2: Are the findings sufficient for firm conclusions?

├── **Yes** → Use supported conclusions with calibrated certainty

├── **Partially** → Use qualified conclusions and state limitations

└── **No** → Use descriptive findings plus explicit need for further investigation

STEP 3: Does the report address consistency, diagnosis, causation, severity, or all four?

├── **One or two only** → Limit the report to what is supported

└── **All four** → Ensure each is separately analyzed and not conflated

STEP 4: Are there major limitations that affect confidence?

├── Missing records, language barriers, partial interview, fatigue, unresolved contradictions, lack of baseline

│ └── State limitations transparently

└── No major limitations

└── Proceed with stronger formulation

STEP 5: What conclusion format is appropriate?

├── **Strongly supported** → Clear conclusion + degree of consistency + causal / diagnostic wording as appropriate

├── **Qualified** → Core conclusion plus expressly limited certainty

└── **Preliminary** → Descriptive findings with recommended next steps

Report rule:

The report should match the evidence actually available. It should never imply finality where the record only supports a provisional or qualified conclusion.

C. Essential Report Elements

The elements below represent the core building blocks of the standard report. Appendix D shows how these same elements are scaled and adapted across a preliminary template, a standard forensic template, and an advanced systemic-investigation template.

Every IAJ forensic psychological evaluation report must contain:

1. Header and Identifying Information:

- Title: "Forensic Psychological Evaluation Report Pursuant to the Istanbul Protocol"
- Date of report
- Evaluator name, credentials, and contact information
- Individual's name (or pseudonym if safety requires)
- Date(s) of evaluation
- Location of evaluation
- Language(s) used
- Interpreter information (if applicable)
- Referral source

2. Table of Contents (for reports exceeding 10 pages)

3. Executive Summary:

- Brief statement of purpose
- Summary of alleged torture/CIDT
- Summary of psychological findings
- Consistency assessment
- Key conclusions

4. Informed Consent and Confidentiality:

- Documentation of informed consent process
- Explanation of confidentiality and its limits
- Individual's understanding and agreement

5. Sources of Information:

- Clinical interviews (dates, duration)
- Psychological testing administered
- Records reviewed
- Collateral contacts (if any)
- Other sources

6. Background Information:

- Demographic information
- Relevant pre-torture history
- Medical and psychiatric history
- Substance use history
- Educational and occupational history
- Family and social history

7. Account of Alleged Torture/CIDT:

- Detailed narrative of alleged acts
- **Chronological Map of Institutional Harm**: Consistent with the IAJ mandate for enhanced causation, this section must present a data-rich map documenting
- **Institutional Contact Sequence**: Exact dates of first and subsequent contacts with the institutional system
- **Environmental Triggers**: Documented institutional interventions, orders, or denials with specific dates
- **Biological/Functional Response**: First and subsequent observable changes in psychological and physiological functioning (e.g., MS relapses, cardiac spikes) linked to those dates
- **Trajectory Analysis**: Progression of symptoms chronologically anchored and clinically analyzed (where data density permits — see Quantitative Evidence Rule below — quantitative modeling may supplement this analysis) with the institutional events
- **Baseline Comparison**: A summary of current presentation compared directly to the documented pre-incident baseline
- Perpetrators and context
- Individual's responses during and after
- Documented in individual's own words where possible

8. Post-Torture History:

- Immediate aftermath
- Course since alleged torture
- Treatment received
- Ongoing stressors
- Current circumstances

9. Mental Status Examination:

- Appearance
- Behavior
- Speech
- Mood and affect
- Thought process and content
- Perception
- Cognition
- Insight and judgment

10. Psychological Testing:

- Instruments administered
- Scores and interpretation
- Validity assessment
- Integration with clinical findings

11. Behavioral Observations:

- Presentation during evaluation
- Response to trauma-related questions
- Emotional responses
- Signs of distress or avoidance

12. Clinical Formulation:

- Diagnostic impressions (using DSM-5 or ICD criteria)
- Relationship between symptoms and alleged torture
- Consideration of alternative explanations
- Assessment of severity and functional impact
- Any material methodological limitation arising from session pacing, evaluator fatigue, required breaks, partial deferral, or transfer/consultation, where such factors affected the scope or confidence of the formulation

When the formulation includes alleged stress-mediated deterioration or "distress-induced harm," the report should apply the causation framework in the chapter "The Doctrine of Distress-Induced Harm", Section IV (B), including event anchoring, foreseeable harm, and differential analysis.

13. Consistency Assessment:

- Application of IP consistency framework
- Internal consistency of account
- Consistency between account and psychological findings
- Consistency with known torture patterns
- Factors supporting credibility
- Any inconsistencies and their explanation

14. Conclusions:

- Summary of findings
- Opinion on whether findings are consistent with alleged torture
- Degree of consistency (using IP framework)
- Any qualifications or limitations
- If applicable, a brief statement that the evaluation was paused, split, or limited to preserve reliability, and whether additional assessment by the same or another evaluator is recommended

Any conclusion regarding causation, aggravation, or acceleration of harm should be stated in language calibrated to the evidentiary level described in the Chapter "The Doctrine of Distress-Induced Harm", Section IV (B), and should identify whether the opinion is supported, qualified, or requires additional investigation.

15. Recommendations:

- Treatment needs
- Safety concerns
- Further evaluation needed
- Other recommendations

16. Evaluator Attestation:

- Statement of evaluator's qualifications
- Statement of methodology used
- Statement of independence and impartiality
- Signature and date
- Statement that the evaluator monitored for fatigue, vicarious trauma, and other factors that could impair neutrality or attention, and took appropriate steps to preserve methodological integrity

17. Appendices (as applicable):

- CV of evaluator
- Copies of testing protocols
- Timeline/chronology
- Supporting documents

D. Language and Terminology Standards

1. Certainty Expressions:

Use precise language to express the degree of certainty:

Expression	Meaning
"Highly Consistent (IP §543(e))"	Could only have resulted from alleged torture
"Typical of"	Usually found in cases of this type
"Highly consistent with"	Common finding, specifically supports allegation
"Consistent with"	Could have resulted from alleged torture but non-specific
"Not consistent with"	Cannot be explained by alleged torture

For distress-induced harm claims, certainty language should track the graded evidentiary framework in the chapter "The Doctrine of Distress-Induced Harm", Section IV (B) rather than imply absolute or sole-cause attribution.

2. Attribution Language:

When describing the individual's account:

- "The individual reports that..."
- "According to the individual..."
- "[Name] described..."
- "[Name] stated that..."

When describing clinical findings:

- "The evaluation revealed..."
- "Testing indicated..."
- "The individual presented with..."
- "Clinical examination showed..."

When offering opinions:

- "It is my clinical opinion that..."
- "Based on this evaluation, I conclude that..."
- "The findings suggest that..."
- "In my professional judgment..."

In stress-mediated harm cases, attribution should distinguish between substantial contributing factor, material aggravation, plausible contribution, and unresolved causation, consistent with the chapter "The Doctrine of Distress-Induced Harm", Section IV (B)

When domestic forums apply narrower legal standards, attribution language should preserve the treaty-based conclusion where supported, while also stating the underlying findings in clinically precise, non-conclusory language that remains usable even if the tribunal rejects the international label.

3. Avoiding Problematic Language:

Avoid	Use Instead
"The victim claims..."	"The individual reports..."
"Allegedly" (excessive use)	State as reported, note source
"I believe..."	"It is my clinical opinion..."
Definitive statements about events	Statements about consistency
Legal conclusions (guilty, liable)	Clinical conclusions (consistent, typical)
"The examinee's symptoms have	"Symptom progression is chronologically
worsened over time."	anchored to [specific institutional dates]
	as documented in the Chronological Map."

Avoid language that masks preventable methodological impairment; if fatigue, overload, or session truncation affected the assessment, describe the limitation transparently rather than presenting an unjustified appearance of completeness.

5. Rule of Non-Legal Attribution

When a report uses the term 'directly attributable' under the **Diagnostic Certainty Standard**, it refers exclusively to **Clinical Causation**—the degree of scientific fit between the stressor and the biological outcome. Evaluators are cautioned that 'attribution' in a forensic report does not imply a legal finding of liability, which remains the sole province of a court.

6. Standard for Multiaxial Communication

When documenting systemic harm, the multiaxial format allows clinicians to capture comorbidity and integrate medical factors effectively. Evaluators should utilize this to demonstrate the **Causation Synthesis** required by *Daubert* . For example:

- **Axis I:** Complex PTSD, recurrent.
- **Axis III:** Multiple Sclerosis (Distress-Induced Relapse).
- **Axis IV:** Systemic judicial discrimination; denial of ADA safe harbor.
- **Axis V:** GAF score 30 (reflecting severe functional impairment).

E. Report Structure for Different Audiences

1. For Courts and Legal Proceedings:

- Emphasize admissibility considerations

- Include detailed methodology section
- Provide clear foundation for opinions
- Address applicable legal standards
- Include evaluator qualifications prominently

2. For Asylum Proceedings:

- Emphasize nexus between persecution and protected ground
- Document country conditions when relevant
- Address credibility clearly
- Connect findings to asylum legal standards
- Consider including country-specific torture patterns

3. For International Bodies (UN, Regional Human Rights Courts):

- Emphasize consistency with UNCAT definitions
- Reference Istanbul Protocol standards explicitly
- Document state involvement or acquiescence
- Address relevant treaty provisions
- Consider broader human rights context

4. For Reparations and Compensation:

- Emphasize functional impact and damages
- Document treatment needs and costs
- Quantify impairment where possible
- Address rehabilitation requirements
- Project future needs

These audience distinctions should also guide template selection in **Appendix D**. A court-facing report may require fuller methodology, admissibility-oriented structure, and "carefully bounded" opinion language[176]; a human rights submission may require stronger treaty framing and institutional

[176] In the context of the IAJ Psychological Investigation Standard's skeleton report, the instruction "If applicable, Article 1 / Article 16 or other framework conclusion (carefully bounded)" directs the evaluator to categorize the documented findings within the specific legal definitions of the UN Convention Against Torture (UNCAT), while strictly adhering to forensic neutrality and jurisdictional limitations. 1. Categorization by UNCAT Framework The evaluator must determine which specific "track" of the treaty the documented harm supports: Article 1 (Torture): Findings are categorized here if there is evidence of severe pain or suffering inflicted for a prohibited purpose (such as punishment, intimidation, or discrimination) by or with the acquiescence of a public official. Article 16 (CIDT): This applies to other acts of Cruel, Inhuman, or Degrading Treatment or Punishment that do not reach the threshold of torture . Critically, unlike Article 1, CIDT requires no proof of intent—the focus is entirely on the nature of the treatment and its effect on the victim . 2. The "Carefully Bounded" Mandate The term "carefully bounded" is a mandatory forensic safeguard intended to protect the expert's credibility and the report's admissibility . It requires the evaluator to: Distinguish Clinical vs. Legal Conclusions: The evaluator must state that findings are "clinically consistent with" a framework, rather than offering a binding legal verdict of guilt or liability, which is reserved for the trier of fact. Acknowledge Jurisdictional Gaps: In U.S. proceedings, the evaluator must bound the conclusion by noting that domestic courts may apply narrower legal standards than the international UNCAT framework. Cite Methodological Limits: The conclusion must be bounded by a transparent disclosure of any limitations, such as evaluator fatigue, required breaks, or incomplete records, which may have influenced the

mapping; and an immigration-focused report may require clearer nexus, chronology, and risk language. The evaluator should adapt emphasis, not alter the underlying factual record or clinical integrity of the report.

In U.S. court or agency filings, the evaluator should use a dual-track structure that preserves the UNCAT / Istanbul Protocol analysis while also presenting the same findings in a narrower factual and clinical format suitable for domestic procedural use.

F. Model Report Template

Appendix D provides a **tiered model report template suite**, not a single fixed form. It includes:

- a **basic template** for lower-complexity or preliminary documentation;
- a **standard forensic template** for most torture/CIDT evaluations;
- an **advanced systemic-investigation template** for complex, multi-actor, policy-based, or high-stakes matters.

Each template is annotated to explain the purpose of each section, includes examples of language to use and language to avoid, and provides audience-specific adaptation notes for courts, human rights bodies, immigration authorities, and related proceedings. Evaluators should select the least complex template that still permits accurate, complete, and defensible documentation.

Tiered Model Report Templates and Fillable Skeleton Report

I. How to Use This Appendix

This Appendix provides multiple model report templates at different complexity levels so that evaluators can match the structure of the report to the needs of the case without sacrificing rigor. These templates are guides, not rigid forms. Each section includes:

- the **purpose** of the section,
- **model language** that is generally appropriate,
- **problematic language to avoid**,
- and **adaptation notes** for different audiences, including courts, human rights bodies, and immigration authorities.

The evaluator should select the least complex template that can still accurately document the case. A shorter report is acceptable if it remains methodologically sound, transparent about limits, and proportionate to the available evidence.

II. Template A: Preliminary / Lower-Complexity Report

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level of certainty. 3. Relevant Purpose in U.S. Proceedings This section operationalizes the Dual-Track Rule. By carefully bounding the framework conclusion, the report: Preserves the Substantive Truth of the violation for international review (such as UN bodies) . Maintains Domestic Utility by presenting the same facts in factual and clinical terms that can be evaluated under narrower U.S. standards, such as "deliberate indifference".

Use when:

- the evaluator has limited records,
- the matter is urgent or preliminary,
- the report is for early screening, protective action, or referral,
- a full forensic workup has not yet occurred.

Suggested structure

- Header and Identifying Information
- Informed Consent and Confidentiality
- Sources of Information
- Brief Account of Reported Harm
- Presenting Symptoms / Functional Impact
- Behavioral Observations
- Preliminary Clinical Formulation
- Preliminary Consistency Statement
- Immediate Recommendations / Need for Further Evaluation
- Evaluator Attestation

Annotation

The purpose of this template is to document what is presently supportable without overstating certainty. It is especially useful when the priority is preservation of evidence, urgent protection, referral, or early record creation.

Sample language

- "The individual reports that…"
- "At this stage, the available information is consistent with…"
- "A fuller evaluation is recommended before any definitive diagnostic or causation conclusions are made."

Avoid

- "This proves torture."
- "The events occurred exactly as described."
- "There is no other explanation."

Audience adaptation

- Courts: clearly label as preliminary and avoid implying final expert conclusions.
- Human rights bodies: emphasize need for protection and further investigation.

- Immigration authorities: focus on immediate trauma indicators, fear, and need for full medico-legal follow-up.

III. Template B: Standard Forensic Torture/CIDT Report

Use when:

- the evaluator has completed a full interview and relevant testing/record review,
- the report may be used in litigation, immigration, administrative proceedings, or human rights documentation,
- the evaluator can support conclusions beyond a preliminary level.

Suggested structure

- Header and Identifying Information
- Table of Contents (for reports exceeding 10 pages)
- Executive Summary
- Informed Consent and Confidentiality
- Sources of Information
- Background Information
- Account of Alleged Torture/CIDT
- Post-Torture History
- Mental Status Examination
- Psychological Testing
- Behavioral Observations
- Clinical Formulation
- Consistency Assessment
- Conclusions
- Recommendations
- Evaluator Attestation
- Appendices (if applicable)

Annotation

This is the core model for most reports. It should be used when the evaluator is prepared to provide a structured forensic opinion on symptom pattern, diagnostic formulation, consistency, severity, and—where supported—causation or aggravation.

Sample language

- "The reported history and current presentation are highly consistent with…"
- "The findings support the conclusion that…"

- "The available evidence indicates that the reported events likely contributed materially to…"

Avoid

- legal conclusions such as "liable," "guilty," "unconstitutional,"
- overconfident historical assertions such as "this definitely happened,"
- imprecise advocacy language that blurs source, observation, and opinion.

Audience adaptation

- Courts: emphasize methodology, qualifications, and clear evidentiary basis.
- Human rights bodies: reference UNCAT definitions and institutional involvement/acquiescence.
- Immigration authorities: emphasize credibility-sensitive formulation, nexus-relevant details, and country-pattern context when relevant.

IV. Template C: Advanced Systemic / High-Complexity Report

Use when:

- there are multiple actors, institutions, or time periods,
- the case involves systemic/policy-based torture or CIDT,
- distress-induced harm, institutional entrapment, or cumulative coercion is central,
- the report is intended for high-stakes litigation, international advocacy, or broader investigative use.

Suggested structure

- Header and Identifying Information
- Scope, Referral Questions, and Intended Audiences
- Informed Consent, Limits, and Security Considerations
- Sources of Information and Record Matrix
- Background and Contextual Framework
- Chronology of Alleged Conduct
- Institutional Actor Mapping / Systems Involved
- Account of Alleged Torture/CIDT
- Psychological and Functional Consequences
- Testing / Structured Measures / Collateral Integration
- Clinical Formulation
- Credibility / Reliability Analysis
- Causation / Aggravation / Distress-Induced Harm Analysis
- Severity and Ongoing Risk Assessment

- Consistency with Article 1 / Article 16 Framework
- Conclusions
- Recommendations (clinical, protective, investigative, legal-process)
- Limitations and Need for Further Investigation
- Evaluator Attestation
- Appendices (timeline, matrix, records reviewed, instruments, supporting exhibits)

Annotation

This template is for cases where a simple narrative report is not enough. It allows the evaluator to separate:

- factual chronology,
- clinical findings,
- credibility analysis,
- causation analysis,
- systemic pattern analysis,
- and legal-framework consistency,

so that complex conclusions remain transparent and defensible.

Sample language

- "The available record supports a pattern of repeated institutional conduct associated with…"
- "The findings are best understood as cumulative and systemically maintained rather than isolated."
- "The evidence strongly supports Article 16 concerns, while the Article 1 analysis is discussed separately below."

Avoid

- collapsing all conclusions into one broad accusation,
- mixing factual allegations with evaluator opinions without signal phrases,
- treating systemic theory as a substitute for evidence in the individual case.

Audience adaptation

- Courts: use only if the complexity genuinely requires it; keep legal labels tightly bounded.
- Human rights bodies: especially appropriate where structural or policy-based abuse is central.
- Immigration authorities: use selectively; excessive systemic content should not obscure the applicant-specific persecution analysis.

V. Section-by-Section Annotation Guide

For each major report section, add a short explanation like this:

1. Sources of Information

- **Purpose**: to identify the evidentiary basis of the report and distinguish interview data, records, testing, and collateral sources.
- **Why it matters**: without source transparency, the report is vulnerable to challenge.
- **Common mistake**: mixing what the examinee said with what records independently show.

2. Account of Alleged Torture/CIDT

- **Purpose**: to document the reported events clearly, chronologically, and in the individual's own account.
- **Why it matters**: this creates the narrative basis for later consistency and causation analysis.
- **Common mistake**: slipping into legal conclusions or rewriting the account as though it were already adjudicated fact.

3. Clinical Formulation

- **Purpose**: to synthesize symptoms, function, testing, history, and context into a clinically coherent interpretation.
- **Why it matters**: this is where the evaluator explains the case, not merely lists symptoms.
- **Common mistake**: repeating the symptom list without interpretation.

4. Consistency Assessment

- **Purpose**: to explain whether the clinical findings are consistent, highly consistent, typical, etc., with the reported harm.
- **Why it matters**: this is the core forensic bridge between history and clinical evidence.
- **Common mistake**: stating certainty more strongly than the record supports.

5. Conclusions

- **Purpose**: to present the final, calibrated opinions.

Why it matters: this section is often the most quoted and the most attacked.

- **Common mistake**: adding new facts here that were not developed earlier in the report.

You can continue this style for each core element.

VI. Problematic Language and Better Alternatives

A. Overstatement of Fact

- **Avoid**: "The torture occurred exactly as alleged."
- **Use instead**: "The reported account is consistent with the available clinical and collateral evidence to the degree described below."

B. Legal Overreach

- **Avoid**: "The judge/agency/official is guilty and liable."

- **Use instead**: "The evaluation identifies findings clinically consistent with torture/CIDT as defined in the applicable framework; legal adjudication remains outside the scope of this report."

C. Biased Source Framing

- **Avoid**: "The victim claims…"
- **Use instead**: "The individual reports…" or "According to the individual…"

D. False Precision

- **Avoid**: "This caused the condition."
- **Use instead**: "This was a substantial contributing factor," "likely aggravated," or "materially contributed," depending on support.

E. Hidden Limitations

- **Avoid**: presenting a partial interview as if it were complete.
- **Use instead**: "The assessment was limited by…" / "Additional records would strengthen…"

F. Advocacy Disguised as Opinion

- **Avoid**: "This case proves a corrupt system."
- **Use instead**: "The available evidence supports concern regarding repeated institutional conduct affecting the individual in the following ways…"

This section should explicitly tell evaluators that strong advocacy and strong forensic writing are not the same thing.

VII. Audience Adaptation Notes

A. Courts and Legal Proceedings

- foreground qualifications and methodology;
- separate observations, history, and opinions cleanly;
- use tightly calibrated certainty language;
- avoid unnecessary treaty exposition unless directly relevant to the forum.

B. Human Rights Bodies

- connect findings explicitly to UNCAT / Istanbul Protocol framework;
- document state action, acquiescence, or institutional involvement clearly;
- include broader structural and contextual facts where relevant;
- preserve a stronger emphasis on pattern, impunity, and need for independent investigation.

C. Immigration Authorities

- emphasize trauma effects on memory and presentation;
- state credibility findings with nuance;

- connect the harm to protected-ground or persecution context when relevant;
- include country-pattern context only where it helps explain the applicant-specific account.

D. Administrative / Disability / Accommodation Proceedings

- emphasize functional impairment, predictability of harm, accommodation history, and practical recommendations;
- reduce unnecessary global legal framing unless it assists the specific adjudicative issue.

E. Reparations / Compensation Contexts

- emphasize severity, function, treatment needs, rehabilitation, future consequences, and damages-related documentation.

F. Courts / U.S. Proceedings

Add the following model paragraph for Dual-Track International / Domestic Framing for U.S. Proceedings:

"This report applies internationally recognized torture-documentation standards, including the ***Istanbul Protocol and the Convention Against Torture (UNCAT). Under that framework, the evaluator has assessed whether the documented facts and clinical findings are consistent with torture and/or cruel, inhuman, or degrading treatment (CIDT) as defined by the applicable international standard. The evaluator also recognizes that some domestic U.S. courts or agencies may apply narrower legal definitions or procedural limits. Accordingly, this report is presented on a dual-track basis: first, it states the evaluator's consistency findings under the governing international framework; second****, it presents the same underlying facts, symptom patterns, functional impairments, chronology, and causation analysis in factual and clinical terms that remain usable even if the tribunal declines to adopt treaty terminology. Any domestic refusal to apply or recognize the full international standard does not alter the underlying clinical findings, the documented severity of harm, or the evaluator's treaty-based consistency analysis."*

Core rule: audience adaptation changes emphasis and organization, not honesty, source transparency, or methodological rigor.

VIII. Template Selection Quick Guide

Use Template A if:

- the record is incomplete,
- urgent protection is needed,
- the evaluation is preliminary,
- or the primary goal is preservation and referral.

Use Template B if:

- the evaluation is complete enough for a standard forensic report,
- the case is significant but not structurally complex,
- and the audience needs a conventional medico-legal product.

Use Template C if:

- the case involves systemic, policy-based, cumulative, or multi-actor abuse,
- distress-induced harm / institutional entrapment is central,
- or the report must address both individual and structural dimensions.

If uncertain: start with Template B and add only the sections truly required.

IX. Model Section XII. Forensic Conclusions and Attribution Analysis

This section must be completed in full to satisfy the Forensic Probability Standard.

A. Summary of Principal Findings

[Drafting Note: Provide a narrative synthesis of symptoms and injuries].

For example: Based on the interview, records reviewed, behavioral observations, and any testing or structured measures used, the examinee demonstrates clinically significant psychological symptoms and functional impairment associated with the reported events. Based on the multiaxial synthesis of interviews, behavioral observations, and objective biological data, the examinee demonstrates clinically significant psychological symptoms (Axis I) and objective biological deterioration or injury (Axis III). The presentation includes the symptom patterns, distress responses, and functional consequences described above, subject to the limitations stated in this report.

B. Consistency and Probability Assessment

The reported history and current clinical findings are **[consistent with / highly consistent with / typical of / diagnostic of]** the alleged torture and/or cruel, inhuman, or degrading treatment as evaluated under the applicable forensic framework described in this report. Under the IAJ **Forensic Probability Standard**, these findings possess a **[High / Moderate / Low]** degree of **Clinical Certainty**.

C. Forensic Multiaxial Synthesis

- **Axis I (Clinical Disorders):** [Primary psychiatric outcomes]. [e.g., Complex PTSD; EPCACE]
- **Axis II (Personality):** [Evidence of Shattering of the Self; Learned Helplessness]
- **Axis III (Biological Anchor):** [Objective tissue injury or cardiac biomarkers].[e.g., MS relapse; cardiac biomarkers chronologically anchored to Axis IV triggers]
- **Axis IV (Institutional Stressors):** [The specific institutional "force"].[e.g., Systemic Judicial Discrimination; Denial of ADA Safe Harbor]
- **Axis V (Functioning):** GAF Score of [X], reflecting severe functional impairment

D. Causation / Aggravation / Distress-Induced Harm Analysis

Where specifically addressed in this evaluation, the available evidence **[supports / supports with qualification / is insufficient at present to firmly establish]** the conclusion that the reported acts or conditions were a **[substantial contributing factor / material aggravating factor / plausible contributing factor]** in the examinee's psychological and/or stress-mediated deterioration. The available evidence supports the conclusion that the identified **Axis IV institutional stressors** were a

[substantial contributing factor / material aggravating factor] in the observed **Axis III biological destruction**. This attribution is based on event chronology, clinical plausibility, known or foreseeable vulnerability, differential analysis, and consideration of alternative explanations. Where disease-specific literature is relevant, it may support the plausibility of the temporal relationship. If additional investigation is needed, that limitation is stated expressly.

E. Severity and Functional Impact

The documented harm is best characterized as [**mild / moderate / severe / severe and urgent**], based on the combined weight of symptom intensity, persistence, functional impairment, and risk. The effects described above materially affect the examinee's [**daily functioning / capacity to participate in proceedings / health stability / occupational or social functioning**].

F. Legal Sufficiency Note

This conclusion is offered as an expert clinical opinion based on structured professional judgment and clinically grounded attribution. It is a clinical consistency finding and is not offered as a legal verdict of liability or guilt.

G. Scientific Neutrality Affirmation

This evaluation is conducted as a neutral forensic inquiry. IAJ evaluators are trained to state, where the record supports it, findings that are taboo in conventional expert practice but are scientifically and methodologically grounded: "The findings are highly consistent with CIDT under UNCAT Article 16." "The documented deterioration is temporally anchored to institutional stressors and supported by objective biological markers and published disease-specific evidence." "The system's refusal to provide accommodation despite documented notice is evidence relevant to knowledge, foreseeability, and institutional tolerance of harm under UNCAT Article 1." "This report preserves an international-law characterization of the documented facts, regardless of any domestic label or prior judicial finding." These are not legal conclusions. They are the disciplined output of a standardized method that forces the tribunal to confront the evidentiary record. The evaluator functions as a neutral forensic evaluator aligned with the **Substantive Truth Track** of the Istanbul Protocol. Findings of consistency are based on objective biological markers and the **Functional Analysis of Behavior**, independent of any domestic legal strategy or desired outcome.

****H. Dual-Track International / Domestic Framing****

This report applies internationally recognized torture-documentation standards, including the Istanbul Protocol and the Convention Against Torture. The evaluator understands that this tribunal may apply narrower domestic legal standards. Accordingly, the report presents (1) the evaluator's consistency findings under the international framework and (2) the same underlying facts, clinical findings, and functional effects in factual and clinical terms that can be evaluated under domestic procedures. The clinical findings do not depend on whether the tribunal adopts treaty terminology.

I. Limitations

These conclusions should be read together with the limitations identified in this report, including any constraints arising from incomplete records, partial corroboration, language barriers, pacing, evaluator fatigue safeguards, deferred testing, or unresolved factual disputes. Where such limitations exist, the degree of certainty has been adjusted accordingly.

J. Recommendations

Further recommendations are set out below and may include clinical treatment, protective measures, additional evaluation, accommodation, collateral investigation, or other steps necessary to reduce harm and preserve the integrity of the record.

X. Fillable Skeleton Report

A fillable Skeleton Report is provided for your convenience in Appendix D

Module 6: Ethical Obligations & Expert Protection

Ethical Obligations in Hostile Institutional Environments

Preamble

It is the moral obligation of every human being to defend human rights. It is the fundamental ethical obligation of every care provider to defend human rights by documenting the possibility or actuality of violations. This duty is particularly critical when the mandated investigative authority exhibits a pattern of state acquiescence and participation in the prohibited act. In the absence of an effective National Human Rights Institution (NHRI) in the United States, the IAJ provides the necessary framework to prevent the **Aggravated Suppression** of evidence.

Foundational Distinctions

- **Non-Clinical Status**: For this document, "patient" generally refers to an examinee under investigation without assuming a provider-patient relationship. Forensic evaluations are fundamentally distinct from the "practice of psychotherapy".
- **The Therapeutic Byproduct**: While evaluators provide no vocational care, the forensic pursuit of truth produces an unintended therapeutic byproduct by validating the survivor's reality against institutional erasure.

Universal Ethical Principles

In accordance with the **2022 Istanbul Protocol** and PHR guidance, the IAJ adheres to the four traditional pillars of medical ethics: **Beneficence, Non-maleficence, Autonomy**[177]**,** and **Confidentiality**. To address the "Equivalent Pathway" failure in the USA, the IAJ establishes three mandatory additions:

- **Mandatory Investigation**: Clinicians must not ignore or suppress observed signs of torture or CIDT; they must document observed indicators, offer referral or evaluation, and not coerce disclosure. Physicians and care providers have a duty to document and report torture and ill-treatment (WMA, 2006). The IAJ extends this requirement to all qualified care providers.[178]
- **Mandatory Confidential Documentation**: Fulfilling the **Universal Duty to Document** is a non-discretionary ethical and professional requirement (not an independently imposed legal duty; scope is calibrated to licensed competence) that supersedes institutional preference or convenience. The safety and bodily and mental integrity of a victim of torture and CIDT is superior to employment considerations or institutional and third-party interests.
- **Access Without Preconditions**: The right to independent documentation is absolute and cannot be conditioned on the victim's ability to obtain legal representation.

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[177] Clinicians who evaluate alleged victims who fear reprisals and refuse to consent to a clinical evaluation must never breach the primary ethical duties of "do no harm" and respect for autonomy over the obligation to document and report. Informed consent is imperative and requires clear disclosure of all material information including the purpose of the evaluation, potential risks and benefits, the nature of the evaluation, including the possibility of taking photographs (To document physical indications of torture or ill-treatment), and limits on confidentiality including any mandatory reporting requirements of the clinician.

[178] IP §673 footnote 536: While NGOs, clinicians and health professionals are not obliged under international law to produce evaluations in accordance with the Istanbul Protocol, they are greatly encouraged to do so. In addition, alleged victims reserve the right to decide whether to submit evidence and the types thereof.

The Dual Obligations Conflict

Clinicians employed by state institutions (prisons, military, psychiatric hospitals) face "Dual Obligations"—loyalty to the employer vs. duty to the patient.

- **Primacy of the Individual:** Under the 2022 Istanbul Protocol, the clinician's primary duty is to the examinee. No administrative directive can authorize the certification of "fitness for punishment" (e.g., solitary confinement).
- **Presence of Security Forces:** Medical examinations must be conducted in private. The presence of police, guards, or courthouse security during a forensic psychological evaluation is a breach of ethics and materially compromises confidentiality and the conditions for voluntary disclosure; the evaluator must document this as a methodological limitation and assess its impact on disclosure, distress, and reliability.
- **Complicity via "Cleaning up":** Clinicians are ethically prohibited from using medical skills to facilitate or "conceal" the results of torture. This includes failure to document signs of a biological assault to protect the reputation of the local judiciary. There must exist procedures for identifying and reporting when other medical staff are complicit in or "cleaning up" after torture.

The Legal Representation Barrier

Specialized forensic bodies that require attorney representation as a precondition for investigation create a **structural barrier** that disproportionately impacts indigent victims of systemic judicial torture.

- **The Catch-22**: Victims often lack attorneys precisely because the **Accommodation-Punishment Cycle** has exhausted their resources.
- **Clinician Standards**: A victim's pro se status does not diminish the provider's authority to document observations, diagnostic assessments, and consistency findings. Documentation serves the international record regardless of present domestic legal standing.

Conclusion of the Witness Obligation

An IAJ Psychological Investigator must never commit **Ethical Abandonment** by turning away from a suspected victim of a **Distress Assault: institutional action that foreseeably produces severe distress and documentable biological impairment through a published physiological pathway. Biological Assault: stress-mediated physiological deterioration in a susceptible individual, documented through objective biological markers, anchored to a documented institutional stressor, and supported by published disease-specific mechanism literature. The IAJ Psychological Investigator is trained to go where conventional expert practice has declined to go: to name psychological torture where naming it is professionally hazardous; to document biological injury caused without physical contact where courts have declined to recognize it; to connect institutional procedure to physiological harm where the connection is statistically established but clinically invisible to the uninitiated; and to place that documentation into the evidentiary record so that accountability — however deferred — remains possible. The Witness Obligation is not a suggestion. It is the ethical foundation of the IAJ enterprise.** Informed consent remains imperative, including clear disclosure of the nature of the evaluation and the potential for photographic documentation of physical injuries. In conflict

settings where findings may be intercepted by perpetrators, clinicians must prioritize digital security and the protection of the Human Rights Defender.

In conflict settings[179], clinicians should take steps to ensure digital security and only share the findings of their clinical assessments with the full and informed consent of the alleged victim.

The IAJ has established comprehensive ethical standards for all care providers in the documentation of torture and cruel, inhuman or degrading treatment.[180]

Section 1: The Universal Duty to Document

1.1 The Foundational Principle

Every care provider who encounters a person subjected to torture or CIDT has an affirmative duty to document that torture or CIDT. This duty is not discretionary. It does not depend on the care provider's credential level, licensure status, specialty, or comfort with legal proceedings. It arises from the fundamental ethical obligation of all helping professions to protect the welfare of those they serve and to bear witness to human rights violations.

The Istanbul Protocol establishes this principle unequivocally:

IP §665: "*State-employed clinicians encounter victims in many settings (prisons, hospitals, police custody).* ***In all settings, they have a duty to investigate and document torture** **according to Istanbul Protocol standards."*

IP §673: "*Independent clinicians are crucial for documenting torture. Their work is often essential for the State to meet its obligations."*

The IAJ extends this principle to its necessary conclusion: **the duty to document torture cannot be limited to elite specialists.** If it were, torture would go undocumented in every setting where elite specialists are unavailable—which is to say, in most settings where torture survivors are actually encountered.

1.2 Why Universal Documentation Is Necessary

The restriction of torture documentation to doctoral-level psychologists and psychiatrists creates the unacceptable potential accountability gap:

A. Access Disparity

- Torture survivors are disproportionately poor, marginalized, and without access to specialized forensic evaluators
- Indigent individuals cannot afford doctoral-level forensic specialists
- Rural areas, underserved communities, and institutional settings often lack any access to specialists

[179] Such as settings where the investigation findings may be intercepted by the alleged perpetrators of torture or ill-treatment

[180] This chapter incorporates and expands upon the ethical frameworks established in the Istanbul Protocol (2022), the guidance of the International Rehabilitation Council for Torture Victims (IRCT), the standards of Physicians for Human Rights (PHR), the World Medical Association Declaration of Tokyo, and the ethical codes of the American Psychological Association, National Association of Social Workers, American Counseling Association, and American Association for Marriage and Family Therapy.

- Waiting lists for specialized services may extend months or years—during which time torture continues undocumented

B. Ongoing Violations

- When torture is ongoing (as in systemic legal and institutional abuse), documentation cannot wait for specialist availability
- The only care provider present during ongoing torture may be a community social worker, an LMFT, a counselor, or a supervised trainee
- If these providers do not document, no one will

C. The Gatekeeping Problem

- Limiting documentation authority to elite specialists creates a gatekeeping function that protects perpetrators
- When torture can only be documented by a small number of credentialed specialists, torture documentation becomes rare
- Rarity of documentation does not reflect rarity of torture—it reflects barriers to documentation

The solution is not to demand that torture survivors obtain access to specialists, especially when such access may be difficult. The solution is to ensure that every care provider they do encounter fulfills the documentation duty.

1.3 The Care Provider's Irreplaceable Position

For many torture survivors—particularly indigent, disabled, and pro se litigants navigating institutional abuse—the community-level care provider is **the only professional witness to their suffering.** Consider:

- The mother whose children have been removed by CPS sees her community mental health therapist weekly. Her therapist is an LMFT under supervision. No PhD psychologist or psychiatrist will ever evaluate her. Her LMFT is the **only clinician** who will document what is happening to her.
- The disabled person facing judicial abuse in family court is seeing a master's-level counselor at a community clinic. The counselor is the **only clinician** observing the progressive psychological deterioration as the court proceedings continue.
- The incarcerated person experiencing CIDT in detention is seen by the facility's social worker. The social worker is the **only mental health professional** available. If they do not document, no one will.

The opportunity to document must not be forfeit because the only available care provider fears they are "not qualified enough." The torture survivor's access to documentation cannot depend on their access to elite credentials.

Evaluators must ethically address symptoms such as dissociation, depersonalization, and atypical behaviour, which can manifest during assessments and impede coherent narration (IP §506). These should be documented sensitively, recognizing them as trauma responses rather than inconsistencies, to avoid re-traumatization and ensure alignment with IP's trauma-informed principles.

1.4 The Ethical Conflict of Procedural Preconditions

When documentation organizations or specialized forensic bodies require active attorney representation as a precondition for conducting a torture investigation, they may inadvertently create a **structural barrier**. This requirement disproportionately affects the most vulnerable victims: **indigent individuals experiencing ongoing systemic torture through judicial and institutional processes** .

This creates a profound ethical conflict:

- The victim's need for independent medical documentation is urgent and life-critical.
- The inability to obtain an attorney is often a direct consequence of indigence or the very institutional entrapment being investigated .
- A representation requirement effectively denies access to independent documentation, allowing the biological assault to continue unchecked in the absence of verification .

1.5 Organizational Limitations vs. Fundamental Rights

External documentation bodies may require legal representation to ensure findings are used effectively in court or to protect victims through legal coordination. However, these operational preferences **cannot override the fundamental right to independent medical documentation** of torture under the Istanbul Protocol.

1.6 The Documentation Gap in Systemic Judicial Torture

Victims being harmed through judicial processes face a unique "Catch-22":

- They need documentation to prove the torture .
- They cannot obtain formal evaluation because they lack an attorney.
- They cannot obtain an attorney because the ongoing torture (e.g., the **Accommodation-Punishment Cycle**) has exhausted their resources or destroyed their legal standing .

1.7 Standards for the Individual Clinician

When an indigent victim of systemic judicial torture lacks legal representation, the individual clinician must adhere to the following:

- **Authority is Absolute**: Regardless of whether a formal evaluation body will engage, the clinician has the authority and obligation to document observations, diagnostic assessments, and consistency findings within their clinical scope.
- **Documentation is not Contingent**: The duty to document is not dependent on the presence of an attorney. The record serves as contemporaneous evidence for future litigation, international human rights mechanisms, and the medical record itself.
- **The "If Not Us, Who?" Principle**: When courts act as instruments of harm, the clinician is the only professional witness. Organizations or practitioners that decline to document based on prerequisites the victim cannot meet effectively allow the torture to remain invisible.

1.8 Dual Obligations Whistleblower Protocol

When encountering complicit medical staff, the clinician must utilize the **IAJ Anonymous Reporting Channel** to notify international monitoring bodies. This fulfillment of the **Universal Duty to Document** is protected by the **Ethical Shield** and is superior to any institutional confidentiality agreement designed to conceal human rights violations.

Section 2: Dispelling the Qualification Myth

2.1 The Expert Witness Fallacy

A pernicious myth prevents care providers from fulfilling their documentation duty: the belief that only those who can qualify as expert witnesses in court should create documentation of torture and CIDT.

This belief is false. It conflates several distinct functions:

Function	Who Performs It	Requirements
Clinical observation	Any care provider	Professional capacity to observe and document
Clinical documentation	Any care provider	Professional competence in record-keeping
Diagnosis	Licensed clinicians	Licensure within scope
Forensic opinion	Qualified experts	Training, experience, credentials for the specific opinion
Expert testimony	Court-determined	Whatever the specific court requires

A care provider documenting observations of a patient who reports torture is **not rendering a forensic opinion**—they are performing basic clinical documentation. A care provider diagnosing PTSD in a patient who has experienced torture is **not offering expert testimony**—they are investigating within their scope.

2.2 Documentation Is Not Expert Testimony

Creating clinical records documenting torture does not require the care provider to testify as an expert witness. The documentation serves multiple purposes that do not require expert qualification:

A. Medical Record Function

The documentation becomes part of the patient's medical record. Medical records are maintained for clinical purposes. They exist regardless of whether they are ever used in litigation.

B. Business Records Exception

Medical records are often admissible for certain purposes under business-record exceptions, but admissibility varies by jurisdiction and by the nature of the statements. Diagnostic or causation opinions may trigger expert-testimony requirements. Clinicians should document accurately within scope and assume records may later be scrutinized under applicable evidence rules.

C. Treating Provider Testimony

When a treating provider testifies, they typically testify as a **fact witness** regarding their observations and treatment—not as an expert witness offering opinions for which they were specifically retained.

The treating LMFT who documents that a patient reported torture, presented with specific symptoms, and received specific diagnoses is testifying to facts, not rendering expert opinions.

D. Corroborative Function

Even if documentation is never introduced directly, it corroborates the patient's account. The existence of contemporaneous records made before any litigation strengthens credibility.

E. Non-Litigation Uses

Documentation serves purposes that have nothing to do with U.S. courts:

- Submissions to international human rights bodies
- Reports to civil society organizations
- Advocacy and public education
- Historical record
- Pattern evidence across cases

2.3 The ADA Treating Provider Principle

The Americans with Disabilities Act recognizes that **treating providers possess authoritative knowledge about their patients' disabilities** that warrants deference comparable to that given to expert witnesses. This principle, established through ADA jurisprudence and EEOC guidance, holds that:

- A treating provider's assessment of a patient's functional limitations is entitled to significant weight
- Treating providers have ongoing clinical relationships that provide insight unavailable to one-time evaluators
- The treating provider's documentation of disability-related observations constitutes competent evidence

The IAJ extends this principle to torture and CIDT documentation. A care provider who has an ongoing treatment relationship with a torture survivor has:

- Longitudinal observation unavailable to one-time forensic evaluators
- Documented baseline for comparison
- Contemporaneous records created before any litigation
- Clinical understanding of the patient's symptom trajectory

This treating relationship confers documentary authority that does not depend on forensic specialty credentials.

2.4 Qualification Determination Is Not the Clinician's Decision

Whether a witness qualifies as an expert is determined by the court at the time of trial, not by the clinician at the time of documentation. The clinician's obligation is to document accurately within their competence. Questions of admissibility and qualification are resolved later, by legal decision-makers.

The fear of future disqualification cannot justify present failure to document.

If a court later determines that a particular clinician's testimony does not qualify as expert testimony, that determination:

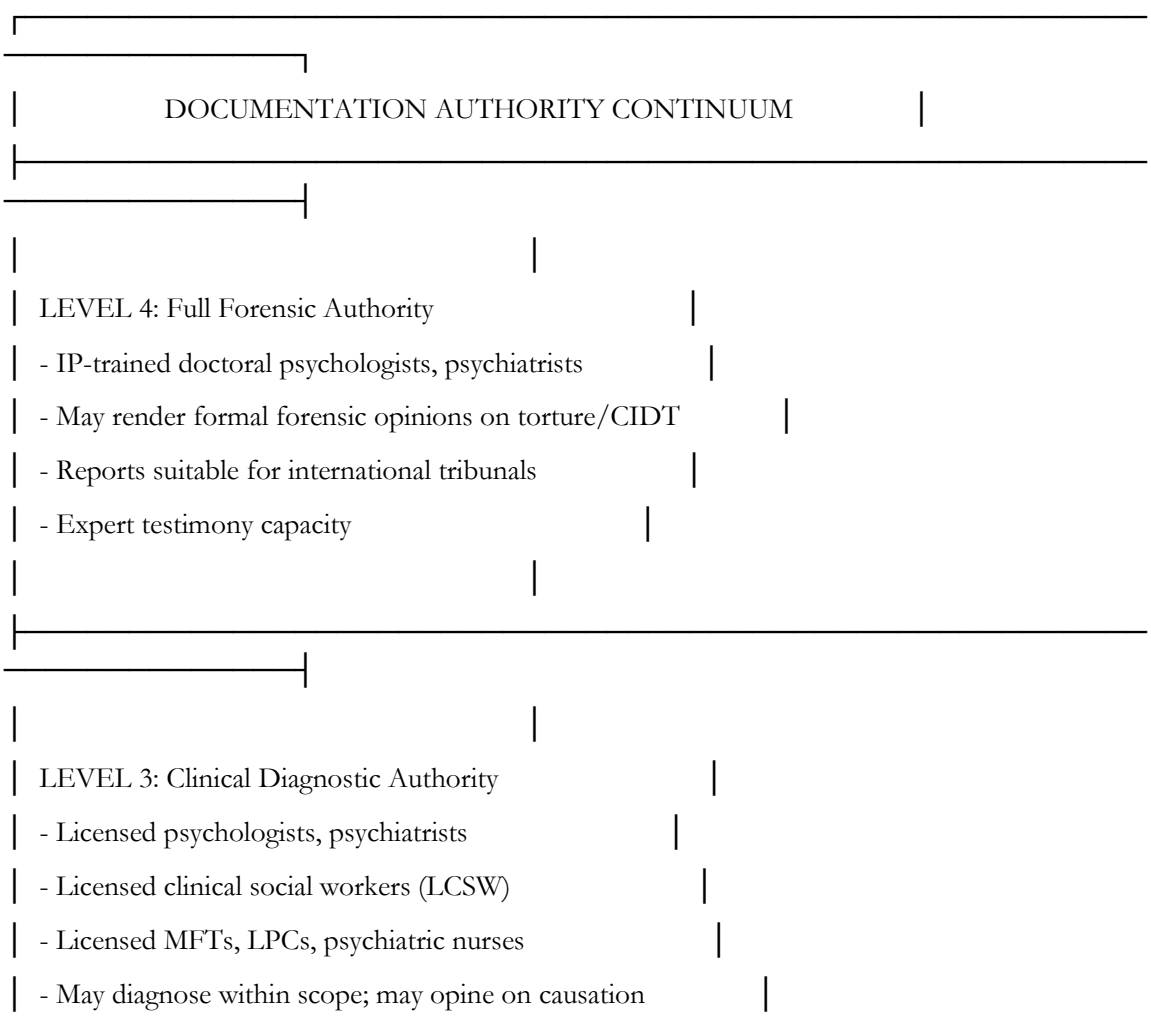
- Does not erase the documentation from the medical record
- Does not prevent the documentation from being used for other purposes
- Does not retroactively make the documentation improper
- Does not establish that the clinician should not have documented

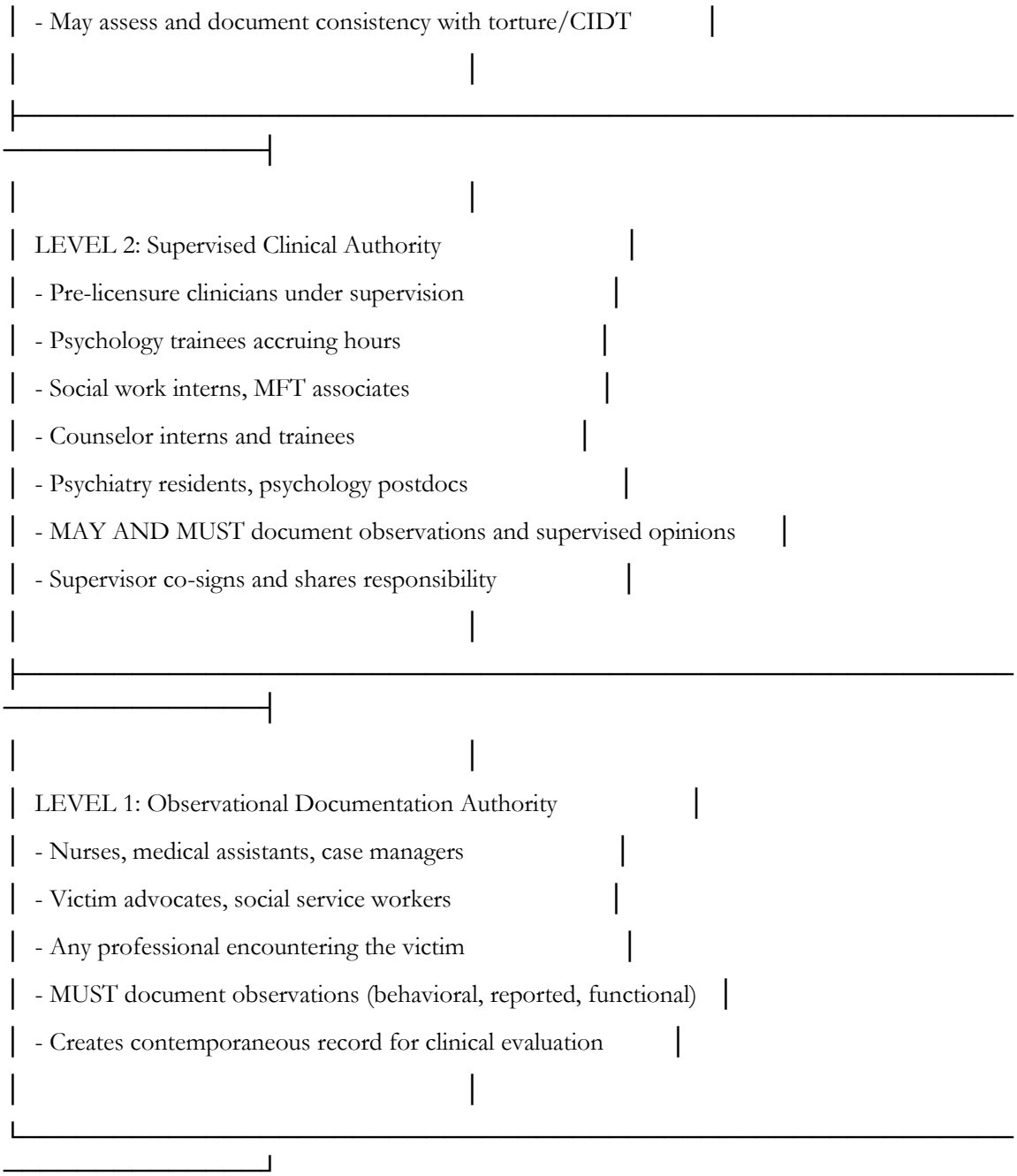
The clinician who documents and is later found not to qualify as an expert has fulfilled their ethical duty. The clinician who fails to document because of fear has violated their ethical duty.

Section 3: The Continuum of Documentation Authority

3.1 All Care Providers Have Documentation Authority

The IAJ establishes a continuum of documentation authority in which **all care providers participate**:





3.2 Level-Specific Obligations

Level 1: Observational Documentation

Every professional who encounters a torture survivor must document what they observe:

- Patient's reported experiences (documented as reports, not facts)
- Observed emotional state and behavioral presentation
- Visible signs of distress
- Functional impairments noted

- Changes from previous presentations

These observations do not require diagnosis. They create the contemporaneous record.

Level 2: Supervised Clinical Documentation

Pre-licensure clinicians working under supervision **must** document torture and CIDT when encountered. Supervision does not diminish the duty—it provides the oversight structure for fulfilling it.

- Supervisees document observations, assessments, and provisional opinions
- Supervisors review, guide, and co-sign documentation[181].
- The supervisory relationship ensures quality without eliminating documentation

Critical rule: A supervisor may not direct a supervisee to omit documentation of torture or CIDT. Such direction would constitute:

- An ethical violation by the supervisor
- Complicity in the ongoing violation
- Potential licensing board offense

Level 3: Clinical Diagnostic Documentation

Licensed clinicians must diagnose trauma-related disorders when present and document the relationship to alleged torture. This is ordinary clinical practice, not extraordinary forensic work.

- Diagnose PTSD, depression, anxiety, and related conditions
- Document symptom onset correlation with reported torture
- Assess and document consistency between presentation and alleged torture
- Refer to Level 4 when formal forensic evaluation is needed

Level 4: Forensic Documentation

Istanbul Protocol-trained specialists conduct formal forensic evaluations suitable for legal proceedings, international bodies, and comprehensive accountability documentation.

- Formal IP-compliant evaluations
- Expert reports and testimony
- Training and supervision of Level 1-3 providers

3.3 The Referral Network—Not Gatekeeping

Higher-level authority does not create gatekeeping—it creates a referral network. Lower-level providers document and refer upward when appropriate. The system works together:

Level 1 observes and documents → refers to Level 2/3 for diagnosis

[181] The Forensic Integrity Attestation in Appendix G is designed for supervisors to formally certify their review and approval of a supervisee's documentation of torture or cruel, inhuman, or degrading treatment (CIDT). This template fulfills the IAJ requirement that supervisors co-sign documentation and share professional responsibility for the findings.

Level 2 documents under supervision → refers to Level 3/4 for complex cases

Level 3 diagnoses and documents → refers to Level 4 for formal forensic evaluation

Level 4 provides forensic evaluation → supports and trains Level 1-3

At no level does a provider decline to document because higher-level resources are unavailable. If no Level 4 specialist is accessible, the Level 3 clinician documents. If no Level 3 clinician is accessible, the Level 2 trainee documents under supervision. If no Level 2 provider is accessible, the Level 1 professional documents observations.

The documentation must happen at whatever level is available.

3.4 IAJ Supervisory Oversight Protocol: Systemic Protection Framework

I. The Non-Negotiable Mandate

Supervision under the IAJ framework exists to improve reliability, protect the clinician, protect the examinee, and preserve documentation integrity. It is not a gatekeeping device and may not be used to suppress, delay, dilute, or strategically avoid documentation of torture or CIDT.

- Mandatory Review of High-Stakes Findings: Supervisors are ethically obligated to review any documentation in which a supervisee identifies potential Article 1 (Torture) or Article 16 (CIDT) violations, systemic patterns of prohibited conduct, severe distress-induced harm, or urgent safety risk.
- Prohibition of Suppression: A supervisor may not direct a supervisee to omit, minimize, recharacterize, or delete documentation of torture or CIDT from the record for institutional convenience, legal defensiveness, reputational protection, or fear of controversy.
- Complicity Warning: Directing a supervisee to ignore, conceal, or distort evidence of torture or CIDT constitutes professional misconduct and may constitute complicity in the ongoing violation.
- Quality Obligation: Supervisors must improve structure, clarity, evidentiary rigor, and ethical defensibility without erasing clinically supportable findings.

II. Supervision Protocols by Evaluator Level

The intensity of supervision should correspond to the evaluator's level, training, and the complexity of the case.

A. Level 1: Observational Documentation

Level 1 personnel do not require formal clinical supervision to record observations within their scope, but they do require referral guidance.

- They must document observed behavior, reported experiences, functional impairment, and visible distress.
- They should refer upward promptly when the record suggests possible torture, CIDT, acute decompensation, or complex causation questions.
- A Level 3 or 4 clinician should review Level 1 material when it becomes part of a clinical or forensic record.

B. Level 2: Supervised Clinical Documentation

Level 2 evaluators require formal supervision as the default, not merely informal consultation.

- Mandatory prospective supervision is required for:
- any case involving potential torture or CIDT;
- any provisional opinion on consistency, causation, credibility, or systemic intent;
- any case involving children, severe disability, psychosis, dissociation, suicide risk, severe retaliation risk, or legal coercion;
- any evaluation likely to be used in court, administrative hearings, international submissions, or advocacy proceedings.
- Level 2 clinicians may gather information, conduct interviews within competence, draft provisional formulations, and propose documentation language.
- The supervisor must review the basis for conclusions, guide corrections, and co-sign any final documentation containing evaluative conclusions.

C. Level 3: Clinical Diagnostic Documentation

Level 3 evaluators may practice independently within their scope, but supervision is still required in defined high-risk contexts, while consultation suffices in lower-risk complex cases.

- Formal supervisory review is required when:
- the Level 3 evaluator is newly applying the IAJ torture/CIDT framework;
- the case alleges systemic or policy-based torture;
- the record will likely be used in high-stakes adversarial proceedings;
- the evaluator is considering a strong causation opinion with limited objective support;
- the evaluator's neutrality may be affected by overload, countertransference, safety concerns, or overlapping roles.
- Consultation (without formal supervision) may suffice when:
- the evaluator is experienced and licensed;
- the case is within competence;
- the issue is discrete (e.g., instrument selection, wording, cultural formulation, causation phrasing);
- no co-signature is required by law or institution;
- the evaluator remains the final responsible author.

D. Level 4: Forensic Documentation

Level 4 evaluators generally function independently, but should use peer consultation or peer review in especially complex, novel, or institutionally sensitive cases.

- Peer consultation is strongly recommended where:
- the case involves novel theory, unusual populations, or major policy implications;

- the evaluator is making a particularly strong torture finding in a contested forum;
- there is significant safety risk or likely retaliation;
- the evaluator is functioning under high cumulative trauma load or moral injury.

III. When Formal Supervision Is Required Versus When Consultation Suffices

The distinction between supervision and consultation must be explicit.

Formal supervision is required when:

- the evaluator is a trainee or pre-licensure clinician;
- the case falls outside the evaluator's established competence;
- the evaluator is issuing provisional or final opinions on torture/CIDT consistency, distress-induced harm causation, systemic intent, or credibility in a high-stakes matter;
- the case presents acute safety risk, severe decompensation, or child-protection implications;
- the record will be used in litigation, detention review, licensure defense, international submission, or other adversarial proceedings;
- institutional pressure, fear of retaliation, or supervisor conflict is already present;
- the evaluator's fatigue, vicarious trauma, or over-identification may materially impair judgment.

Consultation is generally sufficient when:

- the evaluator is licensed and experienced in the relevant domain;
- the issue is narrow and technical rather than global;
- the evaluator remains within competence and retains adequate neutrality;
- no co-signature or delegated supervisory authority is required;
- the consultation is used to refine, not replace, the evaluator's independent judgment.

Rule: When in doubt, default upward to formal supervision.

IV. Minimum Supervision Process

For cases requiring supervision, the following minimum process applies:

- Initial Framing Review

Early case discussion to determine scope, risk, evaluator level, urgent safety issues, and whether formal supervision or consultation applies.

- Mid-Process Review

Review after significant fact-gathering, focusing on chronology, consistency, causation, alternative explanations, and any signs of evaluator strain or drift.

- Pre-Final Review

Review of the draft before signature or submission, focusing on evidentiary sufficiency, language calibration, and legal/ethical defensibility.

- Post-Case Debrief

Debrief after submission when the case involved severe distress, systemic violations, retaliation risk, or major disagreement.

A short case may require only one integrated review. A complex or high-risk case may require repeated supervisory contacts.

V. Escalation Procedures for Disagreements Between Evaluator and Supervisor

Disagreement is expected in difficult cases and must be managed through structured escalation rather than authority alone.

A. Supervisory Falsification Pass

To neutralize confirmation bias, the IAJ Supervisor (Level 4) shall conduct a "Falsification Pass" on all high-stakes findings. This requires the reviewer to actively seek evidence in the record that **contradicts** the consistency finding and to ensure that the final report reflects a neutral, evidence-driven synthesis rather than a circular narrative.

B. First-Level Resolution: Clarify the Disagreement

The evaluator and supervisor should identify whether the disagreement concerns:

- facts,
- interpretation of symptoms,
- causation,
- credibility,
- scope of competence,
- legal phrasing,
- level of certainty,
- or institutional risk tolerance.

C. Second-Level Resolution: Evidence-Based Re-Review

The parties should jointly re-review:

- notes,
- collateral records,
- timelines,
- test data,
- applicable sections of this Standard,
- and relevant Istanbul Protocol provisions.

The goal is to determine whether the disagreement results from missing data, ambiguous facts, different weighting of evidence, or improper overstatement / over-caution.

D. Third-Level Resolution: Peer or Senior Escalation

If disagreement persists, the matter should be elevated to:

- an IAJ Level 4 reviewer,
- a designated peer-review panel,
- or another independent senior clinician with relevant expertise.

This reviewer should assess whether:

- the finding is adequately supported;
- the wording should be strengthened, qualified, or narrowed;
- the case should remain with the evaluator, move to co-evaluation, or be transferred.

E. Fourth-Level Resolution: Protected Documentation of Unresolved Difference

If disagreement remains unresolved after escalation:

- the final record should not be falsified to force unanimity;
- the supervisor may require changes only to remove unsupported overstatement or methodological defects;
- the evaluator may document that certain conclusions were limited, deferred, or referred for higher review;
- if an institution attempts suppression rather than legitimate quality control, the clinician should use the IAJ incident/escalation mechanisms.

Critical rule: Supervisory authority permits quality correction, not compelled misrepresentation.

VI. Documentation Requirements for Supervision Sessions

Every substantive supervision session involving torture/CIDT documentation should be documented in a brief supervision note or secure supervisory log.

At minimum, the supervision record should include:

- Date and time of the supervision contact
- Names and roles of participants
- Case identifier (not unnecessary sensitive narrative in insecure systems)
- Stage of review (initial, mid-process, pre-final, post-case, emergency)
- Issues reviewed, such as:
- consistency analysis,
- causation,
- credibility,
- systemic intent,
- safety,
- evaluator impairment,

- legal pressure,
- scope/competence
- Materials reviewed (notes, records, draft, instruments, collateral)
- Key supervisory guidance provided
- Points of agreement and disagreement
- Disposition, such as:
- proceed,
- revise,
- qualify,
- obtain more data,
- seek consultation,
- escalate,
- transfer
- Signature / attestation status:
- consultation only,
- reviewed but not co-signed,
- formally supervised and co-signed
- Follow-up actions and deadlines

Where security is a concern, the detailed rationale may be stored in a confidential supervisory file rather than the ordinary chart, but the fact of supervision and its procedural effect should still be documented.

VII. Triple-Lock Documentation Security

To protect junior clinicians and preserve the record, the following three-step process should be used where institutional hostility or retaliation risk is present:

- Shared Professional Responsibility

Where appropriate, findings may be reviewed and released as supervised or team-reviewed work rather than leaving a junior evaluator isolated.

- Standards Anchoring

Documentation should cite the governing IAJ Standard and relevant Istanbul Protocol framework where doing so clarifies that the documentation follows established forensic and ethical obligations.

- Protected Secondary Review

For Level 2 and high-risk Level 3 cases, document supervisory or senior review in a way that shows the findings were not unilateral, unsupported, or impulsive.

VIII. Responding to Institutional or Legal Pressure

If a supervisor, agency administrator, employer, or legal actor attempts to suppress or distort documentation:

- Direct order to omit: The evaluator should preserve a confidential record of the instruction and escalate through IAJ reporting channels.
- Threats to licensure or employment: The evaluator should seek supervisory and IAJ escalation, preserve contemporaneous notes, and separate legitimate methodological critique from retaliatory pressure.
- Hostile subpoena or legal demand: Supervisory review should occur before disclosure decisions; use the IAJ legal objection and record-protection tools where applicable.
- Pressure to overstate as well as understate: Supervisors must also prevent exaggeration, not just suppression.

IX. Post-Investigation Debriefing (Mandatory) — See Appendix T (IAJ Clinician's Self-Care Protocol for Vicarious Trauma) for the mandatory self-monitoring protocol. This section is consolidated at §3.4.IX below. and Quality Protection

Supervision does not end at signature.

- Vicarious Trauma / Fatigue Review: Supervisors should assess whether exposure to the case impaired, or may continue to impair, the evaluator's functioning.
- Safety Planning: If the case creates retaliation risk, the supervisor and IAJ should implement a safety and documentation-protection plan.
- Learning Review: Significant cases should be reviewed for training lessons, protocol refinement, and future quality improvement.
- Referral / Transfer Review: If the evaluator's functioning was materially compromised, the supervisor should determine whether follow-up work should be reassigned.

V. Post-Investigation Debriefing

- **Vicarious Trauma Screening**: Supervisors must proactively screen Level 2 and 3 clinicians for compassion fatigue and vicarious trauma after evaluating systemic violations .
- **Safety Planning**: If an investigation identifies policy-based torture by powerful local actors, the supervisor and IAJ must develop a safety plan to protect the clinician from professional or personal retaliation.

Section 4: The Ongoing Investigation Imperative

4.1 Ongoing Torture Requires Ongoing Documentation

The IAJ recognizes that the majority of cases reported involve **ongoing** torture and CIDT—violations that have not ceased, perpetrated through systemic legal and institutional processes that continue to inflict harm.

When torture is ongoing:

- The documentation cannot be retrospective—it must be contemporaneous
- The evaluation cannot wait for safety—it must occur during danger

- The care provider cannot postpone—they must document now

This reality transforms the care provider's role. They are not examining a survivor who has escaped torture. They are treating a person who is being tortured. Their documentation is not historical—it is current witness testimony.

4.2 The Summons Question

Many care providers fear that documentation will result in being summoned to legal proceedings—subpoenaed, deposed, forced to testify. This fear is legitimate but must not control.

A. The Fear Is Understandable

Care providers have reason to fear legal involvement:

- Courts can be hostile environments
- Cross-examination can be intimidating
- Legal proceedings consume time and create stress
- The legal system often fails to respect clinical boundaries

B. The Fear Does Not Excuse the Duty

However legitimate the fear, it does not excuse failure to document:

- The patient's need for documentation supersedes the provider's comfort
- The ethical duty to document is not contingent on convenience
- Fear of being summoned to testify does not eliminate professional obligations
- The tortured person's rights outweigh the provider's preference to avoid involvement

C. Summoning Is Not Inevitable

Documentation does not inevitably lead to testimony:

- Many cases never proceed to litigation
- Records may be used without live testimony
- Business records exceptions may apply
- Settlement may occur before trial
- The documentation may serve purposes other than U.S. litigation

D. If Summoned, the Provider Is Protected

The Istanbul Protocol establishes that care providers who document torture are human rights defenders entitled to protection:

IP §679: States must protect those who expose torture from reprisals.[182]

IP §663: States should ensure respect for relevant **legal and medical ethical duties** described in chapter II.

[182] IP §679 requires States to ensure protection policies for whistle-blowers, medico-legal and health personnel who report findings of alleged torture or ill-treatment, and to protect witnesses and other reporters from reprisals.

When courts or attorneys abuse care providers who have documented torture, they violate international human rights standards. The abuse itself becomes evidence of systemic failure.

4.3 The Investigation Continues Regardless

The care provider's documentation duty is not contingent on how the documentation might later be used. The investigation continues:

- Whether or not litigation is pending
- Whether or not the provider might be summoned
- Whether or not the provider feels qualified
- Whether or not the legal system will respect the documentation

The documentation exists because the torture exists. Its subsequent use is a separate question.

Section 5: Protection from Legal System Abuse

5.1 The Norm of Judicial and Legal Abuse

The IAJ acknowledges the uncomfortable truth that in the United States, the legal system routinely abuses care providers who document torture. This abuse takes many forms:

A. Weaponized Subpoenas

- Subpoenas issued to harass documenters
- Demands for records intended to expose the documenter to retaliation
- Repeated subpoenas designed to impose cost and inconvenience

B. Hostile Cross-Examination

- Examination designed to humiliate rather than elicit truth
- Attacks on credentials intended to discourage future documentation
- Implication that documentation was improper

C. Sanctions and Contempt

- Sanctions for "interfering" with proceedings
- Contempt citations for protecting confidentiality
- Professional complaints filed as retaliation

D. Evidentiary Exclusion

- Excluding torture documentation from evidence
- Treating international standards as irrelevant
- Refusing to consider human rights violations

5.2 The Istanbul Protocol Prohibition

The Istanbul Protocol explicitly prohibits this judicial abuse:

IP §195: requires protection of alleged victims, witnesses, and **those conducting the investigation** from intimidation, violence, and reprisals.

IP §666: Forensic and clinical services must be structurally independent from police, prosecutors, [and judicial authorities].[183]

IP §679: Protection for those who expose torture.

When judges, attorneys, or courts retaliate against care providers who document torture:

- They violate international standards binding on the United States
- They commit acts that may themselves constitute CIDT
- They demonstrate the systemic failure that independent documentation seeks to expose
- They confirm the necessity of civil society documentation mechanisms

5.3 Mandatory Reporting of Interference:

Any clinician who experiences weaponized subpoenas, hostile cross-examination, or threats of professional sanctions intended to suppress torture documentation must immediately complete the **IAJ Clinician's Incident Report Form (CIRF)** – Appendix H. This form serves as an 'anti-erasure' mechanism to document the act of silencing as part of the systemic investigation.

A training module for the strategic use of the CIRF is provided in Appendix I.

Clinicians must also report methodological interferences, such as institutional pressure to use unadapted Western tests (e.g., MMPI) that conflict with IP best practices, potentially leading to biased or unethical evaluations. Such conflicts include cultural invalidity (ethnocentric misinterpretation, per IP §270; §§294–295; §§491–493; §497; §§576–580; Annex IV on clinical evaluation guidelines for contextual assessment), re-traumatization risks (power dynamics, per IP §295; §§146–159; §§284–293; §§299–302; §§310–311; §272; §§277–280; §400; §§525–526; §554; §§578–579; Annex II on rapport), and over-pathologization (stigmatization, per IP §148; §§491–506; §270; §§278–279; §294; §398; §414; §496; §498; §§584–585; Annex IV on clinical evaluation guidelines for symptom correlation).

Beyond the CIRF, clinicians should document interference for potential transmission to appropriate international mechanisms, such as the Committee Against Torture through available reporting or review channels, the Special Rapporteur on Torture, relevant treaty-monitoring processes, and qualified NGOs that can assist with escalation and preservation. The report should not imply the availability of a formal UNCAT Article 22 individual-communications pathway unless that pathway is in fact available for the State concerned[184]. For enhanced accountability, collaborate with NGOs like IAJ, PHR or IRCT for peer review of the incident documentation, which may include joint submissions or public reports to expose systemic obstruction.

5.4 The Provider's Response to Abuse

When care providers face legal system abuse for documenting torture:

[183] IP §666 recognizes lack of independence of State-employed health professionals as a major implementation problem and requires States to ensure conditions in which forensic evaluations can be conducted independently, scientifically, and ethically. IAJ concludes that independence of investigation from police, prosecutors, and judicial authorities in the United States is indispensable.

[184] At this time the USA has not ratified Article 22

A. Continue Documenting

The abuse proves the need. The intimidation demonstrates the system's hostility to accountability. Continue creating accurate records.

B. Document the Abuse

The judicial or legal abuse should itself be documented as:

- Evidence of obstruction of torture prevention
- Potential CIDT inflicted on the documenter
- Pattern evidence of systemic failure

C. Invoke Protections

Assert applicable protections:

- Professional ethical obligations requiring documentation
- Therapeutic and psychotherapist-patient privilege
- First Amendment protections for human rights documentation
- International law protections for human rights defenders

D. Seek Support

- Connect with human rights organizations
- Consult attorneys experienced in defending human rights defenders
- Report judicial abuse to appropriate oversight bodies
- Notify licensing boards of inappropriate judicial interference with clinical practice

E. Report Internationally

When domestic systems fail, report to:

- UN Committee Against Torture
- UN Human Rights Council
- Relevant Special Rapporteurs
- Regional human rights bodies

5.5 The Inversion Problem: Perpetrators as Mandated Preventers

The IAJ recognizes the profound structural problem in the United States: **those mandated by UNCAT to prevent and punish torture are structurally enabled to be its primary perpetrators.**

Mandated Role	UNCAT Obligation	Actual U.S. Conduct
Prosecutors	Prosecute torturers	Ignore torture; prosecute victims
Judges	Provide remedy; ensure due process	Inflict CIDT through proceedings
Defense attorneys	Defend rights	Enable violations through ineffectiveness

Police	Protect persons	Inflict CIDT during enforcement
Child welfare	Protect children	Inflict CIDT through separation
Mental health professionals	Document and treat	Remain silent from fear

This inversion means:

- Victims cannot seek remedy from those who are harming them
- Every complaint pathway leads back to perpetrators
- Independent documentation becomes the only accountability mechanism
- Care providers must document despite—and because of—the system's hostility

Guidance on how an evaluator should handle a **hostile subpoena** or **retaliatory professional complaint** is provided in Appendix F.

5.6 Collaboration with NGOs for Peer Review and Accountability

To counter systemic inversion and strengthen documentation integrity, clinicians must collaborate with NGOs for peer review:

- Submit documentation to NGOs (e.g., IAJ, PHR, IRCT, Amnesty International) for independent verification and aggregation into pattern reports.
- Participate in NGO-led peer review processes to validate findings against Istanbul Protocol standards.
- Use NGO channels for joint reporting to UN bodies, enhancing credibility and protection under human rights defender frameworks (IP §679).
- This collaboration creates parallel accountability structures when domestic systems fail, as encouraged by IP §673.

Guidance on NGO collaboration is integrated into the CIRF training (Appendix I).

Section 6: Professional Ethical Frameworks

6.1 Universal Professional Ethics Require Documentation

Every professional ethical framework requires accurate documentation. None contains exceptions for cases involving legal proceedings or judicial sensitivity.

American Psychological Association Ethical Principles (2017):

§ 6.01 Documentation: "Psychologists create, and to the extent the records are under their control, maintain... records and data relating to their professional work..."

§ 3.04 Avoiding Harm: "Psychologists take reasonable steps to avoid harming their clients/patients..."

Failure to document torture harms the patient by depriving them of evidence.

NASW Code of Ethics:

§ 3.04 Client Records: "Social workers should... document... services appropriately."

§ 6.01 Social Welfare: "Social workers should promote the general welfare of society... and advocate for... human rights."

Documentation of torture fulfills both the record-keeping obligation and the human rights advocacy mandate.

American Counseling Association Code of Ethics:

§ A.1.a Primary Responsibility: "The primary responsibility of counselors is to respect the dignity and promote the welfare of clients."

Documenting torture respects dignity by validating experience and promotes welfare by creating evidence for remedy.

American Association for Marriage and Family Therapy Code of Ethics:

§ 3.6 Accurate Documentation: "Marriage and family therapists maintain accurate... records..."

Accurate records include documentation of reported torture and its observed effects.

6.2 Ethical Obligations During Ongoing Harm

Professional ethics require special consideration when harm is ongoing:

A. Duty to Warn and Protect

When a patient is in danger, care providers have enhanced obligations. A patient experiencing ongoing torture is in danger. The documentation duty is heightened, not diminished.

B. Abandonment Prohibition

Care providers may not abandon patients. Refusing to document torture because of fear of legal involvement effectively abandons the patient to undocumented suffering.

C. Competence Within Scope

Care providers must practice within their competence. **Documenting observations of reported torture is within every care provider's competence.** It does not require specialized forensic training—it requires basic clinical documentation skills.

D. Informed Consent

Patients must be informed of documentation practices. Patients should know that their care provider will document reports of torture and its effects. This documentation serves the patient's interests.

6.3 The Supervision Context

Supervision in torture and CIDT documentation is not merely an educational formality; it is an ethical safeguard. The supervising clinician must ensure that supervision is proportionate to evaluator experience, that formal supervision is used where required rather than replaced by casual consultation, that disagreements are resolved through evidence-based escalation rather than authority alone, and that each substantive supervision contact is documented in a secure and reviewable manner.

For supervised practitioners, ethical obligations are shared but not eliminated:

A. Supervisee Obligations

- Document accurately what is observed and reported
- Bring concerns to supervisor's attention
- Do not withhold documentation because of uncertainty
- Seek guidance when unsure how to document

B. Supervisor Obligations

- Review supervisee documentation of torture/CIDT
- Provide guidance on appropriate documentation
- Co-sign documentation and share responsibility
- **Never direct a supervisee to omit documentation of torture**
- Ensure supervisee is not intimidated out of documentation duty

C. Shared Accountability

When a supervisee documents torture under supervision:

- The supervisee has fulfilled their immediate duty
- The supervisor has fulfilled their oversight duty
- The documentation exists in the record
- The patient's interests are served

6.4 The Conscience Obligation

Beyond professional codes, there exists a conscience obligation:

Every human being who witnesses torture has a moral duty to bear witness.

The care provider who encounters a torture survivor is not merely a technician applying a protocol. They are a human being confronting atrocity. Their professional role does not diminish their human responsibility—it enhances it by giving them the tools and standing to document effectively.

Silence in the face of torture is complicity.

Section 7: Specific Obligations by Provider Type

7.1 Psychologists (Licensed and Pre-Licensure)

Licensed Psychologists:

- Full authority to diagnose, assess, and document
- May offer opinions on consistency with torture/CIDT
- May conduct formal forensic evaluations if IP-trained
- Obligated to document when torture is disclosed or suspected
- Should refer to IP-trained specialists for formal forensic evaluations when available

Pre-Licensure Psychologists (Postdocs, Trainees):

- Full authority to document observations under supervision
- May offer diagnostic impressions with supervisor review
- Obligated to document—supervision does not eliminate duty
- Supervisor must co-sign and review but not suppress documentation
- The supervised hours context is not an excuse for non-documentation

7.2 Social Workers (Licensed and Pre-Licensure)

Licensed Clinical Social Workers (LCSW):

- Authority to diagnose within scope (varies by state)
- Full authority to document observations, assessments, and clinical impressions
- Particularly well-positioned for systemic torture documentation (systems expertise)
- Obligated to document and may offer causation opinions within competence

Pre-Licensure Social Workers (MSW, BSW):

- Authority to document observations under supervision
- Case management documentation captures critical evidence
- Collateral contacts and system navigation create documentary record
- Supervision requirement does not eliminate documentation duty

7.3 Marriage and Family Therapists (Licensed and Pre-Licensure)

Licensed MFTs:

- Authority to diagnose within scope (varies by state)
- Unique position to document family-systems torture (parent-child separation)
- Relational assessment documents interpersonal effects of torture
- Full documentation authority within scope

Pre-Licensure MFTs (Associates, Trainees):

- Documentation under supervision
- Often the only clinician accessible to families in crisis
- **Cannot forfeit documentation opportunity due to licensure status**
- The family being tortured through CPS proceedings needs their LMFT associate to document

7.4 Professional Counselors (Licensed and Pre-Licensure)

Licensed Professional Counselors (LPC):

- Authority to diagnose within scope
- Documentation authority for observed and reported torture
- Community mental health settings encounter torture survivors regularly

Pre-Licensure Counselors:

- Documentation under supervision
- Community clinic context means access to underserved populations
- The indigent torture survivor in community mental health is entitled to documentation

7.5 Psychiatric and Nursing Professionals

Psychiatrists:

- Full medical and psychological diagnostic authority
- May document physical and psychological manifestations
- Medication management documentation captures symptom trajectory
- Expert testimony capacity

Psychiatric Nurses and Nurse Practitioners:

- Observation and documentation authority
- Medical documentation of psychological manifestations
- Institutional settings (jails, hospitals) require nursing documentation

7.6 Non-Clinical Professionals

Case Managers, Victim Advocates, Social Service Workers:

- Observational documentation authority
- Cannot diagnose but must document observations
- Collateral documentation (housing, benefits, systems navigation) captures impact
- Creates contemporaneous record supporting clinical documentation

Section 8: Documentation as Treatment

8.1 The Therapeutic Value of Documentation

Documentation as Forensic Witness Forensic documentation is fundamentally distinct from the "practice of psychotherapy" or the intentional vocational rendering of clinical care. While the evaluator provides no treatment and enters into no patient-provider relationship, the process of documenting the truth produces an inherent therapeutic byproduct for the survivor.

When a care provider fulfills the universal duty to document torture, the following forensic functions provide unintended therapeutic benefits:

- **Evidentiary Validation**: The process establishes a formal record that the survivor's experience is real and legally significant, which counters the effects of institutional gaslighting and erasure.
- **Narrative Integrity**: Because trauma often fragments memory, the forensic interview helps organize facts into a coherent chronological narrative for use in human rights proceedings.

- **Witness Accountability**: Providing a professional witness to the biological assault empowers the individual by creating the evidentiary foundation required for future justice and potential Article 14 redress.
- **Psychological Safe Harbor**: Fulfilling the duty to document—especially when domestic forums act as a ***forum nullus***—affirms the individual's dignity as a human being under the Law of Nations, regardless of local procedural hostility.

From a victim's perceptual perspective, when a care provider documents torture:

A. Validation

The patient's experience is validated. Someone believes them. Someone sees what is happening. The documentation says: **This is real. You are not imagining it. I am your witness.**

B. Empowerment

Documentation gives the patient power. A record exists. The truth is preserved. The patient has evidence. Even if justice is not immediately available, the foundation for future justice is created.

C. Narrative Construction

Trauma fragments experience. Documentation helps organize the chaos into coherent narrative. The patient can see their story written down, organized, recognized.

D. Resistance

Documentation is resistance against:

- The torture itself
- The silencing that accompanies torture
- The gaslighting that denies torture
- The system that inflicts torture

E. Hope

Documentation creates hope. It demonstrates that someone cares, that accountability may come, that the truth may prevail.

8.2 Documentation When Healing Is Blocked

When torture is ongoing, traditional therapeutic progress may be impossible. The patient cannot heal while being harmed. In this context:

Documentation becomes the treatment.

The care provider may not be able to help the patient recover—the torture is ongoing. But the care provider can document:

- What is happening
- What it is doing to the patient
- The trajectory of harm
- The correlation between specific acts and specific consequences

This documentation:

- Preserves the truth until justice can be achieved
- Maintains the therapeutic relationship during impossible conditions
- Creates the evidentiary foundation for future remedy
- Resists the torture through witness

8.3 Therapeutic Alliance and Documentation

Documentation should be integrated into the therapeutic relationship:

- Inform the patient that torture/CIDT will be documented
- Collaborate on documentation—review together, ensure accuracy
- Explain how documentation may be used
- Obtain appropriate consents for disclosure
- Use documentation as therapeutic tool (narrative construction, validation)

Section 9: The Imperative of Non-Withholding

9.1 The Prohibition on Withholding

No care provider may withhold documentation of torture or CIDT.

This duty is categorical but must be understood within the limits of the law. It does not admit exceptions for:

- Fear of legal involvement
- Credential insecurity
- Uncertainty about qualification
- Preference to avoid controversy
- Institutional pressure
- Supervisor direction (if supervisor directs non-documentation, supervisee should document anyway and report the direction)
- Court orders: Where a court order compels disclosure, clinicians should assert applicable privilege through counsel, comply if legally required after privilege determination, and preserve the clinical record. This duty does not override lawful court processes, but it does prohibit falsification, erasure, or suppression of clinically supportable documentation

9.2 Withholding as Ethical Violation

Withholding documentation constitutes:

A. Abandonment

Failing to document abandons the patient to undocumented suffering. The patient is left without evidence. The care provider has withdrawn essential support.

B. Harm

Failure to document harms the patient by:

- Depriving them of evidence
- Delegitimizing their experience
- Enabling continued torture
- Foreclosing remedy

C. Complicity

The care provider who sees torture and does not document becomes complicit:

- Silence enables continuation
- Non-documentation protects perpetrators
- The undocumented torture is as if it did not happen
- The care provider has sided with the system

D. Professional Misconduct

Failure to document may constitute:

- Violation of documentation standards
- Failure to meet standard of care
- Licensing board offense
- Malpractice

9.3 The Istanbul Protocol on Complicity

The Istanbul Protocol directly addresses the complicity of non-documentation:

IP §665: "'I was just doing my job' is not a defense for failing to document torture."

This principle applies to every care provider. The excuses—**I'm not qualified, I might be summoned, it's not my specialty, my supervisor didn't direct me to**—are all variations of "just doing my job." None excuses the failure.

9.4 Documentation Despite Opposition

Care providers must document even when faced with:

A. Institutional Opposition

If an employer directs non-documentation of torture, the care provider must:

- Document anyway (patient welfare supersedes employer preference)
- Note institutional opposition in records (if appropriate)
- Consider reporting institutional obstruction
- Protect documentation from institutional interference

B. Supervisory Opposition

If a supervisor directs non-documentation:

- The supervisee should document anyway
- The supervisory direction should itself be documented
- The supervisee should seek guidance from licensing board or ethics committee
- The supervisor's direction may constitute ethical violation

C. Reporting Supervisory Suppression

If a supervisor directs a supervisee to omit or 'soften' documentation of torture or CIDT, the supervisee is ethically obligated to document the incident using the **IAJ Clinician's Incident Report Form (CIRF)** – Appendix H. This report should be transmitted via the **IAJ Digital Security Protocol** to the IAJ and, if necessary, to international human rights bodies.

D. Legal Opposition

If courts or attorneys attempt to suppress documentation:

- Assert clinical record protections
- Invoke privilege where applicable
- Document the suppression attempt
- Continue clinical documentation regardless
- Seek legal support for maintaining documentation rights

Section 10: Implementation Standards

10.1 Immediate Documentation Protocol

When a care provider encounters evidence of torture or CIDT:

Step 1: Document Immediately

Create contemporaneous documentation. Do not wait. Include:

- Date and time of disclosure/observation
- Patient's statements (quote directly where possible)
- Observable presentation (emotional, behavioral, physical)
- Clinical impressions
- Assessment of correlation with reported torture

Step 2: Assess and Diagnose (Within Scope)

Apply clinical judgment:

- Does presentation suggest trauma-related diagnosis?
- Is symptom pattern consistent with reported torture?

- What is the severity and functional impact?
- Document diagnostic impressions (or provisional impressions if supervised)

Step 3: Continue Monitoring

Establish ongoing documentation protocol:

- Track symptom trajectory
- Correlate changes with reported events
- Document ongoing violations as they are reported
- Maintain contemporaneous record

Step 4: Refer When Appropriate

Refer to higher-level resources when:

- Formal forensic evaluation is needed
- Expert testimony is anticipated
- Case complexity exceeds scope
- Specialist resources become available

Referral does not replace documentation. Continue documenting while referral is pending and afterward.

10.2 Supervision Protocol

For supervised practitioners:

All programs implementing this Standard must maintain a defined supervision structure that matches evaluator level, case complexity, and risk.

- Level Assignment

Each evaluator should be designated as Level 1, 2, 3, or 4 under Section 3.2, and work should be assigned accordingly.

- Required Supervision Thresholds

Programs must identify which matters require:

- formal supervision,
- consultation,
- peer review,
- or transfer.
- Supervisor Availability

Level 2 clinicians must have access to a named supervisor for live or reasonably prompt review in any torture/CIDT-related matter.

- Supervisee:

- Document observations and impressions immediately
- Bring torture/CIDT cases to supervisor attention
- Request guidance on documentation approach
- Do not withhold documentation pending supervisor review
- If supervisor directs non-documentation, document anyway and seek outside guidance
- Supervisor:
- Review supervisee torture/CIDT documentation promptly
- Provide guidance on appropriate documentation language
- Co-sign documentation and share responsibility
- Never direct supervisee to omit or minimize torture documentation
- Ensure supervisee understands documentation is mandatory, not discretionary
- Escalation Pathway

Programs must define a clear escalation route when:

- supervisor and evaluator disagree,
- the supervisor may be conflicted,
- institutional pressure is present,
- or a higher-level reviewer is needed.
- Documentation of Supervision

A supervision log or note must record each substantive review, including the issue reviewed, guidance given, and final disposition.

- Protection Against Misuse

Supervision may not be used to suppress documentation, delay urgent protective action, or force unsupported changes for political, institutional, or reputational reasons.

- Quality Review

Programs should periodically audit supervision records for timeliness, adequacy, consistency, and ethical compliance.

Conflict Resolution:

In instances where a supervisor refuses to co-sign or review torture-related documentation, or actively inhibits the documentation process, the supervisee must invoke the **IAJ Clinician's Incident Report Form (CIRF)** (Appendix H) to protect their clinical integrity and fulfill their witness obligation

10.3 Record Security

Documentation of torture requires secure records:

- Maintain confidentiality appropriate to clinical relationship

- Protect records from unauthorized access
- Consider enhanced security for sensitive cases
- Be aware that records may be sought through legal process
- Document consistent with understanding that records may eventually be disclosed

Section 11: Case Vignette -- The Attorney Representation Barrier

The case vignette in Appendix L illustrates a real ethical dilemma faced by psychological investigators documenting torture in the United States. The scenario presents the intersection of indigence, systemic institutional abuse, and barriers to independent medical documentation—a scenario that repeats across countless cases involving victims navigating the American civil rights system without resources.

The ethical lesson is clear: **When institutional mechanisms fail, the responsibility falls to individual professionals who encounter the victim. The duty to document does not disappear because others decline to fulfill it.**

Section 12: Conclusion: The Witness Obligation

11.1 Every Care Provider Is a Witness

Every care provider who encounters a torture survivor becomes a witness. This is not a role that can be declined. It arises from the encounter itself.

The witness has obligations:

- To see accurately
- To remember faithfully
- To document thoroughly
- To testify truthfully (if called upon)
- To preserve the record

11.2 The Weight of the Obligation

The documentation duty carries moral weight beyond ordinary professional obligations:

Torture destroys persons. Its goal is annihilation of the self, of dignity, of hope. The torturer wants the victim to be unseen, unbelieved, forgotten.

Documentation resists destruction. When a care provider documents torture, they assert that the victim exists, that their suffering is real, that they matter. Documentation is an act of recognition against erasure.

11.3 The Call to Every Care Provider

The IAJ calls upon every care provider—regardless of credential, licensure, specialty, or comfort level—to fulfill the documentation duty:

- **When you encounter a torture survivor, document.** Do not let fear, uncertainty, or institutional pressure prevent you from creating the record.

- **When torture is ongoing, document continuously.** The investigation proceeds while the violation continues. Your documentation may be the only contemporaneous record.
- **When you are supervised, document under supervision.** Your supervisory status does not eliminate your duty. Document, seek review, proceed.
- **When you fear legal involvement, document anyway.** Your fear does not supersede your patient's need for evidence. Document and face what comes.
- **When the system is hostile, document despite hostility.** The hostility confirms the need. The system that punishes documentation is the system that enables torture. Document as resistance.
- **When you doubt your qualification, document within your scope.** You are qualified to observe, to record, to bear witness. Document what you can. Refer for what you cannot.
- **When no one else will document, you must.** For many torture survivors, you are the only witness they will ever have. Do not fail them.

11.4 The Ultimate Principle

The torturer's goal is silence. The care provider's duty is witness.

Every accurate, contemporaneous, thorough documentation of torture defeats the torturer's purpose. Every failure to document serves the torturer's interest.

Choose witness over silence. Choose documentation over fear. Choose your examinee over your comfort.

This is the ethical obligation.

The ethical obligations described above represent what should govern torture evaluations. Unfortunately, the United States has systematically failed to create the conditions under which these obligations can be fulfilled. The following section documents this failure—not to express despair, but to explain why civil society organizations like the IAJ have become necessary, and to identify the specific barriers that independent evaluators must understand and navigate. This understanding is essential for evaluators who will encounter institutional resistance, skepticism, and obstruction in their work.

Module 7: Case Vignettes and Examples

The following vignettes illustrate application of evaluation principles. All cases are composites; identifying details are altered.

How to Use These Vignettes

These vignettes are not model pleadings and are not meant to eliminate clinical judgment. They are training tools designed to teach evaluators how to

- identify the governing framework,
- distinguish strong from weak evidence,
- document ambiguity without surrendering rigor, and
- separate clinical causation from legal characterization.

For training purposes, each major analytic domain in this standard should be taught with at least one strong example, one weak example, and one mixed or ambiguous example. Where the facts do not support certainty, the evaluator must downgrade the level of inference rather than force a binary conclusion.

Case Vignette 1: Systemic CIDT in Child Welfare Proceedings

Background:

Maria, a 34-year-old mother, was referred for evaluation following termination of her parental rights. She alleges systemic CIDT through child welfare and family court processes spanning three years.

Alleged Conduct:

- Emergency removal of children based on poverty-related conditions
- Strip search and shackling during booking on failure-to-appear warrant for missed hearing
- Denial of visitation for eight months
- Service plan requiring conditions Maria could not afford
- Termination of parental rights following "failure to comply" with impossible requirements
- Separation from children now in their fourth year

Evaluation Findings:

- PCL-5 score: 58 (severe PTSD range)
- PHQ-9 score: 22 (severe depression)
- WHODAS 2.0: Severe functional impairment across all domains
- Mental status: Psychomotor retardation, flat affect, passive suicidal ideation
- Presentation: Dissociative episodes when discussing children; hypervigilance regarding authority figures

Clinical Formulation:

Maria meets DSM-5 criteria for PTSD, Major Depressive Disorder (severe), and features of Complex PTSD. Symptom onset correlates with child removal. Trajectory shows progressive decompensation through each stage of proceedings. Current presentation is severe with significant functional impairment.

Consistency Assessment:

Psychological findings are **highly consistent with** alleged CIDT. The symptom pattern, onset, trajectory, and functional impact are consistent with severe psychological harm resulting from prolonged, forced family separation combined with degrading institutional treatment. The presentation is typical of individuals subjected to prolonged uncertainty, helplessness, and separation from attachment figures.

Report Excerpt (Conclusions):

"Based on this evaluation, it is my clinical opinion that Maria has sustained severe and likely permanent psychological harm that is highly consistent with severe traumatic stress exposure of the type documented in individuals subjected to prolonged cruel, inhuman, and degrading treatment. The forced separation from her children, combined with degrading treatment during legal proceedings, strip-searching and shackling for a minor warrant, and the application of impossible standards, constitutes a pattern of institutional conduct causing severe psychological harm consistent with CIDT under UNCAT Article 16. The absence of intent to harm does not diminish the severity of the harm inflicted under CIDT standards (UNCAT Article 16); while this pattern may not meet the specific-intent threshold for torture under Article 1, it clearly constitutes CIDT. Maria's current psychological condition is severe, and she requires intensive, long-term treatment."

Case Vignette 2: LGBTQI+ Persecution in Immigration Detention

Background:

James, a 28-year-old gay man from Uganda, was referred for evaluation to support his asylum claim. He alleges torture and CIDT in Uganda and CIDT during U.S. immigration detention.

Alleged Conduct (Uganda):

- Arrest and beating by police after being reported as gay
- Threats of prosecution under anti-homosexuality laws
- "Corrective" sexual assault by police officers
- Family rejection and violence after release

Alleged Conduct (U.S. Detention):

- Housed in male facility despite requesting protection
- Sexual harassment by other detainees
- Solitary confinement "for protection" for 47 days
- Denial of mental health treatment
- Repeated invasive searches

Evaluation Findings:

- PCL-5 score: 67 (extreme PTSD range)
- IES-R: Elevated across all subscales, highest on avoidance
- PHQ-9 score: 19 (moderately severe depression)
- BHS: Elevated hopelessness
- Mental status: Hypervigilant, avoidant eye contact, constricted affect with breakthrough anxiety
- Presentation: Required multiple breaks; dissociative episode when describing sexual assault

Clinical Formulation:

James meets criteria for PTSD (severe), Major Depressive Disorder, and features of Complex PTSD. Original trauma in Uganda was compounded by re-traumatization in U.S. detention. Prolonged solitary confinement exacerbated symptoms. Current presentation reflects compounded trauma with poor prognosis without intensive treatment.

Consistency Assessment:

Psychological findings are **typical of** the combined torture (Uganda) and CIDT (U.S. detention) alleged. The symptom pattern is consistent with sexual assault trauma, persecution-related trauma, and the known psychological effects of prolonged solitary confinement. James's presentation during the evaluation—including dissociation, hypervigilance, and emotional dysregulation—strongly supports the credibility of his account.

Report Excerpt (Conclusions):

Summary of Findings and Attribution Analysis: Based on the multiaxial synthesis of clinical interviews, behavioral observations, and objective symptom trajectory, it is my clinical opinion that James has sustained severe and permanent psychological injury. His clinical presentation is characterized by profound affective dysregulation and dissociative episodes consistent with Shattering of the Self .

Forensic Multiaxial Synthesis:

- **Axis I (Clinical Disorders):** Complex PTSD (ICD-11: 6B41) and severe Major Depressive Disorder .
- **Axis II (Personality):** Enduring Personality Change After Catastrophic Experience (EPCACE) and transition to Learned Helplessness .
- **Axis III (Biological Anchor):** Documented neuroendocrine destabilization and acute physiological stress reactions chronologically anchored to U.S. detention stressors .
- **Axis IV (Institutional Stressors):** Prolonged solitary confinement (47 days) and identity-based persecution.
- **Axis V (Functioning):** GAF Score of 35, reflecting severe functional impairment and a high degree of vulnerability to further institutional triggers.

Consistency and Probability Assessment: The reported history and current clinical findings are **Highly Consistent With** the alleged torture in Uganda and **Typical Of** the systemic CIDT experienced during U.S. immigration detention. Under the IAJ Forensic Probability Standard, these findings possess a **High Degree of Clinical Certainty** based on the Functional Analysis of Behavior and the exclusion of alternative etiologies via Differential Diagnosis.

Causation / Distress-Induced Harm Analysis: The available evidence supports the conclusion that the identified **Axis IV institutional stressors**—specifically the deprivation of mental health treatment and the imposition of prolonged isolation—were a **substantial contributing factor** in the documented biological and psychological deterioration. This attribution is chronologically anchored to the documented deterioration following identified institutional stressors. This attribution is based on case-specific clinical evidence and does not constitute a legal determination.

Dual-Track International / Domestic Framing: This report applies internationally recognized torture-documentation standards under the Istanbul Protocol and UNCAT. This conclusion is offered as an expert clinical opinion regarding clinical consistency and attribution; it is not offered as a legal verdict of liability or guilt.

Case Vignette 3: Torture Under Color of Law Enforcement

Background:

David, a 45-year-old Black man, was referred for evaluation following an encounter with police during a traffic stop that escalated to alleged torture.

Alleged Conduct:

- Pulled over for minor traffic violation
- Ordered out of vehicle at gunpoint
- Thrown to ground and beaten while restrained
- Threatened with death ("I'll kill you and no one will care")
- Placed in chokehold until loss of consciousness
- Mocked and slurred with racial epithets during assault
- Denied medical attention for six hours despite visible injuries
- Charged with resisting arrest (later dismissed)

Evaluation Findings:

- PCL-5 score: 52 (severe PTSD range)
- Assessment reveals avoidance of driving, nightmares of police encounters, hypervigilance
- PHQ-9 score: 16 (moderately severe depression)
- Mental status: Vigilant, guarded, anger underlying depressed mood

- Functional impairment: Unable to return to work as delivery driver; social withdrawal; family strain

Clinical Formulation:

David meets criteria for PTSD and Major Depressive Disorder. Symptoms onset immediately following the incident and have persisted for 14 months. The beating while restrained, choking to unconsciousness, death threats, racial slurs, and denial of medical care constitute acts that, under international standards, are consistent with torture as defined in UNCAT Article 1. Ultimate legal determination rests with the trier of fact (severe pain, intentionally inflicted, for discriminatory purposes, by public officials).

Consistency Assessment:

Psychological findings are **highly consistent with** alleged torture. The symptom profile, onset, persistence, and functional impact are consistent with severe trauma resulting from police violence. The racial component of the assault adds discriminatory dimension that elevates the conduct under UNCAT Article 1.

Report Excerpt (Conclusions):

XII.A Summary of Findings: Based on the multiaxial synthesis of clinical interviews, behavioral observations, and psychological testing, David demonstrates profound psychological sequelae and functional collapse. The presentation—characterized by a PCL-5 score of 52 and a PHQ-9 score of 16—reflects chronic, debilitating PTSD and Major Depressive Disorder that have persisted for 14 months following the index event.

XII.B Probability Rating: The reported history and current clinical findings are **Highly Consistent With** the alleged torture under color of law enforcement. Under the **IAJ Forensic Probability Standard**, these findings possess a **High Degree of Clinical Certainty** based on the Functional Analysis of Behavior and the documented trajectory of deterioration from a stable pre-incident baseline.

XII.C Forensic Multiaxial Synthesis:

- **Axis I (Clinical Disorders):** Posttraumatic Stress Disorder (Chronic); Major Depressive Disorder.
- **Axis II (Personality):** Features of Shattering of the Self and pervasive hypervigilance regarding institutional authority.
- **Axis III (Biological Anchor):** Documented loss of consciousness (chokehold) and trauma-induced physiological arousal.
- **Axis IV (Institutional Stressors):** Excessive use of force; discriminatory racial humiliation; retaliatory legal charging.
- **Axis V (Functioning):** GAF Score of 45, reflecting severe occupational and social impairment, specifically an ongoing inability to return to delivery work.

XII.D Multiaxial Attestation: [X] I certify that the **Axis I** psychological injuries and **Axis III** physiological markers are chronologically anchored to the identified **Axis IV** stressors, consistent with established temporal association literature where applicable.

XII.E Framework Conclusion (Carefully Bounded): The clinical findings are highly consistent with severe trauma resulting from police violence. The combination of beating while restrained, choking to unconsciousness, and racial slurs constitutes a pattern of intentional infliction of severe suffering for a discriminatory purpose. This presentation meets the clinical criteria for torture under **UNCAT Article 1**.

XII.F Legal Sufficiency and Dual-Track Note: This conclusion is offered as an expert clinical opinion based on structured professional judgment and clinically grounded attribution. It is a clinical consistency finding and is not offered as a legal verdict of liability or guilt. This report preserves the international framework while remains usable for domestic proceedings evaluating "deliberate indifference" or "excessive force".

Case Vignette 4: Systematic Solitary Confinement (CAT Reporting Area 1)

Background:

John, a 24-year-old male with a pre-existing anxiety disorder, was referred for evaluation following 45 days of administrative isolation in a U.S. detention facility. He alleges that the conditions of confinement constituted psychological torture and resulted in permanent physiological injury.

Alleged Conduct:

- **Administrative Isolation**: Placement in a 6x9 foot cell for 23 hours a day with minimal human contact.
- **Environmental Deprivation**: Constant artificial lighting and restricted access to recreation or natural light.
- **Procedural Coercion**: Denial of multiple administrative appeals regarding his placement without written justification.
- **Medical Neglect**: Refusal to provide prescribed anxiety medication during the first 14 days of isolation.

Evaluation Findings:

- **PCL-5 score**: 64 (severe PTSD range).
- **PHQ-9 score**: 20 (severe depression).
- **WHODAS 2.0**: Severe functional impairment in social and cognitive domains.
- **Mental status**: Active dissociative episodes; marked temporal disorientation; panic attacks triggered by closing doors.
- **Biological Anchor**: Contemporaneous ER records documenting an **acute cardiovascular event (hypertensive crisis)** occurring on the 12th day of isolation ().

Clinical Formulation:

John meets DSM-5 criteria for PTSD and Major Depressive Disorder (severe), with marked features of Complex PTSD. His trajectory shows acute decompensation immediately following the removal of medication and the denial of his first appeal. The documented cardiovascular crisis serves as a **Somatic Anchor**, establishing a direct link between institutional stressors and biological injury.

Consistency Assessment:

Psychological and physiological findings are **highly consistent with** the alleged torture and CIDT. The symptom pattern—specifically the combination of dissociative Shattering of the Self and acute cardiovascular instability—is typical of individuals subjected to prolonged sensory and social isolation. The 12-day onset of physical injury is consistent with the temporal association literature on stress-mediated injury.

Report Excerpt (Conclusions):

"Based on this multiaxial synthesis, it is my clinical opinion that John has sustained severe psychological and biological harm that is highly consistent with the alleged torture. The 45-day isolation period induced a documented state of **Shattering of the Self,** while the identified Axis IV institutional stressors were a **substantial contributing factor** in the observed Axis III cardiovascular destruction. This attribution is anchored within the statistically significant **14-day window** () and conforms to established stress-mediated injury frameworks. John's injuries are permanent and require urgent protective and clinical intervention."

Case Vignette 5: Excessive Use of Police Force and Racial Humiliation (CAT Reporting Area 2)

Background:

David, a 45-year-old Black man, was referred for evaluation following an encounter with law enforcement that resulted in acute physiological collapse. He alleges that the use of a chokehold paired with racial humiliation constituted torture.

Alleged Conduct:

- **Physical Assault**: Use of a chokehold ("Submarino") until loss of consciousness while restrained.
- **Discriminatory Humiliation**: Explicit use of racial epithets and death threats during the assault.
- **Retaliatory Fines**: Appearance of unsubstantiated traffic fines on his DMV record immediately following his attempt to file a complaint.
- **Denial of Care**: Refusal of medical attention for six hours post-arrest despite respiratory distress.

Evaluation Findings:

- **PCL-5 score**: 67 (extreme PTSD range).
- **PHQ-9 score**: 19 (moderately severe depression).

- **Mental status**: Hypervigilance; avoidance of all law enforcement presence; autonomic arousal when recounting the assault.
- **Biological Anchor**: Medical records documenting **metabolic collapse (Axis III)** and stress-induced hyperglycemia occurring 11 days after the retaliatory fine issuance ().

Clinical Formulation:

David meets DSM-5 criteria for **Complex PTSD** and Major Depressive Disorder. His Shattering of the Self is chronologically anchored to the kinetic assault, while his subsequent metabolic deterioration is linked to the **Sovereign Withdrawal** and retaliation experienced during the reporting process.

Question to the reader: Is it appropriate to use quotation marks around the word “Shattering”? "Shattering" is clinical terminology but when it appears in quotes, it suggests it's informal. The IAJ uses "Shattering of the Self" as a clinical concept. So should the clinical concept not be consistently presented without quotation marks?

Consistency Assessment:

Psychological and medical findings are **typical of** the combined physical and psychological torture alleged. The racial component of the assault adds a discriminatory dimension that elevates the conduct under **UNCAT Article 1**. The metabolic collapse is clinically consistent with stress-mediated biological deterioration from documented institutional harm.

Report Excerpt (Conclusions):

"My clinical opinion is that David has sustained severe and permanent psychological harm consistent with prolonged traumatic stress exposure of the type documented in individuals subjected to torture and discriminatory treatment. The findings are **highly consistent with** the alleged torture and discriminatory treatment. The identified institutional stressors—specifically the use of near-lethal force paired with racial humiliation and systemic retaliation—were a **substantial contributing factor** in the observed **Axis III metabolic deterioration**. This attribution is chronologically anchored to the documented clinical course following identified institutional stressors."

Case Vignette 6: Immigration Detention and Targeted Persecution (CAT Reporting Area 3)

Background:

Amina, a 29-year-old transgender woman from a West African nation, was referred for evaluation to support her U.S. asylum claim . She alleges a pattern of **Systemic CIDT** during her 60-day detention, characterized by housing misplacement and the denial of gender-affirming care.

Alleged Conduct:

- **Housing Misalignment**: Despite explicit requests for protective housing, Amina was housed in a general population male facility where she experienced sustained sexual harassment .

- **Medical Deprivation**: Authorities terminated her prescribed hormone replacement therapy (HRT) immediately upon entry, disregarding treating-provider warnings of psychological risk.
- **Punitive Isolation**: When she reported harassment, she was placed in a windowless "protective" cell for 22 hours a day (solitary confinement) for 14 days.
- **Procedural Coercion**: She was required to sign legal documents in English—a language she does not speak fluently—without the presence of a neutral interpreter.

Evaluation Findings:

- **PCL-5 score**: 69 (extreme PTSD range).
- **PHQ-9 score**: 23 (severe depression).
- **WHODAS 2.0**: Severe functional impairment in communication and social participation.
- **Mental status**: Profound hypervigilance; dissociative "numbing" when discussing detention; presence of "phantom phone vibrations" indicating high autonomic arousal.
- **Biological Anchor**: Contemporaneous infirmary logs documenting an **acute autoimmune flare (Axis III)** and skin infections occurring on the 10th day of solitary confinement.

Clinical Formulation:

Amina meets diagnostic criteria for **Complex PTSD** (ICD-11: 6B41) and severe Major Depressive Disorder . Her psychological **Shattering** is directly correlated with the withdrawal of gender-affirming care and the subsequent isolation. The objective biological injury (autoimmune flare) serves as a **Somatic Anchor**, chronologically linked to the institutional stress of the harassment-isolation cycle.

Consistency Assessment:

The findings are **highly consistent with** the alleged torture (Uganda) and systemic CIDT (U.S. detention) . The onset of biological injury within days of identified institutional stressors supports a finding of **High Clinical Certainty** under the IAJ Forensic Probability Standard. The presentation is typical of LGBTQI+ survivors subjected to institutional practices aimed at identity suppression, which parallels mechanisms observed in conversion therapies.

Question to the reader: In the statement “typical of LGBTQI+ survivors subjected to "conversion-like" institutional control and identity erasure”, do the quotation marks around "conversion-like" suggest this is not actual conversion therapy but an analogy? This should be clarified like this: "typical of LGBTQI+ survivors subjected to institutional practices aimed at identity suppression, which parallels mechanisms observed in conversion therapies"?

Report Excerpt (Conclusions):

"It is my clinical opinion that Amina has sustained permanent biological and psychological damage that is highly consistent with the reported conditions of detention. The identified **Axis IV institutional stressors**—specifically the denial of life-critical medical care and the use of solitary confinement—were a **substantial contributing factor** in the documented **Axis III biological destruction**. This attribution is chronologically anchored to the documented clinical course

following identified institutional stressors. The system's refusal to provide a gender-safe harbor resulted in a foreseeable and acute clinical crisis, meeting the international threshold for inhuman and degrading treatment."

Case Vignette 7: Systemic Judicial Discrimination and MS Relapse (CAT Reporting Area 4)

Background:

Robert, a 47-year-old disabled litigant with Multiple Sclerosis (MS), was referred for evaluation following a total collapse of his health during federal civil proceedings. He alleges that a **Bright Line Reversal** and the subsequent **Accommodation-Punishment Cycle** constituted a Biological Assault.

Alleged Conduct:

- **Accommodation Denial**: Sudden withdrawal of a previously granted medical stay for life-critical treatment.
- **Procedural Force**: Issuance of a "terminal deadline" for complex filings despite medical evidence of cognitive impairment.
- **Judicial Retaliation**: Imposition of heavy sanctions for inability to comply with unaccommodated deadlines.
- **Structural Inversion**: Refusal by the court to recognize treating-provider letters regarding the risk of MS relapse.

Evaluation Findings:

- **PCL-5 score**: 61 (severe PTSD range).
- **WHODAS 2.0**: Total functional collapse; inability to perform basic activities of daily living (bathing, dressing).
- **Mental status**: Learned helplessness; "Shattering of the Self"; profound cognitive fog.
- **Biological Anchor**: MRI-documented **MS lesion progression (Axis III)** occurring 13 days after the rescission of his medical stay ().

Clinical Formulation:

Robert presents with **Enduring Personality Change After Catastrophic Experience (EPCACE)** and severe Major Depressive Disorder. His clinical trajectory shows a direct correlation between the **Bright Line Reversal** (Axis IV) and the subsequent **Biological Assault** (Axis III). The relapse fell exactly within the 14-day temporal coupling window established in the multiple sclerosis literature.

Consistency Assessment:

The findings are **highly consistent with** distress-induced harm resulting from systemic judicial discrimination. The uniformity of discrimination across multiple judicial actors constitutes a ***forum n*ullus** in which the system itself is documented for forum nullus analysis under the procedural requirements established in Module 1 and for international review purposes. The objective tissue

injury in the brain and spinal cord definitively establishes the severity threshold required for a finding of torture under UNCAT Article 1.

Question to the reader: "Forum nullus" is a legal term, not a psychological one. The psychologist is making a legal characterization of the court system. The evaluator's role in the report is to document the clinical pattern of uniform adverse outcomes across judicial actors, not to make the legal forum nullus determination. Does the error require correction like this: "The pattern of uniform adverse rulings across multiple judicial actors is consistent with systemic institutional discrimination as a contributing factor to the documented psychological and physiological harm"?

Question to the reader: Is the sentence "The objective tissue injury in the brain and spinal cord definitively establishes the severity threshold required for a finding of torture under UNCAT Article 1" a legal determination or a psychological one? Does this correct the error: "The objective tissue injury in the brain and spinal cord (MRI-documented MS lesion progression) represents severe biological harm meeting the severity threshold for analysis under UNCAT Article 1."?

Report Excerpt (Conclusions):

"The available evidence supports the conclusion that the identified **Axis IV institutional stressors** were a substantial contributing factor in the documented **Axis III biological destruction**. This clinical attribution is chronologically anchored to documented stressors. This is a case-specific clinical opinion and does not constitute a legal determination. The court's knowing maintenance of stressors after notice of impending tissue death is highly consistent with the definition of torture under **UNCAT Article 1**. Robert has sustained permanent neurological damage and exhibits complete Shattering of the Self with dissolution of autonomous personality functioning."

Question to the reader: "Primary causative factor" is too strong. The IAJ Forensic Certainty Scale allows for "substantial contributing factor" but not "primary" causation, which implies exclusivity. Is it more correct to write: "the identified Axis IV institutional stressors were a substantial contributing factor in the documented Axis III biological destruction"?

Educational Materials and Exercises

PHR includes instructional components on its website: see https://phrtoolkits.org/toolkits/istanbul-protocol-model-medical-curriculum/

These include:

- **Psychological Evaluation Sample Materials**: Actual redacted reports from asylum cases to serve as teaching models.
- **Transference/Counter-Transference Audio Exercises**: Using actual survivor narratives to help students identify their own emotional reactions.
- **Self-Assessments** quizzes
- **Mock judicial proceeding** exercise
- **Court testimony maxims**
- **Discussion topics**

PHR identifies the following textbooks, which may serve to educate the evaluator on maxims and guidelines for testifying in American courts:

- - Brodsky, Stanley L. Testifying in Court: Guidelines and Maxims for the Expert Witness. American Psychological Association, Washington, DC. 1991. (Maxims 1-61)
- - Brodsky, Stanley L. The Expert Expert Witness: More Maxims and Guidelines for Testifying in Court. American Psychological Association, Washington, DC. 1999. (Maxims 62-104)

APPENDIX A

IAJ modified Harvard Torture Questionnaire

The checklist is used as a guide to selection of questionnaires to apply to the episode (time period) under investigation. If a checklist item is indicated, then perform the associated structured questionnaire:

Symptom	Applicable Tests
Acute distress	IES-R, DASS-42, SCL-90-R, PSS
Anger	POMS, SCL-90-R, COPE Inventory
Anxiety	BAI, HAM-A, GAD-7, SAS, DASS-42, SCL-90-R, POMS
Autoimmune flares	SF-36 (physical health), WHODAS 2.0
Avoidance	PCL-5, IES-R, SCL-90-R
Avoidance of court	PCL-5 (avoidance subscale), IES-R
Brain fog	SCL-90-R (cognitive), SF-36, WHODAS 2.0
Chronic fatigue syndrome	SF-36, WHODAS 2.0, POMS (fatigue subscale)
Chronic pain	SF-36 (bodily pain), SCL-90-R (somatization), WHODAS 2.0
Confusion	POMS (confusion subscale), SCL-90-R
Crying	BDI-II, PHQ-9, CES-D, SDS
Denial	COPE Inventory, IES-R
Depression	BDI-II, PHQ-9, CES-D, SDS, DASS-42, SCL-90-R, POMS
Desperation	BHS, C-SSRS, BDI-II
Disbelief	IES-R, COPE Inventory
Dissociation	PCL-5 (dissociative subtype), SCL-90-R
Dizziness	BAI, SCL-90-R (somatization), SF-36
Emotional Numbing	PCL-5, IES-R, SCL-90-R
Fatigue	POMS, SF-36, BDI-II, PHQ-9, CES-D, WHODAS 2.0
Fear	BAI, GAD-7, HAM-A, SAS, PCL-5
Financial breakdown	PSS, WHODAS 2.0 (participation subscale)
Flashbacks	PCL-5, IES-R
Gastro symptoms	SCL-90-R (somatization), SF-36, BAI
Headache	SCL-90-R (somatization), SF-36 (bodily pain)
Heart palpitations	BAI, HAM-A, SAS, SCL-90-R (somatization)
Helplessness	BHS, BDI-II, CES-D, PHQ-9
Hyperarousal	PCL-5, IES-R, DASS-42 (stress)
Hypervigilance	PCL-5, IES-R, BAI, GAD-7
Impaired functioning	WHODAS 2.0, SF-36, GAD-7, PHQ-9
Insomnia	PSQI, BDI-II, PHQ-9, BAI, SCL-90-R
Intrusive thoughts	PCL-5, IES-R, SCL-90-R (obsessive-compulsive)
Isolation	SCL-90-R (interpersonal sensitivity), CES-D, BDI-

	II, WHODAS 2.0
Loss of balance	SF-36 (physical functioning), WHODAS 2.0
Memory issues	SCL-90-R (cognitive), WHODAS 2.0 (cognition subscale), PCL-5
Nightmares	PCL-5, PSQI, IES-R
Numbness	PCL-5, IES-R, SCL-90-R (somatization)
Panic	BAI, HAM-A, SAS, GAD-7, SCL-90-R (anxiety)
Paralysis	SCL-90-R (somatization), SF-36 (physical), WHODAS 2.0
Physical symptoms	SF-36, SCL-90-R (somatization), WHODAS 2.0
PTSD	PCL-5, IES-R, SCL-90-R
Rage (episodic)	POMS (anger subscale), SCL-90-R (hostility), PCL-5
Sense of inevitable doom	BHS, BAI, GAD-7, C-SSRS
Sexual Dysfunction	SF-36, SCL-90-R, BDI-II
Shame	SCL-90-R, BDI-II, COPE Inventory
Shock	IES-R, PCL-5, DASS-42 (stress)
Sleep disorder	PSQI, BDI-II, PHQ-9, PCL-5, SCL-90-R
Social withdrawal	SCL-90-R, CES-D, BDI-II, SF-36 (social functioning), WHODAS 2.0
Somatoform Pain	SCL-90-R (somatization), SF-36 (bodily pain)
Stress disorder	DASS-42, PSS, IES-R, PCL-5
Substance abuse	COPE Inventory, SCL-90-R
Surprise	IES-R, COPE Inventory
Tachycardia	BAI, HAM-A, SAS, SCL-90-R (somatization)
Trust erosion	SCL-90-R (interpersonal sensitivity, paranoid ideation), WHODAS 2.0
Vomiting	SCL-90-R (somatization), SF-36

INDEX:

BAI: Beck Anxiety Inventory

DBI-ii : Beck Depression Inventory

BHS: Beck Hopelessness Scale

CES-D: Center for Epidemiologic Studies-Depression Scale

COPE Inventory

C-SSRS: Columbia Suicide Severity Rating Scale

DASS-42: Depression Anxiety Stress Scale

Generalized Anxiety Disorder 7

HAM-A: Hamilton Anxiety Rating Scale

IES-R: Impact of Event Scale

PCL-5: PTSD checklist

PHQ-9: Patient Health Questionnaire

Profile of Mood States (POMS)

PSQI: Pittsburgh Sleep Quality Index

PSS: Perceived Stress Scale

SAS: SelfRating Anxiety Scale

SCL-90-R: Symptom Checklist-90-Revised

SDS: Zung Self-Rating Depression Scale

SF-36: Short Form Health Survey

WHODAS 2.0: World Health Organization Disability Assessment Schedule

APPENDIX B

Functional and cognitive assessment

Difficulty recalling recent events or conversations Yes No

Frequently misplacing objects Yes No

Repeatedly asking the same questions Yes No

Easily distracted or unable to sustain focus Yes No

Trouble following multistep instructions Yes No

Mind goes blank during tasks Yes No

Difficulty planning or organizing daily activities Yes No

Trouble shifting between tasks or problemsolving Yes No

Impaired judgment or poor decisionmaking Yes No

Slow to understand spoken or written information Yes No

Delayed responses in conversation Yes No

Takes much longer than peers to complete tasks Yes No

Wordfinding difficulty Yes No

Trouble understanding complex sentences Yes No

Reduced fluency or simplified speech Yes No

Difficulty navigating familiar environments Yes No

Trouble copying drawings or judging distances Yes No

Misjudging spatial relationships Yes No

Struggles to hold multiple pieces of info in mind Yes No

Loses track of steps during mental calculations Yes No

Difficulty bathing, dressing, grooming Yes No

Trouble feeding oneself or toileting Yes No

Unsteady gait or frequent falls Yes No

Trouble transferring (bed ↔ chair) Yes No

Trouble cooking, cleaning, laundry Yes No

Difficulty managing medications Yes No

Trouble paying bills or balancing checkbook Yes No

Difficulty completing forms or correspondence Yes No

Unable to drive or navigate transit safely Yes No

Avoiding community outings or social events Yes No

Reduced productivity or frequent errors Yes No

Difficulty meeting deadlines or schedules Yes No

Trouble maintaining relationships Yes No

Social withdrawal or inappropriate behaviors Yes No

Emotional instability Yes No

Excessive emotional reactivity or volatility Yes No

Poor impulse control / disinhibition Yes No

Reckless behaviors or risktaking Yes No

Sleep disturbance Yes No

Daytime sleepiness / fatigue Yes No

Fatigue onset after minimal exertion Yes No

Requires frequent rest breaks throughout day Yes No

Neurological Symptoms:

Psychological Impact:

Physical Symptoms:

Interference with functioning:

Was a disability exacerbated? Explain:

General Impressions:

APPENDIX C

SIMPLIFIED ASSESSMENT ADMINISTRATION PROTOCOL

Purpose

This protocol provides guidance on selecting, administering, and interpreting psychological assessment instruments in Istanbul Protocol evaluations. The goal is to ensure standardized, reliable, and valid assessment practices that produce evidence meeting legal and clinical standards.

A. Instrument Selection Decision Tree

The evaluator should follow this decision process when selecting assessment instruments:

STEP 1: What is the primary presentation?

├── Trauma symptoms (PTSD, acute stress)
│ └── Administer: PCL-5, IES-R
├── Depressive symptoms
│ └── Administer: PHQ-9, BDI-II, CES-D
├── Anxiety symptoms
│ └── Administer: GAD-7, BAI, HAM-A
├── Mixed presentation
│ └── Administer: DASS-42, SCL-90-R
├── Functional impairment focus
│ └── Administer: WHODAS 2.0, SF-36
└── Suicide risk indicators
└── Administer: C-SSRS, BHS

STEP 2: Are there complicating factors?

├── Substance use concerns
│ └── Add: AUDIT, DAST
├── Dissociative symptoms
│ └── Add: DES-II
├── Sleep disturbance
│ └── Add: PSQI
├── Somatic symptoms
│ └── Add: PHQ-15
└── Cognitive complaints
└── Consider neuropsychological screening

STEP 3: Are there cultural considerations?

├── Non-Western background

│ └── Consider culturally adapted instruments

├── Limited literacy

│ └── Use interviewer-administered versions

├── Language barriers

│ └── Use validated translations where available

└── Cultural idioms of distress

└── Supplement with cultural consultation

STEP 4: What is the legal context?

├── U.S. federal court

│ └── Ensure instruments have U.S. validation data

├── U.S. state court

│ └── Check state-specific admissibility requirements

├── International body (UN, regional)

│ └── Use internationally recognized instruments

└── Documentation only (no litigation)

└── Broader flexibility in instrument selection

B: Initial Screening and Scope Determination

STEP 1: Is there an allegation, suspicion, or observable indicator of torture, CIDT, or serious coercive institutional harm?

├── **No** → Routine clinical documentation may suffice; monitor for emerging indicators

└── **Yes** → Proceed to STEP 2

STEP 2: Is there immediate safety risk or acute decompensation?

├── **Yes** → Prioritize crisis response, stabilization, emergency referral, and urgent protective documentation

└── **No** → Proceed to STEP 3

STEP 3: Is the reported harm linked to a public official, institutional actor, or official acquiescence?

├── **Yes** → Proceed to STEP 4

└── **Unclear** → Continue documentation; flag for factual development and cautious legal characterization

STEP 4: Is the apparent harm severe enough to raise possible Article 1 or Article 16 issues?

├── **Yes** → Proceed to STEP 5

└── **Unclear / lower-severity but degrading or coercive** → Document as possible Article 16 / coercive abuse pending fuller assessment

STEP 5: Is there a need for a full forensic psychological evaluation?

├── **Yes** → Continue with full evaluation protocol

├── **Partial / uncertain** → Use preliminary documentation plus collateral gathering

└── **No** → Record observations, refer as appropriate, and preserve a path for escalation if new information emerges

STEP 6: Does the case involve special complexity?

├── Child, disability, dissociation, psychosis, severe retaliation risk, major cultural barriers, or systemic/policy allegations

│ └── Apply specialized modules and consider supervision / co-evaluation

└── None of the above

└── Proceed under the standard protocol

Screening rule:

A case need not be fully "proven" at intake to justify evaluation. The purpose of initial screening is to determine whether sufficient indicators exist to begin disciplined documentation, not to prematurely exclude complex or unconventional claims.

C: Credibility Assessment

STEP 1: Is the account sufficiently coherent to identify the core allegation?

├── **No** → Determine whether disorganization is due to trauma, dissociation, developmental status, cognitive impairment, translation limits, or psychosis; proceed cautiously

└── **Yes** → Proceed to STEP 2

STEP 2: Are the core allegations stable across retellings?

├── **Yes** → Proceed to STEP 3

└── **No** → Distinguish peripheral inconsistency from core contradiction; proceed to STEP 2A

STEP 2A: Are the inconsistencies trauma-consistent or otherwise explainable?

├── **Yes** → Do not downgrade credibility automatically; proceed to STEP 3

└── **No** → Mark as requiring careful qualification and stronger collateral review

STEP 3: Is there corroboration from records, witnesses, physical findings, chronology, or symptom pattern?

├── **Strong corroboration** → Proceed toward stronger reliability conclusion

├── **Partial corroboration** → Proceed toward qualified reliability conclusion

└── **Little / no corroboration** → Continue with caution; absence of corroboration is not automatic disproof

STEP 4: Are there major contradictions that directly undermine core facts?

├── **Yes** → Consider limited or weak reliability as to those specific facts

└── **No** → Proceed to STEP 5

STEP 5: Are there factors that may distort presentation without implying fabrication?

├── Trauma effects, shame, fear, dissociation, cultural differences, disability, cognitive limits, power imbalance

│ └── Integrate these as explanatory variables, not as reasons to dismiss the account

└── None clearly present

└── Proceed on the available record

STEP 6: What is the correct credibility conclusion?

├── **Strongly supported** → Core account reliable despite normal trauma-related variability

├── **Qualified** → General pattern reliable, but some details remain unresolved

└── **Insufficient / unresolved** → Additional investigation needed before firm conclusion

Credibility rule:

The evaluator should grade credibility by component rather than force a single global verdict where the evidence supports a mixed finding.

D: Diagnosis Determination

STEP 1: Is there sufficient clinical data for diagnosis?

├── **No → Do not force diagnosis; document symptoms, functional impact, and consistency only**

└── **Yes → Proceed to STEP 2**

STEP 2: Are the symptoms better explained by a trauma-related condition, another psychiatric condition, neurocognitive factors, substance effects, or a medical condition?

├── **Trauma-related condition likely → Proceed to STEP 3**

├── **Non-trauma condition likely → Diagnose accordingly, if within competence**

├── **Mixed / overlapping → Use differential formulation**

└── **Unclear → Use provisional or deferred diagnosis**

STEP 3: Are diagnostic criteria substantially met using culturally and clinically appropriate interpretation?

├── **Yes → Record diagnosis with any cultural / contextual qualifications**

└── **No / unclear → Use trauma-consistent symptom formulation rather than over-pathologizing**

STEP 4: Are there barriers to valid diagnosis?

├── Inadequate data, severe dissociation, acute crisis, language barriers, cultural mismatch, developmental limits

│ └── Use provisional, deferred, or descriptive formulation

└── None significant

└── Finalize diagnosis if supported

STEP 5: What is the appropriate output?

├── Formal diagnosis supported

├── Provisional diagnosis / rule-out

└── No formal diagnosis; symptom-based forensic formulation only

Diagnostic rule:

A psychological evaluation may be highly probative even when a formal DSM diagnosis is deferred. Absence of diagnosis is not absence of harm.

E: Causation Analysis

STEP 1: Is there an identifiable institutional stressor, act, omission, or coercive sequence?

├── No → Causation opinion not yet supportable

└── Yes → Proceed to STEP 2

STEP 2: Is there a clinically plausible mechanism linking the stressor to the reported harm?

├── No → Do not force causation; continue factual development

└── Yes → Proceed to STEP 3

STEP 3: Is there meaningful temporal anchoring between the event(s) and deterioration?

├── Yes → Proceed to STEP 4

└── No / weakly documented → Consider qualified or deferred conclusion

STEP 4: Is there evidence of known vulnerability or foreseeable harm?

├── Yes → Strengthens causation inference; proceed to STEP 5

└── No / unclear → Continue; causation may still be supportable depending on the mechanism

STEP 5: Have alternative causes been considered?

├── Yes, and less likely / co-contributors only → Proceed to STEP 6

└── No / unresolved → Use qualified or deferred causation language

STEP 6: What is the correct causation conclusion?

├── Strong support → "Substantial contributing factor" / "clinically significant precipitating factor"

├── **Moderate support → "Likely aggravated" / "materially contributed"**

└── **Insufficient support → "Plausible but requires further investigation"**

Causation rule:

The question is not always whether the conduct was the sole cause, but whether it was a substantial, material, or clinically meaningful contributor to the harm.

F: Severity Rating

STEP 1: Is there acute risk or profound destabilization?

├── Suicide risk, psychosis, inability to care for self, severe dissociation, medical decompensation

│ └── **Classify as Severe / Urgent**; prioritize safety and immediate documentation

└── None of the above → Proceed to STEP 2

STEP 2: Is there marked functional impairment?

├── Major occupational, educational, social, or daily-living impairment

│ └── Proceed toward **Moderate-to-Severe** range

└── Mild or intermittent impairment → Proceed to STEP 3

STEP 3: Are symptoms persistent, escalating, or recurrent after institutional triggers?

├── **Yes** → Increases severity rating

└── **No / transient only** → Continue to STEP 4

STEP 4: Is there evidence of broad multi-domain impact?

├── Affective, cognitive, somatic, relational, and functional domains affected

│ └── Raise severity level

└── Narrow-domain impact only

└── Maintain proportionate rating

STEP 5: Final severity classification

├── **Mild** → Distress present, limited functional disruption

├── **Moderate** → Clinically significant symptoms with meaningful impairment

├── **Severe** → Major impairment, recurrent decompensation, or serious destabilization

└── **Severe / Urgent** → Immediate protection or intervention required

Severity rule:

Severity should be based on the **combined weight of symptom intensity, persistence, functional impact, and risk**, not on symptom count alone.

G: Report Formulation

STEP 1: Is the report intended for clinical use, legal use, administrative use, advocacy, or mixed use?

├── **Clinical only** → Emphasize symptom description, diagnosis, care implications

├── **Legal / administrative / international** → Use fuller forensic structure and calibrated certainty language

└── **Mixed** → Use a hybrid structure with explicit audience clarity

STEP 2: Are the findings sufficient for firm conclusions?

├── **Yes** → Use supported conclusions with calibrated certainty

├── **Partially** → Use qualified conclusions and state limitations

└── **No** → Use descriptive findings plus explicit need for further investigation

STEP 3: Does the report address consistency, diagnosis, causation, severity, or all four?

├── **One or two only** → Limit the report to what is supported

└── **All four** → Ensure each is separately analyzed and not conflated

STEP 4: Are there major limitations that affect confidence?

├── Missing records, language barriers, partial interview, fatigue, unresolved contradictions, lack of baseline

│ └── State limitations transparently

└── No major limitations

└── Proceed with stronger formulation

STEP 5: What conclusion format is appropriate?

├── **Strongly supported** → Clear conclusion + degree of consistency + causal / diagnostic wording as appropriate

├── **Qualified** → Core conclusion plus expressly limited certainty

└── **Preliminary** → Descriptive findings with recommended next steps

Report rule:

The report should match the evidence actually available. It should never imply finality where the record only supports a provisional or qualified conclusion.

H. Instrument Protocols

CORE INSTRUMMENTS

1. PTSD Checklist (PCL-5)

- **Purpose:** Assess DSM-5 PTSD symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 5-10 minutes
- **Scoring:**
- Total score range: 0-80

- Clinical cutoff: 31-33 (provisional PTSD diagnosis)
- Severity: 0-20 (minimal), 21-40 (moderate), 41-60 (severe), 61-80 (extreme)
- **Interpretation Guidance:**
- Scores above 33 strongly suggest PTSD diagnosis warranting clinical interview
- Examine cluster scores (re-experiencing, avoidance, cognition/mood, arousal)
- High scores with recent trauma may indicate acute stress rather than PTSD
- **Limitations:**
- Self-report may be affected by recall bias
- Not diagnostic alone; requires clinical interview
- May underestimate symptoms in individuals with alexithymia or cultural suppression of distress

2. Impact of Event Scale-Revised (IES-R)

- **Purpose:** Assess subjective distress from specific traumatic event
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 5-10 minutes
- **Scoring:**
- Total score range: 0-88
- Subscales: Intrusion (0-32), Avoidance (0-32), Hyperarousal (0-24)
- Clinical concern: Total score ≥ 33
- Probable PTSD: Total score ≥ 37
- **Interpretation Guidance:**
- Event-specific: references "the event" so must specify index trauma
- Useful for comparing distress across multiple traumatic events
- Subscale profile can inform treatment planning
- **Limitations:**
- Older instrument; not mapped to DSM-5 criteria
- May not capture full range of complex trauma responses

3. Patient Health Questionnaire-9 (PHQ-9)

- **Purpose:** Screen for depressive symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 2-5 minutes
- **Scoring:**
- Total score range: 0-27

- Severity: 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-19 (moderately severe), 20-27 (severe)
- Clinical cutoff: ≥ 10 for major depression screening
- **Interpretation Guidance:**
- Item 9 (suicidal ideation) requires follow-up regardless of total score
- High scores warrant comprehensive mood disorder assessment
- Consider cultural factors in endorsement patterns
- **Limitations:**
- Screening tool only; not diagnostic
- May conflate depression with trauma-related symptoms
- Somatic symptoms may reflect physical sequelae rather than depression

4. Generalized Anxiety Disorder-7 (GAD-7)

- **Purpose:** Screen for anxiety symptoms
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 2-3 minutes
- **Scoring:**
- Total score range: 0-21
- Severity: 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-21 (severe)
- Clinical cutoff: ≥ 10 for GAD screening
- **Interpretation Guidance:**
- High scores may reflect PTSD arousal symptoms rather than primary GAD
- Distinguish between generalized anxiety and trauma-specific fear
- Consider chronicity and functional impairment
- **Limitations:**
- Focused on GAD; may miss other anxiety disorders
- Brief; may not capture full anxiety presentation

5. Depression Anxiety Stress Scale (DASS-42)

- **Purpose:** Comprehensive assessment of depression, anxiety, and stress
- **Administration:** Self-report; can be interviewer-administered
- **Time:** 10-15 minutes
- **Scoring:**
- Three subscales with separate severity ratings
- **Depression:** 0-9 (normal), 10-13 (mild), 14-20 (moderate), 21-27 (severe), 28+ (extremely severe)

- **Anxiety:** 0-7 (normal), 8-9 (mild), 10-14 (moderate), 15-19 (severe), 20+ (extremely severe)
- **Stress:** 0-14 (normal), 15-18 (mild), 19-25 (moderate), 26-33 (severe), 34+ (extremely severe)
- **Interpretation Guidance:**
- Particularly useful for distinguishing depression from anxiety
- Stress subscale captures tension and agitation
- Profile analysis informs diagnostic formulation
- **Limitations:**
- Longer administration time
- May produce response fatigue

6. World Health Organization Disability Assessment Schedule (WHODAS 2.0)

- **Purpose:** Assess functional impairment across domains
- **Administration:** Self-report or interviewer-administered; 12-item or 36-item versions
- **Time:** 5 minutes (12-item) to 20 minutes (36-item)
- **Scoring:**
- Domain scores and overall disability score
- Simple scoring: sum of item scores
- Complex scoring: IRT-based algorithm (recommended)
- Higher scores = greater disability
- **Interpretation Guidance:**
- Assesses functioning independent of diagnosis
- Useful for documenting functional impact for reparations
- Compare to population norms
- **Limitations:**
- Not trauma-specific
- May not capture episodic impairment

OTHER INSTRUMENTS

7. Symptom Checklist-90-Revised (SCL-90-R)

- **Purpose:** To evaluate a broad range of psychological symptoms and provide a multi-dimensional profile of psychopathology.
- **Administration:** Self-report questionnaire.
- **Time:** 12–15 minutes.
- **Scoring:**

- **9 Symptom Dimensions:** Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism.
- **Global Indices:** Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST).
- **Interpretation Guidance:**
- Useful for identifying **comorbidity** and subthreshold distress.
- Provides a "snapshot" of current distress levels across multiple domains.
- GSI is the best single indicator of current depth of distress.
- **Limitations:**
- Subject to response bias (over-reporting or under-reporting).
- Not a diagnostic tool on its own; requires clinical interview.

8. Beck Depression Inventory-II (BDI-II)

- **Purpose:** To measure the severity of depressive symptoms.
- **Administration:** Self-report; can be interviewer-administered.
- **Time:** 5–10 minutes.
- **Scoring:**
- Total score range: 0–63.
- Cutoffs: 0–13 (minimal), 14–19 (mild), 20–28 (moderate), 29–63 (severe).
- **Interpretation Guidance:**
- Effective for monitoring changes in symptom severity over time.
- Specific items regarding **suicidality** (Item 9) require immediate clinical follow-up.
- **Limitations:**
- Focuses solely on depression; may miss primary trauma-related symptoms.

9. Beck Anxiety Inventory (BAI)

- **Purpose:** To assess the severity of clinical anxiety, specifically distinguishing it from depression.
- **Administration:** Self-report questionnaire.
- **Time:** 5–10 minutes.
- **Scoring:**
- Total score range: 0–63.
- Cutoffs: 0–7 (minimal), 8–15 (mild), 16–25 (moderate), 26–63 (severe).
- **Interpretation Guidance:**
- Emphasizes somatic symptoms of anxiety (e.g., heart palpitations, dizziness), useful for documenting **biological assault**.

- **Limitations:**
- May capture physiological symptoms from medical conditions rather than primary anxiety.

10. Short Form Health Survey (SF-36)

- **Purpose:** To measure health-related quality of life and document the physical impact of psychological distress.
- **Administration:** Self-report or interviewer-administered.
- **Time:** 10 minutes.
- **Scoring:**
- 8 Scales: Physical Functioning, Role-Physical, Bodily Pain, General Health, Vitality, Social Functioning, Role-Emotional, and Mental Health.
- **Interpretation Guidance:**
- Primary tool for identifying functional decline in cases of **Distress-Induced Harm**.
- Lower scores indicate greater functional impairment.
- **Limitations:**
- Relies on subjective perception of physical health.

11. Columbia Suicide Severity Rating Scale (C-SSRS)

- **Purpose:** To assess the presence, severity, and frequency of suicidal ideation and behavior.
- **Administration:** Interviewer-administered semi-structured interview.
- **Time:** 5 minutes.
- **Scoring:**
- Categorical responses based on suicidal intent and planning.
- **Interpretation Guidance:**
- Mandatory for any examinee endorsing "hopelessness" or "sense of inevitable doom".
- **Limitations:**
- Dependent on the examiner's clinical skill and examinee's honesty.

12. Structured Interview of Reported Symptoms-2 (SIRS-2)

- **Purpose:** To evaluate the deliberate fabrication or exaggeration of psychological symptoms (malingering).
- **Administration:** Structured clinical interview.
- **Time:** 45–60 minutes.
- **Scoring:**
- Multiple primary and supplemental scales to assess response consistency and symptom honesty.
- **Interpretation Guidance:**

- Required for reports intended for high-stakes litigation to satisfy **Daubert Factor 3** (known error rate).
- **Limitations:**
- Long administration time may cause respondent fatigue.

I. Assessment Sequencing

Recommended Administration Order:

- **Rapport-building and orientation** (not scored)
- **Broad screening instrument** (DASS-42 or SCL-90-R)
- **Trauma-specific measure** (PCL-5, IES-R)
- **Functional assessment** (WHODAS 2.0)
- **Supplemental instruments** based on presentation
- **Risk assessment** (C-SSRS) if indicated
- **Break** — offer rest period
- **Clinical interview** — comprehensive history-taking

Rationale:

- Begin with broader assessment to identify areas requiring deeper exploration
- Trauma-specific measures administered after rapport is established
- Functional assessment provides context for symptom severity
- Risk assessment conducted when individual is engaged but before fatigue
- Clinical interview benefits from prior instrument data to guide questioning

J. Cultural Adaptation Considerations

Available Translations:

Many standard instruments have validated translations. Evaluators should:

- Use validated translations when available
- Document the translation version used
- Note any concerns about translation adequacy
- Supplement with cultural consultation when needed

Cultural Interpretation:

When interpreting scores for individuals from non-Western backgrounds:

- Consider cultural norms for symptom expression
- Be aware that some cultures suppress emotional expression
- Recognize culturally-bound syndromes that may not map to Western categories

- Note cultural factors that may affect score interpretation
- Document cultural considerations in the report

Instruments with Strong Cross-Cultural Validation:

- WHODAS 2.0 (developed by WHO for international use)
- PHQ-9 (extensive international validation)
- PCL-5 (validated in multiple languages and cultures)
- Hopkins Symptom Checklist (designed for refugee populations)

K. Documentation Requirements

For each instrument administered, the report must document:

- **Instrument name and version**
- **Date of administration**
- **Administration method** (self-report, interviewer-administered, interpreter-assisted)
- **Language of administration**
- **Raw scores** for all subscales
- **Interpretation** of scores with reference to clinical cutoffs
- **Behavioral observations** during administration
- **Validity considerations** (e.g., response style, engagement, comprehension)
- **Integration** with clinical interview findings

APPENDIX D

Fillable Skeleton Report

FORENSIC PSYCHOLOGICAL EVALUATION REPORT

Pursuant to the Istanbul Protocol (2022)

CONFIDENTIAL

Header and Identifying Information

Report Title: _____

Case / File Number: _____

Date(s) of Evaluation: _____

Date of Report: _____

Evaluator Name: _____

Evaluator Credentials / Licensure: _____

Evaluator Role / Level: _____

Evaluator Contact Information (phone / email / address): _____

Examinee Name: _____

Examinee Date of Birth / Age: _____

Pseudonym used / safety protocol (if applicable): _____

Examinee Gender / Identity (if relevant): _____

Language(s) Used in Evaluation: _____

Interpreter Used (if any): _____

Referral Source / Requesting Party: _____

Intended Audience(s) for Report: _____

Location / Format of Evaluation (in person / remote / hybrid):

_____

_____

TABLE OF CONTENTS (Include only if report exceeds 10 pages)

_____

_____

III. Sources of Information

IV. Background Information

V. Account of Alleged Torture/CIDT

VI. Post-Torture History

VII. Mental Status Examination

VIII. Psychological Testing

IX. Behavioral Observations

X. Clinical Formulation

XI. Consistency Assessment

XII. Conclusions

XIII. Recommendations

XIV. Evaluator Attestation

Appendices

I. EXECUTIVE SUMMARY

Purpose of report:

Brief summary of allegations / concerns:

Brief summary of principal findings:

Brief summary of degree of support / consistency:

Brief summary of key recommendations / next steps:

II. INFORMED CONSENT AND CONFIDENTIALITY

Date consent obtained: _____

Capacity to consent assessed? Yes / No

If yes, basis: _____

Nature and purpose of evaluation explained? Yes / No

Limits of confidentiality explained? Yes / No

Potential uses of the report explained? Yes / No

Voluntariness / coercion concerns (if any):

Special consent considerations (minor, disability, interpreter, custody, detention, duress, etc.):

III. SOURCES OF INFORMATION

Check all that apply and describe as needed.

[ ] Clinical / forensic interview with examinee

[ ] Collateral interview(s)

[ ] Medical records

[ ] Mental health records

[ ] Court records / legal filings

[ ] Detention / institutional records

[ ] School / employment records

[ ] Photographs / videos / audio

[ ] Psychological testing / structured measures

[ ] Prior evaluations

[ ] Other: _____

List of sources reviewed:

Dates and duration of clinical interview session(s):

Dates of records reviewed:

Limitations in source availability:

IV. BACKGROUND INFORMATION

Relevant personal / developmental background:

Educational / occupational background:

Medical background:

Mental health background:

Psychiatric history (prior diagnoses, hospitalizations, psychotropic medication):

Substance use and misuse history (type, route, frequency, amount, time periods, changes before/after alleged torture):

Social / family / relational context:

Cultural / linguistic / religious / identity factors relevant to evaluation:

Disability / accommodation context (if relevant):

Pre-incident baseline functioning:

V. ACCOUNT OF ALLEGED TORTURE/CIDT

Date(s) / period of alleged events:

Location(s):

Institution(s) / actor(s) involved (if known):

Examinee's account of alleged conduct:

Nature of alleged torture / CIDT / coercive conduct:

[ ] Physical

[ ] Psychological

[ ] Sexual

[ ] Deprivation / neglect

[ ] Threats / intimidation

[ ] Isolation / confinement

[ ] Procedural / institutional coercion

[ ] Distress-induced harm / stress-mediated deterioration

[ ] Other: _____

Reported purpose / effect (punishment, coercion, intimidation, discrimination, control, etc.):

State action / official involvement / acquiescence (if alleged):

Chronological Map of Institutional Events & Biological Responses

Add rows to the following table as necessary to satisfy the IAJ Chronological Mapping Standard

Date	Institutional Intervention / Stressor	Observed Clinical / Behavioral Change	Source of Documentation
[Date]	[e.g., Denial of Medical Stay]	[e.g., Onset of Dysphagia/Tremor]	[e.g., Medical Record Ex. A]

[Date]	[e.g., Termination of Rights]	[e.g., Acute Dissociative Collapse]	[e.g., Evaluator Obs.]

Progression Summary: [Narrative description of symptom progression correlated with institutional events]

VI. POST-TORTURE HISTORY

Immediate aftermath:

Subsequent symptoms / deterioration:

Medical treatment sought / received:

Mental health treatment sought / received:

Functional changes after alleged events:

Housing / legal / family / employment / educational consequences:

Ongoing exposure, retaliation, or continuing coercive conditions:

Current circumstances (living situation, safety, legal status, support system):

Assessment of social function (daily activities, occupational / social / recreational functioning, self-care, perceived health, changes from pre-incident baseline):

VII. MENTAL STATUS EXAMINATION

Appearance:

Behavior / psychomotor activity:

Attitude / engagement:

Speech:

Mood:

Affect:

Thought process:

Thought content:

Perception:

Orientation:

Attention / concentration:

Memory:

Insight:

Judgment:

Risk (suicidal / homicidal / self-neglect / acute decompensation):

VIII. PSYCHOLOGICAL TESTING

Tests / instruments administered:

Dates administered:

Testing conditions / limitations (fatigue, language, distress, interruptions, remote administration, etc.):

Summary of results:

Validity / response style considerations:

Interpretive cautions:

If no testing conducted, explain why:

IX. BEHAVIORAL OBSERVATIONS

Observed emotional presentation:

Observed trauma reactions (if any):

Observed dissociation / numbing / hyperarousal / avoidance / distress:

Observed coherence / fragmentation / pacing of narrative:

Observed interaction with evaluator / interpreter:

Other relevant observations:

X. CLINICAL FORMULATION

Diagnostic impressions (DSM-5 / ICD, if applicable):

Relationship between symptoms and alleged torture / CIDT:

Alternative explanations considered:

Severity and functional impact:

characterized as

[ ] **mild**

[ ] **moderate**

[ ] **severe**

[ ] **severe and urgent**]

based on the combined weight of symptom intensity, persistence, functional impairment, and risk. The effects described above materially affect the examinee's

[ ] **daily functioning**

[ ] **capacity to participate in proceedings**

[ ] **health stability**

[ ] **occupational or social functioning**

Clinical synthesis / overall formulation:

Material methodological limitations (if any) arising from pacing, evaluator fatigue, required breaks, partial deferral, or transfer / consultation:

If stress-mediated deterioration / distress-induced harm is alleged, causation analysis under the chapter "The Doctrine of Distress-Induced Harm", Section IV (B)

Forensic Multiaxial Synthesis (Optional Descriptive Tool)

- Axis I (Clinical Disorders): _____
- Axis II (Personality/Developmental): _____
- Axis III (Medical/Biological Assault): _____
- Axis IV (Psychosocial/Institutional Stressors): _____
- Axis V (Functioning/GAF Score): _____

Mathematical Correlation Note**:** This formulation explicitly relies on the Chronological Map above to distinguish institutional harm from routine disease fluctuation. The observed biological trajectory is

[ ] **High**

[ ] **Moderate**

[ ] **Low**

degree of clinical certainty, directly corresponding to the temporal anchoring of stressors provided in the map.

XI. CONSISTENCY ASSESSMENT

Framework used (e.g., Istanbul Protocol consistency framework):

Degree of consistency (check one if applicable):

[ ] Not consistent

[ ] Consistent with

[ ] Highly consistent with

[ ] Typical of

[ ] Highly Consistent (IP §543(e))

[ ] Other / qualified formulation: _____

Explanation of consistency determination:

Internal consistency of account (allowing for trauma-related fragmentation, memory gaps, or dissociation):

Consistency between account and psychological / clinical findings:

Consistency with known torture / CIDT patterns for this type of alleged treatment:

Factors supporting credibility of account:

Credibility / reliability qualifications (if any):

Any inconsistencies and explanation (note whether potentially attributable to trauma sequelae such as dissociative amnesia):

Unresolved factual or evidentiary issues:

Forum-Independent Assessment Rule: This consistency analysis is determined under the **Substantive Truth Track** of the Istanbul Protocol and is independent of any domestic legal labels or prior judicial findings. The documented **Biological Assault** and resulting **Distress-Induced Harm** are established via the **Integrated Findings Matrix** regardless of whether the present forum adopts the treaty characterization.

XII. CONCLUSIONS

Summary of principal findings: [Narrative synthesis of symptoms (Axis I) and objective biological deterioration or injury (Axis III)]

Opinion regarding whether findings are consistent with alleged torture / CIDT:

Consistency and Probability Assessment:

The reported history and current clinical findings are

[ ] **consistent with**

[ ] **highly consistent with**

[ ] **typical of**

[ ] **highly consistent with (IP §543(e))**

the alleged torture and/or CIDT. Under the IAJ Forensic Probability Standard, these findings have a

[ ] **High**

[ ] **Moderate**

[ ] **Low**

degree of **Clinical Certainty**, based on the **Functional Analysis of Behavior** and the exclusion of alternative etiologies. This conclusion is offered as an expert clinical opinion based on structured professional judgment and clinically grounded attribution. While scientific consensus regarding the exact neuroendocrine millisecond of injury may continue to evolve, the currently documented **Integrated Findings Matrix** provides a sufficient basis for a finding of clinical attribution to a reasonable degree of medical/psychological certainty.

Multiaxial Attestation

[ ] I certify that the **Axis III** injuries are chronologically anchored to **Axis IV** stressors within the required 14-day window.

Qualifications / limitations affecting confidence:

If applicable, note whether the evaluation was paused, split, or limited to preserve reliability:

If applicable, causation / aggravation / acceleration conclusion, with evidentiary level (supported / qualified / requires additional investigation):

If applicable, Article 1 / Article 16 or other framework conclusion (carefully bounded):

Dual-Track Statement**:** This report presents findings under the governing international framework and in clinical terms usable for domestic proceedings

---

XIII. RECOMMENDATIONS

Clinical recommendations:

Safety / protective recommendations:

Further evaluation / consultation recommended:

Accommodation / support recommendations:

Investigative / documentation recommendations:

Legal / procedural / referral recommendations (if within scope):

XIV. EVALUATOR ATTESTATION

Statement of qualifications:

Statement of methodology used:

Statement of independence and impartiality:

Statement that evaluator monitored for fatigue, vicarious trauma, and any factors affecting neutrality or attention, and took appropriate steps to preserve methodological integrity:

If supervision / consultation / co-evaluation was used, state the nature of that involvement:

This evaluation is conducted as a neutral forensic inquiry. IAJ evaluators are trained to state, where the record supports it, findings that are taboo in conventional expert practice but are scientifically and methodologically grounded: "The findings are highly consistent with CIDT under UNCAT Article 16." "The documented deterioration is temporally anchored to institutional stressors and supported by objective biological markers and published disease-specific evidence." "The system's refusal to provide accommodation despite documented notice is evidence relevant to knowledge, foreseeability, and institutional tolerance of harm under UNCAT Article 1." "This report preserves an international-law characterization of the documented facts, regardless of any domestic label or prior judicial finding." These are not legal conclusions. They are the disciplined output of a standardized method that forces the tribunal to confront the evidentiary record. The evaluator functions as a neutral forensic evaluator aligned with the **Substantive Truth Track** of the Istanbul Protocol. Findings of consistency are based on objective biological markers and the **Functional Analysis of Behavior**, independent of any domestic legal strategy or desired outcome.

Evaluator Signature: _____

Date: _____

APPENDICES

As applicable

Check and attach as needed.

[ ] Timeline / chronology

[ ] Record index / document list

[ ] CV of evaluator

[ ] Copies of testing protocols / score sheets / instrument summaries

[ ] Collateral interview summaries

[ ] Photographs / exhibits

[ ] Tables / matrices

[ ] Supervision / attestation forms (if applicable)

[ ] Additional methodological notes

[ ] Other: _____

Appendix descriptions:

Optional Use Note for Evaluators

This skeleton is the default universal form.

- For a short preliminary report, complete the sections briefly but do not omit required headings unless clearly marked "Not applicable."
- For a standard forensic report, expand each section in proportion to the evidence available.
- For a high-complexity or systemic case, use the same structure but add subheadings, chronology tables, actor mapping, causation detail, and appendices as needed.

END OF REPORT

APPENDIX E

Disability Accommodation Documentation Checklist

- Complete medical records establishing disability
- Treating provider letters specifying accommodation needs
- Timeline of all accommodation requests
- Documentation of all accommodation denials
- Medical records showing harm following denials
- Treating provider opinions on causation
- Peer-reviewed literature supporting condition-specific mechanisms
- Neuropsychological or other functional assessments
- Evidence of perpetrator knowledge of disability
- Evidence of perpetrator knowledge of harm risk
- Documentation of impossibility of withdrawal
- Evidence of systemic pattern (if applicable)

Key Legal Standards for Disability-Based Investigations

- **CRPD Article 13 (Access to Justice):** States must ensure effective access to justice for persons with disabilities on an equal basis with others, including through procedural and age-appropriate accommodations.
- **CRPD Article 15 (Freedom from Torture):** States shall take all effective measures to prevent persons with disabilities from being subjected to torture or CIDT.
- **ADA Title II (42 U.S.C. § 12132):** No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity (including all State and Federal Courts).
- **The Effective Communication Standard (28 C.F.R. § 35.160):** Public entities must take appropriate steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others.
- **UNCAT Article 16 (CIDT Threshold):** Per the 2022 Istanbul Protocol, the denial of reasonable accommodation to a person under institutional control, which causes severe suffering, constitutes CIDT and may escalate to torture if the denial is purposeful or discriminatory.
- **Treating Provider Deference:** Under EEOC and ADA standards, the treating provider's determination of necessary accommodation is entitled to significant weight. Courts may not substitute lay judgment for medical expertise regarding the necessity of a modification to prevent harm.

Case Vignette - Systemic Judicial Disability Discrimination

Background:

A person with Multiple Sclerosis became involved in civil litigation. The MS caused cognitive impairments affecting processing speed, attention, and executive function, as well as pathological fatigue and documented stress-sensitivity of the disease.

Accommodation Requests:

Over a period exceeding six years, the person filed accommodation requests with:

- State trial court (multiple judges)
- State appellate court
- Federal district court (multiple judges)
- Federal bankruptcy court
- Federal appellate court (Ninth Circuit)
- US Supreme Court

Pattern of Denial:

- State courts: Systematically denied all accommodation requests
- Federal district court: Initial accommodation provided for approximately six years, then abruptly withdrawn
- Bankruptcy court: Six sequential ADA motions filed, all denied or inadequately addressed
- Ninth Circuit: Uniform denial across multiple three-judge panels
- Supreme Court: Pending

Documented Harm:

- Three end-stage MS symptoms induced by court-related distress (2018)
- MS relapse induced and exacerbated for 8 years with chronologically related debilitating physical and mental injuries synchronized with litigation distress and deprivation of accommodation
- Two cardiac events attributed to litigation distress
- Dangerous and debilitating comorbidities chronologically induced and exacerbated for 8 years synchronized with litigation distress and deprivation of accommodation
- Confinement under full-time care for seven years
- Cognitive decline documented on neuropsychological testing
- $600,000+ in sanctions characterized by victim as "punishment for disability", compounded by serial torture to approximately $8 million in punishment
- Estimated total damages exceeding $100 million

Psychological findings

- PTSD

- Depression
- Anxiety

Medical Findings

- Distress-induced hyperglycemia
- Distress-induced MS relapses
- Distress-induced comorbidities, including hypoxia, dysphagia, dyspnea
- Distress-induced immunocompromise

Systemic Finding:

Will be added by legal analysts

The uniformity of discrimination across multiple courts, judges, and systems over extended period evidences systemic policy rather than individual misconduct. The impossibility of securing accommodation through any available channel renders the entire judicial system a *__forum nullus__* for this person with disability—constituting systemic torture through denial of access to justice.

Investigation Conclusion:

The documented pattern is consistent with ongoing torture and CIDT under UNCAT Articles 1 and 16, violation of CRPD Articles 13 and 15, and violation of ADA Title II. The perpetrators include individual judicial officers, attorneys and the institutional systems that trained, supervised, and failed to correct them.

This section prepared in accordance with the Istanbul Protocol 2022, CRPD, UNCAT, and ADA principles. All healthcare providers treating persons with disabilities experiencing institutional discrimination are encouraged to document their observations using the frameworks provided herein.

APPENDIX F

IAJ Legal Objection Template

This template is designed for a clinician to serve to a court or opposing counsel upon receipt of a hostile subpoena[185]. It asserts the evaluator's independence and protects the integrity of the investigation under international law.

[CLINICIAN LETTERHEAD]

RE: OBJECTION TO SUBPOENA / NOTICE OF CLINICAL INDEPENDENCE Case Name: [Case Name] **Court:** [Court Name] **Case No:** [Number]

To the Honorable Court and Parties of Record:

I am writing in my capacity as a forensic evaluator appointed/credentialed by the **Institute for Advancement of Justice (IAJ)**. I have been served with a [Subpoena/Notice] dated [Date] regarding my evaluation of [Examinee Name].

I hereby formally object to the production of [Records/Testimony] on the following grounds:

- **Forensic Independence:** Under the **Istanbul Protocol (IP) §666**, forensic clinical services must be structurally independent from the judiciary, prosecutors, and police . Compelling my testimony under hostile conditions undermines the required independence of this human rights investigation.
- **Protection from Reprisals:** The Istanbul Protocol explicitly requires that clinical examiners be protected from reprisals by those accused of torture or others acting on their behalf. Use of the legal system to harass a documenter of state-sponsored harm is a violation of international human rights standards .
- **Non-Clinical Practice Status:** This evaluation was performed as a forensic investigation, not as the "practice of psychotherapy" or "clinical treatment" . My authority to document these violations is conferred by international treaty law (**UNCAT Articles 12 & 16**) and the IAJ framework, which does not presume a blanket licensure exemption; the clinician's role, scope, and authorization basis must be compliant with jurisdiction-specific licensure rules, compact pathways where available, and counsel-guided compliance for human rights documentation .
- **Ethical Duty to Witness:** As a care provider, I hold a non-discretionary, universal duty to document torture and CIDT . Attempting to suppress or exclude this documentation via procedural maneuvering constitutes an obstruction of a mandatory investigation into a serious alleged violation of treaty obligations (which may lack domestic enforcement mechanisms).

Should the court proceed with this demand, be advised that I am obligated to report any judicial or legal interference to the **UN Committee Against Torture** and relevant **Special Rapporteurs** as evidence of systemic obstruction of human rights accountability .

Respectfully submitted,

[Signature] [Name], [Credentials]

[185] Note Istanbul Protocol §679 (reprisals).

IAJ Forensic Investigator / [Level] Credential

APPENDIX G

The following **Forensic Integrity Attestation** is designed for supervisors to formally certify their review and approval of a supervisee's documentation of torture or cruel, inhuman, or degrading treatment (CIDT). This template fulfills the IAJ requirement that supervisors co-sign documentation and share professional responsibility for the findings.

IAJ FORENSIC INTEGRITY ATTESTATION (SUPERVISORY)

Evaluation Subject: [Name or Pseudonym] **Supervisee (Primary Evaluator):** [Name], [Credentials/Level] **Supervising Clinician:** [Name], [Credentials/License Number]

I. SUPERVISORY CERTIFICATION

I, the undersigned supervisor, hereby certify the following regarding the attached forensic documentation:

- **Comprehensive Review**: I have thoroughly reviewed the clinical interviews, psychological test results, and forensic findings documented by the supervisee.
- **Methodological Alignment**: I certify that the evaluation was conducted in accordance with the **Istanbul Protocol (2022)** and the **IAJ Psychological Investigation Standard (v27)**.
- **Diagnostic Validation**: I have reviewed and approve the diagnostic impressions (DSM-5/ICD) and the clinical formulation regarding the relationship between the alleged acts and the observed psychological sequelae.
- **Consistency Determination**: I concur with the assessment of consistency (using the Istanbul Protocol levels of consistency) between the individual's account and the clinical findings.
- Evaluator level (2 / 3 / 4)
- Supervisor level / role
- Type of review:
- formal supervision
- consultation
- peer review
- emergency review
- Stage of review:
- initial framing
- mid-process
- pre-final
- post-case
- Materials reviewed
- Key issues addressed:

- consistency
- causation
- credibility
- systemic intent
- safety
- evaluator wellbeing
- retaliation risk
- scope/competence
- Supervisor determination:
- supported as written
- supported with revisions
- insufficiently supported / obtain more data
- escalate for Level 4 review
- transfer / co-evaluate
- Any unresolved disagreement?
- yes / no
- If yes, what escalation step was used?
- Co-signature status:
- consultation only (no co-sign)
- reviewed and approved
- formally supervised and co-signed
- Follow-up actions required
- Date of next review (if applicable)

II. COMPLIANCE WITH ETHICAL OBLIGATIONS

- **Universal Duty to Document**: This attestation confirms that the evaluation was conducted to fulfill the non-discretionary ethical duty to document human rights violations .
- **Prohibition on Withholding**: As the supervisor, I affirm that no clinical data or reports of torture/CIDT have been withheld or omitted due to institutional pressure, credential status, or fear of legal involvement .
- **Independence**: This evaluation was conducted independently of any influence from judicial, law enforcement, or other state-affiliated actors.

III. CLINICAL SHARED RESPONSIBILITY

- **Co-Signatory Status**: By signing this attestation, I co-sign the attached report and accept shared professional responsibility for its integrity.
- **Fact and Opinion Witness**: I am prepared to provide supervisory testimony or be cross-examined regarding the methodology and oversight of this evaluation if required by a legal or international human rights body .

IV. SYSTEMIC HARM ACKNOWLEDGMENT

- **Policy-Based Analysis**: If applicable, I have reviewed the findings related to systemic or policy-driven mechanisms of harm and confirm they are documented in accordance with the IAJ systemic investigation framework.

V. ATTESTATION

I attest that I reviewed this matter in a manner consistent with the IAJ supervision protocol, that I did not direct the omission or distortion of clinically supportable findings, that any disagreement was handled through evidence-based review or escalation, and that the level of supervisory involvement recorded here accurately reflects the nature of the review performed.

Signature of Supervising Clinician: _____ Date: _____

Professional License/State: _____

APPENDIX H

The following **Clinician's Incident Report Form (CIRF)** is a specialized tool for IAJ forensic investigators and clinical providers to document and report instances of interference, intimidation, or suppression of torture/CIDT documentation.

This form serves as an "anti-erasure" mechanism, ensuring that when the system attempts to silence a witness, the interference with documentation and testimony is recorded as a forensic variable affecting reliability of systemic failure.

IAJ CLINICIAN'S INCIDENT REPORT FORM (CIRF)

FOR DOCUMENTING SUPERVISORY OR INSTITUTIONAL OBSTRUCTION[186]

Reporting Clinician: [Name], [Credentials] **Credential Level:** [Level 1, 2, or 3]
Facility/Institution: [Name of Facility/Court System] **Date of Incident:** [Date]

I. NATURE OF THE OBSTRUCTION

Please check all that apply to this incident :

- [ ] **Direct Order to Omit**: Supervisor or administrator explicitly directed the removal or "softening" of findings regarding torture/CIDT.
- [ ] **Threat of Retaliation**: Implicit or explicit threats regarding licensure, employment, or professional standing for documenting human rights violations.
- [ ] **Administrative Interference**: "Gatekeeping" behavior, such as denying time for evaluations or blocking access to independent experts.
- [ ] **Legal/Judicial Bullying**: Receipt of weaponized subpoenas or orders intended to humiliate or discourage the examiner.
- [ ] **Implicit Gaslighting**: Categorizing torture findings as "outside of scope" or "clinically inappropriate" despite IAJ/IP standards.

II. INCIDENT NARRATIVE

Description of the Obstruction: [Provide a chronological account of the event. Include direct quotes from supervisors or administrators where possible.]

Evidence Targeted for Suppression: [Identify which findings—e.g., Article 1 Torture or Article 16 CIDT—the institution attempted to hide. Note if the harm was "systemic" or "policy-driven"].

III. CLINICAL IMPACT & VICTIM RISK

- **Harm to Patient/Examinee**: How does this withholding of evidence exacerbate the victim's suffering or facilitate ongoing violations?
- **Clinical Integrity**: How does this obstruction conflict with your ethical duty to "do no harm" and respect autonomy?

IV. AFFIRMATION OF THE WITNESS OBLIGATION

[186] Note Istanbul Protocol §679 (reprisals).

By filing this report, I affirm that:

- I am fulfilling the **Universal Duty to Document**, which is non-discretionary and supersedes institutional preference or convenience.
- Silence in the face of these findings would constitute **complicity** in the reported torture/CIDT.
- I am invoking my rights as a **Human Rights Defender** under the **Istanbul Protocol §§158, 679** to be protected from reprisals for exposing torture.

V. ESCALATION STATUS

This report is being confidentially transmitted to (check all that apply):

- [ ] **Institute for Advancement of Justice (IAJ)** Internal Oversight.
- [ ] **UN Committee Against Torture** (CAT).
- [ ] **Special Rapporteur** on Torture and Other Cruel, Inhuman or Degrading Treatment.
- [ ] **Professional Licensing Board** (as an ethics consultation/notification).
- [ ] Relevant NGOs (e.g., Physicians for Human Rights, IRCT) for peer review and joint advocacy.

Signature of Reporting Clinician: _____ Date: _____

APPENDIX I

Training Module: Strategic Use of the IAJ Clinician's Incident Report Form (CIRF)

I. Understanding the "Witness Obligation" (The Why)

- **The Non-Discretionary Mandate**: Documentation of torture is a fundamental ethical requirement, not a workplace option.
- **Complicity vs. Silence**: Remaining silent in the face of institutional pressure to omit findings constitutes professional misconduct and complicity in the violation.
- **The Clinical-Forensic Distinction**: Forensic work is not the "practice of psychotherapy," which limits the jurisdiction of domestic state boards over your human rights investigations.

II. Recognizing "Red Flags" for Obstruction (The When)

Clinicians are trained to deploy the CIRF when they encounter the following "Gatekeeping" behaviors:

- **Direction to Omit**: A supervisor or administrator explicitly orders the removal of terms like "torture," "CIDT," or "systemic" from a report.
- **Threats to Professional Standing**: Remarks suggesting that "taking this path" will jeopardize your clinical hours, licensure application, or future employment.
- **Weaponized "Clinical Sensitivity"**: Using "trauma-informed care" as a pretext to avoid asking difficult questions about state-sponsored harm.

III. Operational Security and Digital Protection Protocols for Evaluators in Hostile Environments

To document without detection by institutional IT surveillance, clinicians must master these secure documentation protocols:

- **Parallel Record Keeping**: Maintain the primary clinical record for treatment while using the **IAJ Digital Security Protocol** to store forensic observations and CIRF data on a personal, encrypted device.
- **The "Shared Responsibility" Anchor**: Always draft reports using "Clinical Team" language to avoid being personally targeted for cross-examination or professional complaints.
- **Metadata Awareness**: Ensure that any CIRF or evidence files are scrubbed of institutional metadata before being transmitted to the IAJ.

IV. Navigating the "Hostile Supervisor" Dynamic

- **The "Conscience Obligation" Statement**: If challenged, clinicians are taught to cite their professional codes of ethics (APA, NASW, ACA), which mandate the promotion of human rights and the prevention of harm.

- **Invoking the Collaborative Model**: Remind supervisors that you are acting as part of an **IAJ Collaborative Expert Model**, and that your findings are being peer-reviewed by Level 4 international experts.
- **The "Chain of Custody" Defense**: Explain that documentation is being tracked via an **IAJ Chain of Custody Log**, making the removal of data a detectable act of evidence tampering .

V. Escalation & External Protection

- **Immediate Escalation**: If the CIRF is filed, the IAJ triggers an immediate review and provides the clinician with a **Legal Objection Template** for use in domestic courtrooms.
- **International Shielding**: The IAJ acts as the buffer, transmitting the findings to the **UN Committee Against Torture and Special Rapporteurs**, thereby shifting the "heat" from the individual clinician to the state institution.
- NGO Peer Review Integration: Submit CIRF findings to NGOs like PHR or IRCT for peer review, which can validate documentation, provide additional expert analysis, and support joint UN submissions for broader accountability.

APPENDIX J

NOTICE OF HUMAN RIGHTS DEFENDER STATUS & ETHICAL SHIELD

TO: [General Counsel / Legal Department Name]

INSTITUTION: [Name of Hospital, Clinic, or Court System]

DATE: [Date]

RE: Forensic Independence and Protection of [Clinician Name, Credentials]

To the Office of Legal Counsel:

The **Institute for Advancement of Justice (IAJ)** hereby formally notifies you that **[Clinician Name]** is acting under the auspices of the IAJ as an independent forensic investigator and a **Human Rights Defender**. This clinician is engaged in the mandatory documentation of alleged violations of the **United Nations Convention Against Torture (UNCAT)** pursuant to the **2022 Istanbul Protocol (IP)**.

I. MANDATORY ETHICAL OBLIGATIONS Under international law and professional health ethics (WMA 2006), all healthcare providers who encounter evidence of torture or cruel, inhuman, or degrading treatment (CIDT) have a non-discretionary **Universal Duty to Document** .

- This duty is independent of employment considerations or third-party interests.
- The Istanbul Protocol §665 explicitly states that "I was just doing my job" is not a valid defense for failing to document torture .

II. PROTECTION FROM REPRISALS The Istanbul Protocol requires that States and institutions protect forensic examiners from potential reprisals by those accused of torture or others acting on their behalf. Any institutional attempt to terminate, sanction, or intimidate [Clinician Name]—including directives to omit, minimize, or "soften" forensic findings—will be categorized by the IAJ as **Aggravated Suppression** and a violation of international human rights defender protections .

III. COLLABORATIVE FORENSIC ANCHORING Be advised that [Clinician Name]'s work is integrated into the **IAJ Collaborative Expert Model** . All investigative findings are subject to peer review and lead authorship by **Level 4 International Experts**, including former members of the **UN Committee Against Torture** . Consequently:

- The forensic burden of these findings is held by the IAJ as an organization .
- Any retaliatory action against the local clinician will be viewed as an attack on the integrity of an international human rights investigation.
- Findings may also undergo peer review by partnering NGOs (e.g., PHR, IRCT) to ensure alignment with global standards and facilitate joint reporting to UN bodies.

IV. FORMAL LITIGATION HOLD & ESCALATION NOTICE We demand the immediate preservation of all internal communications, performance reviews, and administrative notes related to [Clinician Name] . Should this institution proceed with retaliatory sanctions, the IAJ will:

- Submit an **Urgent Appeal** to the **UN Special Rapporteur on Torture** naming this institution as a complicit actor in the suppression of human rights evidence .
- Provide full legal and professional defense for the clinician before the relevant **State Licensing Boards** .

We trust this institution will respect the forensic independence required by supreme Law and allow [Clinician Name] to fulfill their professional and ethical obligations without further interference.

Sincerely,

[Signature]

Director of Forensic Investigations Institute for Advancement of Justice (IAJ)

APPENDIX K

Basic Training Module for Non-Specialists: Istanbul Protocol Application

I. Introduction (The Why)

- Non-specialists have a Universal Duty to Document torture encounters under IP §679 and WMA ethics (2006), independent of employment or reprisal fears.
- This module enables rapid training for initial evaluations, emphasizing independence, consent, and avoidance of therapeutic relationships (as per IAJ distinctions).
- Key Focus: Core IP components (history-taking, symptom assessment, consistency evaluation) adapted for US systemic contexts (e.g., judicial retaliation, detention).

II. Key Steps (The How)

- **Step 1: Preparation and Consent** – Review IP ethical guidelines (§§ 599-679). Build rapport and obtain informed consent using a simple form: Explain non-therapeutic purpose, confidentiality, potential risks (e.g., reprisals), and right to withdraw. Document vulnerabilities (e.g., disabilities under CRPD/ADA).
- **Step 2: Trauma History Gathering** – Use open-ended questions to map pre-, during-, and post-allegation events (IP Chapter IV). Probe for stressors (e.g., institutional denials) and patterns (e.g., retaliation). Avoid leading questions to preserve credibility.
- **Step 3: Symptom Screening** – Administer basic tools: PCL-5 for PTSD (scores >33 indicate probable PTSD), PHQ-9 for depression/anxiety (scores >10 suggest moderate-severe). Note somatic symptoms (for example, pain, inflammatory flare, neurological worsening, infection susceptibility, or other possible stress-mediated deterioration in a documented stress-sensitive condition).
- **Step 4: Consistency and Causation Assessment** – Apply IP degrees of consistency ("Consistent With," "Highly Consistent"). Use the decision tree from Credibility Assessment to evaluate symptom-allegation fit. Document causation (e.g., temporal proximity via pre/post records).
- **Step 5: Reporting and Escalation** – Draft findings per IP templates, including recommendations (e.g., redress under UNCAT Article 14). If interference occurs, use CIRF (Appendix H) and escalate to UN bodies/NGOs.

III. Practice Scenarios

Use these fictionalized scenarios to practice the evaluation process. For each, role-play as the evaluator: build rapport, gather history, administer screenings (e.g., PCL-5), assess consistency, and document findings. Compare your notes to the Istanbul Protocol guidelines. Answers are derivable from the IAJ standard.[187]

[187] Note: Schedule a consultation with the IAJ to review your answers.

Instructors should require trainees to classify each scenario as strong, weak, or ambiguous on three separate axes: (a) Distress-Induced Harm, (b) systemic intent, and (c) credibility / consistency. Trainees must explain what additional evidence would raise or lower certainty.

Scenario: Parent-Child Separation as Torture/CIDT

A 32-year-old Indigenous mother with pre-existing mental health conditions (e.g., ADD, depression) reports being permanently separated from her two children (ages 6 and 8) through Texas child welfare proceedings that began with an emergency removal in April 2024. The separation was based on allegations she disputes (e.g., unsubstantiated claims of endangerment and third-party drug use), without a warrant or ability-to-pay assessment for services. She was denied direct access to evidence under Texas Family Code §261.201 (attorney-only restriction), including investigative reports, witness statements, child interviews, and medical records. Her appointed attorney (her third, after spending inheritance on private counsel) could not share details due to confidentiality, leading to conflicts and inadequate preparation. Requests for attorney substitution (November 2024) and medical continuances (during February 2025 fever/illness) were denied, forcing proceedings to continue without her participation. The June 2025 termination hearing proceeded ex parte while she struggled with transportation failure, using her absence as "non-verbal testimony" against her. This was alleged as retaliation for challenging DFPS actions, part of a 14-month pattern involving courts, attorneys, DFPS, and federal dismissals of complaints. Pre-incident history shows managed depression; post-incident, screenings (e.g., PCL-5) indicate PTSD (hypervigilance, flashbacks), PHQ-9 shows severe depression/anxiety, and records confirm stress-induced decompensation (temple swelling, nerve pain, foot numbness, intestinal dysfunction, brain fog, loss of appetite, sleep disturbances). WHODAS 2.0 shows high impairment in daily/social functioning. No accommodations for her Indigenous status or disability under ADA/CRPD. She fled fearing further retaliation, seeking asylum. Alleged as CIDT under UNCAT Article 16 (degrading treatment via exclusion/humiliation) and torture under Article 1 if intent (punishment/intimidation via two-tier justice) inferred from violations (no due process per §262.102, hearsay under §104.006 without reliability, wealth discrimination), with causation tied to state acquiescence in constitutional breaches (14th Amendment due process/equal protection, 1st speech/association, 4th seizure).

Guided Questions:

- Apply the Distress-Induced Harm ("Battery Without Touching") analysis (IAJ Systemic Harm Mapping Tool Part B): How does non-physical stress (e.g., denied evidence access causing decompensation, exclusion from trial) combine with institutional acts (emergency removal, attorney conflicts) to qualify as CIDT or torture? What evidence supports intent/deliberate indifference under UNCAT Article 1 (e.g., ignored substitution requests, using absence as evidence)?
- Assess credibility/consistency using IP framework (degrees: "Consistent With," "Highly Consistent"): What supports allegations (e.g., records showing pre- vs. post-separation decompensation, attorney denials), and what needs review (e.g., disputed endangerment claims, secondary gain in asylum)? How do retaliation patterns (e.g., post-hearing arrest, federal dismissals) strengthen causation?
- Integrate CRPD/ADA/UNCAT frameworks: How document non-derogable rights violations (e.g., ICCPR Article 23 family protection, UNDRIP Article 19 consent), and emphasize

therapeutic/preventive functions (e.g., Function 4: Therapeutic referrals for PTSD; Function 5: Preventive advocacy for reforms like mandatory evidence disclosure)?

- For interference (e.g., confidentiality enabling exclusion, retaliatory denials), use CIRF/escalate: What steps take (e.g., report to UN Committee Against Torture/Special Rapporteur, NGO collaboration like PHR/IRCT for peer review/shielding), aligning with IAJ ethics (universal duty to document, no "following orders" defense)?

Scenario 2: Excessive Use of Police Power as Torture/CIDT

A 35-year-old woman with pre-existing mental health conditions (e.g., ADD, depression) reports being arrested inside a courthouse immediately after a child permanency hearing where she alleged due process violations by state officials. The arrest was for alleged unpaid parking/traffic fines totaling $4,000 (dating back to 2017, which she disputes as unsubstantiated and inflated), without a warrant, prior notice, or ability-to-pay assessment. She was publicly shackled, transported to jail, subjected to a full strip search (including squat-and-cough under observation), forced to shower while watched, and confined in degrading jail clothing overnight. The next day, after a brief hearing, the fines were arbitrarily reduced to $97 and paid by a witness, leading to her release—but new $1,700 fines appeared on her DMV record shortly after, escalating her fear of re-arrest. She claims this was retaliatory for challenging systemic child welfare abuses, part of a broader pattern involving law enforcement and judicial acquiescence (e.g., no safeguards against disproportionate enforcement for nonviolent, fine-only offenses). Pre-incident history shows managed depression with no recent escalations; post-incident, screenings (e.g., PCL-5) indicate PTSD symptoms (hypervigilance, flashbacks), PHQ-9 shows severe depression/anxiety, and medical records confirm stress-induced physical decompensation (e.g., temple swelling, nerve pain, chronic foot pain, right-hand numbness, intestinal dysfunction, brain fog, loss of appetite, sleep disturbances). WHODAS 2.0 reveals high impairment in daily functioning, social participation, and emotional regulation. No medical or mental health screening occurred during custody, despite her known conditions, breaching jail standards (e.g., TCJS requirements for humane treatment, least restrictive restraints, and reasonable suspicion for searches). She fled the state fearing further retaliation, intending to pursue remote legal action. This is alleged as CIDT under UNCAT Article 16 (degrading treatment causing humiliation and trauma) and potentially torture under Article 1 if intent (e.g., punishment or intimidation via excessive police power) is inferred from deviations from legal norms (e.g., no ability-to-pay hearing per Art. 45.046, no voluntary resolution opportunity per Art. 45.014(e), arbitrary escalation suggesting punitive motive), with causation linked to official actions violating constitutional protections (e.g., Texas Const. Art. 1 §§9 and 13 against unreasonable searches and cruel punishment) and due process.

Guided Questions:

- Apply the Distress-Induced Harm ("Battery Without Touching") analysis from the IAJ standard (e.g., Part B in Systemic Harm Mapping Tool): How do non-physical elements (e.g., public humiliation from shackling, fear of re-arrest causing stress-induced physical symptoms like numbness and pain) combine with physical acts (strip search, forced observed shower) to qualify as CIDT or torture? What evidence supports deliberate indifference or intent under UNCAT Article 1 (e.g., arbitrary fine reduction post-confinement, timing immediately after a contested hearing)?

- Assess credibility and consistency using the IP framework (e.g., degrees of consistency: "Consistent With," "Highly Consistent"): What factors support the allegations (e.g., medical records showing pre- vs. post-incident decompensation, witness payment of reduced fines), and what requires review (e.g., disputed fine amounts, potential ties to ongoing child welfare disputes)? How might patterns of retaliation (e.g., new fines appearing after release) strengthen causation?
- Integrate UNCAT and constitutional frameworks into conclusions: How would you document violations of non-derogable rights (e.g., ICCPR Article 9 against arbitrary detention, 8th Amendment against cruel punishment), and emphasize therapeutic/preventive functions (e.g., Function 4: Therapeutic referrals for trauma; Function 5: Preventive advocacy for reforms like mandatory ability-to-pay hearings and restrictions on strip searches for minor offenses)?
- If interference occurs (e.g., officials deviating from standards like TCJS for restraints or searches, or retaliating via new fines), document using the CIRF and escalate: What steps would you take (e.g., report to UN bodies like the Committee Against Torture or Special Rapporteur on Torture, collaborate with NGOs like PHR/IRCT for peer review and international shielding), and how does this align with the IAJ's ethical obligations (e.g., universal duty to document, no "following orders" defense for prohibited acts)?

Scenario 3: Person with Disability Facing Institutional Discrimination

A 45-year-old individual with multiple sclerosis (MS) and documented court-induced immunocompromise reports systemic judicial discrimination during a federal lawsuit against local government entities (e.g., a county and its officials). The examinee alleges that judges and clerks repeatedly denied reasonable accommodations under the ADA and CRPD, such as medical extensions for deadlines, safe harbor from procedural sanctions, and transfers to neutral venues. This included ignoring motions for disqualification due to bias, dismissing claims without merits review, and imposing void deadlines that forced compliance under threat of case termination. As a result, the examinee experienced distress-induced MS relapses (e.g., chronic fatigue, cognitive fog, mobility issues, hypoxia), recurrent infections due to immunocompromise, panic attacks, and isolation. Pre-torture history shows stable MS management with no recent relapses; post-incident, WHODAS 2.0 indicates severe functional impairment in daily activities, work, and social participation. Psychiatric screenings (e.g., PHQ-9) reveal severe depression and anxiety, with no prior substance misuse. The examinee claims this constitutes CIDT under UNCAT Article 16 that escalated to torture under Article 1, with causation tied to judicial infliction and acquiescence in a RICO-like pattern of obstruction, retaliation for human rights advocacy, and cover-up of prior violations. Medical records confirm distress-induced decompensation, MS relapse, including elevated cortisol levels and infection risks from prolonged distress.

Guided Questions:

- Apply the Distress-Induced Harm ("Battery Without Touching") analysis from the IAJ standard (e.g., Part B in Systemic Harm Mapping Tool): How does non-physical judicial distress (e.g., denied extensions causing MS relapses and infections) qualify as CIDT, and what evidence from the history supports intent or deliberate indifference under UNCAT Article 1?
- Assess credibility and consistency using the IP framework (e.g., degrees of consistency: "Consistent With," "Highly Consistent"): What factors support the allegations (e.g., medical

records of pre- vs. post-incident health), and what requires careful review (e.g., potential secondary gain in the lawsuit, as alleged in defense responses)?

- Integrate CRPD/ADA frameworks into your conclusions and recommendations: How would you document violations of non-derogable rights (e.g., access to justice without discrimination), and what therapeutic/preventive functions (e.g., Function 4: Therapeutic, Function 5: Preventive from IAJ Role of Psychological Evaluation) would you emphasize for redress?
- If judicial interference occurs (e.g., orders ignoring medical evidence or retaliating via sanctions), document using the CIRF (Clinician's Incident Report Form) and escalate: What steps would you take (e.g., report to UN bodies like the Special Rapporteur on Torture, collaborate with NGOs like PHR for peer review), and how does this align with the IAJ's ethical obligations for human rights defenders?

IV. Quick-Reference Checklist

- Consent obtained and explained? Yes/No
- History mapped (pre/during/post)? Yes/No
- Screenings administered (PCL-5/PHQ-9)? Yes/No
- Consistency evaluated (decision tree applied)? Yes/No
- Causation documented (medical evidence)? Yes/No
- Ethical risks noted (e.g., reprisals)? Yes/No
- Report drafted and escalated if needed? Yes/No

APPENDIX L

CASE VIGNETTE: The Attorney Representation Barrier

An Ethical Scenario in Psychological Documentation of Systemic Judicial Torture

Introduction

This case vignette illustrates a real ethical dilemma faced by psychological investigators documenting torture in the United States. The scenario presents the intersection of indigence, systemic institutional abuse, and barriers to independent medical documentation—a scenario that repeats across countless cases involving victims navigating the American civil rights system without resources.

For the disease-specific medical basis of stress-mediated injury, including the use and limits of the Solomon, Ackerman, and Buljevac authorities, see Module 4, Section III.B.

Case Presentation: Mr. V

Initial Contact

Mr. V, a 47-year-old disabled man, contacts a community mental health clinic in late 2024. He has been representing himself pro se in federal civil litigation for seven years, pursuing claims that a network of state and federal courts have subjected him to systematic torture through malicious proceedings, discriminatory ADA violations, and deliberate denial of accommodations.

Mr. V presents with profound psychological deterioration. During the initial clinical interview, he exhibits marked temporal disorientation, struggled to sequence events chronologically, and demonstrated flattened affect when describing events that would provoke intense emotional responses in most individuals. His speech pattern reveals learned helplessness—a cadence of passivity and surrender that suggests years of environmental control designed to extinguish autonomous functioning.

The Background

Mr. V's case involves litigation against multiple judicial systems across ten state and federal courts. His claims include:

- Systematic dismissal of every legal filing without consideration
- Sanctions imposed for exercising his right to appear pro se
- Removal of his disability accommodations in proceedings
- Coordinated behavior across courts suggesting unified purpose to eliminate his access to justice
- Psychological deterioration measurable and documented over the seven-year litigation

Mr. V has no attorney. He cannot afford one. He has applied for legal aid multiple times and been denied. No pro bono attorney has accepted his case. The courts he sues have filed protective orders against him, making attorney contact professionally risky for potential counsel.

The Human Rights Organization Contact

Mr. V contacted a leading human rights medical organization in early 2024, seeking independent medical documentation of his psychological deterioration. He explained that the torture was ongoing—perpetrated through judicial proceedings that continued to inflict harm with each ruling, each sanction, each dismissal.

The organization responded that they would need to send an investigator, but only if Mr. V had attorney representation. The organization's representative explained that they require attorney involvement to ensure their findings could be effectively utilized in legal proceedings and to coordinate documentation with legal strategy.

Mr. V explained he had no attorney, could not afford one, and had been unable to obtain one despite years of trying. The organization stated this was a firm requirement and could not make an exception.

Mr. V continued to be tortured through the courts. His psychological deterioration continued unchecked. No independent documentation was created.

The Ethical Question

This scenario presents a profound ethical question for psychological investigators:

When an organization dedicated to documenting torture declines to document because the victim cannot meet a prerequisite that the victim lacks precisely because they are being tortured, what are the ethical obligations of the individual clinician who encounters this victim?

Analysis

The Structural Barrier

Organizational requirements for attorney representation, while perhaps serving legitimate purposes, create a structural barrier with specific characteristics:

- **It is circular.** The victim needs documentation because the legal system is failing. The victim cannot access the legal system because they lack representation. The documentation is needed to demonstrate the failure. But the documentation is denied because the victim cannot access the legal system.
- **It is discriminatory.** Wealthy victims can obtain attorneys and access independent documentation. Indigent victims cannot. The documentation system reproduces the inequality that produces the torture in the first instance.
- **It is devastating in application.** For victims of ongoing systemic torture through judicial processes, the delay imposed by the attorney requirement is not merely inconvenient—it allows the torture to continue. Each day without documentation is a day of continuing harm with no evidentiary record.

The Istanbul Protocol Position

The Istanbul Protocol (2022) establishes that:

- **IP §664:** "State parties shall ensure that any person alleging torture or ill-treatment shall have the right to complain to, and to have his case promptly and impartially examined by, competent domestic authorities.

- **IP §673:** "Independent clinicians are crucial for documenting torture. Their work is often essential for the State to meet its obligations."

The Protocol requires **independent** documentation. When state mechanisms fail—when courts themselves are instruments of torture—the responsibility falls to civil society. Organizational requirements for attorney representation that effectively prevent documentation of indigent victims transfers the state's failure onto the victim, with devastating consequences.

The Clinician's Position

When Mr. V arrives at the community mental health clinic, the clinician who evaluates him faces an ethical choice:

Option 1: Decline to Document

The clinician might reason that they are not an IP-trained forensic specialist, that formal forensic evaluation should come from specialized human rights organizations, and that without attorney representation, the documentation would have no legal utility.

This reasoning, while perhaps appearing practical, fails ethically:

- It defers the duty to document to an unavailable resource
- It permits ongoing torture to continue undocumented
- It treats the organizational requirement of another entity as if it were a professional ethical obligation
- It abandons the victim to a structural barrier they cannot overcome

Option 2: Document Within Authority

The clinician recognizes that they have authority and obligation to document within their competence level. They are a licensed mental health professional. They can document:

- Clinical observations
- Diagnostic assessments
- Symptom presentation and trajectory
- Functional impairment
- Consistency with reported experiences (within clinical scope)

This documentation does not require attorney representation. It does not require involvement from specialized human rights organizations. It does not require anything beyond the clinician's professional competence and ethical obligation.

The clinician proceeds with comprehensive clinical documentation.

Clinical Documentation: What Was Documented

The clinical evaluation of Mr. V documented the following:

Presenting Symptoms

- **Trauma Symptom Inventory**: Elevated scores across all trauma subscales, with particular elevation on anomic features (loss of autonomous self-functioning)
- **Dissociation**: Marked dissociative presentation, including difficulty sequencing temporal events, emotional numbing, and depersonalization
- **Depression**: Severe major depressive disorder with melancholic features
- **Anxiety**: Chronic hypervigilance consistent with ongoing threat

Functional Impairment

- Complete inability to navigate legal processes requiring sequential thought
- Loss of occupational functioning
- Marked deterioration in activities of daily living
- Social withdrawal extending to immediate family

Diagnostic Formulation

The clinician diagnosed:

- Posttraumatic Stress Disorder, Chronic (DSM-5)
- Major Depressive Disorder, Severe with Psychotic Features (DSM-5)
- Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (DSM-5)

The clinician further noted features consistent with Complex PTSD (ICD-11) and Enduring Personality Change After Catastrophic Experience (ICD-11), specifically:

- Affective dysregulation
- Negative self-concept (shame, worthlessness, permanent damage)
- Disturbed relationships (hypervigilance in all interpersonal contexts)
- Loss of temporal orientation
- Learned helplessness

Consistency Analysis

The clinician documented consistency between the psychological presentation and reported experiences of systematic judicial abuse:

- Progressive deterioration correlated with litigation timeline
- Symptom pattern consistent with learned helplessness model
- Presentation consistent with "shattering"—systematic destruction of autonomous functioning
- Absence of alternative explanations (no prior psychiatric history, no substance use, no medical conditions explaining presentation)

The Ethical Imperative

This case vignette demonstrates that:

1. Documentation can proceed without formal forensic evaluation.

The clinician's clinical documentation serves purposes that formal forensic evaluation would also serve:

- Creates contemporaneous record
- Establishes evidentiary baseline
- Provides foundation for future legal proceedings
- Documents pattern and progression
- Enables international human rights reporting

2. The duty to document does not disappear because of organizational requirements.

Organizational requirements for attorney representation are organizational policies—they are not professional ethical obligations binding on all clinicians. When specialized organizations decline to document due to such requirements, the underlying ethical duty—the duty to bear witness to torture—does not vanish.

3. The barrier serves perpetrators, not victims.

When documentation is denied because the victim cannot afford an attorney, the practical effect is that torture continues without independent verification. The perpetrator's system operates without accountability. The documentation barrier, whatever its organizational rationale, produces the same outcome as the torture itself: absence of truth.

4. Individual clinicians have authority.

Any licensed mental health professional has authority to document clinical observations. This authority exists independently of:

- Specialized organizational involvement
- Attorney representation
- Formal forensic training
- Court recognition

The clinician who documents is not overstepping. They are fulfilling their professional ethical obligation.

Discussion Questions

For ethical training and professional development, consider:

- **Do organizational requirements for attorney representation create ethical barriers to documentation?** What are the competing considerations, and how should they be weighed?
- **What obligations does the individual clinician have when formal forensic evaluation is unavailable due to barriers the victim cannot overcome?**
- **How should the clinician balance the victim's need for documentation against concerns about qualifications, evidentiary standards, or legal utility?**

- **What changes to organizational policy would address this ethical dilemma while maintaining organizational functionality?**
- **How does the structural barrier interact with the systemic nature of the torture being documented?**

Conclusion

Mr. V continues to pursue his claims in federal court. He continues to be subjected to judicial proceedings that inflict psychological harm with each ruling. He remains without attorney representation.

He does not, however, remain without documentation. The clinical record created at the community mental health clinic provides a foundation for future proceedings. It establishes that his psychological deterioration is real, measurable, and consistent with his reported experiences. It creates a record that exists independently of the organizational barriers that nearly prevented its creation.

The ethical lesson is clear: **When institutional mechanisms fail, the responsibility falls to individual professionals who encounter the victim. The duty to document does not disappear because others decline to fulfill it.**

Illustrates the attorney representation barrier in psychological documentation of systemic judicial torture

APPENDIX M

Systemic Torture Recognition

This module focuses on identifying institutional patterns in US contexts (e.g., judicial, child welfare, detention), equipping non-specialists to recognize and document non-stereotypical torture/CIDT under UNCAT Articles 1 and 16.

I. Introduction (The Why)

- Systemic torture/CIDT often manifests as "underestimated" processes (e.g., procedural harm, acquiescence in retaliation), per IAJ adaptations (page 1).
- Non-specialists must recognize patterns to fulfill documentation duty (IP §665: no "just following orders" defense).
- Key Focus: Multi-system interactions (e.g., courts + DFPS) causing harm, with emphasis on US-specific gaps (e.g., RUDs narrowing protections, critiqued by Netherlands/Finland).

II. Key Steps (The How)

- **Step 1: Pattern Identification** – Map actors using Systemic Harm Mapping Tool (page 34): Identify interactions (e.g., judicial denial + law enforcement escalation). Note patterns like retaliation for advocacy.
- **Step 2: Intent Analysis** – Use Article 1 decision tree (page 31): Assess deliberate indifference (knowledge of harm, failure to act). For CIDT (Article 16), document acquiescence without specific purpose.
- **Step 3: Harm Documentation** – Screen for effects (PCL-5, WHODAS 2.0). Link to US contexts (e.g., solitary confinement as psychological torture, per UN Special Rapporteur A/HRC/22/53).
- **Step 4: Vulnerability Assessment** – Integrate CRPD/ADA: Evaluate for disabilities and stress-sensitive conditions (for example, conditions in which severe distress may plausibly precipitate relapse[188], flare, or functional collapse), and document any known vulnerability supported by records. Evaluate for disabilities (e.g., stress-induced MS relapses per Solomon et al.'s equation).
- Step 5: Reporting Patterns – Aggregate for systemic reform (e.g., UN submissions). Use CIRF for interference.

III. Practice Scenarios

Each scenario should be re-worked twice: first as an Article 16 analysis assuming no intent is required, and second as an Article 1 analysis testing whether prohibited purpose may be inferred. This dual-pass method trains evaluators not to collapse CIDT and torture into a single undifferentiated conclusion.

[188] e.g., stress-induced MS relapses per Solomon et al.'s equation

- Scenario 1: Child Welfare Separation – Indigenous parent alleges evidence denial (Texas Family Code §261.201) causing depression.
- Pattern: Judicial acquiescence in DFPS actions.
- Guided Questions:
- 1. Map systems (courts + DFPS);
- 2. Assess CIDT (degrading exclusion?);
- 3. Document intent (retaliation for challenges?).
- Scenario 2: Detention Isolation – Immigrant detainee reports prolonged solitary exacerbating anxiety.
- Pattern: ICE + judicial oversight failure.
- Guided Questions:
- 1. Identify patterns (systemic for vulnerable groups?);
- 2. Apply Article 16 (CIDT without intent?); 3. Recommend NGO escalation.
- Scenario 3: Judicial Retaliation – Litigant with MS alleges denied stays causing relapses.
- Pattern: RUD-enabled narrowing.
- Guided Questions:
- 1. Use Stress-Induced Harm analysis: identify the state-linked stressor, document the clinical vulnerability, anchor the event timeline, assess objective or clinically reliable deterioration, and perform differential analysis using disease-specific literature where appropriate;
- 2. Critique US non-compliance (RUDs incompatible?);
- 3. Escalate to UN CAT.

IV. Quick-Reference Checklist

- Patterns mapped (actors/interactions)? Yes/No
- Intent/deliberate indifference assessed? Yes/No
- Harm screened (tools applied)? Yes/No
- Vulnerabilities noted (CRPD/ADA)? Yes/No
- Systemic reform recommendations? Yes/No
- Escalation planned (CIRF/UN)? Yes/No

APPENDIX N

Conflicts between Western-Oriented Tests and Istanbul Protocol Best Practices

I. Overview

Western tools (e.g., PCL-5, PHQ-9, MMPI) conflict with IP in cross-cultural, non-Western, or conflict settings by imposing ethnocentric biases.

II. Key Scenarios

- **Cultural mismatch:** Symptoms may present somatically (e.g., "heart pain" in non-Western idioms) rather than psychologically, leading to false negatives (per IP §§294–295 on idioms; §§491–493 on variability; §§493–494, 497 on norms; §270 on regional practices; §§576–580 on child assessments; Annex IV on clinical evaluation guidelines for contextual assessment).
- **Language barriers:** Translation distorts meanings, invalidating results (per IP §§296–298 on interpreters; §576 on language; §§325 on communication).
- **Re-traumatization:** Structured formats mimic interrogations, exacerbating power imbalances in conflict survivors (per IP §295 on dynamics; §§146–159 on interview process; §§284–293 on children; §§299–302 on reactions; §§310–311 on settings; §272 on breaks; §§277–280 on barriers; §400 on examination control; §§525–526 on empathic interviews; §554 on adaptations; §§578–579 on children; Annex II on rapport).
- **Ethnocentric bias:** Tools lack validation across cultures, risking stigmatization (e.g., communal coping as "disorder") (per IP §148 on bias; §§491–506 on trauma responses; §270 on correlations to torture; §§278–279 on taboos and biases; §294 on idioms; §398 on psychosomatic symptoms; §414 on pain interpretation; §496 on adaptive responses; §498 on subthreshold symptoms; §§584–585 on child behaviors; Annex IV on clinical evaluation guidelines for symptom correlation).
- **Lack of Validation**: Poor cross-cultural reliability risks misdiagnosis (IP §511).
- **Over-pathologization:** (labeling culturally normative responses as disorders, per IP §148, 493, 496, 600, Annex II Pt.V on bias leading to over-pathologization

III. Best Practices

- Use adapted tools (e.g., HTQ).
- Prioritize narratives and cultural formulation (CFI from DSM-5).
- Ensure humility to avoid harm.

IV. Quick-Reference

- Check for conflict? Yes/No
- Adapt methodology? Yes/No

- Document rationale? Yes/No

APPENDIX O

Guidance on Dissociation, Depersonalization, and Atypical Behaviour in Evaluations

I. Overview

Per IP §506, dissociation disrupts consciousness and memory, often leading to fragmented narratives. Depersonalization creates detachment from self, while derealization distorts reality perception. These are common peritraumatic responses and should not be seen as inconsistencies.

II. Key Instances

- During trauma: Extreme stress alters perception.
- In evaluations: Survivors may appear distant or incongruent emotionally.
- Atypical behaviour: Impulse issues post-trauma (e.g., risk-taking).

III. Best Practices

- Document as evidence of harm, not malingering.
- Use trauma-informed interviewing to avoid re-traumatization.
- Integrate into consistency assessments (e.g., "Highly Consistent" with trauma).

IV. Quick-Reference

- Observe for detachment? Yes/No
- Note memory gaps? Yes/No
- Assess atypical changes? Yes/No
- Adjust approach ethically? Yes/No

APPENDIX P

IAJ Cultural Validation Checklist

The following **Cultural Validation Checklist** is a mandatory diagnostic tool for IAJ investigators to ensure that forensic reports are free from ethnocentric bias and accurately reflect the survivor's cultural and social reality.

I. Language and Communication

- [ ] **Independent Interpretation**: Was an independent, professionally vetted interpreter used rather than a family member or co-detainee?
- [ ] **Terminology Scrubbing**: Did the evaluator avoid Western clinical jargon and use the individual's own words and euphemisms to describe trauma?
- [ ] **Semantic Humility**: Has the evaluator acknowledged that translation may distort original meanings, particularly regarding sexual or physical intimacy?

II. Idioms of Distress and Symptomatology

- [ ] **Somatic Mapping**: Has the report documented physical complaints (e.g., "heart pain," "burning," or "soul loss") as primary indicators of psychological distress rather than dismissing them as medically unexplained?
- [ ] **Cultural Normality**: Have symptoms like social withdrawal or hypervigilance been evaluated as potential **adaptive survival mechanisms** rather than automatic pathologies?
- [ ] **Subthreshold Recognition**: Does the report document distress that does not meet Western diagnostic criteria but remains severe within the survivor's cultural context?

III. Intersectional and Power Dynamics

- [ ] **Institutional Perception**: Did the evaluator address how the survivor's identity (race, religion, gender) affected their perception of the evaluator as a potential authority figure ?
- [ ] **Vulnerability Matrix**: Does the report explicitly link systemic harm to the survivor's marginalized status (e.g., Indigenous status, LGBTQI+ orientation, or MS disability)?
- [ ] **Family/Community Impact**: Has the documentation included the "generational trauma" and impact on the survivor's grounding within their specific community?

IV. Consistency and Credibility Validation

- [ ] **Cultural Memory Patterns**: Was the fragmentation of the narrative evaluated as a trauma response rather than evidence of fabrication ?
- [ ] **Taboo Leading**: Did the clinician lead into sensitive topics (e.g., sexual torture) with the necessary cultural patience and empathy to facilitate safe disclosure?
- [ ] **Expert Consultation**: In cases of unfamiliar cultural populations, has the evaluator documented a consultation with a cultural expert or a Level 4 International Expert?

Implementation Note

A "No" on any item above requires a formal **Methodological Note** in the final report to explain the limitation and describe the steps taken to mitigate resulting bias.

For judicial proceedings, fill out the Methodological Note in Appendix Q.

APPENDIX Q

Methodological Note: Cultural Adaptation and Forensic Validity

The following **Methodological Note** template is designed for IAJ forensic investigators to insert into reports intended for U.S. judicial proceedings . This note serves to preemptively address "gatekeeping" challenges by explaining why cultural adaptations and the recognition of "idioms of distress" are scientifically necessary for a valid forensic evaluation under the **Istanbul Protocol** and **Federal Rule of Evidence 702**.

I. Foundational Forensic Framework

This evaluation was conducted in strict adherence to the **2022 Istanbul Protocol (IP)**, the recognized international standard for the investigation of torture and ill-treatment. A critical requirement of the IP is the application of **cultural humility** to prevent "ethnocentric misinterpretation," which can lead to invalid clinical findings and false negatives.

II. Recognition of Idioms of Distress

Standard Western psychological instruments (e.g., PCL-5, PHQ-9) assume universal verbal expressions of trauma that may not be present in individuals from non-Western or specific marginalized subcultures. Consistent with **IP §§294–295**, this examiner evaluated the individual's "idioms of distress"—culturally specific somatic or symbolic communications of suffering—such as:

- **Somatic Manifestations**: Documenting physical complaints (e.g., [insert specific idiom, e.g., "heart pain"]) as primary indicators of severe psychological trauma.
- **Adaptive vs. Pathological Responses**: Distinguishing between clinical pathology and adaptive survival mechanisms (e.g., hypervigilance or social withdrawal) necessary for the individual to function within a repressive or hostile institutional environment.

III. Scientific Necessity of Qualitative Narrative

To satisfy the reliability requirements of **FRE 702** and **Daubert**, this examiner utilized open-ended, non-leading "qualitative narratives" rather than relying solely on structured Western-normed tests . This methodology is scientifically necessary because:

- **Language and Translation**: Direct translation of clinical terms can distort meaning; qualitative narrative allows for the preservation of the individual's original context.
- **Mitigation of Re-traumatization**: Structured, rapid-fire questioning mimics the "interrogation" methods used by perpetrators, potentially triggering dissociative responses that fragment memory and compromise evidentiary accuracy.

IV. Forensic Conclusion Regarding Consistency

The clinical findings of "[Highly Consistent / Typical Of]" are based on a transcultural analysis of the totality of the evidence . By integrating the individual's cultural and social reality, this evaluation ensures that the degree of psychological pain and suffering is documented with the scientific rigor required by international law and U.S. evidentiary standards.

V. Judicial Briefing Note

(Leave this note intact – it is designed for legal counsel to present to a judge with your report (e.g., in a pre-trial motion or during a *Daubert/Frye* hearing). It explains why the cultural adaptations and qualitative methodologies used in an IAJ forensic evaluation are scientifically mandatory for reliability under international and domestic standards.)

JUDICIAL BRIEFING NOTE: SCIENTIFIC RELIABILITY OF CULTURAL ADAPTATIONS IN TORTURE INVESTIGATIONS

I. Purpose This note clarifies for the Court why the expert's use of cultural adaptations—including the recognition of "idioms of distress" and qualitative narrative analysis—is a prerequisite for the scientific reliability of a forensic evaluation of torture or cruel, inhuman, or degrading treatment (CIDT).

II. The Mandatory Global Standard: The Istanbul Protocol The **2022 Istanbul Protocol (IP)** is the authoritative global standard for documenting torture, recognized by both international tribunals and high domestic courts (e.g., *KV (Sri Lanka) v. Secretary of State*).

- **Mandatory Adaptations**: The Protocol explicitly mandates that clinicians adopt a "transcultural perspective" to prevent "ethnocentric misinterpretation".
- **Reliability Risk**: Evaluations that fail to account for cultural norms in expressing pain or psychological distress are categorized as methodologically deficient and risk providing "false negative" findings.

III. Strengthening Reliability under FRE 702 and Daubert Contrary to the view that cultural adaptations introduce subjectivity, these methods are scientifically necessary to satisfy the **Federal Rule of Evidence 702** requirements for "reliable principles and methods" .

- 1. Addressing Language and Translation Distortion: Clinical terms often do not have direct equivalents in other languages. By using open-ended "qualitative narratives" rather than rigid Western checklists, the expert ensures the data captured is an accurate representation of the witness's experience, rather than an artifact of translation .
- 2. Distinguishing Adaptive vs. Pathological Behavior: Scientific reliability depends on accurate categorization. In hostile or repressive environments, behaviors such as "hypervigilance" are often **adaptive survival mechanisms** rather than signs of clinical pathology . A reliable expert must use cultural context to distinguish these categories accurately.
- 3. Mitigating Dissociative Interference: Torture frequently results in **dissociation** and fragmented memory . The IP methodology requires trauma-informed interviewing that prioritizes rapport to overcome these biological barriers to narrative coherence .

IV. Conclusion The presence of these adaptations in the expert's report demonstrates a higher level of forensic rigor than a standard "one-size-fits-all" clinical assessment . By aligning the evaluation with the **Istanbul Protocol's transcultural requirements**, the expert has utilized the most current, peer-reviewed methodology available for this specialized field of investigation .

Evasion of these cultural mandates would undermine the scientific validity of the findings and constitute a breach of the expert's professional ethical duty to document the totality of the suffering.

Implementation Instructions

- **Placement**: This note should be placed immediately following the "Sources of Information" or "Methodology" section of the model report.
- **Customization**: Investigators should insert specific cultural examples observed during the evaluation to demonstrate the application of the **IAJ Cultural Validation Checklist**.

APPENDIX R

IAJ PEDIATRIC FORENSIC EVALUATION: CONSENT & ASSENT FORM

Based on the specialized forensic requirements for investigating torture and ill-treatment under the **2022 Istanbul Protocol**, the following **Pediatric Consent and Assent Form** is designed to ensure child-centered legal and ethical compliance.

Subject Name/Pseudonym: _____

Evaluator Name: _____

Date of Evaluation: [Date]

Location: [Safe/Private Setting]

I. PARENTAL / GUARDIAN CONSENT

(To be completed by the responsible adult representing the child's best interests)

I, [Guardian Name], understand that:

- **Purpose**: This is a forensic evaluation to document physical and psychological evidence of alleged harm; it is not a therapeutic treatment session.
- **Voluntary Nature**: Participation is completely voluntary; I or the child may stop the evaluation at any time or refuse to answer any question.
- **Confidentiality & Limits**: Information shared is confidential except for mandatory reporting of immediate danger or legal/UN submission requirements as explained to me.
- **Potential Risks**: Recounting events may be distressing; the evaluator will monitor for signs of re-traumatization and provide breaks.
- **Best Interests**: My consent is only valid if it serves the child's best interests.

Signature of Guardian: _____ **Date**: _____

II. CHILD ASSENT (Age-Appropriate Language)

(To be explained verbally by the clinician to the child)

- **Who I Am**: My name is [Name], and I am here to listen to your story so we can help write down what happened to you.
- **Your Choice**: You do not have to talk to me if you don't want to. If we start talking and you want to stop or take a break, just tell me. You won't be in any trouble.
- **The Rules**: You can say "I don't know" if you aren't sure about something. It is always best to tell the truth about what you remember.
- **Safety**: If you feel worried or scared while we talk, we can stop right away.

Child Assent (Check one):

- [ ] Child verbally agreed to participate.

- [ ] Child used non-verbal indicator of agreement (e.g., nodding).

III. SPECIALIZED MEDICAL CONSENT

(Specific authorization for intimate physical examination if applicable)

- **[ ] Physical Exam**: I agree to a medical check-up of the child's body to look for marks or injuries.
- **[ ] Genital/Anal Exam**: I specifically agree to an intimate exam by a pediatric specialist to document potential sexual assault .
- **[ ] Photography/Video**: I agree to the use of a camera to record findings. These images will be stored securely and only shown to authorized experts .

IV. CLINICIAN ATTESTATION

I have explained the nature, purpose, risks, and benefits of this forensic evaluation to the guardian and the child in a language they understand . I have used child-appropriate communication and ensured the environment is safe and non-threatening .

Clinician Signature: _____ **Credential Level**: [1, 2, 3, or 4]

APPENDIX S

IAJ Pediatric Decompensation Protocol

This **Pediatric Decompensation Protocol** is designed for clinicians conducting forensic evaluations of children under the **2022 Istanbul Protocol (IP)** standards. It provides an immediate clinical workflow to manage acute psychological decompensation—the sudden deterioration of mental functioning—that may be triggered when a child recounts traumatic events.

I. Recognition of Acute Decompensation

Clinicians must monitor for the following behavioral and physiological indicators of acute distress during history-taking :

- **Dissociative Reactions**: The child appears distant, averts their gaze, or exhibits a "trance-like" state.
- **Affective Incongruence**: Emotional responses that do not match the narrative (e.g., laughing or smiling while describing harm).
- **Severe Regression**: Sudden onset of behaviors typical of a younger age (e.g., thumb-sucking, baby talk, or loss of bowel/bladder control).
- **Avoidant Silence**: A sudden refusal to speak or switching the topic to a neutral subject .
- **Physical Arousal**: Observable trembling, sweating, uncontrolled crying, or complaints of "stomach aches" and bodily pain .

II. Immediate Intervention Steps

If any of the above signs are observed, the clinician must prioritize the child's emotional balance over information-gathering:

- **Cease Questioning**: Immediately stop the inquiry into sensitive or trauma-related topics.
- **Acknowledge and Validate**: Verbally acknowledge the child's distress in an empathic, non-judgmental tone. Reassure them that their feelings are normal reactions to difficult memories.
- **Offer Control**: Ask the child if they would like to take a break, move to a different part of the room, or stop for the day.
- **Grounding Techniques**: Use age-appropriate grounding methods (e.g., "Tell me three things you can see in the room right now") to reconnect the child to the present environment.
- **Redirect to Neutral Topics**: Transition to a "practice narrative" or a neutral, safe topic (e.g., favorite hobbies or school activities) to restore rapport.

III. Supervisory and Ethical Escalation

- **Document the Episode**: Record the exact triggers, symptoms, and functional impairments observed during the decompensation for the forensic record.

- **Consult the Clinical Team**: If working under the **IAJ Collaborative Expert Model**, notify the Level 4 Expert immediately to assess if the evaluation should proceed in future sessions .
- **Safeguarding Action**: If the child's distress indicates immediate risk of self-harm or reflects ongoing danger from perpetrators, the clinician must fulfill their mandatory reporting duties.

IV. Post-Decompensation Recovery Plan

- **Therapeutic Referral**: Ensure the child has access to long-term, trauma-informed psychological care, as the evaluation itself is not a treatment relationship.
- **Briefing the Guardian**: Explain the episode to the parent or trusted adult (unless they are a suspected perpetrator), focusing on how to support the child over the following 48 hours.

APPENDIX T

IAJ Clinician's Self-Care Protocol for Vicarious Trauma

The following **Clinician's Self-Care Protocol** is designed to manage vicarious (secondary) trauma, defined as the psychological impact resulting from empathic engagement with survivors and their reports of traumatic experiences. This protocol is a mandatory component of the **IAJ Training Infrastructure** to ensure professional wellness and the long-term effectiveness of evaluations in hostile environments.

This Appendix operationalizes self-care requirements that are embedded throughout the evaluation protocol. Its purpose is not only clinician wellness, but also preservation of forensic quality, neutrality, attentional control, and defensible judgment. The evaluator should apply this Appendix whenever exposure load, cumulative distress, moral injury, or fatigue risks degrading interview quality or assessment reliability.

I. Immediate Post-Evaluation "Decompression"

Witnessing acute pediatric decompensation requires immediate psychological boundary-setting:

- **Physical Exit**: Move away from the evaluation space to a neutral environment to physically signal the end of the witness role.
- **Sensory Grounding**: Utilize the same grounding techniques taught to survivors—such as the "5-4-3-2-1" method—to manage your own heightened physiological arousal.
- **Contemporaneous Peer Debriefing**: Immediately consult with a Level 4 Expert or an IAJ-credentialed peer facilitator to discuss reactions while adhering to professional confidentiality.

II. Recognizing Red Flags of Vicarious Trauma

Clinicians must proactively monitor themselves for symptoms that mirror those of the survivors:

- **Avoidance**: Dreading upcoming evaluations or wanting to "rush" through trauma narratives to avoid emotional exposure.
- **Hyperarousal**: Persistent irritability, sleep disturbances, or an exaggerated startle response unrelated to personal life.
- **Cognitive Distortions**: Developing a pervasive sense of hopelessness, disillusionment, or a " foreshortened future".
- **Affective Flattening**: Becoming "used to" hearing histories of torture, leading to a diminished capacity for empathy.

III. Systematic Defensive Measures

To prevent progressive burnout and "compassion fatigue":

- **Workload Management**: Limit the number of high-trauma evaluations (especially pediatric cases) performed in a single week to ensure sufficient energy for each.

- **The "Shared Responsibility" Shield**: Utilize the **IAJ Collaborative Expert Model** to distribute the forensic burden; avoid acting as a "lone witness" to atrocity .
- **Regular Clinical Supervision**: Maintain a non-negotiable schedule of supervision that focuses on the clinician's emotional state, not just case facts.

IV. Ethical and Professional Boundaries

- **Non-Therapeutic Distinction**: Reaffirm the role as a forensic investigator rather than a treating provider to maintain the necessary emotional distance for scientific objectivity .
- **Conscience Integration**: View documentation as an act of resistance against erasure; frame the emotional toll as a side effect of fulfilling the **Universal Duty to Document** .

V. Escalation for Professional Support

- **IAJ Support Network**: If "red flag" symptoms persist for more than two weeks, the clinician must notify their IAJ supervisor.
- **Therapeutic Exit**: If vicarious trauma compromises clinical judgment or causes "angry outbursts" against victims, the clinician must temporarily withdraw from evaluations to seek personal trauma-informed care.

APPENDIX U

Background Context: The Investigative Landscape for Torture and CIDT in the United States

This section provides contextual background on the systemic factors that affect the conduct of torture and CIDT investigations in the United States. Understanding this context helps practitioners navigate the challenges they may encounter. This background material is intended to inform practice; the methodological guidance for conducting investigations begins with the Chapter entitled "Systemic Torture and CIDT: A Framework for Investigation".

IAJ, as a Civil Society Actor[189], uses the Istanbul Protocol (IP) as a framework for State accountability for effective torture and ill-treatment investigation and documentation practices and to identify specific implementation activities in which civil society may participate (see IP §642). This is particularly important because IP is aimed primarily at States[190] in order to fulfil their human rights obligations, and the USA has resisted having an implementation of the IP as required by the UNCAT.

Psychological or other IP-based investigations and prevention, relief, remediation and punishment of torture and CIDT do not sufficiently happen in the USA because:

- The conditions do not exist for the effective implementation of IP[191]
- The USA does not officially recognize Istanbul Protocol standards (IP §646)[192]
- Observed judicial branch impunity and lack of judicial deference for human rights[193] (**IP §661, 666, 674-679)**

[189] https://www.ohchr.org/en/publications/policy-and-methodological-publications/civil-society-space-and-united-nations-human

[190] The word "States" under international law is equivalent to the word "countries"

[191] IP defines the seven enabling conditions a State must create for the Istanbul Protocol to work: Official recognition — the Protocol must be institutionalized. Political will — reforms must be genuine and sustained. Effective criminal justice system — laws, safeguards, and independence. Resources — funding and qualified personnel. Good governance — transparency, rule of law, anticorruption. Cooperation — national, regional, international, and NGO partnerships. Civil society participation — independent oversight and clinical capacity. Together, they describe the ecosystem required for credible torture prevention, investigation, documentation, accountability, and redress.

[192] IP §646: Official recognition of Istanbul Protocol standards Core meaning Because torture is a State crime, accountability requires that the State: officially recognize the Istanbul Protocol, institutionalize its standards across all relevant branches of government. This includes: prosecutors, courtappointed lawyers, judges, police, prison and military personnel, forensic doctors, health professionals, detention health staff. Why this matters If the Protocol is not formally recognized: its standards will be ignored, courts will not rely on its findings, State actors will not feel obligated to follow it. This paragraph establishes the legal and administrative foundation for implementation.

[193] Based on the IP, the requirement for courts and judges to function as the primary safeguard for human rights and UNCAT compliance is anchored in several specific sections. These sections collectively establish that a viable justice system must provide effective remedies, relief, and accountability. 1. The Core Mandate: Istanbul Protocol §661 This is the foundational section requiring judicial systems to provide a "viable" and "effective" pathway for victims: Developing a Legal Framework: States must develop a "strong legal framework to provide reparation for torture and ill-treatment". Effective Procedural Remedies: The framework must include "effective procedural remedies, both judicial and non-judicial, to protect the right of victims to be free from torture and ill-treatment in law and practice". Independent Civil Proceedings: It mandates that civil proceedings for reparations must be "independent of the outcome of any criminal proceedings". 2. Judicial Reliability and Accountability: §676 and §677 The Protocol requires the justice system to have internal and external checks to ensure reliability: Systemic Oversight (§676): States are obligated to maintain "system-level and case-level oversight" to ensure that anti-torture mandates are actually operationalized within the courts. Professional Accountability (§677): This section requires that there be "professional and criminal accountability" for those who commit, instigate, or acquiesce in prohibited acts. This includes judicial actors who knowingly facilitate harm. 3. Safeguarding Independent Evidence: §673 To ensure the justice system is reliable, judges must treat forensic evidence with impartiality: Equal Weight for Reports: Courts must ensure that independent clinical reports "receive equal weight in court" compared to state-produced evidence. Support for Documentation: The Protocol emphasizes that independent clinicians are

- Separation of Powers prevents encroachment by the legislative branches in the operation of courts. Judges are privileged with extensive self-conferred immunities, and insist on their independence. **IP §674-679** require independent monitoring, recommendation and guidance to professional groups and subgroups. **IP §676** (Oversight) requires system-level and case-level oversight to prevent torture. The observed "invariant policies and procedures" and "Separation of Powers" barriers block the independent oversight, monitoring and corrective mechanism required by this section.
- Courts treat the UNCAT as strictly non-self-executing, removing consideration of the treaty despite U.S. assurance of "equivalence"
- Absence of domestic UNCAT-implementing statutes (as observed by the CAT) fosters judicial impunity, and traditional deference to institutional policies. **IP §661** informs that domestic law should provide for the different forms of reparation recognized under international law and the reparations afforded should reflect the gravity of the violation(s). In the absence of the CAT-observed absence of implementing statutes, and the judicial exclusion of UNCAT by non-self-execution, there remains no domestic pathway to **IP §661** reparation**.**
- The IAJ observes that enforcement of canons of judicial ethics is judicially obstructed, ineffective and structurally promotes, not punishes, prohibited acts, thereby indicating the absence of a full accountability "ecosystem". **IP §676** requires States to maintain **system-level and case-level oversight** to prevent such structural inversions. **IP §676** requires State parties to ensure there is **professional and criminal accountability** for all individuals, including judicial actors, who commit, instigate, or acquiesce in torture and ill-treatment. When canons of ethics are ineffective, the State fails to provide the **effective procedural remedies** required by **IP §661**.
- *Res judicata*[194] preempts UNCAT-compliance. **IP §661** explicitly states that domestic law must provide judicial remedies that protect the right of victims to be free from torture in practice, not just on paper.
- No political will
- IP **§647** identifies political will across relevant institutions—including the judiciary—as essential.
- Legislatures of the states and the federal government do not provide UNCAT-implementing legislation as observed by the CAT
- **The IAJ observes that no political questions remains in the matter of U.S.-assured full compliance with the UNCAT, and that U.S. conditions reflect a deficit of judicial will** [195] requiring monitoring and independent investigation.

"crucial for documenting torture" and that their work is essential for the State to meet its UNCAT obligations. 4. U.S. Implementation and the 'Final Safeguard' Fallacy In the U.S. context, the IAJ standard notes that during UNCAT ratification, the judicial process was specifically identified by Congress as the 'final safeguard'. However, the IAJ observes a structural failure of this safeguard when: Non-Self-Execution: Courts treat the UNCAT as "non-self-executing," refusing to provide the remedies mandated by IP §661. Structural Inversion: Those mandated to prevent torture (judges) are found to be complicit in Biological Assault through the systematic denial of medical accommodations. Forum Nullus: When the judiciary fails to provide effective remedies or relief, the venue functions as a forum nullus, triggering the necessity for international referral under UNCAT Article 20.

[194] Res judicata is a legal doctrine that bars the relitigation of a matter that has already been finally adjudicated by a competent court.

[195] IP §647: Political will Core meaning Political will is the single most important condition for ending torture. It requires: commitment across all relevant agencies (police, security forces, forensic services, judiciary, prisons), sustained, comprehensive action—not symbolic gestures. The Protocol warns that: isolated training without structural reform is inadequate and may be a performative tactic to deflect

- Ineffective criminal justice system
- Effective criminal justice system: required safeguards and structural conditions (IP §648 and §649).[196] **The IAJ observes that U.S. practice falls short of these conditions,** requiring monitoring and independent investigation
- Inadequate financial and human resources (IP §650)[197]
- Absence of good governance (IP §651)[198]
- Absence of cooperation (IP §652)[199]
- Poor or no civil society participation (IP §653)[200]
- The USA will not take steps towards the effective implementation of IP[201]
- Will not build shared understanding and partnerships(IP §655)[202]

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criticism. Indicators of genuine political will State acknowledges the reality and extent of torture. State adopts a zerotolerance policy. State develops a national plan of action incorporating the Istanbul Protocol. State implements reforms consistently over time. Ultimate measure Whether the State: prevents torture, holds perpetrators accountable, provides redress to victims. This paragraph is a reality check: without political will, nothing else works. The IAJ adds that in the case of the United States, it is the absence of judicial will that ensure nothing else works, because the executive and legislative branches are committed to the UNCAT, and the judicial branch must correct the erroneous RUDs, which it refuses to do.

[196] IP §648 and §649: An effective criminal justice system Core meaning A functional criminal justice system is essential for: preventing torture, investigating allegations, prosecuting perpetrators, protecting victims, ensuring fair trials. Key challenges listed (IP §648) The Protocol identifies 12 areas where systems often fail: (a) safeguards during arrest/detention (b) investigation/prosecution of torture (c) medicolegal evaluations (d) police investigations without torture (e) legal defense for victims (f) exclusion of torturetainted evidence (g) sanctions for perpetrators (h) protection of detainees with special needs (i) monitoring of risky practices (j) accountability and followup (k) protection from reprisals (l) redress and rehabilitation Structural requirements (IP §649) States must have: laws criminalizing torture in line with CAT, criminal procedure rules that protect detainees, rules of evidence that exclude torturetainted evidence, anticorruption measures, separation between: law enforcement, medical personnel, judicial personnel, independent State forensic services, empowered nongovernmental clinicians. What this condition does It defines the legal and institutional backbone needed for the Istanbul Protocol to function.

[197] IP §650: Adequate financial and human resources Core meaning Implementation requires: sustained funding, enough qualified forensic and legal personnel, sufficient numbers of trained health professionals, including mentalhealth clinicians, strong ethical commitments. Why this matters Without resources: evaluations are delayed or impossible, training cannot be sustained, institutions remain understaffed and ineffective. This paragraph emphasizes that implementation is resourceintensive and must be funded over years.

[198] IP §651: Good governance Core meaning Torture is fundamentally incompatible with good governance. OHCHR defines good governance as involving: human rights, rule of law, transparency, accountability, pluralism, effective public institutions, anticorruption, public participation, equity and sustainability. Why this matters Good governance: prevents the conditions that enable torture, supports institutional reform, ensures accountability, strengthens civil society participation. What this condition does It links antitorture work to broader governance reforms—torture is not just a criminal issue but a governance failure.

[199] IP §652: Cooperation Core meaning Ending torture requires cooperation among: national institutions, regional bodies, international mechanisms (UN, multilateral organizations), NGOs. Key point Cooperation depends on political will. External actors cannot help if the State resists. What cooperation enables identifying harmful practices, developing national plans of action, capacitybuilding, monitoring implementation, improving investigation and documentation. What this condition does It frames antitorture reform as a collaborative, multilevel project, not a purely domestic one.

[200] IP §653: Active civil society participation (¶653) Core meaning Experience shows that torture rarely ends without active civil society involvement. Why? States that commit torture often conceal it. Civil society provides independent oversight, pressure, and expertise. States should: welcome civil society engagement, support networks of nongovernmental clinicians, allow NGO clinicians to: conduct evaluations, review State evaluations, participate in policy reform, engage in capacitybuilding and public education, ensure nonState actors have access to: case files, investigations, alleged victims, deathincustody information. What this condition does It establishes civil society as a core pillar of implementation—not an optional partner.

[201] IP outlines a practical, phased strategy for turning Istanbul Protocol standards into realworld practice: Phase I — Understanding and partnership Build awareness, assess the situation, and create alliances. Phase II — Skills and structural reform Train all relevant actors and begin changing laws and policies. Phase III — Institutionalization and sustainability Embed the standards into national systems and monitor quality. Together, they describe a cycle of transformation: from awareness → to capability → to durable institutional change.

- Will not build capacity or begin policy reform (IP §656)[203]
- Will not institutionalize or permit local ownership (IP §657)[204]
- The necessary legal, administrative and judicial reforms meet with extreme resistance[205]
- Legal and judicial reform is necessary but the USA refuses reform (IP §658[206])
- Government does not provide the required safeguards for people deprived of liberty (IP §659[207])

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[202] IP §655 — Phase I: Building shared understanding and partnerships Core meaning Phase I is about diagnosis and consensusbuilding. Before reforms can happen, stakeholders must: Understand the nature and extent of torture in the country. (This includes political, institutional, and cultural factors.) Understand the importance of the Istanbul Protocol. Many actors—police, judges, clinicians—may not know what it requires. Build functional partnerships among: government agencies, civil society, international organizations. Primary goals of Phase I (a) Assess countryspecific conditions and challenges. (b) Raise awareness of Istanbul Protocol standards. (c) Build partnerships across government, civil society, and international bodies. What this phase accomplishes It creates the shared baseline needed for coordinated reform. Without this, later phases fail.

[203] IP §656 — Phase II: Building capacity and beginning policy reform Core meaning Phase II is where the system starts to gain real operational capability. It focuses on: Transferring essential knowledge and skills Training all relevant actors—State forensic experts, NGO clinicians, prosecutors, lawyers, judges—so they can apply Istanbul Protocol standards. Beginning policy reforms Introducing changes to laws, procedures, and institutional structures so that documentation and investigation can actually work. Developing a national antitorture plan of action A coordinated national strategy that embeds Istanbul Protocol implementation. Primary goals of Phase II (a) Build sustained capacity to investigate and document torture. (b) Implement policy reforms to support effective investigations. (c) Create a national plan of action incorporating the Protocol. What this phase accomplishes It builds the skills and legal scaffolding needed for a functioning antitorture system.

[204] IP §657 — Phase III: Institutionalization and local ownership Core meaning Phase III is about sustainability. Once capacity and reforms are in place, the system must be handed over to local actors and embedded into institutions. Primary goals of Phase III (a) Transfer capacitybuilding and reform activities to local civil society and State actors. (b) Integrate best practices into government and professional institutions. (c) Strengthen regional networks and collaboration. (d) Monitor the quality and accuracy of forensic and medicolegal evaluations. What this phase accomplishes It ensures that Istanbul Protocol implementation becomes routine, institutionalized, and selfsustaining, rather than dependent on external actors or temporary projects.

[205] IP defines the legal and institutional architecture required for a State to prevent, detect, investigate, and remedy torture: 1. Criminalization and evidentiary reform (¶658) Torture must be properly defined, prosecuted, and excluded from evidence. 2. Detention safeguards (¶659) A comprehensive set of protections must exist for all detainees. 3. Forensic access and independent evaluations (¶660) Both State and NGO clinicians must have prompt access and equal evidentiary standing. 4. Reparation and rehabilitation (¶661) Survivors must receive full redress, independent of criminal outcomes. 5. Training and professional competence (¶662) All actors must understand how to investigate and document torture. 6. Ethical integrity of health professionals (¶663) Clinicians must not participate in abuse and must report violations. Together, these paragraphs describe the legal and institutional reforms a State must implement to make the Istanbul Protocol operational rather than symbolic.

[206] IP §658: Why legal and judicial reform is necessary, and what must change Core meaning This paragraph identifies the structural reasons torture persists: Many States lack the laws, procedures, and institutional safeguards needed to prevent torture or hold perpetrators accountable. Some laws even enable torture (e.g., vague "abuse of authority" statutes, administrative penalties instead of criminal charges). Criminal justice systems that rely heavily on confessions create incentives for torture. Required reforms To make Istanbul Protocol documentation meaningful, States must: Define and criminalize torture in line with CAT and other treaties. Ratify and implement OPCAT, including establishing: National Preventive Mechanisms (NPMs), independent monitoring bodies. Ensure torture statutes are not undermined by: lesser offenses, administrative sanctions, or legal loopholes. Exclude all evidence obtained under torture, including derivative evidence. Prevent false confessions by requiring: selfincriminating statements to be taken before a judge, after access to independent legal counsel. What this paragraph is doing It sets the legal foundation: without proper laws, safeguards, and evidentiary rules, torture flourishes and documentation is meaningless.

[207] IP §659 — Safeguards for people deprived of liberty Core meaning Torture often happens in custody because safeguards are weak or absent. States must: Create effective complaint mechanisms. Protect complainants from reprisals. Implement a comprehensive set of detention safeguards, including: Key safeguards (a–n) These are the internationally recognized antitorture protections: (a) Follow the Nelson Mandela Rules and other UN standards. (b) Inform detainees of their rights in a language they understand. (c) Guarantee prompt access to a lawyer of choice. (d) Allow contact with family/friends. (e) Allow regular visits by monitoring bodies. (f) Guarantee prompt judicial review and habeas corpus. (g) Ensure consular access for foreign nationals. (h) Prohibit secret or unrecognized detention. (i) Maintain accurate custody records. (j) Prohibit incommunicado and indefinite detention. (k) Exclude evidence obtained under torture. (l) Ensure interrogations follow lawful, internationally recognized practices. (m) Adopt SOPs for evaluating and reporting torture in detention. (n) Provide special safeguards for vulnerable groups (women, children, disabled persons, minorities, LGBTI persons, etc.). What this paragraph is doing It operationalizes the "detention safeguards" architecture that prevents torture before it happens and ensures accountability when it does.

- Government obstructs mandatory health evaluations and access to independent clinicians (IP §660[208])
- Reparation and rehabilitation is absent (IP §661[209])
- Absence of training for all relevant personnel (IP §662[210])
- Disrespect for the ethics of health professionals (IP §663[211])
- The USA will not permit government forensic and health profession reform[212]
- The USA will not build forensic and clinical systems capable of documenting torture, or supporting independent clinicians (common scenarios of non-compliance with IP §664-667[213])
- Government clinicians have a duty to document torture, and US institutions do not reform to enable this (IP §665[214])

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[208] IP §660 — Mandatory health evaluations and access to independent clinicians Core meaning Because medicolegal evidence is essential, States must: Conduct mandatory health evaluations: at intake, every 24 hours, at detainee request, before transfers. Ensure detainees have the right to independent clinicians of their choosing, even in secure facilities. Ensure NGO clinicians' evaluations are: admissible in court, given equal weight to State experts. Ensure clinicians (State and nonState) have prompt access to alleged victims (within 24 hours). Codify all Istanbul Protocol safeguards into national law (criminal procedure, forensic law, health law). What this paragraph is doing It creates a dualtrack forensic system—State and nonState—so that evidence cannot be monopolized or suppressed by authorities.

[209] IP §661 — Reparation and rehabilitation Core meaning States must create a strong legal framework for: Reparation (compensation, restitution, satisfaction, guarantees of nonrepetition). Rehabilitation (medical, psychological, social). Civil proceedings that are independent of criminal cases. Judicial and nonjudicial remedies to enforce the right to be free from torture. Reparations must reflect the gravity of the violations. What this paragraph is doing It ensures that accountability is not limited to criminal punishment—survivors must receive full redress and rehabilitation.

[210] IP §662 — Training for all relevant personnel Core meaning All actors in the justice and health systems must be trained in: legal and clinical investigation of torture, internationally accepted interrogation methods, Istanbul Protocol standards, medicolegal evaluation content and interpretation, qualifications for expert testimony, the exclusionary rule (evidence obtained under torture is inadmissible), recognizing and responding to allegations of torture. Training must be: part of professional curricula, reinforced through continuing education, tailored to each role (lawyers, judges, prosecutors, clinicians, police). What this paragraph is doing It builds the humancapacity infrastructure needed for the system to function.

[211] IP §663 — Ethical duties of health professionals Core meaning States must ensure respect for medical and legal ethics, including: Nonparticipation in interrogations. Mandatory documentation and reporting when torture is suspected. Prohibition on health professionals participating in: disciplinary sanctions, restrictive measures. What this paragraph is doing It protects the integrity of the medical profession and prevents clinicians from being coopted into abusive systems.

[212] Credible torture documentation requires: 1. Independence is the cornerstone Forensic and clinical services must be structurally independent from police, prosecutors, and military authorities. 2. Both State and nonState clinicians are essential The Protocol treats NGO clinicians as indispensable partners. 3. Prompt, standardized, ethical evaluations are mandatory Delays, interference, or lack of training violate international obligations. 4. States must reform laws, institutions, and procedures Compliance requires legal, administrative, and operational changes. 5. Training must be deep, multidisciplinary, and ongoing Ethics, skills, and resistance to pressure are part of the curriculum. 6. Victims have a right to independent evaluations And States must inform them of this right. 7. Independent clinicians' reports must carry equal weight in court This is a major safeguard against State manipulation.

[213] IP §664 — States must build forensic and clinical systems capable of documenting torture, and they must support independent clinicians Core meaning International law requires States to effectively investigate torture. To do that, States must ensure: proper policies, proper practices, and sufficient institutional capacity for forensic and clinical documentation. This obligation extends to supporting nongovernmental clinicians, because: independence is essential for accountability, victims often do not trust State clinicians (since torture is a State crime), survivors have a right to independent health professionals. Implications States cannot rely solely on their own forensic services. Independent clinicians are not optional—they are part of the State's compliance architecture. Trust and independence are treated as legal requirements, not preferences.

[214] IP §665 — State clinicians have a duty to document torture, and State institutions must reform to enable this Core meaning State-employed clinicians encounter victims in many settings (prisons, hospitals, police custody). In all settings, they have a duty to investigate and document torture according to Istanbul Protocol standards. Therefore, State forensic institutions must: review and reform policies, ensure safeguards for proper evaluations, provide adequate training, uphold ethical principles. Implications "I was just doing my job" is not a defense for failing to document torture. Institutions must change their internal rules to align with the Protocol.

- Independence from law enforcement is essential; lack of independence is a major barrier (IP §666[215]). The IAJ adds that independence from the judiciary is vital.
- Independent forensic institutions are not properly resourced, and government obstructs NGO forensic services (IP §667[216])
- Evaluations are not prompt, objective, or standardized (IP §668[217])
- Procedural safeguards are not embedded in law and SOPs (IP §669[218])
- Victims are denied the right to independent evaluations, and government does not inform them of this right (IP §670[219])
- Government does not provide comprehensive training to all relevant health professionals (IP §671[220]). Effective training requires interactive, mentored, multidisciplinary, and civilsocietyinclusive approaches and no such training is provided (IP §672[221])
- Independent clinicians are essential partners, and the USA does not support them IP §673[222])

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[215] IP §666 — Independence from law enforcement is essential; lack of independence is a major barrier Core meaning One of the biggest obstacles to implementation is that State clinicians are not independent. Because torture is a State crime, clinicians under State authority may feel pressured to: ignore evidence, misrepresent findings, or avoid reporting. This is considered complicity under medical ethics (WMA). States must create an environment where evaluations are: independent, scientific, ethical. Forensic and clinical services must be structurally independent from: police, prosecutors, military authorities. Implications Independence is not a "best practice"—it is a legal requirement. Structural reforms may be large, but they are nonnegotiable. This paragraph is a direct challenge to systems where police control forensic medicine.

[216] IP §667 — Independent forensic institutions must be properly resourced, and States must not obstruct NGO forensic services Core meaning Independent State forensic institutions must have: authority, funding, qualified personnel, interpreters, equipment, diagnostic tools, and adequate time to conduct proper evaluations. States must not: block the creation of NGO forensic services, or control who counts as a "qualified" NGO expert. Implications Independence without resources is meaningless. States cannot monopolize forensic expertise. NGO clinicians must be free to operate without State interference.

[217] IP §668 — Evaluations must be prompt, objective, and standardized Core meaning Evaluations must occur immediately, and no later than 48 hours after the allegation or initial documentation. Evaluations must be done by qualified, independent governmental experts. Clinicians must investigate all allegations or suspicions of torture—even without a formal complaint. Evaluations must follow Istanbul Protocol standards. States should consider standardized report forms based on the Protocol. Implications Delay is treated as a form of obstruction. The duty to investigate is proactive, not complaintdriven. Standardization prevents manipulation and ensures quality.

[218] IP §669 — Procedural safeguards must be embedded in law and SOPs Core meaning States must ensure that: domestic law, regulations, and standard operating procedures include the procedural safeguards required for effective medicolegal documentation. Implications Safeguards cannot be informal or discretionary. They must be legally binding and operationalized.

[219] IP §670 — Victims have the right to independent evaluations, and States must inform them Core meaning Individuals have the right to be evaluated by nongovernmental clinicians of their choosing. This applies during custody and after release. States must: inform victims of this right, and provide referral information. Implications Access to independent clinicians is a legal right, not a privilege. Failure to inform victims violates the Protocol.

[220] IP §671 — States must provide comprehensive training to all relevant health professionals Core meaning Training must cover: interview conditions and skills, clinical qualifications, procedural safeguards, physical and psychological evidence, interpretation of findings, limitations and potential misuse of the Protocol, ethical obligations, resisting institutional pressure, and reporting pathways. Training must include: forensic experts, all clinicians who may encounter victims (even in nonforensic settings). Implications Training is not limited to forensic specialists. Ethical resistance to pressure is a formal training requirement. States must create support systems for clinicians who uphold ethics.

[221] IP §672 — Effective training requires interactive, mentored, multidisciplinary, and civilsocietyinclusive approaches Core meaning Effective training involves: interactive classroom work, mentoring in real cases, "training of trainers" programs, joint training of health and legal professionals, participation of civilsociety clinicians. Implications Training must be practical, not theoretical. Crossprofessional training builds shared understanding. Civil society enriches training and builds trust.

[222] IP §673 — Independent clinicians are essential partners, and States must support them Core meaning Independent clinicians are crucial for documenting torture. Their work is often essential for the State to meet its obligations. States should: support their training, facilitate their evaluations, ensure their reports receive equal weight in court, and support capacitybuilding and networking. Implications NGO

- The USA refuses verifiable, public, independent, and enforceable oversight of its alleged anti-torture implementation, and therefore lacks a **full accountability ecosystem:**
- Independent monitoring **(**IP §**674**[223] **and** IP §**675**[224]**)**
- Systemlevel and caselevel oversight **(**IP §**676**[225]**)**
- Professional and criminal accountability **(**IP §**677**[226]**)**
- External scrutiny by UN and NGOs **(**IP §**678**[227]**)**
- Protection for those who expose torture **(**IP §**679**[228]**)**
- The USA will not internalize IP through shared infrastructure[229], or participate in IP implementation as a duty of solidarity[230]

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clinicians are not "secondary" or "optional"—they are central. Courts must treat NGO forensic reports as equally valid. States must actively support, not merely tolerate, independent forensic capacity.

[223] IP §674 — Why monitoring must be independent, public, and Statemandated. Core meaning Monitoring is essential because you cannot evaluate whether antitorture efforts are actually working without measuring outcomes. State selfmonitoring is often ineffective or corrupt; in some countries it is used to hide torture, not expose it. Therefore, independent monitoring bodies are required. Their findings must be public, because transparency is a form of accountability for State crimes. States must formally mandate and support such independent bodies. Implications Independence is not optional; it is a structural safeguard. Public reporting is a builtin antiimpunity mechanism. States cannot claim compliance if they rely solely on internal oversight bodies (police inspectorates, prison authorities, etc.).

[224] IP §675 — What an independent monitoring body must look like Core meaning The structure of the monitoring body can draw from the model of National Preventive Mechanisms (NPMs) under OPCAT. Existing independent bodies (e.g., NHRIs, ombuds institutions) may already be partially fulfilling this role. Regardless of structure, the body must comply with the Paris Principles: independence, pluralism, adequate resources, broad mandate, credibility. Civil society participation is essential, and selection must be inclusive and transparent. Implications States cannot create a "monitoring body" that is controlled by the executive. Civil society must be inside the monitoring architecture, not merely consulted. Paris Principles compliance is a legitimacy test.

[225] IP §676 — What the monitoring body must actually monitor Core meaning Monitoring must cover: Conditions for effective implementation of the Istanbul Protocol (e.g., independence of forensic services, access to lawyers, prompt medical exams). Development of standards and procedures for legal and health professions. Training of legal and health professionals. Functioning of the national documentation system, including: performance of the system, whether individuals get prompt, independent, impartial investigations, analysis of torture patterns using disaggregated data. The monitoring body may create medical and legal advisory committees of independent experts. Implications Monitoring is not just about counting cases; it is about evaluating the system. Disaggregated data (e.g., by gender, ethnicity, location, detention facility) is required to detect patterns. Technical expertise is necessary; hence advisory committees.

[226] IP §677 — Monitoring must lead to accountability for individuals and institutions Core meaning The monitoring body must: Issue recommendations and guidance to professional groups (lawyers, doctors, judges). Ensure professional accountability through: bar associations, medical boards, psychological associations, judges' associations. When violations of criminal law or professional ethics occur, the monitoring body should trigger: disciplinary proceedings, or criminal investigations. Implications This paragraph operationalizes individual accountability, not just institutional critique. It links monitoring findings to: professional discipline, licensing consequences, and criminal liability. It prevents States from treating torture as a "systemic issue" without naming responsible actors.

[227] IP §678 — States must allow and support external monitoring Core meaning States should support monitoring by: UN antitorture bodies (CAT, SPT, Special Rapporteur), regional mechanisms (e.g., CPT, ACHPR), international NGOs, domestic human rights organizations. Implications States cannot claim sovereignty to block external scrutiny. External monitoring is part of the expected compliance ecosystem. This paragraph reinforces that antitorture oversight is inherently transnational.

[228] IP §679 — Whistleblower protection is mandatory Core meaning States must ensure: Whistleblower protections apply to medicolegal and health personnel who report torture findings. Witnesses and anyone reporting torture must be protected. Officials who fail to report torture—when confidential channels exist—must be sanctioned. Implications Health professionals must be able to report torture without fear of retaliation. Nonreporting becomes a punishable breach, shifting the burden onto State officials. This paragraph protects the integrity of forensic documentation by shielding those who produce it.

[229] IP §680 says that implementing the Istanbul Protocol is not something a State can credibly claim to do in isolation. Because torture and illtreatment are Statelinked crimes, States have a heightened duty to: Cooperate: With whom? UN bodies (OHCHR, CAT, SPT, Special Rapporteurs), ICRC, regional mechanisms (e.g., CPT, OSCE), experienced NGOs, and other States. This frames implementation as a networked project, not a domestic courtesy. Coordinate: Not just ad hoc "engagement," but structured coordination of activities—training, monitoring, documentation, law reform, forensic capacity, etc.—so that Istanbul Protocol standards are applied coherently across institutions (police, prisons, forensic services, judiciary, NHRIs). Seek and accept technical assistance: The Protocol assumes that many

- The USA fails to fulfill its obligations, and civil society (e.g. IAJ) has the practical capacity to fill the gap, and **must not wait for the USA** (see IP §682[231] and IP §683[232])

Even though the USA *formally* holds the responsibility to implement the Istanbul Protocol, **civil society (e.g. IAJ) is often the decisive actor that actually makes implementation happen.** The Istanbul Protocol is a civilsociety empowerment tool. It is not merely a State manual; it is a framework for parallel accountability structures. IP informs that civil society must build independent, transnational, professionalized systems because State systems are often compromised, underresourced, or actively obstructive.

States lack sufficient expertise and infrastructure to meet its standards on their own. Technical assistance from external actors is not ornamental; it is "critical to the successful implementation". Operationally, §680 does three big things: Normalizes external scrutiny and support as part of compliance, not as an intrusion on sovereignty. Creates a presumption of insufficiency of purely domestic mechanisms where torture has been a problem. Supplies a roster of legitimate partners with whom the US can cooperate.

[230] IP §681 says that external assistance is a duty of solidarity, not charity. IP §681 shifts the lens from "how a State gets help" to "how a State gives help." It says States should provide foreign assistance for Istanbul Protocol implementation, especially: On what basis? Development, rule of law, security, cooperation, democratization, nationbuilding. In other words, Istanbul Protocol implementation is framed as a pillar of stable, legitimate governance—not a niche human rights addon. To whom, especially? Emerging democracies and States coming out of longstanding torture and illtreatment practices. This is a quiet acknowledgment that legacies of torture are structural and require longterm, externally supported rebuilding of institutions. What this does in practice: Recasts antitorture work as statebuilding: If a donor State funds "rule of law" or "security sector reform,", the Istanbul Protocol implementation is squarely within that mandate. Creates a soft expectation of donor behavior: It's not binding like a treaty article, but it's a normative standard: States that style themselves as champions of democracy and rule of law are expected to export Istanbul Protocol knowhow and resources. Links past abuse to present obligations: Where there has been "longstanding torture and illtreatment," the paragraph implies that mere cessation is insufficient—there must be reparative, capacitybuilding assistance to transform the system.

[231] IP §682 — Civil society as the real engine of implementation. The core idea is that even though States formally hold the responsibility to implement the Istanbul Protocol, civil society is often the decisive actor that actually makes implementation happen. The paragraph does several things at once: 1. It reframes implementation as a civilsocietydriven ecosystem. The Protocol explicitly recognizes that NGOs, clinicians, lawyers, human rights groups, and rehabilitation centers have—over 20 years—been the ones who: document torture, push for investigations, train state institutions, advocate for legal reforms, raise public awareness, conduct medicolegal evaluations, provide rehabilitation, and monitor compliance. This is a major normative shift: it acknowledges that States often fail to fulfill their obligations, and civil society fills the gap. 2. It validates the breadth of civilsociety uses of the Protocol. The survey results are not decorative—they serve as evidence that the Protocol is: a forensic tool (evaluations, legal investigations), a policy tool (law reform, compelling investigations), a publiceducation tool (awareness campaigns), a clinical tool (intake for medical/mentalhealth treatment), a research and training tool, and even a traumascreening tool beyond torture (child abuse, domestic violence). This breadth signals that the Protocol is not just a medicolegal manual; it is a multifunctional civilsociety instrument. 3. It asserts the legitimacy of independent clinical evidence. The paragraph stresses that: civilsociety clinicians conduct evaluations, and their evidence must be accepted in judicial proceedings. This is a direct response to States that try to exclude NGOgenerated forensic reports. 4. It emphasizes civil society's role in monitoring the State. Civil society is not just a helper; it is a watchdog ensuring that: State institutions are trained, capacitybuilding includes NGOs, and implementation is not monopolized or controlled by the State. In short: ¶682 establishes that civil society is indispensable, empirically proven, and normatively legitimate in implementing, monitoring, and operationalizing the Istanbul Protocol.

[232] IP §683 — Civil society must build its own power, not wait for the State. The core idea is that States should support civil society, but civil society must not depend on State permission or initiative. It must build independent capacity and act even when the State is unwilling or complicit. This paragraph lays out a blueprint for civilsociety autonomy. 1. Civil society must organize independently and transnationally. NGOs, lawyers, clinicians, and human rights experts should: collaborate with international and regional bodies, build their own expertise, and develop internal capacity to implement the Protocol. This is a call for parallel infrastructure, not Statedependent infrastructure. 2. Civil society must use the Protocol as a tool of accountability. The paragraph lists specific functions: conducting medicolegal documentation in individual cases, using the Protocol to evaluate whether State investigations are effective, demanding the conditions necessary for proper implementation, pushing for legal, judicial, and administrative reforms, insisting on independence of forensic and health institutions, establishing monitoring mechanisms. This is a roadmap for civilsocietydriven structural reform. 3. Psychological expertise is highlighted as a critical gap. The Protocol explicitly notes that civil society often lacks: traumainformed psychological expertise, forensic psychological capacity. This is a signal to donors, training institutions, and NGOs: psychological capacitybuilding is a priority area. 4. In contexts of impunity, civil society becomes the de facto rehabilitation system. Where torture is widespread and the State is untrusted: survivors will not seek State services, rehabilitation is provided by NGOs, and these rehabilitation centers become hubs for: documentation, prevention, advocacy, accountability, and community trust. The Protocol is acknowledging a political reality: in abusive States, civil society is the only functioning antitorture institution.

IP §**682 establishes that civil society is indispensable, empirically proven, and normatively legitimate in implementing, monitoring, and operationalizing the Istanbul Protocol**. IP §683 requires that the USA *should* support civil society, but civil society must not depend on the USA permission or initiative. It must build independent capacity and act autonomously even when the State is unwilling or complicit. The IRCT confirms the essential role played by civil society.[233]

Through the IAJ and other civil society organizations, investigations, rehabilitation centers and independent clinicians are not peripheral—they are central. They are the backbone of documentation, prevention, and survivor trust. However, IP highlights psychological expertise as a critical gap. The Protocol explicitly notes that civil society often lacks traumainformed psychological expertise, and forensic psychological capacity. This is a signal to donors, training institutions, and NGOs: **psychological capacitybuilding is a priority area.** This is a priority for the IAJ.

[233] Torture Journal: Civil Society is Essential, vol. 34, No. 1, 2024 – see also https://www.youtube.com/watch?v=rP5PBAd7eYA

APPENDIX V

Daubert Explained for a Medical Audience

Legal citation: *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

In the United States legal system, the **Daubert Standard** acts as a "gatekeeping" mechanism that judges use to determine whether expert scientific testimony is reliable enough to be presented to a jury. For a medical professional, this means your clinical opinions must be based on rigorous, peer-reviewed methodology rather than just personal experience or "anecdotal" clinical impressions.

To survive a **Daubert** challenge, your findings should generally satisfy five key factors:

- **Testability**: The theory or technique you are using must be capable of being tested (empirical validation).
- **Peer Review and Publication**: The methodology must have been subjected to scrutiny by the relevant scientific community.
- **Know Error Rate**: There should be documented data regarding the potential for error in the technique.
- **Standards and Controls**: There must be established protocols or standards governing the application of the method.
- **General Acceptance**: The method must be widely accepted within its specific medical or scientific field.

Clinical Application in Torture Investigations

Under the **IAJ Standard**, complying with **Daubert** requires shifting from simple temporal correlation (timing) to **Causation Synthesis**. This includes:

- Documenting the **physiological pathway** (e.g., how HPA axis activation leads to cortisol-induced tissue damage).
- Conducting a **differential diagnosis** to consider and exclude alternative life stressors.
- Using event anchoring, contemporaneous records, objective or clinically reliable markers, and disease-specific literature where appropriate to assess whether the institutional stressor plausibly precipitated, aggravated, or materially contributed to physical harm.

APPENDIX W

Glossary of Terms and Acronym Index

PART A: Glossary of Key Terms

- Acute Stress Disorder (ASD)
  A mental disorder diagnosed within one month of exposure to traumatic event(s), characterized by intrusion symptoms, negative mood, dissociative symptoms, anxiety, and arousal symptoms.
- Adversarial Legal System
  A legal system in which opposing parties present their cases to a neutral adjudicator (judge or jury), as opposed to inquisitorial systems where a judge investigates the case.
- Affect Dysregulation
  Difficulty controlling emotional responses; common in complex trauma presentations.
- Americans with Disabilities Act (ADA)
  U.S. federal law prohibiting discrimination against individuals with disabilities in various contexts.
- Battery Without Touching
  See "Distress-Induced Harm."
- CIDT
  Cruel, Inhuman, or Degrading Treatment.
- Complex PTSD (CPTSD)
  ICD-11 diagnosis capturing disturbances in self-organization following chronic/traumatic exposure.
- Convention on the Rights of Persons with Disabilities (CRPD)
  International treaty protecting rights of persons with disabilities.
- Daubert Standard
  U.S. Supreme Court standard for admissibility of expert testimony, requiring scientific methodology.
- Decompensation
  Deterioration of previously functioning psychological defenses, leading to symptom exacerbation.
- Deliberate Indifference
  Legal standard requiring officials to knowingly disregard substantial risk of harm.
- Depersonalization
  Feeling detached from one's own thoughts, feelings, or body.
- Derealization
  Feeling that the external world is unreal or distorted.
- Distress-Induced Harm
  Psychological harm caused by intentional infliction of severe emotional distress without physical contact.
- Eighth Amendment
  U.S. Constitutional amendment prohibiting cruel and unusual punishment.
- Enduring Personality Change After Catastrophic Experience (EPCACE)
  ICD-10/11 diagnosis for personality changes following catastrophic stress.
- Expert Witness

Person with specialized knowledge qualified to assist the court in understanding evidence.

- Federal Rule of Evidence (FRE) 702
  Rule governing admissibility of expert testimony.
- First Amendment
  U.S. Constitutional amendment protecting speech, religion, and assembly.
- Forensic Evaluation
  Evaluation conducted for legal purposes rather than treatment.
- Fourteenth Amendment
  U.S. Constitutional amendment guaranteeing due process and equal protection.
- Fourth Amendment
  U.S. Constitutional amendment protecting against unreasonable searches and seizures.
- Gatekeeping
  Practice of restricting access to specialized services or expertise.
- Human Rights Defender
  Person who promotes and protects human rights; may receive special protection status.
- ICD
  International Classification of Diseases (WHO).
- Idioms of Distress
  Culturally specific expressions of psychological suffering.
- Istanbul Protocol (IP)
  International standard for documenting torture.
- IRCT
  International Rehabilitation Council for Torture Victims.
- Learned Helplessness
  Psychological condition where individual believes they have no control over outcomes.
- Malingering
  Fabrication or exaggeration of symptoms for external gain.
- Mental Status Examination (MSE)
  Structured assessment of mental state.
- PHR
  Physicians for Human Rights.
- Posttraumatic Stress Disorder (PTSD)
  Mental disorder resulting from trauma exposure.
- Pro Se
  Representing oneself without attorney in legal proceedings.
- Shattering
  Comprehensive destruction of psychological functioning.
- Sleep Deprivation
  Intentional prevention of adequate sleep.
- State Action
  Conduct attributable to government rather than private actors.
- Systemic Torture
  Torture operating through institutional policies and practices.
- Torture
  Intentional infliction of severe pain or suffering for prohibited purposes.
- UNCAT
  United Nations Convention Against Torture.

- Vicarious Trauma
  Psychological impact on professionals working with trauma survivors.
- WHODAS 2.0
  World Health Organization Disability Assessment Schedule.

PART B: Acronym Index

ADA: Americans with Disabilities Act

CIDT: Cruel, Inhuman, or Degrading Treatment

CRPD: Convention on the Rights of Persons with Disabilities

DSM: Diagnostic and Statistical Manual of Mental Disorders

EPCACE: Enduring Personality Change After Catastrophic Experience

FRE: Federal Rules of Evidence

ICD: International Classification of Diseases

IP: Istanbul Protocol

IRCT: International Rehabilitation Council for Torture Victims

PHR: Physicians for Human Rights

PTSD: Post-Traumatic Stress Disorder

RUD: Reservations, Understandings, Declarations

UNCAT: United Nations Convention Against Torture

WHODAS: World Health Organization Disability Assessment Schedule

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Psychological investigation standard for torture, and cruel, inhuman or degrading treatment or punishment in the United States of America

DATE March 24, 2026

IAJ Document Version Control Log

Document ID: IAJ-STD-20260324-001-PUB
Release Date: 2026-03-24

This Standard (v1.5) supersedes all prior versions on clinical methodology and documentation standards. Companion documents provide the legal and normative framework. Where any prior version conflicts with v1.5, v1.5 controls.

Version History

Version	Date	Author(s)	Summary of Changes
v1.5	2026-03-24	IAJ	various clarifications, citations to IAJ documents. v1.6
v1.4	2026-03-11	IAJ	definitions, report corrections, version correction
v1.3	2026-03-05	IAJ	date error corrected (CAT)
v1.2	2026-03-02	IAJ	Case vignette updates
v1.1	2026-01-29	IAJ	Ethics update, case vignettes
v1.0	2025-08-09	IAJ	Initial release

Classification: IAJ Standard
Access Level: Public