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# LAND ACKNOWLEDGMENT

Voices Against Torture is published on the Unceded Homelands of the displaced xwməθkwəyə̓ m (Musqueam), sel̓ílw̓ itulh (TsleilWaututh), and sḵwx̱w̓ ú7mesh (Squamish) Coast Salish peoples. We pay respect to the Elders past and present and are grateful for the many diverse Indigenous peoples who, over generations, cared for these shared Traditional Territories. We recognize the truth of violence, the painful history of genocide, and the forced removal that took place on this Ancestral Land. We are committed to the everyday actions that can help transform colonial impacts and help us move towards a culture of healing. This also means to us deeper alignment with the values rooted in anti-oppression and universal trauma-informed care, supporting a society based on equity, equality, and justice. We hold ourselves globally accountable to all human rights and to all Traditional Custodians of the Land wherever they now exist or compelled to co-exist. We comprehend that this Land Acknowledgement is a small but essential step in our ongoing process of remaining in right relations and continuum towards transparency and accountability.

# EDITORIAL BOARD

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# EDITORIAL

Each year on December 10th, World Human Rights Day marks a global promise of the promotion of respect for human rights among the ranks of societies and nations, as enshrined in the United Nations' Universal Declaration of Human Rights (UNDHR), since1948.

Last year, the 75th World Human Rights Day theme centered on human dignity, freedom, and justice for all. Despite a growing recognition of the noble cause of human rights and guarantees of safety and security at international and national levels, the human rights landscape is tainted with weeping wounds and scars. Not only are human rights violations witnessed at individual and community levels, but also state-led human rights violations against their own citizens and those of other nation-states are on the increase. This heightened situation of human rights violations compromises human dignity, freedom, and the right to justice.

There is unfortunately a growing incidence of people seeking refuge in other countries because of injustice and a lack of the most basic safety internally within their own country as well as forced exoduses by state-led external aggressors. In the recent past and present, populations in Syria, Yemen, Myanmar, Congo, Sudan and Ukraine are facing this trauma of needing to seek refuge.

Each year, alongside Human Rights Day, World Refugee Day is also celebrated in support of people forced to leave their homes in their countries to escape persecution. The theme of the 2023 World Refugees Day was 'Hope away from home.'

The forced displacement process produces an intergenerational trauma, as many generations are affected by psycho-somatic injuries inflicted on refugees, including *inter alia* economic deprivation, food and nutritional insecurity, and denial of access to health and education services. As a consequence, many face abuse, persecution and violence. Children, women, and the elderly are the ones who bear the major brunt of gender-based violence. Young men are sent to fight wars and enemies that they do not understand, and which produce long-term psychological and physical impacts on those who are lucky enough to survive. During humanitarian crises, environmental catastrophes, and other complex emergencies, this reality is worsened, further marginalizing already disadvantaged communities.

There is tremendous need to further refine, inform and legislate, the global and national policies on human rights, migration, and refugees through well-founded advice and a heightened voice against torture. VAT is committed to being a global voice in this regard by helping expand the knowledge base on human rights, sharing the perspectives of survivors, and helping communities and nations become a hope for all those away from home.

Farooq Mehdi and Frank Cohn

# HUMAN RIGHTS OUTLOOK

# Impact of War Trauma on Interpersonal Mistrust among Syrian Refugees in Germany and Their Interpersonal Trust in Germans

**Ahmad Al Ailan**

**Abstract**

In forced migration literature, there is a lack of studies on the impact of war trauma on interpersonal mistrust among refugees and their interpersonal trust in members of the host society. To contribute to filling this gap, the author studied the impact of war trauma on interpersonal mistrust among Syrian refugees in Germany and their interpersonal trust in Germans. The data are based on semi-structured qualitative interviews with 20 Syrian refugees and asylum-seekers conducted in 2018 and 2019. The author argues that because traumatized refugees are powerfully influenced by past traumatic events experienced in their home country, they tend to mistrust people who can be associated with the place where these traumatic experiences occurred. In contrast, they are inclined to trust people who cannot be linked to the geographical location of the traumatic experiences. The main result of this study is that similarity—that of war-traumatized refugees sharing the same socio-cultural backgrounds—leads to interpersonal mistrust, while dissimilarity leads to interpersonal trust. The author of this paper calls for considering trust-building among war-traumatized refugees, which has significant importance for refugee integration.

**Keywords**: Germany; interpersonal mistrust; interpersonal trust; Syrian refugees; trauma; war

## 1. Introduction

According to the German Federal Office of Migration and Refugees, Syrian refugees are the biggest refugee group in Germany (Bundesamt für Migration und Flüchtlinge 2020). Syrians fled their country due to a destructive civil war described by the UN High Commissioner for Human Rights Zeid Ra'ad Al Hussein, in 2017 as the "worst man-made disaster the world has seen since World War II".

Researchers such as Elbert et al. (2006) and Elbert and Schauer (2002) have explained the mechanism of how war trauma impacts the human mind. In addition, a considerable number of studies on refugees and asylum-seekers have shown a strong relationship between war exposure and depression, as well as the fact that grief is mediated through trauma (Jabbar and Zaza 2014; Bean et al. 2007). Bemak and Chung (2017) found that displacement and premigration situations of war and conflict may involve witnessing or being subjected to torture, killings, atrocities, incarceration, starvation/deprivation (e.g., food, shelter), rape, sexual assault, and physical beatings. Those traumatic experiences can lead to long-term impacts on mental health, including higher rates of anxiety, depression, and post-traumatic stress disorder (Baird et al., 2020).Stotz et al. (2015) found that refugees' exposure to multiple traumatic events poses a risk factor for mental health, including greater suffering and functional impairment due to shame and guilt. Knipscheer et al. (2015) concluded that refugees and asylum-seekers have been shown to be at substantially higher risk of developing post-traumatic stress disorder (PTSD). Refugees exposed to more than three trauma events had a heightened risk of mental illness (Steel et al. 2002), whilst many refugees continue to have PTSD even after being safely relocated (Said 2015).

Several studies have addressed the negative influences of the war on the mental and psychosocial wellbeing of forced migrants from Syria. For instance, Wells et al. (2015) concluded that refugees from the conflict in Syria had been exposed to various stressors known to increase the risk of mental distress. These may include witnessing atrocities as well as dealing with the challenges of surviving in the displacement context. Kliewer et al. (2021) observed high levels of PTSD symptoms among Syrian refugee students in Jordan, particularly among males, for cultural reasons. Syrian refugee students in Turkey reported multiple traumatic experiences, acute post-traumatic stress, and severe emotional and behavioural problems (Gormez et al. 2017). A report by the Global Child Protection Group showed that 98% of Syrian children surveyed in the Zaatari refugee camp in Jordan reported deterioration in their psychosocial wellbeing (Abdel Jabbar and Zaza 2014).

This study concentrates on the mistrust among Syrian refugees and their trust in Germans on the interpersonal level. It refers to "trust and mistrust between people" based only on nationality regardless of the inside variations within the groups of Syrians and Germans, for instance, ethnicity or religion. In addition, it does not include political or institutional trust, such as the office for foreigners and the social office or the German police.

Although there is not only one definition of trauma (Sweeney et al. 2016), in this study, I use the American Psychological Association's definition of trauma:

Trauma is an emotional response to a terrible event such as an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms such as headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.

In this study, I address the question of how war trauma affects interpersonal trust or mistrust towards members of the in-group (Syrians in Germany) and members of the out-group (Germans).

The author aims to develop academic debates about the impacts of trauma on traumatized people. The study addresses new dimensions of trauma impacts, namely, the impact of war trauma on interpersonal mistrust among traumatized refugees and their interpersonal trust in the people of the host country. In this study, the author shows how the traumatic war experiences that Syrian refugees have been exposed to in their country of origin influence their mental and psychological wellbeing and interpersonal mistrust. In addition, it is illustrated how those traumatic experiences also influence their interpersonal trust in Germans. Through the example of Syrian refugees, the author draws attention to the major result of this study, which is interpersonal mistrust among traumatized refugees from war zones follows the rule of similarity, that is, 'having the same socio-cultural backgrounds,' and their interpersonal trust in hosts follows the rule of dissimilarity with the traumatized refugees. This result shows that the phenomena of trust and mistrust among forced migrants from war zones might not always follow the same logic as other researchers found within native's communities.

## 2. Literature Review

Although many researchers and writers in the field of forced migration studies have made reference to trust and mistrust in the lives of refugees, few have focused specifically on these issues (Ní Raghallaigh 2014). However, the literature on refugees' trust and mistrust can be classified into three major strands at least.

The first strand of this literature focused on the institutional trust and mistrust of refugees (refugees' trust in the institutions and organizations of the host society). For instance, Eide et al. (2020) studied unaccompanied refugee minors' distrust of institutions responsible for providing social services in Norway. They found that their distrust was related to the complex system of requirements in the care institutions, such as work schedules, documentation, and, more generally, rules and regulations that make personal relationships difficult to sustain. Furthermore, Majumder et al. (2015) studied the perceptions of mental health services by unaccompanied refugee adolescents in the United Kingdom. They found that many participants held negative attitudes toward mental health care and had a lack of trust in services. This could be explained by their descriptions of their experiences within their home country of psychiatric care, their experiences of being a refugee/asylum-seeker, or cultural differences. Veck and Wharton (2021) studied refugee children's trust and inclusion in school cultures in the United Kingdom. They found that in the schools, there is mistrust directed towards refugees, which takes an entirely depersonalized form when it results from exclusionary processes that situate unique persons within generalized categories. This experience of refugees often accords with the palpable and painful reality that when people are persistently mistrusted, they are themselves all too likely to mistrust, rather than trust, strangers. Therefore, refugee children hold all authority figures, including educators, in suspicion. Lehti et al. (2022) studied the trust of refugee women who have experienced violence in their social counsellors in six European Union Countries. They found that victims often have difficulties trusting their counsellors and are not willing to talk about their experiences for many reasons, such as trauma and fear. They have difficulties recalling the details of the violence, or they feel ashamed; often, they do not understand the value of uncovering their experiences.

The second strand of this literature focused on trust and mistrust of the host societies in refugees (refugees as objects of trust). For instance, T. Hynes (2003) concluded that the rise of mistrust felt towards refugees in the UK is due to past legislation on asylum that has been based on deterrence and other measures restricting the rights of refugees. A more formally structured social exclusion of refugees comes in the form of compulsory dispersal through a separate agency; the national asylum support service has separated refugees from mainstream

society, leading to an entrenchment of the feeling of mistrust towards refugees at a national level. According to Harrell-Bond (2002), the undignified image of refugees, such as the increasing use of negative adjectives such as "bogus," "scroungers," "fortune seekers," and even "sores," to describe refugees leads to a treatment of refugees as institutional subjects that cannot be trusted. Kyriakides (2017) suggested that persons seeking refuge in Europe must sustain an identity of a 'non-threatening victim' if they are to gain recognition in a securitized culture of mistrust.

The third strand of this literature on refugees' trust and mistrust includes many studies that tried to find out why refugees and asylum-seekers are mistrustful. In this regard, researchers have addressed a variety of reasons that can be grouped into five main clusters.

The first cluster contains a group of reasons that are related to the life circumstances of refugees and asylum-seekers inside their origin countries. For instance, Fink (2001) suggested that the authoritarian nature of the political system and the atmosphere of fear and repression that envelopes many refugees' home countries creates a situation whereby the primary lens is suspicion and mistrust. The culture of mistrust has characterized not only the military regime but, in many cases, the opposition groups as well. Gandolfo (2022) studied trust and distrust in the Libyan refugee community in Malta. She found that the regime of Muammar Gaddafi and the ways that political and social distrust was facilitated by the government as a mechanism of regime preservation made distrust percolate into Libyan society. This has impacts on the fabric of Libyan society, which is traced to the present day and has an influence on the diaspora. As the war in Libya continues, particularized and institutional social trust is eroded at home and abroad as the communal fabric is pressured by factionalism, and while the Gaddafi era has ended, social and political distrust remains. P. Hynes (2009) concluded that mistrust that predominates within refugee populations may be due to religious, ethnic, linguistic, political, or other lines of fragmentation made manifest by this restructuring in their host countries. Richlen (2022) found that while external agencies sought a single communal address, Darfurian refugees largely viewed themselves as a collection of ethnic groups, a notion deeply entwined with trust. In this case, Darfurians decided to participate in a government decision that did not take into account these ethnic divisions. According to the same author, this had a direct and extremely negative repercussion on their self-organization, an impact which decisively influenced future Darfurian community organizing in Israel.

The second cluster is 'transnational studies', according to which trust and mistrust are cultural traits transferred from the origin countries of migrants and refugees to their settlement and host countries. For instance, Algan and Cahuc (2010) concluded that the inherited trust of descendants of US immigrants is significantly influenced by the country of origin and the timing of arrival of their forebears. Guiso et al. (2006) found that culture is not continually altered in step with the changes that individuals experience during their lifetimes. For instance, emigrants from Southern, low-trust regions in Italy tend to carry their mistrust to their new locations. Ketabi et al. (2012) studied the trust level among Iranian migrants residing in Toronto, Canada, and found that out-group social trust is significantly higher than in-group social trust. The results of this study suggest that the most influential factors causing this lower in-group trust should be sought in the pre-migration period. The weakness of social trust in the home country is often transferred to other countries—after migration—and is intensified due to problems of the migrant community and the increase in social risks.

Helliwell et al. (2015) demonstrated that migrants tend to make social trust assessments that mainly reflect conditions in the country where they now live, but they also reveal a significant influence from their countries of origin. The latter effect is one-third as important as the effect of local conditions. Rice and Feldman (1997) found that the trust of various immigrant groups in the United States strongly mirrors present-day trust in their ancestral countries. For example, descendants of immigrants from high-trusting Northern European countries, Scandinavian countries in particular, are more trusting than descendants of immigrants from low-trusting Southern European countries.

In this vein, Fukuyama (1995) stated that trust is a cultural heritage resulting from shared values that allow individuals to subordinate their interests to those of larger groups. According to Dohmen et al. (2012), trust attitudes are transmitted from parents to children through their education. In contrast with these studies, Dinesen and Sønderskov (2018) confirm that finding that present-day trust of immigrant's correlates with trust in their ancestral country is not unequivocal evidence for trust being a cultural trait.

The third cluster contains several studies that have answered the question why refugees and asylum-seekers

are mistrustful of the traumatic events that they have been exposed to inside war zones. For instance, Riaño-Alcalá and Goldring (2014) studied how social dynamics of trust and mistrust influence community organizing and networking locally and transnationally. They concluded that Colombian refugees in Canada have limited ability to return home, and barriers to community building in Canada are caused by deep mistrust rooted in the armed conflict time. In this vein, Morina et al. (2016) suggested that it is possible that the extent to which refugees were exposed to interpersonal trauma, such as torture, led to an erosion of their capacity to trust others. Kline and Mone (2003) demonstrated that, because of the impact of the war, people are no longer trustworthy or predictable. Neighbours often turn against neighbours, and traditional beliefs and customs, which at one time meant safety and security, are now used to justify murder and mayhem. The actions of others no longer fit established patterns observed throughout childhood.

A similar result was found by Robinson and Segrott (2002), who concluded that the reasons for mistrust are related to the fact that many asylum-seekers and refugees have been victims of persecution, harassment, and violence in their countries of origin. Nguyen and Bowles (1998) stressed that survivors of torture and trauma often find that their faith in life and people is shattered. Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. In line with these findings, Kijewski and Freitag (2018) demonstrated that civil war is negatively related to social trust. This effect proves to be more conclusive for individual war experiences than for contextual war exposure. Arguably, the occurrence of instances of violence with lasting psychological as well as social structural consequences provides people with clear evidence of the untrustworthiness, uncooperativeness, and hostility of others, diminishing social trust in the aftermath of war.

Furthermore, Bell et al. (2019) found that higher trauma scores were associated with lower levels of trust. Individuals who experienced interpersonal trauma could indicate acquired insensitivity to social rewards or inflexible negative beliefs about others as a sequel of the traumatic experience, which increases in relationship with the severity of the trauma. Vromans et al. (2021) conducted longitudinal research investigating the psychological distress in at-risk refugee women one year after resettlement in Australia. They found that the absence of trust in community members was associated with trauma and depression.

The fourth cluster comprised studies that have explained refugees' and asylum-seekers' mistrust of the asylum journey itself. For instance, Baker (1990) explained refugees' mistrust through what he called the 'refugee experience' that had taught them not to trust people anymore. Similar results were found by Lyytinen (2017), who explained refugees' mistrust by what she called 'exilic journeys,' suggesting that the question of trust building and/or loss is associated with the journey from the country of origin to the country of exile. T. Hynes (2003) concluded that flight is often imminent as the refugee no longer trusts their own government with their life.

The fifth cluster includes studies that illustrate refugees' and asylum-seekers' mistrust by the life circumstances inside their host countries. For instance, Voutira and Harrell-Bond (1995) found that within refugee camps, where competition for food and other resources is high, individuals may often feel that it is necessary to engage in the deception or manipulation of others to cope or survive. Trust in others, whether fellow refugees or aid workers, is unlikely to develop in such circumstances and indeed may not be in the best interests of individual refugees. Ní Raghallaigh (2014) found that the reasons for mistrust are embedded within the social contexts from which asylum-seekers have come and that they are exacerbated by the social contexts in which they are now living. Bilodeau and White (2016) confirm that immigrants to Canada make a clear distinction between trusts in other people in general and trust in Canadians in particular: the former is grounded in pre-migration cultural influences, while the latter is grounded in immigrants' experiences in the new host country.

However, studies on natives often have attributed different causes to interpersonal trust and mistrust phenomena. For instance, according to some researchers, people who are socially closely related tend to trust each other. Glaeser et al. (1999) concluded that differences in race and nationality reduce the level of trustworthiness; however, according to Glaeser et al. (2000), when individuals are closer socially, trust and trustworthiness occur. Trustworthiness declines when partners are from different races and nationalities. Delhey and Newton (2005) found that generalized trust is strongest when people have something in common with others, particularly when they are from the same ethnic background. Liang (2015) demonstrated that people trust those inside their circle more than those on the outside. Guiso et al. (2009) found that the coefficient of somatic distance shows that citizens of one country tend to be more trusting towards citizens of other countries

that are somatically closer. Barr (1999) determined that people trust each other less due to a lack of familiarity that leads to uncertainty when people try to predict each other's behaviour in strategic situations.

According to various trust researchers, economic equality and social equality give rise to social trust. For instance, Rothstein and Uslaner (2005) concluded that social trust is caused by two different yet interrelated types of equality: economic equality and equality of opportunity. Both types of equality lead to a greater sense of social solidarity, which spurs generalized trust. Kawachi et al. (1999) found that citizens' belief that most people could not be trusted was highly correlated with the degree of income inequality.

Alesina and La Ferrara (2002) found that the strongest factors associated with low trust belong to a group that historically felt discriminated against, such as minorities (black populations in particular) and, to a lesser extent, women, as well as being economically unsuccessful in terms of income and education, and living in a racially diverse community or in one with a high degree of income disparity. Mirowsky and Ross (1983) concluded that mistrust is produced through the interaction between the belief in external control and low current socioeconomic status. Mistrust is greatest where victimization is greatest; lower social classes are more likely to be victims of assault, robbery, purse snatching, pickpocketing, personal larceny, rape, and attempted rape. Life under such threatening conditions promotes mistrust.

The literature on refugees' trust and mistrust addressed several dimensions of these phenomena and suggested a variety of reasons for refugees' and asylum-seekers' mistrust. In addition, studies on natives have shown different reasons for interpersonal trust and mistrust. However, one hardly finds studies on interpersonal mistrust among refugees and asylum-seekers, and so far, there is no study that focuses on interpersonal mistrust among Syrian refugees and asylum-seekers in Germany. Furthermore, to the knowledge of the author, there is no study that focused on refugees and asylum-seekers interpersonal trust in members of the host society.

## 3. **Theoretical Background**

Despite decades of interdisciplinary research on trust, the literature remains fragmented and balkanized, with little consensus regarding its origins. We still lack a common conceptual understanding of what constitutes trust (Robbins 2016). There is no general theory of trust; rather, there is a degree of conceptual and theoretical confusion and a variety of partial approaches (Delhey and Newton, 2005). According to McKnight and Chervany (2000), trust is naturally hard to narrow down to one specific definition. Fisman and Khanna (1999) concluded that the definition of trust has been much debated by social scientists over the past decade. No single definition is entirely satisfactory. P. Hynes (2009) demonstrated that trust is an ambiguous term; it is complex and multifaceted, and once lost, it takes time to restore.

However, definitions of trust can be classified into two strands. First, trust refers to positive expectations about the trustee's behaviour. Second, trust is understood as a social relation between people and not as a decision taken individually.

Regarding the first strand, Amiraslani et al. (2017) concluded that trust is the expectation that another person will perform actions that are beneficial, or at least not detrimental, to us regardless of our capacity to monitor those actions. Gambetta (2000) concluded that when we say we trust someone or that someone is trustworthy, we implicitly mean that the probability that he will perform an action that is beneficial or at least not detrimental to us is high enough for us to consider engaging in some form of cooperation with him. Lewicki et al. (1998) define trust as confident, positive expectations regarding another's conduct, and distrust in terms of confident, negative expectations regarding another's conduct. Lyytinen (2017) defined trust as a positive feeling about or evaluation of the intentions or behaviour of another and conceptualized it as a discursively created emotion and practice which is based on the relations between the 'trustor' and the 'trustee'.

Yamagishi and Yamagishi (1994) defined trust as a bias in the processing of imperfect information about the partner's intentions. A trusting person is one who overestimates the benignity of the partner's intentions beyond the level warranted by the prudent assessment of the available information. Tanis and Postmes (2005) demonstrated that trusting behaviour will only be displayed when people think that others will not take advantage of the situation and when reciprocity is expected. Hardin (1992), who studied trust epistemologically, found that rational choice and other accounts of trust base it upon objective assessments of the risks and benefits of trusting. One trusts someone if one has adequate reason to believe it will be in that person's interest to be trustworthy in the relevant way at the relevant time. Omodei and McLennan (2000) defined interpersonal mistrust as a general tendency to view

others as mean, selfish, malevolent, or unreliable people who are, thus, not to be depended on to treat one well. In this vein, Dinesen and Sønderskov (2018) confirm that social trust is the inclination to trust unknown others in situations where little information exists about their trustworthiness.

Regarding the second strand, Lewis and Weigert (1985), who studied trust as a sociological concept, argue that trust must be conceived as a property of collective units (ongoing dyads, groups, and collectives), not of isolated individuals. Being a collective attribute, trust is applicable to the relations among people rather than to their psychological states taken individually. According to Rothstein and Uslaner (2005), social trust is a measure of how people evaluate the moral fabric in their society. Frederiksen (2014) argued that trust is not solely an individual phenomenon based on individual perception but also develops from and within social relations.

In this study, the author defines trust as an attitude based on positive expectations about the trustee, that his or her behaviour will be beneficial to the trustor and not harmful. Therefore, trust does not refer to the positive expectations themselves because those expectations happen first as reasons of trust; then, due to those reasons a trust attitude emerges. Moreover, trust is not a social relation because the social relation between the trustor and the trustee comes as a result of the trust attitude. This means that trust is embodied in social relations between the trustor and the trustee. Hence, the author argues that trust can neither be defined by reasons (positive expectations) nor by the result (social relations), but it is an attitude located between the two. For example, if someone has a trusting attitude towards another, this will be because he or she has positive expectations about the conduct of the other. As a result, the trustor finds himself or herself encouraged to have a social relation with the trustee.

However, the reasons for those positive and negative expectations are varied and variable and might be rational or irrational. For instance, they can be based on real information and direct personal experiences with the trustee, or they can be established on false information or the negative impacts of trauma. As a result, trust and mistrust can be logical or illogical attitudes. This explains, for example, why people can be disappointed after certain trust relations.

This study shows how Syrian refugees and asylum-seekers, under the impact of war trauma, establish irrational interpersonal mistrust attitudes towards each other and irrational interpersonal trust attitudes towards Germans. Interpersonal mistrust among traumatized Syrian refugees is established on the rule of similarity, meaning 'having the same socio-cultural backgrounds,' and their interpersonal trust is established on the rule of dissimilarity. This means that reasons for interpersonal trust and mistrust of traumatized war refugees seem to be different from those of native communities, as will be discussed in this study.

## 4. Methodology

According to Strauss and Corbin (1998), social reality is based on the interplay between personal conceptions and knowledge of the world. Accordingly, the data analysis of this study aimed to explain the phenomenon of interpersonal trust and mistrust of Syrian asylum-seekers by uncovering the causal and intervening conditions around the phenomenon. Data were collected in 2018 and 2019 in different parts of Germany.

Following the tradition of grounded theory, the data were collected and analyzed concurrently, starting with purposive sampling based on the topic of the study to understand the phenomenon of trust and mistrust among Syrian asylum-seekers in Germany. The sample size could not be decided in advance; only when no more categories occurred during the coding process was the recruitment of new respondents stopped. The final sample consisted of 20 semi-structured qualitative interviews with male asylum-seekers and refugees from Syria who, at the time, were all single. Their age at the time of the interview was between 20 and 35 years. They are from different ethnic backgrounds and religious affiliations from urban and rural areas in Syria. For cultural reasons, the author could not access female participants; for a male researcher, it is difficult to access their accommodation and to conduct interviews with them. Although this sample size is not large, the 20 interviews, each around 60 to 90 min long, provided information that is rich enough to fulfil the requirement of theoretical saturation (Strauss and Corbin 1998). Participants were recruited by using snow-ball sampling.

The semi-structured one-on-one interviews allowed participants to concentrate on and feel free to talk about the topic and share their experiences, feelings, and perceptions related to the process of trust and mistrust. Before answering the interview questions, all participants agreed to the informed consent provided in the Arabic language. All the interviews were conducted in Arabic,

tape-recorded, transcribed, anonymized, and translated into English by the author of this article.

After the interviews were transcribed, in the first step, the researcher started with open coding to find the major categories of information and their different dimensions. Based on that process, the researcher selected the category "similarity vs. dissimilarity" as a core phenomenon of interest resulting from the interviews. During the second step of data analysis, the causal conditions that influence the core phenomenon, respondents' ways of negotiating and making sense of the core phenomenon, and the context and intervening conditions that shape respondents' perceptions were identified (Strauss and Corbin 1998). Participants were recruited by using snow-ball sampling.

During the research and data analysis, two biases had to be considered and overcome: the personal experience and pre-knowledge bias and the asymmetrical power relationship between interviewer and interviewee. First, my personal experience as someone with the same background as the respondents provides me with an insider perspective that might be different from the perspective of a researcher without this experience. This is particularly relevant with respect to the topic of mistrust towards members of the in-group. Being aware of this potential bias, this perspective also offers the advantage of a way of analyzing that might be difficult for other researchers to carry out due to barriers of language and culture. In addition, the asymmetrical power relationship between interviewer and interviewee always bears the danger of affecting data collection. In the case of the present study, the interviewer is an academic who lived in Germany for several years, while the respondents did not have an academic background and had just arrived in Germany some time ago at the time of the interviews. Therefore, it was important to always encourage the respondents to share their ideas freely and to avoid giving any signs of approval or disapproval of their stories.

## 5. **Findings**

This section first shows the traumatic experiences that Syrian refugees have been exposed to in their origin country. Based on these insights, the interpersonal mistrust among Syrian refugees and asylum-seekers is explained. Finally, the section shows Syrians' interpersonal trust in Germans and their justification for this attitude.

### 5.1. *Syrian Refugees Being Exposed to Traumatic Experiences*

All Syrian interviewees reported that they had been exposed to and witnessed many traumatic experiences in their home country. These experiences include witnessing the death of members of their families, being subject to cruelty or torture, seeing wounded or dead people, or living in an area sieged militarily for a long time. For some, this occurred when they were minors.

One Syrian refugee, who witnessed his parents' and his neighbours' deaths due to a military aircraft raid, explained how it is so difficult for him to continue his life normally even after more than a year of his arrival to Germany.

*"From January 2013 on, the city was exposed to shelling. On 12 January 2013, a military plane bombed the building where our home was. All inhabitants died, including my parents; I was the only survivor. Then, the area was sieged by the regime and its allies. For three years, we had no electricity, no clean water, we ate animals' food […] When there was shelling, the ambulance cars went to bring wounded or dead people from under the rubble; I saw the cars pass in front of me, carrying wounded and dead people".*

*Interviewer: "Do the visual images of those events still affect you?"*

*"It does not leave me. Even now, I feel panic at the noise of a plane or even if someone sharply closes a door. There is a panic; there are psychological issues. I always have nightmares. I dream that I return there under the shelling. I have lost my appetite; I have lost more than ten kilos of my weight".*

(Interview three)

Another refugee from a different Syrian city was a child when his father died from gas inhalation in front of him, as the interviewee reported. He is afraid that his mother in Syria may die before he has a chance to see her again, as his refugee status does not allow visits to his home country.

*"[…] My dad died in front of us (members of his family) because of a strange smell that came out of a rocket that hit the house of our neighbour […] I feel the most afraid of this feeling; maybe my mom dies before I can meet her again".*

(Interview eight)

The traumatic events that Syrians have experienced inside their country of origin, and that may have been aggravated because of the situation inside the transit countries or the destination country, severely impacted their psychological and mental wellbeing inside Germany. For instance, interviewees have stated that they suffer from nightmares, visual images of traumatic

events, loss of appetite, loss of concentration, etc. The following quotations reflect this:

*"I go to school, half of the information I understand and half I cannot. And when I return home and try to study […] no more than half an hour, then I throw the book because I cannot concentrate".*

(Interview five)

*"It was the first time in my life that I saw dead people, three young people. I saw them dead; they were my neighbours. […] perhaps the travel to Europe made me 20 years older. How we reached Europe, only God knows. This makes me unable to concentrate, especially when I hear that something bad happened in Lebanon, where my family is still living. I cannot study on those days".*

(Interview 14)

Previous studies in different countries have stressed the bad influence of the war on the mental and psychosocial well-being of Syrian refugees, such as studies by Wells et al. (2015), Kliewer et al. (2021), and Gormez et al. (2017). In line with these existing results, as the data in this study show, Syrian refugees in Germany have been exposed to traumatic events in their origin country, which negatively impact their mental and psychological wellbeing, even after years of their arrival to Germany.

5.2. *Interpersonal Mistrust among Syrian Refugees*

All the Syrian refugees interviewed in this study reported that they suffer from interpersonal mistrust in members of their community, even though they are from the same nationality and have the same social and cultural backgrounds. Moreover, some of them reported that they mistrust even their siblings and parents. The following quotations show that:

*"I do not trust anyone, even my father. The bad circumstances that we had made me doubt even myself because of loneliness and depression. All souls have badly changed; even members of the same family have badly changed. Here in Germany, no one acts against you like the sons of your country. You must be careful about everyone and everything."*

(Interview five)

Another interviewee reported, "[…] Trust! I don't trust anyone, even my family members. I don't trust any of them" (Interview 17)

The main reason for the interpersonal mistrust among Syrian refugees, as they reported, is that they do not expect reciprocity. Moreover, they think that trust in members of their community will bring them the risk of harm, and there are no expected benefits from trusting other Syrians. Their conclusion, as they reported, is based on bad experiences, primarily during wartime and, in some cases, even after their arrival in Germany. Due to these experiences, they concluded that Syrians are selfish and only try to achieve their own personal goals. In addition, those interviewed believed that Syrians are dishonest and reveal the secrets of others. Because of these feelings, the Syrian refugees I interviewed had a mistrusted attitude towards members of their community. These experiences let them conclude that Syrians are selfish and only try to achieve their personal goals. In addition, they are dishonest and reveal the secrets of others. For all of that, they establish a mistrust attitude towards members of their community. The following quotations illustrate that:

*"It is well known that Syrian people cheat each other, just like what they are doing here in Germany […] If we were good, it wouldn't happen in Syria what is happening now".*

(Interview 19)

*"Every person wants his interests; you cannot trust anyone. From my experience, I was exposed to many stories that made me mistrust people".*

(Interview two)

*"People lie, you cannot trust anyone, and if you do trust someone, then he gets angry with you, he will uncover your secrets".*

(Interview 13)

*"After what I saw during the Syrian revolution and that people can be changed by money, and every person has his own interests, I cannot trust people".*

(Interview 14)

*"I don't trust anyone; even your best friend will cheat you […]"*

(Interview 20)

*"Currently, I do not trust people. I trusted guys two years ago for insignificant reasons; they told everything about me".*

(Interview six)

Based on the previous quotations, we can see that when a group of refugees is exposed to many traumatic events in their home country, similarity, or 'sharing the same social and cultural background,' does not necessarily and automatically lead to rising interpersonal trust but, in this particular case, interpersonal mistrust. This result seems to be different from what other researchers have found in

different contexts and different fields of study. For instance, Glaeser et al. (1999, 2000), who studied a sample of Harvard nonemigrant undergraduates, found that trust and trustworthiness increase when individuals are closer socially and that differences in race and nationality reduce the level of trustworthiness.

Likewise, Barr (1999), who studied natives in Zimbabwe, concluded that a lack of familiarity leads to uncertainty when people try to predict each other's behaviour in strategic situations and to a lower level of trust. Delhey and Newton (2005) found that generalized social trust is strongest when people have something in common with others, particularly when they are from the same ethnic background. This result shows that mistrust and trust among refugees from war zones seem unique in some respects in comparison with native communities.

Furthermore, it may not be enough to explain interpersonal mistrust among Syrian refugees in their life within camps, as Voutira and Harrell-Bond (1995) suggested; where competition for food and other resources is high, refugees may often feel that it is necessary to engage in deception or manipulation of others to cope or survive. Nevertheless, some of the interviewees in this study who had already been granted asylum were not living in camps but in small apartments. However, their interpersonal trust and mistrust attitudes are the same.

Syrian refugees' conclusion that other Syrians are harmful and not beneficial is because they have lived through civil war—a war fought not against an external enemy but between members of the same society. It is understandable to lose their trust in each other; this can be understood as a strategy to survive in the war zone. Trusting others in the war zones is dangerous and can end up in losing one's life. However, their mind keeps the same mentality, even after their arrival in Germany. Therefore, they have low expectations from members of their community and classify them as a source of danger. This is the case regardless of the relationship between them—parents, siblings, relatives, and neighbours—because they are Syrians, and Syrians are a source of danger in their minds. Therefore, this result, 'traumatic experiences as the reason of interpersonal mistrust,' corresponds with the studies in the third cluster that contains studies which explain why refugees and asylum-seekers are mistrustful of the traumatic events that they were exposed to inside the war zones. For instance, this is addressed by Riaño-Alcalá and Goldring (2014), Morina et al. (2016), Robinson and Segrott (2002), and Kijewski and Freitag (2018), etc., as shown in the literature review section.

5.3. *Syrian Refugees' Interpersonal Trust in Germans*

Despite the cultural and religious differences between Syrian refugees and Germans, language barriers, and the short period of time in Germany, all interviewees reported that they trust Germans. They addressed many reasons that made them have positive expectations of Germans, which led them to see them as trustworthy. For instance, for some interviewees, Islam is reflected in German culture and the way in which people interact with each other. The following quotation indicates that:

*"[…] I noticed that Islam is here in Germany".*

*Interviewer: "how did you conclude that?"*

*"Through their honesty when they deal with you, their commitment to deadlines. I did not find that in Arab countries, but I found it here in Germany. In general, I do not know many Germans, but I trust Germans more than Arabs".*

(Interview 18)

For some Syrian refugees, Germans, unlike Syrians, keep secrets and do not use them against the person who trusts them when the relation with them falls out for one reason or another. The following quotation reflects that:

*"Through my experience, and I have German friends, so far, I haven't seen anything bad from Germans. But Arabs, and through my experience with them, I saw a lot of bad things. Let me say that my confidence in Germans is greater. Unfortunately, this is a fact; if you tell your secret to an Arabic person, he will use it against you one day. Unfortunately, we have problems with backbiting and gossip".*

(Interview seven)

Some of the respondents trust Germans because Germans were brought up respecting the laws of the country. In addition, Germans know the legal consequences of breaking the law. Therefore, dealing with them is safer than dealing with other Syrian refugees. In addition, some interviewees found themselves sharing democratic principles with Germans. The following quotation shows this:

*"I trust Germans more because they were brought up in a legal environment, and they know the consequences of breaking the law. For example, the refugee, even if he knows the consequences, might underestimate them. I mean, it is possible for a refugee to attack me and disappear, and then nothing happens. But if a German wants to assault a person, he knows what the consequences are. Another thing, I feel that there are many common ideas between Germans and me, unfortunately not with my countrymen. Ideas such as democracy, respect for the other opinion even if it is offensive to you".*

(Interview four)

For some, honesty is the reason for trust in Germans; they think that Germans do not lie when they promise something. The following quotation reflects that:

*"The good thing about Germans is that they don't lie. When a German person says something, his words are true, not false. But you know, we lie a lot".*

(Interview 13)

Some Syrian refugees trust Germans because they help them solve problems that they face as new people in a foreign country. This might include, for instance, helping them with learning the language or supporting their asylum application. The following quotations reflect that:

*"The thing that influences me negatively is that, where I live, all people are Arab. So, I want to go to the job centre and ask them to send me to an area where there is no Arabic person. I need people who can help me in this country so I can stand again on my feet. The key to this country is the language. If you don't have it, you don't own anything in this country. Without it, you will live on the margins of life, and in my whole life, this never happened to me".*

(Interview ten)

*"I wasn't exposed to any problem with Germans; the situation is the opposite of that. In a room in the library, we come and sit with German people, and we talk transparently. They are very kind and accept our situation as refugees in Germany. They help us in solving many problems. There is an organization for helping refugees, and they have an attorney, and every person can come and speak his problems, and they will help him".*

(Interview eight)

As the previous quotations show, the case of trust in Germans among Syrian refugees who have newly arrived in Germany appears unique in some respects. They trust Germans because they think that Germans keep the laws of the country, keep the secrets, and they will help them to have better chances inside Germany. Therefore, the reasons for the trust that have been suggested by researchers in other contexts seem to be insufficient to explain this case of traumatized Syrian refugees in Germany from war zones. In other contexts, Fukuyama (1995) concluded that trust is a 'cultural heritage', but if Syrian refugees' interpersonal mistrust exists because they were brought up in a culture where people mistrust each other, that means they should also mistrust Germans, perhaps even more so than each other since they are not familiar with Germans, who have different nationality and culture; yet, as the previous quotations show, Syrian refugees trust Germans but not each other.

These findings suggest that trust and mistrust can be an irrational attitude, and the case of war-traumatised refugees may illustrate that. Because they are powerfully influenced by past traumatic events experienced in their home country, Syrian refugees and asylum-seekers tend to mistrust people who can be associated with the place where these traumatic experiences occurred. In contrast, they are inclined to trust people who cannot be linked to the geographical location of the traumatic experiences. Thus, the empirical results confirm what was already discussed in the section above on the theoretical background of this study.

In addition, interpersonal trust in Germans among Syrian refugees might be hard to explain by the 'transfer theory' in the field of migration studies since Syrian refugees were not in contact with Germans before their arrival to Germany. Hence, the argument by the authors of the studies in the second cluster in the literature review that trust and mistrust transfer from the home country of migrants to the destination countries (Algan and Cahuc 2010; Guiso et al. 2006; Ketabi et al. 2012), could be inapplicable in the context of forced migrants from war zones.

### 5.4. *Importance of Trust and Trust Building among Refugees*

Several studies have addressed the importance of trust relationships in general. For instance, Chappell and Funk (2010) studied the relationship between social capital and health status and examined social capital through social participation and trust. They found significant associations between trust and health. Nummela et al. (2012) demonstrated that low trust is a sensitive indicator of higher mortality risk among ageing men in Southern Finland.

Helliwell and Huang (2010) concluded that trust in neighbours, the police, and the workplace are strong determinants of respondents' subjective wellbeing. Helliwell et al. (2016) found that living in a high-trust environment makes people more resilient to adversity, and high-trust communities respond more successfully to natural disasters or economic shocks. In their study on Japanese people, Tokuda and Inoguchi (2008) found a strong relation between interpersonal mistrust and unhappiness.

Furthermore, trust researchers have addressed the importance of trust for economic growth and development. For instance, Knack and Zak (2003) showed that interpersonal trust substantially impacts

economic growth and that sufficient interpersonal trust is necessary for economic development. Alesina and La Ferrara (2002) found that when people trust each other, transaction costs in economic activities are reduced, large organizations function better, governments are more efficient, and financial development is faster; more trust may spur economic success. Zhang and Ke (2003) determined that trust affects the growth of the economy, the size of enterprise distribution, and the foreign direct investment inflow. Algan and Cahuc (2014) found that trust has a causal impact on economic development through its channels of influence on the financial, product, and labour markets and with a direct effect on total factor productivity and the organization of firms.

In addition, some studies have addressed the importance of trust in social relationships. For instance, Lewis and Weigert (1985) concluded that trust is functionally necessary for the continuance of harmonious social relations. Dinesen and Sønderskov (2018) confirmed that social trust is important for the human cooperation that underpins successful societies because most humans will cooperate only if they trust others to do the same.

According to Rothstein and Uslaner (2005), people who believe that, in general, most other people in their society can be trusted are more inclined to have a positive view of their democratic institutions, to participate more in politics, and to be more active in civic organizations. They also give more to charity and are more tolerant toward minorities and people who are not like themselves. Herreros and Criado (2009) found that societies with high levels of social capital facilitate the integration of immigrants because those members with high levels of social trust will tend to have more positive attitudes towards immigration. Hibbard (1985) found a relationship between trusting others, having greater social ties, and health status. Individuals low in interpersonal trust have been found to be less confident, less popular with others, and lonelier (Mitchell 1990).

In contrast, Kawachi et al. (1999) from the United States found that levels of interpersonal mistrust were strongly correlated with both violent and property crime. Greater interpersonal mistrust was linked with higher homicide, assault, and robbery, as well as burglary.

In the field of forced migration studies, fewer researchers have addressed the importance of studying trust among refugees, trust building, and the impact of distrust on refugee life. According to Richlen (2022), while there is significant literature about trust, relatively little research has examined trust within refugee communities. This has not been sufficiently theorized in terms of its impact on participation and representation. In her study on Darfurian refugees in Israel, she found that distrust decisively influenced future Darfurian community organizing in Israel. Gandolfo (2022), who studied trust and distrust in the refugee Libyan community in Malta, found that because of the distrust problem, the Libyan refugee community was loosely structured and less inclined to participate in the events organized by the Libyan civil society organizations. Riaño-Alcalá and Goldring (2014) concluded that the social dynamics of trust and distrust influence everyday relations and networks among Colombian refugees in Canada. For instance, there is a significant difference between those who arrived as economic immigrants and those who came as refugees regarding their participation in the Colombian associations in Canada. Participation in the association was confined mainly to professionals who arrived in Vancouver as economic immigrants. Although a significant number of the refugees in Vancouver had a professional degree, their participation was very limited.

Similar results were found by Guarnizo et al. (1999), who also studied Colombian refugees in New York City and Los Angeles. They showed that generalized mistrust has become a major stumbling block for the political organization of Colombians as a group.

In line with this result, I found that Syrian refugees in Germany, due to the negative impacts of interpersonal mistrust, also become unable to establish their own community within their host country even years after their arrival and despite their big numbers. Although there are around 800,000 Syrian refugees in Germany, so far, they have not established a 'Syrian community'. This is in direct contrast to other groups of migrants from Turkey and Morocco who have established their own schools, mosques, and cultural centres in Germany.

Therefore, as Lyytinen (2017) demonstrated, the question of trust-building among refugees can be of significant importance when refugees' integration and durable solutions are deliberated. The effect of length of time in a host country on the trust among a refugee group is not conclusive from the literature. More likely, time alone, without fundamental help, might not be enough to overcome distrust and political divisions among refugees.

Some researchers made suggestions in different contexts that policy-makers in Germany might take advantage of. For instance, Gandolfo (2022), for the case of Libyan refugees in Malta, suggested a cooperation between the

organizations and the refugee community leaders to solve the problem of social and political distrust.

Similarly, for the case of Colombian refugees in Canada, according to Riaño-Alcalá and Goldring (2014), local immigrant settlement organizations, an intercultural non-profit organization, and the social work department of a local university facilitated a process of community mediation. The immigrant community recognized the institutions as legitimate, and Colombians responded positively to an invitation to participate in a series of workshops. The workshops highlighted distrust, silences and traumatic experiences of loss and disorientation among Colombians and concluded with a proposal to create an association (Colombiestrie) dedicated to building trust, facilitating peaceful relations among its members, and supporting the formation of social networks for local incorporation.

The importance of trust for health, happiness, economic growth, and harmonious social relationships has been addressed by many researchers, as shown above. However, in the case of refugees, interpersonal trust has multiple factors of importance because of the critical situation of refugees in foreign host countries. For instance, because of the myriad differences between Syria and Germany and their lack of proficiency in the German language, Syrian refugees, as newcomers, need to trust each other to cooperate and benefit from exchanging experiences. In this way, they can cope with problems that emerge due to the lack of social and cultural capital. Therefore, interpersonal mistrust among Syrian refugees might lead to another problem, one the author calls 'lack of community.' This problem, as shown above, has already been noticed by some researchers, but regarding other groups of refugees who live in other countries, such as Colombian refugees in Canada and the US, and Darfurian refugees in Israel.

## 6. Discussion

Through the example of traumatized Syrian refugees and asylum-seekers in Germany, this study shed light on how traumatized refugees from war zones established their interpersonal trust and interpersonal mistrust attitudes based on the negative impacts of war trauma on them. Studies showed that interpersonal mistrust attitudes are established on negative expectations, whilst interpersonal trust attitudes are established on positive expectations. However, I argue that trust and mistrust attitudes are not the expectations themselves, as some researchers suggested because those expectations happen first as reasons, then trust or mistrust attitudes emerge as results.

Moreover, I argue that trust is not a social relation, as other researchers have suggested because the social relation between the trustor and the trustee comes as a result of the trust attitude. Therefore, trust can neither be defined by the reasons (positive expectations) nor by the results (social relations), but it is an attitude situated between the reasons and the results. Furthermore, because reasons for those expectations are varied and variable and can be real or unreal, interpersonal trust and mistrust can be rational or irrational attitudes. Traumatized Syrian refugees and asylum-seekers in Germany have established irrational interpersonal mistrust attitudes towards each other and irrational interpersonal trust attitudes towards Germans based on the negative impacts of trauma.

In this study, it is argued that the reasons for interpersonal trust and mistrust attitudes among war-traumatized refugees and asylum-seekers seem to be unique in comparison to the situation of native communities. Interpersonal mistrust among traumatized refugees is established on the rule of similarity—having the same socio-cultural backgrounds—and their interpersonal trust in members of the host society is based on that of dissimilarity. That is because traumatized refugees are powerfully influenced by past traumatic events experienced in their home country; therefore, they tend to mistrust people who can be associated with the place where these traumatic experiences occurred. In contrast, they are inclined to trust people who cannot be linked to the geographical location of the traumatic experiences.

Interpersonal mistrust inside the civil war zones can be understood as a defence mechanism that people tend to use to survive the war circumstances. Syrian refugees and asylum-seekers, as they reported, have personally suffered and witnessed many traumatic experiences, such as the death of family members, living in an area sieged militarily for prolonged periods, and personal exposure to torture. Since the war in Syria is a civil war, the agents of those traumatic events are mainly Syrians. Therefore, their minds tend to classify Syrians as sources of danger as a coping strategy for surviving inside the war zone. However, their minds cannot automatically switch off the survival strategies used inside the war zones as soon as they arrive in the host country; thus, their minds work in the same manner upon arrival in Germany. Consequently, the reasons for interpersonal mistrust among Syrian refugees and asylum-seekers, as they reported, are selfishness, dishonesty, and revealing

secrets. Most of it is based on the image of other Syrians in wartime more than on real experiences that they have encountered with other Syrians in Germany.

Moreover, it is argued that Syrian refugees' interpersonal trust in Germans also exists because traumatized Syrian refugees are inclined to trust people who cannot be linked to the geographical location of the traumatic experiences. Since German people cannot be linked to the civil war and the traumatic experiences there, Syrian refugees trust them. Therefore, the examples that Syrian refugees have listed to justify their trust attitude in Germans—such as honesty, keeping secrets, and commitment to the law—cannot be considered the real reasons. Because the Syrian refugees who newly arrived in Germany usually speak little German and do not have enough life experiences with Germans, it is still early for them to conclude that all Germans are trustworthy.

However, studies in the first strand of the literature review, such as the ones by Eide et al. (2020) and Majumder et al. (2015), have shown that refugees and asylum-seekers in different contexts mistrust institutions in their host countries. Therefore, the result of this study opens new horizons for future studies to explore the question of whether Syrian refugees have institutional trust or not, as is the case for refugees in other Western countries. Another question of interest for further research is what the reasons for institutional trust or mistrust of Syrian refugees in Germany are and what similarities and differences to the case of Syrian refugees' interpersonal trust in Germans exist.

Furthermore, because the reasons for interpersonal mistrust among traumatized refugees and their interpersonal trust in their hosts seem to be unique in comparison with natives, most of the reasons for those phenomena, as suggested by researchers in other fields, could be inapplicable in the case of traumatized refugees of war zones. For instance, familiarity, or having the same race and nationality, has been suggested by some researchers as reasons for trust. However, in the case of traumatized Syrian refugees, they are reasons for interpersonal mistrust. Likewise, interpersonal mistrust among traumatized refugees and the interpersonal trust in Germans might not be explained completely by the "transfer theory" which sets that trust and mistrust are transferred from the origin countries of migrants to the destination countries. Because Syrian refugees were not in contact with Germans before the war, we cannot consider their trust in Germans as transferred from Syria to Germany. However, we do not have enough evidence to prove that interpersonal mistrust among Syrians existed before the time of the civil war and whether it was at the same level or escalated by the circumstances of the war.

## 7. **Conclusions**

This study draws attention to several decisive cases. First, the traumatic war experiences to which refugees have been personally exposed or have witnessed in their home countries have severe and long-lasting impacts on their lives in their destination countries, even years after their arrival. Second, it is the rules of similarity and dissimilarity that determine the interpersonal mistrust among traumatized refugees and their interpersonal trust in their hosts. This is based on the impact of war trauma on their mind, as shown above.

Third, the results of this study show the need for more social and psychological support targeting trust-building among refugees who have fled war zones to achieve a better integration of them. Furthermore, it is important to understand refugees in a different way than migrants are understood. Thus, putting war-traumatized refugees and asylum-seekers together upon their arrival or linking them to each other might not make their lives easier in the host countries because they mistrust each other. Fourth, traumatized refugees' interpersonal trust in their hosts, which is based on the rule of dissimilarity with them, can be seen as a good potential that might facilitate their integration into the host society, for instance, by establishing friendship relations with members of the host society and adapting to the laws and the culture of the host country, unless the host society itself hinders that through different means such as complex and bureaucratic administration systems and negative stereotype images of refugees. This was shown, for instance, in the second strand of the literature in T. Hynes (2003) and Barbara Harrell-Bond (2002).

## 8. **Limitation**

This study focuses on refugees from the civil war zone in Syria, and it does not include other groups of forced migrants, such as people who fled their countries for economic reasons. This study showed that interpersonal mistrust among traumatized Syrian refugees and asylum-seekers and interpersonal trust in Germans exist because Syrians are powerfully influenced by the past traumatic experiences in their home country. Hence, the interpersonal mistrust and trust towards other groups of forced migrants, such as those who flee their countries for economic or environmental reasons, might be different.

Moreover, this study is about Syrian refugees who arrived in Germany no longer than three years ago. Therefore, since psychological distress and PTSD symptomology decrease over time, Syrian refugee's and asylum-seekers' interpersonal mistrust might decrease after they spend more time in Germany, and the effects of trauma gradually recede. Furthermore, their trust in Germans might decrease the longer they stay in Germany and have more life experiences with Germans, speak better German, and face difficulties in integration, such as finding a job or being exposed to discrimination and racism. Additionally, the asylum procedure in Germany might exacerbate their psychological situation and influence their attitude toward Germans, particularly due to the uncertainty that results from the unclear path towards permanent residency and German citizenship.

Finally, the study includes only male Syrian adult refugees; the situation regarding those two phenomena within other groups of refugees, such as females, older age refugees, and minors, may well be different.

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# Escalating Human Rights Crisis: The Plight of Migrants at the Belarus-EU Border

**Shan Muhammad and Malik Hammad Ahmad**

## Abstract

In recent years, the European Union (EU) has faced a growing number of refugee crises as people from war-torn countries desperately seek safety in Europe. At the same time, Belarus has become a hub of political turmoil and severe human rights abuses. These intertwined issues have created a complex and challenging situation that demands a coordinated response from the EU and the international community. One of the critical concerns revolves around human rights violations at the Belarus-EU border. Belarus has been accused of actively facilitating illegal migration into EU countries, using migrants as political tools due to the sanctions imposed by the European Union on the part of the Belarusian government.

These actions unequivocally infringe upon the fundamental human right to seek asylum in direct contravention of the protection provided by international conventions and agreements. By exploiting vulnerable migrants for political gain, Belarus undermines the principles of compassion, dignity, and protection that underpin human rights. While the Belarusian government bears significant responsibility for these violations, the European Union has also faced criticism. Some accuse EU countries of disregarding their obligations under international law by forcibly turning away migrants or detaining them in deplorable conditions upon arrival. The substandard treatment and inadequate living conditions in detention centers exacerbate the suffering of those seeking safety, raising concerns about the EU's commitment to upholding human rights. The current state of affairs at the border between Belarus and the European Union has intensified the strained relations between the two, with each party accusing the other of transgressing international law and human rights. This article, hence, tries to highlight the neglected situation of migrants at the EU-Belarus border.

### 1. The Authoritarian Grip and Human Rights Challenges in Belarus

Belarus[1] is a nation that emerged out of the Soviet Union's shadow in 1991 and subsequently adopted the name Republic of Belarus. Belarus has unfortunately become synonymous with human rights violations. Situated as a landlocked nation, it shares borders with Lithuania and Latvia to the north, Russia borders the east, Ukraine is situated to the south, and Poland is positioned to the west of Belarus[2]. While its neighbouring countries like Poland, Latvia, and Lithuania have embraced the principles of the European Union, Belarus, Russia, and Ukraine remain outside its fold[3]. Before 2020, the Belarus-Poland border, spanning a length of 418km, was largely unrestricted, allowing for relatively unhindered movement[4]. Since assuming power in 1994, President Alexander Lukashenko has maintained an iron grip on Belarus, gradually tightening his authoritarian rule. His governance tactics heavily rely on a powerful police force and Special Forces unit known as OMON, which are often employed to suppress dissent. In addition, strict censorship measures and a firm grip on media outlets contribute to stifling free speech and independent reporting.

A notable incident occurred in December 1994 when various newspapers, prevented from publishing critical articles about Lukashenko, protested by printing their pages with blank spaces as a symbolic act of defiance. Despite international condemnation and calls for reform, Lukashenko has remained at the helm, currently serving his sixth term[5]. The presidential elections conducted in August 2020 further exemplified the erosion of democratic values in Belarus. Lukashenko claimed his sixth term in office in a disputed victory, marking a continuation of unfair electoral practices that have plagued the country since his initial election[6]. Accusations of widespread election fraud cast doubt on

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[6] Leukavets, A. (2021). Russia's game in Belarus: 2020 presidential elections as a checkmate for Lukashenka?. *New Perspectives. Interdisciplinary Journal of Central & East European Politics and International Relations*, *29*(1), 90-101.

the "official" results, prompting supporters of opposition candidate Svetlana Tikhanovskaya to assert her rightful victory. The Belarusian people, refusing to accept the questionable outcome, took to the streets in unprecedented numbers, staging protests that endured for nearly three months. These demonstrations constituted some of the largest displays of dissent ever witnessed in the country, underscoring the deep-seated discontent and the desire for a fair and just political system.

2. **Human rights abuses and international condemnation**

The European Union has condemned Belarus for its blatant disregard of migrant rights and the exploitation of human lives as a political tool. Conversely, Belarus has accused the EU of employing double standards in its treatment of migrants and exploiting the refugee crisis for its own geopolitical agenda. These allegations and counter-allegations deepen the situation's complexities and impede efforts to find a resolution that safeguards the rights and well-being of those affected. Addressing the human rights violations at the Belarus-EU border requires a comprehensive and coordinated response from the international community. It is of utmost importance for the European Union and its member states to ensure that their actions align with international human rights standards and principles.

This includes providing adequate protection and support to individuals in need, regardless of their migration status, and guaranteeing access to fair asylum procedures. Additionally, engaging in dialogue with Belarus while holding the government accountable for its human rights abuses can be a constructive step toward finding a sustainable solution. Moreover, the international community should collaborate, including regional organizations, neighbouring countries, and relevant stakeholders. To effectively tackle the underlying reasons behind forced displacement and the political instability in Belarus, it is imperative for the European Union and its member states to take measures aimed at addressing the root causes. By addressing the underlying factors that drive individuals to undertake dangerous journeys, such as conflict, persecution, and economic instability, long-term solutions can be developed to alleviate the suffering of those affected and prevent future breaches of human rights. The intersection of the refugee crises in the EU and the human rights abuses in Belarus presents a complex challenge. The violations at the Belarus-EU border, committed by both Belarus and certain EU member states, emphasize the urgent need for a coordinated response that upholds human rights, compassion, and solidarity principles. By addressing immediate concerns while tackling underlying causes, the international community can strive toward a future where the rights and dignity of all individuals are respected and protected.

By November 2020, an excess of 30,000 individuals had been apprehended, with approximately 900 individuals facing criminal charges and multiple casualties reported. President Lukashenko received congratulations on his re-election from Russian President Vladimir Putin, making him the first world leader to do so. Nevertheless, numerous Western nations declined to acknowledge the legitimacy of Lukashenko's extended term, citing the elections as lacking both freedom and fairness. Given the democratic nature of the surrounding countries, the citizens of Belarus, incensed by election fraud, sought to overthrow the dictator. On August 16th, 2020, a significant number of individuals protested against Lukashenko. Distrust in the official election results spurred spontaneous and peaceful demonstrations across the country, including the capital city, Minsk. The widespread and systematic use of torture and other forms of inhumane treatment against detainees triggered a negative response from both domestic and international communities.

The Human Rights Center "Viasna" documented at least 500 cases of torture, providing evidence of its pervasive and organized nature[7]. Journalists faced persecution for their professional activities, enduring repeated detentions, physical abuse, accreditation revocations, and deportations. In certain instances, reporters were subjected to the use of weapons. Extensive censorship was imposed, blocking access to numerous news sites and civil society platforms, including those of human rights organizations. Internet access was periodically disrupted. The people protested against Lukashenko's government, initially referring to the protest as the "Freedom March" and later, on August 23rd, adopting the name "New Belarus." Each march drew over 200,000 individuals to the streets, demanding new elections. Belarusian opposition leader Svetlana Tikhanovskaya asserted that her country's people had undergone a transformation and would no longer accept Lukashenko's rule[8]. The newly elected government dispatched police forces, including riot police, and deployed dozens of military trucks carrying soldiers to the center of the capital, marking the first instance of military deployment in central Minsk. In neighbouring Lithuania, a demonstration of solidarity commenced, with plans to form a human chain from Vilnius to the Belarusian

[7] Viasna," T. H. R. C. (2020, September 2). Human Rights Situation in Belarus: August 2020. Spring96.Org. https://spring96.org/en/news/99352.

[8] Brown, C. S. Overcoming the 'Barrier of Fear'in Order to Resist: the 2020 Protests against the Lukashenko Regime in Belarus. *Journal of Resistance Studies*, 10.

border. The police crackdown resulted in the arrest of nearly 7,000 people, leading to distressing allegations of torture and mistreatment while in police custody. The European Union dismissed the presidential election results, which awarded Lukashenko 80 percent of the vote. The police used violence, made arrests, and imprisoned protesters. Between August 24 and December 31, 2020, the Belarusian government detained and interrogated opposition leaders and strike committee members. Most opposition figures were imprisoned or compelled to leave the country. Russia was the first nation to express support for the Lukashenko government**.** In response, the European Union and the USA declared economic sanctions against Lukashenko's government. These sanctions were not significant until a shocking incident occurred by European standards.

**3. EU's Challenges in Addressing Belarus's Human Rights Violations**

During a flight from Greece to Lithuania, Belarusian blogger and political activist Raman Pratasevich, known for his critical stance against the Belarusian government, was subjected to a grave violation of human rights. As the previous editor of the opposition's Next channel on the Telegram messaging application, operating from outside Belarus, Pratasevich played a significant role in mobilizing street protests, evading strict state censorship, and accumulating nearly two million subscribers. Following his visit to Greece with his Russian girlfriend, Sofia Sapega, and participation in an economics conference in Athens, together with fellow Belarusian dissidents, they were returning to Lithuania when the Belarusian authorities took extreme measures. Belarus dispatched a fighter jet to intercept Ryanair flight FR4978, originating from Athens and heading to Vilnius, under the pretext of a bomb threat. The aircraft was forcibly landed in Minsk, where, upon disembarkation, the police apprehended Mr. Pratasevich. Witnesses reported his evident fear during the arrest. Sofia Sapega was also taken into custody. Belarus claimed the diversion was due to a bomb scare issued by the Palestinian extremist organization Hamas, presenting a letter from the alleged group as evidence. However, Hamas denied any involvement, highlighting their lack of historical operations beyond Israel and the Palestinian territories. German Chancellor Angela Merkel emphasized the implausibility of Belarus' claims. This incident has garnered widespread international condemnation, with numerous countries demanding the Prompt liberation of Mr. Pratasevich through Inquiry. Disturbingly, both Pratasevich and Sapega later appeared in coerced videos, seemingly confessing to offences committed against the Belarusian authorities. On June 25th, it was revealed that they had been subjected to residential confinement. Whilst Ms. Sapega was subjected to confinement within a residence in Minsk, Mr. Pratasevich's location remained undisclosed, purportedly under the supervision of secret police. This blatant violation of human rights and suppression of dissent has sparked outrage worldwide. His fellow blogger, Mr. Putilo, expressed concerns about the dangers of flying over their home country due to the oppressive regime's actions. Mr. Protasevich, a journalist and activist, found himself facing severe charges as he was included in Belarus's roster of individuals engaged in acts of terrorism despite no substantial evidence supporting such allegations. The charge of causing mass unrest, which he was accused of, carries a maximum sentence of 15 years in prison. However, the authorities used terror offences to subject him to even harsher penalties. As he was forcefully taken off the plane, witnesses heard him uttering words that reflected his fear of receiving the death penalty upon his return to Belarus[9].

The act of diverting the flight, which was travelling between two foreign countries and compelling it to land in Belarus, constituted nothing less than a hijacking and should be classified as a terrorist act. In retaliation against the fraudulent presidential elections orchestrated by the Lukashenko regime in August 2020 and subsequent violent repression of opposition candidates and protesters, the European Union (EU) has incrementally expanded its sanctions against Belarus since October 2020. The EU imposed additional sanctions following the Belarusian government's forced landing of a Ryan air flight and the subsequent detention of journalist Roman Protasevich[10]. European Union leaders have declared their non-recognition of the recent Belarusian election results and announced forthcoming sanctions against those involved in electoral fraud. While the EU called for peaceful dialogue between the government and the opposition, it stopped short of explicitly demanding a rerun of the election, as demanded by the opposition. Instead, they offered to support a peaceful transition of power in Belarus. European Union foreign ministers unanimously condemned the election results as fraudulent and reached an agreement on imposing sanctions. The EU demanded the release of unlawfully detained protesters[11]. The United Kingdom has suspended the operating license for the state airline

[9] Walker-Werth, A. (2021). Here's to Belarus's Freedom Fighters. *The Objective Standard*, *16*(3).

[10] O'Loughlin, J., & Toal, G. (2022). The geopolitical orientations of ordinary Belarusians: survey evidence from early 2020. *Post-Soviet Affairs*, *38*(1-2), 43-61.

[11] Hanania, R. (2020). Ineffective, Immoral, Politically Convenient: America's Overreliance on Economic Sanctions and What to Do about It. *Cato Institute Policy Analysis*, (884).

Belavia in Belarus, and European Union leaders have urged member states to adopt similar measures. Various Belarusian officials, including President Alexander Lukashenko, are already under EU sanctions, including travel restrictions and asset freezes, due to their involvement in suppressing opposition figures.

The European Union classified the forced landing of the Ryanair flight in Minsk and the subsequent detention of journalist Roman Protasevich as an act of "piracy." In response, the EU implemented a ban on all Belarusian airlines, prohibiting their operations within European Union airports or airspace[12]. Moreover, the EU prohibited the import of key commodities, such as petroleum products and potash fertilizer, from Belarus. In December, the European Council implemented its fifth package of sanctions targeting Belarus to denounce ongoing human rights abuses and the manipulation of migrants. These new sanctions include restrictions on 17 individuals, including judges, as well as 11 entities involved in facilitating and organizing illegal border crossings into Poland, Lithuania, and Latvia. The primary airline responsible for transporting migrants, Belarusian airline Belavia, was specifically named in the sanctions[13]. Additional measures entailed the imposition of travel bans and the freezing of accounts for 88 individuals associated with the Belarusian state apparatus, including seven Belarusian companies supporting the autocratic regime. In retaliation to these sanctions, President Alexander Lukashenko of Belarus prohibited the importation of beef, pork, specific vegetables, dairy products, fruits, and nuts from the European Union, the United States, Canada, Britain, Norway, and several other countries for the duration of six months. The Belarusian government, renowned for its human rights violations, declared on September 9, 2021, that it would respond to the imposed sanctions by banning food imports from Western nations starting in January of the following year. Belarus, plagued by numerous instances of human rights abuses, reported food imports worth $530 million in the initial ten months of 2021, as disclosed by the Minsk government. Although the government did not specify the items included in the import ban, it threatened to expand the list of prohibited food imports in response to subsequent Western sanctions[14].

Nevertheless, the effectiveness of these actions in exerting pressure on the Belarusian regime is overshadowed by the significantly harsher sanctions imposed by the European Union in response to the contentious presidential elections of 2010. Acknowledging the grave human rights conditions prevailing in Belarus, the United Nations Human Rights Council endorsed a resolution led by the European Union to intensify scrutiny over alleged human rights abuses subsequent to the disputed August presidential election[15]. According to Anaïs Marin, a human rights investigator appointed by the United Nations, over 10,000 individuals have been subjected to arbitrary arrests following President Alexander Lukashenko's declaration of victory in the presidential election on August 9. Alarming reports reveal the existence of over 500 well-documented instances of torture, accompanied by numerous occurrences of brutal beatings, all of which have been inflicted upon a significant number of individuals. The widespread violations led to Belarus facing economic isolation, resulting in a significant shock to its economy. In 2020, approximately 50% of Belarus's petroleum products were exported to the European Union and the UK[16]. Following the incident involving the forced landing of a Ryanair flight on May 23, 2021, and the subsequent arrest of a prominent opposition activist, the European Council responded by imposing fresh sanctions on Belarus. These measures encompassed a prohibition on the provision of specialized technological equipment and dual-use goods with military applications, as well as limitations on the export of Belarusian petroleum products, potassium chloride (commonly known as "potash"), tobacco, and tobacco-related items. Furthermore, Belarus faced restricted access to EU capital markets, and the European Investment Bank halted funding for public sector projects in the country. Despite the implementation of these new sectorial sanctions, they were not anticipated to deal a fatal blow to the Belarusian economy.

The regime had the potential to redirect some of its petroleum product exports to alternative markets, such as Russia, for re-export to Western Europe. In a display of

[12] Whartnaby, L. (2023). Turbulent Skies: Legal Strategies on Responding to the Diversion of Ryanair Flight 4978. *BU Int'l LJ*, *41*, 183.

[13] Brady, Erin, EU Eyes Sanctions for Airlines, Tourism Companies Aiding Migrants Entrance to Belarus, Newsweek, 24 November, 2021.

[14] Reuters Staff, UPDATE 1-Belarus to ban some Western food imports in retaliatory move, Reuters, 7 December, 2021.

[15] Sédou, L., Akkerman, M., & Vranken, B. (2020). Militarisation of the European Union: Fresh money for the military industry. In *Military Spending and Global Security* (pp. 61-82). Routledge.

[16] Astrov, V., Dobrinsky, R., Pindyuk, O., & Podkaminer, L. (2021). *Monthly Report No. 9/2021* (No. 2021-09). The Vienna Institute for International Economic Studies, wiiw.

solidarity with the protesters and political opposition in Belarus, the European Union offered targeted financial assistance. In December 2020, the EU approved a €24 million aid package, which was part of a larger €53 million support package designed to directly support Belarusian civil society, youth groups, and select small and medium-sized enterprises[17]. Furthermore, in December 2020, the United States enacted the Belarus Democracy, Human Rights, and Sovereignty Act, which granted the president enhanced powers to impose sanctions on the Belarusian regime and offer support to Belarus in various forms[18]. However, the Belarusian dictator, Alexander Lukashenko, buoyed by the support of Russia, remained defiant. In September 2020, Lukashenko received a $1.5 billion loan from Russia, enabling him to continue suppressing the ongoing demonstrations and maintaining his grip on power[19]. Putin and Lukashenko met twice in February and April 2021, illustrating the robust connections between the two nations. Furthermore, the Belarusian regime received assistance from Russia in thwarting an alleged coup attempt in April 2021 through a joint counterintelligence operation. Given the landlocked nature of Belarus, the country's economic woes were exacerbated by being banned from airspace and restricting exports. The Belarusian dictator pondered how to exact revenge on the European Union, which brings into question the European Union's weak points in addressing the human rights violations perpetrated by Lukashenko's regime."

**4. The Plight of Vulnerable Migrants at the border between Belarus and the European Union**

Since July 2021, a significant number of migrants, including individuals seeking refuge from conflict-ridden regions like Iraq and Syria, have encountered grave violations of their human rights as they strive to cross the Belarusian border into neighbouring EU countries, namely Poland, Lithuania and Latvia. In response, these nations have declared a state of emergency and deployed their military forces along the borders. The border checkpoints with Belarus have been closed to deter unauthorized crossings, and barriers have been erected. The EU, alleging that Belarus actively facilitates the migrants' arrival at the border and coerces or aids them in illegally entering the EU, has made alarming accusations. Belarus, however, vehemently denies these allegations. In early January 2021, refugees sought refuge in Minsk, Belarus' capital, due to the devastating civil wars ravaging countries such as Iraq, Syria, Afghanistan, and Congo. The situation in these countries was dire, compelling thousands of war-displaced individuals to flee for their safety[20]. Online advertisements on various social media platforms to inform refugees and migrants that choosing to cross through Belarus would provide a safe and secure route for entering the European Union[21].

The majority of refugees arrived in Minsk via air travel facilitated by tourist agencies operating in the Middle East and other regions. Direct flights from various Middle Eastern destinations, including Beirut, Dubai, and Baghdad, landed in Minsk. Furthermore, flights originating from Istanbul, Turkey, arrived in Belarus under the pretense of tourism, as Belarus offered a 30-day tourist visa[22]. Upon arrival in Minsk, refugees embarked on overland journeys to reach EU borders, particularly Poland and Lithuania, utilizing taxis, buses, or other means of transportation. Human smugglers often played a role in assisting them with illegal border crossings. However, as time passed, it became increasingly challenging for these refugees to enter the European Union through conventional means such as vehicles. Shockingly, the Belarusian government resorted to forcibly abandoning these vulnerable individuals in forests near the EU border, equipping them with wire cutters to breach the barbed wire fences. This callous act put their lives at risk and further violated their human rights. Among the migrants stranded at the border were young men, females, and youngsters predominantly from the Middle East and Asia. This dire situation intensified an escalating international dispute, leaving several thousand individuals trapped in a humanitarian crisis with their rights gravely disregarded. The situation unravelling at the Belarus-EU border is deemed a tool of hybrid warfare, targeting the EU's policies, principles, and values. Over the past months, Alexander Lukashenko has been accused by the European Union, NATO, and the US of deliberately provoking a renewed migrant crisis in Europe. Many migrants from the Middle East have

[17] Fetting, C. (2020). The European Green Deal. *ESDN Report, December*.

[18] Leukavets, Alla, 2022, Crisis in Belarus: Main Phases and the Role of Russia, the European Union, and the United States, Kennan cable, No. 73.

[19] Leukavets, A. (2021). Russia's game in Belarus: 2020 presidential elections as a checkmate for Lukashenka? *New Perspectives. Interdisciplinary Journal of Central & East European Politics and International Relations*, *29*(1), 90-101.

[20] Reality Check, Belarus border crisis: How are migrants getting there, BBC, 26 November 2021?

[21] Adams, Paul and Nevett, Joshua, Poland-Belarus: How social media posts fuelled the migrant crisis, BBC, 11 November 2021.

[22] Bruneau, C., Plucinska, J., & Abi Nader, Y. (2021). How Minsk became a Destination for Migrants Travelling as Tourists. *Dostępne pod adresem: https://www.reuters. Com/world/europe/how-minsk-became-mecca-migrants-travelling-tourists-2021-11-15/ [dostęp: 24.01. 2022]*.

flocked to Belarus's borders near the European Union. Lukashenko, whose legitimacy following widely disproved electoral process election has been questioned, refuses allegations of Enticing people to relocate as countermeasures for imposed sanctions after violent repression of activists and opponents. The severity of the situation has escalated persistent efforts to overcome the razor-wire fences on the eastern frontier of Poland. Defense Minister Mariusz Blaszczak revealed, "It wasn't a calm night. Indeed, there were many attempts to breach the Polish border." Police documented two distinct occurrences comprising assemblies of roughly 50 individuals.

The border patrol observed that, within the preceding 24-hour period exclusively, there were 599 unlawful border crossings, culminating in the apprehension of nine persons, all hailing from the Middle East. Both Poland and Belarus have levelled accusations against one another concerning acts of aggression directed toward the migrants stranded in proximity to the fence. As temperatures dropped below freezing, those trapped at the border faced dire conditions, running out of food and water. Aid worker Ania Chmielewska expressed deep concern over Poland's state of emergency, hampers aid workers from entering the affected area. Chmielewska lamented, "For us, it is heartbreaking. We are here near the border but cannot enter the zone and help people. We can only assist those who manage to cross the border and make it out of the restricted area." The actions of Belarus have been denounced by the European Commission, which has accused them of employing deceitful assurances of effortless access to the European Union as part of an "inhumane, criminal-like strategy." The commission has identified approximately 20 nations, primarily from the Middle East, as the origins of migrants who arrive in Minsk, frequently holding tourist visas. In light of these developments, German Foreign Minister Heiko Maas has asserted that the EU will not yield to extortion and will augment sanctions on Belarus, specifically targeting individuals involved in the organized smuggling of migrants[23]. The European Commission has also criticized Belarus's strategy of enticing refugees to Minsk on behalf of easy entry into the European Union[24]. Refugees arriving in Minsk are reportedly being directed towards the EU border. Lithuanian officials have further revealed that Belarus has streamlined the visa process for potential migrants from Iraq, enabling them to enter under the guise of "tourists." The memories of the 2015 refugee crisis between Turkey and Europe, where Turkey allowed a massive influx of migrants until a deal was struck with the EU, have resurfaced, causing apprehension among the refugees. While the motives of these migrants - political instability, fear of conscription and lack of employment - are similar to those of migrants worldwide, their chosen route through Belarus is relatively new. Initially, Belarusian travel companies issued electronic invitations for people to board flights to the capital. However, the rules were modified as illegitimate operations emerged, profiting from counterfeit invitations.

Now, migrants require a physical visa stamp on their passports before they can book a flight. It takes longer, but it still is not complicated[25]. Meanwhile, Lithuania has reported a significant increase in migrants attempting to cross unpermitted from the Republic of Belarus. Lithuania claims that Belarus is facilitating this migration as a form of retaliation against the West's sanctions[26]. The migrants themselves have stated that they are fleeing persecution and war in their home countries. The European Union (EU) has expressed its view that Belarus used this crisis to squeeze the EU over the sanctions imposed. President Lukashenko of Belarus has conceded the possibility that his nation may have facilitated the transportation of migrants toward the European Union; however, he vehemently refutes extending an invitation to them to enter Belarus. Both Poland and Lithuania have claimed to possess evidence suggesting that Belarusian authorities have assisted migrants in arranging their journeys to the border. Such allegations raise concerns about potential human rights violations, including the right to seek asylum, protection from persecution, and fair treatment. It is important for all countries involved to prioritize the protection and well-being of migrants and refugees. International human rights standards require that individuals fleeing persecution or war should be given access to fair asylum procedures and humane treatment. Any actions by authorities that impede or deny these rights may constitute human rights violations. Given the complexity of the situation, it is essential for the international community, including the EU, to engage in dialogue and cooperation to address the root causes of migration and seek solutions that uphold human rights principles. This could involve supporting countries that are experiencing an influx of migrants, enhancing border management practices, and addressing the underlying issues that force individuals to flee their homes. Respecting human rights is a moral obligation and a legal one. The international community must collaborate in order to safeguard the rights of migrants and refugees and

[23] Belarus migrants: Poland faces fresh border breaches, BBC, 10 November 2021.

[24] Belarus migrants: EU accuses Lukashenko of gangster-style abuse, BBC, November 9, 2021.

[25] **Adams, Paul,** How Belarus is helping 'tourists' break into the EU, BBC, 22 October 2021.

[26] Lithuania blames Belarus for migrant crisis, BBC, 10 August 2021.

to establish mechanisms that ensure accountability for any infringements on their human rights.

**5. Humanitarian Crisis Escalates at the EU-Belarus Border**

In the year 2021, a multitude of flagrant human rights violations unfolded as a significant number of individuals endeavoured to enter the European Union via Lithuania, Latvia, and Poland, originating from neighbouring Belarus27. The situation at the borders reached critical levels, particularly during winter, subjecting numerous individuals to prolonged exposure to freezing conditions. Tragically, the attempts to cross the border from Belarus to the EU in late 2021 and early 2022 resulted in the loss of at least 24 lives. Disturbingly, the Polish border guards reported a staggering 977 recorded attempts to cross the border in April 2022 alone, reaching a cumulative count of nearly 4,280 since that year's commencement28. These figures, although lower compared to the previous November, when thousands of migrants gathered along the border within days, indicate an ongoing dramatic and overlooked crisis, especially in the shadow of the attention directed toward the exodus from Ukraine. When countries like Poland witnessed this unfolding humanitarian situation, they heightened security measures at the border, called in reinforcements, and implemented stringent checks to impede such smuggling attempts. The installation of additional barbed wire further fortified the border. In January 2022, the Polish government embarked on the construction of a new wall along the Belarus border, specifically designed to deter refugee crossings. Spanning a height of 5.5 meters and extending along 186 kilometres of the border, nearly half of its total length, the wall will be completed by June 2022. The Belarusian government's active encouragement of these vulnerable individuals became evident. Exploiting the refugee crisis that unfolded in 2015 when large numbers of refugees sought refuge in Europe, Belarus seized upon this vulnerability. They openly encouraged refugees to enter their country only to subsequently abandon them at the border. The forested areas surrounding the border, characterized by temperatures ranging from -5°C to -7°C, became the harsh backdrop for their plight. The Belarusian government remained apathetic, offering no assistance in terms of food, shelter, or provisions, leaving these individuals to endure the bitter cold. Tragically, several lives were lost due to the extreme conditions, with approximately ten individuals perishing while awaiting passage at the border[29]. Desperate and left with no other choice, some individuals resorted to fighting the border police and undertaking perilous attempts to cross the border at any cost, driven by the will to survive. In an interview, one refugee eloquently expressed the dire situation: "They are playing with us as if we were a football. Belarus beat us and pushed us to the Poland border; on the other hand, Poland beat us to push us back to Belarus." These words encapsulate the inhumane treatment and disregard for the rights and well-being of these vulnerable individuals caught in the crossfire between the two countries. This series of events constitutes a grave violation of human rights, characterized by endangerment of lives, exposure to life-threatening conditions, lack of assistance, and a cycle of violence perpetuated by authorities. The situation calls for urgent attention and intervention to safeguard the fundamental rights and dignity of those affected by this crisis.

**6. The Escalation of the Border Crisis in Poland**

The gravity of the border crisis intensified significantly as Polish authorities resorted to using tear gas and water cannons to deter migrants seeking to cross into the country. In response to the heavily fortified crossing, some migrants resorted to throwing missiles at the Polish forces, resulting in several injuries30. Notably, Belarus denied the presence of Polish police in the area and advised migrants to cross the border through the wires. Poland's completion of a new steel wall at its border with Belarus aimed to control the influx of undocumented asylum seekers31. The erection of this wall served as a preventive measure aimed at deterring individuals who were fleeing from the turmoil of conflict and poverty in the Middle East and Africa. These individuals had been encouraged by the Belarusian government to seek entry into the European Union as part of a broader dispute with the bloc. The leader of Belarus adamantly denied extending any invitations to refugees while simultaneously acknowledging the involvement of his forces in aiding migrants to cross into Poland. For several months, a significant number of migrants, predominantly from the Middle East, have been persistently attempting to enter the European Union through the borders of Belarus. The situation along the border had been

[27] Amaya Valcárcel, reliefweb, Out of Sight – Refugees and Migrants at the Belarus-Poland Border, 2 Jun 2022.

[28] Adler, Nils, Poland-Belarus border: 'People are dying in the forest' Aljazeera, 15 Nov 2021

[29] Adler, Nils, Poland-Belarus border: 'People are dying in the forest' Aljazeera, 15 Nov 2021

[30] Poland border crisis: Belarus moves migrants stranded in camp, BBC, 17 November 2021.

[31] Poland completes Belarus border wall to keep asylum seekers out, Aljazeera, 30 Jun 2022.

obscured by a state of emergency imposed by Poland until September 2, 2021, which restricted access for journalists, human rights workers, and others, impeding their ability to witness the human rights crisis[32].

The Belarusian leader, Lukashenko, levelled accusations against the European Union, alleging human rights violations due to their refusal to grant entry to these migrants, asserting that such actions contravened international asylum regulations. Nonetheless, a number of countries within the United Nations Security Council assert that this crisis represents a manifestation of hybrid warfare being employed against Europe[33]. Furthermore, the Republic of Belarus has issued a threat to disrupt the gas supply by switching off the gas pipelines, which would have significant economic consequences for Europe[34]. Since a considerable portion of Europe's gas supply originates from Russia and passes through pipelines in Belarus, such a disruption would have far-reaching effects. The threat has already contributed to high gas prices in Europe, exacerbated by other factors. Poland has blamed Russia for these developments, while the Kremlin spokesperson denied any involvement and challenged the EU to provide financial assistance to Belarus to address the crisis[35]. The EU, in turn, has suggested that it is the responsibility of Lithuanian authorities to ensure their asylum policies align with EU law, although human rights groups have criticized the EU for allegedly disregarding the situation on the ground.

### 7. Human Rights Violations and Double Standards at the Polish-Belarusian Border

Natalia Gebert, founder and CEO of the Polish NGO for refugees, Dom Otwarty, expressed concerns regarding human rights violations in Poland. She highlighted the discriminatory treatment faced by individuals offering rides to refugees at the Belarus border compared to those at the Ukrainian border. While local citizens assisting refugees from Ukraine are hailed as heroes, those aiding refugees at the Polish-Belarusian border are labelled as smugglers and can face severe punishment, including up to eight years of imprisonment. Poland has been praised for welcoming over two million Ukrainian refugees fleeing the ongoing war. They provide them with support such as a stipend, national identification numbers for accessing healthcare and education, the right to work, and temporary housing[36]. However, a different scenario unfolds at the Polish-Belarusian border, where refugees, asylum seekers, and migrants find themselves trapped in a forested area under the constant surveillance of border guards. They are often taken to detention centers or forcibly pushed back to Belarus. Non-Ukrainian refugees and migrants face further ostracization by politicians and state media, leaving them devoid of aid except for the assistance provided by local activists who themselves risk imprisonment[37]. Human rights activists point out a double standard in the treatment of refugees, drawing attention to the differential treatment of Ukrainian refugees, who are predominantly Christian, female, and white, compared to those originating from the Middle East and Africa, who are primarily male and Muslim[38]. Reports from human rights organizations shed light on unlawful and violent practices employed by Poland, including the forceful return of migrants and asylum seekers to Belarus[39]. Upon their return, these individuals face serious abuses, such as physical assault and rape perpetrated by border guards and security forces[40]. Amnesty International meticulously documented a multitude of instances involving arbitrary detention and mistreatment, which encompassed distressing practices such as strip searches, forced sedation, and the gradual reduction of medication dosage, affecting close to two thousand asylum seekers who made their way into Poland from Belarus in the year 2021[41]. Asylum seekers who managed to cross the Polish-Belarusian border are subjected to detention in overcrowded and unsanitary facilities, where they endure abusive treatment and are denied contact with the outside world. In February 2022, UN experts raised concerns about threats against human rights defenders, including media workers and interpreters, at the border of Polish and Belarusian. These

[32] **Rosenberg, Steve,** Belarus's Lukashenko tells BBC: We may have helped migrants into EU, 19 November 2021.

[33] Belarus/EU: New evidence of brutal violence from Belarusian forces against asylum-seekers and migrants facing pushbacks from the EU, Amnesty International, and December 20, 2021.

[34] Belarus threatens to cut off gas to EU in border row, BBC, 11 November 2021.

[35] McNamara, E. M. (2023). Ireland, NATO and "the Return of Geopolitics" in Europe. In *The EU, Irish Defence Forces and Contemporary Security* (pp. 373-392). Cham: Springer International Publishing.

[36] Poland completes Belarus border wall to keep asylum seekers out, Aljazeera, 30 Jun 2022.

[37] Al Jazeera. Worlds apart: 24 hours with two refugees in Poland, 22May, 2022 https://www.aljazeera.com/features/2022/5/22/worlds-apart-24-hours-with-two-refugees-in-poland.

[38] End 'double standards' on refugees, UN expert urges Poland, Aljazeera, and 28 July 2021.

[39] Poland-Belarus border wall built, Arkansas Democrat Gazzete, July 1, 2022.

[40] Violence and pushbacks at Poland-Belarus Border, June 7, 2022.

[41] Poland/Belarus: New evidence of abuses highlights 'hypocrisy' of unequal treatment of asylum-seekers, Amnesty International, April 11, 2022.

experts urged Poland to thoroughly investigate all allegations of harassment and ensure the safety of journalists and humanitarian workers, granting them access to the area. Instances of harassment against journalists were also reported, as armed soldiers harassed and mistreated Maciej Moskwa and Maciej Nabrdalik, journalists covering the arrival of migrants and asylum seekers. Soldiers who did not identify themselves were subjected to searches, handcuffing, and scrutiny of their equipment and phones[42].

By March 2022, aid organizations had reported a deepening refugee crisis at the border shared by Poland and Belarus, with migrants in a camp situated in Bruzgi, Belarus, facing forced displacement. This dire situation left the most vulnerable individuals, including families with children, those with existing illnesses, and individuals with disabilities, struggling to survive amidst the surrounding forest. In April 2022, a distressing incident unfolded involving a young man from Yemen who was forcibly pushed back to a compound established by the Polish government near the border police, located between Kuźnica and Szudziałowo. Disturbingly, the man endured physical abuse by the Belarusian police over a span of several days. He was part of a group consisting of four adults and four minors, all originating from Yemen. Video connections with medical professionals revealed the urgent need for medical attention, but their requests for help and water from the Polish border police were refused[43]. As of now, the fate of the man remains unknown, leaving uncertainty about his survival. These accounts paint a grim picture of human rights violations occurring at the Polish-Belarusian border, necessitating immediate attention and action to address these grave concerns.

**Conclusion**

In conclusion, the ongoing refugee crisis triggered by the actions of the Belarusian president, Alexander Lukashenko, raises serious concerns regarding human rights violations and the need for immediate action in accordance with human rights principles. Lukashenko's authoritarian governing style, heavily relying on the police and Special Forces, coupled with the controversial 2020 general election, fueled tensions within Belarus. The resulting protests and opposition against the government led to widespread repression, including the unlawful detention of thousands of individuals, criminal charges against dissenters, and loss of life. These grave human rights violations were further compounded by the persecution of journalists, who faced repeated detention, physical violence, accreditation deprivation, deportation, and even the use of weapons against them. Belarus also enforced extensive censorship, suppressing freedom of expression and information.

The situation worsened when a blogger's flight was forcibly landed in Minsk under false pretenses. In response to these actions, the European Union imposed sanctions on Belarus and expressed its non-recognition of the election results, urging peaceful dialogue between the government and the opposition. However, President Lukashenko retaliated by banning the import of EU goods. Belarus has additionally been accused of facilitating the arrival of refugees at its borders and coercing them to illegally enter the European Union. These refugees, often aided by tourist agencies, have been forcibly pushed towards EU borders, leading neighbouring countries to declare states of emergency and deploy military forces. Border closures and the erection of barriers have been erected and implemented for preventive unauthorized passage. Shockingly, the Belarusian government has abandoned refugees in forests near the EU border, equipping them with wire cutters to cut through barbed wire fences. This manipulative use of refugees as pawns in a hybrid warfare strategy against the EU undermines the principles and values of the Union. Tragically, lives have been lost in perilous attempts to cross the border under harsh winter conditions.

The European Commission has condemned Lukashenko's manipulation of migrants, labelling it an "inhuman, gangster-style approach" aimed at pressuring the EU over imposed sanctions. EU member states have resorted to employing coercive measures, including the deployment of tear gas and water cannons, as a means to repulse migrants who are endeavouring to gain access to their respective territories. It is important to note that this crisis should not apply to Ukrainian refugees, as borders remain open for them. Finding a resolution to this complex situation poses a challenge. While the EU should consider withdrawing economic sanctions to avoid further retaliation from Belarus, doing so could inadvertently support the oppressive regime. Nonetheless, it is imperative that the EU provides emergency transportation and extends necessary assistance and international protection to the refugees stranded at the Belarus-EU border. Such actions would align with human rights principles and reflect the EU's commitment to upholding the dignity and well-being of all individuals, regardless of their circumstances.

[42] Human rights defenders threatened at Poland-Belarus border, UN report, 15 February 2022.

[43] Out of Sight – Refugees and Migrants at the Belarus-Poland Border, Relief web, 1 Jun 2022.

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ANALYSIS
ORGANIZATION
COMPLEX

# RESEARCH

# Social Support needs for the Parents of Premature Babies

Urwah Ali

**Abstract**

The Neonatal Intensive Care Unit (NICU) can be a difficult environment for parents because it is noisy, hot and crowded; in addition, advanced medical equipment and complex medical language serve as barriers between parents and their newborns (Mizrak, 2015). According to the World Health Organization (WHO), out of ten countries with the highest preterm birth rate, Pakistan is in fourth rank (WHO, 2012). Parents, especially mothers whose newborns are in the NICU, can have psychological problems due to having a sick baby, the thought of losing their baby and failure to fulfill traditional parenting roles. In Pakistan, little emphasis has been given to mothers of NICU babies and maternal stress. The present study investigated the role of social support among mothers of pre-mature babies in the NICU. The sample was selected from Rawalpindi and Islamabad. The study was carried out in two stages, i.e. stage I and stage II. The interview protocol was generated at stage I and qualitative interviews were carried out at stage II. Thematic analysis was employed to analyze the themes from the interviews. Results revealed that emotional responses were directly dependent upon social and husband support. Whomsoever in-laws were reported as supportive, that indicated less stress and anxiety level on the part of mothers as reported in the sample. If in-laws are not supportive, psychological issues and anxiety arise in the mother, which in turn affects the mother and child's health. Mothers need psychosocial support during this period in order to ensure the mothers' emotional balance and decrease negative emotions that can lead to poor health outcomes. This study is helpful for mental health professionals in understanding the importance of social support for mothers of premature babies in the NICU.

**Keywords**: Social support. Maternal stress, NICU mothers, premature babies.

## Introduction

Being blessed with a baby is the biggest gift of one's life. The baby brings a lot of happiness and joy to the family. But not every parent is blessed with a healthy baby, and the mother and child have to go through a life-changing experience where the health of the mother and child may also be in danger. Parents go through ups and downs while the baby is in the Neonatal intensive care unit (NICU). Parents' emotional state of well-being naturally declines over the first few months after the baby's birth as they face such distressing variations. This distress has been referred to as intense and increased care of the baby, loss of sleep, loss of personal time, and perhaps the loss of a job (Miller & Sollie, 2000).

Prenatal and postnatal can be an occasion of happiness, cheerful expectations, tension, and complications. Pregnancy and delivery bring some physical difficulties and psychosocial differences, and parents face new challenges during this time (Smith et al., 2011). Stress has been identified as one of the prime factors after delivery. Increasing evidence has associated stress with multiple chronic diseases over the years. Stress affects not only the mother but also her baby. This is particularly true in studies investigating preterm births. Preterm birth is one of the leading causes of baby mortality and childhood diseases, mainly caused by premature rupture of the membrane (Cha & Masho, 2013).

Pregnancy outcomes can be influenced by many factors. One major factor is social support, which can reduce mental stress and improve mental health during pregnancy; stress, anxiety, or depression cause preterm birth. Post-birth experience has exclusive physical and psychological characteristics on mothers like weakness, disturbed sleeping because of the deteriorating health of the baby and the implementation of new practices such as breastfeeding (Elsenbruch et al., 2007).

## Preterm Birth

WHO characterizes preterm birth as a birth that happens before 37 weeks of pregnancy. Immaturity was characterized based on birth weight lower than 1.500 grams and with a gestational age under 32 weeks, though, in recent years, the late gestational age has been considered as the primary marker of physical and neurological development of preterm babies (Sansavini & Faldella, 2013).

## Neonatal Intensive Care Unit

NICUs are classified in a level classification from I to III, depending on the capacity to care for a particular society of newborn children. The level III NICU exhibits the physical condition, workers and hardware consistently accessible to consider modestly sick and a seriously sick newborn is significantly in high danger and with

complicated and significant wellness (Lockwood and Lemons, 2007). The level III neonatal intensive care unit provides care to infants born within the same hospital or shifted from the local hospital services to the more isolated neonatal care (Smithgall, 2010).

***WHO guidance stresses the need to ensure the mother and family take the pivotal role in their baby's care. Mothers and newborns should remain together from birth and not be separated unless the baby is critically ill. The recommendations further call for improvements in family support including education and counselling, peer support and home visits by trained health-care providers.***

Preterm birth

**Preterm birth**

*Every year, an estimated 15 million babies are born preterm (before 37 completed weeks of gestation), and this n...*

The neonatal intensive care unit gives care to babies conceived unwell, premature, or requiring observation after birth. NICU units are an extremely busy part of a hospital, with most working at the full limit with infants requiring serious nursing, therapeutic consideration, and mediation most days of the year (Abdel-Latif et al., 2013).

The Neonatal Intensive Care Unit (NICU) experience can cause vigorous ecological and emotional suffering. With over 480,000 premature babies conceived each year. An expanding literature recommends that postpartum depression and a few related psychosocial factors, for example, tension, social support, and stress related to the NICU condition, are fundamentally identified with both newborn child and parental results (Gillis et al., 2006). In addition, the infection of their child, the absence of knowledge in regard to treatment and medicinal activities, the absence of correspondence with wellbeing experts, not taking an interest in being taken care of by their newborn children, and the absence of social support can prompt stress (Davis et al., 2003).

**Social Support**

Social support positively affects pregnant women and children, which in turn influences etiological processes related to fetal growth. As a result, pregnant women enjoy a healthier lifestyle and outcomes. Social support refers to every relationship that has an enduring and optimistic influence on a person's life. Social support network supports you to collect assets to increase control of emotional and distressing circumstances (Hobel et al., 2008).

A supportive partner can help to comfort uncertainties and tensions. Sharing a healthy lifestyle before, during and after pregnancy is significant. Social support networks help increase confidence, fearlessness, and thoughts of self-esteem, which in turn encourage and maintain psychological modification (Findler et al., 2007).

A family is a network of social associations, relations, and designs that happen among individuals of families. Normally, the family is connected emotionally, and the parent is the sensitive person for responsibility and analytical solving in the family. Thus, it might badly affect the family structure and the parent's capability for emotional adjustment and critical thinking (Gustafsson et al., 2015). Researchers discovered that spouses (i.e., husbands or wives) were an important source of help earlier and after the discharge of premature babies. Relatives commonly give social support. Nevertheless, its significance still is that family support seems to be the most accessible promptly after the birth of a preterm and decreases throughout the subsequent couple of months. Scientists concluded that perceived social support is dissimilar from received social support. Strong people will probably have more social support than non-strong people (Rowe & Jones, 2010).

**Parents of Premature Babies in NICU**

Parents of NICU newborn babies usually encounter elevated amounts of pressure and thoughts of powerlessness, which frequently indicate an absence of information about parenting, interaction and taking care of their neonates during the neonatal intensive care unit visit (Melnyk et al., 2001).

The distressing effect and dissatisfaction experienced by the mother and father establish a distressing background when a baby is admitted to the NICU. With the loss of the parenting role, the staff nurses look after newborn babies. These were a few recognized stressors for parents of babies admitted to the NICU (Heidari et al., 2013).

Parents of pre-term babies also have to leave their daily routine and spend several hours in the NICU, where they keep on experiencing the babies' weakness and mortality (Clottey & Dillard, 2013).

**Prevalence of Preterm Birth in Pakistan**

Pakistan has an expanding measurement with 748,100 Preterm births every year and the fourth most noteworthy number after India, China, and Nigeria. Pakistan stayed eighth on the planet, first among Asian nations enrolling preterm births. Pakistan had made it very slow. Development in maternal and child well-being. According to global figures, Pakistan appeared with very deprived figures for preterm births and existence (Alam, 2012). Approximately 15–25 percent of pre-term births are because of fetal or maternal complexity during pregnancy. In over 184 nations, pre-term birth rates range from 5 to 18 percent of all infants born. The prevalence of pre-term birth is contradictorily extending from 11.4 to 22.8 percent in nearby populations; the prevalence of pre-term birth is likewise growing in developing nations at a disturbing level and is up to 12 percent among each newborn (UNICEF, 2016).

**The Rationale of the Study**

This research study aims to explore social support among parents of premature babies. Pakistan, a third-world country, has most of the population living in rural and far-flung areas where there are few resources for medical assistance, especially for mothers and premature babies. Luckily, some facilities are available in big cities and the country's capital.

These facilities are equipped with the latest and well-equipped NICUs under the supervision of good doctors and paramedics. But, as described above, most of the hospitals don't have such facilities. Some of the hospitals with these facilities are not well maintained, and the condition of this equipment is not very satisfactory. Two or more babies are put together in one incubator in such hospitals. Most of the hospitals in Pakistan lack specialized equipment and fully trained personnel for equipment handling and maintenance.

In recent decades, the progress of medical knowledge, particularly in the field of reproductive induction approaches and their laboratory process, is one reason for premature births. Cesarean deliveries, likewise, have increased the premature birth rate. It has been revealed that mothers with a neonatal in the NICU label this as an extremely stressful experience. The neonatal intensive care unit environment is quite terrible and threatening for Mothers are constantly afraid of some unpleasant situations that might happen when their baby is admitted to the NICU.

The proposed study will also find how different social support levels affect NICU babies' parents. This study will be beneficial for mental health professionals in understanding the stressful experiences of mothers with premature babies in the neonatal intensive care unit, and through social skills and proper counselling, mothers can provide better ways to cope with these stressful situations.

The present study focused on the Research Question: What social support system is available to mothers of premature babies in NICU?

## METHOD

The present study is designed mainly to explore the role of social support among mothers of premature babies in the NICU.

**Research Design**

The present study has explored the experiences of mothers of premature babies by using qualitative research methods. The interview method was selected as it has characteristics of discussion.

**Participants**

A sample of 15 respondents was selected using a purposive sampling technique from different hospitals in Rawalpindi and Islamabad. Data will be collected through semi-structured interviews. The age range of the sample will be between 20 to 40 years.

Inclusion Criteria. For the present study, mothers of first-born babies and babies born less than 37 weeks are included in this research.

Exclusion Criteria. Mothers with no previous record /experience with NICU and mothers with no past history of mental disturbance are excluded.

**Procedure**

Participants in this research are entirely voluntary. After a brief introduction, the researcher explained the objectives of the research. Confidentiality was assured. Verbal and written consent was taken from the participants before conducting the interview. The interview method was utilized. The interview provides access to the purpose and aim of the research, and the researcher has clear ideas about the type of research question being asked. Each interview lasted for approximately one to two and a half hours.

**Analysis**

The interview sessions were audio recorded, transcribed, and analyzed; the researcher used thematic analysis, a qualitative method, to identify and report the themes extricated from the data. A coding framework was

followed for the analysis, and the themes were organized as common themes, main themes, sub-themes and data were refined until the similarities and contradictions were fully explained (Auerbach & Silverstein, 2003).

## RESULTS

Discussions and in-depth interviews included some illustrations of the conversations between participants rather than simply presenting isolated quotations from the context. The themes were extracted in detail with references to international research. Themes are patterns across data sets that are vital to explaining a fact and are related to particular research questions. The themes turn into categories for analysis (Jennifer & Cochrane, 2006).

Demographically, six mothers of premature babies with a mean age of 25 - 60 years; two of the mothers had attained 12 years of education, two had 14 years of education, and two had 16 years of education, respectively, were selected for the present study. The socioeconomic status of mothers revealed that five of the sample belonged to the middle class, and one was identified as lower class. Two mothers were from the nuclear family system, and four were from the joint family system.

Furthermore, the sample consisted of three mothers with baby boys, two mothers with baby girls and one with twins. In the study, the average length of a baby who stayed in the incubator was 30 days.

Table 1. Social Support & Mental Pressure of Mother

| Theme | Category | Code |
|---|---|---|
| Social Support | Partner Support | Caring and Loving |
| Lack of Emotional Support | Not Supportive | Hesitant and Aloof Behavior of In-Laws |
| | | Mother-In-Law Blame for Birth of Baby Girl. |

Themes and categories are briefly explained below:

### Social Support

#### *Partner Support*

The results of perinatal outcomes (including birth weight) during pregnancy can be correlated with the partner's social support and support or involvement (Elsenbruch et al., 2007).

One of the significant verbatim is:

*"By the grace of Almighty Allah, I do not have any kind of mental pressure. Whenever I wanted to see my child, I just communicated this to my husband. He will take me to NICU so I may see my child and offer reassurance too"* (Mother 2).

A lot of emotional distress, anxiety, and depression experienced by women can be reduced if support is shown by the husband, which also improves a woman's mental health (Hobel et al., 2012).

### Lack of Emotional Support

#### *Not Supportive in-laws*

The birth of a premature baby surely adds more financial and emotional stress to the family. Lack of social support from the husband of the family negatively impacts a mother's ability to cope and handle such difficult circumstances (Table 1, Social Support & Mental Pressure of Mother).

Studies show that women are emotionally strong after childbirth and avoid emotional reactions if they receive or are expected to receive social support. Women expect that their friends, family, and particularly their husband can understand their conditions after childbirth.

Mother expressed her experience in the following verbatim:

*"Behavior of my in-laws was quite" (Mother 1).*

Another mother said:

*"Yes, my mother-in-law used to taunt me after the birth of the baby girl. She used to say you were impregnated with a girl, so what is so special about it? I was given child after four years at least I was happy, and my husband was happy too, but my mother-in-law used to pressurize me" (Mother 5).*

Poor health care for these mothers may result from a lack of understanding. It is thus interesting to know how stress and lack of social support affect health. Mothers who received less social support from their husbands and in-laws admitted that the stress in the relations provoked their stress levels.

## DISCUSSION

As time passes, a lot of advancement is coming in every field of science and technology, specifically in the field

of reproductive induction methods. The number of premature births is increasing due to more and more cesarean delivery procedures, and thus, the number of mothers who experience this procedure has increased. Most of mothers complain about this procedure. They reported that they were not in good physical condition after the procedure and felt very tired. In addition, for a few days, they were also unable to take care of their babies (Beck et al., 2010).

***The well-being of a woman and of her newborn are interconnected, and both can be marginalized in the process of childbirth and the ensuing months. Focusing on preventing maternal and newborn morbidity and mortality is not enough. Care during this period needs to encompass basic human rights, including the rights to respect, dignity, confidentiality, information and informed consent, the right to the highest attainable standard of health, and freedom from discrimination and from all forms of ill-treatment. A woman's autonomy should be recognized and respected, as should her emotional well-being, choices and preferences—including the right to have a companion of choice during labor and childbirth. Respect and recognition of the woman can benefit the newborn, who also has rights and requires respect and recognition. Together, the woman with her partner and family should be supported to care for and make the best decisions for their newborn.***

*https://www.healthynewbornnetwork.org/hnn-content/uploads/Respectful-Maternity-Care-Charter-2019.pdf*

The mothers who participated in this study belong to different age groups. Some mothers were in their twenties when they had their babies, and others were in their thirties when they were blessed with babies. Interview responses vary due to this age difference. An interview containing fifteen questions was prepared, and all these mothers were interviewed. Social Support is divided into spouse and family support, the relationship of the couple after the birth of the baby and the mental pressure on the mother. Resilience is divided into hope, patience and coping strategies.

It was observed that mothers who got support from their spouse were a bit relaxed but still were afraid of other societal impacting factors like in-laws. Zachariah (2009), found that the primary resource for preterm infant mothers is family members. In addition, preterm infants reported that their spouse is the most helpful and useful resource.

The mothers who not only had their spouse's support but also had the support of their family and friends were more relaxed and focused, and we were learning from their training to handle their babies in NICU.

Some of these mothers were observed to be psychologically stronger than the mothers, and these mothers responded that they had family support and did not have any guilt for giving birth to a premature baby.

During NICU hospitalization, pre-mature babies' mothers' who received social support from society anticipated positive relief, which helps to release the mother's stress (Amankra et al., 2011).

When it comes to giving birth, it doesn't really matter if the baby is born premature or normal, but what matters the most is the first interaction between the baby and the mother. Most of the mothers were still not able to express their feelings.

It has been observed that the mothers who had pre-mature babies were relieved but scared at the same time. They are the ones who seek out family support and doctoral guidance. They usually blame themselves if they are not getting enough support from their family.

These mothers seek out the help of their partners and families. Some of them get the support they look for, some of them get the support of their partners but not the in-laws and some of the mothers have to face the very criticism of the family. All these factors start affecting the health of the mothers, and they start to hold themselves responsible for the pre-mature birth of their baby. This leads to health issues, and these mothers face social, psychological and sleep disorders. Their fear continues to grow, and they start blaming the doctors and nurses in the NICU.

There are multiple psychological reactions following a premature baby's birth. Most of the mothers empathize. Some of them criticize themselves. There was no sleep disorder for mothers with all the support and care. However, sleep disorder was reported for mothers where support was not provided either by spouse or family. Now, sleep is directly related to the mother's mental health, and if sleep is disturbed, the mother won't be able to take good care of herself or the baby.

## CONCLUSION

Premature babies seek a lot of attention, and this is why the NICU is the only suitable place for them. Mothers of these babies have to go through many problems that directly and indirectly affect their health, leading to major sleeping disorders. Interviews conducted during this research helped in the identification of emotional triggers that majorly lead to sleep disturbance. The emotional triggers are maternal stress, negative feelings, social support, and resilience. These triggers are divided into themes, which are (labour experience, emotional experience, hospital experience, psychological distress, social support, marital behaviour, and personality change). Results from this study can help the caretaking teams in NICU to understand the experience of mothers better and help them with coping strategies and techniques for infant birth management. A mother must convey her feelings to get better support to manage and look after the child while ensuring she is physically and psychologically healthy by sleeping comfortably. During the study, some mothers reported that they didn't have sleep disturbance as they faced the situation (premature birth of the baby) with the support of NICU staff, which helped them to understand the situation, which led to no sleep disturbance.

### Limitations and Suggestions

The limitation of the study, among many two, is the major limitation of this research. The first one is that the fathers of these babies were not included in the interview sessions, and the second one is that the interviews were only conducted with the mothers residing in Rawalpindi and Islamabad selected for data collection. The NICU environment is very sensitive, and most mothers don't agree to interviews; they are not able to give interviews at once and have not fully recovered from that trauma. The participants are mostly from the middle class, and the study did not cater to the upper middle class.

It is proposed that further studies on the physical and psychological health of the mothers must be carried out on a much wider and larger scale and include mothers who have normal deliveries but still have their babies shifted to NICU for some time.

### Implications

This study will be helpful for mental health professionals in understanding the stressful experiences of mothers of premature babies in NICU, providing ways to cope with these stressful events in life.

NICU can be stressful for the mother, and a preterm baby's hospitalization subsequently affects her psychological well-being. The effective use of coping strategies, support from spouses, and support from doctors and nurses will reduce the level of maternal stress.

This study will help mothers separate from their pre-mature babies and give them more patience and stress their experience in hospital settings. And this study will help to enlighten and guide training in motherhood and NICU facilities. This study's worth of social support confirms the benefits of caring and supportive involvement in reducing the possible psychological and emotional responses.

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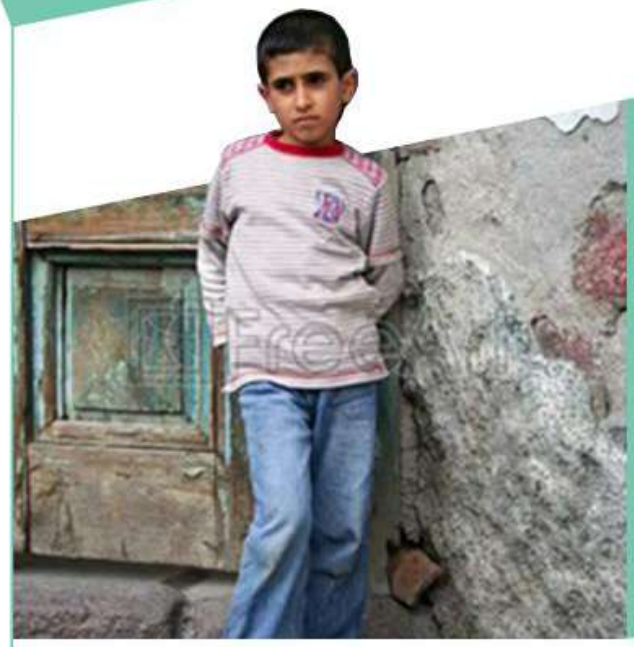

# CASE STUDIES

# Never-Ending Trauma: A Tale of Refugees

**Alyka. M, Laesa. F, Shazia Munir**

***There are many cross-roads, intersections, paths, and tracks to choose from. With every step, a new and different crossroad or intersection emerges- forward, back, right, left, diagonal, in different degrees. At the beginning of the journey, we are not sure where it will end nor what will be discovered- Morgan (2000, p. 3).***

Becoming a refugee affects all aspects of one's life. Therefore, it is not surprising that refugee issues are studied within and across various disciplines (Castles, 2003). This essay provides a detailed account of the ongoing impact of displacement and encampment of refugees who do not have access to resettlement support services or are resettled in locations of cultural and linguistic diversity. Following the journeys of displaced families who left South Asia to seek resettlement in Australia. This is framed around the concept of a journey that prepares for the road ahead by examining literature from the fields of refugee studies, education and career development.

***To know the road ahead, ask those coming back. - Chinese Proverb***

The article is divided into three sections: (i) global, national and local perspectives on refugee issues; (ii) migration and resettlement in Australia; and (iii) education and career pathways.

Despite the official definition of the Refugee Council of Australia, 2006c the current article adopts a broader perspective which recognizes that "it is the refugee-like experience rather than the official designation as a refugee… that defines the relevant population" (Coventry et all, 2002, p. 13). Therefore, it involves South Asian refugees who migrated to Australia with visas within the humanitarian migration stream, including Refugee (200), Special Humanitarian Program (202), and Woman at Risk (204) visas. These refugees need not continually be defined by their status as humanitarian entrants. Some writers have used the term "people with refugee experience" (Department of Education and Children's Services, 2007) and "from refugee backgrounds." The term "refugee young people" is used in the context of literature pertaining to youth (Ignacio Correa-Velez & Gerald Onsando, 2013). This terminology assumes a more inclusive paradigm, demonstrating respect to individuals while acknowledging their previous refugee experience.

South Asia has been and remains a site of struggle and conflict. Some authors have suggested that fundamental causes of the conflict concerned economic and political exclusion, instability, poverty and injustices (Woodley, D. 2015). Regardless of their origins, it is clear that these conflicts have shaped the lives of millions of people and have significantly contributed to the global refugee situation.

***The road doesn't tell the traveller what lies ahead. - Chinese Proverb***

When individuals become refugees, their entire social world is overturned, resulting in a loss of life's repetitious, recursive patterning (Mintzberg, 2009). Therefore, that profound loss is a defining characteristic of the refugee experience, typically involving multiple losses of personal, physical, economic, social and cultural resources (Wilson, Murtaza, & Shakya, 2010). The refugees are not well prepared to face such a diverse range of problems; as a result, they are caught unprepared and unaware of a web of issues (Barber, 2021). These are issues which they cannot control or resolve as they are refugees in an unknown territory with limited rights. As a result, they suffer from double mental trauma, one of fleeing from their home country and the second of adjusting to the new and unreceptive environment of the host country. Unfortunately, most of the asylum seekers have to stay in detention centres. Numerous studies have been conducted which clearly highlight that the health of children as well as adults in detention centres is jeopardized (Killedar & Harris, 2017).

With an extensive migration history, Australia is among the top ten recipient countries for refugees (RCOA 2022) and is considered to take more refugees than any other country relative to its population. There are two major entry pathways: United Nations High Commissioner for Refugees resettlement programme and Irregular Maritime Arrivals (IMAs) seeking asylum. However, the Australian Government's policies towards IMAs since July 2013 are controversial, inflexible, and consistently strict, with asylum seekers held in detention centres for prolonged periods (Earnest ET all, 2015). Statistics show that 940,159 refugees arrived through offshore resettlement and onshore protection processes between 1 January 1947 and 30 June 2022 (Refugee Council of Australia, 2023). However, the government must act on a pledge for more refugee places as global displacement reaches an all-time high. The Australian Labor Party has committed itself to reversing recent cuts to the Refugee and Humanitarian Program and increasing it to 27,000 places a year with 5,000 additional places for community sponsorship (RCOA 2023). Australia's Humanitarian

Program is reviewed annually and involves assessments conducted by the UNHCR regarding the resettlement needs of onshore and offshore refugees (RCOA 2021). The World Health Organization's Quality Rights Tool Kit would possibly function as the inspiration for a framework to reform Australia's immigration detention system, with a unique emphasis on drastically improving the bad intellectual fitness of detained asylum seekers (Campbell et al., 2015).

***"No one puts their children in a boat unless the water is safer than the land." Warsan Shire (Poem - Home)***.

Refugees flee their countries of origin due to supreme hardship and threat to life, frequently having witnessed mass atrocities. Resettlement is motivated by a sense of security and opportunity involving access to food, accommodation, and freedom from dangers (Garnier, Jubilut, & Sandvik, 2018). The course of resettlement often involves a series of inherently complex transitions. Asylum seekers and refugees have distinct stressors, which can create additional challenges. The grade to which these challenges are embraced impacts the ability to adapt. According to Khawaja et al. (2008), refugees utilize several coping strategies across all phases, including crediting religious beliefs, social support, and cognitive approaches such as reframing the situation, relying on their central resources, and focusing on future desires and aspirations. Themes documented by research (Earnest ET all. 2015) that language, its impact, and experience with education, health, and social events, support structures provided to refugees, and supporting future goals are critical to successful resettlement. Fluency in English, especially spoken, was considered a facilitator of successful resettlement in Australia.

***"Refugees didn't just escape a place. They had to escape a thousand memories until they'd put enough time and distance between them and their misery to wake to a better day." Nadia Hashimi***

Every immigrant seeking asylum has a unique tale of where they came from, their journey, and achieving protection in Australia. Clinicians (Stroja, 2022) are exposed to tragic stories when providing treatment to refugees who have suffered torture and trauma. Furthermore, therapists who deal with asylum seekers are frequently obliged to operate in the setting of deportation proceedings and ambiguity about their clients' futures, thereby aggravating the already challenging nature of trauma treatment and negatively impacting professional wellbeing. The sharing of tales allows these professionals (Posselt et al., 2019; Posselt et al., 2020) to commemorate and honour their journey and educate the communities about the fortitude and commitment that refugees make.

Despite South Asia's cultural, linguistic and genetic diversity, three central elements have been recognized. These include kinship, spirituality and collective practices and beliefs. Asian cultures are, therefore, outlined by a collectivist ideology in which collaboration and interdependence are emphasized (Missbach, A. 2022). When these refugees migrate to Australia, they do so in the context of transitioning from a collectivist culture to a predominantly individualist society in which there are different orientations of time and approaches to social interactions (Neblett et al., 2010). Contrary to the general perception that relocation to Australia is a smooth process, new refugees to Australia have reported (Stroja, J. 2022) substantial difficulties in the transition phase. In addition to this, most of them have a hard time acquiring accommodation, education, health, and employment and are subjected to plenty more tiers of mental and emotional misery than the common population.

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# ART & SCIENCE OF HEALING

# In the Middle of Winter, an Invincible Summer: Assessing the Therapeutic Potential of MDMA-Assisted Psychotherapy (MA-PT) for Torture Survivors

**Lukasz Felczak**

Posttraumatic stress reactions, most often captured by the clinical construct of posttraumatic stress disorder (PTSD), are a significant global mental health problem, with a lifetime prevalence rate estimated at 3.64 to 3.9 % worldwide (Illingworth et al., 2021). PTSD is especially prevalent in conflict-affected populations, including refugee populations (Illingworth et al., 2021). Among refugees, torture survivors are especially vulnerable to developing posttraumatic reactions in addition to co-occurring symptom profiles congruent with depressive and anxiety disorders (Campbell, 2007; Daud et al., 2005; Hárdi et al., 2011; McColl et al., 2010). Among refugees and torture survivors, congruent with strengths-based and non-pathological therapeutic frameworks, these reactions are best conceived as normal responses to abnormal circumstances, including circumstances of co-occurring geo-political violence, social injustice, and the gross violation of human rights.

There are many types of psychotherapies used to both manage and resolve posttraumatic reactions, including but not limited to expressive arts therapy (EXA) (McNiff, 1992), somatic experiencing (SE) (Levine, 2010), sensorimotor psychotherapy (SP) (Ogden et al., 2006), exposure therapies, trauma-focused cognitive behavioural therapy (TF-CBT); interpersonal therapy (IPT), and eye-movement desensitization and reprocessing (EMDR) (Mithoefer et al., 2010). In terms of psychopharmacology, selective serotonin reuptake inhibitors (SSRIs), as well as the serotonin-norepinephrine reuptake inhibitor (SNRI), Venlafaxine, appear to be most effective at treating trauma-related symptomatology (Mithoefer et al., 2010).

Despite good evidence for the efficacy of several psychotherapeutic approaches in the therapeutic remediation of trauma-related reactions, a significant portion of trauma survivors – estimated at 30-60% – do not achieve symptom remission regardless of the psychotherapeutic or psychopharmacological approach used (Illingworth et al., 2021; Mithoefer et al., 2010). Also, research suggests that the prevalence of posttraumatic stress disorder (TR-PTSD) may be over-represented among torture survivors (Baker, 1992; Hárdi et al., 2011; Miller, 1992; Sapporta et al., 1992; Somnier et al., 1992).

Given the prevalence of TR-PTSD among torture survivors, there is a pressing need to explore and validate efficacious and potentially novel treatments to better support this population.

3,4-methylenedioxymethamphetamine (MDMA) is a monoamine releaser with a signature pharmacodynamic profile that, when administered in conjunction with psychotherapy, appears to increase the tolerability and effectiveness of psychotherapeutic treatment (Jerome et al., 2020). The operant psycho-physiological mechanisms associated with these treatment gains appear to be associated with MDMA's effects on serotonin, serum oxytocin, prolactin, reduced amygdalar activity, reductions in neural activation associated with fear and negative emotionality, as well as with subjectively perceived increases in empathy, extroversion, and confidence (Jerome et al., 2020; Mithoefer et al., 2010). The non-clinical phenomenological effects of MDMA administration include both complex and sometimes paradoxically and heterogeneously pleasant and unpleasant somatic, sensory, social, and transpersonal experiences (Wagner et al., 2017). Somatically, these experiences can range from muscle tension to muscle relaxation, increased yawning, coldness and/or extremely pleasant waves of euphoria. Sensorily, tactile sensations may appear richer, and colour often appears more vibrant and brighter. The perception of music can become extremely pleasant and engrossing. Emotionally, these experiences may include anxiety or deep calmness, felt security, pure contentment, or extreme pleasure. These feelings are often accompanied by the generally felt sense of being able to see the world more clearly. Socially, there is an increased pleasure in sharing feelings and ideas with others and with a marked absence of social anxiety. Transpersonally, there may be a felt sense of ultra-connection to all living beings, persons, and things. There may be a marked fascination and wonderment with existence, a felt sense of being 100% complete of the world being perfect just the way it is. There can also be the felt-sense-cognition that the present moment is all

you will ever need (Lifey Health, 2023; Psyched Substance, 2023; Wagner et al., 2017).

Clinical populations undergoing trials of MDMA-assisted psychotherapy (MA-PT) have experienced significant and lasting gains in the reduction of posttraumatic symptomatology. MA-PT has also shown promising results on measures of well-being and psychological growth not captured by the Clinical Administered PTSD Scale (CAPS), which serves as the primary measure in evaluating PTSD in clinical trials (Barone et al., 2019). In addition to significant PTSD symptom reduction, participants in MA-PT have reported significant and lasting improvements in self-awareness, relationships, social skills, occupational functioning, substance abuse problems, openness to continued therapy, reduced medication use, enhanced spiritual life, increased empathy and self-compassion, as well as increased "openness to experience," which may itself represent a deep-rooted personality transformation (Barone et al., 2019; Jerome et al., 2020).

To date, MA-PT trials have focused on trauma survivors with TR-PTSD of diverse traumatic backgrounds, including but not limited to combat veterans, first responders, and sexual abuse and sexual assault victims. MA-PT has yet to be shown to be an effective therapeutic adjunct to the rehabilitation of torture survivors. This paper intends to critically explore and discuss both seminal and current research regarding the therapeutic efficacy of MA-PT, as well as its relevance as a novel treatment modality in the rehabilitation of torture survivors. This paper also proposes a common factors model to better understand the therapeutic mechanisms of MA-PT, as well as important directions for future research.

**Common Themes and Problems: MA-PT and Torture Rehabilitation**

Common themes and problems researchers must address in exploring the intersection between MA-PT and the rehabilitation of torture survivors include addressing complex and confounding research participant variables. These include, but are not limited to, variables associated with settlement factors and stressors, ethno-racial and socio-cultural factors, factors associated with the complex clinical interplay between organic tissue damage, tissue scarring, acute and complex pain (de C. Williams et al., 2010; Liedl et al., 2011; McColl et al., 2010), as well as factors associated with the phenomenological anxiogenic experience of perceived lack of control secondary to MDMA administration (Psyched Substance, 2023). In this regard, the administration of a potentially anxiogenic substance could be re-traumatizing – especially if the survivor's torture experience included the forced administration of drugs or other noxious or psychoactive substances. Other potential research considerations include ethical-religious factors pertaining to the prohibition of ingesting "intoxicants," as well as the determination process to decide which psychotherapeutic approach/modality to augment vis-à-vis MDMA administration.

**Clinical Literature Review – Seminal and Current Research**

Since the criminalization of MDMA in Canada in 1968 and in the United States in 1985, Mithoefer et al. (2010) conducted and reported on the first clinical trial evaluating MDMA as a therapeutic adjunct to psychotherapy in the treatment of TR-PTSD.

Twenty participants (N=20) with TR-PTSD were enrolled in the study. Subjects were between 21 and 70 years old, with a mean age of approximately 40 years old. Average PTSD duration was estimated at 19+ years. The sample was predominantly white, female, and self-reported sexualized violence in either childhood or adulthood.

Eligible participants (N=20) were randomized, double-blind, to receive two experimental sessions of either MA-PT or the same psychotherapy with active placebo. Several outcome measures were employed in this study, including the CAPS to assess PTSD symptoms at baseline, after each experimental-MDMA session, as well as at 2-month follow-up.

Following analysis, it was found that the MA-PT group had significantly greater improvements in PTSD symptoms than controls. A significant portion of the treatment group (10/12 subjects) no longer met DSM-IV criteria for PTSD. All three participants who reported significant occupational impairment returned to work.

Mithoefer et al. (2010) concluded that with monitoring and support, MA-PT can be used with short-lived and acceptable side effects in a carefully screened group of individuals with TR-PTSD. They concluded that MA-PT resulted in clinically significant reductions in PTSD symptomatology not only at 2-month follow-up but at 17+ month's follow-up as well (Mithoefer et al., 2013).

In this seminal study, Mithoefer et al. (2010) demonstrate the efficacy of MA-PT in the treatment of TR-PTSD. This study also provides preliminary evidence for the limited side effects and neurocognitive risks of this treatment intervention. However, although sexualized violence may be a common and significant contributor to the overall trauma presentation among torture survivors (Hárdi & Kroó, 2011), the results cannot be readily generalized since many displaced persons, including torture survivors, experience complex stressors and traumas (i.e., which may or may not include sexualized

violence). Moreover, most torture survivors who survive to access rehabilitation services oftentimes become racialized BIPOC minorities in their host countries. In this regard, this preliminary study fails to account for complex identity intersections in treatment outcomes.

Lastly, a significant theoretical bias in this study is the authors' focus on the bio-psychoactive response of MDMA administration instead of the therapeutic impact of the phenomenological experience of MDMA administration itself. MDMA produces potent phenomenological alterations to present-moment conscious experience. Perhaps the phenomenological impact of the treatment, as much as the bioactive response, is responsible for these promising clinical outcomes.

To better understand the long-term qualitative impact of MA-PT, Barone et al. (2019) conducted a follow-up study of a clinical trial of MA-PT for a sample of individuals with TR-PTSD (N=19). Research participants included combat veterans, police officers, and firefighters with a confirmed diagnosis of moderate to severe TR-PTSD. Most eligible participants identified as male and as combat veterans (13/19). Nearly all participants identified as white (18/19).

At one year follow-up, participants of this MA-PT phase II clinical trial completed a long-term follow-up (LTFU) questionnaire and interview. Interviews were recorded, transcribed, and underwent Interpretive Phenomenological Analysis (IPA). IPA is an approach that is especially relevant for evaluating novel treatment modalities since it illuminates the *meaning* that participants make of their experiences in clinical trials.

Results indicate that most participants reported improvements in friendship (11/19), family relationships (12/19), substance abuse problems (13/19), as well as openness to further therapy (14/19). Furthermore, at one-year follow-up, all participants (19/19) reported improved self-awareness, engagement in new activities, enhanced quality of life, and reduction in PTSD symptoms. Participants perceived that the therapy sessions, in conjunction with the therapeutic benefits of MDMA, as well as the strong rapport with the therapy team, significantly contributed to these sustained long-term therapeutic gains.

According to the study authors, these results indicate that MA-PT can positively and sustainably impact a range of psychosocial functions and improve the overall quality of life, regardless of changes to PTSD symptoms or status.

These clinical findings are particularly useful since all the participants in this study, as is often the case with survivors of torture, specifically experienced adult-onset traumas. The results of this study may be further generalized to survivors of torture, as far as many survivors have also experienced the ongoing stress and terror of war. However, the generalizability of this study suffers from the homogeneity of the predominantly male and white study sample. Generalize to torture survivors who were tortured as a "consequence" of their perceived role in social service or social justice work (i.e., as human rights advocates).

In a more recent effort to summarize clinical findings, Illingworth et al. (2021) conducted a review of the extant clinical literature exploring the use of MA-PT in the treatment of TR-PTSD. A meta-analysis was performed on four clinical trials employing a moderate-sized sample (N=85). All four trials were double-blind, randomized, and compared MA-PT to psychotherapy and placebo. Primarily, outcome measures included scores on the CAPS as well as the Beck Depression Inventory (BDI). Secondary outcomes included measures for physically adverse and neurocognitive effects.

When compared to placebo, treatment groups administered 75mg and 125 mg (but not 100 mg) with psychotherapy (PT) had significant decreases in CAPS scores. A significant decrease in BDI was only observed at 75 mg of MDMA administration. In addition, treatment groups were found to experience minimally adverse physical and neurocognitive side effects. Illingworth et al. (2021) also highlighted that according to this review of treatment efficacy, combat veterans, as well as survivors of domestic violence, may be especially amenable to MA-PT.

These unique indications in terms of treatment amenability may generalize to some torture survivors since the experience of torture is often confounded with war stress and terror, as well as by interpersonal entrapment. With this said, however, neither gender, ethno-racialization, nor cultural characteristics were reported regarding this aggregate sample. Additionally, as the study was biased toward psychometric measures of clinical impairment, it lacked a framework to discuss the surprising inconsistencies within the study. If this study had included alternate psycho-clinical frameworks, for example, the zone of workability from CBT, One significant omission in the study is a discussion of the potential role that perceived social service and benevolent self-sacrifice can have on the onset, persistence, and remediation of trauma-related symptomatology. For example, there may be under-explored common factors within this study population that may (Mithoefer et al., 2010) Or *the window of tolerance* from SP (Ogden et al., 2006), then perhaps some of these paradoxical findings, including over-activation of the autonomic nervous system (ANS) at higher doses of MDMA, might be better explained.

To explore the maintenance of these positive treatment outcomes at long-term follow-up, Jerome et al. (2020) conducted a longitudinal pooled analysis of six (6) randomly assigned, double-blind, controlled phase 2 trials of MA-PT compared to active placebo for TR-PTSD. Eligible participants (N=107) of heterogeneous trauma etiologies received MA-PT or PT with active placebo. PTSD symptoms were assessed using the CAPS at baseline, 1-2 months after the last active MDMA session, and at least 12 months at long-term follow-up (LTFU). Treatment benefits at LTFU were also assessed using a questionnaire.

CAPS scores were shown to decrease from treatment exit to LTFU. Additionally, the number of participants who no longer met positive diagnostic criteria for PTSD increased from treatment exit to follow-up (56-67%). At treatment exit, 82% of participants (88/107) exhibited clinically significant improvement, with symptom improvements sustained from 1 to 3.8 years post-treatment. Jerome et al. (2020) also found that positive long-term impacts of the treatment included "enhanced spiritual life," "increased self-awareness and understanding," "increased empathy", and "greater involvement in the community" (p. 2494). Taken together and consistent with non-clinical findings (Wagner et al., 2017), the authors suggest that MA-PT may result in changes in facets of personality, such as openness to experience, which may be considered a deep-rooted therapeutic transformation. This change may represent a broad re-orientation of the central nervous system (CNS) from a general experiential physio-emotional-psycho-social pattern of constriction, risk aversion, and social disconnection to a nervous system more broadly characterized by patterns of curiosity, exploration, and sociability (Courtois et al., 2009).

These findings may be of special clinical importance to the rehabilitation of torture survivors since, in addition to TR-PTSD, many authors have described a constriction of personality as a long-term consequence of the torture experience (Baker, 1992; Hárdi et al., 2011; Miller, 1992; Sapporta et al., 1992; Somnier et al., 1992). However, like previous studies, this pooled analysis fails to assess the impact of gender, ethnic-racial, and cultural variables on treatment response. Lastly, this study fails to account for the phenomenological impact of the treatment experience on treatment outcomes. For example, there may be common factors to MA-PT, as well as to other experiential psychotherapies (e.g., EXA, SE, SP, and Accelerated Experiential Dynamic Psychotherapy [AEDP]) that privilege novel and pleasurable experiences of transformance as a primary mechanism of psychotherapeutic change.

As previous research on the efficacy of MA-PT was mostly limited to non-Hispanic, white samples, Ching et al. (2022) conducted a pooled analysis to assess whether MA-PT is also an effective treatment for Black, Indigenous, and other racialized populations (i.e., BIPOC populations). Secondary analysis was conducted on two phase 2 open-labelled trials and a phase 3 randomized, blinded and placebo-controlled trial to compare MA-PT for PTSD between sub-groups of BIPOC (N=37) and non-Hispanic white (N=90) participants. The primary measure was the CAPS score at baseline and at the primary end-point post-treatment. No significant ethno-racial differences were found in terms of CAPS score pre- and post-treatment. These findings provide preliminary evidence for the efficacy of MA-PT for the treatment of PTSD across diverse ethno-racial groups.

These findings are significant in rehabilitating torture survivors since many torture survivors become racialized as BIPOC individuals within predominantly white host countries. However, ethno-racial diversity cannot be conflated with cultural diversity. Nor can contextual factors, such as unmet settlement needs, be ignored in any discussion of the potential efficacy of treatment on symptom reduction. Future studies on the efficacy of MA-PT across ethno-racially diverse sub-groups should include sub-populations with diverse migration statuses to determine if positive MA-PT treatment will also generalize to displaced persons with complex psychosocial needs.

**Discussion and Clinical Implications**

Preliminary, as well as phase 2 and phase 3 clinical trials have found that MA-PT is an effective treatment for TR-PTSD. The treatment efficacy of MA-PT appears to target not only PTSD symptoms but also broader areas of psychosocial functioning. Treatment gains can be observed at treatment exit, as well as at long-term follow-up. Among some treatment samples, these treatment gains appear to reflect deep-rooted and adaptive changes in personality. Treatment gains have been observed across diverse trauma etiologies in both childhood and adulthood. The treatment gains of MA-PT were observed, in most cases, with limited and tolerable side-effects and minimal risk in terms of substance abuse or other neurocognitive effects.

This body of research indicates that MA-PT may be a viable treatment option in the rehabilitation of torture survivors with presenting TR-PTSD symptoms. However, more research is needed, with diverse migrant samples, to better assess the viability of this novel treatment modality. Treatment participants report that close therapeutic support with their clinical teams was an important contributing variable in the perceived benefit of MA-PT treatment (Barone et al., 2019). In this regard, future trials of MA-PT in the rehabilitation of torture survivors would benefit from in-house wrap-around

approaches of care and psychosocial support already present in many torture rehabilitation centers worldwide.

MA-PT highlights phenomenological aspects of psychotherapeutic transformance that are common to many forms of psychotherapy. These common phenomenological aspects of transforming may account for the clinical impact of the treatment beyond the specific administration and psychoactive effects of MDMA. Common phenomenological factors associated with MA-PT may include generalizable, in-session experiences of transformants, which, in addition to the extinction of fear conditioning in the trauma response, may themselves inform the mechanisms of change and personality expansion beyond any remediation of PTSD symptomatology. Common phenomenological/psychotherapeutic factors in trauma-focused treatment modalities (i.e., EXA, SE, AEDP, SP, and MA-PT (Ruse et al., 2008) include:

- Inviting the client to stay present with their own inner experience.
- Fostering willingness to explore new and unexpected perceptions.
- The therapist's attention to the client's account of their inner experience.
- The therapist's capacity to observe a delicate balance between focusing on inner experience while at the same time exploring it in an open-ended way.
- The creation of a therapeutic space where the therapist and client can surrender to the process without controlling or over-determining its outcome.
- Both therapist and client recognize that therapy is a non-linear process that may shift and resolve in unexpected ways.
- The foundational principle is that a human being's inner healing intelligence, in conjunction with *medicine*, will bring forth whatever experiences are needed for healing and growth so that anything that arises is viewed as part of the healing process.
- The therapist's role is often to follow rather than guide.
- Facing painful experiences is a path toward healing. (Ruse et al., 2008)

To better understand the interplay between common factors in trauma-informed and trauma-focused therapies of phenomenological expansion and transformation, future studies exploring the differential subgroup treatment outcomes of MDMA-assisted expressive arts therapy (MA-EXA), MDMA-assisted somatic experiencing (MA-SE), or MDMA-assisted sensorimotor psychotherapy (MA-SP), may shed light on the specific therapeutic mechanisms of change in any MDMA-assisted psychotherapeutic approach.

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# Torture in Art throughout History

**Anna Danielson Graduate, Graphic Design Advisor: Lopa Basu***

**Abstract**

Art is a valuable asset in drawing attention to difficult issues in a different way. Controversial and taboo subjects, such as torture, are often ignored in people's daily lives, but no subject is off-limits in the art world. Exposing people to artwork that depicts torture provides them with a starting point to begin a conversation with others about a difficult subject or to dig deeper into their own minds. Sometimes, the best work of art is not the most visually pleasing or beautiful but is instead the piece that connects to the viewer emotionally and makes them think about why it was created. By looking at the portrayals of torture in art from before 1275 B.C. through the present day, I was able to learn about the reasoning behind why torture was used and why artistic documentation was necessary. I continued my research of torture depicted in art by creating my own digital painting and an accompanying artist statement.

**Keywords:** art, controversial, taboo, torture

**Torture in Art throughout History**

In art, the human body is celebrated; in many famous paintings and sculptures, the subject is nude or scantily clothed. When studying art, students are taught to see these pieces for their visual qualities and the techniques that were used in their creations. This approach allows the students to learn how to critique art, no matter their personal opinions on the content of the piece. However, sometimes, it is impossible to look at certain works of art and see the beauty behind the image when they are portraying terrible events like torture. Today, torture is typically a topic too taboo to talk about in daily life, but in the art world, no subject is off-limits. How does the depiction of torture in art affect the viewer, and what is the purpose of its creation?

Torture has been portrayed in art since before 1275 B.C., but the reasons behind why torture was used and documented in an artistic way have changed throughout time. In the Renaissance era, torture was commonly used as a punishment for criminal acts. While the act of torture took care of the legal consequences that were mandated for breaking the law, it was also seen as a beneficial act for the criminal. In this time period, religion and spirituality played a major role in how people lived their daily lives. When a 1 Anna was in the Honors College of UW-Stout (Ed.), a person committed a crime; they were not only breaking a law created by the government, but they were also going against the word of the Lord. The pain and suffering that torture produced were seen as a way for criminals to take on similar qualities to Christ and hopefully provide them with the possibility of salvation. Salvation would only be an option if the criminals repented for their sins; if no repentance occurred, the pain that they experienced would be seen as foreshadowing the cleansing trials they would experience in Purgatory or what they would endure during an eternity in hell. Other art forms, such as writing and preaching, also enforced the belief that people needed to live their lives devoted to Christ and his teachings. Jonathan Edwards' sermon, Sinners in the Hands of an Angry God, used intense imagery and language in the hope that the sermon would awaken the audiences to the terrible reality that awaited the sinners of the world. To discourage others from committing the same crimes, an artist would be hired to create a visual record of the punishment of the wrongdoer. These powerful images would be displayed in areas of high traffic, such as a town square or in a church, where all of the citizens could witness the consequences of breaking the law (Guzik 22).

Artistic renderings of torture were not just limited to criminals. Many churches commissioned a series of paintings or frescos that depicted the saints undergoing their trials and tribulations, usually in the form of torture. Saint Bartholomew, for instance, was skinned alive because he was spreading Christianity against the king's orders (Please refer to Figure 1, p. 203). The main visual distinction in the portrayals of saints and sinners in art is how the face and body are portrayed. Saints are usually illustrated in a delicate way that suggests purity; they show little to no emotion because they are dying for a religious purpose that they believe in. Those who were punished for committing a crime are typically created using high contrast (extreme darks and lights) with their faces and bodies contorted in agony.

This difference between the bodies of the innocent, repentant, and guilty can be clearly seen in Lucas Cranach's woodcut, The Crucifixion (Please refer to Figure 2, p. 203). The middle figure, Jesus Christ, is in a serene position and seems to be unaffected by the pain he should be enduring. Jesus' lack of emotion can be related back to his decision to use his suffering as a tool to create salvation and redemption for the children of God. The two thieves that flank Jesus' sides, on the other hand, show varying amounts of distress and agony. While both of the thieves display the pain they are feeling in their

faces and bodies, the one on Jesus's right-hand side is depicted in a more tranquil form because, according to Luke 23:39-43, one of the thieves repented for his sins while the other simply hurled insults at Jesus. Many early depictions of Jesus' crucifixion draw attention to the positive message of resurrection instead of the physical realities of execution, but in recent artistic portrayals, such as Mel Gibson's The Passion of the Christ, focus more on Jesus being human and capable of suffering.

This allows people to relate better to the sacrifice he endured for them. In the present age, religion does not play as large of a role in torture as it did in the Renaissance era, and the rationale for using torture has moved away from a form of punishment to an interrogation technique. With the end of the Cold War, the United States' involvement in torture seemed like a thing of the past. That was certainly the case until the 9/11 attacks brought torture back into the public's eyes (Pallitto 490). Because of the attacks on the Twin Towers, the search for members of the terrorist parties led the United States military overseas, where they imprisoned alleged terrorists in Abu Ghraib, Iraq. Torture was used by the military in these situations as a way to obtain information from a source that was unwilling to share what they were hiding. While torture can sometimes produce reliable intelligence, it is not the best way to gather information, especially when the people being held captive are innocent and are in no way involved with terrorist groups. Taxi to the Dark Side, the documentary film, begins with the unsolved murder of an innocent Afghani taxi driver who was taken for questioning and ended up dying from excessive physical abuse. The film uses this specific example as a starting point to explore the reasoning behind the corrupt techniques that were being used for interrogation purposes and looks at the public backlash that was created when the Abu Ghraib photos were leaked. The public's response to the newfound knowledge of what their military was doing caused great controversy, and artists took the opportunity to capture the pain and suffering of the prisoners on canvas and stone.

Fernando Botero, a famous figurative artist known for his depiction of overweight and inflated figures (Please refer to Figure 3, p. 204), created a series of over eighty drawings and paintings as a reaction to the photos that were leaked from the Abu Ghraib prison (Please refer to Figure 4, p. 205). He used these paintings as a way to express his anger at the hypocrisy of the entire situation. He abandoned his traditional style to better represent the anger he needed to get out of his system; his usual inflated figures were transformed into muscular and solid beings. Botero created these paintings quickly by using harsh brush strokes and dark, dirty colours. This series has been shown all over the world, but it does not provide the typical evening at the museum experience. The drawings and paintings feature nudity, blood, bodily functions, and humiliating scenarios that allow the viewer to empathize with the prisoners like they were never able to before (Baker). Betero once said: "…art is important in time; it brings some kind of reflection to the matter. We have analyzed this thing [the infamous Abu Ghraib photographs] from editorial pages and books, but somehow, this vision by an artist completes what happened. He can make visible what's invisible, what cannot be photographed." In a photo, a photographer just clicks a button to capture a certain moment in time, but an artist has to put in time and energy. This concentration of energy and attention brings additional depth and emotion to a subject that other media cannot fully replicate.

Artwork depicting torture is a valuable way to draw attention to the issue in a different way. As Botero said, art has a part of the artist's energy and soul in the piece, which allows for a unique and emotional viewing experience. Sometimes, the best work of art is not the most visually pleasing or beautiful. It is instead the piece that connects to the viewer emotionally and makes them think about why it was created. It does not matter if the artist used the correct techniques or visual qualities; the importance of paintings and sculptures that feature torture is not based on how they were created but on why.

**Artist Statement**

As an artist, I try to create pieces that the viewer can emotionally relate to, even if they are unsure about the reasoning or story behind the work. Tortured Soul was created to bring awareness about the people that were captured after 9/11 as suspected terrorists and what they endured while in captivity. I took inspiration from Marc Falkoff's book Poems from Guantanamo: The Detainees Speak; the poems in this book gave me a chance to look into the minds of the prisoners and helped me to understand what they were going through emotionally as well as physically. The emotions I felt while reading these poems needed an outlet, and through the creation of Tortured Soul, I was able to make a visual representation of the feelings I experienced. Tortured Soul is a digital painting that metaphorically represents the alleged terrorists being imprisoned at Abu Ghraib and Guantanamo Bay. This is done through the use of different techniques and the visual correlation between the imagery and their implied connotations. A majority of the prisoners being held were older, but through the use of young and childlike facial features, I was able to represent the innocence of the people who were being held captive. These people were held captive for no reason other than being taken by a bounty hunter on a

whim or being in the wrong place at the wrong time. The dark, monochromatic colour scheme signifies the depression and isolation that accompanied their fear and humiliation. I emphasized this feeling of hopelessness by creating a sense of endlessness filled with the fear of the unknown. This was done by having the figure swallowed by a dark expanse that extends to the edges of the piece. With the juxtaposition of the soft and hard edges throughout my digital painting, I was able to create a visual representation of the deterioration of the prisoners' minds and bodies as they were being tortured for information that they did not have (Please refer to Figure 5, p. 206)

The best part about art is that there is no single way to view and interpret it. Art uses our own personal experiences, thoughts, and feelings to lead us on a journey of discovery and inspiration. For my digital painting, I did not want to steer anyone's thoughts in a certain direction; I wanted them to look at it and ponder about how it made them feel. I created this piece to connect to the audience on an emotional level as well as bring torture back to the forefront of our minds. Torture is a topic that people typically only hear about on the news when a big event is happening, but unfortunately, torture is not limited to those publicized events. It goes on every day all over the world. Torture is used to break a person down mentally and physically, and the images I referenced showcased so much pain and emotion that I felt obligated to replicate that emotion in my own piece. Through the creation of this piece, I was able to approach a difficult topic and experience deep emotions in a safe environment. I wanted to provide this experience to other people through the creation and display of my digital painting. Torture is a subject matter that does not normally get discussed or is shown in a way that creates a safe environment to explore deep emotions and thoughts.

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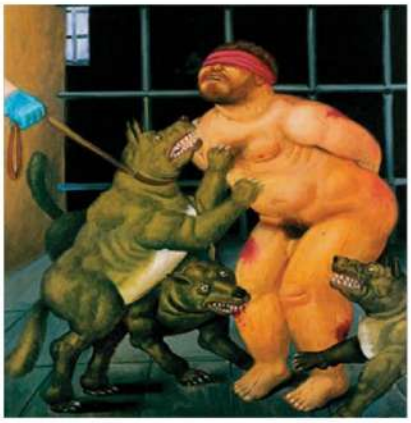


Abu Ghraib Painting 52 (Fernando Botero) 2005

Tortured Soul (Anna Danielson) 2014

Mona Lisa (Fernando Botero) 1977

*The Absence*

*Koua Xiong*

*Mentor: Bryan Ritchie*

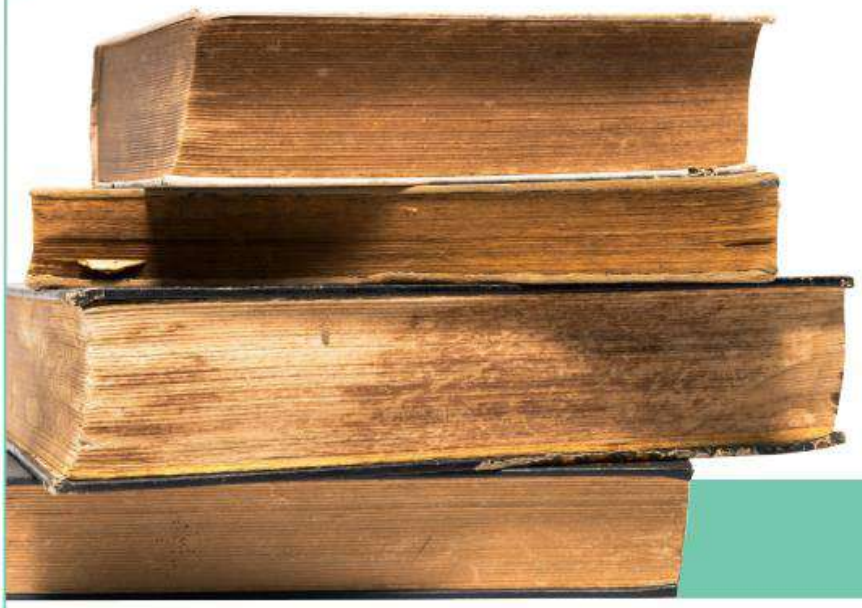
*Absences fill our lives. As an abstraction of the nonexistent, these variables can present themselves in myriad and miscellaneous forms. Some - times they begin as an insignificant loss, but with time, they become a considerable burden. But on other occasions, they erupt as bursts of agony and develop into a more durable suffering, the intensity of which the host feels varies upon the absence of the object, person, place, or thing. It is even possible for the host to be unaware. However, being ignorant of the variable does not equate to being free. For absences are parasitic, they exist to be fulfilled. And it is how we choose to fulfill them that defines us.*

*The motivation for my oeuvre can be traced to my primary absence. My interest in themes of sexual deviancy, dualism, spirituality, and the consequences that ensue was an investigation into how and why I've dealt with the absence. And inversely, the series of works presented thrusts the Absence into the foreground.*

*Being a gesture of resolution, this series is a narration of the relationship between myself and it. Each form, a conceptual entity manifested, is an embodiment of who I am, being affected by the Absence. The entities represented are my sexuality, identity, and spirituality. The final piece is the confrontation between myself and the Absence. To present the symbiotic bond between myself and the Absence, I employed the usage of the void. The presence of a void is the closest physical representation of an Absence. With the addition of the void, the objects are distorted, changing the context of each piece by making it incomplete. To refill the now empty slot, light and shadow acted as a form of concealment. However, as light and shadow are also intangible sources, whether they are penetrative of obscuring voids is speculative.*

*My intent is to portray my relationship with an absence and request the audience to question how they interact with their own, or if they simply choose to remain absent.*

* ***Danielson, A. (2016). Torture in art throughout history. University of Wisconsin-Stout Journal of Student Research, 15, 196-206.***



# BOOK REVIEW

# The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma

**Author: Bessel A. van der Kolk**
**Publisher: the Penguin Group Penguin Group (USA) LLC**
**Year of Publication: 2014**
**Reviewer: Patrick Swanzy**

In recent times, discourses on Trauma have heightened; this may be because of the serious health implications caused by trauma that have become common knowledge. Trauma is perceived to be an emotional response to a terrible phenomenon. The danger this poses to human life seems to make it continue to attract authors who publish issues on the phenomenon that are more scholarly. Even though a lot of books have been published on trauma since time immemorial, one such outstanding book is "The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma," authored by Bessel A. van der Kolk. Since the publication of this book in 2014, it has been reviewed by many renowned authors, scholars and practitioners. Notable among these categories of persons are Professor Jon Kabat-Zinn, professor of medicine emeritus of UMass Medical School; Alexander McFarlane AO of the Centre for Traumatic Stress Studies, The University of Adelaide, Australia; Stephen W. Porges, professor of psychiatry, University of North Carolina at Chapel Hill; and many more. It can be inferred that upon their review, these persons have already endorsed the book and accorded it an excellence accolade. This makes it seem like this current review is irrelevant. However, with the global reach of this book, more reviews should be expected.

This review will probably add to the existing literature on this book review and end the dearth of reviews from African scholars and practitioners that seem to be absent. In 20 chapters' grouped into five parts, Bessel A. van der Kolk extraordinarily dissects trauma using data from his clients' experiences, his academic background and experiences from practice, interaction with other scholars and practitioners, and research by other people and theories.

In the first part of the book, labelled "The Rediscovery of Trauma," which comprises three chapters, the author uses the experiences of Vietnam veterans to unravel some mysteries surrounding trauma, which, unfortunately, his educational training had not offered him in-depth knowledge to deal with. In that chapter, the author claims that the consequences of trauma make it difficult for persons who have been traumatized to engage in intimate relationships.

Chapter 2 of Bessel's book highlights how his professional training assisted him in dealing with terrifying and confusing realities associated with traumatized clients. Through engagements with his clients, the author formulated a rule to guide his students in their practice. The rule stipulates that whatever your engagement with your client is, you should consider whether you are unwittingly replicating a trauma from the patient's past.

Chapter 3 of the book deals with the neuroscience revolution. In this chapter, Bassel gives credence to the role technology played in deepening the understanding of scholars, researchers and practitioners on trauma. Part two of the book consists of chapters four, five, and six. Using an account from an eyewitness of the September 11 terrorist attack on the World Trade Centre, the author interestingly concludes that during disasters, children usually look up to their parents and that as long as their caregiver remains calm and responsive to their needs, they often survive terrible incidents without serious psychological scars. To the author, with I side with, trauma affects the entire human organism, that is, the body, mind, and brain and used this as a justification why trauma treatment should engage the entire organism-body, mind, and brain.

The author introduces the fifth chapter by revisiting theories advocated by Charles Darwin in his books "the Expression of the Emotions in Man and Animals" and "The Descent of Man," published in 1859 and 1871, respectively. Bessel argues that Darwin's theories have helped deepen the understanding of trauma in modern times.

In chapter 6, the author uses a story by Sherry to suggest that chronic emotional abuse and neglect can be as devastating as physical abuse and sexual molestation. According to the author, it is impossible for trauma victims to recover unless they become familiar with and befriend the sensations in their bodies.

Part 3 of the book, captioned "The Minds of Children," consists of chapters (7, 8, 9, and 10) with interesting titles. In this part of the book, the author gives readers a

very interesting take home. Key among these is that, as one grows up, he/she gradually learns to take care of oneself, both physically and emotionally, and that one gets his/her first lesson in self-care from the way that he/she is cared for. In addition, mastering self-regulation depends to a large degree on how harmonious our early interactions with our caregivers are. Furthermore, if one is abused or ignored in childhood or grows up in a family where sexuality is treated with disgust, his/her inner map contains a different message.

The "Imprint of Trauma" is the title given to part 4 of this book, with chapters 11 and 12 forming this part. In this part of the book, the author uses a narration from Julian (pseudonym) to illustrate the complexities of traumatic memory. Amazingly, the author claims that whether one remembers a particular event and how accurate the memories are largely depends on how personally meaningful it was and how emotional the person felt about it at the time. Taking us back to history, Bessel argues in chapter 12 that scientific interest in trauma has fluctuated wildly during the past 150 years by chronicling how concerns about trauma have evolved over the years. The most interesting part of this book is the Part 5. Captioned as the "Path to Recovery," it comprises eight chapters from 13-20, making it unique from the other parts of the book. In this section, the author highlights that people cannot put traumatic events they have experienced behind until they are able to acknowledge what has happened and start to recognize the invisible demons they are struggling with. The author argues that at the core of trauma recovery is self-awareness. Bassel, in the subsequent chapter, discusses the role other organizations played in finding interventions for victims of the World Trade Centre. He further praises yoga for bringing to bear trauma's impact on the body. He then described yoga as looking inward instead of outward and listening to one's body. To Bessel, this confirms contemporary neuroscience's assertion that our sense of ourselves is anchored in a vital connection with our bodies. The author mentions that mindfulness makes it possible to survey our internal landscape with compassion and curiosity and actively steers us toward self-care. What the book draws our attention to is that every trauma survivor is resilient in his or her own way, and every one of their stories inspires awe at how people cope. It is clear that Bessel's book is very resourceful and a masterpiece on trauma. This book is a must-read for scholars, researchers and practitioners concerned with trauma.

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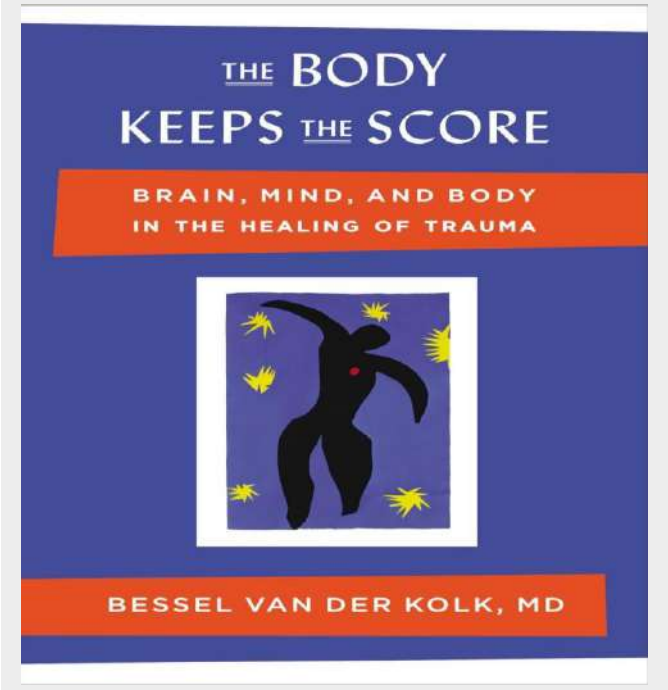

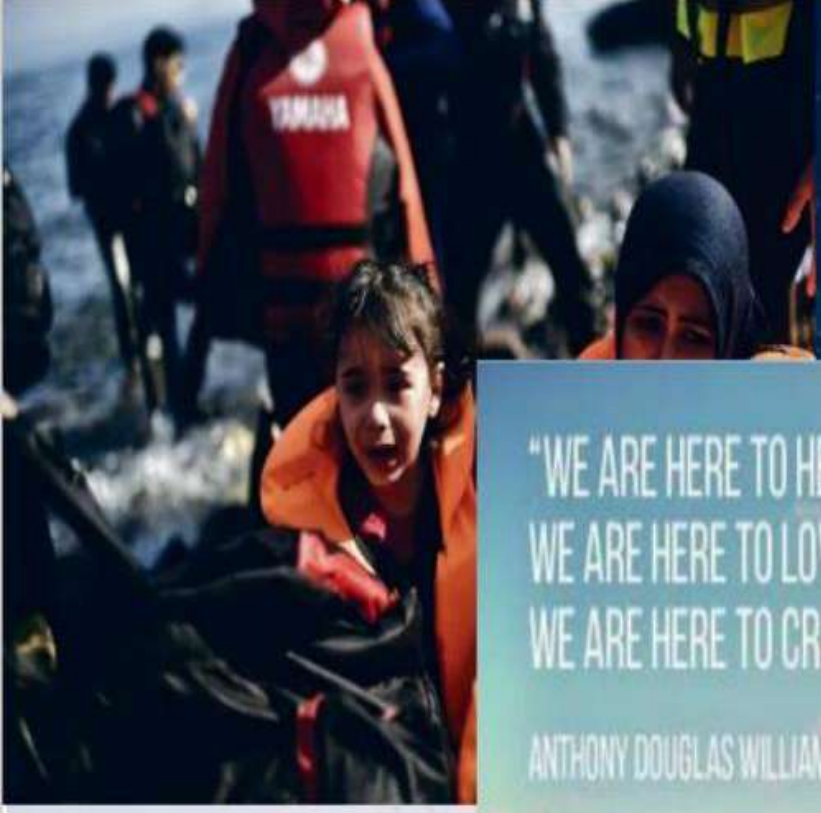

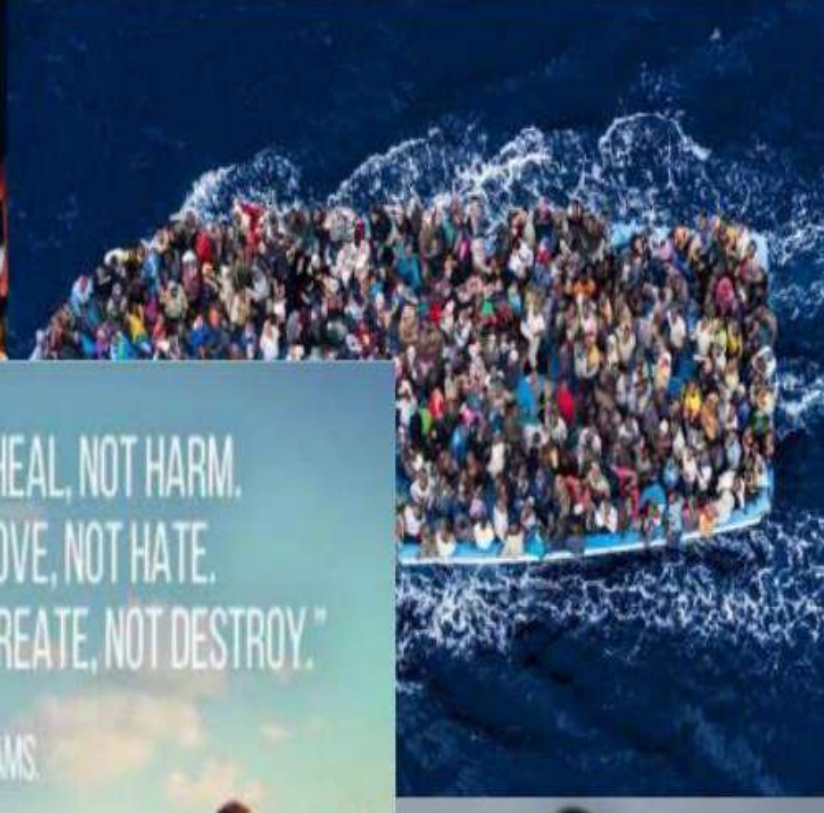

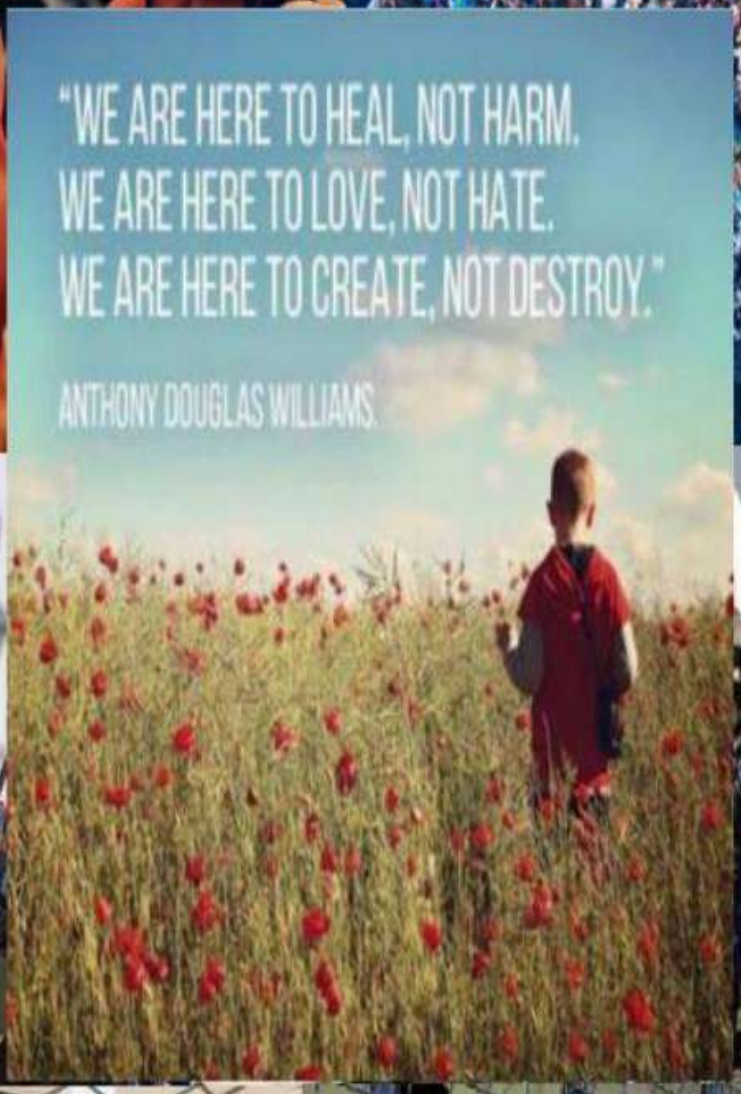
"WE ARE HERE TO HEAL, NOT HARM.
WE ARE HERE TO LOVE, NOT HATE.
WE ARE HERE TO CREATE, NOT DESTROY."
ANTHONY DOUGLAS WILLIAMS





# TORTURE TODAY

# The Trauma of Displacement and Refuge: An Overview in the Global Context

**Hammad Ahmed Hashmi**

## Introduction and Background

There is a dire need to facilitate aid and assistance for millions of refugees and asylum seekers. It is a complex process that is impacting numerous locations around the world. This situation is made more difficult by diverse attitudes in many countries, including racialized or negative sentiments that can have an ongoing impact on the experience of the resettlement process for refugees. Displacement is the transfer of negative feelings from one person or thing to another. The theory is that a person deals with the tension or anxiety associated with negative feelings, such as fear or anger, by releasing them on a non-threatening target. Refugees, asylum seekers and irregular migrants are of special concern and need protection and support. There were an estimated 272 million international migrants in 2019 (1). Migrants and refugees can be exposed to various stress factors affecting their mental health and well-being before and during their migration journey, settlement, and integration. The prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) tends to be higher among migrants exposed to adversity and refugees than among host populations. Many migrants and refugees lack access to mental health services or experience barriers to accessing these. They also face disruptions in the continuity of care.

In studying forced or involuntary migration, sometimes referred to as forced or involuntary displacement — a distinction is often made between conflict-induced and disaster-induced displacement.

Displacement induced by conflict is typically referred to as caused by humans, whereas natural causes typically underlay displacement caused by disasters. The definitions of these concepts are useful, but the lines between them may be blurred in practice because conflicts may arise due to disputes over natural resources, and human activity may trigger natural disasters such as landslides.

According to IOM, forced migration is "a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion."[1] The definition includes a note that clarifies that "While not an international legal concept, this term has been used to describe the movements of refugees, displaced persons (including those displaced by disasters or development projects), and, in some instances, victims of trafficking. At the international level, the use of this term is debated because of the widespread recognition that a continuum of agency exists rather than a voluntary/forced dichotomy and that it might undermine the existing legal international protection regime." (IOM Glossary on Migration, 2019).

According to the 1951 United Nations Convention relating to the Status of Refugees and its 1967 Protocol, refugees are persons who flee their country due to "well-founded fear" of persecution due to reasons of race, religion, nationality, membership of a particular social group or political opinion, and who are outside of their country of nationality or permanent residence and due to this fear are unable or unwilling to return to it. UNHCR includes "individuals recognized under the 1951 Convention relating to the Status of Refugees, its 1967 Protocol, the 1969 Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa, those recognized by the UNHCR Statute, individuals granted complementary forms of protection, and those enjoying temporary protection. The refugee population also includes people in refugee-like situations." (UNHCR, 2017).

Persons in a refugee-like situation include "groups of persons who are outside their country or territory of origin and who face protection risks similar to those of refugees, but for whom refugee status has, for practical or other reasons, not been ascertained." (UNHCR, 2013).

According to UNHCR, asylum-seekers are "individuals who have sought international protection and whose claims for refugee status have not yet been determined" (2017, 56).

Internally displaced persons (IDPs) are defined as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border." (Guiding Principles on Internal Displacement, E/CN.4/1998/53/Add.2.).

Mixed movement (also called mixed migration or mixed flow) is "a movement in which a number of people are travelling together, generally in an irregular manner, using the same routes and means of transport, but for different reasons. People travelling as part of mixed movements have varying needs and profiles and may include asylum seekers, refugees, trafficked persons, unaccompanied/separated children, and migrants in an irregular situation." (IOM Glossary on Migration, 2019).

Disaster-induced migration is the displacement of people as a result of "a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses or impacts, which exceeds the ability of the affected community or society to cope using its own resources." (UN Office for Disaster Risk Reduction, 2009).

According to IOM, resettlement is the "transfer of refugees from the country in which they have sought protection to another State that has agreed to admit them — as refugees — with permanent residence status." (IOM Glossary on Migration, 2019). Resettlement programmes are carried out by both IOM and UNHCR.

Countries faced with forced displacement — induced by humans or nature — collect data on displaced populations. Such data are typically collected through a combination of population censuses, household surveys, border counts, administrative records and beneficiary registers.

At the international level, data on forced migration are collected and/or compiled by various intergovernmental organizations (IGOs), such as the Office of the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM), as well as non-governmental organizations (NGOs), such as the Internal Displacement Monitoring Centre (IDMC).

**Forced displacement due to persecution, conflict, violence, and human rights violations or events seriously disturbing public order**

According to UNHCR, the number of forcibly displaced people both within countries and across borders as a result of persecution, conflict, generalized violence, human rights violations, or events seriously disturbing public order was more than double the number a decade ago; there were 42.7 million forcibly displaced people as of the end of 2012, and the figure was 89.3 million by the end of 2021. This represents the highest number available on record (UNHCR, 2022).

Refugees (27.1 million) and asylum-seekers (4.6 million) made up slightly more than 35 percent of the 89.3 million people forcibly displaced due to persecution, war, conflict, generalized violence, human rights violations or events seriously disturbing public order. 53.2 million internally displaced people and 4.4 million Venezuelans displaced abroad accounted for the remaining 60 percent and 5 percent, respectively (ibid.). Such figures show it is important to keep in mind that forcibly displaced persons are not only comprised of refugees and asylum seekers who seek protection in other countries but also, and indeed mainly, of individuals who have been displaced within the borders of their own countries.

The drastic increase in total forced displacement — both within countries and across borders — as of the end of 2021 compared to the end of 2012 was mainly due to several crises — some already existed, some were new, and some resurfaced after years. The number of countries affected by conflict has also doubled in the last decade (ibid.).

**Refugee Resettlement**

In 2021, UNHCR submitted 63,200 refugee applications for resettlement, and according to government statistics, 57,500 people were resettled (UNHCR, 2022). Though this is 67 percent more than the number resettled in 2020, numbers are significantly lower than pre-pandemic numbers in 2019 (107,700) (ibid.). In 2020, refugee resettlement plummeted to its lowest level in almost two decades as a result of travel restrictions related to the COVID-19 pandemic and temporary suspensions of resettlement programmes from mid-March to mid-June 2020 (UNHCR, 2021). Eighty-six percent of the cases submitted by UNHCR in 2021 were for survivors of torture and/ or violence, people with legal and physical protection needs, and particularly vulnerable women and girls. Fifty-two percent of the total resettlement submissions were for children (UNHCR, 2022.).

In 2020, the COVID-19 pandemic posed considerable challenges to return migration because of lockdowns, travel restrictions, limited consular services, and other containment measures, and had a decelerating effect on return activities. In 2021, many countries lifted travel restrictions and different types of migration, including return migration, resumed but not to pre-pandemic levels. The number of beneficiaries of IOM's Assisted Voluntary Return and Reintegration (AVRR) in 2021 increased by 17 percent (from 37,043 in 2020 to 43,428 in 2021) (IOM, 2022). The number of voluntary humanitarian return beneficiaries increased by 57

percent, from 4,038 in 2020 to 6,367 in 2021. The top 5 host/transit countries for AVRR in 2021 were Niger (10,573), Germany (6,785), Libya (4,332), Greece (2,736), and Morocco (2,372) (ibid.).

***Forced displacement within countries due to conflict and disasters***

By the end of 2022, 71.1 million people were living in internal displacement as a result of conflict, violence, and disasters (the stock of internal displacements) (IDMC, 2023). Of this total, 62.5 million people in 65 countries and territories were internally displaced by conflict and violence, and at least 8.7 million people in 88 countries and territories were internally displaced by disasters (ibid.). It is important to note that displacement by conflict and displacement by disaster cannot always be reliably distinguished because many people can be displaced for one reason and then get displaced for a second or even third time by a different reason.

In 2022, there were 60.9 million new internal displacements, the highest figure recorded and an increase of 60 percent from 2021 (ibid.). Disasters triggered more than 53 percent (32.6 million) of the new displacements recorded; the rest, about 28.3 million, were prompted by conflict and violence (ibid.).

Most of the new displacements triggered by conflict and violence (about 60%) were in Ukraine (ibid.). The five countries with the highest number of new internal displacements in 2022 due to conflict and violence were Ukraine (16.9 million), the Democratic Republic of Congo (4 million), Ethiopia (2 million), Myanmar (1 million) and Somalia (621,000) (ibid.)

98 percent of the 32.6 million new disaster displacements in 2022 were the result of weather-related hazards such as storms, floods and droughts (ibid.). Floods surpassed storms for the first time since 2016, triggering 6 out of 10 internal displacements due to disasters in 2022, with monsoon flooding in Pakistan causing 25 percent of internal displacements due to disasters globally that year (ibid.). Somalia experienced its worst drought in 40 years and recorded 1.1 million movements. In Tonga, 2 percent of the population had to relocate following a very rare volcanic eruption (ibid.). The five countries with the highest number of new internal displacements in 2022 due to disasters were Pakistan (8.2 million), the Philippines (5.4 million), China (3.6 million), India (2.5 million) and Nigeria (2.4 million) (ibid.)

**What Have Refugee Families Experienced?**

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred. These traumatic events may occur while the refugees are in their country of origin, during displacement from their country of origin, or in the resettlement process here in the US.

While in their country of origin, refugee children may have experienced traumatic events or hardships, including:

a. Violence (as witnesses, victims, and/or perpetrators)
b. War
c. Lack of food, water, and shelter
d. Physical injuries, infections, and diseases
e. Torture
f. Forced labour
g. Sexual assault
h. Lack of medical care
i. Loss of loved ones
j. Disruption in or lack of access to schooling

During displacement, refugee children often face many of the same types of traumatic events or hardships that they faced in their country of origin, as well as new experiences such as:

a. Living in refugee camps
b. Separation from family
c. Loss of community
d. Uncertainty about the future
e. Harassment by local authorities
f. Travelling long distances on foot
g. Detention

**Refugee Core Stressors**

Refugee children may feel relieved when they are resettled in the US. However, the difficulties they face do not end upon their arrival. Once resettled in the US, refugees may face stressors in four major categories: Traumatic Stress, Acculturation Stress, Resettlement Stress, and Isolation.

**Traumatic Stress:** Occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being. Refugees can experience traumatic stress related to:

a. War and persecution
b. Displacement from their home
c. Flight and migration
d. Poverty
e. Family/community violence

**Resettlement Stress:** Refugee children and families experience stress as they try to make a new life for themselves. Examples include:

a. Financial stressors
b. Difficulties finding adequate housing.
c. Difficulties finding employment.
d. Loss of community support
e. Lack of access to resources
f. Transportation difficulties

**Acculturation Stress**: Stress that refugee children and families experience as they try to navigate between their new culture and their culture of origin. Examples include:

a. Conflicts between children and parents over new and old cultural views
b. Conflicts with peers related to cultural misunderstandings.
c. The necessity to translate for family members who are not fluent in English.
d. Problems trying to fit in at school.
e. They struggle to form an integrated identity, including elements of their new culture and culture of origin.

**Isolation Stress:** Stressors that refugee children and families experience as minorities in a new country. Examples include:

a. Feelings of loneliness and loss of social support network
b. Discrimination
c. Experiences of harassment from peers, adults, or law enforcement
d. Experiences with others who do not trust the refugee child and family.
e. Feelings of not fitting in with others
f. Loss of social status

**Some of the most common mental health conditions refugees and IDPs may face include:**

a. Post-Traumatic Stress Disorder. PTSD is one of the most common disorders experienced by refugees
b. Anxiety and Depression
c. Obsessive Compulsive Disorder
d. Substance Use Disorder
e. Grief
f. Alienation
g. Chronic Stress

**Addressing Barriers to Receiving Mental Health Care**

Addressing barriers to receiving mental health care should include:

a. Provision of clear information on mental health care entitlements and how to receive services (e.g., through reception centres, community outreach, schools, and religious or cultural settings).
b. Outreach to at-risk groups (e.g., unaccompanied minors, persons with disabilities, and persons who identify as LGBTIQ+).
c. Facilitation of affordable and non-discriminatory access to care regardless of legal status, ensuring financial coverage of mental health services and care provided.
d. Facilitation of communication (e.g., through engaging interpreters and cultural mediators);
e. Providing person-centred care that is respectful of cultural differences and
f. Facilitating the engagement of multiple sectors and systems (e.g., law enforcement, protection, social services and education) to integrate mental health considerations and support and ensure referral and access to mental health services.

**Integrating Mental Health in Primary Health Care**

Making mental health care available through general health care can help identify migrants and refugees with mental health conditions and can make care more accessible and cost-effective (e.g. see WHO mhGAP intervention guides mhGAP-HIG and mhGAP-IG). The delivery of interventions may require adaptation to migrant and refugee populations to consider language and cultural considerations. Interventions provided should be consistent with the national guidelines and policies on the mental health of the host country.

**Ensuring continuity of care:** When providing mental health care, an important consideration is related to the length of stay of the migrant or refugee in the host country. The continuity and quality of mental health care of migrants and refugees on the move can be improved by creating international protocols for assuring continuity of care, improving communication among different social and mental health service providers and providing key written information tailored to the needs that migrants and refugees can take with them and share with different providers.

**Addressing social determinants and promoting social integration and inclusion:** Migration management policies and stresses that have proved to harm the mental well-being of migrants (e.g. separation of families and

children) should be avoided. The social integration of migrants and refugees can be facilitated by equal access to employment opportunities and decent work, vocational training, financial support, social protection services, legal and law enforcement agencies, mental health care, and psychosocial support. The recognition of skills and qualifications acquired pre-migration can also help their integration into the employment sector. Activities and events that promote the social inclusion of migrants and refugees include community forums or peer-mentorship programs organized by members of the same refugee or migrant group who are already well-integrated into the local community. Special attention is required to support asylum seekers.

**Conclusion**

Displacement and refugees can be traumatic experiences that can have long-lasting effects on mental health. The mental health needs of migrants and refugees should be addressed by organizing inclusive and accessible promotion and prevention programs, strengthening mental health as part of general health services, and ensuring timely diagnosis, treatment, and rehabilitation. Access to employment, basic services, and social support can all help counter the trauma and stress experienced by migrants, as can family reunification and learning the language of the host country. Access to education is important for children, as are feelings of safety.

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# The Evolution of Islamophobia in the West: A Case Study of France

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**Abstract**
The pluralist Western societies are witnessing the rise of an exclusivist and polarizing idea – Islamophobia, which is ideologically driven and action-oriented. France is the epicentre of hate against Muslims because of its colonial history and the practice of peculiar secularism and laicism. Drawing upon Social Constructivism, this paper examines the ideological, populist, and strategic roots of Islamophobia in the West and France in particular. This study identifies the role of language and socio-political frames-cum-rationale that the French leadership uses to construct Islam as a threat to the French Republic. In addition, it attempts to expose the selective representations of the Muslims that, in return, discursively construct the Muslims in France as unacceptable for the native people on French soil. Furthermore, this interpretative study reveals how the French elite uses generalizations to criminalize Islam and Muslim symbols like Hijab, Azan, and beard, which run contrary to their secular values. Finally, this study concludes that Islamophobia is a socially constructed reality that leads to its violent manifestation.

**Keywords:** Social Construction, Islamophobia, Identity, Enemy Image, Muslim Threat, Secularis

**Introduction**
Democratic societies of the West face a grave threat of exclusionist Islamophobia, founded in the public speeches of politicians and intellectuals and seen in the practices against Muslims. Divisive politicians instrumentalize history by referring to the remote past events, such as the Crusade wars between the Christian West and Islam and terrorist events with Islamic connections, and create security suspicions by labelling Muslims as 'aliens' to be feared of (Zahid, 2019).

Islamophobia in the West is a toxic campaign and discrimination against Muslims, leading to incitement and bigotry. It is often defined as "rooted in racism and is a type of racism that targets expressions (Hijab, Azan, Quran, and Mosque) of *Muslimness* or perceived *Muslimness*" (C. Allen, 2018). This is contrary to the spirit of the liberal political ideas that Western societies cherish and champion, prohibiting discrimination based on race, colour, or religion. Islamophobia is an identity claim that represents Muslims as a threat to the Western Way of life based on oppositional binaries, 'us' versus 'them' and 'in' versus 'out'.

Muslims' mere presence in the West is being taken as a 'threat' (A. Ahmad, 2017) and dealt with in the security realm. Muslim immigrants are seen as invaders and would-be occupiers if not dealt with on a prior basis (Zahid, 2019). Islamophobia, popularly defined as "prejudice, anger, and hatred towards Islam" (Gallup, 2011), is not an objective reality but rather a constructed one that results in verbal and physical assaults against Muslims by far-right people. These callous acts are the answers to an identity question – 'self' versus 'other.' Identity in social contexts is not pre-given and 'out there' but discursive and subjectively constructed (L. Hansen, 2006). People and societies are not made but constructed through social and cultural interaction (N. G. Onuf, 1989, p. 78-81). Hence, people and communities are what others perceive them.

The 9/11 incident provided the context for constructing a Muslim enemy in the West. Before that, publications like 'Muslims Are Coming' and 'Clash of Civilizations' had provided the ideological ground only to be exploited by the far-right populists in the future. In the last 20 years, Muslims have been subject to violence by Westerners, be it in New Zealand (Al-jazeera, 2019). Or the Imam (prayer leader) of New York, or the indiscriminate killing of Muslims having tea in a restaurant in Switzerland.

Since 2004, France has been the epitome of hatred and aggression against Muslims (M. A. Valfort, 2018), who comprise ten percent of its population (Reuters, 2010). The Muslims in France face discrimination, and bans on headscarves, burkinis, and *burqa*. Because the government in France believed the headscarf was a sign of oppression and radicalism and against French secularism, Laicite imposed a fine of 150 Euros if violated by the Muslims (O. Else, 2022). During election campaigns, the use of the Muslim card – headscarf illustrates the deep-seated roots of hatred against Muslims (T. Akyol, 2018).
In social practices, Muslim centers are attacked, mosques are vandalized, and their Prophet is caricatured to hurt their religious sentiments (K. V. Belt, 2021). More than 2000 common rooms and make-shift mosques in France

were closed after the 2015 Charlie Hebdo attack (D. Chazan, 2015).

This paper defines Islamophobia as "the hatred-wrapped fear and discrimination directed against Muslims based on populist and ideological appeals for political and geostrategic purposes with a scope ranging from domestic politics to civilizational one" and explains the reasons for exclusion and discrimination against Muslims in the West & France, and examines how Muslims are represented as 'contentious community' in schools, politics, and workplaces.

This study, using social constructivism, provides the answers to these questions. What are the drivers of Islamophobia in the West and France in particular, and how is this anti-Muslim hate being constructed and manifested in French society's social practices?

**Theorizing the Concept of Islamophobia**

Islamophobia is generally defined as 'fear of the Muslims or hatred against the Muslims' that falls into the domain of the perception of the 'Self' and 'Other' – hence identity. Identity in social contexts is not pre-given and 'out there' but rather is discursive and subjectively constructed (L. Hansen, 2006, p. 6). Therefore, social constructivism has been employed as a framework for this study to understand the hatred against Muslims in France. As Onuf believes, people and societies are not made but constructed through social and cultural interaction (1989, p. 78-81). Hence, people and communities are what others perceive them.

Islamophobia in the West presents a perfect epitome of construction, wherein Muslims have been constructed as a threat to Western values. 9/11 events gave the premise and context to the elite's performative language to do the job. Vivien Burr believes that technology plays an important role in shaping public opinion when it is conveyed persuasively, consistent with social norms and values (V. Burr, 2003, p. 12). Language, with its constitutive potential, in a particular context and system of meanings, produces specific words, relates those words to objects, and strategizes the actions and thinking about objects. In this way, contrary to "constructed and artificial," they appear as "natural and normal" (R. Diaz-Bone et al., 2008, p. 12). France, as opposed to other US and European societies, has a rather more intense form of anti-Muslim prejudice because of its peculiar secularism – *Laicism*.

This is an aggressive form of secularism that, instead of co-existing with religion, seeks triumph over religion (Olivier Roy, cited by M. Francois-Cerrah, 2015). Western academic-defence complex, based on shared ideas and social practices, constructs a homogenous 'self' against the 'other' – whose *Muslimness*, despite living under the same socio-political and economic order, makes them heterogeneous to go against (A. Wendt cited by S. Theys, 2018). This is done by re-contextualizing the history of the Crusade Wars and invoking the Huntingtonian Clash of Civilization thesis into the post 9/11 context, the ontology of whom is analogous to the famous 'X' article of George F. Kennan (1948) with the potential to shape future policies (N. Sheikh, p. 106, 2003). Therefore, expanding the argument, the Clash of Civilizations thesis formed another bipolar description of the world—the USA versus Islam and crescent versus cross (Zahid, 2016).

French elite securitizes the secular values of the republic and presents the Muslims as a threat to those values. Securitization has roots in a post-positivist tradition that draws upon the speech acts – construction through utterances. Speech acts are performatives (K. E. Jorgenson, p. 185, 2018). Speeches are not mere descriptive words but constitutive and construct objects – about which they speak to securitize (Jorgenson, p. 185). The French political and intellectual elite securitizes the country's secular values by deeply politicizing them and declaring that they (values) are facing existential security threats that demand extraordinary measures (R. V. Munster, p. 38-39, 2009). They refer to Muslims and Islam as a threat to that referent object – secular values, and propose extraordinary measures, like expelling them from the country, ridiculing them, marginalizing them, killing them, or taking their *Muslimness* away by banning *Hijab, Burkini, Azan* (VandenBelt, 2021).

Islamophobia in the West shows that it is changing. The source of this change is hatred and discrimination against Muslims, kicking the argument of what this hate should be called – Islamophobia, anti-Muslim bigotry, or racism. It is all. Though Islam is not a race, Muslims have been racialized in France by using certain frames by politicians. Most revered personalities of Islam are caricatured, Muslim men are portrayed as fundamentalist, women as oppressed, Islamic symbols are mocked, and overall, Muslims are seen with a skepticism born out of the belief that Muslims are traitors.

**Material and Methodology**

To answer the questions, the qualitative method has been used to understand the drivers of Islamophobia in the West at large and France in particular. Because of its theoretical rationale, this study is an interpretative examination of a single case involving a rich, understudied case description. Secondary data sources that include published books, journal articles, newspaper articles, speeches, public talks, interviews of politicians, and web sources with inductive reasoning have been used

for this research. Finally, qualitative content analysis has been used to arrive at certain findings/conclusions for the truth claims.

**Literature Review**

Since 2004, France has shown hostile tendencies against Muslims that are more lethal than any other country. Nearly 5 Million Muslims live in France, which is 10 percent of the French population (Reuters, May 19, 2010). The Muslims in France have recently been subject to religious discrimination. In 2004, the French Government banned wearing all types of religious symbols in school, whether it is the headscarf, the cap that Jews wear, the cross sign of Christians, and most importantly, Muslim women are also banned from covering their faces in public places because the Government of France claimed that, the headscarf is the sign of radical Islam as it against the norms of *Laicite*. In one of his interviews, Jacques Chirac talked about the importance of this law and that any infringement of this law would be a fine of 150 Euros (O. Else, 2022). The ban on the headscarf was one of his tactics during the election to get voters' attention. It is against the basic fundamental rights that no one has the right to pressure someone to wear clothes forcefully, whether it is burkinis or bikinis. The person has the right to wear whatever he or she wants. However, Muslim women have been mocked, ridiculed, and attacked when they cover their faces in the public domain or have burkini on – as the latter covers the woman's full body, the French government considers a symbol of women's imprisonment and radical Islam (T. Akyol, 2018).

The attacks on community centres of Muslims and mosques are burned and vandalized (VandenBelst, 2021). More than 2,000 common rooms in France for Muslim prayers were closed after the 2015 Charlie Hebdo attack. The Muslims have requested the government to build new mosques, but the government did not accept their request (D. Chazan, 2015). The *mosques* are the places for hiding weapons used against incidents like 'Charlie Hebdo,' responded the French Government. An Arabic Center came under attack when a young Muslim boy was found to have been visited before beheading Samuel Patty, who showed the caricatures of the Prophet Muhammad (PBUH) in the class.

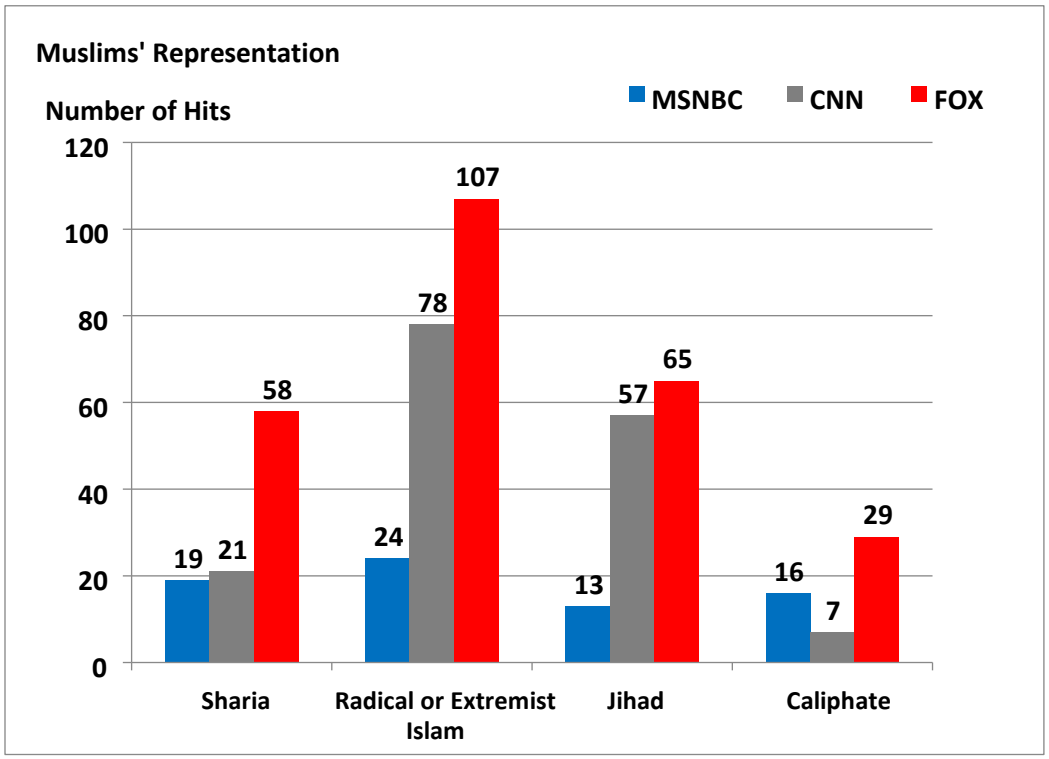
The study conducted by the *Universite Gustave Eiffel* revealed that those students who applied for Graduate or Post Graduate programs with a Muslim surname were not selected, and other students who had ethnically French names were admitted. (C. Cook, 2022). Muslims faced the same treatment at the workplace and did not get jobs wherever they applied for private or government jobs.

**Evolution of Islamophobia in the West: A Background**

The word Islamophobia surfaced after the 1990s. This paper defines Islamophobia as "the hatred-wrapped fear and discrimination directed against Muslims based on populist and ideological appeals for political and geostrategic purposes with a scope ranging from domestic politics to civilizational one" and explains the reasons for exclusion and discrimination against Muslims in the West & France, and examines how Muslims are represented as 'contentious community' in schools, politics, and workplaces.

European Monitoring Centre on Racism and Xenophobia's report after 9/11 found Muslims vulnerable to racial and religious discrimination in different countries of Europe (J. Esposito and I. Kalin, 2011). Danish Cartoon Crises in September 2005 and Pope Benedict XVI's speech at Regensburg University in 2006 were regarded by Muslims as a blatant attack on Islam, wherein he said, "Show me just what Muhammad brought that was new, and there you will find things only evil and inhuman, such as his command to spread by the sword the faith he preached," (BBC, February 11, 2013). Former President of the USA George W. Bush used the term 'Islamo-fascism,' which gave intensity to the anti-American sentiments in the Muslim countries. One of the allegations against Muslims is that they first considered themselves Muslims rather than other nationals like American, French, Spanish, etc. Hence, Islam is blamed for not teaching pluralism to its followers, which is a fallacy. In Germany, Muslims have been raided and arrested for their beliefs. So, the criteria of a loyal European citizen is being a white citizen, Christian preferably, or a secular one.

Research about the 'enemy image' of Muslims has concluded that the media has a proclivity to alter images. As attitudes of the political elite evolve, the enemy's image changes. During the Cold War, the Western media propagated "demonizing generalizations" about Communism, which has now been replaced by Islam (Zahid, p. 109, 2016). A coherent set of journalistic labels has been developed about "Muslim terrorism," "Islamist militancy," and "Jihad journalism." In February 2012, the *Think Progress* website issued a study that underlined specific methods that TV channels utilized language that portrayed *Muslims and Islam to be feared.* Using three months' data gathered from numerous television programs from November 2010 to January 2011 shows how frequently Fox, MSNBC, and CNN used terms like 'Sharia,' 'Radical or Extremist Islam,' 'Jihad,' and 'Caliphate' that portrayed a negative image of the Muslims.




The USA, with its hard and soft power potentials, is the world's sole superpower. Americans publicly claim to be an 'Indispensable Nation,' the upholder of democracy, champion of human rights, and beacon of freedom for those living in America as well as in different parts of the world (M. K. Albright, 1998). An international society inhabited by immigrants, home of people who belong to all religions, the land of opportunities with liberal rights and opportunities that attracted rare talents across the world. However, 9/11 marked a horrific beginning for Muslims in America. After that incident, Muslims became the targets of hatred and racism. Mosques were burned, community centres were attacked, and Muslims received death threats and tortured on the streets. Even Sikhs came under attack because of their appearance and resemblance to the Muslims. According to a 2017 Pew poll, hate crimes and assaults against Muslims surpassed the 2001 level. In 2016, 127 cases of assaults were reported compared with 93 in 2001 (K. Kishi, 2017). President Donald Trump was to be blamed for the recent surge in property destruction and vandalism incidents and verbal and Physical assaults on Muslims for his populist appeal to attract Far-right voters for his White Supremacism. He turned his electoral campaign pledges into policy when he imposed a ban on six Muslim countries with Executive Order 13769 (V. Niayesh, 2019). Furthermore, he believed "Islam hates us, that Muslims harbour unbelievable hatred, and it is very hard to separate radical Islam from the religion as a whole (New York Times, 2017). His anti-Muslim rhetoric to attract evangelical Christians or white supremacists for domestic purposes has resulted in the rise of societal polarization and violence in the years to come.

Joram Van Klaveran, a member of the Dutch far-right party a harsh critic of Islam, accused Islam of being 'a lie', and the Quran 'a poison' (E. Schaart, 2019). But, interestingly, after parting ways with the party of Geert Wilders, a man who did not conceal his hatred against Islam started to write a book on Islam and ended up converting to Islam.

Germany has also witnessed the rise of anti-Muslim sentiments in recent years. Far-right Alternative for Germany party's anti-immigrant and anti-Muslim leader, Farauke Petry's inflammatory remarks have fueled the fire of hatred against Muslims. Her rise owes to the rise of a populist tide that propelled the rise of Donald Trump to the presidency and many other European political leaders and parties to mainstream national politics. In February 2020, a far-right extremist attacked two shisha bars in Hanau, Germany, killing nine people of foreign background, most of whom were of Turkish descent. The attacker's manifesto revealed a deep-seated Islamophobic and racist ideology, reflecting a broader issue of extremism in Germany (Olterman and Connolly, 2020). Mosque Attacks: There have been instances of attacks on mosques and Islamic centres in Germany. These

incidents include arson attacks, vandalism, and desecration of religious sites. For example, in 2020, a mosque in Berlin was vandalized with Islamophobic graffiti.

One-third of the British believe Islam threatens their way of life (Perraudin, 2019). Anti-Muslim prejudice is the major driver of the far-right growth. A 2022 European Islamophobia report recorded a 37 percent rise in religious hate offences compared to the previous year, totalling 8,730 cases, with 42 percent of them against Muslims – 3,459 cases (Report, 2022, pp. 557). According to the report, 1,800 mosques across the UK experience at least one religiously motivated attack yearly.

Like other European countries, Denmark has witnessed incidents of anti-Muslim hate crimes. These crimes range from verbal abuse and harassment to physical assaults against individuals perceived to be Muslim. Mosques, Islamic centres, and Muslim-owned businesses have also been targeted with vandalism and arson attacks. Some politicians and groups have expressed Islamophobic sentiments in Denmark. Political debates surrounding immigration, integration, and religious freedom have sometimes fueled Islamophobic rhetoric, which can contribute to a hostile environment for Muslims. The cartoon controversy involving depictions of the Prophet Muhammad in Denmark dates back to September 2005, when the Danish newspaper Jyllands-Posten published provocative and insulting cartoons of the Prophet Muhammad. That satirical content sparked significant controversy and ignited a global debate on freedom of speech, religious sensitivity, and cultural understanding. The cartoon controversy resulted in more than 200 deaths in different countries and the bombing of the Danish embassy in Pakistan in 2008 (Berkley Center, 2015).

**France: The Hotbed of Islamophobia**

The fear, prejudice, or hatred towards Islam and Muslims has been on the rise worldwide, especially in European countries. France is one of the main countries where Islamophobic sentiments are higher than in any other European country. Almost 5 Million Muslims live in France, which is the largest minority of Muslims in any country.

French perspective on Islam was shaped in the 16th century during the rule of the Ottoman Empire. France and many modern-day European states were under the influence of the Ottoman Empire. Nevertheless, when the Turkish cultural movement called Turquerie spread in different parts of Europe, especially in France, the latter saw this cultural influence as a threat to their values, and as a retaliatory strike, the famous French poet and play writer, Marquis Henri de Bornier wrote a play called "Mahomet" (Muhammad); that included derogatory statements regarding Prophet Muhammad Peace Be Upon Him (A. Tufekci, 2020). It enraged the Ottoman Sultan Abdul Hamid II, who ordered the play to be taken down for its offensive script. Fearing the Sultan's wrath, France stopped the drama.

Since the 17th century, France was a colonial power, and many African nations were its colonies. For instance, Algeria, a Muslim-majority state, was a French colony, and like many other African nations, it had to fight (1952-1962) against its colonial masters – the French to win its independence. Jean Marlie Le Pen fought this war as an army officer. He believes, "We fought very hard to be French no longer; I fought them in hand-to-hand combat. I'll be damned if they get anything from us when they come here." (Fieschi, 2020).

In 1972, he founded a political party – 'National Front,' now known as the 'National Rally,' led by his daughter, Marine Le Pen. Her husband Louis Allot questioned the identity and loyalty of the Muslims to the French state and society, "Who (Muslims) are they? They are French or not? What [do] they know about France? They only follow the footsteps of their imams and do whatever they order them" (Haddad, 2019).

When France imposed the ban on headscarves in 2004, former President Jacques Chirac, in his statement, emphasized, "*No one may, in the public space, wear an outfit intended to conceal the face. These practices can threaten public safety and disregard the minimum requirements of life in society." S*ince 2004, French politicians have attempted to use policy to forge a version of Islam that they believe would be more compatible with the republic's values. While introducing his plan to combat radical Islam, President Macron unveiled his plan to "free Islam in France from foreign influences" and to create an "Islam des lumières" – Islam of enlightenment (A. Sandford, 2020). This has led to the weaponization of laïcité, a tool for curtailing religious freedoms for French Muslims (T. Jamal, 2021). In a similar theo-ideational vein, Frédérique Vidal, education minister, termed Muslim university students as "Islamo-leftists" and "radical Islamists" who demanded racial and religious equality. (T. Jamal, 2021).

Le Penn, a far-right leader and former candidate for the presidency, proposed a hijab ban in the public sphere and accused the government of appeasing Muslims and allowing the rise of Islamism and terrorism, "you are limiting everyone's freedom to try to modify the freedoms of a few Islamists," (M. Solletty, 2021). History guides, French, using the excuse of their values, have often used objectionable content to malign Islam and inflict emotional injuries on Muslims.

They attach ill-defined and contested concepts of 'radicalization' and 'radical Islamism' with Muslims to justify their drive against them. For instance, Gilles Kepel, a right-wing professor at Sciences Po, uses a structuralist argument, disregards the human agency, and maintains that Islam and dysfunctional sociology are to be blamed for the radicalization of Muslims in France. However, Olivier Roy, another French academician at the European University Institute, Italy, rejects this purposeful generalization and emphasizes individual behaviour and psychology in jihadism, which he considers marginal to Islam. For him, Jihadists come from a marginalized background with colonial grievances and use Islam as a vehicle for their violent fantasies, making the phenomenon "Islamicization of radicalism" not the radicalization of Islam projected by Mr. Kepel. (A. Nossiter, 2016). Hence, he exonerates Islam as the source of terrorism in France and rather holds the structural causes as the root cause of the violence in the country.

**Anti-Islam Bigotry in France**

France is a consolidated democracy that claims to uphold its people's individual rights and liberties. However, in the case of Muslims, it appears to be a far reality. Muslims feel that they are marginalized and discriminated against, all because of their Muslimness, despite the protections guaranteed by the French constitution. They are seen as second-grade citizens of the state, wherein they are not allowed to practice their religion freely – as enshrined in the constitution and consistent with the French Republic's values. Muslim women are attacked for wearing Hijab and men for beards.

A far-right movement, Nouvelle Droite (ND), emerged in France in the late 1960s that saw immigrants as 'invaders' and sought to send them back to their homelands (Wilson, 2019). ND's underlying premise is known as the "Great Replacement" theory, which views non-white people in the West as aliens on a mission to plunder and replace the white populations from Europe and the USA (Hussain, 2019). Among the immigrants, Muslims get disproportionate attention, and they are discursively constructed as a threat to the French values on the 'us' versus 'they' structures and as a legitimate target for verbal and violent assaults. Strikingly, the Christchurch mosque shooter in 2019 was also influenced by this far-right argument that sees immigrants as aliens.

After the 9/11 tragedy, French politicians labelled Muslims as a "5$^{th}$ Column" and loyal to the country of their origin as opposed to French values and France itself (Wilson, 2019). This identity-mediated threat construction represents Muslims as traitors and allows the authorities to introduce extraordinary measures and legislation against Muslims in the name of security. This construction has been deep-rooted in the last four centuries – starting from the Ottoman era to European colonialism and the post-colonial consciousness of native people about foreigners. Contemporary France is no different from its old days when discrimination against Muslims was common. According to a study conducted by Jean Jaures in 2019 (Guerin and Fourel, 2021), overall, 42 percent of Muslims experienced faith-based discrimination; this number rises to 60 percent for women with a headscarf or other types of veils.

**Hatred against the Muslim Women**

Muslim women in France have faced stigmatization and discrimination, fueled partly by negative stereotypes and public discourse that associate Islam with extremism or terrorism. Muslim women are the target of religious hatred and verbal abuse. France has implemented laws prohibiting wearing Hijab and headscarf in public spaces such as schools and government offices (Costello and Ahmed, 2021). Critics argue these laws disproportionately target Muslim women and infringe upon their religious freedom. Albeit choosing the attire is perfectly consistent with liberal and secular values, it is an individual's choice. Two men assaulted a pregnant Muslim woman in France for wearing a headscarf.

Similarly, in another instance, two women attacked two pregnant Muslim women, tried to rip off their veil, and used racist slurs (France 24, 2020). Resultantly, the victims of this anti-Muslim bigotry suffered miscarriages. The former President of France, Nicolas Sarkozy, commented about the veil:

*The burka is not a religious problem; it's a problem of liberty and women's dignity. It's not a religious symbol but a sign of subservience and debasement. I want to say solemnly that burka is not welcome in France. Our country can't accept women prisoners behind a screen, cut off from all social life, and deprived of all identity. That's not our idea of freedom (Chrisafis, 2009).*

Since the Hijab ban in 2010, as reported above, 60 percent of Muslim women in France have felt discriminated against because of their Muslim faith.

**Mob Attacks on the Mosques**

Since Charlie Hebdo, France, home to West Europe's largest Muslim community, the number of Islamophobic attacks on Muslim symbols has risen sharply. According to the National Observatory of Islamophobia, 154 attacks were reported in 2019, and with a 53 percent jump, 2020 witnessed 235

attacks (Daily Sabah, 2021). The reports also recorded a 35 percent increase in Mosque attacks in 2020. These attacks reflect the religious intolerance and

discrimination towards Muslims only. The Bayonne Mosque shooting (October 2019) by an anti-immigrant and anti-Muslim man and the knife attack at the Paris Mosque attack (January 2020) by a far-right extremist are a few examples to quote.

President Macron's remarks, "Islam is in crisis," and policy of raids on Mosques and Islamic foundations and proposed "anti-separatism" law in the name of 'ensuring domestic security' are viewed by the Muslims as a systematic effort to restrict the Muslim community's mobility and political activism by constructing them as "suspect community" and "reluctant French citizens." French Ministry of Interior closed a mosque, accusing the site of promoting "a radical practice of Islam and "cultivating a feeling of hate towards France," is against the spirit of democracy, contradictory to French values, and destined to leave Muslims more vulnerable to abuse (Jabkhiro, 2022). Mosque attackers, with "next time, we will target your head" spread fears among Muslims (Chalabi, 2015). The anti-Muslim hate permeated so deeply that a request for the construction of the mosque was turned down when local complainants opposed the project, citing, "mosque is not fit in this urban environment" (Al Arabiya, 2010). This increasingly narrowing space for Azan (call for prayer) and mosques led the Muslims to arrange 2000 common rooms for praying, as reported in 2015.

**Faith-based Discrimination in Schools and Workspaces**

French Muslims are also facing economic marginalization that drives them to poverty and other street crimes. This is where O. Roy appears appealing that it is not Islam but rather the structural causes that cause radicalization; hence, 'Islamicization of the radicalism.' White French Christians get more jobs, and Muslims only make up 5 percent of the total job market. Men get terminated for having a beard, and women for wearing a headscarf. Schools do not accept students with beards and veils. Schools do not allow girls to wear a particular swimsuit, 'Burkini,' which was banned in 2016. A far-right mayor of Beaucaire, Julien Sanchez, banned pork-free meals on the first day of school in 2015. He also expressed his disdain, saying, "Those who don't want to eat pork, it is better for them not to eat anything (Guardian, 2015). As part of France's secular "Republican principles," schools promote expression that is often found provocative and injurious to Muslim sentiments.

**Conclusion**

Muslims and Christians in the West have lived peacefully up till recently. Despite living under the same socio-economic and political order, Muslims are represented as a threat because of their Muslimness in the West. French secularism, laicism, unlike Euro-American secularism, is aggressive towards religion and restricts religious symbols in certain public spaces, such as schools and government offices. This identity-mediated discourse securitizes French values and constructs Muslims as alien to French society, which in return, asks the Muslims to preserve their religious identity by strictly adhering to symbols like the beard and headscarf and attending mosques for daily prayers.

The populist dimension of Islamophobia legitimizes hatred against Muslims as a norm and compares immigration to the invasion. Its strategic dimension is its political instrumentalization wherein the Western leaders use deliberate manipulation and exploitation of anti-Muslim sentiments for political and strategic purposes. This cultural construction employing demonizing discourse against Muslims has roots grounded in the famous Huntingtonian 'Clash of Civilizations' thesis. Muslims have constructed threats to the Western way of life and French secular values on the 'Us' versus 'them,' 'In' versus 'Out,' and 'for' versus 'Against' discursive structures. Lexical resources are intelligibly used to represent secular values as an 'object to be defended' against the existential threat posed by Islam. In social practices, Muslims face discrimination in jobs and workplaces. Muslim children find it hard to get admission to schools and, when admitted, face bullying and harassment for their faith. Mosques are attacked, women wearing veils have been considered 'oppressed', and men with beards are made fun of as backward, uncivilized, and subject to verbal abuses and physical assaults. Owing to the challenge posed by Islamophobia, Muslims are now more determined to preserve their religious identity by adhering to the Islamic way of life. This amounts to securitization versus securitization: Westerners want to securitize liberal values by demonizing Islam, whereas Muslims respond by strictly adhering to Islamic symbols and rituals as the sources of their identity. This vicious cycle will continue unless the 'Islamic threat' is deconstructed.

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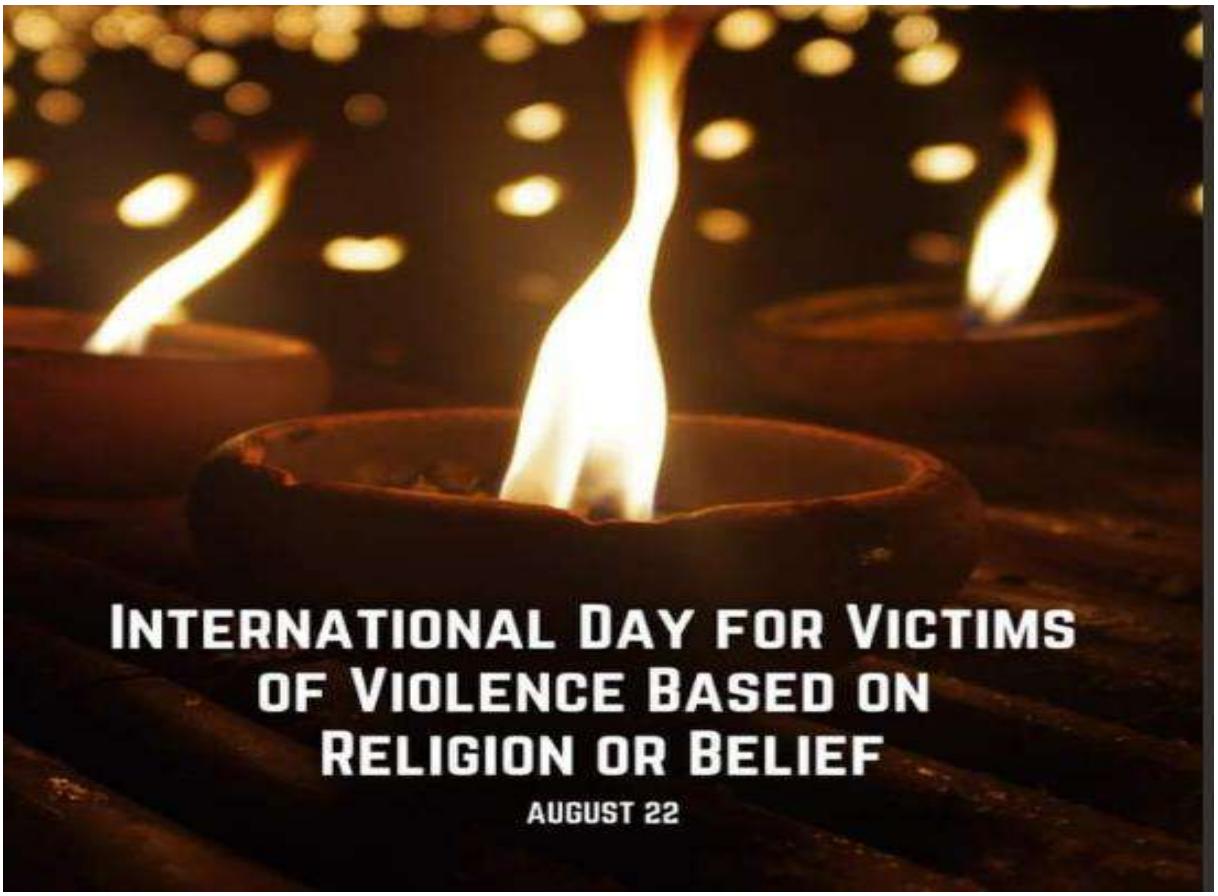

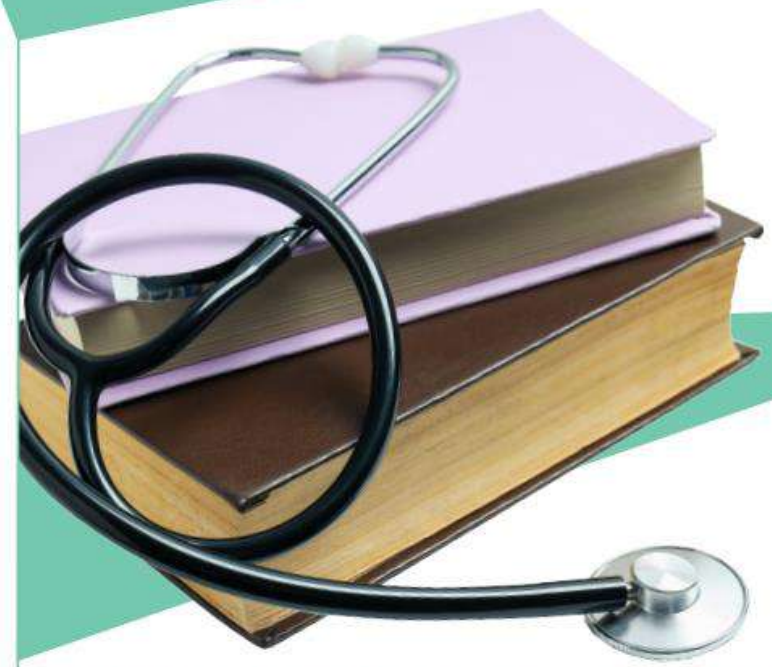

# MEDICAL & CLINICAL SCIENCES

# Why Torture Doesn't Work: The Neuroscience of Interrogation*

**Lasana T. Harris commends a book exposing the lack of scientific basis to 'enhanced interrogation techniques'.**

In 2009, following the abuse of prisoners at its Guantanamo Bay detention camp, the US government made a significant decision. It moved the responsibility for 'enhanced interrogation techniques' from the CIA to a new government organization: the High-Value Detainee Interrogation Group (HIG). The move upset many CIA insiders; torture had been in their toolkits since the early days of the Cold War. The remarks of one official at a HIG-organized conference on torture in Washington DC can be summed up as: How could a new agency, created to both conduct and study torture, replace the decades of practice and perfection attained by the CIA? By adding a scientific component, responded the newly appointed head of the HIG.

Detainees were held at the United States' Guantanamo Bay detention camp in Cuba in 2002. Credit: Petty Officer 1st Class Shane T. McCoy/US Navy/Getty

This exchange highlights the theme of neuroscientist Shane O'Mara's Why Torture Doesn't Work. Rightly, O'Mara takes a moral stand against torture (forced retrieval of information from the memories of the unwilling). However, instead of simply providing utilitarian arguments, he argues that there is no evidence from psychology or neuroscience for many of the specious justifications of torture as an information-gathering tool. Providing an abundance of gruesome detail, O'Mara marshals vast, useful information about the effects of such practices on the brain and the body.

For instance, he explains why, physiologically, it is ludicrous to claim that stress, pain and fear will coerce a suspect to surrender critical information. The prolonged release of stress hormones such as cortisol damages the hippocampus — a brain structure crucial for encoding and retrieving memories — as well as the prefrontal cortex, which is implicated in decision-making and executive control processes. Such damage works in opposition to the goal of torture. Furthermore, chronic stress creates a negative feedback loop, causing enlargement and hyperresponsiveness of the amygdala, the brain structure that underlies emotional salience directs attention, enables learning and communicates with most of the brain.

Another striking example that O'Mara discusses is the effect on the brain of sleep deprivation. The practice was described in the 'Torture Memos' — legal memoranda drafted in 2002 by US Deputy Assistant Attorney General John Yoo, advising the CIA and President George W. Bush on the use of torture. Officially limited to a maximum of 180 hours and often combined with physical restraint, isolation, starvation and beatings, sleep deprivation has been used to coerce subjects into revealing information.

The memos further argue that sleep deprivation is harmless. O'Mara, however, discusses research suggesting that it erodes memory processes and general cognitive function by flooding the brain with glucocorticoid hormones. Even military scientists have produced literature that admits psychophysiological issues with sleep deprivation. In 1990, Paul Naitoh and his colleagues at the US Naval Health Research Center in San Diego, California, published evidence that the practice leads to an increase in circulating stress hormones and the development of psychomotor epileptic discharges (P. Naitoh et al. Occup. Med. 5, 209–237; 1990). They argued, too, that if combined with other stressors, such as food and water deprivation and waterboarding, sleep deprivation could negatively affect respiratory–and cardiovascular function.

Yet some officials and politicians continue to make announcements that run counter to such scientific evidence. Former Pennsylvania senator and Republican presidential hopeful Rick Santorum, for instance, commented in a 2011 interview that after being broken, people become cooperative. Most shocking maybe this

year's revelation that a handful of officials in the American Psychological Association were complicit in torture by the United States after the September 2001 attacks on New York and the Pentagon, thus providing a veil of scientific legitimacy to the practice.

Torture also affects the torturer. The cognitive dissonance required to inflict suffering results in symptoms similar to those of post-traumatic stress disorder, O'Mara warns. He cites Joshua Phillips's None of Us Were Like This Before (Verso, 2010), which describes how many US veterans who had engaged in torture in Iraq experienced intense guilt or turned to substance abuse once back in the United States. Interviews with former interrogators in Northern Ireland, published by Ian Cobain in Cruel Britannia (Portobello, 2012), reveal that many believed what they had done was wrong but saw it as a desperate attempt to end the violence engulfing their society.

Conversation with a detainee may yield results comparable, and probably superior, to those obtained from torture.

Given that information obtained under torture is rarely reliable (because the victim will generally say anything to make the pain stop) O'Mara recommends an alternative: conversation. Having a conversation with a detainee may yield results comparable, and probably superior, to those obtained from torture. He cites three pieces of evidence.

First is a 1993 study by Stephen Moston and Terry Engelberg of police interrogations, which found that of more than 1,000 detainees, only 5% refused to talk (S. Moston and T. Engelberg Polic. Soc. 3, 223–237; 1993). Second, research by Robin Dunbar and his colleagues finds that 40% of what we reveal in conversation is

related to the self, suggesting that refusing to self-disclose is very difficult (R. I. M. Dunbar et al. Hum. Nat. 8, 231–246; 1997). Third, a study by Diana Tamir and Jason Mitchell showed that people are willing to forgo money to talk to others about themselves. Indeed, the nucleus accumbens (part of the brain's reward circuitry) activates during such an opportunity, suggesting that people find disclosure intrinsically rewarding (D. I. Tamir and J. P. Mitchell Proc. Natl Acad. Sci. USA 109, 8038–8043; 2012). O'Mara does acknowledge that the difficulties of having such a conversation with a non-compliant person demand advanced social skills that are comparable to those of clinical psychologists and psychiatrists, who often deal with non-compliant patients. He suggests that alternative approaches, such as virtual reality and role-playing, may be useful for information gathering during interrogation.

Why, then, given its uselessness in eliciting valuable information, do people torture? It is a form of vengeance or punishment intended to discourage the victim from future transgressions and to communicate to others that harm will not be tolerated. In some cases, it occurs because the torturer believes that terrorists have mental illnesses. In science, however, punishment is not a viable response to someone with such an illness — just as torture is not a viable method for gathering information, as O'Mara repeatedly points out.

* Neuroscience: Tortured reasoning - Nature

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# Re-traumatization of Torture Survivors during Treatment in Somatic Healthcare Services: A Mapping Review and Appraisal of Literature Presenting Clinical Guidelines and Recommendations to Prevent Re-traumatization

Re-traumatization of torture survivors during treatment in somatic healthcare services: A mapping review and appraisal of literature presenting clinical guidelines and recommendations to prevent re-traumatization.

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## ABSTRACT

Rationale: The number of torture survivors is on the rise, posing issues for their care in healthcare settings. Even healthcare experts with training in refugee care are unaware of the health difficulties faced by torture survivors. Any medical evaluation or treatment has the potential to re-traumatize torture survivors, thereby reactivating trauma symptoms without applicable guidelines to prevent re-traumatization. Objective: Our objective was to identify, characterize, evaluate, and organize current, available evidence presenting existing recommendations and suggestions to prevent re-traumatization during the treatment of torture survivors' physical diseases in healthcare services. Methods: A comprehensive search of electronic databases was conducted. Gray literature coverage was obtained by searching for publications from relevant associations and healthcare organizations focusing on torture survivors. Clinical practice guidelines (CPGs) and research focusing on somatic healthcare services for adult torture survivors, regardless of study design, were eligible for review. Studies that concentrated on psychiatric departments were excluded. To conduct an overview of the available research and describe the scope and distribution of evidence, a mapping review methodology was used. Results: Forty out of 13,111 initial citations met our criteria. There were two guidelines, and text and opinion statements predominated. Two authors independently assessed the risk of bias in each primary research study using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for the research design. Conclusions: This mapping review identifies triggers that may re-traumatize torture survivors during treatment and makes recommendations for prevention. Only a few studies have considered torture survivors' perspectives on treatment and re-traumatization. According to the findings of the mapping review, healthcare providers should consider survivors' biopsychosocial situations, demonstrate cultural sensitivity, and change their personal attitudes. They must also identify tortured patients and determine when professional interpreters should be used.

**Keywords:** Mapping review Torture survivors Re-traumatization Guidelines Recommendations Somatic healthcare services

**Introduction** worldwide. Torture is defined as follows:

"Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind" (United Nations, 2022, p. 20).

Defining torture is important because perpetrators are often law enforcement officials or members of security services seeking to extract a confession from the victim (Luci, 2017). The involvement of an authority figure in acts of torture is a consequential factor that contributes to the reactivation of

The exact prevalence of torture is unknown, yet a sizable number of asylum seekers and refugees are torture survivors (Ostergaard et al., 2020). The physical and psychological repercussions of torture are significantly unreported (Weisleder and Rublee, 2018); thus, survivors endure complicated physical and mental health difficulties requiring medical treatment (Luci and Di Rado, 2019).

A survivor's basic trust in others may be destroyed after being subjected to brutal violence inflicted by another person (Bell et al., 2019). Due to people in official positions and healthcare providers being involved in torture (Jones, 2019), survivors' mistrust of healthcare providers is reinforced. Therefore, every medical assessment or treatment has the potential to reactivate trauma symptoms, and the fear connected with this can lead to re-traumatization (Jacobs and Iacopino, 2001). Healthcare professionals in departments treating physical disorders are frequently unsure of how to identify and interact with traumatized patients; thus, re-traumatization is a risk (Juhler, 2004).

Re-traumatization occurs when memories, feelings, or thoughts of torture trigger the reactivation of trauma symptoms (Duckworth and Follette, 2012). Depending on survivors' reactions and adaptational styles to past traumatic experiences (Alexander, 2012) and potential triggers, re-traumatization may cause serious and lasting post-traumatic stress disorder (PTSD) symptoms (Schock et al., 2010; Watson, 2016). Thus, healthcare personnel who treat traumatized patients must acknowledge re-traumatization and the nature of traumatic memories, including conscious and unconscious recollections of torture (Schock and Knaevelsrud, 2013). The reactivation of trauma symptoms may occur because of a new traumatic experience or as a result of treatment-related stimuli. Trauma-related stimuli during treatment may include interactions, the environment, medical equipment, and pain associated with medical procedures (Schock and Knaevelsrud, 2013). Patients who experience re-traumatization may experience flashbacks (intrusive memories accompanied by a sense of reliving past events in the present) (Brewin, 2015), nightmares, and other symptoms during or after treatment. Knowledge of potential reactions during re-traumatization as well as the ability to help patients when such reactions occur will improve healthcare professionals' competency. Identifying stress reactions can help healthcare professionals identify indicators of re-traumatization and initiate adjustments to stop the process as well as help patients cope with treatment-related issues.

Electrocardiograms (ECG), gastroscopy, a general medical examination, or dental treatment can reactivate memories of torture and cause re-traumatization (Gruber and Byrd, 1993; Høyvik et al., 2019). The re-traumatization of torture survivors during treatment is caused by a combination of variables, such as a lack of competence of healthcare personnel and inadequate adjustments of services (Murray and O'Donnell, 2013). In an overloaded workday, healthcare professionals often lack the time or resources to carefully consider the underlying evidence supporting all the decisions they must make. Therefore, medical recommendations are essential for decision-making support (Allodi, 1991).

Understanding how trauma affects patients enables healthcare providers to identify trauma symptoms and respond trauma-informedly, potentially avoiding re-traumatizing patients (Grossman et al., 2021). Furthermore, developing clinical practice guidelines (CPGs) based on existing evidence on torture survivors can improve healthcare quality while driving evidence-based practice (Gerrish et al., 2007). To make informed treatment decisions and identify research needs, evidence about torture survivors' experiences with both torture and healthcare is required. Nonetheless, there are challenges with recruiting responders as well as ethical concerns (Dickson-Swift et al., 2007); therefore, research on torture survivors is limited (Clark-Kazak, 2017). It is critical to map evidence to determine whether there is sufficient evidence for treating torture survivors, preventing re-traumatization, and identifying research gaps in this area. This process will aid in the selection and prioritization of the research areas.

A comprehensive review of the relevant research in the field is essential before engaging in a meaningful discussion about how to minimize the re-traumatization of torture survivors during treatment in departments treating physical diseases. With our strategy, we aimed to systematically locate literature containing recommendations for treating torture survivors as well as to provide an overview of the literature on healthcare factors serving as triggers for re-traumatization. Furthermore, we planned to identify research gaps and make recommendations to improve research on the treatment of torture survivors in somatic departments as well as to facilitate the prevention of re-traumatization during treatment.

## 2. Methods

A systematic mapping review (Grant and Booth, 2009) of published literature on the treatment of torture survivors in departments other than psychiatric departments was conducted as part of a larger study aiming to develop and assess the feasibility of a set of clinical guidelines for the prevention of re-traumatization of torture survivors (Schippert et al., 2021). The goal of systematic mapping is to describe the scope of research in a field and to identify gaps in the research base where additional primary research is required as well as areas where no systematic reviews have been conducted (Petersen et al., 2015; Grant and Booth, 2009). Inspired by Katz et al. (2003), six steps were chosen to construct a map of recommendations for the prevention of re-traumatization during treatment of torture survivors in somatic healthcare services: (a) identify the evidence map scope, (b) define key variables, (c) establish a comprehensive search strategy, (d) identify the study's inclusion and exclusion criteria, (e) systematically retrieve, screen, and classify evidence, and (f) report findings on the map (Katz et al., 2003).

### a) Identify the Systematic Map Scope

The initial scope focused on the main recommendations related to (1) identifying torture survivors, (2) preventing re-traumatization, and (3) potential triggers causing re-traumatization. These issues were addressed during a meeting with healthcare providers (general, surgical, and anesthesia nurses working in a surgery department). Several themes manifested as healthcare providers faced challenges when treating torture survivors. Four questions emerged from the themes and were used to ensure a thorough review of the evidence. 1. Is there any evidence regarding the treatment of torture survivors providing recommendations to prevent re-traumatization during treatment in somatic departments? 2. Is there any evidence that certain triggers may cause retraumatization? What triggers are mentioned in the literature? 3. Which recommendations does the research provide for managing triggers to prevent re-traumatization? 4. How strong is the evidence on the treatment of torture survivors in somatic healthcare, presenting recommendations to avoid retraumatization? Text, opinions, systematic reviews, clinical guidelines, questionnaires, case series or reports, and websites were used to answer these questions.

b) Define Key Variables

To obtain the targeted and relevant search results, we structured our search strategy using a modified version of the problem-interest-context (PICO) framework (Scells et al., 2017). We searched bibliographic databases using keywords aligned with the PICO elements of the research questions. A combination of medical subject headings and text word terms (Yu, 2018) were employed per the database thesaurus, as shown in Table 1.

c) Establish a Comprehensive Search Strategy

We searched through nine databases and websites as well as reference lists from relevant publications and major article citations. Additionally, we examined gray literature sources for non-indexed guidelines and studies (Paez, 2017). A full description of the search strategy is shown in Table S1, and the sample search conducted on MEDLINE is depicted in Table S2.

d) Identify the Study Inclusion and Exclusion Criteria

The eligibility criteria for the literature to be reviewed included clinical practice guidelines (CPGs) and studies providing recommendations for the treatment of adult torture survivors in somatic healthcare services, independent of study design, published from January 2000 to November 2022. The study contexts were limited to healthcare facilities in somatic healthcare services. Clinical practice guidelines, except those designed only for use in psychiatric treatment, were included. Studies in English, French, Spanish, Portuguese, and Scandinavian languages were considered. The search results (n = 13,111) were uploaded to the Covidence article management system (https://www.covidence.org/), a web-based software program that assists researchers in screening references and extracting data. Following the removal of duplicates, eligible studies were identified by screening titles and abstracts. Then, based on full-text records, potentially relevant studies were screened against the eligibility criteria. Two review authors independently performed title/abstract and full-text screening. Disagreements were resolved through discussion until consensus was reached; a third reviewer was consulted when necessary to reach a consensus. Table S3 displays the inclusion criteria. Fig. 1 presents the flow of reports and studies into the synthesis.

e) Systematically Retrieve, Screen, and Classify the Evidence. This review mapped and organized 40 records by attributes. Table S4 lists the study's aim, country of origin, study design, publication year, sample size, and context.

f) Report Findings on a Map

Recommendations emerging from the records were extracted and organized in a table. Later, the recommendations were organized by.

| P (problem) | I (interest) | CO (context) |
|---|---|---|
| *Refugees* | *Guidelines* | *Somatic* |
| Asylum seekers | Recommendations | Hospitals |
| War victims | Suggestions | Healthcare centers |
| Prisoners of war | Advice | Emergency departments |
| Torture survivors | Treatment | Operating theaters |
| Victims of ill-treatment | | Intensive care departments |
| | | Outpatient units |
| | | Medical care |
| | | General practice |
| | | Health examination |

the following themes: recommendations to identify torture survivors in healthcare, triggers potentially causing re-traumatization, and recommendations to prevent re-traumatization. This process is illustrated in the results section with the subheading "Themes." To condense the text in the results section and the tables, all included records were given a number from 1 to 40 as shown in the appendix.

*2.1. Quality included records assessment*

To assess the methodologically included studies' limitations, two authors independently assessed the risk of bias for each primary research study using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for the studies' research design (Briggs, 2017; Jordan et al., 2019; Santos et al., 2018, Briggs), and a risk of bias table for each included study was completed. The quality assessment includes an overall assessment of the finding's confidence per the Grading of Recommendations Assessment, Development, and Evaluation – Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual) approach (Lewin et al., 2015; Lewin et al., 2018b;

Lewin et al., 2018c). The CERQual assessment rates the quality of the findings based on the following characteristics: (1) methodological limitations, (2) relevance to the review question, (3) findings coherence, and (4) data adequacy based on richness and data quantity supporting the findings. Based on the judgments made for the four aforementioned CERQual components, the assessment was divided into four levels: high, moderate, low, or very low (Lewin et al., 2018a). The quality of the included CPG was assessed using the Appraisal of Guidelines Research and Evaluation (AGREE) Instrument, Version II (AGREE II). The procedure has been previously published (Schippert et al., 2021). To ensure a standardized approach, the reviewers (ACS and AKB) completed the AGREE II online training tutorials before conducting the quality assessment (Brouwers et al., 2016). For the CPGs, a quality score was calculated for the AGREE II (described in Fig. S1) six domains using the formula shown in the AGREE II User's Manual (Brouwers et al., 2010).

## 3. Results

### *3.1. Characteristics of the included studies*

Nineteen records (47%) were conducted in the United States (US), 10 (25%) in Western Europe, and 6 (15%) in North Europe. Three studies (7.5%) were conducted in Canada, one (2.5%) in New Zealand, and one (2.5%) in Australia. No relevant studies from the African continent or South America were identified. One study was jointly conducted in the United Kingdom and Denmark (31), and another was jointly conducted in the US and Portugal (35). (Study numbers appear in a list in the Appendix.) Although we intended to include literature written in Norwegian, Danish, Swedish, Portuguese, Spanish, French, and German in addition to English, no non-English records met the inclusion criteria for this mapping review. Twenty-three articles comprised text and opinion statements. Two documents from the Center for Victims of Torture in the US (39, 40) focusing on torture survivors in primary healthcare were included in the gray literature search. Two sets of guidelines were included in this review: One from Canada (20) focused on immigrants and refugees in general healthcare and one from England (7) focused on torture survivors receiving healthcare in detention. Furthermore, 35% (k = 14) of the records were published before 2010, and twenty-six (65%) were published between 2010 and 2022. Twenty-three (58%) of the included records were text opinion papers, five (12.5%) were reviews, two (5%) were case reports, four (10%) were qualitative studies, and two (5%) were cross-sectional studies. Studies by context are outlined in Fig. 2, and Table 2 shows an overview of included publications by country and design and included participants by sex and by designation. A description of all included records is illustrated in Table S4

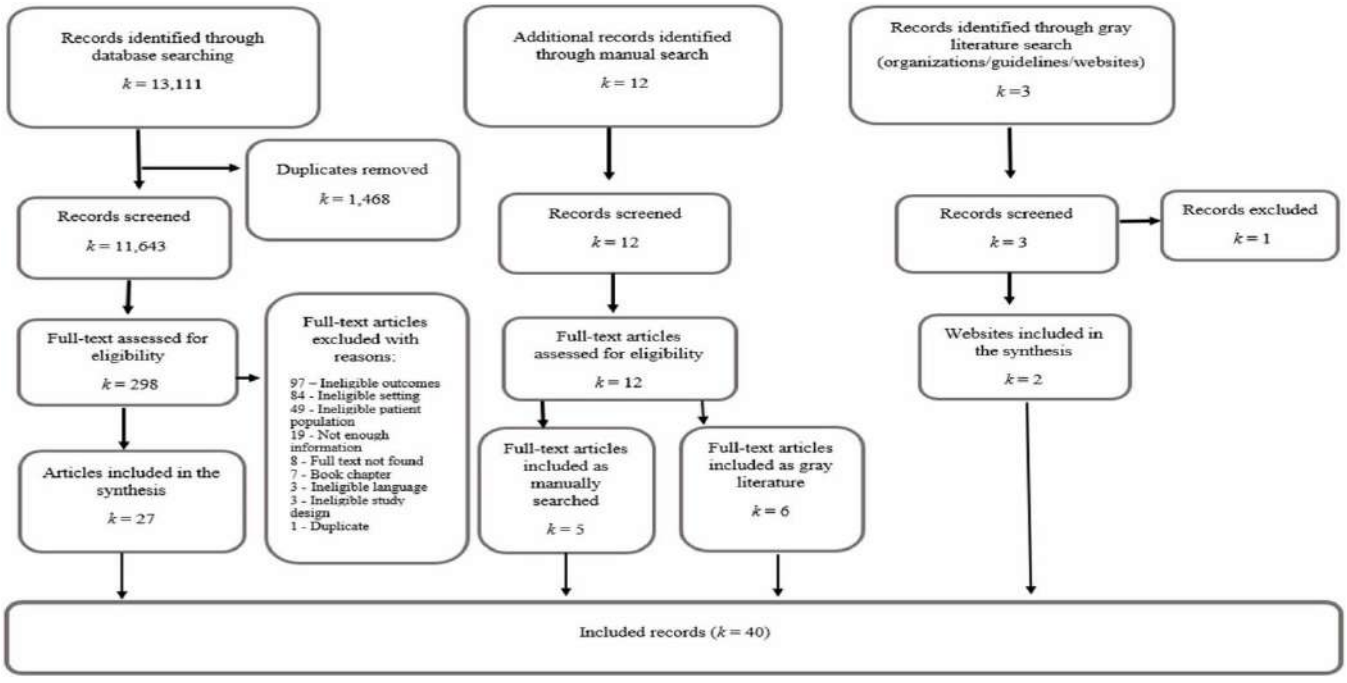


**Fig. 1.** Search strategy and article review process.

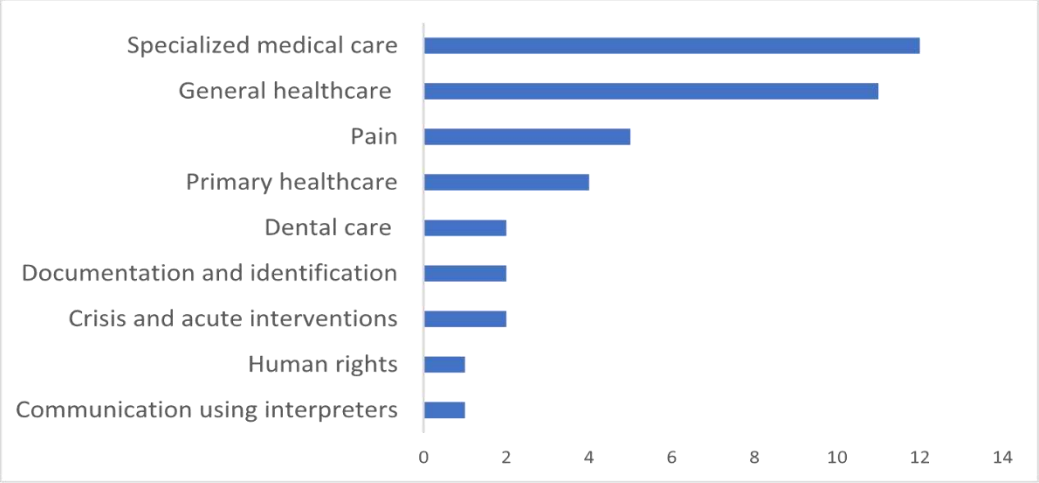


**Fig. 2.** Studies overview by context.

mentioned in connection with communication, the use of rs, and

Publications overview by year and included participants by sex and designation.

Publications by country

| | |
|---|---|
| US | 19 |
| United Kingdom | 7 |
| Denmark | 3 |
| Canada | 3 |
| Norway | 3 |
| Australia | 2 |
| Belgium | 1 |
| Sweden | 1 |
| New Zealand | 1 |

Publications by design

| | |
|---|---|
| Text and opinion papers | **23** |
| Reviews | 5 |
| Case reports | 2 |
| Websites | 2 |
| Qualitative studies | 4 |
| Cross-sectional study | 2 |
| Guidelines | 2 |

Participants by sex

**Table 2**

| | |
|---|---|
| Sex not specified | 222 patients<br>57 experts |
| Female | 613 |
| Male | 511 |

Participants by designation

| | |
|---|---|
| Migrants | 312 |
| Torture survivors | 572 |
| Refugees | 451 |
| Veterans | 2 |
| Experts and practitioners | 57 |

*3.1.1. Characteristics of text and opinion statements*

Twenty-three (57.5%) records were text and opinion papers. Three (13%) focused on torture-pain treatment (1, 31, 32). These and other studies (35, 36) offer suggestions on how to ask patients about torture and other aspects that healthcare professionals must be aware of and have knowledge about. One record focusing on dental treatment provided suggestions for how healthcare providers should respond when patients reveal traumatic experiences (11). Cultivating trust and safety is disclosure. Cultural competency, sensitivity, and the importance of using a multidisciplinary team to treat torture survivors are also depicted as important (2). One study focusing on skin lesions after torture (6) presented recommendations about physical examination and patients' need for control (specifically, recommendations on how to ask about torture and mentioned unexplained conditions and the importance of referring survivors to mental healthcare). Asylum medicine and best practices were the focus of one paper, recommending the

need to acknowledge scars and acquire knowledge about torture methods (8). Eleven articles focused on the general healthcare context (recommendations about the need for sufficient time when treating torture survivors as well as the importance of having knowledge about torture and being aware of the challenges of being a torture survivor). Suggestions about adjustments to the environment were also presented. Using professional interpreters, the necessity of cultural competence and empathy in treating torture survivors was described in this context. Grodin (2004) and Mollica (2004) provided recommendations for identifying torture survivors (35, 36).

Reports including potential triggers (9, 11, 17, 26, 30, 31, 33, 35, 38) also provided recommendations regarding the use of interpreters, physical examination and control, sufficient time to treat the patient, ensuring patients' privacy, cultivating relationships of trust and safety, inquiring about torture, healthcare professionals' awareness of torture, and the utilization of a multidisciplinary team when treating torture survivors. Moreno and Grodin (2002) highlighted the neurological sequels of torture, described triggers inducing re-traumatization, and provided suggestions about communication and the use of interpreters (30). Cultural competency, sensitivity, and awareness were also addressed (30) and echoed in other papers (11, 34). Three articles focused on the importance of trauma-informed care (9, 21, 25); one focused on the connection between low-quality outcomes and discriminatory attitudes among healthcare providers (25) and the importance of promoting staff well-being. When providers can recognize and seek support for their emotional responses to the work, including burnout, compassion fatigue, and secondary trauma reactions, they may contribute to preventing the re-traumatization of patients during treatment (9).

*3.1.2. Characteristics of the reviews*

Two systematic reviews (3, 27), two literature reviews (12, 37), and a clinical review (28) were included. These focused on the treatment of persistent pain (3), primary healthcare 27), and human rights and medical assessment (37). Suggestions on pain assessment, identification of torture survivors, asking questions about torture, and the importance of referring survivors to mental healthcare were included. Zander et al. (2015) provided an interview guide for use by primary healthcare professionals (27).

*3.1.3. Characteristics of the case reports*

Two papers with case reports were included. One (14) focused on the surgical treatment of veterans, presenting recommendations about adjusting the environment, preparation before treatment, and considerations about medication and post-anesthesia care. Another study (18) reported treatment with antiretrovirals and medication as potential triggers.

*3.1.4. Characteristics of the qualitative studies*

Four qualitative studies (5, 10, 15, 23) were included. In one study (23), semi-structured interviews were used to explore neuropsychological assessment and the use of professional interpreters. The findings recommended providing extra time for the medical assessment to cultivate the ability to listen to patients and give them a sense of control. Lønning et al. (2021) interviewed 46 experts and practitioners to explore the challenges and opportunities professionals see and experience in seeking to provide adequate treatment for torture survivors. Suggestions about specialized and interdisciplinary competency were given as one priority to improve the quality of healthcare delivered to torture survivors (15). Board et al. (2021) focused on healthcare services for pain and interviewed 13 participants. Recommendations about how to ask about torture in a clinical context are given (5). One study focuses on dental care by examining interviews with 10 torture survivors and provides recommendations on how to deal with potential triggers during treatment, the use of interpreters, and the importance of improving healthcare professionals' knowledge about torture (10).

*3.1.5. Characteristics of the cross-sectional study*

Two cross-sectional studies (13, 29) were included. One study (29), including 121 patients, focused on the identification of torture survivors among a general patient population. This study recommended building trust and asking questions about torture and suggested strategies for effective communication. It also suggested using a multidisciplinary team to treat torture survivors. Kira et al. (2022) focused on the torture effects in the context of Covid-19 and how discrimination as a concurrent stressor with Covid-19 amplified the impact of torture on patients' symptoms (13).

*3.1.6. Characteristics of the websites*

Two websites were included. One (40) provides a manual that primary care providers can use to ease the suffering of refugees and help them begin the healing process. This website presents recommendations about using interpreters and the importance of educating patients on how to handle trauma and trauma reactions. The second website (39) aims to help healthcare providers evaluate the current methods used for interviewing, diagnosing, and treatment planning.

***3.1.7. Characteristics of the guidelines***

Two clinical guidelines were included in this mapping review (7, 20). Pottie et al. (2011) offers evidence-based clinical guidelines for immigrants and refugees. It recommend using professional interpreters at disclosure and increasing cultural competency and sensitivity to improve awareness about issues related to torture survivors**.** Cohen and Green (2022) list recommendations that aim to increase the identification of torture and healthcare outcomes and to reduce the risk of causing harm during treatment (7). Suggestions on how to facilitate disclosure are given while focusing on using sufficient time, building trust, using interpreters, and providing a suitable quiet environment with privacy. According to Cohen and Green (2022), healthcare professionals must identify and report torture.

A map of the included studies' characteristics appears in Table 3.

*3.1.8. Characteristics of the records presenting triggers*

Most records examining triggers are text and opinion papers, followed by qualitative studies, reviews, and websites. Although case reports and cross-sectional studies provide only a few triggers, one qualitative study focusing on dental health present several triggers. Only one guideline offered a few triggers (7). For some triggers, no recommendations for how to manage them were identified.

*3.2. Themes*

The emerging themes from the included studies were organized, and Fig. 3 shows the conceptual map constructed after the mapping review, including the main recommendations for how to prevent the re- traumatization of torture survivors during treatment**.**

*3.2.1. Recommendations for the identification of torture survivors*

Eight records emphasize the importance of knowing the details of a patient's torture history (3, 6, 26, 27, 28, 31, 32, 37). Trauma, medical, and family histories should be assessed in torture survivors. Regardless of when it happens, torture can affect the clinical picture; and not knowing the patient's trauma history can lead to major errors in assessment and treatment. Healthcare providers can diagnose, treat, and refer patients better when they know the patient's history. Studies have suggested asking patients broad questions about their health and life to identify past traumas: Ask whether any circumstances, items, or treatment interactions cause significant feelings or reactions.

*3.2.2. Recommendations for preventing Re-traumatization during treatment.*

In this category, we included outcomes related to general recommendations, awareness knowledge, building trust, physical examination, interdisciplinary teams, documentation, communication, adjustments during treatment, and using interpreters.

**- General Recommendations**

Most of the recommendations identified in the records were included in this category, and 20 records are represented (4, 6, 7, 9, 10, 11, 15,16, 20, 21, 22, 24, 25, 28, 29, 30, 31, 37, 39, 40). Some recommendations emerged regarding the need to educate providers regarding the importance of addressing biological, social, and psychological patient needs. Healthcare staff should be educated about torture and its effects (7, 11, 14, 31) to understand what situations, objects, or interaction aspects can cause re-traumatization. This education can facilitate treatment (28, 30, 32) and allow them to adjust, neutralize, remove, or adapt triggers to patients' needs and special situations (31, 35). To protect patients against re-traumatization, it is recommended that racially and culturally responsive inpatient care (9) and implementation of trauma-informed care (7, 9, 21, 25) emphasize safety, trust, choice, collaboration, and empowerment (7). For clinical interviews, survivors should be assessed individually (34) in comfortable surroundings offering ample time if needed (14, 16, 23, 30). In clinical settings, every refugee patient should be treated as a possible torture survivor. Observe other risks like if patients are members of a minority group, if they were persecuted for political, religious, or for sexual orientation reasons. Torture and related traumas should be deemed as health issues by healthcare providers, and torture should be considered in patients with unexplained psychological, skin, neurological, or orthopedic disorders.

Trauma survivors may experience a transient rise in trauma symptoms after recounting their stories or during some medical procedures. Explaining what to expect during visits is vital. In the initial interview, treatment strategies must be established. Gender concerns are important, especially for sexual assault survivors. The patient may prefer female doctors, especially for gynecology. Some refugees who are persecuted by their own cultural group may prefer healthcare providers from another culture.

Healthcare personnel should not presume that memory in-consistencies indicate history falsification when assessing torture. It is crucial to understand the histories and discuss them with patients. Patients should be referred to a mental health professional for psychological assessment and therapy when needed.

**- Awareness**

Recommendations about aspects that healthcare providers must be aware of related to torture survivors' treatment in somatic healthcare services emerged from 10 records (1, 2, 5, 6, 10, 12, 15, 17, 24, 31).

Healthcare providers should comprehend how a patient's migratory status affects them as well as how sociocultural issues and difficulties in adjusting to a new culture affect survivors. Due to the involvement of health professionals in torture, survivors may mistrust them. When examining patients, healthcare practitioners must consider the pain-fear dynamic. Understanding how shame and embarrassment can result from exposing torture, especially sexual torture, can help healthcare workers better comprehend patients' reluctance to reveal their torture histories. When counseling torture survivors, healthcare providers must be conscious of their own subconscious personality traits (5).

**- Building Trust**

Recommendations on how to create trust and safety were presented in 11 records (2, 6, 7, 16, 17, 19, 24, 28, 31, 34, 37).

It is advised to wait until trust has been established before inquiring about trauma history (37), and torture trauma should never be explored until trust has been established (34). Trauma disclosure can be distressing when made in unsafe circumstances, when patients do not trust healthcare providers, or when made by relatives or children. On the other hand, torture survivors may take a long time to trust others. Survivors

**Table 3**
Summary of the characteristics of the included studies and the quality of the emerged themes.

| Summary of text and opinion papers ($n = 23$) | Summary reviews ($n = 5$) | Summary case reports ($n = 2$) | Summary Qualitative studies ($n = 4$) | Summary cross-sectional studies ($n = 2$) | Clinical guidelines ($n = 2$) | Summary websites ($n = 2$) |
|---|---|---|---|---|---|---|
| Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics |
| **Focus:** General healthcare ($n = 9$), primary healthcare ($n = 2$), pain ($n = 3$), Neurological sequelae ($n = 1$), crisis interventions ($n = 1$), skin lesions after torture ($n = 1$), asylum medicine ($n = 1$), acute consultation ($n = 1$), communication with help of interpreters ($n = 1$), documentation of torture ($n = 1$), relationship between the patients and healthcare professional ($n = 1$), and dental care ($n = 1$). | **Focus:** Persistent pain treatment ($n = 1$), primary healthcare ($n = 1$), obstetrics ($n = 1$), trauma histories ($n = 1$), and human rights and medical assessment ($n = 1$). | **Focus:** Surgical treatment ($n = 1$), treatment with antiretrovirals ($n = 1$). | **Focus:** Pain ($n = 1$), dental care ($n = 1$), general healthcare ($n = 1$), and neuropsychological assessment ($n = 1$). | **Focus:** Identification of torture survivors ($n = 1$) and torture effects in the Covid-19 context ($n = 1$). | **Focus:** General healthcare ($n = 2$). | **Focus:** Primary healthcare ($n = 2$). |
| **Recommendations**<br><br>**General recommendations**<br>. Use trauma-informed care principles (21, 25) and racially and culturally responsive inpatient care (9).<br>. Acquire knowledge about different protocols (16).<br>. Identify the patient's background, country of origin, ethnicity, language, medical history, refugee history, and residential status. Explore the patient's resources and needs (11).<br>. Treat each refugee patient as having a possible torture history (35) and as an individual with a different life (1, 2).<br>. Show respect (22).<br>. Show genuine interest in the patient's cultural background (4, 24, 30).<br>. Keep torture in mind when refugee patients present unexplained conditions (6).<br>. Refer survivors to a mental health professional for adequate psychological treatment if needed (6, 19).<br>. Do not assume that memory inconsistencies mean that history is falsified. Check the history with documents and discuss it with the patient (11, 16).<br>. Acquire knowledge about migration trauma (2) and torture methods (31).<br><br>. Avoid waiting time (32).<br>**Awareness**<br>Healthcare providers should be aware of the following:<br>. Survivors' distrust extends to health professionals (11, 31, 36).<br>. The importance of dynamic pain-fear (1).<br>. Socio-cultural aspects and difficulties adapting to a new culture (1, 2, 17).<br>. Torture in general, especially sexual torture, can be shameful for patients to reveal (6, 24). | **Recommendations**<br>**General recommendations**<br>. Be aware of factors indicating that patients can be torture survivors:<br><br>- A refugee or a political asylee.<br>- A member of a minority, discriminated against or persecuted for political or religious reasons, or because of sexual orientation (37).<br>. Prior to encounters, seek information about conditions in the refugee's country of origin (28).<br>. The medical assessment should include trauma, medical, and family histories.<br>. Allow patients to tell their stories at a comfortable pace.<br>. Make treatment plans, accompanied by the responsibility for carrying out these plans over time (37).<br>. Acquire knowledge about medical conditions resulting from trauma and torture (28), the survivor's world (37), and cultural background (3, 12).<br>. Show understanding of the importance of coping strategies connected to religion (12).<br>**Identification of torture survivors** | **Recommendations**<br>**General recommendations**<br>. It is important to provide staff with training about torture (14).<br>**Treatment**<br>. Create a calm environment.<br>. Employ consistent principles (same staff through all treatments).<br>Use intraoperative sympatholytic therapy.<br>. Provide patients with education (patient teaching on emergence, agitation, and interventions) during treatment.<br>. Be vigilant to the occurrence of unusual challenges related to PTSD (high risk of flashbacks).<br>. Control medication (preoperative) patients usually take to identify medications used for psychiatric conditions.<br>. Create an evidence-based care plan for patients with flashbacks in the PACU (post-anesthesia care unit).<br>. Be alert to psychiatric medications, especially those prescribed for nightmares.<br>. Avoid using benzodiazepines, particularly midazolam.<br>. It is not necessary to avoid using | **Recommendations**<br>**General recommendations**<br>. It is important to include frameworks for identifying, documenting, treating, and rehabilitating torture injuries and competence within existing service provisions (15).<br>. Dentists need knowledge and enough time for torture survivors, and triggers need to be explored individually.<br>. All dentists working with traumatized individuals must know how to handle psychological reactions and how to bring patients back to the "here and now" (10).<br>**Interpreters**<br>. Use professional interpreters with extra time for translation (10, 23).<br>**Treatment**<br>. Give patients a sense of control over the processes of assessment and listen when they want to share their trauma stories (10, 23).<br>**Identification of torture survivors**<br>. If torture experience remains undisclosed, psychological, and social factors influencing the pain remain unaddressed (5).<br>**What or how to ask**<br>. Questions such as | **Recommendations**<br>**General recommendations**<br>. Recognize the possibility that some of your patients may have problems related to torture (29).<br>**Identification of torture survivors**<br>. Learn how to identify immigrant patients who may have been exposed to torture (29).<br>**What or how to ask**<br>. Provide a safe environment, build a trusting relationship, and be empathic when interviewing patients.<br>. Ask about the history of torture in patients born in other countries.<br>. Providers must know how to reduce the risk of re-traumatizing their patients by asking about torture.<br>. Refer survivors to appropriate health and social services, including specialized treatment centers (29).<br>**Treatment**<br>. Be aware of the effects of torture on Covid-19.<br>. When treating torture survivors, it is important to focus on discrimination and Covid-19 as a stressor factor that has an impact on symptoms and treatment outcomes (13). | **Recommendations**<br>**General recommendations**<br>. Trauma-informed care emphasizes safety, trust, choice, collaboration, and empowerment (7).<br>. It is important to train providers to reduce the triggers of re-traumatization.<br>. Healthcare professionals must identify themselves with patients to create transparency (7).<br>. Do not push for disclosure of traumatic events.<br>. Become familiar with the patient's cultural background (20).<br>**What or how to ask**<br>. Do not explore trauma and its consequences in the first meeting unless it is the patient's primary complaint (20).<br>**Identification of torture survivors**<br>. Identify and report torture.<br>. Facilitate disclosure.<br>. Use sufficient time to facilitate disclosure (7).<br>**Interpreters**<br>. Use a professional interpreter.<br>. Disclosing traumatic experiences through relatives, family members, or children can be traumatic (7, 20).<br>**Physical examination**<br>Explain the purpose | **Recommendations**<br>**General recommendations**<br>. Have a conversation about the patients' country to help patients divulge the torture history and to manage fear of not being believed and the shame involved.<br>. Educate providers to optimally address patients' biological, social, and psychological needs (39).<br>. Avoid stress in patients to prevent the reactivation of trauma (40).<br>. Show sensitivity to gender issues to women who have experienced sexual assault, especially for gynecological care.<br>. Be aware that some refugees who were persecuted by members of their own cultural group may be more comfortable with healthcare providers from a different cultural group.<br>. Be attentive to the fact that trauma survivors may experience increased trauma symptoms after telling their stories or during medical procedures (40).<br>**Treatment**<br>. Alert patients before making any sudden changes (switching lights off, touching from |

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**Table 3** (*continued*)

| Summary of text and opinion papers ($n = 23$) | Summary reviews ($n = 5$) | Summary case reports ($n = 2$) | Summary Qualitative studies ($n = 4$) | Summary cross-sectional studies ($n = 2$) | Clinical guidelines ($n = 2$) | Summary websites ($n = 2$) |
|---|---|---|---|---|---|---|
| Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics |
| **Building trust**<br>. Build trust before proceeding with further steps (6, 11).<br>. Discuss individual preferences and needs with the patient (2).<br>. Create a safe environment and use sufficient time (16).<br>. Use compassionate listening (17, 19).<br>. Ensure doctor-patient confidentiality (including interpreters) (24, 31, 34).<br>**What or how to ask**<br>. Asking about past experiences can help the patient. (11, 31).<br>. Be aware that patients may be reluctant to share their experiences, and professionals may fear re-traumatizing patients by inquiring about their past, but not understanding a patient's background may create additional trauma.<br>. Do not expect spontaneous disclosure (32).<br>. Healthcare staff must be able to deal with responses, neither forcing disclosure nor feeling overwhelmed by it (31).<br>. Approach patients with open-ended questions without being too direct (6).<br>. If patients show discomfort, do not force them to disclose (26).<br>. If patients reveal traumatic experiences, a possible response may be, "I'm sorry this occurred to you," may be said to traumatized patients. How're you? "Thanks for telling me. Can I help you as your dentist? "Thanks for telling me. Nobody deserves what you told me …" "Does this affect you today? Would you like me to recommend someone to speak with about this?" (11).<br>. Use a holistic approach that addresses the patient's situation in a culturally sensitive way (36).<br>**Physical examination**<br>. The patient's history should be consistent with the physical examination. Do not overlook physical sequelae such as chronic pain (6).<br>. Try to obtain explanations for each scar and document it (8).<br>. Undertake a sensitive and gentle physical examination with an explanation of the investigation, empathy, and interest (17).<br>. Avoid overtreatment and frequent debriefing of somatic exams. (19).<br>. There should be no dark curtains or folding screens in the examination rooms, and the temperature should be | Healthcare practitioners might ask about sleeping problems, nightmares, headaches, anger, thoughts about traumatic previous events, fear, memory problems, and trouble concentrating to identify traumatized refugees. Any positive response indicates risk of re-traumatization. (27).<br>**Awareness**<br>. Be aware of how migration status affects patients (12).<br>**Building trust**<br>. Invite patients to tell their trauma stories to establish trust.<br>. Allow patients to tell their stories comfortably.<br>. Show understanding if patients do not want to talk about traumatic experiences.<br>. Use attentive listening, communication, empathy, and respect.<br>. Address the refugee's priorities to foster trust (28).<br>. Wait to ask about torture until a trusting relationship has been established (37).<br>Make patients feel safe (37).<br>**What or how to ask**<br>. Use the following questions when inquiring about experiences with torture:<br>- Country of origin?<br>- The reason for leaving the country?<br>- Eventual problems due to culture or tribe, political beliefs, religion, or gender?<br>- Were you arrested?<br>- Were you attacked by | ketamine. Intraoperatively, clonidine, dexmedetomidine, droperidol, and promethazine should be administered.<br>. Touching the feet is the only type of tactile stimulus used to reduce the risk of eliciting fear when touching the upper body (14).<br>. Offer psychotherapy to patients who meet the criteria for a mental health condition due to the risk of recurrence of past traumatic symptoms when using antiretrovirals.<br>. In torture survivors, EFV with ZDV, effective antiretroviral treatments, should be used after an appropriate discussion between the patient and provider about this medication's possible role in precipitating the exacerbation of PTSD symptoms (18). | "Can you tell me why you came to the UK?" "Were you ever treated badly in your home country?" or "Have you ever been arrested or put in prison?" can assist in opening a dialogue regarding possible torture experiences (5).<br>**Awareness**<br>. Understand who a potential torture survivor may be and acquire knowledge about the common challenges faced by torture survivors (10, 15).<br>. Reflect upon unconscious bias to influence the practice when you treat torture survivors (5). | of the examination (7).<br>**Communication**<br>. Use effective and accurate communication for the full disclosure and assessment of healthcare needs (7). | behind, using instruments, etc.).<br>. Educate the patient about the importance of continuing medications.<br>. Explain what to expect during the visit.<br>. Reassure patients, where possible, of their physical well-being.<br>. Ask and encourage patients to talk about their experiences in their country of origin (39, 40).<br>. Make sure that painful procedures are executed under anesthesia (40).<br>**Interpreters**<br>. Use trained interpreters.<br>. Do not use family members to interpret.<br>. Try using the same interpreter for the same patient (40). |

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**Table 3** (*continued*)

| Summary of text and opinion papers ($n = 23$) | Summary reviews ($n = 5$) | Summary case reports ($n = 2$) | Summary Qualitative studies ($n = 4$) | Summary cross-sectional studies ($n = 2$) | Clinical guidelines ($n = 2$) | Summary websites ($n = 2$) |
|---|---|---|---|---|---|---|
| Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics |
| acceptable (35).<br>. Give patients a sense of control and allow them to terminate the interview or stop the examination at any time (30).<br>**Communication**<br>. Pay attention to indirect communication, ask about phrases, figures of speech, and metaphors you don't understand, and talk about the patient's nation of origin and exile or diverse cultures within one country to relax them (24).<br>**Interpreters**<br>Use professional interpreters. Book an interpreter for the initial meeting and any subsequent ones (11, 22, 32).<br>. Remember interpreter drawbacks. Confidentiality issues can arise with national interpreters. (30, 31).<br>. In some cases, phone interpreting may be preferred because it is anonymous (11, 32).<br>. When working with interpreters, reassure the patient about confidentiality (17,22) and maintain eye contact. Speak directly to the patient and use short simple sentences with frequent pauses (17).<br>**Treatment**<br>. Explain procedures reminiscent of torture, such as those involving electrical equipment or scans performed in closed tubes (11, 31).<br>. To minimize flashbacks, create a calm atmosphere, provide detailed explanations of planned procedures, obtain informed consent, and facilitate the patient's control over procedures (31).<br>. Discuss torture cases with colleagues or get supervision to maintain a therapeutic attitude and keep treatment effective (38).<br>. Use empathic communication to protect against harmful reenactments and recognize one's own mistakes (9). | soldiers, police, or rebel groups?<br>- Did you see or hear others being beaten or attacked?<br>- Were any family members arrested or attacked because of their culture, tribe, political beliefs, or religion (28)?<br>. Ask about personal values, current life situation, family situation, and external social support (37).<br>. Ask about possible countertherapeutic associations of treatments (3).<br>**Communication**<br>. Acquire knowledge about communication styles in other cultures (e.g., direct eye contact and appropriateness of shaking hands with the opposite sex).<br>. Be aware of power differences, making refugees not feel comfortable initiating conversations about torture.<br>. Be aware of the possibility that physicians who have participated in torture can be a reason for mistrust and discuss this with patients.<br>. Be attentive to non-verbal communication and expressed language, observing whether questions are too sensitive or painful (37).<br>**Interpreters**<br>. Use certified professional interpreters in all encounters with patients, and anonymous phone interpreters should be used when sensitive topics are discussed.<br>. The interpreter's ethnicity or tribal affiliation should be considered (28, 37).<br>**Treatment** | | | | | |

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**Table 3** (*continued*)

| Summary of text and opinion papers ($n = 23$) | Summary reviews ($n = 5$) | Summary case reports ($n = 2$) | Summary Qualitative studies ($n = 4$) | Summary cross-sectional studies ($n = 2$) | Clinical guidelines ($n = 2$) | Summary websites ($n = 2$) |
|---|---|---|---|---|---|---|
| Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics |
| | . For elective surgery, patients should receive an orientation and even walk through the operating room and recovery room in advance.<br>. The anesthesia team should be alert to the possibility of emergence flashbacks (28).<br>. Healthcare providers should be aware of and confident in referring patients to appropriate services (37).<br>. Treatment should involve a multidisciplinary team (3). | | | | | |
| **Potential triggers**<br>. Physical examination and procedures.<br>. Recording the medical history may bear a strong resemblance to interrogations experienced during torture.<br>. Being exposed to questioning.<br>. Electrical equipment uniforms, waiting, waking from unconsciousness (e.g., anesthesia).<br>. Health professionals.<br>. Rushing patients or asking serial questions.<br>. Failing to explain interviews, examinations, or diagnostic tests.<br>. MRI scanners.<br>. Electrodes.<br>. Interpreters.<br>. Medical setting.<br>. Lying still in a loud MRI scanner.<br>. ECG leads or EMG needles.<br>. Diet and weight loss.<br>. Examination rooms.<br>. Needles, instruments, and EKG electrodes.<br>. Pronated or angled positions.<br>. Pelvic and rectal exams.<br>. Loud noises.<br>. A gastroscopy, or a general examination.<br>. Treatment with teeth extraction.<br>. Instruments with water spray.<br>. Listening to patients who are crying.<br>. Uncompassionate or unfriendly staff members.<br>. Rooms without windows.<br>. Sharp instruments.<br>. Certain electronic devices.<br>. Sharp lighting<br>. Dental chair.<br>. Lying almost underneath the dentist.<br>. The mouth filled with cotton. | **Potential triggers**<br>. Interviewers who are too aggressive.<br>. Clinicians.<br>. The hospital.<br>. Physical environment.<br>. Being touched or examined.<br>. Waiting.<br>. A doctor wearing a white coat.<br>. Dental treatment or extractions. (28, 37) | **Potential triggers**<br>. Pain.<br>. Specific anesthetic agents.<br>. Induction of sleep state.<br>. Confusion.<br>. Noise stimuli.<br>. Unfamiliar environment.<br>. Antiretroviral treatment. (14, 18). | **Potential triggers**<br>. Pain.<br>. Healthcare professionals who rush and treat without informing.<br>. Sight of equipment.<br>. Anticipation of pain. The dentist's behavior.<br>. Fear of getting pain.<br>. Pain from clinical procedures.<br>. Thought of needles.<br>. Feeling of numbness.<br>. Post-operative pain.<br>. Taste of blood.<br>. Situations involving elements of surprise.<br>. Vibration, sound, and drilling.<br>. Prone position during treatment.<br>. Dentist (as government worker).<br>Dental chair.<br>Use of water during treatment.<br>. Feeling unsafe.<br>. Healthcare providers working and talking above the patient's head.<br>. Dentists who never smile.<br>Lack of interpreters (10). | **Potential triggers**<br>. Eliciting a history of torture (29).<br>. Covid-19 (13). | **Potential triggers**<br>. Talking about torture experiences.<br>. Sights.<br>. Sounds.<br>. Smells (7). | **Potential triggers**<br>. Certain smell types under treatment.<br>. General discomfort with being examined.<br>. Routine tests.<br>. Male healthcare providers.<br>. Medical setting.<br>. Instruments may cause anxiety.<br>. Provider's lack of interest in or empathy for survivors' history.<br>. Routine events.<br>. Electrocardiogram.<br>. A gynecologic exam.<br>. Unexpected loud noises (39, 40). |

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**Table 3** (*continued*)

| Summary of text and opinion papers ($n = 23$) | Summary reviews ($n = 5$) | Summary case reports ($n = 2$) | Summary Qualitative studies ($n = 4$) | Summary cross-sectional studies ($n = 2$) | Clinical guidelines ($n = 2$) | Summary websites ($n = 2$) |
|---|---|---|---|---|---|---|
| Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics | Characteristics |
| . Instruments.<br>. Drilling without anesthesia.<br>. Pain.<br>. Fear of pain.<br>. Anesthetic injections.<br>. Cold temperature.<br>. Discrimination.<br>. Racism.<br>. Hospitalization.<br>. Negative interactions with providers.<br>. Seclusion and restraint.<br>. Insufficient attention to material, emotional, or safety needs.<br>. Violations of trust.<br>. Confinement.<br>(9,10,11,17,26,30,31,33,35,38) | | | | | | |
| **Quality of evidence** | **Quality of evidence** | **Quality of evidence** | **Quality of evidence** | **Quality of evidence** | **Quality of evidence** | **Quality of evidence** |
| . **Minor concerns about coherence** → findings reasonably consistent within and across studies.<br>. **No concerns about relevance**<br>. **Moderate concerns related to overall methodological quality** → two studies with minor concerns: It is unclear if sources of opinion have standing in the field of expertise (25, 34). In one study with minor concerns, it is unclear if extant literature is referenced (19). | . **Minor concerns about coherence** → findings reasonably consistent within and across studies.<br>. **No concerns about relevance**<br>. **Moderate concerns related to overall methodological quality** → one study with minor concerns in which it is unclear if the likelihood of publication bias was assessed (3). In one study with minor concerns, it is unclear whether there were methods to minimize errors in data extraction (12). | . **Minor concerns about coherence** → findings reasonably consistent within and across studies.<br>. **No concerns about relevance**<br>. **Minor concerns related to overall methodological quality** → one study with moderate concerns (it is unclear if the patient's history was clearly described and presented as a timeline and unclear if adverse events (harms) or unanticipated events were identified and described (14). | . **No concerns about relevance**<br>. **Minor concerns related to overall methodological quality** → in one study it was unclear if there was congruity between research methodology and representation and analysis of data and if participants, and their voices were adequately represented (23). Two studies had minor concerns as it was unclear if there was congruity between the stated philosophical perspective and the research methodology (15). | . **No concerns about relevance**<br>. **Minor concerns with methodology** → in one study it is unclear if there were strategies to deal with stated confounding factors (13). | . **No concerns about quality** → domain applicability (how well healthcare providers may be able to implement the CPG recommendations in their daily clinical practice) scored 69% in both included guidelines. We consider the score to be high and not causing concerns, giving credit to the presented recommendations. | |

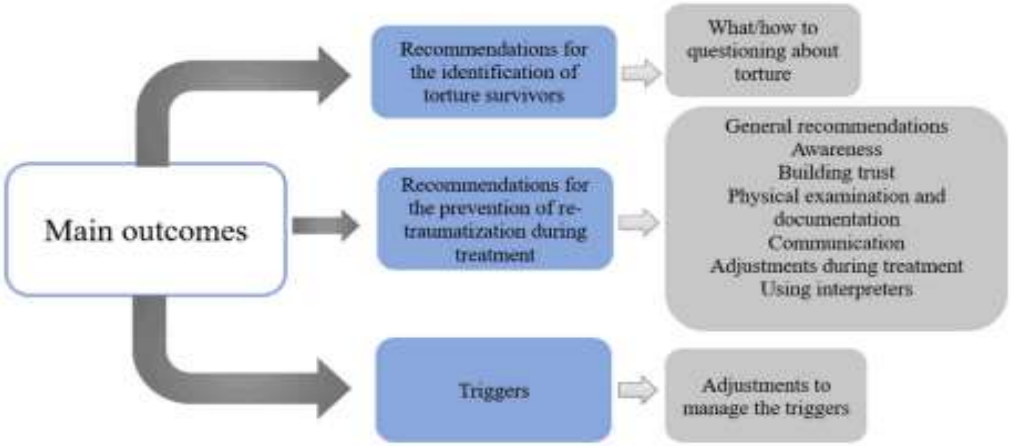


**Fig. 3.** Themes from the included records.

may perceive healthcare professionals as government agents or the healthcare institution as a government institution, making them hesitant to reveal information if they do not understand the confidentiality that characterizes patient-professional relationships (28). Trust is especially important in medical settings because aspects like the use of uniforms (28, 30, 31, 33) can serve as a reminder of healthcare providers' participation in torture (33). Building trust with survivors may also be facilitated if healthcare providers know the customs of the survivor's culture (2, 28, 34), use sufficient time to build trust, and engage in compassionate listening (17). Using professional interpreters, allowing extra time for translation, and giving patients control over their treatment may all help build trust (28). Trauma-informed care emphasizes trust and choice (7), allows patients to discuss their individual preferences and needs, and ensures provider-patient confidentiality (also including the interpreter). When interpreters are present, physicians should be aware of potential drawbacks, and when interpreters are fellow nationals, confidentiality issues can arise. Telephone interpreting may be preferred in some cases because it is anonymous, and it is best if the same interpreter is used for all the refugee's healthcare appointments.

**- Physical Examination**

Six records presented recommendations related to the torture survivor's physical examination (6, 7, 8, 17, 19, 30). The patient's history and physical examination should be consistent. Physical sequelae, such as chronic long-term pain, should not be overlooked. Healthcare providers should try to obtain explanations for scars, which they should measure, describe, and record in text using a diagram. Somatic problems can be exacerbated by new stress, therefore, they should be evaluated as both mental and somatic. Furthermore, the examination room should not resemble a prison cell, should be free of curtains or folding screens, and should be at a comfortable temperature. Healthcare providers should always explain procedures, give patients a sense of control, and allow them the ability to terminate interviews or stop examinations at any time.

**- Communication**

Four records presented several recommendations related to communication (7, 24, 28, 37). Healthcare providers may observe torture patients' nonverbal responses to inquiries and treatments to see if the questions are sensitive and if they want to explain or clarify their replies. Providers may also be unfamiliar with refugee communication habits, including avoiding eye contact and shaking hands with the opposite gender. Thus, doctors must comprehend their patients' cultural backgrounds. Because of the perceived power imbalance in their relationships with healthcare professionals, torture survivors may be hesitant to initiate conversations about torture and other traumatic experiences. As a result, even if they have physical torture evidence, survivors may be hesitant to tell their life stories and share information about traumatic experiences. Full disclosure and assessment of survivors' healthcare needs demand good communication skills (7).

**- Adjustments and Procedures During Treatment**

Recommendations related to necessary adjustments and procedures during treatment were presented in 13 records (3, 9, 10, 11, 14, 23, 28, 30, 31, 37, 38, 39, 40).

The records suggest that procedures that are reminiscent of torture, such as those involving electrical equipment or scans performed in enclosed tubes, be thoroughly explained. In most cases, procedures can be completed if healthcare providers do so. To reduce flashbacks, healthcare providers should create a tranquil environment, explain planned procedures, obtain fully informed consent, and facilitate the patient's control over procedures. Acute care can be difficult for survivors due to a lack of time for psychological preparation. For elective surgical hospitalizations, patients should receive an orientation and even walk through operating rooms and recovery rooms ahead of time. The anesthesia team and nurses should be on the lookout for the emergence of flashbacks. It is recommended that the consistency principle be followed by using the same staff throughout all treatments. Intraoperative sympatholytic therapy as well as patient education on the emergence of flashbacks, agitation, and interventions, may help patients cope with stressful situations during treatment.

Preparations for treatment should include a preoperative assessment consisting of medication control to identify medication used for psychiatric conditions and an evidence-based care plan for patients with flashbacks in the post-anesthesia care unit (PACU).

Patients who meet the criteria for a mental health disorder and require antiretroviral therapy should be offered psychotherapy due to the likelihood of the recurrence of PTSD symptoms. Effective antiretroviral medicines should be offered to torture survivors following exact information and a conversation with patients regarding the medication's potential role in increasing PTSD symptoms. Providing patients with a sense of control over evaluation methods and listening when they choose to reveal their trauma experiences during treatment is vital. In addition, it is crucial to inform them before making any sudden changes (turning off the lights, touching them from behind, etc.) and to educate them on the importance of taking medications and finishing treatments. Survivors can manage exams and procedures if they are provided with emotional support and information. Some treatments require

sedation for evaluation and execution. Providers should discuss incidents of torture with colleagues or seek supervision to preserve a therapeutic mindset and ensure effective treatment. To prevent damaging re- enactments, it is crucial to respond to patients with empathy, detect discrimination, and recognize enactments as well as one's own attitudes and faults.

**- Using Interpreters**

In this mapping review, 16 included studies presented recommendations for using interpreters (4, 7, 10, 11, 17, 20, 21, 22, 23, 24, 28, 30, 31, 32, 37, 40).

According to the recommendations, to maximize the quality of clinical encounters and minimize the risks of poor treatment outcomes, bilingual clinicians or certified professional interpreters should be involved in encounters with patients with a torture history. Using professional interpreters is recommended not only to ensure communication with patients but also to give them a sense of control. Interpreters are also covered by the confidentiality principle, and both healthcare providers and interpreters should be careful when dealing with sensitive topics. Tips for working with interpreters include reassuring the patient about confidentiality, maintaining eye contact, speaking directly to the patient, and using short, simple sentences with frequent pauses. The use of relatives as interpreters is not recommended because patients may not fully disclose their trauma for fear of hurting their relatives, or relatives may not provide an accurate translation because they are ashamed of the trauma history. At no time should children be used as interpreters for their parents or other relatives; interpreting services should always be offered. Even when survivors appear to be fluent at the first meeting, they may only be conversant in areas associated with education or work; they may not be fluent in describing emotions. It is recommended to always use professional interpreters, to book an interpreter for the first meeting, and thereafter if required.

### *3.2.3. Potential triggers and recommendations for managing triggers*

Of the 40 records, most described specific triggers as potential inducers of the re-traumatization process. Recommendations to neutralize, remove, or adapt triggers to patients' needs appear in Table 2. More than 50 factors within the clinical situation are presented as triggers potentially causing re-traumatization during treatment. Negative interactions with healthcare providers due to aggressivity, lack of interest, and lack of empathy are presented as important factors negatively influencing clinical encounters and treatment outcomes (10, 26, 30). According to the recommendations, healthcare providers must show a genuine interest in the patient's cultural background (4, 24). Most of the records list triggers, but not all offer ways to decrease or prevent re-traumatization. "Healthcare personnel wearing uniforms" is a common listed trigger, but no sources offer advice on how to decrease its impact. Electrical devices, electrodes, and noises are also highlighted, with some suggestions for reducing or eliminating their effects. Fig. 4 shows the 10 triggers that most articles include.

### *3.3. Quality assessment and evaluation*

To assess the methodological limitations of the studies in our sample, we used the JBI Critical Appraisal Checklists. A risk-of-bias table for each included study is presented in Tables S5–S5d. There were minor concerns about coherence related to emerging themes from text and opinion papers and from reviews (i.e., general recommendations, awareness, building trust, how or what to ask, physical examination, communication, using interpreters, treatment, and triggers). The findings are reasonably consistent within and across the included studies. There were no concerns about relevance and there were moderate concerns related to overall methodological quality. Three text and opinion papers raised minor concerns: In Behnia (2004), it was unclear if sources of opinion have standing in the field of expertise; in Nielsen and Jensen (2004), it was unclear if there is reference to the extant literature; and in Willey et al. (2022), it was unclear if any incongruence with literature or sources was logically defended. There were two reviews with minor concerns: In Baird et al. (2017), it was unclear if the likelihood of publication bias was assessed, and in Kassam (2019), it was unclear if methods were used to minimize errors in data extraction.

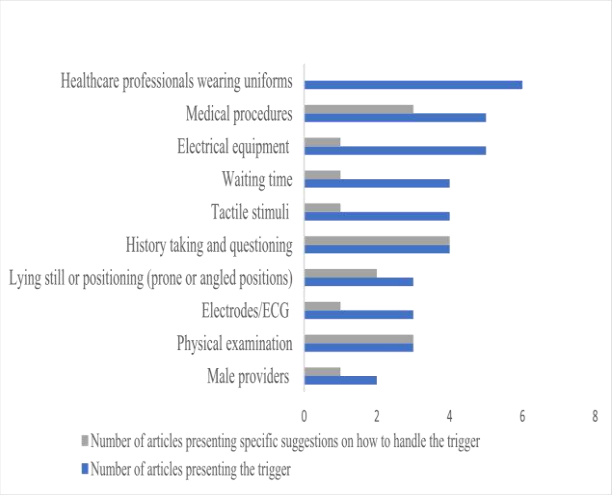


Fig. 4. The 10 triggers presented by most studies.

The emerging themes from the case reports (i.e., general considerations, treatment, and triggers) were reasonably consistent within and across studies. There were a few concerns about relevance but minor concerns related to overall methodological quality; for example, in Lovestrand & P. Steven Phipps CRNA (2013), it was unclear if the patient's history was clearly described and presented as a timeline and if adverse events (harms) or unanticipated events were identified and described. Regarding the themes presented in the qualitative studies (i.e., using interpreters and treatment), there were no concerns about relevance and minor concerns related to overall methodological quality (10, 23). The relevance of themes from the cross-sectional studies (i.e., general considerations, identification of torture survivors, what or how to ask, and triggers) were free from concerns, but there were minor concerns with methodology because no confounding factors were identified and no strategies to deal with confounding factors were stated. Concerning themes emerging from the included guidelines (i.e., general considerations, what or how to ask, and using interpreters), there were no concerns about relevance and there were minor concerns about methodology since no confounding factors were identified and no strategies to deal with confounding factors were stated. The CERQual Summary of Qualitative Findings is presented in Table S6.

The total AGREE II score of the two CPGs was, respectively, 264 points (20) and 239 (7) (out of 322), with an overall quality of 80% (7) and 70% (20). The lowest score for 23 individual items was for item 14, "A procedure for updating the guideline is provided" (2 points) for both guidelines. For Pottie et al. (2011), the domain "applicability" had the lowest score (domain 5; 69%); "editorial independence" had the highest score (domain 6; 92%); and domain 4 "clarity of presentation" had the second highest score of 88%. For Cohen and Green (2022), the domain "rigor of development" had the lowest score (domain 3; 56%), while the domains "scope and purpose" and "stakeholder involvement" had the highest scores (domains 1 and 2; 86%). The scores for 23 items by the reviewer and by domain are demonstrated in Table S7.

## 4. Discussion

To the best of our knowledge, this mapping review is the first to provide an overview of evidence related to torture survivors' treatment in somatic departments, presenting potential triggers causing re- traumatization and identifying recommendations to prevent re-traumatization. We excluded research within the psychiatric treatment of torture survivors and used an approach that included studies with different designs, reviews, and two CPGs. Psychiatry health personnel are more knowledgeable about trauma effects and are focused on treating trauma, whereas somatic healthcare services aim to treat physical illness by protecting patients from harm interfering with psychological trauma. Accordingly, this mapping review does not include guidelines that only apply to psychiatric departments. Although healthcare professionals working in somatic departments must understand torture trauma and its consequences, they are not intended to treat trauma. Offering recommendations designed only for psychiatry may cause frustration to healthcare providers because of their inapplicability in somatic clinical medical contexts, reducing the possibility of successfully implementing the recommendations (McArthur et al., 2021).

We found evidence related to somatic healthcare services, including physical, sociological, and psychological torture aspects, health, and disease. Our results suggest more evidence of torture survivors' experiences in healthcare is needed. The results indicate a low proportion of experimental studies involving refugees; most records were text and opinion publications based on the experiences of specialists working with torture survivors and only two studies offered case study research. Case study research is appropriate when the context is pertinent to the phenomenon being studied (Schoch, 2020). As the clinical context is significant to the phenomena of re-traumatization (Schock and Knaevelsrud, 2013), providing case study research of torture survivors' experiences of re-traumatization during treatment could offer us vital information on the subject. For example, an older case report (Gruber and Byrd, 1993) describes a 42-year-old Vietnamese prisoner of war requiring an endoscopic assessment of the gastrointestinal system. Through descriptions of the healthcare environment, recommendations for healthcare providers to enhance awareness of the special requirements of this patient population to prevent re-traumatization are provided. Our mapping review indicates an underutilization of the case study design for this patient group, which should be taken into consideration when planning future research.

With a comprehensive search strategy, this mapping review includes an important portion of publications within healthcare for torture survivors. The Istanbul Protocol (IP) (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) was published in 1999 as a set of common, international guidelines for the assessment of persons who allege torture and ill-treatment. The IP represents an important milestone of bringing a new and bigger focus on torture survivors into healthcare. For example, in 2009, the Forum for

Medicine and Human Rights at the Medical Faculty at the University of Erlangen-Nuremburg provided the first German edition of this manual (Furtmayr and Frewer, 2010). By including guidelines and recommendations from the last 20 years, we believe that this mapping review covers new and relevant evidence within the torture survivor's treatment in medical contexts. Since new evidence typically prompts updating guidelines and recommendations between 2 and 5 years after publication, we may also have covered guidelines published before 1999 and updated after the IP publication.

As the purpose of this mapping review is to summarize and discuss research on advice to prevent re-traumatization of torture survivors, we strive to convey the discovered recommendations in a transparent manner and the overall assessment of confidence in the research findings. Even so, it is crucial to note that some of the offered potential triggers in the included records are based on the authors' decision to interpret very literally the claims in some retrieved publications that provided little underpinning evidence. Some of the potential triggers were presented in a detailed way and the recommendations for managing these triggers were not adapted to a specific clinical context and may be difficult to apply in everyday clinical settings. The suggestions presented must be interpreted and adapted to the contexts of health professionals. For example, the suggestion of not having curtains is related to issues of avoiding a dark room; nonetheless, the absence of curtains can cause situations where patients become exposed, especially if there are other patients around. These instances requires health professionals to make a concrete assessment of recommendations and adapt them to each situation. Some recommendations may have a background not only in torture exposure but also in cultural aspects. For example, "Touching the foot is the only allowable type of tactile stimuli to reduce fear eliciting risks in touching the upper body" (Lovestrand and Steven Phipps, 2013). These instances may be applicable for some patients, but not all, depending on cultural aspects (Schirmer et al., 2022) and must also be considered in terms of context. If the upper body parts are assessed clinically, this proposal cannot be used. Such challenges may indicate that there is a need to develop applicable recommendations for specific clinical contexts.

Most of the publications represent studies conducted in the US and Western Europe. This effect may be related to the organizational system in these countries where treating torture survivors is delegated to specialized centers, also producing necessary research (Moa Nyamwathi Lønning, 2020). According to Moa Nyamwathi Lønning (2020), Denmark and England are countries in which these types of institutions provide a more structured healthcare response to torture survivors (Moa Nyamwathi Lønning, 2020) and both countries are represented the most in this mapping review's evidence. Only two records contained clinical guidelines. Although the guidelines are of high quality, the scarce amount indicates a general lack of clinical guidelines for healthcare providers on this topic.

Six studies focused on pain, while some of the other contexts as communication using interpreters, human rights, obstetrics, etc. are only addressed in one publication each. This can be explained by the existence of repetitive research on some themes, as reported by P´erez-Sales et al. (2017), who concluded that recent literature on torture neurobiology and re-traumatization has been among the most innovative and influential (P´erez-Sales et al., 2017). Nevertheless, we could not find publications on re-traumatization related to torture neurobiology. This may be because most of the publications included in this mapping review were text papers from experts and, according to P´erez-Sales et al. (2017), experts may see torture neurobiology as being unrelated to their everyday concerns (P´erez-Sales et al., 2017).

Few studies included participants; only three studies used qualitative interviews. This small number indicates that torture survivors are underrepresented in studies about treatment in somatic departments and re-traumatization. This may also indicate difficulties in recruiting refugees and torture survivors for research. Many torture survivors move around, between and within countries, searching for safety, work, and educational opportunities, indicating that researchers may exert greater effort to include survivors in research (Gabriel et al., 2017) so that their voices also become represented in studies focusing on re-traumatization during treatment in somatic healthcare departments. Furthermore, problems with sampling may create significant biases in the results presented in evidence about our understanding of torture survivors. Such a challenge has been discussed by Gabriel et al. (2017) and Dehghan and Wilson (2019), who provided advice on how to recruit refugees for research studies; ethical considerations related to recruiting torture survivors have also been presented in other publications (Gabriel et al., 2017; Dehghan and Wilson, 2019). A greater focus on this topic may also be needed, supporting research on torture survivors' treatment in somatic departments (Higson-Smith and Bro, 2010), and efforts to increase the amount of evidence based on torture survivors' experiences may be a priority.

Participants across the included studies were seldom identified by sex, which can introduce bias into research

about torture because men and women react differently to trauma and re-traumatization (Pabilonia et al., 2010). Still, most participants in the studies who reported sex were female. This variance seems to differ from what is presented in the literature as it is more difficult to recruit female participants in a research study on sensitive topics (Gabriel et al., 2017). Some studies included participants under the designation of migrants without specifying how many refugees and how many have experienced torture. Such a lack of specification can constitute bias since there is a difference in the experiences participants carry with them and how they react to trauma and re-traumatization (Holtz, 1998). Tortured refugees may have a different sensitivity level and different pattern reactions from others who have not been subjected to torture (Holtz, 1998; Jaranson et al., 2004).

The main themes from this mapping review provide a better understanding of what is recommended in the literature to prevent re- traumatization of patients with a torture history during their treatment in somatic healthcare services. The themes "Identification of torture survivors," "Triggers," and "Recommendations to prevent re- traumatization" provide an overview of the main triggers and recommendations presented in the literature. Identification of patients who are torture survivors is the crucial first step in such a patient's somatic treatment (Eisenman et al., 2000), requiring healthcare providers to have special skills, such as the ability to suspect and recognize torture survivors and ask them appropriate questions (Eisenman et al., 2000; Clarysse et al., 2019). According to the evidence from this review, healthcare providers' successful identification of patients who are torture survivors enables them to prepare for patients' treatment and to prevent re-traumatization. Preparing the environment, searching for information about the patient, the patient's country, and culture, and removing or adjusting eventual triggers according to the patient's needs are important tasks for preventing patients' re-traumatization under care (Johnson, 2005; Moreno and Grodin, 2002; Williams and Hughes, 2020).

Managing triggers is a vital aspect of preventing torture survivors' re- traumatization during treatment and almost all included studies discuss potential triggers and communicate suggestions for their effective management. It is important to note that some records describing triggers (Milosevic et al., 2012; Johnson, 2005) did not present a solution or intervention for removing or adapting the triggers to patients and situations. These solutions were found in other studies (Moreno and Grodin, 2002; Veliu and Leathem, 2017) or were not directly found in the literature included in this review (Crosby, 2013) and require the readers' interpretation. This mapping review may contribute to overcoming such a challenge since we tried to organize data. Although some articles had a rich description of triggers and patients' reactions to them (Høyvik and Woldstad, 2022), there is still a lack of suggestions on how to help patients when re-traumatization occurs, which should be prioritized in future research.

Evidence reinforces the importance of using interpreters even when patients appear fluent due to the difficulties of talking about traumatic experiences (Williams and Hughes, 2020). Additionally, it is recommended to be attentive to the potential secondary effects of using interpreters (Moreno and Grodin, 2002). Thus, healthcare providers must constantly weigh the advantages and disadvantages of using interpreters when treating torture survivors. Further research giving torture survivors opportunities to express their thoughts on this subject is needed.

Providing quality healthcare to torture survivors begins with awareness of a patient's torture history (Ahrenholz et al., 2015; Mollica, 2004). Knowing the history aids disclosure, facilitates appropriate management of eventual challenges under treatment (Williams and Hughes, 2020), and prevents re-traumatization (Moreno and Grodin, 2002). The subject of asking about torture is described as an inherent tension in the included studies. On the one hand, healthcare providers should ask patients directly about their torture history (Williams and Hughes, 2020) and support them in disclosing it (Mollica, 2004). Healthcare providers, on the other hand, are advised to avoid asking their patients about their torture history due to the risk of re-traumatization (Pottie et al., 2011; Quiroga and Jaranson, 2005). One study proposed that building trust in the medical context could help resolve this conflict (Behnia, 2004). According to some studies, disclosure should be avoided in situations of distrust (Behnia, 2004; Eisenman et al., 2000; Pottie et al., 2011).

Confidentiality related to patient-professional relationships is also mentioned as important to prevent re-traumatization. This concerns the healthcare providers' ethical obligations to maintain patient confidentiality in treatment settings. The challenge is that this is not absolute, varying within cultures and countries (Jones and McCullough, 2013), causing feelings of insecurity in torture survivors, especially those who experienced healthcare providers' involvement in torture (Ahrenholz et al., 2015). Torture survivors may also be accustomed to the maintenance of confidentiality in psychiatric contexts, with other possibilities of privacy during treatment and time expended on treatment. In contrast, the context in a somatic medical setting characterized by patients sharing rooms, healthcare

professionals rushing around, and the involvement of several healthcare providers in the treatment may be challenging for patients. This demands that healthcare providers adjust and improve the patient's confidentiality. Although the included studies mentioned the importance of maintaining confidentiality during treatment (Crosby, 2013), specific recommendations to handle described challenges are lacking in the literature. It also applies to the recommendation about employing consistency principles by using the same staff throughout all treatments. Characteristics of the medical context with staff rotation do not allow the use of the same staff through all treatments, but some adjustments can be made. Recommendations including this aspect are also lacking in the included studies.

In our review, two included CPGs provide recommendations concerning "the identification of torture survivors," "using interpreters," "physical examination," "communication," "general recommendations," and present "triggers." In Pottie et al. (2022), we identified the CPG domain "applicability" (how well healthcare providers are able to implement the CPG recommendations in their daily clinical practice) as the domain with the lowest score. In Cohen and Green (2022), the domain "rigor of development" (the process used to gather and synthesize evidence) was the domain with the lowest score. Other systematic reviews of CPGs on other healthcare topics have also presented low scores in these domains (Alonso-Coello et al., 2010). Nevertheless, in the included guidelines in this review, domain scores are above 50% (69% and 56%), causing moderate concerns about the presented recommendations. In terms of assessing the risk of bias, the included studies were found to be trustworthy. Nevertheless, recommendations presented by the included records can be difficult to implement in practice due to a lack of details and advice on how to implement them. Recent records, including one of the guidelines, recommend the implementation of trauma-informed care principles. This shows that literature with a focus on refugees follows the development of such a concept. Still, the included records do not present steps for implementation. This echoes findings in a systematic review reporting that, although the term is widely used, it is not well understood how to apply the concept in daily clinical practice (Raja et al., 2015). Considering the benefits (promoting physical and psychological safety for patients and building trusting relationships with them) that implementation of trauma-informed care principles can bring to the quality of services (Miller et al., 2019), further efforts should be made to develop concrete proposals on how to implement these principles within the treatment of torture survivors in somatic clinical contexts.

**5. Strengths and limitations**

Our mapping review is the first attempt to synthesize literature presenting recommendations to prevent re-traumatization of torture survivors receiving healthcare treatment, utilizing the JBI Critical Appraisal Checklist and AGREE II to evaluate the quality of the included studies and clinical practice guidelines. Nevertheless, evidence mapping has several limits, so it must be viewed with caution. The limited number of included guidelines was the primary constraint of the study. Despite our extensive systematic search, it is possible that unpublished or non-indexed studies were excluded. We only included records published after 2000; consequently, there may be substantial literature from prior years that were omitted. Another limitation is related to the exclusion of literature referring to psychiatric healthcare services. Including this type of literature in the mapping may have resulted in a richer outcome. Nonetheless, we followed a systematic and transparent review methodology to ensure the identification of the best available evidence. As a result, studies from diverse geographic regions around the world focusing on torture survivors were included. Nevertheless, as only Western nations are represented in the included studies, this may be a limitation of this mapping assessment as well as the difficulty of generalizing the conclusions to non-Western nations. While we hoped to include literature written in several languages in addition to English, no non-English-language publications met the inclusion criteria for this mapping review. As the search emphasized English-only terms, the results of the literature search may have been biased toward English- speaking nations. Most studies were text and opinion papers, and while these were prepared by experts in the field, the survivors' voices were not as well represented. More research into the perspectives and experiences of torture survivors who are re-traumatized during treatment is needed in the future to better understand this group of patients. More studies presenting healthcare perspectives and difficulties in delivering non-re-traumatizing healthcare services to torture survivors are also needed to supplement the suggestions presented in this mapping review. This viewpoint should be considered when developing future guidelines.

The guidelines included in this mapping review were assessed with AGREE II. We did not have many results from assessments with the same instrument for comparison because there were only two guidelines with similar scores. Overall, the domain reliability rates of AGREE II were high. Nevertheless, AGREE II does not provide an exact cutoff between high-quality and low-quality CPGs, forcing reviewers to decide on the cutoff and adding a source of bias.

The included studies present a few recommendations on how to handle situations in which the torture history is inconsistent with clinical findings or when patients are reluctant to tell their histories, causing healthcare providers to doubt patients. This recommendation refers to how healthcare providers generally meet torture survivors, and as a critical aspect of the clinical context, proposals must address the subject thoroughly. As a result, recommendations on how to deal with inconsistencies in the information provided by torture survivors may be a priority in developing guidelines. Our review summarizes proposals for the prevention of re-traumatization, but we still lack suggestions on how to help patients when re-traumatization occurs. This topic should be worked on and prioritized in further research by offering recommendations on how to detect re-traumatization occurrence during treatment and how to help patients. Parallel to this motion and considering the presented challenges related to torture survivors' reduced trust in healthcare providers together with challenges related to losing control during the treatment, more suggestions on how to take care of their special needs during perioperative care with general anesthesia are needed.

Future study is required to contextualize the guidance given in the literature to prevent the re-traumatization of torture survivors in healthcare settings.

## 6. Conclusions

According to the mapping review's findings, few studies have included torture survivors' perspectives on their re-traumatization experiences during treatment. Future research should consider this gap, and case studies with torture survivors and other qualitative studies can help build a body of evidence to inform practice. A lack of guidelines on the subject is also a source of concern. Themes emerging from the mapping review suggest that healthcare providers should be aware of survivors' language support needs, consider survivors' biopsychosocial contexts, demonstrate cultural sensitivity, and modify their own attitudes. Furthermore, they must identify tortured patients and determine when professional interpreters should be used. Several aspects should be addressed during treatment to manage triggers in a clinical setting, and several potential triggers were presented in this mapping review. Although the review's goal is to map and present evidence, we included additional information specific to the triggers presented. If these triggers arise in routine clinical practice, we propose avoiding potential triggers.

## Appendix B. Supplementary data

as much as possible when no solutions are available and adapting the guidelines to the specific clinical context. This tentative suggestion is a limitation of the mapping review as well as an area for future investigation. Creating context-specific recommendations should be a major priority. More research is also needed to develop more responsive guidelines due to the scarcity of studies and guidelines on the subject. It is critical to include torture survivors in research and to allow them to disclose their re-traumatization experiences during treatment. There are still no recommendations on how to identify symptoms that indicate the occurrence of re-traumatization. Identification of symptoms is beyond the scope of this review, and additional research is required.

### *6.1. Health administrators must facilitate training for healthcare professionals to*

Increase their understanding of torture and its consequences as well as their cultural competency and sensitivity. Health administrators may also prioritize the provision of qualified interpreters. Furthermore, health educators must play critical roles in developing future healthcare personnel's cultural competence and sensitivity. Healthcare providers should have access to guidelines and standards for treating torture survivors.

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## Data availability

No data was used for the research described in the article.

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Appendix A. Overview of the included records numbered from 1 to 40 and categorized following search strategy

| Number | Title |
|---|---|
| Report | |
| 1 | Amris (2004) Chronic pain in survivors of torture-psyche or soma? |
| 2 | Arthur and Ramaliu (2000) Crisis intervention with survivors of torture |
| 3 | Baird et al. (2017) Interventions for treating persistent pain in survivors of torture |
| 4 | Biggerstaff (2022) Review of Best Practices for Nurses Caring for Refugee and Immigrant Populations |
| 5 | Board et al. (2021) Torture-survivors' experiences of healthcare services for pain: a qualitative study |
| 6 | Clarysse et al. (2019) Skin lesions, differential diagnosis, and practical approach to potential survivors of torture |
| 7 | Cohen and Green (2022) Quality standards for healthcare professionals working with victims of torture in detention |
| 8 | Ferdowsian et al. (2019) Asylum medicine: Standard and best practices |
| 9 | Gutowski et al. (2022) Trauma-informed inpatient care for marginalized women |
| 10 | Høyvik et al. (2021) The torture victim and the dentist: The social and material dynamics of trauma re-experiencing triggered by dental visits 11 Høyvik and Woldstad (2022) Providing Dental Care to Torture Survivors |
| 12 | Kassam (2019) Understanding experiences of social support as coping resources among immigrant and refugee women with postpartum depression: An integrative literature review |
| 13 | Kira et al. (2022) The Effects of Torture in the Context of COVID-19 and Continuous Type III Trauma's Variants: The Peri-Post Type III Trauma Mental Health Syndrome in Syrian Torture Survivors |
| 14 | Lovestrand and Steven Phipps Posttraumatic stress disorder and anesthesia emergence (2013) |
| 15 | Lønning et al. (2021) "A random system": The organization and practice of torture rehabilitation services in Norway |
| 16 | McColl et al. (2012) The role of doctors in investigation, prevention, and treatment of torture |
| 17 | Milosevic et al. (2012) The NSW Refugee Health Service: Improving refugee access to primary care |
| 18 | Moreno et al. (2003) Recurrence of post-traumatic stress disorder symptoms after initiation of antiretrovirals including efavirenz: A report of two cases 19 Nielsen and Jensen (2004) The torture survivor |
| 20 | Pottie et al. (2011) Evidence-based clinical guidelines for immigrants and refugees |
| 21 | Siddiq and Rosenberg (2021) Clinicians as advocates in the face of refugee resettlement agency closures |
| 22 | Tribe and Farsimadan (2022) Guidance for clinicians when working with refugees and asylum seekers |
| 23 | Veliu and Leathem (2017) Neuropsychological assessment of refugees: Methodological and cross-cultural barriers |
| 24 | Wenk-Ansohn and Gurris (2011) Intercultural encounters in counseling and psychotherapy communication with the help of interpreters |

# Call for Contributions and Peer Reviewers

Voices Against Torture - VAT journal is a semi-annual journal launched in 2020 as an organic extension of the education, advocacy, and community-building mandate of the Vancouver Association for the Survivors of Torture (VAST). VAT aligns with the values and vision of the VAST community and hopes to lift the voices of torture survivors further to support resilience and dignity.

VAT aims to provide a platform for discussing torture prevention, improving awareness of and support for refugee and immigrant mental health, and highlighting global human rights concerns.

As an interdisciplinary and transdisciplinary journal, VAT invites submissions from a wide range of academic disciplines and actively seeks collaboration and conversation across disciplines. This approach intends to link theory and lived experience to social change, bringing together academics, activists, educators, therapists, healers, and those directly and indirectly affected by torture.

The Journal will consist of the following sections:

- Research Articles (6,000 – 8,000 words)-Our first publication will not have this section; the later publication will.
- Review Essays (<6,000 words)
- Notes from the Field (<4,000 words)
- Policy Review (<3,000 words)
- Creative Interventions and embodiment practices (1,000-3,000 words)
- Book Reviews (1,000-2,000 words)
- Letters to the editor(s)

## Submission Requirements

- Typed in the English language and double-spaced
- Font style: Times New Roman and Font Size:12
- Text submissions should be 500-700 words
- Manuscript only in MS-Word (*.doc or *.docx) format
- Image files (if any) in .jpg format, 300 dpi.
- References/bibliography need to be numbered if provided with the article.
- Follow APA 7th referencing and citation style consistently.

- Tables and figures should be inserted within the body of the text.

## Expression of Interest for Peer-Review

Voices Against Torture journal invites experienced peer reviewers in the area of human rights and torture to join the journal peer review panel. Since promoting the cause of human rights is a public good, we encourage volunteers to join the panel. Their contribution in this regard shall be formally acknowledged.

To register your interest, kindly send your detailed CV along with your expression of interest to vrdc@vastbc.ca

The editor, however, retains the right to suggest any change in style if required.

**Date of Publishing:** **Biannual: March and September**

**Submission:** **Open**

**Submission Deadlines:** **31st December and 30th June**

**Please send your submissions and feedback to the Editor-in-Chief at farooq@vastbc.ca**

## Peer Reviewers

Dr. Gilberto Algar-Faria
Dr. Nazia Hussain
Dr. Rastin Mehri
Dr. Nelofar Kiran Rauf

## EOI: Peer-Review

**Voices Against Torture** Journal invites experienced peer reviewers in the area of human rights and torture to join the journal peer review panel. Since the promotion of the cause of human rights is a public good, we encourage volunteers to join the panel. Their contribution in this regard shall be formally acknowledged.

To register your interest, kindly send your detailed CV along with your expression of interest to: vrdc@vastbc.ca

# Help Eliminate Torture: S.O.S. Appeal

Dear Patrons and Friends,

We, the Members of the Editorial Board of the Journal on VAT (Voices Against Torture- a newly incepted policy research communication organ of Vancouver Association of Torture Survivors (VAST), are gravely concerned over the worsening and deepening state of Torture in many parts of the world- Prohibition of Torture Index 2019-20 (Statista- https://www.statista.com/statistics/1131048/prohibition-of-torture-index-in-cis-by-country/)

As rightly maintained by the World Organization against Torture, "Nothing can justify torture under any circumstances (OMCT- https://www.omct.org/), for it is tantamount to imprisoning both mind and soul. Not only that Torture leave a lasting scar on the bodies and the minds of its victim(s), but as its psycho-social sequel, it also becomes a weeping wound for generations. In the recent past, an exodus of refugees (UNHCR -https://www.unhcr.org/figures-at-a-glance.html ), from many countries; and violence perpetrated against women (BBC- https://www.bbc.com/news/av/world-53014211 ) and neglect and abuse of the elderly during the Contagion COVID pandemic (AGE Platform Europe- https://www.age-platform.eu/press-releases/elder-abuse-has-been-rise-during-covid-19-pandemic-it-high-time-take-it-seriously ) signifies the emergent need to help arrest torture becoming endemic, as stipulated in humanitarian and human rights law, which has unfortunately taken a contagious proportion. In this backdrop, the emergent need for evidence-based/ informed policymaking & and advocacy around human rights; and rehabilitation & and mainstreaming of torture victims need hardly any emphasis. VAST, being mindful of this emergent need to cultivate respect for human rights as an underpinning factor for human security and containment of Torture worldwide, has chosen to reach out to the global stakeholders through VAT Journal.

Alongside VAT Journal, we plan to hold international & and regional workshop(s) via both in-person and online platforms. With this initiative, we aim to help spread awareness in trauma recovery and further educate civil society, academia, and the public sector to help develop Human Rights advocates and empower practitioners to help lead from the front lines of eradicating Torture from our world.

We at VAT Journal Editorial Board, through these lines, seek the support of the international community to join their heads and hands in this noble and emergent cause for the public good.

*Sincerely yours,*

**VAT Editorial Board Members:**

**Dr. Farooq Mehdi, Dr. Fizza Sabir, Dr. Wajid Pirzada, Leila Johnson, Dr. Patrick Swanzy, Dr. Rubina Hanif, Dr. Poulomee Datta, Dr. Hammad Ahmed Hashmi, Shazia Munir, Dr. Malik Hammad Ahmad, Mindy Levine**

**Vancouver Association for the Survivors of Torture, 2610 Victoria Dr, Vancouver, BC V5N 4L2**, **www.vastbc.ca http://vat.vastbc.ca/**

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- تشدد جي خلاف آواز

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