TORTURE 2 2018

Journal on Rehabilitation of Torture Victims and Prevention of Torture

Special section: Forced migration and torture: challenges and solutions in rehabilitation and prevention

VOLUME 28, NO 2, 2018, ISSN 1018-8185

TORTURE

Journal on Rehabilitation of Torture Victims and Prevention of Torture

Published by the International Rehabilitation Council for Torture Victims (IRCT), Copenhagen, Denmark.
TORTURE is indexed and included in MEDLINE. Citations from the articles indexed, the indexing terms and the English abstracts printed in the journal will be included in the databases

Volume 28, No 2, 2018
ISBN 1018-8185

The Journal has been published since 1991 as Torture – Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, and was relaunched as Torture from 2004, as an international scientific core field journal on torture

Correspondence to
IRCT
Vesterbrogade 149, building 4, 3rd floor,
1620 Copenhagen V, Denmark
Telephone: +45 44 40 18 30
Email: publications@irct.org

Subscription
http://irct.org/media-and-resources/publications#torture-journal

Price: EURO 100 per year.
www.irct.org/Library/torture-journal.aspx.
The journal is free of charge for health professionals.

Front page: Mogens Andersen, Denmark
Layout by Jordi Calvet
Printed in Lithuania by KOPA.

Contents

Migration and torture: Building a map of knowledge

Pau Pérez-Sales, Editor in Chief

We already have more than twenty-five years of academic research on migration and torture; the field has developed into an increasingly complex one since the first descriptive and epidemiological studies.

The "refugee crisis"

The recent war in Syria, added to previous conflicts in Afghanistan, Iran, Iraq, has led to mass displacement, especially since 2015, to neighbouring countries and Europe, in what has come to be known as the *refugee crisis*. The concept *crisis* as applied to Europe is a relative one. According to 2018 UNCHR figures,[1] while there are 22.5 million refugees in the world, the top hosting countries are Turkey (2.9 M), Pakistan (1.4 M), Lebanon (1 M), Iran (979,000), Uganda (940,000) and Ethiopia (791,000). While 30% of those living in Lebanon (a country with a very unstable religious and political equilibrium) are refugees,[2] in Europe the proportion of refugees is marginal in demographic terms, even including the increase in the last two years.

Several episodes have marked the European political confrontation around the "refugee crisis" in this period. These include, (a) Germany's decision to both open its doors in 2015 and 2016 and accept more than one million refugees, and then subsequently restrict entry in 2017 after the political environment altered due to various factors, including two Islamist attacks attributed to newly arrived refugees; (b)The EU decision in May 2017 to transfer 160,000 asylum seekers that were stuck in Greece and Italy to other European member states was met with widespread resistance. The European Union was not able to fully act on the decision and the transfer could only partially take place. As a result, around 65,000 refugees remained in both countries, and especially on the Greek Islands in precarious conditions; (c) In March 2016, in exchange for political and financial benefits, the EU signed an agreement with Turkey (recognised as *a safe country*) to accept people being sent back from Greece. In spite of that, only around 2000 persons[3] were sent back due to resistance of the Greek courts to apply the agreement (Roman, Baird, & Radcliffe, 2016). Those who were returned faced detention in overcrowded cells and deportation (Ulusoy & Battjes, 2017).

[1] Resettlement data finder accesed in http://rsq.unhcr.org/en

[2] https://ec.europa.eu/echo/files/aid/countries/factsheets/lebanon_syrian_crisis_en.pdf

[3] http://www.dw.com/en/the-eu-turkey-refugee-agreement-a-review/a-43028295

Europe is now trying similarly unacceptable arrangements with Libya, Egypt, Sudan, and Nigeria, among other countries, countries which can never be considered as *safe countries* for refugees to be sent back to.

The true refugee crisis is of course that around 4,600 persons are estimated to have died trying to cross the Mediterranean in the 2015-2018 period,[4] the sufferings of hundreds of migrants exploited, victims of extortion, tortured and abused on their way north, pushed back at borders violating non-refoulement principles or abandoned to their fate on the sea.

Research on migration and torture

It is worthwhile attempting a structural map of knowledge of where we are currently with respect to research. Figure 1 is not meant to be exhaustive, but illustrative.

Overarching issues

The mental health impact of torture: Different reviews since the 1990s have provided strong evidence of the mental health impact of persecution and torture (Johnson & Thompson, 2008; Momartin, Silove, Manicavasagar, & Steel, 2003; Steel et al., 2009). Just to mention one, a meta-analysis of 161 articles reporting results from a sample of 81,866 refugees from 40 countries showed that torture emerges as the strongest pre-migration factor associated with PTSD and depression, followed by cumulative exposure to potentially traumatic events (Steel et al., 2009).

Distrust as a cross-cutting element: The impact of hardship and torture is not only measurable in clinical terms though. As academic research has shown, if one psychological element illustrates the migrant's experience and provides a framework of understanding of his or her inner experience, it is that of *trust*. The decision to flee for torture survivors is part of a complex process. Voutira & Harrell-Bond (1995) showed, among others, how adaptive distrust shaped the experience of survivors of war and torture. There is a mixture of individual, community, institutional and social mistrust shaped by the context of violence and menace behind the decision to flee (Lyytinen, 2017). Key decisions during the route that could mean the difference between being dead or alive depended on *trusting* decisions. For years, mistrust is the norm (Daniel & Knudsen, 1995). particularly as refugees are often used as a bargaining chip in political disputes amongst countries, traders and local authorities, who often have their own hidden agenda, and NGO's and iNGOs can be unwilling to provide support for an extended period of time (Stedman & Tanner, 2003).

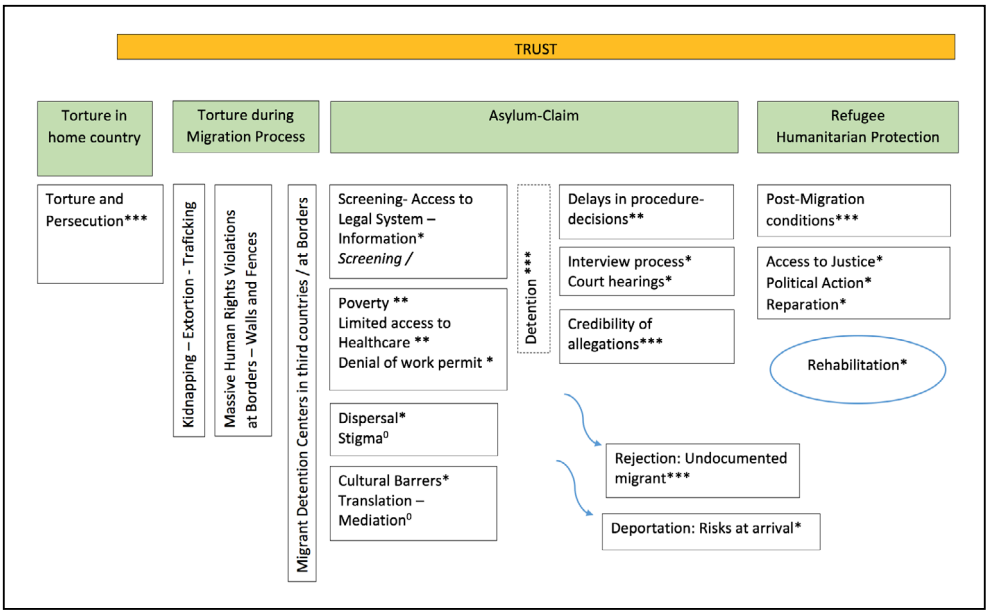
Country of destination is rarely a decision of the asylum-seeker. Studies show that, at the beginning, the main concern is to find a safe place. Final destination, however, depends on having funds and very circumstantial decisions made in the heat of the moment, as well as being directed by smugglers, police, the military, governments, and/or agencies to particular countries with little choice (Robinson & Segrott, 2002). Dispersal within a country or between countries can destabilise precarious social networks as well as disrupt the fragile bonds of trust of early psychological care (Griffiths, 2012; Níraghallaigh, 2014)

Crossing borders: when torture happens during flight

Borders have become places of very serious human rights violations, as the Special Rapporteur against Torture (2018) has noted in his latest thematic report. To give an example, just on the border

[4] https://www.opensocietyfoundations.org/explainers/understanding-migration-and-asylum-european-union

Figure 1: *Migration and torture - Psychosocial determinants of health and well-being and right to rehabilitation*
Negative factors:(0) No evidence, (*) Indicative evidence, (**) Strong evidence, (***) Conclusive evidence. Torture is according to UNCAT definition. Torture during migration progress includes where the State fails it's obligation to protect.



between Guatemala and Mexico, according to official figures and reports of local organizations,[5] an estimated 20,000 people were reported missing ("Desaparecidos") in the period 2015-2017 at the hands of organised crime and trafficking with the necessary cooperation of the State and local police forces. This is to be added to the general situation in the Mexican-United States border itself, where there has been an estimated 800 cases of missing people in the last two years. According to independent reports, the US is maintaining a policy of illegal detention of asylum-seekers including extreme conditions in cells, indefinite separation of minors from their parents, lack of information and access to legal counsel, victimisation and other forms of coercion to accept returning to Mexico, in what human rights groups and the rapporteur himself have considered as amounting to systemic State torture (Hope Border Institute, 2018; Human Rights First, 2017). Europe pursues similar policies by funding detention centres and coercive actions in North Africa where the systematic violations of human rights including torture and summary executions that take place have been denounced.[6,7]

[5] Centro Fray Matias de Córdoba. http://cdhfray-matias.org/web/. Movimiento Migrante Mesoamericano https://movimientomigrantemesoamericano.org/inicio/

[6] See reports in http://ddhhfronterasur2017.org/es/

[7] See reports and maps by Migreurop. http://www.migreurop.org/

There is a special need to address the challenges of migrants who, along their migration route, have suffered violence (including torture by non-state actors and sexual violence). They should be offered similar protection against further abuses and exploitation and to ensure access to basic human rights (to health, housing, education, rehabilitation etc).

Detention centres

The Global Detention Project (GDT) monitors detention of immigrants in "host" countries,[8] and has a global map and detailed data of around 2,000 immigration-related detention sites across the globe. Within the United States, which is the most dramatic example, there has been a sustained expansion with between 430,000-470,000 individuals being recently subject to some form of immigration detention annually compared to numbers as low as 6,000 in 1995 and 16,000 in 1998. Europe has also experienced a rapid expansion of detention, including outsourcing detention to border countries.

There is a large body of literature that analyses the health impact of detention on victims fleeing torture and violence in their countries and indicates that detention substantially worsens the health of asylum-seekers (Fazel & Silove, 2006; Keller et al., 2003; Robjant, Hassan, & Katona, 2009; Sobhanian, Boyle, & Bahr, 2006; Storm & Engberg, 2013). Data show symptoms of depression, anxiety, exacerbation of PTSD, marked increase in reported negative mood states, suicidal ideation and self-destructive thoughts. In all the studies the impacts are directly related to length of detention. Prolonged or indefinite detention *per se* produces learned helplessness and powerlessness (Storm & Engberg, 2013). The transnational DEVAS study showed in 23 EU countries that almost half of the detainees in migration centres inside Europe did not understand the reason for their detention and equate their detention centre with that of a prison. Approximately one third referred to clear physical consequences and half described a negative impact on mental health. There was a general sense of indignity among detainees (Jesuit Refugee Service - Europe, 2010). This is specially so in the subgroup of torture survivors (Filges, Montgomery, & Kastrup, 2018) (Storm & Engberg, 2013). According to recommendations from the United Nations' High Commissioner for Refugees (UNHCR) (2012) and the Special Rapporteur on Torture (2018), torture survivors and other vulnerable groups should generally not be detained. Health professionals should actively oppose this measure based on ethical and deontological principles (Brooker et al., 2016; Pearman, Psych, Olinga-shannon, & Hons, 2017)

Accessing the system of protection for torture survivors

There is an important concern in the anti-torture sector that torture survivors who suffer trauma-related mental disorders are being refused protection by countries in which they seek asylum. A pioneering study (Loneragan et al., 2006) followed a consecutive sample (n=73) of recently arrived asylum seekers attending immigration agents in Sydney, Australia. Participants were followed up to assess the outcomes of their refugee applications. Although the participants reported high rates of torture (51%), and this group is of course at the highest risk of suffering a combination of post-traumatic stress disorder (PTSD) and major depression, neither past torture nor

[8] https://www.globaldetentionproject.org/

current psychiatric disorder predicted the outcomes of refugee applications. Although the Asylum Procedures Directive (European Council, 2013) establishes special measures to detect and properly document torture survivors,[9] there are serious concerns regarding its proper application (IRCT, 2016)

Faced with the increasing numbers of asylum seekers, a number of initial screening tools—up to 20 documented in academic journals and grey literature—have been proposed, the majority of large institutions having their own. There are suggestions and formats from national and international bodies including guidelines from the European Union itself (PROTECT Project, 2016)—see also Mewes, Friele, & Bloemen, (2018) in this issue. The scene is variegated and requires revision as most are non-validated instruments that can be classified into two broad categories: (a) short clinical measures based on abbreviated diagnoses of post-traumatic stress or general psychological distress that can be applied by administrative staff (i.e. Hollifield et al., 2013); and, (b) general indicators of vulnerability (i.e. UNHCR-International Detention Coalition - OAK, 2016). It should be remembered that there is a low to moderate correlation between experiences of torture and psychiatric disorders, and that PTSD is neither the only nor the most likely consequence of torture in the long term. Issues of transcultural validity of screening tools are also relevant. A review of validated measures and more theoretical debate and consensus is needed (Gadeberg & Norredam, 2016; McColl, McKenzie, & Bhui, 2008).

Post-migration without status

Silove and colleagues have been providing sustained evidence of the negative impact on mental health of conditions of reception for asylum seekers in Australia, showing that its impact was even greater than torture and persecution in country of origin (Silove, 2000; Z Steel & Silove, 2001; Steel et al., 2009). A Norwegian case-control study in an in-patient psychiatric ward found highly significant differences in PTSD prevalence between asylum seekers, living in centres (n=53, 43.3%), and refugees (n=45, 11%), associated to the stresses of life in reception centres and the risk of being expelled from the country more than the experiences in countries of origin (Iversen & Morken, 2004). Other studies have expanded these results to medical conditions (Porter, 2007). In a recent systematic review (Kalt, Hossain, Kiss, & Zimmerman, 2013), combining data from 23 peer-reviewed studies among asylum-seekers (30% torture survivors), it was concluded that highly stressful asylum-seeking processes produced adverse mental and somatic health effects, associated to specific forms of exclusion linked to social conditions and hostile policy environments.

Whilst these conditions vary from country to country, there are some salient themes:

Poverty: Asylum seekers face economic hardship through an increasingly short and limited system of state social support and assistance even where there is one

[9] The Asylum Procedures Directive (recast) was adopted by the European Parliament and the Council in 2013 and was to be transposed into Member States' national legislations by July 2015. The Commission presented in July 2016 a Proposal for a new Asylum Procedure Regulation. Point 31 states that, *"National measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or psychological violence, including acts of sexual violence, in procedures covered by this Directive may, inter alia, be based on the (…) Istanbul Protocol."*

(Allsopp, Sigona, & Phillimore, 2014). While waiting for a determination decision, they often receive basic temporary benefits, well below the minimum of the country, usually aggravated by the denial of permission to work. This situation can extend for a long period of time. As an example, in a 2013 study for *Freedom for Torture*, Pettitt reveals that more than half of a sample of 84 torture survivors in the UK asylum system reported that they could never or not often afford to buy enough food of sufficient quality and variety to meet their needs for a nutritionally balanced diet. 34 were never able to buy enough food of any quality to avoid hunger. 53 could not buy adequate winter clothing (Pettitt, 2013). It is hard to imagine the situation of asylum seekers in countries with even lower levels of assistance.

Access to healthcare: According to the HealthQUEST study (Tirado, 2008), most European countries limit the access of migrants and asylum seekers to health care, usually reducing it to basic care and emergencies. The system of free specialised healthcare is usually banned. The study shows that in Europe providing comprehensive adequate care (including mental health) would, paradoxically, save costs. In the United States where there is no national health system, the situation is so precarious that Asgary, Charpentier, & Burnett (2012) showed in a sample of sub-Saharan asylum seekers (most of them torture survivors) that they had better access to social and health services in their home African countries than in the US.

Stigma: There is growing evidence that perceived discrimination carries a psychological toll. A wide study following a participatory action research process in Scotland showed how this was linked to mental health problems, especially in VoT (Quinn, 2014).

Cultural Barriers: Language and culture have been documented as central sources of stress, particularly in the long term (Montgomery, 2011). The role of cultural mediators is crucial, undoubtedly another insufficiently researched topic.

Access to justice and providing meaning to the experience of torture: Arriving in a host country is, for many survivors, part of a process of social and political commitment which cannot be easily continued. Giving testimony, being part of an ideological or political movement, helping those who remain in their country, and pursuing justice can be essential elements to providing meaning to the experience of torture and to have a sense of continuity in life. The asylum system too often victimises survivors and keeps them in a vulnerable legal position that precludes any possibility of activism or empowerment and the impacts of this are not well researched. (EATIP, GTNM/RJ, CINTRAS, & SERSOC, 2002; Tay & Silove, 2017)

Facing assessment

Abbreviated procedures: McColl (2008) has shown that processes that are too *fast-track* can preclude proper medical documentation of allegations of torture or persecution.

Delay of decision: In a series of focus group with survivors of torture in UK, , the three biggest problems described were uncertainty, lack of perspective and a shortened future associated with endless waiting for a decision (Haoussou, 2017). Although the European Asylum Procedures Directive (European Council, 2013) envisages a maximum of six months for an asylum determination, the decision

normally takes much longer, sometimes years. At the American border, asylum claimants often spend many years waiting for the adjudication of their cases creating a limbo situation (Haas, 2017). A cross-sectional survey with Iraqi refugees whose determinations were pending showed that survivors waiting for a decision generally felt socially isolated and lacking in control over their life circumstances with a strong sense of injustice (Johnston, Allotey, Mulholland, & Markovic, 2009).

Stress of the interview and court hearings: After initial acceptance, and after a long waiting process, survivors of torture must prepare and undergo an in-depth interview (and sometimes a court hearing) where her fate will be decided. This is not a neutral process. A recent study in Berlin suggested that the asylum interview might decrease posttraumatic avoidance but trigger posttraumatic intrusions (Schock, Rosner, & Knaevelsrud, 2015). Due to this stress, the interview might have a negative result. Similar studies in other countries have found less conclusive results (Hocking, Kennedy, & Sundram, 2015)

Medical reports: Some studies show the importance of medical reports for proper documentation of torture. In a sample of close to 2000 asylum-seekers in the US, 89% of those with a medical report from Physicians for Human Rights (PHR) were granted asylum, compared to the national average of 37.5% (Lustig, Kureshi, Delucchi, Iacopino, & Morse, 2008). We need more data on which aspects of forensic assessment in general and the Istanbul Protocol in particular are relevant for an administrative body or court to make a final decision on a protection claim, a much needed demand in the anti-torture sector (Freedom for Torture, 2016; Pérez-Sales, Witcombe, & Otero Oyague, 2017).

Credibility: It is probably the assessment of the credibility of allegations of torture that is the one of the most complex issues and on which, paradoxically, there is less academic research (Jubany, 2017). On the one hand, there is a debate on whether health professional should make judgments of credibility (Good, 2004). The debate often mistakes the credibility of the victim with the credibility of the victim's account. There is arguably an ethical duty to have a forensic report provided, especially in contexts in which the victim of torture lacks any other evidentiary element, has fled without any documentation, and there are no physical injuries or witnesses that can support her allegations (Pérez-Sales, 2017). This is particularly the case when considering the crude reality that torture survivors are being refused protection in all likelihood due to the difficulties in giving a proper account of the facts (Loneragan et al., 2006; Masinda, 2004).

There are numerous guidelines for credibility assessment of the different institutions and bodies working within the framework of asylum (Gyulai, Kagan, Herlihy, Turner, & Lilli, 2013; Home Office, 2015; Kane, 2008; Mackey & Barnes, 2013; Mind, 2010), with very different perspectives and approaches and sometimes conflicting criteria. While in some cases the victim's account is said to be the weakest piece of evidence, in others it is the opposite that is emphasised and guidelines are worked out for the analysis of the narrative and its relationship with sources of corroboration or triangulation. None of the available guides to best practice have been validated and they are in any case only recommendations from experts. We also lack data for comparing

credibility in this area with credibility in other fields and the standards of proof required (Freedom for Torture, 2016).

It unfortunately remains the case that the asylum determination process relies heavily on remembering and narrating traumatising stories in a *convincing* way and without contradictions, despite mental health issues.

Deportation

In 2016 alone, the EU allocated a total of 806 million Euros to activities related to the deportation of migrants, including the expulsion of 113,835 people to the 15 countries with which Europe has signed a repatriation partnership agreement and the financing of migrant centres in countries such as Pakistan or Lybia. This figure would have increased noticeably if the agreement with Turkey had not been a failure[10] and if transfer among EU members in application of the Dublin procedure were included.[11] During President Obama's administration, a record 2.5–3 million immigrants were deported in his eight years in office. In 2016, immigrant detention and deportation machinery alone in the US cost 3.3 billion dollars (Baker, 2017). What happens with asylum-claimers who have been rejected and deported? Although some organizations try to keep track of them (Amnesty International, 2017), there is scarce data on their fate. There are some ethnographic studies on the hardships of reintegration after deportation for economic migrants (e.g. Khosravi, 2018) but literature is scarce on rejected asylum claimants.

The organisation Justice First followed in 2011 a sample of Congolese people deported from France and found out that all failed asylum seekers had been imprisoned, tortured, forced to pay a ransom, raped or subjected to sexual harassment upon their return (Ramos, 2011). Reports from Freedom for Torture (2012) and Human Rights Watch (2012) have documented the systematic detention and torture of Tamils who were rejected asylum claimants and deported to Sri Lanka. Similar data have been reported for deportees to Eritrea, Malta, Libya including summary executions of deportees in Sudan (Alpes, Blondel, Preiss, & Monras, 2017). There are documented cases of detention and torture of Ugandan citizens that demanded asylum due to being a member of the LGTBQ community (Onyoin, 2017), and already mentioned is the fate of people deported to Turkey in application of the EU-Turkey agreement. This data should not be a surprise. In many countries, the deported person is handed to the national authorities on arrival. Having claimed asylum is viewed as suspicious and the person is often immediately detained and interrogated. All together, these studies suggest that there is a real danger for deported people and this must be the responsibility of deporting authorities that do not have a post-deportation follow-up system (Stefanovska, 2016). Additionally, a Rights Disability International campaign claims that deporting people with severe mental disorders or disabilities to countries where they will have no access to proper care or treatment or be secluded in institutions with conditions that can amount to torture

[10] http://www.publico.es/internacional/union-europea-agencia-deportacion-masiva-migrantes.html

[11] In January 2011, the European Court of Human Rights (EchRT) declared that the transfer of one person from Belgium to Greece in application of the Dublin rules violated Article 3 (torture and inhuman or degrading treatment or punishment) and Article 13 (effective remedy) of the European Chart of Human Rights. Following this decision, most of the member states of the European Union stopped Dublin transfers to Greece.

should be enough to stop deportation and humanitarian protection should always be granted (Rosenthal, 2018).[12]

The top of the vulnerability pyramid: undocumented migrants

The alternative for survivors whose application has been rejected is to stay undocumented in the host country in even worst conditions than before. If asylum seekers and refugees suffer poverty, stigma, lack of health services or a work permit, this is to be added to having to hide from police, being defenceless from crime and violence and working in the underground economy. Overwhelming data show that this is the group with the highest risk of severe mental health disorders. One study, among many, in Zurich (Switzerland) showed that more than 80% had at least one clinically significant symptom, and more than 50% fulfilled the criteria for PTSD. This should come as no surprise as more than 60% had suffered imprisonment and 30% torture. The prevalence of torture was slightly lower than those of asylum seekers, but the prevalence of mental health problems was higher. The study showed, again, not only that refugee and humanitarian decision-making procedures may be failing but also that undocumented migrants are probably the most vulnerable and affected of populations due to an aggravation of pre-migration symptoms and the impossibility of access to treatment according to their right to rehabilitation (Mueller, Schmidt, Staeheli, & Maier, 2011).

Once status is granted: 'El Dorado'

The long journey finally ends for an estimated 30-40% of torture survivors that ask for international protection obtaining it (Loneragan et al., 2006; Mueller et al., 2011; UNHCR, 2017). The majority is, thus, undetected or rejected. There is a large body of literature showing that the refugee population, even with protection status, has very high levels of psychological suffering resulting from their pre-migration experiences, but particularly from life in the new host country (Porter, 2007; Porter & Haslam, 2005). A decent standard of living is not guaranteed.

Right to rehabilitation

Torture survivors have a right to rehabilitation, as set out in the Convention against Torture and General Comment No. 3. Programs for VoT who move about are a challenge. There is a need for short-term interventions that follow the do-no-harm principles in contexts where it might not be the time to talk. This creates a special set of conditions for rehabilitation programs that deserve special research, including long-term follow-up and non-clinical measures.

Where next?: Concluding remarks

The over twenty-five years of research in the field appears to provide conclusive evidence regarding the negative impact on torture survivors of human right violations taking place throughout the *migration continuum.*

This idea of a migration continuum deserves special attention. Migrants who along their migration route have been suffering violence (including torture by non-state actors, sexual violence, and being unable to access basic conditions that respect human dignity) should be also offered protection and access to basic human rights (to health, housing, education, rehabilitation etc).

Figure 1 is intended to show a summary of the relationship between mental health

[12] https://www.driadvocacy.org/

and well-being and pre- and post-migration factors and the amount and strength of available evidence. Although we need more studies on psychosocial determinants during the asylum claim process, there is strong evidence on the impact of poverty and limitations of access to health care. Most of the research highlighted here is in relatively well-off host countries which reflects the absence of literature in more complex situations (e.g. Lebanon and Greece, not to mention other neighbouring countries to refugee-producing countries in the rest of the world). More research is especially needed regarding the migration process itself and the impact of massive human rights violations at borders, migrant detention centres in third countries, and by State and Non-State actors on victims of persecution and torture fleeing from their country. This also applies to research on what happens to people being denied protection and deported to their countries of origin. Although there are indicative data, more research is also needed on the screening process and appropriateness of detention of torture survivors and vulnerable populations, the impact of the asylum process and interviews, on the role of translators and cultural mediators, and the effect of policies of dispersal and delays in procedure decisions. With respect to proper identification procedures, the need is poignant and urgent. Finally, we still lack more research and stronger evidence on the efficacy of rehabilitation programs for migrant torture survivors.

In this issue

Some of these topics are addressed in the Special Section of this issue, the papers of which have been developed from presentations at the International Society for Health and Human Rights' 2017 tri-annual conference in Novisad (Serbia) on *Mental health, mass people displacement and ethnic minorities,* and from a call from the Journal. It has been made possible thanks to the financial support of the Danish Ministry of Research. It starts with a paper by Caterina Spissu and colleagues from Médecins Sans Frontières teams in Rome exploring the difficulties in early identification of torture victims by non-professionals working in front-line resources. This is followed by a the study on the psychometric evaluation of the Protect Questionnaire mentioned above by Ricarda Mewes, Boris Friele, Evert Bloemen. Simone de la Rie, Jannetta Bos, Jeroen Knipscheer and Paul Boelen from Zentrum 45 in the Nertherlands present several case studies paradigmatic of the difficulties of the cases they attend, as do Gail Womersley and colleagues at Médecins Sans Frontières, this time related to work in Athens. Interpretation is then tackled with Filiz Celik and Tom Cheesman from Swansea University in Wales addressing whether non-professional translation by volunteers from the same country can be a useful tool in counselling for refugees and torture survivors in a context where professional interpretation is unaffordable. Mechthild Wenk-Ansohn, Carina Heeke, Maria Böttche and Nadine Stammel from Center ÜBERLEBEN in Berlin present results of a multimodal treatment for newly arrived refugees that puts the focus on the initial six months' work; they found mixed results and reflect on them. Caecilie Böck Buhmann, Jessica Carlsson and Erik Lykke Mortensen from the Competence Center for Transcultural Psychiatry in Denmark analyse the cultural acceptability of a western-style, trauma-focused programme combining CBT and antidepressants showing that satisfaction is linked to rapport with the survivor and not to clinical results. This collection of

papers adds new data and knowledge and shows some new avenues of work and research especially regarding early detection, counselling in early stages of arrival and support in the long term. It could not have been possible without the invaluable help of Joost den Otter, past Editor-in-Chief of the Journal and Associated Guest-Editor for this Special Section. Papers that are not directly related to the Special Section include a review entitled 'Debility, dependency and dread: On the conceptual and evidentiary dimensions of psychological torture' by Ergun Cakal and perspectives piece on the development and organisation behind survivor activism at Freedom from Torture in the UK by Shameem Sadiq-Tang which offers a useful and practical guide. Whilst this offers many positive stories, the rest of the content in this issue suggests that, in the case of the migrant victims of torture, they are almost always deprived of any form of control over their lives by an unjust and alienating system.

References

Allsopp, J., Sigona, N., & Phillimore, J. (2014). Poverty among refugees and asylum seekers in the UK An evidence and policy review. *IRiS Working Paper Series*, 1–46.

Alpes, J., Blondel, C., Preiss, N., & Monras, M. S. (2017). Post-deportation risks for failed asylum seekers. *Forced Migration Review, 54*, 76-78.

Amnesty International. (2017). *Human Rights in the context of forced returns.* (Vol. 1). https://doi.org/10.1007/978-3-319-39351-3_10

Asgary, R., Charpentier, B., & Burnett, D. C. (2012). Socio-Medical Challenges of Asylum Seekers Prior and After Coming to the US. *Journal of Immigrant and Minority Health*. https://doi.org/10.1007/s10903-012-9687-2

Baker, B. F. (2017). The Hidden Costs of Mass Deportation. *Anthropology News*, *58*(5), e319–e323. https://doi.org/10.1111/AN.632

Ben Farhat, J., Blanchet, K., Juul Bjertrup, P., Veizis, A., Perrin, C., Coulborn, R. M., … Cohuet, S. (2018). Syrian refugees in Greece: Experience with violence, mental health status, and access to information during the journey and while in Greece. *BMC Medicine*, *16*(1), 1–12. https://doi.org/10.1186/s12916-018-1028-4

Brooker, S., Albert, S., Young, P., Steel, Z., Flynn, M., & Flynn, M. (2016). Challenges to Providing Mental Health Care in Immigration Detention About the Global Detention Project Challenges to Providing Mental Health Care in Immigration Detention, (19).

Crisp, J. (2009). Refugees, persons of concern, and people on the move: The broadening boundaries of UNHCR. *Refuge*, *26*(1), 73–76.

Daniel, E. V., & Knudsen, J. C. (1995). *Mistrusting refugees.* Berkeley: University of California Press.

EATIP, GTNM/RJ, CINTRAS, & SERSOC. (2002). *Paisajes del Dolor, Senderos de esperanza. Salud mental y derechos humanos en el Cono Sur.*

European Council. (2013). L 180/60. Common procedures for granting and withdrawing international protection.

Fazel, M., & Silove, D. (2006). Detention of refugees. *British Medical Journal*, *332*(7536), 251–252. https://doi.org/10.1136/bmj.332.7536.251

Filges, T., Montgomery, E., & Kastrup, M. (2018). The Impact of Detention on the Health of Asylum Seekers: A Systematic Review. *Research on Social Work Practice*, *28*(4), 399–414. https://doi.org/10.1177/1049731516630384

Freedom for Torture. (2012). *Sri Lankan Tamils tortured on return from the UK.*

Freedom for Torture. (2016). *Proving Torture. Demanding the impossible. Home Office mistreatment of expert medical evidence*. London.

Gadeberg, A. K., & Norredam, M. (2016). Urgent need for validated trauma and mental health screening tools for refugee children and youth. *European Child & Adolescent Psychiatry*, *25*(8), 929–931. https://doi.org/10.1007/s00787-016-0837-2

Good, A. (2004). Undoubtedly an expert? - anthropologists in British asylum courts. *Journal of The Royal Anthropology Institute*, *10*, 113–133. https://doi.org/10.1111/j.1467-9655.2004.00182.x

Griffiths, M. (2012). Vile liars and truth distorters. *Anthropology Today*, *28*(5).

Gyulai, G., Kagan, M., Herlihy, J., Turner, S., & Lilli, H. (2013). *Credibility assessment in asylum procedures. A Multidisciplinary Training Manual* (Vol. 1). Hungarian Helsinki Committee.

Haas, B. M. (2017). Citizens-in-Waiting, Deportees-in-Waiting: Power, Temporality, and Suffering in the U.S. Asylum System. *Ethos*, *45*(1), 75–97. https://doi.org/10.1111/etho.12150

Haoussou, K. (2017). Perspective—The long journey

to rehabilitation for torture survivors i. *Torture*, *27*(1), 66–74.

Hocking, D. C., Kennedy, G. A., & Sundram, S. (2015). Mental disorders in asylum seekers: The role of the refugee determination process and employment. *Journal of Nervous and Mental Disease*, *203*(1), 28–32. https://doi.org/10.1097/NMD.0000000000000230

Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E. C., Woldehaimanot, T., Yamazaki, J., … SooHoo, J. (2013). The Refugee Health Screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General Hospital Psychiatry*, *35*(2), 202–209. https://doi.org/10.1016/j.genhosppsych.2012.12.002

Home Office. (2015). *Asylum Policy Instruction: Assessing Credibility and Refugee Status*.

Hope Border Institute. (2018). *Sealing the border. The criminalization of asylum seekers in the Trump era.* El Paso.

HRW. (2012). *UK: Halt Deportations of Tamils to Sri Lanka*.

Human Rights First. (2017). Violations at the Border, (February). Retrieved from http://www.humanrightsfirst.org/sites/default/files/hrf-violations-at-el-paso-border-rep.pdf

IRCT. (2016). *Falling Through the Cracks: Asylum procedures and reception conditions for torture victims in the European Union*. Copenhahue: IRCT.

Iversen, V. C., & Morken, G. (2004). Differences in acute psychiatric admissions between asylum seekers and refugees. *Nordic Journal of Psychiatry*, *58*(6), 465–470. https://doi.org/10.1080/08039480410011696

Jesuit Refugee Service - Europe. (2010). *Becoming vulnerable in detention - Civil Society Report on the Detention of Vulnerable Asylum Seekers and Irregular Migrants in the European Union (DEVAS)*.

Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: a review. *Clinical Psychology Review*, *28*, 36–47. https://doi.org/10.1016/j.cpr.2007.01.017

Johnston, V., Allotey, P., Mulholland, K., & Markovic, M. (2009). Measuring the health impact of human rights violations related to Australian asylum policies and practices: A mixed methods study. *BMC International Health and Human Rights*, *9 (1)*.

Jubany, O. (2017). *Screening asylum in a culture of disbelief: Truths, denials and skeptical borders*. *Screening Asylum in a Culture of Disbelief: Truths, Denials and Skeptical Borders*. https://doi.org/10.1007/978-3-319-40748-7

Kalt, A., Hossain, M., Kiss, L., & Zimmerman, C. (2013). Asylum seekers, violence and health: A systematic review of research in high-income host countries. *American Journal of Public Health*, *103*(3). https://doi.org/10.2105/AJPH.2012.301136

Kane, J. (2008). Judging Credibility. New York: American Bar Association.

Keller, A. S., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., Sachs, E., Leviss, J. A., … Ford, D. (2003). Mental health of detained asylum seekers. *Lancet*, *362*(9397), 1721–1723. https://doi.org/10.1016/S0140-6736(03)14846-5

Khosravi, S. (2018). *After deportation. Ethographic perspectives.* Palgrave McMillan.

Loneragan, C., Steel, Z., Touze, D. le, Harris, E., Ceollo, M., Susljik, I., … Brooks, R. (2006). Torture, Mental Health Status and the Outcomes of Refugee Applications among Recently Arrived Asylum Seekers in Australia. *International Journal of Migration, Health and Social Care*. https://doi.org/10.1108/17479894200600002

Lustig, S. L., Kureshi, S., Delucchi, K. L., Iacopino, V., & Morse, S. C. (2008). Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States. *Journal of Immigrant and Minority Health / Center for Minority Public Health*, *10*, 7–15. https://doi.org/10.1007/s10903-007-9056-8

Lyytinen, E. (2017). Refugees' 'Journeys of Trust': Creating an Analytical Framework to Examine Refugees' Exilic Journeys with a Focus on Trust. *Journal of Refugee Studies*, few035. https://doi.org/10.1093/jrs/few035

Mackey, A., & Barnes, J. (2013). *Assessment of Credibility in Refugee and Subsidiary Protection claims under the EU Qualification Directive Judicial criteria and standards Prepared by Allan Mackey and John Barnes for the International Association of Refugee*.

Masinda, M. T. (2004). Quality of Memory: Impact on Refugee Hearing Decisions. *Traumatology*. https://doi.org/10.1177/153476560401000205

McColl, H., McKenzie, K., & Bhui, K. (2008). Mental healthcare of asylum-seekers and refugees. *Advances in Psychiatric Treatment*, *14*, 452–459. https://doi.org/10.1192/apt.bp.107.005041

Mewes, R., Friele, B., & Bloemen, E. (2018). Validation of the Protect Questionnaire: A Tool to Detect Mental Health Problems in Asylum Seekers by Non-Health Professionals. *Torture*, *This issue*.

Mind. (2010). *Achieving justice for victims and witnesses with mental distress. A mental health toolkit for*

prosecutors and advocates. London: Mind-For better health.

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2003). Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia. *Social Science & Medicine*, *57*(5), 775–781. https://doi.org/10.1016/S0277-9536(02)00452-5

Montgomery, E. (2011). Trauma, Exile and Mental Health in Young Refugees. *Acta Psychiatrica Scandinavica*, *124*(September).

Mueller, J., Schmidt, M., Staeheli, A., & Maier, T. (2011). Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers. *European Journal of Public Health*, *21*(2), 184–189. https://doi.org/10.1093/eurpub/ckq016

Níraghallaigh, M. (2014). The causes of mistrust amongst asylum seekers and refugees: Insights from research with unaccompanied asylum-seeking minors living in the republic of Ireland. *Journal of Refugee Studies*, *27*(1), 82–100. https://doi.org/10.1093/jrs/fet006

Onyoin, C. A. (2017). A grim return : post-deportation risks in Uganda. *Forced Migration Review*, (February), 81–83.

Pearman, A., Psych, B., Olinga-shannon, S., & Hons, B. B. A. (2017). Australian immigration detention and the silencing of practitioners, 90–93.

Pérez-Sales, P. (2017a). *Psychological Torture: definition, evaluation and measurement.* London-New York: Routledge.

Pérez-Sales, P. (2017b). Psychotherapy for torture survivors—Suggested pathways for research. *Torture : Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *27*(1), 1–12.

Pérez-sales, P., Witcombe, N., & Otero Oyague, D. (2017). Rehabilitation of torture survivors and prevention of torture: Priorities for research through a modified Delphi Study. *Torture*, *27*(3), 3–48.

Pettitt, J. (2013). The Poverty Barrier: The Right to Rehabilitation for Survivors of Torture in the UK, (July).

Porter, M. (2007). Global Evidence for a Biopsychosocial Understanding of Refugee Adaptation. *Transcultural Psychiatry*, *44*, 418. https://doi.org/10.1177/1363461507081642

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association*, *294*(5), 602–612. https://doi.org/10.1001/jama.294.5.602

PROTECT Project. (2016). *PROTECT. Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment*. Brussels.

Quinn, N. (2014). Participatory action research with asylum seekers and refugees experiencing stigma and discrimination: the experience from Scotland. *Disability and Society*, *29*(1), 58–70. https://doi.org/10.1080/09687599.2013.769863

Ramos, C. (2011). *Unsafe Return: Refoulement of Congolese Asylum Seekers*.

Robinson, V., & Segrott, J. (2002). Understanding the decision-making of asylum seekers. *Home Office Research Study*, (243), 84.

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: systematic review. *British Journal of Psychiatry*, *194*(4), 306–312. https://doi.org/10.1192/bjp.bp.108.053223

Roman, E., Baird, T., & Radcliffe, T. (2016). Why Turkey is Not a "Safe Country." *Statewatch Analysis*, *2013*(February), 1–26.

Rosenthal, E. (2018). *The right of people with disabilities to asylum and protection from deportation on the grounds of Persecution or Torture Related to their disability*.

Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *European Journal of Psychotraumatology*, *6*(March). https://doi.org/10.3402/ejpt.v6.26286

Silove, D. (2000). Policies of Deterrence and the Mental Health of Asylum Seekers. *Jama*, *284*(5), 604. https://doi.org/10.1001/jama.284.5.604

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention*, *11*(3), 237–248.

Sobhanian, F., Boyle, G. J., & Bahr, M. (2006). Living in the Australian Community Psychological Status of Former Refugee Detainees From the Woomera Detention Centre Now Living in the Australian Community. *Psychiatry, Psychology and Law*, *13*(2), 37–41.

Special Rapporteur Against Torture. (2018). *Migration-related torture and ill-treatment (A/HRC/37/50)*. *United Nations*. https://doi.org/CAT/C/MAR/CO/4

Stedman, S. J., & Tanner, F. (2003). *Refugee manipulation. War, politics and the abuse of human suffering*. Washington: Brookings Institution Press.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., van Ommeren, M., & Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van O. M. (2009). Association of torture and other

potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA : The Journal of the American Medical Association*, *302*(5), 537–549. https://doi.org/10.1001/jama.2009.1132

Steel, Z., & Silove, D. M. (2001). The mental health implications of detaining asylum seekers. *Medical Journal of Australia*, *175*, 596–599.

Stefanovska, V. (2016). Diplomatic Assurances and the State ' s Responsibility When Considering Extraditing a Person Whose Human Rights May Be Violated. *VARSTVOSLOVJE, Journal of Criminal Justice and Security*, (2), 167–182.

Storm, T., & Engberg, M. (2013). The impact of immigration detention on the mental health of torture survivors is poorly documented - A systematic review. *Danish Medical Journal*, *60*(11), 1–7.

Tay, A. K., & Silove, D. (2017). The ADAPT model: bridging the gap between psychosocial and individual responses to mass violence and refugee trauma. *Epidemiology and Psychiatric Sciences*, *26*(02), 142–145. https://doi.org/10.1017/S2045796016000925

Tirado, M. C. and I. G.-S. (2008). *Quality in and Equality of Access to Healthcare Services. Country Report for Romania*. Brussells.

Ulusoy, O., & Battjes, H. (2017). Situation of Readmitted Migrants and Refugees from Greece to Turkey under the EU-Turkey Statement, (15), 1–42.

UNHCR-International Detention Coalition - OAK. (2016). *Vulnerability Screening Tool. Identifying and addressing vulnerability: a tool for asylum and migration systems*.

UNHCR. (2017). *UNHCR- Global Trends. Forced displacement in 2016*. Geneva. Switzerland.

United Nations High Commisioner for Refugees. (2012). Detention guidelines. UNHCR.

Viñar, M. (2007). Civilization and torture : beyond the medical and psychiatric approach. *International Review of the Red Cross*, *89*(867), 619–633.

Voutira, E., & Harrell-Bond, B. (1995). In search of the locus of trust: the social world of the refugee camp. In E. V. Daniel & J. C. Knudsen (Eds.), *Mistrusting refugees* (pp. 207–225). University of California Press.

Debility, dependency and dread: On the conceptual and evidentiary dimensions of psychological torture[1]

Ergun Cakal, LLM*

Key points of interest:

- Psychological torture is prohibited by international law, but is ill-defined and regularly interpreted as not amounting to torture. Mental suffering needs to be clarified and expanded upon as part of the definition of torture.
- Psychological torture is complex and lacks appropriate acknowledgement in evidence-based fora.

Abstract:

Background: Psychological torture is deployed to break and obliterate human resistance, spirit and personality, but it is rarely afforded sufficient attention. Deficiencies in conceptualising, documenting and adjudicating non-physical torture mean that it is frequently left undetected and uncontested by the public, media and the courts, bolstering impunity for its perpetrators. A review of the current literature to map conceptual and evidentiary shortcomings from an inter-disciplinary perspective is therefore warranted. **Method:** The relevant texts were identified through a systematic full-text search of databases, namely HeinOnline, HUDOC, UNODS and DIGNITY´s Documentation Centre, with the keywords `psychological torture´, `mental pain and suffering´, `severity´, `humiliation´, `interrogation techniques´, and `torture methods´. The identified texts, limited to English-language journal articles, NGO reports, court-cases and UN documents from 1950 to date, were then selected for relevance pertaining to conceptual, evidentiary, technological and ethical critique provided therein. **Results/Discussion:** Evidential invisibility, subjectivity of the suffering, and perceived technological control are the primary ways in which psychological torture methods are designed, and how they manage to evade prosecution and consequently be perpetuated. Cognisant of the need for further research, pertinent questions highlighting the need to develop approaches, sharpen standards and use a medical/psychological/legal interdisciplinary approach are suggested.

*) Legal Advisor, DIGNITY - Danish Institute Against Torture.

[1] This review has significantly benefited from an ongoing REDRESS-DIGNITY collaboration on the topic. Whilst particular appreciation is owed to REDRESS, any errors and views remain the author's own. The title is a reference to Farber, Harlow & West (1957).

Correspondence to: erca@dignityinstitute.dk

Definitions and Concepts

Whilst it is important to view torture in its totality and to not disproportionately focus

on certain methods to the exclusion of others (see Ginbar, 2017, p. 305), there exists clear definitional and conceptual challenges with respect to otherwise headline-grabbing examples of psychological torture, e.g. 'enhanced interrogation techniques'. This section will broadly outline the main conceptual approaches that have been or may be used to define and conceptualise psychological torture.

Methods of torture and the mind and body dichotomy

Difficulties in adequately defining torture are magnified when it comes to psychological torture. As the physical and psychological may be viewed as two sides of the same coin, conceptually delineating between the two poses a difficulty in itself, as we straddle the mind/body dichotomy. According to Sveaass, the psychological impact of powerlessness, fear and uncertainty for any victim of torture means that 'there is no such thing as physical torture "by itself"' (2008, pp. 313-314). In other words, physical methods of torture also have strong psychological effects on a victim, and *vice-versa*. Rape is an oft-cited example here as, although often involving a physical act, its objective is a psychological one to 'punish, intimidate and humiliate' (see *Raquel Martí de Mejía v. Perú*, 1996). Providing an additional distinction, Pérez-Sales differentiates between two categories within psychological torture, namely between *pure psychological techniques* (e.g. humiliation, threats) and *attacks on the self through attacks on bodily functions* (e.g. exhaustion, sleep deprivation) (Pérez-Sales, 2017, p. 9). For present purposes, psychological *effects* of torture (e.g. anxiety, depression, PTSD) will be distinguished from psychological *methods* (both targeted at the body, e.g. exhaustion, and 'pure,' e.g. threats), with the latter being the focus of this review.

Terminology used to describe, dismissively or otherwise, the mental suffering as produced by such methods reflect these intersections. Some notions, such as 'evidence-free torture', emphasise the invisibility of the torture whether inflicted through physical means or not. Terms used in the literature include but are not limited to: 'non-physical torture'; 'white torture'; 'invisible torture'; 'no-touch torture'; 'clean torture'; 'evidence-free torture'; 'hands-off torture'; 'mental torture'; 'torture-lite', and 'psychological torture'.

Sveaass points out that 'it may be possible to describe extremely painful situations where no direct or obvious physical pain is inflicted' (2008, p. 315). For these situations, the label of 'psychological torture' remains apt given that 'the brutality of psychological torture is very much based on what we know of human psychological function ['personal agency, values, emotions, hope, relationships, and trust'], on information and knowledge developed within the realm of psychology' (Sveaass, 2008, p. 316). As the methods with which this review concerns itself target an individual's psychological integrity based on psychological or pseudo-psychological concepts, the term 'psychological torture' will be used throughout this review. Notwithstanding this, the pedagogical nature of this choice must be borne in mind.

Definitional elements

While international and regional human rights frameworks recognise that the use of psychological methods in and of themselves can constitute torture (as one need only refer to the inclusion of 'mental pain or suffering' under Article 1 of the *Convention against Torture* (UNCAT)), there is a need

to produce more workable understandings. It is notable to find that its drafters did not discuss at any length the meaning of 'mental pain or suffering' but some agreed on the difficulties therein (Nowak & McArthur, 2008, p. 38). Nowak points to the *travaux preparatoires* in arguing against any notion that the 'drafters intended a narrow interpretation that would exclude conduct as intentional deprivation of food, water, and medical treatment from the definition of torture' (2006, p. 819). While strict categorisations of forms of torture are avoided, it is clear in most jurisdictions that some psychological forms have been accepted as constituting torture or inhuman and degrading treatment or punishment.

Beyond a handful of cases, there remains a superficiality to judicial reasoning which warrants further dialogue with non-legal understandings here. Surveying relevant jurisprudence, Crampton proposes the following criteria as being useful, but not definitive, indicators of psychological torture: i. actions that prevent the detainee from maintaining stable mental health (i.e. forced absorption); ii. significance of the psychological maltreatment; iii. design and planning of the torture; and, iv. the perpetrator's focus on affective bonds to pressure the victim (2013). Similarly, another set of criteria entails: 'i. the relationship pattern between torture and tortured; ii. circumstances of the torturing system (political persecution, ethnic cleansing, law enforcement procedure); iii. Whether techniques target identity; iv. the severity of each experience from both an objective and subjective point of view' (Pérez-Sales, 2017, p. 4).

Notwithstanding its breadth, a preliminary review of international jurisprudence reveals that international law does not provide a uniform approach to methods of psychological torture. It is beyond the scope of this review to further outline the definitional dynamics (interpretative variations, gaps, and limitations) with respect to psychological methods of torture in international law. What is clear is that, with the exception of the UN Special Rapporteur on Torture (UNSRT), there is a tendency, where specific conclusions have been reached by certain bodies, to fix a high threshold for psychological torture violations. It suffices to say, however, that it remains unclear why some factual matrices are found to attract stronger criticism than others, and the inconsistency which reigns with respect to *when* exactly these bodies specifically condemn a psychological method as torture appears to thwart any meaningful analysis.

Categorisation and typology

Another approach in striving for conceptual clarity, amidst such ambiguities, has been through categorisation (or an extensional definition), which involves providing a detailed list of techniques known to not leave physical marks. Rejali provides four categories with which to conceptualise such techniques including: i. positional torture, ii. exercising to exhaustion, iii. restraint torture, and iv. beatings (2007). Admittedly, these are also known to leave physical marks such as bruises and nerve damage. Ojeda, defining the phenomenon as 'the intentional infliction of suffering without resorting to direct physical violence', provides a relatively detailed starting point here in his 13 categories:

> **isolation** (including complete or semi-solitary confinement); **psychological debilitation** (deprivation of basic needs, forced physical exertion); **spatial disorientation** (small, dark cells); **temporal disorientation** (denial

> of natural light, erratic scheduling of activities); **sensory disorientation (**inducing perceptions of sensory failure, narcosis or hypnosis); **sensory deprivation (**hooding, blindfolding, darkness, sound proofing etc.); **sensory assault (overstimulation)** (bright lights, loud noise/music); **induced desperation** (arbitrary arrest, indefinite detention, random punishment, forced feeding, implanting sense of guilt or abandonment); **threats** (to self or others, mock executions, forced witnessing of torture); **feral treatment** (forced nakedness, denial of personal hygiene, overcrowding, forced interaction, bestialism, incest); **sexual humiliation** (forcing victim to witness or partake in sexual behaviour); **desecration** (forcing victims to witness or partake in violating religious practices (irreverances, blasphemy, profanity, defilement, sacrilege); **pharmacological manipulation** (non-therapeutic use of drugs or placebos). (Ojeda, 2008, pp. 2-3)

A similar categorisation is found in Behan's work:

> **disruption of daily rhythms and routines** (night interrogation, disruption of sleep and biorhythms, early morning arrest, manipulating diet, sleep patterns, removal of all comfort items); **isolation and sensory deprivation** (solitary confinement, eliminating lights, sounds, odors, hooding); **monopolisation of perception** (constant bright cell, physical isolation, barren environment, restricted movement, monotonous food, sensory overload, interrogation in non-standard locations); **induced debilitation; exhaustion** (starvation, sleep deprivation, prolonged constraint, interrogation); **threats** (against self and/or family members of death, non-repatriation, endless isolation and interrogation, vague threats); **lies and deception** (re evidence against detainee, use of falsified documents or reports); **occasional indulgences; demonstrating omnipotence and omniscience; degradation** (use of foul language, preliminary humiliation, confinement, denial of personal hygiene, filthy environment, denial of privacy, stripping, removal of clothing); **enforcing trivial demands** (forced writing, enforcement of extremely detailed rules); **heightened suggestibility, hypnosis and narcosis; self-induced physical pain** (forced sitting on edge of chair of stool, forced upright kneeling and standing, stress positions); **physical abuse** (waterboarding, manhandling, mild physical contact such as grabbing, poking, pushing); **exploitation of phobias** (individual or religious phobias, such as dogs); **sexual humiliation** (forced stripping etc.) (Behan as quoted in Ojeda, 2008, p. 120)

Unless explicitly emphasised that they are non-exhaustive, the patent danger with such categorisation, *inter alia*, is it becoming restrictive. As Pictet observed in his commentary to the Geneva Conventions as early as 1958:

> However great the care taken in drawing up a list of all the various forms of infliction, it would never be possible to catch up with the imagination of future torturers who wished to satisfy their bestial instincts; and the more specific and complete a list tries to be, the more restrictive it becomes. (Pictet, 1958, p. 204)

The Human Rights Committee ('HRC') adopts the same position in saying that it is

not 'necessary to draw up a list of prohibited acts or to establish sharp distinctions between the different kinds of punishment or treatment; the distinctions depend on the nature, purpose and severity of the treatment applied' (Human Rights Committee, 1992, §4). This rings especially true if we are to accept the assertion, by one account, that military technology is a decade or two more advanced than that of clinical or academic research (Pérez-Sales, 2017, p. 331).

A narrow definition embracing categorisation, or enumeration, of prohibited acts of psychological torture has been adopted by the United States of America. In domestically implementing the UNCAT, the definition adopted by the United States' federal government presents an interesting case study. It refers to psychological torture as the:

> ...mental pain or suffering refers to prolonged mental harm caused by or resulting from: (1) the intentional infliction or threatened infliction of severe physical pain or suffering; (2) the administration or application, or threatened administration or application, of mind altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (3) the threat of imminent death; or (4) the threat that another person will imminently be subject to death, severe physical pain or suffering, or the administration or application of mind altering substances or other procedures calculated to disrupt profoundly the senses or personality. (18 U.S.C. §2340(2)(B))

There have been two main criticisms made against this definition: that enumerating the actions unduly (to threats of imminent death for instance) narrows the understanding of psychological torture, and that it requires *prolonged* mental harm, a requirement not found in the UNCAT. The latter point was explicitly made by the Committee against Torture (Conclusions and Recommendations: USA, 2006; hereinafter 'CAT').

Conceptions and their contestations: The legal versus the non-legal

The ruling of whether a particular act or omission constitutes torture is ultimately a judicial one. It is, however, inevitably informed by medical understandings due to the anatomical and psychological conceptualisations of pain. The dominance of blindly legal conceptualisations of torture has been contested for being devoid of this necessary non-legal perspective, for its opaque focus on severity, bias towards the physical, and its Euro-centrism. A number of experts, namely Pérez-Sales, Sveaass and Başoğlu, have argued for a better-informed definition which can help instigate a more scientific understanding of particularly psychological torture. Başoğlu, to reproduce one argument, explains that 'a legal understanding of torture provides protection from torture to the extent that it comes closer to its psychological formulation' (2017, p. 492) and that what is needed is a 'broader definition of torture based on scientific formulations of traumatic stress and empirical evidence rather than on vague distinctions … that are open to endless and inconclusive debate and, most important, potential abuse' (2017, p. 397).

Sveaass understands psychological torture to be 'the process by which psychological pain is transformed into humiliation and dehumanisation, where the essence of being human—namely personal agency, values, emotions, hope, relationships, and trust—is under attack' (2008, p. 304; see also Sveaass, 1994, p. 43). Pérez-Sales

also attempts to posit a workable definition as being 'the use of techniques of cognitive, emotional or sensory attacks that target the conscious mind and cause psychological suffering, damage and/or identity breakdown in most subjects subjected to them; such techniques may be used alone or together with other techniques to produce a cumulative effect' (2017, p. 8).

The disconnect between the legal and non-legal conceptualisations coupled with the dominance of the former clearly presents a problem for the advancement of our understanding of torture generally, and perhaps an even greater hindrance with respect to psychological torture. The minor role given to dignity and humiliation (linked to self and identity) which feature more prominently in non-legal understandings is problematic when compared to 'pain-producing techniques' in legal understandings (Pérez-Sales, 2017, p. 262). As shall be discussed later, severity has also proven a challenge for legal minds.

Practices and perpetuation of psychological methods

This section will explore how psychological methods are designed, enabled and perpetuated under the guise of science and lawfulness. The conceptual argument persists as we draw on 'lawful sanctions', 'intentionality' and the difficulties with respect to distinguishing between torture and cruel, inhuman and degrading treatment (CIDT).

Scientific complicity: The 'benevolence' of technology

The scientific milieu out of which these methods have sprung is also of import to understanding the phenomenon. Technology, be it in the use of techniques, knowledge or personnel, has been used by state actors to act as an illusion of control purportedly safeguarding the process from breaching the pain threshold.

This was recognised as early as 1978 in the case of *Ireland v. the United Kingdom*, where in his dissenting opinion, Judge Evrigenis, calling the majority out on their reasoning, found that torture in the case was:

> ... based on methods of inflicting suffering which have already been overtaken by the ingenuity of modern techniques of oppression. Torture no longer presupposes violence, a notion to which the judgment refers expressly and generically. Torture can be practised—and indeed is practised—developed in multidisciplinary laboratories which claim to be scientific. (ECHR, 1978)

Rejali points out that at best this is also sourced from the perceived humanism and polyvalent use of technology. Pointing to the general public value in electricity-based technologies as an example, Rejali argues that any ill-conceived use, say as constituting a torture method, is faced with a 'civic doubt' as to whether such a technology can be as harmful given its benefits to humanity (2003).

Relatedly, revelations on the use of music as torture (its coerced listening (loud or otherwise), playing, singing or dancing) by the United States in places such as Guantánamo Bay promptly spawned a debate amongst academics and musicians alike. Music's use as therapy renders it difficult to think of its use as torture. Spielmann, a past president of the European Court of Human Rights, has observed that certain uses of music 'can amount to torture, and lyrics can be the vehicle of human rights abuses' (2012, p. 371). Such statements have been seen to herald a change in perceiving non-physical methods (Papaeti, 2013).

Grant's assessment is that there is nothing intrinsically harmful about music so context is paramount. She prescribes:

> Preventing the worst abuses of physical and mental integrity that can be inflicted through music begins with the much more simple act of removing the sheen from musical activities as in some way intrinsically beneficial and morally good. We need to face up to both the possible negative health effects of different musical practices and the long-standing conjunction between music and processes of humiliation and shaming (Grant, 2013, p. 11).

Perceived control: The perversion of 'trust' and 'regulation'

The complicity of psychology and, perhaps to a lesser extent, psychiatry, intentionally or not, in lending their expertise to state intelligence apparatuses, from the beginnings of the Cold War to the 'War on Terror', is widely accepted in the literature (Physicians for Human Rights, 2005; Pope & Gutheil, 2009; Soldz, 2011). It is important to recognise the psychology underpinning the psychological techniques of torture and warfare, which has been well-documented elsewhere (Lavik, 1994; McCoy, 2012; Suedfeld, 1990).

Soldz has, for instance, illustrated in some detail the role of psychologists at Guantánamo Bay, in designing the environment to disrupt cohesion and communication among detainees and to foster dependence and compliance instead, and also controlling the minutiae of interrogations to the point of prescribing the limited provision of toilet paper to one detainee (2010). Yet, to the American public, the role of mental health professionals were represented here as ensuring that the pain threshold was contained to a level below that of torture (American Psychological Association, 2005, p. 2). Trust in science was co-opted in order to appease public and institutional consciences. The wheeling out of the phrase 'safe, effective, legal, and ethical' by the Bush Administration was symbolic in manipulating the perception of torture:

> … into an expert activity with "scientific techniques" and other accoutrements of professionalism provided advantages to the torturers, conscious and unconscious. The pseudo-scientific façade Jessen and Mitchell developed for the military created a fig-leaf of cover that the torture was not the primitive and sadistic behaviour it really was. It also gave senior military personnel a chance to escape accountability by turning torture over to "the docs"." The Justice Department in effect created a "safe harbour" for interrogators. If a psychologist was involved in the interrogation, by the mere fact of the psychologist's involvement, the "enhanced interrogation" was per se "safe, effective, legal, and ethical". There was no requirement that the psychologist even do anything of a protective nature. His or her very presence, by executive definition, meant that the enhanced interrogation was "safe, effective, legal, and ethical". (Welch, 2010, p. 6)

For Kalbeitzer, the coerciveness of interrogations, as designed by psychologists, was as simple as 'designing the room in such a way as to create an intimidating atmosphere' (Kalbeitzer, 2009). Such tailoring took into account the individual vulnerabilities of the subject. Başoğlu also provides a comprehensive account of the centrality of 'learned helplessness' in CIA's design of its torture regime (Reyes & Başoğlu, 2017).

For what it is worth, the US Senate

confirmed that the CIA conducted no 'significant research to identify effective interrogation practices, such as conferring with experienced US military or law enforcement interrogators, or with the intelligence, military, or law enforcements services of other countries with experience in counterterrorism and the interrogation of terrorist suspects' (US Senate Select Committee on Intelligence, 2014, p. 20).

Observing this, O'Mara has deployed the term 'cargo cult science' to refer to such 'use of the language and even behaviours that bear some resemblance to science but critically without the scientific method and the intellectual commitments that follow from the adoption of the scientific method' (2015, p. 30). Similarly, McCoy has also explored the nexus between science and impunity, and the means by which science sanitises and assists in emboldening and legitimating psychological methods of torture, where he states:

> The language of science can make psychological torture seem like a series of carefully controlled procedures, sanctioned by rational experts who have the aura of authority that comes with knowledge and credentials (McCoy, 2012, p. 24).

As a side note, McCoy's work on the CIA's development and propagation of psychological methods of torture extensively explores the relationship between impunity, history and public forgetting. The fragility of collective memory means that publicised cases of psychological torture are also susceptible to contestation and manipulation by media and the state, which, according to McCoy, 'tear at the threads of collective memory, making each exposé seem isolated, anecdotal, and ultimately insignificant' (McCoy, 2012a, p. 38). He goes on to underscore the power of history in diffusing efforts at prosecution and prevention.

As a belated point of qualification, one must bear in mind that as much as Rejali alludes to the unacknowledged malleability of technology towards different ends, one must also refrain from holding science to be 'purely truth-seeking' and devoid of values. Moreover, Evans and Morgan militate against torture as conventionally 'unrestrainedly savage', instead depicting it as having long been cruel yet controlled, a 'carefully-regulated practice' (1998, p. 58).

Humiliation: Torture or inhuman and degrading treatment?

Back-tracking to powerlessness, fear and uncertainty, the relational dynamics, or the power imbalance, between the perpetrator and the victim, particularly with the use of psychological methods must also be considered. Whilst it is not exclusive to psychological torture, it may be argued that its significance is distinct when compared to the use of physical methods. For Pérez-Sales, torture arises where, upon this background of 'powerlessness and suppression', there occurs a violation of dignity and autonomy (2017, pp. 84-85, 261). When the phenomenology of torture is surveyed further, we can see that the torturer demonstrates his power to exhaust, disorient, create dependency, create fear and humiliate his victim (Hauff, 1994, p. 21). Such a violation may also involve self-betrayal, where a victim for instance is forced in the circumstances to do something to acknowledge their absolute helplessness and submission. Doerr-Zegers, speaking from experience on treating Chilean torture victims, states that the 'psychological component of torture becomes a kind of total theatre, a constructed unreality of lies and inversion, in a plot that ends inexorably with the victim's self-betrayal and

destruction' (McCoy, 2006, p. 10).

The notion of humiliation readily springs to mind here, which is conventionally associated with cruel, inhuman and degrading treatment, and more specifically with degrading treatment (*Ireland v. United Kingdom*, §167). Yet, as shall be discussed below, psychologically-informed systems of torture, such as those operated by the CIA, feature humiliation as a part of an overall method as a means of breaking the will and extracting information. It is upon this background that Nowak as UNSRT unearthed the centrality of 'powerlessness' to torture:

> as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness of the victim which usually means deprivation of personal liberty or a similar situation of direct factual power and control by one person over another. … A thorough analysis of the *travaux préparatoires* of Art 1 and 16 CAT as well as a systematic interpretation of both provisions in light of the practice of the Committee against Torture has led me to the conclusion that the decisive criteria for distinguishing torture from CIDT is not, as argued by the European Court of Human Rights and many scholars, the intensity of the pain or suffering inflicted, but the purpose of the conduct and the powerlessness of the victim. (Nowak & McArthur, 2006, p. 150; 2008, p. 76; see also Nowak 2006, p. 832; Sifris, 2013)

This is also central for Manderson who sees the 'experience of absolute powerlessness that reduces the victim, in their own eyes as well as their torturer's, to an animal, a body without will or dignity of any kind … the destruction of identity' (Manderson, 2005, p. 640). Applying this conceptualisation in his assessment of the detainees at Guantánamo Bay, it was pointed out that:

> Treatment aimed at humiliating victims may amount to degrading treatment or punishment, even without intensive pain or suffering. It is difficult to assess in abstracto whether this is the case with regard to acts such as the removal of clothes. However, stripping detainees naked, particularly in the presence of women and taking into account cultural sensitivities, can in individual cases cause extreme psychological pressure and can amount to degrading treatment, or even torture. The same holds true for the use of dogs, especially if it is clear that an individual phobia exists. (UN Commission on Human Rights, 2006, §51).

Başoğlu, Livanou & Crnobaric, in their oft-cited study, conclude that stress indicators of psychological methods including humiliation are similarly severe when compared to physical methods. They posit this as follows:

> Ill treatment during captivity, such as psychological manipulations, humiliating treatment, and forced stress positions, does not seem to be substantially different from physical torture in terms of the severity of mental suffering they cause, the underlying mechanism of traumatic stress, and their long-term psychological outcome. Thus, these procedures do amount to torture, thereby lending support to their prohibition by international law. (Başoğlu, Livanou & Crnobaric, 2007)

This brings into question the feasibility of equating humiliation with the lesser category of inhuman and degrading treatment as most adjudicatory bodies continue to do. It must be said that, whether assumed or dismissed, explicit mention of 'powerlessness' in the work of relevant human rights bodies and

international law is negligible. Given its centrality, techniques of humiliation that seek to achieve a sense of powerlessness in the victim and the victim's family, and are all too often found to amount to be less severe than torture, need to be seriously reconsidered, given the material differences between the consequences that flow from it, and any underestimation of pain and suffering addressed.

Whilst it is accepted that the particular stigma attached to torture must remain reserved for the most atrocious instances of ill-treatment, the use of powerlessness firms up an opening for ill-treatment to be treatment that is not simply physically brutal. Yet, the resort to severity in differentiating between torture and CIDT has also been increasingly critiqued and abandoned. In *Keenan v United Kingdom* (2001), the European Court stated that while 'it is true that the severity of suffering, physical or mental, attributable to a particular measure has been a significant consideration in many of the cases decided by the Court under Article 3 of the ECHR, there are circumstances where proof of the actual effect on the person may not be a major factor' (§113). Coupling this with the *Selmouni* ruling, for the European Court, 'the level of pain inflicted is increasingly a less determinate factor, as acts it once considered only "inhuman" could now rise to the level of torture, depending on the context and purpose for which physical force is employed' (Evans, 2002, p. 373; Selmouni v. France, 1999).

A brief note on purpose under the UNCAT definition is warranted. It is widely interpreted to be inclusive of 'such purposes as' obtaining information or a confession, punishment, intimidation and coercion or discrimination and that it is, therefore, not exhaustive. Yet, there remains a dearth of analysis here when compared to the depth of discussion on other constitutive elements also found therein such as *severity of pain and suffering* and *official capacity*. During the drafting process, it seems that the United Kingdom's proposal to include 'gratuitous torture', conceivably meaning torture without purpose or for self-gratification, was not adopted (Nowak & McArthur, 2008, p. 75). As pointed out by Burgers and Danelius, purposes explicitly stated in the definition are based on state interest (1988, pp. 118-119). This may mean that acts intended to humiliate or debase, those arguably closer to gratuitous, do not fall within the category of state interest, and therefore do not amount to torture. That said, even where private sadism predominates, there is 'usually an element of punishment or intimidation' sufficient to satisfy the purposive element under Article 1 (Burgers & Danelius, 1988, p. 119). Conversely, Article 2 of the Inter-American Convention against Torture, whilst listing similar purposes, includes 'for any other purpose', hence not proscribing purposes to ones based on state interest.

'Enhanced Interrogation Techniques' (EITs) and the 'Five Methods'

Despite experience disproving the efficacy of coercive tools in eliciting reliable information, the context of interrogation poses a fertile ground for the infliction of torture (Costanzo & Gerrity, 2009). This is front and centre of UNCAT Article 1's purposive element. Yet, much in the vein of psychological methods of torture, abusive interrogations have not been adequately and explicitly proscribed by international law. In remedying this, by calling for a protocol for non-coercive interviewing, the UNSRT (Mendez) recently stated that:

> Torture and ill-treatment harm those areas of the brain associated with

> memory, mood and general cognitive function. Depending on their severity, chronicity and type, associated stressors typically impair encoding, consolidation and retrieval of memories, especially where practices such as repeated suffocation, extended sleep deprivation and caloric restriction are used in combination. Such practices weaken, disorient and confuse subjects, distort their sense of time and render them prone to fabricate memories, even if they are otherwise willing to answer questions. They are also detrimental to the establishment of trust and rapport, and compromise the interviewer's ability to understand a person's values, motivations and knowledge — elements required for a successful interview. (UNSRT, 2016, §18)

Accusatorial, protracted or suggestive interviews overlayed with threats, manipulation and coercion are underscored as unethical, and depending on their 'degree, severity, chronicity and type, undue psychological pressure and manipulative practices' may be ill-treatment (UNSRT, 2016, §44). At the very least, one must accept the view of the CAT that 'moderate physical pressure', even when viewed as a 'lawful' mode of interrogation by a state (i.e. Israel), is 'completely unacceptable' as it creates conditions leading to the risk of torture or CIDT (CAT, 1994, p. 10).

Undoubtedly, the gravest contemporary regime of psychological torture, to be publicised at least, has been the United States' abuses of prisoners, by the later disavowed use of 'enhanced interrogation techniques', in various 'black-sites' around the world and notoriously in Abu Ghraib and Guantánamo Bay. In their seminal report 'Break Them Down', Physicians for Human Rights (PHR) lists the employed techniques as including: 'sensory deprivation, isolation, sleep deprivation, forced nudity, the use of military working dogs to instil fear, cultural and sexual humiliation, mock executions, and the threat of violence or death toward detainees or their loved ones' (PHR, 2006, p. 1).

Herman underscores that such 'techniques of establishing control over another person are based upon systematic, repetitive infliction of psychological trauma' (Herman, 2015, p. 69). Moreover, it is in the context of 'highly controlled detention and interrogation environment used to exploit helplessness and vulnerability' engendering the 'denial of autonomy and dependency on interrogators' that such techniques must be viewed (Physicians for Human Rights & Human Rights First, 2007, p. 6). Similarly, this system has been described as 'ambiguous almost by design' and the 'product of deliberate attempts to engineer tactics that provoke subtle forms of pain, relying on technological, psychological, and pharmacological innovations that maximize the pain or discomfort of the detainee's experience while leaving minimal perceptible evidence of brutality' (McDonnell, Nordgren & Loewenstein, 2011).

Further on the point of 'design', it is axiomatic to say that trauma can be 'culture-bound' and can differentiate across individuals as the 'meaning of torture and trauma is shaped by social support and religious, cultural and political beliefs' (Physicians for Human Rights & Human Rights First, 2007, p. 7). Another primary point of discussion has been the exploitation of cultural sensitivities of Arab men regarding sexual taboos (e.g. forced nakedness, contact with a woman) and other phobias (e.g. relating to dogs), based on a text called *The Arab Mind* by Patai from 2002.

Surveying the mentioned regimes of

psychological torture, Reyes concludes that 'accumulation of methods' together with 'unpredictability and uncontrollability' (an aggravating feature similar to 'powerlessness') are distinct features here (Reyes, 2007, p. 591). In the same vein, Başoğlu posits that the 'most deleterious consequences stem from uncontrollable aversive events that are also unpredictable' (Başoğlu & Mineka, 1992, p. 199).

The cumulative or combined nature of these techniques warrants some expansion. Contextually, some legitimate interrogatory methods which may seem 'minor' or 'innocuous' at first glance 'become coercive if used over prolonged lengths of time' (Reyes, 2007, p. 599). That is not to say that this is exclusive to or necessary for psychological torture. Also, isolated instances of methods such as mock executions, death threats or forcefully witnessing torture have been found to amount to torture. The thesis here rather is that such seemingly legitimate or innocuous means 'form a system deliberately designed to wear and break down, and ultimately also to disrupt the senses and personality' (Reyes, 2007, p. 599). In its latest report to the United States, the CAT explicitly recommended that uses of sensory deprivation and sleep deprivation at Guantánamo Bay were violations of the UNCAT and should be abolished (CAT, 2014, §17). The UNSRT has similarly assessed that 'jurisprudence of both international and regional human rights mechanisms is unanimous in stating that such methods violate the prohibition of torture and ill-treatment' (UNSRT, 2004, §17).

Furthermore, the UNSRT has also seen it necessary to explicitly point out that 'the simultaneous use of these techniques is even more likely to amount to torture' (UN Commission on Human Rights, 2006, §52). During his examination of 'enhanced interrogation techniques' as UNSRT, Rodley pointed out that '[e]ach of these measures on its own may not provoke severe pain or suffering' but may do so in combination 'applied on a protracted basis of, say, several hours' (UNSRT, 1997, §121). Therefore, he considered a certain degree of combining methods or their accumulation and duration as requisite before the severity threshold became relevant. Sleep deprivation may also prove an apt case to illustrate the cumulative, as opposed to inherent, dynamics here. In its criticism of Israel, the CAT did not categorically state that sleep deprivation, in *all* cases, amounted to torture but detailed certain durations over specific periods that did (CAT, 1998, §24).

Two European Court of Human Rights cases of *Al Nashiri v. Poland* (2014) and *Husayn (Zubaydah) v. Poland* (2014) where 'EITs' were found as having been used in CIA black-sites in Poland make for enlightening reading here. In *Al Nashiri*, the victim was subjected to two mock executions (one with a power drill), stress positions and 'EITs'. The Court characterised these techniques as 'deliberate inhuman treatment causing very serious and cruel suffering' amounting to torture under Article 3. In its assessment, the Court stated all the measures were applied in a:

> premeditated and organised manner, on the basis of a formalised, clinical procedure, setting out a "wide range of legally sanctioned techniques" and specifically designed to elicit information or confessions or to obtain intelligence from captured terrorist suspects. Those—explicitly declared—aims were, most notably, "to psychologically 'dislocate' the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist ... efforts to obtain critical

> intelligence"; "to persuade High-Value Detainees to provide threat information and terrorist intelligence in a timely manner"; "to create a state of learned helplessness and dependence"; and their underlying concept was "using both physical and psychological pressures in a comprehensive, systematic and cumulative manner to influence [a High-Value Detainee's] behaviour, to overcome a detainee's resistance posture". (§§ 515-516)

Husayn (Zubaydah) v. Poland involved another CIA detainee who had been subjected to the 'EITs', and at 'least 83 waterboard sessions in a single month', before being implicitly threatened with such a method again if he failed to comply. In its assessment, the Court observed:

> that this permanent state of anxiety caused by a complete uncertainty about his fate in the hands of the CIA and a total dependence of his survival on the provision of information during the "debriefing" interviews must have significantly exacerbated his already very intense suffering arising from the application of the "standard" methods of treatment and detention in the exceptionally harsh conditions. (§ 509)

A clear antecedent to this system was the 'five techniques' as used by the British Military firstly in Northern Ireland, during the Troubles, on individuals suspected to be involved with the Irish Republican Army (IRA). It consisted of:

> **(a) wall-standing:** forcing the detainees to remain for periods of some hours in a "stress position", described by those who underwent it as being "spreadeagled against the wall, with their fingers put high above the head against the wall, the legs spread apart and the feet back, causing them to stand on their toes with the weight of the body mainly on the fingers"; **(b) hooding:** putting a black or navy coloured bag over the detainees' heads and, at least initially, keeping it there all the time except during interrogation; **(c) subjection to noise:** pending their interrogations, holding the detainees in a room where there was a continuous loud and hissing noise; **(d) deprivation of sleep:** pending their interrogations, depriving the detainees of sleep; **(e) deprivation of food and drink:** subjecting the detainees to a reduced diet during their stay at the centre and pending interrogations. (§96)

When considering these methods, the (now defunct) European Commission of Human Rights, focusing on the combined psychological impacts, found that the five techniques constituted torture on the grounds of the intensity directly affects the personality:

> physically and mentally [and that] the systematic application of the techniques for the purpose of inducing a person to give information shows a clear resemblance to those methods of systematic torture which have been known over the ages... a modern system of torture falling into the same category as those systems... applied in previous times as a means of obtaining information and confessions. (*ECommHR, 1976: Ireland v. United Kingdom*, § 512)

When it progressed to the European Court of Human Rights however, it disagreed and held that the ill-treatment only amounted to cruel inhuman and degrading treatment but not to torture because the necessary severity and intensity of harm that a finding of torture required was not established (according to the *de minimis* rule). In his dissenting opinion, holding that

the treatment constituted torture, Judge Matscher stated that:

> the more sophisticated and refined the method, the less acute will be the pain (in the first place physical pain) which it has to cause to achieve its purpose. The modern methods of torture which in their outward aspects differ markedly from the primitive, brutal methods employed in former times are well known. In this sense torture is in no way a higher degree of inhuman treatment. On the contrary, one can envisage forms of brutality which cause much more acute bodily suffering but are not necessarily on that account comprised within the notion of torture.

By some accounts, this was a lost opportunity to stamp out the contemporary uses of such techniques, and has been linked to the reluctance of the Court to find a violation of torture from 1978 to 1996 (Rouillard, 2005, p. 30). Recently reviewing the case upon disclosure of new evidence, the Court decided not to change its original conclusion (*Ireland v. the United Kingdom,* 5310/71, 20 March 2018) primarily upon the principle of legal certainty. Despite this, in view of its subsequent statements as noted above and in *Selmouni v. France* (1999, see §101), the Court would now clearly find a regime similar to the five techniques as amounting to torture.

Two decades later, a combination of interrogation methods comparable to the five techniques, for instance, as has been used by Israel on Palestinian prisoners, were documented by the CAT in 1997 to include:

> (1) restraining in very painful conditions, (2) hooding under special conditions, (3) sounding of loud music for prolonged periods, (4) sleep deprivation for prolonged periods, (5) threats, including death threats, (6) violent shaking, and (7) using cold air to chill …

It assessed this regime as amounting to violations of Articles 1 and 16 of the UNCAT (CAT, 1997, § 257). Similarly, the HRC assessed the Israeli use of 'the methods of handcuffing, hooding, shaking and sleep deprivation to have been and continuing as being used as interrogation techniques, either alone or in combination' and that it violated Article 7 of the International Covenant on Civil and Political Rights (HRC, 1998, §19).

Assessment and documentation of psychological methods

The preceding discussion has attempted to sketch out a number of inter-related elements which obscure a thorough consideration of psychological torture. Compounding these, perhaps more intentional, biases are shortcomings in assessing and documenting allegations of psychological ill-treatment. When compared with the visibility of physical signs of ill-treatment, the relative invisibility of psychological impact can frustrate the processes of evidence-seeking fora.

The 'Break Them Down' report observes the health consequences of psychological methods to be 'extremely destructive' in the short and long term, including:

> … memory impairment, reduced capacity to concentrate, somatic complaints such as headache and back pain, hyperarousal, avoidance, irritability, severe depression with vegetative symptoms, nightmares, feelings of shame and humiliation, and posttraumatic stress disorder … incoherent speech, disorientation, hallucination, irritability, anger, delusions, and sometimes paranoia … depression, thoughts of suicide and nightmares, memory loss, emotional problems, and are quick to anger and have difficulties maintaining relationships and employment. Based

> on past experience, post traumatic stress disorder is likely to be common. (PHR, 2005, p. 9)

The main issue with respect to the evidentiary dimension is formulating approaches to best understand and document such effects. Most conventional understandings of torture involve the application of physical force; documentation has, therefore, entailed primarily analysing the ensuing physical marks and indicators. Thus, it is imperative to find processes, legal and medical, on which evidentiary corroboration can be formed, specifically sensitive to psychological torture.

Admittedly, specific means of documenting psychological torture remain limited. Psychiatric and psychological sequelae are strong indicators of psychological torture as it is of physical torture. Yet, it is notable that psychological methods are used in combination, either simultaneously or sequentially, to reach a desired effect, as illustrated in the 'five techniques' and 'EITs' (see ICRC, 2007, p. 9). It has been argued that this makes it 'nearly impossible to determine the specific cause of psychopathology shown' (PHR, 2005, p. 70).

Psychological methods of torture and the Istanbul Protocol

Importantly, the *Istanbul Protocol* accepts that, since torturers increasingly seek to conceal their crimes, 'the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.' (OHCHR, §161; see also §§ 159, 259, 260). Yet, the unrealistic expectations placed on medical experts who treat and document torture (Freedom from Torture, 2015) coupled with the persisting materialist bias (that is, a preference for the physical) of decision-makers render this declaration, despite increasing awareness, less than fully realised in practice.

Ultimately, however, the *Istanbul Protocol* conflates the physical and psychological methods and rejects a clear dichotomy as 'artificial' (OHCHR, 2004, §145). For Reyes, this is understood by the fact that, from a holistic, evidence-based perspective, both physical and psychological torture and effects need to be anticipated. Yet, for him, this somewhat undercuts the stand-alone importance of psychological torture and obfuscates the understanding of the stand-alone impact of psychological methods (2007, pp. 600-603). Also, for Pérez-Sales, the *Istanbul Protocol* needs to refine its conception here, and that just because 'the distinction is artificial (i.e. made for epistemological purposes), it does not mean that we shouldn't keep in mind that the ultimate target of torture is the conscious self, and that we should reflect on contemporary torture and the complex ways in which this conscious self is attacked and controlled' (2017, p. 308).

The logic between the act and the effect (without overemphasising the effect) is problematic. It is difficult to frame the question with sufficient specificity; concepts like 'causality', 'link', and 'relation' though useful can prove to be problematic as direct causality rarely exists in medicine. Medical professionals work with percentages and likelihoods in merely identifying where there is corroboration and working with a patient's statement. It is important to refrain from overemphasising the role of individual resilience. Therefore, requiring effect will disadvantage resilient victims. While existence of psychiatric sequelae remains a 'powerful indicator' of psychological torture insofar as 'depression, anxiety and posttraumatic symptoms' can *corroborate* the treatment

alleged (Pérez-Sales, 2017, p. 144), such sequelae, however, can never be said to be *diagnostic* of 'any particular source in the way that a particular scar is diagnostic of a burn or electrical shock' (Jacobs, 2008, p. 169). Moreover, in rejecting legal notions of causality in favour of relativity, Pérez-Sales points out that it is a fallacy to expect science to establish 'an unequivocal *causal* relationship between certain practices and their consequences in order to determine the limits of torture' (Pérez-Sales, 2017, pp. 274-275).

Difficulties arising out of the invisibility of impact lead the discussion to exploring the purposive alternatives as well as environmental assessments. For Pérez-Sales, evaluating torture environments can be a significant means to document psychological torture. He defines the torture environment as:

> … a milieu that creates the conditions for torture … made up of a group of contextual elements, conditions and practices that obliterate the will and control of the victim, compromising the self. … In epidemiological terms, any element can be considered part of a torturing environment if it has been identified as likely to increase the relative risk of severe physical or psychological suffering, if it is used within the context of torture or if it is employed with the purpose of inflicting torture. … Given that methods aren't used alone but as part of a system, the environment they operate in also needs to be holistically assessed. (2017, pp. 285, 330)

In a study conducted by Pérez-Sales et al, Basque prisoners held in incommunicado detention were interviewed at length in order to 'elaborate a prototypical process of detention and ill-treatment which helped to understand the dynamics of an interrogation procedure' (Pérez-Sales, 2016, p. 21). There, the authors underscore that this methodology builds on conventional descriptive and testimonial documentation to encompass a broader epidemiological approach:

> The creation of a Torturing Environment requires the interaction of several elements: (a) sensorial and temporal disorientation and confusion of the self- reflecting mind; (b) fear and terror that starts from the outset of detention and remains present throughout; (c) humiliations and attacks on identity that contribute to eroding any sense of control; and, (d) tension and beatings that produce physical and emotional exhaustion. The capacity of the victim for proper understanding, retrieval of memories, judgement and reasoning is progressively undermined. The techniques of emotional manipulation and cognitive distortion used during the interrogation complete the process.

Soon strengthened by validation (see Pérez-Sales, Martínez-Alés, Gonzalez Rubio, p. 2018), the Scale represents a leading tool of documentation with respect to psychological methods.

This is identified by its author as complementing and compatible with the *Istanbul Protocol*, primarily to bring to the fore, and hence better appreciate, methods of psychological torture. Whilst this is a promising and innovative proposal, it remains to be tested and used more widely. Similarly, explorative studies into the neurobiology of psychological torture also promise to provide corroborative evidence through identifying biological markers (Ojeda, 2008).

Subjectivity and severity: Obfuscation of pain, bias, resilience

Whilst also tied to physical instances of ill-treatment, the elements of subjectivity and

severity feature distinctively with respect to psychological torture. Subjectivity is used here to refer to both specific factors pertaining to individuals claiming to have been subjected to torture as well as the unfounded bias of decision-makers assessing 'severe pain' to require the physical and downplaying the psychological.

In her seminal work, Scarry explains that the 'unshareability' of pain underscores the significance of considering subjectivity in assessing torture claims (Scarry, 1986). Some commentators have argued that this 'unshareability' is constant, for it is seen to be based on human impulses to be self-serving in our assessments (in using ends-based reasoning) and having a hot-cold empathy (not being able to register pain through witnessing or hearing about it) (Nordgren, McDonnell & Loewenstein, 2011). Tied to this, the concept of severity has been critiqued by prominent commentators as being 'vague and open to interpretation', 'not susceptible to precise gradation' and 'virtually impossible' based on these reasons.

Conversely, it must be pointed out that medical professionals diagnose and administer relief when treating varying levels of pain, physical and psychological, on a daily basis. It is instructive to note that the difficulties present with respect to subjectivity have also been used as an excuse to conclude 'pain is a subjective experience and there is no way to objectively quantify it' (Stover, Koenig & Fletcher, 2017, p. 392). Accordingly, theoretical problematising, as outlined below, must be approached with some degree of caution.

The methods at hand challenge 'reliance on a solely objective analysis of suffering, due to the difficulties in measuring intangible psychological injuries' (Yarwood, 2008, p. 336). Partially arising out of this, conventional understandings of severity also reveal a materialist or physical bias, 'that the physical is more real than the mental' (Luban & Shue, 2011, p. 823). Reyes compares the relative ease of documenting the physical with the psychological in the following passage:

> Physical forms of pain and suffering are more readily understood than psychological forms, although physical suffering may also be hard to quantify and measure objectively—defining severe pain and suffering involves an assessment of gravity that is difficult to make, as these notions are highly subjective and may depend on a variety of factors, such as the age, gender, health, education, cultural background or religious conviction of the victim. (Reyes, 2007, p. 593)

Attempts, by notorious figures in the Bush Administration, to obscure the conceptualisation of torture have entailed the unfounded claims such as 'mental suffering is often transitory, causing no lasting harm,' (US Senate Committee on Foreign Relations, 1990, p. 17) or that torture is 'broken bones, electric shocks to genitalia … pulling your teeth out with pliers … cutting off a limb … Is waterboarding at the same level? I'd say probably not.' Similarly, it has been suggested that psychological methods such as solitary confinement or sleep deprivation are more readily dismissed as we all experience and tolerate small doses of solitude and sleeplessness in our daily lives, without ever understanding the impact of the extremities (McDonnell, Nordgren & Loewenstein, 2011). Commenting on this mentality, O'Mara assesses this as being:

> the all-too-common mistake of consulting the contents of his consciousness to define torture—not statute law, not international treaties, not medical authorities, not the scholarly literature. This leaves us with a

> problem: when we think of torture, our thinking is deeply colored by images of medieval cruelty: the rending of flesh, the breaking of bones, and pain made visible through scar and scream. We do not think of techniques that leave no visible record of their presence, techniques that manipulate the metabolic and psychopathological extremes of body, brain, and behaviour, and which are, by any reasonable standard, torture. (O'Mara, 2015, p. 11; see also Posner, 2004, pp. 291-292)

This brings into focus the discomfort versus ill-treatment debate. Pérez-Sales admits that it is 'difficult to know why some techniques [such as the use of music] and not others would qualify as "uncomfortable"; the distinction between "torture" and "discomfort" seems to be merely semantic' (2017, p. 328). Interrogations, after all, regularly exploit specific vulnerabilities of an individual in making them uncomfortable. What is more, recognising that a vast proportion of torture victims prove resilient (as high as 60% by one measure (Pérez-Sales, 2017, p. 144), distinguishing the impact of psychological torture as opposed to discomfort is made additionally difficult (Başoğlu, 2009, p. 142).

Compounding this, psychological torture is defined as anything but torture by those partaking in its infliction or legitimisation: the torturer defines it as a technologically-controlled method designed to fall short of severe harm (Sveaass, 2008, p. 304); politicians have narrowly defined it in times of national security issues as 'enhanced interrogation' (McDonnell, Nordgren & Loewenstein, 2011, p. 94; see also Luban & Shue, 2011, pp. 826-827); and, some domestic courts have avoided attributing torture to state authorities, if possible (see *PCATI v. Israel*, 1999).

Biased preconceptions against defining psychological methods as torture are infamously illustrated by the European Court of Human Rights' decision in *Ireland v United Kingdom* as the five techniques were found not to 'occasion suffering of the particular intensity and cruelty implied by the word torture'. This equated torture with 'acts of extreme barbarity' and not the 'systematically researched and applied subtle techniques of psychological manipulation which nullify the human will' (Spjut, 1979, p. 271).

This has been remedied, fully cognisant of subtle mechanisms of torture, in the definition of the *Inter-American Convention to Prevent and Punish Torture* which reads:

> Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish. (OAS, 1985, Article 2)

Here: i. pain is not required; ii. severity of suffering is not required as the emphasis is on methods not consequences; iii. purpose is to 'obliterate the personality of the victim' or to 'diminish his mental capacities' (Pérez-Sales, 2017, p. 3). As the measure of severity is side-stepped, a purposive measure of psychological torture, one more conducive to capture the phenomenon, can be applied. This also brings into play a number of elements Pérez-Sales deems to be especially significant to the psychological torture context, including: i. the relationship pattern between torturer and tortured; ii. circumstances of the torturing system (political persecution, law enforcement procedure, etc.); iii. whether techniques target identity; and, iv. the severity of each experience from both an objective and subjective point of view.

Taking into account the conceivably infinite iterations of psychological methods as designed to target an individual's particular values, it can be argued that the complexity of subjectivity surpasses that of physical pain. Interpersonal elements, such as the increased susceptibility to psychological harm for those with a supportive familial environment ('securely attached') on the background of their trust in humanity and benevolent worldview (Kanninen, Punamäki, Qouta, 2003), and the use of an individual's severe phobia of the dark during coercive interrogations have been but two aspects documented in the literature (Lewis, 2005).

A comparable complexity is confirmed in medical literature on trauma, as there 'are infinite ways of reacting and psychologically processing the same event' (Pérez-Sales, 2017, pp. 129-133). Pérez-Sales points out that DSM's definition of trauma has been refined from 'an extensional definition ("extraordinary events"), to a subjective consequentialist definition ("overwhelming emotions"), and now to an objective consequentialist definition ("threat")' (2017, pp. 133-134). To mirror this development, torture would exclude the objective severity test, avoid an extensional definition, and consider 'exposure to threat as the core feature'.

How does, for instance, a male decision-maker fully appreciate the impact of sexual humiliation of a woman? (Arcel, 2003) How does one articulate witnessing the regular desecration of the Koran or being prevented from praying? (Khan, 2010; McCoy, 2012) How can a decision-maker gauge the anguish of a third party such as a relative or witness who vicariously experiences the impact of torture? The questions abound but not for a lack of interest in the answers.

Conclusions: Room for reflection and research

In light of the difficulties outlined in this paper, international and national bodies need to better incorporate a medical understanding, particularly a psychological one, that is workable within the severity paradigm. Questions arising from some of the key literature in this review include: How can the law better reflect the phenomenon of psychological torture through the prism of psychology, in terms of quantifying severity, duration and effects? How do we then achieve a confluence between the two fields with respect to this issue? To quantify level of pain, medical professionals resort to notions of 'duration', 'frequency', and 'intensity'. Other notions such as 'dignity', 'agency', and 'fear' perhaps need to be factored in more strongly.

At the very least, these must be understood and engaged with by the law. Related understandings also need to be accepted. The three decades of research, some of which is outlined here, does not support the equation that the magnitude of applied stress will result in a corresponding magnitude of impact. That is, little stress could lead to a significant impact, and great stress to little impact. There are many variables (e.g. age, culture, health) to render general rules unsuitable such as a minimum six hours of sleep for every 24, or that certain symptoms are exclusively linked to certain acts.

Given the shortcomings in the law, there exists enough space to develop and sharpen standards, both regionally and internationally. Identifying institutional, cultural and practical shortcomings of professionals, namely police, lawyers, judges, psychologists and doctors etc., and their related institutions in this area will be important in developing the necessary tools of training and documentation.

Relatedly, it has been pointed out that what is required is to fix a common understanding of psychological torture which is defined based on strong research, which international and national bodies, recognising its value, would adopt and operationalise in their work. Specifically, they need to clarify and expand on the notion of 'mental suffering' as part of the definition of torture. To that end, two broad sets of issues can be identified as those that impede this understanding, as follows:

i. How do victims' prior psychological states (broader than the notion of 'condition' to include personal values and other subjective qualities) influence assessments of psychological torture's impact? Can we, and if so how do we, differentiate the trauma an individual is subjected to, due to their mere interaction with criminal justice apparatus and processes, from anything that amounts to ill-treatment of any severity (torture or not)? Taking victims as one finds them is a basic principle of civil and criminal law. At the very least, it is not a mitigatory factor in international law. Accordingly, factoring in a victim's 'predisposition to suffer', or conversely 'resilience', raises complicated issues.

ii. How do we overcome the existing hierarchies (where some physical torture methods enjoy quicker recognition than, for example, humiliation)? Is a western psychological understanding of trauma, particularly with respect to psychological torture, applicable and transferrable to non-western jurisdictions? If not, what are the issues arising for the recognition of psychological torture in those jurisdictions? What are the factors, such as common misconceptions, professionals demonstrate in contributing to and/or dealing with the prevalence of psychological torture? What is the level of awareness that psychologically coercive acts can amount to torture? How many domestic criminal codes fail to recognise the mental element? What training tools can be developed to complement or re-work the existing deficiencies in knowledge and process?

Outstanding questions necessitating further reflection and research, arising out of this review, point to improved dialogue between of psychology and law, developing and sharpening standards with respect to documentation and, in turn, prevention, prosecution and adjudication.

References

American Psychological Association. (2005). *Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security.* http://dx.doi.org/10.1037/e419822005-001

Arcel, L. T. (2003). Inhuman and degrading treatment of women: psychological consequences. In: Kjærum, M., Thelle, H., Xia Yong & Bi Xiao Quing (eds.). (2003). *How to eradicate torture* (pp. 951-984). Beijing: Social Sciences Documentation Publishing House.

Başoğlu, M. (ed). (2017). *Torture and Its Definition in International Law: An Interdisciplinary Approach*. New York: Oxford University Press. https://doi.org/10.1093/med/9780199374625.001.0001

Başoğlu, M. (2009). A multivariate contextual analysis of torture and cruel, inhuman, and degrading treatments: implications for an evidence-based definition of torture. *American Journal of Orthopsychiatry*, *79*(2), 135–45. https://doi.org/10.1037/a0015681

Başoğlu, M., Livanou, M., & Crnobaric, C. (2007). Torture vs other cruel, inhuman, and degrading treatment. *Archives of General Psychiatry*, *64*, 277–85. https://doi.org/10.1001/archpsyc.64.3.277

Başoğlu, M., & Mineka, S. (1992). The role of uncontrollable and impredictable stress in postraumatic stress responses in torture survivors. In: Başoğlu M. (Ed.). (1992). *Torture and its consequences: Current treatment approaches* (pp. 182-225).New York: Cambridge University Press.

Burgers, J.H, & Danelius, H. (1988). *The United Nations Convention against Torture: A Handbook on the Convention Against Torture and Other Cruel, Inhu-*

man or Degrading Treatment or Punishment. Dordrecht-Boston-London: Martinus Nijhoff.

Costanzo, M.A. & Gerrity, E. (2009). The effects and effectiveness of using torture as an interrogation device: using research to inform the policy debate. *Social Issues and Policy Review, 3*(1), 179-210. https://doi.org/10.1111/j.1751-2409.2009.01014.x

Crampton, D. (2013). *What indicators exist, or may exist, to determine whether a violation of the prohibition of torture, inhuman or degrading treatment or punishment has occurred on the basis of psychological maltreatment, and whether it amounts to psychological torture*. LLM Dissertation. School of Law. University of Essex (on file with author).

ECHR. (1978). *Ireland v. United Kingdom*, 5310/71, 19 January 1978.

ECHR. (2018). *Ireland v. United Kingdom,* 5310/71, 20 March 2018.

ECHR. (2001). *Keenan v. United Kingdom*, 27229/95, 3 April 2001.

ECHR. (2014). *Al Nashiri v. Poland*, 28761/11, 24 July 2014.

ECHR. (2014). *Husayn (Zubaydah) v. Poland*, 7511/13, 24 July 2014.

ECHR. (1999). *Selmouni v. France*, 25803/94, 29 July 1999.

ECommHR. (1976). *Ireland v. United Kingdom,* European, Yearbook of the European Convention on Human Rights, 19.

Evans, M.D. (2002). 'Getting to Grips with Torture'. *International and Comparative Law Quarterly 51*(2), 365-383.. https://doi.org/10.1093/iclq/51.2.365

Evans, M.D. & Morgan, R. (1998). *Preventing Torture: A Study of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. New York : Oxford University Press.

Farber, I.E., Harlow, H.F. & West, L.J. (1957). Brainwashing, conditioning, and DDD (debility, dependency, and dread). *Sociometry*, *20*, 271-285. https://doi.org/10.2307/2785980

Freedom from Torture. (2015). "*Proving" Torture: An ever-rising bar for medical evidence?* Conference October 2015.

Ginbar, Y. (2017). Making Rights Sense of the Torture Definition. In: Başoğlu, M. (ed.). (2017). *Torture and Its Definition in International Law: An Interdisciplinary Approach* (pp. 273-314). New York: Oxford University Press.

Grant, M. J. (2013). The illogical logic of music torture. *Torture*, *23*(2), 4–13.

Hauff, E. (1994). The Phenomenology of Torture. In Lavik, N.J., Nygaard, N., Sveaass & E. Fannemel (eds.). (1994). *Pain and Survival: Human Rights Violations in Mental Health*. (pp.19-28). Oslo: Scandinavian University Press.

Herman, J. (2015). *Trauma and Recovery: The Aftermath of Violence - from Domestic Abuse to Political Terror.* New York: Basic Books.

High Court of Israel. (1999). *Public Committee Against Torture in Israel v. Israel* H.C. 5100/94.

Inter-Am.C.H.R, *Raquel Martí de Mejía v. Perú*, Case 10.970, Report No. 5/96, OEA/Ser.L/V/II.91 Doc. 7 at 157 (1996)

International Committee of the Red Cross. (2007). *Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody.*

Jacobs, U. (2008). Documenting the neurobiology of psychological torture: conceptual and neuropsychological observations. In: Ojeda, A. E. (Ed.). (2008) *The trauma of psychological torture* (pp. 163-172). Connecticut and London: Praeger.

Kalbeitzer, R. (2009). Psychologists and Interrogations: Ethical Dilemmas in Times of War. *Ethics and Behaviour, 19*(2), 156-168. https://doi.org/10.1080/10508420902772793

Kanninen, K., Punamäki, R-L. & Qouta, S. (2003). Personality and Trauma: Adult Attachment and Posttraumatic Distress Among Former Political Prisoners. *Peace and Conflict: Journal of Peace Psychology, 9*(2), 97–126. https://doi.org/10.1207/s15327949pac0902_01

Khan, A. (2010). Faith-Based Torture. *Global Dialogue*, *12*(1-2). https://doi.org/10.2139/ssrn.1504754

Lewis, N. A. (2005). Interrogators cite doctors' aid at Guantánamo. *New York Times,* 24 June 2005.

Luban, D., & Shue, H. (2012). Mental torture: A critique of erasures in U.S. law. *The Georgetown Law Journal*, *100*, 823–63. https://doi.org/10.1017/cbo9781107279698.011

Manderson, D. (2005) Another Modest Proposal. *Deakin Law Review, 10*(2), 640-653. https://doi.org/10.21153/dlr2005vol10no2art297

McCoy, A. (2006). *A Question of Torture: CIA Interrogation, from the Cold War to the War on Terror.* New York: Metropolitan Books.

McCoy, A. (2012). *Torture and Impunity: the US Doctrine of Coercive Interrogation*. Madison: University of Wisconsin Press.

McCoy, A. (2012a). In the Minotaur's Labyrinth: Psychological Torture, Public Forgetting, and Contested History. In: Carlson, J. & Weber, E. (eds.). (2012). *Speaking about Torture* (pp. 37-58). New York: Fordham University Press. https://doi.org/10.5422/fordham/9780823242245.003.0003

McDonnell, M., Nordgren, L. F., & Loewenstein, G. (2011). Torture in the eyes of the beholder: the psychological difficulty of defining torture in

law and policy. *Vanderbilt Journal of Transnational Law*, *44*, 87–122.

Nordgren, L., McDonnell M., & Loewenstein G. (2011). What Constitutes Torture? Psychological Impediments to an Objective Evaluation of Enhanced Interrogation Tactics. *Psychological Science, 22*(5), 689–694. https://doi.org/10.1177/0956797611405679

Nowak, M. & McArthur E. (2008). *United Nations Convention Against Torture: A Commentary.* New York: Oxford University Press. https://doi.org/10.1093/law/9780199280001.001.0001

Nowak, M. & McArthur, E. (2006). The Distinction between Torture and Cruel, Inhuman or Degrading Treatment. *Torture*, *16*(3), 147-151.

Nowak, M. (2006). What Practices Constitute Torture?: US and UN Standards. *Human Rights Quarterly, 28*(4), 809-841. https://doi.org/10.1353/hrq.2006.0050

O'Mara, S. (2015). *Why Torture Doesn't Work: The Neuroscience of Interrogation.* Cambridge, MA: Harvard University Press.

Ojeda, A. (ed). (2008). *The Trauma of Psychological Torture*. Connecticut and London: Praeger.

Organization of American States (OAS). (1985). *Inter-American Convention to Prevent and Punish Torture*. 9 December 1985, OAS Treaty Series, No. 67.

Papaeti, A. (2013). Music, Torture, Testimony: Reopening the Case of the Greek Military Junta (1967-1974). In: Grant M.J., Papaeti, A., (eds.). (2013). *The world of music: Music and Torture, Music and Punishment 2*(1). 67-89.

Pérez-Sales, P. (2017). *Psychological Torture: Definition, Evaluation and Measurement.* London: Routledge. https://doi.org/10.4324/9781315616940

Pérez-Sales, P., et al. (2016). Incommunicado detention and torture in Spain, Part III: 'Five days is enough': the concept of torturing environments. *Torture, 26*(3), 21-33.

Pérez-Sales, P, Martínez-Alés, G, Gonzalez Rubio, R. (2018). Beyond torture checklists. Reliability and Construct Validity of the Torturing Environment Scale (TES). *Conflict and Health* (submitted/personal communication).

Pictet, J. (ed.). (1958). *The Geneva Conventions of 12 August 1949: Commentary, Vol. IV, Geneva Convention Relative to the Protection of Civilian Persons in Time of War*. Geneva: International Committee of the Red Cross.

Physicians for Human Rights. (PHR). (2005). *Break them Down: Systematic Use of Psychological Torture by US Forces*.

Physicians for Human Rights and Human Rights First. (2007). *Leave No Marks: "Enhanced" interrogation techniques and the risk of criminality.*

Pope, K.S., Gutheil, T.G. (2009). Psychologists abandon the Nuremberg ethic: Concerns for detainee interrogations. *International Journal of Law and Psychiatry, 32*, 161–166. https://doi.org/10.1016/j.ijlp.2009.02.005

Posner, R. (2004). Torture, Terrorism and Interrogation. In: Levinson, S. (ed.). (2004). *Torture: A Collection* (pp.291-298). New York: Oxford University Press.

Rejali, D. (2003). Modern Torture as a Civic Marker: Solving a Global Anxiety with a New Political Technology. *Journal of Human Rights, 2*(2), 153-171. https://doi.org/10.1080/1475483032000078152

Rejali, D. (2007). *Torture and Democracy*. Princeton: Princeton University Press. https://doi.org/10.1515/9781400830879

Reyes, H. & Başoğlu, M. (2017). Control as a Defining Characteristic of Torture. In Başoğlu, M. (2017). *Torture and Its Definition in International Law: An Interdisciplinary Approach* (pp. 49-59). New York: Oxford University Press.

Reyes, H. (2007). The worst scars are in the mind: psychological torture. *International Review of the Red Cross, 89*(867), 591–617. https://doi.org/10.1017/s1816383107001300

Rouillard, L-P. (2005). Misinterpreting the Prohibition on Torture Under International Law: The Office of Legal Counsel Memorandum. *American University International Law Review, 21*(9), 9-41.

Scarry, E. (1986). *The Body in Pain: The Making and Unmaking of the World*. New York: Oxford University Press.

Sifris, R. (2013). *Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinisation of Torture*. London: Routledge. https://doi.org/10.4324/9780203074749

Soldz, S. (2010). Psychologists Defy Torture: The Challenge and the Path Ahead. In: Harris, A. & Botticelli, S. (eds.). (2010). *First do no harm: the paradoxical encounters of psychoanalysis, warmaking, and resistance* (pp. 67-106). New York: Routledge. https://doi.org/10.4324/9780203885192

Soldz, S. (2011). Fighting Torture and Psychologist Complicity. *Peace Review: A Journal of Social Justice, 23*(1), 12-20. https://doi.org/10.1080/10402659.2011.548240

Spielmann, D. (2012). Variations on an Original Theme: Music and Human Rights. In: Casadevall, J. (ed.). (2012). *Freedom of Expression: Essays in Honour of Nicolas Bratza* (pp. 363-381) Oisterwijk: Wolf Legal Publishers.

Spjut, R. (1979). Torture Under the European Convention on Human Rights. *American Journal of*

International Law, *73*(2), 267-272. doi:10.1017/S000293000010764X

Stover, E., Koenig, K.A., & Fletcher, L.E.. (2017). The Cumulative Effect. In: Başoğlu, M. (2017). *Torture and Its Definition in International Law: An Interdisciplinary Approach* (pp. 375-407). New York: Oxford University Press.

Suedfeld, P. (ed.). (1990). *Psychology and Torture*. Washington, DC: Hemisphere Publishing Corp.

Sveaass, N. (1994). The Organized Destruction of Meaning. In: Lavik, N.J., Nygaard, N., Sveaass & E. Fannemel (eds.). (1994). *Pain and Survival: Human Rights Violations in Mental Health* (pp. 43-65). Oslo: Scandinavian University Press.

Sveaass, N. (2008). Destroying Minds: Psychological Pain and the Crime of Torture. *New York City Law Review, 11*(2), 303-324.

UN Commission on Human Rights. (2006). *Situation of Detainees at Guantánamo Bay*. E/CN.4/2006/120, 27 February 2006.

UN Committee Against Torture. (2006). *Conclusions and Recommendations, USA*. CAT/C/USA/CO/2, 25 July 2006.

UN Committee Against Torture. (1994). *Summary of the 184th Meeting, 12th Session.* CAT/C/SR.184.

UN Committee Against Torture. (1997) *Report on Israel*. A/52/44, 10 September 1997.

UN Committee Against Torture. (1998) *Consideration of Report on Israel*. CAT/C/SR.336, 20 November 1998.

UN Committee Against Torture. (2014) *Conclusions and Recommendations on USA*. CAT/C/USA/CO/3-5.

UN Human Rights Committee. (1992). *CCPR General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)*,10 March 1992.

UN Human Rights Committee. (1998). *Concluding Observations on Israel*. CCPR/C/79/Add.93.

UN Office of the High Commissioner for Human Rights (OHCHR). (2004). *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Istanbul Protocol')*. HR/P/PT/8/Rev.1

UN Special Rapporteur on Torture. (1997). *Report*. E/CN.4/1997/7, 10 January 1997.

UN Special Rapporteur on Torture. (2004). *Report*. A/59/324, 1 September 2004.

UN Special Rapporteur on Torture. (2016). *Report*. A/71/298, 5 August 2016.

US Senate Select Committee on Intelligence. (2014). *Committee Study of the Central Intelligence Agency's Detention and Interrogation Program*. (With declassification revisions of 3 December 2014).

US Senate Committee on Foreign Relations. (1990). *Convention Against Torture: Hearing Before the S. Comm. on Foreign Relations.* 101st Congress 13

Welch, B. (2010). The Torturer's Apprentice: Psychology and Enhanced Interrogations. *Global Dialogue, 12*(1-2), 1-14.

Yarwood, L. (2008). Defining Torture: The Potential for Abuse. *Journal of the Institute of Justice & International Studies, 8*(3), 324-351.

"It never happened to me, so I don't know if there are procedures": identification and case management of torture survivors in the reception and public health system of Rome, Italy

Caterina Spissu,*, Gianfranco De Maio,*, Rafael Van den Bergh,*, Engy Ali,*, Emilie Venables,*,, Doris Burtscher,***, Aurelie Ponthieu,*, Mario Ronchetti,****, Narciso Mostarda,****, Federica Zamatto***

Key point of interest:

- Staff who come into contact with refugees should be trained in how to sensitively identify torture survivors and to refer them to appropriate services for rehabilitation.

Abstract

Background: Access and linkage to care for migrant torture survivors is contingent on their identification and appropriate referral. However, appropriate tools for identification of survivors are not readily available, and the (staff of) reception systems of host countries may not always be equipped for this task. This study explores practices in the identification and case management of torture survivors in the reception structures and in the public health sector in Rome, Italy. **Method**: Data were analysed manually and codes and themes generated. **Results**: A non-homogeneous level of awareness and experience with torture survivors was observed, together with a general lack of knowledge on national and internal procedures for correct identification of torture survivors. Identification and case management of torture survivors was mainly carried out by non-trained staff. Participants expressed the need for training to gain experience in the identification and management of torture survivors' cases, as well support and increased resources at both the reception and public health system levels. **Conclusions**: The crucial process of identification and *prise en charge* of survivors of torture among migrant and refugee populations is relegated to non-trained and inexperienced professionals at different levels of the reception system and public health care sector, which may carry a risk of non-identification and

*) Médecins Sans Frontières - Operational Centre Brussels
**) University of Cape Town, School of Public Health and Family Medicine, Division of Social and Behavioural Sciences, Cape Town, South Africa
***) Médecins Sans Frontières, Vienna Evaluation Unit, Vienna, Austria
****) Azienda Sanitaria Locale Rome 6, Rome, Italy
Correspondence to: caspissu@gmail.com

possible harm to survivors. Additional resources and structured interventions are urgently needed, in the form of developing procedures, training, and adapted multidisciplinary services.

Keywords: Torture; asylum seeker; refugee; identification; case management

Introduction

Torture survivors constitute a sizeable proportion of mixed-migration flows (OHCHR, 2017), with an estimated 5 to 35% among refugee populations (Baker, 1992). In addition to the torture, persecution and abuse faced in their country of origin, refugees and migrants are exposed to violence and ill-treatment during the long and perilous journey to reach safety, and they also face a variety of post-migration difficulties (Carswell, Blackburn, & Barker, 2011). This can constitute a challenge for countries faced with mixed flows, as detection and care for survivors of torture may be complex and can require a high level of specialisation (Wenzel, 2007). While State signatories of the United Nations Convention Against Torture (UNCAT) are obliged to offer rehabilitation services for survivors of torture, this is not systematically provided. Even in countries where rehabilitative services—such as medical and psychological care, along with legal and social support—are provided, access is challenging for survivors of torture in transit or in a post-migratory condition, due to cultural and language barriers, the sense of confusion and disorientation upon arrival in a new context (Kirmayer, Narasiah, Munoz, Rashid, Ryder, Guzder, et al., 2011), and the sense of isolation and distrust which is a common feature of individuals who

Acronyms

ASL: Azienda Sanitaria Locale [Local Health Authority]

CARA: Centri Accoglienza Richiedenti Asilo [Reception Centres for Asylum Seekers]

CAS: Centri Accoglienza Straordinaria [Emergency Reception Centres]

CDA: Centri di Accoglienza [Reception centres]

CIR: Consiglio Italiano Rifugiati [Italian Council for Refugees]

CPSA: Centri di Primo Soccorso e Assistenza [Centres for First Aid and Assistance]

CSM: Centro di Salute Mentale [Public Mental Health Department]

INMP: Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà [National Institute for Health, Migration and Poverty]

McT: Medici contro la Tortura [Doctors against torture]

MeDU: Medici per i Diritti Umani [Doctors for Human Rights]

MoH: Ministero della Salute [Ministry of Health]

MoI: Ministero dell'Interno [Ministry of the Interior]

MSF: Médecins Sans Frontières [Doctors without Borders]

NHS: National Health System

SPRAR: Sistema di Protezione per Richiedenti Asilo e Rifugiati [Protection System for Asylum Seekers and Refugees]

have experienced torture (Sousa, 2013). These challenges are compounded by a general lack of appropriate tools for the identification of torture survivors, and can prevent or delay identification and referral of torture survivors to specialised care. Identification and referral are essential to prevent physical and mental conditions from deteriorating and becoming chronic (OSCE, 2016), or from impacting the accuracy of the incident account (Yawar, 2004) to the determining/adjudicating authorities; in Italy the Territorial Commissions in first instance, and the Civil Courts in case of appeal (OSCE, 2016; Towers, Reventlow, de Rengervé, de Witte, 2016).

In recent years, Italy has experienced a fluctuating and growing influx of mixed-migration flows, mainly arriving through the Central Mediterranean Route (Frontex, 2017). In 2016, it became the first entry point in Europe for migrants and refugees, with 181,436 migrants disembarking in the country after being rescued at sea. According to official data, the main nationalities declared at arrival are Nigerian, Guinean, and Ivorian (UNHCR, 2017). Prior to arrival in Italy, many transited for weeks or months in Libya, where they were confronted with violence, torture, arbitrary detention, ill-treatment and forced labour (UNSMIL, 2016). The reception system in Italy is overstretched in its attempts to respond to the needs of the migrant population hosted in both ordinary and emergency reception facilities across the country. With regards to the obligation to provide access to redress—including rehabilitation—to survivors of torture, Italy has been a signatory to the UNCAT from 1989 but has only recently introduced a bill criminalising torture. This bill does not, however, contain provisions for the redress and the overall rehabilitation of survivors of torture. Italy is one of the few European states which does not legislatively foresee an identification procedure of torture survivors during the asylum interview process (Towers, Reventlow, de Rengervé, de Witte, 2016). Nevertheless, the Italian Ministry of Health (MoH) has newly issued guidelines on the psychological treatment of refugees who have faced torture or other forms of violence (Ministry of Health, 2017), though it is unclear whether any form of training or sensitisation on their use will be provided. Refugees who are survivors of torture are also included among the vulnerable categories listed by the Law Decree 142/2015, which recognises their specific reception needs in compliance with the European Reception Directives (European Union, 2013).

Such developments in legislation seem to collide with the reality of the response that survivors of torture receive in the country. A number of specialised services for survivors of torture exist in Italy, including a *Médecins Sans Frontières* (MSF) clinic opened in Rome in 2015. In this clinic, most cases come from reception structures in the Rome province. However, anecdotal figures show that many referred individuals are *not* survivors of torture, with approximately 33.5% being considered out of scope following in-depth assessment at the MSF clinic which took place during the period October 2015-December 2017. Additionally, numbers of self-referred cases are increasing (from 4,3% in 2015 to 37% at the end of 2017), suggesting that there is a gap in the identification and referral processes.

Understanding the challenges in identification and referral is essential for

improving referrals and for enhancing the possibility of survivors of torture accessing rehabilitation services. However, there is limited published evidence on this topic. While a 2016 review assessed the challenges of identifying victims of torture in various national asylum systems in Europe, North America and the Pacific, it focused mainly on organisational and procedural issues, and did not fully address the challenges and needs at the level of the frontline workers in the reception systems (Towers, Reventlow, de Rengervé, de Witte, 2016). We therefore conducted a qualitative study investigating practices in the identification and management of torture survivors' cases in the Italian reception and health contexts, and specifically in the reception centres and MoH sub-districts in the metropolitan area of Rome.

Method[1]

Study design

This is a qualitative study, based on in-depth interviews with care providers at reception centres, general practitioners, and the syndromic teams (tasked with disease control) at the sub-district levels of the (*Azienda Sanitaria Locale*)-District 6 (ASL) in Rome, covering the southern metropolitan territory. Practitioners from the MSF rehabilitation of victims of torture clinic in Rome were involved in the study design, and facilitated its implementation. As the research did not directly involve survivors of torture, they were not involved in the design or implementation of the study.

Study setting - the reception system in Italy

Migrants and refugees making their way to Italy typically arrive by sea in the southern regions of the country (UNHCR, 2017; Ministry of the Interior, 2017. Cruscotto Statistico), most commonly after being rescued at sea. Once registration and finger-printing procedures are finalised, migrants and refugees are transferred to the reception structures throughout the country. In Italy, the reception of those seeking protection is managed by the Ministry of the Interior (MoI) through the Department of Civil Liberties and Immigration. The reception system consists of different types of reception facilities for the lodging of international protection seekers across all regions in Italy (Decree Law, no. 142, 2015):

- first aid and assistance structures (CPSA), mainly located at disembarkation points (first phase).
- collective/governmental centres (CDA and CARA (second phase).
- reception by the SPRAR (Protection System for Asylum Seekers and Refugees) (third phase).
- reception in extraordinary/temporary structures (CAS) is foreseen where there is no space in the governmental centres or in SPRAR. In fact, the majority of

[1] This research was conducted through the Structured Operational Research and Training Initiative (SORT IT), a global partnership led by the Special Programme for Research and Training in Tropical Diseases at the World Health Organization (WHO/TDR). The model is based on a course developed jointly by the International Union Against Tuberculosis and Lung Disease (The Union) and Medécins Sans Frontières (MSF/Doctors Without Borders). The specific SORT IT programme which resulted in this publication was jointly developed and implemented by the Centre for Operational Research, The Union, Paris, France and the Operational Research Unit (LuxOR), MSF Brussels Operational Centre, Luxembourg.

protection seekers are hosted in CAS (78%) and in governmental centres (8.5%) (Ministry of the Interior, 2017. Cruscotto Statistico).

In governmental and CAS centres, a number of services such as provision of food and non-food items, health care assistance, legal information, administrative assistance, and social and psychological support should be ensured (Ministry of the Interior, 2017. Schema di Capitolato). In SPRAR, in addition to the services provided in governmental centres and CAS, services aiming at promoting socio-economic inclusion (SPRAR, 2017) are provided: these include orientation to employment and enrolment in training courses. The composition of reception centre staff includes both general workers and specialised staff such as social and legal workers, cultural mediators, psychologists and in some cases nurses and/or doctors. Although the SPRAR system is dedicated to the reception and integration of protection seekers and refugees, its capacity is limited and it currently hosts only 13.5% of those applying for international protection.

In 2015, syndromic teams were created at a sub-district level within Rome ASL-6: the task of these teams is the prevention of outbreaks such as tuberculosis and scabies among the migrant population. Each sub-district team consists of one medical doctor, one nurse and one social worker. Socio-medical activities include the provision of medical services to migrants/refugees, physical and psycho-social support for conditions related to torture and ill-treatment, and the monitoring of health conditions in the reception structures. All sub-district teams work under the coordination of the ASL-6 district team consisting of a psychologist, a social worker, a medical doctor and a number of technical referents.

According to the administrative status of the migrant/refugee hosted in the reception centre a general practitioner should be assigned. However, due to administrative delays or obstacles in the registration, often entitled migrants/refugees do not have a general practitioner assigned.

Workers in the SPRAR and CAS are assisted by cultural mediators, a cadre of workers whose responsibilities and tasks are aimed at improving mutual understanding, and facilitating access to public services and the process of integration for immigrants (Ministry of Interior, 2009).

Guidelines on the identification and referral of possible cases of torture or ill-treatment were issued in 2017 by the Ministry of Health, to health staff and reception staff alike. The guidelines stipulate a short training for reception centre staff on the issue of identification of cases of torture, as also specified in Decree 142, art. 17, clause 8. The implementation of these guidelines is however a regional responsibility, and is therefore highly dependent on the regional resources and the presence of actors at local/regional/national level. In Rome province, there are seven service providers to which cases of torture and ill-treatment can be refferred: the *Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà* (INMP), the SaMiFo clinic, a joint public and private initiative (ASL 1 and Centro Astalli), the *Consiglio Italiano per Rifugiati* (CIR), *Medici contro la Tortura* (McT), CARITAS, MSF and *Medici per i Diritti Umani* (MeDU) (De Maio, Pettinicchio, 2018). The range of services provided differs from one service

provider to another, however, it might include medical care, psychological and psychiatric support, physiotherapy, legal and social services, and provision of medical, legal and psychological certification.

Study population

Professionals were purposively selected in order to gain a range of the different professions for the interviews. A total of 28 in-depth interviews were conducted with the following categories of professionals:

- Reception officers in six reception centres: 15 interviews were conducted with nurses, psychologists, social and legal workers and cultural mediators.
- Syndromic teams in charge of reception centres in three sub-districts of ASL-6: 11 in-depth interviews were conducted with medical doctors, nurses, and social workers.
- General practitioners assigned by the local health system: two in-depth interviews were conducted with medical doctors.

All participants were frontline workers interacting at reception and health system level with the migrant/refugee population. Only one person refused to participate when asked.

Exclusion criteria: Reception officers in reception centres and health practitioners in the ASL-6 district who had received training sessions by MSF on the identification and management of survivors of torture were excluded from the study before the initiation of the interviews.

Selection and recruitment of study population: Reception centres and sub-district teams in the ASL-6 district were purposively selected based on discussions with the social worker of the district team of ASL-6 and the project coordinator of the MSF rehabilitation clinic. The selection of reception structures was based on the location of the reception centres, the characteristics of the hosted migrant and refugee population (mixed gender and age, adult males, families, women and accompanied minors), and the capacity and status of centres (SPRAR and CAS structures). To ensure that a variety of reception centres were considered in the study, we included two centres designated for adult males, one centre for women, accompanied minors and families, one centre for women and accompanied minors, and one centre for men and families.

Governmental centres such as CARA were excluded, as these structures have a larger capacity and are usually intended to host the migrant and refugee population for short periods of time. Likewise, structures dedicated to unaccompanied minors were disregarded, as the MSF clinic for rehabilitation of survivors of torture mainly sees adult survivors. Sub-district teams with an incomplete working team were also excluded.

General practitioners were selected through the reception structures: over the course of the interviews with the reception centre staff, contact information of general practitioners assigned by the National Health System was obtained.

Once the selection was completed, the ASL-6 district sent an informative note to centres and sub-district teams to introduce the study and its content, and facilitated contact between the principal investigator (first author) and the staff of the reception centres and sub-district teams. The

first author then contacted and visited the staff of the sub-district teams, the selected reception centres and the general practitioners to present the study and request their participation. The interviews were conducted in the ASL-District of Rome by the first author.

Data collection

The study took place between July and September 2017. Data was collected by the first author, who is a member of the MSF coordination team in Italy, working in the advocacy department. Interview questions were initially elaborated by the first author and validated by two experienced co-authors; questions were also shared and discussed with some of the MSF clinic staff. Interviews were audio-recorded upon agreement of participants and in-depth interview guides with open-ended questions were used. On a few occasions, manual notes were also taken during the interview. The length of the interviews varied from 40 minutes to approximately two hours. The language used in the interview was Italian, which is the native language of the first author and most of the participants. One interview was conducted in both Italian and English, as the interviewee whose native language was English found it easier to use the native language.

Data analysis

An external transcriber-translator was hired for the translation and transcription of the audio files, which were transcribed and translated verbatim from Italian to English. The first author verified the accuracy of both the translation to English and its transcription by listening to the audio-recordings and reading the transcripts. The transcripts were then re-read several times by the first author and one of the co-investigators, and were subsequently manually coded and analysed line by line. No data analysis software was used during the analysis process. A thematic content analysis was used, following an approach in which the researcher becomes familiar with the data, generates codes, searches for and names themes, whilst continuously reviewing and refining the themes that arise (Creswell, 2007; Braun, Clarke, 2006.). The coding framework was developed based on pre-identified themes as well as themes that emerged during data collection and discussions with the study team who were familiar with the data and the context. Neutrality was ensured by having the second investigator, who was not present during the interviews, review and code the transcripts in parallel. Differences in interpretation were resolved through discussion between the investigators.

Informed consent and confidentiality

Written informed consent was obtained from all interviewees before starting the interviews. All participants read and understood the informed consent in Italian, and translation was thus not necessary. A non-disclosure agreement was signed by the translator-transcriber to ensure that confidentiality of data would be maintained. All identifying information, including names of participants, reception centres, indication of sub-districts, and references to names or locations, was removed from transcripts before analysis.

Ethical approval

The study was approved by the Ethics Review Board of MSF (Geneva,

Switzerland) and by the Lazio 2 Ethics Committee (Rome, Italy).

Results

The main themes identified in this study included participants' knowledge of the definition of torture and (identification) procedures, practices and challenges in identification/detection, and case management.

Identifying survivors of torture—practices and gaps

When questioned on the process of identification, many professionals reported a lack of awareness or an absence of standardised procedures at national and internal levels to correctly identify torture survivors. They also expressed limited knowledge and doubts on the effectiveness of the guidelines recently issued by the Ministry of Health.

> *"I miraculously stumbled upon these guidelines on torture. That was recently!"* Social worker - T1
>
> *"I have them [MoH guidelines] on my tablet. I read those and I read the Istanbul Protocol but I think that for a reception officer or an ASL professional they don't have much practical value in managing daily tasks and meeting guests, it is for a higher level. In any case the sub-district team in ASL does not have the skills for that. The information has no practical relevance for the ASL sub-district team or for a reception officer, so we rely on instinct and our own common sense."* Social worker—T3
>
> *"There are guidelines to be followed. The latest is from May 2017, for political refugees, and it does mention torture victims, but I can't say exactly which law this is. They were issued by the Ministry (…) for Social Policies."* Social worker—T10
>
> *"I must confirm there is no dedicated [internal] procedure. It would be beneficial, very beneficial…"* Psychologist—T13

Participants showed different degrees of knowledge and understanding when asked to define torture and degrading treatment. A lack of prior experience with torture survivors was also observed. The type and level of violence reported by migrants in relation to their journey in Libya, as well as trafficking episodes, were often identified as torture.

> *"I can intuit something because I've heard someone talk, I've seen reports on TV. I've read books, articles… I've read magazines and so on. But first-hand experience, I've never had."* Health practitioner—T16
>
> *"How would I define torture? An inhumane act."* Legal advisor—T2
>
> *"Previously my idea of torture was, say, I am a military, an official in a dictatorship, I torture someone to get information, because there is political opposition. But here I discovered there is another kind of torture, which is gratuitous… with no real reasons."* Health practitioner—T7
>
> *"[T]hen there is Libya. And here we can avert our gaze, because what is happening in Libya is unspeakable, whether you are there for one day, two days or six months. (…). The women who went through Libya and suffered rape, gang rape, imprisonment, what is that? (…) Well I don't think they are held by the military, or by officials, but that's still torture."* Psychologist—T5

"We saw cases of traditional or ritual conditioning when they leave for Italy. To ensure they will compensate for this travel, which is paid by third parties, they undergo a sort of voodoo ritual which (…), keeps them in a condition of constant stress, … if the person does not pay the debt, damage would be done through this ritual to this person or to their loved ones. This is a type of psychological torture (…) Almost everyone travelled through Libya, …, some were openly sold in these sex houses, and they were tortured in sexual terms, because they were forced to agree to these actions, for various reasons, because they were imprisoned, threatened, or had to pay a ransom." Cultural mediator –T6

"Torture is a situation in which a person is nullified as an individual. Practices are put in place to collect information from the person tortured, who for this reason is subject to repeated mistreatment (…) The essential difference is maybe that in torture there is an objective to gather information, the others are conditions of general violence." Psychologist - T8

Overall, the identification of torture survivors can occur in all of the stages of the reception process by reception officers or health practitioners in the public health sector. It can happen during the preparation for a Commission hearing, when physical scars are noticed during a medical consultation, in counselling sessions, during the observation of the refugees and migrants by reception officers, or at any other point in the reception process. However, signs and symptoms were seen as arduous to "read" and often certain behavioural traits such as isolation and/or aggressive conduct were perceived as "difficult". The below quotations show the differing ways that professionals suspected or identified torture in the migrant and refugee populations they worked with.

"With a visit we can see if they have physical damage, so to speak. But we don't know if these are signs of torture. Psychologically you can look at them, observe them a moment (…) but I really don't know how to start." Health practitioner—T15

"If they stay all day in the room and don't eat, something isn't right. If he argues and discusses with everyone, that is another symptom. If when seeing a reception officer he starts asking a thousand things, there is a state of anxiety (…) For sure physically you can tell, you see wounds, scars. On the psychological level, it's harder. It depends on the reception officer's sensitivity to understand." Legal advisor –T2

"You can recognise victims of torture from how they are in the centre. It's not that you automatically recognise them but you notice who is doing worse than the others. They are isolated, may have aggressive reactions. Sleeping problems are very common, sleeping pattern changes, nightmares, recurring flashbacks. (…) It is evident, some cases are more evident, and some are more hidden." Psychologist—T8

Other obstacles in the identification of torture survivors indicated by the interviewees included language barriers and refusal to talk. Others mentioned survivors having a lack of trust towards the reception officers. The tension between the need

for "identification"—instrumental for the provision of protection—and the reticence of the migrants to open up; and the presence of staff with no prior experience in the context of migration within the reception system. While basic needs are met, the provision of specialised care is left to improvisation.

> *"The topic of cultural mediators becomes essential, it's the first thing, language. I must be able to ask everything, get answers on everything."* Health practitioner—T 27
>
> *"When he was asked 'were you a victim of violence?' He was troubled. But more (…) a refusal to remember, like 'talk to me about something else, please ask me something else'."* Health practitioner—T16
>
> *"Because we work in the legal aspect we are seen as policemen, and they put up defences."* Legal advisor—T2
>
> *"When I meet people for the first time I always ask. Usually with the intention of letting them know that if they have physical signs, obviously it's important for the Commission that these are documented. I say this and it's a little soft, like blackmailing: 'if you tell me this, it can help with the Commission', and at the same time it will help me get the information about the problem."* Psychologist—T5
>
> *"I think the challenge is that there is no clarity in the procedure. With staff there is too much of a difference among reception officers: those who are trained and those who are not. So it's left to improvisation. [they are] not specialists in the field. So since staff are not homogeneous (…) if roles are confused, it's a problem. And it's a problem if you have to control it: it's a problem for people to trust you and share things that might inform you."* Legal advisor—T26

Management of torture survivor cases within the reception and public health systems

Prise en charge in the reception centres was reported to be challenging at different levels. The ability to provide adapted services within the reception structures was seen as being restricted due to the limited availability of human resources, while the public health system was seen as unprepared to respond to the specific needs of this population. One participant indicated that power dynamics embedded in the reception system, where reception officers exert control on the hosted migrants, could lead to the perception of officers as perpetrators, a situation that requires trained professionals to manage. This combination of factors tended to trigger the decision to rely on specialised actors with an expertise in the field.

> *"There is no enough time for all the work here, I bring work home with me. This is very frustrating and leads all us reception officers to burnout."* Psychologist –T8
>
> *"[It's necessary] to have a different behaviour towards these people than with the other beneficiaries, a special care that is not always possible to provide or guarantee in the SPRAR. These people for example need, if they don't want to be in contact with the other beneficiaries, to have a room of their own. The team needs to work with everyone and cannot always dedicate attention to a single beneficiary and give them the attention they need."* Legal advisor—T25
>
> *"The possibility for all of us to access [cultural] mediators at any time (…) If I want to speak with someone, for example in an emergency situation, I cannot. I have to book an appointment, postpone, sometimes it takes time, and sometimes this brings us far*

from the problem (…). The CSM don't have a specialist's knowledge in this field: while [specialist external actors] have a lot, a lot of cases, they are specialised in this kind of case." Psychologist—T5

"These people are specific cases. We cannot treat them in the same way as someone going to physiotherapy for arthrosis. These people might do physiotherapy after a very strong trauma and must be followed in overall psychosomatic terms. Once more, this is a very delicate sector, I cannot say there is a service which can perform this function in terms of rehabilitation and psycho-dynamics. Certainly the rehabilitation services we have today work, but are not really dedicated to this aspect." Psychologist—T 13

"I had the feeling of being put in the role of oppressor. (…) It's difficult unless a reception officer is well trained to distinguish that this is symbolic and not related to him/her personally. There are complicated (…) power dynamics, someone who has suffered torture, in the relation with a reception officer can relive it. The reception officer is the one who has to tell an adult that 'you cannot do this or that, you cannot cook in your room (…)." Legal advisor—T26

Referral of torture survivors to specialised actors

Reception officers acknowledged their reliance on specialised actors for the provision of specialised services and care. However, they also highlighted the limits of this reliance, due to the overstretched capacity and the length of time necessary for the *prise en charge* by these specialised actors. The waiting times were not seen as meeting the needs of the centre, or meeting the need to promptly submit medico-legal certification to the authorities adjudicating protection claims.

"She might tell me 'this person has a psychological vulnerability so maybe he should be referred for psychological support with [specialist external actors]. They also work with the forensic doctor, who checks the scars and can say if they are derived from torture, which I don't know how to do." Health practitioner—T7

"All the problems are around timing. Say maybe the appointment in Court is in 10 days and a report is not ready, so you don't know whether to delay the appointment. And it's important to understand at what point the person is of the medical process." Legal advisor—T12

"What i have seen is that [specialist external actors] are overcrowded…but they still give appointments. (…) There are too many, too many cases in need." Health practitioner—T7

"One day I was with a colleague who accompanied a young man to [their clinic], and the reception officer, my colleague… they sent her outside and said "we need to talk to this person on his own and you must wait outside." So in that case we don't know anything about the person, we don't know what they talked about, what the doctor said, what he lived through or didn't live through, and so on. If you are not there, with the doctor, specifically, you cannot follow or organise." Cultural mediator—T23

"Sometimes we are lacking reference contacts, people who have the role of taking care of referrals (…) often we don't know who we should talk to (…) Knowing how sensitive these cases are." Psychologist—T24

Self-identified recommendations within the reception system

First and foremost, interviewees called for training on the identification and management of torture survivor cases. The lack of training was seen as both a handicap to the reception officers and health practitioners and as a possible danger to the beneficiaries. An interest was expressed in having experts from the different external actors in the field share their experiences.

> *"We lack training. We have never had courses on this topic. We have always been considered a centre for suspected victims of trafficking. Torture, we've never even talked about it."* Cultural mediator—T6
>
> *"Some have never worked in this sector, some do but may not be having the same sensitiveness. It would be useful to the team to have guidelines, because I might notice some things, but someone else might not. And I may be bound by confidentiality. My colleague who does not know anything might not understand the instructions given by the coordination team, and would then behave differently. Maybe we are not dealing with situations in the correct way. After this, after doing this internally in the centres, at the level of ASL there is really a need for a serious dedicated training, really serious."* Legal advisor—T2
>
> *"A training to enable us to face such delicate topics (…) If one doesn't know how to manage them, one can create further problems for the person who suffered. So it's a very, very, very delicate terrain."* Psychologist—T13
>
> *"If we are not given the opportunity of training specifically, they [survivors of torture] can escape us. Some people are not skilled, it's not their fault, but they aren't, so it's necessary to distribute skills on these matters."* Psychologist—T13

Other recommendations included the importance of guaranteeing reception in smaller-sized structures, supported by specialised and multidisciplinary services. Services should be structured to develop social inclusion, relying on synergy between the different stakeholders. The responses also highlighted the importance of a guaranteed response that takes into consideration the individual and the specific needs of torture survivors. Public services stressed the need to have additional internal resources that can serve the response.

> *"A smaller context, in distributed reception would be ideal (…) Also with the internal presence of a team for support, because (…) if he wakes up at night he needs someone, a reception officer who knows."* Psychologist—T8
>
> *"In order for torture to emerge, what is required is a dedicated space and skills of the person managing the conversation. Much more than we can do today."* Psychologist—T13
>
> *"Multi-professional, for sure: a psychiatric consultation or assistance on its own could not solve the issue (…) Social services because he must be slowly re-acquainted with a context which is even harder for him, because he is also foreign. [He] would find it difficult to integrate again in his natural environment, imagine in a foreign environment."* Health practitioner—T22
>
> *"We come twice a week, so identification is already difficult. To offer continuous support with such a large number of guests is*

even harder. We can support, we can identify, but we need external assistance for sure, so more adequate situation would perhaps be a centre where people can be followed individually." Social worker—T10

"Someone vulnerable who is a victim of torture [will] find it more difficult to access jobs, trainings and so on, but I think there should be extra funds for this, because a vulnerable case should be supported." Psychologist—T8

"In terms of improvements, mediators are essential, possibly ours, and not from the [reception] centre." Health practitioner—T16

"Since the Municipality is involved in managing the SPRAR… the idea of creating a project, combining the various actors, the Prefecture the Municipality, us for the healthcare aspects and place them in a civic context to give a sense to their stay here, for months and months." Social worker—T21

Discussion

This study represents an in-depth qualitative exploration of the challenges in identification and linkage to care of torture survivors among the migrant and refugee population in the reception and public health systems in Italy. The study comes at a historic moment when the country is called to manage an influx of migrants and refugees—who are at high risk of having been exposed to torture and ill-treatment (Baker, 1992; Carsell et al., 2011; OHCHR, 2017)—while just having introduced torture as a crime in national legislation. Against this background, guidelines on the rehabilitation response and psychological treatment of victims of torture and violence were also recently published. Considerable confusion and uncertainty was observed in relation to the existence and implementation of procedures, both at national level and internally in the reception and health structures where they are to be implemented. The knowledge and understanding of the phenomenon of torture was mainly related to the personal exposure and/or prior experience of the individual, and was commonly associated and/or confused with episodes of trafficking or extreme violence faced by migrants/refugees in Libya.

Our results indicate how the detection and linkage to care of torture survivors among the migrant and refugee population principally occurs at the hands of non-trained health practitioners and reception officers, with no prior experience in the areas of torture and migration in general. This observation is consistent with similar studies (Asgary, Metalios, Smith, Paccione, 2006), and a recent review that identified that Germany and Croatia are the only European states with legislation on who is responsible for the identification of torture survivors (Towers, Reventlow, de Rengervé, de Witte, 2016). In addition to the lack of training, reception officers and health practitioners are confronted with a number of difficulties ranging from linguistic and cultural barriers—due to a lack or insufficient presence of cultural mediators—and mistrust and reticence of torture survivors.

This set of conditions may carry adverse consequences for the rehabilitation of survivors of torture among the migrant population. The lack of trust of survivors and their refusal to talk as a consequence of their experiences, also described elsewhere (Yawar, 2004), is further exacerbated by the dynamics in the reception system, where the role of reception officers appears to be linked to a degree of power and control over

the refugees/migrants, evoking memories of and generating associations with perpetrators of torture and potentially impacting the development of a trusting relationship—a fundamental aspect in rehabilitation (Larson-Stoa, Jacobs, Jonathan, Poudyal, 2015). In light of this complex interaction, the lack of expertise and skills related to the identification of torture survivors, in combination with the lack of appropriate tools for identification, carries the risk of non-identification, and may conceivably cause harm when survivors are solicited for catharsis or ventilation (Jaranson, Kinzie, Friedman, Ortiz, Friedman, Southwick, et al., 2001), or when exposed to direct questioning. Our study also highlights the difficulty and possible risk of subjecting torture disclosure to time constraints in the frame of a legal procedure, rather than being considered an instrumental aspect of the rehabilitation process.

The available resources, including staff, were considered dramatically insufficient to respond to the needs of the migrant and refugee population and of torture survivors in particular. The presence of a small number of external actors specialised in torture represented a solution for the *prise en charge* of survivors in the region, but seemed insufficient in the face of the large number of referrals. Additionally, in several instances, referral was perceived as a means to comply with the timeframe of legal procedures, rather than as a step toward rehabilitation. The collaboration with services offered by specialised actors was characterised by a general lack of structured communication and referral systems, conceivably hampering the referral process and possibly impacting the effectiveness of the intervention. The recommendations formulated by the participants tended towards requests for additional resources in order to address the self-identified gaps in the area of training—considered essential for accurate identification and to avoid possible harm—and to strengthen the capacity of reception officers and health practitioners to appropriately handle cases and refer survivors.

The study faced a number of limitations, including being conducted in one specific geographical region of Italy, the small sample size and the focus on SPRAR and CAS centres, while CARA and centres for unaccompanied minors were excluded. Additionally, the study focused on care providers only, and thus no triangulation with experiences of the migrant/refugee population was done. A particular strength of the study was that it was conducted with frontline staff, capturing the situation "on the ground" while benefiting from the expertise of the practitioners from the MSF rehabilitation of victims of torture clinic in Rome.

A number of conclusions and recommendations can be drawn from this study. In light of the multiple gaps in the correct identification and case management of survivors of torture and ill-treatment, and the general difficulties in identifying such conditions, partly due to the lack of appropriate screening tools (Towers, Reventlow, de Rengervé, de Witte, 2016; Asgary, Metalios, Smith, Paccione, 2006; Visentin, Pelletti, Bajanowski , Ferrara, 2017), a considerable number of unidentified cases likely exist within the migrant and refugee population in Italy: the prevalence of torture is an overlooked issue by both the MoH and MoI. The lack of knowledge of the legal definition of torture has an impact not only on the correct identification of victims of

torture but also on victims of other forms of violence, equally entitled to a range of services and specialised care. It is paramount that cases who face similar violence or criminal acts, without falling under the UNCAT definition, are correctly identified and referred to specialised services. This would prevent delay in the necessary delivery of care and avoid excessive workload for the clinics specialised in the rehabilitation of torture survivors.

While the legislative tools exist, defining the crime of torture to ensure the right of torture survivors to access rehabilitative care (OHCHR, 2012), proper assessment of reception needs (European Union, 2013), and provision of specific measures of assistance including adequate psychological support (Decree Law, no. 142, 2015) and while guidelines to orient the rehabilitative intervention were issued (Ministry of Health, 2017), they urgently need to be reinforced through dissemination, coupled with training and implementation. This should be combined with clear instructions on how identification should be conducted and, in the long run, development of tools to allow/help identification. Such reinforcement should at the very least consist of relevant training—as foreseen by relevant legislation (European Union, 2013)—for all reception officers employed in the reception structures and health and social practitioners at the public level.

Other trainings for health practitioners and social workers in public health services, and for reception officers employed in reception structures, should focus on migration-related topics to strengthen their sensitivity and the adoption a culturally adapted approaches with the migrant population, which would facilitate the emergence or identification of the torture condition. Trainings should be designed and tailored to fit the specificities of each profession involved.

Professional cultural mediation should be systematically provided in reception centres and public health structures to overcome language and cultural barriers, to establish and facilitate relationships between reception officers and beneficiaries, and to enhance the chances of detection or self-reporting of physical or psychological symptoms (Flores, 2005). It is essential that public health structures and general practitioners work with the systematic support of dedicated and trained cultural mediators without having to rely on cultural mediators employed by reception centres, in order to guarantee strict respect of confidentiality and avoid any possible conflict of interest.

Furthermore, we recommend that the Italian government allocates funds to support the existing expertise in the mixed private-public sector and for the development of specialised structures within the public health services, employing dedicated multidisciplinary teams of experienced medical and non-medical personnel and including cultural mediators as part of the interdisciplinary model. This would offer a conducive environment (far from the possible forms of control present in the reception structures) for torture survivors to develop a sense of trust and rapport with those involved in their rehabilitation. Additionally, considering that housing constitutes a major social determinant in health outcomes, alternative solutions to the current reception measures should be explored to meet the subjective needs of torture survivors and to strengthen rather than inhibit the rehabilitative process

(Ziersch, Walsh, Due, Duivesteyn, 2017).

In conclusion, our study identified a lack of awareness and a vacuum of (the implementation of) procedures for identification and referral of torture survivors among the migrant population arriving in Italy. These essential processes are relegated to non-trained and often inexperienced professionals at the different levels of the reception system and public health care sector. Additional resources and structured interventions are urgently needed, in the form of developing and implementing procedures, training and dedicated interdisciplinary services.

Acknowledgements

We acknowledge with gratitude the general practitioners and the personnel of the selected reception centres and the sub-districts in the Rome ASL 6 for their enthusiastic participation in this study. Without their contribution this article could never have been written. We would also like to show our gratitude to the Direction of the ASL Rome 6 for the collaboration and for allowing Médecins Sans Frontières, Italy Mission, to conduct this study in its territory. Additional thanks to MSF colleagues from the clinic for Victims of Torture in Rome for providing their inputs, suggestions and reflections on the topic.

A special posthumous acknowledgment goes to Mrs. Maria Grazia Germani, who worked as Responsible for the Social Services Department ASL 6, Rome Italy. Mrs. Germani's contribution has been instrumental for the identification of reception centers and the sub-district teams of ASL Rome 6 and for facilitating the contact with the principal investigator.

Funding

The training programme and open access publications costs were funded by the Department for International Development (DFID), UK and La Fondation Veuve Emile Metz-Tesch (Luxembourg). The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

References

Asgary, RG., Metalios, EE. , Smith, CL., Paccione, GA. (2006). Evaluating asylum seekers/torture survivors in urban primary care: a collaborative approach at the Bronx Human Rights Clinic. *Health and human rights, 9*(2):164-79.

Baker, R. (1992). Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In: Basoglu M. editor (Ed), *Torture and Its Consequences: Current Treatment Approaches* (pp. 83-101). Cambridge, England: Cambridge University Press.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2):77-101.

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *Int J Soc Psychiatry, 57*(2):107-19.

Creswell, J. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. Thousand Oaks, CA, USA: Sage Publications, Inc.

Decree Law, no.142. (2015). Attuazione della direttiva 2013/33/UE recante norme relative all'accoglienza dei richiedenti protezione internazionale, nonche' della direttiva 2013/32/UE, recante procedure comuni ai fini del riconoscimento e della revoca dello status di protezione internazionale, Decreto Legislativo 18 agosto 2015, no. 142. [Implementation of the directive 2013/33/UE on current norms regulating the reception of asylum seekers].

De Maio, G., Pettinicchio, V. (2018). Accoglienza e cura delle vittime di tortura a Roma, 30 anni di esperienze. Osservatorio Romano, Tredicesimo Rapporto Report on the reception conditions and rehabilitation for victims of torture in Rome, 30 years of experience. [Report on the recep-

tion conditions and rehabilitation for victims of torture in Rome, 30 years of experience.]. Centro Studi e Ricerche Idos.

European Union., (2013). Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical care research and review : MCRR,62*(3):255-99.

Frontex., (2017). Central Mediterranean Route. Frontex. http://frontex.europa.eu/trends-and-routes/central-mediterranean-route/.

Jaranson, JM., Kinzie, JD., Friedman, M., Ortiz, SD., Friedman, MJ., Southwick, S., et al. (2001). Assessment, Diagnosis, and Intervention. In: Gerrity, E., Tuma, F., Keane, T.M., (eds). *The Mental Health Consequences of Torture The Plenum Series on Stress and Coping*. Boston, MA, USA: Springer, pp. 249-275.

Kirmayer, LJ., Narasiah, L., Munoz, M., Rashid, M., Ryder, AG., Guzder, J., et al.(2011). Common mental health problems in immigrants and refugees: general approach in primary care. in *CMAJ Canadian Medical Association journal = journal de l'Association medicale canadienne, 183*(12), E959-67.

Larson-Stoa, D., Jacobs, GA., Jonathan, A., Poudyal, B. (2015). Effect of counseling by paraprofessionals on depression, anxiety, somatization, and functioning in *Indonesian torture survivors. Torture, 25*(2):1-11.

Ministero dell'Interno. [Ministry of the Interior.] (2009). Ministero dell'Interno, European Union. Linee di Indirizzo per il Riconoscimento della Figura Professionale del Mediatore Interculturale, del Gruppo di Lavoro Istituzionale per la promozione della Mediazione Interculturale. Rome, Italy: Centro Informazione e Educazione allo Sviluppo. [Guidelines on the recognition of intercultural mediators.] Rome, Italy.

Ministero dell'Interno. [Ministry of the Interior.] (2017). Cruscotto Statistico Giornaliero 12 Aprile 2017. Rome, Italy: Ministero dell'Interno. [Daily statistics on 12th April 2017.] Rome, Italy. http://www.libertaciviliimmigrazione.dlci.interno.gov.it/sites/default/files/allegati/cruscotto_statistico_giornaliero_12_aprile_2017.pdf.

Ministero dell'Interno. [Ministry of the Interior.] (2017). Ministero dell'Interno. Schema di Capitolato di Appalto. [Contract documents.] Rome, Italy. http://www.libertaciviliimmigrazione.dlci.interno.gov.it/sites/default/files/allegati/schema_di_capitolato_di_appalto_p.pdf.

Ministero della Salute. [Ministry of Health.] (2017). Linee guida per la programmazione degli interventi di assistenza e riabilitazione nonché per il trattamento dei disturbi psichici dei titolari dello status di rifugiato e dello status di protezione sussidiaria che hanno subito torture, stupri o altre forme gravi di violenza psicologica, fisica o sessuale. [Guidelines for the programming of intervention of support and rehabiliatation programs, including for the treatment of mental health disorders affecting refugees and asylum seekers entitled to subsidiary protection, victims of torture and of cruel or other forms of inhumane degrading treatment, psychological, physical violence or sexual violence.] Rome, Italy.

OHCHR, UN Committee Against Torture (2012). *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.*

OHCHR, UN Committee Against Torture (2012). *General Comment no. 3: Implementation of Article 14 by State Parties*.

OHCHR, & United Nations Human Rights - Office of the High Commissioner(2017). *Two-thirds of torture victims supported by UN Fund are migrants and refugees*. New York, USA. http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21533&LangID=E.

OSCE, Regional meeting on Rehabilitation for Victims of Torture for countries in the OSCE region (2016). *Good Practices and Current Challenges in the Rehabilitation of Torture Survivors - discussion paper*, June 23rd 2016. Copenhagen, Denmark.

Sousa, CA. (2013). Political violence, collective functioning and health: A review of the literature. *Medicine, Conflict and Survival, 29*(3): 169-97.

SPRAR., (2017). System of Protection for refugees and asylum seekers [Sistema de Protezione per Richiedenti Asilo e Rifugiati. SPRAR - English.] Rome, Italy]

Towers, R., Reventlow, M., de Rengervé, H. , de Witte, M. (2016). *Recognising victims of torture in national asylum procedures - A comparative overview of early identification of victims and their access to medico-legal reports in asylum-receiving countries.* Copenhagen, Denmark: IRCT.

UNHCR (2017). Operational portal - refugee situations. *Mediterranean situation*. https://data2.unhcr.org/en/situations/mediterranean/location/5205#category-1.

UNSMIL, United Nations Support Mission in Libya, United Nations Human Rights - Office of the High Commissioner (2016). *"Detained and dehumanised": Report on human rights abuses against migrants in Libya*. Libya.

Visentin, S., Pelletti, G., Bajanowski, T., Ferrara, SD. (2017). Methodology for the identification of vulnerable asylum seekers. *International journal of legal medicine*.

Wenzel, T. (2007) Torture. *Current opinion in psychiatry*, *20* (5):491-6.

Yawar, A. (2004). Healing in survivors of torture. Journal of the Royal Society of Medicine, 97(8): 366-70.

Ziersch, A., Walsh, M., Due, C., Duivesteyn, E.(2017). Exploring the Relationship between Housing and Health for Refugees and Asylum Seekers in South Australia: A Qualitative Study. *International journal of environmental research and public health*, *14*(9), 1036.

Validation of the Protect Questionnaire: A tool to detect mental health problems in asylum seekers by non-health professionals

Ricarda Mewes, PhD*, Boris Friele, Prof. Dr., Evert Bloemen, MD*****

Key points of interest:

- Early recognition of mental health sequelae of torture or serious violence is of utmost importance for asylum seekers who enter the EU since such sequelae are likely to have a significant impact on the asylum procedure itself as well as rehabilitation and integration.
- It is important that non-health professionals are able to detect mental health issues using effective screening tools.
- Data presented here supports the hypothesis that the PROTECT Questionnaire is a valid and reliable tool for non-health professionals in deciding whether to offer an asylum seeker special legal procedures and whether or not to refer an asylum seeker for a clinical examination.

*) Outpatient Unit for Research, Teaching and Practice, Faculty of Psychology, University of Vienna

**) Faculty of Social Work, IUBH International University, Campus Berlin

***) Pharos, Dutch Centre of Expertise on Health Disparities, Utrecht, The Netherlands

Correspondence to: b.friele@iubh-dualesstudium.de

Abstract

Introduction: Prevalence rates of trauma-related mental disorders such as posttraumatic stress disorder (PTSD) or major depression (MD) are high in asylum seekers. The PROTECT Questionnaire (PQ) was designed to detect indications of those disorders in asylum seekers. Empirical data are needed to evaluate the PQ psychometrically. The objective of this study is to investigate the reliability, validity, sensitivity, and specificity of the PQ. **Method:** The PQ and validated questionnaires for PTSD (Posttraumatic Diagnostic Scale, PDS) and depression (Patient Health Questionnaire-9, PHQ-9) were filled in by a sample of recently arrived asylum seekers in Germany (n=141). A sub-sample of 91 asylum seekers took part in a structured clinical interview to diagnose PTSD or MD (SCID-I). **Results:** The PQ showed a one-factor structure and good reliability (Cronbach's α = .82). It correlated highly with the PDS and the PHQ-9 (rs=.53-.77; ps≤.001). Diagnostic accuracy with regard to PTSD (AUC=.74; SE=.06; p<.001; 95%-CI=.63-.84) and MD (AUC=.72; SE=.06; p<.001; 95%-CI=.61-.83) was adequate, suggesting an optimal cut-off of 8 or 9. By categorizing participants into a low- and high-risk category, the PQ differentiated well between asylum seekers who fulfilled a PTSD or MD diagnosis and

those who did not. **Discussion:** The results support the use of the PQ as a reliable and valid instrument for the purpose of detecting signs and symptoms of the two most common mental disorders in asylum seekers. Persons found to be at risk of mental disorders should be referred to a clinical diagnostic procedure.

Keywords: asylum seekers, major depression, posttraumatic stress disorder, screening tool, validation

Introduction

The recent large influx of asylum seekers in the European Union (EU) represents a major public health challenge. Many of the asylum seekers as well as other migrants have been confronted with adverse conditions, e.g. war, violence, torture, loss of beloved persons, jobs, and property. This makes them vulnerable to negative mental health consequences. In the EU, the Asylum Procedures Directive and the Receptions Conditions Directive give guidance to member states on how to deal with the special needs of vulnerable asylum seekers (European Union, 2013). According to these directives, the needs have to be identified and taken into account with respect to reception facilities, health care provisions, and the need for special legal procedural guarantees. These requirements are based on the knowledge of high prevalence rates of mental disorders in asylum seekers and refugees. Posttraumatic Stress Disorder (PTSD) and Major Depression (MD) are among the most frequent mental disorders in asylum seekers and refugees who have experienced war, torture, or other forms of serious violence (Gäbel, Ruf, Schauer, Odenwald, & Neuner, 2006; Ikram & Stronks, 2016; Steel et al., 2009). The European Asylum Support Office (EASO) considers these mental health problems as one of the indicators for special procedural needs in asylum procedures. For this reason a practical guide on evidence assessment and a digital tool were developed (EASO, 2015 & 2016).

Evidence shows that mental health problems are associated with impairments in concentration and memory, which hinder asylum seekers from properly recounting the often traumatic background of their asylum request, resulting in wrongful asylum decisions (Cameron, 2010; Herlihy, Jobson, & Turner, 2012; Memon, 2012; Rogers, Fox, & Herlihy, 2014). These impairments also hinder learning capacities and can influence the person's ability to take part in social and working life in the host country. On the other hand, secure life circumstances and adequate care and treatment have considerable positive health impacts for asylum seekers (Heeren et al., 2014; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel et al., 2006).

Considering the high number of steadily arriving asylum seekers, a procedure which allows for an efficient identification of vulnerable persons needing special mental health care and special procedural attention is imperative. There is a need for a tool to easily detect symptoms of mental disorders as an expression of vulnerability and special needs. Non-health professionals especially are in need of such a tool, as they are most often in contact with asylum seekers without having the clinical knowledge and experience to detect mental health problems. The PROTECT Questionnaire (PQ), investigated here, can be used by non-health staff even in less favorable situations such as asylum hotspots or detention centers. In these places, mental health is a major issue and the identification of vulnerable

individuals is a challenge due to lack of capacity to respond and an absence of standardized tools (European Union Agency for Fundamental Rights, 2016; MSF, 2017).

Against this background, a group of specialized treatment centers for torture victims in several European countries started the PROTECT project that focused on early identification of vulnerable asylum seekers as a result of posttraumatic problems. The PROTECT project[1] suggests a three-step procedure:

(1) detecting signs and symptoms of typical mental health-related sequelae of adverse experiences through a simple and short questionnaire and categorizing into risk categories;
(2) referring medium-risk and high-risk cases to an in-depth medico-psychological examination, including the diagnosis of disorders and the identification of related special needs;
(3) making known these needs in order to provide adaptations in the asylum procedure and adapted reception conditions, care, and treatment for the respective asylum seekers. With regard to step one, an easy to use screening tool is needed.

As Brewin (2005) summarizes, screening tools should be short, with items that are easy to understand, and avoid extended rating scales (e.g. use yes/no answers). They should have a clear purpose, be acceptable to respondents, and provide a simple scoring method to yield results. Focusing on short screening instruments for PTSD as one typical mental health-related sequelae in asylum seekers and refugees, Brewin (Brewin, 2005) found 14 instruments that had been subject to evaluation studies, but only four which consisted of fewer than 15 items. However, the BPTSD (Fullerton et al., 2000) and the SPAN scale (Meltzer-Brody, Churchill, & Davidson, 1999) require a severity scoring from 0 to 4 for each item instead of the recommended simple rating scales. The Disaster-Related Psychological Screening Test DRPST (Chou et al., 2003) was specifically designed for survivors of disasters and might not be applicable to other populations. The Primary Care PTSD Screen PC-PTSD (Prins et al., 2003) claims good predictive validity by using a very low cut-off of three or even two positive answers. Another frequently used screening instrument for PTSD in refugees (published after Brewin's review) is the Trauma Screening Questionnaire (TSQ) (e.g.(McDonald & Sand, 2010)). However, the PC-PTSD and TSQ were developed for specific contexts. They presuppose the experience of a potentially traumatic event and were validated under this premise. A rather new questionnaire, currently attracting attention, is the Refugee Health Screener-15 (Hollifield, 2013; 2016) . The RHS-15 was designed specifically as a screening instrument for refugee populations, and good psychometric validity was found in two evaluation studies. However, despite this broad range of instruments, none of them meet the requirements for screening asylum seekers as outlined by Brewin (2005). Moreover, they do not cover signs of depression as a frequent disorder among asylum seekers (Steel et al., 2009).

PROTECT Questionnaire

The PROTECT Questionnaire (PQ) (PROTECT, 2012) was developed for adult asylum seekers to meet the demands described above. The PQ is designed to be used by non-health professionals as they

[1] http://protect-able.eu

lack the repertoire of questions to identify symptoms of mental disorders. Health professionals do not need a tool like the PQ as they have their diagnostic skills and clinical experience.

In terms of its general structure, the PQ is similar to the TSQ. Ten questions addressing specific symptoms are answered with yes or no. The questions are related to symptoms of PTSD (nightmares, anger, thinking about painful past events, being scared or frightened) and to symptoms of both MD and PTSD (sleeping problems, forgetting, losing interest, troubles concentrating). In order to account for possible cultural differences without being too specific to any particular culture, the questions of the PQ also place some emphasis on pain symptoms (headaches and non-specified pain), as it is well known that persons from non-Western cultures, as well as refugees, are more likely to experience, or at least report, somatic rather than psychological symptoms (Rohlof, Knipscheer, & Kleber, 2014). By counting the "yes" answers a sum score is produced. The result is then assigned to one of three categories of risk for suffering from posttraumatic symptoms suggested by the PROTECT project based on clinical experience and preliminary data. A score of three or less is considered as low risk, a score of four to seven reflects a medium risk, and a score of eight or above suggests a high risk. For the medium- and high-risk categories, referral to a more in-depth examination by a psychologist or psychiatrist is recommended. Contrary to other screening instruments for PTSD, the PQ does not ask about the existence of potentially traumatic event(s). Such questions would presuppose a specific context in terms of time, trust, and expertise that is not compatible with a fast screening setting.

The present study aimed at investigating the reliability, validity, sensitivity, and specificity of the PQ in a sample of recently arrived asylum seekers in Germany.

Materials and methods

Local ethics committee approval for the study (Institutional Review Board of the Department of Psychology, University of Marburg, Germany) was obtained and all subjects provided written informed consent before participating in the study. The study was conducted in accordance with the Declaration of Helsinki. The study design was cross-sectional in nature. Data assessment took place in the German Federal state of Hesse between February 2014 and March 2015.

Procedure and participants

Asylum seekers were recruited for a study investigating the psychological health of adult asylum seekers who had been living in Germany for a maximum of one year. The study was funded by the European Refugee Fund (EFF-12-775). Asylum seekers living in Hesse, a Federal state of Germany, were approached in their accommodation or at meeting points for asylum seekers (e.g., cafés) and provided with information about the study. Asylum seekers who were willing to take part in the study were asked about several risk factors and protective factors for mental health using questionnaires and a structured clinical interview (see below).

Eligibility criteria were an age above 18 years, had been living in Germany for a maximum of 12 months, and had applied for asylum but not yet being recognized as having a right of asylum. Moreover, the participants had to be fluent in understanding and speaking (but not reading or writing) Farsi, Arabic, Kurdish, or English, or had to bring a translator of

their language of choice. The choice of the available languages was based on data about the most frequent countries of origin and mother tongues of asylum seekers in 2014 and the years before 2014 (Bundesamt für Migration und Flüchtlinge, 2014).

Assessment instruments

All questions were provided in Farsi, Arabic, Kurdish, or English according to the participant's choice, and translators for these languages were present in case of further questions. Moreover, the software 'MultiCasi' (Knaevelsrud & Müller, 2008) was used to present the questions and possible answer categories in a language-based manner via a laptop with touch-screen. Questionnaires that were not available in the languages of interest were translated in a forward-backward translation process in accordance with the guidelines of Van de Vijver and Hambleton (1996).

Sociodemographic data were assessed through questions about sex, age, country of birth, mother tongue, religion, highest level of education, and the amount of time living in Germany.

Traumatic events and posttraumatic symptoms were assessed via self-report using an extended version of the Posttraumatic Diagnostic Scale (PDS) (Foa, 1995). The first part of the PDS, the trauma scale, was extended by adding items from the Harvard Trauma Questionnaire (Mollica et al., 1992) asking about traumatic events often experienced by asylum seekers. At the same time, the answer format was extended in accordance with the suggestions for traumatic events in the DSM-5 (American Psychiatric Association, 2013). Thus, it ranged from 'experienced the event myself' (highest score, 3), via 'experienced it as a witness' (2), and 'heard of it' (1), to 'none of the named possibilities' (lowest score, 0). The second part of the PDS comprises questions concerning the time and impact of the most severe traumatic event. The third part consists of 17 items assessing re-experiencing, avoidance, and arousal. The total score of the third part can range from 0 to 51, with higher scores indicating more severe posttraumatic symptomatology. The validity of the PDS has been supported in several studies. Among others, good reliability and validity for the Arabic version were found (Norris & Aroian, 2008). Cronbach's alpha for the PDS (third part) in the present study was .96.

Depressive symptoms were assessed using the Patient Health Questionnaire-9 (PHQ-9) (Kroenke, Spitzer, & Williams, 2001). The PHQ-9 is a nine-item self-rating instrument, with each item representing one of the DSM-IV criteria for a depressive episode. Each item can be scored as 0 (not at all), 1 (several days), 2 (more than half the days), or 3 (nearly every day), according to the frequency of experiencing difficulties in the respective area in the previous two weeks. Sum scores range from 0 to 27, with higher scores indicating a higher intensity of depressive symptoms (Kroenke, Spitzer, Williams, & Lowe, 2010). The PHQ-9 is one of the most frequently used and best validated questionnaires for the assessment of depression worldwide (Löwe et al., 2004; Lowe et al., 2004). It is recommended as a general measure of depression severity by the DSM-5 (American Psychiatric Association, 2013) and has been translated into over 70 languages and dialects (Pfizer Inc., 2013). Cronbach's alpha for the PHQ-9 in the present study was .92.

In a subsample of the participants, the *diagnoses Posttraumatic Stress Disorder (PTSD) and Major Depression (MD) (episode)* were assessed by thoroughly trained psychologists with the help of translators.

To this end, the respective sections of the Structured Clinical Interview for DSM-IV (SCID-I) (Wittchen, Schramm, Zaudig, & Unland, 1997) were used. Moreover, the section for PTSD was complemented by questions assessing the newly introduced criteria for PTSD in the DSM-5 (i.e., negative cognitions and mood (American Psychiatric Association, 2013)).

Statistical analyses

SPSS 22.0 was used for all statistical analyses and only persons with full data on the respective questionnaire were included in the corresponding analyses regarding that questionnaire, i.e. persons with missing data were excluded from the relevant analyses but not from other analyses.

First, the factor structure of the PQ was analyzed using exploratory factor analysis to determine the underlying factor structure of the PQ and to have a basis for the following analyses. To test the adequacy of the items for factor analysis, the Kaiser-Meyer-Olkin test of sampling adequacy and Bartlett's test of sphericity were applied. A principal axis factor analysis with promax rotation was conducted that allows for intercorrelations between factors, as intercorrelations are typical for scales assessing symptoms of mental disorders. The scree plot was used to determine the number of factors to be extracted. As a measure for the reliability of the PQ total score, Cronbach's α was determined.

Second, descriptive analyses of the PQ and calculations of percentages of participants in each of the three risk categories of the PQ (low risk for a PTSD, MD, or other trauma-associated mental disorder: sum score of 0-3; medium risk: 4-7; high risk: 8-10) were carried out.

Third, Pearson correlations between the PQ score and the measure for depression (PHQ-9), the sum score of the extended trauma list of the PDS, and posttraumatic symptoms (PDS total symptom score) were calculated. Moreover, two t-tests for independent samples were conducted, with (a) PTSD (SCID-I criteria fulfilled vs. not) and (b) MD (SCID-I criteria fulfilled vs. not) as group variables and the sum score of the PQ as dependent variable. The variables were tested for inequality of variances using the Levene test and statistics were adapted in accordance with the results. To determine the ability of the PQ to detect persons with a PTSD or MD, the percentages of participants with or without the respective disorder in each of the three risk categories of the PQ were determined.

Fourth, to assess diagnostic accuracy, a receiver operating characteristic (ROC) curve was calculated with the PQ as predictor variable and the SCID-I diagnosis of PTSD and MD, respectively, as dependent variable.

Results

Description of the investigated sample

141 asylum seekers participated in the study. They had an average age of 32 years, and two thirds were men (see Table 1). The percentage of men precisely mirrors the percentage of all new asylum seekers in Germany in 2014 and the relatively young age is typical for asylum seekers in Germany (Bundesamt für Migration und Flüchtlinge, 2014). Most participants came from Iran, Afghanistan, Syria, or African countries and had been living in Germany for eight to nine months at the time of the study. To achieve a meaningful sample size, 16 asylum seekers who had been living in Germany for more than 12 months at the date of the assessment (up to a maximum of 42 months; their asylum cases were still ongoing) were included in the study sample.

128 asylum seekers provided full data in the PQ (the remainder had missing data) and 91 of them took part in the structured clinical interview (SCID-I). The most frequent reasons for not taking part in the SCID were the person was no longer reachable (n=10), illness (n=8), no time (n=7), no longer interested in the study (n=4), deportation (n=2), or no translator available (n=1). The group that did not take part in the SCID-I did not differ from the group that did take part in the SCID-I with regard to age and symptoms scores in the PQ, PDS, or PHQ-9 (all p>.16), but there were more women in the group that did not take part in the SCID-I than in the group that did take part (64% vs. 31%).

Factor structure and reliability of the PQ

The items in the present data set yielded a good Kaiser-Meyer-Olkin value of .85. The Bartlett test for sphericity was significant ($\chi^2(45) = 335.2$; $p \leq .001$), showing that the variables were appropriate for factor analysis. The scree plot favored a single-factor solution, precluding the need for a rotation strategy. The factor accounted for 39% of the variance in the items. Internal consistency can be considered as good (Cronbach's $\alpha = .82$).

Table 1: *Sociodemographic characteristics (n=141)*

Age (years); mean ± SD Min-max	31.9 ±7.8 (19 - 55)
Percentage men	67%
Highest education	
No graduation from formal schooling	12.5%
Primary school	8.3%
Secondary school	14.6%
School leaving examination or higher	51.4%
Missing information	13.2%
Born in	
Iran	47.9%
Afghanistan	16.0%
Syria	12.5%
Somalia	6.9%
Eritrea	5.6%
Algeria	2.1%
Other countries/ missing information	9.1%
Living in Germany for (months) mean ± SD	8.5 ± 7.5

Descriptive data on the PQ

The factor analysis showed that the PQ was a one-dimensional measure. Therefore, the use of a sum score as the core descriptive value seems to be appropriate. The investigated sample had a sum score of 7.9 (SD = 2.5) on average. Twelve participants (9.4%) were categorized into the lowest category of vulnerability for PTSD, MD, or other trauma-associated disorders, 28 (21.9%) were in the medium category, and 88 (68.8%) were in the highest category.

Relationships with other questionnaires and with diagnoses

The PQ showed high correlations with the PHQ-9 ($r(119)=.73$; $p\leq.001$), with the extended trauma scale of the PDS ($r(89)=.53$; $p \leq .001$), and with the PDS total symptom score ($r(106)=.77$; $p\leq.001$).

Participants who fulfilled the SCID-I criteria for a PTSD had significantly higher sum scores on the PQ (8.9, SD = 1.5) than participants who did not fulfill the criteria (6.9, SD=2.7; $t(51.6)=-4.1$; $p\leq.001$). Likewise, participants with MD (according to the SCID-I) had higher scores (8.9, SD = 1.4) than participants without MD (6.8, SD=2.9; $t(42.1)=-3.99$; $p \leq.001$).

Table 2 shows the descriptive results of the percentages of participants who fulfilled the criteria for PTSD (SCID-I) versus those who did not and their respective risk categorization according to the PQ. The PQ differentiated well between participants with PTSD versus those without in the low- and

high-risk categories, but was only at chance level in the medium-risk category

The results for the differentiation with regard to MD were similar, with good differentiation in the low- and high-risk categories but at chance level in the medium category (shown in Table 3).

Diagnostic accuracy

The PQ showed adequate diagnostic accuracy with regard to PTSD (AUC=.74; SE=.06; p<.001; 95%-CI=.63-.84) and MD (AUC=.72; SE=.06; p<.001; 95%-CI=.61-.83) in the present sample. Considering the higher importance of sensitivity than specificity for a screening instrument for the early detection of posttraumatic symptoms, cut-off scores of 8 (sensitivity was .85 for PTSD and .83 for MD; specificity was .49 for PTSD and .47 for MD) or 9 (sensitivity was .74 for PTSD and .68 for MD; specificity was .68 for PTSD and .62 for MD) might be regarded as optimal.

Table 2: *Number and percentage with/without PTSD according to SCID-1*

	No Post-traumatic Stress Disorder	Post-traumatic Stress Disorder
Low risk (0-3), n (% of category)	7 (87.5%)	1 (12.5%)
Medium risk (4-7), n (%)	11 (61.1%)	7 (38.9%)
High risk (8-10), n (%)	19 (29.2%)	46 (70.8%)

Table 3: *Number and percentage with/without major depression according to SCID-1*

	No Major Depression	Major Depression
Low risk (0-3), n (% of category)	8 (87.5%)	0 (0%)
Medium risk (4-7), n (%)	8 (44.4%)	10 (55.6%)
High risk (8-10), n (%)	18 (27.7%)	47 (72.3%)

Discussion

The early detection of signs of mental disorders in asylum seekers is essential for the provision of appropriate care and for adaptations in the asylum-seeking procedure. To this end, a screening instrument, the PROTECT Questionnaire (PQ), has been developed. The current study investigated the reliability, validity, and diagnostic accuracy of the PQ.

The PQ showed a one-factor structure together with a good internal consistency. It correlated strongly with validated (but longer) questionnaires assessing symptoms of PTSD and MD. Moreover, persons with a diagnosed PTSD or MD, respectively, had significantly higher scores on the PQ than persons without the respective disorder, and the PQ showed adequate diagnostic accuracy for a short screening instrument. Using the three risk categories, the PQ differentiated well between asylum seekers who fulfilled the respective diagnosis and those who did not in the low- and high-risk categories. Additionally, the cut-off criterion for the high-risk category of a sum score of eight was confirmed by the presented analyses. However, the PQ was at chance level in the medium-risk category. Those findings are in line with the recommendation of the suggested PROTECT procedure, which is to refer all persons in the medium- and high-risk categories for a follow up and a more in-depth examination. That said, even persons in the low-risk category might have a mental

disorder, although the probability is lower than for persons in the other categories. Those persons might benefit from re-testing.

Whereas pragmatic requirements such as 'short and simple' are crucial for screening tools, psychometric criteria cannot be ignored. In this regard, our findings are in accordance with Brewin (2005, p.59), who states that "measures with fewer items, simpler response scales, and simpler methods of scoring perform as well if not better than longer measures requiring more complex rating." Nevertheless, in order to consider specific requirements for a screening tool to be administered in the asylum procedure, it is fruitful to take into account the concerns regarding cultural sensitivity expressed by Jakobsen, Thoresen, & Johansen (2011). They investigated the validity of the Harvard Trauma questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL-25) among asylum seekers in Norway and did not find acceptable sensitivity and specificity for detecting PTSD. In accounting for these shortcomings, they emphasized the influence of differing cultural backgrounds on the performance of screening tools. This factor was also highlighted by McDonald and Sand (2010), who are in favor of an 8-step methodology for developing culturally sensitive assessment tools as suggested by Miller and colleagues (2006), and exemplified this by creating the Afghan Symptom Checklist (ASCL). However, it may not be practicable to conduct such a large scale cross-country study. At the same time, pragmatic considerations and the available evidence might complement rather than contradict each other. The PQ is a shorter and hence less demanding instrument than the HTQ and the HSCL-25 and might possibly be less influenced by cultural factors and could be much easier to translate and administer to different cultural groups. A tool that is easy to handle and distribute can be administered broadly, leading to a fairly good cost-benefit ratio. Even more importantly, it starts addressing mental problems at an early stage after arrival in the host country, thus contributing to the prevention of silencing these problems, as happens often in many of the cultures where asylum seekers come from.

As long as there is a lack of available health professionals to conduct screenings and further evaluations early in the asylum procedure, investing in mental health screening of asylum seekers by non-health professionals seems to be the best solution to improve awareness about the special needs of asylum seekers. This should eventually result in appropriate consideration of those needs in the asylum procedure and care provided. In addition, awareness and knowledge about special needs revealed by mental health screenings underlines the need to foster and support treatment facilities for asylum seekers with mental health care needs. These two challenges, i.e., a mental health screening with potential further evaluation and appropriate treatment, are closely linked to each other. However, the early documentation of symptoms of mental disorders itself, even independent of an appropriate treatment, might be of high importance for the course of the asylum application and procedure, particularly when claiming mental health concerns at any point of the administrative or judicial procedure.

Limitations

Beside the strengths of the presented study (e.g., the investigation of recently fled asylum seekers from different countries and the comparison with validated questionnaires and diagnoses), there are also some shortcomings. The current study was restricted to persons who spoke Farsi, Arabic, Kurdish, or English. Although these

are the main languages among the current asylum seekers in Germany, generalizability to other languages and other ethnic groups is nevertheless limited. Similarly, although the lower percentage of women in the investigated sample is in line with the available data on sex percentages in asylum seekers in Germany, this may reduce the ability to transfer the findings to women.

Conclusion

The presented results support the use of the PQ as a reliable and valid instrument for the early identification of posttraumatic symptoms in asylum seekers from the main countries of origin at the time of the study. They underline the use of the PQ in the first step of the three-step procedure suggested by the PROTECT project, i.e. for the detection of signs and symptoms of typical mental health-related sequelae of severe violence and the categorization into risk categories. However, persons working with the PQ should be aware that it, like every screening instrument, only gives a first impression of symptoms and a first evaluation of the risk of suffering from depression and/or PTSD. The PQ does not replace normal diagnostic work, but contributes to finding those asylum seekers who have psychological symptoms and who do not mention their symptoms without prompting. In case of a high or medium score, those persons need to be examined more thoroughly. This clarification is even more important with regard to the legal context in which screening results could be communicated. Although the PQ seems to be successful in identifying affected persons, false-negative cases are possible. Misunderstanding the result of the PQ as a diagnosis could particularly cause harm for those individuals. Thus, the front page of the PQ contains the comment "A low risk doesn't exclude the possibility of the asylum seeker having suffered traumatic experiences". Even persons whose sum scores in the PQ are in the low risk category may benefit from a retest after a month and a short psychoeducation about possible counseling services and contact addresses. Future studies should further investigate the diagnostic accuracy of the PQ as well as its validity in other ethnic and language groups.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, Fifth Edition (DSM-5®)*.

Brewin, C. R. (2005). Systematic review of screening instruments for adults at risk of PTSD. *Journal of Traumatic Stress*, *18*(1), 53-62. https://doi.org/10.1002/jts.20007

Bundesamt für Migration und Flüchtlinge (2014). Migrationsbericht des Bundesamtes für Migration und Flüchtlinge im Auftrag der Bundesregierung [Migration Report of the Federal Office for Migration and Refugees on behalf of the Federal Government] (Migrationsbericht 2014).

Cameron, H. E. (2010). Refugee Status Determinations and the Limits of Memory. *International Journal of Refugee Law, 22*, 469-511. https://doi.org/10.1093/ijrl/eeq041

Chou, F. H., Su, T. T., Ou-Yang, W. C., Chien, I. C., Lu, M. K., & Chou, P. (2003). Establishment of a disaster-related psychological screening test. *Aust N Z J Psychiatry, 37*(1), 97-103.

European Asylum Support Office (EASO) (2015). EASO Practical Guide: Evidence Assessment.

European Asylum Support Office (EASO) (2016). EASO tool for identification of persons with special needs.

European Union (2013). Directive 2013/32/EU and Directive 2013/33/EU of the European Parliament and the Council of 26 June 2013. *Official Journal of the European Union, 29.6.2013* (L 180/60). https://doi.org/10.3000/19770677.L_2013.180.eng

European Union Agency for Fundamental Rights (FRA) (2016). FRA Opinion on fundamental rights in the 'hotspots' set up in Greece and Italy, 2016, 5.

Foa, E. (1995). *Posttraumatic Stress Diagnostic Scale Manual*. United States of America: National Computer Systems Inc.

Fullerton, C. S., Ursano, R. J., Epstein, R. S., Crowley, B., Vance, K. L., Craig, K. J., & Baum, A. (2000). Measurement of posttraumatic stress disorder in community samples. *Nordic Journal of Psychiatry, 54*(1), 5-12. https://doi.org/10.1080/080394800427519

Gäbel, U., Ruf, M., Schauer, M., Odenwald, M., & Neuner, F. (2006). Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. [Prevalence of posttraumatic stress disorder among asylum seekers in Germany and its detection in the application process for asylum] *Zeitschrift für Klinische Psychologie und Psychotherapie, 35*(1), 12-20. https://doi.org/10.1026/1616-3443.35.1.12

Heeren, M., Wittmann, L., Ehlert, U., Schnyder, U., Maier, T., & Muller, J. (2014). Psychopathology and resident status - comparing asylum seekers, refugees, illegal migrants, labor migrants, and residents. *Comprehensive Psychiatry, 55*(4), 818-825. https://doi.org/10.1016/j.comppsych.2014.02.003

Herlihy, J., Jobson, L., & Turner, S. (2012). Just tell us what happened to you: Autobiographical memory and seeking asylum. *Applied Cognitive Psychology, 26*(5), 661-676. https://doi.org/10.1002/acp.2852

Hollifield, M., Toolson, E. C., Verbillis-Kolp, S., Farmer, B., Yamazaki, J., Woldehaimanot, T., & Holland, A. (2016). Effective Screening for Emotional Distress in Refugees: The Refugee Health Screener. *J Nerv Ment Dis, 204*(4), 247-253. https://doi.org/10.1097/NMD.0000000000000469

Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E. C., Woldehaimanot, T., Yamazaki, J., SooHoo, J. (2013). The Refugee Health Screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *Gen Hosp Psychiatry, 35*(2), 202-209. https://doi.org/10.1016/j.genhosppsych.2012.12.002

Ikram, U., & Stronks, K. (2016). *Preserving and Improving the Mental Health of Refugees and Asylum Seekers*. Den Haag: bijlage bij Briefadvies Geestelijke gezondheid van vluchtelingen [The Hague, attachment with Advisory letter mental health of refugees].

Jakobsen, M., Thoresen, S., & Johansen, L. (2011). The Validity of Screening for Post-traumatic Stress Disorder an Other Mental Health Problems among Asylum Seekers from Different Countries. *Journal of Refugee Studies, 24*(1), 171-186. https://doi.org/10.1093/jrs/feq053

Knaevelsrud, C., & Müller, J. (2008). MultiCASI (Multilingual Computer Assisted Self Interview). Berlin: Springer.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med, 16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R. L., Williams, J. B., & Lowe, B. (2010). The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *Gen Hosp Psychiatry, 32*(4), 345-359. https://doi.org/10.1016/j.genhosppsych.2010.03.006

Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, B. A., & De Jong, J. T. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *J Nerv Ment Dis, 192*(12), 843-851. https://doi.org/10.1097/01.nmd.0000146739.26187.15

Löwe, B., Grafe, K., Zipfel, S., Witte, S., Loerch, B., & Herzog, W. (2004). Diagnosing ICD-10 depressive episodes: superior criterion validity of the Patient Health Questionnaire. *Psychother Psychosom, 73*(6), 386-390. https://doi.org/10.1159/000080384

Lowe, B., Spitzer, R. L., Grafe, K., Kroenke, K., Quenter, A., Zipfel, S., Buchholz, C., Witte, S., Herzog, W. (2004). Comparative validity of three screening questionnaires for DSM-IV depressive disorders and physicians' diagnoses. *J Affect Disord, 78*(2), 131-140. https://doi.org/10.1016/S0165-0327(02)00237-9

McDonald, T. W., & Sand, J. N. (2010). *Post-Traumatic Stress Disorder in Refugee Communities: The Importance of Culturally Sensitive Screening, Diagnosis, and Treatment*. New York: Nova Science Publishers.

MSF (Medecins sans Frontieres((2017). A Dramatic Detoriation for Asylum Seekers on Lesbos.

Meltzer-Brody, S., Churchill, E., & Davidson, J. R. (1999). Derivation of the SPAN, a brief diagnostic screening test for post-traumatic stress disorder. *Psychiatry Res, 88*(1), 63-70. https://doi.org/10.1016/S0165-1781(99)00070-0

Memon, A. (2012). Credibility of Asylum Claims: Consistency and Accuracy of Autobiographical Memory Reports Following Trauma. *Applied Cognitive Psychology, 26*, 677-679. https://doi.org/10.1002/acp.2868

Miller, K. E., Omidian, P., Quraishy, A. S., Quraishy, N., Nasiry, M. N., Nasiry, S., Yaqubi, A. A. (2006). The Afghan symptom checklist: a culturally grounded approach to mental

health assessment in a conflict zone. *Am J Orthopsychiatry, 76*(4), 423-433. https://doi.org/10.1037/0002-9432.76.4.423

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis, 180*(2), 111-116.

Norris, A. E., & Aroian, K. J. (2008). Assessing reliability and validity of the Arabic language version of the Post-traumatic Diagnostic Scale (PDS) symptom items. *Psychiatry Res, 160*(3), 327-334. https://doi.org/10.1016/j.psychres.2007.09.005

Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D., S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2003). The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry, 9*, 9-14. https://doi.org/10.1185/135525703125002360

PROTECT. (2012). Project Report. Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment.

Rogers, H., Fox, S., & Herlihy, J. (2014). The importance of looking credible: the impact of the behaviourial sequelea of post-traumatic stress disorder on the credibility of asylum seekers. *Psychology, Crime & Law, (21(2)*, 139-155. doi.org/10.1080/1068316X.2014.951643

Rohlof, H. G., Knipscheer, J. W., & Kleber, R. J. (2014). Somatization in refugees: a review. *Soc Psychiatry Psychiatr Epidemiol, 49(11)*, 1793-1804. DOI 10.1007/s00127-014-0877-1

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: assocations with pre-migration trauma and post-migration stressors. *Br J Psychiatry, 170*, 351-357. https://doi.org/10.1192/bjp.170.4.351

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA, 302*(5), 537-549. https://doi.org/10.1001/jama.2009.1132

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *Br J Psychiatry, 188*, 58-64. https://doi.org/10.1192/bjp.bp.104.007864

Van de Vijver, F.J.R., & Hambleton, R. K. (1996). Translating Tests - Some Practical Guidelines. *European Psychologist, 1*(2), 89-99. https://doi.org/10.1027/1016-9040.1.2.89

Wittchen, H. U., Schramm, E., Zaudig, M., & Unland, H. (1997). *SKID. Stukturiertes klinisches Interview für DSM-IV, Achse I, deutsche Version*. [*Structured clinical interview for DSM-IV, German Version*]. Göttingen: Hogrefe.

Annex I

Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences

The tool is not applicable to determine the legal status of a person and cannot be used to limit any claims or rights in later process.

What is the purpose of the Questionnaire ?

The PROTECT Questionnaire at hand has been developped to facilitate the process of receiving asylum seekers in accordance with the directives of the European Council[1].

The Questionnaire facilitates the early recognition of persons having suffered traumatic experiences, e.g. victims of torture, psychological, physical or sexual violence.

Asylum seekers having suffered such traumatic experiences should be referred to professionals of the Health Care System at an early stage in the asylum process in order to avoid deterioration and chronic manifestation of health problems and enable adaptations in reception conditions and asylum procedure.

When to use the Questionnaire ?

Upon arrival in the receiving country first aid and physical shelter should be provided. It is appropriate to carry out an interview with the asylum seeker using this Questionnaire preferably after a period of rest (e.g. 7/10 days).

The Questionnaire should be applied even under difficult circumstances, rather than being neglected.

Sometimes psychological problems caused by traumatic experiences begin to appear later. That's the reason why another investigation should be carried out or the Questionnaire should be filled out a second time and the rating may have to be corrected.

1 With respect to article 17 in particular but also to articles 15 and 20 the Council Directive laying down minimum standards for the reception of asylum seekers (2003/9/EC of January 27th 2003) and with particular respect to article 12 §3 and article 13 §3 indent a) of the Council Directive on minimum standards on procedures in Member States for granting and withdrawing international protection (2005/85/CE of December 1st 2005).

PROTECT
Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment

How to apply the Questionnaire ?

Before asking the set of questions, please read the following short introduction to the asylum seeker to inform him or her about the purpose of the Questionnaire and to support an environment of trust and reassurance.

The Questionnaire establishes a rating system ("low risk", "medium risk" or "high risk") for having suffered traumatic experiences.

After completing the Questionnaire a copy should be given to the asylum seeker with the recommandation that he or she submits this paper whenever meeting a Health Care System professional, a legal advisor or a reception official.

Text to be read before asking the following questions :

Dear Madam, Dear Sir,

The European Union has issued instructions to take into account the situation of some asylum seekers who need specific care.

This Questionnaire has been created jointly by specialized health and legal professionals. It will allow us to speak about your health. You can refuse to answer it.

The aim of this Questionnaire is to support you through raising awareness about your special needs.

Consequently, there are no good or bad answers to the questions and it is important that you answer as freely and naturally as possible.

Please answer the questions by YES or NO. When answering, keep in mind the experiences of the last weeks.

Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences

Questions *"Often" means : more than usual and causing suffering*		Yes	No
1	Do you often have problem falling asleep ?		
2	Do you often have nightmares ?		
3	Do you often suffer from headaches ?		
4	Do you often suffer from other physical pains ?		
5	Do you easily get angry ?		
6	Do you often think about painful past events ?		
7	Do you often feel scared or frightened ?		
8	Do you often forget things in your daily life ?		
9	Do you find yourself losing interest in things ?		
10	Do you often have trouble concentrating ?		
Number of questions answered "Yes" →			

Rating :	0-3	4-7	8-10
Please mark the proper category with an X to indicate the level of risk of traumatisation →			
	Low risk	**Medium risk**	**High risk**

PROTECT
Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment

In case of a "medium risk" or a "high risk" rating the asylum seeker should be referred for medical ans psychological examination !
A "low risk" doesn't exclude the possibility of the asylum seeker having suffered traumatic experiences. Symptoms may appear later. Another screening should be carried out.

Further observations (*For example : the person cries a lot, doesn't react, pays no attention... / difficulties to understand the questions / special circumstances for the interview...*) :

These observations must be shared with the person

Name of asylum seeker :

Date of birth :

Country of origin :

Date :

I agree that a copy of this document will be kept by the interviewer's organisation and can be used for statistical purpose (signature)

Organisation (stamp if possible)

After the review a copy of the Questionnaire should be given to the asylum seeker with the recommandation that he or she submits this paper whenever meeting with a Health Care System professional, a legal advisor or a reception official.

"My mind is not like before": Psychosocial rehabilitation of victims of torture in Athens

Gail Womersley,*, Laure Kloetzer,*, Rafael Van den Bergh,, Emilie Venables,**, ***, Nathalie Severy,**, Nikos Gkionakis,****, Christina Popontopoulou,*****, Manolis Kokkiniotis,*****, Federica Zamatto,****

Key points of interest:

- Torture and forced migration represent two significant interrelated sources of trauma.
- This study highlights the significant impact of the political, legal, and sociocultural environment on processes of psychosocial rehabilitation.

Abstract

Introduction: The dual trauma of being a victim of torture as well as a refugee is related to a myriad of losses, human rights violations and other dimensions of suffering linked to torture experienced pre-migration, as well as different forms of violence experienced during and after migration. **Method:** To present three case studies to explore culturally-informed perspectives on trauma among victims of torture and track trajectories of psychosocial rehabilitation in relation to environmental factors. The case studies are part of a larger qualitative study of asylum seekers and refugees in a center for victims of torture in Athens, managed by Médecins Sans Frontières and Babel in collaboration with Greek Council for Refugees, which follows beneficiaries, their care providers and community representatives and leaders. **Results:** Key themes emerging include the substantial psychological impact of current material realities of migrant victims of torture as they adapt to their new environment and engage in rehabilitation. Delayed asylum trials, poor living conditions and unemployment have a substantial impact on posttraumatic symptoms that in turn influence psychosocial rehabilitation. Personal, social, and cultural resources emerged as having a mediating effect. **Discussion:** The results highlight the significant impact of the political, legal, and sociocultural environment on psychosocial rehabilitation. Practical implications for interventions are to ensure

* Institute of Psychology and Education, University of Neuchatel, Switzerland
** Médecins Sans Frontières - Operational Centre Brussels
*** Division of Social and Behavioural Sciences, School of Public Health and Family Medicine, University of Cape Town, South Africa
**** Babel Mental Health Day Care Centre, Athens, Greece
***** Médecins Sans Frontières - Operational Centre Brussels, Centre for Victims of Torture and ill-treatment, Athens, Greece
Correspondence to: gail.womersley@unine.ch

holistic, interdisciplinary, and culturally sensitive care which includes a focus on environmental factors affecting resilience; and with a dynamic focus on the totality of the individual over isolated pathologies.

Keywords: Torture, rehabilitation, environmental impact, trauma, post-traumatic stress disorder

Introduction

The mental health impact of atrocities endured by refugees[1] is clear, with a high prevalence of post-traumatic stress disorder (PTSD) reported among this population. Torture has emerged as a particular triggering factor (Haenel, 2015; Hodges-Wu & Zajicek-Farber, 2017; Silove, Ventevogel, & Rees, 2017; Song, Subica, Kaplan, Tol, & de Jong, 2017). This is no surprise, given the multiplicity of challenges to which refugee Victims of Torture (VoTs) are exposed. The dual trauma inherent in being both a VoT as well as a refugee is related to a myriad of losses, human rights violations and other dimensions of suffering linked not only to torture experienced pre-migration, but trauma experienced during and post-migration as well (Hodges-Wu & Zajicek-Farber, 2017). Trauma does not stop at the border.

Torture itself represents an extraordinary exception in the psychopathology field. The act itself is taught, organised, elaborated, and perpetrated by humans against other humans, disrupting our connections to all that make us human (Sironi, 1999; Viñar, 2005). It is not an individual act, but a social and political one. These far-reaching effects may interact and manifest in complex and diverse ways, mediated by culture, gender and other aspects of the context of the torture survivor, the context of torture and the context of the recovery environment (Patel, Kellezi, & Williams, 2014). Furthermore, environmental stressors associated with exile, resettlement, and acculturation continue to further threaten individual health and well-being among refugee VoTs. Post-migration factors are a fundamental consideration in light of the additional critical life events which refugees face, and which have clearly emerged in the literature as exacerbating post-traumatic reactions (Hollander et al., 2016; Schock, Böttche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016; Song, Kaplan, Tol, Subica, & de Jong, 2015; ter Heide, Mooren, & Kleber, 2016). Yet, despite this growing body of critical literature, there has been relatively little research regarding how current environmental factors and resettlement variables affect the psychosocial rehabilitation of VoTs (Hodges-Wu & Zajicek-Farber, 2017; Whitsett & Sherman, 2017).

It must be noted that criticism has been levelled against the use of PTSD as a diagnosis within this context. Navarro-Lashayas and colleagues (2016) highlight the risk of medicalising a socio-political problem and individualising social suffering. This oversimplification of the complexity of human suffering serves to depersonalise and victimise the individual (Kotsioni, 2016). Torture is not a disease. In terms of clinical approaches, Papadopoulos (2007) underlines that psychological reactions to adversity vary enormously from individual to individual. His framework suggests that even psychological phenomena such as a post-traumatic response do not occur in social isolation; the wider community and cultural contexts matter a great deal as they are

[1] Here, we use the term "refugee" as defined by the Geneva Convention of 1951 to include both refugees legally recognised in a host country as well as asylum-seekers.

active in forming at least part of the meaning systems, and consequently the rehabilitation, of each individual.

These theoretical frameworks take into account the fact that humans are essentially social beings, and that, equally, symptom severity is not static but fluid and changing due to a wide range of interacting intrapsychic and external factors. There is thus a need to explore trauma 'in context'—notably through exploring processes of psychosocial rehabilitation of victims of torture within the specific historical, cultural, social, and political context of the "reception crisis" in Europe. This is important not only in order to challenge the concept of PTSD, but also to provide more appropriate mental health care to VoTs with a consideration for both cultural factors as well as the impact of current environmental stressors on the process of rehabilitation. Therefore, in order to i) explore culturally-informed perspectives on trauma among VoTs from an individual, qualitative perspective and ii) track trajectories of psychosocial rehabilitation in relation to environmental factors, we present a case series from the results of 12 months of research among asylum seekers and refugees in a center for victims of torture in Athens, managed by Médecins Sans Frontières (MSF) and Babel (a mental health unit for migrants and refugees operating in Athens since 2007) in collaboration with the Greek Council for Refugees (GCR).

Methodology

The study design involved in-depth interviews with three VoTs and their care providers over the course of a year.

Study setting

Victims of torture in Athens, Greece: As the "reception crisis" continues unabated, Greece remains one of the first ports of sanctuary. While the country is still gripped by one of the worst financial and societal crises of the past 40 years, little attention or funding is available to provide mental health and psychosocial support to refugees (Gkionakis, 2016). According to recent statistics provided for March 2018 by the UNHCR,[2] over 50,000 asylum seekers and refugees currently remain in Greece, following the 2015-2016 mass flow. This population is legally entitled to free access to medical care, yet the ability of the Greek health system to provide adequate health care to refugees upon entry is severely stretched as a result of the ongoing economic crisis, resulting in numerous barriers to access (MDM, 2016). These challenges are even more pronounced for migrants faced with a lack of information and linguistic and cultural barriers to accessing an unfamiliar system. Often living in harsh and isolating conditions, a 2017 report by UNHCR[3] estimates that many migrants will wait for over two years to find out about their asylum status.

There are few reliable statistics concerning the number of VoTs currently in Greece (European Union Agency for Fundamental Rights, 2017; MSF, 2016; UNHCR, 2017). The UNHCR has estimated that among refugee populations, between 5 and 35 percent are torture survivors, yet highlights that the actions that are needed to identify and support and enable them to claim their rights are too often ignored or purposely excluded (UNHCR, 2017). In Greece, few rehabilitation or identification services are

[2] https://reliefweb.int/sites/reliefweb.int/files/resources/62950.pdf

[3] http://www.unhcr.org/publications/operations/58d8e8e64/unhcr-recommendations-greece-2017.html

provided to survivors of torture by a state structure or sustainably by NGOs apart from one organisation, Metadrasi, who certified 650 VoTs from 2017-2018.[4] Most efforts of identification appear to be ad-hoc or dependent on some form of self-identification. This complex asylum system, the poor identification of VoTs and the many barriers in accessing basic services in Athens and across the country have had a substantial, adverse impact on mental health (Kotsioni, 2016). It has also lead to health professionals under pressure "medicalising" the psychological suffering (for example, through the use of a certified PTSD diagnosis) as part of the identification process (FRA, 2017), as has been noted elsewhere in Europe (d'Halluin, 2016; Fassin & d'Halluin, 2005).

MSF and Babel clinic for rehabilitation of victims of torture and other forms of ill-treatment: In April 2013, the GCR jointly with Babel Day Centre and Dignity (the Danish Institute Against Torture) started the implementation of the Prometheus project, funded by the EU. Prometheus project's main goal was to deliver identification and rehabilitation to VoTs through health and mental health service provision, as well as legal and social support. In September 2014, MSF joined this partnership. Since 2014, MSF, Babel and GCR have established a unit delivering medical care, legal support, mental health care and social support to VoTs, training and supervision to the staff of this unit and training and consultation to other actors who work with VoTs. The unit adopts the IFRC definition of torture and ill-treatment (where torture is defined as consisting of severe pain or suffering, whether physical or mental, inflicted for such purposes as obtaining information or a confession, exerting pressure, intimidation or humiliation) and operates as an interdisciplinary team applying a holistic approach to the rehabilitation of torture survivors.

Study population
This case series is a part of a larger qualitative study conducted by the first author over the period of a year in the MSF clinic in collaboration with Babel, with supervision and assistance by the other authors. Ten individual VoTs, collectively identified by the health professional team were followed over this period, with an average of five in-depth interviews being conducted with each participant. All ten had been beneficiaries of the clinic for over six months and had found accommodation in Athens, not in the refugee camps. For this case series, three VoT participants out of the ten were selected as representative cases to explore the impact of the environmental, legal, and cultural context on psychosocial rehabilitation of torture.

Ethics
All study participants were informed of the purpose of the research, and provided written consent for the interviews to be taken and their information to be used. Consent was given for care providers to be interviewed by the individual beneficiaries of the project. The study was approved by the ethics committee of the University of Neuchatel, the Ethics Review Board of MSF and the scientific review committee of Babel.

Results

Key themes emerging across interviews with the three selected participants included the substantial psychological impact of current material realities of migrant VoTs as they adapt to their new environment

[4] http://metadrasi.org/en/campaigns/certification-of-torture-victims/

and engage in a process of psychosocial rehabilitation. The periods before and after being granted asylum were identified as two distinct phases in the psychological lives of these individuals, each with specific stressors. Delayed asylum trials, poor living conditions and unemployment emerged as having a substantial impact on post-traumatic symptoms that in turn influenced psychosocial rehabilitation. Personal, social, and cultural resources similarly emerged as having a mediating effect on the stressors identified above.

The first case presented, that of D, focuses on the influence of environmental context (including, for example, current political, material and economic conditions). The second case, that of J, focuses on the legal context and the third case, that of B, focuses on the cultural context.

The case of D

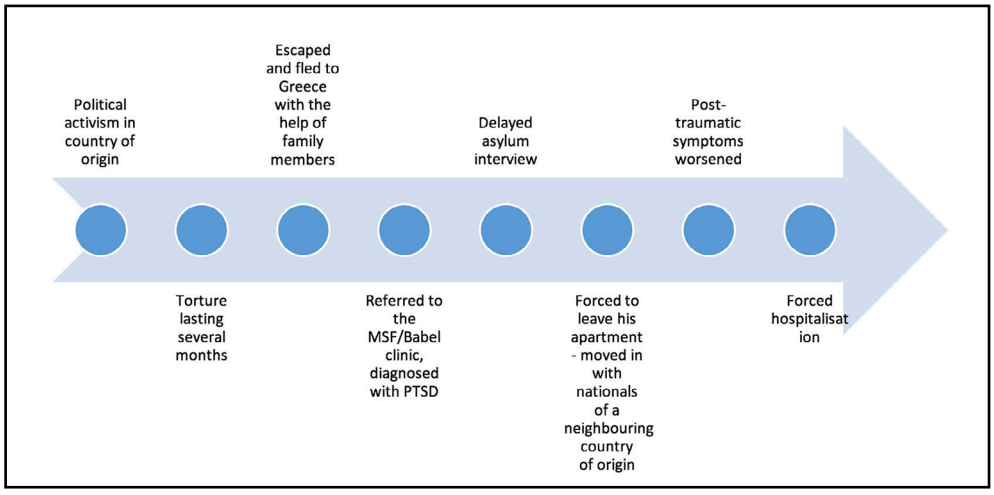
D is a 30-year-old asylum seeker and VoT. In 2007, he was arrested and tortured on numerous occasions in his country of origin, often for months at a time, due to his involvement as a political activist. He managed to escape from prison with the help of an uncle, and arrived, alone, in Athens to seek asylum where he was referred to the MSF/Babel centre.

Over the course of the four interviews, he described the various methods of torture to which he was subjected, in minute detail, including sexual abuse, his legs being "ripped apart", the meta-tarsals in his feet being broken, as well as electrification: "They give me the scars on my soul…lots of things from my mind has been wasted."

For the first four months after his arrival, he was living alone in a 30 meter-squared hotel room in an old building recently remodelled to house asylum seekers. During this time, he explained:

> *"I don't have any friends here, I don't have any relatives, I don't have any family members, I don't even know any [religion removed] community here. I know that there are a lot of [religion removed] people living here, my new community is here, not 'my'*

Figure 1: *Timeline of the key elements in the pre-migration and post-migration life of D, emphasising the influence of environmental context.*



community… when I am staying at a hotel, whenever somebody is knocking at the door, I feel scared… I never go out"

The physical, social, and cultural isolation served merely to exacerbate his post-traumatic symptoms: a vicious cycle of feeling scared and alone, alone and scared. Furthermore, the disconnection cannot be considered as a "one-off" event, which occurred at a particular moment: disruptions continued with each phone call bringing news from his home country and every day spent alone in a hotel room. D was given an appointment for his asylum interview. However, the administrator responsible was not present on the day and the procedure was delayed. This contributed to further disconnections in visibility, representation and the acknowledgement of the torture which he had endured. The uncertainty, and sense of being "stuck" also appeared to have impeded his process of psychosocial rehabilitation:

"*I know only one thing, that my world is just only this room… I'm just killing my time here until I'm not getting my papers or they are not going to take my interview*"

Due to financial reasons, he was forced to move out of his small hotel room into shared accommodation. He accused his roommate of spying on him, a roommate who incidentally came from a neighbouring country that D suspected of having political ties with his own. Psychotic symptoms started to emerge, including auditory hallucinations and symptoms of paranoia. Many of the voices were those of authority figures, including the torturers in his country of origin and, tellingly, police officers, bureaucrats and judges in the asylum procedure in Greece. He reported experiencing auditory hallucinations, with voices claiming that he was going to be homeless. The voices also told him that "they" would not believe him, that "they" would send him back to his home country. Given his current living conditions in Athens, these fears were not without reasonable grounds.

He was hospitalised as a result of these hallucinations in a psychiatric ward of a general hospital. He perceived this repeated institutionalisation as a further enforced period of detention where he was subjected to bodily treatments against his will. It appeared to have triggered memories of the past torture he endured. He described the hospital as having a prison-like atmosphere. The hospital staff promised that they would not give him injections, which they subsequently did. This deepened his sense of mistrust, paranoia and isolation—further exacerbating symptoms. Furthermore, during this period he received news that his mother was in prison, and suffering from severe medical complications. There was no clear news about his father. With each phone call from his country of origin, psychotic symptoms worsened.

One caregiver noted the impact of his current reality on the process of diagnosis:

"*I could see the face of the psychiatrist who at first said, 'You think the secret services of [country removed] are after you?' I could see the paranoia. Then he said his story. There he goes, "Oh, oh, oh, oh." [laughter] This is not paranoia. This is real life.*"

The phrase "this is real life" is indeed telling: D's "real life"—characterised by poor living conditions, social isolation, and delayed asylum trials, played a key role in his mental health. His case highlights the role of "feedback loops" (Kirmayer & Ramstead, 2017)—vicious cycles wherein symptoms were exacerbated by "real life" events and which played a key role in his psychosocial rehabilitation.

The case of J

J is a 45-year-old African man, unmarried and the father of one nine-year-old son. He was arrested and tortured after engaging in anti-government protests. After arriving in Athens in December 2015, he was referred to MSF/Babel for serious medical complications as a result of the torture he suffered, and was seen by a doctor, physiotherapist, lawyer, social worker and psychologist.

When first interviewed, J described his situation as the following:

> *"We are human beings, but I am an adult without a wife, without a child. My life is bloody ruined, everyone is in the same hole, who can change it? Nobody. Nobody cares about us… [these problems] devour us. If I was well, you could see that I was well, but I'm sick, I'm not in good health. I'm physically fine, but in my interior— I'm not at all okay […] I'm with the others but not in spirit"*[5]

His mental health, did, however start to improve with a multi-disciplinary intervention. A few weeks later, he confirmed that:

> *"I was traumatised before, I had too much fear, but the social worker did everything to calm me […] the psychologist is also a person that you can tell everything to: social, emotional, everything…"*

During his first asylum interview, he had to speak about the torture he endured, an event that he described as having "retraumatised" him:

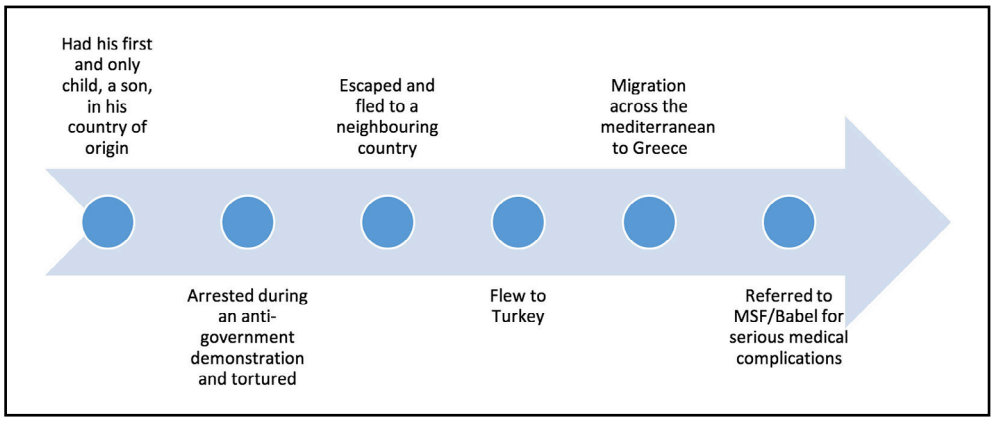
> *"It's a story that hurts you and causes a lot of emotions […] the pain that I felt that day, that could be at 10%, if the pain has passed, but if you have to repeat the story, you feel it at 100% […] it hurts you to have to tell your story, yes it hurts. Even during the interview, it hurts you."*

Despite his testimony, and having medical certification attesting to the physical injuries resulting from the torture, his request for asylum was denied. J, however, refused to accept this:

> *"I refused. I said "no, this can't be happening, I have all the proof to show…I*

[5] Loose translation from the original interview conducted in French.

Figure 2: *Timeline of the key elements in the pre-migration and post-migration life of J, emphasising the influence of the legal context.*



can talk, I can lie, but the proof doesn't lie, the echocardiogram proves everything." I was really affected. I had a fever […] yes I was emotional, I was alone with the interpreter and the three judges and the lawyer. It's tough. Man, man has no pity for man, no pity. Oh it's tough! To be a migrant is tough, to re-enter into a normal life is tough […] during the asylum interview, my head heated up. All of the calculations that I'd had, none of them worked out. I thought that, with this news, they won't give me a house, it's difficult to eat, in these really bizarre conditions."

As was the case for D, the fact that his story was not believed appeared to have the most significant impact on him. Furthermore, he equated being an asylum seeker as living in "bizarre conditions" of permanent temporariness. He described feeling mocked, teased, humiliated and ill-treated by bureaucrats throughout the asylum process. Despite his request for asylum being denied, Mr J requested an appeal and continued his process of psychosocial rehabilitation. When interviewed after submitting the appeal, he stated that:

"There have been some big changes because when you cry a lot, there's a moment where you stop crying. You see the reality in front of you. I have already suffered a lot from thinking, thinking. I must think until where and until when? Must I spend my whole life crying? […] Since being here, the pain has changed […] The essential is that I'm in good health. I'm alive. It's not the end of the world. Life continues."

He suggested that his improvement in mental health was related to a variety of factors: the resilient spirit that his father had instilled in him as a young boy, the assistance of a community in Athens from his country of origin, the holistic and multidisciplinary approach of his psychosocial rehabilitation and, simply, time. His case exemplifies the impact of the legal context on mental health. It highlights the necessity of a multi-disciplinary approach to psychosocial rehabilitation, including a team of social workers, lawyers, psychologists, doctors, cultural mediators, and psychiatrists. If one element of these is lacking, it may slow down or inhibit the activities of the others.

The case of B

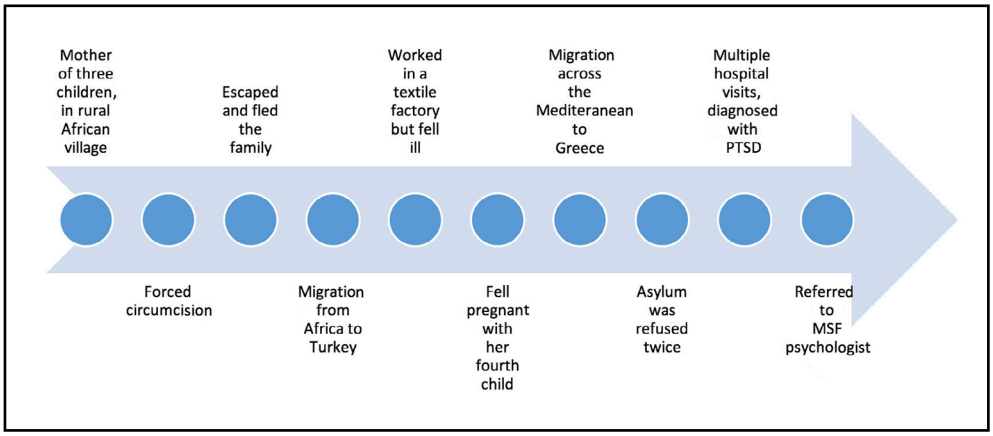
B is a 35-year-old African woman, mother of four children and a victim of torture and of forced circumcision. Upon arriving in Greece, she presented frequently to the emergency services with multiple physical complaints, which were diagnosed as psychosomatic. She was similarly diagnosed with PTSD and referred to MSF/Babel for mental health care.

When asked about her experience of trauma during our first interview, B explained that:

"I have a fear of everything, a fear of life, in fact, because me, I always say, "if you don't take decisions, I wouldn't have left my country" and that fear of 'that practice' [of torture] also evoked fear in me. I left my children behind me—what will happen to them? How are they over there? How do they live? How are they eating? How are they sleeping? This fear has developed in me and it's tiring. I even told my psychologist that I have this fear that I don't know how to explain, this fear that I want to leave me…"

She related her experience of fear to both the isolated incident of torture she endured, as well as to multiple other factors, including having been forced to leave her children, as well as her uncertain future. She felt unable to return to her country, but also unable to engage in a process of rehabilitation for

Figure 3: *Timeline of the key elements in the pre-migration and post-migration life of B, emphasising the influence of the cultural context.*



the future. No one single incident could account for this unexplainable fear. Thus paralyzed, she remained isolated from others, barely leaving her apartment except for the occasional visit to the clinic to see her psychologist.

A few months later, she explained:

> *"The psychologist told me that the nightmares are linked to the past, because I told him that I'm being chased. He told me that it's linked to the past, that's it."*

I told him that it's spiritual, but afterwards, when he spoke, I told myself that "I don't know" but it's also possible that it's linked to what I'm thinking in my head. It's also that. Because I leave what's in my head. If I remove what's in my head, it can sort itself out. Apparently, when you have dreams where people are chasing you, we, we say that it's witchcraft. Among the Africans, we say that it's witchcraft. But he, he explained to me that … for example, I had a dream the night before last. I remember two dreams. Where they chained me up, he said that it's linked to my past and that it's me myself who is chaining myself up.

B was confronted with two varying, and culturally informed, ways of understanding her post-traumatic symptomatology. For her, the nightmares she experienced may be explained "spiritually"—in other words, based on the spiritual and cultural belief systems of her home community. Within this belief system, the nightmares are not perceived to be directly linked to the torture she experienced, but to witchcraft: the family has cursed her for leaving. She appeared to examine these two possible explanations. Her words, "I don't know but it's also possible" reflected her ambivalence towards the meaning behind the nightmares:

> *"Because maybe, in my head, I am guilty, it's true….but Christ has already forgiven me. That's also the problem […] spiritually, it's complex. What I see, I explain spiritually with the hand of witchcraft. It means that the family isn't leaving me in peace. Spiritually, they are following me, they followed me two nights ago until I was scared. I don't know, there are two explanations. Apparently there is an explanation that's different to what I think myself. So I don't know which to leave or*

take. I don't know…but I told myself that maybe that one's right as well."

The spiritual resources she drew on to understand the meaning of the nightmares are linked not only to African traditional spirituality involved in witchcraft, but to Christian beliefs. She herself highlighted the complexity of this. On a symbolic level, the fact that she believed Christ to have forgiven her appears to have had a significant impact on her levels of guilt and other associated forms of emotional distress. She further explained that apart from going to see her psychologist, the other person to whom she was able to share her experiences of trauma was her priest.

A few months later, she described a dramatic decrease in her symptoms—both physical and psychological. There was similarly an increase in her social connections to others:

"I was speaking with the psychologist. Speaking really helped me a lot. I don't have nightmares any more. Because of speaking with him, because of his advice, I would say that things are going all right. And there are many changes, because of speaking with him, I smile, I'm not too stressed like before. There are many changes that I see in myself."

What's interesting to note is the key involvement of social relations in her rehabilitation process. The decrease in symptoms was attributed to "*speaking*" which "*really helped me a lot*." Another integral part of her rehabilitation has been the connection to others. Being able to speak not only to the psychologist, but to her roommates, was part of the process of rehabilitation as well as a potential indicator of its success—she framed the social connection as both something which helped her to forget, as well as an indicator of change in herself. As such, the social connections possibly reflect both the cause and consequence of the improvement in her mental health; a positive feedback loop wherein connection to others decreases the post-traumatic symptoms and this decrease in symptoms allows for an increase in ability to connect socially.

Discussion

The cases above attest to the significant impact of the environmental, legal, and sociocultural context on processes of psychosocial rehabilitation among refugee VoTs. This includes the broader socio-economic framework in host countries and the ways in which these frameworks may hinder or facilitate rehabilitation. Daily stressors represent proximal, ongoing and often chronic threats to psychological wellbeing. Due to this chronicity, these daily stressors may gradually erode coping resources and tax mental health—creating conditions for feelings of powerless and helplessness linked to a real or perceived loss of control over the environment (Miller & Rasmussen, 2017). This echoes the plethora of research already conducted on mental health of refugees indicating the adverse effects of post-migration stressors (Chen, Hall, Ling, & Renzaho, 2017). As for many other VoTs across the world, the process of seeking asylum itself was a seemingly retraumatising experience for the participants on many levels. Firstly, it could be argued that the perception of ill-treatment at the hands of an indifferent yet powerful state apparatus may be reminiscent of the torture conditions to which they were subjected in their country of origin. Secondly, the very experience itself of having to recount the horror of the experience of torture in an asylum tribunal may be equally traumatising (Schock, Rosner, & Knaevelsrud, 2015).

All three people in the cases highlighted above were diagnosed with PTSD, yet the diagnosis did not appear to be particularly relevant to their lives, or the way in which they made sense of their psychological suffering. None referred to the diagnosis spontaneously during the multiple interviews conducted over a 12 month period. Their main concerns appeared to be focused on the present conditions in which they found themselves, characterised by numerous environmental stressors and an uncertain future. There did not seem to be anything "post" about the "P" of PTSD. This echoes the conclusions of Patel and colleagues (2014) that "problems of torture survivors need to be defined far more broadly than by PTSD symptoms, and recognition given to the contextual influences of being a torture survivor, including as an asylum seeker or refugee, on psychological and social health" (p. 2). In contrast to the seeming irrelevance of the formal diagnosis of PTSD, the relationship with the multidisciplinary team was noted by all of the participants as being an integral part of their rehabilitation. What appears to have had the most impact was being seen as an individual human being, and being treated with dignity.

Conclusion

The research findings highlight the need for psychosocial interventions to incorporate a more contextualised understanding of trauma as being largely determined by larger cultural systems and socio-political contexts. It also highlights the importance of seeing the strengths and resilience of most refugees and their potential contributions to host societies (Bäärnhielm, 2016). Psychosocial rehabilitation of torture survivors, particularly refugees, needs to reflect this complex reality. Focus should be placed on the practical realities of the post-migration environment, interdisciplinary approaches to care and quality cultural mediation. Interventions should become the mirror in which the individual will be able to relink the shattered pieces of him/herself into a totality. This requires a strong team of experienced professionals, teamwork of an inter-disciplinary nature, and stability at an organisational level (Kotsioni, 2016) for an integrated system of care for VoTs which provides a coordinated, compassionate, and comprehensive support (Kira, 2010). For the above aim to be achieved, it is important that the interventions planned and implemented take into consideration the environmental factors and the broader socio-economic and political system of the reception countries. The needs of this population are varied and complex, necessarily demanding a multidisciplinary approach to intervention which may be beyond the current capacity of the national health service at present.

VoTs may experience a disconnection from their body, their emotions and their identity and need to regain trust in other human beings, society and themselves. This is a complex process in which professionals need to be able to acknowledge the individual not as a patient, but a totality. It is vital that the professionals do not limit themselves to a diagnosis and treatment of symptoms but rather focus on how to empower the individual to regain control. Conceptualising the mental health of refugees requires the recognition of the role of both pre-migration trauma and post-migration stressors and that psychological distress can manifest in various ways. As stated by Viñar (2005), we cannot listen to a tortured man and see an understanding of his person unless we dare to take a little interest in the oppressive order that destroyed him; not only to seal his wounds, but also to restore his humanity.

References

Bäärnhielm, S. (2016). Refugees' mental health-a call for a public health approach with focus on resilience and cultural sensitivity. *European Journal of Public Health, 26*(3), 375-376. https://doi.org/10.1093/eurpub/ckw055

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. *The Lancet Psychiatry, 4*(3), 218-229. http://dx.doi.org/10.1016/ S2215-0366(17)30032-9

d'Halluin, E. (2016). Le nouveau paradigme des «populations vulnérables» dans les politiques européennes d'asile [The new paradigm of «vulnerable populations» in the European politics of asylum.] *Savoir/Agir, 36(2), 21-26.* https://doi.org/10.3917/sava.036.0021

Fassin, D., & d'Halluin, E. (2005). The truth from the body: medical certificates as ultimate evidence for asylum seekers. *American Anthropologist, 107*(4), 597-608. https://doi.org/10.1525/aa.2005.107.4.597

FRA [European Union Agency for Fundamental Rights]. (2017). *Current migration situation in the EU: Torture, trauma and its possible impact on drug use*. Luxembourg: Publications Office. http://dx.doi:10.2811/82527

Gkionakis, N. (2016). The refugee crisis in Greece: training border security, police, volunteers and aid workers in psychological first aid. *Intervention, 14*(1), 73-79.

Haenel F. (2015) Special Problems in the Assessment of Psychological Sequelae of Torture and Incarceration. In: Schouler-Ocak M. (eds) *Trauma and Migration* (pp. 95-107). Springer, Cham. https://doi.org/10.1007/978-3-319-17335-1_8

Hodges-Wu, J., & Zajicek-Farber, M. (2017). Addressing the Needs of Survivors of Torture: A Pilot Test of the Psychosocial Well-Being Index. *Journal of Immigrant & Refugee Studies, 15*(1), 71-89. https://doi.org/10.1080/15562948.2016.1171941

Hollander, A.-C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. *BMJ, 352*, i1030. https://doi.org/10.1136/bmj

Kira, I. A. (2010). Etiology and treatment of post-cumulative traumatic stress disorders in different cultures. *Traumatology, 16*(4), 128. https://doi.org/10.1177/1534765610365914

Kirmayer, L., & Ramstead, M. J. (2017). Embodiment and Enactment in Cultural Psychiatry. In Durt, C., Fuchs, T. & Tewes, C. (Eds.) *Embodiment, enaction, and culture: Investigating the constitution of the shared world*. Cambridge, MA: MIT Press. 2017, p. 397-422.

Kotsioni, I. (2016). *Rehabilitation for survivors of torture and other forms of ill-treatment in Athens, Greece - Responding to a protracted refugee crisis.* Paper presented at the 4th MSF Workshop on the thematic of torture: caring for the human beyond the torture, Rome, Italy.

MDM [Medecins Du Monde/Doctors of the World]. (2016). *Legal report on access to healthcare in 17 countries*. European Network to Reduce Vulnerabilities in Health.

Miller, K., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and psychiatric sciences, 26*(2), 129-138. https://doi.org/10.1017/S2045796016000172

MSF, [Medecins Sans Frontieres/Doctors Without Borders] (2016). *Obstacle Course to Europe: A policy-made humanitarian crisis at EU borders*. https://www.doctorswithoutborders.org/article/obstacle-course-europe-policy-made-humanitarian-crisis-eu-borders on 30/05/2018.

Navarro-Lashayas, M. A., Pérez-Sales, P., Lopes-Neyra, G., Martínez, M. A., & Morentin, B. (2016). Incommunicado detention and torture in Spain, Part IV: Psychological and psychiatric consequences of ill-treatment and torture: trauma and human worldviews. *Torture, 26*(3), 34-45.

Papadopoulos, R. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling, 9*(3), 301-312. https://doi.org/10.1080/13642530701496930

Patel, N., Kellezi, B., & Williams, A. C. d. C. (2014). Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *The Cochrane Library*. https://doi.org/10.1002/14651858.CD009317.pub2

Schock, K., Böttche, M., Rosner, R., Wenk-Ansohn, M., & Knaevelsrud, C. (2016). Impact of new traumatic or stressful life events on pre-existing PTSD in traumatized refugees: results of a longitudinal study. *Eur J Psychotraumatol., 2016, 7* (32106). https://doi: 10.3402/ejpt.v7.32106

Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *Eur J Psychotraumatol., 6*. https://doi.org/10.3402/ejpt.v6.26286

Silove, D., Ventevogel, P., & Rees, S. (2017). The con-

temporary refugee crisis: an overview of mental health challenges. *World Psychiatry, 16*(2), 130-139. https://doi.org/10.1002/wps.20438

Sironi, F. (1999). *Bourreaux et victimes: psychologie de la torture*. [Executioners and victims: psychology of torture]. Odile Jacob.

Song, S. J., Kaplan, C., Tol, W. A., Subica, A., & de Jong, J. (2015). Psychological distress in torture survivors: pre-and post-migration risk factors in a US sample. *Social Psychiatry and Psychiatric Epidemiology, 50*(4), 549-560. https://doi.org/10.1007/s00127-014-0982-1

Song, S. J., Subica, A., Kaplan, C., Tol, W., & de Jong, J. (2017). Predicting the Mental Health and Functioning of Torture Survivors. *The Journal of nervous and mental disease. 206* (1), 33-39. https://doi.org/10.1097/NMD.0000000000000678

ter Heide, F. J. J., Mooren, T. M., & Kleber, R. J. (2016). Complex PTSD and phased treatment in refugees: a debate piece. *Eur J Psychotraumatol., 7*.

UNHCR. (2017). *Torture victims in the context of migration: identification, redress and rehabilitation.*

Viñar, M. N. (2005). La spécificité de la torture comme source de trauma [The specificity of torture as a source of trauma]. *Revue française de psychanalyse, 69*(4), 1205-1224.

Whitsett, D., & Sherman, M. F. (2017). Do resettlement variables predict psychiatric treatment outcomes in a sample of asylum-seeking survivors of torture? *International Journal of Social Psychiatry, 63*(8), 674-685. https://doi.org/10.1177/0020764017727022

Non-professional interpreters in counselling for asylum seeking and refugee women

Filiz Celik,* PhD, Tom Cheesman,* MA, DPhil

Key points of interest:

- Given appropriate training and supervision, non-professional interpreters can bridge the language gap, act as cultural mediators, and improve the quality of multilingual counselling provision.
- Possible disadvantages (quality, confidentiality, safeguarding and ethics) are outweighed by the benefits.
- When they share similar backgrounds to those of asylum seekers and refugees, non-professional interpreters may be invaluable to the therapeutic process by joining in the conversation and contributing to a culturally sensitive, user-led and holistic counselling approach, and this approach has a particular value to women who come from cultures that place greater stigma on mental health issues.

*) Department of Modern Languages, Translation and Interpreting, Swansea University, Wales, UK
Correspondence to: filiz.celik@swansea.ac.uk; t.cheesman@swansea.ac.uk

Abstract

Introduction: Non-professional interpreting warrants further study, particularly in environments where professional interpreters are scarce. **Method:** The lead researcher (a qualified interpreter and counsellor) joined 32 group sessions as a participant observer, and 12 individual sessions as an observer. Additional data sources were 30 semi-structured interviews with counsellors, clients and interpreters, and two half-day forums organised for community interpreters to discuss their concerns. **Results:** The positive value of engaging non-professional interpreters is highlighted within the specific context of non-medical, community-based, holistic counselling. In this context, formal accuracy of translation is less important than empathy and trust. Non-professional interpreters may be more likely than professionals to share clients' life experiences, and working with them in counselling has positive psychosocial value for all participants. This is because it entails inclusive, non-hierarchical practices in the client-counsellor-interpreter triad: mutual sharing of linguistic resources and translingual communication, and a more relaxing dynamic with fluid roles. In group sessions, a strong sense of a cross-linguistic community is created as women interpret for one another, an expression of mutual support. In the context of this

study, counsellors, clients and interpreters alike all regard non-professionals as being more appropriate than professionals in most counselling situations.

Keywords: Asylum seekers; refugees; counselling; torture; translating; interpreting; multilingualism; mental health services

Introduction

> *"A lot of things happened to me, I don't like talking about them because no one believes me… and sometime, I think may be if I speak good English they understand me, I don't know… I have counselling here, I had interpreter, she was nice, you know, from my country, she was not like the interpreters on the phone. I now go to women's group, it is good, at least I am not sitting at home and crying, other people are like me, there other asylum seekers, some of them have worse English than me, we wait for each other to speak, sometimes I interpret if they are from my country. We do other things as well, not just counselling, it is like you are not alone here…" (An asylum-seeking woman receiving counselling; we will refer to her as Z.)*

These are the words of a client of the counselling services at the African Community Centre (ACC) in Swansea, Wales, where the first author conducted research in February to August 2017. 'Z.' does interpret: informally, in group counselling sessions and other meetings of local asylum-seeking women. She has experience of being 'formally' interpreted—both by professionals over the telephone (widely used in UK health services), and by a 'nice' woman 'from my country', in individual counselling at the ACC—a woman who in fact has no interpreting qualifications. Z.'s English is much better than many asylum seekers, but still, she would struggle to gain a UK interpreting qualification, assuming she wanted to and could afford the course fees. However, Z. could be a good candidate for work as an interpreter at the ACC in future (if she is granted refugee status and gets a work permit). If the counsellors deem her to have appropriate personal qualities, and if she responds well to training and supervision, then they may employ her, in preference to a professional.

This paper argues that, in the field of refugee counselling at least, non-professional interpreters are not just a necessary evil, plugging gaps due to local lack of suitable professionals, and/or lack of means to pay professional rates. Non-professionals can bring skills and experience to counselling settings that may enhance the quality of the mental health services significantly. Engaging non-professionals in counselling must be done carefully, but it can bring therapeutic and psychosocial benefits to the client and additional benefits to her environment.

It is important to understand that 'counsellor' and 'counselling' have specific meanings here. This kind of counsellor is someone trained to 'help people talk about their feelings' such as relationship difficulties, grief, mild to moderate mental health problems, substance abuse issues, etc. A counsellor 'holds sessions with individuals and groups in a safe and confidential environment' in order to 'encourage them to look at their choices and find their own way to make a positive change in their life' (NHS Health Career Service, 2018). Counsellors may have various kinds of training and work in various contexts with various approaches. At the ACC, the counsellors are part of a large team of paid workers and volunteers who collectively aim to make life better for asylum seekers and refugees, displaced people who face many problems. The emphasis is placed on building community among local people and newcomers

together. The ACC's counselling approach is non-medical (concepts of diagnosis, treatment, or cure are not used), holistic (deals with the person as a whole: mind, body, emotions, spirit, and their entire life-context), culturally sensitive (acknowledges and works with cultural differences) and community-based. Community-based counselling is an 'approach linked to a critical perspective, [which] highlights the importance of going beyond individualist assessments and interventions towards comprehensive approaches that locate the person in context, and that listen carefully to and engage openly with all voices in a way that highlights dynamics that oppress ourselves and others, for the purposes of building a supportive and health promoting environment for all.' (Lazarus et al., 2009) In the particular kind of counselling context at the ACC, non-professional interpreters are valued as active promoters of the mutually supportive environment which creates a context in which people can flourish through supporting one another. As part of a culturally informed approach to mental-health service delivery (Harris and Maxwell, 2000), interpreters drawn from the same cultural field as the clients are valued because their formal linguistic skills are less essential than their capacity for empathy and ability to inspire trust.

Use of professional interpreters is generally recommended in mental health provision, as in other contexts when clients and service providers do not share the same language. The use of non-professional interpreters such as family members, children, friends, acquaintances, or random people recruited ad hoc, is generally said to lead to communication failures and to less full disclosure of information by the client (Bauer and Alegria, 2010; Miller et al., 2005). Bauer and Alegria argue that non-professional interpreters' poorer language skills directly correlated with their potential to make errors. At the same time, it is well known that in many times and places, there is inadequate interpreting provision for a variety of pragmatic reasons (Bauer and Alegria, 2010; Raval and Smith, 2003; Sen, 2016). However, the positive value of non-professional interpreters, in certain contexts and appropriately managed, has not been explored enough in the literature.

Asylum-seekers and refugees have been socialised in widely different cultural value systems, and are initially unfamiliar with the systems of law, care, education and so on in the host country. These factors, as well as lack of host-country language skills, have been cited as factors jeopardising migrants' access to mental health services (Raval and Smith, 2003). Asylum seekers and refugees in Wales come from all parts of Africa, Asia and eastern Europe, and speak a great variety of languages. Languages encountered at the ACC during this study, beginning with A, included: Afrikaans, Albanian, Arabic, Aruba, and Azerbaijani. In total we observed about 40 languages spoken during our research. In 2000, the local education authority reported 50 languages spoken in schools in the area, in addition to English and Welsh.[1] By 2017 this had risen to 145.[2] Speakers of languages other than English, who are new to the UK, may have fluent English. Some were educated up to postgraduate level in English. Most have little English and are learning it at beginner to intermediate level.

[1] Personal communication (September 2017) from the local authority's Migration, Asylum Seeker and Refugee Officer.

[2] Pupil census (January 2017), reported in a local authority consultation document (http://www1.swansea.gov.uk/snap/snapforms/2018/03_18/EMAU/emau_t.htm) and in Youle (2018).

Some professional interpreters are available in Wales, especially for some locally 'large' languages such as Arabic, Bengali, or Mandarin and other Chinese languages. Communities speaking these languages in Wales are rooted in the 20th century. However, even in these cases, an Arabic interpreter with, for example, Egyptian heritage, and fluent in formal Arabic, will struggle to communicate with someone from a village in northern Iraq. A Mandarin interpreter is little use to a Hakka speaker. Linguistically appropriate professional interpreters are rarely available to the ACC But even if they were, they would not necessarily be employed.

An increasing volume of research addresses the work of professional interpreters in various counselling settings (Bauer and Alegria, 2010; Guruge et al., 2009; Paone and Malott, 2008; Raval and Smith, 2003; Tribe and Morrisey, 2003). Non-professional interpreting (which is of course universally far more common than professional interpreting) is also gaining increasing academic attention (Pérez-González and Susam-Saraeva, 2012; Smith et al., 2013). But non-professional interpreting in counselling has yet to be adequately studied. Ours is only a small case study in a very specific context. However, it adds weight to findings such as that reported by Smith et al. (2013: 493), who describe 'informal interpreters' (in their case, cleaners in a psychiatric hospital in South Africa) as 'fulfilling an additional beneficial role in terms of the overall care of patients which goes beyond the ambit of the interpreting session'. Smith et al. also argue that 'it is clear that informal interpreting may usefully be viewed as a form of hidden care work. A detailed ethnographic study aimed at exploring this further is therefore recommended.' Similarly, the work of non-professional interpreters in counselling deserves much more detailed investigation. It is not that it is 'hidden'; these interpreters are formally recruited, trained, supervised, and paid for their time. But the value of this kind of work is still hidden to those who are strictly committed to the ideal of a monopoly of professional interpreting.

It is well known that interpreters in most settings, certainly healthcare settings, are not expected (or even able) to be simple 'conduits', 'transmitters' of information across language gaps. Instead, their role is defined variously in the literature as 'cultural brokers', 'clarifiers', 'managers' of the medic-patient relationship, and sometimes (though this strictly requires additional qualifications) 'advocates' or 'mediators' (Sleptsova et al. 2014). In mental health, cross-cultural misunderstanding of how psychological distress is communicated in a different culture can result in incorrect psychiatric diagnoses, as a human response to trauma and extreme distress is construed as mental disorder (Di Tomaso, 2010; Guruge et al., 2009; Silove et al., 1998). Interpreters must then do much more than 'transmit' the meanings of words, and 'broker' or 'advocate' are preferred terms. In the particular context we studied, one of community-based, non-medical counselling sessions at a small non-profit organisation which serves an extremely diverse migrant population, none of these descriptions fits the requirements, because they all posit a role hierarchy which the counselling practice aims to avoid.

Background

The African Community Centre is located in Swansea, a city of under a quarter of a million people, in Wales (a semi-independent UK nation), about three hours by rail or road from London. Despite its name, the African Community Centre provides a

range of services for people of all continents: primarily Black and Minority Ethnic (BAME) people, but also members of majority British white populations. The ACC runs two counselling projects specifically for the growing local population of 'asylum seekers and refugees'.

These two terms 'asylum seeker' and 'refugee' refer to distinct migration statuses. Asylum seekers are people who have registered an asylum claim with the Home Office (ministry of the interior), citing the UNHCR Refugee Convention. Most do so when they enter the UK (legally or illegally); some do so after a visa has lapsed. If they cannot support themselves, they are 'dispersed' somewhere in the UK, accommodated, given a small weekly allowance, and wait for their case to be adjudicated. Eventually they will usually either be deported, or given 'leave to remain' (permission to settle) at least for some years, or else just evicted and left to fend for themselves.

Asylum seekers have come to Wales in significant numbers only since 2000: they have been 'dispersed' from London following implementation of the 1999 Immigration and Asylum Act. In Wales in 2017 there were 2,872 occupied asylum-seeker accommodation places (National Assembly for Wales, 2017). About one third of these places are in the city of Swansea. Asylum seeker accommodation is in ordinary rented private dwellings, scattered all over the urban area. Public transport is very expensive, and many asylum seekers become very isolated.

For 'refugees' there is no general statistical data, but the National Assembly for Wales (2017) estimated 10,000 in Wales. Refugees are people who have been granted leave to remain. A few refugees enter the UK with refugee status already granted, such as the few hundred Syrians who have so far been resettled in Wales under the UK Government's Syrian Resettlement Program. Refugees can (and do) become UK citizens.

Asylum seekers and refugees are very often suffering traumas, due to events in the countries they have fled, and often also events during the journey to safety, in other countries, at sea, in lorries etc. (Sen, 2016). Many also have traumatic experiences in the UK. Many endure a long, anxious wait for a decision on their asylum case: commonly two to four years and some up to 10 years or more, with no right to work, no autonomy, very limited opportunities for meaningful use of their time. Asylum seekers are highly vulnerable to psychological distress and many suffer mental illness such as PTSD, clinical depression and anxiety (Cowen, 2003; Fazel, Wheeler and Danesh, 2005) due to the ongoing uncertainty of their migration status, their experiences of the threat of detention, their long-term forced inactivity as well as loss and lack of family support (Robjant, Hassan and Katona, 2009). They are liable to unlimited 'immigration detention' at any time. If an asylum claim is refused, many are not detained or deported, instead just evicted and left destitute: homeless, unable to access any kind of state support, totally dependent on the charity of friends or others. Decision-making by the Home Office is inconsistent. If refusals are appealed, the appeal is very often successful, but accessing the necessary legal advice and support is difficult. Also, casual racism is widespread in some parts of the local 'white' populations.

Many asylum seekers and refugees have previously suffered severe trauma, including rape and torture. Pre-'dispersal' screening in London should keep people in the capital city, if they need specialist services, such as torture and rape survivors (Gorst-Unsworth

and Goldenberg, 1998). However, the screening is rudimentary, and traumatised asylum seekers often do not disclose pertinent issues. The ACC refers people with severe mental health problems to statutory (state-run) services. However, no specialist services for the 'new' population, such as cross-cultural services specialising in severe issues faced by asylum seekers and refugees, have yet been established in Wales.

The ACC is a non-profit charity, funded by grants from charitable foundations. It provides counselling services tailored to the needs of asylum seekers and refugees with moderate mental health problems. A group of qualified counsellors, who have been specifically recruited for their relevant expertise and outlook, provide counselling through two interlinked projects: AMANI (individual counselling)[3] and PAMOJA (group counselling and art therapy).[4] The ACC's overall mission is to create a positive impact on the lives of the beneficiaries across cultures, faith groups, gender, sexual orientation, disabilities, age groups and migration statuses. Inclusivity and community are key watchwords. The ACC delivers a range of services, such as advice, arts and cultural projects, for the local Black, Asian and Minority Ethnic (BAME) communities, 'in partnership with indigenous Welsh people'.[5] The staff and volunteers work to 'integrate' new asylum seekers and refugees by helping them participate in the full range of activities open to them at the ACC or with affiliated local organisations where they are welcomed and supported. Counselling clients are often self-referred, having heard of the services through others; they may also be referred from other non-statutory organisations, or the local team of the National Health Service which serves the asylum-seeker population.

Method

The first author is a qualified interpreter and counsellor, so was permitted to join 32 group sessions as a participant observer, and 12 individual sessions as an observer. Additional data sources were 30 audio-recorded, semi-structured interviews with counsellors, clients and interpreters (average length 25 minutes, range 4-180 minutes), and two half-day forums organised for 'interpreters in the community' to discuss their concerns. Invitations to these interpreter forums were circulated through local NGO networks. Participants included 20 non-professionals (of whom three were affiliated to the ACC) and five professional interpreters (the latter also work in a voluntary capacity in various community settings). Further details of data collection can be found in the Appendix.

The research was conducted over nine months in 2017. The main focus was on asylum seeking and refugee women receiving counselling at the ACC, and interpreters working with them. The women ranged in age from 19 to 58. Their experiences included torture, rape, female genital mutilation (FGM), loss of members of the close family and other loved ones, loss of livelihood and identity through traumatic displacement, among others.

Recorded data were anonymised during transcription, triangulated with data noted during session observations and participant observation, and coded using Thematic

[3] AMANI means 'what you wish' for in Swahili. The AMANi Project provides individual counselling services.

[4] PAMOJA means 'together' in Swahili. The PAMOJA Project provides group therapy and other art-based therapeutic activities.

[5] See africancommunitycentre.org.uk.

Analysis (TA), which enables flexible coding of emerging themes, independent of prior theory and epistemology (Roulston, 2001). TA is based in a constructionist paradigm (Braun and Clarke, 2006) where 'meaning' is understood as constructed rather than 'expressed' in language (Barrett, 1992, p.203). Critical self-reflection is essential to minimise the researchers' own assumptions and worldviews skewing the analysis (Elliot, Fischer and Rennie, 1999). The first author kept a reflexive journal and had frequent discussions with the other researcher (who is very different in terms of gender, ethnicity, migration history, disciplinary training, etc.).

Ethics approval for our research project was obtained both from our university through the Human Ethics Committee and from the ACC, in accordance with their ethical procedures. Verbal consent was obtained from all clients, interpreters and counsellors involved, if necessary using one of the ACC's non-professional interpreters. Ethics were revisited as required, e.g., when a new member joined a counselling group, or a client requested that information be excluded from the research process. Our ethical guidelines were examined and developed in collaboration with participants as Tagg, Lyons, Hu and Rock (2016) recommend: ethical issues should be approached as a decision-making process, rather than a fixed set of guidelines to follow. This gives participants autonomy to align themselves with the research as the circumstance and perceptions shift.

Findings

The value of non-professional interpreters

The ACC provides help and support to all members of the Black, Asian and Minority Ethnic communities, but the counselling services are offered to asylum seekers and refugees only. Clients are assessed to determine their needs and offered individual or group counselling as appropriate. In individual counselling, interpreters were needed for the majority of women clients. Women from countries such as Nigeria and India may have English as their mother tongue or have been educated in English, but still most experienced challenges due to their accents and unfamiliarity with British English and the local spoken English usage. Most women clients encountered during this research had only very basic English.

The ACC does not have a policy against recruiting professional interpreters, but during our research we only observed them engaging non-professional interpreters, that is, people who have no accredited training but have acquired enough bilingual resources to translate spoken messages between English and a language used in the asylum and refugee population. Most are refugees. Non-professional interpreters are very carefully assessed for their roles, rigorously trained by the ACC, and their work is subject to ongoing supervision.

Training includes, first, an initial generic session for potential interpreters, introducing the ACC, its ethos, the aims of counselling, and fundamental issues of ethics, confidentiality and safeguarding. Next, the potential interpreter meets the counsellor for an information session about a potential match with a client. This session involves assessing whether the social, political and cultural backgrounds of client and interpreter may create conflict for either party (e.g. affiliations with different sides of a political conflict). All being well, the interpreter and client are introduced at a counselling session. The first statement which the interpreter is asked to convey from the counsellor explains that the client can refuse to work with them, and that this would not be construed as a personal

affront; a different interpreter would be identified. If there is no objection, the interpreter then begins the interpreting process by translating messages from counsellor to the client about the ground-rules of confidentiality between client, counsellor, and interpreter.

After each counselling session, the interpreter is de-briefed about any linguistic difficulties they experienced (understanding the client, their speech style, accent, vocabulary) as well as difficulties arising from the nature and content of the conversation. If needed, a session is arranged to work on the possible vicarious effects on the interpreter (see below). If possible, the ACC 'pairs' clients and interpreters throughout the counselling process, which lasts at least eight weeks and sometimes much longer.

In group sessions there are no assigned interpreters, but members of the group are encouraged to interpret for one another as needed. Issues of ethics, confidentiality and safeguarding are addressed via an explicit 'group contract', which is developed between the members of the group and the counsellor at a first session. The contract is both written and oral: many of the women are only partially literate. The contract is presented to new group members orally and in writing, via informal interpreting as needed. It is revisited at least every eight weeks, and occasionally amended in response to changed circumstances.

Women clients who took part in this study were native speakers of 15 different languages. Many were bilingual or multilingual (e.g. women from Pakistan or Afghanistan speaking combinations of Punjabi, Urdu, Dari). All women were keen to learn English, but their English language acquisition was being hindered by inability to attend English language classes in local colleges due to travel costs, childcare duties, or insufficient places at the requisite level. They relied on others to interpret for them, usually informally, in most cases outside the home.

From observations, interviews and forums, three themes emerged, all embedded in the cross-cultural, community-based ethos: translanguaging; migration status; and vicarious traumatisation.

Interpreting and translanguaging in group counselling: When group counselling members acted as interpreters for each other, they drew on resources including digital tools and aids (translation apps, bilingual dictionaries, images and maps), body language, mimicking and role playing, singing and dancing, in order to facilitate communication. They presented speech to the group in their own languages, inviting efforts to interpret by others who at least knew related languages. They self-interpreted into the common language, English, as best they could, with help from others. Understanding one woman became a group effort of all. This can be understood in terms of 'translanguaging', a concept that originally referred to interactions among non-native English speakers in educational settings, where various cognitive, linguistic and material tools and skills are used to enable small-group communication (Garcia, 2014). The term translanguaging challenges 'monolingual' normative views of language behaviour and strengthens the understanding that flexibility in using diverse language resources, at diverse levels of familiarity and fluency, is not only functionally effective but helps build cross-lingual communities (Creese and Blackledge, 2011). In group counselling at the ACC, the diversity of languages in the room became a common resource for facilitation of the group's conversations, engaging women of different linguistic abilities to aid each other.

Multi-lingualism as translingualism brought much more of the 'unsaid' into the sessions for each woman, and strengthened their sense of common identity and solidarity.

Across all our observations and interviews, there was no perception that linguistic diversity or the wide variance in ability to communicate in English was in any way negative. On the contrary, this is a typical statement from a participant (first language Nigerian English):

> "*We need to stand together, as women we need to try to understand each other… I think it is good that some women cannot speak good English, we learn how difficult it is to not speak English, we wait for each other, we learn… We support each other, our English are different level but our pain is similar…*"

In the group counselling sessions, women were respectful of each other, appreciated linguistic challenges, and came together to give space to those whose level of English did not match others'. Linguistic barriers in fact brought women together through the effort and process of trying to understand each other, creating a sense of solidarity in the group.

The ACC's counsellors encourage this translingual dynamic. They avoid presenting English speech which is likely to be hard to translate (e.g. professional terminology), they strive to be cross-culturally sensitive and inclusive, they support mutual translanguaging. Their non-medical, community-based approach to mental wellbeing promotes integration and community building among a very vulnerable and underprivileged population. It promotes clients' self-empowerment as a group because mutual social support is an important protective factor in emotional wellbeing, critically important to reducing stress, maintaining health, and achieving self-sufficiency (Simich, Beiser, Stewart and Mwakarimba, 2005).

Migration status—common experience of clients and non-professional interpreters: The model of interpreting in group counselling sessions, with informal translanguaging building mutual social support, is similar to that used in individual counselling, in terms of the underlying ethos. The essential elements are trust and wellbeing through common identity. The benefits of non-professional interpreting were articulated by both clients and counsellors. They stated that non-professional interpreters have specific skills and understanding to aid the process of communication, partly because they are not bound by fixed professional codes and norms. They are freer to act as cultural brokers and better at understanding implications or making educated predictions about the intersubjective meanings specific to micro-cultures. Whilst this may also apply to professional interpreters, above all, it was clear that the interpreters in this study had clients' trust because they have empathy with them and more often than not share the clients' experiences of being asylum seekers. They have experienced the same problems in the country of origin, the same flight to safety, the same process of arriving in the UK, claiming asylum, being 'dispersed' to a random town, waiting for the Home Office decision, enduring the precarious status of 'asylum seeker', as well as all the other issues related to adapting to the new country.

We observed that the interpreters often asked counsellors to expand on the issues relating to the migration status of the clients, such as psychological stress relating to their current migration status and the indefinite period of waiting during which they are unable to function in society. The interpreters, in sessions, prompted

counsellors to give clients more space to articulate their experiences and feelings about their current status. Among women receiving counselling, migration status emerged as a major factor affecting their psychological wellbeing, and it was often interpreters who brought this out.

Migration status also had a strong negative impact on English language acquisition in many cases, hence on the need for interpreters. One asylum seeker client reflected:

> *"As an asylum seeker, you don't know what is going to happen tomorrow… I am thinking about the past, I don't want to but I think about it… I feel afraid when someone is walking behind me, I feel afraid that something is happening to my mother… I want to learn more English but my mind is not accepting new learning, because I don't know if Home Office will accept my case. If they send me back, what good is to speak English…"*

English language acquisition is motivated by confidence that the learner has a future in the English-speaking world. Uncertain status undermines that confidence. Professional interpreters, who have invested heavily in acquiring advanced, formal English skills, may be less likely to empathise with this state of mind than non-professionals.

Participants in the interpreters' forums we organised all agreed that acting in a non-professional capacity helped to establish better relationships with the clients. This view was shared by the professionally qualified interpreters who participated, all of whom also worked in a voluntary capacity in their communities. The interpreters agreed that clients trusted non-professional interpreters more, so they disclosed more. One non-professional explained:

> *"When an interpreter comes from an agency, they [the clients] think they are against them, but when they know you are from the community they trust you more and they tell you more, which helps the English speaker to better understand their issues…"*

This could be seen as self-serving rationalisation. But the point was generally agreed by all research participants. Asylum seekers and refugees who need interpreters in counselling have also had experience of interpreters in other settings: immigration interviews, legal proceedings, and in the state healthcare system. As Z. said (quoted at the start of this paper), the interpreter at the ACC is 'not like' others; she is 'nice' and she is 'from my country'. This was a typical statement. Professional interpreters are perceived as acting for the organisation which pays them, i.e. serving the interests of the Home Office (which is looking for reasons to refuse an asylum claim) or the National Health Service (which is seeking to save money and trouble). It can therefore be very challenging for professional interpreters to win the trust of asylum seekers. In the ACC, professionally qualified interpreters could in principle do the work, though for lower rates of pay than they would normally charge. We did not observe any. Professionals who work in legal and medical interpreting may also avoid working in counselling because of a potential conflict of interest, e.g. if they deal with the same client in different settings.

Effects on interpreters: vicarious trauma and personal growth: Interpreting is taxing work. Interpreters not only witness others' intense emotions and narratives, but are obliged to voice them. Vicarious traumatisation is a major risk in interpreting with survivors of torture and other trauma (Paone and Malott, 2008). Vicarious detrimental effects were reported by interpreters we interviewed, and participants in the interpreters' forums. The issues reported included: being unable to understand or take

in clients' experiences of torture and other extreme violence and suffering; feeling shock and disbelief towards clients' narratives; feeling clients' pain and suffering themselves; having flashbacks about the content of sessions; and being unable to forget what they interpreted. The efforts of the ACC to deal with these effects were viewed as exemplary, compared with other organisations interpreters had worked with (non-professionals are widely employed in a range of medical, advisory, legal and other settings).

However, the interpreters also talked about experiences of personal growth and enhanced appreciation of their experiences as a result of their work with asylum seekers and refugees in the counselling setting. Little research addresses the balance or imbalance of negative and positive effects experienced by interpreters. Splevins et al. (2010) introduced the idea of 'vicarious post-traumatic growth' (see also Manning-Jones et al., 2015). Many non-professional interpreters in our study indicated that they have emerged from challenging and upsetting experiences with a sense of personal fulfilment through helping others, and a sense that they have greater resilience in facing their own difficulties. They described developing new life skills during their work as interpreters, and transferring them into other parts of their life, in ways which correspond closely to the features of vicarious post-traumatic growth, i.e. enhanced interpersonal relationships, self-perception and life philosophy (Tedesschi & Calhoun 1995, 2004, cited in Splevins et al., 2010).

It is worth asking whether non-professional and professional interpreters would experience this differently, as well as which other factors (interpreting settings, modes, work-patterns) would be influential. We observed that interpreters tended to attach two kinds of meaning to their experiences during the counselling sessions, which correlated with the way they reported the impact on them. All interpreters expressed a desire to help the clients. However, some concluded that they could not make any difference. Then they referred to their experiences as making them feel sad, upset and powerless, and they reported disturbances such as compulsively thinking about their client after the session. However, if the interpreter felt they were successfully supporting their clients, enabling them to get through a difficult ordeal, then they reported feeling useful and empowered. One interpreter explained:

> *"It's often difficult not to be affected by their stories. I find some comfort in knowing that at least I can assist them. I try to separate my work from my personal life. And I keep in mind that I'm not there to feel upset for them, sorry for them, but to be resourceful, to help them…"*

We observed that in most cases the training, briefing and supervision provided by the ACC helped interpreters working there to appraise their roles in a more favourable light for the clients, community and themselves.

Concluding Remarks

The ACC's practice is still developing. Managing the counselling projects for the full benefit of participants and the wider community is often challenging. The lead counsellor was asked in an interview: 'How do you manage when members of the group have really differing levels of English language competency?' She replied at length, beginning:

> *"I hope that there will be someone in the group who may be able to translate or interpret for them. But I would probably be watching that person who is not able to understand and I might perhaps get from*

their body language what is, if they are feeling comfortable or uncomfortable… It is a rather difficult one but I think I would rather have them in the group, experiencing being together, rather than being isolated and being on their own."

Community, participation, escape from isolation are essential. The counsellor immediately turned to non-linguistic challenges:

"When I started group [counselling] six years ago we had two [X] ladies in the group, it was a very small group […] and we had a [professional] interpreter and it just didn't work, because the two [X] ladies knew each other and the [X] community is very close, and they were not able to disclose their stuff because they didn't want each other to hear about what their life experiences was or didn't want to tell their personal stuff. So we decided to abandon that…"

The small scale and closeness of migrant communities in this location presents many such problems. With these specific clients in mind, the counsellor goes on to discuss problems in individual counselling which couple the linguistic with the cultural. Noticeably, in this narrative, the pronoun 'we' or 'us' is used twice for the team of counsellors, at one point for counsellor and interpreter, and at one point, at the emotional heart of the story, for the triad of client, counsellor and interpreter:

"The older lady, we decided it was better if she started one-to-one counselling, […] we had a very good [non-professional] interpreter for her and it was about session five that I realised this women didn't know what counselling was, she thought she was coming for chatting. So I had to challenge her about what the counselling meant, through the interpreter, and we realised that she doesn't understand. And […] later she [the interpreter] told me that this women had seen her son blown up in front of her in [X]. That was so shocking, shocking for the three of us really. […] Everything started to come out, when she realised what counselling was. The interpreter then came back to us [the team of counsellors] saying that she recognised that she [the interpreter] had trauma, she was carrying trauma as well. So I worked a little bit with her as well, to keep her safe, it is really really important to keep people safe."

The counsellor returns finally to her initial point:

"I think from that point on, I was much more careful, it taught me something: people don't always understand what counselling is, [or] what group therapy is, but even so to be in the group is better than being isolated at home."

From our observations at the ACC, we believe that with appropriate training, supervision and support, non-professional interpreters can bring skills to counselling that enhance the quality of mental health services significantly. Indeed, they enable mental health services to be offered which would otherwise certainly not exist. What they bring into the sessions goes beyond cultural brokerage. What we observed in community-based counselling sessions was that counselling became a triadic relationship, in which the interpreter's ability to comprehend and convey the difficulties of the clients, their empathy and ability to inspire trust, were more important than their English language proficiency. At the ACC, interpreters often 'negotiated' meanings with the client and the counsellor, and provided context for both to better understand intended meanings, helping the culturally distant parties to come closer in understanding. But beyond this, the non-professional interpreters, sharing similar migration histories with the clients, enriched the

interpreting process with their inputs. They did not just bridge the communication gap, they joined with counsellor and client in seeking wellbeing.

Involving non-professional interpreters in a counselling or other therapy process does raise concerns about confidentiality and safeguarding of the clients, and about impacts on interpreters. In the case we observed, these concerns were addressed in a professional way. The African Community Centre in Swansea has developed excellent skills in providing counselling services to asylum seekers and refugees. Staff are highly experienced in understanding the difficulties associated with the forced migration process, from pre-migratory traumatic experiences of torture, loss and trauma to post-migratory experiences, the uncertainty of the asylum process, resettlement and adaptation in the UK. They choose to use non-professional interpreters for the benefit of their clients and for the wider benefit of the newly developing local community of asylum seekers and refugees.

Acknowledgements

For their generous collaboration and support in this research, we thank all staff and volunteers, clients and interpreters at the African Community Centre, in particular Jill Duarte, the lead counsellor and director of the organisation.

Funding

This research was funded during 2017 by the Arts and Humanities Research Council (AHRC) through the Open World Research Initiative (OWRI) 'satellite' project (part of the OWRI Cross-Language Dynamics programme) at Swansea University's Department of Modern Languages, Translation and Interpreting.

References

Bauer, A. M., & Alegria, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: A systemic review. *Psychiatric Services*, *61*(8), 765-73. https://doi.org/ 10.1176/ps.2010.61.8.765-773.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa.

Cowen, T. (2003). *Suffering alone: an examination of the mental health needs of asylum seekers and refugees in Barnet*. London: Refugee Health Project, Barnet Voluntary Service Council, Barnet Primary Care Trust.

Creese, A., Blackledge, A., et al. (2011). Separate and flexible bilingualism in complementary schools: Multiple language practices in interrelationship. *Journal of Pragmatics*, *43*(5), 1196-1208. https://doi.org/ 10.1016/j.pragma.2010.10.006.

Di Tomasso, L. (2010). Approaches to counselling resettled refugee and asylum seeker survivors of organised violence. *International Journal of Child, Youth and Family Studies*, *1*(3/4), 244-264. http://dx.doi.org/10.18357/ijcyfs13/420102086

Falzon, M.-A. (2016). Introduction: Multi-sited ethnography: Theory, Paraxis and Locality in Contemporary Research. In M.-A. Falzon (Ed.), *Multi-sited Ethnography: Theory, Praxis and Locality in Contemporary Research* (pp. 1-24). London: Routledge.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalance of serious mental disorders in 7000 refugees resettled in Western countries: a systematic review. *The Lancet*, *365*(9467), 1309-1314. https://doi.org/10.1016/S0140-6736(05)61027-6.

Garcia, O. (2014). Translanguaging and Education. In O. Garcia & L. Wei, *Translanguaging: Language, Bilingualism and Education* (pp. 63-77). Hampshire, UK: Palgrave Language and Lingusitic Collection.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. *The British Journal of Psychiatry*, *172*, 90-94. https://doi.org/10.1192/bjp.172.1.90

Guruge, S., Berman, R., Tyyska, R., Kilbride, K. M., Woungang, I., Edwards, S., & Clune, L. (2009). Implications of English proficiency on immigrant women's access to and utilization of health services. *Women's Health and Urban Life*, *8*(2), 21-41.

Harris, K., & Maxwell, C. (2000). A needs assessment in a refugee mental health project in North-East London: Extending the counselling model to community support. *Medicine, Con-*

flict and Survival, *16*(2), 201-215. https://doi.org/10.1080/13623690008409514.

Lazarus, S., Baptiste, D. & Seedat, M. (2009) Community counselling: values and practices, *Journal of Psychology in Africa*, *19*(3):449-454. https://doi.org/10.1080/14330237.2009.10820314.

National Assembly for Wales (2017). *"I used to be someone": Refugees and asylum seekers in Wales.* Cardiff: Equality, Local Government and Communities Committee, National Assembly for Wales.

Manning-Jones, S., de Terte, I., & Stephens, C. (2015). Vicarious posttraumatic growth: A systematic literature review. *International Journal of Wellbeing*, *5*(2), 125-139.

Marcus, G. E. (2015). Multi-sited Ethnography: Five or Six Things I Know about It Now. In: S. Coleman & P. Von Hellerman (eds.), *Multi-Sited Ethnography: Problems and Possibilities in Translocation of Research Methods* (pp. 16-34). New York: Routledge.

Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez , D. (2005). The role of interpreters in psychotherapy with refugees: an exploratory study. *American Journal of Orthopsychiatry*, *75*(1), 27-39. https://doi.org/10.1037/0002-9432.75.1.27.

NHS [National Health Service] Health Career Service (2018). Counsellor. Retrieved May 1, 2018: www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/counsellor.

Paone, T. R., & Malott, K. M. (2008). Using interpreters in mental health counselling: A literature review and recommendations. *Journal of Multicultural Counselling and Development*, *36*:130-142. https://doi.org/10.1002/j.2161-1912.2008.tb00077.x.

Pérez-González, L., & Susam-Saraeva, Ş. (2012). Non-professionals translating and interpreting: Participatory and engaged perspectives. *The Translator*, *18*(2), 149-165. DOI: 10.1080/13556509.2012.10799506.

Raval, H., & Smith, J. A. (2003). Therapists' experiences of working with language interpreters. *International Journal of Mental Health*, *32,* 6-31. https://doi.org/10.1080/00207411.2003.11449582.

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: sytematic review. *British Journal of Psychiatry*, *194*(4), 306-312. doi: 10.1192/bjp.bp.108.053223.

Roulston, K. (2001). Data analysis and 'theorising as ideology' . *Qualitative Research*, *1*(3), 279-302. https://doi.org/10.1177/146879410100100302.

Sen, P. (2016). The mental health needs of asylum seekers and refugees - challenges and solutions. *British Journal of Psychiatry*, *13*(2), 30-32. doi: 10.1192/S2056474000001069.

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica*, *97*(3), 175-181. https://doi.org/10.1111/j.1600-0447.1998.tb09984.x.

Simich, L., Beiser, M., Stewart, M., & Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: challenges and directions. *Journal of Immigrant Health*, *7*(4), 259-268. https://doi.org/10.1007/s10903-005-5123-1.

Simon, S. (1996). *Gender in Translation: Cultural Identity and the Politics of Translation.* London: Routledge.

Sleptsova M., Hofer G., Morina N., Langewitz W. (2014). Role of the health care interpreter in a clinical setting–a narrative review. *Journal of Community Health Nursing*, *31*(3), 167-84. https://doi.org/10.1080/07370016.2014.926682.

Smith, J., Swartz, L., Kilian,S. and Chiliza, B. (2013). Mediating words, mediating worlds: Interpreting as hidden care work in a South African psychiatric institution. *Transcultural Psychiatry*, *50*(4), 493–514.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research*, *20*(12), 1705–16. https://doi.org/10.1177/1049732310377457.

Tagg, C., Lyons, A., Hu, R., & Rock, F. (2017). The ethics of digital ethnography in a team project. *Applied Linguistics Review*, *8*(2-3), 271–292. doi: 10.1515/applirev-2016-1040.

Tribe, R. (1999). Bridging the gap or damming the flow? Some observations on using interpreters/bicultural workers when working with refugee clients, many of whom have been tortured. *Psychology and Psychotherapy: Theory, Research and Practice*, *7*(4), 567-576. https://doi.org/10.1348/000711299160130.

Tribe, R., & Morrisey, J. (2004). Good practice issues in working with interpreters in mental health. *Intervention, 2*(2), 129-142. https://doi.org/10.1080/17542860903115976.

Tribe, R., & Morrissey, J. (2003). The refugee context and the role of interpreters. In R. Tribe, & H. Raval (Eds.), *Working with Interpreters in Mental Health* (pp. 198-218). London and New York: Routledge.

Youle, R. (2018). These are the top 10 languages spoken in Swansea schools after English and Welsh. Walesonline. https://www.walesonline.co.uk/news/wales-news/top-10-languages-spoken-swansea-14427381.

Acute short-term multimodal treatment for newly arrived traumatized refugees: Reflections on the practical experience and evaluation

Mechthild Wenk-Ansohn,*[1], Carina Heeke,*, **[1], Maria Böttche,*,, Nadine Stammel*,****

Key points of interest:

- A multimodal short-term treatment program of approximately six months was developed including psychotherapy, social work, group therapy and psychiatric treatment modules for newly arrived refugees who experienced trauma-related symptoms after recent traumatization in their home country and/or during their flight.
- Improvements in symptom severity could be achieved despite the extremely high symptom load at the beginning of treatment, uncertainties regarding residence status, and the often unstable living conditions.
- In addition to psychotherapy, newly arrived refugees need comprehensive social work and counselling for legal aspects in order to deal with difficulties regarding their asylum applications.

*) Center ÜBERLEBEN, Berlin, Germany
**) Freie University Berlin, Department of Clinical-Psychological Intervention, Germany
[1] Shared first authorship.
Correspondence to: m.wenk-ansohn@ueberleben.org

Abstract

Background: A short-term multimodal acute treatment program of approximately six months' duration for newly arrived refugees at Center ÜBERLEBEN (Berlin Center for Torture Victims) was developed. The purpose of this study was to evaluate this program by examining changes in PTSD, anxiety and depression symptom severity after treatment, and to reflect on practical experiences in carrying out the program. **Methods:** At the beginning (T1) and following completion of the short-term treatment program (T2) patients in a single-group design were assessed with the Posttraumatic Stress Disorder Checklist for PTSD and the Hopkins-Symptom Checklist for depression and anxiety (per-protocol analysis). **Results:** Of the 92 patients who completed T1, 44 completed T2 assessments. Medium to large effect sizes were found for reductions in overall PTSD (d = 0.88), depression (d = 0.83), and anxiety symptoms (d = 0.67). While at the beginning of treatment (T1) 97.7% (n = 43) fulfilled diagnostic criteria for both PTSD and depression, and 95.5% (n=42) for anxiety, at T2, 70.5% (n = 31) fulfilled the criteria for clinically relevant PTSD, 79.5% (n = 35) for depression and 70.5% (n = 31) for anxiety. **Discussion:** Despite the high symptom load at the beginning of treatment, uncertainties regarding residence status, and

the unstable living conditions, patients seem to benefit from the multidisciplinary short-term treatment. This study adds preliminary evidence to the efficacy of multimodal treatment and suggests that improvements in symptom severity can be achieved within the often extremely stressful period after arrival.
Keywords: Refugees, asylum seekers, trauma, multidisciplinary, short-term treatment, stepped care, early interventions, PTSD

Introduction

Global forced displacement has increased and many people flee their homes due to war, armed conflict, torture and other systematic human right violations. Current estimates project that there are 65 million refugees, most of which are internally displaced persons (UNHCR, 2016). In 2015 and 2016, altogether 1,164,269 asylum requests were submitted to the German Federal Agency of Migration and Refugees with 36.5% of asylum applicants coming from Syria, 13.6% from Afghanistan, and 10.8% from Iraq (Bundesamt für Migration und Flüchtlinge [German Federal Agency of Migration and Refugees], 2017). In addition to the potentially traumatic experiences in their home countries, refugees are often confronted with further potentially traumatic experiences during their flight and ongoing stressors in their host country (Lambert & Alhassoon, 2015). The traumatization is often experienced sequentially (i.e. before, during and after the flight), increasing the risk for the development of severe mental health problems, such as posttraumatic stress disorder (PTSD) or depression (Bogic, Njoku, & Priebe, 2015; Fazel, Wheeler, & Danesh, 2005). Average rates of 25-30% for PTSD and 30-43% for depression have been reported among populations exposed to mass conflict and displacement (Chung et al., 2018; Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015; Steel et al., 2009; Tinghög et al., 2017). For refugees in Germany, PTSD rates between 18% and 40% and for depression between 22% and 55% have been reported (Butollo & Maragkos, 2012; Führer, Eichner, & Stang, 2016; Gäbel, Ruf, Schauer, Odenwald, & Neuner, 2006; Richter, Lehfeld, & Niklewski, 2015). Due to a lack of representative studies in Germany, the findings in these studies were only preliminary.

A number of factors can affect the complexity and severity of a mental disorder after trauma, such as the gravity and duration of the trauma, the number of cumulative traumatic events, experiences associated with feelings of shame and guilt, few personal resources to deal with and compensate the trauma, as well as the situational context after the traumatic event (Brewin et al., 2017; Herman, 1992; Wenk-Ansohn, 2017).

Post-migration stressors such as problems with the asylum process or difficult living conditions may hinder refugees to feel safe in their host country and therefore aggravate psychological disorders. Several studies demonstrated that the extent of post-migration stressors was associated with psychological distress (Nickerson, Schick, Schnyder, Bryant, & Morina, 2017; Schweitzer, Melville, Steel, & Lacherez, 2006). These studies also suggested that refugees who have been traumatized in the past may have a greater vulnerability to develop adverse mental health outcomes such as PTSD when confronted with post-migration stressors.

Depending on their experiences prior, during and after their flight, refugees may suffer not only from PTSD or depression, but also from adjustment disorders, suicidal tendencies, somatic symptom

disorders, anxiety, impulse control disorders, severe dissociative disorders, substance abuse, prolonged grief, or even enduring personality change after catastrophic experiences (Priebe, Giacco, & El-Nagib, 2016). Additionally, pre-existing or newly developed physical illnesses due to stress might develop or become more aggravated (Gurris & Wenk-Ansohn, 2013).

Although refugees are at high risk of psychological impairment, their access to the German health-care system is initially restricted (Bozorgmehr & Razum, 2015). Even when after 15 months this structural restriction to the welfare system is lifted, the lack of interpreters and resulting communication difficulties often impede access to adequate care. Specialized psychosocial centers offer comprehensive care and treatment, taking into account the diverse problems faced by refugees. However, these centers usually have limited capacities and are not available in every part of Germany. As a result, the mental health care provision in Germany, as well as in other European countries, is insufficient, leaving a great number of refugees without necessary treatment (Bozorgmehr & Razum, 2015). Figures for 2015 show that an estimated 379,848 refugees were in need of mental health treatment in Germany, but only about 5% actually received treatment (Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BAfF) [German Network of Rehabilitation Centres for Refugees and Survivors of Torture], 2016). Thus, many traumatized refugees did not find access to the regular mental healthcare system during the vulnerable period after arrival in the host country.

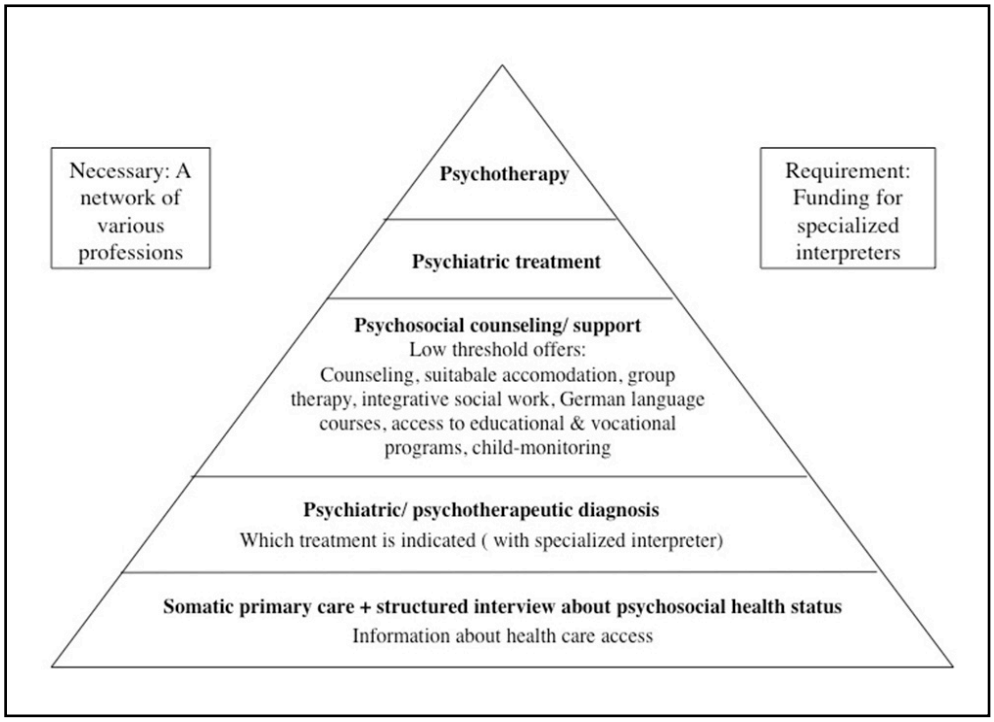
Depending on the needs of the patients as well as on the locally existing mental health care structures, stepped care approaches seem generally useful to adequately meet the demand and to ensure an overall better health care provision for this patient group and to offer care as soon as possible. Figure 1 displays the various levels of an intervention pyramid for traumatized refugees adapted from the intervention pyramid for humanitarian catastrophes (IASC Guidelines, Inter-Agency Standing Committee, 2007) and adjusted to the conditions of a developed health care system in Western host countries (see Wenk-Ansohn, 2017). A transfer from one level to the next is possible, depending on the needs of the survivors over time similar to a "stepped care-model" (see NICE-Guidelines for PTSD, National Institute for Health and Care Excellence (NICE), 2005).

Adequate material and social reception conditions for refugees form a basic requisite in order for medical and psychotherapeutic measures to be effective. In the European Reception Directive (Art. 19 Par. 2 RL 2013/33/EU, European Union, 2013), consideration and care for the special needs of vulnerable groups is demanded—but many European countries are yet to implement this guideline (CIR Rifugiati, 2017; Leisering, 2018).

Specialized care

Specialized centers for the medical and psychosocial rehabilitation for victims of war and torture (in Germany organized under the umbrella organization BAfF) offer comprehensive care and treatment for refugees who are victims of war-related violence, torture or other human rights violations. This is mostly realized with a multidisciplinary and multimodal approach, which differs to a large extent from out-patient primary care provided by hospitals and resident psychiatrists or

Figure 1: *Elements of adequate health care*



Source: Adapted from Inter-Agency Standing Committee (2007).

psychotherapists. Nonetheless, where no specialized center is accessible, establishing networks of different professions can provide similar levels of care.

Usually, multimodal treatment refers to the application of different interventions and multidisciplinary approaches refer to the collaboration of persons with different professional backgrounds. Multimodal and multidisciplinary approaches often go hand in hand, meaning that a multimodal treatment is carried out by a multidisciplinary team and the terms are often used interchangeably. For reasons of brevity, in the following we only use the term "multimodal" when referring to both multimodal and multidisciplinary treatment.

The multimodal approach addresses the broad spectrum of problems refugees present following exposure to torture or war-related traumatic events, subsequent post--migration stressors, as well as resettlement and acculturation challenges by providing medical, psychotherapeutic and psychosocial assistance, as well as legal support during the asylum procedures. This approach requires knowledge of psycho-traumatology, at various levels (body, mind, social field), cultural awareness, and specialized interpreters (Maier & Schnyder, 2007; Pabst, Gerigk, Erdag, & Paulsen, 2013; Sjölund, Kastrup, Montgomery, & Persson, 2009). The aim of a multimodal approach is to offer the patients an individually tailored

psychotherapeutic concept by taking into account the individual's syndrome, their limitations in day to day life, their current situational context, their cultural heritage as well as their level of education (Silove, Ventevogel, & Rees, 2017). Thereby, a close cooperation between the attending physicians, therapists, lawyers and social workers is necessary. Integrated and well-coordinated social support fostering the patient's autonomy and inclusion into the host society is necessary for treatment and rehabilitation measures to have an effect (Brandmaier & Ahrndt, 2012; Gissendanner, Callies, Schmid-Ott, & Behrens, 2013; Wenk-Ansohn, Weber-Nelson, Hoppmann, & Ahrndt, 2014). This approach not only aims at alleviating symptoms, but also at supporting the rehabilitation process and in order to include the refugees as best as possible in the host society.

Treatment programs at Center ÜBERLEBEN according to individual indication

The center is a specialized non-governmental organization for the treatment and rehabilitation for survivors of torture and war-related violence. Treatment follows the aforementioned multimodal approach including culturally sensitive medical, psychiatric, psychotherapeutic and social treatment services. If indicated, supplementary body and creative therapeutic modules are integrated (Wenk-Ansohn et al., 2014). The psychotherapists at the center have a medical or psychological background and are trained as psychotherapists in a cognitive-behavioral, psychodynamic or systemic approach. In addition, they received trauma-therapeutic trainings. Therapy sessions are conducted with the help of professional interpreters who are specially trained for psychotherapeutic settings (i.e. technically and psychologically) and who receive regular supervision with regard to complex and problematic cases, potential secondary traumatization as well as setting, methods and cultural issues. Depending on the indication presented by the patient, treatment in the center is offered in various settings, such as the outpatient clinic for adults, the outpatient clinic for children and youth, a day clinic and a specialized service for traumatized women. In order to meet the higher influx of refugees to Germany from 2013 onwards and to offer specialized care to persons with an immediate and high need of care and treatment, the outpatient clinic for adults developed an acute treatment program for newly arrived traumatized refugees. It was hypothesized that the early access to adequate care can reduce the symptom severity and also the risk of chronification of trauma-related disorders. The acute program focuses on stabilizing and supporting patients in the particularly vulnerable period after their arrival with a short-term multimodal approach of up to six months as outlined below. For refugees who already lived in a more stable context (e.g. secure residence status, living conditions), but who suffered from complex and mostly chronic posttraumatic symptoms, the outpatient clinic continued to offer a long-term multimodal treatment and rehabilitation program. The long-term program focuses on trauma-oriented psychotherapy in combination with integrated clinical social support and lasts on average 1.5 years (Wenk-Ansohn et al., 2014). A recent evaluation demonstrated that the long-term program was accompanied by a significant decrease in trauma-related psychological symptoms and an increase in subjective quality of life (Stammel et al., 2017). After-care is available for patients after discharge from either program.

First consultation and acute short-term treatment program

Treatment-seeking refugees are mostly referred to the center through their refugee shelters, through hospitals or through lawyers or they learnt about the center and its services through their community. Refugees who are interested to enter a therapy program at Center ÜBERLEBEN can arrange appointments for a personal interview in a weekly telephone consultation hour. During the telephone consultation, a first screening takes place to assess whether the treatment-seeking person is likely to fulfil the eligibility criteria at Center ÜBERLEBEN (victims of war and/or torture, trauma-related psychological problems, need for treatment with interpreters). If the person is likely to fulfil these eligibility criteria, and if there is capacity for intake, an extensive initial clinical interview is offered (see Table 1). This interview is conducted with a psychotherapist, a social worker and a specialized interpreter. It covers the client's symptoms, overview of the personal history, needs (psychosocial, psychiatric and psychotherapeutic), and her/his motivation to take part in therapy. At the end of this initial interview, it is determined whether there is an indication for further diagnostics and treatment in the center and which of the support programs will be offered. In case of non-admission to the treatment services, a referral to the public healthcare system or the network of NGOs for psychosocial and legal support is offered. Usually the therapy requests exceed the center's capacities by far, so that only persons who are severely affected will be admitted to the programs.

Inclusion criteria for the acute multimodal treatment program requires patients to be newly arrived in Germany (weeks or a few months), to show acute trauma- and stress-related symptomatology and to have a current unstable context with regard to the asylum procedure and/or living conditions. Most of the patients admitted to

Table 1: *Steps before, during and after the initial interview with a specialized interpreter*

Before interview	Telephone consultation to register, clarify symptoms, and if appropriate refer to other external offers.
During interview	Current Symptoms. Biographical background and potentially traumatic experiences (overview). Current stressors. Social situation and asylum status, lawyer. Motivation for treatment. Prior diagnostics and treatment.
At the end of interview	Preliminary diagnoses; in cases of no diagnoses, consultation on whether other problems present, e.g. main emphasis on current unstable life situation or other external factors. Motivation for therapy. Indication for treatment.
Decision	Which measures/treatments are indicated? Which measures can be offered, which cannot? (where applicable: concluding counselling and referral). Decision whether acute intervention or a long-term psychotherapeutic treatment process is indicated. If admitted to the acute program treatment, it starts as soon as possible after the initial interview.

Table 2: *Elements and steps in the acute short-term program*

In case of admission to the acute treatment program:
1. Clinical diagnostic phase—if applicable: documentation of somatic injuries, and if needed preparation of a professional psychotherapeutic statement for the asylum process.
1. Psychological standardized assessment (T1).
2. Up to 25 individual therapy sessions (psychiatric, psychotherapeutic, social therapy).
3. If indicated, in addition—up to 12 group therapy sessions (psychoeducation and body therapy).
4. Along the therapeutic process, integrated autonomy promoting social work.
5. If children accompanied patients, initiation of appropriate help for the children (child-monitoring).
6. Psychological standardized assessment at the end of the program (T2).
7. If necessary: after-care. > the modules are applied in a flexible manner according to the individual's needs.

the acute program at intake lived in mass-housings or provisory shelters.

Table 2 provides an overview of the elements applied within the acute multimodal short-term treatment program. The case example further exemplifies the first consultation.

Reflections by the therapeutic team

Practical experience with the acute program was gathered in team workshops in order to adjust our procedures to the challenge of delivering a type of service that was new to us. We observed that newly arrived asylum seekers had a higher need for legal counseling provided by social workers compared to patients in the long-term therapy program. In the early stages of the acute program, patients commonly required support with their asylum application, accommodation and with restoring contact with lost relatives. Later, help was needed to access language courses, vocational preparation courses, or job opportunities in general. After a successful asylum application, support might have been needed during the family reunification process. Also, more psychiatric differential diagnostics (e.g. to exclude psychosis, dissociative states, suicidal ideation) and treatment with an anti-depressive medication with sleep-inducing properties was prescribed in many cases, although taken largely only temporarily in the first moths after intake. In many cases, crisis interventions were needed in situations of overwhelming current stressors, such as a negative decision concerning the asylum application, or confrontations with trauma-associated triggers in the accommodation. Likewise, news about renewed conflict at home, where family members might be in danger, often caused major crises. In some patients, these experiences triggered suicidal tendencies and a temporary admission to a psychiatric hospital became necessary.

Though patients benefitted from group therapy, they also reported that individual psychotherapy sessions were of central importance to them. Individual sessions focused on stabilizing and resource-oriented interventions as well as grief counselling. Furthermore, a narrative approach formed an integral part of the acute program (testimonial therapy; Agger, Raghuvanshi, Shabana, Polatin, & Laursen, 2009), which aimed at reconstructing the biography including traumatic experiences. In many cases, the life line method (manualized by Schauer, Neuner, and Elbert (2011)) was used to identify traumatic as well as positive life events without going into in-depth

Case example and reflections by the therapeutic team

Case study (part I)
Mr. A. arrives for a first consultation at the Berlin Center ÜBERLEBEN. He reports that he is 32 years old and arrived from Syria two months ago. Currently he suffers from sleep disturbances such as trouble falling and staying asleep. He describes nightmares, where scenes of torture and bombing occur, with accompanied feelings of fear and arousal. He reports that, in his dreams, he also sees his wife and son yelling for help in their bombed-out home, a scene he had not directly witnessed. He reports being restless and irritable, whilst experiencing hopelessness and feelings of increasing tiredness, guilt and uselessness in combination with worries that he might not be able to bring his family to Germany. He reports that he had taken the overland route and had been arrested, beaten and registered by the Bulgarian border police. Now he faces the threat of deportation to Bulgaria due to the 'Dublin procedure'. He describes the living conditions for a refugee family in Bulgaria as being inhumane. He mentions that he feels trapped and that sometimes he had even considered ending his own life. When asked about difficult experiences in Syria, he discloses that he had been imprisoned in Damascus for two years and that a number of his political friends had died during incarceration and that he also has scars from torture. During the first consultation he does not want to go into further details about his experiences during his imprisonment. He reports that his family paid money to get him released from prison. Also, that he witnessed bombings and that he transported injured persons with his van. When asked about the course of his symptoms, Mr. A. mentions having nightmares since release from prison, albeit more severe since arriving in Europe and that he feels hopeless and without energy (he begins to cry). He's currently living in a refugee shelter and feels ashamed because he screams in his dreams. Due to his acute symptomatology and his ongoing unsafe and stressful situation, he is admitted to the acute program where support will start immediately.

exposure. The life-line method focuses on bringing life experiences into a coherent narrative and providing some cognitive restructuring inputs or interventions concerning psychodynamic aspects. Patients evaluated the possibility of communicating their experience to an empathic and neutral listener, who set a framework and limited the amount of the exposure to a bearable limit, as helpful and relieving. By working with the narrative approach, the traumatic experience is disclosed as far as possible in the actual psychological status, allowing the therapist in later stages of the therapeutic process to expand on it when working with individual triggers, on contents of nightmares, and feelings of powerlessness, shame and guilt (Boos, 2005).

We were able to discharge most of the participating patients within the six-month

period of the acute program, whereas only a minority of the patients indicated a need and motivation to continue therapy in the scope of the trauma-oriented long-term therapy program. The majority reported that after having received intensive support in the early stage after flight from the acute program, they then felt sufficiently stabilized to manage their daily life in exile. They had become more active and started to visit language or professionalizing courses. Many of those who had gone through the acute program, especially those who were still waiting to hear about their asylum claim, or ongoing worries about their family in their country of origin made use of low frequency appointments or crisis interventions on demand within our after-care offer.

Working with newly-arrived, severely traumatized refugees was highly demanding for the team of the outpatient clinic. The therapists and interpreters had insights into the atrocities the patients had gone through. The team was often confronted with critical states, dissociative fits and suicidal tendencies of their patients. To reduce the strain of the team and prevent compassion fatigue (Figley, 1995), multidisciplinary case conferences and external supervisions of all persons involved in the care setting was necessary. Also, the option to debrief after a particularly straining session was important for the team members working in the acute program. Without the option to share and discuss as well as supporting each other, therapists and interpreters were at a high risk of burnout, whereas sharing and also communicating successes helped to alleviate the strain and brought energy and job satisfaction.

Method

The purpose of the present study was to evaluate the progress of patients participating in the short-term multimodal acute treatment program by examining changes in PTSD, anxiety and depression symptom severity in the course of treatment. We hypothesized that patients even in this early phase of their asylum process and under conditions of ongoing post-migration stressors can benefit from a multimodal treatment approach by showing a decrease in PTSD, anxiety and depressive symptoms, thus enabling them to better manage their life in exile.

During the diagnostic phase at the beginning of the acute program, a psychological standardized assessment was carried out assessing exposure to traumatic events and symptom severity of PTSD, depression and anxiety (T1). Exclusion criteria for the standardized assessment were acute suicidality, severe dissociative disorder or psychotic symptomatology. Following completion of the acute program after approximately six months (M = 201 days; SD = 83), a second standardized assessment was carried out (T2).

The data included in the present study were collected between February 2015 and May 2017. During that period, 1,484 persons made use of the telephone consultation seeking advice or a place for treatment. Based on this consultation, an initial interview for 359 people was carried out at the outpatient clinic for adults, thereafter 169 persons were assigned to the short-term acute treatment approach as they fulfilled the inclusion criteria. Moreover, 190 persons were either assigned to the long-term treatment approach of the center or referred to other internal or external offers. Of the 169 persons assigned to the short-term acute treatment approach, 92 persons completed the standardized mental health assessment by filling in the questionnaires. 77 persons were excluded from the standardized assessment due to fulfilling one the exclusion criteria (see above). In most cases, the questionnaires (i.e.

Case study (part II)

Upon admittance, Mr. A. showed symptoms related to PTSD after a series of sequential traumatic experiences while simultaneously suffering from a depressive syndrome as a result of the current ongoing stressful situation. Due to his depressive symptoms and in order to alleviate his sleep problems, he was prescribed an anti-depressive medication (Mirtazapine 30mg), which he took for only three months. The social worker organized Mr A.'s participation in a German language course and recommended a lawyer for the asylum process. Subsequently, Mr. A. was willing to talk about his experiences during his imprisonment. Scars from injuries where documented according to the Istanbul Protocol (United Nations High Commissioner for Refugees, 2001) and a comprehensive professional statement was prepared. Additionally, the patient took part in a psychoeducative group. A major topic in the individual psychotherapeutic sessions was his feeling of guilt towards his family, whom he had to leave behind during his flight, and towards the fellow inmates in prison, some of whom died during incarceration.

The Federal Office for Immigration and Refugees (BAMF) decided not to activate the Dublin procedure and processed his request for asylum in Germany. He was granted asylum according to the Geneva Refugee Convention, which relieved him immensely, especially since he was now able to request a family reunification with the support of the social worker. Overall, at the end of the acute program, the depressive and PTSD-symptoms had significantly decreased, the PTSD symptoms still being above the cut-off point. Mr. A. did not accept the offer to continue his treatment in terms of a long-term trauma-oriented psychotherapy. He was at the point of prioritizing his practical life in Germany. He provided the feedback that the program had helped him immensely, and that he also learned that therapeutic conversations worked. He asked if he could report back to us if the symptoms persisted or became worse. To support his desire to start working as soon as possible, the social worker was able to organize a vocational preparation course.

Mr. A. returned twice in the frame of aftercare requiring assistance in managing crisis situations. The family reunification request took time and during both crises bombing in Syria caused the telephone connection to disconnect. Both times, Mr. A. despaired and even considered going back to Syria. After approximately six months, he arrived at the center without an appointment. He was radiant with joy and had his wife and two kids (a girl, 10 years of age, and a boy, 5 years of age) with him. We had a small celebration together. However, his wife reported that her daughter often screamed in her sleep and was overly introvert. Thus, we organized a first consultation with an Arabic speaking children and adolescent psychiatrist for diagnostic and parental counselling (child monitoring makes part of the program).

T1 and T2) were carried out via face-to-face interviews with clinical psychologists and interpreters while some patients filled out the questionnaires in their own homes by themselves. Informed consent was obtained from every participant at T1.

Instruments

Sociodemographic information included gender, age and country of origin. The number of either psychotherapy, social work, group therapy and psychiatric treatment sessions the patient had received was noted according to our digital patient documentation. These included questionnaires (described below) which were translated into Arabic, Farsi, Turkish and Russian and then back-translated by an interpreter unfamiliar with the original version. Discrepancies between translation and back-translation were discussed until a final version was agreed upon following a rigorous translation process as recommended for cross-cultural research (Guillemin, Bombardier, & Beaton, 1993).

Traumatic Events: Traumatic events were assessed using an adjusted list based on two standardized instruments, the Harvard Trauma Questionnaire (Mollica et al., 1992) and the Posttraumatic Diagnostic Scale (Foa, Cashman, Jaycox, & Perry, 1997). Therefore, 24 traumatic events were assessed altogether, including one item allowing participants to indicate an additional traumatic event. Participants were asked whether they had personally experienced, witnessed, or heard/learnt of the event.

PTSD: The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) is a screening instrument for PTSD including 20 items that correspond to the diagnostic criteria of PTSD of the DSM-5 (Blevins, Weathers, Davis, Witte, & Domino, 2015). Items are rated on a five-point Likert scale ranging from 0 "not at all" to 4 "extremely". A preliminary cut-off of 33 suggested to indicate a severity of PTSD symptoms at a clinical level (Weathers et al., 2013). The PCL-5 shows good psychometric properties (Blevins et al., 2015). In the current sample, Cronbach's alpha was .82.

Depression and Anxiety: The Hopkins Symptom Checklist-25 (HSCL-25) is a 25-item questionnaire based on self-report data containing two subscales which measure symptoms of anxiety (items 1 – 10) and depression (items 11 – 25) (Derogatis, 1974). It is a well-established screening instrument and has been widely used in a number of different cultural contexts (Ventevogel et al., 2007). Each item is ranked on a four-point Likert scale from 1 "not at all" to 4 "extremely"). To interpret the results, the mean value of each of the subscales is calculated and a cut-off value of >1.75 is suggested to identify clinically relevant symptomatology. Current evidence supports the construct validity and reliability of the Arabic version of the instrument (Selmo, Koch, Brand, Wagner, & Knaevelsrud, 2016). Cronbach's alpha in this sample was α=.85 for anxiety and α=.86 for depression.

Participants

The total sample at T1 consisted of N = 92 participants. Approximately 80 per cent were male (81.5%; n = 75). The sample had a mean age of M = 31.25 years, SD = 9.05 (range: 18-55). The majority of participants came from Syria (n = 48, 52.2%), 12.0% (n = 11) from Afghanistan, 7.6% (n = 7) from Iraq, and 7.6% (n = 7) from Turkey, others came from Iran, Iraq, Pakistan, Egypt, Chechnya, Somalia, Eritrea, Libya or Lebanon (Palestinians).

Data for exposure to traumatic events were available for only 77 participants. The most frequently reported personally experienced traumatic events were "being close to death" (n=68, 87.2%), "exposure to combat situation" (78.9%, n= 60) and "assault by a stranger" (76.9%, n= 60). Torture (as defined by UNCAT) was reported by 70.1% (n=54) on the traumatic events list. Of the 92 patients who completed T1, 44 completed T2 assessments.

Statistical Analyses

Missing data were analyzed for systematic patterns. Missing data in the pre-post comparison (n=44) were missing completely at random (MCAR) and were replaced separately for pre and post data using Estimation Maximation methods (Tabachnick & Fidell, 2001). T-tests and the chi-square test were applied to test whether completers and non-completers differed in terms of sociodemographic variables or symptom severity of PTSD, depression, and anxiety. For pre-post comparison, completer analyses were conducted. Paired sample t-tests were individually performed for PTSD and each of the PTSD symptom clusters, anxiety, and depression. Cohen's d was calculated as a measure for the respective effect sizes (d = .20: small effect, d = .50: medium effect, d = .80: large effect, according to Cohen (1988)). All statistical analyses were conducted using SPSS, version 24.

Results

Severity of symptoms at T1 (N = 92)

Of the entire sample (N = 92), 95.7% (n = 88) fulfilled the criteria for PTSD as measured with the PCL-5 with a mean severity of symptoms of M=54.25 (SD = 11.79). Similarly, 95.7% (n = 88) scored above the cut-off of 1.75 for depression on the HSCL-25 with a mean symptom severity of 3.03 (SD = 0.62). Finally, 93.5% (n = 86) of the patients scored above the cut-off for anxiety with a mean symptom severity of 2.92 (SD = 0.71).

Patients with pre-post test diagnostics (n = 44)

For pre-post comparisons, data were available for n = 44 participants (n=35 (79.5%) male; age M = 30.64, SD = 9.46). In total, 48 participants did not fill out the post assessment (T2) due to several reasons: several patients were released from treatment earlier than three months after T1 or dropped out of treatment, one patient was deported to Spain under the Dublin procedure; some were discharged after six months without a final assessment after having missed the appointment for the final testdiagnostic assessment repeatedly, seven patients with ongoing difficulties in managing a day-to-day structure were referred to intensive daily care at the day clinic or the women's housing program of the center and about 20% of patients initially admitted for the acute program were transferred to the long-term treatment program. However, completers and non-completers did not differ from each other in any of the sociodemographic variables age ($t(90) = 0.62$, $p = .54$) or gender ($\chi^2 = .22$, $p = .64$), nor the severity of symptoms of PTSD ($t(90) = 0.16$, $p = .87$), depression ($t(90) = -0.79$, $p = .43$) and anxiety ($t(90) = -0.26$, $p = .80$) at the initial assessment (T1).

At the beginning of treatment (T1), four of the 44 participants (9.1%) had been granted asylum, while 31 (70.5%) were still in the asylum process. The remaining nine patients had either been denied asylum (n=1), were temporarily protected from deportation (n=1), or were undergoing the Dublin regulation (n=7).

At T2, 13 (29.5%) had been granted asylum and 23 (52.3%) were still in the asylum process. From the remaining patients, six (13.6%) where temporarily

protected from deportation, and two (4.5%) still faced the Dublin regulation.

All patients received psychotherapy and at T2, patients had received an average of 14 individual sessions of psychotherapy (M = 13.68, SD = 8.22). 63.4% (n = 28) also received psychiatric sessions (about 4 sessions on average (M = 3.86, SD = 3.45) but not all of those were treated with a medication. The majority of patients received social work (n = 38, 86.4%) and had an average of four sessions of social work (M = 4.48, SD = 2.84). About half of the patients had participated in group therapy (n = 24, 54.5%) and received on average six sessions of group therapy (including psychoeducation and body work; M = 5.58, SD = 3.48).

Pre-Post comparison (n = 44)

Table 3 presents pre- and post-comparison data and results of the dependent t-test for all symptom clusters. Results indicate a significant decrease in symptom severity for depression, anxiety, and overall PTSD. While the PTSD symptom clusters 'intrusion', 'changes in mood,' and 'cognition,' and 'alterations in arousal and reactivity' show a significant decrease in severity, the cluster 'avoidance' increased slightly, however to a non-significant degree. Effect sizes for reductions of depressive and overall PTSD symptomatology, PTSD intrusions, PTSD alterations in arousal and reactivity can be classified as large, whereas the effect size for the reduction of anxiety symptoms and PTSD changes in mood and cognition can be classified as medium according to the conventions of Cohen (1988).

While at the beginning of treatment (T1), 97.7% (n=43) fulfilled diagnostic criteria for each PTSD and depression, and 95.5% (n=42) for anxiety, at T2, 70.5% (n=31) still fulfilled the criteria for clinically relevant PTSD, 79.5% (n=35) for depression and 70.5% (n=31) for anxiety.

Table 3: *Means and standard deviation for pre and post data (n=44)*

	T1 M (SD)	T2 M (SD)	T (df)	*p*	Cohen's d [95% CI]
PTSD	54.04 (11.65)	42.19 (15.20)	5.32 (43)	<.001	0.88 [0.26–1.49]
Intrusion	15.39 (3.44)	11.50 (4.71)	5.08 (43)	<.001	0.94 [0.32–1.57]
Avoidance	4.71 (2.65)	5.55 (2.32)	-1.66 (43)	.10	
Changes in mood and cognition	18.11 (5.59)	14.10 (6.09)	3.98 (43)	<.001	0.69 [0.08–1.29]
Alterations in arousal and reactivity	15.83 (4.14)	11.04 (6.00)	5.75 (43)	<.001	0.93 [0.31–1.55]
Anxiety	2.94 (0.68)	2.41 (0.88)	3.86 (43)	<.001	0.67 [0.07–1.28]
Depression	3.08 (0.55)	2.53 (0.76)	4.40 (43)	<.001	0.83 [0.21—1.45]

Note: abbreviations: df= degrees of freedom CI= Confidence Interval, M= mean, SD= standard deviation, T= t-test, p = significance level

Discussion

The aim of the study was to evaluate the short-term multimodal acute treatment at the outpatient clinic at Center ÜBERLEBEN. The results show a significant decrease in symptomatology between pre- and post-treatment measurement for overall PTSD, anxiety, and depression. Despite the extremely high symptom load at the beginning of treatment, the uncertainties regarding residence status, and the often ongoing difficult living conditions in refugee accommodation, patients seem to benefit from the multimodal short-term treatment. Large effect sizes were found with regard to reductions in overall PTSD and depression and a medium effect size was found for reductions in anxiety symptoms. This adds to previously inconsistent findings on the efficacy of multimodal treatment which in some cases has not found any changes in PTSD, depression and anxiety between pre- and post-treatment assessments (Birck, 2004; Carlsson, Mortensen, & Kastrup, 2005; Mollica et al., 1990), while other studies have found significant reductions in symptom severity (Arcel et al., 2003; Brune, Eiroa-Orosa, Fischer-Ortman, & Haasen, 2014; Palic & Elklit, 2009; Stammel et al., 2017). However, assessments at T2 showed that after treatment, about 70% of the patients still scored above the cut-off for PTSD and anxiety and about 80% for depression. Previous research shows that refugees often still suffer from high rates of psychopathology, after treatment (de Heus et al., 2017; Schock, Böttche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016; Stammel et al., 2017). There are several reasons why refugees may benefit less from psychotherapy compared to non-refugee patients. First, with respect to this study, only severely affected cases with an urgent need for treatment were admitted to the treatment, so that patients had on average very high symptom loads at the beginning of treatment. An earlier meta-analysis has shown that high pre-treatment PTSD severity was predictive of smaller treatment effects than moderate symptom severity at intake (Haagen, Smid, Knipscheer, & Kleber, 2015). Second, refugees are confronted with a wide range of ongoing stressors. After discharge from our acute program, more than half of our patients were still waiting for an asylum decision or for family reunification, and most of the patients were still living in refugee accommodation. These factors may have substantially contributed to an increased symptom severity (Nickerson, Steel, Bryant, Brooks, & Silove, 2011; Schock et al., 2016).

The long-term course of the wellbeing of traumatized refugees not only depends on successful therapeutic and psychosocial interventions but to a large part on the safety, living-conditions and social openness of the country of exile. Therefore, part of our acute program was to document their history and write expert opinions for the asylum procedure. Patients who still suffered from reactive psychological symptoms at or following the end of the acute program, could attend the aftercare program of the outpatient clinic that offered further support with low frequency sessions or crisis interventions, when necessary.

Results further showed that while symptom severity in the PTSD symptom clusters ‘intrusions’, ‘changes in mood and cognition’, and ‘alterations in arousal and reactivity’ significantly decreased, the mean symptom severity in ‘avoidance’ did not change. This finding may be explained by the fact that the acute short-term treatment program, primarily focused on supporting patients to manage current stressors,

symptoms, and trauma-associated triggers, an approach that may not be sufficiently effective to treat avoidant behavior in PTSD. In personal feedback, some patients revealed that when responding to the questionnaire they had indicated avoidance because they had improved their ability to control trauma-related triggers consciously. For example, they would not watch news about war-related developments in their home country late at night anymore, which in turn had resulted in better sleep and a reduction in nightmares. A trauma-focused approach, that in various studies was demonstrated to be an efficacious approach to treating PTSD in war-exposed refugee populations (see meta-analysis by Lambert & Alhassoon, 2015), was not the primary focus of this program. The reason behind not primarily conducting a trauma-focused approach was that not only war- or flight-related trauma were the cause for the patients' symptomatology, but also post-migration stressors such as uncertainty regarding residence status in the host country and worries about family members who were still exposed to war in their home countries (Miller & Rasmussen, 2010), or even wounded, killed or missing. An in-depth processing of traumatic memories during the phase of acute stressors was not indicated in this early period of migration since the traumatic process the patients were in was still ongoing (Flatten et al., 2011). Although the acute program only allowed a mild trauma-focused approach, pre to post treatment assessment indicated a significant reduction of symptoms including PTSD even after the relatively short treatment period of six months.

Limitations of the study

Several limitations of the study should be considered when interpreting the results. First, this study was conducted without a control group. It is therefore not possible to state whether the effects found can be attributed to the intervention itself or rather to spontaneous remission of symptoms, or to the effects of attention received by the patients within the therapeutic relation. However, due to the ongoing stressors and uncertainties regarding residence and housing situation, substantial changes in the symptom load without therapeutic interventions cannot be expected. As many patients were male family fathers whose families were still in the conflict-affected regions, having a regular appointment with a supportive listener may have been particularly effective in dealing with feelings of guilt, hopelessness and loneliness. Although it would be advisable for future research to use control groups to measure the efficacy of multimodal interventions as compared to a waiting list, it has to be noted that for ethical reasons, it is difficult to have a waiting list for a period of six months when offering therapeutic support for traumatized persons in an acutely stressful situation.

Second, for a variety of reasons, about half of the patients assessed at T1 did not participate in the second assessment. Thus, we cannot rule out the possibility that a selection bias occurred in the sense that only those patients who benefitted from therapy were assessed at the second time point. However, patients did not differ from each other with regard to sociodemographic data or symptom severity at T1, so that a systematic reason for the dropout from the second assessment could not be identified in this regard. Furthermore, we performed a completer-analysis, which generally shows larger effects than intention-to treat analysis and is therefore at risk of overestimating the treatment effect.

Third, the interventions applied were not standardized but therapeutic modules were applied in a flexible way. Thus, the evaluation at hand does not allow conclusions about effective components responsible for improvements in symptomatology. The current analysis was conducted in a natural setting with the primary objective to provide multimodal treatment tailored to the needs of these patients. The scientific objective was only secondary and the data should therefore be seen as preliminary and explorative. Fourth, we used different language versions of each questionnaire, which might result in a bias in responsiveness. However, we used the recommended procedure for translating questionnaires to ensure a rigorous translation process.

Conclusions

This study evaluated an acute short-term multimodal treatment program for newly-arrived traumatized asylum seekers and provided reflections on the experiences within this program. Our results suggest that the early access to this type of treatment seems to result in significant decreases in trauma-related symptoms. So far, the results of the acute program have been promising: On admission, all patients who took part in the survey were severely strained and more than 95% of patients were suffering from severe symptoms of PTSD, anxiety and depression. Results show that within the six-month period of the acute program, it seems possible to stabilize the majority of patients. However, we do not yet know if the reduction of symptom levels is stable over time and if the program helped patients in their participation in the host society. We assume that some participants of the acute treatment program will later on sign up for further trauma-oriented psychotherapy due to remaining or recurrent symptoms. Despite methodological shortcomings, this study adds further preliminary evidence to the efficacy of multimodal treatment and shows that improvements in symptom severity can be achieved even within the vulnerable period after arrival in the host country.

Acknowledgements

We would like to thank Benedikt Taud for the translations and Maike Stolz for the preliminary analyses. We would like to express our gratitude towards the specialized interpreters at our center for their support in collecting the data. Furthermore, we thank our patients who agreed to take part in this study.

References

Agger, I., Raghuvanshi, L., Shabana, S., Polatin, P., & Laursen, L. K. (2009). Testimonial therapy. A pilot project to improve psychological wellbeing among survivors of torture in India. *Torture 19*(3), 204-217.

Arcel, L. T., Popovic, S., Kucukalic, A., Bravo-Mehmedbasic, A., Ljubotina, D., Pušina, J., & Šaraba, L. (2003). The Impact of Short-term Treatment on Torture Survivors. The Change in PTSD, Other Psychological Symptoms and Coping Mechanisms after Treatment. In: *Treatment of torture and trauma survivors in a post-war society.* Association for Rehabilitation Torture Victims; Center for Torture Victims, Sarajevo.

Birck, A. (2004). Symptomatik bei kriegs-und folterüberlebenden Flüchtlingen, mit und ohne Psychotherapie. *Zeitschrift für Klinische Psychologie und Psychotherapie; Forschung und Praxis, 33*(2), 101-109. http://doi.org/10.1026/0084-5345.33.2.101

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*(6), 489-498. http://doi.org/10.1002/jts.22059

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights, 15*(1), 29. http://doi.org/10.1186/s12914-015-0064-9

Boos, A. (2005). *Kognitive Verhaltenstherapie nach chronischer Traumatisierung: Ein Therapiemanual*. Göttingen: Hogrefe Verlag.

Bozorgmehr, K., & Razum, O. (2015). Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013. *PloS One, 10*(7), e0131483. http://doi.org/10.1371/journal.pone.0131483

Brandmaier, M., & Ahrndt, A. (2012). Neue Perspektiven–Klinische Sozialarbeit mit traumatisierten Flüchtlingen [New Perspectives—Clinical social work with traumatized refugees.] In S. Gahleitner & G. Hahn (Eds.), Übergänge gestalten, Lebenskrisen begleiten (pp. 305-323). Bonn: Psychiatrie Verlag.

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., . . . Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review, 58*(Supplement C), 1-15. http://doi.org/10.1016/j.cpr.2017.09.001

Brune, M., Eiroa-Orosa, F. J., Fischer-Ortman, J., & Haasen, C. (2014). Effectiveness of psychotherapy for traumatized refugees without a secure residency status. *International Journal of Migration, Health and Social Care, 10*(1), 52-59. http://doi.org/10.1108/IJMHSC-07-2013-0022

Bundesamt für Migration und Flüchtlinge [German Federal Agency of Migration and Refugees]. (2017). *Das Bundesamt in Zahlen 2016. Asyl [The Federal Office in figures 2016. Asylum]*. https://www.bamf.de/SharedDocs/Anlagen/DE/Publikationen/Broschueren/bundesamt-in-zahlen-2016.pdf?__blob=publicationFile

Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BafF e.V) [German Network of Rehabilitation Centres for Refugees and Survivors of Torture]. (2016). *Versorgungsbericht zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland (3. Auflage) [Report on the Psychosocial Care of Refugees and Torture Victims in Germany]*. http://www.baff-zentren.org/wp-content/uploads/2017/02/Versorgungsbericht_3-Auflage_BAfF.pdf

Butollo, W., & Maragkos, M. (2012). *Gutachterstelle zur Erkennung psychischer Störungen bei Asylbewerbern* [Auditor for the detection of mental disorders in asylum seekers.] http://www.pgasyl.de/cms/images/stories/PGAsyl/abschlussbericht%20lmu%20endfassung%2017.12.2012.pdf

Carlsson, J. M., Mortensen, E. L., & Kastrup, M. (2005). A Follow-Up Study of Mental Health and Health-Related Quality of Life in Tortured Refugees in Multidisciplinary Treatment. *Journal of Nervous and Mental Disease, 193*(10), 651-657. http://doi.org/10.1097/01.nmd.0000180739.79884.10

Chung, M. C., Shakra, M., AlQarni, N., AlMazrouei, M., Al Mazrouei, S., & Al Hashimi, S. (2018). Posttraumatic Stress Among Syrian Refugees: Trauma Exposure Characteristics, Trauma Centrality, and Emotional Suppression. *Psychiatry*, 1-17. http://doi.org/10.1080/00332747.2017.1354620

CIR Rifugiati. (2017). *Time for needs: Listening, healing, protecting*. https://www.ueberleben.org/wp-content/uploads/2017/10/Report_TIME-FOR-NEEDS_CIR.pdf

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York: Academic Press.

de Heus, A., Hengst, S. M. C., de la Rie, S. M., Djelantik, A. A. A. M. J., Boelen, P. A., & Smid, G. E. (2017). Day patient treatment for traumatic grief: Preliminary evaluation of a one-year treatment programme for patients with multiple and traumatic losses. *European Journal of Psychotraumatology, 8*(1). http://doi.org/10.1080/20008198.2017.1375335

European Union. (2013). *Directive 2013/33/EU of the European Parliament and the Council of 26 June 2013*. Brussels: Official Journal of the European Union, 29.6.2013 (L 180/96)

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, 365*(9467), 1309-1314. http://doi.org/10.1016/S0140-6736(05)61027-6

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* (pp. 3-28). Baltimore, MD, US: The Sidran Press.

Flatten, G., Gast, U., Hofmann, A., Knaevelsrud, C., Lampe, A., Liebermann, P., Maercker, A., Reddemann, L., Wöllern, W. (2011). S3–LEITLINIE Posttraumatische Belastungsstörung ICD-10: F43. 1 [S3–Guidelines Posttraumatic stress disorder ICD-10: F43.1]. *Trauma und Gewalt, 5*(3), 202-210.

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*(4), 445-451. http://doi.org/10.1037/1040-3590.9.4.445

Führer, A., Eichner, F., & Stang, A. (2016). Morbidity of asylum seekers in a medium-sized

German city. *European Journal of Epidemiology*, 1-4. http://doi.org/10.1007/s10654-016-0148-4

Gäbel, U., Ruf, M., Schauer, M., Odenwald, M., & Neuner, F. (2006). Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis [Prevalence of posttraumatic stress disorder (PTSD) and ways of identification in asylum procedures practice]. *Zeitschrift für Klinische Psychologie und Psychotherapie, 35*(1), 12-20. http://doi.org/10.1026/1616-3443.35.1.12

Gissendanner, S., Callies, I., Schmid-Ott, G., & Behrens, K. (2013). Migrantinnen und Migranten zwischen Trauma und Traumabewältigung. Implikationen aus Migrationssoziologie und interkultureller Psychotherapie für die psychiatrische, psychosomatische und psychotherapeutische Behandlungspraxis [Migrants between trauma and trauma coping. Implications of migration sociology and intercultural psychotherapy for psychiatric, psychosomatic and psychotherapeutic treatment practice]. In R. E. Feldmann & G. H. Seidler (Eds.), *Traum(a) Migration. Aktuelle Konzepte zur Therapie traumatisierter Flüchtlinge und Folteropfer* (pp. 61-80). Gießen: Psychosozial-Verlag.

Guillemin, F., Bombardier, C., & Beaton, D. (1993). Cross-cultural adaptation of health-related quality of life measures: Literature review and proposed guidelines. *Journal of Clinical Epidemiology, 46*(12), 1417-1432. http://doi.org/10.1016/0895-4356(93)90142-N

Gurris, N. F., & Wenk-Ansohn, M. (2013). Folteropfer und Opfer politischer Gewalt [Victims of torture and victims of political violence.] In: A. Maercker (Ed.), *Posttraumatische Belastungsstörungen* (4th ed., pp. 525-574). Berlin & Heidelberg: Springer.

Haagen, J. F. G., Smid, G. E., Knipscheer, J. W., & Kleber, R. J. (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review, 40*, 184-194. https://doi.org/10.1016/j.cpr.2015.06.008

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391. doi:10.1002/jts.2490050305

Inter-Agency Standing Committee. (2007). *IASC Guidelines for mental health and psychosocial support in emergency settings*.

Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of Counseling Psychology, 62*(1), 28-37. http://doi.org/10.1037/cou0000048

Leisering, B. (2018). *Geflüchtete Menschen mit Behinderungen: Handlungsnotwendigkeiten für eine bedarfsgerechte Aufnahme in Deutschland [Refugees with disabilities: Need for action for needs-based admission in Germany]*. https://www.institut-fuer-menschenrechte.de/fileadmin/user_upload/Publikationen/POSITION/Position_16_Gefluechtete_mit_Behinderungen.pdf

Maier, T., & Schnyder, U. (2007). *Psychotherapie mit Folter-und Kriegsopfern: Ein praktisches Handbuch [Psychotherapy with Torture and Victims of War: A Practical Handbook]*. Bern: Hans Huber/Hogrefe.

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine, 70*(1), 7-16. http://doi.org/10.1016/j.socscimed.2009.09.029

Mollica, R. F., Caspiyavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic-stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease, 180*(2), 111-116. http://doi.org/10.1097/00005053-199202000-00008

Mollica, R. F., Wyshak, G., Lavelle, J., Truong, T., Tor, S., & Yang, T. (1990). Assessing symptom change in Southeast Asian refugee survivors of mass violence and torture. *The American Journal of Psychiatry, 147*(1), 83-88. http://doi.org/10.1176/ajp.147.1.83

National Institute for Health and Care Excellence (NICE). (2005). *Post-traumatic stress disorder: Management. Clinical guideline.* (Vol. cg26). London: National Institute for Health and Care Excellence.

Nickerson, A., Schick, M., Schnyder, U., Bryant, R. A., & Morina, N. (2017). Comorbidity of Posttraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees. *Journal of Traumatic Stress, 30*(4), 409-415. http://doi.org/10.1002/jts.22205

Nickerson, A., Steel, Z., Bryant, R., Brooks, R., & Silove, D. (2011). Change in visa status amongst Mandaean refugees: relationship to psychological symptoms and living difficulties. *Psychiatry Research, 187*(1), 267-274. doi:10.1016/j.psychres.2010.12.015

Pabst, A., Gerigk, U., Erdag, S., & Paulsen, G. (2013). Ein multiprofessionelles Behandlungsangebot für psychisch erkrankte Flüchtlinge [A multiprofessional treatment program for mentally ill refugees.] In: R. E. Feldmann & G. H. Seidler (Eds.), *Traum(a)*

Migration. Aktuelle Konzepte zur Therapie traumatisierter Flüchtlinge und Folteropfer. (pp. 115-136). Gießen: Psychosozial-Verlag.

Palic, S., & Elklit, A. (2009). An explorative outcome study of CBT-based multidisciplinary treatment in a diverse group of refugees from a Danish treatment centre for rehabilitation of traumatized refugees. *Torture 19*(3), 248-270.

Priebe, S., Giacco, D., & El-Nagib, R. (2016). *Public health aspects of mental health among migrants and refugees: A review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region*.

Richter, K., Lehfeld, H., & Niklewski, G. (2015). Warten auf Asyl: Psychiatrische Diagnosen in der zentralen Aufnahmeeinrichtung in Bayern [Waiting for asylum: Psychiatric diagnosis in Bavarian admission center]. *Gesundheitswesen, 77*(11), 834–838. http://doi.org/10.1055/s-0035-1564075

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd ed.). Cambridge: Hogrefe Publishing & Huber Publishing.

Schock, K., Böttche, M., Rosner, R., Wenk-Ansohn, M., & Knaevelsrud, C. (2016). Impact of new traumatic or stressful life events on pre-existing PTSD in traumatized refugees: results of a longitudinal study. *European Journal of Psychotraumatology, 7*(1), 32106. http://doi.org/10.3402/ejpt.v7.32106

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179-187. doi:10.1111/j.1440-1614.2006.01766.x

Selmo, P., Koch, T., Brand, J., Wagner, B., & Knaevelsrud, C. (2016). Psychometric properties of the online Arabic versions of BDI-II, HSCL-25, and PDS. *European Journal of Psychological Assessment, 0*(0), 1-9. http://doi.org/10.1027/1015-5759/a000367

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry, 16*(2), 130-139. http://doi.org/10.1002/wps.20438

Sjölund, B. H., Kastrup, M., Montgomery, E., & Persson, A. L. (2009). Rehabilitating torture survivors. *Journal of Rehabilitation Medicine, 41*(9), 689-696. http://doi.org/10.2340/16501977-0426

Slewa-Younan, S., Uribe Guajardo, M. G., Heriseanu, A., & Hasan, T. (2015). A Systematic Review of Post-traumatic Stress Disorder and Depression Amongst Iraqi Refugees Located in Western Countries. *Journal of Immigrant and Minority Health, 17*(4), 1231-1239. http://doi.org/10.1007/s10903-014-0046-3

Stammel, N., Knaevelsrud, C., Schock, K., Walther, L. C. S., Wenk-Ansohn, M., & Böttche, M. (2017). Multidisciplinary treatment for traumatized refugees in a naturalistic setting: symptom courses and predictors. *European Journal of Psychotraumatology, 8*(sup2), 1377552. http://doi.org/10.1080/20008198.2017.1377552

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA, 302*(5), 537-549. http://doi.org/10.1001/jama.2009.1132

Tabachnick, B. G., & Fidell, L. S. (2001). Missing data. In B. G. Tabachnick & L. S. Fidell (Eds.), *Using multivariate statistics* (pp. 62-72). Boston: Pearson Education.

Tinghög, P., Malm, A., Arwidson, C., Sigvardsdotter, E., Lundin, A., & Saboonchi, F. (2017). Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey. *BMJ Open, 7*, e018899. http://doi.org/10.1136/bmjopen-2017-018899

UNHCR. (2016). *Global Trends. Forced Displacement in 2015*. http://www.unhcr.org/576408cd7.pdf

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. Bosten, MA: National Center for PTSD.

Wenk-Ansohn, M. (2017). Akutversorgung und traumaorientierte Langzeitbehandlung bei traumatisierten und psychisch belasteten Geflüchteten [Acute care and trauma-oriented long-term treatment in traumatized and psychologically disstressed refugees]. In A. Liedl, M. Böttche, B. Abdallah-Steinkopf, & C. Knaevelsrud (Eds.), *Psychotherapie mit Flüchtlingen, Neue Herausforderungen, spezifische Bedürfnisse, das Praxisbuch für Psychotherapeuten und Ärzte* (pp. 147-162). Stuttgart: Schattauer.

Wenk-Ansohn, M., Weber-Nelson, C., Hoppmann, F., & Ahrndt, A. (2014). Behandlung und Rehabilitation von Folterüueberlebenden und Kriegstraumatisierten [Treatment and rehabilitation of torture survivors and individuals traumatized by war]. *Psychosozial, 37*(4), 55-74.

Satisfaction of trauma-affected refugees treated with antidepressants and Cognitive Behavioural Therapy

Caecilie Böck Buhmann, MD, PhD*, Jessica Carlsson MD, PhD*, Erik Lykke Mortensen, MSc**

Key points of interest:

- A western model based on cognitive behavioral therapy was found satisfactory by bi-cultural patients, who have lived in Denmark for more than a decade.
- Satisfaction was not associated with treatment outcome, but with the patients' own interpretation of whether their condition had improved due to treatment.

Abstract

Purpose: This study seeks to evaluate the satisfaction of trauma-affected refugees after treatment with antidepressants, psycho-education and flexible Cognitive Behavioral Therapy (CBT) including trauma exposure. **Material and methods:** A treatment satisfaction questionnaire was completed by patients at the end of a randomised controlled trial (RCT) comparing treatment with CBT and antidepressants. A patient satisfaction score was developed based on the questionnaire, and predictors of satisfaction were analysed in regression models. Telephone interviews were conducted with patients dropping out of treatment before the end of the trial. **Results:** In total, 193 trauma-affected refugees with PTSD were included in the study. Patients were overall satisfied with flexible CBT including exposure treatment in cases where this was part of the treatment. There was no statistically significant association between treatment outcome and satisfaction and satisfaction and treatment efficacy were independent of each other. The results showed that bi-cultural patients who had lived in Denmark for more than a decade were satisfied with the treatment based on a western psychotherapy model. **Discussion:** Treatment with selective serotonin reuptake inhibitor and flexible CBT, including trauma exposure, is acceptable for trauma-affected refugees. More studies are needed to evaluate patient satisfaction with western psychotherapy models in refugee patients who have recently arrived and to compare satisfaction with alternative treatment models.

Keywords: PTSD, trauma, refugee, cognitive behavioural therapy, treatment-satisfaction, anti-depressants

*) Competence Centre for Transcultural Psychiatry, Mental Health Centre Ballerup, Denmark
**) Department of Public Health and Center for Healthy Aging, University of Copenhagen, Denmark
Correspondence to:
caecilie.boeck.buhmann@regionh.dk

Background and aims

There are an estimated 60 million refugees and internally displaced persons worldwide and in 2015, UNCHR estimated that 3.5 million of these are in Europe. Refugees and asylum seekers suffer from diverse mental health problems such as PTSD and depression (Steel et al., 2009). Recommended treatments of these trauma-related conditions are Selective Serotonin Reuptake-Inhibitors (SSRI) and Trauma-Focused Cognitive Behavioural Therapy (TFCBT) (Bisson, 2009; Stein, 2009). Nevertheless, only a few evaluations of the effect of these standard treatments for trauma-affected refugees have been carried out (Crumlish & O'Rourke, 2010; Nickerson, Bryant, Silove, & Steel, 2011; Palic & Elklit, 2011). TFCBT involves the use of prolonged exposure, which is when the patient assisted by the therapist and in homework, repeatedly recounts the traumatic events or listens to a recorded narrative of the traumatic event (Foa, Hembree, & Rothbaum, 2007). This treatment has received some attention in qualitative studies describing the patient experience of the treatment and its acceptability. The studies suggest that prolonged exposure is as acceptable as treatment with sertraline (Chen, Keller, Zoellner, & Feeny, 2013) and in some cases preferred over sertraline (Kehle-Forbes, Polusny, Erbes, & Gerould, 2014). However, it is a challenge to ensure patient compliance with treatment (Shearing, Lee, & Clohessy, 2011) even in non-refugee patient samples (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Only a few studies have examined acceptability of these treatments amongst trauma-affected refugees and asylum seekers despite the challenge of applying psychotherapy to patients with diverse cultural backgrounds (Silove et al., 1997; Vincent, Jenkins, Larkin, & Clohessy, 2013). Two qualitative studies have examined the meaning of illness and expectations for treatment amongst trauma-affected refugees (Maier & Straub, 2011; Vincent et al., 2013), but no studies specifically investigate the patient satisfaction with TFCBT offered in a Western setting. Evaluating patient satisfaction is further complicated by the lack of consensus of a theoretical framework on patient satisfaction (Batbaatar, Dorjdagva, Luvsannyam, Savino, & Amenta, 2017). In the absence of actual patient satisfaction studies, drop-out rates can be examined, but drop-out rates are generally reported inconsistently in studies of trauma-focused treatment (Schottenbauer et al., 2008). This is also the case in studies on the treatment of trauma-affected refugees where drop-out rates vary from 0% in small studies to 30% in others (Palic & Elklit, 2011). The physiological response to pharmacological treatment may also be different among patients with different ethnic backgrounds as there is evidence of diversity on pharmacokinetics and pharmacodynamics (Noerregaard, 2012; Sonne, Carlsson, Bech, & Mortensen, 2016). The aim of the present study was to examine satisfaction with the treatment offered among trauma-affected refugees and to identify predictors of treatment satisfaction. The treatment offered consisted of CBT including trauma exposure, psychoeducation and sertraline. Our hypothesis was that satisfaction may be influenced by the patients' country of origin and religion as proxies for their cultural background. In addition, we hypothesised that the need of translation and the use of exposure during treatment might affect satisfaction.

The satisfaction study was conducted as part of a RCT evaluating the effectiveness of the administered treatments on PTSD in

a population of trauma-affected refugees in Denmark. The RCT showed no effect on PTSD symptoms, no effect of psychotherapy and no interaction between psychotherapy and medicine. A small but significant effect of treatment with antidepressants and psychoeducation was found on depression (Buhmann, Nordentoft, Ekstroem, Carlsson, & Mortensen, 2016).

Method

Trial design

The satisfaction survey was a part of a pragmatic randomised controlled 2x2 factorial trial. Randomisation meant that the treatment received did not reflect patient preferences. Patients were allocated to treatment with psychoeducation and antidepressants, or CBT with a trauma exposure component, or a combination of psychoeducation, CBT and antidepressants or to a waiting list. Patients randomised to the waiting list received a combination treatment after waiting for six months and completed the satisfaction survey afterwards. Thereby, the patients who participated in this study all received treatment with either medicine, CBT or a combination of the two, but some of the patients had been waiting six months before they started treatment (Buhmann et al., 2016).

Participants

Participants had to be 18 years or older and had to be refugees or a family member reunified with a refugee. Furthermore, participants had to have PTSD according to the ICD-10 research diagnostic criteria, and to have a history of war-related psychological trauma such as imprisonment, torture, inhuman and degrading treatment or punishment, organised violence, prolonged political persecution and harassment or war. Of these, 42% were torture survivors according to the UNCAT definition of torture. Additionally, the participants had to be motivated to receive treatment and to give written, voluntary informed consent. Potential participants were excluded if they had a severe psychotic disorder (ICD-10 diagnosis F2x and F30.1-F31.9), were addicted to psychoactive substances (ICD-10 F1x.24-F1x.26), had a need of somatic or psychiatric hospitalisation, or were pregnant or breastfeeding.

All data were collected at the Competence Centre for Transcultural Psychiatry (henceforth called CTP), which is part of the public mental health care services of the greater Copenhagen area in Denmark. CTP offers outpatient treatment specifically to immigrants and refugees with mental health problems and specialises in treating patients with trauma related to war, torture or persecution (Carlsson, Sonne, & Silove, 2014). The trial ran from June 2009 until December 2012. In total, 380 patients were screened, 280 patients were included in the trial and 217 completed the trial, and of these, 193 answered the satisfaction questionnaire and were included in the current analyses. Translation services were provided during assessment and treatment consultations on an as-needed basis (which was the case for 54% of the patients). All of the interpreters were associated with CTP and had experience in translating rating scales, psychotherapy and psychoeducational sessions.

Interventions

Psychopharmacological treatment consisted of sertraline in doses of 25-200 mgs. For patients reporting problems sleeping, the pharmacological treatment was supplemented with mianserin in doses of 10-30 mgs at night. Psychoeducation was provided by the medical doctor and

covered the illness, treatment, sleep, life-style (including relaxation-exercises), physical activity and social relations, pain, cognitive function, and the influence of the illness on the family. The CBT was manualised and included core CBT methods, methods from acceptance and commitment therapy (ACT), mindfulness exercises and in-vivo and visualised exposure (TFCBT). The psychotherapy methods were flexibly applied from the manual and not all methods were used with all patients. We have therefore chosen to use the term "flexible CBT" to describe the treatment. Of the 193 participants in the study, only 37 participants received treatment with trauma-focused exposure (either interoceptive exposure or visualised exposure). The trauma-focused exposures were repeated on average twice and therefore did not amount to a sufficient number of repetitions for it to be termed "prolonged exposure". The patient population at CTP is multicultural, and it was therefore not feasible to make specific cultural adaptations in the manual. However, the manual allowed for flexible use of methods and the cultural background of the individual patient was taken into consideration in the individualised version of psychotherapy. The psychotherapy has been described in detail elsewhere (Buhmann, et al., 2015).

Outcome measures

The outcome measures of the trial included:

- Self-rated PTSD severity (Harvard Trauma Questionnaire's symptom part IV, HTQ) (Kleijn, Hovens, & Rodenburg, 2001; Mollica et al., 1992; Mollica, Wyshak, de, Khuon, & Lavelle, 1987).
- Self-rated symptoms of depression and anxiety (Hopkin's Symptom Checklist-25, HSCL-25) (Kleijn et al., 2001; Mollica et al., 1992; Mollica et al., 1987; Oruc et al., 2008).
- Blinded observer-rated symptoms of depression and anxiety (Hamilton depression and anxiety scales, Ham-D & Ham-A) (Hamilton, 1959, 1960).
- Self-rated somatic symptoms (Symptom Check List-90, SCL-90) (Derogatis, 1994).
- Pain (visual analogue scales, VAS, for headache, backache, pain in the arms and pain in the legs (Olsen, 2007), which were combined to a composite pain-score.
- Self-rated level of functioning (Sheehan Disability Scale, SDS) (Lam, Michalak, & Swinson, 2005; Sheehan & Sheehan, 2008).
- Self-rated quality of life (WHO-5) (Bech, 2012).

The ratings have been described in detail elsewhere (Buhman et al., 2014; 2015; 2016). Ratings were completed at pre-trial assessment and at the end of treatment. All self-report questionnaires were available in the six most common languages at CTP (Arabic, Farsi, Bosnian/Serbo-Croatian, Russian, Danish and English), which included the languages of 85% of patients. If no translation was available, an interpreter translated the official version into the language of the patient.

The patient satisfaction questionnaire: A questionnaire exploring the patients' view of the treatment and the centre was developed specifically to be used at CTP. There is no accepted gold standard for the content of satisfaction surveys. When developing items for the present satisfaction questionnaire, we were inspired by literature on the topic, a template for a satisfaction survey used elsewhere in Danish mental health care as well as our clinical experience working with trauma-affected refugees. The questionnaire

was constructed to reflect the patient's treatment experience with a broad focus on the content of the service provided, the service providers as well as the cultural understanding in the clinic. Of all the items in the questionnaire, only 10 items were specifically related to satisfaction. The questions covered the patient's satisfaction with the contact to the medical doctor, social worker and psychologist at CTP, satisfaction with the different treatment modalities and satisfaction with the understanding of the patient's cultural background at CTP. The ten items were used to construct a satisfaction score. Each question was of a 1- 4 Likert type format (see Table 2). Score 1-2 were "not at all" and "only to some degree" and score 3-4 were "to a certain degree" and "to a high degree". Thereby the total of the satisfaction score ranged from 10–40. Missing items were assigned the participant's mean value of the other items of the scale. Cronbach's alpha for the scale was 0.88. The questionnaire was completed at the end of treatment without the presence of a therapist or medical doctor from CTP. Patients were encouraged to complete the questionnaire before leaving CTP at their last appointment. The questionnaire was translated to the same six languages as the outcome ratings and if needed, translation was provided in person. If patients did not show up for their last appointment, the questionnaire was mailed with a stamped return envelope.

Drop-out interviews

Of the 280 patients included in the trial, 63 patients did not finish the trial. Of these, 43 were withdrawn as they did not continue to meet the inclusion criteria and 20 patients dropped out. If patients dropped out of treatment, they were contacted by a secretary by phone and asked about the reasons for dropping out. The choice of interviewer was deliberately to prevent patients feeling pressured to give positive responses to a therapist they knew. Formal answer categories included lack of effect of treatment, inconvenience, transport costs, cultural differences, other obligations, lack of energy, lack of respect, psychotherapy or medicine unacceptable, feeling better, leaving the country or other reasons. Patients who dropped out were also encouraged to fill out the satisfaction questionnaire, which was mailed to their home address with a stamped return envelope, but none were returned.

Data analysis

The association between satisfaction score and the change from pre- to post-treatment (difference scores) was analysed by univariate linear regression models (see Table 3). Following this, a linear regression model was generated with the satisfaction score as outcome and including difference scores for ratings that were significantly associated with satisfaction in the univariate models as predictors in addition to other potential predictors of satisfaction (age, gender, trauma exposure in treatment, religion, country of origin and the need of translation). All analyses were made in STATA 12 & 13 (StataCorp LP, College Station, TX, USA).

Results

Description of patient sample

Of the 217 trial patients, 193 patients responded and completed the satisfaction questionnaire. Differences between respondents and non-respondents with regard to age, gender, religion, country of origin, trauma, use of trauma exposure in treatment and score on outcome ratings at baseline and follow-up were analysed with

paired t-tests and chi2-test. The responders were slightly older and had a slightly better level of functioning measured on SDS, but otherwise there were no differences between responders and non-responders. A summary of the socio-demographic information and information about the treatment of the participants is presented in Table 1.

Patient satisfaction

The responses to the 10 questions in the satisfaction score are summarised in Table 2. The sum of the scale was 34.0 (SD 5.7). The theoretical maximum was 40. The mean score on each item ranged from 2.9 to 3.7 on a scale from 1 to 4 with 4 corresponding to most satisfied. When condensing the

Table 1: *Baseline description of patients (N=193 unless otherwise specified)*

Background	**N (%) or Mean (sd)**		**N (%) or Mean (sd)**
Sex (male)	113 (59)	***Previous psychiatric treatment***	
Country of origin		***Any prior psychiatric treatment***	155 (80)
Iraq	68 (35)	***Needs translation for treatment***	105 (54)
Iran	26 (13)		**Mean (sd)**
Lebanon	22 (11)	***Age***	45 (9)
Ex-Yugoslavia	31 (16)	***Years since arrival in Denmark***	15 (6)
Afghanistan	19 (10)	***Treatment***	
Other	27 (14)	Duration of treatment (months)	6.0 (1.3)
Religion (Muslim) (N=184)	141 (77)	No. of sessions with psychologist	9 (6)
Trauma history		***Randomization group***	**N (%)**
Torture (N=190)	80 (42)	Antidepressants and CBT	91 (47)
Ex-combatant (N=191)	46 (24)	Antidepressants	54 (28)
Socioeconomic		CBT	48 (25)
Currently employed (N=121)	17 (14)	***Psychopharmacological treatment***	
Never employed (N=172)	33 (19)	Sertraline	136 (70)
No education (N=185)	6 (3)	Mianserin	121 (63)
Married (N=187)	100 (53)	***Psychotherapy***	
Has children (N=187)	163 (87)	Have been treated with exposure	37 (19)
Mental health condition		Discomfort due to therapy	13 (7)
Depression	181 (94)	***Patient perceived outcome of treatment (N=111)***	
Personality Change after Catastrophic Events (F62.0)	55 (29)	Condition improved due to treatment	97 (87)
Psychotic during treatment	16 (8)	Condition worsened due to treatment	1 (1)
In treatment for somatic symptoms	75 (39)	Condition improved due to other factors than treatment	13 (12)

Table 2: *Treatment satisfaction score items*

Scale item	N	Mean (sd) (1-4)	Satisfied N (%)
Were you satisfied with the contact with the administrative staff?	189	3.7 (0.6)	182 (96)
Did you receive the information about your illness and the treatment that you needed?	184	3.4 (0.8)	158 (86)
Were you generally satisfied with the contact with the doctor at CTP?	188	3.7 (0.6)	181 (96)
Were you generally satisfied with the contact with the psychologist at CTP?	175	3.7 (0.6)	169 (97)
Were you generally satisfied with the contact with the social worker at CTP?	174	3.5 (0.7)	158 (91)
Were you satisfied with the influence you had on your treatment at CTP?	176	3.4 (0.8)	157 (89)
Do you feel there was an understanding of your cultural background at CTP?	168	3.4 (0.8)	149 (89)
Were you satisfied with the psychotherapy treatment?	167	3.3 (0.8)	142 (85)
Were you satisfied with the drug treatment?	154	2.9 (1.0)	106 (69)
Did you find the treatment at CTP worth your time and efforts?	167	3.1 (1.0)	135 (81)
Sum score satisfaction score (10-40)		**34.0 (5.7)**	

response scale by combing categories 1 and 2 ("not at all" and "only to some degree") and categories 3 and 4 ("to a certain degree" and "to a high degree") to "not satisfied" vs. "satisfied", the vast majority of patients were satisfied with the treatment. The range of satisfaction was from 69% satisfaction with pharmacological treatment to 96-97% satisfaction with the medical doctor, the psychologist and the administrative staff. There was a high rate of satisfaction (89%) with the understanding of the patient's cultural background. In the univariate linear regression models, a small but significant association was found between satisfaction and difference score on HTQ, HSCL-25, SDS and VAS-score (see Table 3) and between the patient's self-rated evaluation of treatment effect and satisfaction. In the linear regression model, including the significant difference scores and various predictors, a significant association between being Muslim and lower satisfaction scores (reg. coeff.=-3.1, p=0.02) was found, whereas the difference scores did not remain significant in this model. If the patient's self-evaluated perceived outcome of treatment was included in the model, the effect of being Muslim was no longer significant (reg. coeff.=-2.4, p=0.07), whereas a self-evaluated positive outcome was significantly associated with satisfaction (reg. coeff=-3.9, p<0.01). We did not find a significant association between satisfaction and the use of trauma exposure in treatment or between satisfaction and the need for translation or country of origin.

Drop-out interviews

Of the 20 patients who dropped out of treatment, 14 were interviewed about their reasons for dropping out. The reasons

Table 3: *Change in outcome ratings from baseline to post-treatment and results of univariate linear regression models of satisfaction score and change in rating*

Rating	N	Mean change in score pre- to post-treatment (SD)	Linear regression coefficient (95%-confidence interval)	p-value
HTQ	181	0.1 (0.6)	-1.7 (-3.0 to -0.5)	<0.01
HSCL-25	181	0.1 (0.7)	-1.4 (-2.6 to -0.2)	0.03
Ham-D	164	0.7 (6.5)	-0.1 (-0.2 to 0.0)	0.10
Ham-A	157	0.4 (8.5)	-0.0 (-0.1 to 0.1)	0.45
SCL-90	177	-0.1 (0.8)	-0.8 (-1.8 to 0.3)	0.16
SDS	176	0.1 (2.2)	-0.5 (-0.9 to -0.2)	<0.01
WHO-5	177	3.8 (18.5)	0.0 (0.0 to 0.1)	0.78
VAS pain score	176	0.5 (7.8)	-0.1 (-0.2 to 0.0)	0.01

mentioned for drop-out were inconvenience (4 patients), lack of energy (4 patients), other obligations (4 patients), lack of treatment effect (2 patients), transportation difficulties (2 patients) and having left the country (2 patients). When asked directly, no patient confirmed that psychotherapy, pharmacological treatment, lack of respect or lack of understanding of their culture had influenced their choice to leave treatment. The 43 patients who did not complete treatment because they were withdrawn from the trial were not interviewed. They were withdrawn because the patient did not meet the inclusion criteria.

Discussion

In this quantitative study of patient satisfaction amongst trauma-affected refugees in treatment with flexible CBT and antidepressants, we found high general satisfaction with the treatment. Furthermore, 89% of patients reported that they were satisfied with the cultural understanding they had encountered at CTP and no patients dropped out of treatment because they felt their culture was not considered sufficiently in the treatment. In the linear regression model, we found an association between satisfaction and being a Muslim (compared to non-Muslims), although this effect disappeared when self-evaluated treatment outcome was included in the model. No association between country of origin or the need of translation and satisfaction was found. Patients were generally very satisfied with the medical as well as the psychotherapeutic treatment, and no association between satisfaction and the use of trauma exposure in treatment was found. Although we found limited effect of treatment on PTSD in the original trial as measured by the outcome variables (C. B. Buhmann et al., 2016), the patients were generally satisfied with the treatment they received.

A striking result is that patients were satisfied despite relatively small treatment effects in the trial. Satisfaction was not associated with changes in self-report rating scales on symptoms, quality of life and level of functioning, including the HTQ primary outcome variable, or on observer ratings, including the Hamilton scales. Nevertheless, satisfaction was associated with the patient's

self-evaluated positive or negative effect of treatment (when asked directly whether they experienced that their condition had improved and whether this was associated with treatment or other factors). This could indicate that satisfaction is an independent outcome in itself. The results may be influenced by the trial excluding patients who were openly not interested in receiving treatment. However, most studies require informed consent and would therefore exclude patients, who did not wish to receive a given treatment. In our case, only five out of 380 patients screened for the trial were deemed not motivated.

One of our aims was to examine whether sociodemographic factors like country of origin, need for translation, and religion were associated with satisfaction with treatment. When working with patients from a different cultural context, it cannot be expected that treatment to be as acceptable as in studies with non-refugee patients from a Western country of origin. There is therefore an urgent need to explore the acceptability of standard PTSD treatments in transcultural patient populations.
Few studies have looked specifically at satisfaction amongst trauma-affected refugee patients in a Western treatment setting. An Australian study comparing satisfaction among refugees with general mental health services and specialised services for trauma-affected refugees found that there was an overall higher satisfaction with specialised services, but also that patients who were more fluent in English were less satisfied with treatment in either treatment setting (Silove et al., 1997). Another study has found that language is the most important barrier to treatment (Maier & Straub, 2011). Our results point in a different direction. Culture was not mentioned as a reason for drop-out despite the fact that the psychotherapy was only culturally adapted to the extent that the flexible manual allowed general adjustment of therapy to the individual patient's problems and understanding. However, although the direct answers in the satisfaction questionnaire suggest that patients did not experience culture as a barrier, they may have underreported dissatisfaction out of politeness. In addition to this, we found lower satisfaction amongst Muslims, which could also suggest that the treatment is more suited for people of Western background. On the other hand, patients had been in Denmark on average 14 years at the time of the study and therefore cultural differences may play a smaller role than in newly arrived refugees, because participants could have adapted to Danish culture to some extent. Despite this, half of the patients needed translation, which points to cultural isolation given the long period they have been staying in the country.

The results do not confirm that trauma exposure in treatment influences patient satisfaction. However, the study may not have been able to evaluate the satisfaction with trauma exposure therapy properly, as only 27% of patients in psychotherapy received trauma exposure therapy of any kind and only 20% of patients received trauma-focused exposure. Although the reasons for this have not been systematically studied, the psychologists' impression was that this was mostly due to resistance towards the treatment amongst the patients. In other populations, whilst it has been difficult to motivate patients to have trauma exposure treatment, those who have experienced trauma exposure seem to be satisfied with the treatment, and effect studies on other populations show that this is the most effective treatment for trauma-related disorders. For example, despite prolonged

trauma exposure being the recommended treatment in the department of Veteran Affairs in the U.S., only 1.5% of the patients undergo a full trauma exposure treatment (Shiner, 2012). Studies have found that the therapeutic relationship and proper preparation of the trauma exposure in therapy, including explaining the method to the patients and positive previous patient experience with trauma exposure, is important (Chen et al., 2013; Kehle-Forbes et al., 2014; Shearing et al., 2011). Satisfaction scores are often related more to patients' appreciation of the therapists and nonspecific aspects of treatment than they are to any demonstrated gains from treatment (Batbaatar et al., 2017). This may explain why patients were generally very satisfied with treatment although the gains were limited on outcome measures in the trial.

Fewer patients were satisfied with pharmacological treatment than with psychotherapy in the satisfaction questionnaire. The difference in satisfaction between psychotherapy and medicine is limited. The difference could be explained by side effects as there was a high prevalence of side effects in the study population, and a significant proportion of patients (23%) had to stop treatment with sertraline or mianserin before the end of the trial due to side effects (Buhmann et al., 2016). This could reflect ethnic differences in pharmacodynamics (Noerregaard, 2012; Sonne et al., 2016).

The study had several limitations, which may also have influenced the results. Patients may have been biased by their relationship with the staff at CTP and the fact that an interpreter was sometimes present. For this reason, they might have rated higher levels of satisfaction out of politeness. This could have been addressed by further stressing that the questionnaire was voluntary and that answers did not have to be positive. Another limitation of the study is the lack of a qualitative element to elaborate on the findings, which makes it more difficult to interpret the results. It is furthermore unknown whether all patients understood the questions in the questionnaire, especially those who completed it without the help of an interpreter at home. Although our results indicate few differences in baseline characteristics and outcome between patients who completed the questionnaire and those who did not, we cannot rule out that non-respondents and drop-outs were less satisfied with treatment. The sample is small, which may have affected the predictor analyses as weak associations would have been difficult to detect. Finally, the scale is newly developed and has not been validated in other patient samples.

In conclusion, trauma-affected refugees were overall satisfied with the standard treatment for PTSD. The need of translation, country of origin or the use of trauma exposure in treatment were all unrelated to satisfaction, but an association was found between satisfaction and religion. However, satisfaction may be influenced by factors that were not assessed in this study and the answers given by the patients could have been influenced by politeness towards the clinic. This needs to be further explored.

Acknowledgements

We would like to thank all therapists and research workers at the CTP, who have made this paper possible and Sarah Musoni for proof reading.

Declaration of interests

The study was supported by the Mental Health Services of the Capital Region of Denmark and the Tryg Foundation. The authors report no conflicts of interest. The

authors alone are responsible for the content and writing of the paper.

References

Batbaatar, E., Dorjdagva, J., Luvsannyam, A., Savino, M. M., & Amenta, P. (2017). Determinants of patient satisfaction: a systematic review. *Perspect Public Health, 137*(2), 89-101. https://doi:10.1177/1757913916634136

Bech, P. (2012). *Clinical psychometrics*. Oxford: Wiley Blackwell.

Bisson, J., Andrew, M. (2009). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews 3*. https://doi.org10.1002/14651858. CD003388.pub4

Buhman, C., Mortensen, E. L., Lundstrom, S., Ryberg, J., Nordentoft, M., & Ekstrom, M. (2014). Symptoms, quality of life and level of functioning of traumatized refugees at psychiatric trauma clinic in Copenhagen. *Torture, 24*(1), 25-39.

Buhmann, C., Andersen, I., Mortensen, E. L., Ryberg, J., Nordentoft, M., & Ekstrom, M. (2015). Cognitive behavioral psychotherapeutic treatment at a psychiatric trauma clinic for refugees: description and evaluation. *Torture, 25*(1), 17-32.

Buhmann, C., Mortensen, E. L., Nordentoft, M., Ryberg, J., & Ekstrom, M. (2015). Follow-up study of the treatment outcomes at a psychiatric trauma clinic for refugees. *Torture, 25*(1), 1-16.

Buhmann, C. B., Nordentoft, M., Ekstroem, M., Carlsson, J., & Mortensen, E. L. (2016). The effect of flexible cognitive-behavioural therapy and medical treatment, including antidepressants on post-traumatic stress disorder and depression in traumatised refugees: pragmatic randomised controlled clinical trial. *Br J Psychiatry, 208*(3), 252-259. https://doi:10.1192/bjp.bp.114.150961

Carlsson, J., Sonne, C., & Silove, D. (2014). From pioneers to scientists: challenges in establishing evidence-gathering models in torture and trauma mental health services for refugees. *J Nerv Ment Dis, 202*(9), 630-637. https://doi:10.1097/NMD.0000000000000175

Chen, J. A., Keller, S. M., Zoellner, L. A., & Feeny, N. C. (2013). "How will it help me?" Reasons underlying treatment preferences between sertraline and prolonged exposure in posttraumatic stress disorder. *J Nerv Ment Dis, 201*(8), 691-697. https://doi:10.1097/NMD.0b013e31829c50a9

Crumlish, N., & O'Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *J.Nerv.Ment.Dis., 198*(4), 237-251. https://doi:10.1097/NMD.0b013e3181d61258 [doi];00005053-201004000-00001 [pii]

Derogatis, L. R. (1994). *SCL-90-R: Symptom Checklist-90-R. Administration, scoring and procedures manual* (3rd ed.). Minnesota, USA: National Computer Systems.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007) Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide. Oxford, UK: Oxford University Press.

Hamilton, M. (1959). The assessment of anxiety states by rating. *Br J Med Psychol, 32*(1), 50-55.

Hamilton, M. (1960). A rating scale for depression. *J Neurol Neurosurg Psychiatry, 23*, 56-62. http://dx.doi.org/10.1136/jnnp.23.1.56

Kehle-Forbes, S. M., Polusny, M. A., Erbes, C. R., & Gerould, H. (2014). Acceptability of prolonged exposure therapy among U.S. Iraq war veterans with PTSD symptomology. *J Trauma Stress, 27*(4), 483-487. https://doi:10.1002/jts.21935

Kleijn, W. C., Hovens, J. E., & Rodenburg, J. J. (2001). Posttraumatic stress symptoms in refugees: assessments with the Harvard Trauma Questionnaire and the Hopkins symptom Checklist-25 in different languages. *Psychol. Rep., 88*(2), 527-532. https://doi.org/10.2466/pr0.2001.88.2.527

Lam, R. W., Michalak, E. E., & Swinson, R. P. (2005). *Assessment scales in depression, mania and anxiety*. London: Taylor & Francis.

Maier, T., & Straub, M. (2011). "My head is like a bag full of rubbish": concepts of illness and treatment expectations in traumatized migrants. *Qual Health Res, 21*(2), 233-248. https://doi:10.1177/1049732310383867

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis, 180*(2), 111-116. http://psycnet.apa.org/doi/10.1097/00005053-199202000-00008

Mollica, R. F., Wyshak, G., de Marneffe, D., Khuon, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. *Am.J.Psychiatry, 144*(4), 497-500. https://doi.org/10.1176/ajp.144.4.497

Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clin Psychol Rev, 31*(3), 399-417. doi:10.1016/j.cpr.2010.10.004

Noerregaard, C. (2012). Kultur og biologi ved psyko-

farmakologisk behandling af etniske minoriteter. [Culture and biology in psychopharmacological treatment of ethnic minorities.] *Ugeskrift for laeger, 6*, 337–340.

Olsen, D. R., Montgomery,E., Boejholm,S., Foldspang,A. (2007). Prevalence of pain in the head, back and feet in refugees previously exposed to torture: A ten-year follow-up study. *Disability and Rehabilitation, 29*(2), 163-171. https://doi.org/10.1080/09638280600747645

Oruc, L., Kapetanovic, A., Pojskic, N., Culhane, M., Lavelle, J., Miley, K., Forstbauer, S., Mollica, RF & .Henderson, D.C. (2008). Screening for PTSD and depression in Bosnia and Herzegovina: validating the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. Int.J.Culture Ment.Health, 1(2), 105-17-133116.

Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult refugees: a systematic review of prospective treatment outcome studies and a critique. *J Affect Disord, 131*(1-3), 8-23. https://doi:10.1016/j.jad.2010.07.005

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: review and methodological considerations. *Psychiatry, 71*(2), 134-168. https://doi:10.1521/psyc.2008.71.2.134

Shearing, V., Lee, D., & Clohessy, S. (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for post-traumatic stress disorder? *Psychol Psychother, 84*(4), 458-475. https://doi:10.1111/j.2044-8341.2010.02012.x

Sheehan, K. H., & Sheehan, D. V. (2008). Assessing treatment effects in clinical trials with the discan metric of the Sheehan Disability Scale. *Int.Clin.Psychopharmacol., 23*(2), 70-83. https://doi:10.1097/YIC.0b013e3282f2b4d6 [doi];00004850-200803000-00002 [pii]

Shiner, B., D'Avolio L.W., Nguyen, T.M., Zayed, M.H., Young-Xu, Y., Desai, R.A., & Watts, B. (2013). Measuring use of evidence based psychotherapy for posttraumatic stress disorders. *Administration and Policy in Mental Health, 40*, 311-318. https://doi: 10.1007/s10488-012-0421-0

Silove, D., Manicavasagar, V., Beltran, R., Le, G., Nguyen, H., Phan, T., & Blaszczynski, A. (1997). Satisfaction of Vietnamese patients and their families with refugee and mainstream mental health services. *Psychiatr Serv, 48*(8), 1064-1069. https://doi.org/10.1176/ps.48.8.1064

Sonne, C., Carlsson, J., Bech, P., & Mortensen, E. L. (2017). Pharmacological treatment of refugees with trauma-related disorders: What do we know today? *Transcult Psychiat*ry, *54*(2):260-280. https://doi:10.1177/1363461516682180https://doi:10.1177/1363461516682180

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van, O. M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA, 302*(5), 537-549. https://doi.org/doi:10.1001/jama.2009.1132

Stein, D. J., Ipser,J.C., Seedat,S. (2009). Pharmacotherapy for post traumatic stress disorder (PTSD) *Cochrane Database of Systematic Reviews1: CD002795.* https://doi.org/10.1002/14651858.CD002795.pub2

Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: a qualitative study. *Behav Cogn Psychother, 41*(5), 579-593. https://doi:10.1017/S1352465812000550

Case report: The impact of torture on mental health in the narratives of two torture survivors

Simone M. de la Rie,*, Jannetta Bos,*,** Jeroen Knipscheer, *,**,***, Paul A. Boelen**,***

Key points of interest:

- The effects of NET may be improved by tailor-made or culturally sensitive interventions that address shame, guilt, disgust and cognitions about safety, trust, power, self-esteem, and intimacy.
- Building trust and taking time to pace the therapeutic process is particularly important when treating survivors of torture.

Abstract

Introduction: Torture survivors risk developing Posttraumatic Stress Disorder (PTSD) as well as other mental health problems. This clinical case study describes the impact of torture on two survivors who were treated for their PTSD with Narrative Exposure Therapy. **Method:** The reports of the narratives of two torture survivors were qualitatively analyzed. It was hypothesized that torture yields overaccommodating cognitions, as well as mental defeat, which in turn, are related to severity of psychological complaints. **Results:** Both patients have experienced an accumulation of traumatic events. The psychological and physical torture they experienced lead to increased anticipation anxiety, loss of control and feelings of hopelessness, as well as overaccommodating cognitions regarding self and others. **Conclusions:** Cognitions, culture and beliefs, as well as issues of confidence and a more long-term perspective affect therapeutic work. Building trust, pacing the therapeutic process, and applying tailor-made interventions that focus on cognitions regarding self-esteem, trust in relationships, as well as safety and control are warranted.

Keywords: Refugees, torture, PTSD, trauma, narrative exposure therapy

Introduction

> *It was so frightening to hear the footsteps from the guards in the corridor. What would happen? Who would be selected? We all shivered at the moment we heard these footsteps and the key turning in the lock.*

The account of Ahmed, a 40-year-old man from an Arab country in the Middle East, on his traumatic experiences in prison, is only one example of the horrific events recurring in the nightmares and intrusive memories that torture survivors need to deal

*) Foundation Centrum '45, Partner in Arq, Diemen, The Netherlands
**) Arq Psychotrauma Expert Group, Diemen, The Netherlands
***) Department of Clinical Psychology, Utrecht University, Utrecht, The Netherlands

with everyday. Torture[1] is found to have a long-lasting effect on physical, psychological, and social areas of life. Physical as well as psychological symptoms are documented (Peel Lubell, & Beynon 2005; Quiroga & Jaranson, 2005; Rasmussen, 2006; Skylv, 1992). The most common mental health disorders documented as an effect of torture were posttraumatic stress disorder (PTSD) and depression, which often co-occur (Nickerson, Schick, Schnyder, Bryant, & Morina, 2017).

Torture survivors are at an increased risk of a shattered sense of control and cognitive understanding about the self and others. Several studies have shown that when the event was perceived as uncontrollable, mental defeat (i.e. perceived loss of oneself as an autonomous person) during trauma may inflate symptom severity (Ehlers, Clarck, Dunmore, Jaycox, Meadows & Foa et al., 1998, Ehlers & Clark, 2000; Wilker, Kleim, Geiling, Pfeiffer, Elbert, & Kolassa, 2017). In a study on traumatized women, Iverson et al. (2015) stated that assimilated or overaccommodated thoughts regarding safety, trust, power, esteem, and intimacy as opposed to realistic, "accommodated" thoughts, may interfere with recovery from treatment. Assimilation refers to hindsight bias, self-blame, undoing, minimizing, and denial of the event. Overaccommodation refers to modifying one's beliefs in such a way that overgeneralizations emerge, e.g. about the self (e.g., "I am a worthless person"), others (e.g., "No one can ever be trusted"), and the world (e.g., "The world is a dreadful place"). Torture may induce these types of cognitions in individuals as it deliberately attempts to "break someone's will" (Perez-Sales, 2017a). The fear- and helplessness-inducing effects of captivity determines the perceived severity of torture and psychological damage in detainees (Başoğlu et al., 2009; 2017).

Treatment

Torture survivors benefit from treatment only moderately (Patel, Kellezi, & Williams, 2014; Perez-Sales, 2017b). A promising type of treatment is Narrative Exposure Therapy (NET). NET is an evidence-based, short-term intervention for trauma victims, designed for use in patients from all cultural backgrounds, in particular people who experienced multiple or complex traumatic events (Gwozdziewycz & Mehl-Madrona, 2013; Lambert & Alhassoon, 2015; Robjant & Fazel, 2010; Schauer, Neuner, & Elbert, 2011). During NET, therapist and patient collaboratively develop a narrative of the patient's life by identifying the most meaningful (positive and negative) life events, symbolized by "flowers" and "stones", respectively. The therapist supports the patient in constructing a chronological narrative of his/her whole life. Exposure to each traumatic event in a chronological order aims to reconnect fragmented traumatic memories with the autobiographical memory in order to diminish trauma related complaints (Schauer, Neuner & Elbert, 2011). All trauma-related sessions are documented in a written narrative which is handed to the patient at the end of treatment.

Aims

The current study examines the narratives of two torture survivors who underwent NET. This intervention was offered as an individual therapy embedded in a phased day treatment program for refugees (Figure 1). Their trauma

[1] Following the definition of torture from Article 1 of the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT, 1984).

Figure 1: *Day treatment program for refugees, Centrum '45**

Time	Phase 1 (4 months)	Phase 2 (4 months)	Phase 3 (4 months)
10.00	Welcome		
10.15	Group Psychotherapy	Creative Therapy	Psychomotor Therapy
11.30	Creative Therapy/ Psychomotor Therapy	Narrative Exposure Therapy	Societal Orientation
12.45	Lunch		
13.15	Sociotherapy	Psychomotor Therapy	Consultation Hour
14.30	Consultation Hour	Consultation Hour	

Group-based, phase 1, 2 & 3 combined

Group-based, separate for each phase

Individual

*The day treatment program for refugees was developed by the first author in collaboration with the multidisciplinary team as a phased-based day treatment; each phase having a duration of four months. The first phase focuses on building trust, enhancing understanding of the complaints and improving coping, emotion regulation, and sleeping. The second phase focuses on processing the traumatic memories, by means of individual NET. The third phase focuses on personal and societal rehabilitation. Throughout the entire program, patients can consult any of the other practitioners (psychiatrist, psychotherapist, social worker, socio-therapist, creative therapist, psychomotor therapist) when needed.

history, the appraisal of torture experiences, and their impact on perceived mental health are examined by labelling the cognitions as being either accommodating, assimilating, over accommodating cognitions or mental defeat. We hypothesized that torture yields over-accommodating cognitions, as well as mental defeat, which in turn, are related to the severity of psychological complaints.

Methods

Assessment

At intake, criteria from the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) were assessed. The Clinician-Administered PTSD Scale (CAPS)—a clinician rated interview—was used to assess the severity of PTSD symptoms before and after NET (Weathers et al., 2017).

Global Assessment of Functioning (GAF) was rated by the clinician (not the NET therapist) before and after NET. The score reflects an individual's occupational, psychological, and social functioning on a continuum ranging from poor to excellent functioning (Startup, Jackson, & Bendix, 2002).

Analysis

The therapist actively asks for cognitions and emotions in response to life threatening situations as part of exposure sessions of NET. The therapist asks about cognitions "back then" and "here and now. " A report is written of each session which results in a reconstruction of the life history of the patient at the end of treatment. The NET reports of two torture survivors are analyzed. Their cognitions—which are the sections which are not italicized in the descriptions below—are, when possible, labelled as being either assimilating,

accommodating, over-accommodating cognitions or mental defeat.

Results

The narratives of Ahmed and Morteza[2]

The case of Ahmed

Ahmed is a 40-year-old Arab-speaking patient originating from a Middle Eastern country, who fled to the Netherlands when he was 30 years old. At intake he reports that he is suffering from posttraumatic stress and severe depressive symptoms. He also reports somatic complaints, his body hurts; especially his hands, feet and shoulders for which he has needed medical treatment. He has no job and avoids contact with other people as much as possible.

As a child he felt rejected by his mother. He reports bad memories of his childhood. As an adult he has been imprisoned for several years because of political activities. He fled the country as soon as he was released from prison, but the memories are recurring in his nightmares or in broad daylight. His asylum procedure is an ongoing stress factor in his life. He is diagnosed with PTSD and Major Depressive Disorder (MDD). His score on the CAPS before NET is 46. His GAF score is 51.

Treatment process: Ahmed participates in the day treatment program (Figure 1). He is reluctant to share anything, but participates in group therapies when invited. He builds trust in the therapist whom he already got to know before the start of the day treatment program. At phase 2 he starts with NET. He refers to five periods in his life in which he has experienced severe and multiple traumas. He is able to discuss these events in detail with the therapist and to complete NET, although treatment duration exceeds the time scheduled.

Ahmed's narrative on torture: The fourth period in the life of Ahmed in which he has experienced multiple trauma, was during his imprisonment, as follows:[3]

> *"After my arrest I had to follow them into a small room, somewhere down below. The walls were thin. I could hear other people screaming. They started questioning me. I had no clothes on. They beat me. They used an electric wire. They hit me on my head, legs, hands, back, stomach, and genitals. I was tied up on a chair, blindfolded. After every answer, they were hitting me. I thought: 'I will die'. I smelled my flesh; it was burning because of the electric wire. I felt nauseous. I lost consciousness. Afterwards they threw me in a bath with very cold water. That was also hurting me a lot. I thought that I would drown. I still have a lot of scars on my body. They hanged me for 7–8 hours, with my legs upward and my head down. That was so difficult and very painful. I was so terribly scared. They were laughing. I was blindfolded and taken to a secret prison."*
>
> *"Most people with whom I shared the cell were tortured. The torturing lasted more than a year. Sometimes one person was torturing me, another time 3 or 5 men. One day they chose me, the other day one of my fellows. It was so frightening to hear the footsteps from the guards in the corridor.* What would happen? Who would be chosen? *We all shivered at the moment we heard these footsteps and the key turning in the lock. It was dark in the cell. We were*

[2] Written consent concerning the narrative has been obtained from both patients. The narratives of the torture survivors are anonymized—i.e. names have been changed.

[3] Cognitions are in normal font.

with many prisoners in one cell. I saw their injuries. Some never returned. During the torturing, legs, and arms could be broken. They broke my wrist. A lot of people died, due to the beating or the electricity, or because they fell ill, or were not treated for their diabetes, their heart disease. People also died due to the very bad food and the hunger. Sometimes the guards were quiet, sometimes not, depending on the amount of alcohol they had been drinking. We were all punished when someone talked too loudly. Then we were chased out of our cell and we had to stand in the hall for hours in our underwear. I felt so tired, I could hardly stand on my feet. I had to prevent that I would collapse. Collapsing meant that the beating would start again."

"*I knew they could do things like this. The people who did this to us were drinking a lot of alcohol. I could smell it. They were also using drugs. I was blindfolded. They were with three to five people. One was lashing my back. The others were pushing me to the wall. They pushed me down.* I am often thinking: 'I want to die' when this memory is coming up. *I feel disgusted. (Note from therapist: at this point of the story patient can't sit, is jumping up and restless. He wants to vomit. Sweat is all over his face. He is trembling all over.) They raped me, one by one. They are laughing loudly. I could smell his body, the alcohol. It was so painful.* I could only think: 'I want to die' *I still can feel these people inside me. I feel dirty until now.* Some people killed themselves. They hanged themselves. I survived. I don't know why."

The completion of NET: After NET was completed, other complaints were aggravated due to current life stressors related to the asylum procedure. Additional treatment was offered to support Ahmed in dealing with these stressors. The CAPS score decreased, albeit, marginally, from 46 to 45 and the GAF score from 51 to 45.

The case of Morteza

Morteza is a 48-year-old man, born in Teheran, Iran. At intake he reports severe PTSD complaints, having recurrent nightmares and flashbacks of his imprisonment in Iran. He suffers from intrusions: thoughts, images and scents. He has problems falling asleep, and he ruminates a lot. He has problems with concentration, anger outbursts, and avoids reminders of the past. He also reports severe somatic complaints, chronic pain in chest and shoulders, recurrent headaches. He failed to finish education in the Netherlands and was never able to work. He is currently living alone in a small apartment, after having wandered on the streets for years, using drugs. In his childhood he experienced multiple traumatic experiences during the Iran-Iraq war. He managed to finish high school education and before his imprisonment he was a university student. He was arrested because of political activities at university four times. He escaped the fourth time and fled the country. He is also feeling depressed, detached and isolated. He is diagnosed with PTSD and MDD. The severity of his PTSD complaints as assessed by CAPS prior to treatment was 48. His GAF score was 45.

Narrative Exposure Therapy: At the start of the day treatment program Morteza is reluctant to enter treatment. He fears the idea of talking about his past experiences which he has avoided so far His coping skills to handle his emotions are not sufficient and during Phase 1 of the day care treatment program—prior to the NET—the focus was

on handling these emotions. No-show is high. Nevertheless he agrees to start NET in Phase 2 and is able to describe several traumatic events in his life line, but is very scared of saying too much. He needs time to build trust in the therapist. The process of treatment is hampered because Morteza frequently does not show up for his sessions. This has been discussed and as therapy continues he learns to trust the therapist and opens up. He discloses several other traumatic events during imprisonment which he did not dare to share before because of shame. Although treatment duration of NET is longer than expected, he is able to complete NET.

Morteza's narrative: After several childhood events have been addressed by means of exposure, he mentions that the most debilitating events were yet to come. The accounts of his experiences during imprisonment are as follows:[4]

> *"I was taken to prison and pushed into a small isolation cell. It was white, the walls were filthy and written on. There was a small window through which I could talk with guards. I could hear others in the corridor. The first two months were the worst. I had little sleep and was taken away for questioning at unexpected moments, sometimes even in the middle of the night. The interrogators were aggressive, threatening, mean, and scolded at me. I was beaten with fists, but also with a whip. That was very painful. Sometimes they tied my hands on my back and hit me on my back, on my legs, but also on my soles. Then they forced me to walk. I felt so much pain. I cried, I shouted. Whenever they thought you'd lied, they beat you even harder.* I could not do anything. *Now I'm afraid of the police, afraid they're going to get at me, despite knowing that's not happening here.* I'm afraid people do not believe me, they think I'm lying. I feel insecure now too. *The pain was bad, but what was worse was that* I could think of nothing else all day long. *I was constant in fear that they came to take me away again and that they would hurt me again. It was terrible.* I thought, "they are worse than I ever could have imagined."
>
> *"After my first imprisonment*, I was no longer the person I used to be. I often got negative thoughts that I felt ashamed of. I felt bad and worthless. I ruminated a lot *and stayed at home often. After half a year I was arrested again, and I was detained for six months this second time. The first few months I was tortured a lot, once a week.* You never knew when they would come. So you were always scared. I ruminated a lot. Would they come for me? *When they summoned me to follow them, they blindfolded me before taking me to a room. I was scared what would happen again.* Would I die? Could I keep it up? *The room had white, dirty walls, filled with torture tools. Then* I was afraid they would use that. *These thoughts went through my mind.* I was afraid to be a coward. *First, they tied me to a chair. They were usually two men. Then they asked questions. They beat me, with their hands and legs, but also with a whip. They said I was lying. I was sometimes pulled up by my legs, then they hit me on the soles of the feet and forced me to walk. Or they would hang a stick under my knees and tied with my hands against each other. They hung the stick on two tables and then I waved upside down. They hit me in many places. It was unbearable.* I had no control over my thoughts, they hit me all over my body, I forgot about where I was, who I was. I can still feel pain in my arms and legs.

[4] Cognitions are in normal font.

I could not bear it, I felt different kinds of pain. I cried and screamed because of the pain. What I found terrible was that they hung me on the ceiling with my hands in handcuffs. That was awfully painful, just electricity. In retrospect, I think I was lucky too. There were moments I thought if it continues, I'll tell everything. *After a few months, they stopped, they knew everything and we were brought to court.*"

"*The fourth time I was arrested and was in prison was the worst of all. It was a tough time, many people were executed. The tortures were violent, many people started talking. When the guards discovered that I had lied, they got very angry and the torture aggravated. They threatened me with everything, with rape, with execution. They said I was dirty, worthless.* I was afraid, feeling little. I thought, I'll never come out, I'll die. I felt worthless. Life is nothing anymore, many people were killed. I expected to die. Everything could happen. *During earlier imprisonments the rules were more clear: they finished torturing when they assumed they had all the information they needed. But now there were guards who continued with torture and seemed to enjoy the pain.* I felt hate, but then at some point I thought: it's over. I had no control whatsoever. I gave up. Now I have sometimes the same feeling, as if everything is hopeless and I feel worthless."

"*But the worst of the worst torture is rape*. I can not say or believe this has happened, but I heard a lot of others. *During the torture I often felt unconscious. One day I was beaten and threatened. I fell unconscious. There were three men. A stranger grabbed me by the arm and pulled me to the ground. I was in a room, the light was dimmed. I laid on the ground. The ground was cold and I sensed the smell of earth. I once again fell unconscious.* I only have patches of memory. *When I woke up* I felt worthless and saw no future. *I was afraid and wanted to escape*."

The completion of NET: At the last session of NET he feels he has been able to discuss his life in more detail than ever before. However, several comorbid complaints remain. His CAPS score after NET is 38 and his GAF score is 50. Although he felt some improvement in daily functioning and less overwhelmed by flashbacks, several complaints remained. He has been referred for further treatment for his other complaints.

Discussion

The narratives of Ahmed and Morteza illustrate the tremendous psychological, physical, and social toll of torture for individuals and the long-lasting impact.

Psychological torture

In their narratives, both Ahmed and Morteza described how they experienced a lack of control. The unpredictability of the experiences, hearing other people being tortured or never seeing them return to their cell induced fear and contributed to their hopelessness, and later on, in the loss of self-worth—most evident in the story of Morteza. Psychological torture during captivity induced a sense of fear and helplessness, as stated by Başoğlu (2009). This psychological torture appears to be detrimental for the ability to cope with these overwhelming experiences. The constant threat that torture could be repeated reinforced the impact of the memories. The accounts of both Ahmed and Morteza refer to anticipation anxiety, a constant free-floating anxiety while in prison due the process of dehumanization and humiliation. The uncertainty and unpredictability aggravated the anxiety and

resulted in a generalized free-floating anxiety, even up to the present as if these events could happen again at any time. These anxious expectations are related to the severity of the anxiety complaints.

The appraisal of torture events
The cognitions regarding the torture events of both Ahmed and Morteza revealed that over-accommodating thoughts are provoked by both physical and psychological torture which affected their level of distress. In particularly the devaluating, stigmatizing, degrading remarks, laughing and shouting as well as the deliberate violation of culturally sensitive taboos (by means of rape), induced thoughts that you are 'a nobody' and feelings of shame, guilt and disgust. Emotions such as shame, guilt and humiliation attack dignity which can aggravate the breaking assumptions on self, the others and the world (Perez-Sales, 2017a).

Mental defeat, the complete lack of control during the traumatic event, did contribute to the belief that "everything is hopeless and there won't be a future." The analysis of the narrative of Morteza illustrates this. As he felt a total loss of control or was unable to anticipate anything that happened to him during his last imprisonment, he expected to die and felt totally demoralised and hopeless. They both at some point expected to die.

Interplay of physical and psychological torture
The interplay between physical and psychological consequences of torture was evident. Physical torture induced anxiety for pain and the physical harm was a constant reminder of the pain which reinforced anxiety. Both Ahmed and Morteza reported that daily pains trigger flashbacks about the traumatic events. Furthermore, the flashbacks are also triggering pain as was witnessed by the therapist when Ahmed recalled memories. It is important to note that a neurocognitive overlap of social and physical pain has been found (DeWall et al., 2010; Eisenberger & Lieberman, 2005).

Implications for treatment
In the case of both Ahmed and Morteza, a constant feeling of threat and the accumulation of different type of traumatic events during captivity called for a pacing of the therapeutic process to disentangle the traumatic events as distinct "events" in order to reconstruct the narrative. At first, some "stones" were not named or even mentioned at all, because of shame. The chronological reconstruction required to take one step at a time.

Building trust within the therapeutic alliance and taking time by pacing the therapeutic process with patience was particularly important. It was important to be aware of accumulation of trauma and (the interplay of) physical and psychological harm, and the notion that shame may prevent sharing of the most painful or shameful events recurring in nightmares and flashbacks. Recalling memories once again induce feelings of shame and humiliation and the loss of dignity. The reluctance to say this and to show up at appointments at the beginning of the process can be understood as avoidance. Trust developed gradually within the therapeutic relationship, which eventually facilitated both Ahmed and Morteza to open up about even the most painful memories. An open, respectful, patient, empathic attitude of the therapist and calmness when listening to their horrific stories while validating the emotional impact of these experiences appears to be helpful in achieving a solid therapeutic alliance.

The moderate effects of NET may be improved by more tailor-made or culturally

sensitive cognitive behavioural interventions that address shame, guilt, disgust and cognitions about safety, trust, power, self-esteem, and intimacy (Ehlers, A., Clark, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, 1998, 2000; Iverson, King, Cunningham, & Resick, 2015; Perez-Sales, 2017). Interventions that address core cognitions as those applied in schema therapy may be useful for the long-lasting impact of torture on the cognitions regarding self—"I am worthless, I have no control"—and others—"No one can be trusted. People may hurt me again"—(Young, Klosko & Weishaar, 2003). This may contribute to alleviating the symptoms, and patients may feel empowered to be more in control of their emotions while the process progresses.

Although both torture survivors were able to complete NET, learned to trust the therapist, and showed some improvements, the results were limited in terms of improvements in PTSD and GAF scores. It is remarkable that several positive changes could be observed in the patients, but not so much in terms of diminishing PTSD complaints. The ongoing asylum procedure and the fear of being sent back to his country and to be imprisoned and tortured again had a detrimental impact on Ahmed, because of which he had difficulties in benefiting from treatment.

It is important to look beyond physical and psychological symptoms, to broader adaptive functioning in terms of the individual's ability to feel confidence in their own capacities, in the predictability of the world, and the trustworthiness of the human community (Campbell, 2007; Hocking, Kennedy & Sundram, 2015; Jaranson & Popkin, 1998; Kirmayer, Rousseau & Measham, 2010; Steel et al., 2009). This may help torture survivors to feel more in control of their life again in the long run.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC.

Başoğlu, M. (2009). A multivariate contextual analysis of torture and cruel, inhuman, and degrading treatments: Implications for an evidence-based definition of torture. *American Journal of Orthopsychiatry 79* (2), 135-145. https://doi.org/10.1037/a0015681

Başoğlu, M. (Ed.). (2017). *Torture and its definition in international law: An interdisciplinary approach*. New York: Oxford University Press.

Campbell, T. A. (2007). Psychological assessment, diagnosis, and treatment of torture survivors: a review. *Clinical Psychology Review, 27*(5), 628-641. https://doi.org/10.1016/j.cpr.2007.02.003

DeWall, C. N., MacDonald, G., Webster, G. D., Masten, C. L., Baumeister, R. F., Powell, C., Eisenberger, N. I. (2010). Acetaminophen reduces social pain: Behavioral and neural evidence. *Psychological Science*, *21*(7), 931–937. https://doi.org/10.1177/0956797610374741

Eisenberger, N. I., & Lieberman, M. D. (2005). Why it hurts to be left out: the neurocognitive overlap between physical and social pain. In: K. D. Williams, J. P. Forgas, & W. von Hippel (Eds.), The Social Outcast: Ostracism, Social Exclusion, Rejection, and Bullying (pp. 109-127). New York: Cambridge University Press.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behavior Research and Therapy*, *38* (4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Ehlers, A., Clark, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, E. B. (1998). Predicting response to exposure treatment in PTSD: The role of mental defeat and alienation. *Journal of Traumatic Stress*, *11* (3), 457–471.

Ehlers, A., Maercker, A., & Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: The role of mental defeat, alienation, and perceived permanent change. *Journal of Abnormal Psychology*, *109* (1), 45–55. https://doi.org/10.1037//0021-843X.109.1.45

Gwozdziewycz, N. M. A. & Mehl-Madrona, L. (2013). Meta-Analysis of the Use of Narrative Exposure Therapy for the Effects of Trauma Among Refugee Populations. *Permanente Journal, 17* (1), 70-76. https://doi.org/10.7812/TPP/12-058

Hocking, D. C., Kennedy, G. A., & Sundram, S. (2015). Mental disorders in asylum seekers: The role of the refugee determination process and employment. *Journal of Nervous and Mental*

Disease, *203*(1), 28–32. https://doi.org/10.1097/NMD.0000000000000230

Iverson, K.M., King, M., Cunningham, K.C., & Resick, P.C. (2015). Rape survivors' trauma-related beliefs before and after Cognitive processing therapy: Associations with PTSD and depression symptoms. *Behaviour Research and Therapy 66,* 49-55. https://doi.org/10.1177/0886260515592618

Jaranson, J., & Popkin, M. (Eds.). (1998). *Caring for Victims of Torture*. Washington, DC: American Psychiatric Press.

Kirmayer, L. J., Rousseau, C., & Measham, T. (2010). Sociocultural considerations. In D. Benedek & G. H. Wynn (Eds.), *Clinical manual for the management of posttraumatic stress disorder*. Washington: American Psychiatric Publishing, Inc.

Kross, E., Berman, M. G., Mischel, W., Smith, E. E., & Wager, T. D. (2011). Social rejection shares somatosensory representations with physical pain. *Proceedings of the National Academy of Sciences*, *108*(15), 6270–6275.

Lambert, J. E. & Alhassoon, O. (2015). Trauma-Focused Therapy for Refugees: Meta-Analytic Findings. *Journal of Counseling Psychology, 62*(1), 28–37. https://doi.org/10.1037/cou0000048

Nickerson, A., Schick, M., Schnyder, U., Bryant, A.E. & Morina, N. (2017). Comorbidity of

Posttraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees. *Journal of Traumatic Stress, 30* (4), 409–415. http://dx.doi.org/10.1002/jts.22205

Patel N., Kellezi B., & Williams A.C.D.C. (2014). Psychological, social and welfare interventions for psychological health and well-being of torture survivors. *Cochrane Database of Systematic Reviews*, Issue 11. https://doi.org/10.1002/14651858.CD009317

Peel, M., Lubell, N., & Beynon, J. (2005). *Medical Investigation and Documentation of Torture. A Handbook for Health Professionals*. Human Rights Center: University of Essex.

Pérez-Sales, P. (2017a). *Psychological torture: Definition, evaluation and measurement*. London: Routledge.

Pérez-Sales, P. (2017b). Psychotherapy for torture survivors – Suggested pathways for research. *Torture, 27*(1), 1–12.

Quiroga, J. & Jaranson, J.M. (2005) Politically-motivated torture and its survivors: A desk study review of the literature. *Torture, 15,*(2-3)

Rasmussen, O. V. (2006). The medical aspects of the UN Convention against Torture. *Torture, 16*(1), 58–64.

Schauer M, Neuner F, Elbert T. (2011). *Narrative Exposure Therapy. A Short-term Intervention for Traumatic Stress Disorders after War, Terror or Torture*. 2nd, expanded edition, Göttingen: Hogrefe & Huber Publishers.

Skylv, G. (1992). The physical sequelae of torture. In: Başoğlu, M. (ed), *Torture and its consequences: current treatment approaches* (pp 38-55). New York: Cambridge University Press.

Startup, M., Jackson, M. C., & Bendix, S. (2002). The concurrent validity of the Global Assessment of Functioning (GAF). *British Journal of Clinical Psychology, 41* (4), 417-422. https://doi.org/10.1348/014466502760387533

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Journal of the American Medical Association, 302* (5), 537-549. https://doi.org/10.1001/jama.2009.1132

United Nations (1984). Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., & Marx, B. P. (2017). The Clinician-Administered PTSD Scale for DSM–5 (CAPS-5): Development and initial psychometric evaluation in military veterans. *Psychological Assessment*, *30*(3), 383-395.

Wilker, S. Kleim, B., Geiling A., Pfeiffer A., Elbert, T. & Kolassa I.T. (2017). Mental defeat and cumulative trauma experiences predict trauma-related psychopathology: Evidence from a post-conflict population in Northern Uganda. *Clinical Psychological Science, 5*(6),974–984. https://doi.org/10.1177/2167702617719946

Young, J. E; Klosko, J. S; Weishaar, M. E. (2003). *Schema therapy: a practitioner's guide*. New York: Guilford Press.

Building survivor activism: An organisational view

Shameem Sadiq-Tang,*

Introduction

The purpose of this paper is to share how different models of survivor activism can be built in a clinical charity with a human rights ethos and to set out the value that has come from growing survivor activism organically, based on experiences at Freedom from Torture. The work was formally established as survivor activism eight years ago although it began years before. Since then it continues to evolve and, as a result, there is a strong programme based on collaborative approaches and good practice for safe and informed engagement. From an organisational perspective, it is possible to highlight risk reduction, empowered spaces and enabling survivors of torture to be their own agents of change as key factors in a successful survivor activism programme.

It is widely acknowledged that survivor involvement is important, not only in shaping the rehabilitation and other services they receive but also in advocating for positive change in the wider world. Juan Mendez, former UN Special Rapporteur on Torture,[1] amongst others, has indicated that governments need to be consulting survivors, who are the experts, rather than the top-down method. But, survivor activism can mean many things, and there are questions over how it can best be carried out in an environment already plagued by a lack of resources. At Freedom from Torture, we distinguish survivor activism from the work we also do to engage service users in our own organisation. We see survivor activism as amplifying the voices of survivors of torture in discussions and debates in spaces of influence and decision- making fora. It must go beyond tokenism or consultation. To me, this means that survivors voices, words and narratives are aimed at shaping and changing policy and practice on torture and its impact. It means formally recognising survivor activism as a body of work and allocating resources to support survivors to meaningfully engage in activism. Our survivor activism has not developed in response to research findings based on samples or methodologies, but a genuine belief amongst service users and staff in the value of activism by those with lived experience of torture. It is based on years of working in collaboration with survivors of torture and getting their positive feedback, and simply getting out there and doing and learning along the way.

In a climate of limited funding, organisations have to make difficult decisions about where to invest resources. Freedom from Torture is one of the larger torture rehabilitation centres but we still face these dilemmas. However, a commitment to putting survivors of torture at the heart of everything we do including in our external influencing work is embedded in the organisational strategy at Freedom from Torture, so we have been lucky enough to have ring-fenced resources for a number of years.

1 https://www.freedomfromtorture.org/survivor_activism

*) Survivor Activism Manager, Freedom from Torture, UK. Shameem has led the Survivor Activism team for eight years.
Correspondence to:
ssadiqtang@freedomfromtorture.org
(Also to find out more about survivor activism).

Activism groups and activists

Survivor activists in Freedom from Torture projects are men, women and young people who have been tortured and are either asylum applicants or refugees in the UK. They are all current or former clients of Freedom from Torture. They are supported by a team of volunteers and staff and together we have grown survivor activism into an area of work that is now acknowledged within the organisation as an important part of the rehabilitative journey for survivors of torture. The three groups, two adult and a third being set up for young people, focus on promoting survivor-led or supported interventions in public spaces, policy debates and practice about torture, but they all have different ways of working.

Survivors Speak OUT (SSO)

> *"As an activist, I can address some of the injustices of my past and present. For too long others told my story but now I am speaking for myself and for other torture survivors. We are taking back control and working hard to make sure that we are part of finding and shaping solutions about our lives",* Serge Eric Yamou, co-founder of SSO, and now Trustee at Freedom from Torture

Survivors Speak OUT is a survivor-led activist network supported by the charity but which was in fact initiated by a small group of service users[2] who had a passion to speak out against torture and its impact. The network is now ten years old. There are more than 30 active members all of whom have completed treatment at one of Freedom from Torture's five centres (London & South East, Glasgow, Manchester, Newcastle and Birmingham). Recently, their work has focused on direct advocacy with domestic and international decision makers like the UK Home Office, the Foreign and Commonwealth Office and cross-party governmental scrutiny bodies, but its members also speak at events in the UK and abroad including at colleges and universities, in Parliament, and to the United Nations, to raise awareness and press for change.

The group speaks as a network of survivors with one voice. This strengthens their message but also supports their own personal well-being. A driving philosophy of their work is to let people know that as survivors of torture, they are not simply a source of testimony but that their lived experience of torture and its impact means they have crucial insights to shape change and create meaningful solutions.

Examples of their impact include staff training implemented in the UK Home Office's Asylum Intake Unit about greater awareness of behaviours and attitudes on asylum applicants. This training was implemented after joint advocacy work by SSO and Freedom from Torture with the Intake Unit; and the introduction of a principle in the UK Preventing Sexual Violence Initiative's (PSVI) Global Principles for Action to tackle Sexual Violence in Conflict on empowering survivors to speak out.

As an organisation, we support the network by helping members to access opportunities to influence others. The process of support is intensive and includes capacity building for their public speaking, media training and advocacy skills, preparation through workshops to support them to develop policy positions and key messages, help to write speeches

[2] A user of Freedom from Torture's rehabilitation services

and articles, work to develop and promote their brand as a network, and also as individual advocates. In addition, there is a need to develop and manage safeguarding, good practice around a range of issues including individual security and self-care. Throughout this process the focus is always on supporting network members to develop their identities as activists so that they are recognised within their own right.

SSO has taught us the power of speaking with a collective voice. This approach sometimes stops survivors being included in discussions and debates because those reaching out to the group are interested only in testimony about specific torture experiences. But this model has allowed us to help the Survivors Speak OUT network to develop collaborative policy positions which helps to reduce the risk of personal credibility attacks and protects the network from claims of bias in relation to a country or an issue. We have also taken partners along with us on this journey—for example, we convinced the UK Foreign & Commonwealth Office that survivors could contribute more than their stories. The coordinator of the network now serves on the ministerial steering group for the UK's Preventing Sexual Violence in Conflict Initiative. This approach also enables survivor perspective on human rights issues to inform the influencing programmes and policy positions of Freedom from Torture.

Write to Life

> *"Writing to me is activism—it makes me feel who I am"… "I write to empty myself of my memories, to choose things to remember and challenge myself to move on",* Quotations from Survivor Activists participating in Write to Life

Write to Life,[3] our creative writing and more recently performance group, is now 20 years old. The group began as a therapeutic space based in our clinical department. It has now evolved into a group supported by professional writers who work with its members and support them to reach out to new and previously untapped audiences through poems, films, music and theatre, most of which the members perform themselves. Unlike Survivors Speak OUT, members of Write to Life are both current and former service users. Again, an important principle for the group is that they do not recount torture experiences but find creative and engaging ways to tell their versions of their stories, whatever that may be, on their terms.

One of Write to Life's key achievements has been through transforming stories and words into artistic forms of self-expression that has enabled new audiences to be reached that might not otherwise be interested in torture and its' impact. An example of this is the play, Souvenirs, that was written and performed by members of the group (all survivors of torture) which toured theatres to packed-out audiences. One audience member said, "Souvenirs burned itself on my soul. Not in any way bleak or sympathy stealing. It felt like a true human connection between audience and performers. This is the most important thing I have seen a theatre do."

Appropriate safeguards to reduce risks and respond to incidents that might impact mental health must continuously be developed, improved and implemented. Another current focus is promoting collaborative approaches between group

[3] https://www.freedomfromtorture.org/survivor_activism/write_to_life

members and support staff/volunteers. We strive to find a balance in providing enough space for the group to nurture its creative approach that enriches writing and performance. At the same time, we also look at how their work can support the strategic policy priorities set by the organisation in collaboration with survivors, for example through performances for advocacy targets or creative projects aligned to campaign objectives.

Youth Voices

The third group, Youth Voices, is for younger torture survivors aged 16 to 25 who have an interest in activism. The purpose of this group is to create a space for young survivors to have a more prominent voice and speak out on issues that impact their lives in the UK. Young people in the UK experience the asylum system and other services differently and too often their voices are not heard over adult interests. The direct engagement phase with young people begins in summer 2018.

What does it take?: Dedicated resources

Enabling engagement: When people (survivor activists) join our groups, it begins with an induction about the group, its members, what is involved, a two-way discussion about expectations, how to make a complaint and a set of policies to support good and safe practice. It is important to be clear that survivor activism is not a clinical group or a formal part of the therapeutic process because it is of course essential for group members to know if they are a therapy client for a number of reasons; ethically they need to be clear about their relationship with the organisation; therapy clients may have access to different internal services; and staff in survivor activism are not clinical therapists although there are situations where we are supported by clinical staff.

Nonetheless, some people see our survivor activism work as an important part of their rehabilitation journey and writing like that of Write to Life certainly has therapeutic benefits. Elif from Write to Life describes how writing enables distance from a painful past and allows me to focus on the present and the future.

One important way to support engagement in activism is by holding regular group meetings for survivor activists to come together, discuss issues, reach common agreement and generally bond as a group with a common cause. This is important because our groups are made up of women and men from different backgrounds, cultures, expectations and experiences so taking the time to understand each other is important

It is important to inspire people to engage through skill-building workshops that are relevant to them and that they enjoy. These workshops might involve support to members of our groups to formulate policy positions, recommendations for change, write speeches or poems. If survivor activists are volunteering their time and energy around initiatives related to deeply personal and traumatic issues, they need to feel the value of their engagement.

People are supported to express themselves in their own words, avoiding jargon and using simple language. They don't need to speak the best English but they will have to have some level of English to speak to their audience directly—they may need support to do this even though it in itself can create challenges around authentic voice and feelings of frustrations when someone cannot clearly express themselves in the way that they want or need to.

All of the activities and events we help the groups to participate in are

supported by briefings as a group before, if necessary during, and always after, because preparation, preparation and more preparation is essential for impact. This approach creates confidence and also fosters an environment for reflection and learning and in turn, progression. Things can and will go wrong so a key part of my role is to facilitate a process of checking in throughout and supporting the group to make a decision together about next steps.

Involvement with survivor activists means that we develop long-term relationships through activism, in a way which for obvious reasons is rarely experienced in the more boundaried clinical environment. That means that we see the lasting impact of torture, exile, rehabilitation and survival. This unique perspective supports our work with survivor activists because we often understand the issues and the drivers that they prioritise. It also means that we learn of, and are sometimes called on to provide support on legal and welfare issues they are experiencing. At Freedom from Torture we are fortunate to have specialist colleagues in house to give legal advice and/or signpost to welfare support services, when they have capacity. This is an issue we continue to explore internally given limited resources and the need to prioritise those with the most need while also wanting to meaningfully support the people we have long-term relationships with.

> *"Black writing ran wildly around the page like spiders. All I could see was the word 'refusal'. I lost my courage. I could not continue to read. The world had gone blue. My solicitor read out the rest"*, Extracts from 'The Letter' by Anon from Write to Life

People: A dedicated team makes it possible to build relationships, develop trust and, as a result, is more effectively able to build know-how, appropriate polices, and good practice to monitor the work and ensure that it is safe and as risk free as it can be for survivor activists to engage.

A key element of the success of survivor activism at Freedom from Torture is the existence of a dedicated team which supports the work, as well as a ring-fenced set of organisational resources. This commitment is embedded in our organisational strategy to put survivors of torture at the heart of everything we do including in decision making.

There has been a conscious decision to ensure that this is not extra work tagged on to that of all or other teams but a body of work in itself. This is of course important because survivor activists are still potentially vulnerable people living with deeply traumatic pasts and in many instances very difficult present circumstances. They are highly motivated to engage in this work for a number of reasons including so that others do not face what they have had to, but part of the journey for them, and for us, can involve exploring issues which they may not have had cause to address in therapy or other support, for example the potential to meet a government representative from their home country in an international meeting.

Operational budgets: Activities for the groups can be costly. Realistic and dedicated budgets for the day-to-day running of the work are important. Money is needed to bring people together, to pay for skills-building initiatives and to attend conferences (e.g. within the charity, homelessness and/or health sector), and provide basic costs to enable practical involvement of activists, including travel fares and costs related to the

provisions of childcare. This has significant cost implications but also challenges in ensuring the implementation and navigation of a transparent system. Despite this, a conscious decision has been made not to replicate the barriers that survivor activists face in their day-to-day life because of their gender and/or their asylum status. We believe this is also essential to move survivor engagement away from tokenistic models into meaningful engagement because it allows for sustained development of skills, and gives the groups the opportunity and time to develop thoughtful advocacy positions. In our view, this means that we have to break down the barriers that prevent meaningful engagement in a progressive way that leads to up-skilling and growing confidence (as opposed to passive involvement). We are fortunate in the UK that, as well as the support of the organisation, there are a number of funders that share our vision and support this work.

Good practice: The survivors we work with are without a doubt incredibly resilient, but it is also important to recognise that they are also susceptible to setbacks, not only because of the torture they have survived and its long term impact on their lives, but also due to the myriad of challenges faced living as an asylum seeker or refugee in the UK. Survivor activism by its nature more often involves exposing survivors and their experiences to strangers on platforms in the UK and internationally. Together these issues can bring a host of challenges and risks.

Measures need to be in place to ensure that our day-to-day work is based on safe practices and guides staff and activists to respond appropriately when faced with these challenges. It is not about wrapping people up in cotton wool but as an organisation taking our duty of care in a survivor activism context seriously.

It is important that informed consent is based on a thorough assessment to support survivor activists to navigate the risks and benefits associated with involvement in an activity. It should also include information on how to withdraw consent and there should be a responsibility on the staffer or facilitator to ensure that they have explained it clearly, discussed the appropriate risks and benefits, and follow through to make sure an individual's choices are respected.

Preparation for activities should always include gathering enough information to carry out a risk assessment without which the informed part of consent (permission based on full knowledge and consequences) can't be given by survivor activists. Participants need to clearly understand what will happen to the information they share, where it might be used and what exposure it will be subject to including on social media and the internet. Exposure on digital channels opens up other issues to consider including issues around stigma, the potential for their experience to reach a far wider audience including in their home country with implications for family members wherever they might be, and more.

That is why for survivors of torture navigating consent is not about focusing simply on the present but the future too. The increasingly hostile efforts of states towards refugees seeking protection means that we do not know if they might face return to a torturing state either on refusal of asylum status or renewal of refugee status. Our responsibility to the well-being and safety of survivor activists is paramount and overrules our need to be relevant in debates or raise organisational profile.

Another essential tool is the Critical Incident Protocol which allows us to

respond to situations that result in survivor activists experiencing a serious deterioration of mental health including thoughts of suicide, and any child protection issue. This might be the result of a particular activity or something external to the work. The protocol sets out clear guidance on how to spot these signs and respond to situations both in and outside of working hours for non-clinical staff in the survivor activism team. It is as much about supporting the person experiencing a mental health set-back as it is for the staffer or activist responding to the incident. Having such a protocol in place is essential not only for the well-being of individuals but also as a safeguard for the organisation which may have legal and other questions to face in such a situation from regulatory bodies as well as others.

There are also other policies and practices implemented to respond to other seemingly simple but in reality more complex issues. This includes communications within the activism groups on online platforms such as social media or mobile apps where information and video footage moves around at a rapid pace and can include graphic and distressing content; and approaches between and amongst staff and survivor activists to maintain clear and professional boundaries in the context of friendships born out of this work often outside of core working hours.

Strategic development: Survivor-centred to survivor-led

> *"I may have lost some dignity and respect I was once treated with, but I want to say that in all that you do, always remember the words and contributions of women survivors of torture. Our pasts may have left us in shock and in pain but we are resilient. I now speak out against torture and its impact and that takes courage and it means that I control my own narrative and for me, that is important"*, Tracy N'dovi, Survivor Advocate, SSO

Working *with* and not just *for* survivors is an important principle, especially within an organisation with day-to-day contact with survivors of torture. Before being able to create an opportunity to work alongside survivors in a meaningful way, an environment that supports people to build their skills and capacity to engage in activism and feel confident about speaking out needs to be created.

We do this by putting survivors and the impact of their experiences at the centre of our approach. This involves working with people to understand how they process information, how their experiences of torture impact their engagement, what the environment needs to feel and look like to enable engagement, whether there are barriers that inhibit engagement, how factors like people, gender, status and culture influence involvement, and crucially what needs to be in place to encourage and motivate people to join discussions and debates.

Ultimately, the goal is to move to a survivor-led approach. This is a long-term aspiration in which investment is put into supporting survivors to lead on their own organising, their own facilitation, and their own activism whatever that may look like. However, it is important to realise that even when survivors have been politically active in other contexts, such as their home countries, this may take time. For example, it is important to explore and understand different advocacy spaces given that some of the survivor activists were human rights defenders in their home countries. Looking at cultural differences in influencing public audiences or decision makers in the UK or at international fora like the United Nations,

and finding common ground is a critical part of capacity building.

The survivor-led approach is about supporting people to take more control and responsibility to deliver the impact that they have identified. In practice, this is resource-intensive and involves commitment from the survivor group together with the skills and know-how to carry out parts of the day-to-day work. There are also some more thorny issues of accountability to other group members, funders, the host organisation and others. The reality is that ultimately you are working with people and not all people conform to a particular approach that might be needed by the organisation. These are issues that arise day to day in every work place and this area of work is no exception.

From experience, we know that this approach might not always or consistently work; we are grappling with and exploring different approaches, and this has value in itself. For example, whether to include survivor activist in work behind the scenes like workshop design or facilitation, work closer to delivery stage including speech development and delivery, or both whilst considering capacity in terms of availability, time, skills and budget. As an organisation it is important to be prepared to be flexible about the type and level of support that is needed.

Learning along the way

Monitoring and evaluation: Good practice should include having mechanisms in place to evaluate this work both in terms of benefits to survivor activists and shaping more progressive ways to engage survivors in influencing opportunities, but also for policy impact. We do continuous evaluation through listening to survivor activists at the meetings and workshops mentioned above but we do not do circulate evaluation forms after each event; when a group is strong, individual feedback forms are often not wanted. Instead, creating a climate of trust and building confidence means that survivor activists will express themselves when they need to. And this works two ways in a mutually respectful relationship. All of this information is collated and fed back into the development of the projects. Unfortunately, we have not yet had the resources to carry out any clinical evaluations as a result of our projects. Certainly, for many of the survivor activists, although anecdotal evidence, they report that their involvement has led to an increase in their skills and confidence, and many have since secured employment including in engineering, academia, as interpreters, writers and authors, and as well as organisations like Freedom from Torture. Additionally, Freedom from Torture carried out a survivor-led six month study in 2016 involving over 100 clients to explore the meaning of rehabilitation to survivors. Some clients reported that feeling empowered to speak out about what had happened to them, and advocating for other survivors with decision makers or to public audiences, was a key part of rehabilitation. "They said that using their voice empowers them and helps restore their confidence. This is especially important for people who previously felt unable to use their voice to speak out in public." (Haoussou, 2018 p. 69)

The number of survivor activists who have engaged with us over the years is small in comparison to the number of clients at Freedom for Torture. This reflects that survivor activism is still a comparatively new area of work, and the resources we currently have reflect the capacity we have to deliver our work safely.

Recommendations: The wealth of learning is not possible to share in its entirety

here but brief issues to highlight for other organisations looking to build similar models are:

- Few, if any, of the survivors now engaged in activism came as professional public speakers, advocates or performers. Yet because of torture, they are now doing just that so they need significant support. Take the time to invest, support and build trust;
- Support people to control their own narratives. Help them to or directly resist requests purely for testimony and focus on the messaging and positive action that are important to survivor activists;
- Try to secure dedicated resources to support survivor activism rather than adding this approach to other posts;
- Make sure you are able to spot risk including signs of deteriorating mental health and have the appropriate safeguards in place to respond appropriately;
- As in all groups that work together and can form strong bonds, there will not always be agreement; sometimes there will be falling out. Implement fair and appropriate support and responses to help navigate out of the situation;
- Don't let engagement be tokenistic, make it meaningful and when you're not able to do that, think about if it is fair to continue;
- Don't be afraid to give constructive feedback when things don't go to plan as learning is important. But consider the individual first and tailor your approach so that they don't feel demotivated. And of course, always praise when it all goes well;
- Keep an eye on individual and organisational egos (we all have them) so that the work remains balanced, fair and everyone's voices are amplified;
- Monitoring and evaluation in collaboration with survivor activists is important for progress, learning and funders; and
- We all need to find ways to share good practice and embed survivor activism in the anti-torture movement, in keeping with the human rights principles of empowerment and participation.

How to do this work with fewer resources: It is still possible to support survivor engagement in activism with fewer resources, but be realistic about what you can and can't do. The list below are some initial points to think about when considering this work for the first time:

- Have a clear sense of resources including staff time, skills in-house and budget;
- Have a clear and simple strategy with an aim (what do you want to achieve) and objectives (what must happen to help you achieve your aim);
- You must be able to deliver your strategy within existing resources and crucially, with buy-in and support from survivor activists and other support staff;
- Develop guidance to support good practice and at a minimum, be clear about gathering 'Informed Consent' that includes a thorough risk and safety assessment; and have a plan in place about how you will respond in the event of an emergency or risk to safety/well-being;
- Be clear about what the engagement can and can't offer—be realistic;
- Start preparing for the activity and put in practice time before hand;
- Make sure that appropriate support is in place during the activity and debrief afterwards (to survivor activists and staff/volunteers);

- Monitor progress and record well-being and any other risk issues that emerge;
- Consider your plan for next steps including assessing impact; and
- Maintain good boundaries throughout the process.

Conclusions

For organisations interested in building similar survivor activism models, this is a small offering of advice based on my personal perspective of what is necessary to consider to move any involvement away from tokenistic participation to a survivor-centred space.

There is a lot of hidden work that goes on behind the scenes including constant reflection about how to build on and improve for the future. Of course there are times where we might get it wrong. There are also times where internally our approach might not be in sync with other departments. But this is constant work in progress and our organisation continues to demonstrate its commitment to amplifying survivor voices including through survivor activism where we continue to build on our successes and look to grow over the coming years.

References

Haoussou K., (2017) Perspective—The long journey to rehabilitation for torture survivors. *Torture 27*, (1) 66-74.

Evans, III, B. F., Hass, G. (2018). Forensic Psychological Assessment in Immigration Court. New York: Routledge.

Edited by Barton F. Evans III, Giselle A. Hass

Published by Routledge. New York.
(ISBN-13: 978-1138657731)

Mari Amos, MA, MPh*

This guidebook by Barton F. Evans III and Giselle A. Hass, published in the US this year, has been written by two experts in the field. Barton F. Evans III, Ph.D, a clinical and forensic psychologist as well as a Clinical Professor of Psychiatry and Behavioral Sciences, and Giselle A. Hass, Psy.D., ABAP, a licensed psychologist and a diplomate by the American Board of Assessment Psychology. Both of the authors have had long-standing professional careers in the area of assessments for immigration courts in the United States of America.

*) Current Member of the United Nations Subcommittee on Prevention of Torture
Correspondence to: mari.amos@gmx.com

The book is an essential, specialized guide for psychologists and clinicians who work with immigrants. It is an attempt to draw together the authors' knowledge about forensic psychology, psychological assessment, traumatology, family processes, and national and international political forces to present an approach to effective and ethical practice of forensic psychological assessment in courts.

The book consists of three parts. The first part of the book gives an insight into the conceptual background, such as, culture, gender, credibility etc. The second part offers numerous applications of forensic assessment approaches to common areas of immigration law practice. In the third part, the use of psychological tests and methods, report writing and expert testimony for the immigration courts are explained. This approach leads the reader, via theory to practical information about carrying out an evaluation and delivering the results to both customer as well as the court. Personal reflections and experiences and practical examples about the cases the authors have been dealing with are also included throughout the book.

There are many key messages that the keen reader can discover and benefit from. For example, in Chapter 1, principles of forensic psychology and how they are relevant to the immigration court (IC) are clarified. In this framework, it stresses the fundamental differences between the forensic assessor and the mental health clinician that should be kept in mind. The most important difference is that the forensic assessor must take an objective, neutral stance in the evaluation which is different from the supportive, accepting, empathic, and confidential relationship critical to good clinical treatment. The evaluator should therefore always remain

neutral and be able to back-up findings with scientific, well-acknowledged tools and methods. Chapter 2 explores cross-cultural, gender, and language perspectives. The authors remind us to understand issues of race, ethnicity and culture. For example, the emotional impact of abuse and discrimination on account of race, ethnicity and culture is further aggravated when immigrant workers are forced by necessity to accept jobs of a lower status than they would have in their native countries. One aspect of this issue has to do with limited English proficiency and acculturation which, according to the authors, is unfortunately rarely assessed in forensic assessments.

The main value of the book certainly lies in Part III–Methodology which consists of three chapters (Diagnostic Interviewing and Trauma-Specific Instruments in Immigration Evaluations, Rorschach and Performance-Based Measures in Immigration Evaluations, and Report Writing and Expert Testimony) which are comprehensive, appropriately detailed and practical. Chapter 9 explains that psychological assessment instruments include clinical interviews, symptom-specific tests, and comprehensive personality tests. Several tests are introduced and described with respect to their content, usability and value. Chapter 10 attempts to highlight how the Rorschach and other Performance-Based Measures can be used in evaluations in the context of relevant legal issues by the appropriately trained assessor in forensic evaluation in the IC. The section concludes with useful practical tips for writing a report and presenting it. This being so, Part III is very helpful for those who are interested in or have to start practising in, or exploring the area. Parts of it act like a manual in that, on certain occasions, it takes a step-by-step approach.

Table 2.1 is quite inspirational, giving a long list of recommendations when using interpreters. At the same time, as the book generally appears to be aimed at those who have at least some knowledge about this issue, the list could be considered too basic.

Readers are reminded about the importance of the evaluator's professionalism in such proceedings and Chapter 2 and Figure 2.1 are very helpful in this regard as they provide an overview of the main necessary competences as well as a tool for self-reflection for those who are already active in the area. This level of detail might in fact attract novices to purport to have more skills than they actually have and follow tools detailed in the book without the appropriate professional background. Another important, but often neglected area is the need for self-care for evaluators. Supervision, peer-support etc are crucial for working fruitfully and efficiently on this field.

Despite the aspects to recommend it, the book lacks a common approach and style. It mixes personal stories and reflections; scientific research in forensic medicine and psychology; lots of statistics, numbers and facts; overviews and assessments of tools; checklists and so on. All three parts of the book are absolutely different—starting from a collection of quotations in the first one, ending with very practical tips in the last one. Even the individual chapters are written in an un-unified way. Doubtless, there is much information available about immigration, evaluations, and hardships that people who have had to cut their roots are facing, but I am not sure all this needs to be included with science, stories and tools.

This raises the question: who is the addressee of this book? It fails to be a

practical guidebook for practitioners precisely because of its lack of systematism and the absence of an easy-to-use format. At the same time, it does not qualify as academic as it does not provide synthesis and new approaches. Some parts of the book are written in a well-structured way, whilst other parts use a different style and content, with even minor technical things like references being put in different ways. Perhaps the real beneficiary of this book is the possible "examinee" who could (by skipping the first theoretical parts) get rather a good idea on how to pass proceedings with "clean records"?

After Deportation: Ethnographic Perspectives

Edited by Shahram Khosravi

Published by Palgrave Macmillan (ISBN-13: 978-3319572666; ISBN-10: 3319572660).

Louise Victoria Johansen, PhD, Ass.Prof.*

In *After Deportation: Ethnographic Perspectives*, thirteen chapters by different authors provide strong accounts of what happens when migrants and rejected asylum seekers are deported from countries in which they have resided for shorter or longer periods. This anthology highlights a phase of deportees' lives that is seldom ethnographically studied when compared to the much larger interest given to immigration detention and deportation. The ethnographies highlight post deportation phases from different geographic, gendered and social perspectives. Some of the narratives include deportation from EU countries to countries such as Nigeria, Cameroun, Mali and Togo, while other chapters analyze experiences of deportees from the United States to the Caribbean, from Australia to Samoa, or even from Iran to Afghanistan. The authors show how the very different circumstances in which people are deported shape their constraints and possible strategies.

*) Faculty of Law, University of Copenhagen, Denmark
Correspondence to: louise.victoria.johansen@jur.ku.dk

Many of the contributions cite Natalie Peutz's call for an 'anthropology of removal' (2007), focusing on spatial and temporal dimensions of deportation. The authors thus distance themselves from the general notion of deportation as a movement from one nation state to another. While politically, deportation is couched as *ending* migration, deportation is for many migrants just part of a migration cycle in which new possibilities for migrating will continuously be explored. Therefore, the present book argues that deportation involves longer periods of time, geographical spaces, institutions, and people than perhaps expected. Deportation is seen as a transnational, intercontinental and postcolonial phenomenon. Through its involvement with individual deportees, the book shows how they are part of larger sociopolitical and economic agendas. The so-called 'Global North' needs labor from the 'Global South' but wishes to regulate this flow through possibilities of importing and deporting laborers. The authors criticize the official rhetoric surrounding deportation through the use of concepts like 'home country', 'family' and 'reintegration'. These discourses serve to depoliticize deportation which is precisely characterized by separating families in the country of deportation. Similarly, programs of 'assisted voluntary returns' are mostly not voluntary nor are they perceived as a 'return' by deportees themselves. The book pinpoints how 'assisted voluntary returns' are instead part of neoliberal governing practices through which deportees are perceived as self-governing subjects who are able to handle decisions about their own deportation.

Methodologically, most of the chapters use qualitative or mixed methods, although the volume of qualitative data varies somewhat from chapter to chapter. The studies often involve a longitudinal approach, following people through different phases of their deportation. As a consequence, most studies are multi-sited and use different kinds of communication technology such as Skype and other internet media, underlining how an ethnography of deportation cannot just be about 'places' to study, but also about *who* to study and *how* to follow people on the move.

Several of the contributions analyze gendered aspects of post-deportation. For instance, gender is crucial to understanding female sex worker migrants from Nigeria, who have been deported from an EU country. Not all sex workers are victims of human trafficking, but they are often depicted as such. By accepting this categorization, they may gain access to some kind of economic support from the deporting countries, but at the cost of having to perform 'the good victim' as entrepreneurs in the country of return.

The problem of receiving economic support in the process of deportation, called 'pay-to-go' models, is also addressed in other chapters of the book. The relative success or failure of this model is dependent on several issues. A key to success is if migrants have had the chance to plan their departure. Unfortunately, this is precisely not the case for deportees, who are often picked up without notice by police and transported directly to migration detention. Furthermore, rejected asylum seekers often return to countries still at war, making it almost impossible to set up a business or the like. These obstacles highlight how pay-to-go initiatives are political legitimations for deporting people, but with little or no positive outcomes for either deportees or receiving countries. One further interesting perspective put forward in another chapter is the fact that deportees have a better chance of coping with deportation if they have been

imprisoned in the deporting country than if they have been in immigration detention. Being in prison may involve access to education and the possibility of planning their own deportation.

A criminal conviction is one of the recurring reasons for deportation. Authors show how this may have particular negative consequences for deportees because they have often been long-term legal residents in the country of deportation, where they also have families. As deportees, they feel total estrangement, loss, and regret over past actions. At the same time, their new community often meets them with fear and hostility.

Running through all chapters is the overall description of loss, separation and failure following deportation. Some informants describe how it is more stigmatizing to be a deportee than to be a sex worker because it is perceived as a sign of downward social mobility. The economic and social situation may also have changed for the worse in the country of return, making it extremely difficult for deportees to cope. Deportation is depicted as a life-changing event, placing deportees in strenuous situations of liminality because of their role of being in-between different countries, cultures and communities.

The anthology renders detailed portraits of people who live in these post-deportation situations. Each chapter provides different perspectives on their hardships and the coping strategies they develop. Authors as well as informants insist on the fact that deportees are not victims but actors trying to navigate in the new situations they encounter, for instance by developing 'transnational survival strategies' and using their skills from the 'Global North' in their receiving environments.

As such, *After Deportation : Ethnographic Perspectives* conveys strong accounts of people who experience the period post-deportation and its consequences on their own lives, their families, and the communities they form part of. Nevertheless, it might be interesting to pursue further aspects in future post-deportation studies. For instance, the book analyzes single aspects of gender or age and their impact on how people experience deportation, but it would be interesting to analyze in a more in-depth way how intersections between race, age, gender and class influence deportees' life situations in different ways. Several chapters mention the legal aspects of deportation, for instance, that insufficient knowledge about how to renew a residence permit may lead to deportation. In addition, the 'externalization' of border controls by the 'Global North' to places of departure is shown to create new criminal categories such as 'illegal *emigration*', and thus also new legal norms in 'Global South' countries. These legal and often quite technical aspects of (post) deportation would be rewarding to study further since they both visibly and covertly shape deportation processes.

Tainted by Torture: Examining the Use of Torture Evidence

Edited and Published by REDRESS and Fair Trials. (Free access)

Sara Lopez. PhD. Senior Legal Advisor*

In 80 pages, the report *Tainted by Torture: Examining the Use of Torture Evidence*, jointly written by Redress and Fair Trials, analyses legislation, jurisprudence and data on the admission of evidence obtained under torture. It identifies not only the different models of regulation in applying Article 15 of the Convention against Torture,[1] but particularly focuses on the limitations, both interpretative and practical, found in this provision.

The authors draw on a comparative survey of the law and practice of 17 countries, namely, Australia, Brazil, China, England and Wales, France, Germany, Indonesia, Japan, Kenya, Mexico, Spain, South Africa, Thailand, Tunisia, Turkey, the United States of America and Vietnam. As they explain, this data was used to examine different ways of implementing the prohibition on using evidence obtained under torture, to identify challenges in the course of applying it and any gaps in the protection against its use. The great contribution of this report, compared with previous reviews, is precisely its effort to identify the real translation of the prohibition into different state models, providing evidence on existing formats and how they function in practice. Taking on this complex and ambitious task is not only courageous but is also important as it provides an evidence-based proposal to limit the judicial legitimation of torture. The proposals and conclusions of the report are a remarkable starting point for undertaking this work.

The report is divided into several chapters, dealing with different aspects of the admissibility of evidence obtained under torture in the named countries, including whether: (i) the prohibition is absolute; (ii) it extends to other forms of inhuman or degrading treatment or punishment; (iii) it covers evidence obtained from the torture of a third party; (iv) it covers derivative evidence/'fruits of the poisonous tree'; and (v) there are effective legal procedures in place to identify and exclude 'torture evidence'.

Chapter I, "The prohibition on torture and the exclusionary rule", examines the international regulation on the prohibition of torture, with a particular focus on the rights and principles to do with the violation of the exclusionary rule with respect to the use of confessions obtained under torture.

Chapter II, "The components of the exclusionary rule", analyses the different models, monistic or dualistic, express or implied regimes, which can be adopted with respect to the prohibition on 'torture evidence' in different countries. Of particular interest is the study of the balancing act between the system in the Commonwealth and Western Australia. The chapter also addresses challenges arising from the fact that the prohibition of

*) SiR[a] Center.
Correspondence to: acdc@nodo50.org

1 Article 15 of the Convention states that, "Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made".

torture is not extended to other forms of cruel, inhuman and degrading treatment. The analysis of the differing national implementation of the evidence obtained by torture of a third party is particularly relevant. Similarly, the varying application of excluding derivative evidence ('the fruits of the poisonous tree' or evidence obtained illegally) is also reviewed in detail and with considerable cross-national evidence.

Chapter III, "Triggering the procedure", reviews in detail the different models of regulation and procedural practices in combating the use of evidence obtained under torture. It examines the different moments in which the illegality of the evidence may be challenged; it defines the standards relating to the right to a fair trial under international law; it verifies the different systems of burden of proof, again with numerous comparative evidence; and considers the different types of evidence that courts can take into account when assessing whether evidence was obtained by torture. The breadth of the legal, jurisprudential and practical review of the chapter provides a clear overview of the advantages and weaknesses of the different models analysed.

One of the most relevant chapters is Chapter IV, "Making the exclusionary rule effective in practice". The absence of official data compels the authors to review whether NGOs and treaty-monitoring bodies are reporting instances of 'torture evidence' admitted in criminal cases. The chapter reviews the major problems for professionals in the justice sector, including the lack of training for judges on the relevant domestic laws and international standards; and, institutional disincentives among judges, such as the weight of work, or the risk of an adverse public, political or diplomatic response to a prosecution. The disincentives that operate among defence lawyers are also discussed, including the fact that they do not believe the court will exclude the evidence anyway, are concerned about their personal safety or that of their client, and fear that it will be detrimental to their future work. Similarly, the chapter thoroughly reviews practical barriers, which include the difficulties in ensuring the protection of complainants; the limitations in obtaining evidence of the existence of torture; the obstacles posed by delays in cases where the complainant is in pretrial detention; and the very frequent guilty pleas, which involve the withdrawal of the complaint in exchange for favourable treatment in application of the complainant's punishment. The clarity with which these complex practical dilemmas are identified in the report successfully lays bare the challenges that need to be addressed in this area.

Chapter V, "Tackling confessions-based criminal justice", in turn, proposes a clear approach to judicial models based on a single source of evidence that can easily be obtained under torture. Thus, different proposals for corroborating evidence are reviewed, as are the diverse systems of confession given at different stages in the proceedings or to different actors within the justice system. Reviewed too is the varied systems of procedural safeguards during the investigation in different countries. The chapter concludes with the need to reinforce the initiative of Juan Mendez, the former UN Special Rapporteur on Torture, to elaborate a universal protocol for interrogations.

Chapter VI, "Prosecutions and disciplinary sanctions stemming from revelations about torture evidence", briefly addresses the Convention's requirement that countries define torture as a specific offence in their Criminal Codes. It also reviews the major difficulties posed by the

duty to investigate in various countries; and examines some systems of administrative complaint bodies or inspectorates which have the power to investigate and sanction any unlawful conduct.

Chapter VII, "Remedies and reparation for victims", sets out the need for specific forms of reparation for forced confessions and reviews, in turn, the elements of the duty of reparation to victims (restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition) in the various systems under study, in order to identify the insufficiency of measures in this regard and to define future lines of work.

The final chapter, "Conclusions and recommendations", reviews the proposals made at the beginning of the report, providing suggested resolutions on each of the aspects addressed. The signatory organisations, Redress and Fair Trials, argue that the exclusionary rule should be accorded a more prominent role in the work undertaken to combat torture; it should define a clear focus for advocacy efforts, including by domestic civil society actors. They argue for clarity on the extent to which the exclusionary rule overlaps with derivative evidence and evidence obtained as a result of inhuman or degrading treatment or punishment. The elaboration of approaches which address how the law is operating in practice is proposed, and an increased focus on rights-compliant police investigations is recommended. Not least, the report calls for the adoption of reparation measures for victims in accordance with the requirements of General Comment No. 3 of the Committee against Torture. All in all, it is a thorough and geographically broad analysis which is at the same time a reasonable and understandable rallying cry in the name of justice for torture survivors.

Grotesque image can never be forgotten nor forgiven

An adult male was admitted in Rani Laxmibai Medical College, Jhansi, MP, India, where his leg was amputated. Regrettably, the patient's amputated leg was tucked under his head as a pillow while the patient was recuperating in the emergency section of the hospital.

This situation is clearly professionally unethical, promotes medical ostracization, creates psychological issues for the victim, and works against inherent humanistic values and medical progress and accepted norms of decency. This form of mental torture may not exactly conform to the definition of torture in the Convention against Torture. However, it must certainly be degrading treatment, at the very least, and such practices must surely be condemned by the medical professional worldwide. In this case, a non-implantable body part which has become 'non-self' being used as a pillow is highly likely to seriously detrimentally psychologically affect the patient.

Why did this happen? Whilst in a hospital such incidents should never take place, still they do. The problem of lack of resources and the increase in patient load has created an atmosphere where apparently minor lapses and unethical practices are often overlooked, or normalised. Additionally, patients find it hard to question the quality of health care as their treatment is going on, particularly as they may not consider healthcare to be their birth right - despite assurances given by the Indian government. Justification for incidents such as these is often inadequacies in the health care system. However, it is our firm view that this context does not and must not give free reign for medical professionals and other to indulge in blatantly unethical and unprofessional practice. It is important that standards are maintained to avoid traumatising or tortuous environments in healthcare settings (Centre for Human Rights and Humanitarian Law Anti-Torture Initiative, 2013).

We feel obliged to speak out particularly as this is not the first time that such a practice has been identified. On this occasion, the matter was highlighted by the press (Hindi Daily, 2018). Previously, similar situations have been shown to occur time and again in India (Husain, M., Anjum, A, Alshraim, M, Usmani, A, Usmani, J.A., 2012).

We urge that such practices be stopped and counselling should be provided to those hospital employees who are so susceptible to stress that they take short cuts without realising that these may cause deep hurt and downgrade professional values.

*Md Mojahid Anwar, MD, Ass Prof., Mohd Asrarul Haque, MD, Ass Prof, Afzal Haroon, MD, Ass Prof., Hena Fatima, *, Munawwar Husain, MD, Prof., ***

References

Centre for Human Rights and Humanitarian Law Anti-Torture Initiative. (2013) Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report. Washington College of Law: Washington, USA.

Edward (2005). *Principia Ethica.* Bames & Noble Publishing House.

Hindi Daily. (2018). *Dainik Jagran, Aligarh*, 11th March 2018, p.16.

Husain (2001). A proposal to revisit the UN torture definition. *Torture, 11* (21-22).

Husain, Anjum, Alshraim, Usmani, Usmani (2012). Situation Ethics: How relevant is 'right' versus 'useful' theory in ethical practice? *J Indian Academy Forensic Med, 34* (2), pp 154-155.

UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. A/RES/39/46.

How to support the Torture Journal

Help us to continue research development through the Torture Journal by sharing the journal and donating to the IRCT.

By credit card

Please visit www.irct.org to make a donation using a credit card. All transactions are guaranteed safe and secure using the latest encryption to protect your personal information.

By bank transfer

Danske Bank
Holmens Kanal Branch
Holmens Kanal 2
1090 Copenhagen K
Denmark
SWIFT code: DABADKKK

Danish Kroner (DKK) account
Registration No. 4183
Account No. 4310-821152
IBAN DK90 3000 4310 8211 52

Euros (EUR) account
Registration No. 4183
Account No. 3001-957171
IBAN DK69 3000 3001 9571 71

U.S. Dollars (USD) account
Registration No. 4183
Account No. 4310-005029
IBAN DK18 3000 4310 0050 29

Campaign to reach 3,000 subscribers

Help us to disseminate the knowledge in the Torture Journal to where it is needed:

By encouraging your contacts to sign up
via www.irct.org.

By sending contact details of relevant organisations
to publications@irct.org.

Subscription:
Write to publications@irct.org to receive an email when a new issue is published or for a printed version (stipulating your profession and address).

The Torture Journal is a scientific journal that provides an interdisciplinary forum for the exchange of original research and systematic reviews by professionals concerned with the biomedical, psychological and social interface of torture and the rehabilitation of its survivors. It is fully Open Access online, but donations are encouraged to ensure the journal can reach those who need it (www.irct.org). Expressions of interest in the submission of manuscripts or involvement as a peer reviewer are always welcome.
The Torture Journal is published by the International Rehabilitation Council for Torture Victims which is an independent, international organisation that promotes and supports the rehabilitation of torture victims and the prevention of torture through its over 150 member centres around the world. The objective of the organisation is to support and promote the provision of specialised treatment and rehabilitation services for victims of torture.

With the generous support of

Uddannelses- og Forskningsministeriet

OSSTT

STARTTS NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

ISSN 1018-8185