The Important Role of an *Amicus* Brief on Cases of Torture, Abuse, and Injury

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This editorial expands on the *amicus* brief[1] filed by medical experts, including psychiatrists, in support of the petitioner, Encep Nurjaman, in the case before the U.S. Court of Appeals for the District of Columbia Circuit.[2] The case concerns allegations of torture and the use of torture-derived information in legal proceedings. Mr. Nurjaman has petitioned the U.S. Court of Appeals for the D.C. Circuit regarding his referral for trial before the Military Commissions in Guantánamo. He has asserted that the evidence against him was collected following torture and should be excluded. Mr. Nurjaman filed a Petition for a Writ of Mandamus before the U.S. Court of Appeals for the D.C. Circuit in October 2023. He requested that the Court of Appeals vacate the convening authority's order of January 2021 referring his case for trial before a military commission. He had been transferred to Guantánamo in 2006 and charged in 2017 for funding terrorist activities.

The brief argues that evidence obtained by torture is not admissible in pretrial commission proceedings. The *amici curiae*, consisting of professionals with expertise in the treatment of torture victims, present a comprehensive argument on the unique physical, psychological, and systemic harm caused by torture and its implications for the legal system. The *amici* argue that victims of torture exhibit unreliable memories and are compromised in sharing memories with counsel for assisting in their defense.[1]

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Victims of torture and survivors of severe trauma and stress share characteristics, symptoms, and impairments that commonly manifest in clinical presentations. Assessing defendants with evidence of severe trauma or torture for their competency to stand trial, capability for legal decision-making, and mental state during court proceedings presents significant challenges. This journal has published a series of articles on posttraumatic stress disorder (PTSD) and the implications for forensic psychiatry.[3–5] PTSD has factored into defenses of insanity, unconsciousness, self-defense, and diminished capacity. Questions and concerns over PTSD as a defense arise on how its characteristic hyperarousal affects mental state, memory, and disposition to impulsivity. Some courts have required the demonstration of a direct connection of PTSD to the offense.

I suggest that victims of torture stand out as exemplars for understanding survivors of severe trauma and stress in the practice of forensic psychiatry. Victims of torture and survivors of severe trauma and stress share symptoms, conditions, and illnesses that present special challenges to conducting a thorough evaluation of their impairments and functional capacities. I have evaluated dozens of victims of torture in many different countries subjected to extreme brutality and harsh, cruel, and inhumane treatment, including detainees in Guantánamo. I have observed that these victims developed and live with complex posttraumatic stress disorder (C-PTSD) for the duration of their lives.[6] Setting aside the illegality and inhumanity of torture, the *Nurjaman* case spotlights important concerns and challenges for the practice of forensic psychiatry. The manifestations of C-PTSD

from torture or severe and prolonged trauma and abuse adversely affect mental state for a lifetime.

Impact of Torture, Trauma, and Stress

The act of torture creates fear, emotional distress, and physical and neurological harm that affect mental well-being and inflict long-lasting adverse consequences on quality of life. The victims of torture detained in Guantánamo were subjected to "enhanced interrogation" programs designed to psychologically "dislocate" the detainee, maximize feelings of vulnerability and helplessness, and reduce or eliminate the will to resist.[7] The detainees were typically subjected to an escalating series of brutal and harsh tactics of social isolation, food deprivation, sleep disruption, and facial slaps, building up to dousing with cold water, water boarding, and walling (throwing a detainee against a wall up to 20-30 times). They developed symptoms and impairments because of the cumulative impact of the tactics used on them.

The picture of fear, emotional distress, and physical and neurological harm affecting mental well-being is not unique to torture. It is observed in other patterns of adverse childhood events, combat exposure, and enduring conflicts. Adverse childhood events (ACEs) span histories of childhood physical and sexual abuse, economic deprivation, exposure to domestic violence, parental divorce or separation, parental substance use problems, hospitalization as a child, and apprehension by a child protection service. Evidence of childhood sexual abuse, physical abuse, and neglect contribute to 20 to 30 percent of serious mental illnesses and suicidal behavior, as well as the likelihood of persistence of the disorders and disturbances.[8] Military veterans applying for disability and health care commonly present with a cluster of symptoms and impairments, including PTSD, acute depression, problematic substance use, traumatic brain injury, amputations, and spinal cord injuries.[9] Civilian victims of war zones endure harsh and brutal living conditions over many years.

Symptoms and Impairments

Victims of severe trauma and stress, including torture, have typically experienced multiple injuries, illnesses, and conditions that manifest as a syndrome of C-PTSD. The syndrome of C-PTSD includes the core PTSD symptoms of hypervigilance, irritability, and dissociation,[10] plus additional symptom clusters including disturbances in self-organization, affective dysregulation, negative self-concept, and disturbances in relationships.[11] The array of comorbid illnesses and injuries commonly occurring with C-PTSD include postconcussion syndrome, chronic pain, sleep disturbances, metabolic diseases, and infections. Individuals with C-PTSD manifest alterations of brain functioning and impairments that impede the disposition and ability to trust people and maintain social relationships.[12] Signs and symptoms exhibited with C-PTSD include impairments in cognitive processing and memory. The processing of memories from trauma differs from "regular" negative or sad memories in the processing of the narratives.[13] The mechanisms of processing memories in PTSD are complex and engage the neurocircuitry of the hippocampus and amygdala. The *amicus* brief argues that "(t)orture. . . makes its victims' memories unreliable, obstructs their ability to articulate the memories that remain, and otherwise causes psychological disorders that directly disturb an accused's cognition, motivation and ability to engage in his own defense" (Ref. 1, p 27). Alterations in memory processing have been observed analogously with extreme stress and trauma as in the unique circumstances of torture. Observations of alterations in memory have been associated with activity in the basolateral amygdala that affects memory consolidation and neural plasticity.[14]

Commonly, victims of trauma and serious injury incur traumatic brain injuries and experience postconcussion syndrome that aggravates impairments in memory, concentration, and attention. Significant numbers of victims of military traumatic brain injury demonstrate moderate to severe cognitive impairment and are diagnosed with PTSD and depression.[15] The incidence of new-onset mental health conditions and suicide is higher among individuals with military-related brain injury.[16] The findings of traumatic brain injury are not unique to military personnel and veterans and require clinical consideration in cases of trauma, serious injury, head injury, and severe stress.

Limitations and Flaws in Diagnosing

The diagnostic criteria for PTSD as stipulated in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[10] have expanded the amorphous nature of the classification to 636,120 combinations.[17] Multiple and varied stressors contribute to the symptoms of PTSD.[18] The synergistic and cumulative effects of severe trauma and stress alter mental status and influence assessments of abilities and capabilities. The impacts of severe trauma and stress extend

beyond making the diagnosis and listing the symptoms. Research has demonstrated that clinical presentations differ significantly across cohorts, even though scores on standardized instruments and questionnaires aggregate them.[19] The DSM-based criteria for diagnostic entities introduce artifacts that include individuals with remarkably different symptom profiles that confound classifications for evaluation of treatment effects and research. Mental illnesses lack discrete etiologies and pathology that commonly occur across medical and surgical diseases. Few, if any, mental illnesses have identifiable biomarkers that confirm diagnosis and inform treatment options. Moreover, the processes of clinical decision-making are complex and confounded by time constraints, values, emotions, uncertainty, and individual judgment. Even though research across the mental health field has attempted to work around complex and subjective variables by using standardized questionnaires and instruments, making the diagnosis does not adequately explain either the cause or clinical presentation seen by the examiner. Accordingly, comprehensive forensic evaluations of victims of severe trauma and stress, including torture, entail detailed elaboration and explanations of the symptoms and impairments that influence mental state, thinking, and behavior.

Capacity

The criteria for decisional capacity standards have been challenged in the past few years as jurisdictions are considering statutory changes.[20] For decades, the field has adhered to guidelines based on fundamental skills of clear communication, exhibiting consistent choice, appreciating the situation, understanding the risks and benefits of choices and options, and engaging in rational deliberation. The debate over decision-making capacity for health care has focused on values and acceptance of science as well as loss of ability with cognitive impairment. The guidance for assessing diminished capacity has focused on the capacity to interpret the reality of the circumstances and having the state of mind to act knowingly and purposefully toward an intent.[21]

A history of trauma, stress, and injury undermines the ability of victims to fully participate as a party in their defense. Victims of trauma, stress, and injuries experience severe physical and psychological impairments and exhibit deteriorations in cognitive, emotional, and behavioral functions that can endure for a lifetime.[22] PTSD is not curable, and most people who experience it must learn to cope with and manage symptoms and impairments.

The effects of C-PTSD interfere with effective representation by counsel. Clients with C-PTSD are compromised in their ability to engage in clear communication, exhibit consistent choice, appreciate their situation, understand the risks and benefits of choices and options, and conduct rational deliberation. Impairments in short- and long-term memory compromise the ability to provide reliable information and explain vital and necessary details to counsel. The hallmark signs and symptoms of intrusive memories, flashbacks, and dissociation are attributed to the impact of the stress and trauma on the mind and body. The experience of chronic, extreme stress moreover degrades mental capacity and functioning in circumstances that trigger memories of the trauma and stresses. The events, as well as memories of trauma and extreme stress, generate heightened excitability or arousal in the brain and body and interfere with conversation, recall of events and surroundings, and rational decision-making. Extreme stress and trauma imprint memories and alert victims that current or future events will be very unpleasant and remind victims of experiencing a lack of control.[23] I have observed clients dissociate when discussing the details of their case with attorneys and yet appear fully clear and communicative at other times. Such shifts in mental state lead to confusion in communication between client and attorney and compromise the capacity of the client to effectively disclose and explain vital information.

Impairments in cognitive functioning and executive processing impair and limit meaningful understanding of the legal proceedings against clients. Dissociation, disturbances in self-organization, and anxiety compromise the capacity to understand complex and nuanced legal proceedings. The signs and symptoms of C-PTSD are episodic and vary in duration and intensity. Clients can appear clear-thinking and attentive to the details of complex problems at times, then exhibit obvious limitations and shortcomings in executive processing. They are unable to appreciate the breadth and depth of their situation, understand the risks and benefits of choices and options, or engage in rational deliberation. It is often confounding that the lapses and limitations in executive processing are unpredictable and not easily obvious to observers. Nonetheless, attorneys discern over time that their clients do not grasp or comprehend the questions that are most relevant to their cases and that inform important decisions.

Criminal Responsibility

Guina *et al.*[4] assessed the incidence of posttraumatic stress disorder in defendants adjudicated not guilty by reason of insanity (NGRI). They found a prevalence of 86 percent of lifetime trauma among acquitees. They noted that patients with severe mental illness had lifetime histories of trauma as high as 91 to 98 percent and rates of lifetime PTSD from 7 to 42 percent. This contrasted to trauma experience and PTSD in the general population that was estimated at 51 percent and 7.8 percent, respectively. Hiromoto *et al.*[5] contend that the courts display a high level of skepticism for various reasons, including that defendants may be feigning the diagnosis of PTSD to escape punishment. They underscore the importance of discerning the style of communication in cases of PTSD, assessing the impact and severity of symptoms, and gathering information on adequacy and duration of treatments.

Implications

Severe trauma, stress, and injury have pervasive and pernicious impacts on the justice system. The long-term consequences and impacts on mental state are not unique to torture and manifest in other circumstances that impose severe stress and long-term injuries that degrade mental capacity and manifest as complex posttraumatic stress disorder. Impairments and limitations can be attributed to the consequences and symptoms of trauma, stress, serious injury, and comorbid illnesses and conditions. The capacity to engage effectively in analysis, understanding, and discussion of evidence are diminished and compromised by dysfunctions in cognitive processing, memory, and related mental functioning. The *amicus* brief filed in *Nurjaman*[1] illustrates the unique physical, psychological, and systemic impacts of C-PTSD and its implications for the legal system.

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