PSYCHOLOGICAL INVESTIGATION STANDARD

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

IN THE UNITED STATES OF AMERICA

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RELATED IAJ DOCUMENTS

IAJ Quick Reference to Psychological Evaluation and Intermediate Manual — companion to this Standard

IAJ Licensing Duty Equivalence Companion — licensure-tier duties and scope under this Standard

IAJ Plain-Language Guide to Psychological Evaluation — entry point for non-specialists; first step in the reading sequence

UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It

Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks (evidentiary source for Appendix U judicial-conduct findings)

Brief for the Institute for the Advancement of Justice & Human Rights as Amicus Curiae, In the Interest of K.N., K.L., K.L., and K.L., Children, Cause No. 24-0881, Supreme Court of Texas

PARENT–CHILD SEPARATION IN THE UNITED STATES: A Unified Constitutional and Human-Rights Framework — Integrating the Constitutional Architecture of Troxel II with the IAJ Multi-Treaty Synthesis

Quia Timet and the Prevention of Threatened Torture and Cruel, Inhuman or Degrading Treatment by Domestic Authorities

TABLE OF CONTENTS

TABLE OF CONTENTS 2
Module 1: Legal & Normative Framework 14
IAJ Framework Reference Architecture 14
PREFACE 15
What is being investigated? 22
Important clarifications about torture and CIDT in the USA 25
Application of UNCAT Definitions to Systemic Institutional Torture 48
Definition of Terms 49
Navigating U.S. Treaty Reservations and Domestic Legal Requirements 56
Mandated Safeguards Against Ill-Treatment 57
Constitutional Standards for Psychological Evidence Correlation 63
I. Primary Constitutional Anchors 63
II. The "Equivalency Gap" and the Incompleteness of RUDs 64
III. The Mandate for Specialized Competence 64
IV. Judicial Duties Under the 2022 Istanbul Protocol (IP Chapter III, §§257–261): 64
V. Determination of State Action 65
Physical Documentation in Psychological Investigation 65
Who may perform the psychological evaluations 66
Part A: Foundational Distinctions 66
Part B: What the Istanbul Protocol Actually Requires 68
Part C: Psychological Tests Are Components, Not Assessments 69
Part D: Qualified Evaluators Under the IAJ Framework 70
IAJ Level Designations and External Credential Requirements 70
Part E: Who May NOT Independently Perform the Evaluation 73
Part F: The Mainstream Bias and How to Overcome It 74
Part G: The IAJ Collaborative Expert Model 74
Part H: Expert Witness Qualification in U.S. Courts 75
Part I: Overcoming Challenges 78
Part J: Conclusion 84
Operational Rule: Navigating Domestic Proceedings While Preserving International Standards 84
IAJ Training Infrastructure: Capacity-Building in Hostile Environments 90

Strategic Mandate for Independent Capacity....90
Module 2: Investigation Methodology & Intent Analysis....91
Systemic Torture and CIDT: A Framework for Investigation....91
Characteristics of Systemic Torture/CIDT: 91
Evaluating Systemic Torture/CIDT: 92
Essential Principles for the psychological evaluation....94
Intent Analysis for Systemic Violations: 100
Applied Case Guidance: Systemic Intent Determination....106
Intent in Technology-Facilitated Torture and Psychological Abuse 109
A: Introduction....109
B: Forms of Technology-Facilitated Torture....109
C: Psychological Impact....109
D: Legal Framework for Intent Analysis....109
E. Intent Determination by Scenario Category....110
Module 3: Psychological Evaluation Procedure & Applied Forensic Workflow....112
Performing the psychological evaluation....112
Quick-Reference Decision Tree: Diagnosis Determination....113
Interview Process....113
Pacing, Breaks, and Session Integrity 114
Components of the psychological/psychiatric evaluation 115
(a) History of torture and ill-treatment....115
(b) Current psychological complaints 121
(c) Post-torture history 122
(d) Pre-torture history....122
(e) Medical history....123
(f) Psychiatric history....123
(g) Substance use and misuse history....123
(h) Mental status examination 123
(i) Assessment of social function....123
(j) Psychological testing and the use of checklists and questionnaires 124
(k) Interpretation of findings: Psychological Consistency Analysis 124
(l) Supplemental Forensic Multi-Axial Framework....126
(m) Beyond Standard PTSD: Comprehensive Diagnostic Frameworks for Systemic Torture . 127
(n) Correlating Psychological Sequelae with Physical Methods....129

Neuropsychological assessment 130
(a) Limitations of neuropsychological assessments 130
(b) Indications for neuropsychological assessment 132
(c) Post-traumatic stress disorder 133
Children and torture 135
(a) Developmental considerations 135
(b) Considerations for conducting the evaluation 137
(c) Clinical considerations 138
(d) Diagnostic classification 140
(e) Family context 142
(f) Role of the family 142
(g) Special Considerations for Assessment of Sexual Assault in Children 143
Male Survivors of Torture and CIDT 144
Section A: Prevalence and Context 144
Section B: Forms of Torture Specific to Male Victims 144
Section C: Psychological Presentations 144
Elderly Persons and Torture/CIDT 144
Section A: Introduction 144
Section B: Contexts of Abuse 144
Section C: Unique Presentation Considerations 144
Lesbian, gay, bisexual, transgender and intersex persons and torture and ill-treatment 145
A. Specific Forms of Persecution and Torture Targeting LGBTQI+ Individuals 146
B. Cultural Competency Requirements for Evaluators 147
C. Evaluation Considerations for LGBTQI+ Individuals 148
D. Intersectionality Considerations 149
E. Report Writing for LGBTQI+ Evaluations 150
Immigration Detention and Immigrant Populations 151
Section A: Scope and Relevance 151
Section B: Forms of Persecution Targeting Immigrants 151
Section C: Evaluation Considerations 151
Section D: Documentation Requirements 151
Evaluating Persons with Disabilities in Torture and CIDT Investigations 151
A. Introduction and Scope 151
B. Legal and Normative Framework 152

C. Disability as a Target and Mechanism of Torture 153
D. Systemic Discrimination as Ongoing Torture 155
E. Documentation Protocols for Disability-Related Torture 156
F. Psychological Impact Assessment 158
G. Special Considerations by Disability Type 159
H. The Treating Provider's Role 161
I. Investigation Strategy: Disability Discrimination as Systemic Torture 162
J. Ethical Obligations in Disability Investigations 163
K. Conclusion: Disability Rights as Human Rights 164
L. Appendix 165
Summary Checklist for Specialized Populations 165
Disability 165
LGBTQI+ 165
Intersectionality 165
Credibility and Reliability Assessment 165
A. Purpose and Framework 165
B. Istanbul Protocol Consistency Framework 167
C. Applied Case Guidance: Credibility Assessment in Strong, Weak, and Ambiguous Presentations 169
D. Conflicts with Western-Oriented Tests and Methodologies 171
E. Factors Bearing on the Reliability of Clinical Evidence 173
F. Factors Requiring Careful Assessment 173
G. Secondary Gain Assessment 174
H. Response Validity, Feigning, and Misclassification Risk 175
I. Documentation in the Report 177
Cultural Humility: A Transcultural Framework for Torture Investigation 177
I. Foundational Principles 178
II. Idioms of Distress: Beyond Western Symptomatology 178
III. Intersectional Frameworks in the U.S. Context 178
IV. Clinical Guidelines for Culturally Humble Evaluations 179
V. Integration of Cultural Humility into Consistency Assessments 179
VI. Enhanced Cultural Humility Framework 179
Role of the Psychological Evaluation 181
I. Foundational Purpose 181

II. The Five Functions of Psychological Evaluation 181
III. The Scope of Psychological Evaluation 183
IV. The Principles Governing Psychological Evaluation 186
V. Why Psychological Evaluation Is Essential 187
VI. The Psychological Evaluation in Context 188
VII. Synthesis: The Role Defined 190
VIII. Integration of Istanbul Protocol Chapter IV: General Considerations for Interviews 191
IX. Adaptations of the Istanbul Protocol to scenarios of torture and CIDT in the USA 194
Module 4: Harm Documentation & Causation Synthesis 199
Psychological consequences of torture and ill-treatment 199
Quick-Reference Decision Tree: Severity Rating 200
Decompensation in Torture Contexts: 201
Evaluator Guidance on Decompensation: 202
Evidentiary Significance: 202
Dissociation, depersonalization and atypical behaviour 203
The Doctrine of Distress-Induced Harm 203
I. Introduction 203
II. Legal Foundations 204
III. Medical and Scientific Basis 206
IV. Barriers in American Jurisprudence: Navigating the Gap Between International Standards and U.S. Jurisprudence 210
V. Limitations to Ensure Responsible Application 224
VI. Application in U.S. Contexts 224
VII. Conclusion 224
Enhanced Causation Analysis and Documentation Methodology 225
Functional Analysis of Behavior Approach 225
The IAJ Clinical Attribution Rating, the Istanbul Protocol consistency categories and the IAJ Forensic Certainty Scale 226
Chronological Mapping 227
Systemic Harm Mapping Tool 227
Part A: Multi-System Interaction Matrix 227
Part B: "Battery Without Touching" -- Analysis of Distress-induced Harm 227
Part C: Applied Case Guidance: Distress-Induced Harm 228
Part D: Narrative of Institutional Entrapment 230

Confidential Reporting:..... 230
Assessment Administration Protocol..... 231
Purpose..... 231
A. Instrument Selection Decision Tree..... 231
B. Core Instrument Protocols..... 232
C. Assessment Sequencing..... 236
D. Cultural Adaptation Considerations..... 236
E. Documentation Requirements..... 237
Module 5: Documentation Standards & Forensic Credibility..... 238
Report Writing Standards..... 238
A. Purpose of the Report..... 238
B. Quick-Reference Decision Tree: Report Formulation..... 238
C. Essential Report Elements..... 239
D. Language and Terminology Standards..... 243
E. Report Structure for Different Audiences..... 245
F. Model Report Template..... 246
Tiered Model Report Templates and Fillable Skeleton Report..... 247
I. How to Use This Section..... 247
II. Template A: Preliminary / Lower-Complexity Report..... 247
III. Template B: Standard Forensic Torture/CIDT Report..... 248
IV. Template C: Advanced Systemic / High-Complexity Report..... 250
V. Section-by-Section Annotation Guide..... 252
VI. Problematic Language and Better Alternatives..... 252
VII. Audience Adaptation Notes..... 253
VIII. Template Selection Quick Guide..... 254
IX. Model Section XII. Forensic Conclusions and Attribution Analysis..... 255
X. Fillable Skeleton Report..... 257
Module 6: Ethical Obligations & Expert Protection..... 258
Ethical Obligations in Hostile Institutional Environments..... 258
Preamble..... 258
Section 1: The Universal Duty to Document..... 260
Section 2: Dispelling the Qualification Myth..... 263
Section 3: The Continuum of Documentation Authority..... 265
Section 4: The Ongoing Investigation Imperative..... 275

Section 5: Protection from Legal System Abuse 276
Section 6: Professional Ethical Frameworks 280
Section 7: Specific Obligations by Provider Type 282
Section 8: Documentation as Treatment 284
Section 9: The Imperative of Non-Withholding 286
Section 10: Implementation Standards 288
Section 11: Case Vignette -- The Attorney Representation Barrier 291
Section 12: Conclusion: The Witness Obligation 291
Module 7: Case Vignettes and Examples 294
Case Vignette 1: Systemic CIDT in Child Welfare Proceedings 294
Background: 294
Alleged Conduct: 294
Evaluation Findings: 294
Clinical Formulation: 295
Consistency Assessment: 295
Report Excerpt (Conclusions): 295
Case Vignette 2: LGBTQI+ Persecution in Immigration Detention 295
Background: 295
Alleged Conduct (Uganda): 295
Alleged Conduct (U.S. Detention): 295
Evaluation Findings: 296
Clinical Formulation: 296
Consistency Assessment: 296
Report Excerpt (Conclusions): 296
Case Vignette 3: Torture Under Color of Law Enforcement 297
Background: 297
Alleged Conduct: 297
Evaluation Findings: 297
Clinical Formulation: 298
Consistency Assessment: 298
Report Excerpt (Conclusions): 298
Case Vignette 4: Systematic Solitary Confinement (CAT Reporting Area 1) 299
Background: 299
Alleged Conduct: 299

Evaluation Findings: 299
Clinical Formulation: 300
Consistency Assessment: 300
Report Excerpt (Conclusions): 300
Case Vignette 5: Excessive Use of Police Force and Racial Humiliation (CAT Reporting Area 2) 300
Background: 300
Alleged Conduct: 300
Evaluation Findings: 301
Clinical Formulation: 301
Consistency Assessment: 301
Report Excerpt (Conclusions): 301
Case Vignette 6: Immigration Detention and Targeted Persecution (CAT Reporting Area 3) 302
Background: 302
Alleged Conduct: 302
Evaluation Findings: 302
Clinical Formulation: 302
Consistency Assessment: 302
Report Excerpt (Conclusions): 303
Case Vignette 7: Systemic Judicial Discrimination and MS Relapse (CAT Reporting Area 4) 303
Background: 303
Alleged Conduct: 303
Evaluation Findings: 303
Clinical Formulation: 304
Consistency Assessment: 304
Report Excerpt (Conclusions): 304
Case Vignette 8: Allegation Not Supported by the Clinical Evidence (negative case) 304
Case Vignette 9: Mixed Evidence — Severe Suffering Established, Institutional Attribution Unresolved (mixed case) 306
Educational Materials and Exercises 308
Module 8: Rights-Controlling Ecosystem Methodology 309
I. Purpose, status and relationship to Modules 1–7 309
II. The Non-Prerequisite Rule 309
III. Step 1 — Ecosystem mapping 309

What is mapped 310
How it is recorded 310
IV. Step 2 — Structural and protection gaps 310
The four functions and their external standards 310
Gap classification 311
V. Step 3 — Outcome and collective harm 311
VI. Step 4 — Evidence-weighted alternatives 312
The standard alternatives 312
How alternatives are weighed 312
VII. Step 5 — Control, notice and persistence 312
VIII. Step 6 — Bias controls 313
IX. Outputs and determinations 314
X. Limits 314
APPENDIX A 316
IAJ Symptom-to-Instrument Selection Guide 316
APPENDIX B 319
Functional and cognitive assessment 319
APPENDIX C 321
SIMPLIFIED ASSESSMENT ADMINISTRATION PROTOCOL 321
APPENDIX D 335
Fillable Skeleton Report 335
APPENDIX E 346
Disability Accommodation Documentation Checklist 346
Key Legal Standards for Disability-Based Investigations 346
Case Vignette - Systemic Judicial Disability Discrimination 347
APPENDIX F 349
IAJ Legal Objection Template 349
APPENDIX G 351
IAJ FORENSIC INTEGRITY ATTESTATION (SUPERVISORY) 351
APPENDIX H 354
IAJ CLINICIAN'S INCIDENT REPORT FORM (CIRF) 354
APPENDIX I 356
Training Module: Strategic Use of the IAJ Clinician's Incident Report Form (CIRF) 356
I. Understanding the "Witness Obligation" (The Why) 356

II. Recognizing "Red Flags" for Obstruction (The When) 356
III. Operational Security and Digital Protection Protocols for Evaluators in Hostile Environments 356
IV. Navigating the "Hostile Supervisor" Dynamic 356
V. Escalation & External Protection 357
APPENDIX J 358
NOTICE OF HUMAN RIGHTS DEFENDER STATUS & ETHICAL SHIELD 358
APPENDIX K 360
Basic Training Module for Non-Specialists: Istanbul Protocol Application 360
I. Introduction (The Why) 360
II. Key Steps (The How) 360
III. Practice Scenarios 360
IV. Quick-Reference Checklist 362
APPENDIX L 363
CASE VIGNETTE: The Attorney Representation Barrier 363
Introduction 363
Case Presentation: Mr. V 363
The Ethical Question 364
Analysis 364
Clinical Documentation: What Was Documented 366
The Ethical Imperative 367
Discussion Questions 367
Conclusion 368
APPENDIX M 369
Systemic Torture Recognition 369
I. Introduction (The Why) 369
II. Key Steps (The How) 369
III. Practice Scenarios 369
IV. Quick-Reference Checklist 370
APPENDIX N 371
Conflicts between Western-Oriented Tests and Istanbul Protocol Best Practices 371
I. Overview 371
II. Key Scenarios 371
III. Best Practices 371

IV. Quick-Reference 371
APPENDIX O 373
Guidance on Dissociation, Depersonalization, and Atypical Behaviour in Evaluations 373
I. Overview 373
II. Key Instances 373
III. Best Practices 373
IV. Quick-Reference 373
APPENDIX P 374
IAJ Cultural Validation Checklist 374
I. Language and Communication 374
II. Idioms of Distress and Symptomatology 374
III. Intersectional and Power Dynamics 374
IV. Consistency and Credibility Validation 374
Implementation Note 375
APPENDIX Q 376
I. Foundational Forensic Framework 376
II. Recognition of Idioms of Distress 376
III. Scientific Necessity of Qualitative Narrative 376
IV. Forensic Conclusion Regarding Consistency 376
V. Judicial Briefing Note 377
Implementation Instructions 378
APPENDIX R 379
IAJ PEDIATRIC FORENSIC EVALUATION: CONSENT & ASSENT FORM 379
I. PARENTAL / GUARDIAN CONSENT 379
II. CHILD ASSENT (Age-Appropriate Language) 379
III. SPECIALIZED MEDICAL CONSENT 380
IV. CLINICIAN ATTESTATION 380
APPENDIX S 381
IAJ Pediatric Decompensation Protocol 381
I. Recognition of Acute Decompensation 381
II. Immediate Intervention Steps 381
III. Supervisory and Ethical Escalation 381
IV. Post-Decompensation Recovery Plan 382
APPENDIX T 383

IAJ Clinician's Self-Care Protocol for Vicarious Trauma 383
I. Immediate Post-Evaluation "Decompression" 383
II. Recognizing Red Flags of Vicarious Trauma 383
III. Systematic Defensive Measures 383
IV. Ethical and Professional Boundaries 384
V. Escalation for Professional Support 384
APPENDIX U 385
Background Context: The Investigative Landscape for Torture and CIDT in the United States. 385
APPENDIX V 397
Daubert Explained for a Medical Audience 397
APPENDIX W 397
Glossary of Terms and Acronym Index 397
PART A: Glossary of Key Terms 398
PART B: Acronym Index 400
APPENDIX X 401
Ecosystem Mapping Record (Module 8) — fillable instrument 401
INDEX 404

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.

Status of the terms in this table. Distress-Induced Harm, Biological Assault, Forum Nullus, Aggravated Suppression and Sovereign Withdrawal are IAJ doctrinal proposals. They have not been adopted by a treaty body, Special Procedure or court. The External Legal Grounding column identifies the sources on which the IAJ relies by analogy or extension, not sources that adopt the doctrine. The Clinical Attribution Framework and the Dual-Track Rule are IAJ methods that have not been independently validated.

Term / Doctrine	External Legal Grounding	IAJ Companion Document
Distress-Induced Harm "Battery Without Touching" Status: IAJ doctrinal proposal; not adopted by any treaty body, Special Procedure or court.	ECHR Art. 3; IP §§6–10; CAT GC No. 2 §21	UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dim. V Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §6.1–6.3
Biological Assault (physiological harm pathway) Status: IAJ doctrinal proposal; not adopted by any treaty body, Special Procedure or court.	State-created danger doctrine; CRPD Art. 15; UNCAT Art. 1	Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §6.2–6.3 UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dim. V.B
Forum Nullus Status: IAJ analytical construct; not adopted by any treaty body, Special Procedure or court.	Exhaustion of domestic remedies; VCLT Art. 53; CRPD Art. 13	UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dim. VI.D Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §6.7
Aggravated Suppression Status: IAJ analytical category; not adopted by any	U.S. RUD equivalence failure; CAT/C/USA/CO/3-5; VCLT Art. 19(c)	UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial

treaty body, Special Procedure or court.		Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dim. IV Brief for the Institute for the Advancement of Justice & Human Rights as Amicus Curiae, In the Interest of K.N., K.L., K.L., and K.L., Children, Cause No. 24-0881, Supreme Court of Texas
IAJ Clinical Attribution Framework (formerly "Forensic Probability Standard") Status: IAJ structured professional judgment framework; not externally validated; no known error rate.	IP §§417, 524; FRE 702; SPJ literature	Appendix V UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dim. VI.A
Dual-Track Rule (Two Legal Planes) Status: IAJ procedural rule.	Medellín v. Texas (plane b only); UNCAT Art. 1 & 16 (plane a)	UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Prefatory Note & Dim. IV.B
Sovereign Withdrawal Status: IAJ doctrinal proposal; not adopted by any treaty body, Special Procedure or court; definition pending Institute adoption.	Judicial immunity limits; VCLT Art. 53 jus cogens	Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §6.5 UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, 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.

Each institution's conduct, omissions, structural design, protective functions and actual consequences are assessed on the evidence. No institutional finding is accepted or rejected merely because of its source; the IAJ evaluates the underlying facts independently, identifies contrary evidence and authority, and explains any departure from established interpretations. Independence is not a presumption that wrongdoing occurred; it is the requirement that neither institutional status nor established practice may prevent a proper investigation or dictate its outcome. Statements in this Standard about U.S. institutions record the IAJ's observations from its investigations, as distinct from findings of responsibility in a particular case.

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

No institution is categorically excluded from IAJ scrutiny by reason of its legal status, constitutional role, international mandate, institutional reputation, professional authority, privileges and immunities, or prior contribution to human-rights protection. Wherever the evidence warrants, the investigative scope extends to courts, legislatures, executive authorities, public agencies, private entities exercising relevant control, professional bodies, oversight mechanisms, national human rights institutions, international organizations, UN mechanisms, treaty bodies, and the IAJ itself. Immunity from a particular forum's jurisdiction is not immunity from investigation, factual scrutiny or human rights accountability.

Universal Institutional Scope and Independence. The IAJ has observed, through its investigations of alleged and documented human rights violations in the United States, recurring structural and institutional conditions that warrant systematic investigation, including ineffective protective mechanisms, barriers to independent examination, failures of accommodation, inaccessible remedies, institutional control over evidence, and deficiencies in accountability. These observations are among the reasons for establishing this Standard.

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.
- In the IAJ's observation, certain categories of prohibited acts that may constitute torture and CIDT have no domestic remedy, relief or punishment, and institutions and courts in matters investigated by the IAJ have prevented exhaustion of remedies that the U.S. assures the international community are available in the USA.[2][3]

In the IAJ's assessment, 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.

[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

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. In specific IAJ case investigations, the IAJ has documented what it terms a structural inversion (an IAJ doctrinal proposal), in which, on the IAJ's assessment, institutional actors responsible for maintaining safe harbor 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.[4]

IAJ case records indicate that institutions have not integrated Istanbul Protocol 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 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

[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) responsible for maintaining this safe harbor may, on the IAJ's analysis, facilitate what the IAJ terms biological assault through coercive procedures. Forum Nullus: When these domestic safe harbors are systematically denied, the IAJ may characterize the venue as a forum nullus (an IAJ doctrinal proposal)—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.

[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/

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.

Status of this Standard. External peer review or scientifically established error rates must not be claimed unless actually demonstrated. This Standard is published by the Institute for the Advancement of Justice & Human Rights. It incorporates the 2022 Istanbul Protocol but is not endorsed by OHCHR, the Committee against Torture, the IRCT or any court. No institution's characterization of the facts, including that of a court, a treaty body or the IAJ, is treated as conclusive; authorities are cited for their reasoning and with their actual status, and where the IAJ departs from an authority it says so and gives reasons. Doctrines and methods originated by the IAJ are identified as such in the IAJ Framework Reference Architecture. They have not yet been independently peer reviewed. The IAJ is commissioning review by independent experts in forensic psychology, international human rights law and neurology, and will record the reviewers' conclusions and the known limitations of each IAJ method in the version log.

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 become familiar quickly with the investigation of alleged or suspected torture and ill-treatment, particularly where historically underestimated processes are implicated in systemic violations, and to participate in, and ultimately conduct, forensic clinical evaluations within their demonstrated professional competence and lawful scope (Module 1, Parts D–E). IAJ orientation is optional; it informs, but does not confer, that competence.

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;
- 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 §§539–540.

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 licensing laws can limit who may conduct examinations in a given State. 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 Licensing Duty Equivalence Companion 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 UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dimension IV.B on domestic enforceability as distinct from the international legal obligation.[10]

[10] Article VI of the U.S. Constitution. Note: the United States declared Articles 1–16 of UNCAT non-self-executing, and courts do not enforce them directly (Medellín v. Texas, 552 U.S. 491 (2008)); the obligation binds the United States internationally irrespective of domestic enforceability. Text: "…This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all

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.

Clinical Attribution (formerly "Forensic Probability")

To support U.S. admissibility requirements for "reliable principles and methods," IAJ evaluators shall frame conclusions using the IAJ Clinical Attribution Framework (formerly "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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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 preserve the evidence and promptly consider appropriate IAJ protective procedures and communications to relevant UN Special Procedures, including the Special Rapporteur on Torture, subject to consent, confidentiality and security. Information may also be supplied to the Committee against Torture through applicable reporting and monitoring processes, but the United States has not accepted the Committee's individual-communications procedure under UNCAT Article 22. None of these communications guarantees a protective response. 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?

DIAGNOSIS-INDEPENDENCE (summary). The IAJ evaluates alleged torture or CIDT by the applicable conduct, State involvement, severity, purpose and contextual elements under UNCAT, not by whether the individual presently or historically meets the criteria for PTSD, complex PTSD, EPCACE or any other psychiatric diagnosis. A diagnosis may corroborate effects; its absence is not a negative human-rights finding. The inquiry remains open where the individual has recovered, has subthreshold symptoms, had no clinical access, or cannot safely take part in an examination. See the controlling IAJ Severity-Independence Rule (Module 3, Performing the psychological evaluation) and Istanbul Protocol (2022) §§390–391, 493, 498 and 542.

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]

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[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. 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. 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

__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 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.

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

1. Addressing U.S. Non-Compliance and "Aggravated Suppression" (an IAJ analytical category)

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 treated the absence of physical contact as a shield. Institutions have treated the invisibility of psychological harm as a license. This Standard enables investigators to document harm that is not physically visible, including harm arising in institutional settings.

- The Equivalent Pathway Failure (Structural Accountability Gap): 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. The IAJ Standard responds to this Aggravated Suppression by conducting substantive international-law analysis under the full UNCAT standard first.[16][17]
- **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, including event anchoring and differential analysis, informed by published prospective evidence of association between stressful life events and disease exacerbation (e.g., MS: Ackerman et al. 2002; Buljevac et al. 2003). Population associations support plausibility; individual attribution requires case-specific evidence and differential analysis.

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

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

Mechanism of Harm	Focus on direct physical/psychological torture.	Focus on Distress-Induced Harm (an IAJ doctrinal proposal): physical deterioration (e.g., MS relapse, cardiac events) associated with non-physical procedural stressors, assessed case by case.
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 incidents of interference for separate legal assessment.
- **Forum Nullus Determination: The Standard defines specific data points to assess whether to characterize a domestic venue as *forum nullus* (an IAJ analytical construct not adopted by any treaty body, Special Procedure or court, and not a designation by a court or treaty body)—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.**[18]

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. For torture, the prohibition is a peremptory norm binding on every State regardless of ratification; the prohibition of CIDT is also binding through ICCPR Article 7 and, in the IAJ's view, customary international law.

[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 similarly situated cases, with the number of cases and the basis of comparison stated; (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 made by the IAJ directorate on institutional and legal evidence; Level 4 clinical input is optional — 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. In the IAJ's view, CAT findings are authoritative (though non-binding) 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 reporting procedure (Article 19) but not individual communications (Article 22) 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.' The United States accepted the Article 21 inter-State procedure but not Article 22 individual communications; periodic reporting under Article 19 and Special Procedures communications remain available. These limits require 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.

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

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 (procedural accommodations for persons with disabilities are addressed by CRPD Article 13 and HRC interpretation).
- **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" is cited by the IAJ as persuasive analogical support for its Biological Assault and Sovereign Withdrawal proposals (both IAJ doctrinal proposals, not adopted by any treaty body, Special Procedure or court). The Court has not addressed those 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 designed to record pattern evidence that may be relevant to the "widespread or systematic" element .
- **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 of torture is a peremptory norm of international law from which no derogation is permitted; the peremptory status of the CIDT prohibition is widely asserted but less settled. 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 are subject to universal jurisdiction and prosecution, while retaining fair-trial rights. 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 regarding individual cases, including alleged ongoing harm.
- 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 UNCAT has been criticized in the Committee against Torture's concluding observations and in the objections of the Netherlands and Finland to the U.S. reservation to Article 16 (see FN25–26 for the depositary text). Through the periodic reporting procedure under Article 19, the Committee has repeatedly expressed concern that the RUDs hinder full compliance and has recommended their withdrawal (CAT/C/USA/CO/3-5, paras. 9–10; see also CAT/C/USA/CO/2 (2006), para. 13, calling for a federal crime of torture consistent with article 1). Article 19(c) of the Vienna Convention on the Law of Treaties, which reflects customary international law, prohibits reservations incompatible with a treaty's object and purpose; the view that such reservations are severable derives from Human Rights Committee General Comment No. 24 and regional practice. The United States has not ratified the VCLT. No U.S. court has adjudicated this question on the merits.[29][30][31][32]

[29] See the depositary text of the Netherlands and Finland objections reproduced in FN25–26. These objections concern the U.S. reservation to Article 16. The Committee against Torture's concluding observations (e.g., CAT/C/USA/CO/3-5, 2014) express related concerns about the RUDs.

[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. In the IAJ's view, these actions engage the U.S. in the Committee's oversight; concluding observations are authoritative but non-binding recommendations that States must consider in good faith. 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 (CAT/C/USA/CO/3-5) express concerns and recommendations on, among other matters: definition and criminalization of torture and the RUDs, including "prolonged mental harm" (para. 9); extraterritoriality and the reservation to Article 16 (para. 10); the CIA rendition, secret detention and interrogation programme and inquiries into torture overseas (paras. 11–12); military accountability (para. 13); Guantanamo Bay (para. 14); abuse of State secrecy provisions and immunities that prevent redress (para. 15); transfers and diplomatic assurances (para. 16); interrogation techniques (para. 17); expedited removal and asylum (para. 18); immigration detention (para. 19); solitary confinement (para. 20); sexual violence in detention, including the shackling of pregnant women (para. 21); deaths in custody (para. 22); juvenile justice and life-without-parole sentences for juveniles (paras. 23–24); the death penalty (para. 25); police brutality and excessive force (para. 26); electrical discharge weapons (para. 27); training of staff, including medical personnel, in accordance with the Istanbul Protocol (para. 28); redress, compensation and rehabilitation (para. 29); and sexual violence in the military (para. 30).

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 Against Torture and its Concluding Observations[38], rather than adopting narrower domestic

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[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] In the IAJ's view, the Concluding Observations by the CAT are authoritative, though non-binding, interpretations of U.S. treaty obligations, which the U.S. must consider in good faith. The U.S. is obliged under the Convention 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 the Convention the United States is bound to take effective measures to prevent torture and ill-treatment (Articles 2 and 16), to investigate (Article 12), to examine complaints and protect complainants (Article 13), to provide redress (Article 14) and to report to the Committee (Article 19). The Committee's Concluding Observations are authoritative but non-binding recommendations which the State must consider in good faith. The IAJ assesses that specific recommendations made since 2006 remain unimplemented.

[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 reservation to Article 16 upon ratification. The Netherlands considered the reservation "to be incompatible with the object and purpose of the Convention, to which the obligation laid down in article 16 is essential"; Finland objected on the ground that a reservation consisting of a general reference to national law without specifying its contents does not clearly define the extent to which the reserving State commits itself (depositary texts reproduced in footnotes 25 and 26). These objections 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 — Minimize Committee findings. The 2014 concluding observations recorded concerns across most areas of the Convention; the Committee's 2016 follow-up assessment and the United States' 2021 periodic report record partial responses but, in the IAJ's assessment, no general implementing legislation, no independent national investigative mechanism, and no systematic redress programme for the categories of victims the Committee identified 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. In the IAJ's assessment, the available mechanisms are not functionally equivalent to the Convention's requirements: there is no independent national investigative mechanism of the kind the Protocol describes; judicial remedies exist in form but, for the categories of conduct the IAJ investigates, are blocked by immunities and procedural doctrine; no general implementing legislation has been enacted; and executive enforcement is discretionary and, on the Committee's record, inadequate (CAT/C/USA/CO/3-5, paras. 9, 15, 26, 29). The IAJ's finding is that existing remedies are not effective or equivalent, not that none exists in law. 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, prompt and impartial investigation is required under Articles 12 and 16; the IAJ assesses that it is not provided for the conduct it investigates. The IAJ performs, as a civil-society body, an investigative function the United States has not established. 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):

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.

The prohibitions of torture and cruel, inhuman or degrading treatment or punishment are absolute and non-derogable. UNCAT Article 2(2) expressly prohibits invoking exceptional circumstances to justify torture; the prohibition of both torture and CIDT is non-derogable under ICCPR Articles 7 and 4(2). Article 1 excludes from the definition of torture pain or suffering arising only from, inherent in or incidental to lawful sanctions; the lawfulness of a sanction is determined by reference to both national and international law, with international law taking precedence (IP §5), so that no sanction can be "lawful" if its implementation violates absolute human rights, irrespective of the domestic laws used to characterize the act. No derogation from these absolute prohibitions is permitted; the prohibition of torture is also a peremptory norm of customary international law (latin: "jus cogens").

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 **Brief for the Institute for the Advancement of Justice & Human Rights as Amicus Curiae, In the Interest of K.N., K.L., K.L., and K.L., Children, Cause No. 24-0881, Supreme Court of Texas**, 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 (Foster v. Neilson, 27 U.S. 253 (1829); Medellín v. Texas, 552 U.S. 491 (2008); see also Whitney v. Robertson, 124 U.S. 190 (1888), on the last-in-time rule). Because Congress has not enacted comprehensive implementing legislation for UNCAT, many courts essentially ignore its mandates. 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 implementing legislation; evaluators should therefore present UNCAT/IP conclusions on the

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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

Substantive Truth Track, while documenting how those conclusions are translated for domestic admissibility and remedy doctrines under the Dual-Track Rule.[4041]

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 support a reliability assessment under FRE 702 (see Appendix V).

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 Dual-Track Rule applies. The IAJ directorate determines in its separate legal analysis whether the institutional acts were purposeful under UNCAT; the evaluator documents the clinical and factual evidence relevant to purpose and to 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 to such an extent that, potentially, if a psychological investigation follows the proper interpretation of the UNCAT (i.e. the IAJ approach), then the clinical findings may be consistent with the alleged treatment, and the IAJ directorate may conclude that the conduct constitutes torture or CIDT under UNCAT, while official records and the government positions and even expert testimonies recorded against the alleged or suspected victim may definitively proclaim the prohibited acts as being lawful, and warranted or justified. Stated another way, if a psychological investigation follows the U.S. version of torture law, conduct the IAJ directorate characterizes under UNCAT Articles 1 and 16 may not be recognized 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.[424344]

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

[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. reserved that it considers itself bound by Article 16 only insofar as "cruel, inhuman or degrading treatment or punishment" means the cruel, unusual and inhumane treatment or punishment prohibited by the Fifth, Eighth and/or Fourteenth Amendments; the United States has also treated the obligation as limited to its territory (a position the Committee rejects, CAT/C/USA/CO/3-5, para. 10) 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

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)

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] 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

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

[46] i.e. no one can bring an action under UNCAT itself for torture or CIDT within the USA; domestic claims proceed under constitutional and statutory standards

[47] The IAJ observes, from its case investigations, that judges frequently 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 by narrowing Article 16 to the treatment prohibited by the Fifth, Eighth and Fourteenth Amendments. The USA also inappropriately included 'prolonged mental harm' in its interpretation of Article 1, whereas the UNCAT text does not specify a duration requirement.[48]

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 is assessed objectively from the circumstances (CAT General Comment No. 2, para. 9). The following mental states are relevant, with different levels of support:

- Knowledge that severe pain or suffering is practically certain to result: generally accepted as intent.
- Willful blindness: may support an inference of knowledge on the facts.
- Deliberate indifference (knowing continuation after notice): may support an inference of knowledge and intent on the facts; it is a U.S. constitutional standard and is not itself the UNCAT test.
- Recklessness combined with a prohibited purpose: the IAJ's interpretation is that this may satisfy Article 1; the point is not settled in treaty-body practice.
- Foreseeability of harm: relevant evidence of knowledge, but not by itself sufficient for Article 1. A prohibited purpose must be established in every case.

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].

[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 IAJ's analyses of Article VI treaty supremacy. Note: 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

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 suffering was inflicted for a prohibited purpose (e.g., punishment, intimidation, coercion, discrimination). Article 16 still requires State responsibility — acts committed by, at the instigation of, or with the consent or 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. Treaty minimum: an act or treatment reaching the cruel, inhuman or degrading threshold, and official involvement or acquiescence. The Article 1 "severe pain or suffering" threshold and the prohibited-purpose element do not apply. Intent under Article 16: the Committee against Torture has held that Article 16 ill-treatment may be committed through acts or omissions and that negligence may suffice where the remaining Article 16 predicates are established (Černáková v. Slovakia, CAT/C/72/D/890/2018, paras. 9.3 and 9.5, decision adopted 19 November 2021; the case concerned a woman with disabilities confined and forcibly sedated in a social-care facility); some commentators read an intent requirement into Article 16 by analogy to Article 1. Three propositions are kept distinct: the Committee's interpretation (negligent acts or omissions may constitute ill-treatment); the IAJ's determination that this applies wherever the Article 16 predicates are satisfied, including qualifying systemic and judicial institutional conduct; and the case-specific question whether conduct, severity, State responsibility and the applicable obligation are established. IAJ conclusion, consistent with that jurisprudence and set out in UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It: where the State is responsible for the conditions and the treatment reaches the Article 16 threshold, purely negligent conduct can fall within Article 16.

Under Article 16:

- No prohibited purpose is required.
- Ill-treatment arising from systemic conditions and institutional practices can fall within Article 16. Negligence may suffice where the remaining Article 16 predicates are established (Černáková v. Slovakia, CAT/C/72/D/890/2018, paras. 9.3 and 9.5); the IAJ applies that holding where the State is responsible for the conditions and the treatment reaches the Article 16 threshold.
- Discriminatory, humiliating or degrading treatment does not require a prohibited purpose, but must still reach the level of cruel, inhuman or degrading treatment.
- Conditions such as prolonged solitary confinement or shackling pregnant women have been identified by the Committee against Torture as raising Article 16 concerns. In every case the report must establish the treatment, its severity, and the involvement or acquiescence of a public official.

This is why Article 16 captures:

- Police brutality

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obligations exist on the international legal plane (plane a). See UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dimension IV.B.

- 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. understanding states that, "in order to constitute torture, an act must be specifically intended to inflict severe physical or mental 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
- 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 reservation — CIDT means only the treatment prohibited by the Fifth, Eighth and/or Fourteenth Amendments

In the IAJ's assessment, this effectively guts Article 16.

Consequences:

- CIDT is narrowed to the constitutional standard rather than the treaty standard (42 U.S.C. §2000dd prohibits cruel, inhuman or degrading treatment of persons in U.S. custody, but defines it by reference to the reservation)
- Structural abuses on which the Committee expressed concern in 2014 (solitary confinement, CAT/C/USA/CO/3-5, para. 20; police brutality, para. 26; conditions of detention, paras. 21–22) cannot be pleaded domestically as violations of UNCAT itself, because Articles 1–16 are

[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 reservation to Article 16 "incompatible with the object and purpose of the Convention" and stated that the Article 1 understanding "appears to restrict the scope of the definition of torture" (see FN25). 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.

non-self-executing and create no directly enforceable cause of action absent implementing legislation; claims under constitutional and statutory law remain available, the international obligation continues, and how courts treat such claims is a question of fact requiring its own record

- Courts do not apply Article 16 as a directly enforceable cause of action, because of the non-self-executing declaration; the Article remains binding on the United States internationally and claims under domestic standards remain available

The Committee against Torture has expressed concern about this reservation and recommended its withdrawal.

Violations as assessed by the IAJ flow from these RUDs as follows (citing the corresponding CAT concern where one exists):

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. reservation narrows the accepted Article 16 standard to treatment prohibited by the Fifth, Eighth and/or Fourteenth Amendments; 42 U.S.C. §2000dd prohibits cruel, inhuman or degrading treatment of persons in U.S. custody or physical control but defines it by reference to that reservation (on its operational non-equivalence with Article 16, see The Completion of the Non-Self-Execution Analysis: Medellín v. Texas, the Equivalence Representation, and the Test of Domestic Equivalence). In the IAJ's assessment, protection and remedies for CIDT outside that definition remain inadequate.

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

The IAJ is concerned that statements obtained through coercion that does not meet the narrower U.S. definition of "torture" may be admitted in proceedings; Article 15 requires the exclusion of statements made as a result 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

Indicators relevant to inferring intent (drawn from CAT General Comment No. 2, para. 9, and the Committee's concluding observations). Foreseeability alone does not establish intent (see A above):

- **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. This is generally accepted as intent under Article 1.

3. Recklessness

The actor consciously disregards a substantial risk. The IAJ's interpretation is that this may satisfy Article 1 when combined with a prohibited purpose; the point is not settled.

4. Negligence

Failure to perceive a substantial risk. Not enough for Article 1. For Article 16, the Committee against Torture has accepted that negligence may suffice where the other Article 16 predicates are established (Černáková v. Slovakia, CAT/C/72/D/890/2018, paras. 9.3 and 9.5; see above).

C. Practical indicators relevant to intent

- 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

Several of these practices are matters of concern in CAT/C/USA/CO/3-5 (e.g., paras. 20, 22, 26, 27).

Conceptualizing the "No Prohibited Purpose" Element of Article 16 may be done as follows: Article 16 has no prohibited-purpose element.

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 purpose is not required

Because CIDT focuses on:

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

The Committee has repeatedly expressed concern about systemic conditions of detention, such as prolonged solitary confinement, prison violence and deaths in custody, without requiring proof of a prohibited purpose (e.g., CAT/C/USA/CO/3-5, paras. 20–22).

In summary:

Concept	UNCAT Standard	U.S. RUD Standard	Result
Intent (Art. 1)	Intentional infliction (including knowledge) plus a listed purpose, assessed objectively	Specific intent only	Many acts of torture excluded
CIDT (Art. 16)	No prohibited purpose element required (State responsibility still required)	Limited by reservation to treatment prohibited by the Fifth, Eighth and/or Fourteenth Amendments	CIDT largely unenforced
Investigations	Mandatory	Prosecutorial and agency discretion; no treaty-conforming investigative duty enforced domestically (IAJ assessment)	Systemic noninvestigation
Redress	Mandatory	Blocked by immunities	Victims denied remedies
International Critiques	Objections from States Parties (e.g., Netherlands/Finland) view RUDs as	US maintains RUDs are valid and sufficient for compliance	Supports the IAJ's assessment of US non-compliance; strengthens IAJ's use of

	incompatible with UNCAT's object and purpose under Vienna Convention Article 19(c); no derogation allowed from absolute prohibitions		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. accepts Article 16 only as narrowed by its reservation, and its statutory prohibition (42 U.S.C. §2000dd) adopts that narrowed definition; in the IAJ's assessment, protection and remedies remain inadequate.
- 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 treat institutional or judicial findings of fact as conclusive, and must test them against the evidence as it tests all other accounts. 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

[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 Brief for the Institute for the Advancement of Justice & Human Rights as Amicus Curiae, In the Interest of K.N., K.L., K.L., and K.L., Children, Cause No. 24-0881, Supreme Court of Texas - see https://iaj.institute/publications/IAJ-AMI-20260217-001-LEG.pdf

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.

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' obligations under international law to investigate torture require effective policies, practices and capacities for documentation by State-employed experts, extending to support of non-governmental clinicians (IAJ determination: the underlying duty is UNCAT Article 12, read with Article 2(1))*

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.
- The Protocol treats support of independent clinicians as part of the State's obligation to investigate (IAJ determination: UNCAT Article 12).
- Trust and independence are treated by the Protocol as essential conditions of effective documentation.

[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)

Istanbul Protocol §665 addresses documentation responsibilities of State-employed forensic experts and clinicians; the specific extent of institutional reform duties must be supported separately.[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, the Protocol states that State forensic institutions need to:
- review and reform policies,
- ensure safeguards for proper evaluations,
- provide adequate training,
- uphold ethical principles.

Implications

- The documentation duty under §665 applies regardless of institutional role.
- Institutions need to change their internal rules to align with the Protocol (IAJ determination: UNCAT Arts. 12–13).

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,

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

- military authorities.

Implications

- Independence is treated by the Protocol as essential, not optional.
- 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 State forensic institutions should be vested with authority, funds and resources; States should not prohibit or obstruct the establishment of non-governmental forensic or medico-legal services, nor have authority to qualify or disqualify non-governmental experts (IAJ determination: obstruction of independent documentation is inconsistent with UNCAT Articles 12 and 13)*

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 — *State institutions should ensure that evaluations are prompt (the Protocol's benchmark: immediately and not later than 48 hours), objective and conducted by qualified, independent experts, and should consider standardized report forms (IAJ determination: promptness is required by UNCAT Article 12; the 48-hour figure is the Protocol's benchmark, not a treaty term)*

Core meaning

- The Protocol sets a 48-hour benchmark for State medico-legal evaluation (IP §668). It is a safeguard against State delay and loss of evidence, not a deadline after which suffering ceases to be investigable.

Timeliness, Diligence and Historical Investigation (IAJ rule). Investigations proceed with the greatest practicable promptness, diligence, completeness and independence, and with regard to

the safety and circumstances of the affected person. Circumstances demand adaptation, not fixed time rules: no fixed period determines whether an allegation may be recorded, investigated, clinically evaluated or referred, or whether historical suffering may be established. Numerical benchmarks in the Istanbul Protocol are standards against which State delay is assessed; they do not disqualify assessments made later. The investigator explains material delays, their causes and their effect on the evidence. No person is penalized for delay attributable to disability, serious illness, lack of resources, fear, institutional obstruction, unavailable experts, inaccessible records or other circumstances outside their effective control. Promptness is an institutional duty to act, not a temporal burden on the victim.

- 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 — *State agencies should ensure that procedural safeguards for medico-legal documentation are included in domestic law, regulations and standard operating procedures (IAJ determination: UNCAT Article 2(1))*

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

- The Protocol states that States should respect and facilitate this right.
- Failure to inform victims violates the Protocol.

IP §671 — *States should provide training on the investigation and documentation of torture, and State institutions should ensure that all relevant personnel receive training on the Protocol (IAJ determination: UNCAT Article 10 requires education and information regarding the prohibition of torture for medical personnel)*

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 — *The Protocol describes how effective training can be achieved: interactive classroom training, mentoring and supervision, training of trainers, joint legal–health training and civil-society participation*

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, non-governmental clinicians play a critical role, their capacity is often essential to the State in fulfilling its obligations, and States can and should support them and ensure that their reports receive equal weight (IAJ determination: UNCAT Articles 12–13)*

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.
- States should ensure that NGO forensic reports receive equal weight in judicial proceedings.
- States must actively support, not merely tolerate, independent forensic capacity.

Synthesis: What IP §§664–673 collectively describe, with the Committee against Torture's 2014 observations where they exist and the IAJ's own assessments identified as such (see Appendix U)**:**

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: the Protocol states that States should ensure them.
- **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 should carry equal weight in court (IP §673):** 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, and the pattern criteria in FN18 are satisfied, the IAJ may characterize the venue 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) made by the IAJ directorate on institutional and legal evidence, with any clinical contributions identified by source (Level 4 involvement is optional); 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 support a submission that domestic remedies are unavailable or ineffective, which is decided by the receiving mechanism under applicable treaty procedures. See UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It, Dimension VI.D (exhaustion analysis); Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §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 documents the cumulative effect of these stressors so that the IAJ directorate's legal analysis can assess severity under UNCAT. 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 (the Nowak Commentary treats powerlessness as a defining feature of torture; the IAJ reading set out here is its interpretation), 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. They are interpretive descriptions of forms of ill-treatment, not a hierarchy of legal thresholds: the Article 16 analysis in Sections A–B governs, and it turns on the nature and purpose of the conduct, State responsibility, humiliation, vulnerability and context, not on intensity alone.

1. CRUEL TREATMENT

Definition: Treatment involving the infliction of severe suffering. ECHR Article 3 does not use the word "cruel"; Nowak's Commentary treats cruel and inhuman treatment together and distinguishes torture from CIDT by purpose and powerlessness rather than intensity. The intensity approach of Ireland v. UK is the alternative view.

Key Elements:

[55] The United Nations Convention Against Torture and its Optional Protocol, Manfred Nowak, Moritz Birk and Giuliana Monina (eds.), 2nd ed., Oxford University Press, 2019.

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

- Severe suffering (the Nowak Commentary describes cruel treatment with reference to intensity; intent is not an element of Article 16 as the Committee applies it — see Section A–B above)
- Severe suffering (described as a high-intensity category in the historical ECHR approach; the IAJ does not apply an intensity threshold)
- Does not require a specific purpose (unlike torture)

2. INHUMAN TREATMENT

Definition: Treatment that causes intense physical or mental suffering (ECtHR, e.g., Kudla v. Poland (2000)).

Key Elements:

- Causes intense physical OR mental suffering
- Does not require specific purpose
- Placed between "degrading" and "torture" in the intensity approach of Ireland v. UK; not a threshold under this Standard

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"** (ECtHR, e.g., Pretty v. UK (2002)).

Key Elements:

- **Humiliation** of the victim
- **Dignity** is compromised
- Causes feelings of **fear, anguish, and inferiority**
- **Described as the lowest of the three categories in the intensity approach; under this Standard the categories are interpretive descriptions, not legal threshold**s

4. Illustrative intensity spectrum (Ireland v. UK approach). Illustrative only: this ranking is contested, is not a rule of this Standard, and does not bind the Article 16 analysis in Section A–B above, under which no prohibited purpose is required and the sufficiency of negligence is the IAJ's position (see above)

Level	Term	Intensity approach (Ireland v. UK; historical, not adopted as a ladder)	Key Element
1	Degrading	Treated as lowest in that approach	Humiliation, dignity, feelings of inferiority
2	Inhuman	Treated as middle in that approach	Intense physical/mental suffering
3	Cruel	Treated as high in that approach	Severe suffering (descriptive category; intent not required under Article 16)
4	Torture	Treated as highest in	Severe suffering,

		that approach	intentionally inflicted, plus a listed purpose and official involvement (Article 1 elements)

KEY SOURCE: Ireland v. UK (1978) — decided under ECHR Article 3, which distinguishes torture from inhuman or degrading treatment and has no separate category of cruel treatment; its intensity analysis does not supply a four-rung taxonomy and is recorded here as history, not as the IAJ's method

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 — documentation of the suffering

- IAJ's psychological evaluations can establish "intense mental suffering"
- Individual vulnerability assessment helps show heightened impact
- Document the nature, duration and effects of the suffering; no fixed intensity threshold applies

3. CRUEL — documentation of the suffering

- The historical ECHR approach distinguished "severe" from "intense" suffering; the IAJ does not adopt that ranking as a rule, and ECHR Article 3 has no separate category of cruel treatment
- IAJ's medical/psychological evidence can support this

4. TORTURE — distinct elements

- Requires **both**: severe suffering + specific purpose
- Article 1 explicitly includes "discrimination of any kind" as prohibited purpose
- Article 1 requires that the suffering be inflicted for a listed purpose or for any reason based on discrimination; discriminatory effect alone is not enough, but discrimination need not be the sole motive (see FN165).

- Torture is distinguished by its elements, not by a higher rung on an intensity ladder

5. IAJ's methodology documents the evidence relevant to each category, without applying an intensity ladder:

- **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: a listed purpose, or a reason based on discrimination, must be shown on the evidence; discriminatory effect alone is not enough (see FN165).

6. Distinction between INTENSE and SEVERE suffering

Severity of suffering is a context-sensitive human-rights assessment, not a diagnostic code or a substitute for it. Evaluators may describe suffering as clinically severe when warranted by evidence, while distinguishing that description from the Article 1 legal threshold. A high level of historical suffering may be supported by duration, coercive conditions, loss of autonomy, extreme fear or humiliation, deprivation, vulnerability, functional effects, and contemporaneous accounts, even if there is no lasting mental disorder. No fixed duration, post-event psychiatric condition, or permanent injury is imposed by the UNCAT definition.

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.

D. The Cleanest Academic Distillation

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

The following guidance can be used 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
- may describe suffering as clinically severe where the evidence supports it, but does not state that the Article 1 legal threshold is met
- **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 also the legal threshold for torture. The psychologist may describe suffering as clinically severe where the evidence supports it, but does not declare that the legal threshold is met; they document the clinical indicators that bear on 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
- contemporaneous indicators: overwhelming fear, helplessness, physical pain, the duration and conditions of the treatment, and the person's vulnerability. None of these indicators is required; severe suffering may be historical and need not persist.

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. Istanbul Protocol-based structure

A psychologist should document suffering using the following four elements, drawn from IP Chapter VI:

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 may assess and describe clinically severe suffering, including reconstructed historical suffering, using the nature, intensity, duration, context, and functional consequences of the experience. The ultimate classification under UNCAT Articles 1 and 16 additionally requires assessment of the applicable legal elements and must not be equated with a DSM/ICD diagnostic threshold.

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. understanding to UNCAT Article 1 requires that torture be "specifically intended" to inflict severe physical or mental pain or suffering, and the federal definition (18 U.S.C. § 2340) contains no prohibited-purpose element. Where a domestic forum applies this standard, the psychological evaluation documents the evidence relevant to knowledge and to the perpetrator's awareness of the consequences; whether intent or purpose is established is a legal question.

Under the U.S. understanding of "mental pain or suffering" as codified in 18 U.S.C. § 2340(2), mental pain or suffering must amount to "prolonged mental harm." This requirement has no basis in

UNCAT (see above). Important limitation: 18 U.S.C. § 2340A applies only to acts of torture committed outside the United States. For conduct occurring on U.S. soil, the domestic pathways that may apply include, by way of example and each with its own factual and legal predicates: the Eighth and Fourteenth Amendment "deliberate indifference" framework for persons in custody (Estelle v. Gamble, 429 U.S. 97 (1976)); substantive due process and other constitutional standards outside custody; 42 U.S.C. § 1983 (a cause of action against persons acting under color of state law, not itself a substantive prohibition); and the Americans with Disabilities Act and Rehabilitation Act for disability-related conduct. The IAJ's equivalence analysis examines each pathway separately. Where a U.S. forum applies the understanding, document the duration and course of mental harm on the Domestic Presentation Track. No duration requirement applies under UNCAT, and DSM duration criteria do not define "prolonged".

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 risk indicator of a high-risk environment (see CAT General Comment No. 2, para. 13):

- **Right of Notification:** The State must provide immediate notification of the reason for any detention and of the 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.
- **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-

[57] Jurisdictional custody is the IAJ's proposed functional category on the UNCAT plane, developed in UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It (Dimension VII); it is not a Fourth Amendment holding, and no court has adopted it

Representation Barrier" for indigent victims—shall be documented, with its effect, as a potential 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 (IAJ proposed safeguard): litigants should have access to an independent clinician (Level 3 or 4) upon entry into an institutional system and following any reported use of force, coercion or intimidation, so that physiological and psychological harm is documented while evidence exists. This proposal implements the existing right to complain and to prompt, impartial examination (UNCAT Article 13; IP §§668, 670); it is not a rule presently imposed on U.S. courts by UNCAT or by domestic law**.
- Mandatory Independent Investigation and Oversight: Under UNCAT Article 13, every person alleging torture has the right to complain and to have the case promptly and impartially examined by competent authorities; IP §668 sets the standard for prompt medico-legal evaluation.

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 may be evidence of acquiescence for the IAJ directorate's legal analysis and may be considered under the IAJ forum nullus criteria (Module 1).
- The NGO Necessity: Because independence is essential for accountability and victims often do not trust State-affiliated clinicians, the Protocol treats access to an independent health professional as essential (IP §§664, 670).
- **Logical Consistency:** If the State is the alleged perpetrator, it cannot also be the sole investigator. The absence of an independent buffer (the mechanism) may increase the risk of unremedied harm but does not by itself establish a mathematical prediction.
- Legal Precision: Under the Law of Nations, the duty to investigate is non-derogable. In the IAJ's analysis, using "Administrative Correctness" to block independent forensic documentation is inconsistent with the United States' obligations under UNCAT Articles 12 and 16.
- Clinical attribution: During a Supervisory Falsification Pass, the Level 4 Expert documents the absence of independent oversight as a contextual factor without automatically raising any clinical rating that institutional stressors were "knowingly maintained" for a prohibited purpose.

Supervisory Falsification Pass (SFP) — Operational Protocol: The SFP is an enhanced quality safeguard performed by a Level 4 expert whenever one is available. It is preferred for every IAJ report and is required before the IAJ designates a report "IAJ-reviewed" — a designation meaning that a Level 4 expert independent of the evaluator has read the complete report and record and recorded the SFP; reports without that designation are IAJ reports supported by the Non-Obstruction Rule and carry no implication of defect. It is not a prerequisite for a clinician's own report, for IAJ reliance on that report, or for any IAJ determination or referral (see the Non-Obstruction Rule below). Where performed, 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.

Non-Obstruction of Investigation and Institutional Determination

A Level 4 forensic review is an enhanced quality safeguard, not a jurisdictional, diagnostic, evidentiary or institutional prerequisite for the documentation, investigation, reporting or recognition of alleged torture or cruel, inhuman or degrading treatment or punishment.

A qualified Level 3 clinician may independently document psychological findings and provide bounded clinical consistency and causation opinions within demonstrated competence, lawful professional scope and the evidence available.

The IAJ directorate may rely on those findings, together with first-hand testimony, contemporaneous evidence, medical documentation, institutional records and other probative material, even where independent Level 4 review is unavailable.

Every report identifies the evaluator's actual qualifications and level, the scope of the evaluation, the methodology, the evidence supporting each finding, material limitations, and whether independent specialist review was obtained. Where Level 4 review was unavailable, the report says so. That circumstance creates no presumption against the reliability of a competent Level 3 opinion and does not prevent a supported institutional determination, evidence preservation, protective action or reporting.

The IAJ directorate may make an independent determination under UNCAT Articles 1 and 16 on the evidence sufficient for that determination. Where the record supports a credible allegation, or reasonable grounds for investigation, but not a final characterization, the IAJ states that evidentiary status and may transmit the matter to competent national or international mechanisms for examination, protective measures and accountability. No conclusive finding of torture is required before reporting: UNCAT Article 12 requires a prompt and impartial investigation wherever there is reasonable ground to believe that torture has been committed, and Article 13 gives every person who alleges torture the right to complain and to have the case promptly and impartially examined. The Special Rapporteur on Torture acts on credible

information through the communications procedure; other mechanisms act under their own mandates and procedures.

The subsequent action, inaction, agreement or disagreement of any mechanism is evaluated on its merits and does not automatically determine the correctness of the IAJ's findings. The absence or failure of an investigative safeguard must be disclosed and addressed; it must never become a means of extinguishing the investigation itself.

Clinical Referral Dossier and Directorate Review

IAJ cooperation with clinicians. The IAJ cooperates fully with clinicians. IAJ investigators may have witnessed and recorded events, physical and psychological states, and medical records that the affected person no longer remembers, cannot convey, or never fully grasped. That information reaches the clinician through a referral dossier so that the clinical evaluation is well informed. The dossier includes, as available: a dated chronology; contemporaneous IAJ observations of physical and emotional states, each with its date, observer and method; witness accounts; medical and institutional records; known contrary or exculpatory evidence; and records that are missing, withheld or controlled by other institutions.

Active bias prevention in the dossier. The dossier separates established facts, allegations, investigator observations, institutional positions and IAJ interpretations, and labels every contested point. It contains no legal characterization and no suggested consistency category. Where feasible, the clinician first records the person's own account and the clinician's own observations, and then reviews the dossier (sequential unmasking), so that the clinician's findings can be traced to their sources. The clinician may request further material, question the dossier, and disagree with the IAJ; disagreements are recorded, not resolved by pressure. The report states what the IAJ supplied and how it was used. Clinicians do not make legal determinations; the IAJ directorate makes them separately.

Directorate review. Every clinical report receives an evidentiary-integrity review by the IAJ directorate: source attribution, material contradictions, omissions, conflicts, uncertainty, and the separation of clinical from legal conclusions. In addition, the directorate applies a technical review whose depth is proportionate to the evaluator's demonstrated expertise, the complexity and novelty of the findings, and identifiable risks of error. Level 3 reports ordinarily receive closer technical scrutiny than reports by Level 4 experts with demonstrated expertise in the specific question; the level designation alone does not determine the scrutiny applied. The directorate does not overrule a clinical judgment on clinical grounds without clinical expertise; where a clinical disagreement cannot be resolved, it is recorded in the 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 distinct from clinical treatment, 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.

A Level 4 reviewer may participate in a centralized document-only Supervisory Falsification Pass where the role and jurisdiction-specific licensing rules permit. Credentialing by the IAJ, international expertise, or a license held elsewhere does not by itself confer legal authorization to practice in every U.S. state. The coordinator must document the reviewer's scope and a lawful authorization basis before assignment; where the role would constitute regulated practice, use a locally authorized clinician or applicable compact/temporary-practice pathway. These jurisdictional safeguards allocate the forum for the work; they do not reduce the independent international-law analysis.

IAJ Central SFP Panel

Where the applicable licensing law permits remote methodological review, the SFP reviewer need not be co-located with, or licensed in the same state as, the primary evaluator, and 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, reducing the need for a separately-licensed Level 4 reviewer in each state; each assignment is checked against the nature of the work and the licensing law of the jurisdictions concerned. 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 (the four elements of the SFP Record listed 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 — a limited peer attestation, distinct from the full independent SFP — for routine, lower-complexity reports (typically Template A cases with no Article 1 allegation and no forum nullus characterization):

- 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 is a limited peer attestation. It certifies only that the Panel member examined the Level 3 attestation and the report summary; it is not a full independent SFP, it does not satisfy the full Level 4 review that the "IAJ-reviewed" designation requires, and the report carries the designation "peer-attested" instead. The three states are therefore: full independent SFP ("IAJ-reviewed"); peer attestation ("peer-attested"); and no SFP (an IAJ report supported by the Non-Obstruction Rule).

- Escalation Trigger: Tiered SFP is not available where the case involves an Article 1 allegation, a *Forum Nullus* determination, a Biological Assault finding, or any finding the primary evaluator designates as high-stakes or novel. In those cases a full independent SFP by a Level 4 Panel member is preferred; where none is available, the Non-Obstruction Rule applies and the report discloses that no SFP was performed.

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, with the operational objective of multiplying Panel capacity; whether quality-control coverage and reliability are maintained under the tiered model has not been empirically established and is to be evaluated. A Peer Attestation co-signature certifies only what the co-signer examined (the Level 3 attestation and summary) and is never represented as equivalent in depth to a full independent SFP; a report reviewed only by Peer Attestation is not designated "IAJ-reviewed".

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 may be discoverable, subject to the applicable discovery rules, privileges and protective orders; (iii) the review applies explicit, pre-defined criteria (the four elements of the SFP Record listed above); and (iv) the reviewer's professional credentials and jurisdiction of licensure are disclosed in the SFP Record. The IAJ is not aware of any court holding 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 may be subject to disclosure in U.S. proceedings, depending on the applicable discovery rules, privileges and protective orders, and is prepared on the assumption that it may be disclosed. The SFP Record addresses the standards-and-controls factor; it does not supply an error rate.

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, with dates and sources, for assessment of acquiescence in the IAJ directorate's legal analysis.
- **Documented Risk and Temporal Evidence: Record specific institutional acts or omissions, notice of clinical vulnerability, actual clinical changes, baseline, and the time relationship between exposure and outcome. Do not label an individual 14-day interval as a measured risk or causation window. Ackerman et al. (2002) found an average of 14 days between stressful events and MS exacerbations versus 33 days before control dates**

($p < .0001$); that group observation supports temporal association and does not establish an individual causal cutoff.

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 and Human Rights Center, UC Berkeley School of Law, HR/PUB/20/2, 2022) governs collection methodology. The Chronological Map (Module 5, Template C; Appendix D, Section V) 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" supports the IAJ directorate's separate legal analysis under UNCAT and under applicable constitutional standards.

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 records the accommodation requested, the response, notice of risk, and the subsequent clinical course (ADA; CRPD as a persuasive international standard, which the United States has signed but not ratified).
- **First and Fourth Amendments:** Correlating psychological sequelae with retaliatory conduct for protected speech, or with seizures of the person. Court-compelled participation in civil proceedings is analysed by the IAJ on the international plane as jurisdictional custody — a functional category proposed in UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It by analogy to OPCAT Article 4(2), with four elements (a State authority with coercive legal power; a compulsory legal relationship the person cannot exit without catastrophic consequences; and the further elements stated there), and not yet adopted by any treaty body or applied by any court. Whether such control also amounts to a Fourth Amendment seizure is a separate domestic question that the IAJ corpus does not resolve; the evaluator documents the control exercised and its effects without characterizing it.

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. 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 must be particularly vigilant in exercising oversight of the physical and psychological integrity of persons deprived of liberty (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).
- Judges should ensure that IP principles and standards are upheld in all legal proceedings, including civil and administrative proceedings (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. (This bears on State involvement and intent; it does not by itself establish a prohibited purpose under Article 1.)

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 evidence against the allegation (IP §390), and note that it is consistent with methods that leave no marks.

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 is therefore consistent with such methods and must not be treated as evidence that torture did not occur (IP §390).

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.

Evidentiary significance of psychological evidence — IAJ operational rule, informed by the 2022 Istanbul Protocol: Pursuant to the 2022 Istanbul Protocol, psychological evidence can independently provide strong support; the weight of each finding depends on its quality and consistency, not a prescribed numerical equivalence. 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. In the IAJ's reading of IP §§390 and 542, 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

INVESTIGATIVE ENTRY RULE. Assessment of prohibited conduct and suffering precedes diagnostic classification. Administrative intake, documentary preservation, and other authorized factual investigation must begin without waiting for PTSD screening or Level 4 availability. The investigator shall state qualification limits and refer clinical questions to appropriately authorized professionals without suspending evidence preservation.

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

A diagnostic impression alone ordinarily cannot substitute for a comprehensive forensic psychological assessment. Nevertheless, preliminary observations, contemporaneous records, treatment notes, accounts of suffering, and other reliably collected evidence may preserve information relevant to torture or CIDT even where a full clinical assessment is delayed, unavailable, or infeasible. Such documentation must disclose its sources and limitations and must not be misrepresented as a completed medico-legal evaluation. The absence of a completed assessment is not evidence that severe suffering did not occur.

2. Forensic Evaluation Is Distinct from Treatment Psychotherapy

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) differs in purpose and professional relationship from treatment psychotherapy; it may nonetheless fall within regulated practice of psychology or medicine under applicable jurisdiction-specific statutes.**

A forensic evaluator ordinarily does not undertake a treatment relationship. Cross-jurisdictional participation may be arranged through lawful licensure, temporary-practice or compact authorization, consultation, or appropriately scoped document review. Examples of potential collaborating professionals include:

- 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

The Istanbul Protocol identifies substantive qualifications and independence safeguards but does not supply a geographic licensure exemption under domestic law. Where an evaluation or professional opinion constitutes regulated practice, clinicians must comply with applicable licensing rules; independent human-rights factual documentation and clinical practice must be differentiated by role.

4. Training for Non-Specialists:

Non-specialists may participate in appropriately supervised intake, factual documentation, history gathering, and observation after training within the limits of competence and applicable authorization. Completing the IAJ Basic Training Module (Appendix K) does not alone qualify an individual to independently perform or sign a comprehensive forensic psychological evaluation. The 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's evaluation components include:

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, where indicated (IP §§373, 539):

- 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)

Report formal diagnoses (not impressions) where criteria are met. Where no psychiatric diagnosis is made, the evaluator shall report a dimensional symptom and suffering profile, or expressly explain why no clinical examination was possible. Absence of diagnosis is not a finding of absence of severe suffering (IP §542).

8. Mandatory Causality Opinion (2022 IP, Chapter VI, §§546–547 — required)

Where a qualified evaluator has completed an examination, the report must state a clinical opinion on the relationship between the findings and the alleged torture or ill-treatment (IP §§546–547), with sources, limits, and those alternative explanations that have an evidentiary foundation (IP §386). "Not assessable" may be used after a completed examination only with stated reasons. For psychological findings, apply the Istanbul Protocol consistency framework: Not consistent with (§543(a)); Consistent with (§543(b)); Highly consistent with (§543(c)); Typical of (§543(d)); and Diagnostic of (§543(e)). The last category is rarely appropriate for psychological evidence. Where no direct clinical examination occurred, preserve the reported suffering and factual evidence, record the scope limitation, and do not offer a consistency opinion.

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.

Minimum qualification principle (Level 3). Higher qualifications are always preferable. In the domain of torture and CIDT, however, paper qualifications must not become a bar to competent and accurate investigation, documentation and reporting. Doctoral psychologists and psychiatrists with torture-documentation experience are scarce, and many decline courtroom work. A licensed clinician who can diagnose independently and has relevant trauma competence is preferable to no licensed provider. A clinician's competence to document severe suffering does not depend on IAJ credentials. IAJ orientation (making a clinician "IAJ-informed", defined below) is a resource; it is not clinical training. The limits on Level 3 work therefore follow the licence and the task, not the degree: any clinician refers medical causation to a physician, restricted psychological tests to a qualified psychologist, and physical examination to a physician.

IAJ-Informed Clinical Participation

For purposes of this Standard, "IAJ-informed" describes a clinician's familiarity with the Institute for the Advancement of Justice & Human Rights, its investigative functions, applicable international human rights standards, and the requirements of independent truth-finding. IAJ orientation is confined to: (a) international standards that the clinician may not have encountered, including UNCAT, the Istanbul Protocol and the distinction between clinical findings and legal determinations; (b) recognition that institutional authority, customary practice, professional convention and official determinations do not replace independent evaluation of the underlying evidence; (c) independence without fear of consequences or persecution, together with awareness of the risks of improper influence and retaliation and of the protections, reporting channels and safety procedures available

(independence does not require a clinician to accept reckless personal risk); and (d) familiarity with what the IAJ does and how it operates, including its investigative procedures, referral dossiers, confidentiality protections and the separate responsibilities of clinicians and the IAJ directorate.

The IAJ does not train clinicians in their clinical professions, determine their clinical competence, prescribe their clinical methods, or direct their diagnoses, consistency findings or causal opinions; no interference with clinical practice is intended or may be inferred. Professional competence is determined by qualifications, demonstrated skills, applicable clinical standards and lawful professional scope. Validated clinical methods, ethical safeguards, informed consent and licensing obligations continue to apply; what the IAJ rejects is uncritical deference to an authority or custom where it conflicts with reliable evidence, applicable human rights protections or the duty of independent investigation. IAJ-informed status is not a certification, qualification or prerequisite: a clinician may become IAJ-informed through written materials, orientation, case briefing or collaboration, and the absence of prior orientation never obstructs competent documentation, investigation, evidence preservation or referral. No IAJ briefing may direct a clinician toward a predetermined result.

IAJ investigative roles (Intake Investigator; Supervising Investigator), defined in the IAJ Level 1 Investigator Role Description and Operating Instructions, are operational roles distinct from the clinical Levels 1–4 of this Standard; an investigative supervisor holds no clinical authority by virtue of that role, the numbering of the two schemes is not interchangeable, and IAJ investigative orientation or training confers no professional licensure, clinical competency or authority to issue restricted forensic opinions. Report authorship and testimony are separate roles. A Level 3 clinician may author the report; the testifying expert may be the author or another qualified expert who relies on the evaluation under FRE 703. Courts decide expert qualification under FRE 702 by "knowledge, skill, experience, training, or education", not by degree alone. The principal value of Level 4 involvement is in preparing expert testimony: some factfinders may give more weight to information from a specialist with extensive torture-documentation experience. The Level 4 designation itself is an internal IAJ role, not a category of evidence. Under FRE 703 a testifying expert may rely on another clinician's evaluation if experts in the field would reasonably rely on it, but must form and explain their own opinion; the testifying expert must not act merely as a conduit for another clinician's conclusions.

IAJ Level	External Credential Minimum	Scope
Level 1	Any professional or trained staff member (e.g., nurse, case manager, victim advocate); licensed clinicians without demonstrated trauma-evaluation competence	Observation, factual documentation, evidence preservation, triage and referral; no diagnosis or forensic opinion
Level 2	Pre-licensure clinician (associate, intern, trainee, resident) under supervision, or a licensed clinician working under supervision while developing trauma-evaluation competence	Primary interview and testing under Level 3 supervision
Level 3	Clinician licensed to diagnose independently in the jurisdiction of the work (psychologist, psychiatrist, LCSW, LMFT, LPC/LPCC, psychiatric nurse practitioner), with demonstrated competence in trauma evaluation from training, supervised practice or	Full evaluation; diagnosis within licence; bounded clinical consistency and causation opinions within demonstrated competence and lawful professional scope; report authorship. Task limits: medical causation → physician; restricted psychological tests → qualified psychologist; physical examination

	experience	→ physician.
Level 4	Level 3 requirements plus substantial torture-documentation experience; doctoral, board-certified or forensic fellowship training preferred; competence in the IAJ legal framework	SFP review, supervision and training, complex and high-stakes cases, expert testimony where willing; optional specialist clinical consultation to the IAJ directorate (forum nullus determinations are made by the directorate)

The IAJ recognizes the following categories of qualified forensic evaluators:

1. International Human Rights Experts, for example

- **Former 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

- Psychologists, psychiatrists, physicians, licensed clinical social workers, marriage and family therapists, professional counselors and psychiatric nurse practitioners 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-Informed Clinicians

- Licensed clinicians who are IAJ-informed (see "IAJ-Informed Clinical Participation" above). IAJ-informed status supplements, but does not create, professional competence.

5. Recognition of Qualifications from Other Jurisdictions

IAJ expert-selection criteria recognize relevant qualifications from different jurisdictions. This is an internal standard for selecting and supervising experts, not a blanket exemption from the law governing the location and nature of professional practice. Direct examinations and regulated clinical opinions must be assigned through a lawful jurisdiction-specific authorization route. The relevant professional qualifications include:

- Professional licensure appropriate to the task (doctoral-level training preferred for Level 4 roles, not required for Level 3)
- **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

Cross-jurisdictional forensic work is common, but whether it requires local authorization depends on the jurisdiction and the role. Use the authorization routes in Part D and the Operational Rule in this Module.

The Istanbul Protocol does not require the evaluator to be licensed where the survivor resides; domestic licensing law may.

Part G: The IAJ Collaborative Expert Model

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

IAJ Collaborative Expert Model

• Testifying Expert (for U.S. courts): licensed in the forum jurisdiction; trauma expertise; IAJ-informed.

• IAJ Forensic Investigator: an expert with international torture-documentation experience (for example, former service on a treaty body or Special Procedure, authorship of Istanbul Protocol materials, or academic expertise); IAJ-informed.

• The two collaborate on a Joint Forensic Evaluation using Istanbul Protocol methodology, standardized assessment instruments where indicated, and comprehensive documentation.

Evaluators may use this model as a structured 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

Evaluators may address the Daubert factors as follows, and should be prepared to articulate each factor that applies under cross-examination:

- Published by OHCHR; institutional publication does not itself constitute independent peer review of IAJ-specific methods.
- General acceptance: the Protocol is the recognized international standard for torture documentation
- Testability: the methodology is detailed and its application can be reviewed
- Standards and controls: explicit protocols
- Error-risk mitigation: The Istanbul Protocol emphasizes independence, careful consideration of inconsistencies and, where fabrication is suspected, additional interviews by a second clinician under §386. It does not impose universal malingering tests, mandatory blinded review, or the IAJ Supervisory Falsification Pass. The IAJ adds structured independent review and documented differential reasoning as internal safeguards. These measures may assist a case-specific reliability assessment, but do not themselves establish a known error rate or compel admission under FRE 702/Daubert. See Appendix V for the methodological discussion.

State Standards

Maxims for Objective Forensic Testimony

Standard	Test
FRE 702 / Daubert (federal; Texas applies a comparable test). Since the 2023 amendment the proponent must show that each admissibility requirement is more likely than not satisfied.	Reliability + relevance gatekeeping
Frye-type "general acceptance" (e.g., NY, IL). California: the Kelly test for novel scientific techniques, with trial-court gatekeeping of expert reasoning (Sargon).	"General acceptance" (Frye); Kelly/Sargon (California)
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

[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 (2023).

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:** Address whether other stressors (e.g., poverty, divorce) or the natural course of the disease better account for the findings, and state the evidence either way.
- **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. Under the IAJ's role allocation (not a universal rule of evidence law, which in federal court permits opinions on ultimate issues other than mental state under FRE 704), the evaluator does not opine that torture occurred; testimony is limited to clinical findings, diagnoses where established, and the degree of consistency with the reported history.

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 Maxims 38 ("agree to be an expert only when genuine expertise is

present") and 104 (ultimate-issue testimony to be approached with caution), the expert's scope is strictly limited to:[59]

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

Whether those findings satisfy the legal definition of torture is addressed by the IAJ directorate in its separate legal analysis and, for domestic legal consequences, by the trier of fact; the clinician does not decide it.

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.

Response Validity, Suspected Simulation, and Independent Review (2022 Istanbul Protocol §386; additional IAJ safeguards identified separately). Investigators must not presume feigning or treat unexplained inconsistency as proof of deception. Where specific evidence supports concern about fabrication or self-inflicted injury, the following procedure applies:

- Evaluate the specific concern through records, clinical interview, cultural and disability-sensitive differential analysis, and, when appropriate and feasible, validated symptom- or performance-validity measures. The PCL-5 does not contain official embedded validity scales. Explain selection, applicability and limitations of any measures; no instrument alone proves intentional fabrication.
- Consistent with Istanbul Protocol §386, where the clinician suspects fabrication another clinician should conduct additional interviews, and the possibility of fabrication should be reflected in interpretation and conclusions only with agreement between both clinicians. The IAJ additionally requires appropriately qualified independent supervisory review before a definitive allegation of malingering is reported; blinded review or particular tests are not universal IP mandates.
- A finding of intentional fabrication requires identified evidence and reasoned differential assessment. An unsupported clinical impression or a single validity score is insufficient. Compliance with any IAJ enhanced review procedure must be distinguished from the Istanbul Protocol's own wording and from a court's independent determination under evidence rules.
- Where evidence is ambiguous, the report must document the ambiguity rather than resolve it against the subject.

Part I: Overcoming Challenges

[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/

Overcoming the Ziskin & Faust Adversarial Attack

Challenge	Response
"The evaluator is not licensed here."	Forensic evaluation differs from treatment: the evaluator is not treating the subject. It may nonetheless be regulated professional practice under the law of the jurisdiction concerned (see Part D and the Operational Rule in this Module). 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 and is the recognized international standard; whether testimony based on it is admissible is for the court under FRE 702.
"This expert has never testified in a U.S. court."	Prior testimony is not a requirement. A clinician with substantial torture-documentation experience, including service on international bodies, may have 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 2022 Istanbul Protocol, applied with validated instruments where indicated (e.g., PCL-5, 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 conclusions use documented chronology, functional analysis, clinical observations, and condition-specific scientific literature. I disclose contrary evidence and limitations. Internal Level 4 supervisory review, where performed,**

is a quality-control measure; it does not eliminate errors or establish independent external peer review."

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 and transparent reasoning that another reviewer can follow and test, rather than undocumented 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 structured internal review designed to reduce idiosyncratic error. 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 Ackerman et al. (2002) temporal result describes an observed mean interval, not a clinical cutoff or proof of individual causation)".**
- IAJ Expert Response example: "The Dual-Track Rule ensures that we don't rely on self-report alone; we assess the biologically plausible pathway supported by condition-specific literature, and whether the record supports a contribution in this case. 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 reduce, but not eliminate, the biases identified in the forensic literature, this report states whether a Level 4 expert performed a Supervisory Falsification Pass; where one was performed, the reviewer actively sought evidence contradicting the findings. This process 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 assess whether the record supports 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 assess the evidence on whether institutional procedure contributed to documented biological deterioration — 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 applies a designed error-control safeguard, the Supervisory Falsification Pass, where a Level 4 expert is available; it is a review step, not a measured reduction in error rate. This protocol requires the 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"

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: "Solomon et al. describe a published longitudinal statistical modelling approach applied to a single patient. The approach may inform event anchoring and clinical hypothesis testing. It is not a validated diagnostic or individual-causation test, and its publication does not establish an independently measured error rate. In this evaluation, it is used as background rather than stand-alone proof of causation."
- **IAJ Expert Response example: "Prospective MS research supports biologically important stress–relapse associations. Ackerman et al. (2002) reported stressful events an average of 14 days before exacerbations versus 33 days before control dates ($p < .0001$); Buljevac et al. (2003) reported elevated exacerbation risk following stressful events (RR 2.2; 95% CI 1.2–4.0). These results support a scientifically grounded investigation of stress-related biological deterioration but do not alone demonstrate that a particular institutional event caused a specific relapse. Solomon et al. (2023) describes individualized longitudinal statistical characterization; von Drathen et al. (2024), a systematic review and meta-analysis of 30 studies (26 cohorts; 24,781 cases), found a weak-to-modest association between psychological stressors and MS onset, a 1.87-fold increased MS risk with diagnosed stress disorders (95% CI 1.06–3.43), and, across 19**

heterogeneous studies of relapse risk, a threefold increase in relapses in two cohorts exposed to the same military threat (relapse rate ratio 3.0; 95% CI 1.56–5.81); medical records, differential causes, and case-specific chronology remain necessary. Whether my methods satisfy Rule 702 is for the court."

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 provides for a Supervisory Falsification Pass, in which a Level 4 expert actively seeks evidence that contradicts my consistency findings; my report states whether that review took place."
- **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 stated in Ferebee v. Chevron Chemical Co., 736 F.2d 1529 (D.C. Cir. 1984), a pre-Daubert decision whose reasoning has since been limited: "In a courtroom, the test... is not scientific certainty but legal sufficiency".

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**:

- Physiological Mechanism: a biologically plausible pathway (e.g., HPA axis activation → cortisol dysregulation → condition-specific pathophysiology). The evaluator documents the evidence bearing on whether this mechanism operated in the case; accountability is addressed by the IAJ directorate and, in litigation, by counsel and the court.

- **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 answers "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:

Illustrative medical/psychological attribution language (adapt to the evidence): "My opinion considers the documented clinical condition and medical record, biologically plausible mechanisms supported by condition-specific literature, the timing of events and clinical changes, individual vulnerability, the natural history of the condition, competing or concurrent causes, and limits of the available evidence. Where supported, I explain whether an identified exposure materially contributed to the observed condition and the degree of uncertainty. Population associations alone do not prove individual causation. Legal characterization under UNCAT is made separately."

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 (an IAJ doctrinal proposal): Evaluators should consider whether institutional actors responsible for safeguards maintained policies after notice that they were causing harm.

("Structural Inversion" and "Biological Assault" are IAJ doctrinal proposals; see the IAJ Framework Reference Architecture.)

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—with the authorization required where the work is performed.

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 continues to document findings under the Istanbul Protocol, and the IAJ directorate applies the text of UNCAT and authoritative treaty interpretation in its separate legal analysis, while the report is also prepared 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 records the clinical findings and the Istanbul Protocol consistency category for the alleged treatment. The IAJ directorate — the IAJ being an independent civil-society organization performing a reporting and truth-finding function of the kind contemplated by the Paris Principles, without statutory national-human-rights-institution designation or GANHRI accreditation — characterizes the conduct under UNCAT Articles 1 and 16 in its separately authored legal analysis. That characterization is an independent institutional determination; it is not binding on domestic courts.

- **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: The clinical report presents the clinical findings and consistency category. The IAJ directorate's UNCAT characterization is presented in its own labelled document ("Substantive Truth Track — UNCAT/Istanbul Protocol Standard") attached to or filed with the report, and the domestically accessible formulation appears in a separately labelled section ("Domestic Presentation Track").

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 IAJ directorate labels the Substantive Truth Track document: "Substantive Truth Track — UNCAT/Istanbul Protocol Standard" and the domestic section: "Domestic Presentation Track." This dual preservation creates a record that may be submitted to the Committee against Torture, including for consideration under Article 20. 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. The IAJ applies its investigative standard, discloses it, and complies with the court's procedural orders; it builds an evidentiary record that survives domestic non-engagement. The domestic decision is itself documented as evidence: the ruling, its stated reasons, the legal constraints the court was under (including non-self-execution) and its actual consequences are recorded. A court's declining to apply the international characterization does not extinguish it. Whether a particular decision also evidences acquiescence, supports a forum nullus characterization or forms part of a pattern of systemic non-compliance is a separate question the IAJ directorate answers on the basis of the decision's reasons and consequences, not from the refusal alone.

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**
- **Clinical consistency findings (the UNCAT characterization is made by the IAJ directorate)**

- **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;
- the clinical findings relevant to the Article 1 and Article 16 elements, for the IAJ directorate's analysis; 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 supportable clinical findings merely because a domestic court may reject the treaty framework. The evaluator states the clinical findings explicitly, and the IAJ directorate states the UNCAT characterization explicitly in its own analysis, with a parallel factual and clinical formulation usable in domestic proceedings.

Model phrasing:

- "The available psychological findings are [specify applicable IP §543 consistency category] with the reported experiences, subject to the evidentiary limitations stated here. The assessment of Article 1 and Article 16 legal elements is separately reasoned by the IAJ directorate."
- "Even if the forum applies a narrower domestic standard, the documented facts and clinical findings remain as stated, with their limitations."
- "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 clinical findings are consistent with the alleged treatment under internationally recognized clinical-investigative standards, and that the IAJ directorate's UNCAT characterization is set out separately. 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 the IAJ directorate's 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;
- attach the IAJ directorate's treaty-based characterization as a separate, clearly labelled document;
- 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 applies the IAJ investigative standard, discloses it, complies with the court's procedural orders, 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 through the communications procedure.

This documentation protocol creates a record that may support a submission on the availability and effectiveness of domestic remedies, and transforms each instance of domestic non-engagement into affirmative evidence of structural non-compliance.[60]

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 (a) the clinical consistency analysis, accompanied by the IAJ directorate's treaty-based characterization, 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.
- Neither the evaluator nor the IAJ directorate may lower the definition of torture or CIDT to match domestic under-enforcement.
- The evaluator may not omit supportable clinical findings, and the IAJ directorate 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 clinical truth under the Istanbul Protocol (with the IAJ directorate applying UNCAT), present it in a procedurally usable form domestically, and preserve the institutional response as part of the broader record of compliance or noncompliance.

[60] 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.
- Protection of the Human Rights Defender: By integrating local clinicians into the IAJ Collaborative Expert Model, the infrastructure adds Level 4 review and institutional support to high-stakes findings; it does not transfer the individual clinician's professional responsibility.
- Correctness of Methodology: Training explicitly addresses the "Qualification Myth", establishing that factual documentation of human rights concerns is an ethical duty of all clinicians, while regulated clinical opinions require lawful authorization.[61]

[61] 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 come to satisfy the distinct elements of Article 1 torture (intentional infliction, a listed purpose or discrimination, official involvement) as the victim attempts to escape or resist or as the systemic pathway progresses; escalation is established by proof of those elements, not by severity alone.

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 operates as the source of harm; for UNCAT purposes the analysis still identifies the officials whose acts or acquiescence engage State responsibility

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 applies the Distress-Induced Harm framework where objective or clinically reliable physical deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization) or clinical crisis (e.g., acute cardiac event) is documented following an institutional trigger. Neither permanence nor any psychiatric diagnosis is required; whether the harm meets UNCAT severity is assessed in the IAJ directorate's legal analysis.

Distress-Induced Harm Causation Protocol — Structured Sequential Analysis: To distinguish routine institutional stress from actionable harm under the Distress-Induced Harm doctrine (an IAJ doctrinal proposal), the evaluator completes five analytically independent steps, each documented separately in the report. The doctrine addresses cases where (i) a person has a documented biological vulnerability; (ii) institutional actors had notice of that vulnerability; (iii) a documented coercive institutional act is alleged to have triggered physiological harm through a published biological pathway; and (iv) the resulting deterioration is documented in contemporaneous clinical records. The evaluator documents the evidence on the mechanism; whether the conduct satisfies a legal doctrine (UNCAT Articles 1 or 16, battery, deliberate indifference, ADA) is addressed in the IAJ directorate's legal analysis and, in litigation, by counsel and the court. A Distress-Induced Harm finding is warranted only when all five steps are independently supported.[62]

- Step 1 — CLINICAL DOCUMENTATION: Document the specific physiological or psychological harm with clinical specificity (diagnosis, onset date, severity, treating clinician

[62] 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

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: 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: Record the event and outcome chronology, medical baseline, disease-specific plausibility, relevant alternative causes, and the uncertainty of each interval. Ackerman, Buljevac, Solomon and the von Drathen meta-analysis describe different forms of MS evidence and do not establish a universal 14-day individual causal cutoff. Missing timestamps or weak case-specific evidence may limit attribution strength but do not preclude investigation or documentation of suffering.
- 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 alternative causes of the documented harm by evidence-weighted differential analysis: exclude, weigh or, where scientifically supportable, quantify them. Competing contributions that cannot be quantified are disclosed as such, not assigned numerical values. The conclusion must state the degree of confidence (High / Moderate / Low, or not assessable with reasons) with basis stated. Where any step lacks adequate evidentiary support, the finding must be qualified or withheld.

Essential Principles for the psychological evaluation

IAJ Adversarial-Neutrality and Rival-Hypothesis Protocol (IAJ additional safeguard; not a verbatim IP requirement)

This Standard is independent of the interests of complainants, accused officials, courts, governments and the IAJ itself. No investigator may begin with a presumption that torture/CIDT occurred or that a domestic decision is valid merely because it was judicial. The same burden of evidentiary scrutiny applies to assertions by all actors. The IAJ shall publish supported negative, mixed and unresolved findings as well as affirmative findings.

Before forming conclusions, the investigator shall write down material alternative explanations for which a case-specific evidentiary foundation exists, including where supported: legitimate administration of a legal process; error, negligence or resource constraints without a prohibited purpose; ordinary or unrelated stressors; the natural history of illness; medication, infection and other clinical factors; inaccurate institutional records; inaccurate complainant recollections; and intentional fabrication where particular evidence warrants examination. These explanations are hypotheses to test, not automatic excuses or reasons to disbelieve.

Prepare a claim-level evidence ledger recording alleged act, date, source, direct observation or hearsay status, independent corroboration, contrary evidence, missing data, source reliability and reasons for

accepting or rejecting each proposition. Document both evidence sought and material evidence unobtainable. Apply equivalent scrutiny to institutional and survivor accounts. Record when an investigator changes or withdraws a provisional theory.

Run a prospective falsification pass before finalizing any significant conclusion. An independent reviewer should identify the strongest rival explanation, contrary records, selection and confirmation-bias risks, and evidence that would change the result. A second reviewer does not prove validity, supply a measured error rate, or guarantee admissibility. Record substantial reviewer disagreement and disclose unresolved material disagreement in the final institutional analysis.

Outcome categories are: (1) supported torture under the IAJ international-law analysis; (2) supported CIDT but Article 1 elements not established; (3) supported rights violation or clinical harm without sufficient evidence of torture/CIDT; (4) inconsistent with the allegations on material evidence; or (5) insufficient evidence to determine. These are institutional investigative classifications, not diagnoses or validated numerical probabilities. A clinical evaluator states clinical findings and consistency independently; legal characterization is separately attributed to a qualified legal/institutional reviewer.

All case examples and training exercises must include at least one genuinely negative, one mixed or unresolved, and one supported finding. Evaluators must not be graded on reaching a torture finding, and investigative funding or supervision must not depend on accusation rates.

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[63]
- 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[64]
- identify specific purpose:
- Human rights reports
- Advocacy
- Media reports
- Investigation by international legal bodies
- Future criminal prosecution of alleged perpetrators
- Education and systemic reform

[63] Including standards applicable to psychotherapy and neuropsychology

[64] 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

- Any combination of the above
- photographs, recordings for clinical assessment
- Use of information
- Anonymous versus personal identification
- diligently attend to:
- Interview Settings[65]
- Safety of the alleged victim[66]
- Earning Trust & Building Rapport[67]
- Maintaining confidentiality[68]

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[65] 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.

[66] 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 The IAJ adds the following (not part of the PHR guidance): use Western-oriented tests (e.g., MMPI or structured interviews) with caution because they may re-traumatize through power dynamics or cultural mismatch; prioritize narrative approaches (IP §§329, 339, 368, 371). If using standardized tools, ensure cross-cultural validation to prevent ethnocentric bias and over-pathologization of cultural coping mechanisms. 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

[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) 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 informative 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.

[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) 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

- Mitigating the risk of retraumatisation as much as possible[69]
- Demonstrating cultural humility and sensitivity[70]
- Understanding important gender issues[71]
- Recognizing the special needs of children[72]
- Working effectively with interpreters[73]
- Appropriate demeanor[74]
- Understanding emotional reactions and their potential effects[75]

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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

[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) 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 [PHR (2022), PDF p. 18, printed slide 17, "Mitigate the Risk of Re-traumatisation."]

[70] 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."

[71] 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.

[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) 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 the IAJ publication "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"

[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) 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.

[74] 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[76]
- Using effective interview techniques[77]
- Pursuing inconsistencies and potential reasons for them[78]
- document psychological findings
- formulate clinical impressions and conclusions
- review transference[79], counter-transference[80], re-traumatisation issues
- apply diagnostic classifications (ICD-11 and DSM-5-TR) in the evaluation of psychological evidence of torture and ill-treatment, with understanding of their value and limitations

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[75] 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.

[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 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

[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) 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

[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) 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. [PHR (2022), PDF pp. 27–28, printed slides 26–27, "Pursue Inconsistencies and Potential Reasons for Them."]

[79] 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

[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) 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[81]
- a detailed account of allegations including:
- torture or ill-treatment methods
- physical symptoms
- psychological symptoms
- a record of:
- physical findings[82]
- 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, or refer for, physical assessment. Stressful events are associated with exacerbation of some medical conditions (for MS, see Module 4, Section III); where a stress-sensitive condition is present, physical findings must be documented by a qualified physician.[83]

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[81] 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

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

[83] 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*."

Intent Analysis for Systemic Violations:

These tools are applied in the IAJ directorate's separate legal analysis. The clinical evaluator documents the facts and clinical findings relevant to each step and generally does not state the legal characterization.

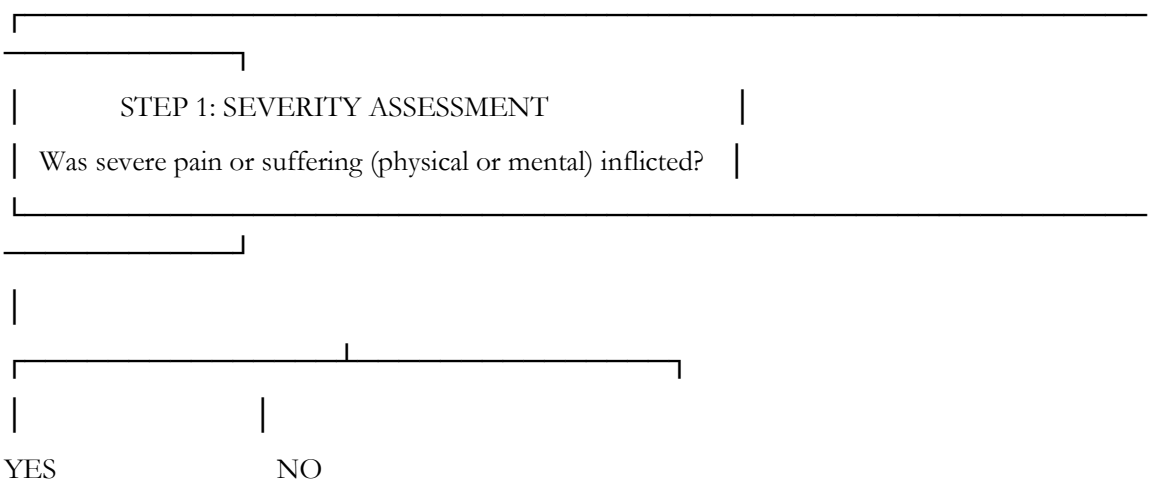
Under Article 1 (Torture), intent in systemic violations may be established through:

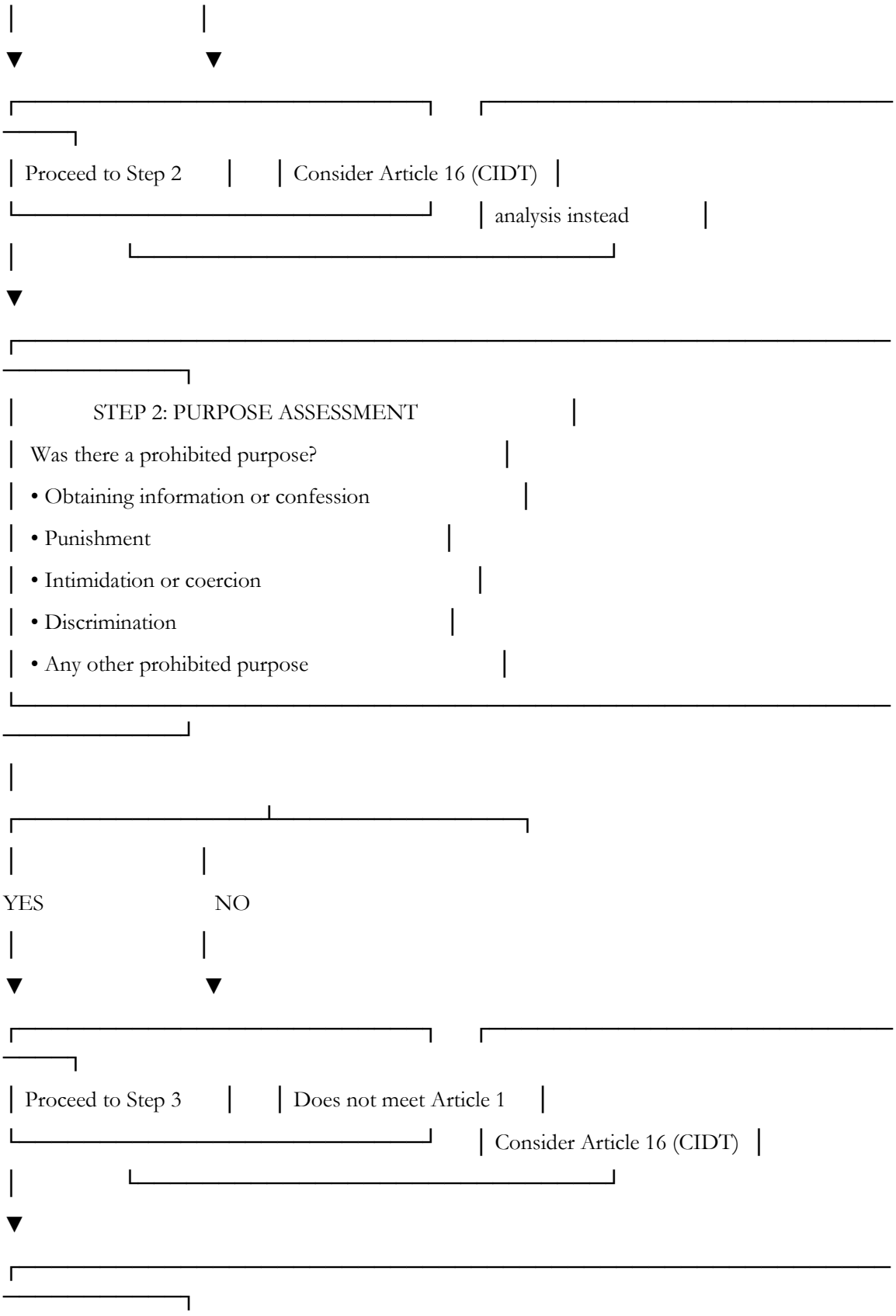
- Policy adoption with knowledge of harmful consequences
- Continuation of policies after harm is documented
- Failure to reform despite complaints and evidence
- Pattern of similar violations across multiple victims
- Institutional benefit from the harmful practices (e.g., cost savings, case closure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

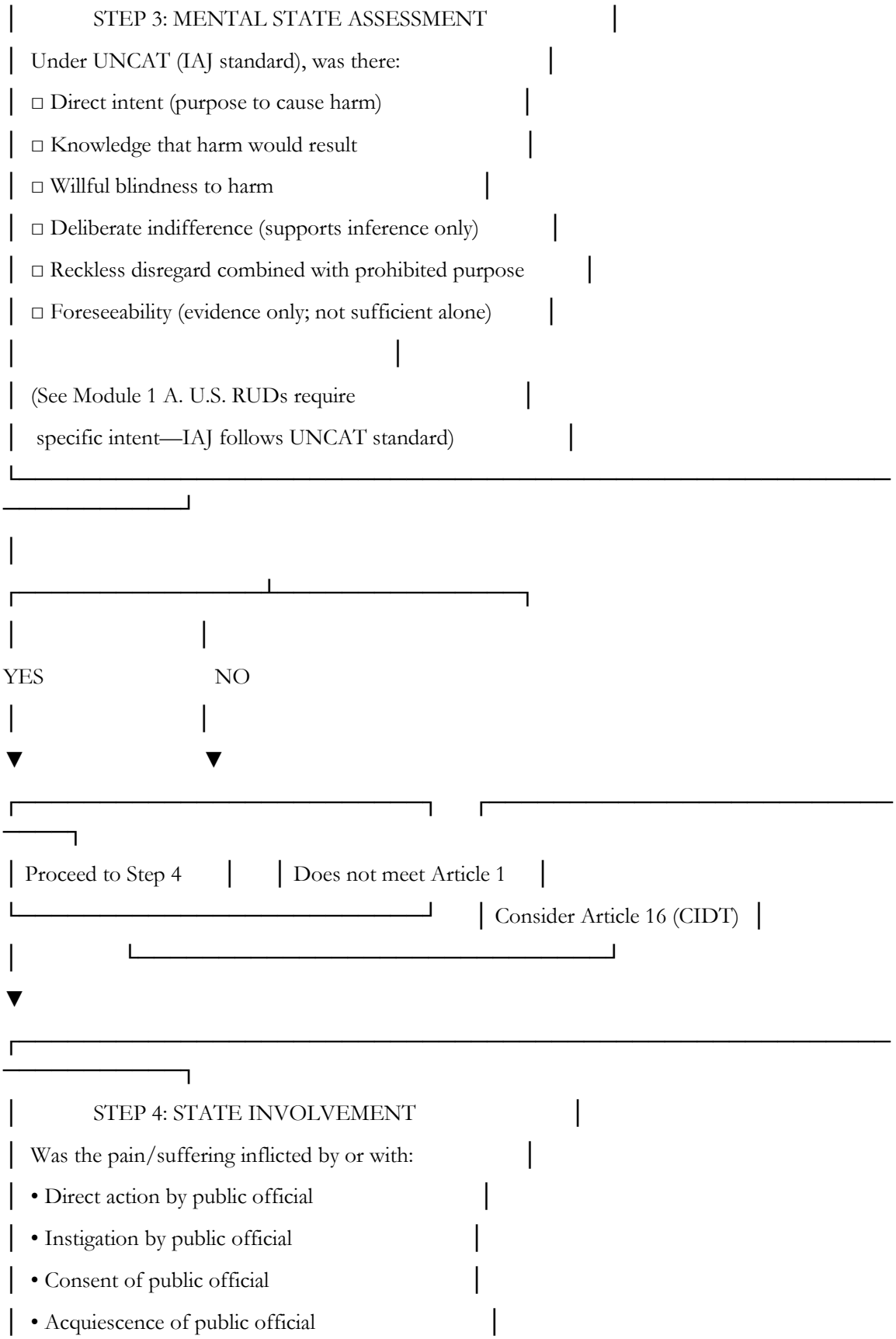
Under Article 16 (CIDT), no prohibited purpose is required (negligence may suffice where the other Article 16 predicates are met: Černáková v. Slovakia, CAT/C/72/D/890/2018, paras. 9.3 and 9.5; see Module 1). The evaluator documents:

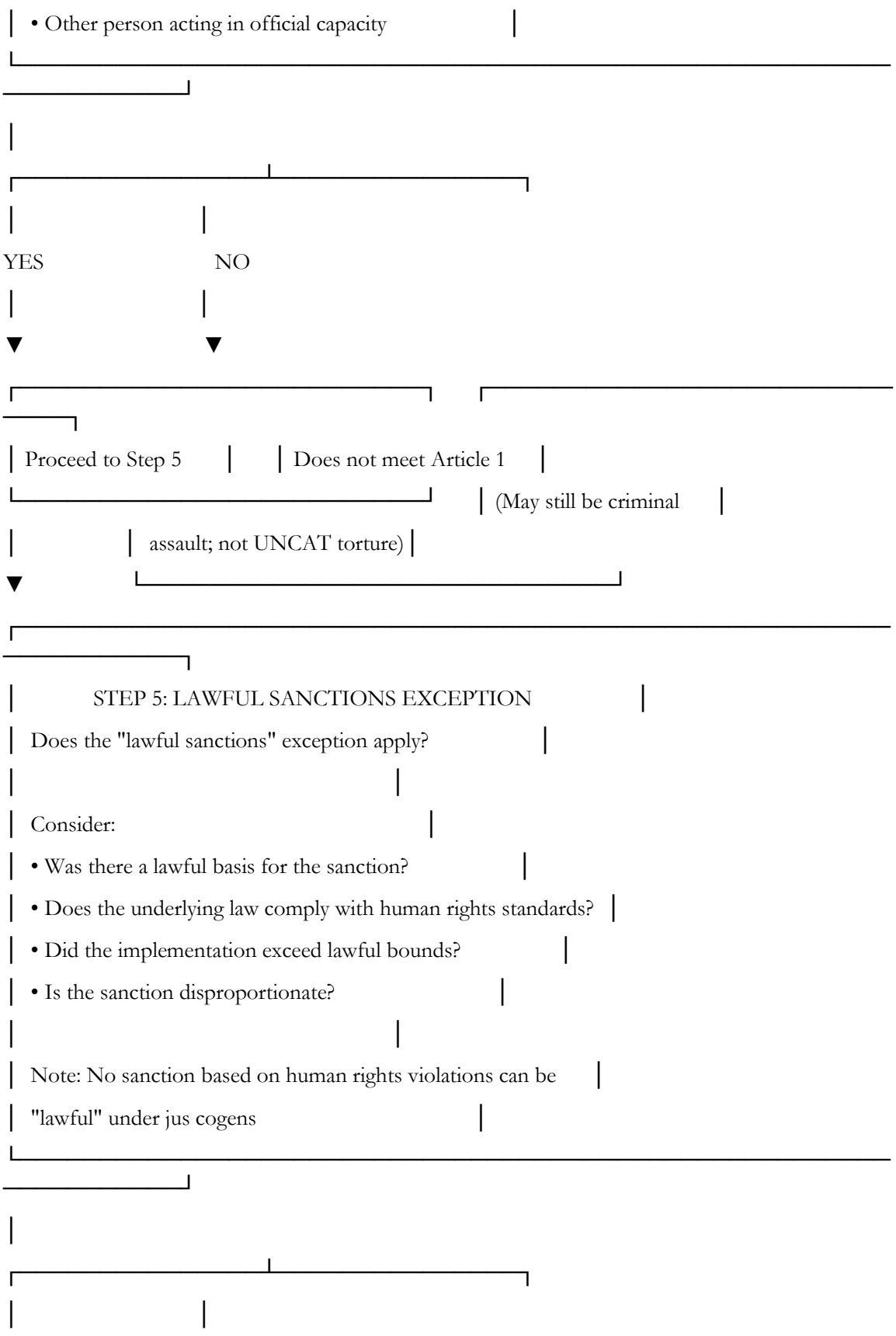
- The nature of the treatment
- The effect on the victim
- The involvement of public officials or official systems

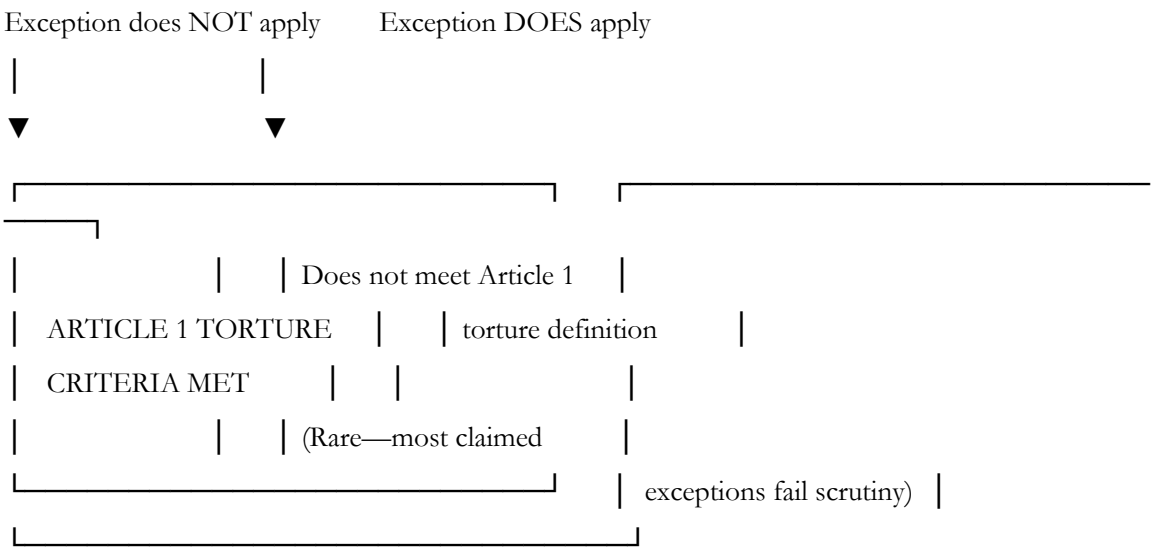
Flowchart for Article 1 (Torture) Analysis:



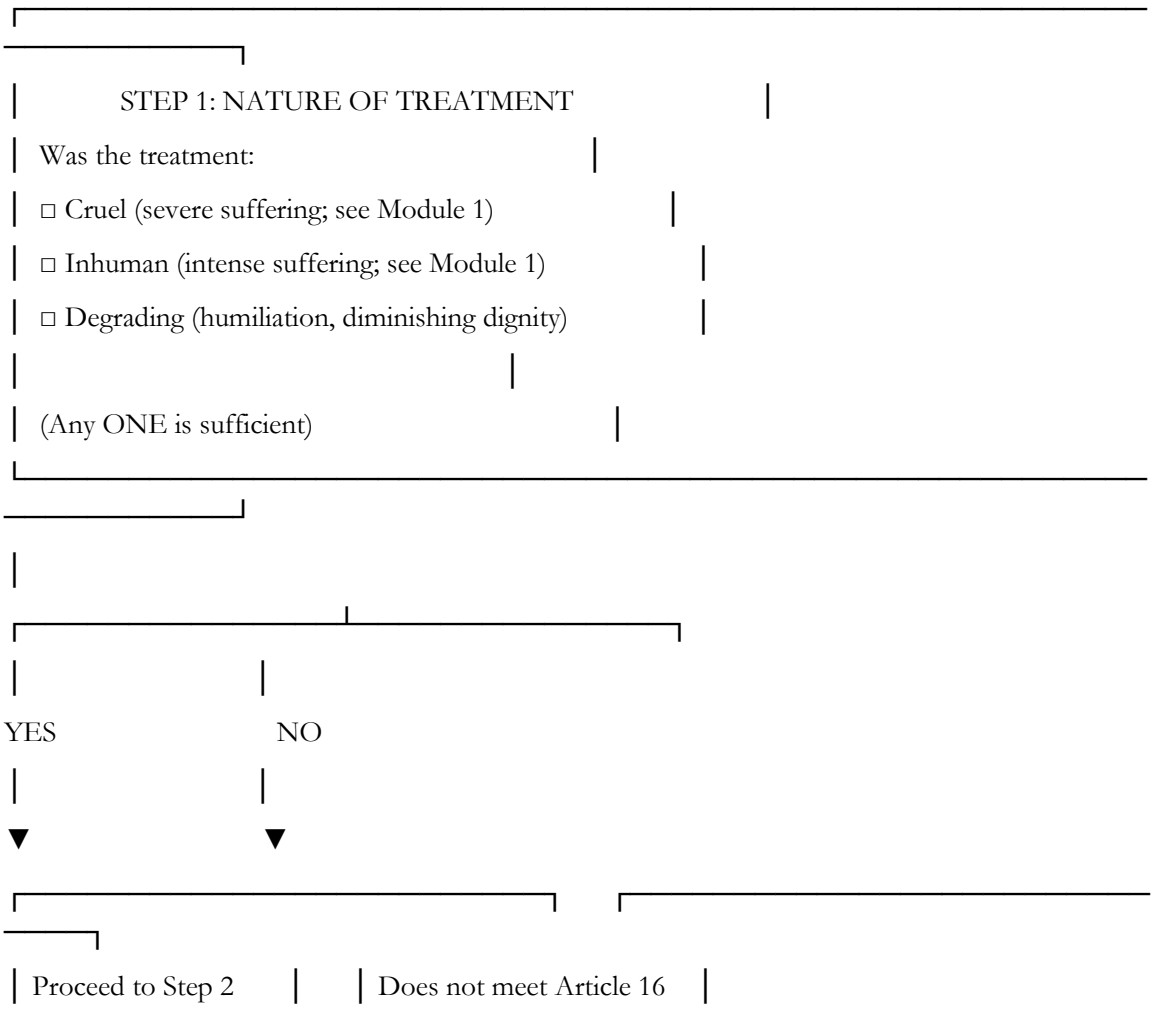

Proceed to Step 2
Consider Article 16 (CIDT) analysis instead
STEP 2: PURPOSE ASSESSMENT
Was there a prohibited purpose?
• Obtaining information or confession
• Punishment
• Intimidation or coercion
• Discrimination
• Any other prohibited purpose
YES
NO
Proceed to Step 3
Does not meet Article 1
Consider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

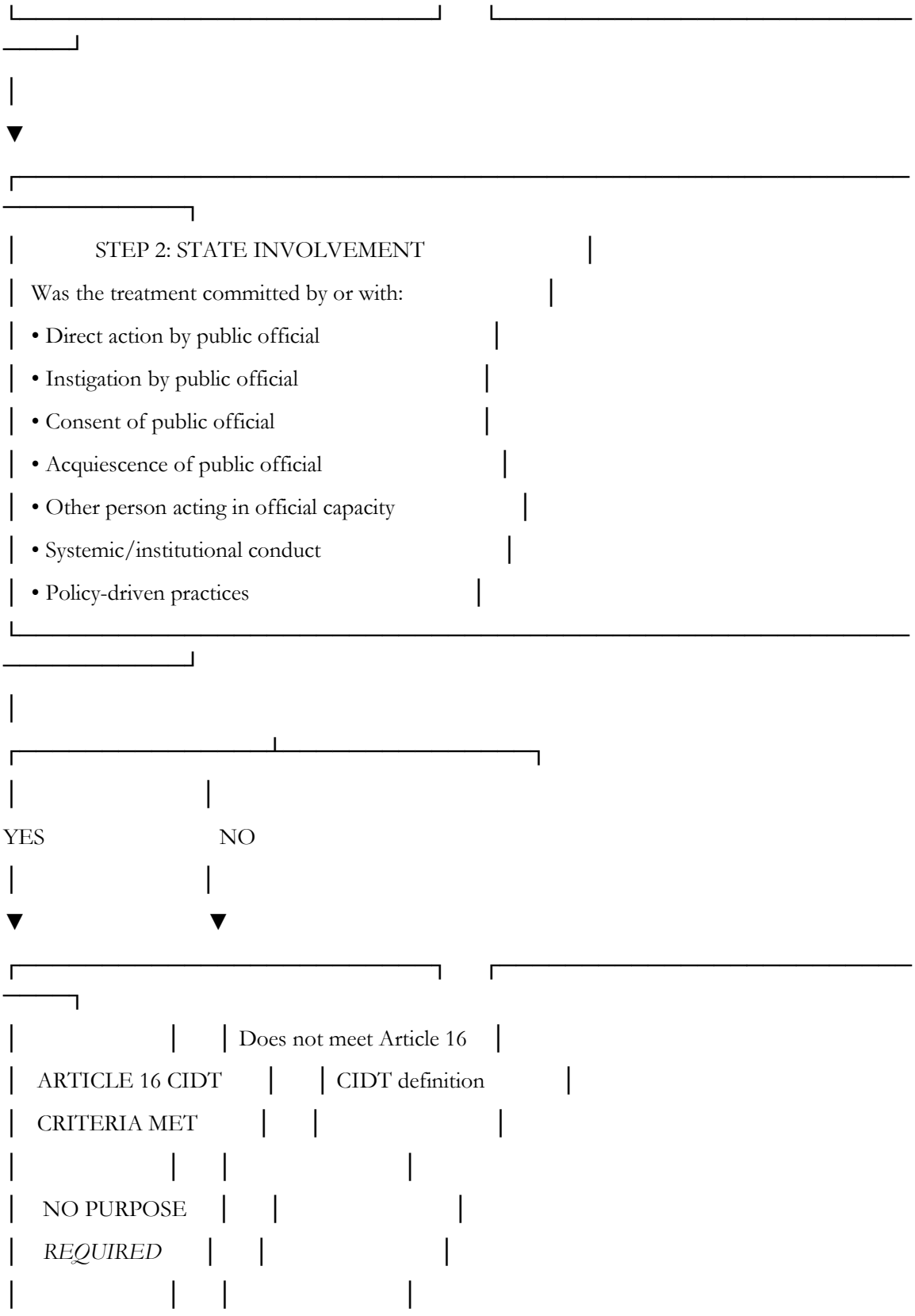

STEP 3: MENTAL STATE ASSESSMENT
Under UNCAT (IAJ standard), was there:
□ Direct intent (purpose to cause harm)
□ Knowledge that harm would result
□ Willful blindness to harm
□ Deliberate indifference (supports inference only)
□ Reckless disregard combined with prohibited purpose
□ Foreseeability (evidence only; not sufficient alone)
(See Module 1 A. 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 PURPOSE 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. All three flowcharts are summaries: no classification follows automatically from a branch, and each result is tested against the full elements and sources in Module 1, Sections A–B, before the IAJ directorate characterizes conduct.

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 the circumstances show they must 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: Pattern supports an inference of knowledge and intent (CAT General Comment No. 2, para. 9)

│ └── Article 1 only if the evidence also shows a listed purpose (including discrimination); otherwise Article 16

├── 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, intent and prohibited purpose are distinct elements, determined objectively from the circumstances; the same evidence may establish both (CAT General Comment No. 2, para. 9). Here, sanctions imposed for failing to comply with conditions the institution refused to modify indicate punishment or coercion, and the refusal of reasonable accommodation is itself disability discrimination (CRPD Art. 2). The report names the features of the evidence that support each element. Repetition after notice establishes intent; it does not by itself establish purpose.
- 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:
- **Intent and prohibited purpose 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 fully, 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, intent is relevant to the IAJ directorate's separate legal analysis of conduct that causes Distress-Induced Harm. 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, intentional infliction and a listed purpose are separate elements; the purpose must be one "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. Constructive knowledge (what actors should have known) does not establish Article 1 intent, but may be relevant to Article 16 and to domestic standards.

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 is relevant evidence from which intent may be inferred together with other facts.

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 that the technology would cause psychological harm and failed to implement mitigations; what they merely should have known is relevant to Article 16 but does not establish Article 1 intent.

Practical Documentation Protocol

For each technology-facilitated scenario, the psychologist documents the indicators reported or observed; the assessment of intent is made in the IAJ directorate's legal analysis. 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 psychologist does not rate the perpetrator's intent; a clinician cannot assess a third party's intent from the examinee's presentation. Neither the Istanbul Protocol consistency categories nor the IAJ Clinical Attribution Rating applies to intent.

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

IAJ SEVERITY-INDEPENDENCE RULE (controlling text). Whether the evidence supports severe pain or suffering is determined from the conduct, its duration and context, the person's experience and vulnerability, and its effects. It does not depend on a diagnosis of PTSD, complex PTSD, EPCACE or any other psychiatric disorder, on a positive screening score, on the descriptive Shattering construct, on complete functional collapse, on permanence, or on irreversible tissue injury. A diagnosis, where clinically established, is corroborative evidence. Its absence, partial recovery, remission, delayed evaluation, or lack of access to a specialist is not evidence that severe suffering did not occur at the relevant time. Every report records separately: (i) the alleged conduct and its sources; (ii) suffering during the conduct and the later symptom course; (iii) current findings; (iv) diagnostic status (established, provisional, subthreshold, none, or not examined); (v) any medical causation opinion, supported by disease-specific evidence and differential analysis; and (vi) the limits of the evidence. A factual investigation is never presented as a completed clinical examination. Legal characterization under UNCAT Articles 1 and 16 is made by the IAJ directorate in its separately authored legal analysis (Module 2, Adversarial-Neutrality and Rival-Hypothesis Protocol), as an independent institutional determination that is not binding on domestic courts; the clinical evaluator generally does not state it, and domestic legal consequences are for the courts. Authority: Istanbul Protocol (2022) §§390–391, 493, 498 and 542. IP §390 identifies reliance on the absence of PTSD diagnostic criteria to disregard evidence of torture as a misuse of the Protocol. Other statements of this rule in this Standard and in the IAJ Quick Reference to Psychological Evaluation and Intermediate Manual are summaries; where they differ, this text controls.

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; IAJ enhancements are identified by headings such as "The IAJ elaborates".

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[84] 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[85]
- Humiliation/Degradation Tactics[86]
- Procedural Violations[87]
- Coercion/Intimidation Tactics[88]

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

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

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

[87] 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

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

- Discrimination, including discrimination based on disability[89]
- Applicable ethics violations
- detailed description of the causation, any motive[90], 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 have 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
- 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[91] 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[92] (very important)
- Did the alleged victim report/complain about the act to anyone?[93]
- Did any other person report/complain about the act to anyone?

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

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

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

[92] Is also perpetrated against others

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

- 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 ever reported to any human rights bodies?
- Where physical injury is indicated, refer for, or obtain the records of, a medical examination by a qualified physician for each distinguishable episode (time interval), and document from those records and the examinee's report:
- Dates, times, nature and frequency of injuries
- Symptoms list with dates of onset, exacerbation(s) and remission(s)
- If physical injuries are indicated
- injuries, sites, nature and scars/marks as examined by the physician, with photographs where consented[94]
- 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

[94] Follow the protocol by Physicians for Human Rights for documenting and evaluating physical torture. Except in 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

- Use the IAJ Symptom-to-Instrument Selection Guide (Appendix A) as a selection guide when applying structured 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 during and directly after the act
- Short-term impact in the following days and 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
- 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[95]
- 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

[95] Psychological trauma and distress can cause physical symptoms

- complications
- barriers to treatment, recovery or rehabilitation
- locations/facilities of care provided
- identity of each person who provided care with dates and nature and location
- identity 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
- 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

The evaluator shall separately reconstruct psychological complaints during the alleged conduct and the post-event trajectory. Present symptoms cannot substitute for the historical severity assessment. Record the symptom-free, recovered, intermittent, and never-evaluated presentations without negative inference.

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, flashbacks 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", in particular the episode-by-episode documentation and impact assessment.

(c) Post-torture history

Historical reconstruction: identify the date and source of each claimed symptom, including contemporaneous records, retrospectively reported experiences, third-party observations, clinical contacts, and periods of recovery. Assign source-specific confidence; do not infer that records were available or that no record means no symptom.

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.*[96] *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

NON-DIAGNOSTIC CONSISTENCY: Assess the degree to which historical and present clinical evidence is consistent with the reported treatment even if no DSM/ICD threshold is met. Identify supportive, contradictory, and unavailable information. Do not equate "no PTSD" or "no positive questionnaire" with "not consistent with torture/CIDT." IP §542 governs.

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*

[96] 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.

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.

IAJ note: consistent with the Cautionary note in Module 1, the IAJ investigator's assessment of "credibility" is limited to the reliability of clinical evidence and the consistency of findings; credibility is for the adjudicator (IP §§388–389).

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) "Diagnostic of": the psychological findings could not have been caused in almost any way other than the alleged torture or ill-treatment.

IAJ note: "Diagnostic of" is rarely appropriate for psychological findings, and its use requires individualized justification; "Highly consistent with" is the distinct category in §543(c).

The IAJ notes the Rule of Non-Legal Attribution: the Istanbul Protocol consistency categories (e.g., "highly consistent with") describe the fit between psychological findings and the alleged treatment. The IAJ Clinical Attribution Rating (e.g., "substantial contributing factor") is a separate clinical-causation judgment about a medical outcome. Neither implies a legal finding of liability, which remains for the courts.

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

This five-axis structure is an IAJ organizational framework adapted from the former DSM-IV multiaxial format; DSM-5 and DSM-5-TR do not use a multiaxial system. Axis I may validly record "no psychiatric diagnosis established," "subthreshold clinical findings," or "clinical examination unavailable," alongside a fully documented historical severity and suffering profile. Axis II and Axis V cannot impose complete personality loss, permanence, or a numerical baseline requirement as prerequisites to human-rights findings. Current validated functioning measures are preferable to legacy GAF scoring.

While the IAJ uses DSM-5-TR and ICD-11 diagnostic criteria, evaluators may use the five-axis format below, adapted from the former 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 – Psychiatric diagnoses where clinically established, together with clinically significant symptom clusters, historical suffering, and subthreshold findings where no**

formal diagnosis is established. EPCACE (ICD-10 F62.0) is historical and must not be represented as a current ICD-11 category.

- **Axis II – Enduring Patterns: Describe personality-related or developmental changes if supported by records or evaluation, distinguishing prior traits, coping adaptations, and post-event changes. "Shattering" is a separate IAJ descriptive construct, not a clinical cause or required psychiatric diagnosis.**
- Axis III – General Medical Conditions: Documents physical conditions and injuries, including any alleged to have resulted from institutional stressors, with the evidence bearing on that relationship.
- **Axis IV – Psychosocial and Environmental Problems:** Identifies institutional stressors such as **Institutional Entrapment**, housing instability, or family conflict.
- **Axis V – Functioning and participation: Document baseline, reported, and observed functioning by domain, with sources and limitations. Use WHODAS 2.0 or another appropriate instrument where justified. Do not require or infer a Global Assessment of Functioning (GAF) score; GAF is a legacy measure and is not part of the DSM-5-TR.**

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

Severity-Independence Rule — application to diagnostic frameworks. The controlling text of the rule appears in Module 3, Performing the psychological evaluation. Applied to this section: PTSD, ICD-11 complex PTSD, historical ICD-10 EPCACE and the descriptive Shattering construct are evaluated only where clinically indicated and are never prerequisites for documenting severe suffering. Non-clinical personnel may preserve evidence within their lawful role, without presenting factual reports as diagnostic opinions. Access barriers and missing evidence are reported as limitations and, where the facts support it, as potential State omissions for separate legal analysis (Istanbul Protocol footnote 535: the cost of mandatory health evaluations, as a State obligation, should be borne by the State).

IP §546. *Clinicians should formulate a clinical opinion on the possibility of torture or ill-treatment based on all relevant clinical evidence, including, "physical*[97] *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.*

[97] 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.

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 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)

Where the presentation suggests it, assess for ICD-11 Complex PTSD (CPTSD), which requires the PTSD core features and disturbances in self-organization; it most commonly follows prolonged or repetitive events from which escape is difficult or impossible—a pattern seen in 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)

Enduring Personality Change After Catastrophic Experience (EPCACE; ICD-10 F62.0) is a historical diagnostic classification that can inform retrospective interpretation of severe, sustained trauma-related changes. It is not a separate current ICD-11 diagnosis and must not be presumed or preferred merely because conduct is alleged to be systemic. Evaluate the current ICD-11 categories, including CPTSD where criteria are met, and describe clinically supported personality and functional changes independently of any formal diagnosis.

ICD-10 described F62.0 by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being "on edge" as if constantly threatened, and estrangement, persisting for at least two years. IAJ descriptive constructs such as Shattering of the Self and learned helplessness are not EPCACE criteria and are documented separately.

IV. Shattering as an IAJ Descriptive Construct; Forensic Attribution Limitations

The IAJ uses "Shattering" as a descriptive investigative construct for profound disruption in coping, identity, autonomy, functioning, or bodily integrity associated with alleged ill-treatment. It is not a psychiatric diagnosis, a validated scale, or a threshold that must be met

before torture or CIDT can be investigated or supported. Where relevant, evaluators should document the following dimensions, without treating any one of them as mandatory:

- **Baseline Contrast: Compare post-event functioning with available pre-event information; when a documented baseline is unavailable, reconstruct cautiously from collateral material and state the uncertainty. Partial recovery, resilience, or absence of a baseline does not negate historical suffering.**
- **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: Describe whether functional or clinical effects are transient, fluctuating, persistent, remitting, or possibly permanent, according to the available evidence. A determination of permanence is not required for recognition of severe suffering.**

(n) Correlating Psychological Sequelae with Physical Methods

I. Foundational Principle: The Somatic-Psychological Bridge

While this Standard gives particular attention to neuroendocrine and stress-mediated harm, evaluators must document traditional physical methods to identify the totality of cumulative harm. In systemic institutional investigations, physical evidence can corroborate psychological findings, including findings relevant to ICD-11 complex PTSD where its criteria are met.

II. Clinical Correlation Table for Traditional Methods

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

II-A. Clinical Correlation Table (continued)

Physical Method	Primary Clinical Signs	Psychological sequelae commonly reported (non-specific; IP §544)
Falanga (Bastinado)	Chronic pain, gait disturbance, orthopedic damage to the feet.	Fear of movement; chronic pain-related distress.
Suspension (Positional)	Brachial plexus injuries, joint dislocations, long-term nerve damage.	Helplessness; persistent pain-related distress.
Asphyxiation (including water or suffocation methods)	Petechiae (broken capillaries), chronic respiratory distress.	Panic, fear of suffocation, intrusive memories.
Electrical Injuries	Characteristic 1–5 mm "punched-out" lesions or skin burns.	Anticipatory fear; hypervigilance.

Evaluators integrate these findings in an overall synthesis. IP §544: psychological consistency does not refer to the connection between a specific symptom and a specific method, but to the overall presentation.[98]

- Physical corroboration: Use physical examination findings to corroborate the account of physical methods; document distress-induced harm separately.
- Differential Analysis: Assess which Istanbul Protocol consistency category the physical findings support, considering alternative causes.

IV. Mandatory Documentation Protocols

Evaluators shall integrate specialized physical examination protocols as supportive data:

- Dermatologic Evaluation: With consent, refer for systematic mapping of scars and lesions by a qualified physician.
- Musculoskeletal Review: With consent, refer for physician assessment of gait or joint impairments.
- Genital & Perianal Examination: Where sexual torture is alleged and the person consents, refer for examination by a qualified physician in accordance with IP Chapter V.

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/.

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.*

[98] Integration of physical and psychological findings: physical findings and their psychological correlates are documented together so that the trier of fact can consider the full clinical picture. Separating physical and psychological findings can understate cumulative harm. This approach is consistent with the Istanbul Protocol's treatment of physical and psychological evidence as complementary.

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.*[99] *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.*[100] *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 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*

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[99] 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.

[100] 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.

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.*[101] *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*

[101] 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.

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 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.*[102]

(c) Post-traumatic stress disorder

PTSD is a diagnosis of a particular response to qualifying exposure, not a diagnosis of torture. DSM-5-TR Criterion A and ICD-11 exposure criteria differ and cannot replace UNCAT Articles 1 and 16. Failure to satisfy those criteria does not exclude severe pain/suffering, psychological injury, CIDT, or the need for investigation. Evaluate contemporaneous suffering, subthreshold symptoms, recovery, and alternative conditions independently.

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*

[102] 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).

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".*[103] *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.*[104] *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*[105] *to 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.

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[103] 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.

[104] 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

[105] 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.

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.*[106]

(a) Developmental considerations

IP §569. *Developmental factors affect the capacity of children and adolescents to perform tasks that are relevant to the assessment.*[107] *Research on forensic interviewing notes that children begin to manifest the capacity to recall events accurately between the ages of 3 and 6, but there is high variability.*[108] *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.*[109]

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.*

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[106] 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).

[107] 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.

[108] 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.

[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.

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.*[110] *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.*[111]

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 influenced by the immediate reactions and attitudes of caregivers following the event.*[112] *Nevertheless, it is important to note that younger children's reports are no less accurate than those of older children.*[113]

IP §575. *A child's reactions to torture depend on age, developmental stage and cognitive skills.*[114] *For children under the age of 3 who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.*[115] *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*

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[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. 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.

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

[112] 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.

[113] 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.

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

[115] 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.

children develop the ability to provide a reliable chronology of events.[116] *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.*

(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 able to provide.*[117] *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.*[118] *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.*[119] *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.*[120] *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*

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

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

[118] 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.

[119] 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.

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

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."[121]

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 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.*[122] *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.*[123]

(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.*[124] *Collecting information from*

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

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

[123] 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.

[124] 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

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,[125] *and that exposure to traumatic experiences increases the risk of learning and behavioural problems, obesity*[126] *and psychotic symptoms in childhood.*[127] *Neurobehavioural development research shows 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.*[128] *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.*[129]

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.*[130] *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*

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).

[125] 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.

[126] 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.

[127] 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.

[128] Atilgan Erozkan, "The link between types of attachment and childhood trauma", Universal Journal of Educational Research, vol. 4, No. 5 (2016), pp. 1071–1079.

[129] UNHCR, The Heart of the Matter, pp. 58–60.

[130] See Terr, "Childhood traumas"; Zero to Three, DC:0–5 Diagnostic Classification; Sironi, "'On torture un enfant'"; and Bailly, Les catastrophes et leurs conséquences

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

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.*[131] *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.*[132] *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.*[133]

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.*[134]

(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*

[131] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

[132] Research Triangle Institute International, DSM-5 Changes: Implications for Child Serious Emotional Disturbance (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).

[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).

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.

(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.*[135] *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

[135] 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.

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. 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.*[136] *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.*[137] *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.*[138] *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*

[136] Yael Dvir and others, "Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities", Harvard Review of Psychiatry, vol. 22, No. 3 (2014), pp. 149–161.

[137] Center for Victims of Torture, Healing the Hurt: A Guide for Developing Services for Torture Survivors (Minneapolis, 2005), chap. 2.

[138] 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.

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.

(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 IP §568, where 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, using appropriate guides.

II. Mitigating Retraumatization During Evaluation

Evaluators should be aware that the examination process[139] 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.

[139] 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

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.
- **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. Abuse by private persons is torture or CIDT only where a public official is involved or acquiesces.

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.*[140] *Lesbian, gay, bisexual and transgender adult asylum seekers also have particular persecution experiences, with consequences for mental health.*[141] *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;[142]

(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;[143]

(d) Ask about persecution and abuse that target sexual orientation and gender identity during childhood and adolescence;[144]

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[140] 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.

[141] 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.

[142] Alessi and others, "'The darkest times of my life'" supra

[143] 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.

[144] 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.

(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;

(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*[145] *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:

[145] American Psychological Association, Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2011).

- 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:

- 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:

- LGBTQI+ cultural competency training proportionate to the case
- 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. The Committee against Torture has expressed concern about expedited removal procedures that do not adequately consider asylum seekers' circumstances, mandatory detention of asylum seekers and other immigrants, the use of solitary confinement in immigration facilities, and sexual assault in immigration detention (CAT/C/USA/CO/3-5, paras. 18–19). Evaluations should document conditions of detention, access to medical and mental-health care, and any risk on return (UNCAT Art. 3; IP Chapter VI).

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 (a feature of torture in the Nowak Commentary and Special Rapporteur reports, not a textual element of 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 IAJ's analysis, drawing on Committee against Torture concerns and Special Rapporteur reports (CAT General Comment No. 2, para. 21, on persons especially at risk; A/63/175; A/HRC/22/53), is 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
- Powerlessness (Nowak Commentary; A/63/175) 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 §52**, 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 evidence on necessary accommodation is often given significant weight; the weight given is decided case by case
- Failure to accommodate, when combined with coercion, may cross threshold to CIDT

Key ADA Principle for Investigators:

The person's request and the treating provider's evidence should be given careful weight; courts and institutions decide accommodation requests through an individualized inquiry, which the investigator should document, including any failure to consider the medical evidence.

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

Training Example (composite):

Training example (composite): a court acknowledges on several occasions that a litigant's medical treatment is essential, then orders unaccommodated participation followed by documented deterioration. Such a pattern may support an inference of knowledge and intent for the IAJ directorate's legal analysis; a prohibited purpose requires separate evidence.

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:

- Prospective research associates stressful life events with subsequent MS exacerbations. It does not isolate judicial proceedings as a stressor or establish individual causation; the contribution of any institutional event must be assessed against the specific medical record, baseline, chronology, and competing and concurrent causes.

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

Where the evidence supports it, the resulting physical harm (neurological, cardiac, immune) may 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
- Training Example:

Training example (composite): a disabled litigant's accommodation requests are denied by every decision-maker encountered over several years (for example, twelve decision-makers and more than forty requests). A uniform pattern of this kind may support an inference of systemic practice for the IAJ directorate's legal analysis; alternative explanations must be stated.

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:

Composite example: a person with a neurological condition and associated cognitive impairments requests accommodation for discovery obligations in civil litigation. The request is denied; the person cannot comply; the court imposes substantial sanctions for non-compliance. The person reports that the sanctions punished the disability; the institutional position is that the sanctions enforced ordinary procedural rules. The investigator documents both positions and the medical evidence on the relationship between the disability and the non-compliance.

3. Forum Nullus

When systemic discrimination renders an entire court system or circuit inaccessible to persons with disabilities, the IAJ may characterize it as forum nullus under the criteria in Module 1. 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 no judge or decision-maker within a system provides adequate accommodation, the pattern may support an inference of systemic practice for the IAJ directorate's legal analysis.

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 longitudinal evidence about necessary accommodation is often given significant weight; the weight given is decided case by case. The investigator must document whether the medical evidence was considered.

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:

Composite example: over several years a litigant files accommodation requests in state trial and appellate courts, a federal district court and a federal court of appeals, and petitions for further review:

- numerous ADA accommodation motions in state courts (outcome: denied or not addressed)
- ADA motions in federal district court (initially granted, later withdrawn)
- appeals with accommodation motions (denied)
- petitions for further review (denied)

A record of this kind may support an inference of systemic practice; the institutional reasons given for each denial must also be documented.

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

Documentation checklist (composite):

Composite example: a judge establishes an accommodation practice (for example, stays for medical treatment) and applies it consistently over several years, then abandons it without explanation. The abrupt reversal after consistent application may be relevant to the IAJ directorate's legal analysis of intent; the court's stated reasons, if any, must be documented.

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

Training Example:

Composite example: neuropsychological testing documents impairments in processing speed, attention and executive function relevant to the person's ability to meet court deadlines. Continued imposition of those deadlines with knowledge of the impairments may be relevant to the IAJ directorate's legal analysis of intent.

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

Documentation checklist (composite):

Medical records documented:

- Published literature supporting stress-associated MS exacerbation, where relevant; do not claim research specifically proves that court proceedings cause relapse.

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: repeated stress exposure may increase future cardiovascular risk in susceptible persons

- Irreversibility: some stress-related cardiac events cause lasting damage; others, such as Takotsubo cardiomyopathy, usually resolve

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
- Independent causation opinions: each provider states their own opinion within their specialty; disagreements are recorded
- 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
- Systemic nature: document the evidence of a systemic pattern for the IAJ directorate's legal analysis

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 the accommodation grant rate; a very low rate across many decision-makers may support an inference of systemic practice (state the sample and alternative explanations)
- 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 the IAJ directorate characterizes systemic disability discrimination as torture or CIDT, recommendations may include:

- 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 severe pain or suffering is intentionally inflicted, for a listed purpose or a reason based on discrimination, by or with the acquiescence of a public official; powerlessness is a relevant contextual factor
- 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 evidence on necessary accommodation is often given significant weight; the weight given is decided case by case
- 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 the denial causes severe suffering, may constitute CIDT or, where intentional infliction and a listed purpose (including discrimination) are shown, torture. Investigators document the facts and clinical findings; the IAJ directorate makes the legal characterization.

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 stressor, and the evidence for and against its contribution to any 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 PTSD diagnosis does not verify an account; the absence of PTSD, remission, lack of treatment, or unavailability of testing does not impeach an account. Evaluate specific propositions, source reliability and alternative explanations rather than diagnostic status as a global proxy for credibility.

A. Purpose and Framework

A central function of the forensic psychological evaluation is to assess the consistency of the clinical findings with the account and the reliability of the clinical evidence. 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 helps characterize the evidentiary reliability of particular reported events and clinical observations without treating trauma-related inconsistencies as proof of fabrication.

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 supported evidence-reliability 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 state the reliability and limitations of each clinical or factual component rather than pronounce on the person's overall truthfulness.

B. Istanbul Protocol Consistency Framework

The Istanbul Protocol[146] 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
- Few other possible causes (IP §543(c))
- Do not by themselves establish the event

4. Typical Of: The clinical findings:

[146] IP §§379–381 for the interpretation of findings and consistency levels or §§540–545 for psychological consistency specific to Chapter VI

- Are typically found as a consequence of the alleged torture or ill-treatment, with few other possible causes (IP §543(d))
- Not more corroborative than "highly consistent with" (IP §545)

5. Diagnostic Of: The clinical findings:

- 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

This decision tree provides a step-by-step guide for applying the IP consistency framework, for Level 3 and Level 4 clinicians; non-specialists document and refer.

STEP 1: Evaluate overall psychological presentation

├── Consistent with genuine trauma (e.g., dissociation, hypervigilance)?

│ ├── Yes: Proceed to STEP 2

│ ├── No: Absence of typical trauma symptoms is not inconsistency; consider recovery, delayed onset, resilience and cultural expression

├── 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" only where the findings could not have been caused by the alleged treatment

├── 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?

│ ├── Exceptional and independently justified: Consider "Diagnostic of" (IP §543(e)); this classification is rarely appropriate for psychological findings. Otherwise assess the supported §543(a)–(d) category without treating any classification as a legal verdict.

│ ├── 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
- Relationship between functional impairment and the alleged treatment (recovery and resilience do not negate severity)
- 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 Reliability 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 reliability 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 reliability 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 Reliability / Record-Level 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 reliability 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 Reliability / 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 §§294–295; 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 §§539–540.

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 Bearing on the Reliability of Clinical Evidence

The following considerations may support the reliability of reported experiences or clinical findings; each requires contextual evaluation:

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 a concrete external incentive warrants evidence-proportionate inquiry, applying the same scrutiny to institutional and complainant incentives; it does not itself establish 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)
- 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 seriously harm a genuine survivor (whether such a finding amounts to CIDT is a separate legal question); 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: Under IP §386, when fabrication is suspected, another clinician should conduct additional interviews; the possibility of simulation should be noted with the agreement of both clinicians. Separately, the IAJ requires independent second-clinician review and supervisory scrutiny before a definitive feigning determination is included 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.[147]
    - 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 (IP §386). If, after the steps above, the evaluator still suspects fabrication, IP §386 recommends that another clinician conduct additional interviews; the IAJ requires independent second-clinician review before a definitive feigning determination. As an additional IAJ safeguard (not an IP requirement), 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.

[147] 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.

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.

I. Documentation in the Report

The reliability-of-clinical-evidence section of the report should include:

- Methodology: How credibility was assessed (interviews, testing, collateral)
- Consistency Analysis: Assessment of internal and external consistency
- Supporting Factors: Evidence supporting the reliability of specific observations or reported events
- 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 the reliability of the clinical evidence and the consistency of findings
- Limitations: Any limitations on the reliability assessment

Sample Language:

"Based on the psychological evaluation, the internal consistency of [Name]'s account, the consistency between reported symptoms and the alleged treatment, the presentation during the evaluation, and the absence of indicators suggesting fabrication, the clinical findings are [consistent / highly consistent] with the account, and the clinical evidence is reliable in the following respects: [specify]. The credibility of the account is a matter for the adjudicator (IP §§388–389)."

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.[148]

- **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

[148] Includes U.S.-specific subcultures (e.g., the intersection of race, poverty, and disability in the "Child Welfare" systemic 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:

- **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: 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 Trauma 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:

II-A. Population Table

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")	Document somatic expressions of distress; assess any physical illness separately on medical evidence.
LGBTQI+ Immigrants	"Identity Erasure" or specific taboos	Document how the trauma of "Conversion" practices or targeted sexual violence prevents early verbal disclosure .

		III. Protocol for Consulting Cultural Experts

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 advise whether the presentation is a recognized idiom of distress in that culture; the evaluator integrates the advice into the consistency assessment.
- Integrate Expert Findings: Incorporate the consultant's analysis into the final Consistency Assessment, citing the expert as a secondary source.

Role of the Psychological Evaluation

I. Foundational Purpose

The psychological evaluation serves as the central evidentiary pillar in torture and CIDT investigation because:

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 the reliability of the account

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: ICD-11 CPTSD disturbances in self-organization; historical ICD-10 EPCACE for older records

Function 3: CAUSATIVE

Establishing the relationship between torture and harm

The Istanbul Protocol establishes the consistency framework for causation assessment:

Level	IP §543 meaning (paraphrase)	Interpretive safeguard
Not consistent with	Finding could not have been caused by the alleged torture or ill-treatment.	Explain the specific inconsistency and evidence.
Consistent with	Finding could have been caused by the alleged torture or ill-treatment but is non-specific; many other causes are possible.	Do not equate non-specific evidence with proof.
Highly consistent with	Finding could have been caused by the alleged torture or ill-treatment and few other causes are possible.	Justify alternatives and clinical relevance.
Typical of	Finding is typically found as a consequence of the alleged torture or ill-treatment; few other causes are possible.	IP §545: not necessarily stronger than “highly consistent”; rarely used for psychological evidence.

Diagnostic of (IP §543(e))	Finding could not have been caused in almost any way other than the alleged torture or ill-treatment.	Exceptionally rare for psychological evidence; give individualized grounds.

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:

In the IAJ's view, documentation is not merely forensic; it can also be therapeutic, because the survivor's experience is witnessed and preserved.

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
- Support, and expose gaps in, the fulfilment of State obligations under UNCAT Articles 12–13

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[149]

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

└── **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

[149] 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.

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 purpose of the medico-legal evaluation … is to provide a clinical interpretation of the degree to which clinical findings correlate with the alleged victim's contention of abuse …" — Istanbul Protocol §268

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

Psychological consequences of torture are often more persistent than physical findings (IP §491), but they may also remit; remission does not mean that severe suffering did not occur.

- 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 often heal; psychological consequences are often more persistent (IP §491), though they may remit:

- Scars fade or become non-specific
- Fractures heal without trace
- Soft tissue injuries resolve
- PTSD, depression and personality changes often persist, but remission does not negate past severe suffering
- 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

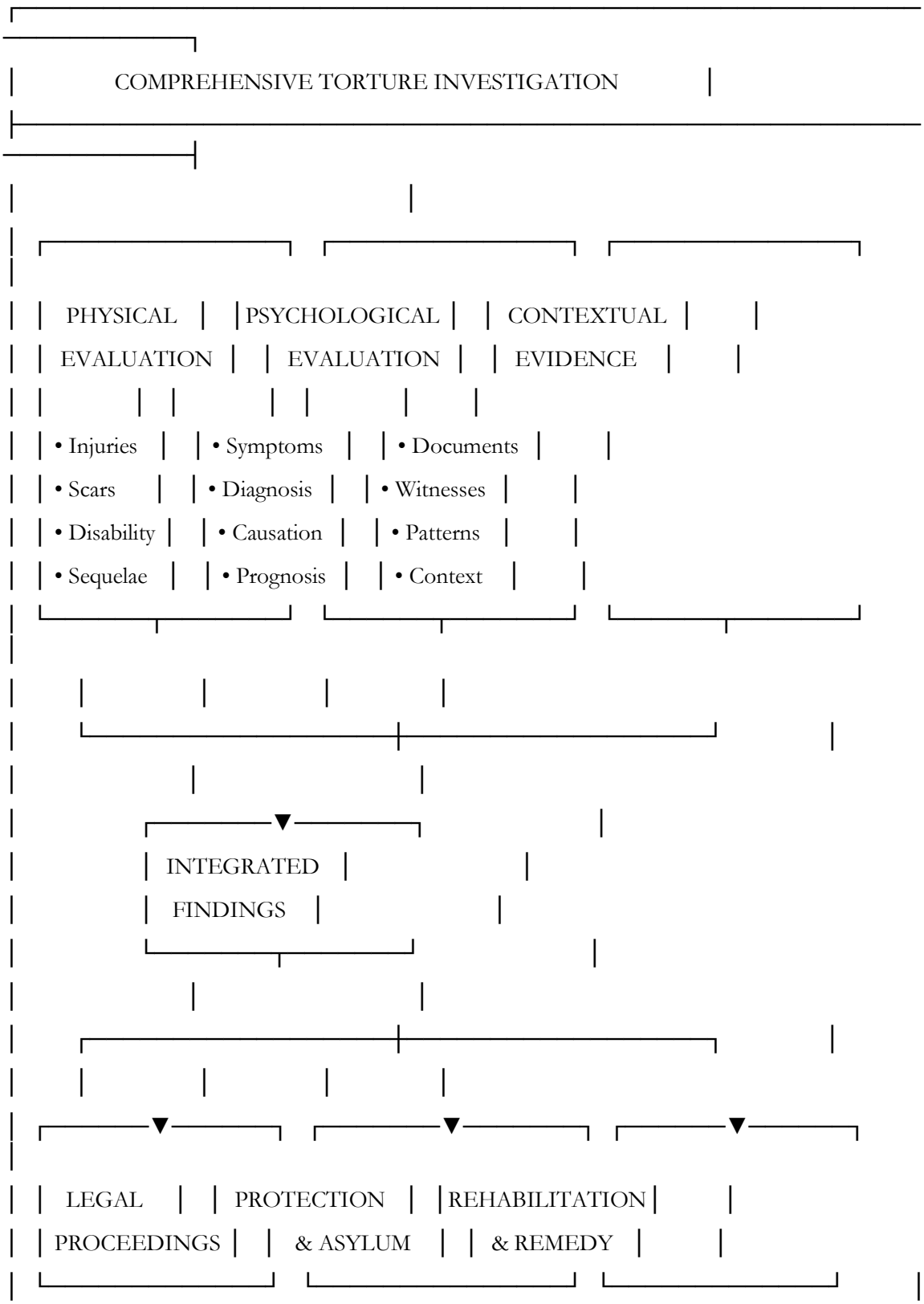
Under UNCAT, torture is defined by severe pain or suffering. Psychological evaluation:

- Documents the suffering directly
- Provides evidence bearing on 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

In the IAJ's paraphrase of IP §§523–524: when physical findings are absent, non-specific or have resolved, the psychological evaluation often provides the principal medical evidence of torture.

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 alleged violations, recording the examinee's account of those involved, and documenting patterns of abuse;
- Serving therapeutic functions through validation, witnessing, narrative construction, and treatment planning;
- Supporting, and exposing gaps in, the fulfilment of State obligations 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:

In the IAJ's words: the torturer's goal is to break the person—to destroy their sense of self, their connection to others and their capacity for hope. The evaluation documents this harm, and in witnessing it, helps to preserve the truth and make accountability possible.

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 §§267–268)

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 Chapter IV; consent and confidentiality)

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 §§310–311)

(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 for the initial interview, adapted to the person's needs, with further sessions where required
- 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 §§272, 326–339)

(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 §§296–298)

See the interpreter guidance in Module 2 (Essential Principles) and IP §§296–298

- Special Considerations (IP Chapter IV)

(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*[150] *of torture are often more persistent and protracted than physical sequelae*[151] *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 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*[152]. ***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.*[153] *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**

[150] 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).

[151] 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).

[152] 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.

[153] Almerindo E. Ojeda, ed., The Trauma of Psychological Torture (Westport, Praeger, 2008); and Pau Pérez-Sales, Psychological Torture: Definition, Evaluation and Measurement (Routledge, 2016).

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*[154]*.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.*[155] *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 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.*[156]

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.*[157] *A cross-cultural study of depression provides helpful information.*[158] *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*

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[154] 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.

[155] 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)

[156] 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.

[157] 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.

[158] Norman Sartorius, "Cross-cultural research on depression", Psychopathology, vol. 19, No. 2 (1986), pp. 6–11.

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),*[159] *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.*[160] *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 lawyers and judges.*[161]* **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.*[162]

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":

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[159] 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.

[160] 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.

[161] 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" (IP 2022, footnote 412).

[162] 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

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 2022 §492; 2004 §235)

Internationally accepted definitions of torture acknowledge that provoking mental suffering is often the intention of the torturer.[163]

- *All kinds of torture inevitably comprise psychological processes.*
- *Torture often causes psychological/psychiatric symptoms at various levels.*
- *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.

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[163] Where actors know that a policy is causing severe pain or suffering and continue to apply it without individual consideration, intent may be inferred objectively from the circumstances (CAT General Comment No. 2, para. 9). Intent and prohibited purpose are distinct elements of Article 1, but the same course of conduct may establish both. Purpose is shown where the evidence indicates how the suffering operated or what it was used for: for example, sanctions attached to non-compliance (coercion or punishment), escalation after complaint (intimidation or punishment), or differential treatment of a protected group. In disability cases, the denial of reasonable accommodation is itself discrimination (CRPD Art. 2), so knowing infliction of severe suffering through that denial may satisfy "for any reason based on discrimination of any kind." Where knowing infliction is established but nothing in the record indicates a listed purpose, the purpose element is not established on the present evidence and the conduct is analysed under Article 16.

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

FIRST BRANCH — Which time and question? Distinguish (A) the severity of suffering during the conduct (retrospective or contemporaneous), (B) current clinical impairment, and (C) present urgency. They may differ sharply. FINAL RULE — No diagnostic or permanence gate. Severe past suffering may be independently supported where PTSD, current symptoms, long-term injury, objective biomarker, or specialist examination is absent. Distinguish evidence of suffering from ultimate Article 1 legal assessment; for CIDT do not impose the Article 1 severity threshold. (See the controlling Severity-Independence Rule, Module 3.)

For (B) current clinical impairment and (C) urgency only. Severity of suffering during the conduct (A) is assessed under the Severity-Independence Rule. This decision tree supports rapid classification of the seriousness of present 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 the alleged treatment and psychological deterioration, together with differential analysis, supports an opinion on the relationship
- Specific trauma-related triggers may support clinical consistency with the reported experiences; they do not independently establish historical events
- 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 (§§540–545) 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
- **Diagnostic of (IP §543(e)): extremely rare for psychological evidence; use only when the particular findings meet the Protocol's criterion and the reasoning and limits are stated. Do not conflate this with "Highly consistent with" (IP §543(c)).**

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

Distress-induced suffering may be severe without a subsequent psychiatric diagnosis or observable permanent biological damage. Where injury is alleged, document medical causation separately and within competence. Failure to demonstrate a bodily-injury pathway does not extinguish evidence of psychological suffering or negate other elements of torture/CIDT.

I. Introduction

The doctrine of "Distress-Induced Harm," refined from the "Battery Without Touching"[164] analysis in the original IAJ Psychological Investigation Standard (Part B of the Systemic Harm Mapping Tool), provides a structured framework for assessing non-physical institutional or judicial actions that cause severe physical harm through psychological stress mechanisms. This refinement addresses

[164] 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

potential conceptual overreach by emphasizing physiological causation rather than analogizing to traditional battery torts, which could dilute legal precision or invite dismissal.

Status. The clinical mechanism on which this doctrine relies (stress-associated exacerbation of susceptible conditions) is supported by the published literature summarized in Section III. The characterization of such harm as torture or CIDT is an IAJ doctrinal proposal. It has analogical support in Special Procedures reports on persons with disabilities and on health-care settings (A/63/175; A/HRC/22/53), which concern custodial and medical settings. No treaty body, Special Procedure or court has applied it to judicial or procedural conduct. Each report must state which of these categories the case falls in.

The doctrine of Distress-Induced Harm provides for the clinical documentation of what the IAJ terms "Biological Assault". It addresses institutional psychological stressors that produce significant distress episodes and, through physiological mechanisms, severe physical pain or objective biological deterioration or injury. The evaluator documents the mechanism and its evidentiary support. Whether the conduct meets the definition of torture or CIDT under the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) is determined in the separate legal analysis, taking account of foreseeability and knowing maintenance.

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, which may be relevant to the IAJ directorate's legal analysis of torture or CIDT.

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 reliability, 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).

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) states that the conditions that give rise to ill-treatment frequently facilitate torture, so the measures required to prevent torture must be applied to prevent ill-treatment (para. 3). The 2020 report of the Special Rapporteur on Torture on psychological torture (A/HRC/43/49) addresses methods inducing severe mental suffering without physical means; the "debility, dependency and dread" framework is discussed in the literature (e.g., Cakal 2018). The Special Rapporteur's interim report A/63/175 (2008) annexes the Istanbul Statement on solitary confinement; the Special Rapporteur's solitary-confinement report is A/66/268 (2011).
- Landmark cases: The European Court of Human Rights (ECtHR) in El-Masri v. Macedonia (2012) found that the applicant's treatment, including serious physical abuse during rendition,

constituted torture, and that his secret detention was inhuman and degrading treatment. 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 that the prolonged isolation and incommunicado detention involved in enforced disappearance constitute cruel and inhuman treatment. The Special Rapporteur (A/66/268) found that prolonged solitary confinement may amount to torture or CIDT; A/HRC/22/53 addresses abuses in health-care settings, including isolation and restraint of persons with disabilities.

- 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) held that excessive force may violate the Eighth Amendment without serious injury; Hope v. Pelzer (2002) found an Eighth Amendment violation where a prisoner was handcuffed to a hitching post for hours, recognizing gratuitous infliction of pain and humiliation. 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) addressed the procedural due process required for supermax placement.
- 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)[165] 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)[166] 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.

[165] Pérez-Sales, P. Psychological Torture: Evaluation, Detection and Evidence. Routledge, 2017

[166] 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

- Leach (2016) reviewed psychological (isolation, sensory deprivation and overload, sleep deprivation), psychophysiological (thermal, stress positions) and psychosocial factors in exceptional, extreme and torturous environments.[167]
- Prospective MS studies provide statistically significant evidence associating stressful life events with subsequent exacerbations. Ackerman et al. (2002) reported that stressful events occurred an average of 14 days before exacerbations compared with 33 days before control dates ($p < .0001$). The finding supports temporal association in the studied population; it is not a definitive or universally applicable individual causation window (Ackerman et al., Psychosomatic Medicine 64(6):916–920, 2002). Buljevac et al. (2003) is cited below.[168]
- Cakal (2018)[169] on "debility, dependency, dread" emphasizes relational dynamics in non-physical torture.
- ACLU litigation (e.g., Salim v. Mitchell, filed 2015, settled 2017) against CIA psychologists highlight designed psychological harm (e.g., waterboarding simulations) as torture.
- The forcible administration of "truth serums" to compel disclosure is widely regarded as prohibited under international law and as at least inhuman or degrading treatment (see A/HRC/43/49 on psychological torture).

III. Medical and Scientific Basis

Stress-mediated physiological deterioration is a serious subject for forensic investigation, and disease-specific research supplies empirical evidence of association and plausible biological pathways. In MS, Ackerman et al. (2002) reported stressful events averaging 14 days before exacerbations versus 33 days before control dates ($p < .0001$), while Buljevac et al. (2003) found an increased risk of exacerbation in the four weeks following stressful life events (RR 2.2; 95% CI 1.2–4.0). These findings strengthen the foundation for structured clinical attribution, but population-level associations must not be presented as direct proof of the mechanism or cause of an individual injury. Other disease contexts require their own scientific evidence.[170][171]

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[167] Leach, J. "Psychological factors in exceptional, extreme and torturous environments", Extreme Physiology & Medicine 5:7 (2016), doi:10.1186/s13728-016-0048-y

[168] Buljevac, D., et al. "Self-reported Stressful Life Events and Exacerbations in Multiple Sclerosis: Prospective Study." BMJ, 327(7416), 646, 2003

[169] Cakal, E. Debility, Dependency and Dread: On the Conceptual and Evidentiary Aspects of Psychological Torture. Torture Journal, 2018

[170] Benjamin Solomon, Peter Boruta, Dagmar Horvath and John MacKellar, "The Multiple Sclerosis Stress Equation", Journal of Medical Statistics and Informatics, vol. 11, article 1 (Herbert Publications, 13 June 2023), doi:10.7243/2053-7662-11-1 (copy archived at iaj.institute/publications/MSpaper.pdf), analyzed seven years of one patient's recorded symptom-set data and proposed a quantitative stress–disease model. The paper does not independently establish MRI-confirmed lesion causation or histological tissue death from each recorded stressor. See also S. von Drathen, S. M. Gold, J. Peper, A. C. Rahn, C. Ramien, M. Magyari, H.-C. Hansen, T. Friede and C. Heesen, "Stress and Multiple Sclerosis – Systematic review and meta-analysis of the association with disease onset, relapse risk and disability progression", Brain, Behavior, and Immunity, vol. 120 (2024), pp. 620–629, doi:10.1016/j.bbi.2024.06.004.

[171] Different sources support distinct propositions: Ackerman et al. (2002), temporal proximity of stressors to MS exacerbations; Buljevac et al. (2003), prospective four-week exacerbation risk (RR 2.2; 95% CI 1.2–4.0); Solomon et al. (2023), longitudinal statistical modeling of symptom-set patterns in one RRMS patient; von Drathen et al. (2024), pooled population-level associations between stressors and MS onset, relapse and progression. They are not interchangeable evidence of patient-specific tissue injury.

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 (Strongest case-specific evidence) — 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 to support plausibility, without treating it as proof of individual causation.
- **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:

- MS Relapse Research: Ackerman et al. (2002) and Buljevac et al. (2003) provide disease-specific temporal and risk associations between stress and MS exacerbation. Solomon et al. (2023) develops an individual longitudinal statistical approach that may inform event anchoring and hypothesis testing. von Drathen et al. (2024), a systematic review and meta-analysis of 30 studies (26 cohorts; 24,781 cases), found a weak-to-modest association between psychological stressors and MS onset, a 1.87-fold increased MS risk with diagnosed stress disorders (95% CI 1.06–3.43), and, across 19 heterogeneous studies of relapse risk, a threefold increase in relapses in two cohorts exposed to the same military threat (relapse rate ratio 3.0; 95% CI 1.56–5.81). These

distinct contributions do not establish a uniform 14-day causal window or replace clinical differential analysis.

- 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) found that psychological manipulations, humiliating treatment, exposure to aversive environmental conditions and forced stress positions overlapped considerably with physical torture in associated distress and uncontrollability, and that the traumatic stress impact of torture, physical or non-physical, appeared to be determined by perceived uncontrollability and distress. The study addresses psychological impact; it does not address physical injury.
- Extreme Environments: Leach (2016) reviewed psychological (isolation, sensory deprivation and overload, sleep deprivation), psychophysiological (thermal, stress positions) and psychosocial factors in exceptional, extreme and torturous environments.

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 deterioration or injury, where supported by individual clinical evidence.

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 is proposed by the IAJ as a structured aid to Event Anchoring (a proposed use of an unvalidated single-patient model, not a generally accepted forensic method), which may help the evaluator organize the chronology when considering whether institutional conduct was a contributing factor to objective or clinically reliable biological deterioration (e.g., relapse activity, inflammatory flare, cardiovascular destabilization). Population-level support for plausibility is provided by von Drathen et al. (2024), a systematic review and meta-analysis of 30 studies (26 cohorts; 24,781 cases), which found a weak-to-modest association between psychological stressors and MS onset, a 1.87-fold increased MS risk with diagnosed stress disorders (95% CI 1.06–3.43), and, across 19 heterogeneous studies of relapse risk, a threefold increase in relapses in two cohorts exposed to the same military threat (relapse rate ratio 3.0; 95% CI 1.56–5.81).

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**

Assess the interval between each identified stressor and deterioration against the person's chronology, condition-specific literature, observed baseline, measurement uncertainty, and reasonable alternative explanations. Ackerman's reported mean of 14 days in an MS study is not a required individual causation window and cannot be generalized to other diseases.

- **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 an IAJ-proposed and unvalidated aid, to structure 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***

- Consider temporal relationship, standardized measures (WHODAS 2.0, PCL-5, PHQ-9), objective medical findings, and differential diagnosis to weigh 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 is not an extension of battery; battery is discussed only as a domestic analogy for injury without physical contact, for which there is no 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. Physical-injury requirements, such as the Prison Litigation Reform Act's requirement of physical injury for mental or emotional injury claims (42 U.S.C. §1997e(e)), 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'. Counsel may argue, under the Charming Betsy canon (which applies to construction of federal statutes), that ambiguous federal 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: a biologically plausible pathway (e.g., HPA axis activation → cortisol dysregulation → condition-specific pathophysiology). The evaluator documents the evidence bearing on whether this mechanism operated in the case; accountability is addressed by the IAJ directorate and, in litigation, by counsel and the court.

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 weighs 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) Documenting onset (no fixed interval applies; the time relationship is one factor in the analysis)

- Acute reactions (e.g., panic attacks, dissociative episodes, acute stress reactions): document the time of onset as precisely as the record allows.
- Subacute reactions (e.g., depressive episodes, anxiety exacerbation, PTSD symptom emergence): document the time of onset and course as precisely as the record allows.
- 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[172]), 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.

[172] Solomon et al. (2023) fitted statistical distributions to repeated symptom-set observations from one RRMS patient. Application to an independent forensic case requires defined stressor and outcome variables, contemporaneous records, model-fit and uncertainty analysis, assessment of other causes, and independent medical evidence of any claimed disease relapse or injury. The paper alone does not eliminate natural disease fluctuation.

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.

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 (relevant to causation, Article 16 and domestic standards; does not establish knowledge)

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, where documented knowledge exists, 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). Psychological findings are assessed for consistency; where a medical causation opinion is offered, the evaluator documents whether, and why, the index institutional stressor was a contributing factor, 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:

Tier A - 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.

Tier B - 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."

Tier C - 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.

Tier D - 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 evaluation of alternative explanations during the relevant period support the opinion that [conduct] contributed to [diagnosis], for the reasons stated."

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 X of the Skeleton Report (Appendix D). A "High" IAJ Clinical Attribution Rating may be assigned only where an Axis III medical finding is anchored to an Axis IV stressor by chronology and case-specific evidence, with differential analysis; disease-specific temporal association literature may support plausibility.

B.12 Evidentiary Handling of Judicial Obstruction

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**:

- Facts relevant to acquiescence (for the IAJ directorate's legal analysis): record any refusal to engage with the evidence, with dates, notice given and resulting deterioration, as evidence relevant to knowledge, foreseeability and institutional tolerance of harm.
- Forum nullus: where decision-makers in a system uniformly reject life-critical modifications, the IAJ directorate may consider a forum nullus characterization under the Module 1 criteria (an IAJ doctrinal proposal).
- **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: Severity is assessed under the Severity-Independence Rule (Module 3). Article 1 requires severe pain or suffering; Article 16 a lower threshold. No chronic disorder or diagnosis is required. Routine institutional stressors are excluded.
- Intent and purpose: UNCAT Article 1 requires intentional infliction and a listed purpose (assessed by the IAJ directorate); Article 16 has no purpose element. Domestically (Eighth Amendment), deliberate indifference applies (Farmer v. Brennan); simple negligence is insufficient there.
- Causation Proof: Objective medical evidence required, including pre/post treatment records. The Istanbul Protocol consistency category is stated with its basis.
- Official Involvement: Claims limited to conduct by public officials or state acquiescence, per UNCAT Article 1.
- Lawful sanctions: No justification permits torture or CIDT (UNCAT Art. 2(2)). The Article 1 lawful-sanctions clause is analysed by the IAJ directorate; incidental stress inherent in lawful processes that do not reach the Article 16 threshold 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): ill-treatment reaching the Article 16 threshold, with official involvement or acquiescence, characterized by the IAJ directorate; no prohibited purpose is required.
- Torture (Article 1): severe pain or suffering, intentionally inflicted (knowing maintenance after notice may establish intent), for a listed purpose (separately evidenced, including discrimination), with official involvement; characterized by the IAJ directorate.

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," provides a structured basis for documenting indirect harms for assessment under UNCAT, without overreach.

Enhanced Causation Analysis and Documentation Methodology

Biological Injury: Causal Rivalry and Quantitative-Limits Rule

Distress-induced deterioration is an investigable medical pathway and the IAJ shall not exclude it because there was no physical contact. But a temporal sequence, a statistically significant association in a population study, and an individualized causal conclusion are different evidentiary propositions. Disease-specific research (including Ackerman, Buljevac, Solomon and von Drathen, when relevant) must be described according to its design, population, effect estimate and limitations.

For a given case, distinguish exposure verification, symptom or injury verification, general biological plausibility, within-person temporal pattern, differential etiologies, and attribution strength. Include positive and negative exposure-response episodes if ascertainable; document baseline variability, regression to the mean, selection bias, confounding, competing stressors, treatment changes, infections and natural disease progression. Do not manufacture a counterfactual or convert a group average (including 14 days) into a mandatory individual deadline.

Quantitative analyses shall disclose original time-stamped inputs, missingness, prespecified versus exploratory comparisons, model assumptions, uncertainty and sensitivity analyses; do not call an IAJ structured-judgment scale a validated probability measure. An evaluator may reach a strong case-specific clinical attribution with adequate evidence, but must state which elements are medical opinion and which remain inferential or indeterminate. Biological injury neither automatically proves prohibited official purpose nor replaces the legal elements of UNCAT Article 1 or 16.

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

Functional analysis may connect documented behavior, exposure, and outcomes. Its strength depends on the available evidence, including alternative and concurrent explanations; it does not, without individualized proof, establish that a particular institutional stressor materially caused an injury.

The IAJ Clinical Attribution Rating, the Istanbul Protocol consistency categories and the IAJ Forensic Certainty Scale

The consistency categories are descriptive evidentiary judgments, not tests for PTSD, diagnostic severity, numerical probability of causation, or legal torture elements. Ratings apply only to the evidence actually evaluated. "Not evaluated" must not be coded "not consistent." In cases with unavailable assessment, preserve the factual investigation with clearly qualified clinical status.

While the Istanbul Protocol utilizes "degrees of consistency", U.S. courts often ask experts for an opinion held to a reasonable degree of certainty (a convention, not a Daubert requirement). To reconcile this conflict, IAJ evaluators shall provide an IAJ Clinical Attribution 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 is not a statement that a specific institutional stressor caused an injury as a matter of law.

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. The attribution rating is distinct from the Istanbul Protocol consistency categories and follows the ranking of potentially competing etiologies.

- High (Clinical Attribution): 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 (Likely Attribution): the evidence supports attribution, but material alternatives or gaps remain.
- Low (Plausible Attribution): attribution is plausible, but multifactorial etiologies remain unresolved. Not assessable: state reasons. The Istanbul Protocol consistency category for psychological findings is stated separately and is not mapped onto these levels.

The IAJ Forensic Certainty Scale (systemic-pattern evidence)

The IAJ Forensic Certainty Scale is used only when the IAJ draws on its inventory and database of documented systemic violations and discernible patterns from other cases. It sits alongside, and does not replace, the Istanbul Protocol consistency categories (clinical consistency of this person's findings with the alleged treatment) and the IAJ Clinical Attribution Rating (case-specific clinical causation). Its function is to complement, clarify and truth-test those assessments by comparing the case with independently documented institutional practices, protection gaps, similar incidents and contrary cases.

Status and safeguards. The Scale is an IAJ instrument under development; it has not been externally validated and must not be presented as a validated measure. Any use states its source data, the criteria applied, the level of corroboration of each comparison case (alleged, corroborated, contradicted, unresolved or institutionally determined), contrary and negative cases, and known selection effects. Repeated allegations from shared sources are not treated as independent

corroboration, and the number of complaints received by the IAJ is not treated as a prevalence estimate. Pattern evidence may support or challenge an inference about recurrence, foreseeability, knowledge or the operation of safeguards; it does not by itself establish clinical causation, intent, prohibited purpose or individual responsibility.

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]

"Unified Terminology Rule: The term Distress-Induced Harm is the primary technical designation for this doctrine. The term 'Battery Without Touching' is retained only as internal IAJ shorthand and as an analogy when challenging domestic requirements for kinetic contact. Reports use 'Distress-Induced Harm' as the descriptive term; it is not a diagnosis."

Application requires documented elements: a specific institutional stressor, temporal proximity to symptom onset, foreseeability based on known vulnerabilities, and severity documented with standardized measures where appropriate (e.g., HTQ) and, for physical harm, medical records.[173]

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: document psychological effects with standardized measures where appropriate; document physical harm from medical records.

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 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.

[173] 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 . 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).

- **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 where supported, and explain how they compare with 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
- With the examinee's informed consent and, for pattern reporting, de-identification: 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)
│ └── Consider, where indicated and culturally appropriate: PCL-5, IES-R
├── Depressive symptoms
│ └── Consider, where indicated and culturally appropriate: PHQ-9, BDI-II, CES-D
├── Anxiety symptoms
│ └── Consider, where indicated and culturally appropriate: GAD-7, BAI, HAM-A
├── Mixed presentation
│ └── Consider, where indicated and culturally appropriate: DASS-42, SCL-90-R
├── Functional impairment focus
│ └── Consider, where indicated and culturally appropriate: WHODAS 2.0, SF-36
└── Suicide risk indicators
└── Consider, where indicated and culturally appropriate: 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
- PCL-5 screening threshold: scores in approximately the low 30s may warrant further PTSD assessment in some populations; threshold performance varies across settings. This score is not, by itself, a provisional clinical diagnosis and cannot exclude serious suffering when below cutoff.
- Interpretation: The PCL-5 total is a symptom screening/severity measure; PCL-5 totals are not to be converted into severity categories. Interpret scores in context and do not infer torture or its absence from the total.
- **Interpretation Guidance:**
- Elevated PCL-5 scores (for example, above 33 in some applications) warrant qualified clinical evaluation, including DSM-5-TR Criterion A and other criteria, differential assessment, and context-specific interpretation. Scores cannot alone diagnose PTSD or determine whether torture/CIDT occurred.
- 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)
- Published screening threshold (e.g., 33) indicates the need for clinical assessment
- A score is not a diagnosis, and a lower score does not exclude serious suffering
- **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 (begin with an initial clinical interview and rapport; IP §§527, 539):

- **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

Mandatory Separate-Plane Findings and Counterevidence Summary

Every substantive report shall distinguish: (A) observed and documented facts, including contested facts; (B) symptoms, examination limitations and clinical consistency findings, including no-diagnosis findings; (C) biological causation analysis where justified; (D) evidence regarding official knowledge, intent and prohibited purpose; and (E) the IAJ institutional assessment under UNCAT Articles 1 and/or 16, followed separately by domestic procedural treatment. Do not allow a psychological diagnosis or lack of one to decide the legal classification.

Include a short Rival Explanations and Disconfirming Evidence section stating the strongest alternatives, the record supporting each, and why they were rejected, accepted, or left unresolved. Specify when the evidence supports serious injury or wrongdoing without supporting torture/CIDT. Report genuinely exculpatory findings with the same prominence as inculpatory ones. Negative and inconclusive conclusions must never be treated as methodological failures.

An IAJ case report shall not call a practice torture merely because it is harsh, discriminatory or unlawful under some other body of law. For Article 1, state independently the evidence for severe pain or suffering, intentional infliction, prohibited purpose, and official involvement, and analyze the lawful-sanctions clause without treating any domestic label as dispositive. For Article 16, separately assess prohibited ill-treatment and State responsibility without inventing an Article 1 purpose requirement. Any contested IAJ jurisprudential determination must be expressly identified as such, with contrary authority stated accurately.

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

REPORT STRUCTURE. Every template contains the Mandatory Report Fields set out in the Fillable Skeleton Report guidance (Tiered Model Report Templates), each either completed or marked "not assessable" with reasons. An unpopulated field is not a failed report, and a blank diagnosis field is never a negative finding.

The elements below represent the core building blocks of the standard report. The Tiered Model Report Templates later in this Module show how these same elements are scaled across a preliminary

template, a standard forensic template, and an advanced systemic-investigation template; Appendix D contains the fillable skeleton report.

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 the Quantitative Evidence Rule, Module 4, Section III — 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-TR or ICD-11 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 bearing on the reliability of clinical evidence (supporting and limiting)
- 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	IP §543 meaning (paraphrase)
Diagnostic of (IP §543(e))	Could not have been caused in almost any way other than the alleged torture or ill-treatment; rarely usable for psychological findings.

Typical of	Typically found as a consequence of the alleged torture or ill-treatment; few other possible causes (IP §545 caution applies).
Highly consistent with	Could have been caused by the alleged torture or ill-treatment; few other possible causes.
Consistent with	Could have been caused by the alleged torture or ill-treatment but non-specific; many other possible causes.
Not consistent with	Could not have been caused by the alleged torture or ill-treatment.

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, the clinical report preserves its clinical findings and consistency category, stated in precise, non-conclusory language that remains usable even if the tribunal rejects the international label; the IAJ directorate's treaty-based characterization is attached separately.

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.

4. Rule of Non-Legal Attribution

When a report uses the term 'directly attributable' under the IAJ Clinical Attribution Framework, 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.

5. Standard for Multiaxial Communication

When documenting systemic harm, the multiaxial format allows clinicians to capture comorbidity and integrate medical factors effectively. Evaluators may use it to present the causation synthesis transparently. For example:

- **Axis I:** Complex PTSD, recurrent.
- Axis III: Multiple Sclerosis (relapse; relationship to stressors addressed in the causation section).
- **Axis IV:** Systemic judicial discrimination; denial of ADA safe harbor.
- **Axis V (Functioning): Describe baseline and current functioning by domain and identify the observations supporting any reported impairment. A GAF score is not required.**

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 the reliability of the clinical evidence and the consistency of findings
- Connect findings to asylum legal standards
- Consider including country-specific torture patterns

3. For International Bodies (UN, Regional Human Rights Courts):

- Present clinical findings relevant to the UNCAT elements; attach the IAJ directorate's characterization
- 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[174]; a human rights submission may require stronger treaty framing and institutional 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 report uses a dual-track structure: the clinical findings and Istanbul Protocol consistency category, accompanied by the IAJ directorate's UNCAT analysis, while also presenting the same findings in a narrower factual and clinical format suitable for domestic procedural use.

F. Model Report Template

This Module provides a tiered model report template suite, not a single fixed form (the fillable skeleton is in Appendix D). It includes:

- a **basic template** for lower-complexity or preliminary documentation;
- a **standard forensic template** for most torture/CIDT evaluations;

[174] The skeleton report asks the evaluator, where requested, to summarize clinical findings relevant to an Article 1 or Article 16 inquiry. It does not ask the evaluator to decide the treaty characterization. That determination is made in the separately authored IAJ legal and human-rights analysis (Module 2, Adversarial-Neutrality and Rival-Hypothesis Protocol, outcome categories), which states independently the evidence for severe pain or suffering, intent, prohibited purpose and official involvement, and addresses the lawful-sanctions clause.

- 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 Section

This section 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

Template A is expressly available when no licensed evaluation or DSM/ICD diagnosis exists. It documents source-specific allegations, historical suffering, observed functioning, documentary corroboration, limits, urgent protective needs, and referrals without creating an unauthorized clinical opinion. Label the document "Preliminary Factual and Observational Record — Not a Completed Medico-Legal Psychological Examination" where appropriate.

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, or a clearly labelled factual/observational summary when no qualified clinical evaluator is available
- Independent assessment of historical suffering and available consistency evidence, with clinical opinion only when the evaluator is qualified
- 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 clinical evaluation may be necessary before a definitive psychiatric diagnosis or specialized biological-causation opinion is offered. Nevertheless, the presently documented conduct, contemporaneous suffering, and evidence requiring preservation remain independently assessable."

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

The template must include a stand-alone Historical Suffering Assessment and a stand-alone Diagnostic Status/Limitations section. Permissible conclusions include "no current PTSD," "no DSM/ICD diagnosis established," and "diagnosis not evaluable," without downgrading separately

supported suffering/consistency evidence.

Use when:

- the evaluator has conducted and documented an appropriately comprehensive inquiry, with any omitted interview, test or record review explicitly explained; the absence of a PTSD diagnosis does not preclude this report.
- 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 reliability-sensitive formulation, nexus-relevant details, and country-pattern context when relevant.

IV. Template C: Advanced Systemic / High-Complexity Report

Systemic cases must distinguish each alleged State act and purpose from clinical sequelae. The report shall not require Shattering, permanence, PTSD/CPTSD, a full-time series of quantitative biomarkers, or a completed psychiatric evaluation before analyzing a documented pattern of severe suffering and official knowledge or action.

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
- Suffering during alleged events; subsequent psychological and functional consequences (including no current diagnosis, remission, or delayed assessment)

- Testing / Structured Measures / Collateral Integration (when available, appropriate, and valid; non-administration explained)
- Clinical Formulation
- Reliability of Clinical Evidence
- Causation / Aggravation / Distress-Induced Harm Analysis
- Severity and Ongoing Risk Assessment
- Clinical Findings Relevant to the Article 1 / Article 16 Analysis (IAJ directorate's characterization attached separately)
- 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,
- reliability analysis,
- causation analysis,
- systemic pattern analysis,
- and the separately attached legal analysis,

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 clinical findings are relevant to the Article 16 and Article 1 analysis, which the IAJ directorate addresses separately."

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

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.

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 clinical findings are [consistent / highly consistent] with the alleged treatment; the legal characterization is addressed in the IAJ directorate's separate analysis and, for domestic consequences, by the court."

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…"

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 findings on the reliability of clinical evidence 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). The evaluator has assessed the consistency of the clinical findings with the alleged treatment; the characterization of the conduct under UNCAT is set out in the IAJ directorate's separate analysis. 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 clinical consistency findings under the governing international documentation standard; 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 the international standard does not alter the underlying clinical findings or the documented severity of harm."

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

MODEL NO-DIAGNOSIS CONCLUSION: "The present examination [or documentary review] does not establish a current DSM/ICD trauma-related disorder [or: no qualified examination was available]. This does not determine the intensity or severity of suffering experienced during [date/period]. Based on [specified evidence], the record supports [clearly graded findings] concerning reported historical distress, circumstances, and functional effects. The limits of retrospective inference, unavailable sources, and differential possibilities are set out above. The international-law characterization of the alleged conduct, official involvement and prohibited purpose is addressed separately."

Complete the applicable components of this model with source-specific findings and express limitations. An unestablished psychiatric diagnosis, unavailable examination, or absent evidence of permanent impairment is not a bar to documenting historical severe suffering; no categorical legal conclusion is implied.

A. Summary of Principal Findings

[Drafting Note: Distinguish evidence of suffering at the time of the alleged events, later symptoms and functional effects, current presentation, and separately any supported diagnoses. Explicitly record if no diagnosis was made or no qualified examination was possible.]

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 clinical findings are [not consistent with / consistent with / highly consistent with / typical of / diagnostic of / not assessable] the reported experiences, for the reasons and limitations identified above. State the evidentiary basis for the selected Istanbul Protocol category. Any IAJ clinical-attribution judgment must be separately explained and must not be

represented as a validated numerical certainty or as a legal determination under UNCAT Articles 1 or 16.

C. Forensic Multiaxial Synthesis

- **Axis I (Psychiatric findings): [Established diagnoses, provisional diagnoses, symptom patterns below diagnostic threshold, no diagnosis established, or not assessed—state evidence and limitations]. EPCACE is historical ICD-10 F62.0; do not present it as a current ICD-11 diagnosis.**
- **Axis II (Personality and enduring adaptations): [Describe supported changes against available baseline; Shattering is an IAJ descriptive construct, not a required diagnosis or permanent-impairment threshold].**
- **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 (Function): [Document domain-specific present, historical, and baseline functioning; use a suitably validated measure if available and appropriate, and do not infer a GAF score where none was administered].**

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. Where the evidence supports it, the identified Axis IV institutional stressors were a [substantial contributing factor / material aggravating factor] in the observed Axis III medical deterioration (IAJ Clinical Attribution Rating: High / Moderate / Low / not assessable). 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

Characterize separately (a) the intensity, duration, and cumulative effects of suffering during the alleged treatment, (b) subsequent or present impairment, and (c) any medical injury supported by competent evidence. PTSD, CPTSD, permanent disability, and current symptoms are not prerequisites for documenting historically severe suffering. Note the evidence and limitations for each conclusion.

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 was conducted as a neutral forensic inquiry. Findings are stated with their evidentiary basis and limitations. The UNCAT characterization of the alleged conduct is addressed in the IAJ directorate's separate analysis. The evaluator functions independently 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 clinical consistency findings under the international documentation standard, with the IAJ directorate's characterization attached separately, 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

MANDATORY REPORT FIELDS (including when no diagnosis or evaluation exists): Historical suffering during alleged events [dates, sources, intensity, deprivation, duration, vulnerability]; delayed symptom trajectory [onset, persistence, fluctuations, recovery]; present findings [separate]; functional and physical findings where supported; DSM/ICD status [established / provisional / subthreshold / none / not examined]; access-to-assessment barrier [none / cost / clinician unavailable / denied access / unsafe / other, with evidence]; source-specific uncertainty; clinical consistency if qualified evaluator available; independent IAJ investigative/legal analysis (separately authored); and needed further investigation. Never treat blank diagnosis as a negative finding.

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 clinical 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 principles of medical ethics (beneficence, non-maleficence, autonomy and justice), together with the duty of confidentiality: Beneficence, Non-maleficence, Autonomy, and Confidentiality. To address the "Equivalent Pathway" failure in the USA, the IAJ establishes three mandatory additions:[175]

- **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.[176]
- **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.

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[175] 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.

[176] 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.

- **Access Without Preconditions**: The right to independent documentation (IP §670) should not be conditioned on the victim's ability to obtain legal representation.

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 not turn 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. (Both terms are IAJ doctrinal proposals.) The IAJ Psychological Investigator documents psychological harm and stress-related physiological deterioration where other practitioners may be reluctant to do so, including where domestic courts have not recognized such harm, and records that documentation so that it remains available to accountability mechanisms. The Witness Obligation 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[177], 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.[178]

Section 1: The Universal Duty to Document

When no forensic psychologist is available, authorized staff should preserve reported accounts, factual observations, documentary sources, dates and functional indicators within scope and lawful confidentiality/consent rules. Do not delay or exclude intake pending a diagnosis or specialist. This duty does not authorize unlicensed clinical assessment, guarantee a forensic conclusion, or overcome statutory privileges and recording restrictions. Record the reason for any missing evaluation and arrange lawful referral where possible.

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 addresses this principle for State-employed clinicians:

Istanbul Protocol §665 addresses the duty of State-employed forensic experts and clinicians to investigate and document clinical evidence of torture or ill-treatment.

IP §673 (paraphrase): independent, non-governmental clinicians play a critical role in documenting torture, and their work is often essential to the State in meeting 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

[177] Such as settings where the investigation findings may be intercepted by the alleged perpetrators of torture or ill-treatment

[178] 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.

- 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
- 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 right to independent medical documentation recognized in the Istanbul Protocol (IP §670).

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 within scope: 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 should consider reporting through the IAJ Anonymous Reporting Channel, with the examinee's consent where required, after taking advice on applicable confidentiality and whistle-blower law.

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

Treating providers' longitudinal observations about a patient's functional limitations are often given significant weight in disability determinations; the weight given is decided case by case. In particular:

- 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

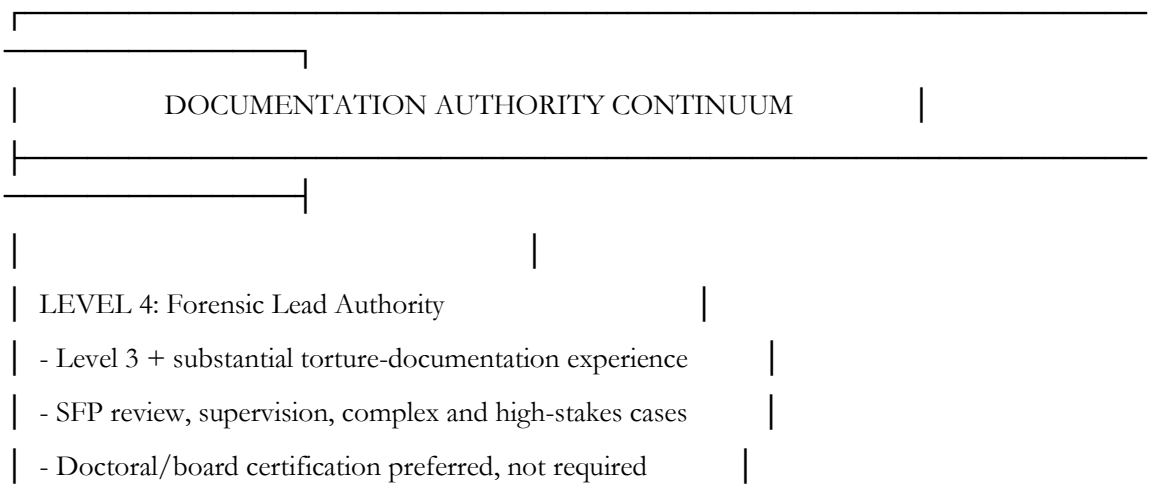
The clinician who documents and is later found not to qualify as an expert has fulfilled their ethical duty. The clinician who fails to document because of fear has violated their ethical duty.

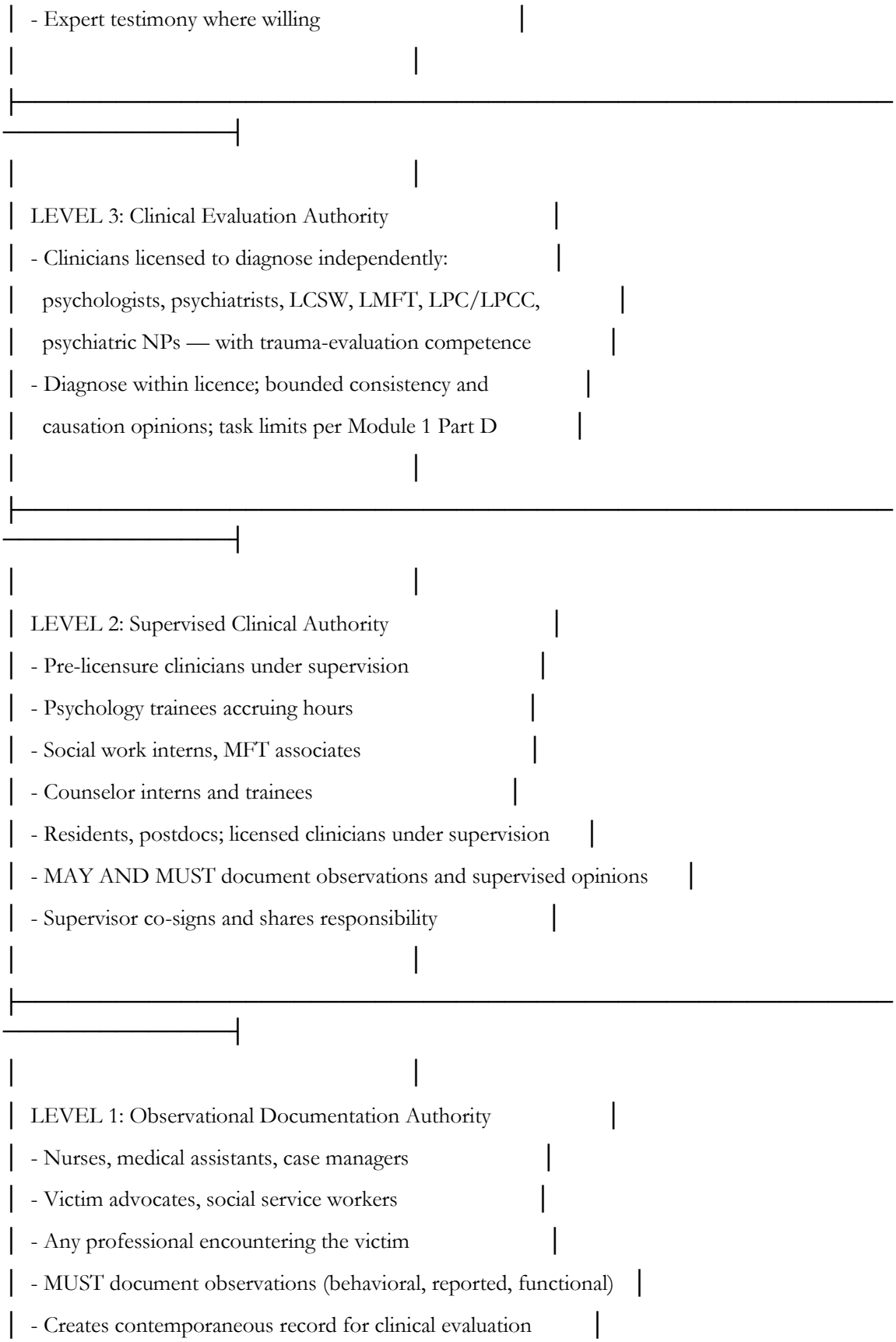
Section 3: The Continuum of Documentation Authority

Level 1/2 factual-documentary products may be completed and retained even when Level 3/4 clinical examination cannot be obtained. Such products shall never be relabeled "no evidence" or "negative clinical findings." Document the absent clinical capacity, supervision limits and referral attempts. Level 3 clinicians may later review these records. Level 3 clinicians may issue appropriately bounded clinical consistency and causation opinions within demonstrated competence and lawful professional scope. Level 4 expertise is required for specialist forensic tasks beyond that competence.

3.1 All Care Providers Have Documentation Authority

The IAJ establishes a continuum of documentation authority in which **all care providers participate**:




- Expert testimony where willing
LEVEL 3: Clinical Evaluation Authority
- Clinicians licensed to diagnose independently:
psychologists, psychiatrists, LCSW, LMFT, LPC/LPCC,
psychiatric NPs — with trauma-evaluation competence
- Diagnose within licence; bounded consistency and
causation opinions; task limits per Module 1 Part D
LEVEL 2: Supervised Clinical Authority
- Pre-licensure clinicians under supervision
- Psychology trainees accruing hours
- Social work interns, MFT associates
- Counselor interns and trainees
- Residents, postdocs; licensed clinicians under supervision
- MAY AND MUST document observations and supervised opinions
- Supervisor co-signs and shares responsibility
LEVEL 1: Observational Documentation Authority
- Nurses, medical assistants, case managers
- Victim advocates, social service workers
- Any professional encountering the victim
- MUST document observations (behavioral, reported, functional)
- Creates contemporaneous record for clinical evaluation

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[179].
- 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

Level 3 clinicians diagnose trauma-related disorders when present, within their licence, and document the relationship to the alleged treatment. Licensed clinicians still developing trauma-evaluation competence document at Level 2 under supervision.

- Diagnose PTSD, depression, anxiety, and related conditions
- Document symptom onset correlation with reported torture
- Assess and document consistency between presentation and alleged torture

[179] 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.

- Refer medical causation to a physician, restricted tests to a qualified psychologist, and complex or high-stakes cases to Level 4

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

Level 2 documents under supervision → refers to Level 3/4 for complex cases

Level 3 evaluates, diagnoses where appropriate, documents, and may offer bounded clinical consistency or causal opinions within demonstrated training, experience, lawful professional scope, and available evidence. Specialist Level 4 consultation is sought for questions exceeding that competence; lack of Level 4 access must not block documentation or appropriately limited findings.

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, or the reliability of clinical evidence;
- 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 consistency, distress-induced harm causation, or the reliability of clinical evidence 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 reduce confirmation bias, the Supervisory Falsification Pass is applied as set out in Module 1 (preferred for every report; tiered review for routine cases; not a prerequisite under the Non-Obstruction Rule). 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 and Quality Protection (mandatory; see also Appendix T)

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.
- **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 alleged 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
- Documentation should not wait for the danger to end, but must not be conducted where reprisals are very likely or certain; weigh safety before proceeding
- 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 reports ongoing ill-treatment. 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 should ensure protection of those who expose torture from reprisals (IAJ determination: UNCAT Article 13 requires protection of complainants and witnesses).[180]

IP §663: States should ensure respect for relevant **legal and medical ethical duties** described in chapter II.

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 IAJ has received reports that the legal system 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

[180] IP §679 states that States should ensure that whistle-blower protection policies cover medico-legal and health personnel who report findings of alleged torture or ill-treatment, and should protect witnesses and other reporters from reprisals.

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

Protection from reprisals (IP §§195, 679):

IP §195: alleged victims, witnesses, those conducting the investigation and their families must be protected from violence, threats of violence and other intimidation or reprisals; those implicated should be removed from positions of control over them. Treaty text: UNCAT Article 13 expressly protects complainants and witnesses. IAJ determination: the IAJ affirms the protection of investigators and families, consistent with §195, and grounds it in the duty of effective investigation (Article 12) as well as Article 13.

IP §666: forensic and clinical services must be independent of law enforcement, prosecution and/or military authority. (The IAJ adds that independence from judicial authorities is vital; see FN183.)[181]

IP §679: Protection for those who expose torture.

When judges, attorneys, or courts retaliate against care providers who document torture:

- Their conduct may be inconsistent with the United States' obligations under UNCAT Article 13
- Their conduct may, depending on severity, be relevant to a CIDT analysis
- 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

[181] IP §666 recognizes lack of independence of State-employed health professionals as a major implementation problem, states that forensic and clinical services must be independent of law enforcement, prosecution and/or military authority, and states that States should 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.

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; §§277–280; §§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 §§294–295; §497; §§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[182]. 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:

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
- Any First Amendment protections that apply (seek legal advice)
- International law protections for human rights defenders

[182] At this time the USA has not ratified Article 22

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**	Risk patterns the IAJ investigates (to be tested on the evidence)
Prosecutors	Prosecute torturers	Failure to investigate reported torture
Judges	Provide remedy; ensure due process	Proceedings alleged to inflict CIDT
Defense attorneys	Defend rights	Ineffective defense enabling violations
Police	Protect persons	Alleged ill-treatment during enforcement
Child welfare	Protect children	Alleged ill-treatment through separation
Mental health professionals	Document and treat	Non-documentation from fear

This inversion means:

- Victims cannot seek remedy from those who are harming them
- Every complaint pathway leads back to perpetrators
- 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 may collaborate with NGOs for peer review, with the examinee's informed consent and de-identification where appropriate:

- 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; the UN Declaration on Human Rights Defenders (A/RES/53/144) sets the standards invoked in advocacy for clinicians who document torture (enforceability depends on the underlying treaty or constitutional right: see Protections for Human Rights Defenders: Origins, State Obligations, and Enforcement — with a Focus on the United States), and IP §679 recommends that States ensure whistle-blower protection policies cover them.
- 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, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice." (This provision supports advocacy, not a documentation duty.)

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." § A.1.b Records and Documentation: counselors create, safeguard, and maintain documentation necessary for rendering professional services. (A.1.a supports the welfare proposition; A.1.b the documentation duty.)

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:

§ 3.5 Maintenance of Records: "Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with professional standards and applicable law." (AAMFT Code of Ethics, effective 1 January 2026)

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 of care and safety planning. A patient reporting ongoing ill-treatment may be 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 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. (For treating providers.) The person's account is heard and recorded. The documentation acknowledges what the person reports and what the provider observes.

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

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 can be part of supportive care; it does not replace 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 §666 records that failure to document and denounce torture is considered a form of complicity by the WMA.

This principle applies to every care provider. Fear of summons, uncertainty about qualification, or lack of supervisory direction does not excuse non-documentation.

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

ACCESS-FAILURE REGISTER: For each identified unmet evaluation need, record the date noticed, clinical urgency, consent, referral attempts, cost barriers, licensing availability, interpreter/accessibility barriers, institutional decisions, evidence preserved, and disposition. Record each access failure as a potential State omission, including a failure to provide or fund evaluation (Istanbul Protocol footnote 535; CAT General Comment No. 3), and refer it with the supporting facts to the IAJ investigative/legal function for analysis under UNCAT Articles 12, 13, 14 and 16. The register records facts; the legal characterization is made separately.

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

Independence and Conflict-of-Interest Control for IAJ Investigations

An IAJ designation does not confer scientific validation, legal authority, or independence by itself. Before assignment, each investigator and supervisor shall disclose material personal involvement, prior advocacy or opinion about the particular case, financial incentives, treatment relationships, representation, communications with parties, and close relationships with alleged actors or victims. A materially conflicted investigator shall recuse from independent final review; case-critical source knowledge may be provided as documented evidence without deciding its own weight.

The IAJ shall retain a publicly stated policy permitting correction, withdrawal and publication of findings unfavorable to complainants or to IAJ hypotheses. The organization shall preserve source records, decisions on conflicting evidence, material dissent and corrections. A reviewer who did not formulate the original accusation shall test major claims against the strongest contrary record. Confidentiality, consent and witness protection still govern disclosure.

12.1 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

12.2 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.

12.3 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. Hostility to documentation is itself a matter to document.
- **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.

12.4 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. Appendix U 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
- 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's reported symptom course, observed presentation, and available records should be assessed separately. A PTSD or depressive-disorder diagnosis may be stated only after its complete diagnostic criteria have been assessed. Independently, document the reported suffering during the three-year proceedings, family separation, impairment, and sources corroborating or qualifying that history. Neither a diagnosis nor permanent injury is required to assess the alleged conduct under the international framework.

Consistency Assessment:

Model assessment (assuming the formulation supports it): the psychological findings are highly consistent with the alleged treatment. The symptom pattern, onset, trajectory and functional impact fit the reported prolonged family separation and institutional treatment, and few other causes are evident in the record; alternative stressors (poverty, pre-existing depression) were considered and are stated in the formulation.

Report Excerpt (Conclusions):

The available evidence describes serious distress and functional impairment during and following the alleged prolonged family separation and institutional treatment. These findings should be assessed for consistency with the reported events, with the strength of support, alternative explanations, and limits stated. Diagnostic classification, if established, is recorded separately; permanence and legal characterization cannot be inferred solely from current test scores.

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
- 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 meets ICD-11 criteria for 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, is consistent with the reported events and supports the reliability of the clinical evidence. The credibility of the account is a matter for the adjudicator (IP §§388–389).

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 psychological injury; permanence cannot be determined on the present record. 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 and enduring adaptations): reported loss of trust and social withdrawal since detention, compared with family accounts of prior functioning; no enduring personality change established.
- Axis III (Medical/physiological findings): no medical deterioration documented in the records reviewed.
- **Axis IV (Institutional Stressors):** Prolonged solitary confinement (47 days) and identity-based persecution.

- Axis V (Functioning): unable to work; limited social participation; WHODAS 2.0 elevated in social and cognitive domains; prior employment documented.

Consistency Assessment: Describe which reported detention-related events are supported by the available records and clinical findings, identify limitations concerning earlier events and available records, and assign an Istanbul Protocol psychological-consistency category only where justified. The clinical evaluation does not independently determine Article 1 or Article 16 legal responsibility.

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 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
- 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 reported beating while restrained, choking to unconsciousness, death threats, racial slurs and denial of medical care are recorded for the IAJ directorate's legal analysis.

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.

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, assessed by clinical interview against full diagnostic criteria (PCL-5 52 and PHQ-9 16 as supporting measures), meets criteria for PTSD and Major Depressive Disorder that have persisted for 14 months following the index event.

XII.B Psychological Consistency Assessment: The evaluator must identify which clinical findings support or limit consistency with the specific reported events and state the reasons, relevant baseline, chronology, and any concurrent explanations. Use a §543 psychological-consistency classification only when supportable; do not assign an unvalidated High Degree of Clinical Certainty. The legal characterization of conduct under Article 1 or 16 belongs in separately reasoned analysis.

XII.C Forensic Multiaxial Synthesis:

- **Axis I (Diagnostic and non-diagnostic psychological findings): Report PTSD or Major Depressive Disorder only if their full criteria were independently evaluated and met; otherwise describe nightmares, avoidance, hypervigilance, depressed mood, historical suffering, functional limitations, and evidentiary limitations without converting screening scores into diagnoses.**
- **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): Document occupational, social and daily functioning, baseline and observed changes with supporting sources. A GAF score is not required.

XII.D Multiaxial Attestation: [X] I documented the dates and reliability of the identified institutional stressors, subsequent symptoms or injuries, relevant baseline, and alternative explanations. No fixed interval was imposed; any medical causation conclusion is separately supported and qualified.

XII.E Clinical Conclusion: The findings may support a clinical assessment of severe psychological suffering consistent with the reported beating, restraint, choking, and discriminatory statements, subject to the identified evidence and alternatives. The separate Article 1 and Article 16 analysis must examine intentional infliction, prohibited purpose, State involvement, and other applicable elements objectively.

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 remaining 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.**
- **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-TR 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 is relevant to a possible relationship between institutional stressors and physical harm, subject to specialist medical assessment.

Independent of whether the person currently meets DSM-5-TR or ICD-11 PTSD criteria, the evaluator must assess the severity of suffering experienced during the 45-day isolation, including contemporaneous distress, deprivation, functional deterioration, and recovery or remission. A current absence of diagnosis neither proves nor disproves historical severe suffering; legal characterization requires separate assessment of the conduct and its context.

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.

Report Excerpt (Conclusions):

"The available records and reported history document substantial psychological distress and functional impairment following the described 45-day isolation. Available evidence may also support a relationship between identified institutional stressors and subsequently documented cardiovascular deterioration, subject to specialist medical assessment, disease-specific evidence, and differential analysis. The present record does not require a PTSD diagnosis, permanent injury, or a fixed 14-day interval to support findings concerning suffering during confinement. The degree of clinical consistency, causal attribution, and unresolved limitations should be stated separately; legal classification under UNCAT is analyzed on its own evidence."

Case Vignette 5: Excessive Use of Police Force and Racial Humiliation (CAT Reporting Area 2)

Background:

Marcus, a 38-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: Reported use of a chokehold 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.**
- **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 reported 11 days after the issuance of the contested fine; this timing alone does not establish an individual causal attribution.**

Clinical Formulation:

The reported findings may warrant assessment for ICD-11 complex PTSD (6B41), as well as depressive disorders if diagnostic criteria are met. Independent of any diagnosis, the report should document the severity and chronology of suffering associated with the alleged physical assault, subsequent institutional responses, and later metabolic changes, subject to records and differential medical assessment. Shattering, where described, is an IAJ investigative descriptor rather than a DSM/ICD diagnosis.

In this example, psychological diagnostic labels are not prerequisites for investigating racial humiliation, use of force, fear, or other reported suffering. The report should distinguish contemporaneous observations and historical evidence from later symptom presentation, and discuss whether the available facts support the relevant Article 1 or Article 16 characterization without presuming it from symptom scores.

Training note: "Shattering of the Self" is an IAJ descriptive and interpretive construct, not a DSM-5-TR or ICD-11 psychiatric diagnosis. Use the term consistently, identify it as an IAJ construct, explain the facts supporting its application, and never treat its absence or the absence of permanent functional loss as evidence against torture/CIDT.

Consistency Assessment:

The psychological findings are highly consistent with the reported use of force and racial humiliation. The relationship of the metabolic changes to the events requires specialist medical assessment and differential analysis. The legal characterization is addressed in the IAJ directorate's separate analysis.

Report Excerpt (Conclusions):

"The clinical findings are highly consistent with the reported use of force and racial humiliation. Marcus's reported fear and humiliation during the encounter, his later symptoms and functional effects, and the metabolic changes recorded afterwards are documented separately, with their sources and limits. The medical relationship of the metabolic changes to the events requires specialist assessment and differential analysis, and permanence cannot be assumed from the present record.

The legal characterization of the conduct under UNCAT Article 1 or Article 16 is addressed in the separate legal analysis."

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.**
- **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:

If the diagnostic criteria for ICD-11 Complex PTSD and Major Depressive Disorder are met, report them with their basis. Document the temporal relationship between the withdrawal of gender-affirming care, isolation and psychological deterioration. The autoimmune flare is a medical finding whose relationship to the harassment-isolation cycle requires disease-specific medical assessment.

Consistency Assessment:

The psychological observations and contemporaneous infirmary findings provide evidence relevant to the reported detention-related distress and deterioration. Assess their consistency with the specific reported U.S. detention conditions, the limits of available records from her country of origin, and

alternative or concurrent causes separately. Clinical consistency ratings do not themselves determine Article 1 or Article 16 liability, and temporal proximity alone does not establish high clinical certainty.

Report Excerpt (Conclusions):

The reported detention conditions, the contemporaneous infirmary documentation, and the psychological findings should be considered in distinct evidentiary categories. If the diagnostic criteria for CPTSD or depression are met, report the diagnosis and basis. Otherwise, report the symptom and functional evidence without adverse inference. Evaluate any autoimmune flare and its possible causes with disease-specific medical evidence and qualified differential assessment; permanence cannot be assumed from the vignette's facts.

Case Vignette 7: Systemic Judicial Discrimination and MS Relapse (CAT Reporting Area 4)

Status note. This vignette illustrates an IAJ doctrinal proposal: the application of Distress-Induced Harm to judicial conduct. Unlike Vignettes 2, 4 and 6, it has no direct treaty-body or Special Procedures support. Reports in such cases must state this status.

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.**
- WHODAS 2.0: very high disability across domains; 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:

The vignette describes a person with MS whose functional and medical status worsened in temporal proximity to specified institutional events. The record should distinguish the alleged acts and notice, reported distress, objective medical findings, baseline disease activity, and competing causes. Published MS stress–relapse research may support temporal plausibility, but a 13- or 14-day interval does not establish individual causation or permanence. A psychiatric diagnosis and the IAJ Shattering descriptor are not prerequisites for assessing severity of suffering.

Consistency Assessment:

The clinical findings are highly consistent with stress-associated deterioration following the documented judicial events, subject to baseline disease activity and alternative causes. MRI-documented lesion progression is objective evidence of biological deterioration and is relevant to the severity analysis. Whether the events support a *forum nullus* characterization (an IAJ doctrinal proposal; Module 1) or meet Article 1 or Article 16 is addressed in the separate legal analysis.

Report Excerpt (Conclusions):

"Where baseline disease activity, chronology and differential analysis support it, the available evidence supports the conclusion that the identified Axis IV institutional stressors were a substantial contributing factor in the documented Axis III biological deterioration (IAJ Clinical Attribution Rating stated with reasons). This is a case-specific clinical opinion and does not constitute a legal determination. The record of continued institutional exposure after notice may be material to the IAJ directorate's Article 1 or Article 16 analysis. The clinical evidence, including prognosis and any descriptive Shattering findings, must be presented with its limits and without presuming permanent injury."

Case Vignette 8: Allegation Not Supported by the Clinical Evidence (negative case)

Purpose of this vignette. Modules 2 and 7 require that evaluators be taught with at least one case in which the evidence does not support the allegation. This composite shows how such a finding is reached and written without discrediting the person or presuming fabrication, and it teaches a distinction that is easily blurred: an allegation that is not established on the available evidence is a different, and weaker, finding from the Istanbul Protocol conclusion that the clinical findings are not consistent with the alleged treatment (IP §543(a)), which means they could not have been caused by it.

Background:

Daniel, a 52-year-old man, was referred by counsel in a civil dispute with a municipal utility. He alleged that the utility's collection practices over two years amounted to cruel, inhuman or degrading

treatment by a public body: repeated disconnection notices, three field visits by agents, a disconnection lasting four days, and telephone calls he described as threatening. He reported anxiety, poor sleep, and loss of appetite since the dispute began, and asked for a report supporting a claim under international standards.

Alleged Conduct:

- **Collection notices and three agent visits over two years, documented in the utility's file.**
- **One disconnection of four days, reconnected on payment of arrears, documented.**
- **Telephone calls described by Daniel as threatening; the utility's call log records seven calls, none recorded; no witness.**

Evaluation Findings:

- **PCL-5 score: 24. PHQ-9 score: 9. GAD-7 score: 11. WHODAS 2.0: mild limitation in participation; no limitation in self-care, mobility or cognition.**
- **Mental status: anxious, irritable, well oriented; no dissociation, no intrusive phenomena, no avoidance beyond the dispute itself; sleep disturbance reported but not corroborated by any record.**
- **Medical record: no treatment contact for the symptoms; a pre-existing hypertension diagnosis stable over the period.**
- **No physical findings; no clinical evidence of pain, fear for life, humiliation or loss of control of the kind described in IP §§491–498 and Module 1, Definition of Terms.**

Clinical Formulation:

The clinical picture is one of situational anxiety and distress of a kind commonly associated with a protracted financial dispute, without the features that characterize the psychological responses to torture or ill-treatment described in the Istanbul Protocol (IP §§491–498). The corroborated conduct is collection activity by a public body under its ordinary procedures; whether that activity was lawful is not a question the evaluator decides. The content of the telephone calls is not corroborated or contradicted by any record. The absence of a psychiatric diagnosis is not the reason the allegation is not supported (Severity-Independence Rule): the reason is that neither the corroborated conduct nor the suffering described reaches the threshold the Protocol describes, and the uncorroborated element (the calls) is not shown to have been of a different character. Alternative explanations (the financial strain itself; pre-existing health worry) account for the presentation on the available evidence.

Consistency Assessment:

Consistent with (non-specific), IP §543(b): the findings could have been caused by the events described, but they are non-specific and have many other possible causes, of which the documented dispute is the most evident. The evaluator does not reach the stronger conclusion "not consistent with" (§543(a)), because non-specific anxiety and an incomplete record about the telephone calls cannot establish that the symptoms could not have arisen from the conduct alleged. The result is that the allegation of cruel, inhuman or degrading treatment is not established on the available evidence. This is a finding about the evidence, not a finding that Daniel is untruthful; his account of the events is largely corroborated by the utility's own file, and his distress is real.

Report Excerpt (Conclusions):

"The clinical findings are consistent with the events described but non-specific: they could have arisen from the protracted dispute itself and are of a kind commonly associated with it. They do not establish suffering of the severity or character described in the Istanbul Protocol for torture or ill-treatment, and the allegation of cruel, inhuman or degrading treatment is not established on the available evidence. No psychiatric disorder is diagnosed, and none is required for this assessment. The evaluator expresses no view on the lawfulness of the collection practices, which is a matter for the appropriate forum. Mr D. would benefit from supportive counselling and debt-advice referral."

Teaching points. A negative outcome is written with the same discipline as a positive one: the conduct is tested against the Protocol's descriptions, the IP §543 category is chosen for what the evidence shows (here "consistent with", non-specific), the stronger "not consistent with" is reserved for cases in which the findings could not have been caused by the alleged treatment, alternatives are stated, no legal judgment is offered, and the person is not discredited. The IAJ directorate records the matter as not established and closes it without referral; the Non-Obstruction Rule does not convert an unsupported allegation into a reportable one.

Case Vignette 9: Mixed Evidence — Severe Suffering Established, Institutional Attribution Unresolved (mixed case)

Purpose of this vignette. The second required training case: the clinical evidence of severe suffering is strong, but the evidence that it was inflicted by or with the acquiescence of a public official is incomplete, and the evaluation says so.

Background:

Lena, a 29-year-old woman, was referred after discharge from a privately operated facility to which she had been committed under a court order for psychiatric evaluation. She described nine days during which she was restrained for long periods, denied access to a telephone, and told by staff that her release depended on her "cooperation"; she reported that a staff member watched her shower on two occasions. The facility is a private contractor to the county; the commitment order and discharge summary are available; the facility's incident and restraint logs were requested and not produced.

Alleged Conduct:

- **Prolonged restraint on at least three occasions (Lena's account; discharge summary records "restraint as needed" without durations).**
- **Denial of telephone access (Lena's account; facility policy document permits calls "at staff discretion").**
- **Statements conditioning release on cooperation (Lena's account; no record).**
- **Observation during showering (Lena's account; no record; facility denies by letter).**

Evaluation Findings:

- **PCL-5 score: 58. PHQ-9: 19. WHODAS 2.0: severe limitation in participation and getting along with people; moderate in cognition.**

- **Mental status: intrusive recollections of restraint; hypervigilance to uniformed staff; shame and avoidance related to bathing; sleep onset insomnia with nightmares; no psychotic features.**
- **Physical findings (physician report): healed abrasions consistent with wrist and ankle restraint, dated to the admission period; no other injury.**
- **Pre-admission functioning: employed, no prior psychiatric treatment; a prior single episode of acute distress precipitated the commitment.**

Clinical Formulation:

Severe suffering during the admission is established on the clinical evidence: the symptom pattern, its onset, the physical findings and the collapse of functioning from a documented baseline are consistent with the treatment Lena describes, and the physician's findings corroborate restraint. The attribution question is divided. That restraint occurred and that Lena was in the custody of a court-ordered facility is established. Whether the restraint was prolonged beyond clinical necessity, whether telephone access was denied as a means of control, whether release was conditioned on compliance, and whether she was observed while bathing are supported only by her account, and the records that would confirm or refute them are controlled by the facility and were not produced. The alternative that restraint was clinically indicated and of ordinary duration cannot be excluded on the present record. The alternative that her symptoms predate the admission is not supported by the available baseline evidence (employment; no prior psychiatric treatment; a single acute episode immediately preceding commitment), but that evidence does not exclude earlier symptoms, and the finding is stated accordingly.

Consistency Assessment:

Highly consistent with the alleged treatment as to the occurrence and effects of restraint (IP §543(c)); consistent with, but not independently corroborated, as to the denial of communication, the conditioning of release and the observation while bathing (IP §543(b)). The evaluator records which findings rest on which evidence.

Report Excerpt (Conclusions):

"The clinical findings establish severe psychological suffering with onset during the admission and are highly consistent with restraint of the kind described; the physical findings corroborate restraint. Whether the treatment exceeded clinical necessity, and whether the further acts alleged occurred, cannot be determined without the facility's restraint and incident records, which were requested and not produced. The characterization of the conduct is a matter for the IAJ directorate; on the present record the evaluator expresses no opinion on it."

Teaching points. The report separates what is established (severe suffering; restraint; custody under court order) from what is not (duration and necessity; the further acts), names the records that would resolve it and who controls them, and leaves characterization to the directorate. The directorate may treat the non-production of records as a fact relevant to the Module 8 analysis of the facility and the county; it may report a credible allegation under UNCAT Articles 12 and 13 without a final characterization; it may not supply the missing facts by inference.

ADDITIONAL TRAINING VIGNETTE — SEVERE HISTORICAL SUFFERING, NO PTSD DIAGNOSIS. A person describes months of solitary confinement and coercive humiliation. Ten

years later, PTSD criteria are not met and the person is functioning well. Contemporaneous correspondence, custody records, and witnesses document intense fear, panic, sleep loss, and profound helplessness during confinement. Correct response: (a) record no current PTSD diagnosis without negative inference; (b) reconstruct historical suffering and document supporting and conflicting evidence; (c) assess clinical consistency where qualified; (d) separately investigate conditions, duration, purpose and official involvement under UNCAT; (e) explain limits and avoid claims that resilience disproves torture. COMPARATIVE WEAK CASE: An individual alleges severe historical suffering but has no contemporaneous support, inconsistent event dates, and multiple plausible alternative explanations. Do not presume either fabrication or torture; preserve the allegation, report uncertainty, specify what corroboration is needed, and maintain an open investigation where appropriate. Neither case is determined by PTSD status.

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.
- Brodsky, Stanley L. The Expert Expert Witness: More Maxims and Guidelines for Testifying in Court. American Psychological Association, Washington, DC. 1999.

Module 8: Rights-Controlling Ecosystem Methodology

I. Purpose, status and relationship to Modules 1–7

Modules 1–7 govern the investigation and documentation of an individual allegation of torture or cruel, inhuman or degrading treatment or punishment. This Module adds a second level of investigation: how the institutions, actors, policies and procedures that control a person's rights interact to produce, perpetuate or fail to prevent such treatment. It is the IAJ Systemic Investigation Methodology approved on 9 October 2026 as Release B of this Standard.

Status. The methodology is an IAJ investigative method. It has not been adopted by any treaty body, Special Procedure or court. Its external grounding is the State's obligations under UNCAT Articles 2, 10, 11, 12, 13, 14 and 16, the Committee against Torture's General Comments No. 2 (2008) and No. 3 (2012), and the implementation conditions described in Chapter VIII of the 2022 Istanbul Protocol (§§646–683). Those sources describe what States are obliged to do and what effective implementation requires; the method for investigating whether an ecosystem of institutions meets them is the IAJ's own. Nothing in this Module alters a conclusion reached under Modules 1–7, the Severity-Independence Rule, the Non-Obstruction Rule, or the allocation of legal characterization to the IAJ directorate.

Terminology. "Ecosystem" means the set of institutions, officials, private actors exercising delegated or de facto control, procedures, records and dependencies that together determine whether a person obtains protection, investigation, accountability and remedy for a given matter. "Rights-controlling" identifies those parts of the ecosystem whose decisions govern the person's access to those four functions.

II. The Non-Prerequisite Rule

Ecosystem analysis is never a prerequisite for documenting, investigating, evaluating or referring an individual allegation. A clinical evaluation under Module 3 is complete without it. An IAJ determination under Modules 1 and 2 may be made without it. A report to a competent mechanism on a credible allegation (UNCAT Articles 12 and 13) does not wait for it. Where this Module is applied, it is applied in addition to, and after or alongside, the individual investigation, and its findings are recorded in a separate section or document so that the individual findings remain usable on their own.

The converse also holds. An ecosystem finding may be relevant to, and may corroborate, an individual allegation, and an individual finding may be relevant to, and may corroborate, a systemic pattern; neither can by itself establish the other. Each conclusion is proved on its own record, with the other admitted for what it is worth. The two are joined where the evidence joins them: where the individual's experience is one instance of a documented pattern, or where the pattern explains how the individual's protection failed.

III. Step 1 — Ecosystem mapping

Objective. To identify, for the matter under investigation, every institution, actor and procedure that controlled the person's access to prevention, investigation, accountability and remedy, and the relationships and dependencies among them.

What is mapped

- Institutions and offices with formal authority over the matter (courts and judicial officers; prosecutors; police and custodial authorities; child-welfare, immigration, health and disability agencies; licensing and oversight bodies; legislatures where a rule is at issue).
- Actors without formal authority who exercised de facto control (appointed counsel; contractors; private providers of detention, health or evaluation services; employers of clinicians; guardians).
- Procedures and rules that governed each decision (statutes, regulations, court rules, standing orders, internal policies, accommodation procedures, complaint mechanisms, confidentiality rules, time limits).
- Records: where each decision and its reasons are recorded, who controls the record, and whether the person had access to it.
- Dependencies: which decisions were conditioned on prior decisions by another actor (for example, an accommodation that required a medical certification that required access to a clinician that required a court order).
- Protective functions available in principle: the mechanisms that could have prevented, investigated, held accountable or remedied the conduct, whether or not they were used.

How it is recorded

The map is recorded in the Ecosystem Mapping Record (Appendix X). Each actor is entered with its authority, the decisions it made or declined to make, the dates, the rule applied, the record location and its relationship to other actors. The map distinguishes what is established by record from what is reported by the person or inferred by the investigator, and it marks every point where the record is missing, withheld or controlled by an actor under investigation.

Sources. Institutional records obtained by the person or by lawful request; court dockets and orders; agency correspondence; published rules and policies; the person's account and contemporaneous documents; witness accounts; the IAJ's prior investigations where the same institutions appear (identified by control number and scope). The map is not built from the Istanbul Protocol or the Convention: those instruments state what the ecosystem should contain, not what this one contains.

IV. Step 2 — Structural and protection gaps

Objective. To determine, for each of the four protective functions, whether the ecosystem contained a mechanism capable of performing it, whether the mechanism was accessible to the person, whether it was used or should have acted without being asked, and what happened.

The four functions and their external standards

- Prevention: effective legislative, administrative, judicial or other measures to prevent torture and ill-treatment (UNCAT Articles 2 and 16; the basic guarantees in CAT General Comment No. 2, para. 13; the safeguards described in IP §§659–660).
- Investigation: prompt and impartial investigation wherever there is reasonable ground to believe torture has occurred, and prompt and impartial examination of complaints (UNCAT Articles 12 and 13; IP §§664–668).
- Accountability: criminalization, prosecution and professional accountability (UNCAT Articles 4 and 7; the monitoring and accountability functions described in IP §§674–679).
- Remedy: an enforceable right to redress, including rehabilitation (UNCAT Article 14; CAT General Comment No. 3; IP §661).

Gap classification

For each function the investigator records one of four findings, with the evidence for it: (a) no mechanism existed; (b) a mechanism existed but was inaccessible to the person (by rule, by cost, by disability, by information, by fear of reprisal); (c) a mechanism was used and did not perform the function; (d) the mechanism performed the function. A "gap" is a finding under (a), (b) or (c). The investigator does not infer a gap from silence in the record alone. A gap is shown by the record of what the person sought and what the mechanism did; or, where the function is one the State must perform without a request — investigation wherever there is reasonable ground to believe torture has occurred (UNCAT Article 12), prevention and the basic guarantees (Articles 2 and 16; General Comment No. 2, para. 13) — by the record that such grounds or risks existed and that the mechanism did not act. A person's inability to complain, including where access to the complaint mechanism is itself under investigation, is a gap finding, not a reason to withhold one.

Structural and individual gaps. A gap is structural where it arises from the rule, design or resourcing of the mechanism and would affect similarly situated persons; it is individual where it arises from a decision in the particular case. The distinction is recorded with its basis, because it determines what inference the IAJ directorate may draw in Step 5 and what remedy is appropriate.

V. Step 3 — Outcome and collective harm

Objective. To examine the cumulative consequences of the mapped conduct and gaps, across institutions and across the persons affected.

Cumulative consequence. The investigator traces the sequence of decisions and gaps and their combined effect on the person: delay, repeated exposure, loss of evidence, escalation of harm, foreclosure of remedy. The method is the Chronological Map of Module 5 extended across institutions, with each institutional contribution dated and sourced. Health consequences are taken from the clinical evaluation under Module 3 and the medical record; the ecosystem analysis does not re-assess them.

Affected persons. The Istanbul Protocol records that torture can damage the will and coherence of entire communities and the relationships between victims and their families and communities (IP §492), and the Committee against Torture treats immediate family and dependants of a victim, and persons who suffered harm in intervening to assist, as victims entitled to redress (CAT General Comment No. 3). The investigator therefore identifies the other persons affected by the same

conduct or gap: family members, dependants, witnesses, other persons subject to the same mechanism. Each is recorded with the evidence of their harm. Collective harm is not inferred from the number of persons subject to a mechanism; it is shown by evidence about those persons.

Aggregation rules. Harm to different persons is recorded separately and is not summed into a single figure. Repeated allegations from a shared source are not treated as independent corroboration. The number of complaints received by the IAJ is not a prevalence estimate. Where the IAJ draws on its own database of other cases, the IAJ Forensic Certainty Scale applies with the disclosures required in Module 4.

VI. Step 4 — Evidence-weighted alternatives

Objective. To test, before any systemic conclusion is drawn, the competing explanations for the mapped conduct and gaps, and to distinguish what the evidence shows from what it is merely consistent with.

The standard alternatives

Every ecosystem analysis states and tests at least the following alternatives, and any others the record suggests: (1) the conduct was a lawful exercise of discretion on a legitimate basis; (2) the gap reflects resource or capacity limits rather than design or indifference; (3) the conduct was an individual error or an isolated decision rather than a pattern; (4) the harm has an independent cause or would have occurred without the conduct; (5) the person's own conduct or choices, including procedural defaults, account for the outcome; (6) the records are incomplete in a way that would change the picture if completed.

How alternatives are weighed

Each alternative is weighed on the evidence for and against it, and the result is recorded in one of three forms: excluded on the evidence (with the evidence stated); not excluded but less consistent with the record than one or more other evidence-supported hypotheses, including hypotheses contrary to the IAJ's initial position (with the comparison stated for each); or not resolvable on the present record. An alternative is never excluded because it is inconvenient, and the absence of evidence for an alternative is not evidence against it where the records that would show it are controlled by an actor under investigation. Correlation between a mechanism and an outcome is recorded as correlation. A causal statement about an institutional contribution to harm requires the exclusion or weighing of the alternatives on the complete evidence; it does not require notice or persistence, since harm may be caused before any notice and by negligent as well as deliberate institutional failure. The Step 5 findings on control, notice and persistence bear on responsibility, knowledge and intent, which the directorate assesses separately.

Individual causation remains individual. The IAJ Clinical Attribution Rating (Module 4) is a case-specific clinical judgment and is not altered by ecosystem findings. Ecosystem findings may explain how a person came to be exposed to a stressor; they do not establish that the stressor caused a clinical outcome.

VII. Step 5 — Control, notice and persistence

Objective. To document, for each actor, what it controlled, what it knew, and whether harmful conduct continued after notice. These are the facts on which the IAJ directorate's analysis of intent, purpose and acquiescence under UNCAT Articles 1 and 16 depends; the investigator records them and does not characterize them.

- Control: the decisions the actor had authority to make or prevent, shown by rule or record; the decisions it actually made; the decisions it declined or deferred.
- Notice: what the actor was told, by whom, when and how (requests, complaints, medical certifications, prior rulings, warnings), with the document or testimony that proves receipt; what the actor could not have failed to know from its own records.
- Persistence: whether the conduct or the gap continued after notice; whether it continued after an opportunity to correct it; whether it recurred in the same or other cases; whether any corrective step was taken and what became of it.

Use by the IAJ directorate. The Committee against Torture assesses intent and purpose objectively from the circumstances (CAT General Comment No. 2, para. 9) and treats a State's failure to exercise due diligence to prevent, investigate, prosecute and punish non-State or private acts, where its officials know or have reasonable grounds to believe such acts are being committed, as consent or acquiescence (para. 18). The directorate applies those standards to the Step 5 record. A finding of persistence after notice is the IAJ's strongest evidence of institutional knowledge; it is not by itself a finding of purpose, which requires its own evidence (Module 1, A; FN165).

VIII. Step 6 — Bias controls

Objective. To prevent institutional assumptions, investigative preconceptions and the IAJ's own interests from determining findings. The controls below are mandatory for every ecosystem analysis and are recorded in the Ecosystem Mapping Record.

- Sequential unmasking. The investigator records the person's account and the primary records before reading any prior IAJ interpretation, prior ecosystem analysis of the same institutions, or the IAJ database of patterns; the order of exposure is logged. This adapts the linear sequential unmasking approach to forensic decision-making (Dror et al., Journal of Forensic Sciences 60(4):1111–1112 (2015)), under which analysis begins in isolation from reference material and later changes are restricted and must be justified.
- Pre-stated hypotheses. Before the Step 2 and Step 4 analyses, the investigator writes down every evidence-supported hypothesis, including the IAJ's working hypothesis and those contrary to it; none is treated as presumptively correct; later additions are dated.
- Disconfirmation log. Every item of evidence that cuts against the working hypothesis is entered as it is found, with its source and its effect; the log is attached to the report.
- Separation of roles. The investigator who builds the map is not the person who makes the directorate's determination; the clinician who evaluated the person is not the investigator of the ecosystem.
- Blind review. The map, gap findings and alternatives analysis are reviewed by a person who has not seen the IAJ's prior characterization of the institutions concerned, who records independently whether the findings follow from the record. Where no such reviewer is available

within the time the matter allows, the analysis proceeds and is marked "not blind-reviewed"; the compensating safeguards are a second investigator's review of the disconfirmation log, the directorate's stated reasons for proceeding, and blind review when a reviewer becomes available. Unavailability of a reviewer never bars evidence preservation, protective action or reporting on a credible allegation.

- Base-rate and selection caution. The investigator records how the cases or records were selected and what population they come from; patterns found in cases that reached the IAJ are not generalized to cases that did not.
- Language discipline. The report uses the language of the record (what was requested, decided, recorded) and reserves characterizing terms (obstruction, retaliation, impunity, forum nullus, Sovereign Withdrawal) for the directorate's determination section, where each is tied to the evidence for its elements.
- Declaration of interests. Where the IAJ, its officers or its investigators have been parties, complainants or witnesses in proceedings before an institution under analysis, that fact is declared in the report and the analysis of that institution is reviewed by a person with no such involvement.

IX. Outputs and determinations

The Ecosystem Report. The analysis is reported in a document separate from any individual clinical evaluation, with the following sections: (1) scope and the matter investigated; (2) the Ecosystem Mapping Record; (3) gap findings by function, with classification and basis; (4) outcome and collective harm, with the persons affected and the evidence for each; (5) alternatives tested and the result for each; (6) control, notice and persistence, by actor; (7) bias controls applied, including the exposure log, hypotheses, disconfirmation log and declarations; (8) the IAJ directorate's determinations, stated separately from the investigator's findings; (9) limitations and the records not obtained.

Determinations. On the Ecosystem Report the IAJ directorate may determine, as its own institutional position and with the status disclosures required by Module 1: that a structural gap exists in one or more protective functions; that conduct persisted after notice; that the record supports inferences of knowledge or acquiescence for the purposes of UNCAT Articles 1 or 16; that an institution or venue meets the IAJ's forum nullus criteria; or that the pattern warrants referral to a competent national or international mechanism. The directorate may equally determine that the evidence does not support a systemic finding, and says so.

Referral and reporting. Ecosystem findings may be transmitted, with the affected persons' consent and with identification removed where required, to the Special Rapporteur on Torture through the communications procedure, to the Committee against Torture through the reporting and monitoring processes available to civil society, to national oversight bodies, and to counsel. No referral asserts more than the Report establishes, and every referral states the IAJ's interests under the declaration in Step 6.

X. Limits

The methodology does not establish individual causation, does not diagnose, does not characterize conduct under domestic criminal or civil law, and does not substitute for the individual evaluation it accompanies. Its findings are no stronger than the records on which they rest, and the Report states, for each finding, the records that were not obtained and why. The IAJ will revise this Module on the basis of its application and of independent review, and records each revision in the version log.

APPENDIX A

IAJ Symptom-to-Instrument Selection Guide

A trauma instrument (PCL-5, HTQ, ITQ, etc.) measures selected symptoms and is not a gate for severe suffering, Article 1/16 classification or investigative access. Record continuous raw scores, source instruments, subthreshold profiles, and administration constraints. Do not translate a negative PTSD screen into "torture unsupported."

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, consider the associated instruments where indicated and culturally appropriate (IP §539). Items marked "medical" require medical records or physician assessment, not questionnaires:

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	Medical: refer for medical documentation; SF-36 and WHODAS 2.0 for self-reported functioning only
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	Medical diagnosis required; SF-36, WHODAS 2.0, POMS (fatigue subscale) for self-reported functioning
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	IES-R; clinical interview (the COPE Inventory measures coping style)
Depression	BDI-II, PHQ-9, CES-D, SDS, DASS-42, SCL-90-R, POMS
Desperation	BHS, C-SSRS, BDI-II
Disbelief	IES-R; clinical interview
Dissociation	DES-II; clinical interview (the PCL-5 does not assess the dissociative subtype)
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; clinical interview
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

BDI-II: Beck Depression Inventory–II

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–Revised

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

ENTRY WITHOUT DIAGNOSIS: If credible conduct/suffering allegation exists, preserve the record first; clinical diagnosis is a separate optional branch. If no qualified evaluator exists, continue nonclinical investigation with transparent limits and referral. Never screen OUT torture because Criterion A, PTSD, CPTSD, EPCACE or Shattering fails.

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)
│ └── Consider, where indicated and culturally appropriate: PCL-5, IES-R
├── Depressive symptoms
│ └── Consider, where indicated and culturally appropriate: PHQ-9, BDI-II, CES-D
├── Anxiety symptoms
│ └── Consider, where indicated and culturally appropriate: GAD-7, BAI, HAM-A
├── Mixed presentation
│ └── Consider, where indicated and culturally appropriate: DASS-42, SCL-90-R
├── Functional impairment focus
│ └── Consider, where indicated and culturally appropriate: WHODAS 2.0, SF-36
└── Suicide risk indicators
└── Consider, where indicated and culturally appropriate: 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: Reliability 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 supported evidence-reliability 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 state the reliability and limitations of each clinical or factual component rather than pronounce on the person's overall truthfulness.

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 INSTRUMENTS

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
- Screening score around 31–33 may indicate probable PTSD warranting further criterion-based assessment; the PCL-5 score alone does not establish a diagnosis
- Interpretation: The PCL-5 total is a symptom screening/severity measure; PCL-5 totals are not to be converted into severity categories. Interpret scores in context and do not infer torture or its absence from the total.
- **Interpretation Guidance:**
- Scores around the low 30s may indicate need for further PTSD assessment, depending on population and setting; they do not themselves establish PTSD or the severity of torture/CIDT.
- 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)
- Published screening threshold (e.g., 33) indicates the need for clinical assessment
- A score is not a diagnosis, and a lower score does not exclude serious suffering
- **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); does not document physical injury.
- **Limitations:**
- May capture physiological symptoms from medical conditions rather than primary anxiety.

10. Short Form Health Survey (SF-36)

- **Purpose:** To measure self-reported health-related functioning.
- **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:**
- Useful for self-reported functional decline; physical harm is documented from medical records.
- 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:**
- Use where suicide risk is indicated, including hopelessness or a 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:**
- Consider where specific grounds for concern about feigning exist (IP §386); not routinely required.
- **Limitations:**
- Long administration time may cause respondent fatigue.

I. Assessment Sequencing

Recommended Administration Order (begin with an initial clinical interview and rapport; IP §§527, 539):

- **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)

_____

_____

I. Executive Summary

II. Informed Consent and Confidentiality

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 and Clinical Changes

Add rows to the following table as necessary (see Module 4, Chronological Mapping)

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

Psychiatric diagnoses, if independently established (DSM-5-TR/ICD-11): _____; alternatively, no current diagnosis / subthreshold presentation / historical symptoms remitted / no qualified assessment available: _____. Describe historical suffering, evidence sources, functional effects, and diagnostic limitations separately.

Relationship between symptoms and alleged torture / CIDT:

Alternative explanations considered:

Present severity and functional impact (record suffering during the alleged events separately, under historical suffering):

characterized as

[ ] **mild**

[ ] **moderate**

[ ] **severe**

[ ] severe and urgent

based on current symptom intensity, persistence, functional impairment, and risk. This rating describes present impairment only and does not measure suffering at the time of the alleged events. 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 — Psychiatric diagnoses, if clinically established, AND relevant non-diagnostic symptoms / historical suffering (with source and time course): _____
- Axis II (Personality/Developmental): _____
- Axis III (Medical conditions and findings): _____
- Axis IV (Psychosocial/Institutional Stressors): _____

- Axis V (Functioning): Document baseline, historical and current functioning by domain; identify the observations and sources. Do not require a GAF score:

_____

Chronology and Attribution Note: Identify the reported institutional events, onset and evolution of symptoms or medical findings, record sources, disease-specific evidence, baseline, and alternative explanations. An observed temporal association is not automatically proof of individual biological causation.

[ ] Strongly supported by case-specific evidence

[ ] Supported with material limitations

[ ] Limited support / not assessable (explain)

Degree of support must be explained through the totality of available evidence and differential reasoning, not assigned solely according to the interval between an institutional event and symptom onset.

XI. CONSISTENCY ASSESSMENT

Framework used (e.g., Istanbul Protocol consistency framework):

Degree of consistency (check one if applicable):

[ ] Not consistent with

[ ] Consistent with

[ ] Highly consistent with

[ ] Typical of

[ ] Diagnostic of (IP §543(e)) — exceptionally, with specific justification; rarely appropriate for psychological evidence.

[ ] Not assessable from available clinical material (explain), or 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 or limiting the reliability of clinical evidence:

Limitations affecting reliability of clinical evidence (do not infer overall witness truthfulness from symptoms or presentation):

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. Where distress-induced harm is alleged, it is assessed through 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 any medical findings (Axis III)]

Opinion regarding whether findings are consistent with alleged torture / CIDT:

Clinical consistency assessment (describe evidentiary support and limitations; do not assign an unvalidated numerical probability):

The reported history and available clinical findings are (select only when supported and explain):

[ ] **consistent with**

[ ] **highly consistent with**

[ ] **typical of**

[ ] diagnostic of (IP §543(e); exceptionally and with specific justification) [ ] not consistent with [ ] not assessable

the reported events or treatment. State how the findings support or limit the clinical opinion; these categories do not decide the legal characterization of torture or CIDT.

Clinical evidentiary support:

[ ] Strongly supported (reasons): _____

[ ] Supported with limitations (reasons): _____

[ ] Limited support or not assessable (reasons): _____. Report competing explanations only where they have an evidentiary foundation, and consider concurrent causes. Do not require a diagnosis or infer motive from symptom presentation.

Multiaxial Attestation

[ ] I documented the dates and reliability of the identified institutional stressors, any subsequent symptoms or injuries, relevant baseline, disease-specific temporal evidence, and alternative explanations. No fixed 14-day interval was imposed as a prerequisite; any individual medical causation conclusion is separately supported and appropriately qualified.

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 requested, summarize clinical findings relevant to an Article 1 / Article 16 inquiry without making an ultimate legal determination solely by virtue of clinical credentials; a qualified IAJ legal/human-rights analyst separately addresses treaty characterization:

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 was conducted as a neutral forensic inquiry. Findings are stated with their evidentiary basis and limitations. The UNCAT characterization of the alleged conduct is addressed in the IAJ directorate's separate analysis. The evaluator functions independently 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 TEMPLATE —

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): Denial of reasonable accommodation is recognized as a form of disability discrimination under CRPD Article 2. Whether a particular denial accompanied by serious suffering constitutes CIDT under Article 16 or torture under Article 1 requires a separate, evidence-based assessment of the applicable elements; the Istanbul Protocol does not itself declare every such denial to be CIDT.**
- Treating Provider Evidence: The treating provider's evidence on necessary accommodation is often given significant weight; for communication aids, the public entity gives primary

consideration to the person's request (28 C.F.R. §35.160(b)(2)). Whether a modification is necessary is decided case by case.

Case Vignette - Systemic Judicial Disability Discrimination

Background:

Composite case (anonymized; facts altered). A person with a stress-sensitive neurological condition becomes involved in civil litigation. The condition causes cognitive impairments affecting processing speed, attention and executive function, and pathological fatigue.

Accommodation Requests:

Over several years, the person files accommodation requests with:

- State trial court (multiple judges)
- State appellate court
- Federal district court (multiple judges)
- Federal appellate court (Ninth Circuit)

Pattern of Denial:

- State courts: requests denied
- Federal district court: accommodation initially provided, later withdrawn
- Federal appellate court: requests denied

Reported harm (allegations; causation to be assessed):

- Recurrent relapses and comorbidities reported by the person to coincide with litigation events and denials of accommodation
- Long-term full-time care; substantial sanctions imposed for non-compliance
- Cognitive decline documented on neuropsychological testing

Psychological findings

- PTSD
- Depression
- Anxiety

Medical findings (relationship to stressors to be assessed)

- Hyperglycemia
- MS relapses
- Comorbidities, including hypoxia, dysphagia, dyspnea
- Immunocompromise

Questions for the IAJ directorate's legal analysis (training exercise):

Does the uniformity of denials across multiple courts support an inference of systemic practice rather than individual decisions? What institutional reasons were given? Do the forum nullus criteria in Module 1 apply?

Exercise:

Trainees identify the clinical findings, the medical evidence needed to assess causation, and the facts relevant to the Article 1 and Article 16 elements, and explain what further evidence would change the analysis. The UNCAT characterization is reserved to the IAJ directorate.

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[183]. 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 engaged by the Institute for the Advancement of Justice & Human Rights (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 and clinical services must be independent of law enforcement, prosecution and/or military authority. 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 .
- Role and Authorization: This evaluation was performed as a forensic investigation, not as clinical treatment. My documentation follows the Istanbul Protocol and my professional ethical obligations; my role, scope and authorization basis are: [state licensure or other lawful basis].
- **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 would impede documentation of a serious alleged violation of treaty obligations. I request that the Court consider a protective order limiting disclosure to what is necessary.

I respectfully request that the Court (a) sustain any applicable privilege and confidentiality protections; (b) review the records in camera before any disclosure; and (c) enter a protective order limiting disclosure to what is necessary for the proceeding.

Respectfully submitted,

[Signature] [Name], [Credentials]

[183] Note Istanbul Protocol §§195, 679 (protection from reprisals). This template must be reviewed by counsel before use.

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 (current version)**.
- **Diagnostic Validation**: I have reviewed and approve the diagnostic impressions (DSM-5-TR/ICD-11) 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 evidence relevant to systemic failure.

IAJ CLINICIAN'S INCIDENT REPORT FORM (CIRF)

FOR DOCUMENTING SUPERVISORY OR INSTITUTIONAL OBSTRUCTION[184]

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 concerning alleged torture or 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?

[184] Note Istanbul Protocol §§195, 679 (protection from reprisals).

IV. AFFIRMATION OF THE WITNESS OBLIGATION

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 request protection from reprisals as a human rights defender (UN Declaration on Human Rights Defenders, A/RES/53/144; IP §§195, 679; see Protections for Human Rights Defenders: Origins, State Obligations, and Enforcement — with a Focus on the United States).

V. ESCALATION STATUS

This report is being confidentially transmitted to (check all that apply):

- [ ] Institute for the Advancement of Justice & Human Rights (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 differs from psychotherapy, but may still be regulated practice; follow the licensure guidance in Module 1.

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 securely in hostile environments, clinicians should follow these protocols:

- Secure Records: Keep the clinical record in the institution's system; store CIRF data in the IAJ secure system. Do not remove patient records or identifiable patient information to personal devices without a lawful basis and advice on confidentiality law (e.g., HIPAA).
- **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 call for the avoidance of harm (APA 3.04; ACA A.4.a), respect for client welfare (ACA A.1.a) and, in the NASW Code, the promotion of social welfare and social and political action (NASW 6.01, 6.04).

- **Collaborative Model: Describe any actual Level 4 supervisory review, its scope, reviewer qualifications, disagreements, and unresolved limitations. Internal review must not be described as independent external peer review or as eliminating the possibility of error.**
- **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 adding institutional support for the individual clinician.
- 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 the Advancement of Justice & Human Rights (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 documentation of alleged violations of the United Nations Convention Against Torture (UNCAT) pursuant to the 2022 Istanbul Protocol (IP).

I. MANDATORY ETHICAL OBLIGATIONS Under professional health ethics (WMA) and the IAJ Standard, healthcare providers who encounter evidence of torture or cruel, inhuman, or degrading treatment (CIDT) have a duty to document.

- This duty is independent of employment considerations or third-party interests.
- Istanbul Protocol §665 addresses the duty of State-employed forensic experts and clinicians to investigate and document clinical evidence of torture or ill-treatment in accordance with Istanbul Protocol standards.

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 documented by the IAJ.

III. COLLABORATIVE FORENSIC ANCHORING Be advised that [Clinician Name]'s work is integrated into the IAJ Collaborative Expert Model . Investigative findings are subject to IAJ Level 4 review. Consequently:

- 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:

- Report the matter to the UN Special Rapporteur on Torture through the established communications procedure.

- Provide full legal and professional defense for the clinician before the relevant **State Licensing Boards** .

We trust this institution will respect the clinician's forensic independence and allow [Clinician Name] to fulfill their professional and ethical obligations without further interference.

Sincerely,

[Signature]

Director of Forensic Investigations Institute for the Advancement of Justice & Human Rights (IAJ)

APPENDIX K

Basic Training Module for Non-Specialists: Istanbul Protocol Application

Trainees shall document a scenario with no psychiatric diagnosis and explain why the absence of PTSD, access to mental-health services, or a post-event symptom does not defeat investigation. A separate supervised exercise shall require distinguishing severe suffering at the time from present psychiatric classification and from the other UNCAT legal elements.

I. Introduction (The Why)

- Non-specialists have a duty to document torture encounters under professional ethics (WMA) and the IAJ Standard, 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 documentation, referral for 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 (Chapter II). 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 Documentation – Record observed and reported symptoms in the person's own words, with dates and sources, including somatic symptoms (for example, pain, inflammatory flare, neurological worsening, or other possible stress-mediated deterioration in a documented stress-sensitive condition). Do not score or interpret screening instruments; refer for qualified assessment.
- Step 4: Timeline and Referral – Record the timeline of events and symptoms and any pre/post records. Consistency ratings and causation opinions are made only by a Level 3 or Level 4 clinician acting within demonstrated competence and lawful professional scope; refer the case and note any barrier to referral.
- **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, document symptoms in the person's own words, record the timeline, and identify what to refer. Compare your notes to the Istanbul Protocol guidelines. Answers are derivable from the IAJ standard.[185]

Instructors should require trainees to classify the documentary record for each scenario as strong, weak, or ambiguous on three axes: (a) timeline completeness, (b) corroborating records, and (c) gaps needing referral. Trainees must explain what additional evidence would raise or lower certainty.

Scenario: Parent-Child Separation as Torture/CIDT

Composite scenario (anonymized). A parent with pre-existing depression reports permanent separation from two young children through child welfare proceedings that began with an emergency removal. The parent disputes the allegations and reports being denied direct access to the evidence (attorney-only access), conflicts with appointed counsel, denial of a continuance during illness, and a termination hearing conducted in the parent's absence. The parent alleges retaliation for challenging the agency. Records show managed depression before the proceedings; afterwards the parent reports hypervigilance, flashbacks, low mood, and physical symptoms (nerve pain, numbness, intestinal dysfunction, sleep disturbance) that medical records describe but do not attribute. The parent reports no accommodation for disability.

Guided Questions:

- Build the timeline: which institutional events, symptoms and records can you date? What records would you request?
- Document symptoms in the parent's own words and note what requires referral to a Level 3 clinician (diagnosis, consistency) and to a physician (physical symptoms).
- Record the accommodation history and any disability needs (ADA/CRPD), and the facts relevant to official involvement, for the IAJ directorate's analysis.
- If interference with documentation occurs, how would you use the CIRF (Appendix H)?

Scenario 2: Excessive Use of Police Power as Torture/CIDT

Composite scenario (anonymized). A person is arrested in a courthouse after a hearing, for disputed unpaid fines, without prior notice or an ability-to-pay assessment. The person reports being shackled, strip-searched, observed while showering and held overnight; the fines are reduced the next day and the person released, after which new fines appear. The person alleges retaliation. No health screening occurred in custody. Afterwards the person reports hypervigilance, flashbacks, low mood and physical symptoms.

Guided Questions:

- Build the timeline and list the records (booking, custody, court, fines) you would request.
- Document reported symptoms and what requires referral for clinical and medical assessment.
- Record facts relevant to official involvement and custody safeguards for the IAJ directorate's analysis.

[185] Note: Schedule a consultation with the IAJ to review your answers.

- If interference with documentation occurs, how would you use the CIRF?

Scenario 3: Person with Disability Facing Institutional Discrimination

Composite scenario (anonymized). A litigant with MS reports that requests for accommodation (deadline extensions, stays) in federal litigation were denied, and that relapses, infections, panic attacks and isolation followed. Records show stable MS before the litigation and relapses during it; the litigant attributes them to the proceedings.

Guided Questions:

- Build the timeline of requests, denials, relapses and treatment; identify the neurology records needed.
- Identify what must be referred: diagnosis and consistency (Level 3), medical causation (neurologist).
- Record the accommodation history for the IAJ directorate's analysis.
- If interference with documentation occurs, how would you use the CIRF?

IV. Quick-Reference Checklist

- Consent obtained and explained? Yes/No
- History mapped (pre/during/post)? Yes/No
- Symptoms documented in the person's own words? Yes/No
- Referred for Level 3/4 consistency evaluation? Yes/No
- Medical records obtained or referral made? 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

Alternative outcome: no clinician was available and no psychiatric diagnosis was made. The investigation nevertheless records the request for assistance, dates, records, observations, refused referrals and barriers without pretending to complete a forensic psychological assessment. The lack of diagnosis or counsel is not adverse evidence. The IAJ evaluates whether institutional conduct contributed to the access gap on documented facts.

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, Buljevac and von Drathen 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 is consistent with learned helplessness; its cause requires assessment.

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 reports that the alleged ill-treatment continued. 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:

- UNCAT Article 13: each State Party shall ensure that any individual who alleges he has been subjected to torture has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. IP §664 separately addresses the State's obligation to build the forensic and clinical capacity needed to investigate and document torture.

IP §673 (paraphrase): independent, non-governmental clinicians play a critical role in documenting torture, and their work is often essential to the State in meeting 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 on Intrusive Experiences, Defensive Avoidance, Dissociation and Impaired Self-Reference
- **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 (DSM-5-TR)
- Major Depressive Disorder, Severe (DSM-5-TR)

The clinician further noted features consistent with Complex PTSD (ICD-11) and historical ICD-10 Enduring Personality Change After Catastrophic Experience, 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
- Profound disruption of autonomous functioning (the IAJ descriptive Shattering construct); cause to be assessed

- Alternative explanations considered: no prior psychiatric history and no substance use; MS-related cognitive and fatigue effects contribute and are distinguished from trauma symptoms with neurology input

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 reports that each ruling causes further psychological harm. 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 documents measurable psychological deterioration, 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.**

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 the IAJ adaptations in Module 3, Role of the Psychological Evaluation, Section IX.
- Non-specialists should recognize and preserve reported signs of possible torture or ill-treatment and refer for assessment within their lawful competence.
- 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 (Module 4): Identify interactions (e.g., judicial denial + law enforcement escalation). Note patterns like retaliation for advocacy.
- Step 2: Facts relevant to intent – Record facts about notice and knowledge (requests, warnings, prior incidents) and refer them for the IAJ directorate's legal analysis.
- **Step 3: Harm Documentation** – Screen for effects (PCL-5, WHODAS 2.0). Link to US contexts (e.g., prolonged solitary confinement as possible torture or CIDT, per UN Special Rapporteur A/66/268).
- **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[186], flare, or functional collapse), and document any known vulnerability supported by records. Evaluate for disabilities (e.g., MS, where prospective studies associate stressful life events with exacerbation; see Module 4, Section III).
- Step 5: Reporting Patterns – Aggregate for systemic reform (e.g., UN submissions). Use CIRF for interference.

III. Practice Scenarios

Legal-analysis exercise (for IAJ legal analysts; non-specialists complete the documentation steps only). Each scenario should be re-worked twice: first as an Article 16 analysis assuming no intent is

[186] Solomon et al. (2023) offers a condition-specific example of longitudinal stress–symptom-set modeling in one RRMS patient. Such modeling may aid clinical investigation but must be integrated with medical records, event chronology, and differential etiological assessment before individual causal attribution.

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.

- 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 Distress-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;
- 3. Escalate to UN CAT.

IV. Quick-Reference Checklist

- Patterns mapped (actors/interactions)? Yes/No
- Facts on notice and knowledge recorded and referred? 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; §§277–280 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 §§294–295 on cultural humility; §§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 §§539–540).
- **Over-pathologization:** (labeling culturally normative responses as disorders, per IP §§294–295, 493, 496, 497, 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 clinical observations; do not treat them as indicators of malingering.
- Use trauma-informed interviewing to avoid re-traumatization.
- Integrate into consistency assessments (considering their fit with the alleged treatment).

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

□ Assessor avoided equating absence of PTSD/CPTSD with absence of suffering; documented culturally expressed suffering and symptom remission; recorded any lack of access, interpreter, qualified clinician or valid instruments, with effects on inference.

The following **Cultural Validation Checklist** is a mandatory methodological checklist 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 possible idioms of distress, with medical causes also considered, 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 assess whether, and with what evidence, the survivor's marginalized status affected the harm (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 support the reliability of the methods under FRE 702, 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 "[insert the supported IP §543 category]" 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, in the IAJ's assessment, 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 recognized international standard 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; any submission to UN bodies or NGOs requires my separate consent.
- **Potential Risks**: Recounting events may be distressing; the evaluator will monitor for signs of re-traumatization and provide breaks.
- **Best Interests**: I understand the evaluator will act in 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: [3 or 4; Level 2 only under supervision]

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 in the following days.

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 distress during any evaluation 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-designated 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[187], 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[188] in order to fulfil their human rights obligations, and the USA has resisted implementation of the IP as recommended by the Committee against Torture.

The IAJ observes that psychological or other IP-based investigations, and the prevention, relief, remediation and punishment of torture and CIDT, do not sufficiently happen in the USA, for reasons including the following (each is an IAJ observation, with the supporting source stated where one exists):

- The conditions do not exist for the effective implementation of IP[189]
- Official recognition of Istanbul Protocol standards (IP §646): in its combined third to fifth periodic report (2013), para. 101, the United States acknowledged the Protocol's important role and described agency awareness and clinician training; in 2014 the Committee recommended training of medical personnel in accordance with the Protocol (CAT/C/USA/CO/3-5, para. 28). Whether the Protocol has been institutionalized across the relevant branches of government, as IP §646 describes, is a separate question; the materials identified for this edition do not establish that such institutionalization has occurred.[190]
- Judicial-branch impunity and lack of judicial deference to human rights, as documented in the IAJ's investigations of judicial disability discrimination: in the two cases the IAJ has investigated

[187] https://www.ohchr.org/en/publications/policy-and-methodological-publications/civil-society-space-and-united-nations-human

[188] The word "States" under international law is equivalent to the word "countries"

[189] 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.

[190] IP §646: Official recognition of Istanbul Protocol standards Core meaning Because torture is a State crime, the Protocol states that it is essential that States, through legislative and administrative action, officially recognize and institutionalize Istanbul Protocol 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 describes the legal and administrative foundation for implementation; the IAJ determines that the underlying duty is the obligation to take effective measures under UNCAT Article 2(1).

in depth, accommodation requests were denied at every level over more than a decade, including eight proceedings in a federal court of appeals and more than twenty petitions to the Supreme Court denied without engagement, and judicial-conduct complaints did not produce corrective action (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, Parts XIV, XVIII, XXIV–XXVII). The IAJ's determination that this pattern reflects structural rather than individual failure is its own jurisprudential conclusion (standards: IP §§661, 666, 674–679).[191]

- 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 state that independent monitoring, public reporting, recommendations and guidance to professional groups, external scrutiny and whistle-blower protection should be ensured (§674: "essential"). IP §676 states that monitoring functions should include the functioning of the national documentation system and individuals' access to prompt, independent and impartial investigation**. The observed "invariant policies and procedures" and "Separation of Powers" barriers block the independent oversight, monitoring and corrective mechanism required by this section.
- U.S. courts treat Articles 1–16 of UNCAT as non-self-executing under the U.S. declaration, so that the treaty is not directly enforceable domestically and creates no private cause of action (Medellín v. Texas, 552 U.S. 491 (2008), on non-self-executing treaties generally); the United States' international obligations under UNCAT are unaffected by that domestic status
- The absence of a general federal offence of torture in full conformity with Article 1 (18 U.S.C. §2340A criminalizes torture committed outside the United States; in 2014 the Committee against Torture regretted that a federal offence conforming to Article 1 had not been introduced, CAT/C/USA/CO/3-5, para. 9) and the obstacles to redress the Committee noted (paras. 15, 29) are, in the IAJ's assessment, conducive to judicial impunity and to traditional deference to institutional policies. IP §661 states that domestic law should provide for the different forms of reparation recognized under international law and the reparations afforded

[191] 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: Independent monitoring (§§674–677): an independent monitoring body should monitor implementation and the documentation system (§676) and seek accountability through recommendations and guidance to professional groups (§677). In the IAJ's analysis, this extends to judicial actors. 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 states that independent, non-governmental clinicians "play a critical role in the effective investigation and documentation of torture and ill-treatment" (§673). 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 (IAJ assessment): those mandated to prevent torture (judges) may, in the IAJ's analysis, facilitate harm through the systematic denial of medical accommodations. Forum Nullus: When the judiciary fails to provide effective remedies or relief, the IAJ may characterize the venue as a forum nullus, and information may be submitted to the Committee, including for consideration under Article 20.

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, in the cases it has investigated, that complaints under the Judicial Conduct and Disability Act (28 U.S.C. §§351–364) alleging systemic accommodation denial were dismissed on the ground that the conduct process cannot reach the substance of rulings (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, §25.4). The IAJ determines that a conduct mechanism which cannot reach the conduct complained of does not supply accountability for it (see The Structural Foreclosure of Effective Protection and Remedy for Rights-Violating Judicial Conduct in the Courts of the United States of America). IP §§674–677 call for an independent body to monitor implementation and seek accountability to prevent such structural inversions. IP §677 calls for an independent monitoring body to seek individual and professional accountability, which in the IAJ's analysis extends to judicial actors who commit, instigate, or acquiesce in torture and ill-treatment. Ineffective judicial-ethics enforcement may contribute to institutional impunity; it does not, standing alone, establish that every effective remedy has been foreclosed. The controlling inquiry is whether the State's available forums and procedures actually furnish independent investigation, accountability and appropriate redress. IP §661 recommends effective reparation mechanisms. UNCAT Article 14 expressly refers to victims of torture; the Committee against Torture interprets it to cover victims of torture and of cruel, inhuman or degrading treatment (General Comment No. 3, para. 1). The IAJ determines that foreclosure of every effective avenue for such redress is incompatible with the governing anti-impunity standard.
- Res judicata: in the cases the IAJ has investigated, prior adverse rulings entered without engagement with accommodation or treaty arguments were later invoked to bar their reconsideration (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, Parts XXIV, XXVI–XXVII). Res judicata is a general doctrine; its effect here is that unaccommodated adjudication becomes self-perpetuating. IP §661 states that domestic law should ensure the right to be free from torture in law and practice and provide for reparation.[192]
- No political will
- IP **§647** identifies political will across relevant institutions—including the judiciary—as essential.
- Congress has not enacted a general federal offence of torture in full conformity with Article 1; 18 U.S.C. §2340A criminalizes torture committed outside the United States. The Committee against Torture regretted the absence of such a federal offence in 2014 (CAT/C/USA/CO/3-5, para. 9; see also CAT/C/USA/CO/2, para. 13). State legislation varies (e.g., California Penal Code §206 criminalizes torture with elements that differ from Article 1) and is not assessed here.

[192] Res judicata is a legal doctrine that bars the relitigation of a matter that has already been finally adjudicated by a competent court.

- **The IAJ observes that no political question remains in the matter of U.S.-assured full compliance with the UNCAT, and that U.S. conditions reflect a deficit of judicial will** [193] requiring monitoring and independent investigation.
- Ineffective criminal justice system
- Effective criminal justice system: required safeguards and structural conditions (IP §648 and §649).[194] **In 2014 the Committee against Torture expressed concern on several of these conditions: safeguards and conditions of detention, including solitary confinement, sexual violence and deaths in custody (CAT/C/USA/CO/3-5, paras. 20–22), police brutality and excessive force (para. 26), the documented impact of training (para. 28) and obstacles to redress (para. 29). For the remaining conditions the IAJ's assessment rests on its own investigations, documented in its Disability Rights Thesis, and is stated as such.**
- In 2014 the Committee noted limited information on rehabilitation programmes and the resources allocated to them (CAT/C/USA/CO/3-5, para. 29) (standard: IP §650); the materials identified for this edition do not establish whether public resourcing of independent forensic documentation of the kind IP §650 describes exists.[195]
- Governance (IP §651): the IAJ's assessment of governance deficits rests on the structural findings in its investigations of judicial disability discrimination (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, Parts XXIV and XXVI) and is stated as the IAJ's assessment.[196]

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[193] IP §647: Political will Core meaning Political will is one of the most important conditions for the effective investigation and documentation of torture and ill-treatment. 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 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, in the IAJ's view, the courts could give greater effect to UNCAT obligations within existing law; the IAJ also notes the absence of implementing legislation (see above).

[194] 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 conditions (IP §649) The Protocol states that effective investigation often depends on a functional criminal-justice system including: 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 describes the legal and institutional backbone needed for the Istanbul Protocol to function. The IAJ determines that criminalization of torture is required by UNCAT Article 4 and exclusion of evidence obtained by torture by Article 15.

[195] IP §650: Adequate financial and human resources Core meaning The Protocol states that States should ensure: 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.

[196] 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

- Cooperation (IP §652): the United States has stated that it does not intend to withdraw its understandings and has not introduced the federal offence the Committee recommended (CAT/C/USA/CO/3-5, para. 9); the IAJ assesses cooperation with the Committee's recommendations, on that record, as limited.[197]
- Civil-society participation (IP §653): the materials identified for this edition do not establish whether a State mechanism for civil-society participation in Istanbul Protocol implementation exists; the Committee recommended in 2014 that non-governmental monitoring of detention be authorized (CAT/C/USA/CO/3-5, para. 21(h)).[198]
- Implementation phases described by the Protocol (IP §§655–657), on which the materials identified for this edition do not establish U.S. action:[199]
- Phase I: building shared understanding and partnerships (IP §655)[200]
- Phase II: building capacity and beginning policy reform (IP §656)[201]
- Phase III: institutionalization and local ownership (IP §657)[202]

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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.

[197] IP §652: Cooperation Core meaning The Protocol states that action to end torture involves 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.

[198] 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.

[199] 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.

[200] 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.

[201] 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.

[202] 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.

- The necessary legal, administrative and judicial reforms meet with extreme resistance[203]
- Legal and judicial reform of the kind IP §658 describes has not occurred at the federal level: no general federal offence of torture conforming to Article 1 had been introduced at the Committee's 2014 review, when the United States stated that it did not intend to withdraw its understandings (CAT/C/USA/CO/3-5, para. 9), and 18 U.S.C. §2340A remains limited to torture committed outside the United States; the United States is not a party to OPCAT[204]
- In 2014 the Committee expressed concern at safeguards for persons deprived of liberty: solitary confinement, sexual violence in detention, deaths in custody and complaint mechanisms (CAT/C/USA/CO/3-5, paras. 20–22) (standard: IP §659[205])
- Health evaluations in custody and access to independent clinicians (IP §660): the IAJ's investigations of judicial proceedings did not concern custody; in 2014 the Committee expressed concern at conditions of detention and complaint mechanisms (CAT/C/USA/CO/3-5, paras. 20–22). The IAJ makes no custody-specific finding here.[206]

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[203] 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.

[204] 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. Reforms described To make Istanbul Protocol documentation meaningful, the Protocol describes the following reforms: defining and criminalizing torture in line with the Convention (required by UNCAT Article 4); ratifying and implementing OPCAT, including National Preventive Mechanisms and independent monitoring bodies (a recommendation; the United States is not a party to OPCAT). 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.

[205] 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.

[206] IP §660 — Health evaluations and access to independent clinicians Core meaning States have a duty to conduct prompt, impartial, independent, effective and thorough investigations of all allegations (UNCAT Article 12). Because medico-legal evidence is essential, the Protocol states that States should implement mandatory health evaluations at the time of detention and every 24 hours thereafter, at the detainee's request and before transfers. The Protocol considers it essential that States ensure an alleged victim's right to evaluation by one or more health professionals of their choosing, at any time during or after custody, including secure detention settings. Evaluations by non-governmental clinicians must be admissible and receive consideration equal to governmental clinical evaluations. Clinicians should receive prompt access, within less than 24 hours, whether or not the person remains in custody, and States should codify Istanbul Protocol safeguards into national law. These Protocol formulations (including the 24-hour benchmarks) are distinguished from the duties arising directly under UNCAT. What this paragraph is doing It creates a dualtrack forensic system—State and nonState—so that evidence cannot be monopolized or suppressed by authorities.

- In 2014 the Committee noted limited information on rehabilitation programmes and expressed concern at obstacles to redress for marginalized groups (CAT/C/USA/CO/3-5, para. 29) (standard: IP §661[207])
- In 2014 the Committee noted that training existed but that its impact was inadequately documented, and recommended mandatory training including for medical personnel (CAT/C/USA/CO/3-5, para. 28) (standard: IP §662[208])
- Ethical duties of health professionals (IP §663): the Senate Select Committee on Intelligence's Committee Study of the CIA's Detention and Interrogation Program (S. Rpt. 113-288, Findings and Conclusions, Finding 13, 9 December 2014) documents that two contract psychologists developed and operated the CIA's enhanced interrogation techniques; this finding concerns those individuals and that programme, not U.S. health professionals generally.[209]
- Reform of government forensic and health-profession practice (IP §§664–667): the materials identified for this edition do not establish whether reform of this kind has occurred.[210]
- Forensic and clinical documentation systems and support for independent clinicians (IP §§664–667): the materials identified for this edition do not establish whether measures of this kind exist; in 2014 the Committee recommended training of medical personnel in accordance with the Protocol (CAT/C/USA/CO/3-5, para. 28).[211]

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[207] IP §661 — Reparation and rehabilitation Core meaning The Protocol states that States should develop a strong legal framework for reparation (compensation, restitution, satisfaction, guarantees of non-repetition) and rehabilitation (medical, psychological, social), including civil proceedings independent of criminal cases and judicial and non-judicial remedies, and that reparation should reflect the gravity of the violations. What this paragraph is doing It ensures that accountability is not limited to criminal punishment. The IAJ determines that the enforceable right to fair and adequate compensation and rehabilitation rests on UNCAT Article 14.

[208] IP §662 — Training for all relevant personnel Core meaning The Protocol states that States should ensure that all actors in the justice and health systems are 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. The Protocol states that training should be part of professional curricula, reinforced through continuing education, and tailored to each role (lawyers, judges, prosecutors, clinicians, police). The IAJ determines that the duty to train rests on UNCAT Article 10. What this paragraph is doing It builds the humancapacity infrastructure needed for the system to function.

[209] IP §663 — Ethical duties of health professionals Core meaning The Protocol states that States should also ensure respect for legal and medical ethical duties as described in Chapter II, including non-participation of health professionals in any form of interrogation practice, compulsory documentation and reporting requirements when torture or ill-treatment is alleged or suspected (subject to the ethical duties of confidentiality and consent described in Chapter II), and the prohibition on any role for health professionals in disciplinary sanctions or restrictive measures. The IAJ determines that the duty to ensure these ethical conditions rests on UNCAT Article 10 and the UN Principles of Medical Ethics (GA res. 37/194). What this paragraph is doing It protects the integrity of the medical profession and prevents clinicians from being coopted into abusive systems.

[210] 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 should carry equal weight in court (IP §673) This is a major safeguard against State manipulation.

[211] IP §664 — States' obligations under international law to investigate torture require effective policies, practices and capacities for documentation by State-employed experts, extending to support of non-governmental 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. The Protocol treats support of independent clinicians as part of the State's obligation to investigate; the IAJ determines that this obligation rests on UNCAT Article 12.

- State-employed forensic experts and clinicians should investigate and document clinical evidence of torture and ill-treatment consistent with the Istanbul Protocol; institutional barriers to performing these duties require separate factual investigation (IP §665).[212]
- Independence from law enforcement is essential; lack of independence is a major barrier (IP §666[213]). The IAJ adds that independence from the judiciary is vital.
- Independent and non-governmental forensic services (IP §667): in the cases the IAJ has investigated, courts declined to consider independent clinical evidence of disability and harm without individualized assessment (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, Parts XVIII and XXIV); the IAJ determines that refusal to consider independent forensic evidence is a form of obstruction within the meaning of IP §667.[214]
- Prompt, objective and standardized evaluations (IP §668): the materials identified for this edition do not establish whether a State mechanism provides such evaluations outside the criminal-custody context.[215]
- Medico-legal safeguards (IP §669): federal regulations contain some related protections, for example medical and mental-health care requirements for victims of sexual abuse in confinement (28 C.F.R. §§115.82–115.83); whether federal and state law and procedure provide safeguards equivalent to IP §669 is an open comparison.[216]

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[212] IP §665 — State-employed clinicians have a duty to investigate and document clinical evidence of torture, and State institutions need to review and reform inconsistent policies 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 Institutions must change their internal rules to align with the Protocol.

[213] 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 The Protocol treats independence as essential. Structural reforms may be large, but they are nonnegotiable. This paragraph is a direct challenge to systems where police control forensic medicine.

[214] IP §667 — Independent State forensic institutions should be vested with authority, funds and resources; States should not prohibit or obstruct the establishment of non-governmental forensic or medico-legal services, nor have authority to qualify or disqualify non-governmental experts Core meaning Independent State forensic institutions must have: authority, funding, qualified personnel, interpreters, equipment, diagnostic tools, and adequate time to conduct proper evaluations. States should not block the creation of NGO forensic services or control who counts as a "qualified" NGO expert. Implications Independence without resources is meaningless. IAJ determination (unchanged in substance): NGO clinicians must be free to operate without State interference; the IAJ grounds this determination in UNCAT Articles 12 and 13 and in the Committee's 2014 recommendation that the United States authorize non-governmental monitoring in detention (CAT/C/USA/CO/3-5, para. 21(h)).

[215] IP §668 — State institutions should ensure that evaluations are prompt, objective and standardized Core meaning The Protocol states that evaluations should be conducted immediately and not later than 48 hours after the allegation or initial documentation, by qualified, independent governmental experts, in accordance with Istanbul Protocol standards, and that forensic experts should be required to investigate all allegations or suspicions of torture even without a formal complaint. 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.

[216] IP §669 — State agencies should ensure that procedural safeguards are included in law and SOPs Core meaning The Protocol states that State agencies should ensure that domestic law, regulations and standard operating procedures include the procedural safeguards for effective medico-legal documentation. Implications The IAJ determines that informal or discretionary safeguards do not satisfy the State's obligation under UNCAT Article 2(1) to take effective measures.

- Access to independent evaluation and information about that right (IP §670): the materials identified for this edition do not establish whether persons are informed of this right; the IAJ makes no custody-specific finding here.[217]
- In 2014 the Committee recommended mandatory training including for medical personnel in prisons and psychiatric hospitals (CAT/C/USA/CO/3-5, para. 28) (standard: IP §§671–672).[218][219]
- Support for independent clinicians (IP §673): the materials identified for this edition do not establish whether support of this kind exists.[220]
- The IAJ determines that formal independence or institutional status cannot substitute for functioning investigation, accountability and victim redress. Measured against IP §§674–679, the oversight mechanisms encountered in the IAJ's investigations (judicial-conduct procedures, appellate review and certiorari) did not perform those functions in the cases investigated (Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks, Parts XXIV–XXVII). The United States is not a party to OPCAT; the Committee against Torture nevertheless recommended non-governmental monitoring of places of detention in 2014 (CAT/C/USA/CO/3-5, para. 21(h)) and expressed concern at State secrecy provisions and immunities that impede liability (para. 15)**:**
- Independent monitoring **(**IP §**674**[221] **and** IP §**675**[222]**)**

[217] 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 States should respect and facilitate this right. Failure to inform victims violates the Protocol.

[218] IP §671 — States should provide training on the investigation and documentation of torture to all relevant health professionals Core meaning The Protocol states that training should 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 should include forensic experts and all clinicians who may encounter victims (even in non-forensic settings). Implications Training is not limited to forensic specialists; the Protocol includes ethical resistance to pressure and support systems for clinicians who uphold ethics. The IAJ determines that the duty to train medical personnel rests on UNCAT Article 10.

[219] IP §672 — Effective training can be achieved through interactive, mentored, multidisciplinary and civil-society-inclusive approaches Core meaning The Protocol describes effective training as involving: interactive classroom work, mentoring in real cases, "training of trainers" programs, joint training of health and legal professionals, participation of civilsociety clinicians. Implications The Protocol favours practical over theoretical training; cross-professional training builds shared understanding; civil society enriches training and builds trust.

[220] IP §673 — Independent clinicians play a critical role, and States can and should support them Core meaning Independent, non-governmental clinicians play a critical role in documentation; their capacity is often essential to the State in meeting its obligations. States should support their training, facilitate their evaluations, ensure their reports receive equal weight in court, and support capacity-building and networking. Implications The Protocol treats NGO clinicians as central, not secondary. The IAJ determines that active State support of independent forensic capacity is part of the obligations under UNCAT Articles 12 and 13.

[221] IP §674 — Why the Protocol calls for independent, public, State-mandated monitoring. Core meaning The Protocol states that it is essential to monitor implementation and measure outcomes; that State self-monitoring is often ineffective and in some countries used to conceal torture; that it is therefore essential that independent bodies monitor implementation; that findings should be publicly reported; and that States should mandate and support an independent monitoring body. Implications The Protocol treats independence as a structural safeguard and public reporting as an anti-impunity mechanism. The IAJ determines that reliance solely on internal oversight bodies does not satisfy the obligation to take effective preventive measures under UNCAT Article 2(1); national preventive mechanisms under OPCAT are a comparative model only, the United States not being a party.

[222] 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 Protocol states that the body's establishment should follow the Paris

- Systemlevel and caselevel oversight **(**IP §**676**[223]**)**
- Professional and criminal accountability **(**IP §**677**[224]**)**
- External scrutiny by UN and NGOs **(**IP §**678**[225]**)**
- Protection for those who expose torture **(**IP §**679**[226]**)**
- Participation in shared Istanbul Protocol implementation infrastructure (IP §§680–681): the materials identified for this edition do not establish whether participation of this kind exists.[227][228]

Principles (independence, pluralism, adequate resources, broad mandate, credibility), that civil-society participation is essential, and that selection should be inclusive and transparent. Implications The Paris Principles are an institutional standard, not a treaty obligation; the IAJ treats compliance with them as the test of a monitoring body's legitimacy.

[223] IP §676 — What the monitoring body should monitor Core meaning The Protocol states that monitoring functions should include: 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.

[224] IP §677 — Monitoring should lead to accountability for individuals and institutions Core meaning The Protocol states that an independent monitoring body should seek to provide systematic accountability through recommendations and guidance to professional groups and should seek to ensure individual professional accountability through professional proceedings (bar associations, medical boards, psychological associations) and, where criminal law or professional ethics are violated, through disciplinary proceedings or criminal investigations. The IAJ's extension of this to judicial actors is the IAJ's own analysis. 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.

[225] IP §678 — States should encourage and support external monitoring Core meaning The Protocol states that States should encourage and support monitoring by UN anti-torture and human-rights bodies (CAT, SPT, Special Rapporteur), regional mechanisms (e.g., CPT, ACHPR), and international and domestic human-rights organizations. Implications No treaty provision creates a general right of NGO monitoring; the Committee has, however, recommended that the United States authorize monitoring by non-governmental organizations in detention settings (CAT/C/USA/CO/3-5, para. 21(h)), and the IAJ treats external monitoring as part of the compliance ecosystem the Protocol describes.

[226] IP §679 — Whistle-blower protection Core meaning The Protocol states that States should ensure that whistle-blower protection policies cover medico-legal and health personnel who report findings, and should ensure the protection of witnesses and of any official or individual who reports torture. The IAJ determines that protection of complainants and witnesses against ill-treatment or intimidation is required by UNCAT Article 13. Officials who fail to report torture must be sanctioned where confidential channels of reporting exist. 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.

[227] 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 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.

[228] IP §681 says that States should provide foreign assistance for implementation of the Istanbul Protocol on the basis of support for development, the rule of law, security, cooperation, democratization and nation-building; the IAJ characterizes this as a duty of solidarity rather than 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

- Where the State has not implemented the Istanbul Protocol's training standards as the Committee recommended in 2014 (CAT/C/USA/CO/3-5, para. 28), civil society (e.g. the IAJ) may act without waiting for the State (IP §§682–683); the IAJ's determination that civil society should act independently does not depend on a broader Committee finding[229][230]

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.

IP §**682 states that civil society often plays the most critical role in facilitating implementation of the Istanbul Protocol, and reports a survey of 220 stakeholders in 30 countries on the uses to which the Protocol is put**. IP §683 states that States can and should encourage and support civil society, while civil-society actors should not rely solely on State initiatives. The IAJ independently determines that civil society must build capacity and act

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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.

[229] 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: in the IAJ's interpretation, §682 supports civil society's central role; its survey reports widespread uses of the Protocol rather than proving universal indispensability.

[230] IP §683 — Civil society should not rely only on the State. The Protocol states that States can and should support civil society, but that members of civil society should not rely only on State initiatives to take independent remedial action. The IAJ adopts this recommendation as its own practice: it builds independent capacity and acts 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.

autonomously where State support is absent or obstructive. The IRCT confirms the essential role played by civil society.[231]

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.

[231] 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.

Under FRE 702 (as amended in 2023), the proponent must show that the testimony more likely than not rests on sufficient facts and reliable methods, reliably applied. Courts may consider the Daubert and Kumho factors below; not every factor applies to every method:

- **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.
- **Known or Potential 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, supporting reliability requires moving from simple temporal correlation to a causation synthesis. IAJ methods are structured professional judgment; they have no established error rate, and admissibility is decided by the court. This includes:

- Documenting the plausible physiological pathway (e.g., HPA axis activation) and the case evidence for it.
- Conducting a differential diagnosis to consider and weigh 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 requiring the core features of PTSD plus disturbances in self-organization, typically following prolonged or repeated trauma.
- 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
  IAJ doctrinal proposal: physical deterioration or injury produced, in a susceptible person, through psychological stress mechanisms following institutional conduct, without physical contact. Intent and legal characterization are assessed separately.
- Eighth Amendment
  U.S. Constitutional amendment prohibiting cruel and unusual punishment.
- Enduring Personality Change After Catastrophic Experience (EPCACE)
  Historical ICD-10 category F62.0 (Enduring Personality Change After Catastrophic Experience); not a current ICD-11 diagnosis. Its clinical descriptors may inform retrospective documentation but neither EPCACE nor enduring personality change is required for recognition or investigation of torture or CIDT.
- 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
  IAJ descriptive construct for profound disruption in coping, identity, autonomy or functioning; not a diagnosis or threshold.
- 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 a listed purpose or any reason based on discrimination, by or with the consent or acquiescence of a public official (UNCAT Art. 1).
- 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

APPENDIX X

Ecosystem Mapping Record (Module 8) — fillable instrument

Part 1 — Matter. Control number; person(s) concerned (identified or anonymized as required); the conduct or gap investigated; period; investigator; date of record; exposure log (what the investigator had read before beginning, in order).

Part 2 — Actors. For each actor: name or designation; type (institution, official, private actor with de facto control); authority over the matter and its source (rule, order, contract, practice); decisions made, declined or deferred, with dates; rule applied; record location and controller; dependencies on other actors' decisions; whether the actor is under investigation.

Actor (name/designation; type)	Authority over the matter and its source	Decisions made / declined / deferred (dates)	Rule applied; record location and controller	Dependency on other actors	Under investigation? (Y/N)

Part 3 — Protective functions. For each of prevention, investigation, accountability and remedy: mechanism(s) available in principle; accessibility to the person and the basis for that finding; whether used, when and by whom; what the mechanism did; gap classification (a)–(d) with evidence; structural or individual, with basis.

Function (prevention / investigation / accountability / remedy)	Mechanism(s) available in principle	Accessible to the person? (basis)	Used, or duty to act without request? (dates; by whom)	What the mechanism did; evidence reference	Gap classification (a)–(d); structural or individual (basis)

Part 4 — Chronology across institutions. Dated sequence of decisions, gaps and consequences, each with source; health consequences cross-referenced to the Module 3 evaluation and medical record.

Date	Institutional decision, gap or event (actor)	Consequence (evidence reference)	Clinical cross-reference (Module 3 / medical record)

Part 5 — Affected persons. Each person; relationship to the matter; harm; evidence; consent status for use of their information.

Person (identified or anonymized)	Relationship to the matter	Harm	Evidence reference	Consent status

Part 6 — Alternatives. Each alternative stated; evidence for and against; result (excluded / less consistent / unresolved) with reasons.

Alternative hypothesis	Evidence for	Evidence against	Result (excluded / less consistent / unresolved)	Reasons; uncertainty

Part 7 — Control, notice, persistence. By actor: control (authority and decisions); notice (what, when, how, proof of receipt); persistence (continuation after notice; recurrence; corrective steps).

Actor	Control: authority and decisions	Notice: what, when, how	Proof of receipt (reference)	Persistence: continuation after notice; recurrence	Corrective steps and outcome

Part 8 — Bias controls. Working hypothesis and alternatives as first written, with date; disconfirmation log; roles and their separation; blind reviewer's statement; selection and population statement; declaration of interests.

Control	Record (hypotheses as first written and dated; disconfirmation log; roles; blind review status or exception; selection statement; declaration of interests)	Responsible person	Evidence reference

Part 9 — Records not obtained. Each record sought and not obtained; from whom; reason given; effect on the findings.

Record sought	From whom; date of request	Reason given for non-production	Effect on the findings

Part 10 — Directorate determinations. Each determination, the elements found, the evidence for each element, the status disclosure, and the determinations declined.

Determination (or determination declined)	Elements found	Evidence for each element (reference)	Status disclosure	Uncertainty and limits

INDEX

A

Aggravated Suppression — Module 1

Amicus curiae (Texas Supreme Court) — Preface; Module 1

B

Battery Without Touching — Module 4

Biological Assault (physiological harm pathway) — Module 4

C

CAT Committee (Committee Against Torture) — Module 1

CAT/C/USA/CO/3-5 — Module 1

CIRF (Clinician's Incident Report Form) — Module 6; Appendices H–I

CRPD (Convention on Rights of Persons with Disabilities) — Module 3; Appendix E

Causation synthesis — Module 4

Children — Module 3

- developmental considerations — Module 3
- evaluation — Module 3

Chronological mapping — Module 4

Consistency analysis (Istanbul Protocol) — Module 3

Credibility assessment — Module 3

- IP consistency framework — Module 3

Cultural humility — Module 3; Appendix P

D

Daubert standard — Module 1; Appendix V

Decompensation — Module 4

Harmonizing the Architecture of Disability Rights: The CRPD, federal disability statutes, the constitutional foundation of non-derogable disability rights, courts as disability-causing actors, and European Hate Crime frameworks — Module 1

Disability — Module 3

- ADA — Module 3; Appendix E
- court-caused harm — Module 3

Dissociation — Module 4; Appendix O

Dual-Track Rule — Module 1

Track 1 (UNCAT standard) — Module 1

E

Elderly persons — Module 3

Equivalence (UNCAT compliance standard) — Module 1

Evaluator levels — Module 1 (Part D); Module 6

Level 1 — Module 1 (Part D); Module 6

Level 2 — Module 1 (Part D); Module 6

Level 3 — Module 1 (Part D); Module 6

Level 4 — Module 1 (Part D); Module 6

Exhaustion of domestic remedies — Module 1

Expert witness qualification — Module 1

F

FRE 702 — Module 1; Appendix V

Feigning (response validity) — Module 3

Forum nullus — Module 1

legal character (legal, not clinical conclusion) — Module 1

H

Harvard Trauma Questionnaire (HTQ) — Module 3; Appendix A (IAJ Symptom-to-Instrument Selection Guide)

I

IAJ Clinical Attribution Framework — Module 4

Forensic Probability Standard — Module 4 (former name of the IAJ Clinical Attribution Framework)

IAJ Framework Reference Architecture — Module 1

Idioms of distress — Module 3

Immigration detention — Module 3

Istanbul Protocol — Modules 1–3

2022 version — Modules 1–3

Intent analysis — Module 2

J

Jus cogens — Module 1

torture prohibition — Module 1

L

LGBTQI+ persons — Module 3

Licensure — Module 1

  state requirements — Module 1

UNCAT and jus cogens: A contemporary perspective. The Evolved Peremptory Prohibition of Torture Beyond the Custodial Paradigm and Its Application to Judicial Conduct and the Immunities That Shield It — Module 1

M

Malingering — Module 3

Mandatory cultural documentation requirement — Preface; Appendices P–Q

Medellín v. Texas — Module 1

Mental status examination — Module 3

Methodological Note (required report section) — Preface; Appendix Q

N

Neuropsychological assessment — Module 3

P

PCL-5 (PTSD Checklist) — Module 4; Appendix C

  embedded validity indices — Module 3

PSYPACT (interstate licensure compact) — Module 1

Persons with disabilities — Module 3; Appendix E

PTSD (Post-Traumatic Stress Disorder) — Module 3

  complex (C-PTSD) — Module 3

R

RUDs (Reservations, Understandings, Declarations) — Module 1

Report writing standards — Module 5

Response validity — Module 3

S

SIRS-2 (Structured Interview of Reported Symptoms) — Module 3; Appendix C

Supervisory Falsification Pass (SFP) — Module 1

  Daubert considerations — Module 1

Systemic Harm Mapping Tool — Module 4

Systemic torture — Module 2

T

TOMM (Test of Memory Malingering) — Module 3

Two legal planes (international vs. domestic) — Module 1

plane (a) international obligation — Module 1

plane (b) domestic enforceability — Module 1

U

UNCAT — Module 1

Article 1 (Torture definition) — Module 1

Article 16 (CIDT) — Module 1

Universal Duty to Document — Module 6

V

VCLT Article 53 (jus cogens) — Module 1

Vienna Convention on the Law of Treaties — Module 1

W

Witness Obligation — Module 6

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This Standard (v1.6) supersedes all prior versions on clinical methodology and documentation standards. Companion documents provide the legal and normative framework. Where any prior version conflicts with v1.6, v1.6 controls.

Version History

Version	Date	Author(s)	Summary of Changes
v1.6	2026-11-11	IAJ	severe suffering is made independent of any diagnosis, opens Level 3 evaluation and report authorship to any licensed clinician with demonstrated trauma competence, and establishes the Non-Obstruction Rule under which Level 4 review is preferred but never a prerequisite, with the IAJ directorate rather than the clinician making the UNCAT Article 1/16 characterization and able to report credible allegations without specialist review. It adds Module 8, the Rights-Controlling Ecosystem Methodology for investigating how institutions interact to produce or fail to prevent torture and CIDT, with mandatory bias controls and a fillable Ecosystem Mapping Record, together with negative and mixed-evidence case vignettes. Every IAJ doctrine is now disclosed as an IAJ proposal with its treaty basis stated separately, Protocol recommendations are quoted in their own modality, Article 16 negligence is grounded in the Committee's Černáková decision, and all IAJ publications are cited by their exact published titles.
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

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