Health impact of human rights testimony: harming the most vulnerable?

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ABSTRACT

Background: Current legal efforts to document human rights violations typically include interviews in which survivors are asked to provide detailed descriptions of their traumatic experiences during a single meeting. Research on similar interview techniques used as part of a mental health treatment (eg, debriefing) has raised concerns that they might worsen mental health—more than doubling the risk of post-traumatic stress disorder in some studies. While controversy over the mental health impact of debriefing continues, debriefing treatments have been discontinued in most clinics nearly 2 decades ago. The purpose of this article is to promote the development and integration of preventative measures to limit potential mental health damage associated with legal endeavours to address human rights violations and international crimes.

Methods and findings: Given the recent growth of the field of global mental health and its current capacity to provide feasible, acceptable, effective care in low-resource settings, we propose a research agenda to identify the mental health impact of current human rights legal practices and test a model of scalable medicolegal care that minimises risk by integrating mental health monitoring and applying up-to-date models of trauma treatment, including multiple meeting sessions, as indicated.

Conclusions: As the fields of global health, human rights law, international criminal law and transitional justice increasingly overlap in their efforts to assist communities affected by grave violence, we propose that synchronisingiens may offer important opportunities to improve mental health for survivors.

INTRODUCTION

More than two decades ago, research suggested that describing one’s traumatic experiences in a detailed one-session manner, as often required for legal documentation, increased the risk of chronic post-traumatic stress disorder (PTSD)—an extremely disabling mental disorder associated with all-cause mortality, violence towards others, depression and substance abuse. In the mid-1990s, mental healthcare for prevention of PTSD included a type of treatment called ‘debriefing’. This treatment consisted of a single meeting in which a survivor of a recent traumatic event was asked to retell the events in detail to a mental health professional. Research on debriefing found, that rather than preventing PTSD, debriefing more than doubled the risk of persistent PTSD 1 year later, and the same heightened risk of PTSD was still present 3 years later, the longest available follow-up period.1, 2 While the findings of these studies are controversial, based on concerns regarding their design, analyses
and interpretation,\[^3\] debriefing has been eliminated as
a recommended treatment for traumatised individuals
in most clinical settings.

In contrast, Mollica,\[^5\] Jones and Kafetsios\[^6\] described
the complexity of emotional responses among trauma-
tised human rights survivors and the need for culturally
informed, gradual review of the trauma ‘story’ or ‘narra-
tive’ with adults and adolescents. Subsequently, pro-
longed exposure therapy, which involves a measured
review of the trauma narrative over many sessions (aver-
ageing 10 sessions of 90 min) has become a current ‘gold
standard’ in PTSD psychological treatments.\[^7\]

**Legal context**

Human rights legal efforts have proliferated over the past
several decades and there are now organisations devoted
to providing extensive documentation of human rights
law enforcement in most parts of the world. International
criminal law has also developed significantly in recent
years: the International Criminal Court (ICC) was estab-
lished in 2002, and is the world’s first permanent court
with jurisdiction over genocide, war crimes and crimes
against humanity. While the ICC does provide psycho-
logical support, including services from the Victims and
Witnesses Unit and the Trust Fund for Victims (TFV) for
the ‘victim-witnesses’ who travel to The Hague to provide
testimony, and to groups of in-country survivors (TFV),
the majority of the victims providing testimony for the
ICC are ‘victim-participants’ who testify without leaving
their country of origin. For victim-participants, the
mechanisms for supporting mental health before, during
and after the process of providing testimony are unclear,
nor mentioned in the ICC guide for prospective
victim-participants and their assistants.\[^8\]

Leading human rights organisations are alert to the
dangers of retraumatising survivors during interviews,
and many have published ‘best practice’ guidelines which
reference the need to avoid retraumatisation. One of the
prominent early guidelines was the 1999 Istanbul
Protocol: a manual on the Effective Investigation and
Documentation of Torture and Other Cruel, Inhuman or
Degrading Treatment or Punishment, published by the
United Nations Office of the High Commissioner for
Human Rights,\[^9\] which concluded a section devoted to
‘Risk of re-traumatization of the Interviewee’ by stating:
‘Despite all precautions, physical and psychological exam-
inations by their very nature may re-traumatize the
patient by provoking or exacerbating symptoms of post-
traumatic stress by reviving painful effects and memories.’

The ICC published regulations in 2009 asserting:

> The physical and psychological well-being of persons who
are questioned by the Office and are considered vulnerable
(in particular children, persons with disabilities and
victims of gender and sexual crimes) shall be assessed by
a psychology, psycho-social or other expert during a
face-to-face interview prior to questioning. This assess-
ment shall determine whether the person’s condition at
that particular time allows him or her to be questioned
without risk of re-traumatisation.

Other prominent organisations such as Human Rights
Watch, Amnesty International and WHO, have also pub-
lished guidelines intended to avoid retraumatisation of
interviewees.\[^10\]–\[^12\] While these guidelines reflect sensi-
tivity to the potential mental health impact of investiga-
tions on survivors of human rights violations, we are not
aware of any requirements to monitor or report the
actual mental health impact of the investigations. As
noted by Amon *et al.*,\[^13\] many human rights research
organisations do not engage research ethics committees
or view human rights documentation as research. With
the exception of some organisations which have created
their own internal review boards, many human rights
organisations do not submit their study plan for inde-
pendent human subjects protection review, or submit
progress reports, with monitoring for, and reporting of,
adverse events.

**Medical context**

At the time when global human rights legal endeavours
began, the field of global mental health (GMH) had not
yet been founded. Now, the huge burden of mental disor-
ders suffered in low and middle income countries is not
debatable.\[^14\]–\[^15\] Also, it is not debatable that common
mental disorders, including those occurring in the
context of traumatic experiences, can be effectively
treated in low-resource settings. GMH has evidence-based
methods of measuring mental health status across diverse
cultural settings, assessing mental healthcare needs and
adapting evidence-based treatments such that they are
locally acceptable and feasible, as well as effective, using
low-cost, scalable delivery models.\[^16\]–\[^18\] Despite the
content similarities discussed above, it is possible that the
short-term and/or long-term emotional impact of provid-
ing legal testimony is different from that of ‘debriefing’.

Given that we now have the ability to deliver evidence-
based mental healthcare in low-resource settings and
partner for sustained scale-up of evidence-based care
where few services have previously existed, evaluating for
remediable mental health impact has potential benefits
for survivors of human rights violations.

Institutional review boards (IRBs) have been used to
approve and monitor biomedical and behavioural
research involving human subjects in the USA since 1974.
Reacting to abuses by Nazi physicians and the Tuskegee
Syphilis study, the goal of IRBs is to protect the rights and
welfare of human subjects according to the principles of
‘respect for persons’, ‘beneficence’ and ‘justice’.\[^19\]

**TENSION BETWEEN CLINICAL AND LEGAL GOALS FOR SURVIVORS**

**Setting a collaborative research agenda**

While the parallels between debriefing and providing
testimony are concerning in regards to potential mental
health impact on the survivors of human rights violations, the topic requires more study for two reasons: there remains substantial controversy regarding the actual mental health impact of debriefing, and differences between legal and medical context may produce different mental health impacts even when the same strategies are used. Indeed, there is a body of legal literature theorising that empowering legal processes, including testifying, can be part of reparative justice that leads to emotional healing on an individual level for the survivors who provide their trauma narrative. The South African Truth and Reconciliation Commission, a well-known example of transitional justice, asserted that ‘revealing is healing’—expressing the belief that exposing the details of personal traumas promotes healing for individuals and the nation. However, to date, there is little to no evidence on the specific impact of providing legal testimony, despite the concerns that research on debriefing raises, and harms that are theorised.

Weinstein and Stover, early investigators of the impact of international criminal law on individuals, surmised that the assumed ‘therapeutic value’ of human rights processing may be ‘more wishful thinking than fact’. While medical and legal processes typically operate separately with different goals, we argue that current assumptions regarding the ability of legal testimony to promote psychological healing cross into the territory of health professionals. Indeed, some practices in human rights law, international criminal law and transitional justice bear a strong resemblance to critical incident debriefing, which is now widely regarded as a risk to mental health. Given the growth of the field of GMH and our present ability to provide evidence-based, effective, sustainable mental health treatment to trauma survivors in low-resource settings, we assert an imperative need to investigate and address the mental health impact of these practices. This opinion is in line with expert opinion that the current lack of evaluation and research on mental health in emergency settings is unethical. For the purposes of this manuscript, we use victim-participants at the ICC as a case example to illustrate where and how this research could be implemented. However, there is a need for this research, and investigation across the fields of human rights law, international criminal law and transitional justice, and the proposed model could be used with UN human rights bodies, regional human rights commissions and courts, truth, justice and reconciliation commissions and the vast number of national and international non-governmental organisations around the world who frequently interview survivors of human rights abuses and international crimes.

**ICC as a case example**

In 2002, the Rome Statute established the ICC with a mandate to address to the international community the most serious crimes of concern, such as genocide, war crimes and crimes against humanity. While the ICC can support only a relatively small number of ‘victim-witnesses’ to provide legal testimony in The Hague, there are comparatively large numbers of victim-participants, who provide their narratives without leaving their country of origin. As of April 2012, in total, nearly 20 000 victim-participant applications had been received by the ICC, with a 300% rise between 2011 and 2012.

**Proposed research agenda: ICC**

**Phase 1: information access and epidemiology—define the problem**

The first step is to better define the health impact of the ICC’s processes for gathering testimony across a range of ICC victim-participant processes and sites. The assessment team could measure the mental health impact of providing testimony to an ICC representative by applying low-burden mental health assessment tools in a low-cost manner using local paraprofessionals (eg, Patient Health Questionnaire-9 (nine items), Primary Care PTSD screen (four items)). Measures could be applied at baseline with prospective ICC victim-participants, and again after they provide their trauma narrative to the ICC representative to test the hypothesis that providing testimony is associated with worsened mental health. Using a mixed-methods design, this quantitative assessment data could be augmented with qualitative interviews before and after testimony regarding expectations/hopes and experiences/mental health impact, respectively. By combining mental health assessment data with demographics and relevant contextual details, risk and protective factors for mental health, the following testimony may be identified. The results of this phase 1 research would provide important prospective data on the mental health impact of providing testimony to the ICC.

**Phase 2: monitoring and intervention—IRBs, informed consent, screening tools and mental health interventions**

Using data generated from phase 1 research, proposed human rights documentation studies could be submitted to the in-country IRB approval mechanism for biomedical/behavioural research, with use of mental health assessment tools for monitoring, reporting and managing adverse events. Correspondingly, human rights study individuals could participate in an informed consent process that includes the risk to health posed by relaying a detailed trauma narrative in a condensed manner.

A mental health intervention could be tailored to meet the needs of victim-participant groups (figure 1). An initial intervention is simply to substitute the ICC word survivor-participants for the word victim-participant. This semantic change took place nearly a decade ago in the field of mental health trauma care to empower individuals toward recovery. At the first meeting, survivors could undergo a mental health screening—those who are highly symptomatic, or at high risk of decompensation, could be scheduled for mental health trauma care (multisession) prior to legal interaction. Survivors could name a trusted contact to be
used in the event of overwhelming emotional distress, and an advocate, such as a healthy community member who completed ICC Victim Participant testimony, could be offered as a supporter who accompanies survivors through the process of providing testimony. Survivors could be offered a choice in how their stories are used and how long they are stored. After providing testimony, survivors could be monitored for recovery with a follow-up mental health screen, and referred for higher-level care, as needed. This mental health monitoring/intervention model could be tested for efficacy with a clustered RCT design of integrated mental health monitoring/treatment versus treatment as usual, testing the hypothesis that providing mental healthcare to those who meet criteria for depression and/or trauma-related disorders will decrease their risk of mental health decompensation following provision of testimony.

Phase 3: effectiveness, implementation and scale-up through policy

Depending on the results from phases 1 and 2, the next phase of the work is effectiveness and implementation research to ascertain generalisability of the intervention, conduct cost-benefit analyses and work with policymakers for scale-up. Specifically, this phase of research could test the hypothesis that providing mental healthcare for individuals who are giving ICC victim-participant testimony, and have depression or trauma-related disorders, would be cost-effective and produce a net economic gain by reducing mental health-related disability early in the course of disease.

CONCLUSIONS

The purpose of this article is to promote the development and integration of preventative measures to limit potential mental health damage associated with legal endeavours to address human rights violations and international crimes. Although we express concerns about the potential health impact of the ICC’s current engagement with victim-participants, we applaud its focus on survivors and understand that the pioneering effort of the ICC is a work in progress. We include the ICC as only one case example of where this proposed research is needed and would be applicable. As the fields of global health, human rights law, international criminal law and transitional justice increasingly overlap in their efforts to assist communities affected by grave violence, we propose that synchronising efforts may offer important opportunities to improve mental health for survivors.

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