***Training Materials on the International Protocol***

**PART VII MODULE 15 – TRAUMA**

**Session objectives:**

By the end of the session, participants should be in a position to:

* Understand the mental health impact of CARSV on victims/witnesses, families and communities
* Identify protective and risk factors impacting on individual resilience to trauma
* Recognise the potential effect of trauma on witness description of experiences

**Suggested duration of session:**  60 to 90 minutes

**Exercise:** None

**Relevant sections of International Protocol:**

Pages 230-243; Module 2 – Understanding Sexual Violence; Module 7 – Do No Harm; Module 8 – Safety and Security; Module 9 – Planning; Module 11 – Interviewing; Module 14 – Analysing Evidence and Information; Module 16 – Sexual Violence against Children

The trainer for this module should have professional experience dealing with victims and witnesses in an investigation or documentation context and should ideally have specific expertise on the impact of trauma on the manner in which they might describe a traumatic event and surrounding circumstances.

This module is the first module of Part VII of the Protocol dealing with cross-cutting issues, namely Module 15 (Trauma), Module 16 (Sexual Violence against Children) and Module 17 (Sexual Violence against Men and Boys). Strategies on how to mitigate the risk of re-traumatisation of victims/witnesses are found throughout the Protocol, especially in Module 7 (Do No Harm), Module 8 (Safety and Security), Module 9 (Planning) and Module 11 (Interviewing) and the trainer may want to refer back to some of the guidance presented in these modules as appropriate. In addition, this module dealing specifically with trauma is closely linked to Module 2 (Understanding Sexual Violence) and Module 14 (Analysing Evidence and Information), as a good understanding of the psychological impact of sexual violence on victims/witnesses and how trauma may affect the accounts of some victims/witnesses is necessary in order to properly assess the credibility and reliability of their testimony.

Conducting proper clinical assessments of the impact of trauma on victims’/witnesses’ testimony is not the role of documenters and investigators and requires specialist training and skills. Nevertheless, it is important that documenters interviewing potentially traumatised victims/witnesses of CARSV have a basic understanding of how a traumatic experience *may* affect victims’/witnesses’ testimony, be in a position to recognise signs of trauma and put in place appropriate strategies to mitigate any risk of re-traumatisation during interviews.

Throughout the session, the trainer should encourage participants to discuss their experiences interacting with victims/witnesses of traumatic experiences, in particular: what possible reactions traumatised victims/witnesses may have had during interviews, what the triggers might have been, how they reacted and consider whether they could have put in place additional safeguards or behaved differently based on the guidance provided in the Protocol. The trainer should also promote discussion among participants about their views regarding actual or seeming inconsistencies, and/or lack of detail and/or coherence in victim/witness testimony, challenge assumptions that participants may have that traumatised victims/witnesses cannot provide credible and reliable evidence and consider how they reacted to lack of detail, consistency and/or coherence in specific instances (e.g. did they believe that the victim/witness was lying or voluntarily keeping information from them, affecting their assessment of the witness credibility; did they become impatient or aggravated; did they consider these as normal; did they seek a medical assessment from a trauma expert to support the victim’s/witness’ testimony?).

The first part of the module (slides 3-7) covers in broad terms what trauma means and the type of events or environments – typically situations involving threats to life or physical integrity - that may cause exceptional stress and be traumatising for those who experience or witness them. The trainer should emphasise that trauma can result not only from specific *natural or man-made incidents and disasters* (e.g. being the victim of a car crash, rape, torture or other physical assault, witnessing the physical assault of others, surviving a terror attack, an earthquake) but also from *chronic or repetitive experiences* (e.g. concentration camps and other forms of detention, sexual slavery, enduring deprivation, combat and violence associated with war, child abuse, neglect, domestic violence).

The trainer should also highlight that trauma is very subjective and that different people can have different responses to the same violent or life-threatening experience. Some may be able to recover and positively adapt relatively quickly and easily, while others might be deeply traumatised and unable to ever lead a “normal” life. The trainer should encourage participants to think about factors *before*, *during* and *after* a violent experience which may either contribute to personal resilience to trauma, or to the contrary, constitute factors increasing the risk of re-traumatisation during interview and long-term psychological harm.

Generally speaking, documenters have no or limited control over risk factors in relation to victims/witnesses (e.g. previous abuse by a victim’s partner or parent, permanent disability or chronic physical injury as a result of the sexual violence, ostracism by community) or conditions before or during the traumatic experience which may act as protective factors (e.g. having grown up in a loving and supporting family, self-confidence and self-esteem, faith in god or life). Although it is beyond the role of documenters to provide professional psycho-social care and treatment to victims/witnesses, documenters can contribute to strengthening victims’/witnesses’ resilience by adequately facilitating the addressing of their needs *after* a traumatic experience (e.g. enabling access to medical and psychological support, protection, housing, employment, vocational training) and working according to a trauma-informed approach.

After this general introduction, the module is split into three sections covering: A) sexual violence and war-related trauma (slides 8-15), B) strategies to mitigate the risk of re-traumatisation during interview (slides 16-21), and C) the effect of trauma on victims’/witness’ description of experiences (slides 22-26).

Slides 8-15 cover the nature and impact of sexual violence-related trauma and war-related trauma and their compound effect – “war-rape” trauma - on survivors of CARSV. As sexual assault (committed in peacetime) and the violence associated with conflict (even in the absence of sexual violence) are considered individually as some of the most destructive experiences of all, it is unsurprising that their combined effect often causes devastating harm to CARSV survivors. Sexual violence does not happen in isolation. CARSV victims are likely to have experienced or witnessed other forms of extreme violence (e.g. loss or disappearance of loved ones, destruction of their homes, shelling, displacement, violent death or extreme suffering of others, food deprivation, torture, detention, persecution of their community) and suffer from *cumulative trauma*.

The trainer should remind participants that having been a victim of sexual violence – however violent and traumatic – may not always, *from a CARSV victim’s perspective*, be the “worst” part of their experience (e.g. a victim might be much more concerned about finding a child or parent separated from them during flight and displacement than about their own sexual assault). The trainer should also emphasise that a CARSV victim may be severely traumatised even in the absence of penetration/rape, as the physical invasion of one’s body is only one of many extreme stress factors which together contribute to causing sexual violence-related trauma. Other factors include pain, humiliation, powerlessness, dehumanisation, destruction of identity, fear of being killed or injured and torture, whether physical or mental.

The trainer should highlight some typical consequences of CARSV trauma (e.g. anxiety, depression, acute stress reactions, substance misuse, post-traumatic stress disorder (PTSD)) and symptoms which may be encountered in different phases following a traumatic experience (e.g. crying but also laughing or seeming unaffected, sleep disturbances, phobias, sexual dysfunction). The trainer may want to refer back to some of the slides in Module 2 (Understanding Sexual Violence) about debunking myths and assumptions about CARSV victims and how they should react or behave and ensure that participants understand that there is no “right” way to react. Different individuals may develop different coping mechanisms in the face of extreme violence and it is important to respect and factor this into the documentation process.

Slides 16-21 cover the risk of re-traumatisation during interview and strategies to work according to a trauma-sensitive approach. The trainer should highlight that certain behaviours, environments, words, smells or sounds may act as triggers and result in the victim re-experiencing the events and feelings of the original trauma. It is therefore important for documenters to avoid specific actions or behaviours based on the prior research and understanding of a victim’s experience (e.g. refraining from wearing strong perfumes if information available about the victim or gathered from other victims refers to nauseating odours associated with the alleged perpetrators, or law enforcement officials refraining from wearing uniforms which may remind the victim of uniforms worn by alleged perpetrators).

Key strategies to mitigate the risk of re-traumatisation are found throughout the Protocol and can be grouped under the following aims: (i) ensuring victims’/witnesses’ physical and emotional safety prior to, during and after an interview, (ii) promoting trustworthiness, (iii) “giving back” to victims/witnesses a sense of agency and control by offering them choices, (iv) ensuring that the process is collaborative and participatory and (v) empowering victims. Providing evidence can be a cathartic experience. While victims/witnesses may become very emotional during testimony, this does not necessarily mean that they are in distress or that the interview must be stopped. A professional, collaborative, respectful and empowering evidence gathering process will respect a person’s wish to continue even if they are showing a lot of emotion (e.g. crying). The trainer should prompt participants to reflect on the strategies presented and to share additional ones that they may have used in their work and found particularly useful.

The last section (slides 22-26) deals with the potential effect of trauma on victims’/witnesses’ description of experiences. The trainer should emphasise that the memories of traumatised individuals (whether they are suffering from PTSD or other psychiatric disorders or not) *can* - not necessarily will - lack detail (especially peripheral details which may relate to, for example, evidence of contextual or common elements of war crimes, crimes against humanity and genocide), consistency and coherence. The trainer should underscore that: whether the account of a particular victim/witness is reliable and credible must be determined on a case-by-case basis; inconsistency, lack of detail and/or problems with memory recall do not necessarily point to credibility issues (this is true for all victims/witnesses, not only those who may be or are suffering from, for example, PTSD or other psychiatric disorders); there is no necessary correlation between trauma and credibility; and collecting evidence from CARSV-traumatised victims/witnesses is not necessarily more difficult than collecting evidence from victims/witnesses of other crimes or from victims/witnesses who are not traumatised as a consequence. The core message is that documenters need to approach every victim/witness, and assess the credibility and reliability of the account of every victim/witness, with equal professional skill and care, regardless of whether they are victims/witnesses of CARSV or other types of crimes and violations, and regardless of whether they may or may not be suffering from trauma, PTSD, etc.

The trainer should encourage discussion of whether medical assessment of traumatised victims/witnesses should, if possible, be sought and submitted as evidence in cases of alleged CARSV even where such assessment is not a legal requirement. Such assessment may not only be unnecessary but also counter-productive and perpetuate damaging myths about the reliability and credibility of victims of sexual violence. That said, such assessment may in some circumstances be important for other reasons.

When discussing these topics, the trainer may want to refer back to some of the slides in Module 14 (Analysing Evidence and Information) as appropriate, and should be able to provide examples of instances where courts and tribunals have reached the conclusion that traumatised victims/witnesses are both credible and reliable despite inconsistencies and/or lack of coherence in their testimony.