



(Updated 22/10/2026)

information on common topics is available in this document:

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1. Psychological diagnoses and symptoms

ICD-11 Post-traumatic stress disorder (PTSD)¹ is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following: 1) re-experiencing the traumatic event, or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

ICD-11 Complex PTSD²: In complex PTSD, diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Dissociation³: ‘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

¹ PTSD. <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fid%2fentity%2f2070699808>

² **Complex PTSD.** <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fcid%2fentity%2f585833559>

³ **Dissociation.** The Istanbul Protocol (2022) paragraph 506.

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. Peri-traumatic 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.'

Somatisation⁴. 'Somatisation refers to physical symptoms caused wholly or partly by psychological factors: Pain, headaches or other physical complaints, with or without objective physical findings, are common problems among torture survivors. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to the physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches. Headaches are very common among torture survivors and may be due to torture-inflicted injury (head and neck injuries are a common part of torture), as well as being caused or exacerbated by poor sleep patterns, stress and anxiety.'

Developmental delay⁵: Asylum seeking young people are at particular risk of developmental delay. They are likely to have had experiences which can impair development. These might include attachment disruption and trauma as well as limited schooling and play opportunities in their home country and during the journey to the UK. Their ability to benefit from school in the UK may be reduced due to issues such as language, culture and discrimination. They may be experiencing mental health problems such as PTSD, depression and anxiety, which can be associated with additional effects on learning and development. (This can happen through impairments in concentration and memory, intrusive memories, difficulty understanding instructions and impaired play etc). They may have a history of poor nutrition, which may independently affect development. Because of these different factors, cognitive abilities may change over time, and may get either better or worse. Identifying intellectual disability, particularly lesser degrees of disability, is likely to be particularly difficult as documentary and third party evidence are likely to be unavailable.

ICD-11 Depressive disorders⁶: Depressive disorders are characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural or neurovegetative symptoms that significantly affect the individual's ability to function. Single episode depressive disorder is characterized by the presence or history of one depressive episode when there is no history of prior depressive episodes. A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. Recurrent depressive disorder is characterized by a history or at least two depressive episodes separated by at least several months without significant mood disturbance.

⁴ **Somatisation**. The Istanbul Protocol (2022) paragraph 507.

⁵ **Developmental delay**. Schutzenhofer, E. (2018) Evaluating the Effects of Refugee Experiences on Cognitive and Social-Emotional Development in Refugee Children in the Primary Care Setting. Accessed on line 4.1.20 at: https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2018/08/Schutzenhofer_IFMCPProjectFinal080818.pdf .

Kaplan, I., Stolk, Y., Valibhoy, M., Tucker, A., Baker, J. (2016) Cognitive assessment of refugee children: Effects of trauma and new language acquisition. *Transcult Psychiatry*. 53(1): 81–109.]

⁶ **Depressive disorders**. <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2f%2fentity%2f1563440232>

2. Suicide Risk

Suicide risk assessment is best conducted by structured professional judgement⁷, that is, by combining clinical assessment and formulation with available evidence about suicide risk factors. Current evidence does not support the use of standalone risk assessment tools.

Applying structured professional judgement involves weighing risk factors as well as any protective factors, considering which are most important and developing a risk management plan, which needs to be reviewed as dynamic and future factors change. In considering future stress, attention needs to be given to predictable future developments which may precipitate or aggravate suicidal ideation.

Known suicide risk factors⁸ include those which are fixed ('static') or relatively fixed ('stable') including : family history of suicide; childhood adversity; older age; male gender and unmarried status; history of previous self-harm; serious previous suicidality; history of mental disorder; substance use disorder; personality disorder or certain personality traits; and previous hospitalisation. In addition, there are 'dynamic' factors which change over time, such as: suicidal ideation, communication and intent; hopelessness; current psychological symptoms; treatment adherence; current substance use; psychiatric admission and discharge; psychosocial stress; and problem-solving deficits. Risk also depends upon contingencies such as access to preferred method of suicide; future service contact; future response to drug treatment and psychosocial intervention; and future stress.

People seeking asylum are at increased risk of suicide⁹. They have increased rates of many of the risk factors for suicide including: higher rates of PTSD, depression and other mental health conditions; social isolation; experiences of trauma, loss, bereavement, torture and armed conflict; unemployment; alienation; poverty; low levels of social support; insecure immigration status; high levels of distress; low quality of life; barriers to using health care. They are also at risk of events that may lead to sudden loss of hope, such as negative asylum decisions, abrupt moves and loss of support networks, and threat of removal. The asylum process itself is thought to contribute to increased risk. People detained in Immigration Removal Centres are at particularly high risk.

GP records. People may be at increased risk of suicide without this being apparent from their GP record (see Section 3 'Interpreting the GP record') .

3. Interpreting the GP record

When using GP records as evidence of past health and healthcare, it is important to take into account their nature and limitations, and the variation between GP practices. A GP record is created for the purposes of recording health and health interventions, and for clinicians and others to communicate with one another. It is not written with a view to being comprehensively relied upon in medico-legal situations. When reviewing a GP record the following points are relevant:

- **Attendance.** Patients with significant health problems will not necessarily be attending their GP practice. Reasons include: barriers to registering with a GP; cultural differences in health service use; not being aware of what can be offered; fearfulness and lack of trust; difficulty getting appointments including

⁷ **Assessment of suicide risk.** Saab, M.M., Murphy, M., Meehan, E. et al (2021) Suicide and Self-Harm Risk Assessment: A Systematic Review of Prospective Research, Archives of Suicide Research, DOI: [10.1080/13811118.2021.1938321](https://doi.org/10.1080/13811118.2021.1938321)

⁸ **Suicide risk factors.** Bouch, J., & Marshall, J. (2005). Suicide risk: Structured professional judgement. *Advances in Psychiatric Treatment*, 11(2), 84-91. doi:10.1192/apt.11.2.84.

⁹ **Suicide in people seeking asylum.** (Wetherall, K. (2024) Are asylum seekers in the UK at increased risk of suicide? <https://suicideresearch.info/2024/06/25/are-asylum-seekers-in-the-uk-at-increased-risk-of-suicide/>).

through lack of assertiveness and language barriers. Patients' attempts to register or to get an appointment are not generally recorded, so apparent lack of contact with primary care is not necessarily because the patient has not tried to get an appointment. In addition, clinicians differ in the frequency with which they offer follow-up appointments.

- **Workload pressures** are now very intense in general practice, and have a bearing on availability of support.
- **Gaps in GP records.** There are many reasons why there may be gaps in a GP record or an apparent delay in registration, including all of the reasons for non-attendance listed above. A GP record only starts when someone arrives in the UK or later and will only cover healthcare from that point. It is not rare for patients to have more than one NHS number and set of records due to mistakes with the spelling of names and other personal details. If this comes to light the records can be merged, but otherwise it results in a gap in the record.
- **Contributors.** A GP record contains entries made by many different members of the primary care team such as nurses and receptionists. They may also contain records from other services which have been imported into the GP record.
- **Interpreting.** Use of interpreters is irregularly recorded in GP records, so it is often not possible to know whether an interpreter has been used. The quality of interpreting in the NHS cannot be guaranteed. Most is now via telephone interpreting services. Regrettably some consultations have to be conducted without interpreters. As a consequence, information available may be limited, and/or errors may be introduced.
- **Accuracy.** Whilst every effort is taken to ensure accuracy, GP records can be inaccurate and imprecise, especially when interpreters are not used, and there are time pressures. It may not be possible to determine if a patient was present when an entry about them was made. Records may contain unclear abbreviations. There may be typing errors. Misunderstandings and interpreting mistakes are not uncommon. Patients do not get any opportunity to correct factual errors.
- **Disclosure.** A significant proportion of patients do not disclose details of past trauma unless asked directly. Clinicians do not necessarily ask directly about trauma. Even when asked, some patients may still take months to disclose full details. Some will never disclose everything that has happened to them. Some even deny that anything adverse has happened because they are not comfortable, at that point in time, with a disclosure.
- **Mental health care.** The absence of appointments, medications and referrals for mental health need does not mean there is no mental health need. There are cultural differences in readiness to disclose mental health problems. GP practices and individual clinicians vary in their interest, skills and confidence around mental health, in their readiness to enquire about it and to screen for depression and PTSD, in the amount of mental health prescribing they are happy with, and in their readiness to make referrals. Not many GPs have training in trauma and asylum related issues. In many areas it is also very difficult to get access to counselling and therapy for people seeking asylum because of a lack of resources in mental health services. Patients are often treated by default with medications for sleep and depression/anxiety. Non-adherence to medication prescribed, in the absence of other support, does not indicate that a person is free of mental health difficulties; if people are prescribed medications without adequate engagement and follow up, it is common for them to discontinue the medication and stop seeking help.
- **Continuity of care.** A clinician who has seen a patient a number of times is more likely to ask questions about trauma and mental health, but often continuity of care is not available.
- **Examinations of injuries and scars relating to ill-treatment.** If there have been any examinations made in general practice these are not likely to be comprehensive. Many GPs will be unaware of the significance of physical injuries in asylum claims and even if they are aware of scarring may not record this.
- **GP records and suicide risk.** The recording of suicide risk assessment in GP records is variable. Comments such as 'not suicidal', 'no suicide risk', 'no thoughts of deliberate self-harm' are commonly made. GP suicide risk assessments usually apply to the particular moment in time, and to acute suicidal ideation, rather than to chronic, background risks due to life experience, social circumstances, and personality style. There can be sudden changes in risk level in response to changes in a person's circumstances. Presence or absence of acute suicidal ideation at a particular moment is only one

component of overall suicide risk assessment, and cannot be taken as a measure of risk at a different point in time.

- **Organisation of records.** GP records may be challenging to read without missing information, especially for those unfamiliar with using them. Print-outs may take from several minutes to several hours to read. They may contain large amounts of information such as blood test results, templated entries and appointment reminders. They often use abbreviations. Often the context of entries is not apparent. Occasionally important information is recorded in free text and may be easy to miss amongst all the formulaic material. Occasionally correspondence that contains key information is not included in the print-out supplied.

4. Psychological factors affecting how people communicate

Difficulties in giving an account

People seeking asylum sometimes have difficulty giving an account of experiences relevant to their asylum claim. They may give accounts that are vague or lacking in detail; they may say different things at different times; they may give an account that seem confusing or contradictory. There are multiple possible scientific reasons for this:

- Human autobiographical memory is not always reliable, especially for dates, chronology and detail.
- People's age, personality, early attachments, social and cultural background, education, intellect all affect what they recall and how they talk about this. For example, these factors affect what detail the person offers, whether they show the 'expected' range of emotion while doing so, and when they are willing to talk about an issue.
- Memories of frightening, distressing experiences may be laid down and recalled differently from other memories.
- Some people may find it particularly difficult to talk about events that they feel shame about, for example sexual abuse, sexuality and gender identity. Cross-cultural differences are very significant. They may disclose such things only after several meetings, or not at all. Sometimes people use coded language, or the body language gives clues to problems with disclosure.
- Fear of consequences may prevent disclosure of certain information. People may be aware that talking about a traumatic experience will cause them distress; they may not trust the interviewer; they may have been threatened by traffickers; or they may have been badly advised by well-meaning friends.
- The interview/assessment setting and approach is crucial. The degree of rapport and trust established, the manner of questioning, the presence of interpreters etc. will all influence the ease with which an individual feels able to talk about difficult experiences. (See 'What can help?')
- A person's state of mind at the time of an interview affects what they are able to recall, what they feel able to speak about, and how clearly they do so. For example, anxiety, dissociation¹⁰ or simple tiredness may affect someone's ability to focus on questions or recall information.
- Those with mental health issues or a history of trauma are likely to have particular difficulties giving their account. For example, depression, PTSD (post-traumatic stress disorder) and individual post-traumatic symptoms such as tiredness, flashbacks and irritability may all affect memory, attention and concentration. Mild intellectual disability and the after-effects of previous head injury may be difficult to spot but affect attention, concentration, memory and reasoning.
- In children and young people, the ability to report life experiences depends on development and may not be fully developed until the early twenties.

¹⁰ **Dissociation** (see footnote 3) is one of the ways the mind copes with too much stress and painful memories. An individual experiencing dissociation can appear to be disconnected from themselves and their immediate surroundings. They typically look as though their thoughts are elsewhere, and they may appear unaware of what is going on around them or as if they don't hear what is said to them.

Psychological issues can pose challenges for interviewers

All of the above interviewee issues make it easy for interviewers to reach conclusions that may not be correct. In addition, interviewers' own social and cultural background may mean their expectations may unwittingly mislead them about verbal and non-verbal communications, for example avoidance of eye contact may be mistakenly seen as a sign either of disrespect or of insincerity. Interviewers' emotional responses may also play a significant part, for example it will be harder for an interviewer to think clearly when an interviewee is very distressed, suspicious, angry or rude.

Talking about upsetting experiences may affect people's mental health

Being questioned about upsetting or frightening experiences can lead to people becoming distressed, anxious, angry, unable to concentrate, or preoccupied by the past. It can trigger flashbacks, or other forms of dissociation where the person is no longer fully aware of what they are being asked, or what they are replying. An increase in symptoms provoked by an interview/assessment can last hours, days, or much longer than this.

These kinds of responses are particularly likely when people have been coping with frightening or distressing experiences by avoiding talking or thinking about these. Avoidance is a common coping strategy. It may be deliberate or involuntary, and in PTSD it is a diagnostic feature of the condition.

What can help enable people to give their account?

It is easy to miss opportunities to enable people to give their account clearly and fully. Measures worth considering include the following:

- Encouraging the person to travel to the appointment accompanied by a trusted person
- Appropriate choice of interviewer and interpreter, especially considering gender and ethnic background of both
- Limiting the number of people in the room
- Explaining carefully what will happen
- Creating an atmosphere of calm, security and respect
- Offering regular breaks
- Keeping questions simple and straightforward
- Allowing time for responses
- Avoiding an adversarial style of questioning, or treating the person as not credible
- Adapting the approach to the individual's age and developmental level
- Noticing when someone's attention is wandering, or they may be beginning to dissociate, and allowing time to recover
- Considering how the person will manage after the appointment.

Generally, a trauma-informed approach is likely to be helpful. The Helen Bamber Foundation guide 'The Trauma-informed code of conduct' provides more information¹¹.

5. Immigration detention

Research shows that immigration detention has a negative impact on mental health¹² including on PTSD, depression and mental health-related disability, and that these negative effects increase with the time in

¹¹**Trauma-informed care.** <https://www.helenbamber.org/resources/best-practiseguidelines/trauma-informed-code-conduct-ticc>

¹²**Immigration detention.** von Werthern, M., Robjant, Chui K et al. (2018) The impact of immigration detention on mental health: a systematic review: <https://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/s12888-018-1945-y>; Steel, Z et al 2006, Impact of immigration detention and temporary

detention, and persist beyond the period of detention. Detention is likely to serve as a reminder of prior traumatic experiences, to increase fear of imminent return, and to disrupt social and professional support, all of which are likely to worsen mental health. PTSD cannot be effectively treated in detention, and appropriate treatment is unlikely to be available in such settings. Those with pre-existing vulnerabilities such as mental health issues or torture are at particular risk of harm as a result of their detention and in most cases there is a likely to be a significant deterioration in mental health.

6. The Istanbul Protocol¹³

The Istanbul Protocol (2022) provides guidance on clinical assessment of reported ill-treatment including torture, and other cruel, inhuman or degrading treatment. It is often referenced in medico-legal reports in asylum claims in the UK. It requires clinicians to provide an *‘interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment’*¹⁴. *‘In cases where the account of torture is, or is likely to be, the subject of challenge...the Istanbul Protocol is particularly instructive. ...’*¹⁵.

The guidelines provided *‘are not intended to be a fixed prescription but should be applied taking into account the purpose of the evaluation and after an assessment of available resources’*¹⁶.

TID medico-legal report writers are trained to use the Istanbul Protocol and kept up to date with developments. TID is ending medico-legal work at the end of 2026 to concentrate on health assessments and routine enquiry.

TID health assessors are trained to understand the Istanbul Protocol but do not provide interpretation on the probable relationship between findings and the torture account. They restrict their comments to health matters, risks and ability to communicate. Interpretation would require a level of time, funding and resources which is not available.

Level of consistency between reported ill treatment and clinical findings.

*‘First and foremost, the reliability of clinical evidence is reflected in the level of consistency between specific allegations of abuse and the documentation of physical and psychological findings’,*¹⁷

*The Istanbul Protocol*¹⁸ states that at a minimum clinical assessment should include an assessment of the level of consistency between all clinical evaluation findings and the allegations of torture or ill-treatment. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed.

The levels of consistency for such correlations are commonly expressed as follows:

- (a) *“Not consistent with”*: the finding could not have been caused by the alleged torture or ill-treatment;
- (b) *“Consistent with”*: the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes;

protection on the mental health of refugees, British Journal of Psychiatry <https://doi.org/10.1192/bjp.bp.104.007864>; Royal College of Psychiatrists (2021) Position statement: Detention of people with mental disorders in immigration removal centres. Online at [position-statement-ps02-21---detention-of-people-with-mental-disorders-in-immigration-removal-centres---2021.pdf](https://www.rcpsych.ac.uk/position-statement-ps02-21---detention-of-people-with-mental-disorders-in-immigration-removal-centres---2021.pdf) (rcpsych.ac.uk)

¹³ **The Istanbul Protocol**: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Professional training series No. 8 / Rev 2, United Nations (2022). [Istanbul-Protocol_Rev2_EN.pdf \(ohchr.org\)](#).

¹⁴ **Istanbul protocol requirements of clinicians**. The Istanbul Protocol, paragraphs 379.

¹⁵ **Istanbul Protocol useful where account is challenged**. SA (Somalia) v. Secretary of State for the Home Department [2006] EWCA Civ 1302. Sir Mark Potter, P, paragraph 29: SA (Somalia) v SSHD [2006] EWCA Civ 1302 ([refworld.org](https://www.refworld.org/)).

¹⁶ **Istanbul Protocol not a fixed prescription**. [The Istanbul Protocol \(2022\)Annex IV.](#)

¹⁷ **Reliability of clinical evidence**. Istanbul Protocol (2022) para 350.

¹⁸ **Consistency between ill treatment and clinical findings**. The Istanbul Protocol, paragraphs 379-380.

- (c) *“Highly consistent with”*: the finding could have been caused by the alleged torture or ill-treatment and there are few other possible causes;
- (d) *“Typical of”*: the finding is usually observed with this type of alleged torture or ill-treatment, but there are other possible causes;
- (e) *“Diagnostic of”*: the finding could not have been caused in any way other than that described.’

Physical findings *‘The degree of consistency between the description of physical injuries and reports of subsequent acute symptoms, the healing process (taking into consideration relevant mitigating factors) and chronic symptoms and disabilities may also support the internal consistency of the clinical findings.’¹⁹*

Psychological findings. The Istanbul Protocol contains detailed guidance about assessing psychological findings in relation to an account of ill-treatment. It states that *‘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 described²⁰.

‘Observations of congruency between an alleged victim’s observed affect (emotional state) during the interview and the content of the evaluation, for example, psychological distress in relating painful experiences, may reflect internal consistency of the clinical findings, bearing in mind that appropriate affect can vary widely due to an individual’s circumstances and coping mechanisms.’²¹

The Istanbul Protocol also identifies factors that may assist interpretation of psychological findings. *‘Clinicians who conduct evaluations of psychological evidence of torture or ill-treatment may consider a number of additional factors that may be relevant to the reliability of psychological findings – for example, the temporal relationship between the alleged abuse and onset of psychological symptoms as well as fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors. The individual meaning assigned to the alleged abuse in light of individuals’ psychosocial history may also be an indicator of internal consistency, as well as the congruency between individuals’ emotions (both reported and observed by the clinician) and their coping mechanisms. Some psychological symptoms of PTSD may refer specifically to the alleged abuse rather than other traumatic experiences. For example, intrusive recollections and nightmares or triggers for intrusive recollections, reliving experiences and avoidance thoughts and behaviour that refer to the alleged torture or ill-treatment are more likely to be caused by the experience of torture or ill-treatment rather than by other traumatic experiences.’²²*

The Istanbul Protocol²³ provides a breakdown of issues to be considered in reaching an opinion; *‘In order to interpret the psychological findings for the purpose of delivering an opinion on the possibility of torture [or ill treatment], the following important questions should be considered by the evaluator:’*

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

¹⁹ **Physical findings** Istanbul Protocol (2022) para 350.

²⁰ **Assessing consistency of psychological findings with reported ill-treatment.** The Istanbul Protocol (2022) para 54.

²¹ **Congruency,** Psychological Istanbul Protocol (2022) para 350.

²² **Interpreting psychological findings – additional indicators.** The Istanbul Protocol para 352

²³ **Interpreting psychological findings – questions to consider.** The Istanbul Protocol, Paragraph 540.

(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 [psychological] picture?

TID report writers consider all these issues when making their diagnoses, preparing their opinion and writing about prognosis.

Overall clinical findings. *‘Clinicians should formulate a clinical opinion on the possibility of torture or ill treatment based on all relevant clinical evidence...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.’²⁴*

It is important to note that the highest level of consistency of an individual finding often determines the level of consistency for all of the clinical evidence. ‘In some cases, the overall evaluation may report a higher level of consistency than each individual clinical finding, especially if there are many clinical findings that, when taken together, confirm the same conclusion.’²⁵

²⁴ **Overall clinical findings.** The Istanbul Protocol (2022) paragraph 546.

²⁵ **Determining overall level of consistency.** The Istanbul protocol (2022) paragraph 381.