MODULE 13

Overview

This module provides an overview of the psychological aspects of working with adult and child victims of trauma in strategic litigation. It is designed to inform civil society organisations and legal practitioners who work on human rights litigation and other forms of public interest litigation involving traumas from violence such as torture, sexual abuse and forced disappearances. [1]

It also provides a basic understanding of key psychological considerations to assist lawyers and Human Rights Defenders ("HRDs") in instructing and working alongside clinicians such as clinical psychologists and medical doctors, perhaps for an expert witness report.

Further, it provides an overview of the psychological effects of trauma on memory and gives considerations for interviewing victims to obtain medico-legal reports and witness statements. It should be read in conjunction with the REDRESS and TTI Practice Notes on Istanbul Protocol Medico-Legal Reports and Working with Child Victims of Trauma, and with *Module 14: Ethics and Client Care*.

Trauma & PTSD

The Human Stress Response

A traumatised person is hardwired to anticipate danger and to survive attacks. Their 'emotional brain' is under-activated, making it more difficult to manage intense emotions. The 'thinking brain' is under-activated, so they may struggle with concentration and attention and be more impulsive. Prolonged and repeated trauma occurring in childhood can alter brain development, leading people to be at greater risk of developing a myriad of mental and physical health conditions.

Childhood trauma has lifelong consequences. Adverse childhood experiences (ACEs) are traumatic events that include direct experiences of emotional, physical, and sexual abuse, and neglect.

A 'one-off' experience of a traumatic event, such as being subjected to or witnessing an act of torture or sexual violence, is in an otherwise stable and loving environment usually less impactful in the long-term compared with prolonged exposure to multiple ACEs, termed *developmental trauma*.

[1] This note was researched and drafted by Dr Brock Chisholm and Dr Anna Churcher-Clarke.

The Threat System

The threat system is activated when the brain senses danger. It can be triggered whether or not actual physical threat is present. For example, during a flashback or expecting a threat even if it is not forthcoming. People who have experienced more traumatic events have a more easily activated threat system.

The threat system, also known as the Defence Cascade,[2] is comprised of freeze, flight, fright, flag, and faint responses. It will cycle through these responses, instinctively selecting the reaction that most ensures survival. Traumatic experiences such as torture or sexual abuse are more likely to elicit a freeze response because the victims are unable to run away or fight back. Freezing stops them even calling for help. There is no conscious selection or control over this response.

Post-traumatic stress disorder (PTSD)

PTSD can happen following a traumatic event and has three primary symptoms clusters: re-experiencing the event as if in the present; avoiding reminders of the trauma; and a persistent sense of current threat that is often manifested as hypervigilance, exaggerated startle response, and insomnia.

PTSD as Defined by The World Health Organisation

The World Health Organisation (WHO) produced a taxonomy of physical and mental ailments entitled *International Classification of Diseases Version 11* (ICD-11).[3] It defines PTSD as:

'A syndrome that develops following exposure to an extremely threatening or horrific event or series of events that 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, which are typically accompanied by strong and overwhelming emotions such as fear or horror and strong physical sensations, or feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event; 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 must persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.'

[2] Schauer, M. and Elbert, T., "Dissociation following traumatic stress: etiology and treatment", *Journal of Psychology* 218(2), 2010, pp. 109–127.

[3] Available at: https://icd.who.int/browse11/l-m/en, as accessed on 30 April 2021. A version of ICD-11 was released on 18 June 2018 to allow Member States to prepare for implementation, including translating ICD into their national languages. ICD-11 was submitted to the 144th Executive Board Meeting in January 2019 and the Seventy-second World Health Assembly in May 2019 and, following endorsement, Member States will start reporting using ICD-11 on 1 January 2022.

Complex PTSD

The WHO also has a diagnostic category of Complex PTSD. This can develop following developmental trauma. Complex PTSD has all of the symptoms of PTSD, but victims also have difficulties in regulating their emotions, feel diminished, worthless, or defeated, and have problems forming and maintaining relationships.

ICD-11 describes Complex PTSD as:

'a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder.

In addition, Complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.'

Impact and Risk of PTSD

Not everyone develops PTSD after an event. The risk of developing PTSD varies according to the type of trauma and vulnerabilities. The greater number of traumas a person experiences in their lifetime, particularly if experienced during childhood, increases the likelihood of developing PTSD. The intensity and duration of traumatic events also affects the likelihood of PTSD. For example, approximately 50% of rape and torture survivors develop PTSD. PTSD is more likely to arise in unexpected events and those caused by deliberate human violence rather than natural disasters or accidents. Reactions are also influenced by age and experience. Children who experience sexual abuse have the highest risk: 30-70% will develop PTSD.[4]

Trauma, PTSD and Memory

PTSD can be considered as a memory disorder. People recall traumatic events in a manner that feels current rather than in the past, like most memories. The memories are sensory (i.e. they are seen, heard or felt and are difficult to put into words). These memories trigger the threat system, so efforts are made to avoid recalling them.

[4] Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Matthews, T., Moffitt, T. E., et al., "The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales", *The Lancet Psychiatry*, 6(3), 2019, pp. 247-256; McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C., "Trauma exposure and posttraumatic stress disorder in a national sample of adolescents'", *Journal of the American Academy of Child & Adolescent Psychiatry* 52(8), 2019, pp. 815-830.

Memory is not an accurate recording of events and is prone to change over time. Details that are extraneous to survival at the time of a traumatic event are more prone to change.[5] Memories of traumatic events contain gaps and inaccuracies.

Traumatic events may be represented differently than other personal memories.[6] They may be hard to describe verbally, can be more vague, jumbled, and contain more gaps and inconsistencies. People with PTSD are much more likely to avoid disclosure and if they do disclose the account is more likely to lack detail.

Implications of Trauma and Memory in Justice Settings

- Victims literally cannot describe what happened.
- Fragmented accounts which jump around in time and place.
- Memories lack contextual details.
- Avoidance of details leading people to appear deceptive.
- Repeated contacts and interviews not adjusted to children's needs increases risk of re-traumatisation.
- Numb, zoned-out appearance leading judges to believe that children are unaffected, do not care, or are lying.

Re-traumatisation

Re-traumatisation is a term that has not been well defined historically. It refers to causing or worsening psychological injury rather than only being painful at the time of recall. Recounting trauma is not inherently harmful and if done sensitively can be healing, even though it will feel painful at the time and temporarily increase distress in the days following. There may be emotionally detrimental beliefs regarding reporting shameful experiences, gaining a mental health diagnosis, or discussing taboo subjects.

Re-traumatised witnesses provide poor-quality, inaccurate evidence. Whilst describing traumatic events in a justice setting can be emotionally painful, it need not be psychologically harmful and can be beneficial if the recommendations below are adhered to. Victims that are enabled to bear witness and are believed can be healed by that process.

Interviewing Victims of Trauma

This section mainly applies to both adult and child victims. Special considerations for child assessment and interviews are in the subsequent section. These guidelines apply to taking witness statements and cross examination as well as medical and psychological assessments.

[5] Herlihy, J., Scragg, P., Turner, S., "Discrepancies in autobiographical memories – implications for the assessment of asylum seekers: repeated interviews study", *British Medical Journal*, 2002, pp. 324-327.

[6] Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010) 'Intrusive images in psychological disorders: characteristics, neural mechanisms, and treatment implications *Psychological review* 117(1): 210.

Readers are also directed to the Istanbul Protocol, where many of these recommendations come from.

Preparation

Understand and communicate the purpose of the assessment. Is to gain a witness statement or to make a professional judgement about consistency between allegations of torture and the physical and psychological markers for an expert witness report, or for something else?

If it is for an expert witness report then gain clear, concise instructions. The person providing instructions should be clear about deadlines, court hearing dates and costs, provide clear written instructions and communicate the legal reasons for these. The instructor should establish what the expert can and cannot comment on. Some questions may not be answered if these are outside the expert's area of expertise.

In the absence of these, the assessor's task is normally to judge consistency between allegations of trauma and physical and psychological sequalae, provide an opinion on the extent of injury from the trauma, suggest treatment needs and costs, and give a prognosis.

Assess collateral information in advance**.** For example, medical records can provide information about a person's health prior to the alleged torture, treatment during incarceration, and accounts and treatment after the alleged event. Information such as history of deliberate self-harm or previous scars is a useful basis to judge consistency.

During the Assessment

*Location***.** If possible, the assessment should be conducted in a safe, private location that does not resemble where the trauma occurred. Assessments conducted in a prison where the alleged torture occurred, or at a medical facility when the person remains incarcerated will present additional challenges. For example, prisoners will not feel safe to disclose allegations of torture in front of a guard, which also breaches confidentiality boundaries.

Ensure privacy and explain confidentiality. Explain clearly why the assessment is being conducted, who may see any information provided and what it may be used for. Explain any limits of confidentiality. For example, if there are risks to the victims or other people.

Obtain Informed Consent. Ensure consent is fully informed, that victims can withdraw consent at any time. Ideally, they would sign a consent form. The need for consent and control of the alleged victim always comes above the need for a detailed account.

Communication Barriers. Address possible communication barriers. Barriers include language differences/use of interpreters, shame and avoidance of aspects of torture, education differences, physical discomfort, lack of privacy, personal biases, dissociation, and traumatic brain injury.

Rapport. Take time to build trust and rapport. This is enhanced by off-topic discussion, open body language, warm empathic communication style and allowing sufficient time in the interview. Have tissues available but do not pass them to people as it indicates it is not OK to cry or express upsetting emotions. Allow people to be upset and offer comfort and sympathy. Consider and address gender issues. For example, some female victims of sexual assault prefer a female interviewer. If not, it can still be helpful to directly acknowledge gender issues.

Tone. Adopt a soft, curious, empathic tone. The interviewer should be curious and non-expert in relation what happened. Do not be formal. Ensure your questioning style does not reflect that used by an interrogator.

Pace. Consider the pace of the assessment. Allow breaks and moderate the tempo of the narrative. Be alert to dissociation – keep the interviewee grounded and orientated in the present. Allow the victim to dictate length of interviews and breaks.

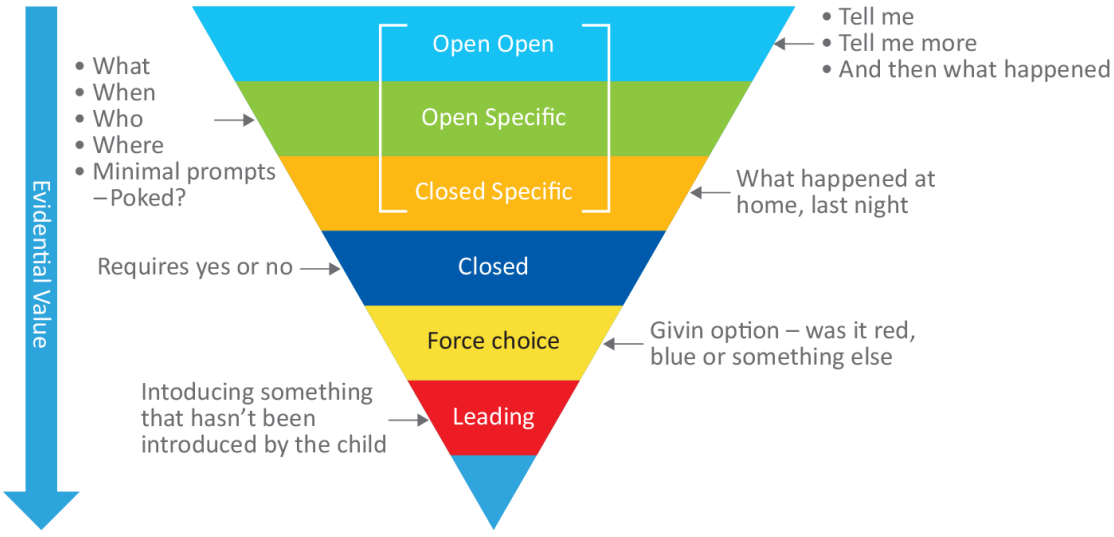
Food & Drink. Hungry thirsty people make poor witnesses. Ensure victims are well hydrated, which can also reduce dissociation during the interview. Snacks throughout and meal breaks for victim's and interviewers are essential.

Grounding. Be alert to dissociation (not being mentally aware in the present). Keep clients grounded in the present by orientating them to the present using sound, smells, and looking around.

Detailed Narrative. Try to gain a detailed narrative of personal history. Experiences of torture must be placed within the context of a person's entire life. An assessment is to appraise the consistency between allegations of torture and current mental and physical health. A detailed personal history regarding events prior to the trauma, during and afterwards to assess causality and impact. People alleging trauma should be encouraged to provide a detailed history but not cajoled or obliged to do so.

Language Use. Language and questioning style of the assessor influence the recall and memories of the victim. Be clear and direct. Adapt language to the interviewee considering aspects such as age, education, ability to concentrate etc.

Open and closed questions. Open-ended questioning can increase the amount of information and build rapport. Closed, focused and probing questions are useful to provide context (which reduces the possibility of a flashback) and assist traumatised people who will have a fragmented memory and provide a disjointed account. The diagram below shows the different questioning types. Generally, the evidential value is highest when open questions are used, and lowest when leading questions are used:



From Specialist Child Witness Interview Course, December 2018 Sam Tarling Consultancy Ltd.

Consider how alleged factors and conditions occurred in synchrony. In particular "no touch" techniques such as sleep deprivation, humiliation, poor diet, cramped conditions or solitary confinement, forced stress positions, forced exercise, threats, and hot or cold cells. If a witness does not spontaneously comment on an aspect, ask probing questions such as "How much sleep were you able to have?" "Were you treated for your injuries?" "Were you able to wash or use the toilet?". In general, leave follow up questions until after a person has finished answering open ended questions.

Using an interpreter. Keep language simple, speaking in short sentences. Allow time to translate.

Shame. Be especially attentive to disclosures likely to produce a shame response such as sexual violence or harming others. Be warm and empathic, allow time. Ask questions when there are gaps, but understand the client controls the amount of detail. It is often helpful to tell a client that asking direct, specific questions can reduce distress. Preface this with an explanation that it is the perpetrator, not the victim who is responsible or at fault. Understand but do not collude with stigma attached to an event.

Traumatising the assessor

Vicarious trauma or directly triggering memories of previous personal traumas is possible among those working with survivors or assessing survivors. Burnout leading to compassion fatigue is possible, which would lead to an impairment of the ability of the assessor to evaluate consistency of the reported torture.

Special Considerations for Interviewing Children

Children may be unwilling to speak about their experiences of abuse – out of loyalty, fear of the consequences and/or shame. Observations of play can therefore sometimes allow access to memories and experiences that the child is unwilling or unable to put into words.

Best Practice for Interviewing Children in Legal Settings

These recommendations are adapted from The Barnahus Model (or *'Child House'*), which was first developed in Iceland in 1998 and is considered to be international best practice. It encapsulates a holistic approach, addressing both justice and welfare, for children who have experienced sexual abuse.

It is understood that many of these recommendations remain aspirational in most countries. However, using the Barnahus approach trebled the number of perpetrators charged and doubled the number of convictions in Iceland.

Interviews should:

- Involve the undertaking of a 'pre-interview assessment' to build rapport with the child; socialise them to the 'rules' of communication; assess their developmental capacities and communication needs, and allow them to practise talking freely about a neutral topic.
- Take place in a home-like setting with all services (medical, psychological, advocacy, police/justice, and social care) delivered under one roof.

- Help victims disclose abuse through exploratory interviewing, conducted by child psychologists.
- Be kept to a minimum by child-expert staff.
- Reduce the need for children to testify in court.
- Provide guaranteed and rapid access to therapy for abused children.
- Take into account that children do not use, process, and understand language in the same way as adults.
- Have the interviewer presenting as curious and non-expert in relation to the child's experience, to demonstrate that the child themselves is 'the expert' on what happened.

An adult interviewing a child should:

- Use simple, common words and phrases.
- Repeat names and phrases often: 'What did Jim say?', not 'What did he say?' . Use of the child's own name with younger children can help keep focus.
- Ask one short question (one idea) at a time.
- Follow a structured approach. Signpost the child, 'Now I'm going to ask you about X'.
- Speak slowly and give children time to answer; younger children (5-7 year-olds) need nearly twice as long as adults.
- Check directly on the child's understanding. Problem words include before/after; in front of/below/ahead of/behind; always/never; different/same; and more/less.
- Find ways to clarify meaning and reduce inconsistencies, for example, 'tell me more about that' and 'what do you mean when you say…'
- The manner in which the child is asked to recall the events should not mimic the conditions that the event initially occurred. This is achieved by giving the child more control, being non-threatening, and preparing the child for what is to come.

Children in Courts

Children as Vulnerable witnesses

All children are considered to be vulnerable witnesses. In the context of sexual abuse, children and adolescents who have experienced sexual behaviours from an adult are considered to have been forced or tricked, never consenting. This includes direct sexual contact and non-contact abuse where the child has not been physically touched by the abuser.

Court conditions can be unpredictable and intimidating for adults, and even more so for children. A large-scale UK study found that approximately 65% of children giving evidence in court experienced problems of comprehension.[7] Questions can be unpredictable, children

[7] Plotnikoff, J. & Woolfson, R. (2009) 'Measuring up? Evaluating implementation of Government commitments to young witnesses in criminal proceedings', available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/measuring-up-report.pdf, as accessed on 30 April 2021.

may be accused of lying, and the question style can be hostile, all in relation to a traumatic event around which they may feel shame in the formal 'adult world' of the courtroom.

Safeguards during legal proceedings to achieve best evidence and mitigate harm

The following section draws upon recommendations made by Plotnikoff & Woolfson (2009) and Achieving Best Evidence in Criminal Proceedings, UK Ministry of Justice (2011).

Throughout the process of legal proceedings, the child should have access to a specially trained child advocate who can help the child's voice, needs, views and wishes be heard.

Before Children Appear in Court

- Children must be supported to provide **informed consent** for giving evidence. For younger children this can involve consultation with their caregivers.
- Judges, legal representatives, and any interpreters from both sides should meet with the child and their advocate beforehand to brief them on the process.
- The child should be familiarised with the hearing room or video conference site.
- There should be a clear explanation of the 'rules' of communication in court.
- There should be a pre-agreed plan around how to identify and manage what to do if the child stops being able to meaningfully engage with the process due to issues with concentration, attention, and/or flashbacks.
- The names of body parts and sexual terms should be rehearsed in front of judges and lawyers.
- Where intimate touching is reported, the child should never be asked to point to their own body. A drawing (body map) should be used.

Giving Evidence in Court

- Measures that should be considered include the child being able to stand behind a screen to give evidence; the child giving evidence via live video link; the child giving evidence in private; public and press excluded from court; the removal of formal dress; the use of a specially trained intermediary; communication aids; and providing a pre-recorded video interview as their evidence-in-chief.
- Being cross-examined on pre-recorded video evidence is preferable to a child having to repeat their whole account.
- Children should have the opportunity to review their previously recorded evidence and have as much prior warning as possible about questions that will be posed.