



A sociocultural exploration of trauma among refugee victims of torture

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IMPRIMATUR

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Le doyen
Pierre Alain Mariaux

p.o.
Michaela Nedelen
(Michaela)

To Constance, my constant, and our Bubby

"I have gathered a posy of other men's flowers and nothing but the thread that binds them is mine own."
John Bartlett

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ABSTRACT

Europe is living through a refugee crisis of historic proportions which has now become one of the continent's defining challenges of the early 21st century. The mental health impact of atrocities endured by refugee populations ¹ is clear, with the literature reporting significantly high prevalence rates of post-traumatic stress disorder (P.T.S.D.) among this population. However, there have been significant concerns raised over the relevance and cross-cultural validity of P.T.S.D. as a diagnostic construct. Furthermore, we cannot ignore the impact of the current economic, political, and sociocultural reality facing refugees on their mental health. We need to locate trauma experiences within sociocultural context. The thesis aims to do so by addressing the following questions:

- Which narratives of trauma circulate among the diverse actors working with refugees within various legal and medical activity systems? How is the diagnostic construct of P.T.S.D. used as a tool within these activity systems?
- How do the individual trajectories of individual refugees, diagnosed with P.T.S.D., unfold over time within this sociocultural context?
- How is trauma understood and made sense of by individual refugees? How is a diagnosis of P.T.S.D. accepted and understood (or not) by asylum seekers and refugees from culturally diverse populations?

The research is centred on a yearlong follow-up of 10 beneficiaries of the M.S.F. Victims of Torture (V.O.T.) Project in Athens and their partner organization, Babel. An average of five open-ended interviews were conducted with these individual participants. Further data was also gained through complementary sources in order to locate these individual narratives within a socio-cultural context. This included 43 semi-structured interviews with “key informants” - professionals working with this population (doctors, psychologists, psychiatrists, social workers etc.), 21 semi-structured interviews with community leaders of various refugee communities across Athens, and four months of participant observation in the project

The results, presented in the form of eight publications, highlight:

- i) the way in which a P.T.S.D. diagnosis is being used strategically as a cultural tool by various actors within medical and legal activity systems put in place to address the large influx of refugees arriving in Europe
- ii) the substantial impact of the current (sociocultural, legal, economic, and political) environment on refugee trauma trajectories
- iii) the culturally diverse narratives of trauma informing refugee mental health, which may compete, contradict, or conform to the narrative of trauma inherent to a diagnosis of P.T.S.D.

¹Throughout the thesis, the term “refugee” as defined by the Geneva Convention of 1951 is used to include both refugees legally recognised in a host country as well as asylum-seekers.

- iv) the multitude of ways in which refugees may exert a power to act as active agents, despite obvious power imbalances characterizing the medical and legal systems within which they manoeuvre

Key words: Trauma, PTSD, Sociocultural Psychology, Refugee, Asylum, Torture, Narrative

RESUME

La migration est devenue l'un des sujets majeurs pour le continent européen en ce début de XXI^e siècle. Les besoins en accompagnement psychologique des populations de réfugiés sont reconnus, la littérature faisant notamment état d'un taux de prévalence significativement élevé du syndrome de stress post-traumatique (SSPT) au sein de cette population. Toutefois, la pertinence et la validité interculturelle du SSPT en tant que construction diagnostique fait l'objet de critiques et d'interrogations. En outre, nous ne pouvons figer les besoins de réfugiés à leur situation pré-migratoire et ignorer l'impact des réalités économiques, politiques et socioculturelles auxquelles ils sont confrontés tout au long de leur parcours migratoire, au sein des pays d'accueil et de destination, sur leur santé mentale. Nous devons situer les expériences traumatisantes dans leur contexte socioculturel.

La présente thèse vise à le faire en abordant les questions ci-après :

- Quels récits du traumatisme circulent parmi les divers acteurs travaillant avec les réfugiés dans le cadre des systèmes d'accompagnement et de prise en charge juridiques, sociaux et médicaux ?
- Comment la construction diagnostique du SSPT est-elle utilisée comme outil par et au sein de ces systèmes ?
- Comment les trajectoires individuelles de chaque réfugié diagnostiqué avec un SSPT se déroulent-elles dans le temps dans leur contexte socioculturel ?
- Comment le traumatisme est-il perçu par chaque réfugié ?
- Comment un diagnostic de SSPT est-il accepté et compris (ou non) par les réfugiés issus de populations culturellement diverses ?

Cette recherche est centrée sur un suivi d'une durée d'un an de dix bénéficiaires pris en charge au sein du projet de Médecins sans Frontières pour les Victimes de Torture à Athènes et par une organisation partenaire, Babel. En moyenne, cinq entretiens ouverts et individuels ont été menés avec chaque participant. Des sources complémentaires ont également été consultées, afin de situer ces récits individuels dans leur contexte socioculturel. Ces dernières comprennent 43 entretiens semi-structurés avec des « informateurs clés » - des professionnels travaillant avec cette population (médecins, psychologues, psychiatres, travailleurs sociaux, etc.), 21 entretiens semi-structurés avec des responsables de diverses communautés de réfugiés à Athènes, et quatre mois d'observation des participants au projet.

Les résultats, présentés sous forme de huit publications, mettent en évidence :

- v) la manière dont un diagnostic de SSPT est utilisé stratégiquement comme outil culturel par divers acteurs au sein des systèmes d'accompagnement et de prise en charge sociale, médicale et juridique ;
- vi) l'impact considérable de leur environnement actuel (socioculturel, juridique, économique et politique) sur les trajectoires de traumatisme des réfugiés ;

- vii) les récits culturellement divers du traumatisme informant la santé mentale des réfugiés, parfois en concurrence, contradiction ou conformité avec le récit du traumatisme tel que porté par un diagnostic de SSPT ;
- viii) les multiples manières dont les réfugiés peuvent exercer leur pouvoir d'action, malgré les déséquilibres de pouvoir évidents caractérisant les systèmes d'accompagnement et de prise en charge sociaux, médicaux et juridiques au sein desquels ils évoluent.

Mots Clés: Traumatisme, SSPT, Psychologie socioculturelle, Réfugié, Asile, Torture, Récit

LIST OF PUBLICATIONS

Chapter six:

- 1) Womersley, G., & Kloetzer, L. (2018). Using Cultural-Historical Theory to Explore Trauma among Refugee Populations in Europe. *Kul'turno-istoricheskaya Psikhologiya [Cultural-Historical Psychology]*, 14(1), 87-97.

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- 2) Womersley, G., & Kloetzer, L. (work in progress) “Crying makes your story more believable”: N/narratives of trauma within the asylum seeking process.
- 3) Womersley, G., & Kloetzer, L. (2018). « En Afrique, aller voir le psychologue, je n’ai jamais entendu ça »: interprétations croisées du psycho-traumatisme entre médiateurs culturels, professionnels de santé et réfugiés victimes de torture à Athènes. *Revue Européenne des Migrations Internationales*, 34(2), 29-54.

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- 4) Womersley, G., & Kloetzer, L. (2018). Voies de « resubjection » chez les demandeurs d’asile victimes de torture. *Nouvelle Revue de Psychosociologie*, 25(1), 131-146.
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Chapter ten:

- 8) Womersley, G. (2019). A Sociocultural Exploration of Shame and Trauma Among Refugee Victims of Torture. In C. H. Mayer, & E. Vanderheiden (Eds.), *The Bright Side of Shame* (pp. 103-116). Cham: Springer.

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CHAPTER ONE: Introduction

As Time Magazine reported in October 2015: “Wave after wave, Europe is facing the largest number of immigrants since WWII.” We are now witnessing the highest level of displacement on record. According to the United Nations High Commission for Refugees (UNHCR), an unprecedented estimated 362,000 refugees² risked their lives crossing the Mediterranean Sea in 2016, with roughly 173,000 arriving in Greece. This movement towards Europe continues – with 140,000 and 125,000 estimated arrivals in 2018 and 2019 respectively. This is a challenge of historic proportions – with subsequent evolving responses now one of Europe’s defining challenges of the early 21st century (Farhat et al., 2018; *Médécins Sans Frontières*, 2016; UNHCR, 2015). Not least among the difficulties are public health challenges of the multiple potentially traumatic experiences faced by this population: the loss of loved ones or caregivers and/or livelihood, the destruction of property, insecure living conditions, war, torture, imprisonment, terrorist attacks, abuse, and sexualised violence, among others. Furthermore, trauma does not stop at the border. A plethora of literature attests to the potentially traumatic impact of post-migration factors with which many refugees are faced upon arrival in host countries (Bhugra & Gupta, 2011; Greene et al., 2017; Greene et al., 2019; Heeren et al., 2014; Schick et al., 2018; Schouler-Ocak et al., 2016; Sijbrandij et al., 2017; Silove, Ventevogel, & Rees, 2017; Ventevogel, Ryan, Kahi, & Kane, 2019; Wenzel & Droždek, 2018). Many seeking asylum experience shock and humiliation at being treated “like criminals” – a manifestation of disempowering symbolic violence (Cleveland et al., 2018). In the post-migration context, potentially traumatic experiences may be related to harsh living conditions, the erosion of mutual social support mechanisms, limited access to basic needs and services and lack of opportunities for maintaining livelihoods and education (Greene et al., 2019; Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2018). Recently, the notion of “slow violence” – a term originally used by President Nixon - has been drawn upon to describe the slowly unfolding everyday violence of enforced poverty which characterizes the lives of so many people seeking asylum in Europe today (Mayblin, 2019). Furthermore, refugees may be facing these stressors in situations where the capacity for self-help and mutual support has been negatively impacted by forced migration, the separation from families and communities, collective violence and mistrust (Sijbrandij et al., 2017).

The severe impact of exposure to potentially traumatic events on the mental health of this population are pervasive and profound - constituting threats to human, social, cultural, and community development (d’Halluin, 2009; *Médécins Sans Frontières*, 2016; Ventevogel et al., 2019; Wilson & Droždek, 2004). This impact has become an object of increased attention since the turn of the century, both in the scientific domain but also within public discourse regarding the influx of migrants (d’Halluin, 2009). In the realms of journalism, social media and public discourse more generally speaking, the notion of “trauma” is invoked repeatedly to testify to the significant level of mental health difficulties (Summerfield, 2000b). Attention to potentially traumatic incidents has also increased in the humanitarian field over the last decade in

²Throughout the thesis, the term “refugee” as defined by the Geneva Convention of 1951 is used to include both refugees legally recognised in a host country as well as asylum-seekers.

particular, with programmes focusing on mental health and psychosocial support now routine elements of a humanitarian response to refugee crises (Weissbecker et al., 2018). It has even been suggested that all forced migrants experience some degree of post-traumatic symptomatology (Copping, Shakespeare-Finch, & Paton, 2010). Furthermore, exposure to potentially traumatic experiences in the host country impedes process of adaptation and acculturation (Steel, Dunlavy, Harding, & Theorell, 2016). The vastness of the dual phenomena of trauma and migration has therefore led it to become an urgent area of inquiry – with research into the key determinants of refugee trauma and potential opportunities to improve mental health now a pressing concern (Hall & Olf, 2016; Tessitore & Margherita, 2017).

Post-Traumatic Stress Disorder (P.T.S.D.) among refugee populations

The literature overwhelmingly attests to significantly high prevalence rates of post-traumatic stress disorder (P.T.S.D.), anxiety and depression among refugee populations when compared to the general population of host communities (Abbott, 2016; de Arellano & Danielson, 2008; Kirmayer, Kienzler, Afana, & Pedersen, 2010; Lambert & Alhassoon, 2015; Schweitzer, Melville, Steel, & Lacherez, 2006; Steel et al., 2009; Sturm, Baubet, & Moro, 2010; Van Ommeren et al., 2001; Weine, Kuc, Eldin, Razzano, & Pavkovic, 2001). In a recent study of over one million people in Sweden, Hollander and colleagues (2016) found that refugees granted asylum were, on average, 66% more likely to develop schizophrenia or another non-affective psychotic disorder than non-refugee migrants from the same regions of origin. This finding confirms a previous meta-review of the literature by Porter and Haslam (2005) who found evidence that refugees from the former Yugoslavia suffered significantly more mental health impairment than non-refugees from the same region across multiple studies.

In terms of P.T.S.D. in particular, two landmark, systematic meta-reviews found prevalence rates among refugee populations of 40% (Turrini et al., 2017) and 30.6% (Steel et al., 2009) respectively. Another meta-review noted that P.T.S.D. prevalence rate among first generation migrants in general and refugees/asylum seekers ranged from 9 to 36 % compared with reported prevalence rates of 1–2 % in the general population (Close et al., 2016). In a recent meta-review of conflict-related forced displacement, P.T.S.D. prevalence rates were consistently high: data varied between 2.2 and 88.3% (Morina, Akhtar, Barth, & Schnyder, 2018). There is evidence that these high prevalence rates of P.T.S.D. persist several years after displacement, both in countries of settlement and refugee camp contexts (Bogic, Njoku, & Priebe, 2015; Kaltenbach, Schauer, Hermenau, Elbert, & Schalinski, 2018; Nickerson et al., 2018).

Exposure to torture has emerged as a particular triggering factor of P.T.S.D. symptomatology (Haenel, 2015; Hodges-Wu & Zajicek-Farber, 2017; Mollica, McInnes, Poole, & Tor, 1998; Silove et al., 2017; Song, Subica, Kaplan, Tol, & de Jong, 2017). According to a recent study among Syrian refugees in Sweden, for example, those exposed to torture were approximately three times more likely to have clinical level symptoms of P.T.S.D. (Tinghög et al., 2017). This

is no surprise. Refugee victims of torture (V.O.T.s) are exposed to a multiplicity of challenges. The potential for exposure to traumatic events inherent in being both a V.O.T. as well a refugee is related to a myriad of losses, human rights violations and other dimensions of suffering linked not only to torture experienced pre-migration, but to different forms of violence experienced during and after migration as well. Indeed, refugee V.O.T.s “often present a complex constellation of symptoms further complicated by cultural variables and post-migration factors including immigration legal issues, economic challenges, diminished social networks, shifting power dynamics, bereavement, and other prolonged stressors” (Hodges-Wu & Zajicek-Farber, 2017, p. 72). The literature suggests that being exposed to torture not only directly leads to higher odds for developing P.T.S.D., but also has a detrimental influence on the individual’s social interactions and social support, which in its turn further heightens the risk for development of P.T.S.D. (Gottvall, Vaez, & Saboonchi, 2019).

The problem with P.T.S.D.

Despite the high prevalence rate of P.T.S.D. noted among refugee populations, the authors of the above-mentioned meta-reviews examining epidemiological data have all highlighted the substantial variability of prevalence rates across symptoms – with a variability range as wide as 0 to 99% (Z. Steel et al., 2009). This discrepancy remains unexplained (Bogic et al., 2012). Larger and more rigorous surveys were found to report lower prevalence rates than did smaller studies, but significant variability persisted across the board (Fazel, Wheeler, & Danesh, 2005; Morina et al., 2018; Silove et al., 2017). Furthermore, a re-analysis of the data of the meta-review by Steel (Steel et al., 2009) conducted by the World Health Organization in 2013 yielded rates of only 15.4% for P.T.S.D. (Nickerson et al., 2018). A number of factors play a role. This includes the level of exposure to potentially traumatic events before, during and after migration, as well as resettlement conditions in the host country. All are thought to influence the prevalence rates – which appear to be dose-dependent (determined by the level of exposure to such events) and occurring in a curvilinear pattern across the resettlement period (Copping et al., 2010; Schick et al., 2016; Turrini et al., 2017). Epidemiological studies regarding the prevalence rate of P.T.S.D. have therefore been criticised for a “snapshot” approach of cross-sectional studies which don’t distinguish migration trajectories with any accuracy – and lack the sensitivity to distinguish between symptom trajectories that indicate recovery as opposed to chronicity (Silove et al., 2017).

A growing body of research demonstrates the substantial and negative impact post-migration factors (including socioeconomic difficulties, as well as stressors relating to the asylum seeking process) may have on mental health (Li, Liddell, & Nickerson, 2016). A recent study conducted by *Médecins Sans Frontières* (2016) among asylum seekers in Italy found that significant differences in prevalence rates were related to gender, the state of vulnerability, nationality, the waiting time before being seen by a specialist, and exposure to potentially traumatic events before, during and after migration. This is a particularly relevant consideration for the mental health of refugees in light of the multiple and arguably ongoing environmental stressors and potentially traumatic experiences with which they are faced. In a multi-agency guide on the

mental health of refugee populations released in 2015, UN agencies and other international humanitarian organizations have highlighted the fact that - for most refugees and migrants - potentially traumatic events from the past are not the only, or even most important, source of psychological distress but that the majority of emotional suffering is directly related to current stresses and worries and uncertainty about the future (Eleftherakos et al., 2018; *Médecins Sans Frontières*, 2016; IASC, 2015; MHPSS, 2015).

Cross-sectional epidemiological studies do not allow for a clear distinction to be made between symptoms of post-traumatic stress related to current contextual stressors within the environment (for example, facing refugee populations in host communities) and a diagnosable mental disorder – based on a psychiatric formulation of mental health located at the level of the individual (Silove et al., 2017). The medicalisation of experiences of trauma on an individual level, linked to fixed “traumatic” events in the past, risks rendering us blind to other ongoing aspects of interpersonal, political and social violence on a more global scale, including significant post migration factors which may be deemed equally traumatic by refugees (Maier & Straub, 2011; Silove, Steel, McGorry, & Mohan, 1998; Silove, Steel, & Watters, 2000; Weissbecker et al., 2018). It also neglects the broader socio-political context within which it occurs (Marsella, 2010; Summerfield, 2001; Young, 1995). Narrowing refugees to stories of trauma, it is argued, stabilizes their experiences too firmly within personal histories of victimisation and injury. It focuses attention on therapeutic outcomes rather than a political response to the structural issues exposing communities to potentially traumatic events (Pratt et al., 2015). Among refugees, this criticism could also extend to scant attention being paid to their current social, political and economic realities and lived daily experiences in host countries (Silove et al., 2000; Watters, 2001). As recently noted by Wenzel and Droždek (2018), the emphasis on vulnerability tends to minimize refugee resiliency and agency, and may not adequately represent the heterogeneity found across refugee populations.

Furthermore, there have been significant concerns raised in the literature over the relevance and cross-cultural validity of P.T.S.D. as a diagnostic construct being used among refugee populations (Bracken, 2001, 2002; Fisher, 2014; Hinton & Lewis-Fernández, 2011; Janoff-Bulman, 1985; Kirmayer et al., 2010; Marsella, 2010; Staeuble, 2004; Summerfield, 2001; Tummala-Narra, 2007; Wasco, 2003; Young, 1995). Notably, the diagnosis has been criticized for ignoring significant variability among symptoms evident in different cultural settings across the world (Hinton & Lewis-Fernández, 2011). One example of this variability which continues to attract considerable debate is the prevalence of psychosomatic symptoms found among some cultures and not others (Eagle, 2014). Not only do our reactions to potentially traumatic events differ according to cultural norms, but the very appraisal of what is or what is not traumatic may similarly be informed by socio-cultural context. Various cognitive and psychodynamic theories purport that the individual’s processing of potentially traumatic events (i.e. their cognitive appraisal or making sense of the event) is informed by internalized representational constructs, both influenced by and reflected through language and culture (Brewin, Dalgleish, & Joseph, 1996; Droždek & Wilson, 2007; Sturm, Baubet, & Moro, 2007; Sturm et al., 2010). The way in which such events are experienced is thus thought to be significantly determined by larger cultural systems and historic contexts (Carlson, 2005; Kirmayer et al., 2010; Marsella,

2010; Marsella, Friedman, & Spain, 1996; Mattar, 2011; Rousseau, Drapeau, & Corin, 1997; Tummala-Narra, 2007; Wilson & Droždek, 2004).

A singular construct of P.T.S.D. is simply inadequate to grasp the complexity inherent in how different human beings in different cultures respond to terrifying events (Marlowe, 2010; Steel, 2001; Summerfield, 2001). Scholars such as Momartin *et al.* (2003), Tummala-Nara (2007) and Afana *et al.* (2010) highlight how little attention has been given to the impact of traumatic experiences on migrants from diverse religious and cultural backgrounds. They argue that refugee populations in particular are exposed to a multiplicity of challenges including losses, human rights violations and other dimensions of suffering. However, the “benign universe” model inherent to the construct of P.T.S.D., is based on white middle-class populations where traumatic events are considered to be infrequent and outside of the range of normal human experience. The relevance of a P.T.S.D. diagnosis is therefore questionable among certain cultures continually exposed to traumatic stressors (Afana *et al.*, 2010; Marsella, 2010) where traumatic events may actually validate instead of violate one’s assumptive worldviews (Tang, 2007).

Briefly put, one could deconstruct the very notion of ‘P.T.S.D.’ by breaking it up into its various linguistic constituents (Post, Traumatic, Stress and Disorder) in order to examine some of the major criticisms which have been levelled against it. The first word, ‘Post,’ refers to a discrete event of the past, thus denying the mental health impact of any ongoing factors of mental distress based on current economic, political and social hardships faced by refugee populations. The second word, ‘Traumatic,’ is problematic insofar as whether an event is perceived to be “traumatic” or not is in part influenced by the individual’s subjective perception of the event, in turn significantly informed by socio-cultural and historical context. The third word, ‘Stress’ implies a specific reaction to the event based on a pre-determined range of psychological symptoms, thereby neglecting the wide range of possible reactions an individual may have to a potentially traumatic event. The fourth word, ‘Disorder,’ necessarily pathologises this reaction, placing it at the level of the individual and squarely within the framework of Western medical discourse. Such reductionist medical discourse arguably stabilizes experiences too firmly within personal histories of victimisation and injury (Pratt, Johnston, & Banta, 2015). Therefore, rather than portraying refugees as homogenous and pathologised “passive victims” suffering from mental health problems, critics have argued that attention should also be given to the resistance of refugees and asylum seekers and the ways in which they interpret and respond to experiences. This includes challenging the external forces bearing upon them and allowing space for the articulation of experiences in their own terms (Harvey, 2007; Tummala-Narra, 2007; Watters, 2001).

Apart from putting into question the validity of a P.T.S.D. diagnosis among refugee communities, the significant discrepancy among prevalence rates provides us with an important reminder that not all refugees are traumatised – a seemingly logical yet oft-neglected fact. The myriad of mental health experiences of refugees are indeed far more complex than can fit into overly simplistic discourses of trauma. Marlowe (2010) is among the many authors who have

highlighted the importance of considering alternative discourses around migration “for developing more sophisticated understandings of how people have responded to trauma beyond the ‘event-worthy’ underpinnings of forced migration” (p.1). She implores a move beyond the “refugee” label, noting that “the story of a person’s experience(s) of trauma associated with forced migration and how it has negatively influenced his/her life can overshadow other co-existing stories which can emphasize something very different about what a person values and readily identifies with” (p. 1). Loizos (2002) similarly problematizes the term “refugee” as often dependent on sometimes arbitrary political decisions. He criticises accompanying discourses around the label fuelling common myths such as the idea that a refugee is usually or necessarily traumatised by the experience of forced migration; that a refugee is a helpless and dependant person; that a refugee is socially isolated; that a refugee will have difficulty in adjusting to life in a new country because of “cultural differences;” and that a refugee needs “across the board” support. Indeed, it has similarly been noted that the process of migration may in fact reinforce internal and group psychological resources (Sturm et al., 2010). As noted by Papadopoulos (2002a), “refugees are defined not as a group of people exhibiting any specific psychological condition but merely as people who have lost their homes” (p. 9).

As neatly summarized by Ventevogel and colleagues (2019),

- Firstly, P.T.S.D. is not the only mental health problem in humanitarian setting
- Secondly, in many cultural settings, people do not have words or concepts for “trauma” or other stress-related mental disorders, or, if they have, these are remarkably different from the prevailing psychiatric definition of P.T.S.D.
- Thirdly, there has been sharp conceptual criticism of posttraumatic stress disorder as a “psychological construct” that obscures the driving socio-political causes of emotional distress and transforms human suffering into a mental disorder in need of treatment
- Lastly, the emphasis on past traumatic events in the development of current emotional distress may ignore the pathogenic role of everyday stressors and the multiple hassles to survive in situations of hardship

Calls for a more contextualised understanding of trauma

Rather than portraying refugees as “passive victims” suffering from mental health problems, critics have argued that attention should be given to the resistance of refugees and the ways in which they interpret and respond to experiences. This includes challenging the external forces bearing upon them and allowing space for the articulation of experiences in their own terms, including discourses of resilience and post-traumatic growth (Harvey, 2007; Tummala-Narra, 2007; Watters, 2001). The notion of “Adversity Activated Development” has similarly been conceptualised by Papadopoulos (Papadopoulos, 2002a, 2002b, 2007) to refer to the phenomenon whereby refugees may not only be resilient in the face of exposure to potentially traumatic events, but that such adversity may conversely lead them to develop as individuals with new psychological resources. A psychiatric diagnosis such as P.T.S.D. has the potential to

deny these realities, to pathologise individuals and homogenously to identify all members of minority groups as passive victims. By placing human suffering within such an exclusively medicalised and trauma-focused paradigm, a thin description of the individual is created where other important socio-historical considerations are easily lost or hidden (Marlowe, 2010). It's an approach which neglects "a concern not to impose order on the world but instead to allow the emergence of other voices and visions, even if this involves increasing complexity and ambivalence" (Bracken, Giller, & Summerfield, 1997, p. 435).

Individual responses to potentially traumatic events are thus increasingly understood as unfolding within the context of systems of relationships which form the environment, as defined by Bronfenbrenner's (1986) Ecological Systems Theory. As Harvey (2007) notes, this ecological perspective is needed to guide inquiries into the understanding of trauma resilience. This is because it incorporates a "resource perspective" which assumes that human communities, like other living environments, evolve adaptively and are deeply embedded in complex and dynamic social contexts in which resources are exchanged. Individuals within this system are capable of negotiating and influencing, as well as being influenced by, this system. Equally, symptom severity is not static but fluid and changing according to a continuum of pathological reactions (Droždek, 2015; Droždek, Rodenburg, & Moyene-Jansen, 2020).

In recent years, there has indeed been a burgeoning of theoretical models for understanding refugees' exposure to potentially traumatic events that situates individual sequelae and recovery within inter-personal, political, and social context. Maercker and colleagues (Maercker & Hecker, 2016; Maercker & Horn, 2013) have recently elaborated and extended a social-interpersonal framework model of P.T.S.D. incorporating a host of influential factors external to the individual. Droždek's (2015) model, Harvey's (2007) "ecological" model, Marsella's (2010) interactive model, and De Jong's (2007b) ecological-cultural-historical model of "traumascape," similarly explore how culture influences the clinical parameters of the diagnostic criteria for P.T.S.D. These models incorporate a systemic understanding of local representations and experiences of potentially traumatic events. Miller and Rasmussen's (2017) ecological model highlights how "mental health among refugees and asylum seekers stems not only from prior war exposure, but also from a host of ongoing stressors in their social ecology, or displacement-related stressors" (p. 1). Such multisystem, ecosocial frameworks consider exposure to potentially traumatic events among refugee populations as

"the endpoint of an imbalance in the multiplicity of countervailing environmental factors that impact on refugees rather than an expression of innate or intrapsychic problems at an individual level. In that sense, the distinction between normative and pathological responses is somewhat blurred and fluid, the vicissitudes of the ecological context determining the direction and extent to which individuals shift on a continuum of stress" (Silove et al., 2017, p. 133)

Such perspectives take into account the fact that symptom severity is fluid, ever changing due to a myriad of interacting intrapsychic and external factors. This requires that we pay attention to the "various, context-dependent, long-term, and complex social, political, and economic measures" affecting the mental health of refugee populations (Wenzel & Droždek, 2018), p. xii).

Adapting mental health interventions and research

As recently noted by Goguikian Ratcliff and Rossi (2015),

“if illness is individual, then we understand that health is collective: the status, place and experience of the human face of health and disease, the modes of social responses and institutions are reconfiguring themselves in a logic of supply and demand, strongly influenced by contemporary social and cultural transformations” (p. 8).³

It is crucial that experiences of exposure to potentially traumatic events are understood as being situated within a specific sociocultural and historical context. Indeed, the past several years of mental health interventions for refugee populations in particular has moved from being exclusively focused on P.T.S.D. (and accompanying specialist interventions) towards a more inclusive and communal approach which recognises cultural variance in mental health as well as the need to develop resilience within already existing health, social and community systems (Weissbecker et al., 2018). This second approach encompasses the increasing trend towards collaborative, integrated and interdisciplinary care for survivors of torture in particular, which aims to provide coordinated, compassionate, and comprehensive support (Esala, Vukovich, Hanbury, Kashyap, & Joscelyne, 2018; Hodges-Wu & Zajicek-Farber, 2017). However, it must be noted that there remain ongoing divisions in the field regarding the risks and benefits of these two approaches (Silove et al., 2017).

Despite a growing trend towards community based interventions aimed at privileging local cultural knowledge and practices, existing cultural and contextual information is rarely utilized effectively to inform the design of programs aimed at addressing the mental health of refugee populations (Greene et al., 2017). A significant void in our knowledge still exists regarding the relation of culture to experiences of potentially traumatic events and the relevance of a P.T.S.D. diagnosis to refugee populations (Droždek & Wilson, 2007; Mattar, 2011; Summerfield, 2000a). One striking example of this gap in our knowledge can be found in an interesting review of tools used to measure levels of P.T.S.D. among refugees conducted by Hollifield *et al.* (Hollifield et al., 2002). They found that of the 125 different instruments used among refugee populations, only 12 were explicitly developed in a refugee sample. This skewed focus on existing tools and concepts created for a western population is problematic as it neglects the cultural and linguistic heritage which influences which experiences are interpreted as “traumatic,” the manifestations and expressions of post-traumatic symptomatology, the interpretation of symptoms, narratives of distress as well as healing models (Droždek, 2007; Janoff-Bulman, 1985; L. Kirmayer et al., 2010; Kleinman & Good, 2004; Luno, Beck, & Louwerse, 2013; Marsella, 2010; Z. Steel et al., 2009).

Inflexible clinical practice drawing on Western diagnostic categories may not take into account the sociocultural context in which experiences of potentially traumatic events unfold for refugee populations – an understanding which could be essential in the interpretation and definition of a psychotherapy (*Médecins Sans Frontières*, 2016). From a public health perspective, the need

³ Loose translation

for culturally relevant tools to accurately detect and predict responses to potentially traumatic events among refugee populations is clearly of no small concern. Clinicians and academics working with such populations have similarly highlighted the continued lack of systematic knowledge regarding concepts of illness, leading health professionals to ignore or misunderstand their needs (Faregh, Lencucha, Ventevogel, Dubale, & Kirmayer, 2019; Greene et al., 2017; Maier, 2006; Maier, Schmidt, & Mueller, 2010; Maier & Straub, 2011; Ventevogel & Faiz, 2018; Wenzel & Droždek, 2018).

Addressing the gap in the literature – implications for research

As noted by Li and colleagues (Li et al., 2016) in a recent meta-review, the majority of research investigating the effect of post-migration stressors on mental health in refugees has focused on identifying which factors most strongly predict psychopathology in a rather static manner. Rather, there is a need to explore *how* the interaction of these factors affect mental health as it develops over time and within specific sociocultural and historic contexts. A plethora of key authors in the field have highlighted substantial gaps in the literature by calling for more longitudinal studies to add to our understanding of exposure to potentially traumatic events from a more culturally, socially and politically relevant perspective. This includes a focus on life trajectories, dynamic processes and current material realities for refugees in host communities which goes beyond the individual to consider the interrelation of mind and society in human development (Eagle, 2014; Harvey, 2007; Nickerson et al., 2011; Goguikian Ratcliff & Rossi, 2015; Summerfield, 1996, 2001b; Wilson & Droždek, 2004). Droždek and colleagues (2020), for example, have recently suggested that future research be based on an in-depth focus on the longitudinal trajectories of those impacted by potentially traumatic events - taking into account the complex ecological and environmental factors that shape these trajectories. In addition, there are calls to enrich understandings of “historical trauma” (Gone, 2013) or collective, cultural, and identity-related trauma, with an emphasis on the social location of human subjects and a recognition that experiences of potentially traumatic events may carry a sense of group burden and collective suffering beyond symptomatic individuals (Eagle, 2014).

These calls for more research has been echoed not only in the world of academia but by many international humanitarian organisations engaged in the implementation of mental health and psychosocial interventions with refugees across Europe and who are looking for more culturally relevant tools (which consider more local idioms of distress, for example) to better address the mental health needs of this population (Einhorn, Rivière, Chappuis, Chevelle, & Laurence, 2018; Faregh et al., 2019; *Médécins Sans Frontières*, 2016; Hecker, Braitmayer, & van Duijl, 2015; IASC, 2015; Tol et al., 2014; UNHCR, 2015; Ventevogel et al., 2019). People from the humanitarian field continue to insist that researchers go beyond estimating prevalence figures of discrete mental disorders and move towards using dimensional approaches to mental health – including making use of contextually appropriate and culturally validated instruments as well as in-depth ethnographic explorations of emotional suffering (Faregh et al., 2019; Ventevogel & Faiz, 2018).

Learning about the impact of dislocation, loss, political persecution, human malevolence, and social systems involving abuse, neglect, and ethnic and cultural rejection is crucial in terms of guiding policy makers and clinicians to assist, and as advocates to address, the social and historical perspectives of potentially traumatic events and their mental health consequences (Wilson & Droždek, 2004). This is particularly pertinent given the refugee “reception crisis” facing Europe. What is needed is an increased understanding of the influence of context on psychological functioning and the empowering possibilities of ecologically informed interventions and public health strategies which do not unduly medicalize socio-political problems or psychologize human rights violations (Harvey, 2007; Wenzel & Droždek, 2018). We have known for some time that culture matters when trauma is concerned; however, we need to fine-tune our knowledge of how culture matters in the definition of what is experienced as traumatic as well as the processes through which potentially traumatic events are experienced and either accommodated or not:

“Intercultural trauma treatment is a new field, one whose time has come. It reminds us yet again of the basic values of human encounters, beyond all sophisticated treatment techniques and devices, and it offers us ways for expanding the borders of our profession” (Droždek & Wilson, 2007, p. 19).

Some key implications for researchers highlighted by experts in the field in a briefing paper on trauma and mental in forcibly displaced populations by the International Society for Traumatic Stress Studies (Nickerson et al., 2018) include:

- Implement community participatory designs to be conducted in collaboration with service providers, clinicians and policymakers where possible
- Investigate the full breadth of psychological disorders and symptoms in refugees, focusing on cultural conceptions of distress
- Implement longitudinal methods to identify mechanisms underlying refugee mental health and determine the temporal causal relationship between refugee experiences, mental health and other outcomes

They recommend that research should be undertaken in collaboration with refugee communities to increase understanding and treatment of psychological disorders amongst refugees and asylum-seekers, and that professional organizations can play an important role in facilitating, promoting and disseminating research on refugee mental health. In their reflections on research into the mental health of refugee torture survivors in particular, published in *Lancet Psychiatry*, Liddell and colleagues (2017) similarly state,

“a new research approach that considers the interactive effects of past trauma, contextual stress, and psychological symptoms on torture survivors could enhance the ecological validity of research. We propose that multimodal research that merges robust clinical and experimental research within appropriate ecological frameworks is needed to advance the field [...] to fully understand the effects of torture, clinical science must go beyond the traditional boundaries of psychiatric research to account for the influence of sociocultural contextual factors.” (p. 1).

It is now time to move on to broader and more operationally relevant research and for researchers to engage with contemporary notions of resilience and social ecology (Weissbecker et al., 2018).

Introducing the research

In order to address some of the needs for more research on potentially traumatic events among refugee populations, this thesis aims to draw on a socio-cultural framework that focuses on the intersubjective, mediational space between the individual and culture-society-interaction. Such an approach presupposes human beings inhabit shared forms of life. Meaning is continually negotiated within the social sphere and “cultural products, like language and other symbolic systems, mediate thought and place their stamp on our representations of reality” (Bruner, 1991, p. 3). This theoretical framework highlights the heterogeneous, fluid and dynamic nature of individual subjectivities and the multitude of socio-culturally determined discourses which may be drawn upon to make sense of life experiences (Gee, 2014; Squire, 2008). As stated by Bruner (1991), such an epistemological underpinning “brings profoundly into question not only the universality of knowledge from one domain to another, but the universal translatability of knowledge from one culture to another. For in this dispensation, knowledge is never ‘point-of-viewless.’” (p. 2). As such, the thesis aims to consider the possibilities of examining refugees’ experiences of potentially traumatic events through the examination of individual stories within sociocultural and historical context (Pratt et al., 2015).

In line with this theoretical background, the thesis draws on qualitative methods as the research question demands an in-depth and nuanced understanding of the manifestations of trauma. Given the fact that the influence of current situational stressors on mental health and a more contextually situated understanding of trauma will be highlighted, the research question lends itself to a follow-up of participants over time. The research is centred on a year-long follow-up of 10 beneficiaries of the *Médecins Sans Frontières* (M.S.F.) Victims of Torture (V.O.T.) Project in Athens and their partner organization, Babel. Further data was also gained through complementary sources in order to locate these individual narratives within a socio-cultural context:

- 1) 43 semi-structured interviews with “key informants” - professionals working with this population (doctors, psychologists, psychiatrists, social workers etc.)
- 2) 21 semi-structured interviews with community leaders of various refugee communities across Athens
- 3) Four months of participant observation in the project – including attending daily team meetings, facilitating workshops and group programmes and teaching English lessons to beneficiaries

Sub questions explored include:

- **Which narratives of trauma circulate among the diverse actors working with refugees within various legal and medical activity systems? How is the diagnostic construct of P.T.S.D. used as a tool within these activity systems?**

- **How do the individual trajectories of individual refugees, diagnosed with P.T.S.D., unfold over time within this sociocultural context?**
- **How is trauma understood and made sense of by individual refugees? How is a diagnosis of P.T.S.D. accepted and understood (or not) by asylum seekers and refugees from culturally diverse populations?**

This **first chapter** serves as an introduction to the socio-political context in which the research was conducted as well as the theoretical framework in which it is embedded. In the **second chapter**, I present the literature on trauma among refugee communities, including pre, peri- and post-migration factors affecting mental health and resilience. The **third chapter** highlights the politicised history of the diagnosis of P.T.S.D., reviewing the literature examining its use among displaced populations in humanitarian contexts. The **fourth chapter** explores culturally informed narratives of – and responses to – trauma, as well as the implications of a sociocultural understanding of trauma for mental health interventions among refugee communities. The **fifth chapter** presents the methodical framework of the thesis – including the method of analysis and the actual study design.

What follows is the eight scientific publications constituting the thesis, in chapters 6-10. Specifically, the **sixth chapter**, in a continuation of a focus on methodology, highlights the use of the theoretical framework of cultural-historical psychology to explore trauma among refugee populations. The first scientific publication is presented. The **seventh chapter** offer a systemic analysis of the complex legal and medical institutions working with refugees entering Europe. This notably includes reflections on the activities of the various actors involved; including psychologists, doctors, cultural mediators, lawyers, as well as individual refugees themselves. The second and third scientific publications are presented. The **eighth chapter** aims to take the reflection further by examining the individual trajectories of refugees as they move through these institutions. The fourth and fifth scientific publications are presented. The **ninth chapter** explore some concrete implications of the research for mental health interventions aimed at refugee populations – in particular, the rehabilitation of victims of torture. This includes a significant focus on the impact of reception conditions on refugee mental health. The sixth and seventh scientific publications are presented. The **tenth chapter** critically reflects on the research in general, and the ethics of conducting research in humanitarian contexts in particular, through an analysis of the role of shame and trauma within the research relationship. The eighth and final scientific publication is presented.

The final chapter of the thesis, the **eleventh chapter**, offers a conclusion to the thesis. Firstly, I return to the research questions presented in the first chapters. I summarise the answers of the eight articles to highlight the contribution this thesis has made or tried to make, from a theoretical and methodological point of view. Secondly, I present some practical implications of the research. Finally, I discuss the limits of the research, which will lead me to propose some future directions for further research before offering some final reflections.

CHAPTER TWO: Trauma among refugee communities

Over the past two decades, there has been an increasing interest in the question of trauma among refugee populations. This body of research has largely focused on the immediate psychological aftermaths of armed conflicts in light of the well-described associations between these psychiatric disorders, displacement, and generalized forms of violence (Morina et al., 2018). In general, the literature attests to the greater mental health difficulties among refugees compared to general populations within host communities. High levels of post-traumatic stress, anxiety and depression have been documented, as well as other mental health issues such as psychosomatic disorders, grief related disorders and crises of existential meaning (Copping et al., 2010; de Arellano & Danielson, 2008; Kirmayer et al., 2010; Lambert & Alhassoon, 2015; Morina et al., 2018; Schweitzer et al., 2006; Steel et al., 2009; Sturm et al., 2010; Van Ommeren et al., 2001; Weine et al., 2001). Significant rates of medically unexplained pain and somatoform disorder have also been highlighted (Droždek, Noor, Lutt, & Foy, 2003; Van Ommeren et al., 2001).

This high prevalence of mental health problems is not surprising. Refugees are typically exposed to a multitude of potentially traumatic events – not only in their countries of origin but all along their migration journey (Crepet et al., 2017). As summarized by Neace *et al.* (2020),

“refugees are also people who have survived the severe trauma not only of whatever caused them to flee their homelands in their first place— things like war, famine, genocide, natural disaster—but of all of the trauma associated with fleeing. Their contexts tend to be of the need-thwarting type, and most refugees do not leave their home by choice, causing a loss of autonomy” (p. 13).

Yet, increasingly, studies focusing on pre-migration exposure to potentially traumatic events exclusively have been criticized for their skewed focus. The argument is that this focus neglects the repeated and prolonged stressors to which refugee communities are typically exposed. In a recent key critical review of the literature, Hynie (2018) concludes that

“historically, the focus of mental health research and interventions with these populations has been on the impact of pre-migration trauma. Pre-migration trauma does predict mental disorders and P.T.S.D., but the post-migration context can be an equally powerful determinant of mental health. Moreover, post-migration factors may moderate the ability of refugees to recover from pre-migration trauma.” (p. 297).

Research over the past decade is indeed starting to shift focus towards the impact of the post-migration environment on the mental health of refugees (Korup Kjærgaard & Koitzsch Jensen, 2018; Li et al., 2016). Unsurprisingly, this research has highlighted the importance of post-migration factors in predicting the maintenance of P.T.S.D. symptoms in resettled refugees – including unemployment, family separation, constant mobility and ongoing conflict in the country of origin (Lie, 2002; Schick et al., 2016). The respective impact of these potentially traumatic events continues to be the subject of increased debate. Some scholars argue that exposure to extreme stressors such as war or torture is the strongest predictor of P.T.S.D., whilst

others have argued that it is the impact of post-migration stressors upon resettlement in the host country (Song, Kaplan, Tol, Subica, & de Jong, 2015).

In this chapter, I present an overview of the literature examining the factors which influence experiences of potentially traumatic events among refugee populations - both pre-, peri- and post-migration. Refugee experiences of potentially traumatic events during these three stages of migration has been referred to as the “triple trauma paradigm” (TTP), where “through each of these stages the refugee or asylum seeker experiences and re-experiences the traumatic events, events that vary during each stage and depend on the particular adverse circumstances and situations they confront” (Ringler-Jayanthan *et al.*, 2020, p. 82). As useful as it is to highlight the factors characterising each phase of the migration journey, what we need to bear in mind (as we embark on this “mapping”) is the interrelation of all of these factors. There is evidently a dynamic, complex and ongoing exchange between all of them – a point to which I return later on in the chapter.

Pre-migration

Given the very nature of the refugee experience, many refugees by definition have been exposed to a variety of potentially traumatic events prior to leaving their country of origin – including those related to war and conflict, persecution, violence and torture experienced by themselves as well as loved ones. Among a sample of 420 refugees living in Sweden, Steel and colleagues (Steel, Dunlavy, Harding, & Theorell, 2016) found that 89% reported having experienced at least one traumatic experience prior to migration. Common sense would dictate that some of the most significant pre-migration factors related to P.T.S.D. would be that of exposure to wartime atrocities inherent to contexts of conflict - a hypothesis which has unsurprisingly been well documented in the literature (Bogic *et al.*, 2012; Heeren *et al.*, 2014; Morina *et al.*, 2018). Several studies have indicated a robust dose-response relationship of exposure to potentially traumatic events to the development of P.T.S.D. (Kartal & Kiropoulos, 2016; Mollica *et al.*, 1998; Momartin *et al.*, 2003; Silove, 1999; Silove *et al.*, 1998; Steel *et al.*, 2009).

Torture

Torture represents an extraordinary exception in the psychopathology field. Past torture is well documented to be a particularly triggering factor for P.T.S.D. It is consistently shown in the literature to be significantly and consistently associated with emotional distress, even years after the event (Carlsson, Mortensen, & Kastrup, 2006; Hodges-Wu & Zajicek-Farber, 2017; Kira, 2010; Le *et al.*, 2018; Liddell *et al.*, 2017). This is particularly true in the case of prolonged exposure to multiple types of torture (Song *et al.*, 2015; Song *et al.*, 2017). Research indicates that it is the perceived uncontrollable nature of, rather than the exposure to, torture, which most accurately predicts P.T.S.D. (Le *et al.*, 2018; Liddell *et al.*, 2017). The variety of complex psychological responses to torture, linked to higher prevalence of P.T.S.D., include alterations in emotion regulation capacity (notably anger), impaired interpersonal processing, reduced perceptions of control, and identity loss (Liddell *et al.*, 2017). The particularity of torture as

pathogenic is linked to the fact that the act itself is taught, organized, elaborated, and perpetrated by humans against other humans (Sironi, 1999; Viñar, 2005b). It destroys the fabric of the social network of which we humans form an integral part. It disrupts our connection to all that make us human. Moreover, it is another human being who has deliberately constructed this unimaginable madness (Goguikian Ratcliff & Strasser, 2009; Viñar, 2005b).

Kirmayer and colleagues (2018) highlight the fact that it is the moral emotions (shame, guilt and humiliation) that are intently used to inflict the most damage in torture. Such moral emotions inevitably reflect the cultural systems of meaning:

“All forms of torture follow an affective logic rooted both in human biology and in local social and cultural meanings of experience. Understanding the impact of specific forms of torture on individuals requires knowledge of their learning histories, and of the personal and cultural meanings of specific kinds of violence. Exploring cultural meanings requires attention to over-arching discourse, embodied practices, and everyday engagements with an ecosocial environment” (p. 84)

To reflect on the consequences of torture from an ecological, social and cultural perspective, they present a model of adaptive systems affected by torture (p. 87):

Table 1: *Adaptive systems affected by torture*

Adaptive System	Threats	Emotional Reactions	Psychopathology	Interventions
Attachment	Separation from significant others, and culture	Anxiety Grief Home sickness Nostalgia	Anxiety Depression Complicated grief	Re-connection with loved ones Mourning Creation of new bonds Membership in social groups Recreating community systems
Security	Uncertainty Loss of control	Anxiety Insecurity Hypervigilance	Anxiety PTSD	Re-assert control over self and environment
Identity/Role	Loss of social and occupational roles and status Misrecognition, identity	Powerlessness, shame and humiliation	Suicidality Role confusion	Recognition of status and identity Opportunities for meaningful action Family interventions Community membership Human right protection Social security
Justice	Sense of injustice, arbitrary violence Impunity	Anger, Hostility Lack of trust Resentment Bitterness	Traumatic anger Paranoia	Engagement Trust redevelopment Family trust redevelopment Truth and reconciliation Human rights protection
Existential Meaning	Loss of sense of coherence, purpose, and hope for future	Search for meaning	Alienation Disengagement Crisis of faith Transgenerational transmission	Testimonial approach, telling one's story Re-engagement in life projects Linking with culture, community and religious traditions Political activism

Adapted from Silove (1999, 2007), Ekblad & Jaranson (2004), and Kirmayer, Rousseau & Measham (2010)

As indicated by the model, the psychopathologic disorder of the survivor cannot be reduced to the intrapsychic plane. It is not an individual act, but a social one. It does not only have individual consequences, but social, legal, and political ones for those who survive. It damages different spheres of an individual including body, personality, hope, aspirations for life, identity, integrity, belief systems, the sense of being grounded and attached to a family and society, autonomy, community relationships, and a sense of safety. It recreates a social order coloured by suspicion, shame, and secrecy (Barudy, 1989). Family disruptions, collective fear and community dysfunction and decomposition have all been noted in the literature as

consequences of exposure to potentially traumatic events (Barudy, 1989; Hodges-Wu & Zajicek-Farber, 2017). As noted by Liddell and colleagues (2017), General Comment 3 of the United Nations Committee Against Torture published on Dec 13, 2012 (which explains the signatory States' responsibilities under Article 14 of the UN Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment) is significant in that it explicitly recognises that the effects of torture extend beyond individuals to encompass their immediate families and dependents. These far-reaching effects may interact and manifest in complex and diverse ways, mediated by culture, gender and other aspects of the context of the torture survivor, the context of torture and the context of the recovery environment (Esala et al., 2018; Patel, Kellezi, & Williams, 2014).

In summary, in considering potentially traumatic events such as torture, one needs to consider the collective impact it may have on entire communities – the severe disruptions and communal losses that such events represent for so many. I now explore the collective impact of such experiences as a pre-migration factor affecting refugee communities.

Collective trauma and communal losses

Potentially traumatic experiences are often not related to one specific event. A host of potentially traumatic events may precede the event that caused refugees to flee (Lindert, Carta, Schäfer, & Mollica, 2016). Furthermore, considering experiences of potentially traumatic events solely on an individual level, and solely related to a single isolated event, is not enough. One needs to consider the collective impact of potentially traumatic events among refugee populations from a sociocultural and historic perspective. Entire communities may have experienced potentially traumatic events, and at various moments across history, disrupting core attachments to families, friends and cultural systems (Lindert et al., 2016). The literature suggests that the consequences of exposure to potentially traumatic events among refugee populations may go beyond individual suffering to impacting family members and entire communities, substantially impairing psycho-social functioning in everyday life (Ainamani, Elbert, Olema, & Hecker, 2017; Womersley & Arikut-Treece, 2019).

Over the past few decades, a plethora of research has highlighted the importance of the sociocultural environment for the way in which individuals, and indeed entire communities, experience potentially traumatic events (Bracken et al., 1997; Eagle & Kaminer, 2013; Nickerson et al., 2016; Wilson & Droždek, 2007). As stated by Jenkins (1996)

“Because traumatic experience can also be conceptualized collectively, person-centred accounts alone are insufficient to an understanding of traumatic reactions. In addition to the social and psycho-cultural dynamics surrounding any traumatic response, the collective nature of trauma may be related to ... the political ethos characterizing an entire society” (p. 177).

Eagle (2014) refers to notions of collective or historical trauma whereby whole groups of people carry a sense of common persecution or victimization:

“The idea of historical trauma is associated most strongly with the history of first nation people in America and the genocidal violence to which they were subjected. Collective trauma is the term that tends

to be used about the response of groups of South Africans subject to a brutal apartheid and colonial history, as well as about the response of groups of Jewish people to the Holocaust. Such trauma may be understood to be transmitted intergenerationally via both conscious and unconscious mechanisms, such that those of generations post those directly victimized nevertheless carry the experience of trauma within themselves. In some respect identity and collective trauma come to be intertwined. Such conceptualizations of trauma may encompass a somewhat broader definition of traumatic stressors including not only relations of oppression that threaten actual survival of the group, but also more ideological forces that threaten the eradication of cultural or group identity. In this framework racism, xenophobia or fundamentalisms based on oppression may be understood to produce collective traumatising." (p. 13)

She suggests that people may be traumatised at multiple levels including collective/social, personal/physical and role identity levels, and that which of these levels is most salient at a particular point in time will be dependent both on life history and current environment. This point is no more pertinent to bear in mind than in the case of refugee populations often faced with a plethora of potentially traumatic events on a collective level. Becker's (Becker, 1995, 2004; Becker, Lira, Castillo, Gómez, & Kovalskys, 1990) concept of extreme trauma further encapsulates the extremity of such collective and historic trauma, defined as the following:

"Extreme traumatising is an individual and collective process that refers to and is dependent on a given social context; a process that is marked by its intensity, its extremely long duration and the interdependency between the social and the psychological dimensions. It exceeds the capacity of the individual and of social structures to respond adequately to this process. Its aim is the destruction of the individual, of his sense of belonging to society and of his social activities. Extreme traumatising is characterized by a structure of power within the society that is based on the elimination of some of its members by other members of the same society. The process of extreme traumatising is not limited in time and develops sequentially." (Becker, 2004, p. 5).

Considering exposure to potentially traumatic events thus as a process, elements of temporality are highlighted, as is the continual interaction of the person with their environment in a given social and historical context. What is particularly interesting in this definition is the highlighting of the socio-political context and power dynamics at play in influencing the mental health of whole populations. Considering the "elimination of some of its members by other members of the same society" referred to in the definition is pertinent both to situations of conflict as well as to societal dynamics at play for refugee communities attempting to integrate into host societies and facing possible discrimination. Following prolonged or repetitive traumatising, entire communities may thus develop a complex constellation of shared feelings, attitudes and behavioural patterns deeply informed by post-traumatic responses and which may force groups into the role of victim – passive, unskilled, unable and unsure (Makhashvili & Tsiskarishvili, 2007).

Loss of "home" as container

Among a sample of Iraqi asylum seekers in the Netherlands – 87.6% reported experiencing the loss of a loved one, with traumatic and multiple losses independently predicting psychopathology (Hengst, Smid, & Laban, 2018). Yet, even among those refugees who have not directly experienced the loss of a loved one, loss is an inevitable component of the migration

experience. As noted by Du and Witmer (2020), loss associated with the refugee experience is not only that of loved ones as well as the geographical home (often representing a loss of decades, if not centuries, of investment), but also of the familiar sociocultural context (which they refer to as the “psychosocial milieu”) as well as a disruption of the life biography (which they define as “a unique web of situated life episodes” [p. 38]) at the level of the individual, the community, and the generations that lived in a certain place at a certain time.

Volkram (2004) argues that “since moving from one country to another involves loss – loss of country, friends and of previous identity – all dislocation experiences can be examined in terms of the immigrant’s ability to mourn and/or resist the mourning process.” (p. 8). The seemingly paradoxical nuance referred to within this literature is that not all refugees suffer from P.T.S.D. on an individual level, yet that pre-migration experiences necessarily involve loss at the communal level which in itself is potentially traumatic. In other words, in order to reflect on the potentially traumatic experiences of refugees, one cannot neglect to examine what has been necessarily been lost to entire communities before embarking on the journey of migration. Rousseau and colleagues (2014) note the impact of the cumulative effects of a grieving process for communal losses and separations related to forced migration, referring to what Eisenbruch (1991) terms “cultural bereavement.” A multi-level path analysis conducted by Nickerson and colleagues (2011) similarly demonstrates how loss associated with potentially traumatic events significantly impacted on psychological outcomes among refugee families as a whole in a way that extends beyond individual mental health.

Papadopoulos (2002a, 2002b, 2007) draws on the notion of “nostalgic disorientation” to refer to the uniqueness of this bewildering predicament:

“The loss is not only about a concrete object or condition but it encapsulates the totality of all dimensions of home.... Refugees sense the impact of this multidimensional, deep and pervasive loss and they feel disorientated because it is difficult to pinpoint the clear source and precise nature of this loss... Whenever the home is lost, all the organizing and containing functions break wide open, and there is the possibility of disintegration at all of these three levels: at the individual-personal level; at the family-marital; and at the socio-economic/cultural-political level” (Papadopoulos, 2002a, p. 15-24).

His main argument is that the loss of home is not just about the conscious loss of the family home with all its material, sentimental and psychological values, but it is a loss of a much more fundamental and symbolic kind which necessarily creates a psychological disturbance.

An important characteristic of home, which inevitably is lost to some extent in the process of migration, is that it grounds and provides coherence to the stories of families. Each family has a story which, its own story which does not necessarily coincide with an external historical account of it. Like all stories, it consists of many more smaller stories of specific facets of the family. As such, “family stories express the interconnection between the personal, family and wider parameters within the context of a sense of home that enables the holding and containing of all opposite and contradictory elements that threaten to disrupt the sense of continuity and predictability” (Papadopoulos, 2002a, p. 25). As Masade (2007) notes “home embodied objects, languages, practices (which evolved into traditions), histories, myths and faiths [are] all bound

to a specific location” (p. 94) which is lost in the process of migration. This loss necessarily contributes towards a sense of empowerment, identity and meaning in life being compromised on a community level (Droždek & Wilson, 2007; Schweitzer et al., 2006). Falicov (2002) similarly reflects on the loss and resilience inherent to the family migration experience, noting that what refugees have in common is the painful loss of home and separations from loved ones and the inevitable mixed emotion of sadness for what they have lost as well as the elation for what they could gain, the ambivalence of wanting to stay and wanting to go.

Migration

It is not only what is lost in leaving one’s home but similarly the migration experience itself which necessarily disrupts family and cultural systems and separations from the family and ethnic community, including stays in unsafe refugee camps during the migration process (Lambert & Alhassoon, 2015). Arriving in Europe, and often not necessarily to the country of their choice, some refugees arrive and are fighting to stay - yet some soon discover that things are not quite as expected and realise they must either go back or proceed to another destination (Gkionakis, 2016). Nathan (1986) argues that the experience of migration is necessarily traumatic— as the “cultural envelope” can no longer hold potentially traumatic, non-elaborated or psychically “indigestible” experiences. In a multi-agency guidance note released in 2015 in collaboration with the UNHCR (MHPSS, 2015), the following factors related to the mental health of refugees and migrants during migration were observed and noted by a conglomerate of humanitarian aid agencies:

“Refugees and migrants who come to Europe often faced war, persecution and extreme hardships in their countries of origin. Many experienced displacement and hardship in transit countries and embarked on dangerous travels. Lack of information, uncertainty about immigration status, potential hostility, changing policies, undignified and protracted detention all add additional stress. Forced migration erodes pre-migration protective supports – like those provided by extended family – and may challenge cultural, religious and gender identities. Forced migration requires multiple adaptations in short periods of time. People - especially but not only - children, become more vulnerable to abuse and neglect. Pre-existing social and mental health problems can be exacerbated. Importantly, the way people are received and how protection and assistance is provided may induce or aggravate problems, for example by undermining human dignity, discouraging mutual support and creating dependency.” (p. 3).

Among a cohort of 200 asylum seekers attending a centre run by *Médecins Sans Frontières* (2016) in Italy, 86.9% said that they experiences difficulties in post-migration life – difficulties which were significantly associated with a diagnosis of P.T.S.D. The most common difficulties in life during the asylum seeking period were found to be "the feeling of uncertainty and fear for the future" (18.8%), "concern for the family back home" (13.8%), "conflicts within the authorities" (11%), "fear of the asylum request being rejected" (8.8%), "the feeling of being neglected" (7.2%), "the inability to integrate and feel integrated"(7.7%), "prolonged waiting times for the [asylum] Commission's outcomes" (5.5%), "lack of daily activities" (3.9%), "a sense of loneliness and boredom" (2.2%) and, to a lesser extent, other difficulties such a widespread sense of injustice and feeling unable to control events.

This is a period which Métraux (1999a) has described as suspended or “mute” time, which he defines as “being absent from all temporality, the social time of [refugees] being also a waiting period, a suspended time, a time dissolved in the heart of an indeterminable parenthesis ⁴” (p. 52), a temporary immobility which only either a forced expulsion, or a negative or positive response to the request for asylum would be able to end.

Requesting asylum

The majority of research regarding forced migration and mental health has focused on refugees, with a more limited number of studies looking at asylum seekers. While there is a crucial difference in the legal status of refugees and asylum seekers, only few scholars have made a distinction between the two in examining risk factors for mental health problems (Georgiadou, Zbidat, Schmitt, & Erim, 2018; Nakash, Nagar, Shoshani, & Lurie, 2017; Solberg, Vaez, Johnson-Singh, & Saboonchi, 2020). In general, the little research that exists does indeed attest to the impact of legal status on mental health, in particular prevalence rates of P.T.S.D. (Georgiadou et al., 2018). Compared to refugees who have received formal refugee status or resident permits, recent research has highlighted how the prevalence rates of mental health disorders are substantially larger - and the associations between post-migratory stressors and mental health disorders appears to be substantially stronger - for asylum-seekers (Solberg et al., 2020). A body of research goes so far as to suggest that the asylum period may cause even greater psychological distress than events that occurred before migration (Schockaert et al., 2020). Among such scholars exploring this is Betty Goguikian Ratcliff (Goguikian Ratcliff, 2016; Womersley, Kloetzer, & Goguikian Ratcliff, 2017). She identifies the period before and after being granted asylum as being two distinct periods in the psychological lives of migrants, noting that both stages involve substantial psychological stress, but for different reasons. She identifies the following stressors related to the period in which asylum is sought:

- Delays in the processing of asylum application
- Fear of repatriation
- Exclusion from the labor market
- Forced dependence on social welfare
- Loneliness, boredom
- Discrimination, marginalization
- Poor housing conditions
- Prolonged uncertainty, insecurity, lack of control

These factors are further confounded by unstable conditions wherein individuals may be forced into a rhythm of perpetual displacement. Many are moved from one center to another, experiencing delayed asylum procedures and poor living conditions in reception centers – often poorly accessible by public transport to main economic and social hubs. Left with a life in limbo, activities of social integration and personal development are hindered under such

⁴ My own loose translation

conditions. The longer one waits for asylum, the less likely one is to find employment (Hynie, 2018), and the higher the risk for psychopathology (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004). Furthermore, a recent meta-review observed associations between length of stay in asylum centres and poor mental health (Korup Kjærgaard & Koitzsch Jensen, 2018).

Hauswirth and colleagues (2004) identify the following specific stressors related to the request for asylum:

- applying for asylum involves a submission of oneself to more powerful authorities, without necessarily have knowledge of the language and administrative functioning necessary to be able to keep a sense of control over key decisions.
- the seemingly random assignment to a place of residence, the obligation to stay in a center, are all related to a loss of freedom and perceived control.
- access to the labour market is made difficult during this period because the individual is unable to guarantee the prospective employer a commitment in the long run because of its status.

A sense of de-individuation and diminishing feelings of self-worth and self-esteem may be exacerbated by the “en masse” treatment of migrants as they enter the host country. In research conducted among refugees and asylum seekers on the Greek island of Lesbos, Eleftherakos and colleagues (2018) noted that the “elimination of each individual’s identity was quoted by many migrants while the response to questions regarding information about their cases or complaints regarding living conditions was usually answered with another insult.” (p. 5). Maier and Straub (2011) unpack the psychological impact of this loss of identity: “through extreme trauma and forced migration, the [asylum seekers] seemed to be thrown back to a biographical ‘zero’ point from which they had to almost redefine their entire identity. The severity of their trauma and loss probably exceeded what any individual, social, cultural, and religious concept available could explain and integrate” (p. 243). Despite the fact that the majority of participants in their study attributed the main source of their current suffering to earlier exposure to potentially traumatic events, one third identified their actual living situation as the essential cause of their traumatic stress, more specifically the harsh conditions in the asylum-seekers camp which lead them to feel trapped, unconfident and with “a dark future” (p. 239).

It is not difficult to imagine that living with constant fear of authorities could similarly trigger old fears related to potentially traumatic events experienced in the countries of origin as well as during the migration period. In examining experiences of potentially traumatic events among asylum seekers on the island of Lesbos in Greece, research conducted by a team from *Médecins Sans Frontières* (Eleftherakos et al., 2018) noted that the majority of participants reported living in a context characterised by a) a state of permanent emergency, b) preoccupation with threats on present and future, and c) absence of protective measures. Such a state of existence, they argue, is related to the concept of continuous traumatic stress, a concept notably developed by South African researchers (Eagle & Kaminer, 2013) to describe the psychological impact of being continuously exposed to potentially traumatic events over an extended period of time. Living under continual threat of repatriation thus serves to reinforce a compromised and

precarious political, social, and economic position which significantly influences mental health (Bogic et al., 2012; Heeren et al., 2014; Kirmayer, 2001; Porter & Haslam, 2005; Silove et al., 1998). Put simply, the fear does not end.

Given the factors mentioned above, it is therefore no surprise that an insecure residency status has been shown in the literature to be one of the strongest predictor of mental health disorders (Heeren et al., 2014; Hynie, 2018; Momartin et al., 2003; Morgan, Melliush, & Welham). As noted in a key review by Nickerson and colleagues (2018), such an insecure status associated with impaired interpersonal functioning and persistent worry and social withdrawal. These may in turn exacerbate P.T.S.D. and depression symptoms regardless of pre-migration exposure to potentially traumatic events. Indeed, a convincing body of literature clearly attests to the fact that stressors associated with the process of seeking asylum contribute to elevated psychological distress, including P.T.S.D. symptomatology (Nickerson et al., 2018). Simply put, the cumulative weight of exposure to potentially traumatic events heightens the risk for mental health disorders over time, and the asylum-seeking process itself adds weight, as an additional potentially traumatic event, to this burden:

“one could speculate that the uncertainty and uncontrollability inherent in the asylum-seekers' psychosocial situation becomes a diathesis or creates a predisposition that interacts with post-migratory stressors, in turn having detrimental effects on mental health” (Solberg et al., 2020, p. 5)

Prolonged detention

In a comprehensive review on the impact of mandatory, indefinite detention on the mental health of asylum seekers, commissioned as part of the independent review of policies and procedures affecting the welfare of those held in immigration removal centres in the United Kingdom (Bosworth, 2016), the following conclusions were drawn:

- Literature from across all the different bodies of work and jurisdictions consistently finds evidence of a negative impact of detention on the mental health of detainees.
- The risk increases the longer detention persists.
- The mental health impact endures long after release.
- Causes identified in the literature include pre-existing exposure to potentially traumatic events (including torture and sexual violence); pre-existing mental and physical health problems; and poor healthcare and mental health care services in detention.

Their findings are echoed elsewhere in the literature (Korup Kjærgaard & Koitzsch Jensen, 2018; Loizos, 2002; Mueller, Schmidt, Staeheli, & Maier, 2011; Robjant, Hassan, & Katona, 2009; Schockaert et al., 2020). Studies from around the world have consistently shown high levels of distress among asylum seekers in immigration detention, with many individuals left feeling disempowered by the experience of waiting for an indeterminate period for the outcome of a discretionary decision over which they have little control, but which will determine their freedom and their future (Cleveland, Kronick, Gros, & Rousseau, 2018).

Another comprehensive review by Silove and colleagues (2007) highlights that the substantial issues related to mental health and prolonged detention include restricted access to work, education, housing, welfare, health care services, abuse, untreated medical and psychiatric illnesses, suicidal behaviour, hunger strikes, and outbreaks of violence reported among asylum seekers in detention centres. Another meta-review of the literature further highlights extended period of time in asylum detention centres, and the number of relocations as significant factors impacting mental health (Korup Kjærgaard & Koitzsch Jensen, 2018).

Court proceedings

Typically following the period of detention is the court proceeding, which risks being a traumatic event in and of itself. The recent findings of Schock and colleagues (2015) working at a centre for victims of torture in Germany, revealed the stressful impact of asylum interviews on refugees which lead to a significance increase in post-traumatic intrusions. They and other authors have hypothesised that a deliberate avoidance of thinking of potentially traumatic events initially serves as a survival strategy during the migration period, yet may be ruthlessly undermined during the testimony phase of a court hearing, consequently fostering significant potential for re-traumatisation (Jakobsen, Meyer DeMott, Wentzel-Larsen, & Heir, 2017; Nickerson et al., 2018; Rogers, Fox, & Herlihy, 2015; B. Turner, 1992; S. Turner, 2015).

There is also an increasing body of scientific evidence looking at the assumptions recorded by authorities in their asylum decisions and the psychological processes at play during the court proceeding. This literature suggests not only that there may be marked uncertainty in how to reach the correct determination but also that there is often the potential for bias against the person genuinely fleeing from potentially traumatic events, with mental health problems negatively impacting on the credibility and consistency of their verbal accounts (Bögner, Brewin, & Herlihy, 2010; Herlihy & Turner, 2018; Linton, 2015; Mueller et al., 2011; Rogers et al., 2015; Schock et al., 2015; B. Turner, 1992; S. Turner, 2015). Bögner, Brewin, and Herlihy (2010), for example, investigated factors related to the disclosure of personal sensitive information during asylum interviews and found that those with a history of exposure to potentially traumatic events (in this study, namely sexual violence) reported more difficulties in disclosing personal information in a coherent manner. The catch-22, as Linton (2015) notes, is that an acceptable demeanour and coherent and credible story remains the basis of being granted asylum:

“Asylum seekers from oppressive regimes may have learned to distrust government officials and may be hesitant or frightened when speaking to authorities. Women in particular may have been taught not to make eye contact and not to reveal private details to strangers. These experiences and cultural norms may cause an applicant to look down, appear nervous and distrustful, sweat excessively, and hesitate during her hearing—all things that could lead an IJ to believe, based on her demeanour, that she is not telling the truth... Ironically, the fraudulent applicant is better situated to relate a detailed story with appropriate demeanour than the genuine applicant” (p. 1085).

Paradoxically, exposure to potentially traumatic events may decrease an asylum seekers’ capacity to recount a coherent narrative of their lives – the very coherence needed for

“credibility,” for their claim to asylum to be believed (Herlihy & Turner, 2018). The high potential for asylum seekers not to be believed during the court proceeding and for their claim to be denied inevitably leads to a situation of increasing physical and psychological vulnerability. For victims of torture and other atrocities, both individual and collective, the responses of criminal and social justice systems in particular may also be importantly implicated in whether people transcend or continue to suffer the impact of potentially traumatic events (Eagle, 2014).

Being denied asylum

As demonstrated by Mueller and colleagues (2011), failed asylum seekers show as much severely affected mental health as pending and temporarily accepted asylum seekers. These are the trapped “invisible” (Sanchez-Mazas et al., 2011), coping with the daily threat of forced expulsion. Apart from the obvious physical, legal and material implications of not being granted refugee status, the psychological impact of the court proceedings, of not having one’s story believed and subsequently being branded ‘illegal,’ is one of many inter-related factors negatively impacting on the mental health of the immigrant. As stated by Sturm *et al.* (2007):

“With migrant populations, we do not only have to work on loss, rupture and bereavement but also on the experience of feeling oneself ‘outside humanity,’ when the individual has lost confidence in others and may carry feelings of guilt and shame... The outcome of the asylum process is of major importance for the mental health of asylum seekers. It is linked to the recognition or not of the testimony (validation or not of experiences), the experience of being recognised as a victim of violence and injustice may be extremely supportive. At the same time, once the individual feels that he or she is in a secure place, they may be overwhelmed with traumatic memories or depressive feelings. Some experience guilt or shame in relation to those whom they have left behind. Others have to deal with the traumatic memories the current situation evokes (for example, not being granted asylum and fearing for the police, not having food or money or shelter...” (p. 213-216)

The result is a loss of all one’s bearings, a sense of absurdity, a misunderstanding the situation in the face of doubts regarding the veracity of the abuse they suffered (Hauswirth et al., 2004).

Post-migration

As noted by Womersley, Kloetzer and Goguikian Ratcliff (2017), many stress factors related to seeking asylum mentioned above may indeed be alleviated by obtaining refugee status. However, after months or years of suspended and uncertain lives, this is a period where refugees are required to quickly adjust and integrate into their new environment. During this transition, many may lose access to benefits specifically allocated to asylum seekers (accommodation, social services, financial aid, etc.). As refugees, they are now expected to fully participate in a new sociocultural environment and locally reconstruct their lives, all the while maintaining their cultural identity. During this stage, new stressors specifically related to this stage of the migration journey may be encountered. Saechao and colleagues (2012), for example, identify six primary stressors during the post-migration phase: economic hardships, discrimination,

acculturation due to language differences, enculturation, parenting differences, and finding suitable employment. Among one cohort of refugees diagnosed with P.T.S.D., such stressors were deemed to impact 39% of sessions with treating clinicians (Bruhn, Rees, Mohsin, Silove, & Carlsson, 2018). As noted by Goguikian Ratcliff (2009), a plethora of studies exist which convincingly demonstrate that psychological, social and cultural difficulties encountered in the host country after arrival have a more significant impact on mental health than pre-migration exposure to potentially traumatic events.

Reception in the host country

Post-migration experiences, such as unemployment, insecure residency, fear of repatriation, and social discrimination have similarly been shown in the literature to be significantly correlated with mental problems in refugees (Bogic et al., 2012; Loizos, 2002; Tekin et al., 2016; Volkan, 2004; Watters, 2001). Volkan (2004) refers to the “Janus-face” (p. 14) reception of refugees by the host society, representing them as at once victims/heroes as well as diseased intruders. As numbers of migrants into Europe swell, attitudes harden with the transforming anti-migration political rhetoric that positions refugees as an economic and social threat. He argues that this serves to remodel refugees’ self-representations as they struggle with the process of integrating the new culture with the old and with the “survivor guilt” of having left loved ones at home in danger in the country of origin.

In a recent review of the literature, Kartal and Kiripoulos (2016) note that the relationships between potentially traumatic events, migration, and mental health outcomes upon arrival in the host country are complex and poorly understood. Acculturative stress within the sample of refugees they examined was associated with greater experiences of cultural loss and nostalgia. This loss itself was found to exacerbate P.T.S.D. symptoms. They suggest that the influence of post-migratory demands on mental health differs not only based on the individual’s acculturation process alone. It also depends on the characteristics of the local context reflecting the acculturative preferences of the host society. The authors highlight these findings as a confirmation of Berry’s (Berry, 1997, 2003; Sam & Berry, 2010) acculturation model which delineates the mechanisms through which the host society impacts on the acculturation process of refugees by imposing either encouraging or less desirable acculturative strategies (either encouraging or oppose ethnic diversity and participation in the larger society) which in turn influences mental health. This model has been confirmed elsewhere in the literature: multiple comparative studies examining correlations between the post-migration context and refugees from the same country of origin yet who have resettled in different countries convincingly demonstrate the significant effect of post-migratory factors on symptoms of P.T.S.D. Bogic and colleagues (2012) for example, assessed 854 war refugees from the former Yugoslavia having resettled across three countries. They found higher rates of P.T.S.D. to be significantly associated with migration-related stress and having a temporary resident permit. Similarly, Kartal and Kiripoulos (2016) assessed a sample of 138 Bosnian refugees resettled in both Austria and Australia. After controlling for age, sex, and exposure to potentially traumatic

events, acculturative stress associated with post-migratory experiences predicted severity of P.T.S.D. Acceptance of the host society matters.

Multiple losses and social isolation

As summarized by Fox (2018) :

“They [refugees] have suffered unimaginable loss of family, friends, home, community, country, and language. Once here, they find themselves subjected to poverty and discrimination as well as a loss of self-esteem, status and identity. Some demonstrate remarkable resilience and fortitude in facing psychological pain, dislocation and hardship...they remain in contact with a life force , a good internal object, that enables them to tolerate and endure these privations and losses. For some asylum seekers who are less resilient, it is the loss of contact with a supportive internal relationship that depletes their capacity for resilience, leaving them inadequately resourced to face and endure the realities of their situation.” (p. 103)

In the process of migration, refugees suffer numerous losses, such as economic stability, familiar surroundings, and relationships that hinder their ability to thrive in their new place of settlement. The literature highlights one of the most powerful stressors experienced by refugees after arrival in the host country as being social isolation, typically associated with ongoing family separation, loss, and a breakdown in familiar social and community structures (Miller & Rasmussen, 2017; Nickerson et al., 2018; Schouler-Ocak et al., 2016). Among a cohort of refugees in Holland, 78% expressed an unmet need for company (Strijk, van Meijel, & Gamel, 2011). Among a cohort of refugees in Australia, such isolation emerged as a major predictor of P.T.S.D. and other mental health challenges (Chen, Hall, Ling, & Renzaho, 2017). Perceived social support has been shown to serve as a significant moderator in the relationship between exposure to potentially traumatic events and P.T.S.D. symptoms among asylum seekers (Nakash et al., 2017; Schweitzer et al., 2006). In a study among African asylum seekers in Israel, social support was associated with lower prevalence rates of P.T.S.D. (except in the case of extreme exposure to potentially traumatic events where social support did not have a substantial impact) (Nakash et al., 2017).

As refugees struggle to maintain cultural identities and networks (Watters, 2001), such isolation brings the further risk of losing the “social capital” (Lecroq, Stafström, Westerling, & Östergren, 2015; Loizos, 2002; Tortelli, Sauzé, & Skurnik, 2017) inherent to resources associated with economic status as well as social and professional identity. The loss of social capital, exacerbated by social discrimination and marginalization, has similarly been linked to poorer mental health outcomes (Brand et al., 2017).

Continual exposure to potentially traumatic events

Research evidence suggests that refugees are continually exposed to multiple, sometimes extreme potentially traumatic events such as torture, rape, or death of family members (Hollander et al., 2016; Kartal & Kiropoulos, 2016; Steel, 2001; Steel et al., 2009; ter Heide,

Mooren, & Kleber, 2016). In a recent analysis of all crimes reported across Switzerland from 2009-2012, Coutennier and colleagues (2016) discovered that cohorts exposed to civil conflicts/mass killings during childhood are on average 40 percent more prone to violent crimes than their co-nationals born after the conflict. Furthermore, their analysis showed that conflict exposed cohorts have a higher propensity to target victims from their own nationality. Rousseau and colleagues (1997) similarly found that the culture of origin radically modulated the relationship between the pre-migration experience and the developing post-migration universe of refugees – mediated through experiences of torture in countries of origin leading to increased levels of violence and social isolation subsequently perpetuated within the family post-migration. Indeed, continuous or sustained exposure to potentially traumatic events has been found to create a life condition that increases further risk of exposure to a multiplicity of other types of potentially traumatic events (ter Heide et al., 2016). Furthermore, there is substantial evidence in the literature that refugees suffering from P.T.S.D. in the aftermath of an initial potentially traumatic event are vulnerable to increased P.T.S.D. symptoms after subsequently experiencing a new potentially traumatic event or ongoing daily stressors (Schock, Böttche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016).

Unemployment

Many consider the lack of employment to add further fuel to this fire: unemployment and unstable working conditions do not only present serious economic challenges, but have understandable negative consequences for social integration and psychological well-being (Kartal & Kiropoulos, 2016; Goguikian Ratcliff & Rossi, 2015; Schick et al., 2016; Silove et al., 1998). As noted by Du and Winter (2020), “not only does unemployment itself threaten one’s identity and role in society, but the lack of recognition for one’s skills and prior career path can lead to further losses of one’s sense of self” (p. 39). Goguikian Ratcliff and colleagues (2014) allude to the phenomenon of ‘deskilling’ which they found to exist among refugee populations. They define this as a downgrade in terms of professional skills and educational levels of achievement recognised in the host country as compared to existing experiences in countries of origin. They attribute the phenomenon in part to restrictive institutional practices anchored in discriminatory legislation, institutional practices, and social representations of refugees. The difficulty in finding employment, deskilling, social isolation, and the significant differences between the pre-migration work expectations and encountered reality on the labor market upon arrival are likely to produce feelings of discouragement, injustice, self-deprecation, social and occupational worthlessness, and lack of satisfaction and, ultimately, are likely to harm mental health.

Referring to the psychological consequences of this lack of agency inherent to situations of unemployment, Holzkamp (2013) states:

“Each individual’s existential orientation is a subjective aspect of the type and degree of her/his agency – that is, opportunities to act and constraints on those opportunities. Human suffering or, generally, any injury, including anxiety, has the quality of being exposed to and dependent upon other - directed circumstances, dissociated from possibilities of controlling essential, long-term conditions, i.e. constraints on possibilities to act... a real improvement in the subjective quality of my life is synonymous with enhanced

influence over my objective life conditions – that is, with my opportunities for forming alliances, i.e. uniting with others.” (p. 20-21).

He argues that “by attempting to obtain some discretion to act through participating in power and utilizing the allowed leeway, one concurrently confirms and reinforces the conditions of one’s own dependency” (p. 24). The implication is that an insecure residency status dependant on being vouchsafed by the particular authorities could be rescind at any time and only serves to perpetuate unequal power relations and negate legitimate freedom to act. The impact is two-pronged: the lack of employment opportunities has inevitable socio-economic consequences which in turn affect mental health - on top of being potentially socially demeaning or devaluing which in turn affects self-worth (Hynie, 2018). A meta-analysis of 56 reports published from 1959 to 2002, representing 22 221 refugees, found that mental health status was worse among those living in institutional accommodation or with restricted economic opportunity (Porter & Haslam, 2005). Successful recovery from potentially traumatic events depends to a large extent on the social, political and economic conditions and opportunities in the receiving country (Heeren et al., 2014).

Race-related trauma

A plethora of research has demonstrated the psychological impact of discrimination and racism experienced by migrants in general (Akhtar, 1999; Kartal & Kiropoulos, 2016; Goguikian Ratcliff et al., 2015). Visible minority status leads to more post-migratory psychosocial adversity (Hollander et al., 2016) and even more so when it comes as a surprisingly new and disorienting experience (Akhtar, 1999). Indeed, race-based traumatic stress has been demonstrated to be significantly related to trauma reactions (e.g., dissociation, anxiety, depression, sexual problems, and sleep disturbance), especially in instances where individuals have endorsed negative race-based experiences as stressful. This race-based traumatic stress model is based on empirical evidence from the racial discrimination, discrimination, race-related stress, and life-event research literatures. Empirical evidence has been generated in support of the construct and measurement of race-based traumatic stress (Carter et al., 2017). Research confirms that stigmatization (linked to discrimination and racism) is strongly associated with a higher prevalence of current and lifetime P.T.S.D., a decreased likelihood of spontaneous remission, and lower therapy success (Schneider et al., 2018).

This literature highlights how, especially among refugees, there are many subtle and complex stressors linked to race-based trauma with significant negative consequences for mental health. These stressors may be perpetuated by being forced to discover a new sense of identity, when many external factors indicate a person’s “otherness.” In considering the role of ethnic identity in post-migration acculturation in particular, Tummala-Nara (2007) highlights how racial trauma can have a profound impact on an individual’s sense of self, identity formation, relationships with others, and perceptions of mental health care. She demonstrates how racially driven trauma poses distinct challenges to an individual’s development of a positive identity by arguing that this type of exposure to potentially traumatic events has the effect of dehumanizing one’s sense of security in and identification with larger social structures. In other words, the experience of race-related trauma, such as misdiagnosis in mental health care systems, racism,

and racially based violence on individual and group levels, has significant impact on individuals' sense of cultural and racial identity and trust in larger social structures. This is particularly true in interactions with professionals of institutions with little or no training in how to think or react in multicultural contexts (Goguikian Ratcliff & Rossi, 2015).

Language proficiency

A key specific aspect of the process of acculturation identified in the literature is that of language, and the role of language proficiency in determining social identity and power relations (Bucholtz & Hall, 2005; Kartal & Kiropoulos, 2016; Norton, 2000; Silove et al., 1998). Unsurprisingly, therefore, language barriers have been shown significantly to affect refugee mental health in both qualitative and quantitative studies (Hynie, 2018). Many authors in the field of socio-linguistics refer to the use of language and semiotic practices in determining social positioning within interactions between migrants and host populations, looking to notions of “indexicality” to examine the relationship between words and their social meanings (Bucholtz & Hall, 2005). The influential role of language in social integration (and by extension, mental health) is not to be underestimated. As Norton (2000) notes:

“Relations of power in the social world impact on social interactions between second language learners and target language speakers. Language is not...a neutral medium of communication but is understood with reference to its social meaning. Identity construction must be understood with reference to relations of power between language learners and target language speakers. The very heterogeneity of society must be understood with reference to an inequitable structured world in which the gender, race, class and ethnicity of second language learners may serve to marginalize them. Subjectivity and language are ... mutually constituted.” (p. 5)

Kartal and colleagues (2018) recently developed a mediation model to examine the relationship between exposure to potentially traumatic events, host language acquisition and mental health among refugee communities. Their robust model convincingly demonstrates that the indirect pathway from exposure to potentially traumatic events to mental health via language acquisition was significant for P.T.S.D.

Gender

The literature indicates that while refugees of both genders are exposed to stressful events to a similar degree, twice as much women develop P.T.S.D. in response to these experiences (Alpak et al., 2015). Tekin and colleagues (2016), however, have noted that gender differences in P.T.S.D. prevalence may simply be a question of how people experience and react to potentially traumatic events: their study revealed that women with P.T.S.D. reported flashbacks, hypervigilance, and intense psychological distress due to reminders of potentially traumatic events more frequently than men, whereas men with P.T.S.D. reported feelings of detachment or estrangement from others more frequently than women. Whether or not women experience more symptoms of P.T.S.D. (or whether they just experience it differently) remains open to debate. However, the literature consistently highlights gender as a significant factor influencing the experiences and subsequent mental health status of asylum-seeking and refugee women.

Firstly, women seeking asylum are less likely to be granted refugee status than men, given greater structural and cultural barriers in the asylum process (Hollander et al., 2016). Goguikian Ratcliff and colleagues (2014) further highlight the link between language proficiency, gender and mental health, noting that refugee women in particular find themselves at the cross-roads of multiple motives for discrimination such as gender, race, level of education and language proficiency. In theorizing the gendered nature of refugee women's experiences, Norton (2000) refers to the silencing that women experience within the context of larger patriarchal structures in society, exacerbated by a gendered access to the public world to which immigrant women in particular are limited. This powerlessness is inextricably linked to what Kiguwa and Hook (2004) term the "triple oppression" of women "in terms of race, class and gender" (p. 239). Among torture survivors in particular, gender has been shown as associated with severely impaired global functioning and poorer mental health including anxiety (Song et al., 2015).

Daily stressors

Due to the very nature of the refugee experience, many typically encounter a myriad of chronic daily stressors in their host environment, including – for example - general and acculturation hassles. Such post-migration or displacement-related stressors have been observed to have a significant impact on the mental health of resettled refugees, compounding the dose-response relationship between past exposure to potentially traumatic events and P.T.S.D. symptoms (Carswell, Blackburn, & Barker, 2011). In a recent study conducted by Minihan and colleagues (2018) among Australian refugees, living difficulties emerged as the most consistent predictor of P.T.S.D. symptomatology. Indeed, the impact of these daily stressors may extend over and above the effects of past exposure to potentially traumatic events (Li et al., 2016; Kenneth Miller & Rasmussen, 2014; Nickerson et al., 2018; Porter & Haslam, 2005; Schock et al., 2016; Song et al., 2015) – a phenomenon referred to by Keles and colleagues (2016) as the "above-and-beyond trauma effect" of such hassles. In a recent study on the impact of new potentially traumatic events on pre-existing P.T.S.D. among refugees, Schock et al. (2016) discovered that, "contrary to our expectations, new stressful life events influenced the symptom course more than the experience of a new traumatic event." (p. 7, my emphasis). In their study, most of the mentioned stressors were related to an insecure residence status and the related insecurity concerning their life and their future – as well as new or ongoing political unrest in their home country. Another study goes so far as to purport that individuals who are resettled longer may encounter a greater accumulation of daily stressors leading to a deterioration in mental health and increasing the predictability of P.T.S.D. (Kubiak, 2005).

Resilience

Despite all of these hardships outlined above, there is often a pragmatic choice to remain in the host country for as long as the material benefits outweigh the social costs, even if this means enduring an existence on the periphery of society and the ambivalence inherent in the decision to stay in order to secure a better and more secure life (Masade, 2007). As Jablensky et al. (1994) conclude "migration has always and will continue to be an integral part of the human

response to threat and opportunity, even in the face of obvious hardships and hazards that are part of the departure, transit, arrival and resettlement phase of migration” (p. 327).

While indeed the stories of refugees are often unfathomably difficult and layered with sometimes profound and potentially traumatizing events, they too are often stories of hope and human triumph (Neace, 2020). The past few decades have seen a substantial interest in the field of resilience among refugee communities (Bäärnhielm, 2016; Bélanger-Dumontier & Vachon; Laban, 2015; Lusk & Baray, 2017; Goguikian Ratcliff, 2007; Roberto & Moleiro, 2016; Simich, 2014; Siriwardhana, Abas, Siribaddana, Sumathipala, & Stewart, 2015; Tummala-Narra, 2007) - as well as the related concepts of post-traumatic growth (Calhoun & Tedeschi, 2014; Droždek & Wilson, 2007; Marsella, 2010; Tankink & Richters, 2007; Tedeschi & Calhoun, 2004; Uy & Okubo, 2018) and adversity-activated development (Papadopoulos, 2002a, 2002b, 2007) – whereby individuals “not only survive the inhuman and cruel conditions they have endured with a significant degree of intactness but, moreover, they become strengthened by their particular exposure to adversity” (Papadopoulos, 2007), p.306).

Increasingly, resilience is considered not as an individual trait, but essentially as a dynamically transforming social and environmental attribute (Lusk & Baray, 2017). As notably conceptualised by Ungar (Ungar, 2004, 2005, 2008, 2011),

“Resilience is both the capacity of individuals to navigate their way into psychological, social, cultural, and physical resources that sustain their well-being and their individual and collective capacity to negotiate for these resources to be provided and experienced in culturally meaningful ways.” (Ungar 2008, p. 225)

Such an understanding of resilience explicitly considers the ecological embeddedness of the individual within social, cultural and historical context in order to consider the complex interactions of protective mechanisms with exterior risk factors. Recent research on resilience in refugee contexts in particular focusses less on the construct as an intrinsic process (Song et al., 2015) but a dynamic one – inevitably context and time specific (Maercker & Hecker, 2016; Sleijpen, Mooren, Kleber, & Boeijs, 2017). Furthermore, this understanding of resilience rejects an understanding of the concept as situated within an individual, but similarly considers the “collective resilience” of entire communities (Meili, Heim, Pelosi, & Maercker, 2019; Tummala-Narra, 2007).

In a recently published study on psychopathology among African unaccompanied refugee minors, Huemer *et al.* (2016) found a surprisingly low prevalence of P.T.S.D.. They noted that “for the majority of subjects, resilience actually co-occurred with indicators of vulnerability.” (p. 1, my emphasis). This echoes the findings of Sleijpen and colleagues (Sleijpen, Haagen, Mooren, & Kleber, 2016; Sleijpen et al., 2017), whose results concluded that there was simply no statistically significant relationship found between post-traumatic growth (PTG) and P.T.S.D. Indeed, they appeared to be independent and co-occurring constructs. What the literature highlights, therefore, is the substantial resilience shown among refugee communities which co-exist with mental health challenges. As argued by Minihan and colleagues (2018), resilience is a common pathway among survivors of potentially traumatic events, and “even in the context of cumulative trauma and resettlement stress, psychosocial adaption is the

normative response” (p. 257). Moreover, the degree of resilience displayed by a person in a certain context may be said to be related to the extent to which that context has elements that nurture this resilience (Gilligan, 2004). Goguikian Ratcliff and colleagues (2014) demonstrate that when faced with local professional social reality, migrant women in Quebec develop specific strategies of resistance and resilience that guide their choices relating to integration: accept unskilled jobs, back to school, favoring ties national or family community, give up work and stay at home, etc. Among Congolese refugees in Kenya, Tippens (2017) identified the following strategies of resilience: (a) relying on faith in God’s plan and trust in religious community, (b) establishing borrowing networks, and (c) compartmentalizing the past and present.

In terms of a resilience in the face of ongoing stressors related to social marginalisation, there is increasing evidence in favour of what Kadianaki (2010) refers to as a “fluid and contextualized immigrant identity, negotiated and constructed in particular social contexts, forged through social representations, dominant social discourses and specific social structures, and affected by issues of power” (p. 438). She highlights several “cases of individuals who responded to the stigmatized representation of their ethnic identities by creating ... ‘symbolic spaces.’ These spaces were ‘furnished’ with interconnected cultural elements and familiar national symbols, which sustained positive identities in the face of opposition, racism, and discrimination.” (p. 443).

This further clouds an already murky picture of experiences of potentially traumatic events among refugees: on the one hand, it is clear that refugees continue to suffer from a plethora of potentially traumatic experiences – facing multiple inter-connected stressors pre-migration, during migration and post-migration. However, the evidence also points to the impossibility of remaining within a simplistic and reductionist discourse of “all refugees are traumatised.” Do the multiple accounts of resilience among refugees serve to demonstrate that not people are affected by potentially traumatic events, or does it simply highlight practical survival mechanisms put in place to defend against it? Furthermore, there is inconsistent evidence regarding the relationship between acculturation and mental health. As noted by Kartal and Kiropoulos (2016), some research suggests that higher levels of acculturation with the host culture are associated with better mental health, while others reported that higher levels of acculturation with the host culture is associated with worse mental health outcomes, a phenomenon named the “immigrant paradox” (Berry, 2003; Kartal & Kiropoulos, 2016; Sam & Berry, 2010). Likewise, post-migration resources were found to offer no contribution to mental health outcomes in multivariate analyses. While several large-scaled studies found associations between post-migration living difficulties and mental health status, findings on post-migration resources such as social support or language proficiency are inconsistent, one possible explanation being a declining influence of resources over the course of time after migration (Heeren et al., 2014). Many questions remain unanswered.

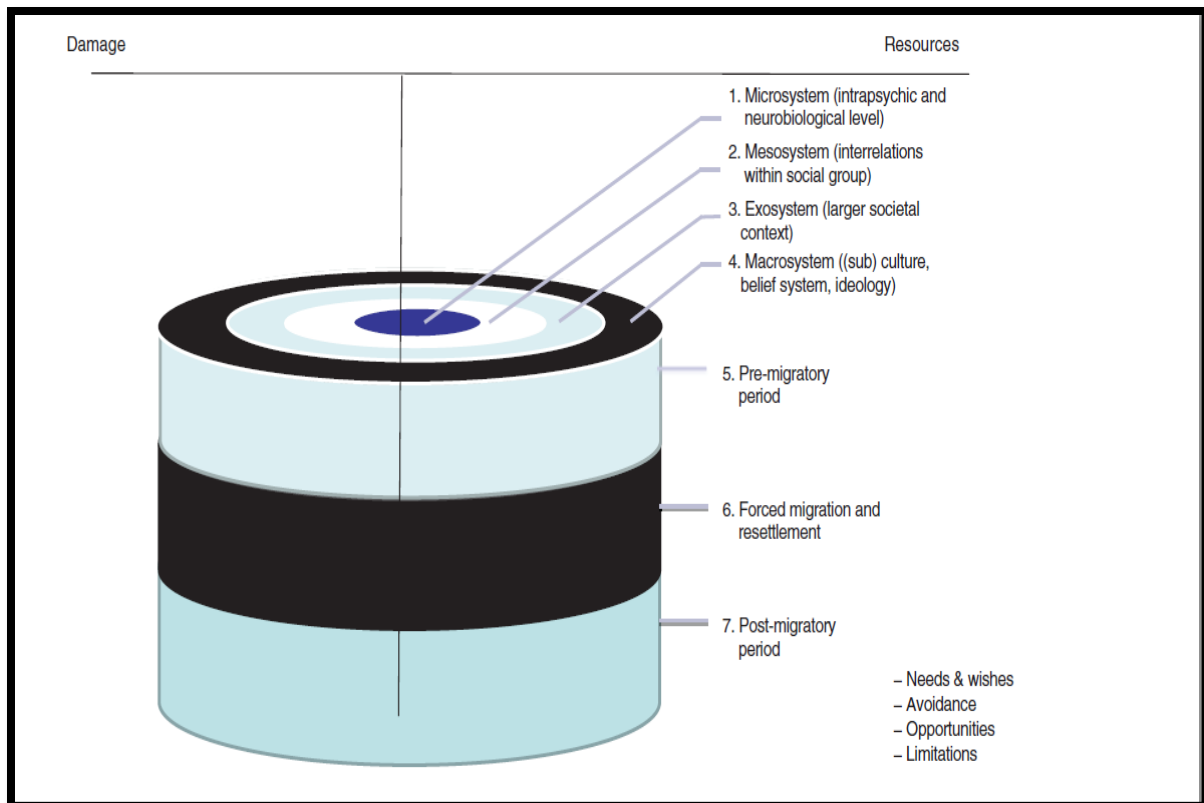
Considering the interrelation of factors

It is clear that the road to recovery for refugees is a long and complicated one, and that the mental health needs of this population remain poorly understood. Many studies on traumatised refugees demonstrating the relationship of ongoing psychological impairment and overextending post-migration living conditions, even if formal safety is achieved (Bogic et al., 2012; Schick et al., 2016). In one example in the literature on mental health among resettled refugees in Switzerland (Schick et al., 2016), participants in general showed remarkably poor integration, particularly in terms of labour market participation and language proficiency, and were subject to a high number of migration-associated living difficulties. This was despite comparably high education and long duration of residency in Switzerland typically over 10 years.

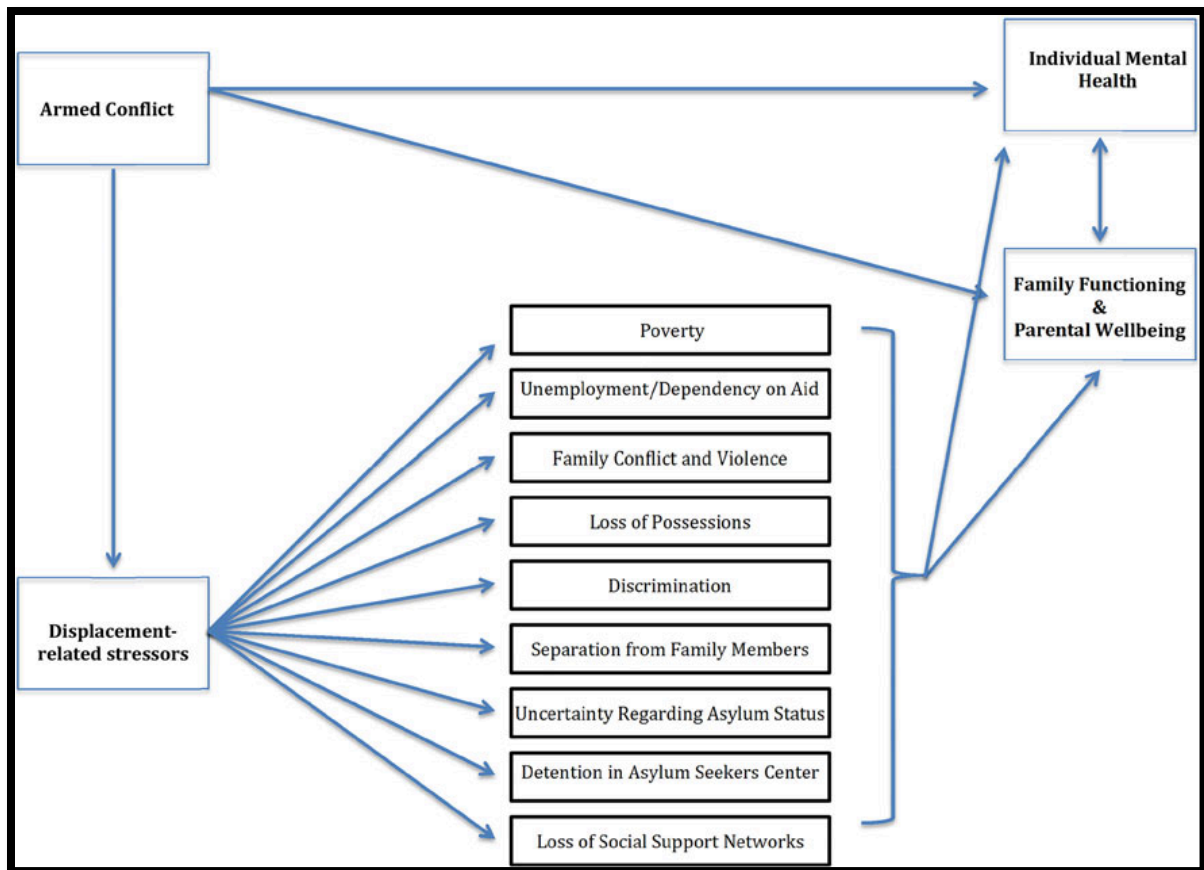
Although systematic research into the mental health of asylum seekers is in its infancy, there is growing evidence that salient migration stress facing asylum seekers adds to the effect of previous potentially traumatic events in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms (Silove et al., 2007; Silove et al., 2000). Once again, what is highlighted is the interplay of pre-migration and migration factors influencing mental health. This includes the physical and material hardships of the journey and poor treatment by authorities. Such difficulties encountered during migration risk perpetuating the structural violence, injustice and intolerance faced by asylum seekers in their countries of origin and once more during the asylum seeking process, thereby serving to reinforce physical and psychological vulnerability (d'Halluin, 2009; Fassin & d'Halluin, 2005).

Two key models highlight this interaction of factors influencing the mental health of refugees pre-, during and post-migration:

- 1) Droždek's (2015) model identifies factors of damage as well as resources during the pre-migratory phase, the period of forced migration and the period of resettlement. Furthermore, these factors are mapped according to the ecological levels of the microsystem, the mesosystem, the exosystem and the macrosystem. Such a model thus incorporates the multiplicity of factors influencing mental health.



- 2) Miller and Rasmussen's (2017, Figure 1, pg. 4) social ecological model similarly expands the view beyond the field's historical focus on pre-migration factors alone, by drawing attention to current stressors associated with the challenges of adapting to life in exile, or displacement-related stressors. They argue that such ecological conceptualisations of refugee mental health show significantly greater predictive power than the more narrowly focused single-event trauma exposure model that has guided earlier research.



Such models, often based on the socio-ecological tradition of Bronfenbrenner (Bronfenbrenner, 1986), conceptualise psychological distress associated with potentially traumatic events as stemming not only from the violence and destruction of isolated events such as war, but also from stressful life conditions linked to social and material conditions of everyday life following displacement.

The multiple stressors faced by refugees are continuous and interconnected – before fleeing home to after having spent years in a host country. Given this complex interplay of factors, it is questionable as to whether or not one could neatly separate the pre-migration, migration and post-migration periods as being distinct phases. The difficulties inherent to each of these speak among each other in a way which appears to be more circular than linear. Therefore, as useful as it is to “map” the factors affecting refugee mental health, one needs to move beyond such a static representation in our reflections. Let us consider the refugee who receives news of a beloved family member’s passing back home in their country of origin, yet who is left with little resources to mourn the death outside of his familiar religious community. Let us consider the refugee whose experience with the police force upon arrival in Europe echoes similar experiences with the police force of her country of origin. It is exactly this dynamic complexity of human experiences of migration and mental health that needs to be considered. Such a consideration, however, does appear in some sense to be in direct contradiction to a more static conceptualisation of “trauma” as essentialised in the nosological category which is a diagnosis of P.T.S.D. Can P.T.S.D. capture this complexity? In the following chapter, I aim to partly explore this question by reviewing the politicised history of the diagnosis – tracking it’s

development in sociocultural and historic context and reviewing the critiques that have been levelled against its pertinence and validity for refugee populations in particular.

“It is necessary not to give way to the social demand to ‘psychiatrize’ this problem, but instead to preserve it as a human problem and a political problem of an enormous scale rather than reducing it to a health problem, this being a perverse trick which makes the establishment feel comfortable.” (Viñar, 2005b, p. 322)

CHAPTER THREE: Critique of P.T.S.D.

P.T.S.D. as a disorder was first introduced as a diagnosis by the American Psychiatric Association (1980) in the D.S.M. III in 1980, with interest in it booming to such an extent thereafter that it was referred to in mass media as “the disorder of the 1990s” (Marsella et al., 1996). There was equally a rapid international diffusion of the concept from its conception, including a politically-driven mobilization of this concept to highlight the suffering of refugees coming into Europe in the late 20th century (d’Halluin, 2009). Referring to the now ubiquitous use of the word “trauma”, Laqueur (2010) notes: “having once been relatively obscure, it is now found everywhere: used in the New York Times fewer than 300 times between 1851 and 1960, it has appeared 11,000 times since” (p. 19). Beyond the field of mental health, this category has also imposed itself in the social world : in public spaces, as a mode of intelligibility of individual and collective experiences related to dramatic events, and in action as a form of response to these situations (d’Halluin, Latté, Fassin, & Rechtman, 2004). It’s a “sexy diagnosis” (Struwe, 1994, p. 319) However, despite its popularity and dominance in Western cultural discourse as an integral part of our collective conscious (Summerfield, 1996), P.T.S.D. has had a much longer and complex history (Andreasen, 2010; d’Halluin, 2009; Fisher, 2014; Larrabee, Weine, & Woolcott, 2003; Summerfield, 2001).

Disputes over the legitimacy of the diagnosis, particularly during the period leading up to its codification as a disorder in the D.S.M.-III, are well documented in the social science literature (Eagle, 2014; Fisher, 2014; Herman, 1992a, 1992b; Young, 1995). Andreasen (2010), for example, highlights how the roots of the diagnosis as a construct as well as its popularity has been inextricably linked to post-war experiences of predominantly white male American soldiers:

“Because World War II brought together psychiatrists from all over the world and from all over the United States, it became clear that they could differ in training, conceptual framework, and in approaches to diagnosis and treatment. A consensus developed that some standardization was needed, and this challenge led to the creation of the first diagnostic manual, developed by the Veterans’ Administration. This provided an incentive to the American Psychiatric Association (APA) to develop its own manual: the first Diagnostic and Statistical Manual of the APA, or D.S.M.-I, which appeared in 1952. This manual included a category called gross stress reaction... The first revision of this manual, D.S.M.-II, was published in 1968. Without any explanation, the diagnosis of gross stress reaction was omitted. The most plausible explanation for the omission is that the concept was closely linked to warfare and combat, and D.S.M.-II was written in a peaceful era” (p. 68).

It was notably with this work with veterans of the Vietnam combat in the 1960’s that the trauma mental health movement (including an awareness of the impact of potentially traumatic events) can really be said to have begun. These socio-political forces and trends drove the rise in the popularity and salience of discourses of trauma – including the political momentum produced

by the Vietnam Veteran's associations and the anti-war movement of the United States who were seeking recognition of the damages of conflict (Eagle, 2014; Herman, 1992a, 1992b). This later expanded to include female survivors of sexual assault (Burgess & Holmstrom, 1974; Foa & Kozak, 1986; Koss & Harvey, 1991). Another significant wave of interest in the category of P.T.S.D. similarly occurred in the nineties, where a surge of humanitarian actors drew on the concept. They used it not only to inform their emergency medical interventions but also as a way to testify to the suffering of populations in the developing world. Indeed, this application of P.T.S.D. was fundamental in the formation a new language of political denunciation of the dramas humanitarian actors encountered in the field (d'Halluin et al., 2004). The stage was similarly set for the modern era of research into potentially traumatic events among refugee populations in particular, with the first studies being conducted among South East Asian refugees – for example Cambodian survivors of the Khmer Rouge (Mollica et al., 1992; Mollica et al., 1998). P.T.S.D. thus has been “glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources” (Young, 1995, p. 5). Today, the burgeoning interest in P.T.S.D. among refugee populations continues to shape the humanitarian field.

Models of trauma: conflicting theoretical traditions

Since the 1950s, two main positions on trauma have been articulated (Andreasen, 2010; Eagle, 2014). The first position (the “neurobiological school”), represented by thinkers such as Selye (1950, 1956), emphasized how environmental stressors set into motion certain physiological reactions mediated through the nervous and the hormonal systems. Selye coined the term “stress” in the 1950s and hypothesized that physiological reactions to stressors within the environment are mediated by the hypothalamic–pituitary–adrenal (HPA) axis. Within this medical model, the HPA axis is generally considered as a healthy and functional system but maladaptive and physically debilitating under continued exposure to extreme stress. The second position (the “psychological school”) was rooted in psychodynamic theory. It considered responses to stress from a more subjective and context-specific perspective by emphasizing the role of the unconscious and of repressed childhood memories in how individuals respond to stressors within their environment.

These two conceptual frameworks, the neurobiological and the psychological, continue to set the stage for debates in the field of traumatology regarding the cross-cultural applicability of P.T.S.D. as a diagnostic construct. Is P.T.S.D. a universal construct? What is the same and what is different across cultures? Scholars falling predominantly into the “neurobiological school” point to the scientific evidence, particularly neurobiological studies, which have documented that affect regulation and right hemisphere alterations in brain functioning are indeed universal (Schore, 2003). They refer to the stable and consistent neurobiological pattern of changes involving the hyper arousal of the sympathetic nervous system such as the augmentation of the acoustic startle reflex, sleep abnormalities and changes in the H-P-A axis (Marsella, 2010; Marsella et al., 1996). This position highlights neurobiological/physical responses to potentially

traumatic events. These are responses not based on conscious or deliberate meaning, but which go directly to the nervous system as an automatic or “primitive” response based on evolutionary tactics for threat detection and survival (Eagle, 2014; Foa & Kozak, 1986).

In contrast to the neurobiological position, many theorists falling into the second “psychological” school of thought have argued that the location of experiences of potentially traumatic events within a psychiatric/neurobiological paradigm neglects the broader socio-political context. They question the applicability of categories that structure Western psychological discourse, arguing that a diagnostic understandings of post-traumatic symptoms do not give careful attention to the notion that people’s ways of seeing the world, their assumptions, and the discourses available to them, inform the meaning which is attributed to experiencing potentially traumatic events. In short, current discourses on trauma are simply inadequate to grasp the complexity of how different human beings in different cultures respond to potentially traumatic events (Bracken, 2001, 2002; Fisher, 2014; Janoff-Bulman, 1985; Kirmayer et al., 2010; Staeuble, 2004; Summerfield, 2001; Tummala-Narra, 2007; Wasco, 2003; Young, 1995). According to Eagle (2014), seen from within this psychodynamic perspective:

“Formulation of trauma impact requires careful exploration of the manner in which the individual describes the traumatic event and their response to it, including for example, the language they deploy, emphases, omissions, affective tone, and fantasy material; with a view to uncovering pre/unconscious associations to the trauma and the way in which intrapsychic constellations have shaped and/or mapped onto the experience. A strongly ideographic approach is maintained in which trauma impact can only be fully appreciated with a careful personal history taking, formulation of personality constellation and dynamics, and attention to unconscious as well as conscious meanings.” (p. 9)

This relativistic and individualistic model is in clear contradiction of the “biological” model of psychiatry which seeks to re-position psychiatry as a medical specialty replete with well-defined disorders with identifiable symptomatology and treatment protocols (Marsella, 2010).

A third school of thought, based on the cognitive tradition, recognises that P.T.S.D. involves specific cognitive and behavioural responses mediated by forms of learning and memory, as well as processes of recall and narrative elaboration that are regulated by the personal as well as socio-cultural meaning of potentially traumatic events (Kirmayer, 2001). The respective fields of ethnopsychiatry in the French tradition (Afana et al., 2010; Aroche & Coello, 2004; Devereux, 1967; Fassin, 2000; Moro, 1992; Nathan, 1986; Sironi, 1999), transcultural psychology (Moro & Baubet, 2013), and medical anthropology (Kleinman, 1978) are among the disciplines which have long criticised the use of P.T.S.D. as a nosological category – considering it to be the result of dialogue among different actors who create normative models to explain and treat suffering relating to experiencing potentially traumatic events. Much criticism from the field of medical anthropology, for example, calls attention to the exclusion of alternate illness presentations related to potentially traumatic events and a neglect of the role of contextual factors in the emergence and characteristics of psychopathology (Lewis-Fernández & Aggarwal, 2013). This, they argue, leads to a pathologization of reactions to potentially traumatic events in part to determine social, cultural, and administrative acknowledgments and consequences.

On reflecting these different theoretical positions, Eagle (2014) wryly notes that “reading the traumatic stress literature (or at least a substantial proportion of it) it is sometimes difficult to comprehend that writers are describing the same phenomenon” (p. 47). She refers to Laqueur’s (2010) observation that trauma is much of a moral as it is a medical category, and to Fassin and Rechtman’s (2009) suggestion that trauma is a “floating signifier that denotes any number of ills which have the name” (p. 19). She concludes: “thus on the one hand we have the validity of traumatic stress ultimately tied to its location in neurophysiology or anatomy, and on the other, a suggestion that traumatic stress is to some extent a discursive or epiphenomenal construction with political and strategic effects. It is difficult to see how these positions might be reconciled” (p. 47).

Fisher (2014) similarly examines this debate and postulates that both the “biological” and “psychological” interpretations of P.T.S.D. may be true. He concludes that biopsychic realities, identified through biomedical knowledge structures, do indeed underlie the P.T.S.D. construct while the manner in which the disorder manifests is equally informed and shaped by the cultural meanings and perceptions attached to potentially traumatic events. In other words, he views the disorder from within a “social diagnosis” framework which presumes that individuals contribute to the creation of a diagnosis which is inextricably linked to political, economic, cultural and social factors. His argument is linked to social constructionist critiques of medical diagnoses in general, as outlined in depth by Brown (1995) and others such as Goguikian Ratcliff (2015) and Turner (1992) who have opened up a sociological debate about illness and advocate for attention to be paid to the individual social experience, language and symbols in order to deconstruct politically charged diagnostic categories and definitions. These ideas are based on Foucaultian (Foucault, 1988) principles of social constructionism which emphasize the role of language, definition-making, symbols and structures in psychiatric “illness” experiences and actions regarding the body, necessarily situated within personal, dyadic and group levels. Such a paradigm would imply that a thorough, integrative understanding of the multiple dimensions of each context is needed (Weine et al., 2002). As such, it is rooted in wider Foucaultian critiques of the way in which the production of academic and professional psychology has led to the “governing of the soul” – through a range of “technologies of subjectivity” that regulate human behaviour, often in ways that sustain deeply problematic power relations (Campbell & Cornish, 2014).

What is “trauma”?

One particular point of criticism highlighted is the fact that P.T.S.D. by its very definition requires a “traumatic” event to have taken place, which in itself relies on the subjective experience of the individual and subsequent cognitive appraisal of the event. The very first criterion required to meet the diagnosis, known as “Criterion A” according to the D.S.M.-V (APA, 2013) is an “exposure to actual or threatened death, serious injury, or sexual violence” (p. 271). Thus, an explicit causal mechanism is built into its very diagnostic criteria. This is inherently related to the socio-political and historical context in which the diagnosis was developed. Indeed, the experience of war has been a central element in the search for relatively

delineated potentially traumatic events, such as a robbery, disaster, or traffic accident, mainly stemming from the second half of the twentieth century, when the psychological aftermath of World War II was being explored (ter Heide et al., 2016). As such, it was heavily based on assumptions of an otherwise “benign universe” being disrupted by a concrete isolatable event.

The reality, however, is not as simple. Not all trauma experiences relate solely to isolated events in the context of an otherwise stable environment. There are many ethical and clinical challenges associated with being able to identify a clear and discrete event as being “traumatic” required by its very definition for P.T.S.D. to be diagnosed. According to Maier and Straub (2011), the causal attribution of symptoms to a single potentially traumatic event inherent to diagnosing P.T.S.D. represents the prevailing biomedical concept of illness, yet is certainly also one of the most significant shortcomings of psychotraumatology. Are the same events necessarily experienced as “traumatic” by everyone? What components determine whether an event is subjectively perceived as “traumatic” or not? Questions remain about the common elements underlying the diverse experiences of people across the world, and critics of a unifying model of P.T.S.D. therefore challenge the assumption that the same responses to a stressor would manifest across a multiplicity of events and contexts (Kirmayer et al., 2010; Momartin et al., 2003; Tummala-Narra, 2007). These critics view the context in which potentially traumatic events are experienced as shaping and in turn being shaped by worldview, cultural norms and constructions of society and individual victims. “Trauma” is therefore not a disembodied construct linked to a discrete event but a cultural and historical construction (Droždek & Wilson, 2007). As Silove (1999) notes, it is possible that the significance and meanings underlying experiences of potentially traumatic events are more important than the concrete details of discrete events in determining risk to P.T.S.D. Considered from this perspective, P.T.S.D. is not a consequence of potentially traumatic events but of the interaction between these events and culture, specifically potentially traumatic events experienced within an individualized western context (Bracken, 2002).

Recent research has highlighted substantial differences in the ways in which people experience ongoing exposure to potentially traumatic events as opposed to those who have experienced a single event (Nicolas, Wheatley, & Guillaume, 2015). P.T.S.D., however, does not take into account the nature of the potentially traumatic event - the near dead, horror, fear, the unthinkable, the unspeakable – in other words, the “trauma story” which may be experienced both singularly and collectively (Maqueda, 2005). For people whose lives are characterized by ongoing hardship, often shaped by discrimination, poverty and other current and future dangers, traumatic events may fall within a continuum of suffering and may not be singled out or experienced with the same precision as the definition of P.T.S.D. appears to demand (Eagle, 2014). Furthermore, individuals with a trauma history rarely experience only a single traumatic event but rather are likely to have experienced several episodes of traumatic exposure (Cloitre et al., 2009). In many countries around the world, conflict is not an abnormal situation of short duration but rather a *“fait connu”* (Summerfield, 1996, p. 33), influencing all aspects of political, socio-economic and cultural relations in a society. As such, extreme trauma owing to torture and war is both an individual and collective process that refers to and is dependent on a

given social context, marked by its intensity, extremely long duration and interdependency between the social and the psychological dimensions (Becker et al., 1990).

In a study conducted by Maier and Straub (2011) among a sample of refugee patients in a health clinic in Zurich, they noted that many of their patients complained more about their current living conditions than they did about earlier trauma:

“Many patients perceived their (then) current suffering not as a consequence of identifiable traumatic events, but as a delayed consequence of their earlier lives under inhuman conditions. This concept is much broader than just the impact of a torture experience or war scene, and it comprises the impact of longer periods of life characterized by a constant threat, a general and complete negation of the values of humanity, and permanent feelings of helplessness” (p. 235).

They continue:

“No participant mentioned a mono-causal concept of illness; none of the patients believed that a single traumatic event, or even a single experience of torture, was an adequate cause to provoke his or her symptoms. Therefore, the academic concept of P.T.S.D. (i.e., identifiable traumatic events directly provoking pathological symptoms) seems to have had limited explanatory value for these patients. However, many of the interviewees gave meaningful testimonies regarding how they lived over long periods of time under inhuman conditions of war and oppression... If their explanatory models had to be situated in the area between biological, psychological, and social concepts, they tended to relate mainly to social and psychological categories” (p. 244).

Several studies on refugees and asylum seekers have confirmed this clinical impression (Silove, 1999; Silove et al., 1998; Van Ommeren et al., 2001). In their intriguingly titled paper, ‘Is life stress more traumatic than traumatic stress?’, Gold et al. (2005) studied traumatic events among four hundred and fifty-four college undergraduates and found that those who reported a traumatic event which met the diagnostic criteria for D.S.M. displayed *fewer* symptoms of P.T.S.D. than those who had not been exposed to a traumatic event meeting diagnostic criteria. This finding highlights the current debate regarding whether or not to remove “Criterion A” from the diagnosis of P.T.S.D., a criterion which appears to reflect political or moral imperative alongside scientific/diagnostic considerations (Eagle, 2014). In a seminal paper on the topic, Brewin et al. (2009) argue that P.T.S.D.’s “dependence on the etiological criterion is now more of historical interest rather than practical importance” (p. 371).

The notion of prolonged exposure to trauma as potentially resulting in a “complex P.T.S.D.” pathology was first developed by Herman (1992a, 1992b) – and has since become an integral concept in the literature examining the complex and prolonged traumatic experiences of refugee communities (Droždek et al., 2003; Mollica et al., 1998; Momartin et al., 2003; Schweitzer et al., 2006). The notions of “cumulative trauma” first developed by Khan (1977), “complex P.T.S.D.” developed by Herman (1992a, 1992b), “extreme trauma” developed by Becker (1990) and ‘Continuous Traumatic Stress’ introduced by those offering psychological services to political activists during the repressive apartheid years in South Africa (Eagle, 2014; Eagle & Kaminer, 2013), were all constructs developed to conceptualize trauma as having been accumulated over time through exposure to repeated stressors within the environment.

Becker (Becker, 2004; Becker et al., 1990) defines extreme trauma thus:

“Extreme traumatising is an individual and collective process that refers to and is dependent on a given social context; a process that is marked by its intensity, its extremely long duration and the interdependency between the social and the psychological dimensions. It exceeds the capacity of the individual and of social structures to respond adequately to this process. Its aim is the destruction of the individual, of his sense of belonging to society and of his social activities. Extreme traumatising is characterized by a structure of power within the society that is based on the elimination of some of its members by other members of the same society. The process of extreme traumatising is not limited in time and develops sequentially.” (2004, p. 5).

Considering trauma thus as a process, elements of temporality are highlighted, as is the continual interaction of the person with their environment in a given social and historical context. What is particularly interesting in these conceptualisations is the highlighting of the socio-political context and power dynamics at play in influencing the mental health of whole populations. Indeed, considering the ‘elimination of some of its members by other members of the same society’ referred to in the definition is pertinent both to situations of conflict as well as to societal dynamics at play for refugee communities attempting to integrate into host societies and facing possible discrimination.

The concept of cumulative trauma similarly incorporates dimensions of time and the interactive relationship between an individual and his/her ecological surroundings into the discussion regarding trauma, thereby transforming the event (traumatic experience) into a process over the individual’s entire life trajectory (Droždek et al., 2020; Khan, 1977). The concept of continuous traumatic stress (Eagle & Kaminer, 2013) likewise developed in opposition to existing conceptualizations of traumatic stress which retained the assumption that traumatic experiences have occurred in the past. This is due to the fact that many patients living in apartheid South Africa faced the realistic prospect of future victimization and were often living under precarious circumstances, including moving from one potential place of refuge to another. As such, the concept is intended to more accurately capture the “experiences and impact of living in contexts of realistic current and ongoing danger” (p. 85). It does this by taking into account the context of the stressor conditions, the temporal location of the stressor conditions, the complexity of discriminating between real and perceived or imagined threat, and the absence of current external protective systems by the state.

Complex P.T.S.D., in comparison, refers not to trauma having accumulated over time specifically, but is used more to describe severe cases P.T.S.D. with comorbidity (dissociation, depression, substance abuse, personality disorders etc.). It is not recognized as a discrete disorder in psychiatric classifications (Droždek, 2015). However, the topic has gained new impetus in recent years, with an official complex P.T.S.D. diagnosis has been proposed for inclusion in the 11th version of the International Classification of Diseases (Maercker et al., 2013; Nickerson et al., 2016; Silove et al., 2017; ter Heide et al., 2016). The clinical definition of complex trauma ⁵ has gone virtually unchanged since its conception, with the ISTSS

⁵ Note that there is a distinction between complex trauma and complex P.T.S.D., with complex trauma referring to complex traumatic experiences, and complex P.T.S.D. to complex posttraumatic symptoms (Ford, Courtois, & Cloitre, 2009; ter Heide et al., 2016).

guidelines for complex P.T.S.D. speaking of “exposure to repeated or prolonged instances or multiple forms of interpersonal trauma, often occurring under circumstances where escape is not possible due to physical, psychological, maturational, family/environmental, or social constraints” (Cloitre et al., 2012, p. 4). Many refugees, almost by definition, meet these definitions. They have left their country of origin because of persecution, war, or organised violence. There is some preliminary evidence for the validity of Complex P.T.S.D. as a diagnostic construct among highly traumatised refugees emerging in the literature (Nickerson et al., 2016; Silove et al., 2017) - yet a plethora of research shows that refugees are more likely to meet a regular P.T.S.D. diagnosis or no diagnosis than a complex P.T.S.D. diagnosis, and that prevalence of complex P.T.S.D. in refugees is relatively low compared to that in survivors of childhood trauma (ter Heide et al., 2016). As such, the literature raises many questions regarding the clinical relevance and utility of both a simple and complex P.T.S.D. diagnosis among refugee communities.

Conflicting concepts of trauma

If P.T.S.D. were to exist between individuals and not only in them, the construct not only would be incapable of understanding the phenomenon but would also influence the appearance of the illness, treatment strategies (Becker, 1995). We need to see beyond narrow western constructs illness at the level of the individual (Nickerson et al., 2011). This is particularly true of researchers and clinicians working within collectivist ⁶ communities wherein individuals rely more heavily on larger family systems and where mental health is typically seen to be more linked to a broader socio-cultural context (Droždek & Wilson, 2007; Tang, 2007). As Tang (2007) notes: “cultures differ regarding their dominant ideas about the ontology of self as well as relationship between self and others, between self and the universe, and between life and death.” (p. 129). From an historical perspective, cultures have been conceptualized as falling into two categories: the individualistic (guilt) and the collectivist (shame) cultures (Droždek & Wilson, 2007). Tankink and Richters (2007) provide the example of South-Sudanese research participants who did not experience themselves so much as an individual in the Western sense of the term, but more as having a “family self” based on relational models where experiences are considered more within the intersubjective realm of the group rather than on an individual, intrapsychic level.

Bracken (2001) reflects on this individualistic versus collectivist cultural debate in the field of traumatology, similarly arguing that P.T.S.D. as a diagnosis is too heavily focused on a western understanding of illness as situated within an individual, neglecting the social or familial context. He quotes the reflection of Jenkins (1996) in her work with Salvadorian refugees:

“Because traumatic experience can also be conceptualized collectively, person-centred accounts alone are insufficient to an understanding of traumatic reactions. In addition to the social and psycho-cultural

⁶ A note on terminology: I am aware that any easy division of societies into “Western” and “non-Western,” “individualistic” and “collectivist,” or “developed” and “developing” is false to the complexity of the contemporary globalized world. My use of these terms does not mean that I am endorsing any sort of strong social or cultural classification (Bracken, 2001)

dynamics surrounding any traumatic response, the collective nature of trauma may be related to what was ... referred to as the political ethos characterizing an entire society" (Jenkins, 1996, p. 177).

and Summerfield's work with Nicaraguan refugees:

"Western diagnostic classifications are problematic when applied to diverse non-Western survivor populations. The view of trauma as an individual-centred event bound to soma or psyche is in line with the tradition in this century for both Western bio- medicine and psychoanalysis to regard the singular human being as the basic unit of study" (Summerfield, 1997, p. 150).

Current thinking around responses to potentially traumatic events shares the same fundamental assumptions with mainstream psychiatry in remaining too focused on an individualistic and positivist agenda, based on a split between "inner" mind, which can be investigated scientifically, and the "outside" world (Bracken, 2001). This "reductionist discourse" locates the experience of distress solely within the intrapsychic realm of the individual, defining subjective experiences of trauma in terms of "illness, recovery, and broken brains" - a master narrative arguably unrepresentative of each individual's lived subjective experience (Adame & Knudson, 2007, p. 157).

Thus, it is evident that an individual's response to potentially traumatic events necessarily be embedded within a socio-cultural context. Furthermore, one could further problematize this individual versus collectivist dichotomous split by acknowledging the fact that it is not only individuals themselves who face potentially traumatic events, but indeed entire communities. Eagle (2014) refers to notions of collective or historical trauma whereby whole groups of people carry a sense of common persecution or victimization:

"The idea of historical trauma is associated most strongly with the history of first nation people in America and the genocidal violence to which they were subjected. Collective trauma is the term that tends to be used about the response of groups of South Africans subject to a brutal apartheid and colonial history, as well as about the response of groups of Jewish people to the Holocaust. Such trauma may be understood to be transmitted intergenerationally via both conscious and unconscious mechanisms, such that those of generations post those directly victimized nevertheless carry the experience of trauma within themselves. In some respects identity and collective trauma come to be intertwined. Such conceptualizations of trauma may encompass a somewhat broader definition of traumatic stressors including not only relations of oppression that threaten actual survival of the group, but also more ideological forces that threaten the eradication of cultural or group identity. In this framework racism, xenophobia or fundamentalisms based on oppression may be understood to produce collective traumatisation" (p. 13).

She suggests that persons may be traumatised at multiple levels including collective/social, personal/physical and role identity levels, and that which of these levels is most salient at a particular point in time will be dependent both on life history and current environment. This point is no more pertinent to bear in mind than in the case of refugee populations, often faced with a plethora of potentially traumatic events on a collective level.

The problem of pathologization

In a recent paper, Droždek and colleagues (2020) have highlighted the “hidden” long-term impact of war and violence, including “dissociative states, attachment problems, personality changes, guilt, shame, rage, identity issues, moral injury, substances abuse, damaged core beliefs, and bodily sensations linked to stress activation.” (pg. 1) - difficulties not adequately captured by a P.T.S.D. diagnosis. The P.T.S.D. diagnosis has been criticized for its failure fully to account for all of the changes and co-morbid clinical presentations that are common among people who have experienced prolonged exposure to potentially traumatizing events (Friedman & Marsella, 1996; Kirmayer et al., 2010; Steel, 2001; Wilson & Droždek, 2004). The existence of the stressor criterion (Criterion A) implies a unique relationship between exposure to a potentially traumatic event and P.T.S.D., yet “trauma” is also associated with an increased prevalence of other disorders, most commonly depression, generalized anxiety disorder (GAD), panic disorder, and increased substance use (Brewin et al., 2009). Not only is it “too little” in accounting for all responses to potentially traumatic events, it also “too much” in prescribing symptomatic responses which are not necessarily found among different populations across the world. In a meta-review of the literature, Hinton and Lewis-Fernandez (2011) found significant cross-cultural variability which cannot be ignored, including the salience of avoidance/numbing symptoms (far more common among western populations and which Bracken (2001) argues is a specifically westernized postmodern construct), the role of the interpretation of trauma-caused symptoms in shaping symptomatology, and the prevalence of somatic symptoms which were generally found to be more common among culturally diverse samples. Maier and Straub (2011) observed the following among a sample of refugee patients diagnosed with P.T.S.D.:

“Whether they suffered from flashbacks and nightmares, general anxiety, sleeplessness, irritability, chronic pain, or depression, the participants considered the symptoms to not be specific indications of any particular disorder, but merely general expressions of distress. The symptoms, although very discomforting, did not seem to be sufficiently mysterious or confusing to the participants to make them repeatedly search for (medical) explanations and clarification.” (p. 239).

Wilson (2004, 2005 as cited in Droždek & Wilson, 2007) has discussed the unique nature of trauma archetypes and trauma complexes and suggests that the experience of potentially traumatic events is both universal and archetypal for the human species yet with specific manifestations of trauma complexes informed by culture. According to him, P.T.S.D. does not take into account the whole spectrum of the post-traumatic change, including core belief changes, dissociative moments, ruptures in the growth and development of the personality or other comorbid disorders such as depression, substance use and somatization, a view endorsed by many others in the field (Droždek & Wilson, 2007; Kirmayer et al., 2010; Marsella, 2010; Marsella et al., 1996).

According to Wilson and Droždek (2007):

“Posttraumatic syndromes involve a broad array of phenomena that include trauma complexes, trauma archetypes, posttraumatic self-disorders and posttraumatic alterations in core personality processes (e.g. the five factor model), identity alterations (e.g. identity confusion) and alterations in systems of morality, beliefs, attitudes, ideology and values. The experience of psychological trauma can have differential

effects to personality, self, and developmental processes, including the epigenesis of identity within culturally-shaped parameters ...given the capacity of traumatic events to impact adaptive functioning, including the inner and outer world of psychic activity, it is critically important to look beyond simple diagnostic criteria such as P.T.S.D. to identify both pathogenic and salutogenic outcomes as individuals cope with the effects of trauma on their lives.” (p. 371)

It would seem that the diagnosis of P.T.S.D. is simply inadequate to capture this vast range of responses. As Hinton and Lewis-Fernandez (2010, 2011) note, even within the strict frame of the D.S.M., exposure to potentially traumatic events can lead to multiple syndromes, including acute stress disorder and adjustment disorder, as well as major depression, panic disorder, and dissociative identity disorder. Such criticisms raise legitimate concerns surrounding the shortcomings of the diagnosis in capturing the full range of human experiences in the aftermath of potentially traumatic events. These criticisms hold true if viewed from the more narrow perspective of a clinical or “medical diagnosis” paradigm even before one widens the frame to consider broader social-constructionist criticisms of diagnoses in general.

Looking beyond the frame of the D.S.M., Young (1995) suggests that the diagnosis is just one part of a dynamic process of individual adaptation to adversities in life and shouldn’t be considered as merely a diagnostic entity in and of itself. In his interactive model of individual reaction to potentially traumatic events within a socio-cultural context, Chemtob (1996, as cited in Droždek & Wilson, 2007) also describes responses to potentially traumatic events as an inevitable interaction of the universal aspects of reactions to such events with the culture-bound reactions and the personal history of the individual. Scientific research on P.T.S.D., however, has been criticized for remaining badly skewed towards the study of psychopathology rather than on the growth, self-transformation, and resilience often observed among people exposed to potentially traumatic events (Roberto & Moleiro, 2016; Tummala-Narra, 2007; Wilson & Droždek, 2007).

Criticism of the use of P.T.S.D. as a diagnosis among refugee communities

Papadopoulos (2002b) notes how the predominant way in which refugees are viewed today is in terms of trauma theories, stating that “although there are numerous and varied theories about the related themes of conflict, violence, power, identity, ethnicity, trauma, etc., it seems that there is unanimity about one prevailing belief that according to which almost everybody affected by war experiences and political oppression is traumatised.” (p.26). Despite this prevailing belief, the relevance of diagnosing P.T.S.D. among refugee populations has been criticized by scholars such as Summerfield (1996), Haans, Lansen and Brummelhuis (2007), Mattar (2011) and Sturm (2010). They highlight the limitations of western clinicians attempting to apply this medicalized construct among ethnically diverse populations with questionable relevance, as a result of having fallen into the “myth of sameness” (Young, 2004 as cited in Lindy, Morales, & Lindy, 2007).

According to Papadopoulos (2002b), the “refugee trauma” discourse (p. 26), is a linear concept which implies a clear causal relationship between external events and intrapsychic consequences. As such, it ignores systematic complexities such as the relational nature of the event’s impact among family, community, and ethnic group members, as well as the effects of the wider societal discourses which colour the meaning, emphasis and quality of events and experiences. Kirmayer (Droždek & Wilson, 2007), similarly notes that:

“P.T.S.D. is a limited construct which captures only part of the construct of violence, ignoring issues of loss, injustice, meaning and identity that may be of greater concern to the traumatised individuals and to their families. A clinical focus on the symptoms of distress that presented by the refugee, survivor or victim may draw away from contexts that define their identities and possibilities. As time wears on, the salient concerns for survivors become less focused on the meaning of the past than the realities of the present, and possibilities for the future. For refugees, this shift in temporal perspective underscores the crucial importance of their place in host societies” (p.vi).

A significant criticism of the P.T.S.D. diagnosis noted by Hinton and Lewis-Fernandez (2011) involves its dangerous potential for medicalizing human suffering; that is, for reducing the social and moral implications of potentially traumatizing events, such as war or genocide, to a strictly professional, even biological, set of consequences. Thus, by emphasizing the “reality” of P.T.S.D. as a universal bio-psychological category, a focus on P.T.S.D. may have unintentionally and paradoxically helped decrease social and moral responsiveness to these events. As Herman (1992a, 1992b) argues, this is another way for the political and social reality causing potentially traumatic events to be denied or pushed out of our collective conscious. This would be particularly true, for example, in cases of war, which typically terrorizes and destroys entire communities, including social networks and collective identities. In such instances, it is likely that even those who have survived personal atrocities would deem their injuries to be social and political rather than psychological (Summerfield, 1996).

An obvious but often neglected point is that **not all refugees are traumatised**. Recent research suggests that, despite a substantially higher prevalence rate of mental health disorders noted among the population, most refugees are not suffering from mental disorders and most appear recover to recover from distress related to experiences of migration within a year of arrival in the host country (Hynie, 2018). As stated by Summerfield (1996, 1999) in his extensive critique of programmes targeting “trauma” and other psychosocial interventions of international NGOs: all refugees need social justice, and just some need psychological treatment. He criticizes the assumptions underpinning much humanitarian work informed by western models. These assumptions, he argues, reflect “a globalization of western cultural trends towards the medicalization of distress” (p. 1449). Marsella (2010), another ardent critic of the use of P.T.S.D. in humanitarian settings, quotes Wessels:

“In emergency situations, psychologists hired by NGOs or UN agencies often play a lead role in defining the situation, identifying the psychological dimensions of the problems, and suggesting interventions... Viewed as experts, they tacitly carry the imprimatur of Western science and Western psychology, regarded globally as embodying the highest standards of research, education, training, and practice... Unfortunately, the dynamics of the situation invite a tyranny of Western expertise. The multitude of problems involved usually stems not from any conspiracy or conscious intent but rather from hidden

power dynamics and the tacit assumption that Western knowledge trumps local knowledge... Local communities have specific methods and tools for healing such as rituals, ceremonies, and practices of remembrance. Since they are grounded in the beliefs, values, and traditions of the local culture, they are both culturally appropriate and more sustainable than methods brought in from the outside” (Wessells, 1999, pp. 274-275).

Refugees are thus placed in the role of passive victims, their own choices, traditions, survival strategies and competencies ignored, and the role of Western “experts” and their technology in the field of mental health exaggerated (Summerfield, 1996).

To illustrate the cultural imperialism inherent in the imposition of psychological knowledge, Summerfield (1996), provides the example of the conflict in Rwanda in the 1990s which lead to many international NGOs implementing “psychosocial interventions.” One of these interventions included an evaluation of the “knowledge learnt” about trauma by refugees – raising the interesting question of whose knowledge is being prioritised in a context where the local language, Kinyarwanda, does not include a direct translation of the word for “stress.” He has been vociferous in his condemnation of this approach which, in his view, pigeonholes refugees as suffering from P.T.S.D. but pays scant attention to their own perceptions and interpretations of distress and their choices in terms of treatment (Summerfield, 1996, 1999; Watters, 2001). Losi (2002) is another ardent critic of humanitarian interventions focused on P.T.S.D., arguing that it leads to a reductive assessment of the refugees plight, victimization and a shift in the interpretation (and understanding) of the refugees’ experiences, where the reasons for their exile are no longer socio-political but belong to a more neutral, “technical” dimensions. He demonstrates how this de-contextualization of the lived experience of refugees leads to languages and concepts being lost and replaced by medical jargon and obscure terms. Simply put, imposing pre-packaged “universal” interpretations, definitions, tools, and approaches to human psychological suffering does not bring them the help they need. According to Watters (2001) a useful way of conceptualising the needs of refugees may be through the construction of a Maslowian hierarchy of needs wherein humanitarian interventions attend initially to needs relating to physical well-being, such as food and shelter and safety, before “higher-level” needs relating to psychological wellbeing are attended to.

In short, diagnosing an individual with P.T.S.D. may serve as a form of western cultural imperialism (Steel, 2001). The act denies the resilience of survivors (Marlowe, 2010) and serves to reinforce existing imbalances of power between Western “expert” and “victim-patient” (Summerfield, 1996). As stated by Pupavac (2002):

“Internationalization and professionalization of adversity, indigenous coping strategies are thus not merely demeaned and disempowered. The community itself is pathologized as dysfunctional and politically delegitimized” (pg. 493).

A narrow preconception of refugees as invariably damaged, weak or scarred, manifest through the use of a diagnosis of P.T.S.D., may have unintended negative consequences for refugee populations by minimizing strengths and positive adaptation mechanisms (Afana et al., 2010; Marlowe, 2010; Papadopoulos, 2002b; Sturm et al., 2010). Tummala-Nara (2007) explores the

notion of “collective resilience” and post-traumatic growth and adaptation among various culturally diverse populations, noting that the research continues to be defined by predominantly middle-class North American and European values based on individualistic principles which “fail to consider the interdependence of individual capacities, salient attributes of family and community, and/or larger cultural belief systems” (p. 34). In response to this criticism, it must be noted that the notion of Post-Traumatic Growth (PTG) has begun to grow into a burgeoning field in the literature on cross-cultural responses to potentially traumatic events (Calhoun & Tedeschi, 2014; Copping et al., 2010; Droždek & Wilson, 2007; Knaevelsrud, Liedl, & Maercker, 2010; Marsella, 2010; Tankink & Richters, 2007; Tedeschi & Calhoun, 2004; Tummala-Narra, 2007; Wagner, Knaevelsrud, & Maercker, 2007), defined as significant beneficial change in psychosocial well-being, beyond previous levels of adaptation, psychological functioning, or life awareness. This growth includes changes in self-perception, interpersonal relationships and life philosophy (Wagner et al., 2007). More recently, key authors in the field have added the notion of sociocultural influences in their model of PTG – including both proximal family and community as well as the wider (distal) sociocultural environment in general (Calhoun & Tedeschi, 2014; Copping et al., 2010).

The diagnosis of P.T.S.D. also neglects to consider the fact that different reactions or non-reactions to potentially traumatic events – not matching those prescribed by P.T.S.D. – may indeed serve as a defensive and adaptive survival mechanism for individuals who may not have the “luxury” of allowing the experience of psychological distress to impede the urgent and daily task of surviving. Refugees from Mozambique and Ethiopia, for example, have been reported in the literature as saying that an active process of forgetting is a culturally normative method used to overcome difficulties (Summerfield, 1996). In such a context, judging individuals according to a predetermined list of symptoms which are either “present” or “absent” is strikingly simplistic.

The instrumentalisation of the diagnosis among asylum seekers

As succinctly highlighted by Droždek and colleagues (2020),

“Nowadays, the P.T.S.D. diagnosis is often a prerequisite for the survivor’s access to specialized treatment services and for obtaining legal recognition or financial compensation when exposed to violence. However, some survivors do not meet all necessary criteria for the P.T.S.D. diagnosis, particularly not in the long term. Therefore, they run the risk of being misdiagnosed, inadequately helped or undertreated, and may remain legally unrecognized and unprotected” (p. 1).

A significant criticism of P.T.S.D. as a diagnostic construct highlighted within the literature relates to its political use as a tool providing evidence of “damage” in order for individuals to claim quite concrete benefits. Fisher (2014), for example, explores the skewed and often confusing incentive structure for soldiers in the American military to claim a diagnosis of P.T.S.D. for obvious secondary gain. Among refugee populations more specifically, such a diagnosis may open the door for access to care (Brown, 1995) or assist the asylum-seeking process. However, this political use brings significant risk as well as potential benefits.

d'Halluin (2009) convincingly demonstrates the dangers inherent in this contentious relationship between immigrant, medicine and social security by arguing that multiple investigations and abundant political discourses relating to the 'safety' of welcoming refugees into Europe or not began with psychiatrists in the 1970s and continues to this day. The result, she concludes, is that the diagnosis has ultimately become a 'pre-requisite' for validating the experiences of migrants, reifying and reducing these experiences by placing them within an exclusively psychiatric paradigm. Furthermore, she argues, by pathologizing asylum seekers, mental health damages inherent to this population have been used in anti-immigration public discourse to highlight security issues related to refugees as a damaged, diseased 'other'. As such, P.T.S.D. as a political tool has indeed been used to limit and control the influx of migrants. A worrying trend she observes by using the example of France is the way in which the supposedly poor mental health of refugees has similarly been used to justify limiting their right to work in host countries, adding further fuel to a disempowering, victimizing fire. It also serves to detract attention away from the structural violence inherent in the asylum seeking procedure of host countries to which many asylum seekers are exposed - a colonization of intimate psychic spaces in a manner of speaking.

For asylum seekers and their lawyers, the medical certificate, including evidence of P.T.S.D., is an "open sesame" (Fassin & d'Halluin, 2005, p. 600); for officials and judges it is a piece of evidence among others; and for both it is an innovation in governmentality. This labelling of asylum seekers is supported by a system in which tabulation of numbers with psychiatric labels forms a crucial basis for the mobilisation of broader social supports (Watters, 2001) and a new form of the transnational administration of people (Fassin & d'Halluin, 2005). It risks tearing individuals away from the potential protection of their own resilience as well as from their community's traditional means of coping with potentially traumatic events (Losi, 2002). As Papadopoulos (2002b) argues, in our efforts to express our justified condemnation of the individuals, groups and policies that lead to political oppression and crimes against humanity, we offer as "proof" the fact that people have been "traumatized" by these despicable actions. In doing so, we ignore all psychological considerations of how people process experiences and, unwittingly, we end up doing violence to the very people we want to help through psychologizing the political dimensions of human suffering.

In terms of Article 1, Chapter 1 of the Geneva Convention of 1951, a refugee is defined as being someone with a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.' The word 'fear' here is of particular interest as it implies that a refugee is defined by his or her psychological response to events, not to the events themselves. This discursive shift away from a wider understanding of the political context from which refugees may be fleeing, towards a narrower and more medicalized concept of such refugees as suffering from P.T.S.D., may also lead to the moral disqualification and criminalization of unsuccessful asylum seekers who are not found to be "traumatized" (Sturm et al., 2010). According to Summerfield (1996) such a politically loaded use of P.T.S.D. indeed leads to "absurd" (p.14) situations whereby victims of torture and other atrocities fear not being believed unless they can 'check off the tick list of symptoms' required to be diagnosed with P.T.S.D.. He notes that it would be terribly ironic if the survivors of

potentially traumatic events felt that their best chance of getting any help was to position themselves in the role of victim and diminish their knowledge, their anger at injustice and their resilience.

This poses a dilemma for health professionals working with asylum seekers. They may in fact be seen as agents of de-culturalisation and de-politicisation in that they transfigure the refugees' accounts of atrocities into individualised pathology – a process refugees themselves may not be averse to as it may be the only avenue available to secure wider legal and welfare benefits. Fassin and d'Halluin (2005) quote the June 2002 newsletter of the organization Primo Levi which aptly asks, “does one need a paper to prove torture?” The authors state:

“For immigrants, the poor, and more generally, the dominated – all of whom have to prove their eligibility to certain social rights – [the individual body and mind] has also become the place that displays the evidence of truth...asylum seekers are more and more submitted to the evaluation of their physical sequels and psychic traumas, as if their autobiographical accounts were not sufficient... Medical authority progressively substitutes itself for the asylum seekers' word. In this process of objectification, it is the experience of the victims as political subjects that is progressively erased” (p. 597).

They argue that the medical certificate is detached from the lived experience of the victims of persecution, attempting a process of objectification through expert's words and thus desubjectifying individual narratives. A health professional they interviewed is quoted as saying that “by issuing certificates, we're busy judging who's guilty and who's innocent. What situation are we in? We're neither experts nor jurists” (p. 601). Another explains: “it is part of a programme designed to destructure and depersonalize the individual” (p.602). This highlights the multitude of challenges often posed to health professionals, torn between the “moral demand” for P.T.S.D. to be diagnosed at the risk of influencing the therapeutic relationship, which by definition is less based on ‘truth funding’ and more on an exploration of the subjective experience of the individual. For many professionals who find themselves on the horn of this dilemma: “it is their burden and their duty to testify” (p. 604). The other health professionals interviewed by the authors similarly perceived the gap between the meaning that potentially traumatic events can have for the people who were subjected to them and the “semantic reduction” (p. 603) of the clinical examination and medical report.

Despite the potential damage caused to the individual by the use of a P.T.S.D. diagnosis, there are instances where it can be used in the service of marginalized individuals or groups. Drawing up a certificate is a way of validating experiences of the violent acts and potentially traumatic events to which the individual has been subjected – not only are people listened to, it is a recognition that the suffering has been seen. It thus carries a deeply symbolic value. Eagle (2014) refers to research conducted by Foster, Davis and Sandler (1987, as cited in Eagle, 2014) on the impact of torture and detention of political activists in apartheid South Africa which was used to substantiate that individuals have been subject to terror or traumatizing conditions, thereby placing moral pressure on the Nationalist government; as well as the mental health evaluations of political refugees that corroborate their need to escape ongoing brutality from repressive regimes (Steel et al., 2009). Furthermore, within the asylum seeking procedure itself, a recognition of the impact of potentially traumatic events may assist judges and other decision

makers in recognizing and being more attentive to the difficulties asylum seekers may have in verbalising and constructing their case as a result of a compromised mental state which “may impede the applicant’s ability to testify in a manner that appears direct, specific, and emotionally appropriate” (Linton, 2015, p. 1085).

As Steel (2001) notes, making use of the P.T.S.D. diagnosis may present a double-edged sword. On the one hand, it may serve as an acknowledgement of the deep pain experienced by survivors of potentially traumatic events and assist in getting the required help. On the other, it risks becoming a trendy ‘catch-all’ diagnosis open to various forms of political abuse or manipulation. What is needed is not a complete throwing of the metaphorical baby out with the bathwater, but a more nuanced and sophisticated appreciation of experiences of potentially traumatic events in their various forms, an understanding which is less politically motivated and which more accurately reflects the lived experiences of individual survivors of potentially traumatic events – including diagnostic constructs and tools which serve the best interests of those genuinely in need.

Conclusion

One could deconstruct the very notion of “P.T.S.D.” by breaking it up into its various linguistic constituents (Post, Traumatic, Stress and Disorder) in order to summarize some of the major criticisms cited above which have been levelled against it. The first word, “Post,” refers to a discrete event of the past, thus denying the mental health impact of any ongoing factors of stress based on current economic, political and social hardships faced by refugee populations. The second word, “Traumatic,” is problematic insofar as whether an event is perceived to be “traumatic” or not is in part influenced by the individual’s subjective perception of the event, in turn significantly informed by socio-cultural and historical context. The third word, “Stress” implies a specific reaction to the event based on a pre-determined range of psychological symptoms, thereby neglecting the wide variety of possible reactions an individual may have to a traumatic event. The fourth word, “Disorder,” necessarily pathologises this reaction, placing it at the level of the individual and squarely within the framework of a Westernised medical discourse.

By framing experiences of potentially traumatic events in clinical and psychiatric terms, P.T.S.D. has the power to legitimise certain forms of victimhood, victimization and suffering. It is not a politically nor socially neutral construct. Rather, notions of who exactly qualifies as a “victim of trauma” are structurally, ideologically, and discursively located (Eagle, 2014). Such a conceptualisation of “trauma,” then, situates suffering within specific social and historical context. Through creating “victims” or “survivors,” it has the power to direct attention away from sociopolitical sources of suffering, towards a sense of damage and entitlement. By ignoring the quintessential sociocultural and political dimensions of this suffering, we restrict the individual to the role of patient-victim, rather than recognising them as an active participant in their recovery, and an active participant within their community (Van Der Kolk, 2015). Briefly put, P.T.S.D. risks pathologising responses to situations (including armed conflict and torture) which are primordially sociopolitical in nature – rather than a normal reaction to

abnormal events (Métraux, 1999a). Yet, in general, psychometric scales measuring prevalence rates of P.T.S.D. based on self-reported symptoms tend to give inflated prevalence estimates, particular in post-conflict or crisis settings, because of the risk of conflating adaptive distress reactions with psychopathology (Ventevogel & Faiz, 2018).

What these critiques highlight, then, is an awareness of the social construction of this diagnostic category, which necessarily needs to be understood within a particular historical and cultural context, including administrative dimensions implying certain rights and treatment (d'Halluin, 2009). As argued by Brinkmann (2017),

“The most powerful tool to mediate our understanding of suffering today has arguably become the psychiatric diagnoses, serving as a widespread “language of suffering.” ...to the extent that psychiatry’s “language of suffering” permeates different parts of modern life, this specific understanding of mental illness and distress is likely to affect the ways we approach, treat and think about our problems.” (p. 1-2).

There is therefore a strong ethical case for taking a cautious approach to the application of P.T.S.D. as a psychiatric category among refugee populations, who come with a plethora of diverse histories, cultural traditions, definitions and understandings of self, economic priorities and health seeking behaviours (Bracken, Giller, & Summerfield, 2016).

In summary: research identifies that refugees often meet the criteria for diagnoses such as P.T.S.D., but that symptoms present as part of complicated constellations of problems for which there is no consensus regarding treatment approaches. Diagnostic labels may well be useful in drawing attention to problems and the need for support and intervention. However, confusion about the suitability of psychosocial interventions indicates that the kinds of problems experienced by people from refugee backgrounds are not necessarily well understood within the current mental health diagnostic nomenclature of universalized individualistic labels. As d'Halluin (2009) demonstrates in her analysis of psychiatric models used among migrant populations in France in the 20th century, such universalist models of mental health developed after the second World War have rejected *a priori* any notion of singularity, or of ethnic or cultural differences in the manifestation of pathologies.

A more sophisticated, nuanced and culturally sensitive understanding of exposure to potentially traumatic events among refugees, merging clinical, psychological, anthropological, and epidemiological perspectives, is needed. As argued by Neace et al. (2020), “anything less than this level of nuance should be treated with suspicion, especially when the dialogue is focused around creating a special class of people, a trend which seems to dominate public and partisan political discourse” (p. 9). Therefore, in the following chapter, I continue these reflections by reviewing the literature exploring how cultural variations in ways of life and social contexts shape the embodied experience of potentially traumatic events.

“We cannot separate our experience of an event from our sensory and linguistic mediation of it. If these differ, so must the experience differ across cultures. If we define who we are in different ways (i.e., self as object), if we process reality in different ways (i.e., self as process), if we define the very nature of what is real, and what is acceptable, and even what is right and wrong, how can we expect similarities in something as complex as madness” (Marsella, 1982, p. 363 as cited in Marsella, 2010)

“Historians and anthropologists have established conclusively that there are historically and culturally diverse emotion vocabularies. I claim that it follows that there are culturally diverse emotions” (Harré, 1986, p. 10)

CHAPTER FOUR: Trauma and culture

Human beings have an inherent need to make sense of their experiences. This may be particularly true of traumatic experiences which have the potential to shake the bedrock on which one's belief systems are based (Droždek & Wilson, 2007; Herman, 1992a, 1992b). Globally, the literature attests to substantial variations in how people worldwide respond to potentially traumatic events. These culturally-determined variations are seen in how experiences of these events are described and labelled, beliefs about the causes of psychological distress, ways in which people heal (including both formal and informal mental health interventions), and how people who have experienced potentially traumatic events are treated within their communities (Weissbecker et al., 2018). Furthermore, recent research has provided evidence that post-traumatic responses “involve bodily and social processes that are based on cultural models, social scripts and scenarios; much of this knowledge is tacit or implicit and emerges in response to specific cultural affordances that depend on social context.” (Kirmayer et al., 2018, p. 173). Simply put, “culture matters when it comes to understanding and treating psychological sequelae of traumatic events” (Chentsova Dutton & Maercker, 2019, p. 1).

This chapter provides an overview of the literature exploring the pertinent question raised by Droždek and Wilson (2007):

“Does culture (i.e. cognitive-affect belief systems) act as a perceptual filter to the cognitive appraisal and interpretation of psychic trauma? If so, how do internalized belief systems and culturally shaped patterns of coping and adaptation, govern the posttraumatic processing of traumatic experience?” (p. 372).

Early approaches to the study of psychological phenomena from a cultural perspective was concerned with the application of biomedical psychiatric categories in non-Western settings. Since the mid-twentieth century, however, a variety of new fields have developed. These contemporary approaches (such as transcultural, ethno- and eco-social psychiatry as well as new cross-cultural psychology) have shifted away from treating culture purely as a confounding factor to be taken into consideration towards recognizing culture as constitutive of different worldviews with an inherently complex impact on experiences of potentially traumatic events (Kaiser & Jo Weaver, 2019). Many are based on the seminal works of medical anthropologist and cross-cultural psychiatrist, Arthur Kleinman, who was among the first to highlight cross-cultural differences in “causal models” or narratives of potentially traumatic events (Kleinman, 1977, 1978; Kleinman & Good, 2004). Particularly, the approaches have highlighted the

importance of paying attention to the ways in which culture shapes expressions of distress and help- and health-seeking (Kienzler, Spence, & Wenzel, 2019). Importantly, this also includes an acknowledgement of the broader political, social, and economic processes impacting mental health – such as the powerful effects of structural violence and social inequality (Kienzler et al., 2019; Kirmayer, 2018, 2019; Kirmayer et al., 2010; Kleinman, 1977, 1978; Petit & Wang, 2018). This chapter offers an exploration of these approaches. It aims in particular to examine the complex interplay between culture and the experiencing of potentially traumatic events among refugee populations.

Defining culture from a sociocultural perspective

Firstly, in order to enter into this debate, the word “culture” itself needs to be deconstructed and examined– as it is neither a static, reified nor tangible concept. Culture is the ever-changing result of negotiated “compromises between the already established and the imaginatively possibly” (Amsterdam & Bruner, 2000, p. 231). According to Droždek & Wilson (2007):

“The concept of culture is about the process of being and becoming a social creature, about the rules of a society and about the ways in which these are enacted, experienced, and transmitted ... Culture regulates the impact and expression of emotions and shapes individual expressions and perceptions of how to suffer under stress and these modes are taught sometimes openly, sometimes indirectly” (p. 6)

From the specific perspective of sociocultural psychology, Sharapova and Goguikian Ratcliff (2018) define it thus:

“Culture here is considered as a set of practices executed in a tangible and observable way by a social group, as well as internal patterns and belief systems, each level mutually reinforcing the other. Furthermore, culture is not a static characteristic of an individual who continually adapts to ever-changing environments. Human development is thus embedded in social networks, interpersonal relations, and local environment. Therefore, culture plays an important role in shaping our identity, and constructs our reality via a process of cultural representations within a specific historical and cultural context” (p. 2).

Such sociocultural approaches to understanding experiences of potentially traumatic events therefore consider them to be a process that exists both in the intrapsychic realm of the individual as well as within sociocultural realm of relations and interactions – that is “embedded, situated, distributed, and co-constructed within contexts while also being intrinsically interwoven into these contexts” (Stetsenko, 2008, p. 7).

According to Marsella (2010), culture is:

“Shared learned behavior and meanings acquired in life activity contexts that are passed on from generation to another for purposes of promoting survival, adaptation, and adjustment. These behaviours and meanings are dynamic, and are responsive to change and modification in response to individual, societal, and environmental demands and pressures. Culture is represented externally in artefacts, roles, settings, and institutions. Culture is represented internally in values, beliefs, expectations, consciousness, epistemology (i.e., ways of knowing), ontology, and praxeology, personhood, and worldviews. Cultures can be situational, temporary, or enduring” (p. 19).

Culture here is thus considered both as a set of practices physically executed in a tangible and observable sense by the group, as well as integral to belief systems located internally within individual members, each level mutually reinforcing the other. Furthermore, culture is not static but continually adapts to ever-changing environments.

Culturally-informed narratives of trauma: perspectives of diverse theoretical traditions

Tankink and Richers (2007) note that culture is created, maintained and sustained among groups through dominant narratives or discourses:

“Every cultural group creates its own cultural discourse which is built up from cultural assumptions, the tracks of its collective past, cultural notions of femininity, sexuality, gender identity and roles, discursive and symbolic formations and practices, and ideas of how to deal with order and chaos. Equally important are ideas of the values of personal responsibility, of how to control the environment, of how daily life should be arranged, and of an orientation toward the future. Those narrative constructions, often called cultural master narratives, inform a person about what gives life meaning and what is inspiring, and also what is dangerous, risky or worth taking a risk for. Such a cultural discourse has the function of a “cultural script, a kind of social character,” directing individual narratives, behaviour and the making of meaning...It is important to realize that a cultural master narrative is not a fixed, static entity but the result of creative activity in which ideas and notions are developed and shared. Its production takes place in a continuous process of dialogue between individuals and the group they belong to; it is linked with specific contexts, and it is always culturally based” (p. 198-199).

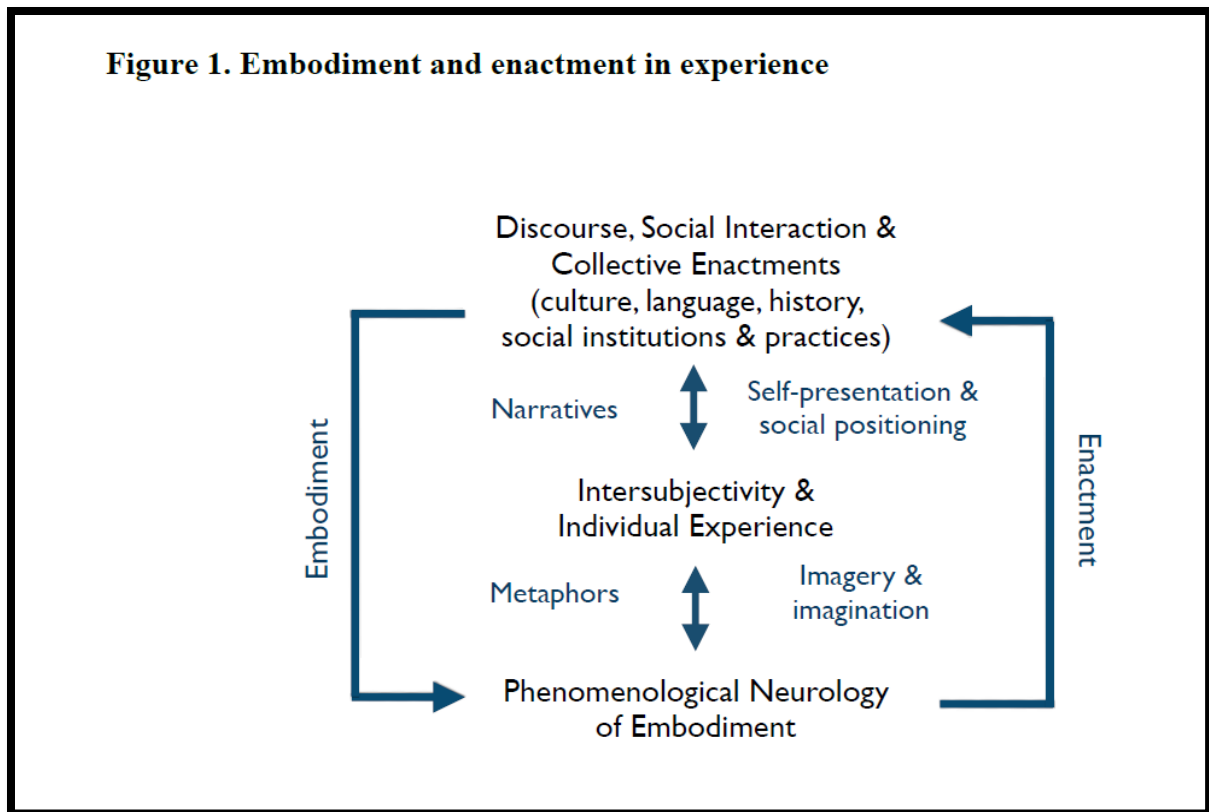
The importance of such culturally-informed narratives related to experiences of potentially traumatic events, or collective representations of psychological distress, has similarly been explored by, among others, those following in the French tradition of ethnopsychiatry founded by Georges Devereux (Baubet & Moro, 2003; Devereux, 1967, 1980; Moro, 1992; Nathan, 1986; Petit & Wang, 2018; Sturm et al., 2007, 2010). In order to examine the role of collective representations in healing from experiences of potentially traumatic events, authors from within this French tradition have drawn on Foucauldian notions that language, political systems and religion are structures of culture. They argue that collective representations of potentially traumatic events and their sequelae provide a frame for the construction of narrations. This frame informs the experiencing of potentially traumatic events and the way in which the individual may be able to convey their distress in socially understandable and acceptable ways. Collective representations enable coherent narratives to be constructed through establishing connections between the present and the past and by providing a meaning behind painful or frightening experiences – thereby bridging gaps between different aspects of an individual’s life experiences which may have become shattered or disconnected as a result of the potentially traumatic event. This includes, for example, theories about the origins of pain and the possibilities of healing, conceptions of family and social bounds, religious or metaphysical conceptions of the world, ideologies or positions in a field of political conflicts (Sturm et al., 2010). In other words, these theories assist in the construction of narratives as a fundamental part of the healing process. Despite the significant impact of collective representations and symbols in experiences of potentially traumatic events, individuals necessarily reproduce them

with transformations in personal ways. They may be commented, questioned, or re-interpreted, or reorganised in a *bricolage* using different symbolic universes (Sturm et al., 2007).

Collective representations or cultural scripts of trauma have alternatively been conceptualised as narrative “master scripts” by the transcultural psychiatrist Laurence Kirmayer and colleagues (Kirmayer, 2019; Kirmayer & Jarvis, 2019; Kirmayer et al., 2018). He notes that “we are narrative beings, fashioning ourselves from the stuff of stories, locating our biographies and life projects in discursive webs of shared meaning” (2019, p. 31). He argues that culturally determined linguistic structures provide the context and rules for interactional processes that underlie complex emotions and provides a lexical base in which emotional experience is embedded (Kirmayer et al., 2010; Kirmayer, 2001). It are these narrative master scripts, or culturally determined linguistic structures which form the “landscape of memory” (Kirmayer, 1996). This emerging field of transcultural psychiatry (alternatively ecosocial psychiatry), spearheaded by Kirmayer among others, has provided some striking examples of how cultural variations in ways of life and social contexts shape embodied experience, and how experiences of potentially traumatic events and their sequelae (including behavioral expressions of distress) vary with cultural knowledge, beliefs, and interpretations. He and others within this tradition (Greene et al., 2017; Kirmayer, 2019; Kirmayer et al., 2010; Kirmayer & Ramstead, 2016; Kirmayer & Minas, 2000) have demonstrated that, while evolutionary history reaches all the way up from brain circuitry to cultural forms of life, culture reaches all the way down to neuroplastic circuitry and epigenetic regulation. Cultural psychiatry, therefore, considers that

“human biology is fundamentally cultural biology and human environments are social environments, constituted by relationships with others and with cooperatively constructed institutions and practices... experience is always preceded by and embedded in cultural systems of meanings and practices, which influence modes of attention and interpretive frames or models.” (Kirmayer & Ramstead, 2016, p. 3).

Figure 1. Embodiment and enactment in experience



As illustrated in the above figure (Kirmayer & Ramstead, 2016, p. 48, figure 1) – cultural psychiatry explores how embodied experiences of potentially traumatic events give rise to metaphors, which structure and shape individual experience, and to narratives, which are amplified, stabilized, and extended through collective enactments. In turn, discursive practices give rise to new metaphors and modes of embodiment.

Other approaches conceptualising mental health from a sociocultural perspective include “medical sociology” - which examines the interplay between social and medical conditions, with the premise that mental health challenges are mediated and modified by social activities and the cultural environment (Nicolas et al., 2015), “social psychiatry” (Di Nicola, 2019), “transcultural psychiatry” (Schouler-Ocak et al., 2019) – which is particular concerned with mental health care for refugee populations - as well as “cultural-clinical psychology.” The latter argues for an integrative approach to understanding clinical disorders in psychology with a consideration of the contextual embedding of these disorders within culturally-determined networks of local meanings, norms, institutions, and cultural products (Ryder, Ban, & Chentsova-Dutton, 2011). Within cultural-clinical psychology, master narratives of trauma have been referred to as “cultural scripts” (Ryder et al., 2011). Originally described by cognitive psychologists in the 1980s, these cultural scripts are defined in cultural-clinical psychology as “specific behavioural and experiential sequences of elements such as thoughts, memories, attention patterns, bodily sensations, sleep abnormalities, emotions and affective expressions, motivation, coping attempts, and ritualized behaviours that are relevant to posttraumatic adjustment” (Chentsova Dutton & Maercker, 2019, p. 1). They are partly culturally shared and intersubjective in nature. They are understood as sequences that are not only familiar to oneself,

but also to others, serving to ground interactions between people. They are guides for understanding and interpreting behaviour as well as rules for behaving. Moreover, they need not be personally experienced to be understood and described by informants in a given cultural context.

Outside of these trans- or socio- cultural traditions, cultural narratives have equally been referred to in the cognitive sciences as “multirepresentational cognitive theorizing in psychopathology” (Brewin et al., 1996; Dalglish, 2004). Dalgiesh (2004), for example, refers to the role of various mental representational constructs (e.g., schemas, propositional representations, pictorial or image representations, distributed networks etc.) in the cognitive modelling of psychopathological states of trauma. The models originate in broader cognitive psychology work on schema and artificial intelligence and draws on the literature on the effects of schema on processing information (Chentsova Dutton & Maercker, 2019). Indeed, “cultural neuroscience” is another tradition exploring the culture-trauma nexus – attesting to the influence of culture on the underlying neural mechanisms involved in the development and maintenance of P.T.S.D. Research within this field increasingly supports the view that mental processes are intrinsically social. It explores how the circuits of the mind extend out into the world, through our tools, discourse, practices, and institutions that enable cooperation. This social view of the brain has now received new recognition and precision thanks to advances in computational neuroscience (Kirmayer, 2019). In relation to culturally-informed narratives surrounding potentially traumatic events and their sequelae specifically, cultural neuroscience argues that those with P.T.S.D. have difficulty in updating these “trauma narratives” – which are shaped by culturally derived self-representations that manifest at both the collective and individual level. Such variations in trauma narratives, they argue, may strengthen specific neural processes that diverge by culture, consolidating particular culturally-informed responses to potentially traumatic events (Liddell & Jobson, 2016; Liddell, Nickerson, & Bryant, 2017).

These diverse approaches seem to agree on the notion that the individual’s experiencing of potentially traumatic events is informed by internalized representational constructs, which is both influenced by and reflected through culture, which is in itself in turn influenced by and reflected through language. The process is inevitably socially situated. Culture thus constructs our reality via a process of socialization within a specific historical and cultural context (Marsella, 2010). It fundamentally affects how people understand and express psychological distress related to experiencing potentially traumatic events. As summarized by Van Maanen (1995):

“Language is auditioning for an a priori role in the social and material world. Moreover, it is a role that carries constitutional force, bringing facts into consciousness and therefore being. No longer then is something like an organization or, for that matter, an atom or quark thought to come first while our understandings, models or representations of an organization, atom or quark come second. Rather, our representations may well come first, allowing us to see selectively what we have described.” (p. 134).

The impact of potentially traumatic events

From a sociocultural perspective, ruptures created by potentially traumatic events are embedded within an intersubjective context wherein severe emotional pain cannot find a relational home in which to be held and integrated (Atwood, Orange, & Stolorow, 2002; Stolorow, 2011). Trauma creates ruptures at the intersection of the individual and their social context and related to safety, trust, independence, power, esteem, intimacy as well as spiritual and existential beliefs. Should this prove to be the case, the lack of connection of past and present can also be understood as preventing the emergence of possible futures. Viewed through the lens of a dialogic systems sensibility, the traumatic world's slipping away from the categories of meaning can be seen as a severe disruption of those relational processes in which meaning is formed (Sucharov, Buirski, & Kottler, 2007). More recently, this rupture in core schemas has been theorised as representing a threat not only to one's core sense of self, but furthermore a violation of self-understanding and worldviews to the extent that it disrupts attachment and interpersonal processing systems necessary for meaning making in the social world (Liddell & Jobson, 2016; Maercker & Hecker, 2016). From within this sociocultural paradigm, this lack of connection to the future is intrinsically linked to a severe disruption of the relational processes by which meaning is dialogically created – the bedrock of which is social recognition. Indeed, research attests to the importance of social recognition in protecting against the development of post-traumatic symptomatology – defined as “positive individual or societal reactions that recognize and acknowledge victims’ traumatic experiences and difficulties” (van der Velden, Oudejans, Das, Bosmans, & Maercker, 2019, p. 287).

Trauma begets trauma. Exposure to potentially traumatic events, itself connected to a breakdown in social connection and exacerbated by the process of migration, risks the individual being caught up in a vicious cycle where no addressee may be found, no language exists to form a coherent narrative whereby the event may itself be collectively represented and made sense of. Indeed, many authors highlight that experiences of potentially traumatic events remain simply inaccessible to verbal recollection (Brewin, 2001; Brewin, Dalgleish, & Joseph, 1996; Brewin et al., 2009), paradoxically the very recollection itself necessary for healing. Returning to the specific context of migration in particular, itself characterized by a rupture in connection to “home” (and all the social, cultural, professional and linguistic connections that this implies) – the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). In such a state, there is no coherently constituted Self: no memory, no clear defining of the Self and of the world in the safe confines of time—only psychological rumination and speaking in embodied signs. Disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and moments in life. Without the container of home-as-it-was, there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012).

According to Kirmayer (Kirmayer, 1996):

“Traumatic experience is not a story but a cascade of experiences, eruptions, crevasses, a sliding of tectonic plates that undergird the self. These disruptions then give rise to an effort to interpret and so to smooth, stabilize and recalibrate. The effect of these processes is to create a specific narrative landscape. This landscape must fit with (and so is governed by) folk models of memory” (p. 14)

Narratives of trauma, then, may be understood then as cultural constructions of personal and historical memory: What is registered is highly selective and thoroughly transformed by interpretation and semantic encoding at the moment of experience (Kirmayer, 1996). Particularly in cases where exposure to potentially traumatic events has been prolonged, “the survivor may be left with large chunks of endured experience with no meaning, creating disquieting gaps and discontinuities in the experience of one’s life history” (Sucharov et al., 2007, p. 2).

For those whose landscapes have been ruptured by potentially traumatic events, “their problem is not the limits of memory but of language—the inadequacy of ordinary words to express all they have witnessed” (p.4). When words fail, when “the temporality of linguistic convention, considered as ritual, exceeds the instances of its utterance, and that excess is not fully capturable or identifiable (the past and future of the utterance cannot be narrated with any certainty)” (Butler, 1997, p. 1), it is naturally falls upon the body to become the site of (re-constructive) action. Métraux (1999a, 1999b) explains this phenomenon as “memory-pain” sticking to the body with an intensity of experience untranslatable by words. Kirmayer (Kirmayer, 1996) further posits that when the image or content of a potentially traumatic memory is unavailable, it is the bodily aspects of memory which persist. In the absence of narrative, the body holds what the mind cannot.

The interplay of factors

Given the complexity of the interrelation between culture and experiences of potentially traumatic events, an examination of the interplay of factors regarding the impact of culture on trauma and trauma on culture requires consideration on several levels:

- 1) The pre-existing cultural context



- 2) The nature of the event



- 3) What meaning is attributed to the event (individually and collectively)

Why did the event occur? What is considered “traumatic” or abnormal versus what is considered “normal?” Arguably, evaluating the ‘toxicity’ of an experience will depend in part on pre-existing cultural norms and “master narratives,” belief structures and group experiences

(including exposure to previous potentially traumatizing events) and the meaning attributed to that event on both an individual as well as a group level.



4) How this sense making determines symptomatic responses

E.g. Guilt due to a belief that bad behaviour caused the rape; fear due to a belief that the tsunami was caused by angry gods who could strike again, acceptance due to a belief in fate...



5) What meaning is attributed to the symptomatic responses

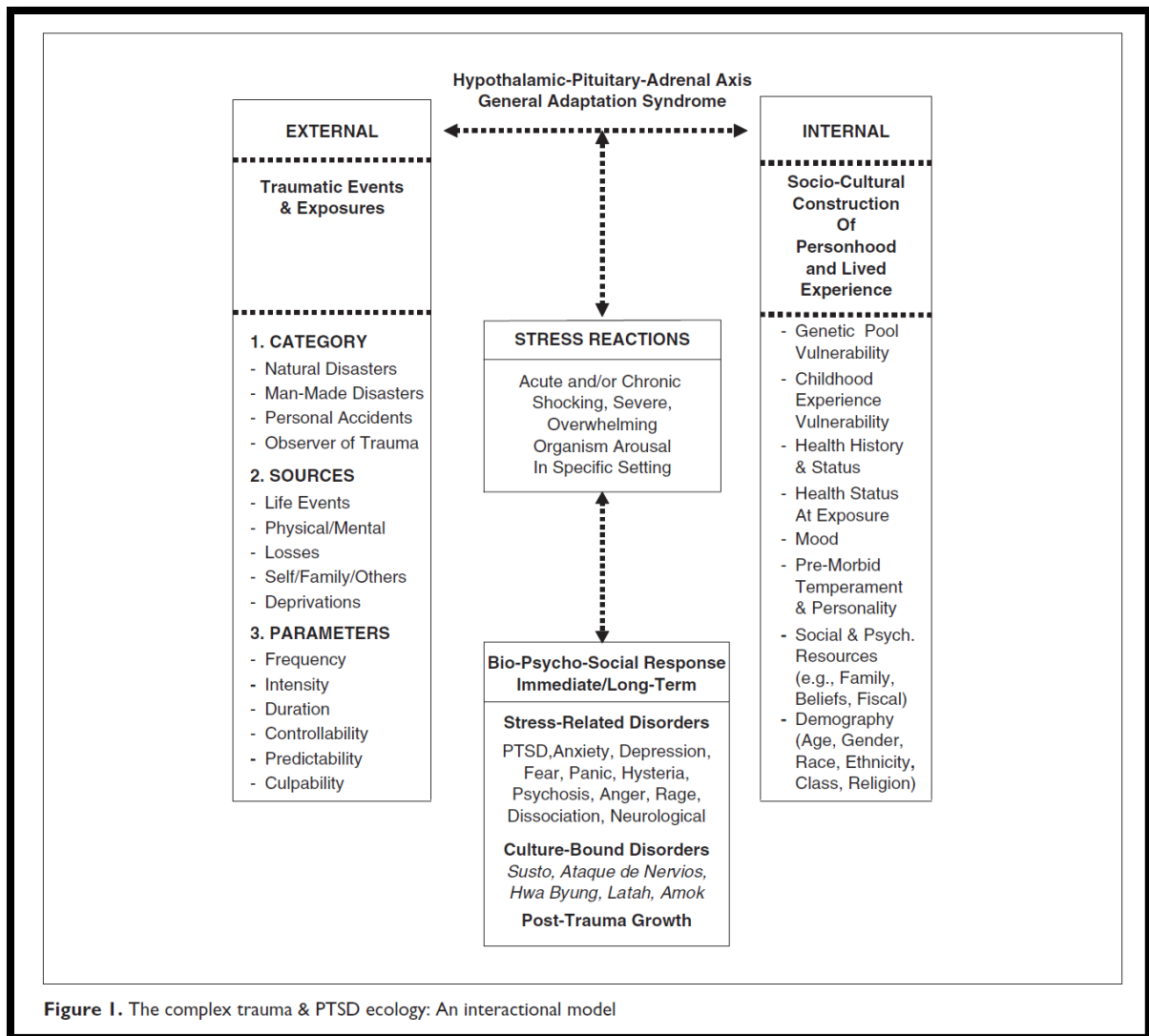
E.g. I'm experiencing flashbacks because I've been possessed by an evil spirit; I am a weak person because I cannot stop crying; my nightmares are messages from the ancestors...

Once again, the meaning attributed to the event is both individual and collective.



6) Healing: How the meaning made of symptomatic response informs health seeking behaviour and treatment outcomes

For a more in-depth exploration of these mechanisms, Marsella (2010) has developed an interaction model from within an ethno-cultural perspective of how culture influences the clinical parameters of the diagnostic criteria for P.T.S.D. and related stress disorders that may occur in response to “traumatic” events (figure 1, p. 21 below). These multi-layered factors may go some way in explaining the interesting cultural variations in response to potentially traumatic events which have been noted in the literature, not only among individuals but also among different cultural groups (Bracken, 2002; Hinton & Lewis-Fernández, 2011; Lewis-Fernández & Kirmayer, 2019; Marsella et al., 1996; Perilla, Norris, & Lavizzo, 2002; Rousseau et al., 1997; Summerfield, 2001).



This model speaks to a larger theoretical debate over the meaning of medical diagnoses in transcultural settings in general. This debate has been well defined by Kleinman (Kleinman, 1977, 1978; Kleinman & Good, 2004) who examines concepts of disease, sickness and illness. He defines the concept of “disease” as describing and categorizing disorders firmly within a Western medical model. “Illness,” however, refers to the subjective experience of this disease, and “sickness” is the social phenomenon which defines the role of the patient and societal expectations around this (Goguikian Ratcliff & Rossi, 2015). As Maier and Straub (2011) note, illness according to Kleinman’s definition is therefore based on conceptual models used by individuals, communities or cultures which provide an explanatory model for the illness. This explanatory model includes more than just ideas about the cause of an illness; they also incorporate ideas about estimating the severity of illness, appropriate treatment, and the meaning of the illness. In other words, explanatory models are based on a

“belief system about illness including which symptoms the ill subjectively experience, beliefs about etiology of the illness, assumptions of the time line or course that the illness will take, perceived consequences (e.g., social consequences) that occur as a result of the illness, and beliefs about what constitutes acceptable treatment options” (Benish, Quintana, & Wampold, 2011, p. 281).

In relation to P.T.S.D. in particular, Maercker and colleagues (Maercker & Hecker, 2016; Maercker & Horn, 2013) have noted that it is one of the rare psychiatric diagnoses that requires an environmental context by its very definition. Not only does it require an exposure to a particular event – the event itself needs to have been interpreted by the individual as being traumatic. They have recently developed a framework model which situates the experience of potentially traumatic events and their sequelae within socio-interpersonal context. The model describes three layers: 1) social affects comprising shame, guilt, anger, revenge, etc.; 2) close relationships including trauma disclosure, social support or negative exchange, empathy, etc.; and 3) culture and society, comprising aspects like the collective experience of potentially traumatic events, social acknowledgment as victim or survivor, cultural value orientation, etc.

Culturally-informed responses to potentially traumatic events: attributing meaning to the experience

Given the significance of the sociocultural environment on experiences of potentially traumatic events, it is therefore no surprise that while symptoms of P.T.S.D. have been found among survivors of both genders, all ages, and diverse racial, ethnic, and cultural groups, it is also true that particular events (such as incest, rape, or spousal abuse) and symptoms (such as dissociation, somatic complaints, *ataques nervios*) may have quite different meanings across different cultural contexts (Harvey, 2007). Droždek and Wilson (2007), highlight some of these differences: Among Cambodian refugees who had suffered multiple potentially traumatic events during the Khmer Rouge regime, many who suffered from P.T.S.D. and depression understood their symptoms in light of their Buddhist beliefs in karma as a station in life, an incarnate level of being and fate where personal suffering is considered from a particular religious-cosmological perspective on the meaning of life. Among the Native American people, illness is thought to result from imbalance, loss of harmony and being dispirited with oneself due to a loss of vital connectedness. A common explanation for the 1988 Yuannan earthquake in China was that a “great dragon” was moving below the earth because he was angry with the people...

Other examples from the literature include Sao Tomean explanations of experiences of potentially traumatic events and their sequelae among migrants in Portugal – where idioms of mental distress typically involved supernatural phenomena rooted in a Christian religious discourse, mixed with indigenous beliefs around witchcraft, “unsatisfied spirits” and the evil eye (Trovão, Ramalho, & David, 2017). A study exploring causal attributions of mental health challenges among Somali refugees in Finland (Kuittinen, Mölsä, Punamäki, Tiilikainen, & Honkasalo, 2017) found that the most commonly endorsed causal attributions were jinn, jealousy related to polygamous relationships, and various life problems. The authors identified five attribution categories which they argue play a crucial role in shaping experiences of potentially traumatic events: (a) somatic, (b) interpersonal, (c) psychological, (d) life experiences, and (e) religious causes. Similarly, in a recent investigation of lay beliefs among asylum seekers of African descent in Germany, asylum seekers attributed symptoms of post-traumatic stress less strongly to potentially traumatic experiences, but more strongly to religious

and supernatural causes such as sorcery, spiritual possession, and being cursed or bewitched (Grupp, Moro, Nater, Skandrani, & Mewes, 2018).

Many researchers and practitioners have made more concerted efforts to engage with these local “idioms of distress,”⁷ and to use this knowledge to re-frame or re-orient interventions to fit with local understandings and lived experience (Kidron & Kirmayer, 2018; Lewis-Fernández & Kirmayer, 2019). A plethora of examples, in response to potentially traumatic events in particular, have been documented in the literature (Afana et al., 2010; Hinton & Lewis-Fernández, 2010; Jayawickreme, Jayawickreme, Atanasov, Goonasekera, & Foa, 2012; Lewis-Fernández & Kirmayer, 2019; Summerfield, 1996). Afana and colleagues (2010), for example, highlight how Palestinian communities have processed continual exposure to war through particular linguistic constructs of trauma: *Sadma* (trauma as a sudden blow with immediate impact), *Faji’ah* (tragedy), and *Musiba* (calamity). *Sadma* is used metaphorically to refer to painful events that happen suddenly, *Faji’ah* is used to describe the reaction to an extraordinary event (mainly the loss of a loved one) and *Musiba* is used when potentially traumatic events are persistent and have long-term consequences. They use these examples to show how such distinctive, historically-bound idioms illustrate communal reflections on the meaning behind experiences of violence, forced displacement, social exclusion, and humiliation. Behind all of the various idioms of distress found across the world lie social representations of “trauma” and ways in which it is defined and processed on a socio-cultural level:

“The idioms we have described borrow from everyday language to make sense of the impact of violence in a situation of protracted conflict. They do not represent discrete syndromes or sharply delimited categories. Rather, they are familiar ways of speaking about traumatic events that invoke specific networks of meaning. They serve to communicate to others within the community about the dimensions of suffering through language that references collective experience and that conveys assumptions about the expected bounds of behaviour, the likely course of distress, and outcome of clinical or social intervention. Generally, these cultural idioms of trauma are not diagnostic entities that require treatment but a vocabulary through which distress is expressed and social support mobilized (Afana et al., 2010, p. 82).”

In research conducted among the Adivasis indigenous people in tribal communities in Pune, India, the most prevalent metaphorical concepts of potentially traumatic events were found to be related to shock and wound. The most predominant expression, which was used by all of the participants of the study, was “this should not have happened” (*asa nahi vhayala pahije hota*) (Rechsteiner, Tol, & Maercker, 2019).

If the meaning attributed to the event is significantly determined by cultural factors, so too are the responses. In a meta-review of 917 patients with symptoms of possessive trance disorders from 14 low- and middle-income countries, Hecker *et. al.* (2015) found that spirit possession following exposure to potentially traumatic events is a phenomenon occurring worldwide which can be understood as a global idiom of distress. Indeed, Mozambique, a country that experienced almost three decades of war and devastation, exhibits a possession prevalence rate of more than 18% of the population. They similarly conclude that social and cultural factors

⁷ Defined by Nichter (Nichter, 2010) as “socially and culturally resonant means of experiencing and expressing distress in local worlds” (p. 405).

also seem to play an important role in the reported disease models and healing rituals related to P.T.S.D. and other forms of pathological spirit possession.

A variety of “cultural concepts of distress” (CCDs) have been explored in recent decades throughout the literature. Hassan (2015) notes that many Syrian refugees attribute obsessive rumination to satanic temptations, using the Arabic word *wisswas* (وسواس) meaning both the devil and unpleasant recurrent thoughts. Among Albanian migrants in Switzerland, this has been referred to as a “point in the heart” or “Brenge” : the beginning of rumination triggered by different causes (Shala, Morina, Gross, Maercker, & Heim, 2020). Droždek and Wilson (2007) highlight some more examples from the literature: In the experience of many Salvadoran refugees who report “*ataques nervios*,” a somatic response involving feelings of anxiety, fear, and anger, and calor, an experience of intense heat that extends through one’s body. Such high rates of somatic responses have equally been found among tortured Bhutanese refugees in Nepal (Van Ommeren et al., 2001), American prisoners of war and holocaust survivors (Herman, 1992a, 1992b), refugees seeking treatment for P.T.S.D. in Switzerland (Morina et al., 2017), as well as South African victims of torture during the apartheid period (Eagle & Kaminer, 2013).

Bowles and Mehraby (2007) write about a particular young male client in Australia from Afghanistan, had symptoms which were “consistent with symptoms of grief, anxiety (P.T.S.D.) and depression, although he described them as ‘burning in his heart’ and understood them as part of G-d’s will. If it was G-d’s will, he would recover and find his family again” (p. 316.). Weissbecker and colleagues (2018) classify these various idioms of distress noted in the literature according to :

- Idioms related to thoughts, e.g. *kufungisisa* meaning “thinking too much” in Shona in Zimbabwe and *yeyeesi* meaning “many thoughts” in Kakwa in South Sudan
- Idioms related to the heart, e.g. *poil-heart* meaning “heavy hearted” in Krio in Sierra Leone, *qalbi-jab* meaning “broken heart” in Somalia, *qalb maaboud* meaning ‘squeezed heart’ in Arabic (referring to dysphoria and sadness) and *houbout el qalb* meaning “falling or crumbling of the heart” (referring to the somatic reaction of sudden fear)
- Idioms related to the head, e.g. *amutwe alluhire* meaning “my head is tired” in Nande in the Democratic Republic of Congo
- Idioms related to the general body, e.g. *jiu sukera gayo* meaning “drying of the body” used by Bhutanese refugee in Nepal to indicate a situation of loss and desperation or *lashe mn grana* meaning “my body is heavy” in the Kirmanji Kurdish dialect

The list of differences in cultural responses to potentially traumatic events is vast. The above examples are just the tip of the iceberg. A comprehensive review of various anecdotal evidence is beyond the scope of this chapter. What is noteworthy is the multitude of differences being noted across all layers of processing, from the meaning attributed to the event to the symptomatic responses to the meaning attributed to the symptomatic response. Furthermore,

ethnographic research suggests that such “idioms of distress take on their communicative meaning in specific social contexts, and therefore require a broad understanding of complex and fluid cultural conceptions of wellness and distress and a detailed exploration of their actual use in a particular instance.” (Kidron & Kirmayer, 2018, p. 3).

Pathways to healing

A central concern of addressing experiences of potentially traumatic events among refugee populations is the efficacy and cross-cultural applicability of methods of coping and treatment intervention (Kirmayer, 2018). Just as the meaning attributed to potentially traumatic events and responses to them vary significantly among cultures, so to do healing practices and health-seeking behavior:

“Each culture develops specific forms and mechanisms... based on ‘cultural wisdoms’ ... for posttraumatic recovery, stabilization and healing... Considered from an evolutionary and adaptational perspective, cultures develop rituals, helper roles, ceremonies and other modalities to facilitate recovery from distressing psychological conditions including those produced by trauma. The viability of culture in the face of collective trauma illustrates ... that there can be no experience of psychological trauma without a cultural history, grounding or continuity of background.” (Boris Droždek & Wilson, 2007, p. 381-382)

Culturally-determined metaphorical idioms for overcoming exposure to potentially traumatic events – notably related to post-traumatic growth and resilience – have been aptly described by Meili and colleagues (2018). Elsewhere in the literature, in their study among a population of refugees in Switzerland, Maier and Straub (2011) identified 4 categories regarding their psychiatric patients’ ‘concept of illness’ and healing regarding the diagnosis of P.T.S.D.: They termed the first concept drawn upon by patients a “scientific/technical” model. This fits most comfortably into the medical model paradigm on an individual level and medical care consequently is deemed the most appropriate treatment method. The second concept was a chronological, time-bound model implying that patients believed that the current psychological difficulties will naturally improve over time. A third concept was a model of “sociocultural depravity” – a model wherein suffering is linked to the current socio-economic and political context and in which healing can only occur once these material conditions have improved. The fourth and least common concept drawn upon by their patients was based on “personal guilt” and implies a more internalized, depressive state of psychological suffering.

Rousseau and Bagalishya (2007) refer to the African family council, a traditional way of facilitating healing among families which may not be available to migrant communities in “Western” host countries:

“In many African societies, G-d is thought to be responsible for various social conditions, for the unequal distribution of good luck and bad, for the birth defects and for accidents of every kind. Ruin, illness, loss, premature death and accidents may all be punishments of an offended G-d, but more often than not they are attributed either to the anger of ancestors or to the witchcraft of living people” (p. 262).

Bigfoot and Schmidt (2010) have emphasised the significant role that indigenous knowledge plays in cultural adaptation in the aftermath of exposure to potentially traumatic events, demonstrating how native American communities intuitively rely on behavioral principles that they practiced for many generations before learning theory came into the literature. Eagle (2014) gives the example of “African cosmology” wherein falling victim to a potentially traumatic event may be interpreted as an indication that one’s ancestors have withdrawn their favour and protective function, and that the likely origins of their displeasure need to be identified and remedied. She similarly remarks that highly religious people of different faiths are likely to draw upon explanatory frameworks concerning suffering, victimization, aggression, violence and loss, located within the particular creeds of their belief systems. Among the Kubandwa cult across the African Great Lakes Area, people afflicted by exposure to potentially traumatic events enter into a peaceful and accepting relationship with a possessing spirit in order to be healed. Part of this ritual includes a technique known as Gucekera, whereby unknown spirits are aggressively driven out of the individual in a form of exorcism (Ventevogel, Niyonkuru, Ndayisaba, Reis, & de Jong, 2018).

Tankink and Richter (2007) highlight the role of religion in healing in particular, which they argue allows people to convey an internal feeling to something outside them, to G-d, which can help to reduce their pain. They note that religion offers

“the formulation, by means of symbols, of an image of such a genuine order of the world which will account for, and even celebrate, the perceived ambiguities, puzzles, and paradoxes in human experiences. The effort is not to deny the undeniable – that there are unexplained events, that life hurts, or that rain falls upon the just – but to deny that there are inexplicable events, that life is unendurable, and that justice is a mirage” (Geertz, 1993, p. 108, as cited in Tankink & Richters, 2007).

The importance of religiously- or spiritually-informed meaning making to inform healing from potentially traumatic events has similarly been highlighted among Sudanese refugees in Australia (Copping et al., 2010), Filipino, Sao Tomean and Indo-Mozambican migrant mothers settled in Portugal (Trovão et al., 2017), and sub-Saharan refugees in Canada – where nearly half of participants privileged prayer as the best treatment for mental health challenges (Langevin, Lavoie, & Laurent, 2017). These studies highlight the role of religion in providing cultural resources aimed at transforming the trauma narrative – as well as the importance of religious networks as generating “social capital” (Tortelli et al., 2017) and opportunities for social mobility and activism.

In a study exploring resilience among Mexican refugees in Texas, the authors demonstrate how culture was a key mediating factor in healing. Culture assigned meaning to the potentially traumatic events to which participants in the study had been exposed through the construction of narratives. The following cultural resources emerged as essential components in – family support, the ability to talk to others about their own experiences, the idea that there is no personal control over the circumstances (fatalism) and religious faith (Lusk & Baray, 2017). In a study on the Cambodian idiom of distress known as *baksbat*, (Kidron & Kirmayer, 2018), ethnographic research among a population exposed to potentially traumatic events suggests that the idiom itself may signify resolution and self-healing rather than continued distress. This

highlights an inherent relationship, within the concept of *baksbat* itself, between the context of distressing events, responses to these events, and pathways to healing. The authors of the study note that in daily family life and in Cambodian communities, the idiom indeed referenced a far richer and dynamic network of meanings than for which the “static” concepts of trauma operating at the health clinics may account.

Within the “dynamic narrative” approach of Colette Daiute (Daiute, 2016, 2017; Daiute & Lightfoot, 2004; Daiute, Todorova, & Kovács-Cerović, 2015; Tarchi, Surian, & Daiute, 2019), she refers to the process of “narrative sense making” defined as a dynamic meaning of accounts of specific events and different perspectives towards these events which change over time. She uses the example of refugee communities involved in conflict and displacement during and after the 1990s wars of the former Yugoslavia to demonstrate how the changes afforded by narrative sense making allow for new perceptions and interpretations of potentially traumatic events experienced. She and colleagues argue that culturally-informed narratives are not only an important means of communication, but that they represent a “sophisticated decontextualized form of reflection and meaning-making” (Tarchi et al., 2019) p. 80). This quality of connecting with others and the world through narratives, of assessing and developing meaning in relational contexts, is defined as “dynamic storytelling.” From within this perspective, Daiute explains, we use storytelling as a complex process for connecting with others for a wide range of purposes:

*“We use storytelling to do things in the world – to figure out what is going on, to connect with others, and sometimes to imagine how life could be. Language genres like narrative are thus human resources for making sense of extremely challenging circumstances, gaining symbolic control over them and possibly creating a path for action... In this way, the **narrative becomes a possible world**” (Daiute, 2017, p. 9).*

The act of narrating is thus understood to be a major relational and developmental tool, especially with positive engagement in collectives addressing bad situations in challenging and rapidly changing environments (Daiute, 2016). In this way, narratives can be resources for engaging critically and creatively with environments and their social structures, a “potential process of possibility—imagining and enacting social change with narrative—a lifelike yet creative symbolic system” (Daiute, 2015, p. 157). Daiute similarly highlights the power dynamics inherent to narrative practice, including the flexible uses of narrating as a mechanism of socio-political engagement and change: “as mediators of human interaction, symbolic discourses, like narrative language, are created in cultures allowing for a range of dynamic relations, not only oppressive functions of master narratives but also counter narratives and complex interactions in daily life” (Daiute et al., 2015, p.46). Further research in the field of narrative psychology has found that redemption—a narrative sequence in which people recount emotionally negative experiences as having positive endings—is a useful mechanism for coping with adversity; in other words, redemption may serve as a cultural master narrative providing individuals with a socially valued script for narrating challenging life experiences (Blackie, McDonald, Mclean, & Colgan, 2020).

Conclusion

This chapter has explored some key concepts of cultural psychiatry (transcultural psychiatry, cross-cultural psychiatry, or ethnopsychiatry): the interdisciplinary field of research and clinical practice concerned with the impact of culture on mental health and illness (Kirmayer, 2018). These different terms for the field reflect particular intellectual and research traditions as well as changing configurations of the social world, but all address questions of enduring importance concerning variations in the causes, experience, expression, and course of mental health problems and the efficacy of specific modes of individual or collective coping, social response, and healing practices.

As recently noted by Kirmayer and colleagues (2018),

“Exploring cultural meanings requires attention to over-arching discourse, embodied practices, and everyday engagements with an ecosocial environment. Restitution, treatment and recovery can then be guided by knowledge of cultural meanings, dynamics, and strategies for coping with catastrophic threats, injury, humiliation, helplessness and loss.” (p. 84).

According to Kirmayer, then, any consideration of experiences of potentially traumatic events among refugee populations therefore needs to include “biological processes of learning and memory; embodied experiences of injury, pain, and fear; narratives of personal biography; the knowledge and practices of cultural and social systems; and the power and positioning of political struggles enacted on individual, family, and community and national levels” (Kirmayer et al., 2010, p. 170). Elsewhere, he notes that

“In research, an ecosocial perspective urges us to move an exclusive focus on the brain to consider the developmental trajectories and situations that shape its architecture and function. We may function well in a range of contexts but expect certain resources to be ready-to-hand and find some kinds of situations, especially challenging. Understanding the mechanisms of mental disorders thus requires attention to the world beyond the individual, including families, communities, and networks, both local and global.” (Kirmayer, 2019, p. 32).

Such approaches to understanding experiences of potentially traumatic events from a cultural perspective go beyond a reductionist focus on “cultural differences” wherein “culture” is perceived to be a reified, crystallised concept and viewed as a potential barrier to be overcome in a process of psychiatric classification (Watters, 2001). In other words, it is a move away from conceptual models dominated by implicit colonial hierarchies or reified notions of culture as a homeostatic variable to be taken into consideration. The aim is not to rely on overly-crude or misleading cultural stereotypes (Kirmayer et al., 2018). Instead, the focus is on ever-changing cultural and social systems which determine the various forms of an individual subjective experience of illness, an experience inevitably in constant flux (Goguikian Ratcliff & Rossi, 2015). This framework similarly recognises that healing from exposure to potentially traumatic events is not an individual project, but a communal process which necessarily recognises the social, economic, and political context affecting the mental health of refugee populations (Sousa & Marshall, 2017).

Such developments in theories of culture, and traumatology have enriched cross-cultural understanding of mental health dynamics and case conceptualization, informing the development of intervention models which aim to go beyond a single-trauma focus to address cumulative trauma dynamics as well collective identity and culture-specific traumas (Groen, Richters, Laban, & Devillé, 2017; Kira, 2010).

In conclusion, the implications for both mental health interventions and for research is a focus on the dynamic inter-relationship of past potentially traumatic experiences, ongoing daily stressors and the fundamental ruptures to core psychosocial systems extending beyond the individual to their sociocultural environment (Silove et al., 2017). The following chapter explores how such critical reflections may lead us towards a sociocultural methodology for studying the impact of culture on refugee experiences. This includes drawing on conceptual models of refugee trauma unfolding within the sociocultural environment as “open, dynamic, heterogeneous, and hybrid social systems that offer individuals resources for self-fashioning and positioning” (p. 9), in order to interrogate, critique, and reconceptualize the nature of psychopathology and psychosocial interventions.

“In practical pedagogical research, one must begin by absorbing a simple methodological truth: Often a scientific researcher’s primary task is to establish some facts which cannot be found directly in reality. The path of research leads from symptoms to that which lies behind them, from the constitution of the symptoms to developmental diagnostics” (Vygotsky 1993, p. 276).

CHAPTER FIVE: Towards a sociocultural methodology

Defining a sociocultural approach to exploring trauma among refugee victims of torture

In order to address some of the needs for more research on potentially traumatic events and their sequelae among refugee populations, the thesis aims to draw on a socio-cultural framework that focuses on the intersubjective, mediational space between the individual and culture-society-interaction to account for the experience of humans in time and in particular social and cultural environments (O'Connor, 2015). Such an approach presupposes human beings inhabit shared forms of life, and utilize semiotic resources with reference to social structures and institutions. Meaning is continually negotiated within the social sphere and “cultural products, like language and other symbolic systems, mediate thought and place their stamp on our representations of reality” (Bruner, 1991, p. 3). In other words, the sociocultural context informs symbolic realities – products of human beings embodying different histories – which objectify themselves in language, discursive practices, social representations, myths, normative systems, religions, and other cultural products. Within these symbolic networks of cultural facts, individuals, institutions, and groups develop their complex and singular subjective organisations. As noted by Dafermos, Triliva, & Varvantakis (2015), “the approach differs radically from theories based on the psychologisation and pathologisation of human development, primarily because it clearly posits that there are inexorable links between social and individual development” (p. 74). It focuses on the exploration of complex, multidimensional, dynamic phenomena (Dafermos, 2018a).

Inspired, among others, by the work of Vygotsky (Roth & Lee, 2007; Stetsenko, 2008; Van der Veer & Valsiner, 1994; Vygotsky, 1987, first published in 1934, 1980), the sociocultural approach has developed into a broad domain with different orientations, nevertheless united by common epistemological underpinnings. Underwritten by ideology of social justice, the common foundation for sociocultural approaches is the notion that collaborative purposeful transformation of the world is the core of human nature and the principled grounding for learning and development. For Vygotsky, the sociocultural context plays a fundamental role in meaning-making processes. Meaning-making is considered to be a social process developing in interaction with the world – with language being particularly emphasised by Vygotsky as vital to mediating the reciprocal relationship between the individual and their environment. From its very conception, then, the sociocultural approach rejects any dichotomy of the individual and the society of which the individual is a constitutive part (Langemeyer & Roth, 2006). It fundamentally has to do with overcoming the Cartesian split between the object and the subject, the person and the world, the knower and the known—to offer instead radically

different theoretical frameworks in which meaning-making processes occur in the mediated space between individuals and their sociocultural world (Markova, 2000; Stetsenko, 2008). As noted by Dafermos (2015), Vygotsy himself was “actively involved in the practice of building a new society, as well as in the process of critical reflection of psychology as a discipline from the perspective of social and scientific tasks that arise in the concrete historical and cognitive context.” (p. 17).

Within this framework, the individual constructs the social and at the same time is constructed by the social (Zepke & Leach, 2002). Similarly, the meaning attributed to an event (for example, whether or not the experience of being forced to marry at 14 years old is experienced by a young woman as traumatic or not) is both a reflection of the individual and their sociocultural environment. Attributing meaning to events is itself a co-constructed activity – with human beings conceived of as communicational agents that are constantly responding to situations within their sociocultural environment, in dialogue with others (Gonçalves & Ribeiro, 2012).

As argued by González Rey (2008),

“social and individual subjectivities are configured recursively through the interactions of active subject’s in the functioning of groups and social institutions. The dialogue between individuals is only a moment within these subjective social dynamic systems that integrate social practices and relations; systems within which the individual is an author rather than a recipient in the dialogical processes. These dynamics represent particular configurations within the broader scenario of social subjectivity.” (p. 187)

To summarize a few fundamental tenants of the theoretical framework of sociocultural psychology:

- the focus is on the way in which individuals, within their sociocultural environment, render reality significant
- individuals are inevitably situated within a specific sociocultural and historic time and place, and are actively engaged in the construction of the meaning of reality with others
- thoughts, feelings and actions of individuals are formed within a sociocultural milieu, mediated by cultural resources (considered as a collective accumulation of experiences of past generations). This relates to Vygotsky’s “first law of development” which states that every acquisition is first social, before being reconstructed on an individual, psychological plane through the process of mediation
- consequently, social and psychological phenomena are processes that exist in the realm of relations and interactions—that is, as embedded, situated, distributed, and co-constructed within contexts while also being intrinsically interwoven into these contexts

This perspective therefore involves a focus on the thread of language and related underlying semiotic systems. It is inherently dialogical (Marková, 2006, 2016). It understands dialogue to be the fundamental dimension of language as well as of human experience (Greco, 2016; Salazar-Orvig & Grossen, 2008). It likewise includes a recognition that all languages are composed of different social languages (Bakhtin, 1981; Gee, 2014). It emphasizes the contextual and unfinished nature of meaning (Gillespie & Cornish, 2014), inevitably situated within a specific sociocultural, historical and political context. As such, this theoretical framework highlights the heterogeneous, fluid and dynamic nature of individual subjectivities (Gee, 2014; González Rey, 2016; Squire, 2008).

Within this framework, an individual's experience of a potentially traumatic event, for example, necessarily is influenced by and reflected through language and culture. Culture (as explored in a previous chapter) is considered both as a set of practices physically executed in a tangible and observable sense by the group, as well as integral to belief systems lying internally within individual members (Brewin et al., 1996; Droždek & Wilson, 2007; Sturm, Baubet, & Moro, 2007, 2010). In other words, the approach highlights the ways in which life experience (in this case, experiences of trauma linked to migration) are mediated through language and culture.

Such an approach would include an acknowledgement that current concepts of mental health, notably a diagnosis of P.T.S.D., are to some extent socially constructed objects produced within a specific historical period (Goguikian Ratcliff & Rossi, 2015). The perception of the potentially traumatic event, then, is mediated, among others, through collective memory and the inter-generationally transmitted historic experiences, myths or stories from the past shaping worldviews (Droždek & Wilson, 2007). Here, elements of temporality are considered, as is the continual interaction of the person with their environment in a given social and historical context. It would therefore follow that not only do reactions to potentially traumatic events differ according to cultural norms, but the very making sense of what is or what is not considered to be "traumatic" may similarly be informed by socio-cultural context (Daute, 2018; Zittoun, 2014; Zittoun, & Sato 2018). Simply put, "culture shapes and gives meaning to the whole of human experience, including potentially traumatic experiences. Both cultural idioms of distress and narratives influence the nature of a pathological experience" (Rechtman, 2000, pg 404). These socioculturally determined idioms of distress have been defined in the D.S.M.-V as "ways of expressing distress that may not involve specific symptoms or syndromes, but that provide shared ways of experiencing and talking about personal or social concerns" (APA, 2013; Lewis-Fernández & Aggarwal, 2013).

The way in which exposure to potentially traumatic events is experienced from within this socio-cultural framework is seen as unfolding within the context of systems of relationships which form the ever-changing environment. As Harvey (2007) notes, this ecological perspective is needed to guide inquiries into the understanding of resilience. This is because it incorporates a "resource perspective" which assumes that human communities, like other living environments, evolve adaptively and are deeply embedded in complex and dynamic social contexts in which resources are exchanged. Individuals within this system are capable of negotiating and influencing, as well as being influenced by, this system. Equally, symptom

severity is viewed as not static but fluid and changing according to a continuum of pathological reactions (Droždek, 2015). For people whose lives are characterized by ongoing hardship, often shaped by discrimination, poverty and other current and future dangers, potentially traumatic events may fall within a continuum of suffering and may not be singled out or experienced with the same precision as the definition of P.T.S.D. appears to demand (Eagle, 2014). This is a particularly relevant consideration for the mental health of refugees in light of the multiple and arguably ongoing environmental stressors and potentially traumatic experiences with which they are faced.

Dialogism

Research from within a sociocultural perspective aims to embody a complete understanding of the development of psychological phenomena (such as experiences of potentially traumatic events) within sociocultural context. The intention is to avoid reducing the complexity of these research objects in the process. Within this school, both Bakhtinian and Vygotskian perspectives share the assumption that certain aspects of human mental functioning, including psychological processes carried out by an individual in isolation, are fundamentally tied to communicative processes and encompass communication (Morasso, 2013). The approach considers that the meeting spaces and dramatic processes of making meaning between different and not reducible consciousnesses constitute the ontological foundation of dialogue (Dafermos, 2018b).

Central to this is **dialogism** – the core tenant of which being that “the mind of the Self and the minds of Others are interdependent in and through the sense-making and sense-creating of social realities, in interpretations of the past, experiencing the present and imagining the future” (Marková, Zadeh, & Zittoun, 2019, p. 2). As argued by Dafermos (2018b), dialogism “penetrates the deeper and most important aspects of human existence.” (p. 4). According to a dialogical perspective, then, experiences of potentially traumatic events are not developed in isolated individual consciousness but in dialogic communication between several consciousnesses. In other words, they are played out at the point of dialogic meeting between two or several consciousnesses.

The above theoretical considerations have methodological implications for studying the meaning of experiences of potentially traumatic events as emerging from intersubjective interactions, and especially for how it can be traced in discourse. It necessitates a focus on “multi-voicedness” to analyse the unit in its hybridity, as well as a focus on the interplay between multiple, mutually reinforcing levels influencing subjective experience (from the micro-interactions between an refugee and their treating health professional, to the macro level of the asylum tribunal to for example). Indeed, central to dialogical analysis is the idea that the voices of others can be found in speech. Words and their meanings are not learned from dictionary definitions, every speech act is in a way a quote from someone else (Bakhtin, 1986). Analysing the main voices present can help us understand to what the speech is a reply, to whom it is addressed, and therefore of which “larger conversation” it is a part. Because of this,

voices may also constitute the clearest traces of the social and historical context of the utterance. Furthermore, if meaning emerges in relation to another and is dependent on social, cultural and historical context, then analysing these voices may be indispensable to understand meanings and their associated processes.

Dialogism is present in the relation between the speaker and people who have talked to him/her recently and who are still present in the speaker's inner discourse: This addressee can be an immediate participant-interlocutor in an everyday dialogue, a differentiated collective of specialists in some particular area (for example – doctors, psychologists, judges, lawyers, refugee community leaders, cultural mediators and even researchers). It can also be an indefinite, unconcretized other (Morasso, 2013).

Furthermore, dialogism presupposes the interdependent self-other relationship to be a single ontological unit. Within this unit,

“one component in each pair defines the other component; if one component changes, the other also changes. In this process the Self and Others not only co-construct knowledge and beliefs, but also evaluate one another, make judgements of their actions, trust and distrust one another, and take and avoid responsibilities. They are bound by ethical concerns. Their dynamic uniqueness is realised in and through language and communication, and through multifaceted forms of interaction in the construction of meanings in concrete local situations.” (Marková et al., 2019, p. 3).

This unit is unbreakable. The interdependence of Self and Other is presupposed. Furthermore, this interdependence lies at the heart of our subjective experiences of ourselves and the world:

“Dialogue and communication have a decisive role on the genesis and development of subjectivity because they are the main channels through which emotions are produced, captured as subjective senses as a result of the presence of the symbolical rituals associated with the emergence of the other, as partners in communication from early childhood. This principle allows for a bridge between emotions and subjectivity to emerge.” (Fleer, Gonzalez Rey, & Veresov, 2017, p. 5)

An inherent part of this dialogical process is “semiotic mediation” – a concept which I now explore.

Semiotic mediation

Vygotsky's work notably examines the crucial role of language in development –mediating external, sociocultural reality and internal mental functions. It considers that the emergence of higher mental functions in particular depends upon the external sociocultural world, the impact of which is mediated through language. In other words, language is the medium by which external reality shapes internal psychology: It is the vehicle connecting the external object and the internal mental representation of that object (Mertz & Parmentier, 1985). **Semiotic mediation** from a broadly Vygotskian perspective thus refers to the ways in which human activity is mediated by the use of cultural tools and/or signs. It is concerned with the cultural mediation of mental development through acts of semiosis, with a focus on the mediational and transformative function of signs, through language (Ma, 2014). It refers to a process

whereby “cognition and reality are brought into homologous, law-like articulation by the mediation of semiosis, a dialogic process” (Mertz & Parmentier, 1985, p. 23). As Dafermos highlights (2018b), “thinking is not a solitary activity of a purely autonomous subject but a dialogical act, unfolding between different subjects. The knowledge representation of an object is socially mediated and the path to knowledge passes through relationships between subjects.” (p. 10). In other words, “the distinctive characteristic of human learning is that it is a process of meaning making—a semiotic process; and the prototypical form of human semiotic is language” (Halliday, 1993, p. 91).

Since a large part of our experience of living is thus mediated through semiotic acts (i.e. by acts of meaning) and, because semiotic acts presuppose an “Other,” both the social and the semiotic are crucially implicated in the processes of the formation of consciousness (Hasan, 2004). A sociocultural approach thus considers how every use of tools and signs is mediated by Others (Vygotsky, 1987, 1980). People actively construct their environment - and cultural tools and “Others” mediate their relation to the world. Moreover, people use complex thinking in everyday life in order to act in the world and give meaning to their experiences (Bruner, 1990, Wertsch, 1998). **Language** is at the core of this mediation. From this perspective, then, the representations we have of the world are both unique – they are constructed in the moment-to-moment exchanges to give sense to the on-going flow of experience – as well as socially and culturally shared. An individual who has experienced a potentially traumatic event, and who is trying to make sense of and recover from it, will mediate this experience through language: talking (or not) to members of the family about what happened, engaging in psychotherapy with a mental health professional, messaging friends on his or her mobile, speaking in private to his or her religious leaders, praying to the ancestors, reading books or newspaper articles about the experience.

Despite the significant impact of collective representations and symbols of trauma, carried in and through language (in other words, signs or cultural tools), individuals necessarily reproduce them with transformations in personal ways. This is the process of semiotic mediation: cultural tools and/or signs may be commented, questioned, or re-interpreted, or reorganised in a *bricolage* using different symbolic universes (Sturm et al., 2007) to form what Kirmayer terms the “landscape of memory” (1996). What is interesting to examine here is the interplay between the specific internal object representations of the individual and the external social world of collective representations. In Bakhtinian dialogism, the psychological processing of potentially traumatic events cannot merely be internally homogenous but involve multiple voices, texts, interests and traditions embodied in each individuals own varied histories and in the artefacts and norms of the system - a source of trouble and of innovation (Bakhtin, 1981). Ultimately, it is within this dialectal sphere between the internal and external, Self, and Other, the personal and political where coherent narratives of a potentially traumatic event may be formed as part of the process of healing.

In order to further understand *how* the social and the individual interact “not as oppositions, but as a dialectical unity” (Fleer et al., 2017, p. 9), I draw upon the Vygotskian notion of *perezhivanie*: a “concept which allows us to study the role and influence of environment on the

psychological development” (Vygotsky, 1994, p. 343) by bringing to light the dynamic interaction between social experience and the emotional sense the individual takes from their experience (Babaeff, 2016).

Perezhivanie

Perezhivanie is a complex concept. Scholars have argued that there is no true English translation of the word that could capture even the most basic element at the core of it, let alone the nuanced range of connotations inherent to the Russian – despite various attempts at translation (“an experience,” “a catharsis,” “living through,” “lived experience,” “direct psychological experience,” “a subjective refracting prism”) (Blunden, 2016; Fler et al., 2017; Veresov, 2016). Vygotsky represents the concept as the connection between how the environment is embodied through the awareness, perceptions, interpretations, feelings, and the manner in which the individual relates to situated experience (Babaeff, 2016). He developed the concept as part of his attempt to “develop an integrative, monistic, and dialectical theory of consciousness and human subjectivity” (Dafermos, 2015, p. 19). Perezhivanie is a complex nexus of different processes and individual (even personal) characteristics of a human being. It includes components of representation, understanding, subjective interpretation and the awareness of an individual in relation to certain events within the environment (Veresov, 2019).

Vygotsky (1998) notes:

“the social becomes the individual, but the dialectics of this becoming is that only those components of the social environment that are refracted by the subjective perezhivanie of the individual achieve developmental significance (p. 294)

In other words, the way in which the social *becomes* the individual is through the unique way in which the individual lives the experiences encountered within the sociocultural environment. The environment determines the development of the individual through the individual’s unique perezhivanie of the environment (Vygotsky, 1998). As such, as noted by Veresov (Veresov, 2014, 2016, 2017) and others, perezhivanie is a reflective *prism* through which the individual perceives, reacts, and responds to the world around them. Vygotsky himself stated in *The Problem of the Environment* that “the perezhivanie of an individual is a kind of psychological prism, which determines the role and influence of the environment on development (Vygotsky, 1994, p. 341). He famously illustrated the idea by drawing on the case of three siblings faced with an alcoholic mother. The three each react differently: the youngest child, seemingly indifferent, the middle child, traumatised, and the oldest child, taking on responsibility beyond his years. This is not a simple matter of internalisation. We see not only *how* the environment may influence the individual, but that the individual’s subjective capacity to make sense of and respond to the environment, their unique window to the world, make up the essential units of analysis for understanding development.

Vygotsky thus soundly interconnects individual thought and emotion with sociocultural influences from the environment as one unit of analysis:

“An emotional experience [perezhivanie] is a unit where, on the one hand, in an indivisible state, the environment is represented, i.e. that which is being experienced – an emotional experience [perezhivanie] is always related to something which is found outside the person – and on the other hand what is represented is how I, myself, am experiencing this, i.e., all the personal characteristics and all the environmental characteristics are represented in an emotional experience [perezhivanie]... ..in perezhivanie we are always dealing with an indivisible unity of personal characteristics and situational characteristics” (1994, p. 341-342).

In studying refugee experiences of potentially traumatic events, then, the characteristics of the individual and the situation are seen as “indivisible.” Indeed, Vygotsky considered any reductive distinction between social and individual to be “naïve” (1986, p. 314). Beyond looking at the influence of forced migration on the individual, we need to use perezhivanie as a tool to study the *process* of development. In other words, we need to study how the experiences of potentially traumatic events develop “both in evolutionary and revolutionary aspects as well as in a unity of macro and microgenesis” (Veresov, 2017, p. 47). Here, both the “macro” revolutionary aspects of the unfolding of the refugee reception crisis across Europe, as well as the “micro” evolution of the daily-lived reality facing refugees, are of importance. “Refugee systems” (including the medical, legal, political, and social systems in which they manoeuvre) in all of their dynamic complexity, should also in turn “be studied as a generative system inseparable from the individual” (Fleer et al., 2017, p. 1), and here I hasten to add, inseparable from the individual experiences of potentially traumatic events, as well as from the development of their activities and relationships.

From within this perspective, refugees are considered as unique subjects interacting with, and processing, the potentially traumatic events in their environment with which they are faced. Whether or not the event will ultimately lead the individual to experience symptoms of post-traumatic stress, however, depends on the dynamic interaction between the two: “perezhivanie, arising from any situation or from any aspect of his environment, determines what kind of influence this situation or this environment will have” (Vygotsky, 1994, p. 339). The potentially traumatic events surrounding forced migration are “factors refracted through the prism of...perezhivanie” (Vygotsky, 1994, p. 340). In other words, they can only be represented through the unique lens (or prism) of those individuals experiencing them. Individual and environment are inseparable.

As summarized by Veresov (2016) in his reflections in how perezhivanie as a concept may be used as a tool to study human development: “perezhivanie represents the minimal unit of the whole, the organic unity of the personality and the environment as it is represented in its process of development” (p. 135). It allows us, then, to examine the interrelation between potentially traumatic events and the impact on individual refugees as a unit of analysis. It allows us to account for both the “macro” level of “refugee systems” (political, legal, medical...) and the “micro” level of the individual’s subjectively experienced daily-lived reality. This without reducing refugee trauma to headline events. As he succinctly concludes:

“it is not merely emotional attitude to environment, but rather a complex nexus of psychological processes that includes emotions, cognitive processes, memory and even volition... Here perezhivanie is a theoretical tool, an analytical lens to study the process of development within a system of other concepts of cultural-historical theory” (p. 130).

Alongside other theoretical tenants of sociocultural psychology, including those linked to the general principles of dialogism, and semiotic mediation, perezhivanie allows us to explore the complexity of experiences of potentially traumatic events beyond subject-object or subject-environment dichotomies. It allows us to explore the interaction between the individual and their environment in all of its dynamic complexity. It is not simply about the influence of the environment on the individual. It is about the process through which the individual develops, the “path along which the social becomes the individual” (Vygotsky, 1998, p. 198). It is about the *how* at the core of dialogism.

Research methodologies informed by dialogical perspectives, including concepts of semiotic mediation and perezhivanie, equally necessitate analyzing the complexities of the interviewer–interviewee relationship. It implores us to explore the different discussions within the same interaction. This highlights a complexity of identities and voices to whom both the interviewer and the interviewee are explicitly or implicitly responding in every utterance (Greco, 2016). It also means taking an ethical responsibility for the Other to which we are inextricably bound. It means respecting the uniqueness of the communication (Marková et al., 2019). The ethical implications for the research relationship are many, which I now explore.

Ethical implications

As systematically demonstrated by Marková in her book, “The dialogical mind: Common sense and ethics” (Marková, 2016), the sociocultural approach “presupposes that the nature of the Self–Other interdependence is ethical and that ethics is embedded in common sense thinking and socially shared knowledge” (p. 4). As such, she argues, any research conducted within this framework is strongly connected with social praxis and “entrenched in ethical action” (p. 106). As noted by Zittoun (2018) in her review of the book, Marková’s

“main proposition is to engage in well-designed case studies, which only can preserve the uniqueness of Self–Other relationship, as these are taking place in specific social, cultural, and historical dialogical dynamics... [this] implies a developmental ontology—acknowledging the fundamentally given fact that we are engaged in relations with Others as human beings—and an ethic: as we are engaged in time, our answerability and responsibility as humans is engaged.” (p. 113-116).

The sociocultural approach, therefore, does not only encourage scholars to reflect on how they produce knowledge, but also on their position as researchers. Firstly, it means reflecting on our relationship as researchers to the object of study. Why the interest in the topic – personally, professionally, politically? Secondly, it means reflecting on the ethical choices made, and on the relation to the research participants. Thirdly, reflecting on our position as researchers also involves accepting the fact that our presence, our position, our ways of interacting and asking questions, of understanding our research topic, are never and cannot ever be neutral. Fourthly,

it means always trying to be surprised by the data and the results of the analysis. In other words, trying to arrive with an open perspective as to what presents itself in the unfolding of the research. Fifthly, it means adopting a critical position towards our topic of research (De Saint-Laurent, 2019).

As Calder-Dawe and Gavey (2017) remind us in their description of what they refer to as a “dynamic sociocultural research methodology,” the approach therefore is as much an ethical and political endeavor as it is an intellectual project. It necessitates a keen awareness of the ethical and political implications of any research project “in the real world.” By attempting to bring the voices of the participants to the fore in a manner as faithful as possible, the methodology aims to transform dominant understanding and representations of subaltern groups such as refugees (Bhimji, 2015). As stated by O’Neill (2008), the approach “counters the sanitized demonized or hidden aspects of the lived cultures of exile and belonging. In doing so, [the] research helps to produce knowledge as a form of social justice” (p. 9). As such, it connects broadly to the umbrella of critical approaches to research characterized by an engagement with the growing complexity of local and global inequalities – as well as a consideration of issues of power being central to research practices (Teo, 2015). Campbell and Cornish (2014), for example highlight research methodologies from the related field of critical health psychology which aim at

“deepening our understandings of power, identity, community, knowledge and social change – in the context of evolving understandings of the spatial, embodied, relational, collaborative and historical dimensions of health..... [it is] also deeply committed to deconstructing the problematic concept of the decontextualised individual and to disrupting the individual–social binary.” (p. 3-4).

They state that such a situated, explicitly anti-individualistic methodology extends beyond overly simplified “onion-like models of micro-, meso and macro-levels of analysis postulating each as distinct “layers” of experience, the notion of “person-in-context” (with context as a static independent variable impacting person as a dependent variable)” (p. 4). Rather, they argue, the method respects a situated and organically evolving and unfolding process of research, grounded in real social situations. Thus, it remains faithful to the complexities of human experience and social change by eluding schematic or dualistic thinking – a thinking, which they argue, may “write out” the subjective experiences of individual’s daily-lived realities.

My understanding of the ethical implications of such situated, constructivist research approaches in general may similarly be complemented by principles of Action-Research, as notably elaborated upon by Reason and Torbert (Reason, 2006; Reason & Torbert, 2001):

“the important principle [is] that all ways of framing and interpreting the world are human constructions framed by language in social interaction. And this is hugely important. Since all human persons are participating actors in their world, the purpose of inquiry is not simply or even primarily to contribute to the fund of knowledge in a field, to deconstruct taken-for-granted realities, or even to develop emancipatory theory, but rather to forge a more direct link between intellectual knowledge and moment-to-moment personal and social action, so that inquiry contributes directly to the flourishing of human

persons, their communities, and the ecosystems of which they are part.” (Reason & Torbert, 2001, pg. 5-6).

Their approach to Action Research is based on the fundamental premise that human beings are socio-culturally situated creatures; and consequently that knowledge is essentially participative, and grounded in the lived, subjective experiences of individuals within a wider sociocultural system. In other words, they argue, since action is always interaction, the methodology emphasizes its participatory, relational nature: “fundamentally, if one accepts that human persons are agents who act in the world on the basis of their own sense-making; and that human community involves mutual sense making and collective action, it is no longer possible to do research on persons. It is only possible to do research with persons” (Reason & Torbert, 2001) p. 10). This necessitates an ethical obligation to adhere to a democratic, emergent, and participant process of knowledge production, grounded in the phenomenology of everyday experience of individuals, which seeks to redress the imbalance of power in the process of knowledge creation. I explore these ethical considerations in more detail in **chapter ten**.

Methodological implications

As stated by Brunner (1991) a sociocultural epistemological underpinning “brings profoundly into question not only the universality of knowledge from one domain to another, but the universal translatability of knowledge from one culture to another. For in this dispensation, and in opposition to an empirical positivism, knowledge is never ‘point-of-viewless’” (p. 2). Indeed, the underlying epistemology calls for a focus on the inner subjective world of individuals, the intra-subjective interactional world and the external world we take as our reality.

Daiute (2016) argues that research designs within a sociocultural approach should be

“sensitive to the fact that narratives are interactions within social systems, as noted in the foundation of cultural historical activity theory. When following the principle that ‘all higher functions originate as actual relations between human individuals’ [Vygotsky, 1978, p. 57], we understand contexts, including social institutions, in order to understand people. The idea presented here is that thought is integrated in activity in the world, not only as abstract representations, but also as social relations in goal-directed activity” (p. 133)

Focusing on language as a cultural tool, on the narrative activity of human beings, allows us to explore the dynamic relationship between the individual and their sociocultural context. To understand people, Daiute argues, is to understand the contexts (including social systems and social institutions) in which they operate.

This approach to research is underlined by the Vygotskian principle that psychological phenomenon necessarily be studied in the process of change and development. Here, human development is interpreted as a process of enculturation and humanization on the one hand, and the individual development in different forms of social agency and activity, on the other (Langemeyer & Roth, 2006). Vygotsky himself argued for “a clear idea of the essence of individual and social psychology as two aspects of a single science, and of their historical fate, not through abstract considerations, but by means of an analysis of scientific reality” (1997, p.

237). The individual and society are thus taken as a single, dynamic ontological unit (Markova, 2000). In essence, the fundamental unit of analysis is the individual in interaction with others and within a particular cultural, historical and institutional setting (Aveling, Gillespie, & Cornish, 2015). Experiences of potentially traumatic events among refugee populations, for example, may only be understood when considered as part of this unit wherein individual, subjective experiences ontogenetically co-evolve in dynamic interaction with a certain sociocultural environment. Dafermos (2018a), highlights necessity of considering this single unit of analysis holistically:

“both psychologization of scientific knowledge and its interpretation as a product of an individual’s psychological states (or traits) as well as the total desubjectification of knowledge and its examination as a result of impersonal objectified structures constitute one-dimensional approaches” (p. 219).

More and more researchers from within this sociocultural tradition criticize research methods which (1) do not reflect the dynamic character of the process under study and (2) are limited in describing the processes in their wholeness. They point out that there are three major domains of oversight in psychology which are (1) eliminating the dynamic flow of the phenomena in the data, (2) eliminating of the hierarchical order (part-whole relations) in the transformation of the phenomena into data and (3) eliminating the immediate context of the phenomenon in its transformation into data (Aaro Toomela, 2007; Valsiner, 2009; Veresov, 2014, 2017, 2019). Rather, “in contrast to widespread reductionism which focuses on analysis of the isolated elements of the reality, [the] approach is oriented toward grasping full complexity of interrelationships of the reality and contradictions that embodies them” (Dafermos, 2015, p. 17).

Langemeyer and Roth (2006) summarize the principles underlying such a sociocultural approach to research methodology:

- study a phenomenon in its most developed form as a way toward explaining its previous forms (historico-genetic perspective);
- study the whole instead of isolated parts or elements to preserve the inner relations between the parts of a whole (holistic perspective);
- reduce the complexity of the objects of investigation without reducing them to false abstractions (in other words, structuralist, integral, or organic abstractions – as would be the case with a simple diagnosis of P.T.S.D., for example);
- study a phenomenon in the process of change (perspective on developmental dynamics, mediations and transformations); and
- reflect the process of theorizing and determine the (historical) limits of scientific concepts, insights and generalizations (self-critical perspective).

Accordingly, they argue, within this approach, objects of study themselves need to be reflected as products of societal forms of perception and thought. Furthermore, such an analytic approach aims linking various levels of analysis (the “micro” to the “macro”) by examining the dialogical

dynamics which structure knowledge, society and subjectivity, as subjects position themselves in interaction with Others in a particular sociocultural context (Aveling et al., 2015).

The theoretical foundations of sociocultural psychology noted above lead me to develop a research methodology based on the following tenants:

- i) The methodology should consider the dynamic and mutually reinforcing relationship between the individual and their sociocultural environment as the **single unit of analysis**

Since sociocultural theories are defined by an examination of individual subjective experiences that are at the same time socioculturally situated, they are obliged to synthesize accounts of changes within this sociocultural context with accounts of changes in personal, psychological life (Lawrence & Dodds, 2007; Valsiner & Rosa, 2007). Methodologically, it is not possible to work with parallel social and psychological units of analysis (Lawrence & Dodds, 2007).

- ii) the methodology should account for the **multiple levels** inherent to this single unit of analysis

As noted above, the unit of analysis should be individuals as wholes and the networks of interdependence in which they develop – including other subjects and objects within their environment (Salazar-Orvig & Grossen, 2008), as well as institutional encounters. As such, any research methodology should account for multiple levels of embeddedness: from the micro-level of the intra-psychic, to intersubjective encounters between individuals, to the meso-level of the institutions encountered by the individual, to the macro-level of the global sociocultural, historic and political context wherein the individual is situated, for example.

- iii) The methodology should be informed by a **critical reflexivity** on the part of the researcher, throughout the research process

Reflexivity is a necessary pre-requisite for the consistency of sociocultural theory. As noted by Castro-Tejerina and Rosa (2007), “it is not enough that a socio-cultural psychological theory explains the individual and collective process of knowledge production, but the explanations provided also have to be compatible with how knowledge production results from historical processes situated in sociocultural settings” (p. 62). Given the ethical implications of a sociocultural approach as noted above, it demands an ethical exigence on the part of the researcher.

This may include, for example, an awareness of, and sensitivity to, the sociocultural and political implications of the research - including an awareness of the power imbalances inherent to the processes of knowledge production. One particular methodological tool I employ, for example, is the use of a diary throughout the research process in order to support such critical reflections. Indeed, engaging the written self-reflective text of a diary facilitates the

microprocesses of meaning-making, bringing the individual to new ideas and understandings (Zittoun & Gillespie, 2012).

- iv) The methodology should privilege an **idiosyncratic** approach to the analysis of unique, individual case studies

Sociocultural psychology privileges ways of generalization that are based on systemic analyses of singular phenomenon. It considers that psychological phenomena are essentially qualitative – with a focus on the constantly evolving specific local and unique subjective experiences of individuals in dynamic interaction with the sociocultural environment. The importance of conducting analyses of rich, single case studies has been outlined by authors in the field, including, for example, Marková (2016), Zittoun (2017) and González Rey and colleagues (2017). The latter argue that “the value of the singular case is also given by its relevance to the theoretical model in development, so that the singular case is one more moment in the advancement of the theoretical constructions of the research.” (p. 203), that it is through processes of abduction as a core mechanism that generalizations may be made from single case studies. This includes both case studies of individual lives as well as case studies of institutions (where the challenge is to account both for institutional dynamics, and for people’s trajectories as they pass through these institutions). Marková and colleagues (2019) have argued that

“acknowledging the properties of Self–Other units clearly excludes the use of methods that require the study of many ‘similar’ or ‘same’ cases, as well as studies that consider that people can be studied outside of the relationships in which they are embedded... The uniqueness of the Self–Other unit calls for studying each unit as a whole, in its singularity, that is, as a ‘single case’, as paradoxical as it may sound.” (p. 3).

They continue highlighting that it is

“evident that generalisation from samples to populations, or statistical generalisation, when applied to dialogical single cases, makes little sense. The researcher motivated to study dynamic and ethical interdependent units does not approach the construction of their case using a method of sampling that treats the Self as something other than an ethical being from whose unique communication with Others something important can be known” (p. 15).

The methodological implication, therefore, is to respect the unique ontological unit by examining it in its wholeness and in its idiosyncrasy. It is not to reduce the case to a statistic. It is to particularise, not generalise.

- v) The methodology should account for the **temporal dimensions** of the development of human phenomena

People, interactions, the social world are all mutually dependent and evolving through time (Van der Veer & Valsiner, 1994; Vygotsky, 1980). Given the significant focus of the sociocultural approach on the development of, and/or processes inherent to, psychological phenomena – a methodological approach should necessarily account for the temporal

dimensions of these developmental processes. This is because the approach considers the development psychological phenomena to be a dynamic process, unfolding during the activity and in interaction with a non-static environment, and the result of a developmental trajectory (Roth & Lee, 2007; Vygotsky, 1987, first published in 1934, 1997). In other words, it assumes the irreducibility of time – acknowledging the temporal, historical, and dynamic nature of human experience.

In summary, as argued by Zittoun (2017):

“To contribute to the scientific project of sociocultural psychology, case studies need to offer material to understand any, if not all, the dynamics just described: not only the perspective of the person alone, but also her relevant environment regarding a specific issue; her situation as located in time; some dynamics of sense-making; and these, through various perspectives, including, if possible, forms of inner-dialogue.” (p. 173).

The research methodology I employ, and which will now be described in detail, was specifically designed with these five principles highlighted above, in mind. For example, to consider the individual within their sociocultural environment, the research focused both on individuals as well as the institutions through which they passed. This included meeting with individuals and organizations as potential research partners to define the methodological approach together, as well as including institutional and community representatives as research participants. Following on from this, the analysis similarly considered these various levels of ecological embeddedness. Ongoing engagement, and a four-month period of participant observation, allowed me to deepen my understanding of the sociocultural context in which individuals were situated, yet also assisted me as a researcher to continue to develop a critical reflexivity towards both the object of study as well as the methodological approach I would adopt when in the field. This reflexive process was further facilitated by my keeping a diary throughout. The methodological process was further designed with individual case studies in mind – both in terms of institutions (for example, health centres frequented by refugees, as well as the asylum tribunal), and individual case studies. To account fully for the importance of the temporal dimensions in regards to the developmental process inherent to subjective experiences of potentially traumatic events, individuals were followed multiple times over a period of a year.

The researched methodology described below is based on qualitative methods, grounded in a sociocultural approach, deemed best suited to address the need for an in-depth and nuanced understanding of how potentially traumatic events are experienced. Given the focus on the influence of current situational stressors, and a generally more contextually situated understanding of mental health, the research question similarly lent itself to a follow-up of individual participants over time. The study design was therefore centred on a yearlong follow-up of 10 beneficiaries of the M.S.F. Victims of Torture (V.O.T.) Project in Athens and their partner organization, Babel. Complementary data was also gained through three supplementary sources in order to locate these individual narratives within their socio-cultural and institutional context:

- 1) Semi-structured interviews with 21 refugee community leaders and representatives across Athens
- 2) Semi-structured interviews with 43 “key informants” – health professionals working with this population
- 3) 4 months of participant observation in the centre for Victims of Torture

It is based on the idea, elaborated upon by Daiute (2018) that “designing multiple activities in terms of diverse purposes, perspectives, and audiences (rather than a single narrative to identify a truth or extended interview with one interlocutor) invites participants in practice and research to explore issues because those issues are confusing, upsetting, or impressive in some other way.” (p. 295).

Study design

Victims of torture in Athens: The Greek context

As the “reception crisis” continues unabated, Greece remains one of the first ports of sanctuary. According to recent statistics provided by the UNHCR, ⁸ over 50,000 asylum seekers and refugees currently remain in Greece, following the 2015-2016 mass flow. Such a massive movement came at a time of the most severe financial crisis, when little state attention or funding could be provided for the medical, mental health and psychosocial care, accommodation and integration of migrants or refugees (Kesisoglou & Issari, 2019). Dafermos (2013) notes of this “crisis ridden context” :

“The economic crisis and the profound social transformations within Greek society in the last few years have highlighted the problems inherent in the models and patterns of development of psychology as an academic discipline in Greece. Moreover, the crisis within the discipline of psychology highlights the importance of developing theory, research and practices taking into account the real problems of the subjects in the particular cultural, historical and social contexts that serve human development” (p. 404).

He and Triliva (2018) have argued that the socioeconomic and political context has been dubbed dangerous social experiments where austerity measures and oppressive policies predominate – and that this creates conditions for a “huge laboratory where what happens to psychological development when society is destroyed can be studied.” (p. 23).

While the country is gripped by a myriad of complex financial and societal crises, little attention or funding is available to provide mental health and psychosocial support to refugees (Gkionakis, 2016). The refugee population is legally entitled to free access to medical care, yet the ability of the Greek health system to provide adequate health care to refugees upon entry is severely stretched as a result of the ongoing economic crisis, resulting in numerous barriers to access (MDM, 2016). These challenges are even more pronounced for migrants faced with a lack of information and linguistic and cultural barriers to accessing an unfamiliar system. Often

⁸ https://data2.unhcr.org/en/situations/mediterranean#_ga=2.261073289.502421353.1580975968-1157819650.1566897203

living in harsh and isolating conditions, a 2017 report by UNHCR ⁹ estimates that many migrants will wait for over two years to find out about their asylum status.

Furthermore, as is commonly reported among refugee populations across the globe, research among refugee populations in Greece in particular has consistently and overwhelmingly highlighted substantially high rates of post-traumatic stress disorder (P.T.S.D.), anxiety, mood, externalizing, and other psychiatric disorders (Eleftherakos et al., 2018; Farhat et al., 2018; Farmakopoulou, Triantafyllou, & Kolaitis, 2017; Gkionakis, 2016). A recent study conducted among refugees in Greece in 2018, for example, reports that over 75% of refugee respondents screened positive for anxiety disorder, which warranted referral for mental health evaluation. The authors note that access to legal information and assistance about asylum procedures were considered poor to non-existent for the majority, and the uncertainty of their status exacerbated their anxiety (Farhat et al., 2018). This seems to be further compounded by high levels of what has been referred to as the “institutional abuse” of refugees – characterised by inhumane living conditions, lack of information in order to make future decisions, humiliation and depersonalization (Eleftherakos et al., 2018).

There are few reliable statistics concerning the number of victims of torture (V.O.T.s) specifically currently in Greece (FRA, 2017; *Médécins Sans Frontières*, 2016; UNHCR, 2017). The UNHCR has estimated that among refugee populations, between 5 and 35 percent are torture survivors, yet highlights that the actions that are needed to identify and support and enable them to claim their rights are too often ignored or purposely excluded (UNHCR, 2017). In Greece, few rehabilitation or identification services are provided to survivors of torture by a state structure or sustainably by NGOs apart from one organisation, Metadrasi, who certified 650 V.O.T.s from 2017-2018. ¹⁰ Most efforts of identification appear to be ad-hoc or dependent on some form of self-identification. Recent research among refugee victims of torture arriving in Europe has further highlighted that the identification and care of this population is often relegated to insufficiently trained and experienced professionals across different levels of reception and healthcare systems (Spissu et al., 2018). This complex asylum system, the poor identification of V.O.T.s and the many barriers in accessing basic services in Athens and across the country have had a substantial, adverse impact on mental health (Kotsioni, 2016). It has also lead to health professionals under pressure to “medicalise” the psychological suffering (for example, through the use of a certified P.T.S.D. diagnosis) as part of the identification process (FRA, 2017), as has been noted elsewhere in Europe (d’Halluin, 2016; Fassin & d’Halluin, 2005).

M.S.F. and Babel clinic for rehabilitation of victims of torture and other forms of ill-treatment

This research site was selected due to the fact that Greece have found themselves at the frontline of the influx of migrants arriving into Europe as a result of their geography. It is among the biggest entry points of migrants into Europe. The Victims of Torture project in Athens is

⁹ <http://www.unhcr.org/publications/operations/58d8e8e64/unhcr-recommendations-greece-2017.html>

¹⁰ <http://metadrasi.org/en/campaigns/certification-of-torture-victims/>

specifically targeting migrants who have been victims of torture or ‘ill treatment’ as defined by the International Committee of the Red Cross – therefore targeting the same population as this research. The project has been running since October 2014 and includes a target population of 500 with around 60 beneficiaries currently in active treatment. Notably, this is a population generally based in Athens and not “in transit” as is the case for the majority of M.S.F. projects focused on migrants in Europe. The team consists of doctors, psychologists, a physiotherapist, a social worker and 4 cultural mediators. They work in close partnership with the local mental health organization, Babel, a day care centre for the mental health of asylum seekers and refugees actively serving 500 beneficiaries.

After obtaining agreement from M.S.F. headquarters in Brussels to conduct research at this site, two preliminary exploratory field visits of a week respectively were conducted in order to better understand the functioning of the project as well as to assess the feasibility and relevance of the research and the interest of the team. This included attending multiple meetings with key stakeholders of the project as well as conducting eight preliminary interviews with health professionals. During this exploratory period, the research methodology was developed in collaboration with the project team – with ethical issues as well as practical issues around access to the research population being key considerations. As will now be outlined, ethical considerations played a key role in the development and implementation of the research project from its very conception, in collaboration with multiple stakeholders involved.

Co-construction of the research project with the project team

A consideration of the ethical implications of conducting research from a sociocultural perspective would not be complete without a consideration for the way in which the entire research project, from start to finish, was developed (both conceived, implemented, and later published) in collaboration with the team. **Chapter ten** of the thesis offers more space for critically reflecting on the importance, nature and impact of this collaboration. In the meantime, however, it is worth outlining the concrete form in which this collaboration took shape.

The very conception of the research project occurred in the context of a constructive dialogue with the field coordinator of the M.S.F. V.O.T. project. It was an exchange bringing together my willingness as a researcher to explore refugee experiences of potentially traumatic events from a sociocultural perspective, and the coordinators’ personal observations on what specific research in this field would be needed and useful for the team. A key consideration from this very beginning was an awareness of the particular vulnerabilities of refugee V.O.T.s as well as the sensitive nature of the work being conducted by healthcare professionals of the team working with this population. The question arose as how best to construct a feasible research design in this context. For example, we discussed how best to tackle issues of confidentiality in conducting research among victims of torture – the vast majority of whom, understandably, already had a very poor level of trust in their doctors and psychologists.

The agreed-upon common goal set in this first discussion was to develop a research project in collaboration with multiple members of the team in a way that would not only avoid “stepping on their toes” and interfering in this already fragile and tense working environment – and which respected the particular points of fragility and resilience of the project’s beneficiaries. This meant exploring ways of acknowledging the status of refugee V.O.T.s as both victims (to be protected against further exploitation) and survivors (with multiple points of resilience to be honoured – for example, in allowing them to bear testimony to their suffering as well as their strength, and affording them opportunities to participate as active and engaged collaborators in the research). This, for example, included relying on the team’s experience and clinical intuition to identify those individual beneficiaries who would benefit from actively participating in the research and those who the team identified as being psychologically too vulnerable or at risk of being harmed by participating.

The next step involved further discussions with multiple members of the team working directly with beneficiaries. This was a critical phase for designing the research. The aim was to prevent the members of the team from having a sense that the research (in particular, my onsite presence as a researcher) was something which the field coordinator, and others in hierarchically superior positions in the organisation, had imposed upon them without consultation. For example, in my first meeting with the psychologists, one of the key concerns expressed was that the research aimed to assess and critique their mental health interventions. They understandably felt the need to protect themselves against negative evaluations, and to protect the beneficiaries with whom they worked. Over multiple meetings, we therefore explored ways in which to design and implement a research project which would offer them helpful insights and which would make sense in terms of their experiences of working with this population. Again, of key importance was feasibility. From a pragmatic perspective, my intervention as a researcher needed to fit within the constraints of the practical organisation of their work. The concrete ethical considerations noted below reflect these multiple discussions with the team.

Concrete ethical considerations

Ethical approval was granted by the University of Neuchâtel as well as the MSF Ethics Review Board. The research was based on the SSP (Société Suisse de Psychologie) and FSP (Fédération Suisse des Psychologues) ethical guidelines.¹¹ These guidelines are referred to in the ethical code of the Psychology and Education department of the University of Geneva¹² as well as the document “*Guide Vert: Recueil de documents relatifs à la déontologie pour la recherche en psychologie et éducation*”¹³ of the University of Neuchâtel which formed the basis of ethical considerations for this research.

¹¹ This document can be found on the following website:

http://www2.unine.ch/files/content/sites/psy/files/shared/documents/documents_utiles/Layout_Integritaet_f_online.pdf

¹² This document can be found on the following website:

http://www2.unine.ch/files/content/sites/psy/files/shared/documents/guides/2015-2016/Guide_Vert_oct2015.pdf

¹³ This document can be found on the following website:

http://www2.unine.ch/files/content/sites/psy/files/shared/documents/guides/2015-2016/Guide_Vert_oct2015.pdf

It must be noted that these ethical research principles - stemming from universal guidelines - do not address the unique challenges of conducting mental health research in emergency settings. Nor does they address the particularities of conducting research in the context of forced migration. As recently noted by Clark-Kazak (2019),

“research with people in situations of forced migration poses particular ethical challenges because of unequal power relations, legal precariousness, extreme poverty, violence, the criminalization of migration, politicized research contexts, the policy relevance of our research and/or dependence on government and nongovernmental services and funding. However, Research Ethics Boards (REBs) are not always aware of these particular ethical issues” (p. 13).

In the past decade, however, more and more humanitarian organizations have been reflecting upon research ethics and developing concrete ethical guidelines (Benelli & Low, 2019; Cherepanov, 2019; Clark-Kazak, 2019). These provide a “system of professional and multidisciplinary values, competencies, and standards that provide guidance and frame of reference for reasoning the complex professional and moral dilemmas arising within the humanitarian context ... with a high degree of moral ambiguity and no good solutions, where humanitarian accountability takes priority over conflicting values (Cherepanov, 2019, p. 81). I also drew on two further ethical guidelines, recently developed in line with this trend:

1. *The International Association for the Study of Forced Migration (IASFM) code of ethics*¹⁴. This code offers critical reflections on research ethics in situations of forced migration in particular. It explicitly “acknowledge(s) that the heightened risks that forced migration poses to both participants and researchers (as well as people who identify as both) requires proactive, thoughtful engagement and continuous critical reflection” (Clark-Kazak, 2019, p. 14).
2. The ethical guidelines outlined in the *“Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings.”* These were developed by the IASC (Inter-Agency Standing Committee) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, a conglomerate of a broad range of United Nations and non-United Nations humanitarian organisations (IASC, 2014, 2015).

Data collection in the field was conducted under the supervision of the project coordinator as well as the clinical psychologist of the team.

Highlighted anticipated harms to participants considered in developing the methodology included:

- Sensitive nature of the questions: potentially re-traumatising effects of having to narrate potentially traumatic experiences
- Danger of “overburdening” the participants who may already have had to share their experiences on numerous occasions with other health professionals

¹⁴ This document can be found on the following website : bit.ly/IASFM-code-ethics

- The “social desirability bias” implicit in the participant feeling obliged to answer questions of a sensitive nature regardless of the psychological impact.

Anticipated benefits to participants considered in developing the methodology included:

- Developmental opportunity to explore culturally relevant ways of facing past and current potentially traumatic events and reinforce internal and external resources
- Community engagement through groups and meeting with key informants – reinforcing social networks and external resources
- Improved accuracy of diagnosis and understanding of post-traumatic symptoms : ensuring that treatment is culturally relevant and based on the specific needs of the individual
- Therapeutic benefit of sharing their narratives

Given the sensitive and potentially re-traumatizing nature of the subject matter,

- Only participants willing and able to give their informed consent and who are evaluated by psychologists of the team to be psychologically stable enough to participate were considered (as detailed in the inclusion criteria).
- Participants had the right to withdraw at any time
- Identifying data was excluded and anonymity upheld
- Referral pathways to mental health services was made available where requested or where a need was identified
- Potential ethical challenges surrounding doctor-patient confidentiality were thoroughly addressed with the team in the event that medical consultations were observed or medical information was obtained
- All interviews were conducted by a clinical psychologist with experience in working with refugees exposed to potentially traumatic events

In accordance with Article D15-D19 of the *Guide Vert*, consent was taken from all participants before the research began. This included obtaining verbal or written informed consent documented in writing or audio/video records. Beneficiaries of M.S.F.’s services who were included in the research were reassured that their participation in the research would not affect their access to health-care, nor any future claims to asylum. Key informants employed by M.S.F. and Babel were likewise informed that their participation in the research would not affect their professional standing with these organizations. Participants were reassured that their participation in the study was voluntary, and that they could stop the interview at any point. Participants were not reimbursed for taking part in the study.

As some of the discussions required conversations about sensitive and emotional issues, psychosocial support was offered to all participants after the interview if required from M.S.F. or from another organisation offering counselling, such as Babel. This was in adherence to Art. D25, page 5 of the *Guide Vert* which states that the researcher has an obligation to minimise the damage of any harm caused to participants by the research process. It also conforms with

the IASC ethical guidelines on protection. This obliges researchers to “ensure participant protection needs take priority over the conduct of research, including referral pathways to accessible services and safety measures.” (IASC, 2014, p. 6).

Another key ethical principle informing the research, and based on the ethical guidelines of the IASC, was that of **participation**. The guidelines highlight the following components of this principle (IASC, 2014) (for more details of each principle, see p. 23-27):

- Participation in research demonstrates respect for individual and community autonomy and self-determination.
- Ethical research practice includes community participation throughout
- Collaborating and coordinating with others in the setting
- Providing information about the research and ensuring it is understood
- Reflecting on the study conduct for collective learning on ethical research practice

In accordance with Art. D23 of the *Guide Verte*, participants had the right to access information on the topics, results and conclusions of the research should they wish. Following the period of data collection, a “*restitution*” was conducted whereby results were presented to and discussed with the participants for the purposes of collaboration and inclusivity. Members of the project team also assisted in writing one of the research articles which form part of this thesis.

Study population

Individual participants

Purposive sampling was used to select individual participants. The selection of the participants was done in collaboration with the project team from the V.O.T. centre as well as Babel, who assisted in the identification of potential participants based on the following inclusion criteria agreed upon by key stakeholders, including the project team.

- Refugees (both those in the process of applying for asylum as well as those recognised as refugees by the Greek state)
- Adult (>18 years)
- Victim of torture or ill treatment as defined by the same criteria used by the V.O.T. project according to ICRC definitions
- Diagnosed with P.T.S.D.
- Psychologically stable enough (according to the clinical judgement of the project team) to participate in the research – this would therefore exclude active psychotic symptoms and acute suicidality
- Willing and able to participate in the research
- Able to be interviewed in English or French

Given the particular vulnerabilities associated with this research population, it was critical that the project team play a crucial role in acting as “gatekeepers” - assisting in only identifying beneficiaries of the project whom they deemed to be best suited to participate. Potential participants were approached by health professionals at the V.O.T. centre, and those willing to take part were introduced to me, the researcher, for an introductory meeting where I explained the objectives and methodology of the research. Ten individuals meeting the criteria agreed to participate,¹⁵ out of which nine were male. This gender imbalance reflects the overall demographics of the beneficiaries of the centre where the vast majority of victims of torture treated at the clinic are male.

An average of five open-ended interviews were conducted with these individual participants over the course of a year, from July 2016-July 2017. These served as an exploration of life trajectories unfolding within specific socio-cultural contexts. The focus of the interviews was on the functional task of recording a narrative of exposure and responses to potentially traumatic events. The interviews were guided by narrative techniques based on the methodological approaches of Kohler-Riessman (2000) and Rousseau (2014) - aimed at facilitating the unstructured sharing of stories, perceptions and experiences of participants. Each interview lasted an average of one and half hours. All participants agreed for the interviews to be recorded with the use of an audio recorder. No visual images or films were recorded. Interviews were conducted on site at the clinic, in a private room, with the exception of two participants who chose for the interviews to be conducted in their apartments. Interviews were conducted in French or in English without the use of a translator.

The following table provides information on the 10 individual participants who participated:

Nationality	Age	Gender	Language spoken	Level of education	P.T.S.D. diagnosis used during the asylum tribunal	Refugee status obtained	Outcome at two years follow-up
Sudanese	55	M	Arab, English, Greek	Five years of higher education	Yes	Yes	Refugee in Greece
Sudanese	35	M	Arab, English, Danish	Two years of higher education	Unclear / not sure	Yes	Refugee in Sweden
Afghani	50	M	Arab, Farsi, English	High school	Awaiting tribunal	Ongoing	Lost contact

¹⁵ For introduction and consent forms related to individual participants – see Annex I

Congolese	40	M	French, Linguala	High school	Yes	Rejected but appealed	Illegally moved to France
Sudanese	45	M	English, Arab	Three years of higher education	Yes	Yes	Refugee in Greece
Indian	30	M	English, Hindu	Three years of higher education	Yes	Yes	Returned to country of origin at own request
Guinean	40	F	French	Elementary education	No	Rejected but appealed - ongoing	Asylum seeker in Greece
Ivorian	40	M	French	High school	No	Ongoing	Asylum seeker in Greece
Syrian	30	M	Arab, French	High school	Yes	Yes	Awaiting family reunification to move to Germany
Ivorian	30	M	French, Arab	High school	No	Yes	Refugee in Greece

Community leaders and representatives interviews

Twenty-one semi-structured qualitative interviews were conducted among refugee community leaders and representatives across Athens. Inclusion criteria was that these were leaders across various refugee communities officially recognised and acknowledged as such by formal and informal associations – such as the Greek Forum for Refugees, the African Women’s Association, the Sudanese Refugee Association and the Syrian refugee association. These participants were recruited by using a “snowball technique” of referrals. The majority of these leaders were recruited among existing contacts provided to me by the V.O.T. centre and their partners. Furthermore, I contacted a few refugee associations across Athens independently, to widen the scope of recruitment.

Nationality	Age	Gender	Role
Eritrean	35	M	Community Leader (Eritrean)
Syrian	30	M	Community Leader (Syrian)
Afghani	35	M	Community leader (Afghani)
Nigerian	44	M	Community leader (Nigerian)

Afghani	50	M	Community leader (Afghani)
Afghani	30	M	Community leader (Afghani)
Afghani	40	M	Refugee leader - head of the Greek Forum for Refugees
Sierra Leonian	50	F	Head of the African Women's Association
Sudanese	50	M	President of the Sudanese Refugee Organisation
Syrian	50	M	President of the Syrian Refugee Organisation
Pakistani	35	M	Community worker
Sudanese	35	M	Community worker
Afghani	40	M	Community worker
Sudanese	30	M	Community leader (Sudanese)
Sudanese	30	M	Community leader (Sudanese)
Sudanese	35	M	Community leader (Sudanese)
Afghani	30	M	Community worker and interpreter for asylum services
Congolese	35	M	Congolese refugee
Sudanese	50	M	Sudanese refugee
Sierra Leonian	25	F	Sierra Leonian refugee
Algerian	60	F	Algerian war survivor and community leader

Interviews lasted between one hour and two hours. They were based on a semi-structured questionnaire aimed at eliciting cultural formulations of experiences of potentially traumatic events within specific communities, inspired by the cultural formulation questionnaire of the D.S.M.-V (APA, 2013) as advocated by Maier and Straub (2011).¹⁶ All participants agreed for the interviews to be recorded with the use of an audio recorder. No visual images or films were recorded. Interviews were conducted in locations across Athens according to the wishes of the participants. This included meeting them in their offices, a coffee shop or in their private homes. Interviews were conducted in French or in English without the use of a translator.

Key informant interviews

Forty-three semi-structured, qualitative interviews were conducted among “key informants.” Inclusion criteria was that these were professionals working in direct contact with refugees – and whose work involved a direct or indirect link to the mental health of this population. This included members of the multidisciplinary team of the V.O.T. project and their partners, such as doctors, psychologists, psychiatrists, cultural mediators (professionals offering translation and/or cultural mediation services for mental health services), and social workers. The participants were recruited among the existing staff of the V.O.T. centre, as well as those professionals associated with the centre, or working in collaboration with the centre from associated organisations.

¹⁶ For introduction, consent forms and interview schedules related to community leaders and representatives– see Annex II

Nationality	Age	Gender	Profile
Danish	27	F	Paediatrician
Dutch	26	F	Medical doctor (GP)
Italian	35	F	Psychologist
Moroccan	30	M	Cultural mediator
Kurdish/Afghani	40	M	Cultural mediator
Greek	25	F	Psychologist
Greek	40	F	Medical doctor (GP)
Greek	37	F	Psychologist
Swiss	26	F	Nurse
Chilean/Swedish	60	M	Psychiatrist
Norwegian	35	F	Psychologist
Turkish	50	F	Psychiatrist
Italian	40	F	Psychiatrist
Italian	30	M	Psychiatrist
Swiss	50	F	Psychologist
Swiss	45	M	Psychiatrist
Senegalese	30	M	Social auditor for the “auditions” of asylum seekers
Italian	35	F	Psychologist
American	50	F	Psychologist and medical activities manager
Greek	50	M	Psychologist (head of Babel)
Greek	30	F	Medical activities manager
Greek	40	M	Physiotherapist
Cameroon	35	M	Cultural mediator
Greek	30	F	Psychologist
Congolese (Brazza)	30	F	Cultural mediator
Iran	45	F	Cultural mediator
Greek/Georgian	35	F	Psychologist
Lebanese	50	F	Cultural mediator
Afghani	30	M	Cultural mediator
Greek	35	F	Psychologist
Greek	30	M	Psychologist
Greek	30	M	Social worker and psychologist
Greek	25	F	Psychologist
Greek	40	F	Medical doctor
Portuguese	35	F	Psychologist
Greek	45	M	Physiotherapist
Greek	30	F	Social worker
Lebanese	50	M	Psychoanalyst
Afghani	30	M	Cultural mediator
Greek	25	M	Doctor

Greek	30	M	Physiotherapist
Greek	30	F	Psychologist
Tunisian	30	M	Cultural mediator

Key informants were interviewed based on a semi-structured questionnaire regarding their perception of potentially traumatic events and their sequelae among refugees and asylum seekers as well as a focus on how a diagnosis of P.T.S.D. may be used as a tool within their work.¹⁷ Interviews lasted between one, and one and half hours, and were conducted in offices at the V.O.T. centre. All participants agreed for the interviews to be recorded with the use of an audio recorder. No visual images or films were recorded. Interviews were conducted in French or in English without the use of a translator.

4 months of participant observation in the centre for Victims of Torture

A collective total of four months of participant observation was spent in the V.O.T. centre, from June-August 2016 and again from July-August 2017. This included participating in the daily morning team meetings – during which time various case studies of individual beneficiaries of the centre (refugee V.O.T.s) were discussed. Other activities in which I participated in the centre involved:

- i. Participating in six **support group sessions for women** facilitated by one of the psychologists of the V.O.T. centre. These sessions were, and at the time of writing continue to be, targeted towards the female beneficiaries of the project (refugee V.O.T.s). Sessions offered a supportive and relaxed space for women wherein different practical activities were organised. The aim of this group was to have a therapeutic affect (including reducing stress and increasing social contact), whilst avoid the stigma attached to having an explicit focus on mental health. The group involved doing crafts such as needlework, artwork, knitting, and jewellery making. All members agreed to my participation. None of the members of the group were individual research participants. These groups were not recorded.
- ii. Providing twice-weekly **English classes** for interested beneficiaries of the project (refugee V.O.T.s) for the duration of the participant observation period. None of the members of the English class were individual research participants. These groups were not recorded.
- iii. Providing two **psychoeducation sessions** for interested beneficiaries of the project (refugee V.O.T.s) for the duration of the participant observation period in August 2016. This was to complement my research activity through facilitating discussions around various experiences of potentially traumatic events with refugee communities. Participants of these psychoeducation sessions were *not* the same group as the individual

¹⁷ For introduction, consent forms and interview schedules related to key informants – see Annex III

research participants, but other beneficiaries of the V.O.T. centre. The identification of participants for these sessions took into account practical considerations - including which languages the participants were able to speak and cultural or political sensibilities in the composition of the group in order to mitigate harm. One group was conducted in French and the other in Arabic (with the assistance of a cultural mediator). With the permission of all participants, the two sessions were recorded with the use of an audio voice recorder.

“Psychoeducation” sessions had the aim of engaging participants in organic discussion around the meaning of “trauma” in their lives and responses to it. A complementary aim was also to introduce the team, specifically the psychologists who took part in the sessions, to experience a new technique for group psychosocial interventions – a technique that I had used in my previous work as a clinical psychologist for M.S.F. in Africa. The *boite image*¹⁸ (collection of images used for the purposes of health promotion), commonly used as a tool for psychoeducation and/or health promotion sessions centred on symptoms of P.T.S.D., was used to facilitate these discussions. This involved showing participants graphic depictions of common symptoms associated with post-traumatic stress and inviting them to discuss their own experiences and understandings of these symptoms. For example, I showed participants a picture of a women appearing to drop her cup and jump up in fright. This image corresponds to an “exaggerated startle response” symptom of the P.T.S.D. diagnosis. Without naming the symptom, I simply showed the image and asked participants to react: What was happening in the picture? Have they seen this in their communities? Have they experienced this themselves? One of the goals of psychoeducation is to “normalise” symptoms – allowing individuals to see that they are not alone in experiencing them, that such symptoms may indeed be considered as a “normal” reaction to potentially traumatic events.

Apart from the benefits to participants, the session also favoured the collection of rich qualitative data well suited to an in-depth exploration of the research question from a socio-cultural perspective. According to Wilkinson (1998) interactive group methods are believed to lead to enhanced disclosure, improved access to participants’ own language and concepts, better understanding of participants’ own agendas, the production of more elaborated accounts, and the opportunity to observe the co-construction of meaning in action. The sessions sought to develop in-depth understandings of individuals’ “lifeworlds,” with groups providing a useful method for learning about the vocabulary and thinking patterns of a population within its social context. In addition, as a relatively naturalistic method, which enables relatively spontaneous interaction between people, groups increase the likelihood of gaining deeper insights than might arise with individual structured interviews or questionnaires. Thus, these group discussions were intended to highlight the “social-situatedness” of individual responses to potentially traumatic events as a source of complementary data.

¹⁸ For the *boite image* toolbox used to instigate discussion – see Annex IV

- iv. Facilitating a **feedback session** with the members of the V.O.T. centre team. This included presenting the results of a preliminary analysis of the data, and allowing the team to provide feedback on the research project in general, the results in particular, and to provide comments on general issues raised during the research. In particular, general themes were identified, shared and discussed among the team in order for further comments and analysis. The session took two hours and was attended by twelve participants. It was conducted in English and was recorded with the agreement of the participants.

Data management

The body of data collected throughout the research project was composed of the following:

- Transcribed recordings of all interviews with individual participants, community leaders/representatives and key informants
- Transcribed recordings of two psychoeducation sessions
- Transcribed recordings of the feedback session with the V.O.T. centre team
- My own reflections noted in a research journal which was updated regularly throughout the research process

All recorded interviews and other group sessions were transcribed and translated into English, where necessary. I was myself solely responsible for these tasks to avoid identification of the participants from the audio-recording. All identifying information was removed from transcripts before analysis. Consent forms were linked by an ID number to their corresponding transcripts allowing participants the possibility for withdrawing from the study at any time. All transcripts were entered into the software Atlas.ti 8 (Scientific Software Development GmbH, 1997). A transversal analysis was conducted using a systematic approach to iterative categorization starting with open coding (identifying key issues or themes emerging from the data) (Neale, 2016). Preliminary codes were generated through a process of triangulation of the data through firstly identifying themes among the distinct groups of participants (individual participants, community members and key informants) and secondly contrasting and comparing these themes among these various groups. As mentioned above, these codes were shared with the V.O.T. centre team in a feedback session for comments and revisions. This preliminary analysis was necessary, albeit arguably superficial, to frame more in-depth analyses conducted later on during the research process which centred on more focused research questions. In other words, it provided the framework from which more detailed analyses – drawing on more in-depth methods – were conducted. I now turn to a more detailed description of my method of analysis.

Method of Analysis

Roth and Lee (2007) highlight the criticism raised by Vygotsky regarding the “atomistic and functional modes of analysis ... [that] treat[s] psychic processes in isolation” (p.1). In line with

a more sociocultural approach to methodology, then, this thesis proposes an investigation of experiences of potentially traumatic events among refugees and asylum seekers through various units of analyses which incorporates both historicity and context as well as social and material environments. It reflects an attempt to go beyond an “atomistic” or individualised framing of psychological difficulties – a particularly relevant consideration for refugee communities in light of the multiple and arguably ongoing environmental stressors with which they are faced as they negotiate material ecologies which both enable and constrain their human activity. The approach “offers an analysis that integrates person in relation to personally important societal actors and issues.” (Daiute, 2016, p. 133).

I return once again to the key principles that I personally take from adopting a sociocultural approach to research methodology:

- i) The methodology should consider the dynamic and mutually reinforcing relationship between the individual and their sociocultural environment as the **single unit of analysis**
- ii) the methodology should account for the **multiple levels** inherent to this single unit of analysis
- iii) The methodology should be informed by a **critical reflexivity** on the part of the researcher, throughout the research process
- iv) The methodology should privilege an **idiosyncratic** approach to the analysis of unique, individual case studies
- v) The methodology should account for the **temporal dimensions** of the development of human phenomena

All of these components were an integral part of the method of analysis. In other words, they formed

“the system of theoretical instruments (tools) for the study of mental development in its dynamics and complexity ... [a method of analysis which] directly follows from the appropriate theoretical concept, and, therefore, theoretical instruments and experimental instruments together create a unity as the main components of this concrete research strategy [...] (1) to reflect and to explain the dynamic character of the processes under study and (2) to investigate the processes in their wholeness and complexity from genetic, developmental perspective [...] This methodology represents the system of interconnected theoretical and experimental research instruments/tools for refocusing the researcher’s lens on development by making visible processes that are ordinarily hidden beneath the surface, namely, changes in behaviour.” (Veresov, 2014, p. 135-146).

The theoretical instruments have methodological implications for analysing experiences of potentially traumatic events among refugees as emerging from and within social interactions, situated within a dynamic and ever-changing social-cultural context. Concretely speaking, the aforementioned theoretical principles led me to focus my lens on the following mutually connected levels of analysis:

- i. A **dynamic narrative analysis of activity systems** in which individuals find themselves – more specifically, in the case of this thesis, related to the medico-legal institutions working directly with refugee V.O.T.s.

Here, the analysis focuses mostly on the “objectively existing sociocultural context, independent of the [individual]” (Veresov, 2019, p. 73). More specifically, the analysis here focuses on medico-legal institutions as constitutive of activity systems (Kloetzer, Clot, & Quillerou-Grivot, 2015; Roth & Lee, 2007; Toomela, 2014; van der Riet, 2012), in which a refugee is connected to numerous other human beings in socio-material situations mediated by institutional identities and rules. Activity systems are here defined as a system of settings, institutions, physical environments, formal and informal, social relations, and events wherein a multitude of actors intersects. For example, in the case of a victim of torture seeking asylum, the activity system probably includes lawyers, doctors, psychologists, bureaucrats, cultural mediators, and asylum seekers themselves, each of whom may construct different narratives of refugee trauma. As such, the activity of individuals are considered as inherently embedded in social context and mediated by instruments which are at the same time used and transformed by individual actors (Kloetzer et al., 2015).

From a Vygotskian perspective, instruments used within these activity systems act on others and on the world, coordinating actions. In other words, by examining narratives of trauma circulating among various actors within the medico-legal activity systems, particularly at the crossroads where asylum seekers’ narratives meet a “centered” bureaucratic language system (Maryns & Blommaert, 2001), the focus is on how language may be a tool purposefully aimed at “conduct[ing] human influence on the object of activity” (Vygotsky, 1980, p.55). The analysis on this level draws specifically on a **dynamic narrative** framework as advocated by Daiute (2013). Dynamic narrative inquiry

“considers expressive genres as utterances in conversation across time and place within domains where certain individuals and institutions have something shared at stake. In addition to conversational turns, dynamic narrative inquiry includes narratives and other extended genres by those in vulnerable positions as well as by those with powerful influence and resources, as though in conversation.” (Daiute, Cerovic, Micic, Sullu, & Vracar, 2020, p. 5).

Drawing on this methodological framework, the focus is on the narratives (stories) and Narratives (scripts) circulating among the various actors within the asylum activity system. Data is analysed with the following questions in mind: How are potentially traumatic events being narrated in this complex setting, by whom, to whom, and for what purpose? Which common or diverse scripts exist across narratives of trauma? This includes examining the narrative activity of diverse actors, particularly the various and often contradicting ways in which P.T.S.D. serves as a tool drawn upon by the different actors within this activity system. The results of this analysis is presented in **chapter seven** of the thesis.

- ii. An analysis of the **individual trajectories** of refugee V.O.T.s as they navigate these institutionalised systems (an analysis particularly addressing both idiosyncratic and temporal dimensions).

The first level of analysis as described above intends to “map” the various activity systems in which refugees themselves upon arrival in Europe. In this second level of analysis, the focus turns to individual journeys of refugees negotiating these systems. Specifically, individual case studies of asylum seekers are analysed to explore the ways in which their experiences of potentially traumatic events are historically based, socially constructed, and culturally shaped; and the ways in which subjective experiences of these events are constantly developing in a dynamic and non-linear fashion. Thus, elements of non-linear temporality are considered in the context of individual refugees’ changing subjective current realities – as they weave together images of the past, present and future to cope with exposure to potentially traumatic events, confer meaning to their current situation and redefine-reposition themselves toward the future. This includes tracking the processes of change in imagining alternative possible lives. It also includes tracking the dynamic development of individual’s subjective experiences of potentially traumatic events within the context of their daily-lived realities. Elements of temporality are considered, as well as the continual interaction of the person with their environment in a given social and historical context. The concept of *perezhivanie* in particular, provides a powerful analytic tool for tracking development over time as well as for the analysis of the influence of the sociocultural context on the course of individual development. The results of this analysis are presented in **chapter eight** of the thesis.

- iii. An analysis of the **concrete implications** of this for healthcare professionals working with this target population (through exploring how subjectivity may be constructed and transformed in various environmental settings)

Having explored the medico-legal activity systems negotiated by refugees arriving in Europe, as well as their individual journeys therein, this part of the analysis focusses specifically on the impact of post-migration factors encountered in Europe, including delayed asylum trials and poor living conditions, on post-traumatic symptoms. The focus of the analysis at this level is on the complex, dynamic interactions of factors influencing the mental health of this population – and the ways on which symptoms of post-traumatic stress may be largely determined by larger cultural systems and socio-political contexts. Here, the analysis similarly explores the “broader range of strategies ... people use to understand the myriad material and symbolic circumstances they encounter in their daily lives” (Daiute & Lucić, 2010, p. 616). At this level, the analysis thus intends to explore the concrete implications of these factors and strategies for developing mental health interventions. The results of this analysis are presented in **chapter nine** of the thesis.

- iv. A reflection on the implications of this research, notably from an ethical perspective (particularly addressing the need for **critical reflexivity**)

It bears repeating that these four lenses of analysis are not understood to be independent of one another, existing as static entities in and of themselves. They are mutually interrelated. This is because a sociocultural method of analysis allows us to take these aspects of the sociocultural environment, identified in an analysis of institutions, neither as absolutely external, objective, nor, at the same time, as absolutely subjective (Veresov, 2019). Thus, the analysis is aimed not

at “objects under study”, but rather at “the process under study” in all its key aspects (Vygotsky, 1997). The results of this analysis are presented in **chapter ten** of the thesis.

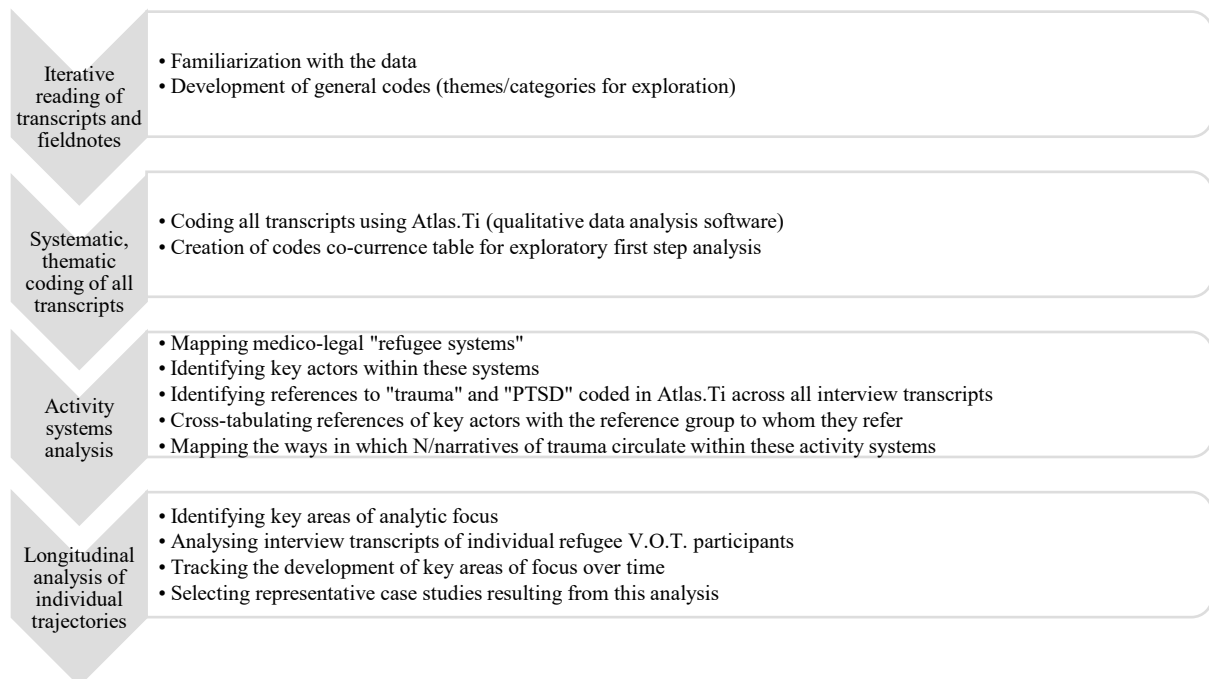
The analytic levels noted above further echo the reflections of Dafermos and colleagues (Dafermos, Triliva, & Varvantakis, 2017) in how best to analyze the aforementioned “inexorable links between social and individual development” (p. 73). They refer to an unpublished paper of Veresov wherein an analysis of the relationship between the following three concepts is proposed: (1) the social world as a background source for human development; (2) the interaction of ideal (developed) and real (present) forms as specific features of mental development; and (3) the general genetic law of cultural development which describes its dramatic character as inter-psychological and intra-psychological collisions.

In summary, analysing human development from a sociocultural perspective implies analysing the process of “how social becomes the individual” (Vygotsky, 1997, p. 186). This is because it is an analysis which considers that

“every function in the cultural development of the [individual] appears on the stage twice, in two planes, first, the social, then the psychological, first between people as an intermental category, then within the [individual] as a intramental category... Genetically, social relations, real relations of people, stand behind all the higher mental functions and their relations...every higher mental function was external because it was social before it became an internal strictly mental function; it was formerly a social relation between two people” (Vygotsky, 1997, p. 106).

In other words, in addressing this cohesion between the individual and societal level of practice, the analysis thus serves as a social, embodied, and transactional prism through which to study potentially traumatic experiences among refugees as a complex process situated within sociocultural systems. It is based on Vygotsky’s (1987, first published in 1934, 1980) methodological principles in which higher psychological functioning is examined in terms of its wholeness rather than its constituent parts as decomposed entities (Ma, 2014). It recognizes the “indivisible unity of personal characteristics and situational characteristics.” (Vygotsky, 1997). This irreducible nature of the reciprocal relationship between people and environment is critical.

Analytic steps



As a first step towards familiarizing myself with the data, and to map a general overview thereof, I generated basic thematic codes. These codes were intended to identify general themes/categories for areas of inquiry. They were based on an iterative reading of the interview transcripts as well as my field diary, a review of the literature, discussions with the M.S.F. project team, and the guiding research sub-questions. Following this discussion, the following themes were identified as areas of exploration:

- Community: this included any reference to community members (such as family members, religious groups, neighbours)
- Culture: This included any reference to cultural resources (belief systems, philosophies, adages, “wisdom” passed on from previous generations, cultural rituals or practices)
- Diagnosing trauma: This included any reference to medical diagnoses, particularly P.T.S.D., the process/act of diagnosing, the meaning of the diagnosis etc.)
- Environment: This included any reference to the physical environment (for example, the city of Athens – architecture, public transport, housing...)
- Fear of retraumatization: This included any reference to being “retraumatized” or “triggered,” any reference to current events serving to remind the individual of past events
- Imagination: this including any references to ideas of how the future may be, concrete plans for the future, or generalised hopes, aspirations, or wishes for the future

- Individual: This included any reference to the subjective experience of potentially traumatic events and their consequences, any reference to subjective experiences of mental health or illness, emotional distress
- Judicial: This included any reference to the judicial system, the asylum process and procedures, legal status, etc.
- Medical: This included any reference to medical procedures, medical consultations, physical health, medical complaints etc.
- Resilience/resources: This included any references to coping mechanisms, strategies, external resources, sources of resilience, aspects of post-traumatic growth and resilience, etc.

All the interview transcripts were coded according to the above themes using Atlas.Ti qualitative software. As a preliminary “thought experiment,” I used Atlas.Ti to generate the following “co-occurrence table”:

	Community	Culture	Diagnosing trauma	Environment	Fear of retraumatization	Imagination	Individual	Judicial	Medical	Resilience/resource
Community		98	119	160	3	81	121	64	59	57
Culture	98		141	39	n/a	3	33	11	131	42
Diagnosing trauma	119	141		113	13	8	43	132	113	22
Environment	160	39	113		16	21	49	52	39	30
Fear of retraumatization	3	n/a	13	16		3	2	17	8	2
Imagination	81	3	8	21	3		58	18	11	16
Individual	121	33	43	49	2	58		76	92	63
Judicial	64	11	132	52	17	18	76		75	19
Medical	59	131	113	39	8	11	92	75		40
Resilience/resource	57	42	22	30	2	16	63	19	40	

This general, preliminary step served to give me an overview (albeit a static one) of the multiple ways in which the categories intersect. For example, I could explore “diagnosing trauma” within the judicial system. I could explore sources of resilience, affiliated with the community, with cultural resources and practices, and the current environment. I could explore the fear of being “retraumatized” connected to the current physical environment, the medical system as well as the asylum procedure. I could explore the impact of the judicial system on imagination. I could explore the relationship between medical processes and individual subjective experiences of mental distress. The exercise was meant as a general initial “thought experiment” for myself, and served to help me further familiarize myself with the data and to further my reflections.

I then turned my analytic focus to “refugee systems.” This notably included a focus on medical and legal systems. The first step was to map the systems and identify key actors within these systems. Secondly, I mapped references to trauma by these key actors (including, for example, fears of retraumatization, any reference to “trauma,” as well as references to a diagnosis of P.T.S.D.). I extracted these references from Atlas.Ti to create a table in MSExcel, cross-tabulating the key actor interviewed, and the individuals to whom they were referring. In other words, references to trauma were tabulated according to who was speaking and to whom they were referring. This included, for example, individual refugee’s references to their lawyers and

the ways in which they understood trauma, to doctors references to how their patients present with symptoms of trauma etc. This has allowed me to further conduct a “dynamic narrative analysis” presented in **chapter seven**.

I further turned my analytic focus to individual refugee trajectories. As presented in **chapter eight**, if the above step in the analysis served to provides a “mapping” of the activity systems wherein refugees act (as asylum seekers, patients...) – this step in the analysis aimed to explore the trajectories of individual refugees *through* these complex medico-legal structures. This included multiple readings of individual refugee participants’ interview transcripts, and tracking the development of their trajectories over the course of the fieldwork period. As a result of this initial analysis of these trajectories, I selected individual cases to best represent general tendencies – according to the specific analytic focus of inquiry. The case of Mr B presented in **chapter six** was used to explore how cultural historical theory may be used to explore his experiences of potentially traumatic events – based on his ability to recount his cultural history in rich detail. The case of Brigitte presented in **chapter seven and eight** served to illustrate the multiple cultural resources (including diverse narratives of trauma) she drew on to make sense of her experiences, based on her rich descriptions of her cultural belief systems appearing in conflict with her current process of psychotherapy. The case of Jules was presented in **chapter nine** was used to explore his dynamic, ever-changing hopes for the future. He is a self-professed “dreamer” – whose ambitions were clearly impacted by current events in his environment, including a rejected application for refugee status. The case of Dilraj presented in **chapter nine** was used as the clearest illustration of how multiple “feedback loops” linked to experiences within his current environment served to reinforce his experiences of torture in his country of origin. The cases selected were on the basis of a “best fit” for illustrative potential, yet still their ability to clearly represent general tendencies found across all participants.

These steps further allowed me, to reflect on some of the ethical implications of the research as well as, in discussion with the M.S.F. project team, to draw some conclusions around practical implications for intervention.

Presentation of the results

In the following five chapters, chapters six to ten, I present the results of the analysis in the form of eight published scientific articles. The presentation of these articles follow directly from the levels of analysis highlighted above. In **chapter six**, I explore the implications of a sociocultural approach to research methodology, notably by demonstrating how cultural-historical theory may be used to analyse refugee experiences of potentially traumatic events. In **chapter seven**, two published articles present the results of a dynamic narrative analysis of the complex sociocultural systems in which individual refugee V.O.T.s find themselves upon arrival in Athens. More specifically, the focus of this chapter is on the medico-legal systems responsible for determining the legal status of asylum seekers, as well as healthcare systems addressing their medical and psychological needs. Within this, I explore the narratives of

trauma circulating among the key actors within these systems. In **chapter eight**, two published articles present an analysis which turns to the personal trajectories of those individuals navigating such complex systems. The focus here is on their subjective experiences of life trajectories. In **chapter nine**, the implications of the results of the aforementioned analyses are explored. The specific focus here is on concrete implications for professionals (specifically healthcare professionals) working directly with refugee beneficiaries. The psychological impact of daily lived realities are considered. In **chapter ten**, I reflect on the ethical implications of the research. Here, a scientific article is presented which reflects on the complex relationship between myself and the research participants, including individual refugee V.O.T.s, healthcare professionals of the V.O.T. project, and key informants from various refugee communities.

CHAPTER SIX: Using cultural-historical theory to explore trauma among refugee populations in Europe

ARTICLE ONE: Womersley, G., & Kloetzer, L. (2018). Using Cultural-Historical Theory to Explore Trauma among Refugee Populations in Europe. *Kul'turno-istoricheskaya Psikhologiya [Cultural-Historical Psychology]*, 14(1), 87-97.

Introduction

Europe is living through a refugee crisis of historic proportions which has now become one of the continent's defining challenges of the early 21st century. Not least among the difficulties are the public health challenges of the multiple traumas faced by this population which constitute severe threats to human, social, cultural, and community development. The psychological impact of atrocities endured by refugees¹⁹ populations is clear, with the literature reporting significantly high prevalence rates of post-traumatic stress disorder (P.T.S.D.) among this population (de Arellano & Danielson, 2008; Kirmayer et al., 2010; 2015; Schweitzer et al., 2006; van Ommeren, et al., 2001; Weine et al., 2001). Despite the high prevalence of P.T.S.D. noted among refugee populations, there have been significant concerns raised in the literature over the relevance and cross-cultural validity of this psychiatric diagnosis: the work of anthropologists (Young, 1995), psychiatrists (Summerfield, 1996), and sociologists (Fassin & Rechtman, 2009), among others, have long criticised P.T.S.D. as a heavily politicized and westernised social construct.

Outside of a standardised clinical understanding of trauma, there is a plethora of research indicating that sociocultural and linguistic heritage influences what experiences are interpreted as “traumatic,” the manifestations and expressions of post-traumatic symptomatology, the interpretation of symptoms, narratives of distress as well as culturally-informed healing models (Janoff-Bulman, 1985; Kirmayer et al., 2010; Kleinman & Good, 2004; Luno et al., 2013; Marsella, 2010). As a diagnostic construct developed for use in Western contexts, P.T.S.D. has been criticized for ignoring significant variability among symptoms evident in different cultural settings across the world (Hinton & Lewis-Fernandez, 2011; Steel et al., 2009). Further criticism is based on the fact that one cannot always link post-traumatic symptoms directly and uncritically to a single event in the life of an individual – a pre-requisite of a P.T.S.D. diagnosis by its very definition. Moreover, scholars globally have argued that the location of trauma at the level of the individual in the form of a P.T.S.D. diagnosis neglects the broader socio-political and cultural context within which it occurs (Marsella, 2010; Summerfield, 2001; Young, 1995).

¹⁹ ¹⁹ Here, we use the term “refugee” as defined by the Geneva Convention of 1951 to include both refugees legally recognized in a host country as well as asylum-seekers

A reductionist vision of trauma inherent in a classical psychiatric diagnosis risks individualizing and medicalizing the issue by focusing attention on therapeutic outcomes rather than a political response to the structural issues that led to trauma in the first place (Pratt et al., 2015). It risks rendering us blind to other ongoing aspects of interpersonal, political and social violence on a more global scale, including significant post migration factors which may be deemed equally traumatic by refugees, including current social, political and economic realities and lived daily experiences in host countries (Maier & Straub, 2011; Silove et al., 1998; Silove et al., 2000). These criticisms of P.T.S.D. therefore highlight the need for a more nuanced, contextualised and ‘decolonized’ understanding of trauma as being significantly determined by larger cultural systems and historic contexts (Carlson, 2005; Dauite, 2018; Kirmayer et al., 2010; Marsella, 2010; Marsella, Friedman, & Spain, 1996; Mattar, 2011; Rousseau, Drapeau, & Corin, 1997; Tummala-Narra, 2007; Wilson & Droždek, 2004; Zittoun, 2014; Zittoun & Sato, 2018).

Given the numerous criticisms surrounding the use of PTSD among refugee populations, we argue that cultural-historical psychology allows for a unique perspective in which to examine trauma among this population. Notably, we aim to bring a critical regard towards “psychiatrisation” and the isolation of the psychic from the sociocultural context (Goulart, 2017; Goulart & González Rey, 2016), arguing instead for a non-reductionist ontological vision of human nature and development as being rooted in material social practices (Stetsenko & Arieviditch, 2004), and wherein subjective human experience is inevitably connected to external reality (Vasilyuk, 1984). This framework therefore advocates for a move away from the essentialist and context-independent notions of PTSD toward viewing experiences of trauma as being embedded within sociocultural contexts and intrinsically interwoven with them (Stetsenko & Arieviditch, 2004). As such, it is “based on the notion that social and psychological phenomena are processes that exist in the realm of relations and interactions—that is, as embedded, situated, distributed, and co-constructed within contexts while also being intrinsically interwoven into these contexts” (Stetsenko, 2008, p. 7).

We draw on a Vygotskian perspective of culture noted by Daiute and Lucić (2010) wherein

“‘culture’ is not presumed to exist in values or beliefs of ethnicity, gender, or other categories but in the creation of meaning through symbolic thought in situations on the ground. As the primary location of development, social interaction, according to this theory, is not only an influence but the basis for human processes of knowing” (p. 616).

Vygotsky’s strong influence on culture and the social origins of psychological processes is particularly relevant to our increasingly diverse multicultural societies, and in particular giving the influx of refugees into Europe (Connery, John-Steiner, & Marjanovic-Shane, 2010). As noted by Roth and Lee (2007), the analytic challenges raised by Vygotsky regarding the “atomistic and functional modes of analysis ... [that] treated psychic processes in isolation” (p.1) remain unresolved. Indeed, one of the principal contributions of the Vygotsky-Luria project is the establishment of a “new psychology” – a “decolonized” way of understanding human thought and activity which takes into consideration the inseparable unity of mind, brain and culture in concrete socio-historical settings (Toomela, 2014). From its very beginning, this collaborative project rejects (a) any dualism between physiological and mental phenomena and

(b) any dichotomy of the individual and the society of which the individual is a constitutive part. Vygotsky's approach thus sees each psychological function as being comprehensible only when we see it as a part of an interrelated structure which ontogenetically co-evolves within a certain sociocultural environment (Langemeyer & Roth, 2006). Indeed, as Smagorinsky (2012) reminds us, Vygotsky took a revolutionary approach to the education of the blind, the deaf, the maimed, the cognitively different, and others falling outside the textbook and diagnostic norm by instead focusing on the settings of human development and their role in supporting and accommodating those who fall outside the diagnostic normal range.

Through the theoretical proposition of subjectivity within a cultural-historical approach, trauma experienced by asylum seekers and refugees cannot be conceived of as a process having an inherent value, occurring outside the network of cultural-historical experience, because it cannot be disconnected from its consequences for the concrete life of the individual. It is related to individuals, as well as social histories and resources (Goulart, 2017; Goulart & González Rey, 2016). Here, we draw on González Rey's (2008) definition of subjectivity as a "nonlinear, non-universal, non-deterministic and a context-sensitive process, whose main subjective configurations are part of an ongoing process... related, first and foremost, to the way in which the history and current contexts of individuals and social instances turn into symbolical emotional processes" (p. 5). Within this framework, the individual constructs the social and at the same time is constructed by the social (Zepke & Leach, 2002). Mental health from this subjective perspective is considered "as a living process, beyond hermetic diagnostic entities, overcoming the objectualisation and hierarchical aspect which frequently characterize the relationship between service users and workers" Goulart & González Rey, 2016, p. 1).

Therefore, consistent with major Vygotskian principles of interactive individual–societal development via the creation of meaning in everyday activities (Daiute & Lucić, 2010), this paper presents the results of a qualitative investigation into the subjective experiences of trauma among refugees. The study incorporates various units of analyses including historicity and context as well as social and material environments in an attempt to go beyond an 'atomistic' or individualised framing of psychological difficulties – a particularly relevant consideration for understanding trauma among refugees in light of the multiple and arguably ongoing environmental stressors with which they are faced as they negotiate material ecologies which both enable and constrain their human activity. In particular, our study aims to address the following questions:

- How is the experience of trauma among refugees "historically rooted, socially constructed and culturally shaped" (Veresov, 2017) ²⁰?
- How do the asylum seekers diagnosed with P.T.S.D. arrange, organize, direct and regulate their life activities to "not only answer to past or present conditions, but also

²⁰ Personal communication, ISCAR Summer University, July 3rd-7th 2017, Moscow.

envisions future ones, contributing to their creation as they evolve in the fabric of social life?” (Stetsenko & Arievitch, 2004).

Methods

We present a case study from a 12-month research intervention with NGOs addressing the refugee crisis in Athens, Greece – a project which included 125 qualitative, in-depth interviews among staff, cultural mediators, community leaders as well as individual refugees diagnosed with P.T.S.D. It also included 3 months of participant observation within a clinic for refugee victims of torture (including facilitating workshops for staff members and beneficiaries and attending morning team meetings, etc.) - an important condition for creating the social space within which the research could be realized (Goulart & González Rey, 2016). Ten individual refugees diagnosed with P.T.S.D. were followed over the period of a year, with an average of five in-depth interviews being conducted with each participant. Individual participants interviewed were all victims of torture in their respective countries of origin who subsequently sought psychological and medical attention from NGO clinics in Athens, Greece. The 20 refugee community leaders were interviewed in order to broaden our exploration into the multiple traumas to which refugee communities are exposed, and some subjective understandings of “P.T.S.D.” as a diagnosis among this population (Schick et al., 2016). By interviewing both individuals as well as community leaders, we attempt to gain a deeper understanding of life trajectories, dynamic processes, interactions and the continual development and change in psychological symptoms; an exploration which equally incorporates a focus on the ever-changing cultural and social systems which determine the various forms of individual subjective experience of psychological difficulties (Goguikian Ratcliff & Rossi, 2015).

The design draws on a cultural-historical framework which focuses on the intersubjective, mediational space between the individual and culture-society-interaction: an approach to understanding human mental functioning and action that focuses on how culture, history and social interactions shape individual consciousness, with a focus on the various levels in which to make sense of human mental functioning: phylogeny (the history of the species), the cultural history of the social group, ontogenesis (the personal history of the individual), and micro-genesis (a microhistory of specific events in the life of the individual, including traumatic events).

Through the analytical lens of dialogism

Telling a story of trauma or reliving it necessarily occurs in a larger dialogical matrix of narrative and social praxis (Kirmayer, 1996). Vygotsky came to postulate that psychological matters should be studied “in the process of change,” in its “development of all its phases and changes” (1987, p. 64-65). Indeed, studying psychological processes in their development

remains a key component of Vygotskian tradition (Langemayer & Roth, 2006; Ma, 2014; Smagorinsky, 2012; van der Riet, 2012). Vygotsky (1980) emphasised that

“We wish to obtain a clear idea of the essence of individual and social psychology as two aspects of a single science, and of their historical fate, not through abstract considerations, but by means of an analysis of scientific reality” (p. 237).

A dialogical analysis of interviews over the course of a year thus allows us to track the dynamic development of individual’s subjective experiences of trauma within the context of their daily-lived realities. Such a dialogical approach presupposes human beings inhabit shared forms of life, that meaning is continually negotiated within the social sphere, and that “cultural products, like language and other symbolic systems, mediate thought and place their stamp on our representations of reality” (Bruner, p. 3). Within this perspective, subjective experiences of trauma cannot merely be internally homogenous but involve multiple voices, texts, interests and traditions embodied in each individuals own varied histories and in the artefacts and norms of the system - a source of trouble and of innovation (Bakhtin, 1986, 2012).

This dialogical analysis explores how an individual’s experience of trauma necessarily is influenced by and reflected through language and culture – acknowledging that current concepts of mental health, notably a diagnosis of P.T.S.D., are to some extent socially constructed objects produced within a specific historical period (Goguikian Ratcliff & Rossi, 2015). The perception of trauma then is mediated through collective memory and the inter-generationally transmitted historic experiences, myths or stories from the past shaping worldviews (Droždek & Wilson, 2007). Here, elements of temporality are considered, as well as the continual interaction of the person with their environment in a given social and historical context.

Results

The case of Mr B

Mr B is a thirty-four-year-old Sudanese refugee victim of torture, referred to the clinic with a diagnosis of P.T.S.D. and a myriad of medical complications needing surgical intervention and ongoing physiotherapy. He begins the first interview by introducing himself:

“My father is X. My grandfather is XX. My father's grandfather XXX. My name I use here is to greet according to family names. My name is XXX but here it has been changed to XXXX [...] I was born in Darfur not north, south of Darfur state. That is a small village [...] At that time, you know the Darfur case, the Darfur case that is the goal is not allowing all the Sudanese to come suddenly to Khartoum. That is difficult. A lot of times happening many things or more things. My history really is long.”

From the moment of introduction, he immediately places himself within a long and complex history dating back to his great great-grandfather. Before stating his own name, the name of his ancestors are given; the entire family line is introduced. Even his own name reflects this rich family history, an integral part of who he is. He relates “my really long history” not only to the family but to the political history of his country, dating back to a time before he himself was

born. The complex and troubled history of his country over decades continues to be a part of him, sitting in a room in Athens, Greece in 2017.

He continues the interview by detailing how he was arrested and detained for six months as a result of his political activism. He was tortured, and forced to live underground without seeing sunlight. After managing to escape:

“Many things happened after. I decided to myself, or I say to myself what can I do to my futures. A, I have no future. A, I have no freedom. A, I have no education. Nothing. What can I do? I have many relations. I have many friends. I talk with them.”

It was through his social connections that he was able to escape and make his way to Europe. Plans for his future were elaborated upon by talking with his “many friends” - the dialogues within this social interaction serving as a resource which allowed him to envisage and create future conditions (Stetsenko & Arievidt, 2004). This continues to be evident in his recounting of his escape from Sudan into Libya, where interactions with others allowed him to construct plans for the future:

“Libya really situation is really difficult for me. I don't know other people. They have no way I can know. I can do some things to myself. After what can I do. I listen some people say, the peoples go to other place, go to Egypt. After to Egypt take the ship, come to Turkish, Greece, Greece to Italy, Italy to somewhere. The people talk, just this information. I have no idea about these things. Just I listened.”

Finding himself removed from his family, community and a familiar sociocultural environment, a new space is opened wherein both he and the asylum seekers around him share information in a collective attempt to negotiate the migration journey and make sense of their experiences. Within the history of the cultural-historical approach, we can understand this process by drawing on Vygotsky's concept of sense which he defines as “the aggregate of all the psychological facts that arise in our consciousness as a result of the world. Sense is a dynamic, fluid, and complex formation which has several zones that vary in their stability” (Vygotsky, 1987, p. 276). Mr B describes attempting to understand and master his new environment: it is a dynamic and fluid process based on the constantly changing environment, a process inevitably socially and culturally situated.

He continues to describe his journey

“I make it to Athens, go to Greece, what can I say. I succeed. I get the paper but really the Greek situation is very difficult. There are many friends from that time who are staying together in X. Some people have good chance, maybe two weeks, or three weeks go to Italy. After Italy people go to France, after go to Holland, go to Sweden and people go to Germany, people go to England, different countries ... these are people who succeed. I am here too. It is difficult here. No schooling. No integration. No, the refugee system is difficult for me, for us.”

He refers to these current difficulties as being equally traumatic for him, a source of suffering having just a significant impact on his mental health as the torture he experienced in his country of origin. All references to the stress encountered in his daily life in Europe are represented

collectively and communally, the situation is not only difficult “for me,” but “for us.” He then continues by describing the fact that he sees very little future for himself in this current situation, far from family back home. Disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affect the internal capacity to make links between different events and moments in life. From within a dialogical paradigm, this lack of connection to a possible future is intrinsically linked to a severe disruption of the relational processes by which meaning is dialogically created. It is difficult for Mr B to make sense of his past, present and future without a dialogical other present : for the transformation of traumatic memories into semiotic forms which connects it through language to its rightful place in time, the elaboration needs to be socially situated and “intersubjectively acknowledged” (Zittoun, 2014, p. 485). Instead, Mr B describes feeling isolated and alone.

“Really, the body has contacts with, you know, with mind and body has contacts to other side. Which other side? This is my family’s pain. I feel the pain of my families. You know, it’s feeling my pain [...] here I am alone. Yes I have friends, you know, all around me I have friends but these friends, eh, yes ... but not something else you know have, can do something to me, to my pains or to my problems...to my knee or something like this. This one. Really, every day or every times, I am thinking to my families. You know, my family. My sisters, my brothers, and my mother. Yeah. This is in my place [...], really I feel the pain of those people.”

He explains that the pain that he is currently feeling is not merely his own, but “the pain of my families.” This contradicts the inherently individual narrative of PTSD. This more collectivist representation of trauma has similarly been noted researchers and clinicians working within collectivist communities wherein individuals rely more heavily on larger family systems; here, mental health is typically seen to be more linked to a broader socio-cultural context (Adame & Knudson, 2007; Bracken, 2001; Droždek & Wilson, 2007; Maercker & Hecker, 2016; Tang, 2007). As Tang (2007) notes: “cultures differ regarding their dominant ideas about the ontology of self as well as relationship between self and others, between self and the universe, and between life and death” (p. 129). Tankink and Richers (2007) give the example of South-Sudanese research participants who did not experience themselves so much as an individual in the Western sense of the term, but more as having a ‘family self’ based on relational models where experiences are considered more within the intersubjective realm of the group rather than on an individual, intrapsychic level.

Equally noteworthy is the fact that he refers not only to the historical pain experienced by generations of family members exposed to conflict in Sudan, of which he himself is also a victim, but also the ongoing conflict in his country to which his family members continue to be exposed. The suffering in Sudan, in “my place” is felt in Greece. Trauma does not stop at the border. Paradoxically, this collective suffering seems to be exaggerated by his physical separation from the family: what is difficult for him is to experience this suffering – affecting his entire family – but to experience it “alone,” among people in Athens who may not be able to relate or understand. In this context of migration, itself characterized by disruptions in connection to ‘home’ (and all the social, cultural and linguistic connections that this implies) – the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only

to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). He continues by poignantly stating that “the more I stay here, really, I feel the pain.”

Analysed through a Vygotskian framework which rejects (a) any dualism between physiological and mental phenomena and (b) any dichotomy of the individual and the society of which the individual is a constitutive part, what is highlighted is Mr B’s representation of trauma: the physical pain affecting his knee is linked to his psychological suffering, his own psychological suffering intrinsically connected to the suffering of his family which in itself is both physical and psychological, both current and historic. In reflecting on this subjective experience of trauma, Mr B summarizes his mental state by saying “my mind is not like before really.”

When interviewed a few months later, in September 2016, the team noted a remarked improvement in his post-traumatic symptoms. They observed that he had more energy to become involved in various projects and that his mood had become more positive. He himself stated:

“You must try, you do something like masters [...] When I was travelling, you talk to different cultures, you talk to different peoples. We have many societies. After this you can get a job easily. You have many degrees or you have many certificates, or you have good mentalities, easily you can get a job or something like this. Actually try to your life, you build your life.”

This is yet another example of the way in which his orientation towards a future, towards building a life, is inevitably dialogic in nature. It is through exposure to different cultures, talking to different people, that he is able to improve both his current material reality (“get a job easy”) and his mental health (“mentalities”). Indeed, within this subjective representation, rebuilding one’s life following a trauma is a) connected to others within the sociocultural environment and b) the current environmental reality, including improved living conditions and being able to work and contribute as a productive member of society. This process of “building a life” is a lived social reality, continually and creatively co-constructed in micro-interactions and inevitably socially, politically, and historically contextualized. It is intersubjective (Bakhtin, 1981, 1986; Larrabee, Weine, & Woolcott, 2003; Marková, 2016).

Interestingly, he relates this improvement to relationships that he has started being able to construct in Europe with various people: neighbors, friends, the Sudanese community of Athens, and the medical team of the clinic:

“I can talk with doctors. I can talk my friends and relatives and you know the people struggling, society, or our communities”

One striking and ironic exception to this is the one relationship which he doesn’t believe to have had a positive effect on his mental health: that with his psychologist. Culturally-informed differences in representations of trauma were apparent, whereby Mr B felt his psychological suffering to be deeply culturally and historically connected, as opposed to his psychologist who felt it to be internal, individual, and related to a fixed incident in the past:

“Then I start to talk, saying, “Okay. You have to listen, you have to record in the mind” you know – this is the psychologist. Just record, make record. Okay tell me, again and again. After really, I suffer to talk. I don’t like, you know, thinking about something that’s happening before. Really, you know, I just want to forget it. I want to put it in the rubbish place. After, really, I start to talk with this psychologist, after I go back to my home, really I feel the pain, I feel the pain. Why? Something is happening before seven years or six years. I don’t like to forget again these things, but now it’s renew again. Why this person is asking these questions? Really, these things, why I am not like, I don’t like to go to psychologist [...] The better thing, really, is if something is happening bad – forget it! After you can remember, not change somethings, not change some things to your future, something has past. Not give you some defence or some power, but a new, a new being. I believe all things you can do good things, you know, to other people or to yourself, for following your future. Really, these bad things, these I’ll not forget to these things”

Many implicit differences emerge in his speech between his own culturally-determined understanding of trauma, and that of the psychologist. He believes that the past is something to “forget,” not talk about. He believes that he needs to orientate himself towards a future, not the past. He believes he should be focused on something “new,” not something “rubbish.” He wants to connect outwards, “to other people,” not inwards. As a result, when he’s asked by the psychologist to talk about the past, it brings him pain:

“the psychologist started to ask me more questions, after I start to answer, really I feel the pain. Body pains, to heart pain. Really I am suffering. Eh, I ... never I can forget these things happening to me. I see that there is a lot of peoples suffering. You know, this one. Suddenly, after I remind these things, really I feel the pain more. Never I can, for example, in the evening, never I can sleep. During all this time, you know, I remind this bad things, I forget before something is happening. Six years, or five or seven years. This is not really can support to me, or give me some power.”

Implicit in the exchange he describes is an unequal distribution of power related to western knowledge: it is the victim of torture diagnosed with PTSD who needs to understand trauma from the perspective of a westernised, medical model of distress. This “internationalisation and professionalization of adversity” (Pupavac, 2002, p. 493) enforcing “the asymmetry of the therapeutic relationship” (Wang, 2016, p. 143) has been criticised in the literature as a form of “cultural imperialism” (Steel, 2001) serving to reinforce existing imbalances of power between Western ‘expert’ and ‘victim-patient’ (Summerfield, 1996; Watters, 2001).

Mr B continues by explaining that his psychological suffering is not exclusively linked to his experiences of torture, but to a myriad of factors within his sociocultural environment:

“Really, I have a long time, I didn’t see my mother or to my family or to my relative, you know [...] I have a lot of friends, the same generation we are growing up together, those people now have families, have children, have many things. But until now I have nothing.”

What he describes as being traumatic is being torn away from his social environment, he no longer sees himself within cultural-historical context, as one in a long line of generations of family members and someone actively engaged in his community:

“Before I have many activities. The people in our village, in our towns, in our area, I have many activities [...] Now our activities are not like before. You know? Our activity is not like before.”

The switch from “my” activities to “our” activities is significant, one more example of the way in which trauma may be collectively or communally represented, not necessarily restricted to the level of the individual as is implicit in a P.T.S.D. diagnosis.

In January 2017, four months after our last interview, Mr B describes feeling even stronger both mentally and physically:

“After slowly, slowly this leg is coming strong. Really I appreciate all to my friend and to my relatives, and I am happy really. As many people support to me, and they support to me - and really I have outside of Greece many friend send me many messages. Really I want to stay at one place. I want to open new chapter. I want to do something, yes, really.”

The improvement is attributed to two factors: a) a physical improvement in his leg, thanks to surgery and ongoing physiotherapy and b) a feeling of social connection. The physical rehabilitation resulted in him receiving social support (“messages from friends”), which in turn resulted in an improvement in his mental health and a new, more positive orientation towards the future. Reflecting on this change, he states:

“Yes, really something has changed. I want to say I'm proud. I'm not like before. How many times I'm thinking when I was here you see my knee, think after two weeks or three weeks maximum it give me more power, I can walk better. Yes, this one, and before some dreams and these things not like before, now it's come better. Yes, I have no more bad dreams. This is a bad dreams and sometimes frustrated and this, no. These things I think I close these chapters.”

The pride he describes is related to having a new social position and outlook for the future, to physical improvements in his knee. As a result, there has been a reduction in his P.T.S.D. symptoms, he no longer experiences nightmares. The experiences of trauma are inherently connected to his material reality. This improvement continued over the following few months. When interviewed in August of 2017, his physiotherapist reflected on this process of change:

“If you have seen him in the beginning, he was a human rag. First of all, he wouldn't take care at all of himself, dirty nails... not dirty, dirty but uncared, very often talking about killing himself based on the idea that, "Is this a life?" "How can I live like that? I will never walk again," every negative thought you can imagine. He is another person. He steps on his feet literally and metaphorically [...] when he believes that the dream is still on then she can go, he's okay. Whenever something... I don't think, it's only the pain or it's also that he feels that this goes on and on. And he cannot go on to realize his plans.”

The physical pain is connected to the psychological, the psychological to the social, the social to his plans for the future. As neatly and rather aptly summarized by Mr B himself:

“You know, my future has contact with my leg.”

By following Mr B's subjective experiences of trauma over the course of the year, what becomes strikingly apparent is the connection of these experiences to his lived social and material reality. His physical health, his ability to work or not, his connection to others... all have an impact on the way in which he attempts to build a life for himself and how he orientates himself towards the future. Furthermore, his understanding of trauma is not static, but dynamic, and deeply connected to the cultural and historical context in which he finds himself.

Conclusion

The case of Mr B illustrates the heterogeneous, fluid and dynamic nature of individual subjectivities and the multitude of socio-culturally determined discourses which may be drawn upon to make sense of traumatic experiences (Gee, 2014; Squire, 2008). Not only do reactions to trauma differ according to cultural norms, but the very making sense of what is or what is not traumatic may similarly be informed by socio-cultural context (Dauite, 2018; Zittoun, 2014; Zittoun & Sato, 2018). This brings “profoundly into question not only the universality of knowledge from one domain to another, but the universal translatability of knowledge from one culture to another” (Bruner 1991, p. 2). It serves to illustrate the possible risks of health professionals, particularly those within a humanitarian context working with refugees, imposing a western representation of trauma that reduces it to the isolated and static level of the individual. According to Goulart and González Rey (2016), this western logic

“conceives of ‘mental disorder’ as a deviation from an idealized general norm and treats it as an individual phenomenon, to the detriment of its subjective, social, and cultural dimensions. Consequently, together with the users’ emotional fragility and lack of social bonds, an institutional configuration that associates mental disorder with social exclusion arises and crystallizes. Thereby, this situation generates an institutional vacuum that precludes the individual from developing a sense of citizenship, leaving him/her in a situation of marked vulnerability.” (p. 7)

By reducing the individual to a diagnostic disorder such as P.T.S.D., one risk is to reinforce a focus on vulnerability, on damage, on social exclusion. Furthermore, presenting a western-orientated representation of trauma risks isolating those with different culturally based understandings of their subjective experiences. As noted by Williams (2006), being aware of these risks has implications for humanitarian interventions among refugee populations: “practitioners, in particular, need to understand the dynamic and multidimensional nature of culture, the impact of power dynamics in their practice, and the steps that must be taken to make evidence-based practices culturally appropriate and responsive” (p. 57). The results of our study show that professionals are, to a more or less extent, aware of these dynamics. This echoes the experiences of clinicians working with refugee populations elsewhere, many of whom have articulated the need to consider the impact of the cultural and political environment on the mental health of this population (Droždek, 2007; Hauswirth, Canellini, & Bennoun, 2004). However, in this article we aim to add to the scientific literature conceptualising these dynamics through a uniquely cultural-historical exploration.

We aim to highlight the important value cultural-historical psychology may bring to this field by enriching understandings of “historical trauma” (Gone, 2013) or collective, cultural, and identity-related trauma among refugee populations, with its emphasis on the social location of human subjects and a recognition that trauma responses may carry a sense of group burden and collective suffering beyond symptomatic individuals. Furthermore, it brings a critical focus to bear on the political and social environment in which trauma occurs. From within this perspective, what is highlighted are the ever-changing cultural and social systems which are in continual interaction with the various forms of an individual subjective experience of mental illness. The individuals interviewed are seen as being deeply embedded in complex and

dynamic activity systems in which resources are exchanged - wherein individuals are both capable of negotiating and influencing this system as well as being influenced themselves by the system. Understanding that people always contribute to social practices, rather than merely participate in or sustain them, places activities that allow individuals to purposefully transform the world at the core of human development, as an instrument of social change (Stetsenko & Arieviditch, 2004). As refugees continue to migrate to Europe, many of them exposed to a myriad of various traumas, future research is imperative in order to continue to explore the ways in which the current political and social conditions in host countries may affect the mental health of these individuals. Cultural-historical psychology allows for this urgent and critical reconsideration of trauma as not only a personal medical condition, but also as the product of the interplay of changing social, historical, material, economic, political and subjective dimensions, in populations fighting to construct their new lives in Europe.

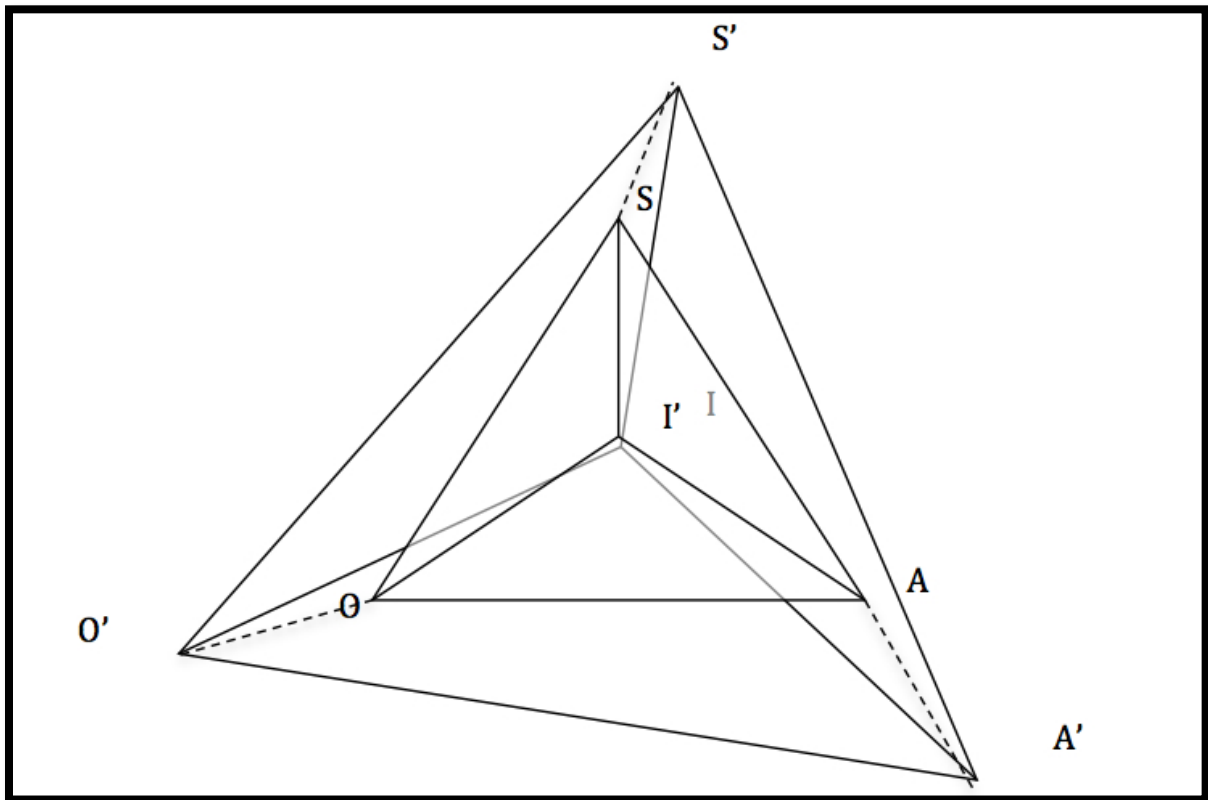
CHAPTER SEVEN: Exploring narratives of trauma within activity systems

Within a sociocultural framework, experiences of potentially traumatic events can only be understood within a broader systems of relations in which they have meaning (Van der Riet, 2009, 2012). Understanding such experiences among refugee populations therefore necessitates a focus on **activity systems** (Kloetzer et al., 2015; Roth & Lee, 2007; Toomela, 2014; van der Riet, 2012), wherein refugees are connected to numerous other human beings in socio-material situations mediated by institutional identities and rules. Activity systems are here defined as a system of settings, institutions, physical environments, formal and informal, social relations, and events wherein a multitude of actors intersects. Actors within these activity systems may include lawyers, doctors, psychologists, bureaucrats, and asylum seekers themselves, for whom P.T.S.D., for example, has a different meaning. As such, the activity of individuals are considered as inherently embedded in social context and mediated by instruments which are at the same time used and transformed by individual actors (Kloetzer et al., 2015). For example, the ways in which potentially traumatic events are narrated is always an interactive process around a culturally developed object (for example, a diagnosis of P.T.S.D.) allowing individuals to act within the world. P.T.S.D. itself, as a medico-legal category, would be understood as a cultural tool circulating among various actors in these activity systems, used in institutional systems to resist, create, understand, and to act.

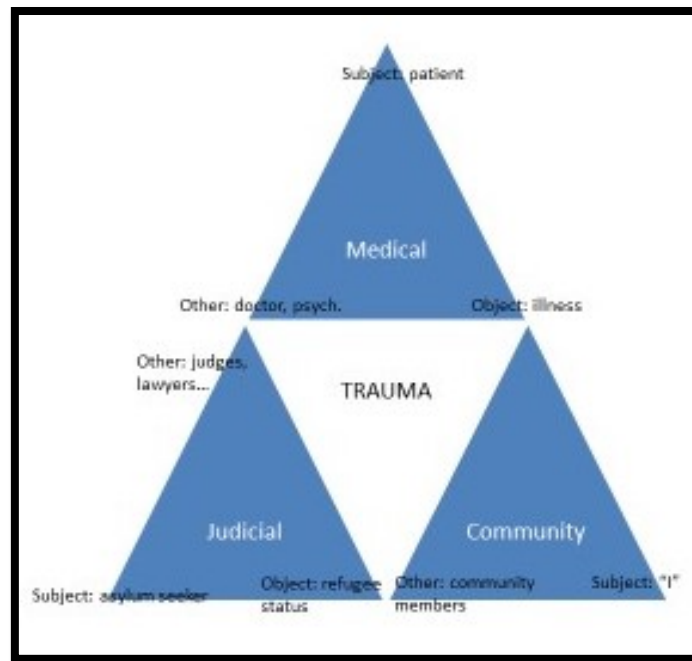
In this chapter, I present two articles focussing on the activity systems in which refugees find themselves upon arrival in Europe. These two articles are based on two particular areas of inquiry: the first article in this chapter presents an analysis of the **legal activity systems** into which refugees enter in order to be granted refugee status; and the second article presents an analysis of the **medical activity systems** into which they enter in order to receive treatment (including mental healthcare). In examining the former, I focus on the asylum process. Here I explore the activity of the judges, lawyers, testifying medical professionals, and the refugees themselves in the role of asylum seeker. The specific focus is on the diagnosis of P.T.S.D., and the ways in which it is used – in a more or less explicitly strategic manner – by the various actors within legal activity systems. In the latter, I focus on mental healthcare interventions. Here I explore the activity of doctors, psychiatrists, psychologists, social workers, cultural mediators, and refugees themselves in the role of patient. Thus, within both legal and medical activity systems, I explore the ways in which various narratives of trauma circulate among the various actors, specifically in relation to social structures, power relations and each actor's diverse activities and objectives.

This exploration is important: from within the sociocultural perspective of this thesis, and largely drawing on the work of Vygotsky (Veresov, 2017; Vygotsky, 1987, 1980), human development is seen as being inextricably linked to **activity**. This notion refers both to the activity of the individual displaying freedom and power to act on his/her environment, and the social activity within which this individual activity occurs (Leontiev & Leontiev, 1959). Some

scholars, notably including Engeström (Engeström, 1999, 2000, 2005), have forged the concept of “activity system” to capture the multiple dimensions organizing collective action. I draw on Clot and colleagues’ (Clot, 2011; Kloetzer et al., 2015) conceptualization of the psychological activity of the human subject as being both directed towards the objects of the world, towards the relation of Others to this object, and to the Subject him/herself – wherein development of the subject may result from development of any of its parts - as illustrated in the following diagram (Kloetzer et al., 2015) :



In applying the general concept of “activity system” to the specific case at hand being explored in this thesis, the diagram may end up looking something like the following:



The above diagram depicts activity systems, wherein each actor is engaged in specific activities wherein the construct of P.T.S.D. circulates as a specific cultural tool used to different ends. Here, I draw on Daiute's (2014) definition of a cultural tool as "symbolic process developed in human relations for interacting purposefully in the world" (p. 23). All actors are involved in the activity of constructing the reality narrated (Di Donato, 2011). For refugees seeking asylum, for example, the activity is narrating their story, their objective is to be believed, and the diagnosis of P.T.S.D. is used to this end as testament to their suffering. P.T.S.D. is colored by culturally informed narratives of trauma, and they are the victim in need of assistance. For health professionals, their activity is diagnosing, their objective is to treat the patient, as well as to attest to their psychological state of mind, and the diagnosis of P.T.S.D. is used as a tool to this end. P.T.S.D. falls within a medicalized Narrative informed by psychiatric categories, and the asylum seeker is the patient. For judges and other officials in the asylum tribunal, their activity is to assess the legal case, their objective is to determine the refugee status of the individual in front of them and P.T.S.D. is used as evidence to this end. P.T.S.D. is colored by a technical, legal narrative genre and the asylum seeker is the defendant whose case is being assessed. To summarize in a table:

Who (actors)	Activity	P.T.S.D.	Narrative genre	Dilemma
Asylum seeker	Tell his or her story to be granted refugee status	Used to testify (to fear/suffering), reinforces the story	Culturally informed	To tell or not (risk of retraumatization)
Medical professional	Treat	Used to determine course of treatment	Psychiatric/medical	To diagnose or not, to write the certificate or not
Bureaucrat in asylum procedure	Assess	Used as evidence to assess the case	Legal, institutional	To grant refugee status or not, to believe or not
Cultural mediator/translator	Mediate/translate	Used to “translate” suffering from one discourse to another	Culturally informed -> legal/institutionalized	To intervene as mediator (for example, as advocate), or simply as a politically neutral translator?

Narratives and narrative interactivity

Narrating is a fundamental activity people use to negotiate complex institutional systems. People narrate to make sense of their experiences, as well as to mediate and manage interactions with other key actors within these systems. Refugees, for example, may narrate their stories (including stories of potentially traumatic experiences they may have experienced) to a variety of different actors: to a social worker in order to secure accommodation, to a lawyer in order to prepare for the asylum tribunal, to a psychologist as a part of the process of psychosocial recovery. They may use narrating as a tool to figure out what is happening in their environment and how to act within and upon the situation.

As noted by Dauite (2013) “much of culture is created in narratives, which means that narratives by many different sources – different persons, roles, institutions, and so on – intermingle in a process of narrative interactivity” (p. 33). It is this **interactivity** that is explored in this chapter: the ways in which participants engaged in the activity of narrating across a variety of different systems, and in different roles. Narratives are interwoven: a medicalized account of trauma, as exemplified within a P.T.S.D. diagnosis, may seep into the legal discourse of the judges of the asylum tribunal, into the communication strategies of humanitarian associations assisting refugees, and into the ways in which individual refugees narrate their own life stories. Daiute further considers narrative as being far more than representations of events. She distinguishes between small **stories** (conversations in everyday discourse) – which we may refer to as

“narratives” with a small “n” – and **scripts** - master narratives or discourses which we may refer to as “Narratives” with a capital “N.” Indeed, within this understanding of narrative interactivity, narrative (and the associated activity of narrating) is understood to be a social process: “the context of narrative is, thus, an ecology – a system of settings, institutions, physical environments, formal and informal social relations, and events.” (p. 34).

There are inherent power imbalances in activity systems. Cultural tools, such as P.T.S.D., are embedded in systems of resources hierarchized in terms of functional adequacy (Blommaert, 2001a). Blommaert and colleagues (Blommaert, 2001a, 2001b; Maryns & Blommaert, 2001), for example, argue how asylum seekers narrating their experiences in the context of the asylum procedure are confronted with a complex set of administrative procedures which presuppose access to various codes (for example, psychiatric or legal codes) requiring a very specific set of westernized narrative resources which may not be available to migrants. Added to this is the power imbalance inherent in the process of diagnosing asylum seekers, as outlined above, which privileges western above local knowledge. Here, as chillingly noted by Blommaert (2001b), “Foucault’s image of subjects being transformed into knowable objects of clinical observation by means of a multilayered complex of discursive and material practices is looming large.” (p. 31). I would argue that P.T.S.D. as a cultural tool may represent just such practices. It is mobilized as a specific tool for performing specific actions in a specific moment under specific circumstances; it reflects “a process of interactions albeit often implicit across individuals, groups, and institutions enacting purposes and meanings relevant to displacement journeys” (Daiute, 2017, p. 6). For legal actors of the tribunal, a diagnosis of P.T.S.D. speaks to the structure, coherence, and meaning brought to bear on established normativities and value judgments inscribed in legal procedures. For asylum seekers, it is used in the art of storytelling, defined as “a complex process for connecting with others for a wide range of purposes.” (Daiute, 2017, p. 9).

Within the concept of narrative interactivity, then, the activity of narrating cannot be considered politically neutral. In other words, there are inherent power imbalances to be found within these systems, in terms of who is narrating, what, and to whom. According to Blommaert (2001a), “the resources controlled by the narrators and their interlocutors are part and parcel of the interpretations given to their stories, and given the central role of the stories in the asylum procedure, matters of resources may influence the outcome of their asylum application” (p. 23). Medical certificates stating P.T.S.D. among asylum seekers therefore “come with a history of use and abuse; they also come with a history of assessment and evaluation... put into a legal/procedural framework, in sum, that every step in the systematically and uniformly performed process involves not replication but far-reaching transformations of the ‘original’ story” (Blommaert, 2001a, p. 23). The story of trauma, then, is also replicated and transformed into the form of a medical certificate attesting to P.T.S.D., a “narrative shaping of individualized experience through contextualization processes [which] entails a shaping of linguistic and narrative tools that operate as contextualization cues” (Maryns & Blommaert, 2001, p. 62). These “contextualization cues” permit the very concept of P.T.S.D. to circulate as a “boundary object” (Star & Griesemer, 1989; Trompette & Vinck, 2009) understood and used differently by various actors. The messy story of trauma then is decoded and converted into a

“depersonalized case” (Maryns & Blommaert, 2001) based on “overly tidy stories” (Bruner, 1990, 1991, 2003) and thus easily convertible into established medico-legal categories.

An examination of **narrative interactivity within activity systems**, as highlighted by the following two articles, thus allows for a broad contextualisation of practices around P.T.S.D., revealing and exposing tensions, and contradictions in how various actors involved in use this diagnostic construct. In other words, by examining P.T.S.D. within activity systems, it is considered as an instrument purposefully aimed at “conduct[ing] human influence on the object of activity” (Vygotsky, 1980, p. 55), circulating at the crossroads where asylum seekers’ narratives meet a “centered” bureaucratic language system (Maryns & Blommaert, 2001). As the results presented here in this chapter demonstrate: to diagnose a refugee with P.T.S.D. has very concrete social, material, and legal consequences.

ARTICLE TWO: Womersley, G., & Kloetzer, L. (work in progress) “Crying makes your story more believable”: N/narratives of trauma within the asylum-seeking process.

Abstract

Asylum seekers entering into Europe are often obliged to tell their story to multiple actors (often with a focus on the “trauma narrative”) in order to be legally recognized as refugees. Lacking alternative evidence, many attempt to prove their “well-founded fear” and the violence to which they have been exposed through a diagnosis of post-traumatic stress disorder (P.T.S.D.). However, the literature highlights the risk of P.T.S.D. becoming a ‘pre-requisite’ for validating the experiences of asylum seekers, reducing these experiences to a reified diagnosis in order to render accounts believable. To categorize an asylum seeker with P.T.S.D. has very concrete social, material, and legal consequences.

To explore this, we present the results of a yearlong research projects among asylum seekers diagnosed with P.T.S.D. as well as their treating health professionals (including doctors, psychologists and psychiatrists) in a center for victims of torture in Athens, Greece. Drawing on a dynamic narrative inquiry with an activity-meaning system design (Daiute, 2014; Daiute et al., 2020; Daiute & Lightfoot, 2004), we sample discourses by diverse participants to analyse the use of the category of P.T.S.D. by these various actors, notably as influencing the decision-making process during the refugee status determination process. The analysis reveals the multiple contradictions in how the various actors involved use this diagnostic construct. We highlight the substantial differences in understanding the diagnosis reflecting existing power imbalances, the way in which narratives of trauma may be purposefully “rehearsed” for the tribunal, and the tensions surrounding the activity of narrating trauma within this activity-system.

Introduction

Europe is living through a refugee crisis of historic proportions; with subsequent evolving responses having now become one of the continent’s defining challenges of the early 21st century. Assessing the thousands of applications of asylum claims on a case-by-case basis remains one of the most significant challenges for host countries. In the face of significant anti-migration sentiment, procedures for testing refugee claims continue to be applied by most countries of the West in order to manage and restrict the flow of displaced persons by drawing on increasingly harsh policies to justify “humane deterrence” (Silove & Mares, 2018; Steel, Frommer, & Silove, 2004). Within this “adversarial” (Crumlish & Bracken, 2011) context, the burden of proof of refugee status rests upon the individual asylum seeker. Refugees not only have to prove persecution, but that they’ve also been damaged by it (Joles, 2018).

In terms of Article 1, Chapter 1 of the Geneva Convention of 1951, a refugee is defined as being someone with a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.” The word “fear” here is of particular interest as it implies that a refugee is defined to some extent by his or her psychological response to events, not events themselves. Therefore, when persecuted individuals seeking asylum cannot give evidence of marks on their body, they have the alternate possibility of proving the “wounds of the soul,” notably a diagnosis of post-traumatic stress disorder (P.T.S.D.) (Fassin, 2011). The asylum process therefore represents a point of intersection between the domains of psychology and administrative law, a setting in which these frameworks may well collide (Steel et al., 2004)

P.T.S.D. is a unique diagnosis. At its very core, there is a story. It is the only diagnosis that requires a narrative plot as the essence of the diagnostic criteria: i) once upon a time, there was an event which occurred (criterion A, “a stressor”), ii) this event lead to specific symptoms (criterion B-D), iii) the symptoms lasted for more than one month (criterion F), and iii) it significantly impaired the functioning of the individual (criterion G).

It is not a legally or politically neutral diagnosis. A diagnosis of P.T.S.D. may ultimately risk becoming a “pre-requisite” for proving refugee status (d’Halluin, 2009, 2016; Fassin & d’Halluin, 2005; Silove & Mares, 2018; Steel et al., 2004). It may enter into the narrative activity of refugees seeking asylum, and those who assist them. According to Daiute (2013), “appearing to be objective accounts of past events – recounting *who, what, when, where, why* – plots are like lenses that guide perception, memory, and interpretation of the dramas of life. Without always being aware, narrators know which stories are worth sharing, which details to include, how to organize these details to capture the attention of their audiences, and which stories are gripping...” (p. 114). Indeed, the question of how to narrate experience and whose narratives matter for which audiences has become increasingly important in relation to inequalities and injustices worldwide (Daiute & Gómez, 2014).

In this article, we explore the ways in which P.T.S.D. as a cultural tool forms part of the narrative activity of various actors within the asylum system, “gripping” the audience and guiding their attention to a specific Narrative in line with the figure of the “traumatized refugee.” We explore narrative interactivity and the ways in which trauma is narrated across “webs of meaning” (Daiute et al., 2020) within the asylum system. We specifically examine the use of a P.T.S.D diagnosis across an interconnected network of actors (including lawyers, health professionals and asylum seekers) – according to the various roles and activities of each actor concerned. By drawing on the case study of victims of torture claiming asylum in Greece, the numerous functions of the diagnosis will be highlighted – including the way in which such functions may change over time even within the activity of each actor.

P.T.S.D. among refugee populations

The mental health impact of atrocities endured by refugees ²¹ is clear, with high prevalence of post-traumatic stress disorder (P.T.S.D.) reported among this population. Torture has emerged as a particular triggering factor (Haenel, 2015; Hodges-Wu & Zajicek-Farber, 2017; Silove et al., 2017; Song et al., 2017). The literature attests to substantially higher prevalence rates of mental health difficulties among refugees compared to general populations within host communities. In terms of P.T.S.D. prevalence specifically, two landmark meta-reviews conducted by Steel and colleagues (2009) and Turrini and colleagues (2017) reveal an average prevalence rate of P.T.S.D. across all surveys of 30.6% and 40% respectively.

Despite the popularity of P.T.S.D. as a “sexy diagnosis” (Struwe, 1994) and its dominance in Western cultural discourse as an integral part of humanitarian interventions for refugee populations, various criticisms levelled against the diagnosis have long been documented in the literature ever since the period leading up to its codification as a disorder in the D.S.M.-III (Bracken, 2001; Bracken et al., 2016; Steel, 2001; Summerfield, 1999, 2001b; Young, 1995). The work of anthropologists (Young, 1995), psychiatrists (Bracken, 2001; Bracken et al., 2016; Bracken et al., 1997; Summerfield, 2001) and sociologists (Fassin & Rechtman, 2009), among others, have long criticised P.T.S.D. as a heavily politicized and westernised social construct. This is in light of the plethora of research indicating that sociocultural and linguistic heritage influences what experiences are interpreted as “traumatic,” the manifestations and expressions of post-traumatic symptomatology, the interpretation of symptoms, narratives of distress as well as culturally-informed healing models (Droždek, 2015; Janoff-Bulman, 1985; Kirmayer et al., 2010; Kleinman & Good, 2004; Luno, Beck, & Louwerse, 2013; Marsella, 2010).

The literature attests to the risk of P.T.S.D. reifying and minimizing the trauma experienced by refugee populations by within an exclusively psychiatric paradigm in order to render narrative accounts of asylum seekers believable in the asylum procedure (Fassin & d'Halluin, 2005; Maier, 2006; McFarlane, 1995; Rogers et al., 2015; Wilson-Shaw, Pistrang, & Herlihy, 2012; Young, 1995). According to Summerfield (1996) such a politically loaded use of P.T.S.D. may lead to “absurd” (p.14) situations whereby victims of torture and other atrocities fear not being believed unless they can “check off the tick list of symptoms” required by P.T.S.D. However, we cannot disregard the diagnosis entirely and throw the metaphorical baby out with the bathwater. Rather, this literature emphasises the necessity of deepening our understanding of trauma as it affects refugee populations.

The importance of correctly identifying trauma in the asylum procedure

There is an increasing body of scientific evidence looking at the assumptions recorded by authorities in their asylum decisions and the psychological processes at play during the court proceeding. This literature suggests not only that there may be marked uncertainty in how to

²¹ Here, we use the term « refugee » as defined by the Geneva Convention of 1951 to include both refugees legally recognized in a host country as well as asylum-seekers

reach the correct determination of refugee status, but also that there is often the potential for bias against the person genuinely fleeing from trauma and persecution. This is because trauma negatively impacts the credibility and consistency of verbal accounts by impairing memory and capacity for coherent verbal recollection (Crumlish & Bracken, 2011). As noted by Linton (2015), “ironically, the fraudulent applicant is better situated to relate a detailed story with appropriate demeanour than the genuine applicant” (p. 1085). Furthermore, the varied responses to traumatic events may fall outside of given cultural norms surrounding expectations of how a traumatised individual “should” act (Bögner et al., 2010; Linton, 2015; Mueller et al., 2011; Rogers et al., 2015; Schock et al., 2015; Silove & Mares, 2018; B. Turner, 1992; S. Turner, 2015).

Among the factors that require sensitive consideration are risk of cultural and linguistic misunderstandings and the effect of trauma on the capacity to provide a coherent narrative (Silove & Mares, 2018). Such a consideration is particularly pertinent when seen in light of the literature demonstrating that the asylum process risks being a traumatic event in and of itself (Rogers et al., 2015; Schock et al., 2016; Schock et al., 2015; B. Turner, 1992; S. Turner, 2015). Here, a culturally sensitive recognition of trauma may assist judges and other decision makers in recognizing and being more attentive to the difficulties asylum seekers may have in verbalising and constructing their case as a result of a compromised mental state which “may impede the applicant’s ability to testify in a manner that appears direct, specific, and emotionally appropriate” (Linton, 2015). This recognition of impairment is critical to assist the comprehensive assessment of refugee claims – as it limits the risk of erroneous decision making based on testimonies distorted by psychological trauma (Silove & Mares, 2018).

There is therefore a need to explore these tensions surrounding the controversial use of P.T.S.D. as evidence in court, as well as to deepen the way in which the impact of trauma among refugee populations is understood. Nowhere is this more pertinent than in the asylum procedure, where questions of legitimacy are central. We therefore argue that understanding how trauma is narrated in the context of the asylum process should necessarily recognise the social-cultural context in which it occurs, in relation to the activity of which it is a part and within a broader systems of relations in which it has meaning (Van der Riet, 2009, 2012).

The asylum procedure as a system of activity

Our research is anchored in cultural-historical psychology, which focuses on processes of human development within a specific and changing cultural and historical situation. It highlights the connection of the person with her environment as lived “drama” (Veresov, 2017; Vygotsky, 1987, 1980). Engagement of humans with their socio-cultural world is mediated by tools, which are a product of cultural development, and allow them to act on the world (technical tools), on themselves, and on the other human beings. From within this perspective, human development is therefore inextricably linked to activity, conceptualized as both the activity of the individual displaying freedom and power to act on his/her environment, and as the social activity within which this individual activity occurs (Leontiev & Leontiev, 1959). Some

scholars, notably including Engeström (Engestrom, 1999, 2000, 2005), have forged the concept of “activity system” to capture the multiple dimensions organizing collective action. The work draws on Clot’s (Clot, 2011; Kloetzer et al., 2015) conceptualization of the psychological activity of the human subject as being both directed towards the objects of the world, towards the relation of Others to this object, and to the Subject him/herself – wherein development of the subject may result from development of any of its parts (Kloetzer et al., 2015).

We thus explore the asylum seeking process as an activity system (Kloetzer et al., 2015; Roth & Lee, 2007; Toomela, 2014; van der Riet, 2012), in which a refugee is connected to numerous other human beings in socio-material situations mediated by institutional identities and rules. Activity systems are here defined as a system of settings, institutions, physical environments, formal and informal, social relations, and events wherein a multitude of actors intersects. The concept of activity system therefore “depicts an environment of everyday life—a cross context slice of life—wherein actors in different social positions interact in some way” (Daiute et al., 2020, p. 5). In asylum procedures, the activity system may include lawyers, doctors, psychologists, bureaucrats, and asylum seekers themselves, for whom P.T.S.D. has a different meaning.

Narratives and narrative interactivity within activity systems

Narrating is a fundamental activity people use to negotiate complex institutional systems. People narrate to make sense of their experiences, as well as to mediate and manage interactions with other key actors within these systems. Refugees, for example, may narrate their stories (including stories of potentially traumatic experiences they may have experienced) to a variety of different actors: to a social worker in order to secure accommodation, to a lawyer in order to prepare for the asylum tribunal, to a psychologist as a part of the process of psychosocial recovery. They may use narrating as a tool to figure out what is happening in their environment and how to act within and upon the situation.

As noted by Daiute (2013), “much of culture is created in narratives, which means that narratives by many different sources – different persons, roles, institutions, and so on – intermingle in a process of narrative interactivity” (p. 33). It is this **interactivity** that is explored in this article: the ways in which participants engage in the activity of narrating across a variety of different systems, and in different roles. Narratives are interwoven. A medicalized account of trauma, as exemplified within a P.T.S.D. diagnosis, may seep into the legal discourse of the judges of the asylum tribunal, into the communication strategies of humanitarian associations assisting refugees, and into the ways in which individual refugees narrate their own life stories. Daiute further considers narrative as being far more than representations of events. She distinguishes between small **stories** (conversations in everyday discourse) – which we may refer to as “narratives” with a small “n” – and **scripts** - master narratives or collective discourses which we may refer to as “Narratives” with a capital “N.” Indeed, within this understanding of narrative interactivity, narrative (and the associated activity of narrating) is understood to be a social process: “the context of narrative is, thus, an ecology – a system of settings, institutions, physical environments, formal and informal social relations, and events.” (p. 34).

There are inherent power imbalances in activity systems. Cultural tools, such as P.T.S.D., are embedded in systems of resources hierarchized in terms of functional adequacy (Blommaert, 2001a). Blommaert and colleagues (Blommaert, 2001a, 2001b; Maryns & Blommaert, 2001), for example, argue how asylum seekers narrating their experiences in the context of the asylum procedure are confronted with a complex set of administrative procedures which presuppose access to various codes (for example, psychiatric or legal codes) requiring a very specific set of westernized narrative resources which may not be available to migrants. Added to this is the power imbalance inherent in the process of diagnosing asylum seekers, as outlined above, which privileges western above local knowledge. Here, as chillingly noted by Blommaert (2001b), “Foucault’s image of subjects being transformed into knowable objects of clinical observation by means of a multilayered complex of discursive and material practices is looming large.” I would argue that P.T.S.D. as a cultural tool may represent just such practices. It is mobilized as a specific tool for performing specific actions in a specific moment under specific circumstances; it reflects “a process of interactions albeit often implicit across individuals, groups, and institutions enacting purposes and meanings relevant to displacement journeys.” (Daiute, 2017, p. 6). For legal actors of the tribunal, a diagnosis of P.T.S.D. speaks to the structure, coherence, and meaning brought to bear on established normativities and value judgments inscribed in legal procedures. For asylum seekers, it is used in the art of storytelling, defined as “a complex process for connecting with others for a wide range of purposes.” (Daiute, 2017, p. 9).

Within the concept of narrative interactivity, then, the activity of narrating cannot be considered neutral. In other words, there are inherent power imbalances to be found within these systems, in terms of who is narrating, what, and to whom: “as the term ‘system’ suggests, the diverse narrator perspectives are not neutral but connected by relations of power-with some having more status and influence in a society and thus over different narrators, some having more resources for spreading their stories, some having better storytelling skills, and some garnering more sympathy for their plight” (Daiute, 2013, p. 44).

According to Blommaert (2001a), “the resources controlled by the narrators and their interlocutors are part and parcel of the interpretations given to their stories, and given the central role of the stories in the asylum procedure, matters of resources may influence the outcome of their asylum application” (p. 23). Medical certificates stating P.T.S.D. among asylum seekers therefore “come with a history of use and abuse; they also come with a history of assessment and evaluation... put into a legal/procedural framework, in sum, that every step in the systematically and uniformly performed process involves not replication but far-reaching transformations of the ‘original’ story” (Blommaert, 2001a, p. 23). The story of trauma, then, is also replicated and transformed into the form of a medical certificate attesting to P.T.S.D., a “narrative shaping of individualized experience through contextualization processes [which] entails a shaping of linguistic and narrative tools that operate as contextualization cues.” (Maryns & Blommaert, 2001, p. 62). These “contextualization cues” permit the very concept of P.T.S.D. to circulate as a “boundary object” (Star & Griesemer, 1989; Trompette & Vinck, 2009) understood and used differently by various actors. The messy story of trauma then is decoded and converted into a “depersonalized case” (Maryns & Blommaert, 2001) based on

“overly tidy stories” (Bruner, 1990, 1991, 2003) and thus easily convertible into established medico-legal categories.

The narrative activity of individuals is thus considered as inherently embedded in social context and mediated by instruments which are at the same time used and transformed by individual actors (Kloetzer et al., 2015). For example, by examining narratives of potentially traumatic events within the asylum activity system, the language used to narrate the story (for example, the medicalized discourse associated with a diagnosis of P.T.S.D.) is considered as an instrument purposefully aimed at “conduct[ing] human influence on the object of activity” (Vygotsky 1980, p. 55) circulating at the crossroads where asylum seekers’ narratives meet a “centered” bureaucratic language system (Maryns & Blommaert, 2001). To categorize an asylum seeker with P.T.S.D. has very concrete social, material, and legal consequences.

Our investigation on narrative interactivity within the activity system of the asylum procedure is based on the results of a yearlong research projects among asylum seekers diagnosed with P.T.S.D. as well as their treating health professionals (including doctors, psychologists and psychiatrists) in a center for victims of torture in Athens, Greece. We explore narrative interactivity among the various actors within the asylum activity system, specifically within narratives of potentially traumatic events and in relation to social structures, power relations and each actor’s diverse activities and objectives.

Method

We conducted 12 months of research among asylum seekers and refugees in an NGO-run center for victims of torture in Athens, Greece. This longitudinal study involved participant observation as well as qualitative, in-depth interviews with 74 various actors. This included a year-long follow up of 10 victims of torture seeking asylum (interviewed an average of five times) – as well as in-depth interviews with 43 health professionals working with refugee victims of torture from a variety of humanitarian organizations, including cultural mediators working in psychosocial interventions for individuals diagnosed with P.T.S.D.. Furthermore, we conducted qualitative, in-depth interviews with 21 community representatives and leaders of diverse refugee associations around Athens in order to explore culturally determined narratives of trauma.

Dynamic narrative analysis

To analyse the data, we specifically draw on a dynamic narrative framework as advocated by Daiute (2013). Dynamic narrative inquiry

“considers expressive genres as utterances in conversation across time and place within domains where certain individuals and institutions have something shared at stake. In addition to conversational turns, dynamic narrative inquiry includes narratives and other extended genres by those in vulnerable positions as well as by those with powerful influence and resources, as though in conversation.” (Daiute et al., 2020, p. 5).

Drawing on this methodological framework, we explore the narratives (stories) and Narratives (scripts) circulating among the various actors within the asylum activity system. Data was analysed with the following questions in mind: How are potentially traumatic events being narrated in this complex setting, by whom, to whom, and for what purpose? Which common or diverse scripts exist across N/narratives of trauma? This includes examining the narrative activity of diverse actors, particularly the various and often contradicting ways in which P.T.S.D. serves as a tool drawn upon by the different actors within this activity system.

This analyse began with a systematic reading of all the interview transcripts, where references to “trauma” or “P.T.S.D.” were specifically highlighted. Key references were cross-tabulated, according to the narrator (research participant) along the x axis and the referee (the individual or group of individuals to which they were referring) along the y axis.

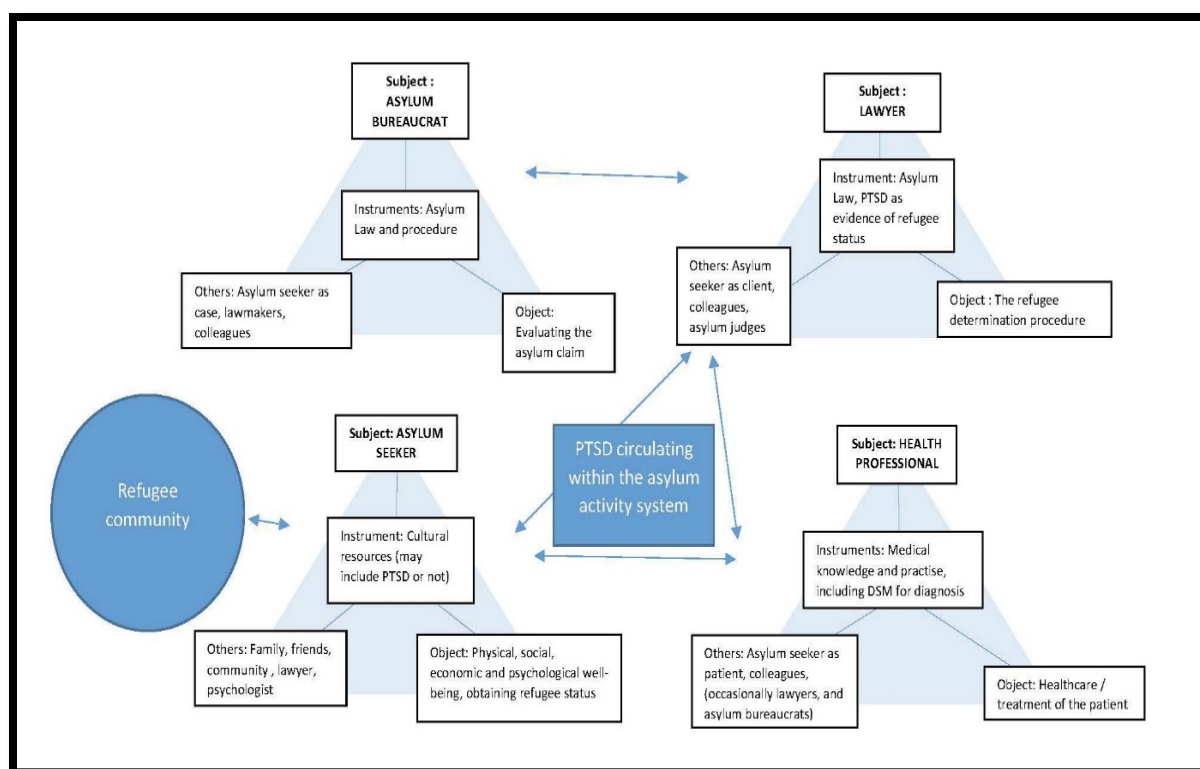
Once this “tableau” had been created, a second analytic reading of the data focused on:

- i) the networks of relationships and interactions within which this narrative activity occurs.
- ii) the various narratives (stories) and Narratives (scripts) various actors draw upon to narrate potentially traumatic events
- iii) the multiple ways in which they select and organize details to serve different purposes within the asylum activity system
- iv) the tensions, conflicts and dilemmas existing within this narrative interactivity
- v) aspects of addressivity: the actual or presumed audiences of the narratives and the relational interaction among narrator, audiences, situations, and issues enacted in narratives (Bakhtin, 1986)

Results

The results highlight the various ways in which trauma is seen and understood by various actors within the asylum activity system, as illustrated in figure 1:

Figure 1: Discrepancies in Narratives and narratives of trauma in a complex activity system



A simplified model of the activity system of the asylum tribunal includes at least five types of different actors: the asylum seeker, community members, health professionals, lawyers, and bureaucrats. Although the asylum seeker is in direct contact with all the other actors, these actors are not necessarily in direct relation with one another. They may however be indirectly in relation, in particular through the diagnosis of P.T.S.D. The diagnosis of P.T.S.D. therefore may have for each of them a double meaning: an intrinsic meaning in their own activity, and an extrinsic meaning in interprofessional or even interagency work.

For asylum seekers, the main activity is to survive in a foreign environment, and to be granted asylum. Their narrative activity is conducted with the hope of being believed. The diagnosis of P.T.S.D. is used within their activity of narrating as testament to their suffering. However, P.T.S.D. may initially be meaningless - narratives are often coloured by culturally informed narratives of trauma and alternative explanation systems (for example, culturally and religiously informed ideologies and belief systems). For some, dominant scripts or Narratives of trauma (exemplified by P.T.S.D. and the associated status of victim in need of assistance) may seep into narratives of their own life stories. In such cases, the diagnosis of P.T.S.D. is intrinsically ambiguous: it is not connected to their subjective understanding of their mental condition, but may bring some benefits in their asylum seeking procedure.

Health professionals aim to treat their patients, and the diagnosis of P.T.S.D., is used as a tool to this end, allowing for tailored professional and interprofessional action. Furthermore, the health professional may occasionally support the asylum seeker through the legal process by

offering a medical certificate of P.T.S.D. – where the diagnosis acquires new meanings which are more or less consistent with its main therapeutic value.

For the lawyer, the main goal is to support his client in the asylum seeking procedure. The diagnosis of P.T.S.D. is one document attesting to the credibility and coherence of the asylum seeker's story. The Narrative serves the purpose of attesting to their client's status as a victim.

For judges and other officials in the asylum tribunal, their activity is to assess the legal case, their objective is to determine the refugee status of the individual in front of them and P.T.S.D. may or may not serve as evidence to this end. The Narrative of trauma is colored by a technical, legal discourse and the asylum seeker is the defendant whose case is being assessed in close relation to this script.

Transformations over time

Not only do the results highlight the various functions of P.T.S.D. for different actors in the asylum activity system, these functions similarly appear to change over time. For example, health professionals may first diagnose P.T.S.D. as a way to make sense of and treat the patient's case, and to communicate this understanding to other health professionals. However, the diagnosis may have a different function when the health professional "explains" the meaning of the diagnosis to the patient. These changing functions are further complicated in the context of the asylum process, where the health professional is not only confronted by a "patient" to treat, but an "asylum seeker" for whom the diagnosis of P.T.S.D. may carry significance in the asylum process.

For the asylum seekers themselves, transformations in the way in which P.T.S.D. functions across activity systems may similarly occur. An understanding and acceptance of the diagnosis may transform the way in which they make sense of their own psychological state of being over time, or may represent inherent power imbalances in the way in which they understand and make sense of their experience. Narratives of trauma, scripts circulating among the diverse actors with whom they interact, may seep into their life stories, allowing them to make sense of their experiences. Transformations in the functions of P.T.S.D. may also occur as they embark on the process of seeking asylum, an activity system where once again P.T.S.D. carries a certain legal salience, an instrument which may function to provide credibility and legitimacy to their claim to refugee status.

Asylum seeker perspectives

An analysis of the asylum seekers' narratives highlight the following:

- i) Discrepancies exist among the various Narratives and narratives of trauma in the asylum procedure

- ii) Existing power imbalances underlie these discrepancies, privileging westernized Narratives of trauma above other narratives
- iii) Asylum seekers sometimes deliberately drew on specifically “westernized” Narratives of trauma in order to best present their case, and
- iv) Many asylum seekers appeared to be retraumatized by the asylum seeking process

We explore these themes through representative case studies and quotes from participants.

Discrepancies in narratives of trauma

Discrepancies in how Narratives and narratives of trauma circulated among various actors were reflected in seven out of 10 participants. One stated that “here, we don’t speak like in Africa.” Another said “because there [*in their country of origin*], there are many people who, when they have something, don’t write. They keep it [*in their head*]. When they have a problem, they just forget about it...here, they note it.” In the context of seeking asylum, the medical certificate was seen as a reflection of western values, knowledge, and ways of being, where the written word is privileged. This finding echoes the words of Blommaert (2001b) who argues that the “process of (re)structuring talk into institutionally sanctioned text involves a dynamic of entextualization that is based on power asymmetries” (p. 3). Differences were evident in individual asylum seeker’s experience of the asylum tribunal itself: “here, it’s a new world. I don’t know how things are done.”

Many felt at a loss as to how to narrate their trauma in the face of these asymmetries. According to one participant: “the people asking you questions, it’s like you’re sitting across from a psychologist. They’re professionals who know their work.” The professionalism of the bureaucrats in the asylum tribunal is highlighted – and, by extension, their superior position. An interesting comparison is made between the bureaucrats of the asylum tribunal and the psychologist: asking questions, probing, evaluating, and judging from a superior position. In the words of one asylum seeker, it is a situation “where one doesn’t understand anything.” Another participant drew a similar parallel: “The psychologist, it’s a game. It’s a toy. He asks you questions, and bases his deductions on your response - and the asylum [procedure] itself, it’s the same.”

Asymmetries in trauma narratives, asymmetries of power

Many contradictions appeared in the way in which the diagnosis of P.T.S.D. was understood between health professionals and asylum seekers (in this case, in the role of the patient). One participant reported:

“Mr. Psychologist doctor, he gave me the report. In that report, he has written that I'm in very big depression. Actually, I don't know I'm in depression or not.”

This participant begins by addressing the doctor as “Mr Psychologist doctor.” On the one hand, it could be argued that the “Mr” and “Dr” is intended as a sign of respect, positioning the health professional as a respected and superior authority. On the other, it indicates some confusion as to the exact role or title of the professional. What is striking is that he refers to the report as stating that he has “depression” – despite the diagnosis being that of P.T.S.D. The report is seen as something “given” to him, as a passive recipient. He displays an element of doubt as to the veracity of the report: “I don’t know if I’m in depression or not.”

When interviewed, his doctor noted:

“He doesn't seem to understand it as an illness. He says that he feels abnormal, he feels wrecked; he says that he's not dangerous; that he is not crazy. Every time I say to him, 'These voices are just a symptom of a disease that will go away eventually,' he doesn't seem to listen.”

This highlights the substantial difference in the way in which the symptoms are interpreted. Neither feels listened to by the other. Furthermore, there is an implicit assumption of the superiority of medical knowledge – the Narrative of “illness” - in words “he doesn’t seem to understand it as an illness.” Despite this, many participants insisted that their psychological state was “not an illness.”

Adopting and adapting trauma Narratives

Arguably aware of the evident power asymmetries inherent in the way in which narratives of trauma are presented and perceived in the tribunal, some participants described successfully drawing on a specifically western Narrative of trauma (as exemplified by the diagnosis of P.T.S.D.) in order to best present their case during the asylum process. In the words of one participant, “crying makes your story more believable.”

Upon preparing for his appearance in front of the asylum tribunal, one participant was told by his lawyer to remove his earrings when he went in front of the asylum tribunal. He explained that the “flashy” jewellery reflected “joy” and that his Narrative, to the contrary, needed to be one of trauma:

“Between a made-up story and the story of what happened, it's not the same...I can tell the story 1500 times, even 15000 times, without fault, because it's what I experienced. It's different to the story that they gave me. That's another person. It's different. It's what you experienced but the way in which you tell it must necessarily change. Some people know how to talk – 'they'll believe this and believe that' but it's no longer the story, the real story. It's the real story that they've complicated. It's the lawyer who will say things and take out certain dirty things to be clean... You need to show people that this story really is your true story, so that they can accept that 'no, he's telling the truth.”

To be granted asylum, he needs to be believed. To be believed, he needs to tell “a good story.” To tell a good story, it needs to be “clean.” Indeed, the literature shows the importance of the “emotional congruence” afforded by a P.T.S.D. diagnosis as a critical factor used to judge the credibility of asylum seeker’s narratives (Rogers et al., 2015). It could be argued that the “clean” story (or, an emotionally congruent narrative) required by the tribunal is reflected in the medical

certificate stating that he has P.T.S.D. Using his trauma narrative as an instrument in order to be believed, he draws upon what Hymes (1998) refers to as “fully formed narratives” - narratives which display growing tightness and structure due to repeating instances of narrating. He is, in essence, an actor rehearsing his script. Narrative details are used effectively to perform an account of his life (Daiute et al., 2020), to attest to the validity of his claim to asylum.

Following the script is not without difficulty. Many participants were confronted with the dilemma of how much to tell. They realise that to increase credibility, the Narrative needs to be emotionally congruent, despite the significant potential for re-traumatisation (Rogers et al., 2015; B. Turner, 1992; S. Turner, 2015). In other words, the narrative should be shaped by the Narrative. As one participant stated:

“It hurts to have to tell it...yes, it hurts. Even during the interview, it hurts you ... but they’re looking for sadness, during the interview ...”

The dilemma centres on the emotional difficulty associated with narrating trauma, and the intended objective of being granted asylum status. The words indicate an acknowledgement that, despite the fact that sharing the trauma narrative “hurts,” it is a necessary and required condition for being granted refugee status. Even the “sadness” is used to validate his experience, addressed to his intended audience in the tribunal who are “looking for it.”

Asylum seekers walk a tightrope – the Narrative is required to be formal (without being too formatted or rehearsed) but also emotional (without being too emotional), this optimal balance assumed to enhance credibility (Montagut, 2016). All of this comes at an emotional cost: having to follow the script may also run the risk of re-traumatization. The majority of participants referred to the emotional distress they experienced in the asylum tribunal. Yet, despite the risk of retraumatization, most appeared to face this psychological challenge with a resilient acceptance. As neatly expressed by one participant, “we are obliged to do it.”

Health professionals’ perspectives

The health professionals highlighted conflicts and tensions around the use of medical certificates for the asylum tribunal. Many strategically and purposefully weighed up the risks and benefits of using a P.T.S.D. diagnosis across various settings and among various actors, recognising the activity of diagnosing as one loaded with political significance:

“A certified traumatic experience opens many advantages, ummm, the doors to, ummm, asylum and added to the facts, it’s a way of saying that the, the health professional has more relevance to his words when he certifies the existence of trauma, more than the person him- or herself”

“In this case, the clinician has a certain power”

Implicit power dynamics are highlighted in the above words, where the health professionals are placed in a superior position, their own medicalised narratives valued above the words of the

asylum seekers themselves. Given this power, many alluded to the purposeful and strategic use of providing a P.T.S.D. diagnosis to help the asylum-seeker within the asylum seeking process:

"[P.T.S.D.] is something that we can try to drag the process on for a while if we're getting a negative response."

"They [the commission] can understand if you provide P.T.S.D." "It's about all the only ammunition that we have."

"It was a way to protect them during the commission."

"As for the asylum process we have to often say that somebody has P.T.S.D. because that's going to be important to sort of validate what they're saying happened to them."

Words such as "protect" and "ammunition" connote war Narratives, with asylum seekers positioned as soldiers going into battle, the medical certificate the "ammunition" provided by their superiors (in this metaphor, the health professionals). We can infer that health professionals are not naïve to the legal weight given to P.T.S.D. They position themselves as one of the actors who influence the asylum process. "We" or "us" refers to either the group of health professionals ("the only ammunition that we have") or to the health professional and the asylum seeker ("if we're getting a negative response"); "they" or "them" referring to the commission or the asylum seeker ("a way to protect them"). Within these shifting alliances, the health professionals are not politically neutral actors. They described purposefully using P.T.S.D. as "ammunition" in cases where, in the words of one participant, the asylum seekers' narratives are "not as psychiatric and not as theoretical and psychological as ours is."

Like the individual asylum seekers themselves, the necessity of having a "coherent" and "linear story" was widely recognised:

"They need something very sure to evaluate a demand, whether they will give asylum or not, which is the simplest way to have a coherent, and very linear story. The more linear and straightforward it is, the best [sic] it is for them."

The "clean story" Narrative is one permeating the activity system, passed around among actors. The health professionals, therefore, allude to an implicit knowledge that their position is a powerful one. By virtue of the fact that they are able to diagnose an asylum seeker with P.T.S.D., they are in a position to construct the Narrative of the individual. The use of a clean and coherent (linear) Narrative, however, was not perceived as being without complications. Many health professionals raised doubts about fitting trauma narratives into such a "clean" story:

"I'm afraid that it victimizes the person ... and so, it becomes that he or she becomes passive, waiting for others to do things for him."

"It has to do with identity if it's totally stripped off, what he was before. He's like just an object."

"They are basing all of their work on P.T.S.D. diagnosis, they completely medicalise and victimise people"

The concerns of the health professionals centred on the fact that to have a “clean narrative” (as seems to be implied by a P.T.S.D. diagnosis) is to reduce the asylum seeker’s story. Their unique and individual “identity” is “stripped off” in order to make the story clean. Thus, a trade-off is implicitly recognised. On the one hand, the benefits of being recognised as a “victim” of P.T.S.D. (and by extension, having one’s story believed and being recognised as a refugee) are many. On the other hand, the very mechanism of reconstructing the trauma Narrative in order to fit into, in the words of one participant, “a perfect victim template” risks reducing the individual to an “object” without identity. As a result, the use of the diagnosis is met with some ambivalence:

“They want to victimize the patient. It's already a mistake from me that I talk about the patient. Sorry, I'm medical. I'm referring to people as the patient and very often people will not be a patient, neither psychiatrically or physically.”

Furthermore, an attempt to reduce these complex narratives to a medical one paradoxically denies those whose narrative is not “clean” (linear, coherent, “medicalisable”) access to certain rights, recognitions, and privileges:

“I think [P.T.S.D. is] being used to filter rights, to filter certain rights and access to certain services, which could be open to everybody.”

“This is extremely dangerous, because being a refugee doesn't mean that you have obvious consequences, even psychological. I'm very, very skeptical that people that they don't have symptoms, they might be considered liars.”

“I think there is a disconnection between what you see in the clinical setting and the evaluation process, there's a, there's a break in the system. And, it's very traumatizing also for the professionals working in such a setting, because you feel helpless [...] yes, this person is in need of support and help and is really traumatised, but his claim doesn't fit the official profile.”

Implicit in the above words of the participants is an understanding of P.T.S.D. as an instrument with political significance, and furthermore that the narratives of many asylum seekers “don’t fit the official” Narrative required. This clear “break in the system” places the health professionals in a “traumatizing” and “helpless” position. The words of one participant reflects the strategies developed to negotiate this complex position:

“For me the diagnosis is something that if you use it, you should know for what reason you use it. You use it because you want to understand better the patient, you use it because you want to help him with the asylum process”

Her strategy includes an implicit understanding of the multiple ways in which P.T.S.D. is understood by the various actors, and the various functions it may have over time and across various activity systems.

Conflicting narratives across the activity system

The health professionals found themselves having to negotiate a variety of conflicting discourses of trauma within the asylum process. Here, their activity of diagnosing patients similarly includes needing to address a variety of different actors, including bureaucrats of the asylum tribunal, lawyers, as well as the asylum seekers – themselves occupying multiple positions associated with being a patient, a client and an asylum seeker. The complexity of this is highlighted in the words of one participant:

“The professional is reading the report with the interpreter and on the spot they explain to the patient what everything means. Then the patient receives the report. Very often he will say that, “This is wrong. With that what you write, you say that I’m crazy, I’m not crazy.” Then, of course, you have to try to explain to the patient that, “I don’t understand what you meant by crazy, I never said that you are crazy. I say that you are suffering from post-traumatic stress disorder.”

For the asylum seeker, having P.T.S.D. is equivalent to being seen as “crazy.” The diagnosis appears to be associated with a certain social stigma for the asylum seeker, who rejects the psychiatric labelling. For the health professional, P.T.S.D. is a familiar instrument of the profession. It is also interesting to note the implicit power dynamics inherent in this exchange, as illustrated by the words “you have to try to explain,” indicative of the value given to his expert medical knowledge above that of the patient’s. This is similarly reflected in the words of other health professionals:

“We will give the report to the patient who will read it and translate it to him and explain to him exactly what he has.”

“They don’t understand that they have it”

P.T.S.D. is implicitly acknowledged as fact, something that the asylum seeker “has.” Rather absurdly, despite the fact that it concerns the psychological condition of the individual, there is an implicit assumption that his own experiences need to be explained to him – in other words, fitted within a pre-established medical narrative. Conflicting N/narratives circulated among the actors, but appeared to create specific tension when it came to the written reports of P.T.S.D.:

“Very often he will not accept it. Very often the beneficiary will tell you, ‘I don’t want you to write that.’”

“Some patients, they will insist [that you] write something worse, exactly because they know that this thing, I will use it like a leverage for my asylum... but [others] don’t like like diagnosis because they think that they are crazy.”

“You see when they ask the report, that they expect to [see written in the report is] this vulnerable identity is that deep inside. They speak of vulnerability. They speak about, ‘I have to prove to them that I’m vulnerable because they didn’t believe.’”

The above quote raises some key considerations i) P.T.S.D. is used by some (but not all) of asylum seekers in a purposeful and strategic manner in their asylum seeking procedure as “proof” of vulnerability ii) it is also used within a therapeutic setting as a helpful clinical diagnosis used to understand symptoms being experienced and receive appropriate

psychosocial treatment iii) many asylum seekers disagree with the diagnosis, due to a belief that it suggests something “wrong” – an indication of resistance to their symptoms fitting into a medical narrative of deficiency. The above-mentioned reactions also seem to be related to whom the diagnosis is addressed (for example, positively regarded in medical and legal spheres as compared to community space where the diagnosis may carry a social stigma). Its use is highly context dependant and continually negotiated across activity systems, with functions changing over time.

Discussion

A dynamic narrative inquiry highlights how “people use different genres to share different intrasubjective experience, knowledge, and intentions, which indicates their ability to employ discursive details addressing different specific audiences (Daiute et al., 2020, p. 7). For asylum seekers and their lawyers, evidence of P.T.S.D. is an “open sesame” (Fassin & d'Halluin, 2005), for officials and judges it is a piece of evidence among others; and for both it is an innovation in governmentality. This labelling of asylum seekers is supported by a system in which psychiatric labels form a crucial basis for the mobilisation of broader social supports (Watters, 2001). By placing human suffering within this medical Narrative, a thin description of the individual is created where other important socio-cultural and political considerations are easily lost or hidden (Marlowe, 2010). Such a shift away from a wider understanding of the political, social and cultural-historical context of the asylum process may equally lead to the moral disqualification and criminalization of unsuccessful asylum seekers who are not found to be “traumatised” (Sturm et al., 2010). In other words, what happens when there is a tension between narratives and Narratives of trauma?

Implications for health professionals working with asylum seekers

In practice, many health professionals are increasingly called upon to provide medical information in order for the state to distinguish between “true” and “fake” refugees. This may pose a dilemma for the professionals themselves, who are often faced with their own doubts regarding the diagnosis and their attempts to be as objective as possible (Joksimovic, Schröder, & van Keuk, 2015; Maier, 2006). They may in fact be seen as agents of de-culturalisation and de-politicisation in that they transfigure the refugees’ accounts of atrocities into individualised pathology – a process refugees themselves may not be averse to as it may be the only avenue available to secure wider legal and welfare benefits. The resulting ethical dilemmas faced by health professionals is aptly described by Steel *et al.* (2004) :

“Clinicians working with asylum applicants often find themselves in a position where forensic demands—namely, the need to obtain trauma testimonies to support refugee applicants’ claims—can be of such a pressing nature that they outweigh usual clinical caution in delving too quickly into traumatic material that could undermine the emotional well-being of their patients (pg. 512).

Similarly, Fassin and d’Halluin (2005) state:

Medical authority progressively substitutes itself for the asylum seekers' word. In this process of objectification, it is the experience of the victims as political subjects that is progressively erased (p. 597).

They argue that the medical certificate is detached from the lived experience of the victims of persecution, attempting a process of objectification through expert's words and thus desubjectifying individual narratives. This highlights the multitude of challenges often posed to health professionals, torn between the "moral demand" for P.T.S.D. to be diagnosed at the risk of influencing the therapeutic relationship, which by definition is less based on 'truth funding' and more on an exploration of the subjective experience of the individual. For many professionals who find themselves on the horn of this dilemma: "it is their burden and their duty to testify" (p. 604).

Conclusion

Making use of the P.T.S.D. diagnosis in asylum procedures may present a double-edged sword. On the one hand, it acknowledges the deep pain experienced by asylum seekers and assists them in getting their refugee status recognized. On the other, it risks becoming a trendy "catch-all" diagnosis open to various forms of political abuse or manipulation. In this paper, we have explored how P.T.S.D. may limit and control, yet at the same time how it is a powerful tool for public recognition and political response. We have examined it as an instrument which various and ever-changing functions for the actors involved in the asylum process, "glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources" (Young, 1995). The category of "traumatised refugee," as reflected in a P.T.S.D. diagnosis, thus privileges certain events to develop a plausible version of the story in a context where the asylum seeker may be constructed as someone with a fragile memory, a fragmented subject who lies, an actor playing a role to deliver his subjectivity (Demazière, 2007). The "plot of P.T.S.D." provides a recognizable structure to asylum seekers' stories as they narrate their lives within the asylum activity system.

The results indicate that P.T.S.D. as an instrument circulates among the different actors yet with specific meanings and functions within each activity system, and which change over time. It may be used by health professionals in certain activity systems to communicate among each other about the clinical symptoms experienced by the patient, and by the bureaucrats of the tribunal as evidence in court of the individual having survived a traumatic experience. The asylum seekers themselves experience the diagnosis in a myriad of different ways. Positioned as political subjects in the asylum procedure, as patients in the consulting room, as clients with their lawyers, as members of their community at home – P.T.S.D. appeared to have different meanings and functions across these activity systems. For the health professionals needing to address a variety of different actors outside of their clinical community, P.T.S.D. is helpful to explain (both to patients as well as to the bureaucrats of the asylum tribunal), to treat and, in some cases, to attest to the trauma experienced by the asylum seeker.

The use of the diagnosis is not politically neutral. In this context, not only are the accounts of the asylum seekers discredited, but their voice can no longer be heard: lawyers speak in their stead; volunteers help with their application, some even specializing in the so-called preparation of narratives; physicians and psychologists attest to their past experience (Fassin & d'Halluin, 2005; Fassin & Rechtman, 2009). P.T.S.D. risks (re)creating Narratives in which asylum seekers are seen in terms of deficits and security threats, which risks facilitating ongoing exclusion from human communities: if the asylum seeker is always represented as an individual victim of psychological damage, object of sympathy, scorn, or fear, initiatives for social inclusion are undermined (Daiute, 2017). Within this activity-meaning system design, we have shown how including perspectives of diverse actors across an asylum system raises questions about such linear concepts as P.T.S.D. (Daiute et al., 2020).

Despite the risks of victimization, psychological evaluation offers professionals a unique and privileged opportunity to help survivors to address and recover from the devastating consequences of trauma. As argued by Gangsei and Deutsch (2007), such evaluations may significantly increase an understanding of the survivors' background, experiences or self-presentation in the tribunal. A recognition of trauma thus empowers individuals to present experiences more fully and confidently, illuminates the often poorly perceived link between current emotional suffering and past trauma, and heals the wounds of mistrust, humiliation, marginalization, and fear. Indeed, as noted by Hanewald *et. al.* (2016), in the case of traumatised refugees, the coaction of legal and medical aspects has to be acknowledged seriously by the medical, legal and political parts involved. Professionals – both legal and medical – working with asylum-seeking populations need to incorporate a nuanced and contextually informed understanding of each individual's trauma narrative. Let us be guided by narratives, not only the Narratives. Let us hear the stories, not the scripts.

ARTICLE THREE (French version): Womersley, G., & Kloetzer, L. (2018). « En Afrique, aller voir le psychologue, je n'ai jamais entendu ça »: interprétations croisées du psycho-traumatisme entre médiateurs culturels, professionnels de santé et réfugiés victimes de torture à Athènes. *Revue Européenne des Migrations Internationales*, 34(2), 29-54.

Résumé en français

Malgré la prévalence élevée d'état de stress post-traumatique, ou S.S.P.T. (Syndrome de Stress Post-Traumatique) diagnostiqué chez les réfugiés, d'importantes critiques ont été soulevées quant à sa pertinence comme construction diagnostique, notamment au plan interculturel. En outre, la collaboration entre les professionnels en santé mentale et les réfugiés se heurte fréquemment aux barrières linguistiques et culturelles, ce qui accroît les risques d'incompréhension. Le médiateur culturel joue dans cet espace un rôle clef de mise en dialogue des conceptions et interprétations variées de la souffrance et du trouble mental entre les réfugiés et les professionnels de santé. Afin d'explorer la diversité des perspectives des réfugiés, des professionnels de santé et des médiateurs culturels sur le traumatisme, nous présentons les analyses issues d'un travail de recherche de 12 mois auprès d'ONG travaillant à Athènes, en Grèce, avec des réfugiés victimes de torture. Nos analyses se centrent sur (a) la manière dont les réfugiés victimes de torture vivent et qualifient leur traumatisme ; (b) la construction des représentations, des pratiques et des normes concernant les troubles mentaux dans l'interaction avec les professionnels de santé ; et (c) la façon dont divers acteurs se représentent, comprennent et utilisent une construction diagnostique telle que le S.S.P.T. Notre recherche souligne la nécessité d'une compréhension plus nuancée et contextualisée du traumatisme, comme étant influencée de façon déterminante par des systèmes culturels et des contextes sociaux, économiques et historiques plus vastes.

Introduction

L'afflux de demandeurs d'asile arrivant en Europe a atteint ces dernières années des proportions historiques et est devenu aujourd'hui l'un des grands défis auquel le continent fait face en ce début de XXI^e siècle (Médecins Sans Frontières, 2016; UNHCR, 2015). La santé mentale de cette population est également devenue un sujet d'attention, tant dans le domaine scientifique que dans le discours public (Abbott, 2016; d'Halluin, 2009). Le concept de Syndrome de Stress Post-Traumatique (S.S.P.T.) en particulier est devenu central dans la prise en charge en matière de santé mentale des réfugiés (statutaires ou requérants), pour qui la littérature scientifique identifie une prévalence élevée (d'Halluin, 2009; de Arellano & Danielson, 2008; Kirmayer et al., 2010; Lambert & Alhassoon, 2015; Schweitzer et al., 2006; Steel et al., 2009; Sturm et al., 2010; Van Ommeren et al., 2001; Weine et al., 2001). Certains auteurs vont même jusqu'à

suggérer que tous les migrants forcés éprouvent un certain degré de symptomatologie du S.S.P.T. (Copping et al., 2010).

Toutefois, d'importantes critiques ont été soulevées quant à la pertinence et à la validité du S.S.P.T. comme construction diagnostique, notamment au plan interculturel. Ce diagnostic néglige les effets du patrimoine culturel et linguistique sur les expériences interprétées comme «traumatisantes», les manifestations de la symptomatologie post-traumatique, les récits de détresse et les trajectoires de guérison (Abbott, 2016; Droždek, 2015; Fassin & d'Halluin, 2005; Fassin & Rechtman, 2009; Goguikian Ratcliff, 2012; Kirmayer et al., 2010; Maercker & Hecker, 2016). En tant que diagnostic développé en premier lieu pour être utilisé dans des contextes occidentaux, le S.S.P.T. ignore la variabilité des symptômes dans différents contextes culturels à travers le monde (Eagle, 2014; Hinton & Lewis-Fernández, 2011; Silove et al., 2017). Cette littérature suggère que non seulement nos réactions aux traumatismes diffèrent selon nos normes culturelles, mais également que l'évaluation même de ce qui est ou de ce qui n'est pas traumatique peut à son tour être influencé par le langage et la culture (Brewin et al., 1996; Droždek & Wilson, 2007; Sturm et al., 2007, 2010). D'après Eagle (2014) : « La formulation de l'impact des traumatismes exige une exploration minutieuse de la manière dont l'individu décrit l'événement traumatisant et ainsi de sa réponse, par exemple, la langue qu'il déploie, les emphases, les omissions, le ton affectif et le matériel fantastique ; en vue de découvrir des associations pré/inconscientes au traumatisme». ²²

Enjeux culturels et langagiers autour de la santé mentale des réfugiés

Le seul concept de S.S.P.T. est insuffisant pour saisir toute cette complexité. La manière dont le traumatisme est vécu est influencé par des systèmes culturels plus vastes et des contextes historiques (Carlson, 2005; Kirmayer et al., 2010; Marsella, 2010; Marsella et al., 1996; Mattar, 2011; Rousseau et al., 1997; Tummalanarra, 2007; Wilson et al., 2004).

Améliorer notre compréhension du traumatisme (et de sa guérison) dans une diversité de cultures prend une importance capitale dans le travail thérapeutique. En suivant l'ethnopsychanalyse française, pionnière en ce domaine (Devereux, 1967; Nathan, 1986; Sturm et al., 2007, 2010), les représentations collectives du traumatisme constituent un cadre narratif qui donne forme au traitement des expériences traumatiques et à la manière dont l'individu peut transmettre sa détresse dans un contexte socialement compréhensible et avec des moyens acceptables. Cela inclut par exemple des théories sur les origines de la douleur et les possibilités de guérison, les conceptions des limites familiales et sociales, les conceptions religieuses ou métaphysiques du monde, les idéologies ou les positions dans des conflits politiques. En ethnopsychiatrie, les catégories nosologiques telles que le S.S.P.T. ne sont pas considérées comme des phénomènes naturels, mais plutôt comme des catégories culturelles qui résultent d'un dialogue et d'un rapport de pouvoir entre différents acteurs.

²² Traduction libre

Différents « idiomes de détresse » et « syndromes liés à la culture » en réponse au traumatisme ont été documentés dans la littérature (Afana et al., 2010; Hinton & Lewis-Fernández, 2010; Jayawickreme et al., 2012; Nicolas et al., 2015). Afana et ses collègues (2010) soulignent par exemple comment les communautés palestiniennes ont traité l'exposition continue à la guerre à travers des constructions linguistiques particulières liées au traumatisme : *Sadma* (traumatisme ressemblant à un coup soudain avec un impact immédiat), *Faji'ah* (une tragédie), et *Musiba* (une calamité). *Sadma* est utilisé métaphoriquement pour se référer à des événements douloureux qui se produisent soudainement, *Faji'ah* est utilisé pour décrire la réaction à un événement extraordinaire (principalement la perte d'un être cher) et *Musiba* est utilisé lorsque des événements traumatiques persistent et ont des conséquences à long terme. Ils utilisent ces exemples pour montrer comment des idiomes distinctifs, historiquement constitués, illustrent les réflexions communes sur le sens des expériences de violence, de déplacement forcé, d'exclusion sociale et d'humiliation.

Derrière toutes les expressions nuancées de la détresse relevées à travers le monde se trouvent les différentes formes sociales des traumatismes et les manières dont elles sont définies et traitées au niveau socioculturel :

« Les idiomes que nous avons décrits empruntent à la langue quotidienne pour donner un sens à l'impact de la violence dans une situation de conflit prolongé. Ils ne représentent pas des syndromes discrets ou des catégories nettement délimitées. Ils sont plutôt des moyens familiers de parler d'événements traumatiques qui invoquent des réseaux spécifiques de sens. Ils servent à communiquer aux autres membres de la collectivité les dimensions de la souffrance à travers un langage qui fait référence à l'expérience collective... Généralement, ces expressions culturelles du traumatisme ne sont pas des entités diagnostiques qui nécessitent un traitement, mais un vocabulaire par lequel la détresse est exprimée et le soutien social mobilisé. » (Afana et al., 2010, p. 82).²³

Les travaux scientifiques soulignent la diversité du vécu du parcours thérapeutique par les réfugiés diagnostiqués avec S.S.P.T. et par leur entourage (Goguikian Ratcliff, 2010; Goguikian Ratcliff & Suardi, 2006; Harvey, 2007; Sylla Diallo, Dembele, Ndiaye, & Konare, 2009). Droždek and Wilson (2007), par exemple, expliquent comment parmi les réfugiés cambodgiens qui ont subi de multiples traumatismes pendant le régime des Khmers rouges, beaucoup de personnes souffrant de S.S.P.T. et de dépression ont compris leurs symptômes grâce à la croyance bouddhique dans le karma comme étape dans la vie, un niveau incarné d'être et de destin, où la souffrance personnelle est considérée comme particulière d'un point de vue religieux-cosmologique sur le sens de la vie. Il ne s'agit que d'un parmi plusieurs exemples qui montrent comment les variations culturelles dans les modes de vie et les contextes sociaux façonnent les expériences du traumatisme (Kirmayer & Ramstead, 2016).

D'autres critiques se sont élevées pour souligner les limites du diagnostic de S.S.P.T., qui d'une part individualise et « pathologise » le traumatisme, d'autre part donne la priorité aux traumatismes de la période pré-migratoire, sous-estimant l'impact des traumatismes répétés de la période migratoire et post-migratoire (Bracken, 2002; Steel, 2001; Steel et al., 2011; Young, 1995). Cette critique est particulièrement pertinente pour la santé mentale des réfugiés. Dans un guide multi-agences sur la santé mentale des populations de réfugiés, publié en 2015, les agences des Nations unies, ainsi que d'autres organisations humanitaires internationales, ont

²³ Traduction libre, c'est nous qui soulignons.

souligné le fait que pour la plupart des réfugiés et des migrants, les événements potentiellement traumatiques du passé ne sont pas les seules, voire les plus importantes sources de détresse psychologique, mais que leur souffrance est directement liée aux tensions générées par les difficultés du présent et l'incertitude quant à l'avenir (IASC, 2015; Ventevogel et al., 2015).

Malgré ces critiques, il existe encore un manque substantiel de flexibilité dans l'utilisation des catégories diagnostiques occidentales, qui ne tiennent pas toujours compte des représentations culturelles des communautés de réfugiés qui pourraient être essentielles dans l'interprétation et la définition d'une psychothérapie (Médecins Sans Frontières, 2016).

Alors que les professionnels occidentaux en santé mentale s'affairent pour fournir de l'aide aux populations qui cherchent asile en Europe, il est important de prendre du recul et de considérer les contextes uniques dans lesquels ce travail a lieu (Nicolas et al., 2015). La collaboration entre les professionnels en santé mentale et les réfugiés se heurte fréquemment aux barrières linguistiques, ce qui rend les échanges difficiles au cours des consultations, et accroît les risques d'incompréhension et d'erreur de diagnostic et de traitement (Gard, 2015; Hecker et al., 2015; IASC, 2015; Karageorge, Rhodes, Gray, & Papadopoulos, 2016; Maier, 2006; Maier et al., 2010; Maier & Straub, 2011; Rechtman, 2000; Wang, 2012, 2016). Cela est particulièrement vrai dans le contexte du traumatisme, où de nombreux auteurs soulignent que les traumatismes restent inaccessibles au souvenir verbal (Brewin et al., 1996; Brewin et al., 2009). Parfois, il n'y a tout simplement pas de mots pour décrire l'horreur. Pour les personnes touchées par ce traumatisme, « leur problème n'est pas les limites de la mémoire mais celles du langage - l'insuffisance des mots ordinaires pour exprimer tout ce qu'ils ont vécu »²⁴ (Kirmayer, 1996, p. 4).

Dans le contexte spécifique de la migration, qui se caractérise par la perte de la « maison » (et de tous les liens sociaux, culturels et linguistiques que cela implique) ; l'isolement physique, social et politique, typiquement vécu par les demandeurs d'asile à leur arrivée dans les pays hôtes et souvent imposé par l'État d'accueil, nourrit des sentiments d'invisibilité et de déconnexion (Bhimji, 2016). Dans une telle situation, la désaffiliation et le déliement à la fois des liens familiaux et des liens sociaux affectent de manière similaire la capacité interne de faire des liens entre différents événements et moments de la vie à l'aide de mots. Sans l'enveloppe psychique de la maison comme elle était (Goguikian Ratcliff, 2012), sans interlocuteur à qui adresser sa détresse (Womersley & Kloetzer, 2018a), il y a peu de membrane pour tenir le symbolique. Dans ce contexte, le rôle des interprètes et des médiateurs culturels défini comme « processus de négociation » (Wang, 2016, p. 141) est essentiel dans le processus de guérison.

Le nombre de programmes centrés sur la santé mentale des réfugiés a augmenté ces dernières années, tout comme le nombre de médiateurs culturels, sans lesquels des services cliniques ne pourraient pas être fournis aux réfugiés (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Le terme « médiateur culturel » insiste sur la nature dynamique et complexe du travail des interprètes communautaires, qui s'étend la plupart du temps bien au-delà de la simple traduction. Ces professionnels sont souvent des médiateurs entre le monde professionnel de la santé et celui du réfugié. Wang (2012, 2016) souligne la « subjectivité » complexe du médiateur culturel : il « doit s'intéresser à la fois au contenu et à la forme de la discussion et apporter une attention

²⁴ Traduction libre

aux relations interpersonnelles » (Wang, 2016, p. 141). Resera et ses collègues (2015) relèvent les défis auxquels les interprètes communautaires dans le domaine de la santé mentale doivent répondre : le besoin d'être précis, émotionnellement détaché, ferme, de savoir se comporter face à une culture spécifique, tout en restant neutre et impartial.

Dans le contexte de la santé mentale, les mots sont les instruments de travail du professionnel. Concernant les médiateurs culturels et interprètes communautaires, la littérature s'est ainsi surtout attachée à leur rôle dans les contextes de santé, notamment de santé mentale (Brisset & Leanza, 2015; Goguikian Ratcliff, Pereira Kraft, & Fierro, 2017; Leanza, 2011; Miller et al., 2005; Mitschke, Praetorius, Kelly, Small, & Kim, 2017; Pestre & Benslama, 2011; Resera et al., 2015; Wang, 2012, 2016). Miller et ses collègues (2005) mettent en évidence le fait que les interprètes communautaires doivent négocier de multiples postes, y compris celui de courtier culturel (fournissant des conseils culturels aux thérapeutes qui manquent de familiarité avec le contexte culturel de leurs clients), d'organisateur ou encore de co-thérapeute. Ils vont encore plus loin en faisant valoir que non seulement la santé mentale est un contexte unique dans l'interprétation chez les populations de réfugiés, mais également que c'est particulièrement vrai pour les victimes de torture et d'autres réfugiés politiques. Ils identifient deux facteurs dans le développement ultérieur de traumatismes psychologiques graves et persistants : d'une part l'exposition à la violence extrême, d'autre part l'expérience de pertes multiples - des réseaux sociaux, des biens personnels, des rôles sociaux reconnus et du sentiment de maîtrise de son environnement. Dans ces contextes psychiques traumatiques en particulier, on perçoit combien l'enjeu de la traduction réside au-delà d'une transcription littérale d'une langue à une autre ou encore d'une simple communication (Pestre & Benslama, 2011). Comme noté par Denis, cité par Maqueda (2005) :

« La présence de l'interprète permet d'apaiser les fantasmes d'empiètement, d'englobement d'une culture par l'autre. L'interprète est un espace transitionnel, à la fois pour le migrant et pour le soignant. Il symbolise le semblable et le différent pour chacun d'eux. Il occupe une position de médiateur culturel éclairant les sous-entendus, les implicites contenus dans toute culture. Il inscrit une parole singulière, porteuse de l'histoire particulière d'un individu, dans un arrière-fond groupal. L'interprète symbolise l'aménagement possible entre deux contextes : culturel mais aussi temporel, entre un avant et un après. Il représente le tissage culturel, permettant de s'adapter sans être tout à fait autre » (p. 3).

Alors comment se déploient les différentes représentations et compréhensions du traumatisme dans cet espace ? Comment sont-elles négociées entre les différents acteurs (réfugiés, psychologues, médiateurs culturels) dans le contexte complexe de la psychothérapie dans le secteur humanitaire ?

Contexte et méthodologie

Après la crise migratoire qui a secoué le pays en 2015-2016, la Grèce reste l'un des premiers ports sanctuaires en Europe. Dans un pays exposé à une grave crise financière et sociétale, peu d'attention et de financements sont disponibles pour assurer des services de santé mentale et un soutien psychosocial aux réfugiés (Gkionakis, 2016). Beaucoup des réfugiés qui rejoignent la Grèce par la mer Egée restent bloqués sur les îles grecques, loin des soins médicaux adéquats qu'ils pourraient recevoir à Athènes. D'autres poursuivent leur chemin en toute illégalité le long

de la route des Balkans et se retrouvent dans l'oubli, incapables de procéder à leur demande d'asile. Le système d'asile souvent long et opaque et les nombreux obstacles à l'accès aux services de base à Athènes et à travers le pays s'ajoutent aux difficultés du quotidien (Kotsioni, 2016).

Notre travail de terrain s'est déroulé pendant 12 mois en 2016-2017 auprès d'ONG travaillant à Athènes, en Grèce, avec des réfugiés victimes de torture. Afin d'explorer cette diversité de perspectives sur le traumatisme, nous en présentons ici les premières analyses. Dix migrants victimes de torture (9 hommes et 1 femme), soignés dans la clinique, ont été identifiés par l'équipe médicale pour participer à ce travail de recherche, leur participation étant entièrement volontaire (Tableau 1). Les critères d'exclusion comprenaient des symptômes psychotiques, des symptômes dissociatifs graves et un risque de suicide aigu. La surreprésentation masculine reflète dans une certaine mesure la démographie des bénéficiaires du centre, qui est composée à 80% d'hommes. Nous avons effectué cinq entretiens qualitatifs approfondis avec chacun d'entre eux, étalés au cours d'une année.

Tableau 1 : présentation des personnes interrogées

	Sexe	Age	Origine	Langue parlée	Niveau d'études
Participant 1	M	55	Soudan	arabe, anglais, grec	Bac +5
Participant 2	M	35	Soudan	arabe, anglais, danois	Bac +2
Participant 3	M	53	Afghanistan	arabe, farsi, anglais	Ecole secondaire
Participant 4	M	52	République Démocratique du Congo	français, lingala	Ecole secondaire
Participant 5	M	42	Soudan	anglais, arabe	Bac +3
Participant 6	M	33	Inde	anglais, hindou	Bac +3
Participant 7	F	40	Côte d'Ivoire	français	Ecole primaire
Participant 8	M	43	Côte d'Ivoire	français	Ecole secondaire
Participant 9	M	30	Syrie	arabe, français	Ecole secondaire
Participant 10	M	32	Côte d'Ivoire	français, arabe	Ecole secondaire

Les entretiens avec les réfugiés ont été axés sur le suivi de la symptomatologie des traumatismes, des expériences subjectives et des modèles explicatifs du traumatisme, ainsi que sur l'évolution de leur exploration de leur environnement socio-politique et des processus

d'intégration dans la société grecque. Les entretiens ont été conduits en anglais ou en français, sans traducteur.

Pour aller plus loin dans notre compréhension des traumatismes dans ce contexte particulier, nous avons mené des entretiens avec 36 professionnels de la santé, travaillant avec des réfugiés victimes de torture et pour diverses organisations humanitaires ainsi qu'avec sept médiateurs culturels ²⁵, parlant le français, l'arabe et le farsi et travaillant avec les patients diagnostiqués avec S.S.P.T.. Ces sept médiateurs culturels étaient tous des employés à plein temps du projet, recrutés sur la base de leurs compétences linguistiques et de leurs expériences professionnelles au sein d'ONG. Il s'agit de 3 femmes francophones et 4 hommes arabophones/persophones, âgés de 22 à 65 ans. Comme bon nombre d'autres acteurs humanitaires actuellement, le centre utilise officiellement le terme de « médiateur culturel » - dans un souci de valoriser l'acte de la médiation entre normes culturelles, qui va bien au-delà d'une simple traduction *verbatim*. Deux des médiatrices francophones étaient grecques et à la retraite, la troisième était une jeune congolaise de 23 ans installée à Athènes depuis trois ans avec un visa étudiant. L'un des médiateurs arabophones était un migrant égyptien de 40 ans habitant en Grèce depuis quatre ans, tandis que les trois autres étaient eux-mêmes des réfugiés arrivés récemment dans le pays. Aucun des médiateurs ne disposait de certificat ou diplôme de traducteur ou médiateur culturel.

Enfin, nous avons mené des entretiens qualitatifs et approfondis avec 21 représentants de la communauté et dirigeants de diverses associations de réfugiés autour d'Athènes afin de mieux comprendre les perspectives et modèles explicatifs existant dans leurs communautés respectives afin de comprendre les traumatismes psychologiques, recontextualisés sur le plan socio-culturel. De plus, trois mois d'observation participante ont été effectués, incluant la participation aux réunions d'équipe et l'animation de séances et d'ateliers auprès des réfugiés.

Pour analyser les données, nous avons d'abord identifié des représentations du S.S.P.T. ou de traumatisme exprimées lors des entretiens avec les victimes de torture. Une moyenne de 1,7 représentation a été identifiée pour les réfugiés, 70% étaient des représentations spontanées énoncées par les participants au cours de l'entretien, et 30% étaient des réponses directes à une question du chercheur. Ces représentations ont été recueillies et une analyse thématique a été réalisée sur le contenu. Cinq grands thèmes émergent, autour de 1) la peur, 2) les pensées excessives, 3) la souffrance collective ou familiale, 4) la douleur physique et 5) la souffrance spirituelle ou le « moral faible ». La majorité des réfugiés interrogés semble contester la notion médicalisée de S.S.P.T. avec laquelle ils ont été diagnostiqués.

Nous avons ensuite suivi la même procédure pour les professionnels de la santé interrogés et les médiateurs culturels : la transcription de ces entrevues a été analysée en relevant toutes les références à des représentations de S.S.P.T. ou de traumatismes. Une moyenne de 3,7 de ces représentations a été identifiée pour chaque participant, 65% étaient des représentations spontanées énoncées par les participants au cours de l'entretien et 35% étaient des réponses directes à une question du chercheur. Ces représentations ont été recueillies et une analyse thématique a été réalisée sur le contenu. Trois grands thèmes ont émergé dans ces représentations qui dessinent un continuum entre 1) l'acceptation complète et non-

²⁵ Nous utilisons le terme « médiateurs culturels » et non « interprètes communautaires » pour respecter le titre officiel utilisée dans le projet

problématique du diagnostic de S.S.P.T., 2) une utilisation du S.S.P.T. nuancée, individualisée et dépendante du contexte, et 3) une critique et une problématisation du diagnostic.

Nous présentons d'abord les représentations culturellement informées du traumatisme qui ressortent de nos entretiens avec des réfugiés. Puis nous mettrons l'accent sur le travail des médiateurs culturels, en considérant leur travail comme un révélateur des tensions existantes entre les représentations des professionnels de santé et celles de leurs patients. L'analyse abordera trois thèmes : 1) la négociation de rôles complexes des médiateurs culturels, 2) les alliances avec les professionnels de la santé et 3) le travail avec des professionnels de santé « culturellement inexpérimentés ». Au travers de l'analyse des enjeux d'interprétariat dans ce contexte, nous explorerons ainsi la place de la culture dans le traitement de réfugiés diagnostiqués comme ayant des « troubles mentaux », et les implications de ces résultats pour l'organisation des soins. Ces enjeux posent un défi aux professionnels de la santé dans la relation entre le traumatisme, la culture et la subjectivité (Rechtman, 2000).

Interprétations croisées du S.S.P.T. entre réfugiés et professionnels de santé

Les représentations culturellement informées du traumatisme

Les victimes de torture diagnostiqués avec S.S.P.T. avec lesquelles nous avons travaillé s'appuient sur des représentations culturelles diverses de la souffrance (« modèles explicatifs ») et des idiomes de détresse partagés socialement pour expliquer leurs expériences subjectives du traumatisme. Pour les analyser cela, nous avons examiné chaque transcription d'entretien au cours de laquelle la personne interviewée se réfère au S.S.P.T. et à ce que cela signifie pour elle. En plus des aspects somatiques (douleurs corporelles), quatre axes thématiques émergent :

1) la peur

« Je suis torturé, j'ai tout le temps peur. [Ce] n'est pas [une] maladie » (Participant 1)

« Le traumatisme c'est une personne qui a beaucoup de difficultés et de peur. C'est une personne sans état d'esprit calme. C'est la peur d'être tué ». (Participant 4)

2) l'excès de pensée, la rumination

« J'avais plein de pensées... J'avais de la « peur », trop de choses dans ma tête » (Participant 9)

« Je suis malade car je réfléchis trop. Ça affecte également mon corps. Si tu penses trop, tu tombes malade » (Participant 7)

3) la souffrance collective ou familiale

« Le problème de ma famille est le choc » (Participant 2)

« Je sens la douleur de ma famille, les blessures du corps et le mal de cœur » (Participant 5)

4) la souffrance spirituelle ou le « moral faible »

« C'est lorsque ton moral n'est pas à 100% » (Participant 8).
« Dans ce cas, le moral n'est pas bon » (Participant 10).

La torture est décrite par le premier participant comme quelque chose que l'on « a ». Cela contredit l'idée que c'est un événement que l'on a connu. Elle est plutôt métaphoriquement représentée comme intériorisée : l'événement est devenu une partie de lui-même et de qui il est. La conséquence directe est sa peur constante. Il refuse catégoriquement d'avoir une maladie - sa peur est liée à la torture qu'il a subie. Selon lui, ce n'est clairement pas une condition médicale.

Pour le deuxième participant, le traumatisme qu'il éprouve n'est pas seulement le sien mais aussi lié au « choc » de toute la famille. Cela contredit le récit intrinsèquement individuel du S.S.P.T. L'idée se reflète également dans les mots du participant 5, qui ressent « *la douleur de sa famille* ». Cette représentation plus collective des traumatismes a également été notée par des chercheurs et cliniciens travaillant dans des communautés où les individus dépendent plus fortement de systèmes familiaux élargis. Ici, la santé mentale est habituellement plus liée à un contexte socioculturel plus large (Adame & Knudson, 2007; Bracken, 2001; Droždek & Wilson, 2007; Maercker & Hecker, 2016; Tang, 2007). Comme le note Tang (2007) : « les cultures diffèrent quant à leurs idées dominantes sur l'ontologie de soi, ainsi que la relation entre soi et les autres, entre soi et l'univers, et entre la vie et la mort » (p 129). Tankink et Richters (2007) donnent l'exemple des participants de recherche sud-soudanais qui ne se perçoivent pas comme des individus au sens occidental du terme, mais plus comme ayant un « soi familial » basé sur des modèles relationnels où les expériences sont considérées plus dans le domaine intersubjectif du groupe, plutôt qu'à un niveau individuel et intrapsychique.

Le modèle explicatif de l'individu 7 est intéressant, car il présente l'esprit et le corps comme connectés. Cependant, inhérente à son modèle semble être la séparation entre une maladie « *médicale* » (le corps étant malade) et un diagnostic psychiatrique ou une maladie mentale (l'esprit étant malade), dont il ne parle pas. En d'autres termes, selon son modèle explicatif, « *trop de pensées* » entraînent une souffrance physique. Il esquisse une maladie dans le corps - qui, en quelque sorte, contourne toute évocation de maladie mentale ou psychiatrique. Cette tendance fait écho à une explication livrée par une psychologue et présente fréquemment dans nos entretiens avec les professionnels de santé :

« *La plupart du temps, quand des personnes souffrent de certains symptômes [du S.S.P.T.], ils lient le plus souvent ces symptômes à des conditions médicales* »

« Ils ne comprennent pas » : ce que disent les professionnels de ce qui pensent les réfugiés à propos du S.S.P.T.

De tels modèles explicatifs contredisent la compréhension des équipes médicales du S.S.P.T.. Un médecin, par exemple, dit :

« Disons qu'ils ne comprennent pas qu'ils l'ont. Ils ne se rendent pas compte que quelque chose ne va pas chez eux, mais nous essayons de leur montrer comment, leur montrer comment ils peuvent se rendre compte qu'ils souffrent de ça »

Un médiateur culturel déclare de manière similaire :

« Parfois, ils disent, vous savez, hum, magie, comme un sort, genre quelqu'un m'a fait de la sorcellerie et ils veulent détruire ma vie ou ils veulent faire ça, parce qu'ils ne m'aiment pas, alors ils jettent un sort sur moi et ils veulent mon argent alors ils me jettent un sort et, à cause de cela, j'ai cette pensée et cette insomnie et beaucoup de choses. Ils ne comprennent pas la psychologie, qu'ils l'ont, à cause d'un événement. »

Les mots *« ils ne comprennent pas »* reflètent un discours récurrent chez les professionnels pour qui le S.S.P.T. est quelque chose à *« comprendre »*. Il y a implicitement une répartition inégale du pouvoir liée à la connaissance de ses professionnels : c'est une victime de torture diagnostiquée avec un S.S.P.T. qui a besoin de *« comprendre »* le diagnostic sous l'angle d'un modèle occidental médical de la détresse. L'équipe médicale possède la connaissance *« vraie »*. Cette *« internationalisation et professionnalisation de l'adversité »* (Pupavac, 2002) imposant *« l'asymétrie de la relation thérapeutique »* (Wang, 2016) a été critiquée dans la littérature comme une forme *« d'impérialisme culturel »* (Steel, 2001) servant à renforcer les déséquilibres existants entre les *« experts »* occidentaux et les *« victimes-patients »* (Summerfield, 1996; Watters, 2001).

Cependant, ce n'est pas toujours le cas. Le discours des professionnels reflète une certaine ambivalence face à de telles contradictions, qui semble s'étendre sur un continuum allant de l'acceptation complète et non problématique du S.S.P.T. (*« il était évident depuis lors qu'il avait un grave trouble de stress post-traumatique... il a eu des flash-back, il a eu des cauchemars. Il s'agit d'un diagnostic médical »*), *« il avait un S.S.P.T. très fort, je voulais offrir un traitement très rapide »*), à une utilisation nuancée, individualisée et dépendante du contexte (*« Le S.S.P.T. en tant que diagnostic peut varier pour les personnes, c'est une catégorie que nous pouvons utiliser et qui sera utile aux personnes »*), *« S.S.P.T., c'est une catégorie qui vous aidera à prédire ce qu'il veut, à prédire ce qu'il va faire et à comprendre ce qu'il a traversé »*), et à une critique exprimée et à une problématisation du diagnostic (*« Je suis très critique du S.S.P.T. »*), *« Il est difficile de définir un, euh, diagnostic, euh, la configuration. Il y a la catégorie du S.S.P.T. et il y a chaque patient individuel ou différentes façons de les exprimer »*), *« Le S.S.P.T. est une construction de contrôle social et il a une certaine histoire dans le domaine de l'anthropologie médicale qui est très critiquée »*).

En regardant les éléments qui organisent ces positionnements, plusieurs facteurs semblent jouer un rôle. Premièrement, le type de formation professionnelle suivie est un facteur influençant l'acceptation ou non du S.S.P.T. A un extrême on trouve un modèle médico-biologique pur chez certains médecins et psychiatres, et, à l'autre extrême, un modèle plutôt psychanalytique prenant plus en compte un regard subjectif et individuel. Deuxièmement, les professionnels avec le plus d'expérience de travail avec les populations migrantes semblent, pour la plupart, plus conscients de l'influence des facteurs culturels sur la manière dont les individus expriment leur détresse ou leur souffrance et y font face. La littérature scientifique (Bourassa-Dansereau, 2013; Leanza, 2011) relève que, face à un contexte culturellement étranger, les professionnels de santé oscille entre des processus de *« normalisation »* (s'appuyant sur les modèles médicaux

occidentaux dominants, en imposant des normes symptomatologiques et explicatives implicitement liés au S.S.P.T. par exemple) et de « particularisation » (en prenant en compte la singularité de chaque individu, y compris son contexte socioculturel par exemple).

Le cas de Brigitte

Le cas de Brigitte¹, souligne les contradictions dans les modèles explicatifs des traumatismes. Brigitte est une réfugiée guinéenne âgée de 40 ans, qui a été torturée et diagnostiquée avec un S.S.P.T. Ses représentations culturelles du traumatisme diffèrent du modèle explicatif proposé par le psychologue :

- B : « Le psychologue m'a dit que les cauchemars sont liés au passé, parce que je lui ai dit que j'étais poursuivie. Il m'a dit qu'ils étaient liés au passé, c'est tout.

- Chercheuse : Et que pensez-vous?

- B : Moi, je lui ai dit que c'était spirituel, mais par la suite, quand il a parlé, je me suis dit: "Je ne sais pas." Mais il est également possible que cela soit lié à ce que je pense. C'est aussi ça. Parce que je laisse ce qui est dans ma tête. Si j'efface ce qui est dans ma tête, cela peut se résoudre. Apparemment, quand vous avez des rêves où les gens vous poursuivent, on dit que c'est de la sorcellerie. Chez nous les Africains, on dit que c'est de la sorcellerie. Mais il m'a expliqué que... j'ai eu par exemple un rêve la nuit dernière. Je me souviens de deux rêves, où ils m'ont enchaînée. Il a dit que c'était lié à mon passé et que c'est moi-même qui m'enchaînais. Parce que, peut-être, ce que je refuse de penser, je m'enchaîne. C'est donc moi qui dois couper les chaînes. Personne ne me poursuit. J'ai besoin de me libérer. Même si ce n'est pas facile, je dois me libérer scientifiquement.

Chercheuse: Il dit ça?

- B : Oui, il a dit, scientifiquement ... moi, je lui ai parlé de la spiritualité mais il a dit cela scientifiquement, les rêves expriment ce que nous ressentons [...] Je pense que c'est la sorcellerie, ce sont les ancêtres [...] Oui, c'est quelqu'un qui veut ça... mais il a dit que, scientifiquement, ce sont mes pensées, dans ma tête, mes pensées parce que j'ai les enfants à la maison [en Guinée] que j'ai eus avec des pères différents, pas avec le même homme. Et parce que je suis chrétienne, je me sens parfois coupable et je me dis que je ne diffuse pas une bonne image de chrétien. Il m'a dit que c'est ce que je pense [...] Je me suis dit que c'est probablement la vérité. Parce que peut-être, dans ma tête, je suis coupable, c'est vrai. Même si j'écoute la parole de Dieu, on pourrait dire que j'ai fait quelque chose pour laquelle je ne me suis pas pardonnée. Mais Christ m'a déjà pardonné. C'est ça aussi le problème [...] spirituellement, ce n'est pas simple. Ce que je vois si je l'explique sur le plan spirituel, ça montre une main de la sorcellerie. Ça veut aussi dire que la famille ne me laisse pas tranquille. Sur le plan spirituel, me poursuivre-- on m'a poursuivi la nuit dernière jusqu'à ce que j'aie eu peur. Je ne sais pas, il y a deux explications. [...] Apparemment, il y a une explication différente de ce que je pense. Donc je ne sais pas laquelle accepter et laquelle oublier. Je ne sais pas ... mais je me suis dit que peut-être cette version est vraie. »

Brigitte est confrontée à une explication différente de la sienne (« apparemment, il y a une explication différente de ce que je pense »). Sa compréhension des cauchemars est conçue comme « spirituelle » - liée à l'idéologie de la sorcellerie africaine. Selon ce modèle, les cauchemars résultent du fait que quelqu'un d'autre la poursuit et lui jette un sort. C'est la famille qui ne la laisserait pas en paix. Elle est ensorcelée, et les cauchemars sont le fait d'un individu externe ou d'un groupe d'individus essayant délibérément de lui nuire. Elle est ensuite confrontée au psychologue qui lui « explique » un modèle « scientifique ». L'utilisation des mots « expliquer » et « scientifique » suggère l'asymétrie inhérente à la relation thérapeutique mentionnée ci-dessus. Ils impliquent que la connaissance du psychologue doit être considérée

comme un fait scientifique incontesté (hiérarchiquement supérieur à d'autres formes de connaissance en dehors du paradigme scientifique occidental). La situation représentée du psychologue qui « *explique* » cette science, le place en position de professionnel compétent et elle dans une position inférieure face à lui.

Les enjeux temporels jouent un rôle dans ces deux conceptions différentes : le modèle « *scientifique* » représenté par le psychologue, est plutôt basé sur le passé – et, par conséquent, plus statique et interchangeable, un modèle dans lequel l'individu est une victime passive de ce qui lui est arrivé. En revanche, dans le modèle « *spirituel* » se trouve une conception d'une volonté plus active, dynamique et changeante, basée sur l'actuel et l'externe, au lieu du passé internalisé.

Tout au long de son discours, sa propre position par rapport au modèle « *scientifique* » apparaît ambivalente. C'est dynamique et en constante évolution. L'explication du psychologue est à la fois contestée et acceptée. Face au modèle explicatif de son psychologue, elle commence par dire : « *J'ai besoin de me libérer. Même si ce n'est pas facile, je dois me libérer scientifiquement* ». La reprise des mots du psychologue est une tentative d'acceptation de son modèle, basé sur une compréhension individualisée et occidentale du traumatisme, où la détresse se situe uniquement au niveau de l'individu et l'individu a le pouvoir et l'obligation de se soigner. Les contradictions entre ce modèle explicatif et celui de Brigitte ressortent dans les mots « *moi, je lui ai parlé de la spiritualité mais il a dit que scientifiquement, les rêves expriment ce que nous ressentons* ». C'est comme si, métaphoriquement, elle examinait les deux modèles. C'est le spirituel contre le scientifique. Son modèle à elle *contre* le sien. Elle continue alors à contredire directement le modèle proposé par le psychologue : « *je pense que c'est de la sorcellerie* ».

Malgré ces contradictions, elle poursuit : « *il m'a dit que c'est ce que je pense* ». Considérons le déséquilibre inhérent du pouvoir implicite dans ces mots : un individu raconte à un autre individu ce qu'il pense. Face à cette interprétation, Brigitte s'attaque à la vérité du psychologue. Elle se repositionne encore une fois. Brigitte poursuit : « *je me suis dit que peut-être cette version est vraie* ». En disant cela, elle semble s'être engagée dans un dialogue interne où elle s'attaque à la vérité des mots du psychologue, à la lumière de la dissonance apparente entre son explication et la sienne. Elle semble résoudre ce conflit, dans une certaine mesure, en adoptant une approche « combinée ». Son explication est « aussi » correcte, tout comme la sienne. Le « *également* » au lieu d'un « *mais* » semble suggérer qu'elle aimerait incorporer cette nouvelle compréhension dans son propre modèle explicatif, acceptant ainsi les deux points de vue comme valides. La conclusion de ceci est illustrée dans ses mots : « *Je ne sais pas... mais je me suis dit que peut-être cette version est vraie* ».

Le cas de Brigitte est exemplaire de la nécessité de travailler avec des réfugiés dans le domaine de la santé mentale avec une large vision du monde dans la rencontre entre les professionnels de la santé et les réfugiés eux-mêmes. Dans ce cas particulier, Brigitte et son psychologue étaient tous deux francophones. Ils n'ont pas eu à travailler avec un médiateur culturel. Malgré le partage d'une langue en commun, la rencontre entre les mondes qui se croisent lors d'une consultation nécessite une médiation. Nous nous intéressons maintenant aux professionnels de cette médiation que sont les médiateurs culturels, employés par les organisations qui offrent des services de santé mentale aux réfugiés à travers le monde.

Les médiateurs culturels, révélateurs des écarts d'interprétation du psychotraumatisme

Les entretiens avec les médiateurs culturels soulignent trois axes : (a) difficulté de leur positionnement dans la traduction, entre précision et interprétation ; (b) complexité du processus d'alliance, entre proximité émotionnelle avec les réfugiés et défenseurs de l'approche professionnelle et médicale de la santé mentale ; (c) défi de travailler avec des professionnels de santé « *culturellement incompetents* ».

Traduire, entre précision et interprétation

En ce qui concerne les expériences avec le diagnostic du S.S.P.T. en particulier, aucun des médiateurs culturels ne s'est référé spontanément au diagnostic en parlant de traumatisme. À la demande du chercheur, tous les sept ont exprimé des doutes quant à i) la signification exacte du diagnostic ainsi que ii) l'utilité de ce diagnostic pour les populations réfugiées. Par exemple, lorsqu'on l'interroge sur le S.S.P.T., une médiatrice culturelle explique :

KI28 : « *elles n'ont pas ce genre de stress parce qu'elles étaient habituées à la joie de vivre. Nous pouvons l'avoir mais elles n'en ont pas. Elles savaient comment battre chaque jour par jour. Ce sont les habitudes, des coutumes. Ce genre de dépression tu ne peux pas le trouver là-bas.* »

Leurs trajectoires personnelles influençant ces doutes. Cette médiatrice culturelle particulière est Grecque, comme en témoigne sa distinction entre « *nous* » (culturellement les mêmes, nous pouvons éprouver le S.S.P.T.) et « *eux/elles* » (autrui, culturellement différents, ils ne peuvent pas). Le fait qu'aucun des médiateurs culturels n'ait été formé en médecine ou en psychologie en particulier pourrait expliquer, dans une certaine mesure, leurs doutes concernant l'utilisation et la signification exacte du S.S.P.T. Beaucoup semblent préférer référer les questions de S.S.P.T. au médecin ou au psychologue, même dans le cadre de nos entretiens avec eux.

Beaucoup de médiateurs culturels sont confrontés au dilemme suivant : ils sont, d'une part, invités à fournir simplement une traduction littérale de ce qui est dit et, d'autre part, doivent jouer un rôle de médiation beaucoup plus impliqué et nuancé. Ce dilemme est souligné par un médiateur culturel :

KI4 : « *Mon rôle consiste juste à traduire les mots, ou bien l'image, le message qu'il veut transmettre au psychologue à propos de son traumatisme, ah, dans le passé. J'essaye de faire mon mieux pour utiliser l'interprétation et pas seulement les mots.* »

Malgré son affirmation initiale que son rôle est « *juste de traduire les mots* », il est évident qu'il voit la nécessité d'élargir cette fonction en offrant quelque chose de plus complexe qu'une simple traduction (« *l'interprétation et pas seulement les mots* »). Cette ambiguïté se reflète également dans les propos d'un autre médiateur culturel :

KI39 : « *Vous essayez de vous assurer de transmettre les mêmes messages que les psychologues [...] Mais vous faites également, en même temps, la médiation des termes.* »

Les débats dans ce domaine portent alors souvent sur la précision (où les médiateurs culturels considérés comme étant les plus professionnels sont ceux qui peuvent traduire les mots avec une exactitude technique) versus la médiation (où les médiateurs culturels considérés comme étant les plus professionnels sont ceux qui arrivent le mieux à saisir les nuances culturelles). Se faire comprendre des deux parties, pour le médiateur culturel, suppose d'adapter avec flexibilité et de manière dynamique sa posture et sa traduction à la situation. Comme l'a souligné un médiateur culturel : *« nous facilitons un rendez-vous, vous changez V.O.T.re rôle de manière continue pour vous adapter à des millions de barrières culturelles »*. Comme l'a souligné un autre, *« je ne peux pas faire comme une machine, une traduction de Google »*. En effet, un système complexe de dynamique interpersonnelle se manifeste dans la triade entre psychologue, médiateur culturel et réfugié, où les médiateurs culturels jouent un rôle actif :

KI5 : *« Ce n'est pas facile de traduire pour la psychologie parce que la personne a de nombreux problèmes mentaux, de nombreux problèmes psychologiques. Je veux qu'il se sente tout d'abord en sécurité avec moi, l'interprète, et non avec le psychologue. Parce qu'il doit me faire confiance. Si je sens qu'il ne me fait pas confiance, je ne peux pas travailler. Je ne peux pas prendre rendez-vous avec la personne. Parce que pour moi, s'il partage, et qu'il veut parler avec la personne, il n'aura pas peur de parler. De cette manière, je crée la confiance entre l'interprète et le patient pour ne pas me sentir mal à l'aise. »*

Ce rôle actif doit également s'accommoder d'un investissement émotionnel dans le bien-être des réfugiés :

KI26 : *« Je suis touchée, ça me plaît à vrai dire de - parce que je crois que j'offre quelque chose à ces gens-là, je crois que je les aide de cette manière - à s'extérioriser, à pouvoir s'exprimer et surtout ce qu'ils sont à l'intérieur. Et évidemment, je suis touchée mais je suis aussi attachée et de mon côté je ne le montre pas et nous avons un rendez-vous, je veux savoir ce qu'il s'est passé dans leur chemin, comment ils ont vécu. »*

Ce qui est remarquable dans l'énoncé ci-dessus, c'est la voix active claire et l'utilisation de la première personne *« je »*. Le médiateur culturel ne mentionne pas le thérapeute mais se considère comme étant celui qui *« est attaché »*. En effet, tous les médiateurs culturels interrogés se sont référés à l'idée qu'ils se sentaient plus proches des réfugiés que les professionnels de la santé :

KI4 : *« L'interprète est toujours la personne qui comprend le plus le patient qui a un problème quelconque, parce que l'interprète est une personne avec sa langue maternelle et peut-être qu'il est plus proche parce qu'il est le plus près de, ah, des choses qui sont arrivées au pays. Ah, mais, hum, j'essaie même d'expliquer, même si nous terminons la session, d'expliquer pourquoi, pourquoi nous disons, juste pour avoir un message. Parce que le patient a toujours dans son esprit le message que « vous ne me comprenez pas, le médecin ne comprend pas ce qui se passe. »*

KI5 : *« Il faut regarder toute personne dans la pièce, le psychologue, l'interprète et le patient. A plusieurs reprises, le patient ne verra pas le psychologue. Parce qu'ils me voient tous, ils parlent avec moi. Chaque fois qu'ils disent: « Je ne vois pas, je veux vous voir, l'interprète. » Ils ne veulent jamais voir le psychologue. Vous demanderez quelque chose et il dira ceci « vous comprenez ce qui s'est passé ». Vous voyez, vous demandez quelque chose qui s'est passé, disent-ils, « N [médiateur culturel], N, j'ai ce problème. »*

KI39: *« Je vois [les séances psychothérapeutiques] d'un même œil que le psychologue. »*

Pour certains médiateurs culturels, ce rôle actif n'a pas été leur choix. Il leur a été imposé par les réfugiés, qui cherchaient une assistance et se sont tournés alors vers eux plutôt que vers les professionnels de santé – surtout ceux qui viennent de la même communauté:

KI29 : « *Beaucoup de gens de notre pays, lorsqu'ils viennent ici et quand je suis le médiateur culturel, pensent que je suis le boss qui décide de tout. Beaucoup de gens pensent que je suis le manager, le psychologue, le médecin, et que je suis tout le monde ici.* »

Pour certains, cette responsabilité est trop grande et inappropriée. Pour se défendre contre le fait d'être placé dans cette position souvent indésirable de co-thérapeute actif et, en outre, même d'avoir à jouer le rôle de « tout le monde ici » avec une responsabilité sur « tout », beaucoup font part de la nécessité de clarifier leurs rôles et de limiter leur poste :

KI29 : « *Nous devons leur expliquer, « ce n'est pas à moi de décider ». Parce que je suis le médiateur culturel, [je ne peux pas] lui donner de l'argent, des médicaments, des soins, un hébergement, tout. Nous devons être clairs dès la première fois [...] ils pensent que 'R [lui-même, le médiateur culturel] est ici, et il décidera de tout.* »

KI39 : « *Pour moi, l'important c'est d'être neutre. Mon rôle principal est simplement de faciliter les rendez-vous. Je ne suis pas psychologue. Je ne suis pas un médecin ou un physiothérapeute pour faire les choses à ma façon.* »

La stratégie consistant à maintenir une neutralité et à clarifier les limites de leur rôle implique un renvoi à la position d'expert du professionnel de santé. À cheval entre deux mondes, celui du professionnel de santé et celui du réfugié, beaucoup de médiateurs développent un discours « nous » contre « eux », selon lequel ils font partie de l'équipe des professionnels de santé, c'est-à-dire forment une alliance avec les professionnels de santé et non avec le réfugié.

Un jeu d'alliance entre réfugiés et professionnels de santé

Les alliances qui se jouent dans l'interaction triadique sont complexes, les médiateurs culturels se trouvant par définition dans les deux « camps » - à la fois eux-mêmes souvent issus de la même population migrante et membres de l'équipe de professionnels. Elles peuvent influencer sur la qualité de la collaboration, et les pratiques des interprètes communautaires s'adaptent avec intelligence au contexte, leur intervention propre (interprétation) étant plus visible dans le domaine de la santé mentale (Goguikian Ratcliff et al., 2017)

Travailler en tant qu'intermédiaire entre des professionnels de santé (les professionnels de la santé mentale en particulier) et des réfugiés qui n'ont peut-être jamais rencontré un psychologue comporte des défis. En s'identifiant parfois comme étant des « agents du système médical » (Leanza, 2011), les médiateurs culturels sont souvent chargés de servir de « défenseurs » des services de santé mentale, en expliquant par exemple le rôle du psychologue et les avantages que le réfugié peut tirer de séances psychothérapeutiques :

KI25 : « *Et aussi on leur explique que le travail d'un psychologue c'est causer avec une personne qui est en danger. Et celui qui a passé un moment difficile, on lui conseille de parler avec le psychologue. Lorsque tu parles avec le psychologue il t'écoute, il te libère et tu racontes ton histoire et ce qui t'a fait*

mal. Quand tu parles, tu racontes comme une histoire normale. Ça ne va plus te faire de mal. C'est une histoire qui ne va plus faire de mal à ta santé. »

Une médiatrice culturelle, par exemple, explique être fier d'aider le psychologue à convaincre les réfugiés d'assister à des séances psychothérapeutiques. C'est parce que, d'après elle,

KI26 : *Avec les séances, [...] le psychologue arrive à obtenir ce qu'il veut. »*

Ces mots résument que les séances thérapeutiques sont ce que le psychologue voulait et cherche à obtenir. C'est leur but, et pas nécessairement celui du réfugié. Elle continue avec un cas particulier, à titre d'exemple :

KI28 : *« On a réussi à la convaincre de voir un psychologue. Elle ne voulait pas parce qu'elle avait honte. Tu peux alors tout à fait comprendre parce que la mentalité est différente. C'est une dame qui n'est pas éduquée. Une dame qui a vécu dans une société qui est vraiment stricte, enfermée. D'autre part son seul souci était de ne pas rester enceinte après cet acte et de se fermer sur elle-même. Mais à la fin, on a réussi, parce qu'elle a commencé à voir un psychologue le soir et elle avait un bébé de quatre mois avec elle. C'était vraiment une réussite [...] Lorsqu'on l'a convaincu d'aller chez le psychologue, c'était vraiment la fête pour nous. »*

Dans cet exemple, les mots « *c'était vraiment la fête pour nous* » impliquent que le fait de réussir à convaincre un réfugié de voir le psychologue est un succès à fêter pour toute l'équipe, y compris le médiateur culturel lui-même. En tant que tel, cela fait partie du rôle des médiateurs culturels de convaincre la population des réfugiés de la « vérité » du savoir psychiatrique occidental et des avantages de voir un psychologue, comme en témoignent les mots d'un médiateur culturel qui donne un autre exemple :

KI4 : *« Je comprends le gars, qui n'avait aucune connaissance avant et quand il comprenait lorsque que le pédopsychiatre expliquait son problème ou son histoire ou son traumatisme d'une autre manière, en dessinant, par des sentiments, c'est alors qu'il comprend cela, «oui, c'est la vérité. » »*

Ici, il y a une acceptation implicite de la « vérité » de ce que dit le psychologue et, grâce à un processus d'explication, il a convaincu le réfugié de cette vérité aussi. Cependant, nous pouvons également noter que, malgré l'alliance apparente avec les professionnels de santé concernant la « vérité » des connaissances psychiatriques occidentales, les mots ci-dessus soulignent également la complexité de la posture : les mots « *je comprends le gars* » peuvent indiquer le fait que les médiateurs culturels se trouvent à la fois dans la perspective du réfugié et dans celle du médecin. Une telle compréhension de ces perspectives diverses n'est pas sans difficultés pour l'action, et est souvent source de responsabilité pour les médiateurs culturels qui se sentent chargés de ce travail de médiation, au sens de Wang qui la définit comme étant un « processus de négociation, facilité par un tiers n'exerçant pas de pouvoir de décision, ayant pour finalité de permettre aux parties concernées de résoudre une situation conflictuelle ou d'établir une relation » (Wang, 2016, p. 141).

Travailler avec des professionnels de la santé perçus comme « culturellement inexpérimentés »

Dans la négociation de leurs rôles, alliances et responsabilités, y compris celui de co-thérapeute actif en alliance avec les professionnels de la santé (comme souligné ci-dessus), beaucoup de médiateurs culturels ont également fait allusion aux défis de travailler avec des professionnels de la santé qui, selon eux, manifestent un manque de compréhension « contextuelle » ou

« culturelle » Il s'agit d'un défi spécifique qui se manifeste au sein du trio thérapeutique : le réfugié, le professionnel de santé et le médiateur culturel qui se trouve entre les deux.

Dans certains cas, les médiateurs culturels se sentent plus « expérimentés » que le professionnel de santé, et se perçoivent comme des « passeurs culturels » (Leanza, 2011) qui doivent « éduquer » les autres professionnels quant aux normes culturelles relatives aux populations réfugiées :

KI4 : *« Pour moi, en tant qu'expert, le psychologue, d'accord surtout le psychologue, je vois qu'il a des difficultés dans la communication avec les patients. Je pense, en particulier pour quelqu'un qui ne connaît pas la culture, d'où appartient ce type, quelle est sa culture, comment il pense, comment il vous regarde, comment il regarde les choses. Bien sûr, ce n'est pas comme nous le pensons, alors, j'essaie un peu de donner quelques conseils aux collègues pour qu'ils puissent essayer certaines choses qui, d'où il vient, des mots ou des choses, essayez, cela aide la personne à se sentir à l'aise et que ce gars, il sait de moi et de ma culture et que je peux lui faire confiance, je peux être à l'aise. »*

KI23 : *« Pour le psychologue, c'est un peu difficile, car cette culture ne comprend pas la psychologie. »*

KI29 : *« J'ai remarqué dans ma carrière de nombreux psychologues qui n'ont pas d'expérience. Et elle dit, elle demande au patient, c'était trop directement, c'était trop directement. Et il avait peur de dire correctement. Mais c'est mon travail, c'est mon travail d'interprète. Je ne peux pas dire d'autres mots. Par exemple, vous êtes psychologue et vous lui demandez si elle avait dans son pays des violences sexuelles, ouais ? Vous ne pouvez pas lui demander ça directement. Mais vous trouvez un moyen pour le faire. »*

Ainsi, les malentendus culturels ont été perçus comme émanant non seulement du réfugié, peut-être novice en psychologie, mais aussi des professionnels de la santé, éventuellement non habitués au travail avec les populations de réfugiés non-Occidentaux :

KI39 : *« Parfois, il existe des obstacles culturels - non seulement du côté du patient, mais aussi du côté du professionnel. »*

Cette divergence dans le savoir culturel et le savoir médical semble parfois inverser une hiérarchie attendue au sein de la dynamique du pouvoir. Ce sont souvent les médiateurs culturels et non les professionnels de la santé, qui se positionnent dans le rôle d'expert :

KI39 : *« Si un psychologue essaie de les aider à comprendre leurs problèmes, alors [...] certains d'entre eux ne conviennent pas culturellement aux patients et à certaines de leurs suggestions. Même s'ils décrivent les choses d'une manière particulière qui n'est pas appropriée. Si je viens juste avec ce message exactement comme pour le patient, cela nuit à la relation thérapeutique qui n'était pas là. Cela réduirait l'efficacité et la qualité de la session. »*

Par conséquent, les médiateurs culturels endossent la responsabilité de l'expertise par rapport à la connaissance culturelle des réfugiés. Ils jouent un rôle actif dans la facilitation des séances, dans la médiation entre le professionnel de santé et le réfugié, lorsqu'ils estiment qu'il faut le faire. Ce parti pris semble présent en particulier lorsque les médiateurs culturels sont eux-mêmes des réfugiés.

Conclusion

En plaçant la souffrance humaine dans un paradigme exclusivement médicalisé et axé sur les traumatismes, une description mince de l'individu est privilégiée, où d'autres considérations socio-historiques importantes sont facilement perdues ou cachées (Marlowe, 2010). Cette approche écarte « l'inquiétude de ne pas imposer l'ordre sur le monde, mais plutôt de permettre l'émergence d'autres voix et visions, même si cela implique une complexité et une ambivalence croissante » (Bracken et al., 1997). En tant que tel, la construction singulière du S.S.P.T. est tout simplement insuffisante pour saisir la complexité inhérente à la manière dont différents êtres humains de différentes cultures répondent à des événements terrifiants (Marlowe, 2010; Steel, 2001; Summerfield, 2001). Des approches qui prennent au sérieux la singularité de l'expérience personnelle, dans son contexte socioculturel, sont nécessaires compte tenu de l'afflux actuel de demandeurs d'asile en Europe, dont beaucoup ont vécu des horreurs indescriptibles, quelle que soit la langue utilisée. De nombreuses organisations humanitaires fournissent un travail important d'offre de soins et d'accompagnement en santé mentale, pour des personnes et communautés qui ont dû faire face à une multitude de traumatismes. Dans ce contexte, le rôle des médiateurs culturels est essentiel. En effet, comme le déclare Summerfield (2005), les défis auxquels ils sont confrontés ne relèvent pas de la « traduction entre les langues mais de traduction entre les mondes » (p. 76, cité par Nicolas et al., 2015). Leur posture oscille entre une position instrumentale de traduction, et une responsabilité étendue, parfois de co-thérapeutes actifs, de défenseurs de l'approche occidentale de la santé mentale et d'experts interculturels, qui aident les professionnels de santé à explorer le monde psychique culturellement (in)formé des réfugiés traumatisés. Ce qui caractérise également la position du médiateur culturel, c'est une relation qui est émotionnellement surinvestie par les réfugiés, du fait principalement de ces derniers. Travailler de façon neutre et impartiale, dans ce contexte, suppose de pouvoir s'appuyer sur une posture professionnelle (au sein des médiateurs culturels) et interprofessionnelle (dans la collaboration entre professionnels de santé et médiateurs culturels) qui prend en compte ce surinvestissement émotionnel des médiateurs culturels par les réfugiés, plutôt que de le nier. La construction de ces postures est un travail collectif encore largement à réaliser.

Notre recherche souligne la nécessité d'une compréhension plus nuancée et contextualisée du traumatisme, qui n'isole pas l'expérience personnelle des systèmes culturels et des contextes historiques, économiques et sociaux plus vastes. Ignorer ces facteurs risque d'ignorer (ou pire, de dénigrer) les systèmes locaux de soutien, de pathologiser et de stigmatiser les individus, et de détourner les ressources des interventions sociales et structurelles (Nicolas et al., 2015). Ceci plaide pour une approche « décolonialisée » de la psychologie.

ARTICLE THREE (English version) : “In Africa, I have never heard someone saying he is going to see a psychologist”: diverse interpretations of psychological trauma among cultural mediators, health professionals and refugee victims of torture in Athens, Greece. *Revue Européenne des Migrations Internationales*, 34(2), 29-54.

Abstract

Despite the high prevalence of trauma among refugees, significant criticism has been raised regarding the intercultural relevance of Post-Traumatic Stress Disorder as a diagnostic construct. Collaboration between mental health professionals and refugees frequently encounter linguistic and cultural barriers, and increases the risk of misunderstandings. Cultural mediation plays a critical role in this space. In order to explore the diversity of perspectives on trauma, we present an analysis of a 12-month research work with NGOs working in Athens, Greece, with refugees victims of torture. Our analysis focuses on (a) how refugees who are victims of torture live and describe their trauma; (b) the construction of representations, practices and standards for mental disorders; and (c) how various actors represent, understand, and use diagnostic constructs such as P.T.S.D. Our research underscores the need for a more nuanced and contextualized understanding of trauma as being heavily influenced by cultural systems and wider historical, economic, and social contexts.

Introduction

The influx of asylum seekers arriving in Europe has reached historic proportions, with subsequent evolving responses having now become one of the continent’s defining challenges of the early 21st century (Médecins Sans Frontières, 2016; UNHCR, 2015). The mental health of this population has become the subject of attention both in the scientific field and in public debate (Abbott, 2016; d’Halluin, 2009), with the diagnosis of Post-Traumatic Stress Disorder (P.T.S.D.) becoming particularly salient in discourses of refugee mental health. A plethora of literature attests to the substantially higher prevalence rates of this diagnosis among refugees compared to host populations (d’Halluin, 2009; de Arellano & Danielson, 2008; Kirmayer et al., 2010; Lambert & Alhassoon, 2015; Schweitzer et al., 2006; Steel et al., 2009; Sturm et al., 2010; Van Ommeren et al., 2001; Weine et al., 2001). Some authors even go as far as suggesting that all forced migrants suffer from some degree of P.T.S.D. symptomatology (Copping et al., 2010).

However, significant criticisms have been raised regarding the relevance and validity of P.T.S.D. as a diagnostic construct across different cultural settings. This diagnosis tends to neglect how cultural context effects experiences qualified as “traumatizing,” as well as post-traumatic symptomatology manifestations, narratives of distress, and health-seeking behaviour (Abbott, 2016; Droždek, 2015; Fassin & d’Halluin, 2005; Fassin & Rechtman, 2009; Goguikian Ratcliff, 2012; Kirmayer et al., 2010; Maercker & Hecker, 2016). As a diagnosis developed primarily for use in western contexts, P.T.S.D. ignores the variability of symptoms reported

across various cultural contexts worldwide (Eagle, 2014; Hinton & Lewis-Fernández, 2011; Silove et al., 2017). This body of literature suggests that not only could our reactions to the various traumas be influenced by language and culture, but that this cultural context may influence the very concept of what is and what is not experienced as traumatic (Brewin et al., 1996; Droždek & Wilson, 2007; Sturm et al., 2007, 2010). According to Eagle (2014):

“Formulation of trauma impact requires careful exploration of the manner in which the individual describes the traumatic event and their response to it, including for example, the language they deploy, emphases, omissions, affective tone, and fantasy material; with a view to uncovering pre/unconscious associations to the trauma and the way in which intrapsychic constellations have shaped and/or mapped onto the experience” (P. 9)

Cultural and linguistic challenges around the refugees’ mental health

A singular construct of P.T.S.D. is thought to be simply inadequate to grasp this complexity. Rather, the way in which trauma is experienced is thought to be significantly determined by larger cultural systems and historic contexts (Carlson, 2005; Kirmayer et al., 2010; Marsella, 2010; Marsella et al., 1996; Mattar, 2011; Rousseau et al., 1997; Tummala-Narra, 2007; Wilson et al., 2004). The importance of culturally contextualised understanding of trauma when working with refugee populations in particular has been explored by, among others, French ethno-psychoanalysts such as Sturm and colleagues (Sturm et al., 2010). They argue that what they refer to as culturally shaped “collective representations” of trauma may provide a frame for the construction of narrations which informs the processing of traumatic experiences and the way in which the individual may be able to convey their distress in socially understandable and acceptable ways. This includes, for example, theories about the origins of pain and the possibilities of healing, conceptions of family and social bounds, religious or metaphysical conceptions of the world, ideologies or positions in a field of political conflicts (Sturm et al., 2010). Within this field of ethnopsychiatry, nosological categories such as P.T.S.D. are not considered as natural phenomena, but are rather the result of a dialogue among different actors.

Various linguistically- and culturally-specific examples of different ‘idioms of distress’ and ‘culture-bound syndromes’ in response to trauma have been documented in the literature (Afana et al., 2010; Hinton & Lewis-Fernández, 2010; Jayawickreme et al., 2012; Nicolas et al., 2015; Summerfield, 1996). Afana and colleagues (Afana et al., 2010), for example, highlight how Palestinian communities have processed continual exposure to war through particular linguistic constructs of trauma: *Sadma* (trauma as a sudden blow with immediate impact), *Faji’ah* (tragedy), and *Musiba* (calamity). *Sadma* is used metaphorically to refer to painful events that happen suddenly, *Faji’ah* is used to describe the reaction to an extraordinary event (mainly the loss of a loved one) and *Musiba* is used when traumatic events are persistent and have long-term consequences. They use these examples to show how such distinctive, historically-bound idioms illustrate communal reflections on the meaning behind experiences of violence, forced displacement, social exclusion, and humiliation. Behind all of the various idioms of distress found across the world, they argue, lie the social representations of trauma and ways in which it is defined and processed on a socio-cultural level:

“The idioms we have described borrow from everyday language to make sense of the impact of violence in a situation of protracted conflict. They do not represent discrete syndromes or sharply delimited categories. Rather, they are familiar ways of speaking about traumatic events that invoke specific networks of meaning. They serve to communicate to others within the community about the dimensions of suffering through language that references collective experience and that conveys assumptions about the expected bounds of behaviour, the likely course of distress, and outcome of clinical or social intervention. Generally, these cultural idioms of trauma are not diagnostic entities that require treatment but a vocabulary through which distress is expressed and social support mobilized” (Afana et al., 2010, p. 82).

This literature has emphasized the diversity experience of the therapeutic path of the diagnosed refugees with the P.T.S.D., and their entourage (Goguikian Ratcliff, 2010; Goguikian Ratcliff & Suardi, 2006; Harvey, 2007; Sylla Diallo et al., 2009). Droždek and Wilson (2007), for example, highlight some of these differences: among Cambodian refugees who had suffered multiple life-threatening trauma during the Khmer Rouge regime, many who suffered from P.T.S.D. and depression understood their symptoms in light of their Buddhist beliefs in karma as a station in life, an incarnate level of being and fate where personal suffering is considered from a particular religious-cosmological perspective on the meaning of life. Among the Native American people, illness is thought to result from imbalance, loss of harmony and being dispirited with oneself due to a loss of vital connectedness. A common explanation for the 1988 Yuannan earthquake in China was that a ‘great dragon’ was moving below the earth because he was angry with the people... all striking examples of how cultural variations in ways of life and social contexts shape experiences of trauma (Kirmayer & Ramstead, 2016).

Other criticisms raised in the literature have highlighted the clinical limitations of the P.T.S.D. diagnosis, which necessary links the experience to a pre-migratory trauma related to a single event experienced in the past. Arguably, this minimizes the impact of migratory and post-migratory events. This is a particularly relevant consideration for the mental health of refugees in light of the multiple and arguably ongoing environmental stressors and potentially traumatic experiences with which they are faced. In a multi-agency guide on the mental health of refugee populations released in 2015, UN agencies and other international humanitarian organizations have highlighted the fact that for most refugees and migrants potentially traumatic events from the past are not the only, or even most important, source of psychological distress but that the majority of emotional suffering is directly related to current stresses and worries and uncertainty about the future (IASC, 2015; Ventevogel et al., 2015).

Despite these criticisms, there is still a substantial lack of flexibility in using Western diagnostic categories (Médecins Sans Frontières, 2016). A call for more research on trauma from a cultural perspective has been echoed not only in the world of academia but by many international humanitarian organisations engaged in the implementation of mental health and psychosocial interventions with refugees across Europe and who are looking for more culturally relevant tools (which consider more local idioms of distress, for example) to better address the mental health needs of this population (Hecker et al., 2015; IASC, 2015; Médecins Sans Frontières, 2016; Tol et al., 2014; UNHCR, 2015).

As such, while western mental health professionals are working to provide assistance to people who seek asylum in Europe, it is important to take a step back and consider the unique contexts

in which this work is done (Nicolas et al., 2015). The collaboration between mental health professionals, and the refugees frequently faces language barriers, thereby rendering communication difficult during consultations, and increasing the risk of misunderstanding, misdiagnosis and errors in treatment (Gard, 2015; Hecker et al., 2015; IASC, 2015; Karageorge et al., 2016; Maier, 2006; Maier et al., 2010; Maier & Straub, 2011; Rechtman, 2000; Wang, 2012, 2016). This is especially true in the context of trauma, which many authors highlight often remains inaccessible to verbal recollection (Brewin, 2001; Brewin et al., 1996; Brewin et al., 2009). Sometimes, there are simply no words to describe the horror. For those affected by this trauma, ‘their problem is not the limits of memory but of language—the inadequacy of ordinary words to express all they have witnessed’ (Kirmayer, 1996, p. 4).

In the specific context of migration in particular, itself characterized by disruptions in connection to ‘home’ (and all the social, cultural and linguistic connections that this implies) – the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). In such a state, disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and moments in life through the use of words. Without the container of home-as-it-was, with no interlocutor to whom to address the distress (Womersley & Kloetzer, 2018a), there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012). In this context, the role of cultural interpretation and mediation, defined as a “negotiation process” (Wang, 2016, p. 141), is necessary in the healing process.

As the number of refugee mental health programs has increased in recent years, so has the use of cultural mediators, without whom clinical services for refugees could not be provided (Miller et al., 2005). Here, the term “cultural mediator” is purposefully used instead of “interpreter” in order to reflect the dynamic and complex nature of their work which often extends far beyond that of simple translation; they are often the mediators between the world of the health professional and that of the refugee. Wang (2012, 2016) points out the complex “subjectivity” of the cultural mediator: “he or she has to be interested in both the content and the form of the discussion, and gives attention to interpersonal relationships” (Wang, 2016, p.141). As noted by Resera and colleagues (2015), this comes with challenges surrounding the need to be precise, emotionally detached, firm, to know how to behave in relation to a specific culture, and being neutral and impartial.

This is particularly true in the context of mental health where words are the tools of the professional. Indeed, the literature highlights mental health as being the most demanding context for cultural mediators compared to their work with other professionals. Here, cultural mediators have been shown to have to negotiate multiple positions including that of a cultural broker, community organizer and even a directly implicated co-therapist (Goguikian Ratcliff et al., 2017; Miller et al., 2005; Mitschke et al., 2017; Pestre & Benslama, 2011; Resera et al., 2015; Wang, 2012, 2016). Miller (2005) goes even further in arguing that not only is mental health a unique context for cultural mediation among refugee populations, but that this is

particularly true for victims of torture and other political refugees. He identifies two factors: 1) the prevalence of exposure to extreme violence and deprivation and the subsequent development of severe and persistent psychological trauma and 2) the experience of multiple losses—of social networks, personal possessions, valued social roles, and environmental mastery. In these traumatic contexts in particular, the challenge of translation goes beyond a literal transcription from one language to another (Pestre & Benslama, 2011). As quoted by Denis (cited by Maqueda, 2005):

“The presence of an interpreter enables to calm fantasies of infringement and involvement of one culture by another. The interpreter is a transitional space both to the migrant and the caregiver. He or she symbolizes the comparable and different to both of them. He or she occupies the position of cultural mediator clarifying the understatement, implicit information in any culture. He or she uses singular words, embodying the particular story of the individual in a background group. The interpreter symbolizes the possible development between both contexts: cultural but also temporal, between a before and an after. He or she represents the cultural weaving, thereby enabling to adapt oneself without quite being another.” (p. 3)

So how are the different representations and understandings of trauma managed in this space? How are they negotiated among the various actors (refugees, psychologists, cultural mediators) in the complex context of psychotherapy in humanitarian settings?

Context and methodology

Since the height of the migration reception crisis that shook the continent in 2015-2016, Greece remains one of first sanctuary ports in Europe. In a country exposed to a serious financial crisis, fewer resources are available to ensure quality mental health services to refugees (Gkionakis, 2016). Several refugees who enter Greece through the Aegean Sea remain blocked on Greek islands, far from the adequate medical care they could receive in Athens. Others continue their way illegally through the Balkan route and find themselves trapped in limbo, unable to make their asylum application. The asylum system which is often long and opaque, and the numerous obstacles to the access of basic services in Athens, and throughout the country add to the day-to-day difficulties (Kotsioni, 2016).

In order to explore this diversity of perspectives on trauma, we present the analyses of 12 months of fieldwork in an NGO-run centre for refugee victims of torture in Athens, Greece. Ten refugee victims of torture (9 men and 1 woman) treated in the clinic were identified by the medical staff to participate in this research. Participation was entirely voluntary. Exclusion criteria included psychosis, serious dissociative symptoms, and acute suicidality. The over-representation of male participants reflects to some extent the demography of the beneficiaries of the centre, of whom 80% are men. We carried out five in-depth qualitative interviews with each of them throughout this one-year period.

	Sex	Age	Origin	Language spoken	Level of education
Participant 1	M	55	Sudan	Arab, English, Greek	Five years of higher education
Participant 2	M	35	Sudan	Arab, English, Danish	Two years of higher education
Participant 3	M	53	Afghanistan	Arab, Farsi, English	High school
Participant 4	M	52	D.R.C	French, Linguala	High school
Participant 5	M	42	Sudan	English, Arab	Three years of higher education
Participant 6	M	33	India	English, Hindu	Three years of higher education
Participant 7	F	40	Côte d'Ivoire	French	Elementary education
Participant 8	M	43	Côte d'Ivoire	French	High school
Participant 9	M	30	Syria	Arab, French	High school
Participant 10	M	32	Côte d'Ivoire	French, Arab	High school

Interviews with refugees were focused on symptoms of P.T.S.D., subjective experiences and explanatory models of trauma, and the integration process within Greece. Interviews were conducted in English or French without a translator.

To further our understanding of trauma within this particular context, we conducted 36 interviews with health professionals working with refugees victims of torture in various humanitarian organizations across Athens, as well as with seven cultural mediators²⁶, speaking French, Arab and Farsi, and working with patients diagnosed with the P.T.S.D. These seven cultural mediators were all full-time employees of the project who had been recruited on the basis of their language skills, and work experience with NGOs. They consisted of three French-speaking women, and four Arab/Farsi men respectively, aged 22 to 65. Like several other humanitarian actors, the centre officially uses the term “cultural mediator” instead of “translator” - in order to highlight the importance of their work as mediating between cultural norms – a job which goes far beyond a simple translation *verbatim*. The other two French-speaking mediators were retired Greeks locals, and the third was a young Congolese of 23 years living in Athens for three years on a student visa. One of the Arab mediators was an Egyptian migrant of 40 years living in Greece for four years, while the three others were themselves refugees recently arrived in the country. No mediator had a translation or cultural mediation certificate or diploma.

Qualitative in-depth interviews were also carried out with 21 community representatives and leaders of various refugee associations around Athens in order better to understand the perspectives, and explanatory models that exist in their respective communities at a

²⁶ We are using the term “cultural mediator” and “community interpreter” in order to respect the official title used in this project.

sociocultural level. Furthermore, we engaged in three-months of participant observation, which included attending daily staff meetings as well as facilitating sessions and workshops with beneficiaries of the project.

To analyse the data, we first identified representations of trauma expressed during interviews with victims of torture. An average of 1.7 representations were identified for each individual, with 70% of spontaneous representations formulated by participants during the interview, and 30% direct answers to the researcher's question. These representations were collated, and a thematic analysis conducted on the content. Five major themes emerged including 1) fear, 2) excessive thoughts or thinking, 3) collective trauma, 4) psychosomatic responses and 5) spiritual suffering or "low morale." The majority of the participants appeared to contest the medical concept of the P.T.S.D. with which they were diagnosed.

Thereafter, we applied the same process to the interviews among health professionals and cultural mediators: the transcriptions of these interviews were analysed by noting all the references made to P.T.S.D. or representations of trauma. An average of 3.7 of these representations was identified for each participant, 65% of them being spontaneous representations formulated by the participants during the interview, and 35% being direct answers to the researcher's question. These representations were collected, and a thematic analysis conducted on the content. Three major themes emerged which highlighted participants' statements falling along a continuum between 1) a complete, non-critical acceptance of a P.T.S.D. diagnosis, 2) making use of a nuanced, individualized and context-dependent diagnosis of P.T.S.D., and 3) criticizing and problematizing the diagnosis.

We first present the culturally informed trauma representations that emerged from our interviews with refugees. We then focus on the accounts of cultural mediators, by taking into account their work as revealing existing tensions between representations of trauma among health professionals and those of their patients. The analysis will focus on three themes: 1) the negotiation of the cultural mediators' complex roles, 2) alliances with health professionals, and 3) working with "culturally inexperienced" health professionals.

Through analysing cultural mediation in this context, we explore the role of culture in the care of refugees diagnosed as having mental disorders, and the implications of these diagnoses for treatment, issues that pose significant challenges to health professionals regarding the relationship between trauma, culture, and subjectivity (Rechtman, 2000).

Crossed interpretations of P.T.S.D. among refugees and health professionals

Culturally informed representations of trauma

The majority of refugee beneficiaries interviewed appeared to contest the medicalised notion of « P.T.S.D. » with which they had been diagnosed. When referring to their subjective experiences of trauma, they drew upon a variety of diverse cultural representations of suffering

(“explanatory models”) and idioms of distress to explain their subjective experiences of trauma. To analyse this, we examined every instance in the interview transcripts that these individuals referred to P.T.S.D. and what it meant for them. Four main themes emerge:

1) Fear:

“I’m tortured, I’m always afraid. [It] is not [an] illness” (Participant 1)

“Trauma is somebody with many difficulties and fear. It is somebody without a calm state of mind. It is fear to be killed”. (Participant 4)

2) Excess thought or thinking, rumination:

“I have many thoughts... I was “afraid”, my mind is full of many things” (Participant 9)

“I’m sick because I think a lot. It also affects my body. If you think too much, you fall sick” (Participant 7)

3) Collective suffering

“The problem of my family is the shock” (Participant 2)

“I feel the pain of my family, the wounds on the body, and the heart ache” (Participant 5)

4) Spiritual suffering or “low morale”

“This is when your morale is not at a 100%” (Participant 8).

“In this case, the morale is not good” (Participant 10).

The first participant describes torture as something one “has.” This is contrary to the idea that it is an event one has experienced. It is rather metaphorically represented as being internalized: the event has become part of him and what he is. The immediate consequence is the constant fear he feels. He absolutely rejects the idea that he is sick - his fear is related to the torture he experienced. According to him, it is clearly not a medical condition.

For the second participant, the trauma he experiences is not only his but related to the “shock” of the entire family. This contradicts the inherently individual narrative of P.T.S.D. The idea is similarly reflected in the words of participant 5, who feels “the pain of my families.” This more collectivist representation of trauma has similarly been noted by researchers and clinicians working within collectivist communities wherein individuals rely more heavily on larger family systems; here, mental health is typically seen to be more linked to a broader socio-cultural context (Adame & Knudson, 2007; Bracken, 2001; Droždek & Wilson, 2007; Maercker & Hecker, 2016; Tang, 2007). As Tang (2007) notes: “cultures differ regarding their dominant ideas about the ontology of self as well as relationship between self and others, between self and the universe, and between life and death.” (p. 129). Tankink and Richters (2007) give the example of South-Sudanese research participants who did not experience themselves so much as an individual in the Western sense of the term, but more as having a ‘family self’ based on relational models where experiences are considered more within the intersubjective realm of the group rather than on an individual, intrapsychic level.

Individual 7’s explanatory model is interesting as it does present the idea of the mind and body being connected. However, inherent to his model appears to be the separation of a “medical” illness (the body being sick) and a psychiatric diagnosis or mental illness (the mind being sick) of which he makes no mention. In other words, according to his explanatory model, “too much

thinking” lead to physical suffering. He refers to an illness in the body – which somehow bypasses any mention of a mental or psychiatric illness. This echoes the word of one psychologist who explained:

“Most of the time, when people are suffering from some symptoms [of P.T.S.D.], most of the time they attribute these symptoms to medical conditions”

“They don’t understand”: health professionals perspectives on how refugees interpret a P.T.S.D. diagnosis

Culturally informed explanatory models contradict the medical team’s understanding of P.T.S.D. One doctor, for example, stated:

“They don’t understand that they have it, let’s say. They do not realise that something is wrong with them, umm, but we’re trying to show them how, show them how they can realise that they, they will suffer from that.”

A cultural mediator similarly stated:

“Sometimes they say, uh, you know, um, magic, like spell, like ‘somebody put a spell on me and they want to destroy my life’ or ‘they want to, because they don’t like me so they put a spell on me and they want my money so they put a spell on me and because of that that I have this thinking and this insomnia and many many of things.’ They don’t understand the psychology, that they have a, because of some event that happened before or some stress or something.”

The words “they don’t understand” reflect a recurring discourse among professionals that P.T.S.D. was something to be “understood.” Implicit therein is an unequal distribution of power related to western knowledge: it is the victim of torture diagnosed with P.T.S.D. who needs to “understand” the diagnosis from the perspective of a westernised, medical model of distress. The medical team ultimately hold the “true” knowledge. This “internationalisation and professionalisation of adversity” (Pupavac, 2002, p. 493) enforcing “the asymmetry of the therapeutic relationship” (Wang, 2016, p. 143) has been criticised in the literature as a form of “cultural imperialism” (Steel, 2001) serving to reinforce existing imbalances of power between Western ‘expert’ and ‘victim-patient’ (Summerfield, 1996; Watters, 2001).

However, the privileging of western psychiatric knowledge wasn’t necessarily always the case. The majority of professional’s discourse reflect a certain ambivalence in the face of such contradictions, which appeared to range on a continuum from complete and unproblematic acceptance of the category of P.T.S.D. (“it was obvious since then that he has a serious post-traumatic stress disorder...he had some flashbacks, he had these nightmares. It is a medical diagnosis,” “he had very strong P.T.S.D. I wanted to, to offer very quickly treatment”), to a nuanced, individualised and context dependant use (“P.T.S.D. as a diagnosis maybe varies for people, it’s a category that we can use and it will be helpful for people,” “P.T.S.D., it’s a category that will help you to predict what he wants, to predict what he will do, and to understand what he has gone through”) to a critiquing and problematisation of the diagnosis (“I am very critical of P.T.S.D.,” “it’s difficult to, um, to, to define in, um, such a rigid, uh,

diagnostic, uh, configuration. There's the, the category of P.T.S.D. and there's each individual patient or different ways to express them,” “P.T.S.D. is a social control construction and he has a certain history in medical anthropology field that there were a lot of critique”).

Looking at the elements which organize these positions, several factors seem to play one role. Firstly, this type of professional training is followed by a factor influencing the acceptance or not of the P.T.S.D. On one hand, we have pure a biomedical model with some medical doctors and psychiatrists, and on the other, a model that is rather psychoanalytic, thereby taking into account a subjective and individual perspective. Secondly, professionals having more work experience with the migrant populations seem, for the most part, more conscious of the cultural influencing factors with which these individuals express their distress or suffering and face them. The scientific literature (Bourassa-Dansereau, 2013; Leanza, 2011) reveals that, when facing culturally foreign contexts, health professionals oscillate between “normalization” processes (based on the dominant western medical models, by imposing symptomatically and explanatory norms related to the P.T.S.D., for instance), and “customization” (taking into account the singularity of each individual, including their socio-cultural context, for instance).

The case of Brigitte

Brigitte's case study¹ underlines contradictions in explanatory trauma models. Brigitte is a Guinean refugee aged 40, who was tortured and diagnosed with the P.T.S.D. Her cultural trauma representations are different from the explanatory model proposed by the psychologist:

“B: The psychologist told me that the nightmares are linked to the past, because I told him that I'm being chased. He told me that it's linked to the past, that's it.

Interviewer: And what do you think?

B: Me, I told him that it's spiritual, but afterwards, when he spoke, I told myself that “I don't know” but it's also possible that it's linked to what I'm thinking in my head. It's also that. Because I leave what's in my head. If I remove what's in my head, it can sort itself out. Apparently, when you have dreams where people are chasing you, we, we say that it's witchcraft. Among the Africans, we say that it's witchcraft. But he, he explained to me that ... for example, I had a dream the night before last. I remember two dreams. Where they chained me up, he said that it's linked to my past and that it's me myself who is chaining myself up. Because of, maybe, what I refuse to think, I chain myself. So it's me myself who has to cut the chains. Nobody is chasing me. I need to liberate myself. Even though it's not easy, I need to liberate myself, scientifically.

Interviewer: He said that?

B: Yes, he said, scientifically ... me, I told him about the spirituality but he said that scientifically, dreams are expressing what we're feeling [...] I think it's witchcraft, it's the ancestors [...] Yes, it's someone who wants to ... but he said that scientifically it's our thoughts, in my head, my thoughts because I have children at home [in Guinea] that I had with different fathers, not with the same man. And because I'm Christian, sometimes I feel guilty and I tell myself that it's not a good image as a Christian. He told me that that's what I think [...] I told myself that it's also probable that it's the truth. Because maybe, in my head, I am guilty, it's true. Even though I listen to the word of Gd, one could say that I did something that I couldn't pardon myself for. But Christ has already forgiven me. That's also the problem [...] spiritually, it's complex. What I see, I explain spiritually with the hand of witchcraft. It means that the family isn't leaving me in peace. Spiritually, they are following me, they followed me two nights ago until I was scared. I don't know, there are two explanations [...] Apparently there is an explanation that's different

to what I think myself. So I don't know which to leave or take. I don't know...but I told myself that maybe that one's right as well."

Brigitte is confronted with a different explanatory model to that of her own ("apparently there is an explanation that's different to what I think myself"). Her understanding of the nightmares is framed as being a "spiritual" one – linked to the ideology of African witchcraft. According to this model, the nightmares are as a result of someone else chasing her and putting a spell on her. It is the family who will not leave her in peace. She is bewitched, and the nightmares are a cause of an external individual or group of individuals deliberately trying to harm her. She is then confronted with the psychologist who "explains" a "scientific" model to her. The use of the words "explain" and "scientific" hint at the asymmetry inherent to the therapeutic relationship mentioned above. They imply that the knowledge of the psychologist is to be taken as undisputed scientific fact (hierarchically superior to other forms of knowledge falling outside of the western scientific paradigm). The represented situation of the psychologist who is "explaining" this science to her places him in the position of knowledgeable teacher and her in the position of the hither-to ignorant learner.

The temporal challenges play a role in these two different conceptions: the scientific "model" represented by the psychologist is rather based on the past - and consequently, it is more static and unchangeable, it is a model in which the individual is the passive victim of what is happening to him or her. On the other hand, with the "spiritual" model there is a more active, dynamic and changing conception, based on the current and external, instead of the internalized past.

Throughout her speech, her own position in relation to the "scientific" model appears ambivalent. It is a dynamic and constantly shifting one, where the psychologist's explanation is both contested and accepted. When confronted with the explanatory model of her psychologist, she begins by saying: "I need to liberate myself. Even though it's not easy, I need to liberate myself, scientifically." Implied in these words is an acceptance of his model, based on an individualised and westernised understanding of trauma, where distress is solely located at the level of the individual and the individual has the power and obligation to heal themselves. The contradictions between this explanatory model and that of hers is highlighted in the words "me, I told him about the spirituality *but* [our emphasis] he said that scientifically, dreams are expressing what we're feeling." It is as though, metaphorically, she holds up the two models to examine them; it is the spiritual versus the scientific; her model *but* his. She then continues to directly contradict the model offered by the psychologist in saying "I think it's witchcraft".

Despite these contradictions, she continues by saying, "he told me that's what I think." Let us consider the inherent imbalance of power implicit to these words: one individual telling another individual what they think. When faced with this interpretation, Brigitte grapples with the truth of what the psychologist is saying. She repositions herself once more. Faced with this interpretation, Brigitte continues: "I told myself that it's also probable that it's the truth." By telling herself, she appears to have engaged in an internal monologue where she grapples with the truth of the psychologist's words in light of the apparent dissonance between his explanation and hers. She appears to resolve this conflict, to some extent, by taking an "also" approach. His

explanation is “also” correct, as is hers. The “*also*” instead of a “*but*” would therefore seem to suggest that she would like to incorporate this newfound understanding into her own explanatory model, thus accepting both points of view as valid. The conclusion of this is illustrated in her words “I don’t know...but I told myself that maybe that one’s right as well.”

The case of Brigitte offers an example of the fact that working with refugee populations in the field of mental health requires a knitting together a variety of worldviews brought together in the meeting between health professionals and the refugees themselves. In this first case study, Brigitte and her psychologist were both French-speakers, yet despite sharing a common language, the meeting of both worlds during a consultation needs a mediator. We now focus on professionals of this mediation namely: cultural mediators, employees through organizations that offer such mental health services to refugees worldwide.

Cultural mediators as negotiating different interpretations of trauma

Interviews with cultural mediators highlight three main themes: (a) the difficulty of positioning their translation between *verbatim* accuracy and interpretation; (b) the complexity of the alliance process between emotional proximity with refugees, and allegiance to a professional mental health approach; (c) the challenge of working with “culturally incompetent” health professionals.

Translation: accuracy versus interpretation

With regards to experiences with the P.T.S.D. diagnosis in particular, none of the cultural mediators referred spontaneously to the diagnosis of trauma. At the request of the researcher, all seven expressed doubts in regard to i) the exact meaning of the diagnosis, as well as ii) the usefulness of this diagnosis to the refugee population. For instance, one cultural mediator explains:

KI28: “They don’t have such stress because they were used to the joy of living. We can have it but they don’t. They knew how to hustle on a daily basis. These are habits and traditions. You cannot find this kind of depression there.”

It should be noted that the individual life history of each cultural mediator has a substantial impact on their position. This particular cultural mediator is Greek - as alluded to in her distinction between “we” (culturally the same, we can experience with the P.T.S.D.), and “them” (others, culturally different, they cannot). The fact that no cultural mediator had previous training in the fields of medicine or psychology may explain, to an extent, their doubts regarding the use and exact meaning of the P.T.S.D.. Many of them seem to prefer referring questions of P.T.S.D. to the medical doctor or psychologist, even during our interviews with them.

Several cultural mediators are confronted to the following dilemma: on the one hand, they are asked to simply provide a literal translation of what is said, and in the other hand, they have to play the role of a more implicated and nuanced mediator. As one participant states:

KI4: "My role consist of just translating words or images, the message they want to transmit to the psychologist in regard to their trauma, uh, in the past. I try to do my best to use the interpretation and not words."

Despite his initial affirmation that his role is "just to translate words", it is clear that he sees the need to broaden this function by offering something more complex than a simple translation ("interpretation and not only words"). This ambiguity is also reflected in the opinion of another cultural mediator:

KI39: "You try to transmit the same messages as the psychologist [...] but at the same time, you also do the mediation of terms."

Most often, discussions in this area focus on accuracy (where cultural mediators who are considered to be the most professional are those who can translate the words with technical precision) versus mediation (where cultural mediators who are considered to be more professionals are those who manage better to grasp the cultural nuances). To be understood by both parties, the cultural mediator is supposed to adapt his position and translation to a situation with flexibility, and in a dynamic way. As one participant states, "we are facilitating an appointment, you switch your role in a continuous way to adapt yourself to millions of cultural barriers." As another one underscored, "I cannot behave like a machine, a Google translation." Indeed, a complex system of interpersonal dynamics seems to play out in the triad between psychologist, cultural mediator, and refugee where the cultural mediators are tasked with taking on an active role – that of a co-therapist:

KI5: "It's not easy, translating for psychology because the person have many mental problems, many psychological problems. First, I want that he feels safe with me, the interpreter, not with the psychologist. Because he has to trust me. When I feel that he doesn't trust me, I can't work. I can't make an appointment with the person. Because for me, especially if he shares, he wants to talk with the person, he's not scared to talk. First of all, with this way I create the, the, trust between the interpreter and the patient to not feel uncomfortable."

This active role of co-therapist similarly involved an emotional investment in the well-being of the refugee beneficiaries:

KI26: "I'm touched, I really like it because I think that I'm offering something to these people. I think I'm helping them in this way to externalize their feelings, to be able to express themselves, and mostly what they have in themselves And obviously, I'm touched, and I get attached. I don't show it, but during the consultation I want to know what happened in their life, about their experiences."

What is noteworthy in the above statement is the clear active voice, and use of the first person "I." There is no mention of the role of the therapist themselves, it is the cultural mediator who sees herself as being the one to facilitate the psychotherapeutic process. Indeed, all of the cultural mediators interviewed referred to the idea that they felt closer to the refugee beneficiaries than the health professionals:

KI4: *"Always, the interpreter is the person who he is understanding more deeply the patient who has any kind of problem because the interpreter is the person that he is native of this language and maybe he's more closer because he's closest with, ah, things that happened to the country. Ah, but, ummm, I try even to explain even when we finish the session to explain why, why we say that, just to have message. Because the patient has in his mind always the message that 'you don't understand me, the doctor don't understand what's going on'"*

KI5: *"You have to see every person in the room, the psychologist, the interpreter and the person. Many times, the person will not see the psychologist, many times. Because they all see me, talk with me. Every time they say, 'I don't see, I want to see you, the interpreter.' They never want to see the psychologist. You'll ask something and he'll say this one, 'you understand what happened.' You see, you ask about something that happened, they say, 'N [cultural mediator], N, I have this problem.'"*

KI39: *"I will see [the sessions in] exactly the same way as a psychologist."*

For some cultural mediators, this active role was not of their own choosing but which they felt was imposed upon by refugee beneficiaries seeking assistance who turned to the cultural mediators, rather than the health professionals, as their primary source of aid:

KI29: *"A lot of people from our country, when they come here, when I'm the cultural mediator, the interpreter, they think I am the best one who decide about everything. A lot of people, they are thinking, I am the first one, I am the manager, I am the psychologist, I am the doctor, and I am everyone here."*

To defend against being placed in this often unwanted position of being an active co-therapist and, furthermore, even having to assume the role of "everyone here" with the responsibility for "everything," many explained the need to clarify their roles and keep within the limits of their job descriptions:

KI29: *"We have to explain them, 'this is not my decision to give you.' Because I am cultural mediator, [I cannot] give her money, pharmacy, medicine, accommodation, everything. We must be clear for the first time [...] they are thinking that 'R [himself, the cultural mediator] is here, and he will decide about everything."*

KI39: *"The major thing for me is to keep neutrality. My primary role is just to facilitate appointments I'm not a psychologist. I am not a medical doctor or a physiotherapist to put things in my own way."*

The strategy of maintaining neutrality and clarifying the limitations of their role implies deferring to the expert position of the health professional. Straddled between two worlds, that of the health professional and that of the refugee beneficiary, many drew on a "us" versus "them]" discourse – whereby as cultural mediators, they were positioned as a member of the health professional team, in other words in alliance with the health professionals and not the refugee beneficiary.

A game of alliances between refugees and health professionals

Alliances done in the triadic interaction are complex. Cultural mediators are by definition in both "camps" - at times they themselves are often from the same migrant population, as well as

being members of the professional team. These alliances can influence the quality of the collaboration. As cultural mediators adapt intelligently to the context, the quality of their interventions are often most visible in field of mental health (Goguikian Ratcliff et al., 2017).

Working as an intermediary between health professionals (especially mental health professionals), refugees who may have never met a psychologist has its challenges. Sometimes, being identified as “agents of the medical system” (Leanza, 2011), cultural mediators are often employed to serve as “defenders” of mental health services, explaining for instance, the role of the psychologist, and the advantages that the refugee may have from psychotherapeutic sessions:

KI25: “Furthermore, they explain to them that the work of the psychologist is to discuss with someone who is in danger. And someone who is going through tough moments, they advise him of her to talk with the psychologist. When you talk to the psychologist, he or she listens to you, he or she liberates you, and you tell your story and what hurts you. When you are talking, it is just as if you are narrating a normal story. It won’t hurt you anymore. It is a story that won’t affect your health anymore.”

One cultural mediator, for example, describes being proud of assisting the psychologist in convincing refugee beneficiaries to attend psychotherapeutic sessions. This was because, according to her,

KI26: “With sessions, [...] the psychologist succeeds in achieving what she or he wants.”

Her words imply that the therapeutic sessions are what the psychologist wanted and is searching to obtain. It is their goal, not necessarily that of the refugee beneficiary. She further continued to give a specific case as an example:

KI28: “We succeeded to convince her to see a psychologist. She didn’t want because she was ashamed. You can quite understand because the mentality is different. This is a lady who is not educated. She grew in a very strict and closed society. On one hand, her only worry was not to remain pregnant and to keep to herself. Finally, we succeeded because she started to see a psychologist in the evening, and she had a four-month baby with her. It was really successful [...]. When we convinced her to go and see a psychologist, it was really a party for us.”

In this example, the words “it was really a party for us” allude to the fact that managing to convince a refugee to see the psychologist was a cause for celebration, a party for the whole team including the cultural mediator herself. As such, it is part of the role of the cultural mediators to convince the refugee population about the “truth” of western psychiatric knowledge and the benefits of seeing a psychologist, as similarly reflected in the words of one cultural mediator who gave another example of such a case:

KI4: “I understand the guy, that he was not having knowledge before and when he get understanding and the peadopsychiatrist explained his problem or his story or his trauma with another way, of explaining, by drawing, by feelings, then he understand that, ‘yeah, this is the truth.’”

There is an implicit acceptance of the “truth” in what says the psychologist, and through an explanatory process, the professionals manage to convince the refugee of this truth as well. we can also note that, despite the apparent alliance with health professionals regarding the “truth”

of western psychiatric knowledge, the words below also underscore the complexity of the position: the sentence “I understand the guy” may indicate the fact that cultural mediators are seeing both the perspective of the refugee and that of the medical doctor. Such an understanding of these different perspectives is not without challenges, and is often a source of responsibility for cultural mediators who, according to Wang (2016), defines their work as a “negotiation process, eased by a third party not exercising the power of decision, whose purpose is to allow the parties concerned to solve a conflict situation or a relationship” (p. 141).

Working with health professionals perceived as “culturally inexperienced”

In negotiating the variety of complex roles, including that of an active co-therapist in alliance with the health professionals, as highlighted above, many also alluded to the challenges of working with health professionals who, according to the cultural mediators, lack a certain cultural proficiency. This was a specific challenge manifesting within the therapeutic triad between refugee beneficiary, health professionals and the cultural mediators who found themselves between the two.

In some cases, the cultural mediators took on a more “experienced” role as a “cultural *passeur*” (Leanza, 2011) in relation to the health professional, who needed to be “taught” by the cultural mediator, in a manner of speaking, of the cultural norms relating to specific refugee populations:

KI4: “For me, as an experience, the psychologist, okay especially the psychologist, I see that they have difficulties to, in communication between the patients. This is, I think, especially for somebody who doesn’t know about the cultural, where does this guy from, what his culture, how he think, how he look at you, how he look at things, of course this is not like as we look, as we think, so, I try to a little bit to give some tips to colleagues that you can use it or you can try some things that will, where he comes from, some words or some things, okay try, that helps the person to feel comfortable and that this guy, he knows about me and my culture and I can trust him, I can be comfortable.”

KI23: “For the psychologist this is a little bit hard, because this culture doesn’t understand psychology.”

KI29: “I saw in my experience life, many psychologists who are not experienced. And she says, she asks the patient, it was too directly, it was too directly. And he was afraid to say correct. But this is my job, this is my job like interpreter. I cannot say other words. For example, you are psychologist and you ask her if she had in her country sexual violence, yeah? You cannot ask her like directly. But you find a way.”

As such, the cultural misunderstandings were perceived as emanating not only from the side of the refugee beneficiary, possibly unused to seeing a psychologist, but also from the health professionals, possibly unused to working with refugee populations:

KI39: “Sometimes there are cultural barriers - not only from the client's side but also from the professional side.”

This discrepancy in cultural knowledge and *savoir-faire* seemed to inverse an expected hierarchy within the power dynamics. It is often the cultural mediators, not the health professionals, who position themselves in the role of the expert:

KI39: *“If a psychologist is trying to help them to understand their problems then [...] some of them culturally is not appropriate to the patients and some of their suggestions. Even describing things in a particular way that is not appropriate. If I just come with this message exactly as it is to the patient then it harms the trust in the therapeutic relationship that wasn't there with. It would decrease the efficiency and quality of the session.”*

Therefore, there appears to be a significant sense of responsibility felt by the cultural mediators to assume the role of “expert” in relation to cultural knowledge of refugee populations. This lead them to assume an active role in facilitating sessions, in mediating between the health professional and the refugee beneficiary, when they felt it was necessary to do so. Thus, mediating between refugees and western medical professionals, psychologist and traumatised patient, it is clear that the role of cultural mediators extend far beyond that of a simple translation. It is a complex task requiring a myriad of subtle negotiations of power. A professional dilemma exists between the fact of wanting more responsibilities in sessions with professionals who are often culturally inexperienced, and on the contrary, refusing this responsibility which is not supposed to be theirs. This research work reveals the complex challenges and tensions surrounding the diagnosis and the implementation of mental health interventions.

Conclusion

As recently quoted by Goguikian Ratcliff and Rossi (2015):

“If the illness is individual, we therefore take into account that the health is collective: the status, the place, and the human experience in regard to health and the illness, the social and institutional response modes are reconfigured in a supply and demand logic, which highly influenced by social and cultural transformations” (p. 8).

By placing human suffering within an exclusively medicalised and trauma-focused paradigm, a thin description of the individual is created where other important socio-historical considerations are easily lost or hidden (Marlowe, 2010). It's an approach which neglects “a concern not to impose order on the world but instead to allow the emergence of other voices and visions, even if this involves increasing complexity and ambivalence” (Bracken et al., 1997, p. 435). As such, a singular construct of P.T.S.D. is simply inadequate to grasp the complexity inherent in how different human beings in different cultures respond to terrifying events (Marlowe, 2010; Steel, 2001; Summerfield, 2001).

Other approaches which take the singularity of the personal experience seriously in a sociocultural context are necessary. This is particularly pertinent given the current influx of asylum seekers into Europe, many of whom have lived through horrors beyond description, indeed beyond words in any language. Here, many humanitarian organisations are engaging in the important work of implementing mental health interventions for communities whose lives have been devastated by a multitude of traumas. Within this context, the role of cultural mediators is an essential one. Indeed, as stated by Summerfield (2005), the challenges they face are “not...of translation between languages but of translation between worlds” (p. 76, as cited

by Nicolas et al., 2015). Within this context, they are active co-therapists, advocates of mental health and experts assisting health professionals to explore the culturally-informed psychic worlds of traumatised refugees.

What further characterizes the position of the cultural mediator is the emotional investment in the relationship on the part of refugees. Working in a neutral and impartial way in this context necessitates taking a detached professional and inter-professional position (in their work in and of itself as well as in the collaboration between health professionals and cultural mediators) which takes into account the substantial emotional impact of the work, rather than denying it. The construction of this position a significant, collective, and ongoing task.

As Carlson (2005) argues, we have known for some time that culture matters when trauma is concerned; however, we need to fine-tune our knowledge of how culture matters in the definition of what is experienced as traumatic as well as the processes through which traumatic events are experienced and either accommodated or not:

“Intercultural trauma treatment is a new field, one whose time has come. It reminds us yet again of the basic values of human encounters, beyond all sophisticated treatment techniques and devices, and it offers us ways for expanding the borders of our profession ...” (Droždek & Wilson, 2007, p. 19).

To ignore these factors runs the risk of ignoring (or worse, denigrating) local support systems, pathologising and stigmatising individuals, and usurping resources from social and structural interventions (Nicolas et al., 2015). This notably calls for a “decolonized” approach to psychology.

CHAPTER EIGHT: Exploring individual trajectories through activity systems

If chapter seven provides a “mapping” of the activity systems wherein refugees act (as asylum seekers, patients...) – this chapter of the thesis aims to explore the trajectories of individual refugees *through* these complex medico-legal structures. This exploration is notably from a **subjective** perspective. Which activities and resources, including symbolic and creative ones, are mobilized? How do individuals creatively resist the various impositions of these institutional structures, maintain a sense of self-coherence and continuity, re-find themselves in a metaphorical manner of speaking? How do they narrate their experiences of potentially traumatic events? How do they maneuver through institutional systems and access the resources needed to continue their activities? How do they interpret or appropriate the activity and discourses of other actors within the system? The chapter further aims to understand what happens when individual refugees’ narrate their experiences of potentially traumatic events in dialogue with other actors within these activity systems and to examine what is accomplished and generated by this narrative activity: self-regulation, understanding and social recognition, manifestation of knowledge, maintenance and exercising of the individual’s agency or power to act.

Briefly put, the focus of the chapter is on the subjective experiences of individuals from a dynamic, temporal perspective. Here, I draw on González Rey’s (2008) definition of subjectivity as a “nonlinear, non- universal, non-deterministic and a context-sensitive process, whose main **subjective configurations** are part of an ongoing process... related, first and foremost, to the way in which the history and current contexts of individuals and social instances turn into symbolical emotional processes” (p. 5). In defining subjectivity, and the processes whereby subjectivity may come about, González Rey draws an interesting connection between subjectivity (on an intra-psychic, individual level) itself, and culture, defined as “a symbolic system within which various human practices and normative systems foster life for the persons who share one particular culture” (2008, p. 182). If, as he continues, subjectivity is the distinctive characteristic of the historical character of individuals, groups, institutions and societies - it logically follows that “the study of subjectivity as human production intrinsically associated with cultural life implies developing concepts capable of understanding the complex subjective units that embody the different subjective trajectories of individuals” (p. 182). According to this theoretical proposition, then, individuals and social functioning are culturally located subjective productions. Subjectivity, then, is the unique configuration of individual meeting social. This is an ever-changing configuration across time.

Studying individual journeys through refugee systems necessitates a consideration of the **temporal** dimensions of this experience. It necessitates a focus on **trajectories**. It necessitates an exploration of individual’s **perezhivanie** of their environment. Veresov (2019), among others, has illustrated the importance “of connecting subjectivity and perezhivanie on both an empirical and a theoretical/methodological level of analysis.” (p. 61). In combining the two concepts of subjectivity and perezhivanie, the analytic focus, he argues, is on the “dynamic

system which is organized by different subjective configurations of different social instances ... enabl[ing] the study of the process of organization of a system of social subjectivity (pg. 78). Indeed, it is perezhivanie, he argues, that might reorganize the subjective configuration of an individual.

A key implication of the concept of **perezhivanie** for exploring refugee experiences of potentially traumatic events is to recognise an individual's unique ability to (re)act to such events. This is because, according to Vygotsky, no particular external factors define individual development, only factors refracted through the prism of perezhivanie (Vygotsky, 1994). This is due to the dialectical process in which "the social subjectivity of which the individual is constituted is also a constituent" (González Rey, 2005, p. 202). It is a unique and complex contradictory process where the individual and their sociocultural environment interrelate to form "a new human production that is part of this world, but it never reproduces it; because the world can only be represented through the lenses of those who experience it" (Fleer et al., 2017). In other words, an individual's subjectivity is not simply "molded by the world 'absorbing' and embodying the world in its dynamics and structures" (Stetsenko & Arievidt, 2004, p. 484). Rather, it is constantly (re) constituted and (re)transformed through perezhivanie.

Rather than passive "receivers" of the environment, slaves to their destiny at the mercy of such events, perezhivanie situates individuals as unique responders:

"an action reflected through the prism of thought has already been transformed into a different action, one that is meaningful, conscious, and consequently free and voluntary; that is, it stands in a different general relationship to the situation from action which is directly conditioned by the situation and which has not gone through the direct and reverse transformation of dynamics" (L. S. Vygotsky, 1998a) (p. 235).

As highlighted by Fleer and colleagues (2017), perezhivanie "relates to a subject, his/her subjectivity as a unique configuration of individual functions being able to master and control direct and reverse transformations of actions and thoughts." (p. 12). The interrelated concepts of perezhivanie and subjectivity may thus be drawn on to analyse how individual refugees navigate and attempt to master the complex new systems in which they find themselves as actors. Perezhivanie shows how subjectivity, or the subjective configuration of the individual, is no less powerful in defining the course of a unique developmental trajectory than the objective characteristics of the environment (Veresov, 2019). Here it must be noted, as Veresov (2019) states, that perezhivanie as a concept is "not an empirically observable phenomenon; it is a theoretical tool for analysis of the influence of social environment on the course of development" (p. 61). As such, it informs the way in which I frame the analysis of individual trajectories, yet the intention is not to identify (or "observe") perezhivanie empirically. What makes perezhivanie a unique phenomenon, and interesting for analysing individual trajectories, is that it allows us to identify which specific aspects/moments of the environment influence the individual, including potentially traumatic events, and at the same time, which personal characteristics of the individual refugee are mobilized and crystallized through perezhivanie in the face of these experiences (Veresov, 2019).

In chapter seven, the entire body of data was analysed to explore activity systems: data collected among not only refugee research participants, but among healthcare professionals, community leaders, cultural mediators ... here, the focus turns to the individual journeys of the ten refugee victims of torture who were followed longitudinally over the course of a year. Rather than a static “snapshot” of activity systems, the focus is on the unfolding of individual trajectories over time.

The first article in this chapter presents the case of Brigitte: a 35-year-old Guinean woman, mother of four children and victim of torture and forced excision. An analysis of her trajectory through the medical activity system (including sessions with her psychologist) highlights how, although she is confronted with multiple and complex ongoing potentially traumatic events, she nevertheless finds the means to summon “creative resources” to not only survive psychically, but to thrive as an engaged, complex and dynamic human being in the world. The second article in this chapter presents the case of Jules: a 45-year Congolese man who was arrested and tortured after engaging in anti-government protests. An analysis of his trajectory through various legal and medical activity systems highlights how imagination in particular is used as a powerful symbolic resource, demonstrating how refugees may “weave together images of the past, present and future to confer meaning to their current situation and imagine new possible futures.” By following Jules’ individual trajectory, the article further serves to track how the emotionality of individual subjective experiences, as well as the sociocultural context, are fundamentally involved in people’s plans to migrate and the development of their ever-changing imagination of, and hope for, a better future elsewhere.

In contrasting the two cases presented in this chapter, we can immediately notice a number of similarities. First among them is the *co-existence* of hope and despair or at least frustration at their current situation in Greece. In the background of this emotional oscillation is, in both cases, an *ambivalence* towards Greece. On the one hand, both express a certain gratitude towards the host society and, on the other, they feel excluded and powerless living within it. “Really here in Greece, I have grown, I get there's many opportunities, you know. In Greece there are many chances, I go to learn, all these things. But it's not easy.” It is especially mundane experiences that surprise and make them feel different and even fearful. Jules recounts how:

“It is the first time in my life that I see, that I entered a bus with many white. It's the first time in my life. It troubled me. I couldn't stand it, really. I feel a little worried that I have entered another race, we don't speak the same language. Even we see that you weren't born to push. You are unable to speak, it was very difficult. You are as always worried. I cannot forget”

Boccagni and Baldassar (2015) have highlighted “the simultaneity of attraction and hope for the better life conditions achievable abroad, alongside the anxiety and distress that meeting these expectations entails” (2015, p. 4). In exploring individual refugee trajectories – their imagination of, and hope for, the future - we see signs of expectations, including towards oneself, and the pressures that come along with it. New possibilities emerge. What look like opportunities can be dead ends, but they at least allow one to imagine and to dream. What the chapter explores, in examining the trajectories of Brigitte and Jules, is the *spaces* of possibility and impossibility created by being in the position of an asylum seeker. The simultaneous

openness to a very different future, in a new country, with many new possibilities, is accompanied by the reality of how difficult it is to be recognised, to integrate, and to act on these apparent possibilities. This leads to ambivalence not only towards Greece, but towards their own situation and emotional life.

One of the key personal, political emotional events for an asylum seeker is certainly having one's case processed and *obtaining the refugee status and a visa*. During this process, Jules states

"I was emotional. Because it's impossible. It can't be done. It can't happen like that. Since they didn't read anything, they only saw the name and gave me a rejection. I went to the computer. I told him to prove to me that they have all the documents I gave. They showed all the documents. I said, but all the documents are here. Even the women – we did it with at least four people. I was alone with the interpreter and the three judges and the lawyer. I said, if it's not okay because of your incompetence, send me to court, it'll be better".

This continuous struggle for recognition leads Jules to feel *stuck* and in an endless state of waiting for things to happen that is emotionally exhausting:

"Yes, I am still in trial. I don't know if someone will answer me after six months or before. If it is six months, it will be in March. If it is before six months – they say they will call me in two months, so September, October, at the latest November. At the latest in November they will call me."

"No, it's getting worse. There is nothing. There's nothing special, it's the same life. You have to go up or back, but you don't go up, you don't go back."

It is the situation of being trapped within one position – of refugee status applicant – and having no mobility out of it: no possibility of going forward (or even backward) and no opportunities to work or build a life in Greece. For both Brigitte and Jules, what is at stake is the future and the possibility of making something of it. They both acutely desire to *move on*. "You have to look to the future" (Jules). However, it is precisely this future of movement that is uncertain. For Jules, being in the position of someone who is being denied compassion and understanding, a formulated future perspective is to help those in a similar situation:

"When I have the money to buy even a piece of land in Africa, I will do everything to build even a one-bedroom house. Having at least ten orphans is over. There, when I am an old man, before I die, I will say something, thank God, I did the thing that you asked me in life. I can die poor, but if I have raised at least ten orphans in my life, I will be happy. That's it."

The position of applicant for refugee status is paradoxical because of its transitional nature – one can either be accepted as a refugee or denied the status and returned home – and, at the same time, its long, indeterminate duration. It is quintessentially the position of someone on the move, yet someone who cannot effectively move anywhere or anything in his or her life. In this context, hope reveals a wide range of opportunities while despair makes them all look impossible or distant. However, things are not again as simple. It is through anxiety and despair that refugees discover the fundamental openness of their existence (Collins & Shubin, 2015). Hope, on the other hand, might not be experienced as empowering by every migrant but potentially frustrating (Collins, 2018). Contrasting emotions are not necessarily confusing; they

help refugees understand their position in the world while, at the same time, enable the imagination of new positions and ignite the movement towards them.

Hope, and the ability to imagine a better future for oneself, is intrinsically related to the ways in which we either position ourselves in the world or are being positioned by others. It colours all of the perspectives or action orientations we develop, and prompts and accompanies changes of physical, social, and symbolic position. Some of these states are possibility-enabling, others possibility-reducing in how they either facilitate or inhibit mobility both geographically as well as between perspectives and positions. What these two case studies show, however, is that the emotional life of refugees facing potentially traumatic events is marked primarily by *ambivalence* and *conflict*. The position of refugee is associated, *at once*, with hope and despair, possibility and impossibility, mobility and immobility.

For both Brigitte and Jules, “possibility enhancing” states related to hope and ability to imagine a better life for themselves were at the foundation of their mobility plans. During such periods, both make plans to continue their journey “ahead over there” towards France, Greece having been considered by both as a temporary stopover on their way to even richer pastures further West. Possibility reducing emotional states, for both, coloured especially by anger and despair, led to these plans being thwarted. *Imagination is seen to be inextricably linked to hope, and to possibility.*

It is important to highlight the concepts of possibility and impossibility into this discussion. They are intimately connected to imagining and hoping for a better future. They ultimately frame the way we feel about and move between positions and perspectives. Acts of repositioning – physical, social and/or symbolic – transform our relation to the world and how we perceive and understand it. New affordances for action can be discovered, new constraints encountered. In the end, movement develops, at all times, slightly different *horizons of possibility (and impossibility)* that are experienced emotionally as rewarding, exciting, painful or frightening. In their study of pre-reflective and affective mobilities, Collins and Shubin (2015) discuss the unexpectedness of migration and the uncertainty about the present felt by English teachers in South Korea. Following Heidegger’s ideas, they stress the fact that anxiety is not only a challenging emotional state – it is one that opens the person up to other possibilities for being in the world. The radical change of position involved by migration and inhabiting a new environment can and does transform how these teachers view themselves and gives them, to some extent, an opportunity to re-invent themselves. These possibilities of “being otherwise” irrupt into normal existence and are intensely experienced. Encountering the unknown can threaten one’s current self-understanding but it also shows that something else might become possible, even as that final destination remains unknown. In the words of the two authors:

“This highlights the value of celebrating ambiguity and excess in mobile lives and challenges the reduction of life events to specific paradigms, which claim to explain and shape how life transitions come about. (...) Indeed, there is a wider need in migration studies to explore the possibility that the time-spaces of migration emerge in ways that do not come from the acts of migrants themselves or the broader systems they are situated within. The Heideggerian approach deployed in this paper offers considerable potential for this task, highlighting the situatedness of migrants and the complex more-than-subjective dimensions of migration while recognising the enduring openness of the world and its possibilities for generating different ways of being and being mobile” (Collins & Shubin, 2015, p. 104).

In focussing on hope, and imagination of a better future, the chapter thus examines the development of individual refugee lives and the ways in which they emotionally dis-connect and re-connect to other people, places, and homes. As noted by Boccagni and Baldassar (2015):

“At all of its ‘stages’, the migration process is characterized by important transformations along the migrants’ life course involving the transmission, reproduction and evolution of emotions in relation to belonging, identity and ‘home’. Indeed, the notion of ‘the migrant condition’ is a reference to the characteristic ambiguities and tensions around emotional connections to ‘here’ and ‘there’” (p. 2).

Through this emphasis, the chapter explores how all acts of migration, independent of what motivates them, present us with ambivalence, uncertainty, and a new sense of what is possible and impossible. Mobility itself open and close spaces of possibility and ways of being in the world. These subjective configurations, associated with a given perspective or relation to the world, contribute to widening or narrowing one’s perception of what is (im)possible. Hope and despair stand out as contrasting examples of this dynamic, with the former raising the possibility of a different future, the latter trapping the person within an unchangeable past and present. Furthermore, it should be noted that all of these emotional states are experienced subjectively by the individual, yet inextricably connected to the sociocultural environment – including social networks and cultural systems wherein the individual is embedded. Indeed, entire communities may collectively experience emotional states connected to mobility. The hopes of an entire village for economic prosperity may rest on the shoulders of one individual migrant. The fear of persecution may restrict movements of entire groups of ethnic minorities. Mixed and contrasting emotions colour Brigitte and Jules’ trajectories, alternating or combining hope and nostalgia, guilt and ambition, affection and disaffection, and the possibility to imagine better futures.

ARTICLE FOUR (French version): Womersley, G., & Kloetzer, L. (2018). Voies de « resubjection » chez les demandeurs d'asile victimes de torture. *Nouvelle Revue de Psychosociologie*, 25(1), 131-146.

Introduction

La torture constitue un cas de figure extraordinaire dans le domaine de la psychopathologie. La particularité de la torture comme pathogène est liée au fait que l'acte lui-même est enseigné, organisé, élaboré et perpétré par des humains contre d'autres humains (Sironi, 1999; Viñar, 2005a). Elle perturbe notre rapport à tout ce qui nous rend humains (Viñar, 2005a). Elle porte atteinte à l'individu dans ses différentes dimensions, y compris le corps, la personnalité, l'espoir, les aspirations à la vie, l'identité, l'intégrité, les systèmes de croyance, le sentiment d'être enraciné et attaché à une famille et à une société, l'autonomie, les relations communautaires et le sentiment de sécurité. Ces effets profonds peuvent interagir et se manifester de façon complexe et diverse, par le biais de la culture, du genre et d'autres facteurs liés au milieu du survivant de la torture, au contexte de la torture et à l'environnement de rétablissement (Patel et al., 2014).

En attaquant l'édifice subjectif et social au fondement de l'être au monde, les actes de torture placent l'événement traumatique « en dehors de toute possibilité d'intégration subjective » (Pestre & Benslama, 2011). Aux traumatismes subis dans le pays d'origine s'ajoutent, dans le cas des exilés, les différentes formes de violence vécues pendant et après la migration (Hodges-Wu & Zajicek-Farber, 2017). Le traumatisme, qui se manifeste en particulier par une rupture du lien social et des processus de signification, associé au processus de migration, risque d'entraîner l'individu dans un cercle vicieux, sans personne à qui s'adresser, sans langage partagé. Isolé, privé d'interlocuteurs, la personne ne parvient pas à développer un récit socialement compréhensible, à inscrire son histoire dans une communauté humaine. Pour les demandeurs d'asile victimes de torture, au traumatisme de départ s'ajoute ainsi les traumatismes potentiels multiples de l'exil, l'errance, la précarité et la vulnérabilité qui diminuent les défenses psychiques. Ce parcours risque de contribuer à l'effondrement du sujet, surtout s'il ne parvient pas à mobiliser des ressources intersubjectives, souvent minées par la peur. Sans possibilité d'identification avec l'autre, sans inscription dans le monde social, la subjectivité ne peut se construire (Pestre, 2015). Être sujet, c'est non seulement être en relation avec d'autres sujets, mais aussi être partie prenante d'une aventure collective qui nous définit en tant qu'être humain.

Mais qu'entendons-nous par « traumatisme » ? En sus d'une compréhension clinique normalisée du traumatisme, il existe une multitude d'études qui montrent que le patrimoine socioculturel et linguistique influence ce que l'on interprète comme traumatisant, les manifestations et les expressions de la symptomatologie post-traumatique, l'interprétation des symptômes, les témoignages de souffrance ainsi que les méthodes de guérison appropriées à une culture (Janoff-Bulman, 1985; Kirmayer et al., 2010; Kleinman & Good, 2004; Luno et al., 2013; Marsella, 2010). De nombreux chercheurs soutiennent que la localisation du traumatisme

au niveau de l'individu - sous la forme d'un diagnostic de Syndrome de Stress Post-Traumatique (S.S.P.T.) - néglige le contexte sociopolitique et culturel plus vaste dans lequel il se produit (Marsella, 2010; Summerfield, 2001; Young, 1995). Du point de vue de la clinique de l'exil, ceci implique une confrontation potentiellement difficile aux normes du pays d'accueil, et peut créer ainsi un « double écart » (Métraux, 2008) - dans la façon dont le traumatisme au sein de cette population est perçu, nommé, étiqueté par les différents acteurs lors de leurs activités de prise en charge des migrants. Nous suivons d'Halluin et al. (d'Halluin, 2004), qui proposent une analyse critique du S.S.P.T.:

« singularisant les situations, psychologisant l'événement, l'émergence de ce registre de dénonciation s'inscrit dans une perspective plus large de reconfiguration du politique où la psychologie et la psychiatrie fournissent un langage culturellement acceptable pour dire les rapports de domination dans notre société et où la compassion devient le registre privilégié d'expression de la solidarité » (p. 73).

Les conséquences liées à l'imposition de telles mesures par un diagnostic S.S.P.T. ne sont ni politiquement ou socialement neutres, ni sans conséquences sur la santé mentale de l'individu (d'Halluin, 2009; Gard, 2015). Comme le dit Pestre (2010): « certains sujets traumatisés se moulent dans cette posture de victime, statut que leur donne la société ou que certains captent dans le social » (p. 259).

Une vision réductionniste du traumatisme, inhérente à un diagnostic psychiatrique classique, risque donc d'individualiser et de médicaliser le problème en concentrant l'attention sur les résultats thérapeutiques, plutôt que sur une réponse stratégique aux problèmes structurels qui ont mené au traumatisme (Pratt et al., 2015). Elle risque de nous conduire à ignorer d'autres aspects permanents de la violence interpersonnelle, politique et sociale à l'échelle mondiale, y compris des facteurs post-migratoires importants, tels que les réalités sociales, politiques et économiques actuelles et les expériences quotidiennes vécues dans les pays d'accueil - autant de facteurs qui peuvent être considérés comme étant tout aussi traumatisants par les réfugiés (Maier & Straub, 2011; Silove et al., 1998; Silove et al., 2000).

Compte tenu de ces nombreuses critiques entourant l'utilisation du diagnostic S.S.P.T. chez les populations de réfugiés, nous cherchons à porter un regard critique sur la «psychiatisation» et l'isolement du psychique par rapport au contexte socioculturel (Goulart, 2017; Goulart & González Rey, 2016), en plaidant plutôt pour une vision ontologique non réductrice de la nature humaine comme enracinée dans des pratiques sociales concrètes (Stetsenko & Arievitch, 2004), et où l'expérience humaine subjective est inévitablement liée à la réalité extérieure (Vasilyuk, 1984).

Une lecture en psychologie historico-culturelle du traumatisme (Womersley & Kloetzer, 2018c) nous invite donc à envisager les expériences traumatisantes comme ancrées dans des contextes socioculturels et intrinsèquement imbriquées avec ces derniers (Stetsenko & Arievitch, 2004). Dans ce contexte socioculturel, comment les sujets négocient-ils les complexités d'une (re)construction de soi et la poursuite de leurs projets dans un environnement institutionnel complexe et parfois hostile, en tant que sujets administratifs et patients en particulier ? Comme le demandent Almudever et Dupuy (2016) : « au prix de quels renoncements, de quels "oublis",

de quels travestissements aussi, résoudre une multiplicité – une dispersion ? Une incohérence ? – qui nous fait courir le risque de n’être "rien", de n’être "personne" ? » (p. 7). Afin d’explorer le processus de « resubjectivation » - conçu par Cahn (2004) comme le processus permettant l’émergence d’un soi créatif et autonome - nous présenterons des analyses d’un cas représentatif venant d’une étude longitudinale réalisée à Athènes dans un centre pour demandeurs d’asile victimes de torture. Ici, le notion de créativité est considérée dans un sens Winnicottien (1988), comme une fonction vitale, une jouissance du sentiment d’exister. Comme le décrit de Rivoyre (2016), « pour être créatrice, une personne doit exister et avoir le sentiment d’exister, non de manière consciente, mais comme une base qui lui permet d’agir. La créativité est alors un faire qui est issu d’un être » (p. 43).

Méthodologie

Nous nous inscrivons dans une démarche de recherche collaborative, c’est-à-dire que l’objet de la recherche, ses objectifs et enjeux, son déroulement et ses méthodes, ainsi que les questions relatives à l’exploitation de ses résultats, ont été discutés, négociés et établis en collaboration avec les partenaires de terrains que sont ici les professionnels de santé de l’ONG avec laquelle nous avons travaillé et les bénéficiaires concernées. La recherche s’est déroulée sur un an (de juillet 2016 à août 2017). Elle a impliqué un travail en collaboration étroite avec les intervenants médicaux de l’ONG (médecins, psychiatres, psychologues), des demandeurs d’asile volontaires, et différents autres acteurs sociaux (notamment médiateurs culturels et représentants communautaires). Pendant la recherche, le premier auteur a effectué trois séjours longs à Athènes, pour effectuer des observations longues au sein de l’ONG (trois mois), pendant lesquelles elle a également animé des ateliers avec les bénéficiaires (ateliers d’anglais et séances de psychoéducation), et réalisé des entretiens individuels semi-directifs répétés avec 10 personnes en situation d’exil - tous victimes de torture dans leurs pays d’origine respectifs et diagnostiqués comme ayant des « troubles mentaux », ainsi que des entretiens avec 31 professionnels du centre, 7 médiateurs culturels, et 21 représentants communautaires ou dirigeants d’associations. Ces derniers entretiens visaient à explorer la manière dont les espaces collectifs sont utilisés pour reconstituer les liens sociaux.

Le premier auteur s’est présenté comme une chercheuse et une clinicienne, mais également comme une participante active dans la communauté. Bien que participante, elle était à plusieurs égards une tierce partie détachée. D’autres aspects de son identité étaient également présents, devenant plus ou moins signifiants lors des échanges. Sa nationalité sud-africaine a fait l’objet de réflexions et discussions avec les personnes d’origine africaine, parfois décrite comme « une sœur africaine » ou « une des nôtres ». Cependant, contrairement au reste des « nôtres », blanche de peau, elle n’est pas soumise aux mêmes manifestations dégradantes ou humiliantes de racisme. Contrairement à eux, elle est « légitimée » dans son droit légal d’être là, de passer inaperçue dans les rues, de circuler librement en Europe. Elle est dans la position privilégiée d’une professionnelle – elle a le droit d’observer, de diriger, d’interroger, de poser des questions. Comme exploré par ailleurs dans notre réflexion sur le travail avec les survivantes sud-africaines de viols (Womersley, Maw, & Swartz, 2011), ces traits communs et différents entre

les marques d'identité, exprimées à travers nos corps et nos attitudes, sont un élément fondamental de l'interaction dans le contexte d'entretiens qualitatifs.

Du point de vue de l'analyse des données, nous adoptons une approche dialogique de Bakhtine (Bakhtine, 1978, 1981, 1986), pour qui dans tout discours se joue un dialogue interne entre soi et autrui, entre le discours propre et le discours d'autrui :

« Dans le champ de quasiment chaque énoncé a lieu une interaction tendue, un conflit entre sa parole à soi et celle de "l'autre", un processus de délimitation ou d'éclairage dialogique mutuel » (Bakhtine, 1978).

Cette relation à d'autres discours – antérieurs et à venir – détermine profondément la nature de l'énoncé. Celui-ci est doublement orienté : on lui répond (par exemple en opposition), il est repris ou reformulé (des mots de l'autre, de ses thèmes, du contenu de son discours), par rapport à des discours déjà tenus et il prépare, anticipe la réponse qu'il peut susciter (Salazar-Orvig & Grossen, 2008). Bakhtine a insisté sur le fait que l'individu deviens lui-même par la reconnaissance de l'autre, à travers l'autre et avec l'aide de l'autre. Cette définition présuppose l'interdépendance entre l'Ego et l'Alter (Marková, 2006), et souligne comment les différentes formes d'Alter représentées de façon symbolique et sociales, et qui sont dans un dialogue intérieur avec l'Ego (Marková, 2016).

Notre analyse dialogique a donc été un processus à trois volets, qui a permis de suivre:

- 1) La « polyphonie » (Bakhtine, 1978, 1981, 1986) des voix, rapportées indirectement et directement par les participants, et la façon dont elles ont été organisées, contestées et adoptées.
- 2) Les ressources créatives puisées dans le champ culturel-symbolique de l'individu pour conduire son projet migratoire, donner un sens aux expériences traumatisantes du passé et à celles du moment, et se redéfinir, se repositionner par rapport à l'avenir. L'autre pouvant être, dans ce cadre dialogique, une ressource créative pour le sujet dans son processus de resubjectivation, en tant qu'individus interprétants, ou par appropriation de leur activité et de leurs discours.
- 3) L'activité des participants au fil du temps alors qu'ils évoluent dans les systèmes institutionnels afin d'accéder aux ressources nécessaires pour poursuivre leurs projets.

Notre analyse dialogique se centre sur les questions suivantes : quelles activités et quelles ressources, notamment symboliques et créatives, ces personnes en situation d'exil mobilisent-elles pour réinjecter de la vie et du lien, là où prévaut le mortifère et la déliaison ? Comment résistent-elles de manière créative aux processus de désubjectivation, afin de maintenir une continuité et une cohérence dans le sentiment de soi ? Comment manœuvrent-elles dans les systèmes institutionnels et accèdent-elles aux ressources nécessaires pour poursuivre leurs activités ? Comment interprètent-elles ou s'approprient-elles l'activité et les discours des autres acteurs sociaux à leur égard, pour penser leur situation et tenter de vivre ?

Résultats

Dans le centre où notre recherche a été menée, aucun bénéficiaire n'avait vu un psychologue avant d'être pris en charge. La moitié n'avait même jamais entendu parler de l'existence de cette profession. Sur les dix personnes que nous avons suivies au cours de ces douze mois, toutes ont été diagnostiquées avec une certaine forme de « troubles mentaux » - notamment le S.S.P.T. Au fil de nos entretiens, pas un seul n'a mentionné le diagnostic en faisant référence à ses expériences subjectives de souffrance psychologique. Ils ont plutôt puisé dans une myriade de « ressources créatives » pour appréhender leur traumatisme – et plus largement leur situation. Une analyse plus poussée d'un cas particulier nous permettra de mettre en évidence le processus de resubjectivation et le potentiel transformatif des ressources créatives pour l'individu.

Le cas de Brigitte

Brigitte est une femme guinéenne de 35 ans, mère de quatre enfants et victime de torture et d'excision forcée. Le premier auteur, en tant que chercheuse, a pu s'entretenir avec elle à cinq reprises au cours de ces douze mois. Une analyse fine du parcours de Brigitte au cours de cette année, tel qu'il se donne à voir dans le texte de ses entretiens, nous a amenées à identifier quatre phases dans son processus de « resubjectivation » depuis son arrivée à Athènes.

La première est une phase pendant laquelle Brigitte, qui fait face à des peurs et culpabilités multiples, parvient à reconquérir un peu de contrôle sur sa propre psyché, ses émotions et son activité mentale. Dans cette phase, Brigitte agit avant tout *sur elle-même* en mobilisant des ressources que nous présenterons ci-dessous. La deuxième est une phase dans laquelle Brigitte passe d'un défaut d'inscription dans son environnement physique, qui se traduit par son retrait de la vie publique et le fait de rester dans son appartement, à une reconquête partielle de son autonomie dans la cité. En ses termes, sa vie qui « était comme un vide » s'inscrit désormais dans son environnement social et spatial : « *Je trouve que je suis là, déjà* ». La troisième phase est marquée par le refus de sa demande d'asile, qui affecte profondément Brigitte : « *J'étais déboussolée* » nous confie-t-elle, mais surtout, par sa construction d'une stratégie de réponse, sous la forme d'un recours, toujours en mobilisant créativement des ressources, cette fois-ci de son environnement. Enfin, dans la quatrième phase, Brigitte cherche à se construire un futur : « *Petit à petit, dit-elle, j'essaye de laisser ça derrière moi* ».

Agir sur soi : mobilisation créative de deux ressources hétérogènes, Dieu et son psychologue

La première entrevue a lieu en août 2016, quelques mois après son arrivée en Grèce. A l'invitation de la chercheuse, Brigitte décrit son cheminement. Dans cet échange, ses

convictions chrétiennes sont mobilisées comme une ressource argumentative pour appuyer son refus de l'excision :

« Je n'ai jamais voulu faire [l'excision], c'est contre la vie, parce que je suis chrétienne [...] Moi, je dis que je ne peux pas faire ça. Quand je médite la Bible, je ne vois pas, je ne vois nulle part ailleurs qu'une femme devrait s'exciser, je ne vois pas »

On note avec intérêt la présence forte de sa propre voix, qui émerge dès le début de la rencontre. Cette voix personnelle mobilise des ressources culturelles, ici religieuses, comme la Bible, pour affirmer son identité et sa liberté de choix en tant que femme chrétienne face à ces conflits.

Malgré tout, l'entretien est marqué par la mention d'émotions négatives, de peurs et culpabilités multiples, qui renvoient tout autant à ce qu'elle a subi dans son pays d'origine, qu'à ce qu'elle a vécu durant son voyage migratoire :

« Le passé, ça t'effraie toujours. Bien que tu es sortie de là mais tu te dis que recommencer encore, quand tu revis ça, ça te donne une grande peur en toi [...] J'aurais pu mourir, je ne suis pas mieux que ceux qui sont restés, oui je ne suis pas plus mieux que ceux-là qui sont restés dans l'eau. C'est pourquoi, c'est la grâce de Dieu seulement [...] Moi, je dis merci à Dieu, je suis sortie de là saine et sauve »

Une fois de plus, Brigitte fait appel à des concepts et sentiments religieux pour faire sens du fait qu'elle a survécu, alors qu'elle n'était pas « meilleure » que ceux qui sont morts, ce qui est parfois décrit comme « la culpabilité du survivant » (Juni, 2016): la « grâce de Dieu », articulé à son propre sentiment de gratitude pour cette vie préservée, lui fournissent des ressources culturelles pour agir sur ses émotions négatives, les tenir sous contrôle, et commencer à les transformer (ici, de la culpabilité à la gratitude). Dans cette première phase, le registre du religieux est mobilisé de façon créative, c'est-à-dire pour poursuivre ses propres projets vitaux, et ici avant tout pour agir sur elle-même. Cette tentative de garder (ou reprendre) la main sur sa psyché n'est pas toujours un succès, et Brigitte évoque la constante intrusion de la peur dans ses pensées : « *le passé, ça t'effraie toujours* ». Elle décrit :

« La peur de tout, la peur de la vie en fait, parce que moi je dis comme ça toujours que, si tu ne prends pas les décisions, je n'allais pas quitter mon pays, et cette frayeur de faire cette pratique-là m'a enlevé la peur aussi. J'ai laissé mes enfants derrière moi - qu'est-ce qu'ils vont devenir ? Qu'est-ce qu'ils sont là-bas ? Comment est-ce qu'ils vivent ? Comment est-ce qu'ils mangent ? Comment est-ce qu'ils dorment ? Cette peur est développée en moi par moment ça me fatigue, j'ai même dit ça à mon psychologue, j'ai une peur que je ne sais pas comment expliquer ; cette peur que je veux ça me quitte »

Ici, il y a peu de mots (« je ne sais pas comment expliquer ») pour relier le passé au présent, et l'ici et l'ailleurs se confondent. La question de l'abandon de ses enfants habite fortement cet échange. Dans d'autres extraits, on comprend que le regard de Brigitte sur cette situation est nourri par le regard, exprimé ou supposé, de ses autres interlocuteurs, notamment celui des mères grecques, qui risqueraient de la condamner comme mauvaise mère – un jugement qui renvoie aux relations parentales dans un univers culturel différent. Dans le contre-transfert, la chercheuse manifeste une volonté de la rassurer sur son comportement de non-jugement. Dans cet extrait, le psychologue (ou plutôt *son* psychologue) apparaît comme une autre ressource créativement mobilisée pour faire face à la peur.

La créativité de Brigitte se manifeste ici doublement : d'une part, Brigitte sélectionne dans les ressources culturelles et sociales à sa disposition des éléments (Dieu et son psychologue) qu'elle utilise de façon singulière pour faire face à ses peurs et agir sur ses sentiments. D'autre part, elle les combine et élabore par elle-même leurs tensions et conflictualités, les deux registres d'explication et de soutien du religieux et de la psychothérapie d'inspiration psychanalytique n'étant pas d'emblée nécessairement compatibles, comme nous le verrons ci-dessous.

Agir sur son environnement proximal : reconquérir Athènes comme espace de vie

Au cours des semaines qui suivirent, Brigitte rapporta que ses craintes avaient commencé à diminuer : « Ce n'est pas que j'ai maîtrisé cette peur, mais je priais dans mon cœur, je demandais à Dieu seulement ». La peur n'a pas disparu, mais elle est « maîtrisée », et ne paralyse plus l'action. S'ouvre alors un processus de subjectivation un peu différent, qui prend cette fois-ci son environnement proximal comme objet. Les angoisses de son passé, liées à la fois aux traumatismes vécus dans son pays d'origine et lors de son voyage migratoire, se mélangent à un « sentiment de vide » au quotidien :

« Si on quitte son pays pour venir vivre dans un autre pays que tu ne connais pas, la mentalité des gens et tout ça, c'est comme un vide. Tu es là, tu ne sais pas où aller »

Comme l'observe Pestre et Benslama (2011), chez les réfugiés : « cette suspension psychique et territoriale a souvent largement immobilisé leur capacité de devenir propre, déterminant leur trajectoire de vie » (p. 20). Dans l'espace psychique gagné sur ses propres émotions et pensées, peut se déployer un processus de ré-ouverture, de ré-adaptation, qui se manifeste par la capacité de Brigitte à quitter sa maison pour se déplacer dans la cité :

« Les jours passés, j'ai ma tête, trop de réflexion, toujours, toujours, mais maintenant ça va. J'essaie d'éviter aussi, d'oublier ces choses, de vivre, qu'est-ce que je peux faire ? [Rires] je n'avais pas de joie. Je commence à me réadapter. Avant j'étais trop renfermée, je ne parlais pas, en train de réfléchir tous les jours. À un moment, je dois m'y faire, parce que qu'est-ce que je peux faire d'autre ? Il faut accepter et faire avec. (...) On m'a dit que je pouvais en parler un peu avec le psychologue [...] On me dit que c'est le stress, trop de stress. C'est ce qui arrive souvent, je n'ai rien, mais si je ne veux pas faire avec, ça ne va pas aller avec moi, je dois accepter ma nouvelle vie, je dois laisser toutes ces choses derrière moi et vivre »

Le « on » demeure confus au fil des rencontres, faisant sans doute écho aux discours portés par des figures de la communauté des migrants africains avec laquelle elle commence à être en contact. La voix de son psychologue paraît de plus en plus proche, une voix qu'elle semble sur le point d'installer dans son discours intérieur, pour l'aider à accepter sa nouvelle vie et « vivre ». Durant cette période, elle se penche avec son psychologue sur le sens de ses cauchemars : « Le psychologue m'a dit que les cauchemars sont liés au passé. » Pendant les semaines qui suivent, elle internalise petit à petit cette nouvelle lecture de sa situation :

« Moi, je lui ai dit que c'était spirituel mais après, quand il a parlé, je me suis dit, je ne sais pas, mais c'est aussi fort probable que ce soit lié à ce que je pense dans ma tête [...] Je me suis dit, c'est fort probable aussi que ce soit la vérité. Parce que, peut-être que dans ma tête, je me culpabilise beaucoup,

c'est vrai. Bien que j'écoute la parole, on dirait que j'ai fait quelque chose que je ne me pardonne pas moi-même. Mais Christ m'a déjà pardonné »

Plusieurs ressources créatives sont ainsi déployées pour attribuer une signification à ses cauchemars - issus des croyances traditionnelles africaines de son village, de ses croyances chrétiennes issues de sa nouvelle église à Athènes et des réponses du psychologue, reliées à la tradition psychothérapeutique occidentale d'inspiration psychanalytique. Le psychologue est mis à contribution pour élaborer son expérience à travers une traduction dans un autre langage de cette dernière - comme le décrivent Pestre et Benslama (2011) : « pour recourir à la consolidation et/ou à la construction d'une passerelle fiable, elle dispose d'un support : un autre humain est là, qui lui délivre l'hospitalité par la langue » (p. 25). Nous pourrions faire l'hypothèse que l'intégration de nouvelles perspectives sur ses sentiments de culpabilité et de peur a permis une réorganisation psychique interne qui lui a permis de se tourner vers son nouvel environnement social et spatial :

« Il y a un changement. Ça va. Ça va, parce que je trouve que je suis là, déjà. Je suis déjà là »

Elle commence à moins évoquer le passé, et de plus en plus sa situation actuelle. Elle se sent « ici ». Au début, les seules voix qui sont apparues étaient celles de Dieu, de sa communauté et de son psychologue. Au cours des semaines suivantes, de nouvelles voix se font peu à peu entendre. Elle commence à parler des autres membres de la communauté migrante d'Athènes:

« Je ne suis pas la seule dans cette situation. Nous sommes nombreux »

Elle fait appel aux différentes ressources de la communauté, y compris les voisins et les membres de son Eglise, pour commencer à partager son expérience en tant que migrante nouvellement arrivée à Athènes. Cela semble lui donner une nouvelle capacité d'agir par rapport à un milieu d'accueil hostile :

« Je vois la vie autrement. La vie n'est pas comme ce que je pensais ».

Soutenue par les autres migrants, les croyants de sa paroisse, et toujours son psychologue, Brigitte passe de plus en plus de temps à se déplacer dans la ville : *« Je découvre Athènes de plus en plus ».*

Agir à partir de son environnement proximal sur son environnement distant : la construction d'un recours

Toutefois, en mars 2017, sa demande d'asile est refusée. Cette décision administrative l'affecte profondément :

« J'étais déboussolée quand j'avais appris qu'on m'a donné le papier de refus de l'asile, j'avais seulement deux mois et quand on m'avait donné le papier le refus de l'asile, ça m'avait affectée beaucoup, ça m'avait affectée beaucoup. J'ai passé tout mon temps à pleurer même je prends toujours les médicaments parce que j'étais malade »

Pour elle, c'est une « confirmation de son existence » (Pestre, 2010) qui est refusée, nouvelle qui la dévaste. Une certaine « fragmentation » (Pestre, 2010) se manifeste par des symptômes psychosomatiques tels que des douleurs à l'estomac. Elle se présente aux services médicaux d'urgence - négociant son accès aux soins avec une efficacité impressionnante dans un milieu hospitalier complexe.

Pourtant, les ressources construites dans la phase précédente (notamment un réseau social mixte lié à la paroisse, qui la met en contact avec les milieux associatifs grecs qui viennent en aide aux réfugiés, ainsi que les professionnels de santé liés en particulier au programme de soins auquel elle participe en tant que victime reconnue de la torture) lui permettent de se mobiliser afin de résister à cette décision légale. Au cours de cette période, elle fait ainsi appel aux membres de la communauté de son église africaine pour avoir accès à un avocat qui l'aidera à négocier sa demande d'asile, ainsi qu'à un travailleur social ce qui lui permettra ensuite de trouver un logement permanent. Ce réseau lui fournit des conseils, et des connaissances, pour naviguer dans les complexes systèmes bureaucratiques grecs. Elle retrouve ainsi petit à petit une capacité d'agir dans le champ légal. Avec l'aide de son avocat et travailleur social, elle fait appel de la décision et reçoit une nouvelle date pour comparaître devant le tribunal, lui donnant un nouvel espoir :

« Quand on m'avait donné les papiers pour dire que je pouvais rester. Ça m'a donné de l'espoir [...] donc ça m'a donné de l'espoir j'ai dit merci seigneur parce que c'est Dieu qui fait toute chose »

Construire un futur

La quatrième phase se caractérise par une réorientation et par une stabilisation au niveau émotionnel. En juillet 2017, elle témoigne que :

« Je réfléchis autrement, puisque je suis là [...] Au début ça n'a pas été facile, mais petit à petit, j'essaye de laisser ça derrière moi. Petit à petit, avec tes amis. Le fait de parler aussi ça fait du bien, ça fait oublier »

En mobilisant et articulant des ressources hétérogènes qui deviennent créatives dans la mesure où elle lui permette de retrouver un pouvoir d'agir sur elle-même et sur son environnement, et en trouvant les paroles nécessaires, Brigitte a essayé de « laisser derrière » elle les événements traumatisants auxquels elle a été exposée. Dans cette quatrième phase, elle se sent prête à s'engager dans son nouveau milieu, professionnellement et socialement, témoignant ainsi de sa volonté de participer activement à sa nouvelle vie à Athènes. Le travail et la maîtrise de la langue grecque sont perçues désormais comme les ressources qui lui permettront de mener ses projets à bien. La recherche d'un travail et l'apprentissage de la langue sont alors l'objet principal de ses soins. Lors de notre dernière entrevue, Brigitte concluait en déclarant de façon émouvante :

« Il faut se battre dans la vie. Faut prendre les études au sérieux. Pour réussir, il faut beaucoup, beaucoup travailler. C'est important »

Discussion

Cette étude de cas, basée sur des entretiens répétés sur une période d'un an avec Brigitte, montre combien l'activité créative des demandeurs d'asile peut passer inaperçue. Elle s'exerce en effet sur des objets qui sont en partie invisibles (comme sa propre psyché, la maîtrise de ses pensées et émotions) ou considérés comme évidents par d'autres membres de la communauté humaine, moins affectés : par exemple, le fait de parvenir à habiter à Athènes, à habiter vraiment, c'est-à-dire non seulement à occuper corporellement un espace dans la ville, mais à pouvoir s'y déplacer, y rencontrer d'autres humains, y construire ses repères et habitudes, est le fruit d'une activité intense, quoique sous-estimée, des demandeurs d'asile.

Elle montre par ailleurs que le processus de resubjectivation prend, à travers le temps, des objets différents : de soi-même à l'environnement proximal, social et géographique, puis peu à peu à un environnement social plus distant, par exemple légal. Quand il fonctionne, il permet aux demandeurs d'asile de garder le contrôle d'abord sur leurs propres émotions et pensées, puis sur leur situation, notamment sociale, matérielle et légale.

Elle montre enfin que l'activité de resubjectivation des demandeurs d'asile s'appuie sur des ressources hétérogènes, culturelles (et ici notamment religieuses), sociales (le psychologue, les membres de la communauté africaine d'Athènes, les membres de sa paroisse, les associations d'aides aux réfugiés...), qu'elle sélectionne et articule de façon créative.

C'est cet alliage de « ressources créatives » qui permis à Brigitte de contrôler sa peur, de se trouver « là », capable d'affronter une nouvelle ville, puis un nouveau système social, légal et médical complexe.

S'intéresser à la santé mentale des réfugiés, alors, signifie prendre acte de la construction sociale de la catégorie de S.S.P.T., de sa dimension administrative qui implique des droits et une prise en charge spécifique (d'Halluin, 2009). En ce sens, la distinction entre une souffrance « normale » et une souffrance « pathologique » a une portée politique ; la souffrance est indiscutablement « psychique » du point de vue du sujet, mais elle peut aussi bien être qualifiée comme socialement ou politiquement construite par « le contexte institutionnel où elle émerge, ainsi que par ses déterminants » (Périlleux, 2014). Le cadre clinique devrait être un espace qui facilite un processus de « resubjectivation » (Pestre & Benslama, 2011), afin que le sujet puisse « récupérer sa capacité de pensée et quelque chose d'une envie de vivre » (p. 26).

Conclusion

L'analyse de la trajectoire de Brigitte montre que bien que confrontée à des traumatismes multiples et complexes, ainsi qu'à une grande incertitude dans sa société d'accueil jusqu'au refus de sa demande d'asile, elle trouve malgré tout le moyen de convoquer des « ressources créatives » pour contrer ces adversités, pour contrer les voix intérieures de la peur et de la honte,

afin de poursuivre son projet vital. Comme elle, de nombreuses personnes qui fréquentent la clinique avec laquelle nous avons travaillé ne sont pas seulement des victimes mais des sujets actifs et créatifs. Ils apparaissent fragmentés par les tortures subies dans leur pays d'origine ainsi que par la « déconstruction psychique directement liée à l'institutionnalisation de son être dénué d'identité politique » (Pestre, 2010). Cependant, les individus rencontrés, confrontés à des situations extrêmes, ont démontré des capacités psychiques parfois inattendues. Comme le constate Roisin (2000) « si nous en connaissons qu'un traumatisme a jetés dans la passivité, nous avons tous pu constater que le passage par le trauma a marqué chez d'autres un renouveau dans leur vie » (p. 5). Beaucoup ont trouvé des « ressources créatives » afin de résister, de s'adapter, de négocier, en somme de « s'en sortir » – il s'agit de voies de resubjectivation essentielles pour retrouver le chemin de l'existence et d'une vie supportable.

ARTICLE FOUR (English version): Womersley, G., & Kloetzer, L. (2018). Voies de « resubjection » chez les demandeurs d'asile victimes de torture. *Nouvelle Revue de Psychosociologie*, 25(1), 131-146.

Introduction

Torture is an extraordinary case in the field of psychopathology. The peculiarity of torture as a pathogen is due to the fact that the act itself is taught, organized, elaborated and perpetrated by human beings against other human beings (Sironi, 1999, Viñar, 2005). It disrupts our link to everything that makes us human (Viñar, 2005). It destroys the individual in its different dimensions, including the body, personality, hope, life aspirations, identity, integrity, belief systems, the feeling of being rooted and attached to a family and a society, autonomy, community relations and sense of security. These profound effects can interact and manifest in a complex and diverse way, through culture, gender and other factors related to the survivor's environment of torture, the context of torture and the recovery environment (Patel, Kellezi, & Williams, 2014).

By attacking the subjective and social edifice of the human being in the world at its foundation, acts of torture place the traumatic event "outside any possibility of subjective integration" (Pestre & Benslama, 2011). In the case of exiles, there are the different forms of violence experienced during and after migration, in addition to the trauma experienced in the country of origin (Hodges-Wu & Zajicek-Farber, 2017). Trauma, which particularly manifests itself by a break in the social bond and processes of meaning associated with the migration process, risks leading the individual into a vicious circle, with no one to turn to and without a shared language. Isolated, with no one to talk to, the person fails to develop a socially understandable narrative and register his or her story within a human community. For asylum seekers who are victims of torture, the initial trauma is compounded by the potential multiple traumas of exile, wandering, precariousness and vulnerability that diminish mental defenses. This route risks contributing to the collapse of the subject, especially if he or she fails to mobilize intersubjective resources, often plagued by fear. Subjectivity cannot be built without possibility of identification with the other, without recognition in the social world (Pestre, 2015). To be a subject is not only to be in touch with other subjects, but also to be part of a collective adventure that defines us as a human being.

What do we mean by "trauma"? In addition to a standardized clinical understanding of trauma, there is a multitude of studies that show that socio-cultural and linguistic heritage influences what is interpreted as traumatic, manifestations and expressions of post-traumatic symptomatology, interpretation of symptoms, evidence of suffering, and culturally appropriate healing methods (Janoff-Bulman, 1985; Kirmayer, Kienzler, Afana, & Pedersen, 2010; Kleinman & Good, 2004; Luno, Beck, & Louwerse, 2013; Marsella, 2010). Many researchers argue that the localization of trauma at the individual level - in the form of a diagnosis of Post Traumatic Stress Syndrome (P.T.S.D.) - neglects the broader sociopolitical and cultural context

in which it occurs (Marsella 2010, Summerfield 2001, Young 1995). From the perspective of the asylum seeker, this implies a potentially difficult confrontation with the standards of the host country and can create a "double gap" (Métraux, 2008) - in the way the trauma is perceived, named, or labeled by the different actors in their activities of caring for migrants in this population. d'Halluin et al. (d'Halluin, Latté, Fassin, & Rechtman, 2004), for example, offer a critical analysis of P.T.S.D. in this context:

"singling out situations, psychologizing the event, the emergence of this register of denunciation is part of a broader perspective of political reconfiguration, where psychology and psychiatry provide a culturally acceptable language for the relations of domination in our society, and where compassion becomes the privileged way of expression of solidarity" (p.73).

The consequences of imposing such measures through a P.T.S.D. diagnosis are neither politically or socially neutral, nor without consequences on the mental health of the individual (d'Halluin, 2009; Gard, 2015). As Pestre (2010) notes: "some traumatised subjects mold themselves in this victim posture, a status given by society or that some capture in the society" (p. 259).

A reductionist vision of trauma, inherent in a classic psychiatric diagnosis, thus risks individualizing and medicalizing the problem by focusing attention on therapeutic outcomes, rather than a strategic response to the structural problems that led to the trauma (Pratt, Johnston, & Banta, 2015). It may lead us to ignore other permanent aspects of global interpersonal, political and social violence; including important post-migration factors; such as current social, political and economic realities and the daily experiences lived in the host countries - many factors that can be considered equally traumatic by refugees (Maier & Straub, 2011; Silove, Steel, McGorry, & Mohan, 1998; Silove, Steel, & Watters, 2000).

Given the many criticisms surrounding the use of P.T.S.D. diagnosis among refugee populations, we seek to critically analyze the "psychiatrization" and the isolation of the psychic from the sociocultural context (Goulart, 2017; Goulart & González Rey, 2016), and instead, arguing for a non-reductive ontological vision of human nature as rooted in concrete social practices (Stetsenko & Arievitch, 2004), and where subjective human experience is inevitably linked to external reality (Vasilyuk, 1984). Understanding trauma from the perspective of sociocultural psychology (Womersley & Kloetzer, 2018a) invites us to consider traumatic experiences as rooted in sociocultural contexts and intrinsically interwoven with them (Stetsenko & Arievitch, 2004). In this socio-cultural context, as administrative subjects and patients particularly, how do the subjects negotiate the complexities of self-(re)construction and the pursuit of their projects in a complex and sometimes hostile institutional environment? As Almudever and Dupuy (2016) ask: "At the price of what renunciations, what 'forgetfulness' and what disguises, to solve a multiplicity - a dispersion? An inconsistency? - which makes us risk being 'nothing', being 'nobody'?" (p. 7). To explore the process of "resubjectification" - conceived by Cahn (2004) as the process allowing the emergence of a creative and autonomous self - we will present analyzes of a representative case from a longitudinal study conducted in Athens in a center for asylum seekers victims of torture. Here, the notion of creativity is considered in a Winnicottian (1988) sense, as a vital function, an enjoyment of the feeling of

existence. As Rivoyre (2016) states, “to be creative, a person must exist and have the feeling of existing, not in a conscious way, but as a base that allows him to act. Creativity is then a doing that comes from a being” (p. 43).

Methodology

We are part of a collaborative research approach, which means that the purpose of the research, its objectives and issues, its development and methods, as well as the questions relating to the exploitation of its results, have been discussed, negotiated and established in collaboration with the field partners who are the health professionals of the NGO with whom we worked and the beneficiaries concerned. The research took place over one year (from July 2016 to August 2017). It involved working closely with the medical staff of the NGO (doctors, psychiatrists, psychologists), volunteers asylum seekers, and various other social actors (including cultural mediators and community representatives). During the research, the first author conducted longitudinal observations within the NGO in Athens (three field work visits lasting three months each respectively), during which she also facilitated workshops with the beneficiaries (English workshops and psychoeducation sessions), and conducted repeated semi-directive individual interviews with 10 asylum seekers - all victims of torture in their respective countries of origin and diagnosed as having "mental disorders," as well as interviews with 31 professionals from the center, 7 cultural mediators, and 21 community representatives or association leaders. These last interviews aimed to explore the way in which collective spaces are used to reconstruct social bonds.

The first author introduced herself as a researcher and a clinician, but also as an active participant in the community. Although participating, she was in many ways a detached third party. Other aspects of her identity were also present, and they became more or less significant during the exchanges. Her South African nationality has been the subject of reflection and discussion with people of African origin, sometimes described as "an African sister" or "one of ours." However, unlike the rest of "ours," white skin, she is not subject to the same degrading or humiliating manifestations of racism. Unlike them, she is "legitimized" in her legal right to be there, to go unnoticed in the streets, to move freely in Europe. She is in the privileged position of a professional - she has the right to observe, direct, interrogate, and ask questions. Besides, as explored in our reflection on working with South African survivors of rape (Womersley, Maw, & Swartz, 2011), these common and different traits between identity marks, which are expressed through our bodies and attitudes, are a fundamental element of interaction during qualitative interviews.

From the point of view of data analysis, we adopt a dialogical approach of Bakhtin (1978, 1981, 1986), for whom in every discourse, an internal dialogue between oneself and another taking place, between the own discourse and the discourse of others:

“In the field of almost every statement, there is a tense interaction, a conflict between his own discourse and that of the ‘other’, a process of delimitation or mutual dialogical illumination” (Bakhtin, 1978).

This relation to other discourses - past and future - profoundly determines the nature of the statement. It is doubly oriented: it is answered (for example in opposition), it is repeated or reformulated (words of the other, its themes, the content of his speech), in relation to speeches already held and he prepares, anticipates the response he can generate (Salazar-Orvig & Grossen, 2008). Bakhtin insisted on the fact that the individual become himself by the recognition of the other, through the other and with the help of the other. This definition presupposes the interdependence between the Ego and the Alter (Marková, 2006), and emphasizes the different forms of Alter represented symbolically and socially, and which are in an internal dialogue with the Ego (Marková, 2016).

Our dialogical analysis was therefore a three-part process, which allowed us to follow:

- 1) The "polyphony" (Bakhtin, 1978, 1981, 1986) of the voices, reported indirectly and directly by the participants, and how they were organized, challenged and adopted.
- 2) The creative resources drawn from the cultural and symbolic field of the individual to lead his migratory project, make sense of the traumatic experiences of the past and that of the time, and redefine, reposition themselves in relation to the future. In this dialogical framework, the others can be a creative resource for the subject in his process of resubjectification, as interpretative individuals, or by appropriation of their activity and their discourses.
- 3) The activity of the participants over time as they evolve in the institutional systems in order to access the necessary resources to pursue their projects.

Our dialogical analysis will center on the following questions: which activities and resources, including symbolic and creative ones, do these refugees mobilize to reinject life and relationship where the deadly and the unbinding prevails? How do they creatively resist the desubjectification processes, in order to maintain a continuity and a coherence in the self-feeling? How do they maneuver in institutional systems and access the resources needed to continue their activities? How do they interpret or appropriate the activity and discourses of other social actors towards them, to think about their situation and to try to live?

Results

In the center where our research was conducted, no beneficiary had seen a psychologist before being cared for. Half had never heard of the existence of this profession. All of the ten people we followed in those twelve months were diagnosed with some form of "mental disorder" - including P.T.S.D. In the course of our interviews, not a single one mentioned the diagnosis by referring to his subjective experiences of psychological suffering. Rather, they used a myriad of "creative resources" to understand their trauma - and more broadly their situation. Further analysis of a particular case will allow us to highlight the resubjectification process and the transformative potential of the creative resources for the individual.

The case of Brigitte

Brigitte is a 35-year-old Guinean woman, mother of four children and victim of torture and forced excision. The first author, as a researcher, was able to talk with her five times during these twelve months. As shown in the text of her interviews, a detailed analysis of Brigitte's course during this year led us to identify four phases in her “resubjectification” process since her arrival in Athens.

The first is a phase in which Brigitte, facing multiple fears and culpabilities, regains some control over her own psyche, emotions, and mental activity. In this phase, Brigitte acts above all *on herself* by mobilizing the resources that we will present below. The second is a phase in which Brigitte goes from a lack of registration in her physical environment, which results in her withdrawal from public life and the fact of staying in her apartment, to a partial reconquest of her autonomy in the city. In her words, her life that “was empty” is now part of her social and spatial environment, “*I can feel I'm already here.*” The third phase is marked by the refusal of her asylum application, which deeply affects Brigitte, “*I was confused,*” she confides, but especially, by her construction of a response strategy, in the form of a recourse, always creatively mobilizing resources, this time from her environment. Finally, in the fourth phase, Brigitte seeks to build a future: “*little by little, I try to leave that behind me.*”

To act on herself: creative mobilization of two heterogeneous resources; God and her psychologist

The first interview takes place in August 2016, a few months after her arrival in Greece. At the invitation of the researcher, Brigitte describes her journey. In this exchange, her Christian convictions are mobilized as an argumentative resource to support her refusal of excision:

“I never wanted to do it [excision], it's against life, because I'm Christian [...] I say I cannot do that. When I meditate on the Bible, I don't see, I don't find anywhere that a woman should be excised, I don't find it”

We find interesting the strong presence of her own voice, which emerges from the beginning of the interview. This personal voice mobilizes cultural resources, which is religious here, like the Bible, to assert her identity and her freedom of choice as a Christian woman in the face of these conflicts.

Nevertheless, the interview is marked by the mention of negative emotions, fears and multiple guilt, which refer as much to what she experienced in her country of origin, as to what she lived on her migratory journey:

“The past always scares you. Although you came out of there, you say this is a new start, but when you think about it, it really scares you [...] I could have died, I'm not better than those who stayed, yes I I'm no better than those who stayed in the water. Therefore, it is only the grace of God [...] Me, I say thank you to God, I went out of there to safe and sound”

Once again, Brigitte uses religious concepts and feelings to make sense of the fact that she survived when she was not "better" than those who died, which is sometimes described as "the survivor's guilt" (Juni, 2016): The "grace of God," linked to her own sense of gratitude for this preserved life, provide her with cultural resources to act on her negative emotions, keep them under control, and begin to transform them (here, from guilt to gratitude). In this first phase, the religious register is mobilized in a creative way, which is to pursue her own vital projects, and here above all, to act on herself. This attempt to take (or retake) control of her psyche is not always successful, and Brigitte evokes the constant intrusion of fear in her thoughts, *"the past always scares you."* She describes:

"The fear of everything, actually, the fear of life, because I always say that if I didn't decide, I wouldn't have left my country. The fear of this practice also took away my fears. I left my children behind me - what will they become? What are they becoming? How do they live? How do they eat? How do they sleep? This fear is developed in me, and sometimes it tires me. I even said that to my psychologist. I'm afraid, and I don't know how to explain it. I want that fear to go away."

Here, there are few words ("I don't know how to explain it") to connect the past to the present, and the here and the elsewhere confused. The question of the abandonment of her children is strongly present in this exchange. In other excerpts, we understand that the look of Brigitte on this situation is fed by the look, expressed, or implied, of her other contacts, including the Greek mothers, which would risk the condemnation as bad mother - a judgment that refers to parenting relationships in a different cultural universe. In countertransference, the researcher shows a willingness to reassure her with her non-judgmental behavior. In this excerpt, the psychologist (or rather *her* psychologist) appears as another resource creatively mobilized to face fear.

Brigitte's creativity manifests itself here doubly: on the one hand, Brigitte selects from the cultural and social resources at her disposal elements (God and her psychologist) that she uses in a singular way to face her fears and to act on her feelings. On the other hand, she combines them and elaborates their tensions and conflicts all alone. The two registers of explanation and support of religion and psychoanalytically inspired psychotherapy are not necessarily immediately compatible, as we will see below.

To act on her proximal environment: to reconquer Athens as a living space

During the following weeks, Brigitte reported that her fears had begun to decrease, *"it is not that I have mastered this fear, but I prayed in my heart, I only asked God."* The fear has not disappeared, but it is "controlled," and no longer paralyzes the action. Then a little different process of subjectification begins, which is taking her proximal environment as an object this time.

The anxieties of her past, linked both to the traumas experienced in her country of origin and during her migratory journey, mix with a "feeling of emptiness" on a daily basis,

"If you leave your country to live in another country you don't even know, with the mentality of people and everything, you have this feeling of emptiness. You're there, and you don't know where to go."

As Pestre and Benslama (2011) observe among refugees, “this psychic and territorial suspension has often largely immobilized their capacity to become clean, determining the trajectory of their life” (p.20). A process of re-opening, re-adaptation, manifested by Brigitte's ability to leave her home to move into the city, can unfold in the psychic space gained over her own emotions and thoughts,

“The days gone by, I had too many thoughts in my head, always and always, but now it's okay. I also try to avoid, to forget these things, to live, what can I do? [laughs] I didn't have joy. I'm starting to readjust. Before, I was too withdrawn, I didn't speak, I was thinking every day. At one point, I have to live with it, because what else can I do? We must accept and live with it. (...) I was told that I could speak a little with the psychologist [...] I'm told it's stress, too much stress. This is what often happens, I have nothing, but if I don't want to live with it, I'll never be okay. I must accept my new life, I must leave all these things behind me, and live.”

The “we” is still confusing during the meetings. It could possibly refer to the discourse shared among figures in the community of African migrants with which she begins to be in contact. The voice of her psychologist seems closer and closer, a voice she seems about to install in her inner discourse, to help her accept her new life and “live.” During this time, she and her psychologist look at the meaning of her nightmares, “The psychologist told me that nightmares are linked to the past.” During the weeks that followed, she gradually internalized this new reading of her situation,

“I told him it was spiritual, but afterwards, when he spoke, I said to myself, I don't know, it is also likely that it is related to what I think in my head [...] I said to myself, it is also very likely that it is the truth. Because, maybe in my head, I feel guilty a lot, it's true. Although I listen to the words, it seems like I did something that I don't forgive myself. But Christ has already forgiven me.”

Several creative resources are thus deployed to assign a meaning to her nightmares - according to African traditional beliefs of her village, her Christian beliefs from her new church in Athens and the answers of the psychologist, related to the psychoanalytically inspired Western psychotherapeutic tradition. The psychologist is used to develop his experience through a translation into another language of the latter - as described by Pestre and Benslama (2011): “to use the consolidation and/or construction of a reliable gateway, she has a support: another human is there, who gives hospitality to her by the language” (p.25). We could hypothesize that the integration of new perspectives on her feelings of guilt and fear led to an internal psychic reorganization that allowed her to turn to her new social and spatial environment,

“There is a change. It's okay. It's okay, because I think I'm already here. I'm already here.”

She begins to talk less about the past, and more and more about her current situation. She feels she is “here.” At first, the only voices that appeared were those of God, that of her community, and her psychologist. During the following weeks, new voices are gradually being heard. She begins to talk about other members of the migrant community of Athens,

“I'm not the only one in this situation. We are numerous.”

She uses the various resources of the community, including neighbors and members of her church, to begin sharing her experience as a newly arrived migrant in Athens. This seems to give her a new ability to act in relation to a hostile host environment,

"I see life differently. Life is not like what I thought."

Supported by other migrants, believers of her parish, and always her psychologist, Brigitte spends more and more time to move around the city, *"I discover Athens more and more."*

Acting from her proximal environment to her remote environment: the building of a recourse

In March 2017, her asylum application is refused. This administrative decision affects her deeply,

"I was confused when I was given the paper of refusal of asylum. I was only here for two months, and when I was given the paper of refusal of asylum, that affected me a lot, it affected me a lot. I was crying all of the time, I always take medication because I was sick."

For her, the "confirmation of her existence" (Pestre, 2010) was denied, a news that devastates. A "fragmentation" (Pestre, 2010) manifests with psychosomatic symptoms such as stomach pain. She goes to emergency medical services - negotiating her access to care with impressive efficiency in a complex hospital environment.

However, the resources built in the previous phase (including a mixed social network linked to the parish, which puts her in contact with the Greek community organizations that help refugees, as well as health professionals related in particular to the program of care in which she participates as a recognized victim of torture) allow her to mobilize in order to resist this legal decision. During this period, she is appealing to members of her African church community to have access to a lawyer who will help her negotiate her asylum application, as well as to a social worker, which will then allow her to find permanent housing. This network provides her with advice and knowledge to navigate the complex Greek bureaucratic systems. She thus gradually finds an ability to act in the legal field. With the help of her lawyer and social worker, she appeals the decision and receives a new date to appear in court, giving her new hope,

"When I was given the papers to say that I could stay, it gave me hope [...] so it gave me hope, and I said thank you Lord, because it's God who does everything"

Building a future

The fourth phase is characterized by a reorientation and an emotional stabilization. In July of this year, she testified that,

"I think otherwise, because I'm here [...] At first, it was not easy, but little by little, I try to leave that behind me. Little by little, with your friends, speaking about it is beneficial; it makes you forget"

By mobilizing and articulating heterogeneous resources that become creative to the extent that it allows her to regain a power to act on herself and her environment, and finding the necessary words, Brigitte tried to "leave behind" traumatic events to which she has been exposed. In this fourth phase, she feels ready to engage in her new environment, professionally and socially, thus testifying her willingness to participate actively in her new life in Athens. The work and mastery of the Greek language are now seen as the resources that will allow her to carry out her projects. The search for a job and the learning of the language are then the main object of her care. At our last interview, Brigitte concluded by movingly declaring,

"You have to fight in life. You have to take studies seriously. To succeed, it takes a lot, a lot of work. That's important."

Discussion

This case study, which is based on repeated interviews over a period of one year with Brigitte, shows how much the creative activity of asylum seekers can go unnoticed. In fact, it is acting on objects that are invisible (such as one's own psyche, the control of one's thoughts and emotions) or seen as obvious by other members of the human community, who are less affected. For example, the fact of living in Athens, of really living, that means not only to physically occupy a space in the city, but to be able to move there, meet other humans, build her bearings and habits there, is the result of an intense, though underestimated activity of asylum seekers. It also shows that the process of resubjectification takes different objects over time: of oneself to the proximal, social, and geographical environment, then little by little to a more distant social environment, for example legal. When it works, it allows asylum seekers to maintain control over their own emotions and thoughts, and then their situation, including social, material and legal. Finally, it shows that the resubjectification activity of asylum seekers is based on heterogeneous cultural (and in particular religious) and social (the psychologist, the members of the African community of Athens, the members of her parish, associations of aid to refugees...) resources, which she selects and articulates creatively.

This combination of "creative resources" allowed Brigitte to overcome her fear, to be "here," to be able to face a new city and a new complex social, legal and medical system. Thus, being interested in the mental health of refugees then means taking note of the social construction of the category of P.T.S.D., its administrative dimension that implies rights and specific care (d'Halluin, 2009). In this sense, the distinction between "normal" suffering and "pathological" suffering has a political significance. From the point of view of the subject, suffering is indisputably "psychic", but it can as well be qualified as socially or politically constructed "by the institutional context where it emerges, as well as by its determinants" (Périlleux, 2014). The clinical setting should be a space that facilitates a process of "resubjectification" (Pestre & Benslama, 2011), so that the subject can "recover his or her capacity of thinking and something of a desire to live" (p.26).

Conclusion

The analysis of Brigitte's course shows that, although she is confronted with multiple and complex traumas, as well as with great uncertainty in her host society, and even refusing her asylum request, she nevertheless finds the means to draw on “creative resources” to face these adversities, to face the inner voices of fear and shame, in order to pursue her vital project. Like her, many people who attend the clinic we worked with are not just victims but active and creative subjects. They seem fragmented by the tortures suffered in their country of origin, as well as by the psychic deconstruction directly linked to institutionalisation and being devoid of political identity (Pestre, 2010). However, the individuals we met, who were confronted with extreme situations, demonstrated sometimes unexpected psychic abilities. As noted by Roisin (2000), “we know that trauma has thrown some into passivity, but we also have been able to observe that the passage through trauma has given others a renewal in their lives” (p.5). Many have found “creative resources” to resist, adapt, negotiate, in short to “make it” - these are resubjectification pathways, which are essential to find the path leading to existence and a bearable life.

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Abstract

Greece represents a unique context in which to explore the imagination-(im)mobility nexus: both a transit country and final destination for refugees. This article explores the imagination of refugee victims of torture in Athens as they weave together images of the past, present and future to confer meaning to their current situation and imagine new possible futures. In the context of a growing interest in emotions and temporalities linked to migration, the aim of this paper is thus to explore the complex interplay between the imagination of migrants and the trauma from the theoretical standpoint of sociocultural psychology. The paradoxes are multiple: i) Migration is inherently imaginative, in the sense that the actualisation of migration begins with individuals imagining their destination ii) however, trauma related to forced migration experiences in particular may impede imagination. To further add to the complexity: it may be imagination itself which acts as an essential component to healing from trauma. The article explores forced migrants' mobility choices and individual migration trajectories to provide insight into how the emotionality of subjective experiences, as well as the sociocultural context, are fundamentally involved in people's plans to migrate and the development of their ever-changing imagination of a better future elsewhere. The results similarly illustrate imagination as being significantly shaped by the collective imaginings of entire communities.

Introduction

According to the United Nations High Commission for Refugees (UNHCR), an unprecedented estimated 362,000 refugees ²⁷ risked their lives crossing the Mediterranean Sea in 2016, with 181,400 people arriving in Italy and 173,450 in Greece. In the first half of 2017, over 105,000 refugees entered Europe. As the "reception crisis" continues unabated, Greece remains one of the first ports of sanctuary. According to recent statistics provided for March 2018 by the UNHCR, ²⁸ over 50,000 asylum seekers and refugees currently remain in Greece following this mass flow. The majority of the one million asylum seekers arriving in the country appear to have seen Greece as a transit country, yet neither of the refugees' routes out of Greece are functioning as anticipated, leaving many blocked (Howden, 2017). Greece therefore represents a unique context in which to explore the (un)imagination and (im)mobility nexus among asylum seekers: perceived both as a country of transit as well as a final destination. Currently, many asylum seekers find themselves "stuck" in limbo in this context, unable to proceed with their asylum claim or continue their journey to the destination countries of Western Europe – often imagined "lands of milk and honey" to which many continue to aspire.

²⁷ ²⁷ Throughout the thesis, the term "refugee" as defined by the Geneva Convention of 1951 is used to include both refugees legally recognised in a host country as well as asylum-seekers.

²⁸ <https://reliefweb.int/sites/reliefweb.int/files/resources/62950.pdf>

For this refugee population, trauma does not stop at the border. Increasingly, there has been a burgeoning of theoretical models for understanding trauma that situates individual refugee's trauma sequelae and recovery within inter-personal, political, and social context. The focus is on the ever-changing post-migration environment (De Jong, 2007; Droždek, 2015; Maercker & Hecker, 2016; Maercker & Horn, 2013; Miller & Rasmussen, 2017). Various studies have demonstrated the detrimental impact on mental health of the migration journey, including prolonged detention or stays in often unsafe refugee camps (Gkionakis, 2016; Lambert & Alhassoon, 2015; Silove et al., 2007) as well as the asylum-seeking process (d'Halluin, 2009; Laban et al., 2004). Migration itself is a complex, nuanced and ongoing process. The act is often driven by individuals or indeed entire communities imagining brighter futures in distant lands, as well as by more pragmatic strategic planning and opportunism. In this respect, it is never singular in its temporality, but rather is an ongoing process where past, present and future are folded together in the emergence of migrant lives (McCormack & Schwanen, 2011). What many asylum seekers have in common is the painful loss of home and separations from loved ones and the inevitable mixed emotion of sadness for what they have lost as well as the hopeful anticipation of what they could gain, the ambivalence of wanting to stay versus wanting to go (Falicov, 2002).

Within this context, the paradoxes are multiple: i) Migration is inherently imaginative, in the sense that the actualisation of migration begins with individuals imagining their destination ii) however, trauma related to forced migration experiences in particular may impede imagination. To further add to the complexity: it may be imagination itself which acts as an essential component to healing from trauma. This is because imagination is one of the processes which serves to repair the multiple ruptures created by trauma. *It* allows for finding the semiotic means by which trauma can be made sense of and resolved. It creates self-continuity between past and future. It facilitates the progressive creation of new links to absorb and transform trauma into semiotic forms (Kadianaki & Zittoun, 2014). For the transformation of traumatic memories into semiotic forms which connects it through language to its rightful place in time, the elaboration needs to be socially situated and “intersubjectively acknowledged” (Marková, 2006; Zittoun, 2014). The process is thus inevitably connected to the sociocultural environment in which the individual is situated.

In the context of a growing interest in emotions and temporalities linked to migration aspirations (Carling & Collins, 2017), the aim of this paper is thus to explore the complex interplay between the imagination of migrants (and associated hopes and aspirations driving their migration journey forward) and the trauma many experience which risks thwarting this process. The article further attempts to contribute to the recent development of interest in the concept of “immobility” in particular, developed as “a cipher for assemblages of blocked, stuck, and transitional movement [...] involving political, economic, cultural, geographical, and human components” (Khan, 2016, p. 93). It thus serves to contribute to the ever-expanding field of mobility studies which “not only encompasses mobility across a wide range of forms, practices, scales, locations and technologies, but also interrogates the politics of mobility and immobility, the material contexts within which they are embedded, and their representational and non-representational dynamics.” (Blunt, 2007, p. 684).

By analysing migration from a sociocultural perspective, the article explores forced migrants' mobility choices and individual migration trajectories – providing insight into how the emotionality of subjective experiences, as well as the sociocultural context, are fundamentally involved in people's plans to migrate and the development of their ever-changing imagination of a better future elsewhere.

Imagination from a sociocultural perspective

To explore the (un)imagination-(im)mobility nexus, I draw on an expansive and developmental view on imagination from a sociocultural perspective as developed by Zittoun (Zittoun, 2012; Zittoun & Cerchia, 2013; Zittoun & Gillespie, 2015; Zittoun & Sato, 2018), Valsiner (Valsiner, 2000; Valsiner & Rosa, 2007) and others. They define imagination as the process of temporarily disengaging from the here-and-now, a process which demands the use of various resources, so as to take some distance from the current present and situated experience. Such an approach emphasizes the importance of non-linear temporality in the context of migrants' changing subjective current realities – as individuals weave together images of the past, present and future to cope with situations of trauma, confer meaning to their current situation and redefine-reposition themselves toward the future. This includes tracking the processes of change in imagining alternative possible lives. From a sociocultural perspective, imagination is understood necessarily to be culturally-informed and shared. In other words, it may be distributed among communities. Imagination is thus theorized as being significantly shaped or contested by the collective imagination of entire communities: for example, from the shared imaginary expectations of life in Europe among communities in countries of origin, to the constantly developing situated imaginaries of refugee communities upon arrival in Europe. As such, imagination is inherently cultural (Zittoun & Glăveanu, 2018). Indeed, “communities of imagination can become galvanized by a vision of the future and seek to institute it, leading to sociogenesis, that is, the development of society itself” (Zittoun & Gillespie, 2015, p. 111). It has similarly been argued that it is culture which constitutes the basis for the “collective aspirations” of migrants (Appadurai, 2004).

Individuals who imagine life elsewhere, for example, are seen within this framework as drawing on communal cultural resources which form part of a collective semiotic guidance system (Valsiner, 2007) – the process is considered to be co-constructed and dialogical. This includes drawing on cultural symbols, patterned practices such as storytelling, mental time travel and other forms of mental projection in order to imagine (Kirmayer & Ramstead, 2016). Imagination among individuals therefore is constantly evolving across the life course in relation to the sociocultural environment. It is “culturally guided and personally-semiotically reconstructed” (Valsiner, 2000, p. 82).

This perspective is captured in Zittoun's model of imagination as a process which creates “loops” out of the present, here-and-now of experiences connected to the material reality of the current environment. As illustrated in her model (figure 1, below), she conceptualises the process as being triggered by some disrupting event, which generates a disjunction from the

person's unfolding experience of the “real” world, and as unfolding as a loop, which eventually comes back to the current, actual experience (T. Zittoun & Cerchia, 2013) (*figure 1*):

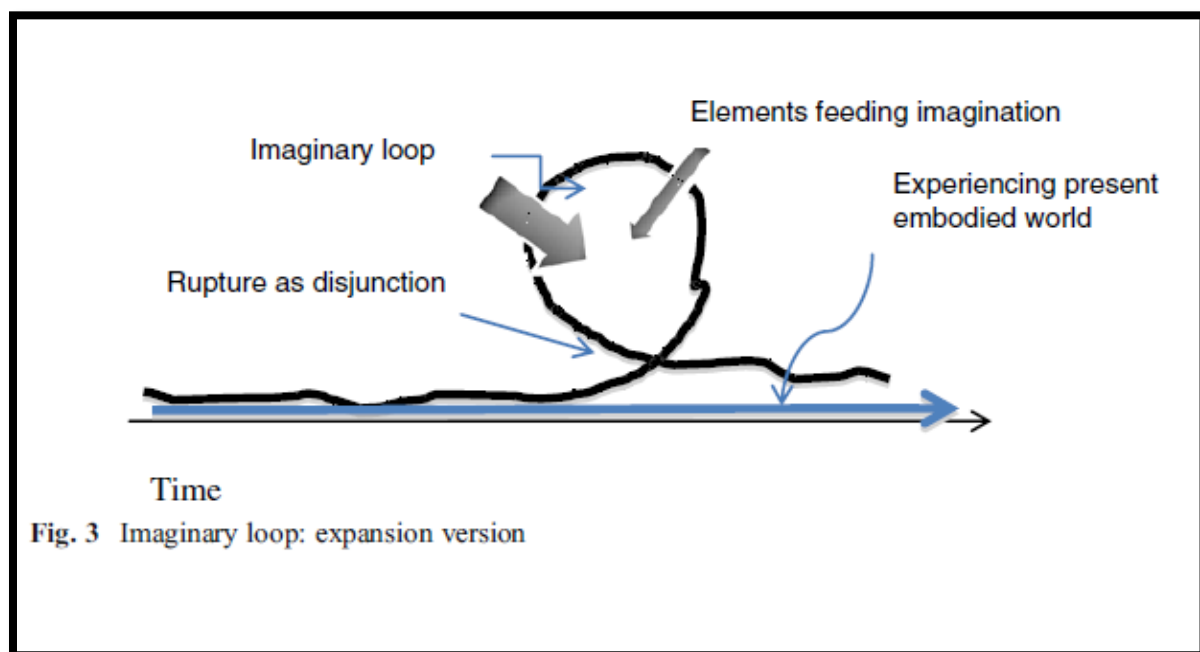


Fig. 3 Imaginary loop: expansion version

Thus, what is conceptualised as triggering imagination is a “rupture,” “disruption” or “misfit” between the given experience of the world and one’s ongoing flow of thinking – a situation requiring new solutions and experiences (Glăveanu, Karwowski, Jankowska, & de Saint Laurent, 2018). This developmental perspective views imagination as a process that allows the individual to take distance from the here-and-now of current experience to consider alternative possibilities: for example, rereading the past or opening possible futures. A rupture in one’s life in Africa, for example, may trigger an individual to imagine a life for themselves in Europe, as a solution. Imagination is therefore a resource for individuals to draw upon to make meaning of – and act upon – the world: an important component of development and a way to expand one’s experience (Vygotsky, 1997, 1980). It allows for the implementation of social and cultural affordances, that is, expectancies, prescriptions, and possibilities for action in context (Kirmayer & Ramstead, 2016). It is a “freedom” which expands experience beyond the here-and-now, allowing humans to reimagine themselves and their future choices, coming to radically new perspectives, ideas and modes of acting (Zittoun & Cerchia, 2013; Zittoun & Gillespie, 2015; Zittoun & Sato, 2018).

Imagination, Trauma and Migration

The act of migration itself is inherently imaginative (Salazar, 2010; Salazar & Smart, 2011). It is motivated by an (often collective, culturally-informed) imagination of a future beyond the here-and-now. As argued by Zittoun and Gillespie (2015), “indeed, all human travel, and exploration in particular, is motivated by an imagination of a future that lies beyond the horizon of the present and which is as-yet not actualized” (p. 113). It may be perceived as an act of

agency on the part of the individual, who turns imagined possibilities into actuality. Due to the constantly evolving nature of imagination, continually developing in relation to the sociocultural environment, the period of transition following migration in and of itself may trigger the imagination of new possibilities. Upon arrival in Greece and first encounters on European soil, asylum seekers may find themselves imagining the possibility of life in a particular town in Sweden, for example.

Yet at the same time, and particularly in the case of forced migration, migration may similarly be perceived as a traumatic rupture: an “a-temporal space” - a transitional and disconnected period wherein experiences, skills, connections acquired and built in the past are rendered inaccessible (Métraux, 1999b). In the specific context of forced migration in particular, itself characterized by a rupture in connection to “home” (and all the social, cultural, professional and linguistic connections that this implies) – the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only to feed monstrous feelings of disconnection (Bhimji, 2015). Disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and moments in life. Without the container of home-as-it-was, there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012). In other words, there may be no or little capacity to imagine. As such, trauma begets trauma. Exposure to trauma, itself connected to a breakdown in social connection and exacerbated by the process of migration, risks the individual being caught up in a vicious cycle where no addressee may be found, no language exists to form a coherent narrative whereby trauma may itself be collectively represented and made sense of.

Here, the notion of trauma is understood to straddle both intrapsychic and interpersonal spaces, and is theorized as creating ruptures in time, memory, language and social connection. It is a freezing in non-dialogical space, a shattering of the capacity to generate meaning, and a severe disruption of those relational processes in which meaning is formed (Sucharov et al., 2007). The result is a significant disconnect between the traumatic events and the current sphere of experiences. The consequent lack of connection between past and present can also be understood as preventing the emergence of possible futures. Put simply, trauma may impede processes of imagination. It has even been defined as a state of “limited or constrained modalities of imagining” (Zittoun & Sato, 2018, p. 203). Returning to Zittoun’s “loop” model of imagination (Zittoun & Sato, 2018), trauma may similarly impede the movement of coming back to the actual, ongoing present. In this case, imagination would be locked in the past, or in an alternative reality.

The theoretical background of sociocultural psychology allows for an exploration of this ever-changing and dynamic development of imagination over time, and within sociocultural context. It evokes a methodology incorporating an exploration “not only of the subjective perspective, but also the dynamics by which the social and cultural environment guide and enable the person’s development” (Zittoun, 2017, p. 171). Of particular interest in this study is the way in which the imagination of refugee populations is influenced by the encompassing fabric of the cultural collective – and the complex interplay inherent to the trauma-(im)mobility-

(un)imagination nexus. This includes a focus on the processes inherent to changes in imagination as (im)mobile individuals configure, reconfigure, and made meaning of ever-changing new realities. The approach similarly highlights the societal, institutional, and individual conditions that form and shape imagination in constantly changing contexts (Adams & Fler, 2017).

Methodology

To explore the way in which the complex imagination-mobility-trauma nexus unfolds in the context of the so-called “refugee crisis” in Greece, I present the results of 12 months of research among asylum seekers and refugees in a center for victims of torture in Athens. This involved 3 months of participant observation in the centre (including attending daily team meetings and co-facilitating sessions with the beneficiaries). Furthermore, 125 in-depth, qualitative interviews with refugees, health professionals, interpreters, and refugee community leaders across Athens. In particular, multiple qualitative interviews were carried out with 10 individual refugee victims of torture, identified as suitable participants by the health professionals of the centre. These individuals were followed over the course of a year, with an average of five in-depth qualitative interviews being conducted with each participant, in order to explore their subjective experiences of migration and their aspirations for the future. 64 health professionals and community leaders were also interviewed, including religious leaders, leaders of refugee associations as well as doctors, psychologists, social workers and cultural mediators working with this population.

A key proposition of analysis from the perspective of sociocultural psychology is to use case studies to explore individual migration trajectories within unique, specific and ever-developing contexts. The analytic focus therefore is on individual trajectories unfolding in relation to the sociocultural environment (including material realities as well as connection to social others), specifically with a view of tracking dynamic processes of “trauma” and “imagination” within these trajectories. In other words, the vignettes presented here as a case study serve to illustrate the complex realities and interrelatedness of migration trajectories, trauma and imagination. In particular, a case of a refugee victim of torture who participated in the research over the course of a year is presented. The intention is to detail how imagination “may be thwarted, and how, through considerable resistance and struggle, it may nevertheless help to overcome the consequences of radical sociocultural disruption” (Keightley & Pickering, 2018, p. 169).

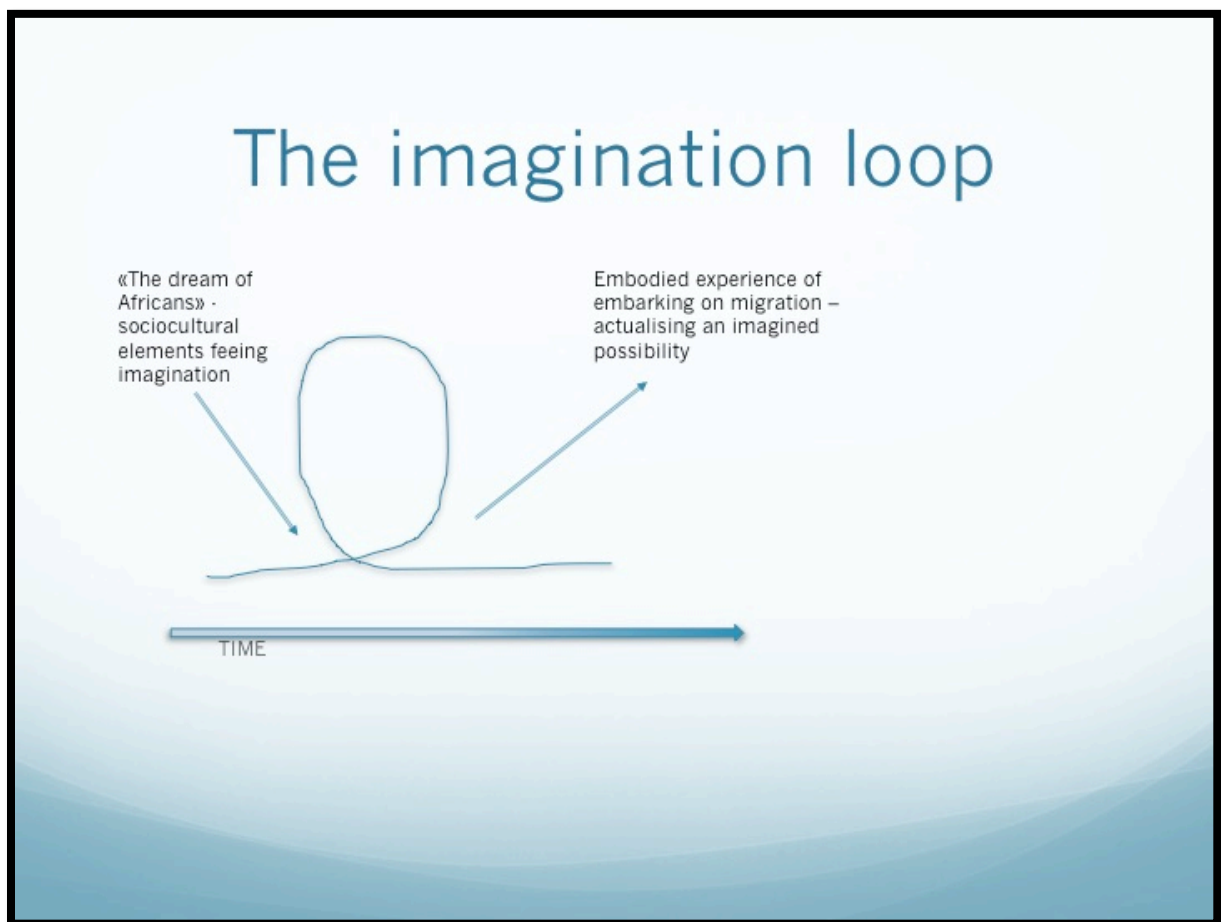
The case of Jules

Jules is a 45-year Congolese man who was arrested and tortured after engaging in anti-government protests. After being released, he fled the country imagining France to be his ultimate destination. He arrived in Athens in December 2015. Our first interview took place in August 2016, nine months after his arrival. During this first interview, he refers to his motivation to continue his journey to Western Europe, stating:

“In any case, all the Congolese know that in France, Belgium, Germany or Austria – that if you ask for asylum they will give you money... someone could sacrifice themselves or a family could sell one person of the family to come to Europe. Europe is the dream of Africans”

His words highlight aspects of the collective nature of the imagination of refugees dreaming of Europe. It's not only him, but all Congolese who know (imagine?) that they will receive money upon entering Western Europe. Furthermore, the motivation to migrate is not necessarily driven by the individual alone, but linked to the aspirations of an entire family who collectively take the decision for one person to migrate on behalf of the others. Europe is a “dream” shared by “Africans.”

According to the imagination “loop” model, it could be argued that this collective “dream” of Africans serves as the sociocultural elements fuelling Jules’ imagination of life in Europe, a dream which he goes on to actualise through the embodied experience of migrating (figure 2):

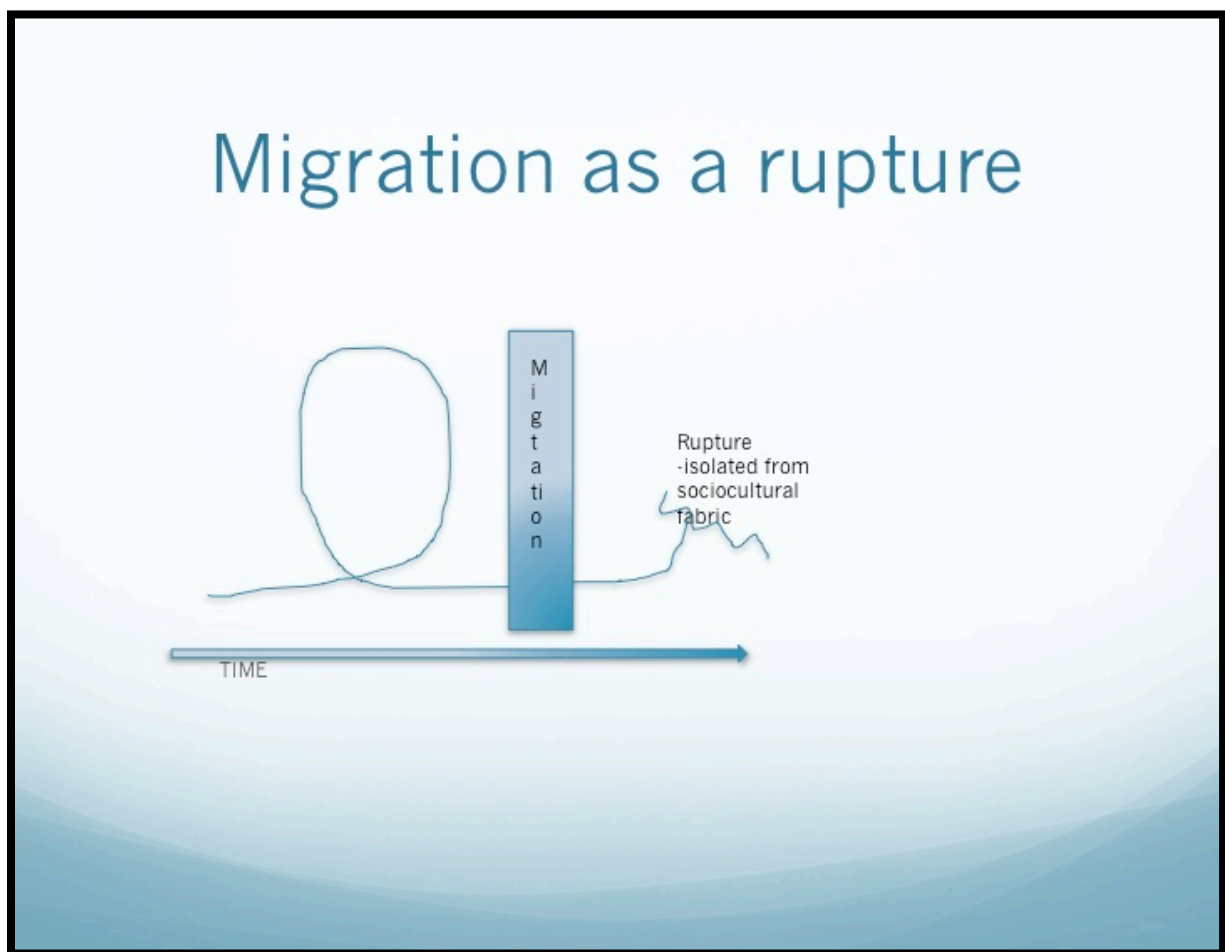


As illustrated in the figure above, Jules’ imagination is nourished by the collective dreams of others within his sociocultural environment, allowing him momentarily to depart from the “here and now” of his life in the Democratic Republic of Congo, in order to imagine a better life elsewhere. It is this figurative departure which allows for a subsequent literal departure to Europe.

In a subsequent interview conducted six weeks later, in September 2016, this initial “dream” to which Jules had so enthusiastically referred, seems somewhat to have been shattered:

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

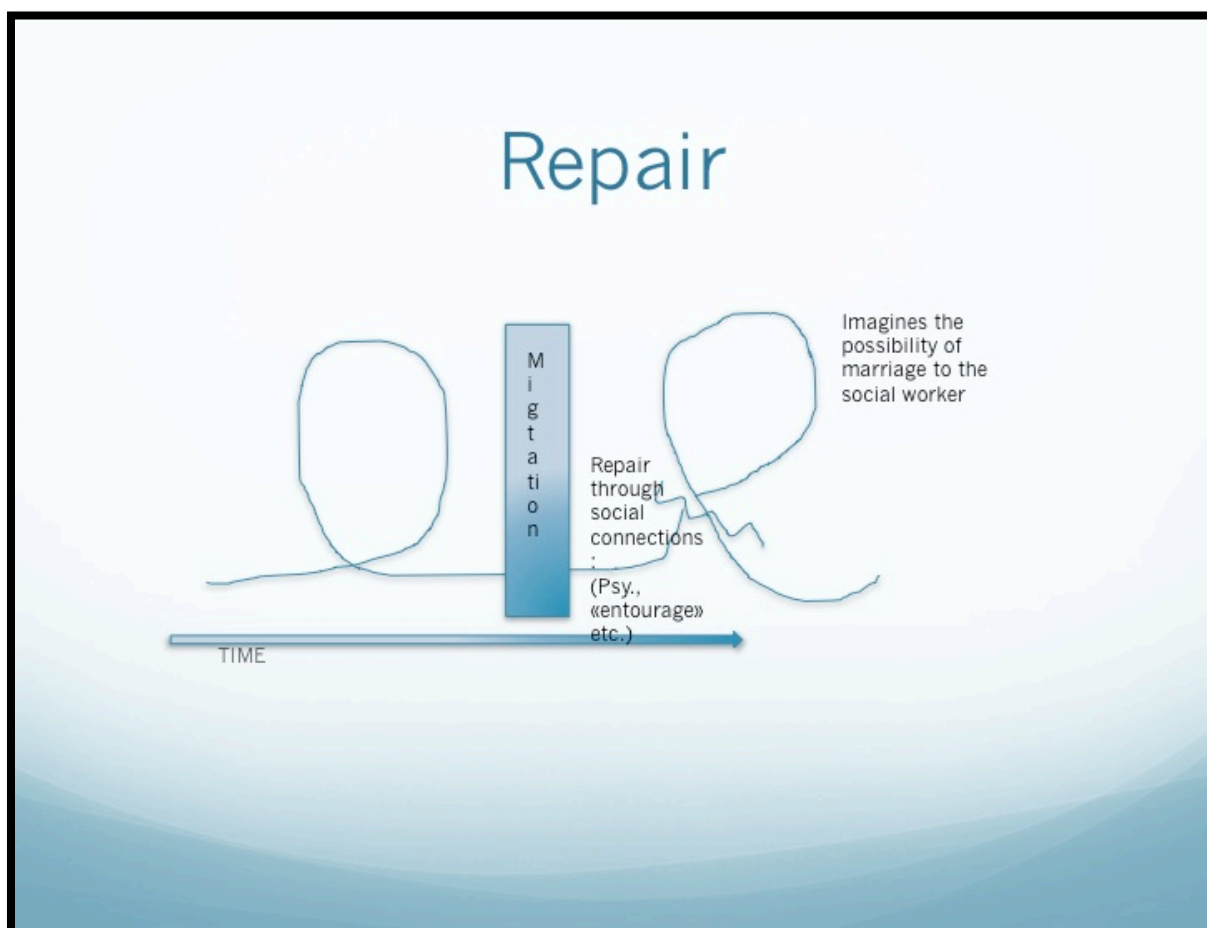
He is confronted with a reality different to that which he had initially imagined – rupturing the sense of social connectedness and identity as a member of a community. He is not a husband, nor a father. Rather, the social fabric within which he was located has fragmented. From a sociocultural perspective, ruptures created by trauma are embedded within an intersubjective context wherein severe emotional pain cannot find a relational home in which to be held and integrated (Atwood et al., 2002; Stolorow, 2011). These traumatic ruptures lie at the intersection of the individual and their social context and are related to safety, trust, independence, power, esteem, intimacy as well as spiritual and existential beliefs. Jules finds himself feeling alone, “not with the others,” and with the perception that nobody cares. Furthermore, this rupture has an impact on his ability to imagine a life for himself in Europe, as depicted in figure 3 below:



As illustrated in the figure above, the experience of migration itself is a traumatic rupture isolating Jules' from his sociocultural environment. However, a few months later, in an interview conducted in January 2017, he refers to new social connections having been formed. There are some repairs to the rupture experienced in the social fabric of his life. He has started to relate more to his neighbours, members of his church congregation, and his psychologist. Notably, he also reports falling in love with his Greek social worker and wanting to marry her:

“And my psychologist asked me ‘and if you aren’t granted asylum, what are you going to do?’ I replied, ‘I will ask my social worker to marry me.’ She asked me why, and I replied ‘why not?’ ... I don’t say anything but she knows that I love her. I’ve told my whole entourage”

Compared to prior periods, he increasingly refers to others in his social world – for example, reporting discussions that he has had with his psychologist as well as members of the Congolese community in Athens. He has a “whole entourage” to tell about his newfound wish to marry his social worker. Similarly, it is during this time that new life projects start to be imagined. He is able to envisage a future as a husband, married to a Greek woman and constructing a life together in Greece. Imagination flourishes, as depicted in figure 4 below,



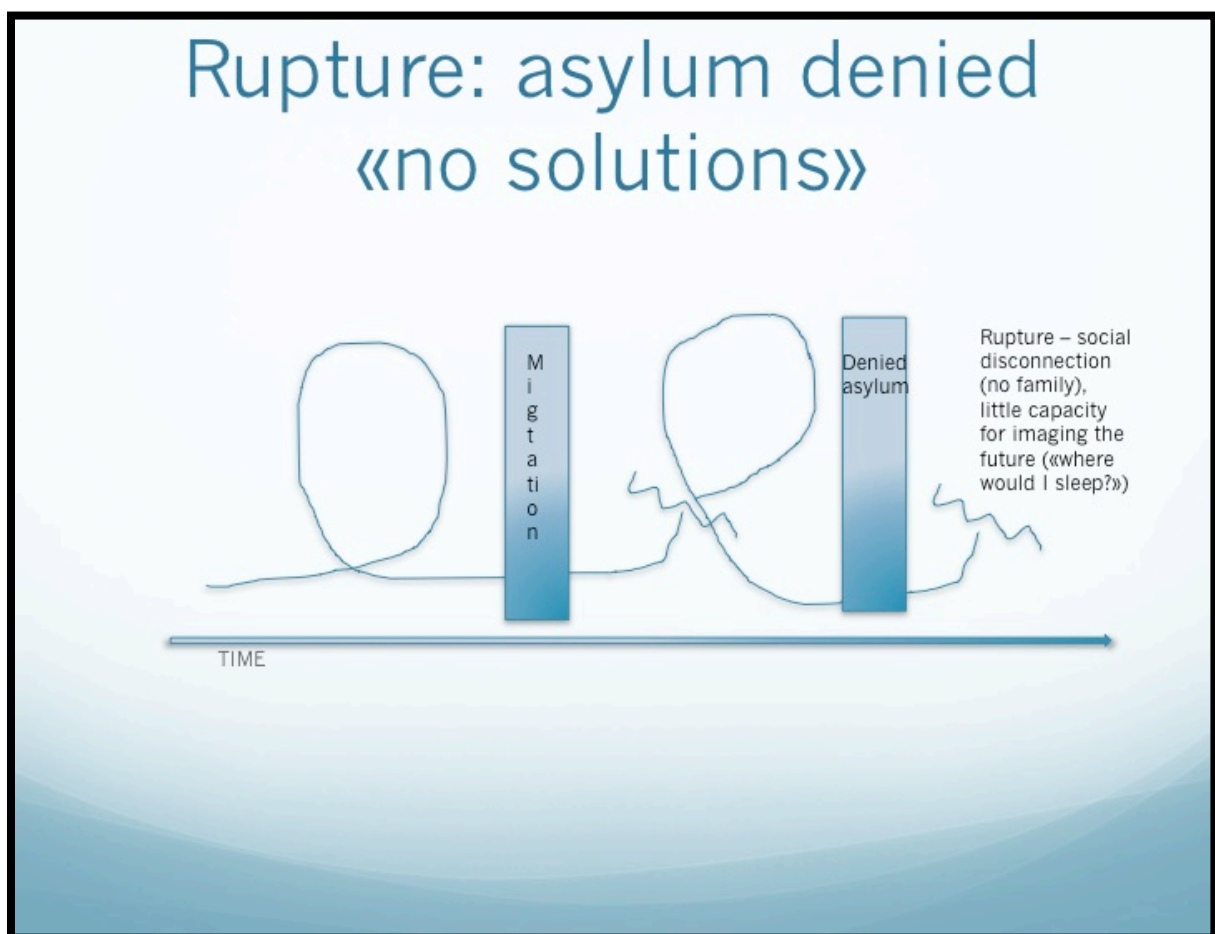
His first asylum interview takes place in September 2017 during which he has to speak about the torture he endured. He describes this event as having “retraumatised” him:

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

His claim to asylum is ultimately rejected a few weeks later. The news devastates Jules. When asked about his future plans following this court decision, he states that:

“My vision is to go somewhere or stay here, I really don’t know...but if I had the idea of going somewhere else, I couldn’t ask for asylum here. Some have their families over there [in Western Europe] already, but I am the only one in my family. So if I had to go to France, well, where would I sleep? I don’t have a place there. It’s hard, but what can I do? I don’t see any solutions.”

It can be argued that the negative decision on his asylum claim is a traumatic rupture in his life, impeding his ability to imagine. He “really doesn’t know” what his “vision” is. There are simply no solutions, no clear idea of a future. Notably, he associates the lack of being able to imagine a future for himself with a lack of social connections: others have families “over there” (in Western Europe), whereas he does not. He cannot imagine having “a place” in Western Europe as he does not have any family or friends to accommodate him. In other words, as depicted in figure 5 below, the traumatic rupture of being denied asylum echoes a social disconnection, impeding his capacity to imagine a future for himself:



Elsewhere (Womersley & Kloetzer, 2018a), we have conceptualised the trauma of migration as a “double” rupture – one rupture related to traumatic events experienced in the country of origin and subsequent forced migration, the second related to issues of displacement and social isolation experienced by displaced population. Particularly for those whose claims to asylum are rejected, this “double rupture” invokes a vicious cycle of trauma and isolation, a series of disruptions to the relational processes nourishing imagination.

In July 2017, a few months subsequent to his asylum claim being denied, Jules reports that:

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

There is evidence of repair to the rupture of being denied asylum. His words highlight him having a new sense of perspective – of past, present and future. He projects himself into the future and decides that he does not want to “spend [his] whole life crying.” Rather, he refers to being able to “see the reality in front of [him].” A new, clear vision for the future appears to have emerged. He imagines a new life for himself – not in Athens but in “other European countries”:

“In other European countries, they easily give you papers [refugee status]. Like in France, papers or not, I’d have work there. In France, anything is authorized. I want to spend the rest of my youth and my old age next to the white people, the Europeans. I need to learn their habits – how do they speak? How do they walk?...”

He imagines a life in France, a life where “anything is authorized,” where he will easily be granted asylum. He imagines being able to work easily, regardless of refugee status. This would be for him the metaphorical land of milk and honey, echoing the dream which initially fueled his desire to come to Europe. This dream similarly includes a newly imagined form of social connectedness – that of being connected to “white people, the Europeans.” He imagines being able to build these social connections through studying their habits, down to the way in which they speak and they walk. This, he imagines, would enable a seamless integration into Western Europe, and would be the key to a rich and successful future.

“I know that the beginning is difficult, but it will be better with time... with friends, with people, with a little help. You can have no money but if you have travel documents and your ideas, you can go anywhere... I’m poor in money but rich in spirit. I know that with my ideas, I can go anywhere...there are people who are here, but who are like a television with the remote control somewhere else. Anything and anybody can change the channel. But me, I’m not like that. I’m here – the television and the remote control in my hands... I’m a visionary, by the grace of god I’m a visionary”

As stated by Pelaprat and Cole (2011), “imagination is the process of resolving and connecting the fragmented, poorly coordinated experience of the world so as to bring about a stable image of the world” (p.399, as cited in Zittoun & Cerchia, 2013). Jules describes being a “visionary” – having a clear idea of what he imagines for his future life in Europe. What is important to note is that he does not believe this imagined future to be possible without “friends...people.”

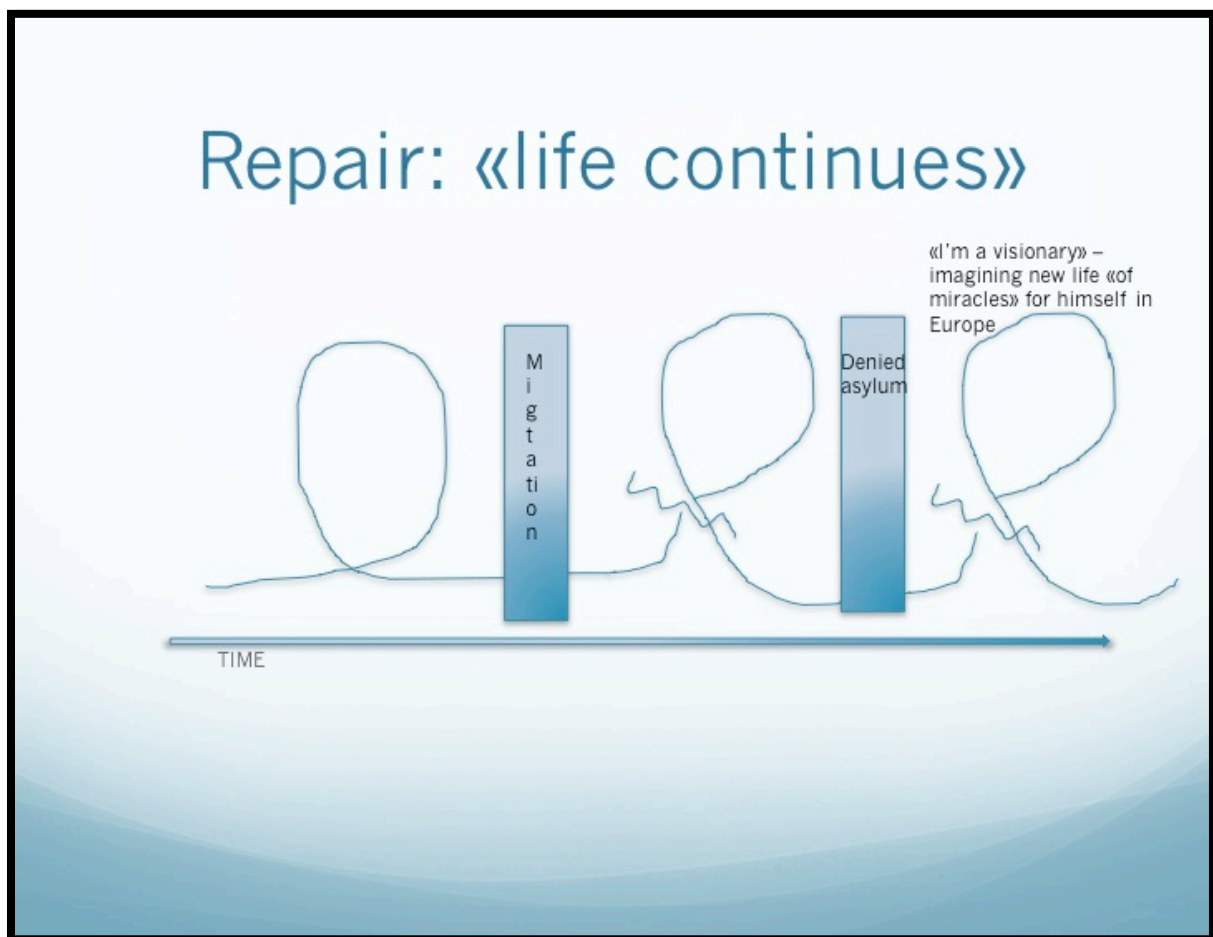
Once again, there is a relationship between his ability to imagine a life where he “can go anywhere” – and the connection to others. Having a new sense of a power to act over his future, having “the remote control in [his] hands,” allows new life projects to be imagined:

“I have ideas, and because I have ideas, I have plans and projects. I know it will all be all right in the end...”

A clear path to his future is imagined:

“I have a rhythm that I’ve adopted. I don’t look left, I don’t like right. I look straight ahead of me, the place where I want to get to, right until I arrive. One single point, that’s all. That helps me not to feel the stress. I see a normal life ahead”

Two years after arriving in Europe, following multiple ruptures and repairs, Jules has a rich capacity to imagine a future for himself in Europe, as depicted in figure 6 below.



As illustrated in the figure above, the repair to the traumatic rupture of being denied asylum lies in the “imagination loop” being completed. The future is once again rich in new imagined possibilities. In our last interview, he boldly concludes that:

“It’s Europe, Europe is miracles”

Discussion

What is revealed through an analysis of Jules' migration trajectory is the importance of socio-cultural resources which shape and define his imagination. The imagination of a "brighter" future in Europe may never wholly be considered "his" alone but collectively shared and distributed. He is not alone in having arrived in Europe after an arduous migration journey fueled by "geographical imaginaries" (Salazar, 2010; Salazar & Smart, 2011) of a better life in Europe. In sharp contrast to the initially imagined "dream" of a "miracle" life in Europe, he felt disillusioned by the every-day reality of Athens - a disillusion seemingly shared by the vast majority of refugees encountered over the course of the research. Many participants reported experiencing a similarly sense of disillusion:

"We had another vision of Europe... Europe is different from Africa. For me, at least, Europe is even more complicated than Africa."

"We came because we had different dreams, we came to see the reality."

"When we dreamed, we then later understood that life is something else."

"Often we had Europe in our minds like the films that we saw. When you watch a film, it's just a scene that they created. You forget that there's a reality behind it. There's an actor, a director, interpreters to make it all look real. Now it's only when you come to Europe that you see that reality."

Note the frequent use of the collective pronoun "we," instead of the singular "I," in the above quotes – alluding to the collective nature of the aspirations of many refugees and a culturally shared imagination of life in Europe.

Jules' case is illustrative of the dynamic interplay between trauma, migration and imagination. However, it is not representative of all research participants. His imagination continues to thrive despite the multiple traumatic ruptures he faces. Among other participants, however, this rich capacity to imagine the future appears to have been thwarted by ongoing traumatic ruptures to their lives. Social isolation, harsh living conditions, insecure residency status and continual exposure to violence and trauma characterises the daily lives of so many of the participants encountered. Without a connection to a meaningful past or a beckoning future, and without a sense of connection to others, they report feeling "trapped" in a traumatic present - as evidenced in the following statements:

"I can't think properly what to do in my future. I'm not able to think about my future, what is going to happen next in my future. I don't know what is going to happen."

"I'm trapped here."

"I don't know when will my life going to take me. I don't know what is going to happen next with me now...I don't want to stay here because there is no life."

We have presented a detailed analysis of a case elsewhere (Womersley & Kloetzer, 2018b), wherein an Indian asylum seeker and victim of torture finds himself in shared accommodation with Pakistani nationals. He accuses his Pakistani roommate of spying on him. Psychotic symptoms start to emerge, including auditory hallucinations and paranoia. Many of the voices

are those of authority figures, including the torturers in India and, rather tellingly, police officers, bureaucrats and judges in the asylum procedure in Greece. He's hospitalized as a result. All of these ruptures create negative "feedback loops" (Kirmayer & Ramstead, 2017), defined as a process whereby an effect is reinforced by its own influence on the process giving rise to it. The case illustrates how such negative feedback amplification extends beyond the individual to include a wider network of relationships and processes wherein the individual is embedded. This again speaks to the vicious nature of the trauma-(un)imagination-(im)mobility nexus: imagination – often socially shared - may drive migration, yet the traumatic ruptures to this social fabric (so often associated with forced migration in particular) may thwart capacity to imagine.

Conclusion

An in-depth analysis of the case of Jules from within a sociocultural framework highlights the complex interplay between imagination, trauma and migration. Imagination is a powerful motivating force driving migration. However, this is not a static, once-off process. There is no singular moment of deciding to migrate. Not only is the imagination of individuals constantly transforming in relation to the ever-changing sociocultural environment: it is significantly shaped and contested by shared or collective imaginings of entire communities. This starts, for example, with collective imagination of life in Europe among communities in the country of origin, and extends to the constantly developing shared imagination of refugee communities as they arrive in Europe. Yet migration, and particularly forced migration, inevitably brings changes which are likely to be experienced as ruptures which radically affect one's subjective sense of self and sense of connection to others. The capacity to imagine, and consequently heal from traumatic ruptures, may only be restored within the context of the sociocultural environment surrounding the individual, and their relation to their social world. As Zittoun and Sato (2018) convincingly conclude, "imagination is facilitated by both [social] recognition and material resources that have cultural meaning and is, in this sense, the process by which post-traumatic growth occurs" (p. 203). If trauma is healed, imagination may be restored. If imagination is restored, trauma may be healed.

The research highlights the important value sociocultural psychology may bring to the field of (im)mobility and migration studies by enriching understandings of trauma and imagination among refugee populations, with an emphasis on the sociocultural location of human subjects. From within this perspective, what is highlighted are the ever-changing cultural and social systems which are in continual interaction with the various forms of an individual subjective experiences of (im)mobility. Furthermore, it highlights how "immobility may transform transnational and transcultural categories, praxis, imaginaries, and subjects" (Khan, 2016). Sociocultural psychology allows for this urgent and critical reconsideration of trauma and imagination as dynamic processes influenced by the interplay of changing social, historical, material, economic, political and subjective dimensions, in populations fighting to construct their new lives in Europe.

CHAPTER NINE: Exploring concrete implications for intervention

As noted by Daiute (2016), “trauma is **real**, [*my emphasis*] and many scholars are studying and treating trauma as a social as well as an individual phenomenon” (p. 130). Through the theoretical proposition of subjectivity as explored in chapter eight, potentially traumatic experiences of refugees cannot be conceived of as a process having an inherent value occurring outside the network of sociocultural and historic experience. This is because it cannot be disconnected from its consequences for the **concrete** life of the individual. Trauma is related to individuals, as well as social histories and resources (Goulart, 2017; Goulart & González Rey, 2016; González Rey, 2008). It cannot be divorced from **daily-lived reality**. Therefore, this chapter nine of the thesis turns the focus towards the psychological impact of the reception conditions of refugees arriving in Europe. Concrete implications for mental health interventions are explored.

Returning for a brief moment to the theoretical tenants of sociocultural psychology underlying this research, the theoretical framework purports that studying human development

“becomes possible only on the basis of dynamic, dramatic interrelations between concrete subjects and society that could not be reduced to their external interactions. The dynamic, dramatic interrelations between concrete subjects and society are not reduced to an adaptation of subjects to social environment as has been accepted in mainstream North Atlantic psychology.” (Dafermos, 2015, p. 21).

We cannot study the development of individual refugee trajectories (including reactions to potentially traumatic events) without considering the concrete: concrete individuals and the concrete reality of their environment. If chapter seven presents an analysis of the activity systems characterizing the environment in which refugees find themselves upon arrival in Europe, and chapter eight considers their individual trajectories through these systems – what are some concrete conclusions which may be drawn? What of lived reality? What of the mental health interventions being offered to this population?

What are the implications of some of the research findings, highlighted in the previous two chapters? Firstly, an understanding of the sociocultural resources drawn upon by various communities in the face of exposure to potentially traumatic events should fundamentally inform mental health interventions for migrant populations. The under-utilization and mistrust of mainstream mental health services by migrants – and ethnic minorities in general - has been well documented (Bigfoot & Schmidt, 2010; Mattar, 2011; Watters, 2001) and may be in part due to the variations in healing practices determined by culture as noted above.

As recently highlighted in a study among mental health services for refugees in Greece, Karageorge and colleagues (2016) note the absence of knowledge regarding the acceptability and validity of current mental health interventions for this population. Their research highlights how both refugees and mental health professionals expressed challenges related to

understanding and respecting respective cultures – a significant barrier to accessing such services. They identify the following barriers to the acceptability and validity of mental health services: 1) mistrust or uncertainty of intentions/expectations 2) having more immediate (practical) concerns than talk, 3) difficulty discussing potentially traumatic events and 4) the inadequate cultural competence of health professionals. A recent desk review released by the World Health Organization (WHO) and UNHCR, the United Nations Refugee Agency, has argued that the development of effective mental health and psychosocial support programs requires knowledge of existing health systems and socio-cultural context, and that familiarizing international humanitarian practitioners with local culture and contextualizing programs is essential to minimize risk of harm, maximize benefit, and optimize efficient use of resources (Greene et al., 2017). Another key report recently released by the *International Society for Traumatic Stress Studies* (Nickerson et al., 2018) exploring experiences of potentially traumatic events among refugee populations similarly highlights that the majority of current refugee crises of the 21st century are situated well outside the cultural contexts in which D.S.M.-5 and ICD-10 nosologies have been organized. The report highlights key cultural barriers to accessing adequate and culturally relevant mental health services include “differential symptom expressions across cultures, the potential for limited construct validity of disorders in different groups, and unclear cultural validity of clinical interventions” (p. 15).

Some concrete implications for interventions – as noted by Nicolas (2015) – include an integrated, multi-disciplinary approach which recognises the importance of a social response. This might include, for example, addressing issues aligned with social role and social support disruption; including a focus on current material concerns around living conditions, family reunification, legal and social justice, employment, establishing socioculturally-informed systems of meaning etc. He and his colleagues (2015), for example, have argued for a “social ecology of trauma risk and recovery” wherein interventions addressing exposure to potentially traumatic events take into account structures of family, community and wider social institutions – and a focus on the social positioning of the individual within these structures. They argue that such interventions must be based on the following premises: a) a recognition that culturally shaped narratives of distress play a role in subjective experiences of trauma across cultures and b) a degree of ethnocentricity is inherent in Western conceptualisations of “trauma.” The field of community psychology, more specifically the “ecological analogy” of community psychology as defined by Harvey (2007) similarly argues for an understanding of healing from what she refers to as “traumatic wounds” within a collective, social context. What is required for healing within this “ecological analogy,” she argues, is a deeper understanding of life trajectories, dynamic processes, interactions and the continual development and change in psychological symptoms. The past decade indeed has seen a rise in interventions situated within a cultural perspective – interventions which have expanded to include services designed and delivered by paraprofessionals who are refugees themselves working in a collaborative team approach with mental health providers (Mitschke et al., 2017).

The first article in the chapter aims “to illustrate the substantial psychological impact of current material realities of refugee victims of torture as they adapt to their new environment.” Notably, an *ecological* approach is taken – an approach which considers the concrete social, political,

and economic realities of refugee lives. Through analysing the case of a 30-year-old Indian victim of torture and asylum seeker of Sikh religion, what emerges is evidence of the striking impact of his current situation in Europe on his post-traumatic recovery. Indeed, there is even a question around whether or not his experiences of potentially traumatic events may truly be considered “post.” What we see in the case are echoes of the past torture endured by the patient on his current life situation. The Indian authorities merge into the Greek, the Indian prison cell merges into the cramped living quarters of a squalid Athenian apartment, the instruments of torture merge into the medical instruments used against his will in a Greek hospital... a *persona non grata* in both his country of origin and the host country, we see how the asylum process itself has a significant impact on his psychosocial rehabilitation.

In a similar vein, the second article presented in this chapter presents three case studies which “track trajectories of psychosocial rehabilitation in relation to environmental factors.” Once again, the importance of considering the current conditions in which refugees find themselves is highlighted. This includes the significant impact of the political, legal, and sociocultural environment on processes of psychosocial rehabilitation. The mediating effects of personal, cultural, and social resources are also explored in the article – suggesting some possible implications for mental health interventions. Importantly, the article is co-authored by various health professionals of the project team. Their input is crucial. Indeed, as argued by Daiute (Daiute, 2017), “implicating a range of actors in the [...] process is a way to analyse and consider possible interventions” (p. 12). Discussing interventions requires the participation of the interveners.

ARTICLE SIX: Womersley, G., & Kloetzer, L. (2018). "This is not paranoia, this is real life": psychosocial interventions for refugee victims of torture in Athens. *Intervention, Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, 16(2), 95-102.

Abstract

The need for culturally relevant treatment interventions for refugees focusing on post-migration factors is clearly of no small concern. To (i) explore culturally informed perspectives on trauma from an individual, qualitative perspective and (ii) track the trajectory of post-traumatic responses in relation to processes of social integration, we present the results of 12 months of research among asylum seekers and refugees in an NGO-run centre for victims of torture in Athens, Greece. This included an in-depth follow-up of 10 victims of torture, as well as interviews with 36 health professionals, seven cultural mediators and 21 refugee community leaders. A case study from the research project is presented to illustrate the substantial psychological impact of current material realities of refugee victims of torture as they adapt to their new environment. An interpersonal-social model is presented which examines various post-migration 'feedback loops' influencing post-traumatic symptomatology.

Introduction

The mental health impact of atrocities endured by refugees and asylum seekers is clear, with significantly high prevalence rates of post-traumatic stress disorder (P.T.S.D.), anxiety, and depression being reported among this population. Torture has emerged as a particular triggering factor for P.T.S.D. (Haenel, 2015; Momartin et al., 2003; Steel et al., 2011). However, there have been numerous concerns raised in the literature over the relevance and cross-cultural validity of current treatment models for P.T.S.D. being used among refugee populations. Criticisms highlight the fact that the medicalisation of trauma on an individual level, linked to fixed 'traumatic' events in the past, risks rendering us blind to other ongoing aspects of interpersonal, political and social violence on a more global scale.

Various studies have demonstrated the detrimental impact on mental health of the migration journey, including prolonged detention or stays in often unsafe refugee camps (Gkionakis, 2016; Lambert & Alhassoon, 2015; Silove et al., 2007) as well as the asylum-seeking process (d'Halluin, 2009; Laban et al., 2004). Post-migration factors, such as unemployment, an insecure residency status and fear of repatriation, insufficient proficiency in a host language, social discrimination, and difficulties with integration have similarly been shown to be correlated with mental problems in refugees (Kartal & Kiropoulos, 2016; Schick et al., 2016b; Sijbrandij et al., 2017; Silove et al., 2017). The psychological impact of these factors and other "daily stresses" (Miller & Rasmussen, 2014) are a relevant consideration in light of the additional critical life events with which asylum seekers and refugees are faced. In a multi-agency guide on the mental health of refugee populations released in 2015, UN agencies and

other international humanitarian organisations have highlighted that potentially traumatic events from the past are not the only, or even most important, source of psychological distress but that the majority of emotional suffering is directly related to current stress factors (Crepet et al., 2017; IASC, 2015; Ventevogel et al., 2015; Médecins Sans Frontières, 2016). Several studies on refugees and asylum seekers have confirmed this clinical impression (Maier & Straub, 2011; Silove, 1999; Silove et al., 1998; Van Ommeren et al., 2001). Furthermore, treatment models developed in Western cultural contexts have been criticized for ignoring significant variability among explanatory models of distress evident in different cultural settings (Hinton & Lewis-Fernández, 2011; Steel et al., 2009). Often, the relationship between the health professionals and asylum seeker or refugee face cultural barriers regarding a lack of shared understanding, explanatory model or idiom of distress, rendering exchanges in the consultation difficult and increasing the risk of incomprehension and errors in diagnosis and treatment. This itself is a barrier to access.

From a public health perspective, the need for culturally relevant treatment interventions considering post-migration factors is clearly of no small concern. A plethora of key authors in the field as well as humanitarian actors have highlighted this gap in the literature and call for more longitudinal studies to add to our understanding of trauma from a more culturally, socially and politically relevant perspective. This includes a focus on life trajectories, dynamic processes, and current material realities for refugees in host communities (Bäärnhielm, 2016; Eagle, 2014; Greene et al., 2017; Hall & Olf, 2016; Harvey, 2007; Goguikian Ratcliff & Rossi, 2015; Summerfield, 1996, 2001; Wilson et al., 2004).

Given these numerous criticisms surrounding the use of P.T.S.D. among refugee populations, we draw on the theoretical framework of cultural-historical psychology to examine trauma among this population (Womersley & Kloetzer, 2018d). Based on Vygotskian principles of interactive individual–societal development via the creation of meaning in everyday activities (Daiute & Lucić, 2010), such a framework explores how psychological phenomena are historically rooted and shaped by the sociocultural context. This framework therefore advocates for a move away from the essentialist and context-independent notions of P.T.S.D. toward viewing experiences of trauma as being embedded within sociocultural contexts and intrinsically interwoven with them (Stetsenko & Arieviditch, 2004). This theoretical tradition differs from transcultural or ethnopsychiatric frameworks often characterised by cross-cultural comparisons. Instead, within this tradition, culture is considered to be “not a fixed, static entity but the result of creative activity in which ideas and notions are developed and shared” (Tankink & Richters, 2007, p. 198). It “is not presumed to exist in values or beliefs of ethnicity, gender, or other categories but in the creation of meaning through symbolic thought in situations on the ground” (Daiute & Lucić, 2010, p. 616).

In recent years, there has indeed been a burgeoning of theoretical models for understanding trauma that situates individual refugee’s trauma sequelae and recovery within inter-personal, political, and social context. Maercker and colleagues (Maercker & Hecker, 2016; Maercker & Horn, 2013) have recently elaborated and extended a social-interpersonal framework model of

P.T.S.D. incorporating a host of influential factors external to the individual. Harvey's (Harvey, 2007) "ecological" model, Droždek's (2015) model, Marsella's (2010) interactive model, and De Jong's (2007) ecological-cultural-historical model of "traumascape," similarly explore how culture influences the clinical parameters of the diagnostic criteria for P.T.S.D. by incorporating a systemic understanding of local representations and experiences of trauma. Such perspectives take into account the fact that symptom severity is fluid, ever changing due to a myriad of interacting intrapsychic and external factors. In the context of refugee distress in particular, Miller and Rasmussen's (2017) ecological model highlights how "mental health among refugees and asylum seekers stems not only from prior war exposure, but also from a host of ongoing stressors in their social ecology, or displacement-related stressors" (p. 1).

Using these ecological models to i) explore culturally informed perspectives on trauma from an individual, qualitative perspective and ii) track the trajectory of symptomatic responses in relation to processes of social integration, we conducted 12 months of research among asylum seekers and refugees in an NGO-run centre for victims of torture in Athens, Greece. This longitudinal study involved participant observation as well as qualitative, in-depth interviews with 76 various actors.

Methodology

The study protocol was developed in collaboration with the multidisciplinary team of the centre for victims of torture in Athens, Greece. Ten victims of torture attending the clinic were identified by the medical team to participate in the research. Exclusion criteria included current psychotic symptoms, severe dissociative symptoms, and acute suicidality. The average age was 39.5, and we conducted an average of 5.2 interviews with each of them over the period of a year. Interviews were focused on tracking trauma symptomatology, subjective experiences, and explanatory models of trauma, as well as exploring the current socio-political environment and processes of integration into Greek society. Three months of participant observation was similarly conducted within the centre, which included attending daily team meetings and participating in group psychosocial activities.

To further contextualize our understanding of trauma within this particular environment, we also conducted interviews with 36 health professionals working with refugee victims of torture from a variety of humanitarian organisations, and seven cultural mediators working in psychosocial interventions for individuals diagnosed with P.T.S.D. Furthermore, we conducted qualitative, in-depth interviews with 21 community representatives in order to explore socio-culturally contextualized understandings of, perspectives on and explanatory models for psychological trauma within their respective communities.

Analysis

Individual victims of torture's experiences of trauma were analysed based on the ecological models noted above (De Jong, 2007; Droždek, 2015; Maercker & Hecker, 2016; Miller & Rasmussen, 2017). This involved firstly defining the migration trajectory of each individual by drawing on Kadianaki's (2009) method of analysis of migration trajectories wherein certain bifurcation points (BFP) are identified: defined as important events or conditions in the lives of the individuals. In a second level of analysis, we analysed all instances whereby participants referred to experiences of trauma, in order to identify and compare the various explanatory models drawn upon by different actors. Data obtained by health professionals related to specific individuals was triangulated.

Key themes emerging included the substantial psychological impact of current material realities for migrant victims of torture as they adapt to their new environment and engage in a process of psychosocial rehabilitation. The periods before and after being granted asylum were identified as two distinct phases in the psychological lives of these individuals, each with specific stressors. Delayed asylum trials, poor living conditions, and unemployment emerged as having a substantial impact on post-traumatic symptoms that in turn influenced psychosocial rehabilitation. Personal, social, and cultural resources similarly emerged as having a mediating effect on the stressors identified above.

Culturally informed representations of trauma

Half of the beneficiaries of the centre where our research was conducted had never heard of a psychologist before. None had been previously to a psychologist themselves. Of the ten individual participants, all were diagnosed with some form of psychological disorder. However, over the course of a year, not one mentioned the diagnosis when referring to their subjective experiences of psychological suffering. Rather, the majority appeared to contest this medicalised explanatory model, drawing instead upon a variety of diverse culturally-informed explanatory models to explain their subjective experiences of trauma. For instance, when asked about his diagnosis of P.T.S.D., one participant explained that "my family's problem is shock." For him, the trauma he experienced was not only his but related to the "shock" of the entire family. This contradicts the inherently individual narrative of P.T.S.D. This was similarly reflected in the words another participant, who felt "the pain of my families." This more collectivist representation of trauma has similarly been noted in the literature, illustrated in the example presented by Tankink and Richers (2007) of South-Sudanese research participants who did not experience themselves so much as an individual, but more as having a 'family self' based on relational models.

Such explanatory models often appeared in contradiction to the medical team's individualised model of P.T.S.D. Elsewhere (Womersley & Kloetzer, 2018c), we have highlighted how the

majority of professional's discourse reflected a certain ambivalence in the face of such contradictions. Attitudes among the health professionals appeared to range on a continuum from complete and unproblematic acceptance of the category of P.T.S.D., to a nuanced, individualised and context dependant use, through to a critiquing and problematisation of the diagnosis.

An illustrative case study allows us to examine these contradictions in explanatory models of trauma, and the importance of the socio-legal environment in processes of recovery. Many cultural factors, such as a specific socio-political identity, were evidently at play for this particular individual. Furthermore, the case clearly highlights the impact of particular legal and medical institutional pathways on psychosocial recovery. It further offers the possibility of triangulating the data obtained from this individual participant, his doctor and psychologist.

Case presentation

Dilraj is a 30-year-old Indian asylum seeker of Sikh religion. In 2007, he was arrested and tortured on numerous occasions, often for months at a time, due to his involvement as a Sikh political activist. He managed to escape from prison with the help of an uncle, and arrived, alone, in Athens to seek asylum in September 2015. He was referred to the centre for victims of torture in June 2016, where his treating doctor describes "a clear case of post-traumatic stress disorder," including symptoms of flashbacks and nightmares, at the first consultation.

We first interviewed Dilraj in August 2016. From the very beginning of the very first interview, he highlighted his family's collective identity as Sikh political activists, with a long history of trauma across the generations:

"My father's, my father family and my mom's family - they are very, very connected with their religion [...] from my mom's family, I have seen a lot of dead bodies. They were innocent and they were killed by the Indian government police and the secret services, because of that, because we were fighting for our freedom."

Over the course of the following four interviews, he described the psychological impact of the various methods of torture to which he was subjected in minute detail, including sexual abuse, his legs being "ripped apart" the meta-tarsals in his feet being broken, as well as electrification:

"From the front, they were giving the electric shocks. They never give the scars on my body but they give me the scars on my personality. They give me the scars on my soul...lots of things from my mind has been wasted."

For the first 4 months after his arrival, he was living alone in a 30 meter-squared hotel room in an old building recently repurposed to house asylum seekers. Alone, lost, and scared of being recognized by other members of the Indian community, he barely left his apartment. At the end of August 2016, he was given an appointment for his asylum interview. However, the administrator responsible was not present on the day and he was given a new date for his interview in December. This seemed to symbolize a denial of his story, of his cultural identity as a Sikh political activist, of his very being. He explained that:

“During the interview, I want to be wearing a turban because during the interview I want to tell them that I am a part of the Sikh religion because of my religion, because of my race, I have been persecuted in my country.”

This fear seemed to echo the past traumatic experience of being tortured, a fundamental part of which involved the torturers removing his turban and mocking his Sikh identity. He consulted a doctor and a psychiatrist at the centre, who wrote a medical report to add to his request for asylum. The report stated that he was suffering from P.T.S.D., yet this was a concept unknown to Dilraj and he continued to refer to his psychological state as one of depression:

“D: Mr. Psychologist doctor, he gave me the report. In that report, he has written that I'm in very big depression. Actually, I don't know if I'm in depression or not. I know only one thing, that my world is just only this room... I'm just killing my time here until I'm not getting my papers or they are not going to take my interview [...]

Interviewer: Tell me about the psychiatrist you said that you're going to be seeing later.

D: Why I'm seeing a psychiatrist – well, without any reason [our emphasis]... In my dreams, I saw this police officer because in front of me, he was kicking my mom's stomach ... I'm still having dark dreams...

Interviewer: Is it helpful for you to see a psychiatrist?

D: No, it's not [our emphasis]. What he is going to do, I don't think he's going to help me in any way. The things that happened to me, what he wants to do, he's just speaking, and speaking, and speaking, and talking about things, nothing much... Why I am coming to the people here, to see the psychiatrist and the doctor, because then they will know that I'm also here. There are thousands and millions of refugees here. If were to come in here, I will be in front of their face, and they will be knowing about me.”

The contradictions between Dilraj’s own explanatory model, and that of the psychiatrist, are striking. He reported not finding the consultations with the psychiatrist helpful, seeing little use in being required to “talk about things.” Not only did he not agree with the P.T.S.D. diagnosis, he mistook it for a diagnosis of depression. There seemed to be little correlation between the words of the psychiatrist and the “scars of [his] soul.” Despite continually being haunted by “dark dreams,” his focus was on being “seen” as a refugee. Never having heard of a psychologist or psychiatrist before, he saw psychotherapy as a useful way to obtain this legal goal.

Towards the end of 2016, his psychological condition deteriorated. Due to financial reasons, he was forced to move out of his small hotel room into shared accommodation. He accused his Pakistani roommate of spying on him. Psychotic symptoms started to emerge, including auditory hallucinations and paranoia. Many of the voices were those of authority figures, including the torturers in India and, rather tellingly, police officers, bureaucrats and judges in the asylum procedure in Greece. He was hospitalized as a result. When interviewed about his hospitalization and the deterioration in symptoms, his psychologist stated:

“One voice said, “You will be homeless you will be homeless,” and there is a possibility to be homeless. Or another voice said that, “They will not believe you they send you back to India,” and that is true... What he hears is normal, it's his fear [our emphasis].”

His doctor similarly noted the potentially harmful effect of forced hospitalization:

“Psychiatrists are not sure whether his post-traumatic stress disorder was that and only that or if he even before had some psychotic elements that now worsened. Hospitalization was difficult for him; it reminded him of prison. All the staff would keep visiting, bringing chocolates or to distract the prison-like atmosphere. I am worried about him, because he doesn't seem to respond to treatment that well... It's not a good time for him generally, because first he found himself living in an apartment with Pakistanis. They could speak the language; he got afraid. They were having drinking, smoking and things like that; he got very scared. That was when things really got bad and he went to this hospital... Then he heard from his relatives in India that his mother and father are in prison. His father is probably killed, because we hear from these relatives too, but he doesn't know. He knows that his father has disappeared in prison. The news that he receives about his mother is that she's in prison with an infected leg. She has nothing, just a rag to wipe the pus. That's what he knows about his mother. This is another stress factor. Another very stressing thing for him is that his interview got postponed till August. That made him really angry and frustrated. All these things add up.”

She also noted the impact of his current reality on the process of diagnosis:

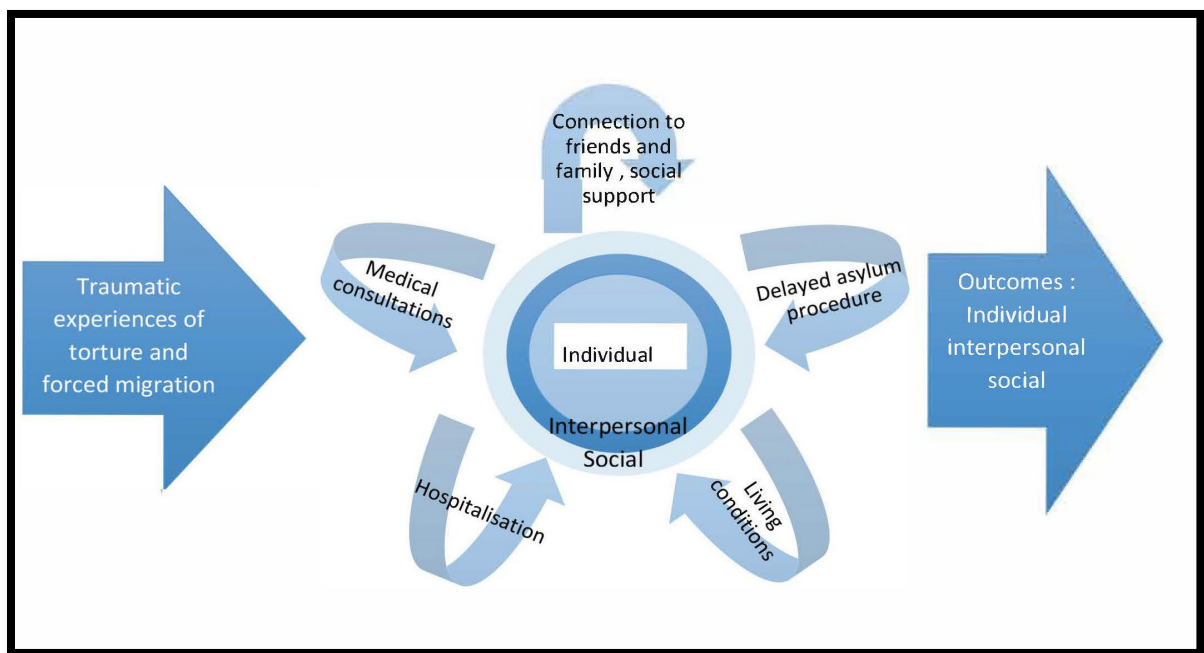
“I could see the face of the psychiatrist who at first said, ‘You think the secret services of India are after you?’ I could see the paranoia. Then [Dilraj] said his story. There he goes, “Oh, oh, oh, oh.” [laughter] This is not paranoia. This is real life.”

Feedback loops

So what is “paranoia” and what is “real life?” To analyse the data, we draw on the concept of feedback or “looping effects” (Kirmayer & Ramstead, 2016), defined by the authors as links in a causal chain “whereby individuals interpret and respond to their own symptoms with culturally varied coping strategies that may change the course of the illness, amplifying or reducing symptoms and distress” (p. 6). They argue that such socio-cultural feedback amplification extends beyond the individual to include a wider network of relationships and processes wherein the individual is embedded.

We posit that such a series of “feedback loops” (which we define as a process whereby an effect is reinforced by its own influence on the process giving rise to it) impacted post-traumatic symptoms as well as Dilraj’s self-representation of his own mental health status. A number of feedback loops may be identified on an individual, interpersonal, and social level, as illustrated by our model below:

Figure 1: Feedback Loops



First feedback loop: Breakdown of interpersonal relations

The experience of being tortured is arguably a traumatic experience in and of itself. However, added to this is the fact that Dilraj is not the only member of his family to have been tortured. His father's presumed death, and mother's alleged detainment and torture alludes to a traumatic experience extending far beyond that of the individual. Indeed, the torture of his family, and subsequent forced migration which he undertook alone, created traumatic ruptures in his interpersonal relationships and by extension, his broader social world. Paradoxically, such connections would have connected him to the very resources necessary to heal. These are both resources found on an interpersonal level in disclosure and sharing emotional experiences, and on a social level within secure group membership. Thus a vicious cycle of isolation and disconnection is perpetuated, seemingly serving to exacerbate his fear. Furthermore, the disconnection cannot be considered as a "once-off" event which occurred at a particular moment in the past: ruptures continue with each phone call bringing news from India.

Second feedback loop: Delayed asylum procedure

A long asylum procedure has been found in the literature to be associated with psychiatric disorders (Laban et al., 2004). For Dilraj, his insecure residency status increased uncertainty regarding his future as well as his ability to integrate, look for work, and create a life for himself. Waiting for his asylum interview, his fear was compounded by being in an irregular legal situation and the risk of being forced out of the country. This fear kept him from leaving his

house and integrating into his new social environment. On an interpersonal level, this reduced opportunities for exchanges. On a social level, the delay arguably contributed to further disconnections in visibility, representation and the acknowledgement of the torture which he had endured within broader societal and political contexts – intricately linked to restorative justice perceptions contributing to the severity and course of P.T.S.D. (Maercker & Hecker, 2016). The loop returns to the level of individual, in Dilrajs' questioning of his own social, cultural, and political identity.

Third feedback loop: Living conditions

The delayed asylum procedure prevented Dilraj from having the right to look for work and find an apartment on his own. Without more financial, legal, or social resources, and thus still dependant on state services as an asylum seeker, he was moved from his own hotel room to new accommodation. Sharing with Pakistanis whom he did not trust, his interpersonal resources were further compromised and his social world further limited by not being able to find work. Such conditions seem to have exacerbated the post-traumatic symptoms, with auditory hallucinations telling him that he would be homeless leading to his hospitalisation.

Fourth feedback loop: Hospitalisation and interpersonal encounters in medical consultations

His post-traumatic stress symptoms exacerbated, Dilraj was hospitalised. Again institutionalised, finding himself once more at the mercy of the state, it was perceived as a further enforced period of detention where he was subjected to bodily treatments against his will. It triggered memories of the past torture he endured. Furthermore, it positioned him in the role of patient – leading him to question whether he was “sick” or not. He was promised by the hospital staff that they would not inject him. They did. This deepened his sense of mistrust, paranoia, and isolation – creating further interpersonal ruptures. Dilraj's hospitalization, and numerous encounters with medical staff, lead him to question his own status as “sick” or healthy, “normal” or abnormal. His psychologist explained:

“when I asked him what is his request and what is his reason and why he decide to visit psychologist, he said to me ‘I don't know, because of my doctor said to me that it's good for me. My psychiatrist said the same, my social worker said the same, a police man who stopped me said the same.’ I asked him, “Then what do you think, why do all this people propose to you to come and see the psychologist?” He said to me, “I don't know, maybe they need a psychologist.”

On an interpersonal level, it speaks to the feelings of both shame and anger he expressed throughout the interviews in being seen as someone in need of psychiatric care. His doctor explained:

“He doesn't seem to understand it as an illness. He says that he feels abnormal, he feels wrecked; he says that he's not dangerous; that he is not crazy. Every time I say to him, ‘These voices is just a symptom of a disease that will go away eventually,’ he doesn't seem to listen.”

Such discrepancies between his own explanatory model for his symptoms, and that of others around him, had an impact on his interpersonal relationships. They seemed only to reinforce his solitude. Here, it is worth returning once more to his stated reason for attending consultations with the psychologist and psychiatrist as highlighted above. It is not because he seems himself as a patient. It is for visibility and recognition. It is so that “they will know that I am also here.”

Discussion

In operationalising Kirmayer and Ramsted’s concept of “feedback loops” to analyse the case of Dilraj, feedback loops may be identified across a number of systems: interpersonal, bureaucratic, medical, and material (related to concrete living conditions). All of the ten victims of torture participating in the study experienced interpersonal disruptions through the experience of migration, had to apply for asylum, were patients at the clinic receiving psychological and medical treatment, and experienced poor living conditions. However, not all of these resulted in such feedback loops - defined by their capacity to “exert powerful influences on the causes, course and outcomes of distress” (Kirmayer & Ramstead, 2016).

We analysed the ten cases of our research exploring feedback loops across the four systems identified above, and identified them when the subjects themselves, or the staff members, explicitly linked some life event to the mental health evolution of the refugees. A brief summary of this analysis is presented in the table below.

Table 1: Feedback loops among the ten participants

(Feedback loops identified in the analysis are marked by an “x” with an accompanying qualitative explanation)

Participant	Interpersonal	Bureaucratic	Medical	Material
1				x (living alone, unemployed - increased auditory hallucinations)
2	x (family killed/lost - "I become crazy")			x (living alone, unemployed - increased ruminations)
3			x (multiple medical emergencies)	x (homeless, being in a refugee camp is a "shock,"

				exposed to violence in the camp)
4	x (socially isolated, subjectively lonely, lost a child)	x (denied refugee status - increased P.T.S.D. symptomatology)	x (risk of physical disability, multiple surgeries)	
5	x (encounters with police triggered memories of the torture)		x (multiple surgeries, physical disability, unable to leave the house)	
6	x (family killed/lost)	x (delayed asylum procedure)	x (forced hospitalization)	x (sharing living quarters with foreign nationals against his will)
7	x (separated from her three children)	x (denied refugee status)	x (multiple hospitalisations linked to psychosomatic complaints)	x (single mother, unemployed)
8		x (asylum procedure delayed for 2 years)		
9	x (separated from wife and children in Germany)	x (delayed family reunification to Germany, imprisoned)		
10		x (imprisoned in Greece)		

Feedback loops were evident across all cases. However, not all experienced multiple feedback loops. Dilraj seems to be both representative of our sample (in the effect of feedback loops on mental health) and an extreme case (in the multiplicity of feedback loops, across all four fields).

Conclusion

Trauma begets trauma. It creates ruptures at the intersection of the individual and their social context. Exposure to trauma, itself connected to a breakdown in social connection and exacerbated by the process of migration, risks the individual being caught up in a vicious cycle where interpersonal or social resources may be comprised, the very resources necessary for the event itself to be collectively represented and made sense of. For many migrants, torn from the

fabric of their collective socio-cultural and political identities, what is potentially compromised is the ability to draw on meaningful interpersonal and social resources to make sense of these events. The multiple traumatic experiences throughout the migratory journey echo exclusion experiences, and the difficulties and uncertainties related to administrative trajectories. In addition, the asylum procedure itself imposes specific, complex institutional pathways which need to be navigated. This is particularly so in the case of victims of torture with specific mental health and medical needs.

As illustrated by the case of Dilraj, post-migration factors encountered in Europe, including delayed asylum trials and poor living conditions, had a substantial impact on post-traumatic symptoms among refugee victims of torture in the study. These symptoms were never static but in a continual state of flux, in dynamic interaction with the socio-cultural environment. Psychosocial interventions need to incorporate contextualised understanding of these interactions, and to recognise trauma as being largely determined by larger cultural systems and socio-political contexts.

ARTICLE SEVEN: Womersley, G., Kloetzer, L., Van den Bergh, R., Venables, E., Severy, N., Gkionakis, N., Popontopoulou, C., Kokkiniotis, M., & Zamatto, F. (2018). "My mind is not like before": Psychosocial rehabilitation of victims of torture in Athens. *Torture: Journal on Rehabilitation of Torture Victims and Prevention of Torture*, 28(2), 72-84.

Abstract

Introduction: The dual trauma inherent in being both a victim of torture as well as a refugee is related to a myriad of losses, human rights violations and other dimensions of suffering linked not only to torture experienced pre-migration, but to different forms of violence experienced during and after migration as well. **Method:** In order to i) explore culturally-informed perspectives on trauma among victims of torture and ii) track trajectories of psychosocial rehabilitation in relation to environmental factors, we present a series of case studies from the results of 12 months of research among asylum seekers and refugees in a center for victims of torture in Athens, managed by *Médecins Sans Frontières* and Babel in collaboration with Greek Council for Refugees. This case series is a part of a larger qualitative study being conducted which follows beneficiaries of the project, their care providers and community representatives and leaders. **Results:** Key themes emerging include the substantial psychological impact of current material realities of migrant victims of torture as they adapt to their new environment and engage in a process of psychosocial rehabilitation. Delayed asylum trials, poor living conditions and unemployment emerged as having a substantial impact on post-traumatic symptoms that in turn influenced psychosocial rehabilitation. Personal, social, and cultural resources similarly emerged as having a mediating effect on the stressors identified above. **Discussion:** The results of this study highlight the significant impact of the political, legal, and sociocultural environment on processes of psychosocial rehabilitation. Practical implications for interventions are to assure holistic, interdisciplinary, and culturally sensitive care which includes a focus on environmental factors affecting resilience; and with a dynamic focus on the totality of the individual over isolated pathologies.

Introduction

The mental health impact of atrocities endured by refugees ²⁹ is clear, with a high prevalence of post-traumatic stress disorder (P.T.S.D.) reported among this population. Torture has emerged as a particular triggering factor (Haenel, 2015; Hodges-Wu & Zajicek-Farber, 2017; Silove et al., 2017; Song et al., 2017). This is no surprise, given the multiplicity of challenges to which refugee victims of torture (V.O.T.s) are exposed. The dual trauma inherent in being

²⁹ Here, we use the term "refugee" as defined by the Geneva Convention of 1951 to include both refugees legally recognised in a host country as well as asylum-seekers.

both a V.O.T. as well as a refugee is related to a myriad of losses, human rights violations and other dimensions of suffering linked not only to torture experienced pre-migration, but trauma experienced during and post-migration as well (Hodges-Wu & Zajicek-Farber, 2017). Trauma does not stop at the border.

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

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

These theoretical frameworks take into account the fact that humans are essentially social beings, and that, equally, symptom severity is not static but fluid and changing due to a wide range of interacting intrapsychic and external factors. There is thus a need to explore trauma ‘in context’ – notably through exploring processes of psychosocial rehabilitation of victims of torture within the specific historical, cultural, social, and political context of the “reception crisis” in Europe. This is important not only in order to challenge the concept of P.T.S.D., but also to provide more appropriate mental health care to V.O.T.s with a consideration for both cultural factors as well as the impact of current environmental stressors on the process of rehabilitation. Therefore, in order to i) explore culturally-informed perspectives on trauma among V.O.T.s from an individual, qualitative perspective and ii) track trajectories of psychosocial rehabilitation in relation to environmental factors, we present a case series from the results of 12 months of research among asylum seekers and refugees in a center for victims

of torture in Athens, managed by *Médecins Sans Frontières* (M.S.F.) and Babel (a mental health unit for migrants and refugees operating in Athens since 2007) in collaboration with Greek Council for Refugees (GCR).

Methodology

Study design

This is a case series, based on a series of in-depth interviews with three V.O.T.s and their care providers over the course of a year.

Study setting

Victims of torture in Athens, Greece: As the “reception crisis” continues unabated, Greece remains one of the first ports of sanctuary. While the country is still gripped by one of the worst financial and societal crises of the past 40 years, little attention or funding is available to provide mental health and psychosocial support to refugees (Gkionakis, 2016). According to recent statistics provided for March 2018 by the UNHCR, ³⁰ over 50,000 asylum seekers and refugees currently remain in Greece, following the 2015-2016 mass flow. This population is legally entitled to free access to medical care, yet the ability of the Greek health system to provide adequate health care to refugees upon entry is severely stretched as a result of the ongoing economic crisis, resulting in numerous barriers to access (MDM, 2016). These challenges are even more pronounced for migrants faced with a lack of information and linguistic and cultural barriers to accessing an unfamiliar system. Often living in harsh and isolating conditions, a 2017 report by UNHCR ³¹ estimates that many migrants will wait for over two years to find out about their asylum status.

There are few reliable statistics concerning the number of V.O.T.s currently in Greece (FRA, 2017; Médecins Sans Frontières, 2016; UNHCR, 2017). The UNHCR has estimated that among refugee populations, between 5 and 35 percent are torture survivors, yet highlights that the actions that are needed to identify and support and enable them to claim their rights are too often ignored or purposely excluded (UNHCR, 2017). In Greece, few rehabilitation or identification services are provided to survivors of torture by a state structure or sustainably by NGOs apart from one organisation, Metadrasi, who certified 650 V.O.T.s from 2017-2018. ³² Most efforts of identification appear to be ad-hoc or dependent on some form of self-identification. This complex asylum system, the poor identification of V.O.T.s and the many barriers in accessing basic services in Athens and across the country have had a substantial,

³⁰ <https://reliefweb.int/sites/reliefweb.int/files/resources/62950.pdf>

³¹ <http://www.unhcr.org/publications/operations/58d8e8e64/unhcr-recommendations-greece-2017.html>

³² <http://metadrasi.org/en/campaigns/certification-of-torture-victims/>

adverse impact on mental health (Kotsioni, 2016). It has also lead to health professionals under pressure to “medicalise” the psychological suffering (for example, through the use of a certified P.T.S.D. diagnosis) as part of the identification process (FRA, 2017), as has been noted elsewhere in Europe (d’Halluin, 2016; Fassin & d’Halluin, 2005).

M.S.F. and Babel clinic for rehabilitation of victims of torture and other forms of ill-treatment: In April 2013, the Greek Council for Refugees (GCR) jointly with Babel Day Centre and Dignity (the Danish Institute Against Torture) started the implementation of the Prometheus project, funded by the EU. Prometheus project’s main goal was to deliver identification and rehabilitation to V.O.T.s through health and mental health service provision, as well as legal and social support. In September 2014, M.S.F. joined this partnership. Since 2014, M.S.F., Babel, and GCR have established a unit delivering medical care, legal support, mental health care and social support to V.O.T.s, training and supervision to the staff of this unit and training and consultation to other actors who work with V.O.T.s. The unit adopts the IFRC definition of torture and ill-treatment (where torture is defined as consisting of severe pain or suffering, whether physical or mental, inflicted for such purposes as obtaining information or a confession, exerting pressure, intimidation or humiliation) and operates as an interdisciplinary team applying a holistic approach to the rehabilitation of torture survivors.

Study population

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

Ethics

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

Results

Key themes emerging across interviews with the three selected participants included the substantial psychological impact of current material realities of migrant V.O.T.s as they adapt to their new environment and engage in a process of psychosocial rehabilitation. The periods before and after being granted asylum were identified as two distinct phases in the psychological lives of these individuals, each with specific stressors. Delayed asylum trials, poor living conditions, and unemployment emerged as having a substantial impact on post-traumatic symptoms that in turn influenced psychosocial rehabilitation. Personal, social, and cultural resources similarly emerged as having a mediating effect on the stressors identified above.

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

The case of D

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

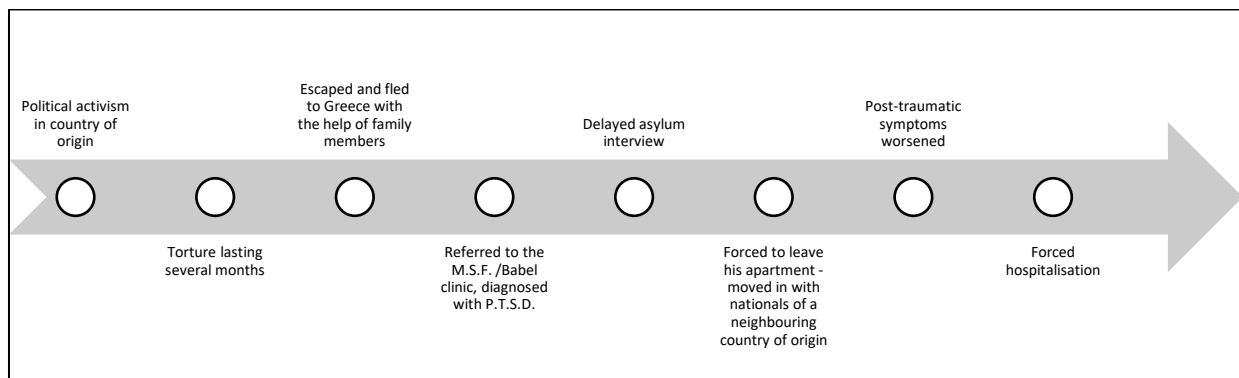


Figure 1: *Timeline of the key elements in the pre-migration and post-migration life of D, emphasizing the influence of environmental context.*

Over the course of the four interviews, he described the various methods of torture to which he was subjected, in minute detail, including sexual abuse, his legs being “ripped apart,” the metatarsals in his feet being broken, as well as electrification:

“They give me the scars on my soul...lots of things from my mind has been wasted.”

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

"I don't have any friends here, I don't have any relatives, I don't have any family members, I don't even know any [religion removed] community here. I know that there are a lot of [religion removed] people living here, my new community is here, not 'my' community... when I am staying at a hotel, whenever somebody is knocking at the door, I feel scared... I never go out."

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

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

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

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

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

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

The phrase “this is real life” is indeed telling: D’s “real life” – characterised by poor living conditions, social isolation, and delayed asylum trials, played a key role in his mental health. His case highlights the role of “feedback loops” (Kirmayer & Ramstead, 2016) – vicious cycles wherein symptoms were exacerbated by “real life” events and which played a key role in his psychosocial rehabilitation.

The case of J

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

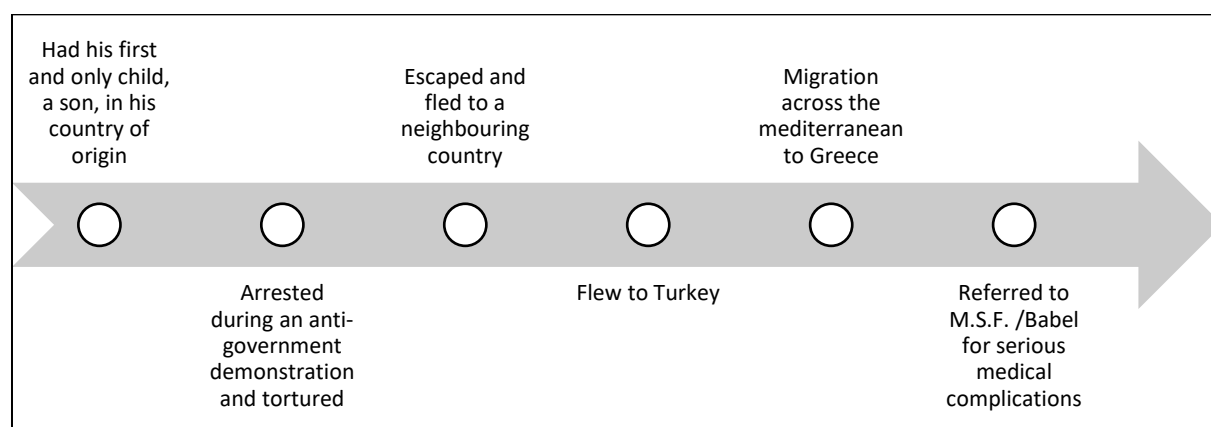


Figure 2: Timeline of the key elements in the pre-migration and post-migration life of J, emphasising the influence of the legal context.

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

“We are human beings, but I am an adult without a wife, without a child. My life is bloody ruined, everyone is in the same hole, who can change it? Nobody. Nobody cares about us... [these problems] devour us. If I was well, you could see that I was well, but I’m sick, I’m not in good health. I’m physically fine, but in my interior – I’m not at all okay [...] I’m with the others but not in spirit”³³

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

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

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

³³ Loose translation from the original interview conducted in French.

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

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

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

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

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

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

The case of B

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

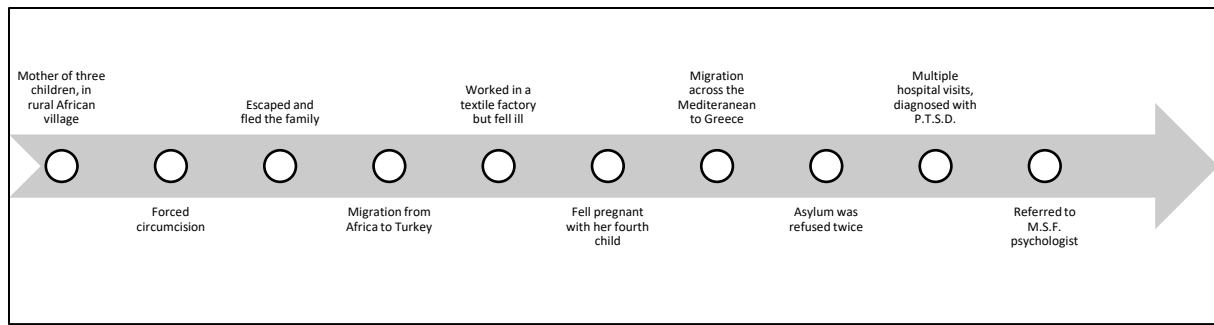


Figure 3: Timeline of the key elements in the pre-migration and post-migration life of B, emphasising the influence of the cultural context.

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

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

She related her experience of fear to both the isolated incident of torture she endured, as well as to multiple other factors, including having been forced to leave her children, as well as her uncertain future. She felt unable to return to her country, but also unable to engage in a process of rehabilitation for the future. No one single incident could account for this unexplainable fear. Thus paralyzed, she remained isolated from others, barely leaving her apartment except for the occasional visit to the clinic to see her psychologist.

A few months later, she explained:

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

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

“Because maybe, in my head, I am guilty, it’s true....but Christ has already forgiven me. That’s also the problem [...] spiritually, it’s complex. What I see, I explain spiritually with the hand of witchcraft. It means that the family isn’t leaving me in peace. Spiritually, they are following me, they followed me two

nights ago until I was scared. I don't know, there are two explanations. Apparently there is an explanation that's different to what I think myself. So I don't know which to leave or take. I don't know...but I told myself that maybe that one's right as well."

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

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

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

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

Discussion

The cases above attest to the significant impact of the environmental, legal, and sociocultural context on processes of psychosocial rehabilitation among refugee V.O.T.s. This includes the broader socio-economic framework in host countries and the ways in which these frameworks may hinder or facilitate rehabilitation. Daily stressors represent proximal, ongoing and often chronic threats to psychological wellbeing. Due to this chronicity, these daily stressors may gradually erode coping resources and tax mental health - creating conditions for feelings of powerless and helplessness linked to a real or perceived loss of control over the environment (Miller & Rasmussen, 2017). This echoes the plethora of research already conducted on mental health of refugees indicating the adverse effects of post-migration stressors (Chen et al., 2017). As for many other V.O.T.s across the world, the process of seeking asylum itself was a seemingly retraumatising experience for the participants on many levels. Firstly, it could be argued that the perception of ill-treatment at the hands of an indifferent yet powerful state

apparatus may be reminiscent of the torture conditions to which they were subjected in their country of origin. Secondly, the very experience itself of having to recount the horror of the experience of torture in an asylum tribunal may be equally traumatising (Schock et al., 2015).

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

Conclusion

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

V.O.T.s may experience a disconnection from their body, their emotions and their identity and need to regain trust in other human beings, society and themselves. This is a complex process in which professionals need to be able to acknowledge the individual not as a patient, but a totality. It is vital that the professionals do not limit themselves to a diagnosis and treatment of symptoms but rather focus on how to empower the individual to regain control. Conceptualising

the mental health of refugees requires the recognition of the role of both pre-migration trauma and post-migration stressors and that psychological distress can manifest in various ways. As stated by Viñar (2005b), we cannot listen to a tortured man and see an understanding of his person unless we dare to take a little interest in the oppressive order that destroyed him; not only to seal his wounds, but also to restore his humanity.

CHAPTER TEN: Reflections on ethics in the research relationship

The research methodology I have adopted in this thesis, grounded in a sociocultural framework, is broadly interactionist, constructivist and subjectivist - emphasizing the processes of mutual recognition, participation and co-construction of the actors involved (Goguikian Ratcliff & Rossi, 2015). It aims to “to capture the interplay between discourse, social institutions, and practices by examining everyday interactions through participant observation and in-depth interviews that explore individual experience ... [to] account for the deep embedding of all experience in local social worlds” (Kirmayer & Ramstead, 2016, p. 8). It advocates a specific focus on the role of language, meaning-making and subjectivity and within which language use seen as inevitably constructing and constructed by the socio-cultural, economic and political context (Danes, Haberman, & McTavish, 2005; Gee, 2004, 2014; Wood & Kroger, 2000). It does not assume objectivity but, instead, privileges positionality and subjectivity (Kohler-Riessman, 2000). As such, a critically reflexive attitude towards thinking about the research relationship necessarily informs the process (Gergen & Gergen, 1991; Kohler-Riessman, 2000; Parker, 2005).

A Levinasian research-ethics strategy, arguably embedded within the dialogical approach that I adopt within this thesis, acknowledges that genuine encounters with an Other necessitates being open to the other (Levinas, 1991; Levinas & Nore, 1994) to the extent that the encounter transforms both the Other and the Self (Gillespie, Kadianaki, & O'Sullivan-Lago, 2012). For Levinas, ethics is a responsibility to other people that is involuntary and singular. The demand of ethics comes from the intimacy of an experienced encounter. Its contours cannot therefore be codified or predicted in advance. In other words, a research relationship can be ethical only if its characteristics are not predetermined. If institutionalised ethical practices are centred round a standard contract setting out the parameters of an ethical relationship prior to an encounter with the Other, then they are the opposite of an ethical relationship. This applies to the position of the researcher within the research relationship. All exchanges are considered unique, embedded within a certain time and within a certain sociocultural context, and transformative.

These ethical reflections therefore demand that I go further than the ethical research protocols highlighted in **chapter five**. They require an examination of the activity of narrating within the researcher-participant relationship in particular, of “the co-production of narratives through the dialogic exchange between interviewer and participant” (Kohler-Riessman, 2000, p. 7). How did the participants use narrating in the interview as a cultural tool to make sense of their experiences of migration? How did the dynamics of the research relationship conform, contest, or transform existing power imbalances inherent to working with socially, economically, and legally vulnerable populations such as refugee V.O.T.s? To what extent were hegemonic narratives adopted, resisted, appropriated, and refashioned? To what extent were participants given the opportunity to be “active agents in the way they articulate their responses to the request to tell their “life stories”... creative agents who shape not only their own social

positioning but [existing] centrist narratives” (Nagar-Ron & Motzafi-Haller, 2011, p.2)? Furthermore, these ethical reflections require an examination - not only of the activity of narrating - but the way in which the narratives are consequently **represented**. How do we (re)present refugee stories not as clichéd “tragedies or hopeless outcomes” (Kottler, Banu, & Jani, 2020, p. 4) – but in doing so bear witness to tragedy?

Within the sociocultural framework adopted in this thesis, both the micro-context of the interview setting and the macro political and sociocultural context in which the interview occurs, must be considered. This includes a consideration of the inevitably unequal power dynamics which frame the exchange between interviewer and interviewee – particularly in the case of vulnerable or marginalized populations (Nagar-Ron & Motzafi-Haller, 2011). In other words, what characterises the exchange is that it is inevitably based on asymmetries in the status and role of the participants and their position in the face of what is being said. The dialogue between interviewer and interviewee is co-constructed in a specific place and time: jointly elaborated upon by both, and situated within complex and dynamic political and sociocultural systems (Salazar-Orvig & Grossen, 2008).

It is crucial that data collected and analysed be viewed as contextually situated and co-constructed by both the researcher and those being researched. Many authors in the social sciences have begun to clear a space for less dominating and more relational modes of interviewing, which reflect (and respect) participants ways of organizing meaning in their lives (Kohler-Riessman, 2000). This “researcher-as-subject” method (Corti, Reddy, Choi, & Gillespie, 2015) necessitates a collaborative practice which acknowledges that researchers and participants interact in particular cultural milieu— with social and historical context being essential to interpretation. Methodologically, a relational mode of interviewing is essential to reflect (and respect) participants ways of organizing meaning in their lives (Kohler-Riessman, 2000). It does so “by enhancing disclosure; by providing access to participants’ own language and concepts; by enabling participants to follow their own agendas; by encouraging the production of elaborated accounts; and by providing an opportunity to observe the co-construction of meaning in action” (Wilkinson, 1998, p. 329). For example, it has been noted by Loizos (2002) that some migrants come from backgrounds in which direct question-and-answer procedures are not common, or carry the unwelcome implications of an interrogation by distant authorities; they may be more articulate in situations where they are invited to “tell stories” about themselves at their own speed. He argues that “this kind of intervention allows the suffering persons to represent their ‘illness’ to themselves, perceiving the illness within their own ideas, according to their culture” (p. 227).

One key ethical consideration for this particular thesis is that of the notion of the **legitimacy of narratives**. In particular, what the research brings to the fore is the way in which certain narratives of trauma are considered more or less legitimate by various actors across various contexts. Indeed, “oppressed groups are frequently placed in the situation of being listened to only if we frame our ideas in the language that is familiar to and comfortable for a dominant group.” (Collins, 1991, p. xiii). This, for example, is put into evidence in the way in which refugee narratives are legitimized or not across various legal and medical activity systems. This

is important: “the dominant cultural values and orientation of society also determine which aspects of culture and identity are recognized and deemed worthy of explicit attention in healthcare policy and practice” (Kirmayer & Jarvis, 2019, p. 12). In other words, it matters if narratives are believed, valued, and perceived worthy of attention. Tamas (2019), a refugee often called upon by international organisations to provide testimony for advocacy purposes, has highlighted the ways in which he felt coerced or obliged to narrate his story in ways curated to fall within an “implicit narrative logic” (p. 3). He notes the fact that although refugees are free to choose the content of their stories, there is an expectation that they should include some details about their past in order to “move the audience” and inspire sympathy. It is a curated form of storytelling which he argues tends to marginalize or oversimplify the complex contexts surrounding these stories.

These same dynamics inevitably play out in the research relationship. Nagar-Ron and Motzafi Haller (2011) reflect on the following case of conducting interviews with vulnerable populations:

“In her encounters with social workers, teachers, and medical personnel, an uneducated working-class Mizrahi woman is often a recipient, a client/patient in need of “treatment” or handout. Her objectification in such power-laden encounters positions her in a powerless spot where it is in her interest to say little and adhere to the model of the needy subject. In this power dynamics, the opening moment of each interview is a space where she must ascertain what is asked of her and whose interest does her narrative serve.” (p. 6).

Much like the Mizrahi participants mentioned above, the research participants of this thesis were also often cast in the passive and subordinate role of recipient. They are patients, victims, clients, beneficiaries. Most of them have never heard of a researcher. All, by virtue of these facts, are vulnerable in some way. I, on the other hand, am a white, university-educated female in her 30s. I have been working with M.S.F., the affiliated NGO, for a few years, and am affiliated to a University in Switzerland. Currently resident in Switzerland, I am originally South African and have experience of working in a variety of different African countries – incidentally, countries where some of the beneficiaries were from. All of this reflects a complex myriad of identities that became more or less salient during the course of the interviews. The participants, on their part, were from a variety of different countries, adhered to a variety of different religions, and were, for the most part, men. Whether or not they identified strongly as (for example) “victims of torture,” “asylum seeker,” “male,” “African,” or “Congolese” also depended on what was happening within the interview. The power dynamics inherent to these shifting identities needs to be acknowledged – overcome to the extent possible, reflected upon, but not denied.

If we return to Daiute’s (Daiute & Lightfoot, 2004) distinction between **narratives (stories) and Narratives (scripts)** highlighted earlier in the thesis (**chapter seven** specifically), it is worth reflecting upon the ways in which Narratives seep into narratives. To what extent did participants, and even myself unwittingly, draw upon Narratives of trauma within the research interview? Did the victims of torture I interviewed speak about potentially traumatic events they experienced by drawing on medicalized or humanitarian narrative genres – positioning

themselves as unquestionable victims and addressing me as a researcher in a way that I may best understand, accept, and validate their experiences (and possibly even go so far as to act upon this by assisting them with social, economic or legal aid)? To what extent did the health professionals I interviewed address me as “one of their own,” so to speak, by framing their own perspectives within the same medicalized or humanitarian narrative genres? To what extent did key informants narrate the experiences of their respective refugee communities by drawing on official Narratives of need and suffering circulating among the various humanitarian actors with whom they frequently come into contact – addressing me as being affiliated with one of the major NGOs able to provide assistance?

This speaks to the crucial ethical concerns around **representation**. How do I as a researcher, represent the stories of the research participants, without an overreliance on scripts? How do I see beyond the Narratives to understand and ultimately represent the narratives? Firstly, it is fundamental to acknowledge *the interview setting itself as a particular narrative genre*. The research methodology is steeped in institutional tradition. I as a researcher embody it, bring it to the setting. I carry the weight of this tradition as I conduct the interviews. In this thesis, I explore P.T.S.D. as a specific cultural tool, yet the interview setting itself is another specific cultural tool I draw upon in my activity as researcher. I am the one defining the theoretical framework, the research question, as well as the key themes emerging from the data I collect. It is not the participants. Secondly, acknowledging the narratives as unfolding within a specific setting, with the inevitable power imbalances inherent to it, is crucial to such ethical reflections. There is an unavoidable tension between accounting for the complexity of an interaction – for example, that arising within the interview setting - and using methodological tools which necessarily “monologise” this complexity (Grossen, 2010).

As noted by Daiute and colleagues, the academic discourse inherent to the interview setting may be “a cultural tool for probing experience rather than being a mirror into one’s soul” (Daiute et al., 2020, p. 2). They note that narrating is action, not representation. When participants narrate their experiences, they are engaging in the specific activity of narrating. There is addressivity, and a particular institutional setting framing the interaction. Her theory of dynamic narrating

“broadens from formulating narrative as a representation of authentic voices, voices from the ‘bottom,’ from those who are ‘silenced’ to defining narrating as an activist process that people use to address problems and solutions interactively with myriad aspects of the context. Social justice is an important goal in these violent times, but researchers and activists who emphasize authenticity of voice can reduce the same voices we want to hear and support. Assuming trauma as the primary response to displacement (rather than anger or agency, for example) can reproduce oppression. Likewise, emphasizing only resistance can reduce subjectivity, questioning, and debate. Alternatively, considering narrating as an interactive process involves taking language seriously to recognize a range of complex processes.”(Daiute & Gómez, 2014, p. 158).

In other words, the goal of authentic “representation” of participants may indeed end up denying the complexity of the multiple processes involved. *What is it that we as researchers aim to represent?* Perhaps, instead of attempting (or claiming) to represent the lives of participants –

we should start simply by attempting to represent the actions or interactions between research participants and ourselves. How and why are participants saying what they're saying to me as a researcher? This could allow us to shift "out of the conceptual realm of representation and into consideration as dynamic activity in praxis" (Daiute & Gómez, 2014, p. 154). As the authors further note,

"As social scientists, we are, thus, also subject to representational dangers. We accept the risk by participating in communities of research interest, explaining our assumptions, collaborating in specific projects, sampling multiple voices, including our own, and doing ongoing collaborative reflection. Moreover, we enact dynamic narrative inquiry by assuming that no narrative stands alone. Each and all narratives speak to others in the immediate context, in the broader (even virtual) context of political-economic forces, in the act of paying close attention to stories... the task is not to account for a representation [...] per se but to listen to and to read narratives as interactions and actions, as acts of understanding, resisting, and imagining." (p. 173-174).

In the following article, I reflect on the ethics of the research relationship. Notably, I draw upon the concept of "shame" as a point of focus for these reflections. The reasons are multiple. As the article highlights: shame is inextricably linked to experiences of potentially traumatic events, to our very sense of self, and to our social as well as private identities. It is at the core of so many hidden vulnerabilities. It is relational, profoundly concerned with the way in which the Self is seen by the Other. I would argue that it therefore offers a well-placed pathway into exploring these complex ethical conundrums.

ARTICLE EIGHT: Womersley, G. (2019). A Sociocultural Exploration of Shame and Trauma Among Refugee Victims of Torture. In C. H. Mayer, & E. Vanderheiden (Eds.), *The Bright Side of Shame* (pp. 103-116). Cham: Springer.

Abstract

Shame profoundly colours the experiences of the thousands of refugees entering Europe. Not only does the literature attest to the high levels of trauma among this population, research in the past decade has increasingly revealed the hidden yet pervasive role that shame may play in posttraumatic symptomatology. Shame may emerge as a result of the many forms of torture, sexual violence and other atrocities experienced in the country of origin, yet is equally exacerbated by degrading and humiliating asylum procedures, having to accept a new and often devalued social identity of being an asylum seeker, and the embarrassment of not meeting culturally-informed expectations to financially support the family back home. Shame is a complex process affecting core dimensions of the self, identity, ego processes, and personality – and is thus inextricably shaped by culture. It has a detrimental impact on health-seeking behaviour, yet its masked manifestations remain often unnoticed by practitioners. This is a critical consideration for clinicians and researchers working with refugee populations, where the relation is typically marked by power differentials across a matrix of identities informing not only the shame of the refugee but of the clinicians or researchers themselves. As both a researcher and clinical psychologist working with refugee populations, I explore the myriad dimensions of shame within this context based on personal reflections of my time “in the field” as well as the burgeoning literature on this topic. Key implications for techniques and methods which may be drawn upon by both researchers and clinicians are discussed.

Introduction

The number of refugees seeking asylum across the world is unprecedented. According to the UNHCR,³⁴ **65.6 million** people around the world have been forced from home. This is a global challenge. Not only does the literature attest to the high levels of trauma among this population, research in the past two decades has increasingly revealed the hidden yet pervasive role that shame may play in posttraumatic symptomatology (Matos & Pinto-Gouveia, 2010; Slewa-Younan et al., 2017; Wilson, Droždek, & Turkovic, 2006; Wong & Tsai, 2007). As defined by Wilson and colleagues (2006), “in the posttraumatic self, shame develops from traumatic experiences that render the victim fearful, powerless, helpless, and unable to act congruently with moral values” (p. 127). In the context of forced migration in particular, both trauma and shame are ubiquitous, pervasive, and contagious.

³⁴ <http://www.unhcr.org/figures-at-a-glance.html>

Shame activates shame. The mystifying dualism of shame is that it is at once an isolating, intimately intra-psychic phenomenon seeking concealment, yet remains deeply embedded in a visual and public interpersonal space where the self is violently and unexpectedly exposed to the critical gaze of the Other (Womersley et al., 2011). Unlike guilt (typically related to a particular action or behaviour), shame taints the entire landscape of the individual – colouring the very sense of self. Shame is therefore considered to be a more complex intra-psychic process than guilt because it involves processes concerning attributes about the core dimensions of the self, identity, ego processes, and personality (Wilson et al., 2006). Inasmuch as it lies within the interactional space between self and other, at the divide between the intimate and the public, the individual and society – it tries to hide itself by its very nature. As such, it often remains unnoticed. Its powerful yet seemingly invisible impact may be hidden behind a myriad of emotional cloaks – anger, dissociation, blame, and resentment - even more so in the context of clinicians working with migrant populations, where a plethora of differently nuanced cultural cloaks may further obfuscate this noxious affect (Buggenhagen, 2012; Slewa-Younan et al., 2017; Swartz, 1988; Wong & Tsai, 2007). However, ethically, clinically, professionally, humanly, professionals working with traumatised populations cannot ignore shame. This is particularly true of work within multicultural contexts, where relations are so typically marked by power differentials in terms of race, class, nationality and socio-economic status. It is here, in this “intersectionality” (Grzanka, Santos, & Moradi, 2017; Moradi, 2017) of identities, that shame is located. Therefore, new approaches are needed for clinicians (both researchers and academics) which consider the interactive effects of shame and trauma within sociocultural context among such vulnerable populations. In this chapter, aspects of migration and post-traumatic shame, and implications for professionals, will be discussed. A case study of shame will be presented, taken from a larger study I conducted exploring trauma among this population in Athens, Greece.

Migration and post-traumatic shame

Shame significantly shapes the migration experience, linked particularly to extreme feelings of powerlessness, degradation and humiliation. It may emerge as a result of the many forms of torture, sexual violence and other atrocities experienced in the country of origin, yet is equally exacerbated by degrading and humiliating asylum procedures, having to accept a new and often devalued social identity of being an asylum seeker (characterised by a loss of social status, social networks, and employment opportunities), and the embarrassment of not meeting culturally-informed expectations to financially support the family (Buggenhagen, 2012). Shame pervades the experience of no longer being “at home” at home, of being cast out of one’s country, of having to metaphorically knock on the door of a potential host country and beg to be accepted, only to be met by significant social discrimination, scrutiny and disbelief at one’s claim to asylum (Bhimji, 2015; Goguikian Ratcliff, Bolzman, & Gakuba, 2014; Sanchez-Mazas et al., 2011; Torre, 2016).

The process of migration may therefore be in and of itself a shameful experience, wherein individual and social identities risk being negated through the systemic trauma associated with

legal and social practices of exclusion (Goldsmith, Martin, & Smith, 2014). This exclusion serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). Furthermore, the stressful experiences that many asylum seekers and refugees are exposed to during forced migration, and during the resettlement process, make them vulnerable to mental health conditions. As a consequence, the prevalence of psychological distress and mental disorders in asylum seekers and refugees as reported in the literature appears to be generally high, with significantly elevated rates of post-traumatic stress disorder (P.T.S.D.) being found among this population (Li et al., 2016; Turrini et al., 2017). Research in trauma over the past decade has seen the development of the concept of “posttraumatic shame,” with key authors stressing the importance of shame as a social emotion that impacts the severity and course of P.T.S.D. symptoms (Hecker et al., 2015; Maercker & Hecker, 2016; Wilson et al., 2006). Indeed, the experience of shame has even been revealed to potentially hold the same properties as traumatic events involving intrusions, flashbacks, strong emotional avoidance, hyper arousal, fragmented states of mind and dissociation (Matos & Pinto-Gouveia, 2010). Shame and trauma are inextricably linked.

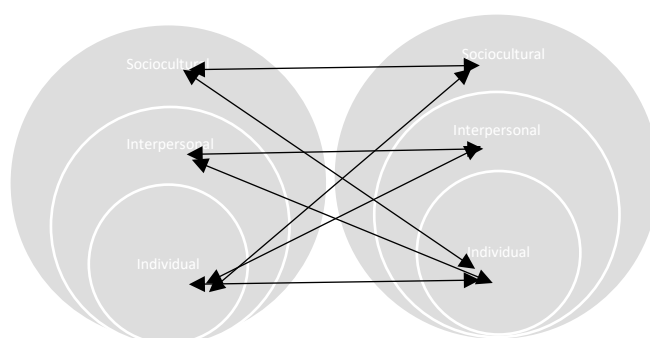
Torture in particular represents an extraordinary exception in the psychopathology field – with significant implications for the shame-trauma nexus. The particularity of torture as pathogenic is linked to the fact that the act itself is taught, organized, elaborated, and perpetrated by humans against other humans (Sironi, 1999; Viñar, 2005b). Arguably, the aim of the perpetrator is to shame, to disrupt the connection to all that makes us human (Viñar, 2005b). As such, torture is not an individual act, but a social one. It is an inherently shameful experience for the tortured, damaging different spheres of an individual including body, personality, hope, aspirations for life, identity, integrity, belief systems, the sense of being grounded and attached to a family and society, autonomy, community relationships, and a sense of safety (Womersley et al., 2018e). Humiliation thus arises from torture experiences where the survivor is abused, dehumanized, and made an exhibition for others, essentially representing a profound loss of dignity and power (Wilson et al., 2006; Wilson et al., 2004). In particular, the dual shame inherent in being both a victim of torture as well a refugee is related to a myriad of losses, human rights violations, shifting power dynamics and other dimensions of suffering linked not only to torture experienced pre-migration, but to different forms of violence experienced during and after migration as well (Hodges-Wu & Zajicek-Farber, 2017).

Cultural manifestations of shame and implications for clinicians

The source of shame can never be completely in the self or in *the Other*, but is a rupture of what Kaufman (1989) calls the “interpersonal bridge” binding the two. In thus theorizing shame as being located at this bridge, we understand the important role it plays in community life through promoting socially acceptable or desirable behaviour. It exerts a force that inclines individuals to adapt to socially sanctioned values, rules and beliefs – an integral component of the promotion of cultural ideals (Swartz, 1988). A significant source of shame is the loss of continuity in upholding culturally defined values, norms and respected patterns of behaviour –

and the self-consciousness over disappointing others within one's social network and embedded within one's culture (Wilson et al., 2006). We may therefore understand the importance of the sociocultural context in determining its various manifestations. This has been highlighted in the plethora of cross-cultural and anthropological literature paying attention attesting to the variety of culturally diverse forms of shame (Wong & Tsai, 2007).

The model below is used to illustrate the various interrelating levels at which shame manifests. When two individuals meet, they also bring with them a specific interpersonal and sociocultural context, all of which inform the interaction. As clinicians and researchers, we come as individuals, yet we come as individuals carrying specific cultural, gender, social and racial identities – and so do the individuals with whom we interact. All of these levels may potentially be sources of shame.



This has significant implications for professionals – both clinicians and researchers – working with populations from a variety of cultural backgrounds. For example, a large potential for misunderstandings between clinicians and traumatised refugees is not only because of a language barrier; very little is known about the concepts of illness and treatment expectations in these patients (Maier & Straub, 2011). Furthermore, shame-related cultural codes of behaviour might prevent migrants from directly reporting earlier traumatic experiences, from trusting the professional or from even attending appointments. As noted by Wilson and colleagues (Wilson et al., 2006), “the powerful emotions of posttraumatic shame are associated with a broad range of avoidance behaviours: isolation, detachment, withdrawal, hiding, nonappearance, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others” (p. 138). These signs are easily misread.

The interpersonal dynamics of this clinical encounter may not be so different from the context of research interviews, similarly marked by power asymmetries (Salazar-Orvig & Grossen, 2008). Here, the individual migrant is placed in the role of a patient-participant object, in the face of an arguably more socially powerful professional subject aiming to scrutinize the most intimate details of their life history. It risks being an inherently shameful encounter, exacerbating extreme feelings of powerlessness, degradation, and humiliation. However, as noted by Wilson and colleagues (2006), shame is a two-way street; it can exist in the patient and therapist at the same time in different intra-psychic configurations. Working with the complexities of shame in the posttraumatic self, both patient and therapist (and arguably,

participant and researcher) share a common ground of human vulnerability whose management likely determines the quality of outcome. As we have illustrated elsewhere in the case of research among survivors of sexual abuse (Womersley et al., 2011), shame pervades the entirety of the relationship. It is contagious. All are affected. As much as the identity of a victim, an asylum seeker, an oppressed ethnic minority may be shaming for the migrant, the identity of the oppressor, the colonizer, the privileged ethnic elite, may be shaming for the clinician or researcher.

We need to consider shame in the context of work with vulnerable migrant populations – not only because it may influence our professional work in profound yet often barely perceptible ways, it is our ethical duty as human beings to reflect on these intersubjective encounters. In order to reflect on some concrete case examples of the ways in which shame may manifest in such encounters, and on some applications in dealing with shame constructively, I draw on my work with asylum seekers and refugees in a centre for victims of torture in Athens.

Contextual description

As the “reception crisis” continues unabated, Greece remains one of the first ports of sanctuary. While the country is still gripped by one of the worst financial and societal crises of the past 40 years, little attention or funding is available to provide mental health and psychosocial support to refugees (Gkionakis, 2016). Many torture survivors in Greece, only some of whom having been identified as vulnerable, are still trapped on the islands, a context characterized by a lack of specialised medical care and poor living conditions (Farmakopoulou et al., 2017; Kadianaki, 2014; Kotsioni, 2016; Maniadaki & Kakouros, 2008). Other torture survivors who have moved to the mainland without permission have also found themselves in limbo, unable to proceed with their asylum claim. The sources of shame within this context are many: from the Greek citizens themselves who may be ashamed of the poor reception conditions, of not being able to do more to help, of the inadequate institutional structures and hostile reactions to foreigners on the part of their compatriots, of not being up to “civilised” Western European standards; to the asylum seekers suddenly finding themselves in an incredibly precarious and vulnerable position, having lost many aspects of their valued social identity linked to their country of origin (Farmakopoulou et al., 2017; Gkionakis, 2016; Kotsioni, 2016).

In this particular context, I conducted participative research in a centre for victims of torture in Athens. Having worked in the humanitarian sector for years, my aim was to study the influence of the sociocultural context on trauma. This involved three months of participative observation with the medical team of the centre: participating in the team’s daily morning meetings and group therapy activities, facilitating psycho-education sessions for the beneficiaries of the project, and teaching English in the centre twice a week. My research also involved conducting qualitative interviews with beneficiaries, the health professionals themselves as well as “community representatives” – leaders of the various refugee communities around Athens. It

was thus a complex mixture of being both a clinician and a researcher, requiring an on-going negotiation of these multiple identities.

The beneficiaries of this particular project were identified as “vulnerable” – victims of torture in their countries of origin and in particular need of multidisciplinary care. They came from all over the world, notably regions affected by conflict. The team, offering mental health support, physiotherapy, and medical care, worked in collaboration with social workers and lawyers who were assisting the beneficiaries in their request for asylum. The needs were many, varied yet interrelated. An accompanying team of cultural mediators was required – not only for translation but as mediators of this new and complex medico-legal system with which people were confronted.

The use of the term “beneficiaries” to refer to the individuals coming to the clinic, as opposed to others such as “patients” or “asylum seekers” or “victims of torture” was a deliberate one. When the project opened, all individuals would all be presented with a “patient” card, that is until one individual refused to take his. It was, he said, not how he chose to identify. The word “patient” evoked a deep sense of shame. He felt that it implied a victimizing and humiliating identity. He was neither, he had insisted, a patient nor a victim – but an individual in his own right.

It became apparent, during the course of my time as a participant researcher in this context, that it was not only trauma, but also shame, which pervaded the space – with significant and potentially destructive implications for the micro-interactions among the health professionals and the beneficiaries. It was present in the daily meetings, where professionals kept expressing a feeling that they were not “good enough,” not doing enough to help the beneficiary find work or shelter, not feeling experienced enough to handle the complexity of the needs of the vulnerable population with whom they were working, ashamed of belonging to a country where the structures supposedly in place to assist the migrants were not meeting their needs. The result appeared to be either an increased or decreased commitment to the work, a feeling of anger which incited a call to action, to respond to the need in front of them – or a resignation, a feeling that they had very little power to effect concrete changes in the lives of the beneficiaries.

As for the beneficiaries of the project, the shame was even more apparent. Finding themselves at the clinic, unable to help themselves and at the mercy of the team of professionals there to help them, ashamed of not being able to support their families financially, of not having met their aspirations of “succeeding” in Europe, ashamed of the humiliating and horrific experiences which they had endured, of how they may have compromised their perceived moral integrity in order to survive, of not being able to fully master the language nor the cultural nuances of their new environment ... this was the shame in some way linked to the identity of “victim.” The result, often, was a need to hide oneself, to not want to be seen entering the clinic for fear of the stigma attached to being a victim of torture, to mask aspects of their narratives, to not want to answer the professional’s questions directly for fear of certain aspects of their lives being exposed or not believed. It resulted in different versions of their life story being told to different professionals. It resulted in many not wanting to see the psychologist as a result of

the shame of being identified as “crazy.” It resulted in quiet waiting rooms, where the silence among the various beneficiaries may have been out of respect for shame – for not wanting to expose each other as victims.

Shame was similarly present within the intersubjective space between myself, the health professionals, and the beneficiaries/participants. As noted above, I came as both a researcher and a clinician, an active participant in the space. I was both part of the team, yet in many ways a detached third party observer. Other aspects of my identity were similarly present, becoming more or less salient within the micro-interactions. I am South African. Therefore, as so often raised by the beneficiaries of African origin, I am “an African sister.” One of “us.” Yet, unlike the rest of “us” – I have White skin, I am not subject to the same degrading or humiliating micro-instances of racism so many experience when coming to Europe. Unlike them, I am “legitimized” in my right to be there, to pass unnoticed in the streets, to move freely around Europe. I am in the privileged position of the professional – I have the right to observe, to direct, to interrogate, to pose questions. I am also a woman, like some and not others. As we have explored elsewhere in reflecting on working with South African survivors of rape (Womersley et al., 2011) – the shame linked to the similarities and differences across marks of identity, so boldly and unavoidably expressed through our bodies, is a fundamental part of the interaction between researcher and researched in the context of qualitative interviews being conducted, particularly among vulnerable populations and particularly when exploring the sensitive topic of trauma.

To explore the myriad manifestations of shame – not belonging to the Self or Other but in the intersubjective space between all of these actors – I present a case study of one beneficiary with whom I had multiple interviews over the course of a year. I intend this to be an illustrative case study which may allow us to track the manifestations of shame as it arose in the interactions between us. It is representative of many of the interviews conducted during this period, and, hopefully, representative of so many qualitative interviews being conducted by qualitative interviewers in multicultural settings across the world. Reflecting on these micro-instances of shame, being able to first of all track it and second of all, through this awareness, allow this reflexivity to influence the way in which we interact with the participants whom we interview in qualitative research, is an ethical obligation. It is our responsibility as researchers, and as human beings.

Applied approach to dealing with shame: The case of Sylvain

Sylvain is a 35-year-old refugee from the Ivory Coast, a beneficiary of the centre for victims of torture in Athens and a participant in my research with whom I conducted five qualitative interviews over the course of the year. Interviews were conducted in French without the use of a translator. However, this is not to say that we were not each interpreting, in our own way, the words of the other. My interpretation and analysis of his words necessarily remain just that – an interpretation necessarily informed by my own culturally determined frames of reference.

Our work together is presented as a study on the myriad of ways in which shame was both manifested, and subsequently transformed, during this period. To analyse the case, instances of manifestations of shame in our interaction were identified in the transcripts, and subsequently grouped according to emerging overarching themes. Four identified sources of shame are presented, accompanied by some reflections on implications for transformation.

The shame of dependence

During our first interview, Sylvain described his situation as the following:

“Often, we are confronted with strangers, and they mistreat us... when he can help you today, it is in two or three weeks that he will help you. They like to play with people, come and go... You go there and you are told to come back where you left first. It is not easy. But we understand them, we have to accept them, otherwise, it's dangerous [...] but we have to accept it is life, it hurts, it's stressful, it's hard, but when you're out there, we have to accept.”

His shame appeared to have been related to being in the vulnerable position of dependence on the help of others, others who may well “mistreat us.” Interestingly enough, the “mistreatment” to which he referred was not related to the many instances of racism he reported, nor to the fact that he was handcuffed by the police and thrown in prison without apparent just cause. Rather, he referred to the people who “play,” who “come and go.” In other words, the mistreatment he referred to is that which he encountered among those meant to “help” – humanitarian aid workers, state social services, medical professionals etc. This, in turn, evoked in me a sense of shame of being somehow related to those who only help “when they can.” Despite my role as an independent researcher, I was still connected to the clinic where he came for assistance. I was aware of this throughout my fieldwork in Athens. In 2015 and 2016, it was a context characterised by a plethora of well-meaning humanitarian workers coming to assist refugees for short periods of time. So many of the asylum seekers with whom I spoke referred to this phenomenon of what I call “trauma tourism” – painting a picture of people arriving, asking questions, offering to help, and then leaving without fulfilling promises of further assistance (Pittaway, Bartolomei, & Hugman, 2010).

Implications for transformation

Sylvain’s words offer a sobering reminder of the way in which the shame associated with being dependant on the assistance of others may be transformed through simply being a) attentive to and aware of the possible impact of shame and b) aware of the responsibility to avoid “playing” with vulnerable populations, to not just “come and go.” I would argue that part of the transformation of Sylvain’s shame, particularly shame related to this experience of being dependant on external aid, came through the consistent relationships he was able to form with staff at the centre over a period of two years. In our own relationship, it was linked to the fact that I kept to our agreed meeting schedule and consistently returned over the period of a year.

It lay in simple details, such as allowing him to choose the time and place of our meetings together – a change compared to the treatment he reported encountering in his dealing with bureaucratic state institutions where he was often left to wait for hours, only to have the appointment delayed by months. Such basic signs of respect seem to have had a transformative impact on his own shame. This allowed for a subtle reshifting of the balance of power in our relationship, allowing my own shame in turn to be transformed in the context of a more equal relationship of mutual respect and “social recognition” (Marková, 2016).

The shame of social discrimination

Throughout our five meetings together, Sylvain reported feeling ashamed at the way in which as an asylum seeker he was treated as a “criminal” by a variety of actors, including the police:

“We start from a good one to frustrate you somewhere, and we fled the violence in Africa, arrived in a country where we say there is the human right, you come to sleep in the things that... I am in Greece I have known handcuffs, it is in Greece I have known handcuffs [...] Because they say I don't have papers. Is an unregistered person a criminal?”

“It's the things we keep in our hearts, in the prison, the police can hit you.”

He also noted facing discrimination by not only local Greek populations, but other migrant communities. In reflecting on this, he highlighted my identity as a white person:

“You're South African, where we are sitting, a lot of people think you're European. So you see, but me seeing myself [...] You go to immigration, they say, you wait and give priority to others.”

Despite us both being African, a fundamental difference is the colour of our skin. Both physically, and also in terms of cultural identity, I am able to pass as European, he is not. I felt ashamed of this identity: of being unwittingly complicit in my “fellow European’s” discrimination against others. I felt the need to apologise on behalf of “Europeans” – regardless of whether or not I identified with this group. His words are testament to the very present psychic consequences of shame and the accompanying feelings of envy seen in the context of deprivation and powerlessness as well as in the ubiquitous (and often unspeakable) presence of racial trauma (Harris, 2000).

Implications for transformation

In outlining his experiences of racism and discrimination encountered in Europe, Sylvain stated the following:

“He [a European] does not distinguish you, he says, “The immigrants.” But it's not just immigrants.”

His words hint at the shame of a loss of individual identity in favour of being seen as “an immigrant.” He contested this notion of being “just immigrants,” in favour of being “distinguished” - in other words, of being seen and recognised as a complete and complex individual self. I would argue that the implications for transforming shame related to such social discrimination lie in the need for individual aspects of identity to be made visible, recognised, and valued. In exploring this, we similarly cannot ignore our own sense of shame related to being in a position of social privilege. Here, what seemed to have had a transformative impact on Sylvain’s shame was my recognition of it. I needed both to be aware of my own shame linked to social privilege, and to recognise and respect his shame related to social discrimination.

The shame of being unemployed

Throughout the year in which we met, Sylvain referred multiple times to the shame he felt at not being able to provide for his family back home who were waiting for his financial assistance. The shame he felt at not being able to meet their expectations eventually got to the point where he stopped answering their phone calls. He did miss them, he explained to me, but he couldn’t face the shame of being unemployed and unable to help:

“Tomorrow when you succeed, you will be the pride of the family: the family and the whole village. But when you become a delinquent, it's [a shame for] the father and mother. These are things you don't really want to talk about.”

He reported feeling frozen in time, unable to move on with his life and contribute as a productive member of society. Jobless, he felt “worthless,” a delinquent who eventually turned to illegal activities in order to make money:

“The situation in Greece here, if you're not morally strong, it can make you do some bad things. It is not easy. We live like we never existed [...] I'm starting to do bad things. When you become envious, you're exposed to everything. And the easiest thing in Greece is selling drugs.”

The shame of being unemployed (Buggenhagen, 2012) was therefore double-edged: not only was there shame around being “useless” to society, in other words a “delinquent” family member unable to provide – the situation as an inexistent *persona non grata* lead him to conduct himself in “shameful” ways which previously would have been unthinkable. The behaviour seems to have been judged as immoral not only by others but by himself, a deep source of shame at the interpersonal bridge between himself and his social world. He was led further and further into the metaphorical shadows of society.

Implications for transformation

Sylvain eventually did find legal work, and the transformative effect on his mental health was remarkable. Not only had his material conditions improved, he felt somehow more legitimate

in his environment. He had become an active contributor to society, able to take the bus in the morning along with others heading to work, able to share the little that he had with friends and family, able to “show his face” in public. The fact of being employed seemed to lessen his sense of shame more than any other factor. As concisely and poignantly stated by Buggenhagen (Buggenhagen, 2012), “money takes care of shame.”

The shame surrounding Sylvain’s unemployment serves as important reminder of the embeddedness of this emotion within a socioeconomic context. In my role as researcher, my primary focus was evidently on his psychological state of mind. However, it became abundantly apparent in interviews, with him and other asylum seekers, that this was significantly dependant on his social and economic environment. His sense of self-worth, relationship with family, socioeconomic status and the material conditions in which he found himself, all mutually reinforced the sense of shame about which he spoke so openly. We may not always have the capacity to effect changes in the socioeconomic lives of the people with whom we interact as clinicians and researchers. We can, however, reflect on this shame in our interactions. This could mean, for example, breaking our professional/ethical codes of conduct to accept gifts which we know individuals can ill-afford but for whom it is a point of pride. It means having the courage to address the sensitive topic of money when raised. Practitioners and researchers working with this population cannot ignore this incredibly salient aspect of shame. To do so risks, in many ways, reinforcing a social silence that so often fosters shame.

Concluding remarks

Shame is manifest on the micro-level of our daily interactions and cannot be separated from the complex matrix of gender, ethnicity and socio-economic class informing our public identities, which are so boldly reflected through our bodies. What did shame obscure, prevent or facilitate within this space between myself and Sylvain? What are the implications of this noxious affect for reflexive research, particularly with refugee populations? The above reflections intend not only to shed some light on the role of shame in the research relationship which unfolded but to consider the way in which it was intrinsically linked to the representations of our multiple and constantly shifting identities (Burman, 2006; Gray, 2008). It is clear that both the psychologist and the client’s individual shame, as well as the shame which they co-construct within the intersubjective space, play an integral part of the therapeutic process. Similarly, reflexive qualitative research should also take into consideration the powerful impact of this affect within the research relationship.

“Nobody is ever just a refugee. Nobody is ever just a single thing. And yet, in the public discourse today, we often speak of people as single things. Refugee, immigrant. We dehumanize people when we reduce them to a single thing” (Chimamanda Ngozi Adichie, Address at the Humanitarian World Day” Event in New York, 19 August 2016).

CHAPTER ELEVEN: Conclusion

The number of refugees across the globe is growing dramatically – a trend predicted to continue due to a global increase in social and political instability as well as socioeconomic conflicts. In places where violence is seen as a necessary factor in achieving peace, ongoing armed conflict, and displacement will likely contribute to continued psychological impairment and suffering among those affected (Morina, Akhtar, Barth, & Schnyder, 2018). Indeed, research overwhelmingly attests to the alarmingly high rates of P.T.S.D. among this population (Schouler-Ocak et al., 2019). This is no surprise. What is surprising, however, is the lack of knowledge concerning refugee experiences of potentially traumatic events from a sociocultural perspective. As recently noted by Zipfel and colleagues (2019):

“we still know very little about how evidence-based concepts of assessing and treating mental health conditions actually work when applied to traumatised refugee populations... Also, the interplay between pre-migration adverse or potentially traumatic experiences, various stressors during the flight, post-migration living difficulties, and mental health is far from being understood” (p. 22).

Within humanitarian interventions targeting refugee populations, “trauma” seems to be something taken-for-granted and assumed. It is a ubiquitous buzzword permeating discourse. Yet, there continues to be very little critical reflection – or indeed consensus - on what it *actually* is. Having worked as a clinician in mental health projects with displaced populations – across a variety of cultural contexts – this was a constant source of personal frustration and concern. I would repeatedly be called upon to report on the number of refugees with P.T.S.D. Repeatedly, I would sit in front of individual refugees for whom the diagnosis made little sense. It seemed a ludicrous discrepancy. Similarly absurd was the implicit assumption that the mental health of this population had very little to do with their current daily reality. I was working as a psychologist, not a social worker, lawyer, or human rights advocate. Yet the social, legal, and economic needs of the beneficiaries continually found their way into our consultations. From a personal perspective, this compelled me to develop this body of research. Importantly, it is research intended to speak to the concrete reality of the humanitarian field. It is research intended simply to make sense. My aim in writing this thesis therefore is that something useful in terms of practical implications for clinical interventions could be humbly offered.

Given the ubiquitous nature of the diagnosis in popular discourse in general, and humanitarian discourses centering on “suffering refugees” in particular, what is missing is an understanding of the context in which experiences of potentially traumatic events are embedded. The staggering discrepancy in rates of P.T.S.D. noted among refugee populations (Morina et al., 2018) could be seen as a further indication that we need to go *beyond* the diagnosis to see what is happening “in the field.” This is not to say that we need to disregard the diagnosis.

The thesis does not intend to position itself as being “for” or “against” its use at such. Rather, the intention is to peek *behind* the metaphorical curtain and explore the stories behind the high prevalence rates of P.T.S.D. – and to explore the borders of the diagnosis itself. Echoing the research aims of Shala and colleagues (2020), the intention is thus “to go beyond such labelling to explore participants’ assumptions about the causes of their suffering, their implicit concepts of how body and mind interact, how language is used to express psychological distress in a culturally congruent and socially acceptable manner, and what expectations people hold about the course (and relief) of their suffering” (p. 19).

The aim of this conclusion is to “connect the dots” of the results of the research, and offer reflections on the theoretical contributions both of and to a sociocultural approach. I take stock of what has been presented in the eight published articles from a more general perspective, as well as the consequences it may have. Firstly, I return to the research questions presented in the first chapters. I summarise the answers of the eight articles to highlight the contribution this thesis has made or tried to make, from a theoretical and methodological point of view. I suggest avenues towards a sociocultural definition of trauma Secondly, I present some practical implications of the research. Finally, I discuss the limits of the research, which will lead me to propose some future directions for further research.

Theoretical contributions of a sociocultural approach

From this point of departure, I thus set off to explore experiences of potentially traumatic events among refugee communities from a sociocultural perspective. The theoretical contributions of a sociocultural approach to exploring the research question have been many. It has allowed for me to look behind the metaphorical curtain of high P.T.S.D. prevalence rates among refugees, as stated above, precisely because it is interested in exploring psychological phenomena from within a developmental perspective – and within sociocultural context. It is dynamic. It considers changes over time. It necessitates in-depth, idiosyncratic explorations. It is an approach that I believe would be fundamentally at odds with a static snapshot of refugee experiences of potentially traumatic events as represented in prevalence rates of P.T.S.D. This is because the approach considers that “development is not a gradual accumulation of quantitative changes or a simple natural growth, but a qualitative transformation that takes place as a result of internal conflicts and crises and attempts of concrete subjects to resolve them.” (Dafermos, 2015, p. 20). As Vygotsky himself stated,

“We need to concentrate not to the product of development but on the very process by which higher forms are established.... To encompass in research the process of a given thing’s development in all its phases and changes—from birth to death—fundamentally means to discover its nature, its essence, for it is only in movement that a body shows what it is.” (Vygotsky, 1998, p. 26).

As noted by Dafermos (2015), it is an approach which privileges the study of the process of transitions. It considers development as existing in flux and constant change, with fluid and

ever-changing, open-ended dynamical processes linking organisms and their environments. Thus, in opposition to research measuring prevalence rates of P.T.S.D.,

“The dynamic, dramatic interrelations between concrete subjects and society are not reduced to an adaptation of subjects to social environment as has been accepted in mainstream North Atlantic psychology” (p. 21).

The approach therefore focuses on the dynamic. It focuses on the dramatic. It focuses on individual-society relations. Development is the fundamental concept (Dafermos & Triliva, 2018). As such, it offers a unique perspective from which to study the humanitarian crisis of refugees arriving in Europe and the myriad of potentially traumatic events to which they are exposed. It allows us, for example, to explore how the activity of narrating mediates human life, and the destruction of life (Daiute & Gómez, 2014).

As highlighted in chapter **five**, the perspective necessitated that I explored this question based on the following methodological principles:

- i) The methodology should consider the dynamic and mutually reinforcing relationship between the individual and their sociocultural environment as the **single unit of analysis**
- ii) the methodology should account for the **multiple levels** inherent to this single unit of analysis : from the micro-level of the individual to the macro-level of the sociocultural and political environment in which they are embedded
- iii) The methodology should be informed by a **critical reflexivity** on the part of the researcher, throughout the research process
- iv) The methodology should privilege an **idiosyncratic** approach to the analysis of unique, individual case studies
- v) The methodology should account for the **temporal dimensions** of the development of human phenomena

The theoretical approach has allowed for an analysis of both the narratives of trauma circulating among the various actors within legal and medical activity systems, as well as the development of individual trajectories within these systems. As noted by Daiute and colleagues (2020),

“In such changing and challenging circumstances, research methodologies must allow for complexity, diversity, and flexibility within and across individuals and institutions so that all can gain understandings of their circumstances, one another, and their possible futures” (p. 4)

A sociocultural approach therefore contributes to a better understanding of human development: how it happens, and how subjectivity is being constructed in and through perezhivanie in various environmental settings. It allows us to explore how, in different moments of time, different components of an environment change and therefore different psychological characteristics are mobilized and crystallized through perezhivanie (Veresov, 2019). Perezhivanie itself has proven to be a powerful theoretical concept or tool for the empirical study of how social environment becomes an integral part of a subjectivity and

influences individual developmental trajectories. In this research, it has allowed me to look beyond individual-environment dichotomies – dualisms which Vygotsky (1993) considered “fallacious” (p. 253). Instead, I have explored the two in complex, dynamic interaction.

The theoretical concept of perezhivanie has thus allowed me to study the process of sociocultural development of refugee experiences of potentially traumatic events, aimed not at “objects under study”, but rather at “the process under study” in all its key aspects (Vygotsky, 1997). It has allowed for a relational understanding of the human condition. It has allowed me to identify the changes in development through an analysis of an individual’s perezhivanie of their situation. It has allowed me to “unfold the dialectics, the evolutionary and revolutionary aspects of development, as well as dialectics of the social and the individual” (Veresov, 2019, p. 76), to explore “the dialectical relations between emotions and feelings, in which crisis, transitions or drama acts as the driving force for development” (Fleer et al., 2017, p. 9). It allows me to account for both the individual suffering linked to experiencing potentially traumatic events – as well as the potentially traumatic events linked to the refugee “reception crisis” which remain unfolding on a global scale; in other words, to account for both the “micro” and “macro” level dynamics driving development, from the macro systems of activity (Clot, 1999, 2011; Clot & Béguin, 2004; Clot & Litim, 2008; Engestrom, 2000; Engeström, 1999, 2005; Kloetzer et al., 2015) to the microsystems inherent to individual subjective configurations (González Rey, 2005, 2008, 2016, 2017). The particularly extreme, contradictory, dramatic, and challenging context of the refugee “reception crisis” in Europe warrants such a complex investigation.

The development of the research/er

This research was developed with the initial aim of better understanding cultural variations in P.T.S.D. in particular. I set off to examine the impact of the sociocultural environment on the nebulous notion of “trauma.” I wanted to understand culture as a *variable* – one of the many factors in how individuals experience potentially traumatic events. A sociocultural approach has allowed me to develop a different vision. As the research progressed, I began increasingly to understand that it is not a question of conducting a simple “factor analysis.” The approach has allowed me to break with traditional dichotomies between “the social” (external, culture) and “the individual” (internal). Rather, what became clearer as the research progressed was the importance of examining complex systems (the individual and environment) as a single unit, in all of its dynamic complexity. Indeed, the sociocultural approach “looks at social and individual as a dialectical unity” (Veresov, 2016, p. 131). Here, perezhivanie is an important concept. The approach has allowed me to understand not the impact of culture or society on an individual, as initially expected – but rather to see that “the social also exists where there is only one person with his individual perezhivanie” (Vygotsky, 1986, p. 314). To summarize this theoretical journey:

“Science commences to be understood dialectically in its movement, i.e., from the perspective of its dynamics, growth, development, evolution. It is from this point of view that we must evaluate and interpret each stage of development.” (Vygotsky, 1998, p. 292)

The unfolding of the research was inevitably messier and more complex than anticipated. This itself has been a significant source of personal development. I needed to understand how to remain humble in the face of unimaginable suffering. How to meet this suffering with empathy, without resorting to “pity” or “sympathy.” How to see and account for the suffering but also the points of resilience, growth, and development. How to see the uniqueness of each individual participant, as complex and dynamic human beings, but also our common humanity. How to find the general tendencies among the unique stories, and the unique stories within the general tendencies.

The risk associated with accepting this dynamic complexity is that one gets lost among all of it. Admittedly, it was confusing at first. Upon the first few weeks on arriving in the field, I wrote in my field diary,

“I still feel that I haven’t yet found ‘the heart’ of the thesis and need to be careful not to run around trying to do too much at once. Things have progressed very fast with the team (not least of all because it is such an intense/manic environment). The fast pace is great – I find it enticing and wonderful for the progression of the research, but I need to avoid being ‘sucked in’ ...[with individual refugee participants] I need to think about boundaries and limits, not offering or promising too much. How not to get sucked in – or is that like asking a piece of string to observe a vacuum cleaner?”

Being “sucked in,” to the messy complexity of this reality was inevitable. I needed to accept the timeline and rhythm of the research participants was not always the same as my own – based on my own objectives, themselves set within a very particular academic institutional framework. Indeed, this institutional culture was sometimes at odds with the reality before me. As always, the academic demands needed to give way to the complex reality of what was happening “in the field.” This similarly raised a host of ethical dilemmas, as explored in **chapter ten**. Some participants themselves were happy to be interviewed in crowded cafés frequented by the other members of their community, in public squares, or in their homes. These were spaces where they felt most comfortable but certainly did not provide for adequate “privacy” or “anonymity” as most ethical research review boards would deem necessary. The world of interviews for research purposes seemed so far from the daily-lived reality of most of the participants, to the point of absurdity. Flexibility was required. That said, both academic demands and the demands of the field needed to be taken seriously. I had to learn how to juggle both.

I also had to learn how to wear multiple hats, metaphorically speaking – and to find the right distance between myself and the research participants. It was not always easy to maintain a required/desired (?) level of objectivity and neutrality within the relational dynamics. This applies as much to the individual refugee participants as it does to members of the V.O.T. team. A few weeks into the fieldwork, I wrote in my field diary,

“Something else which struck me, and which I need to negotiate over my period of fieldwork here, is the relationship between professional and personal...it strikes me that the research participants will feel like colleagues or even friends, happy to share openly or discuss informally over lunch. I need to remind myself to pay attention to this developing dynamic”

More than a year later, when I ended the fieldwork, I noted

“I think it’s safe to say that the [fieldwork] experience has been richer, more chaotic, messier, and more ‘field’ than I ever could have imagined. I entered into a traumatic, intense, raw rough, real environment: refugee homes, shelters, hotels, squares, coffee shops, festivals and tiny NGO offices... and more drinking coffee than anticipated. What a privilege!”

I have worked within the context of humanitarian emergencies before. What has transformed me in the process of conducting this research was having the theoretical tools with which to begin to make some sense of the experience – thus simultaneously “being in” and “reflecting upon.” Thinking more critically about the notion of trauma, and how it pertains to the refugee experience, has opened up as many avenues for questioning as it has found answers to original questions. Indeed, this should be the case for any investigation into complex dynamics, and attempts to account for this complexity. Often, the answer seems to lie in an unsatisfactory “well, it depends, its complex.” What is trauma? “well, it depends, its complex.” Is refugeehood traumatic? : “well, it depends, its complex.” Should P.T.S.D. be used as evidence in an asylum tribunal: “well, it depends, its complex.” Ideally, these answers should be used to guide further investigations: what does it all depend on, and how? My hope is that this research is able to map some of this complexity, if not find all of the answers, and add to our existing body of theoretical and empirical investigations within a sociocultural approach. I now explore some of these possible contributions.

Theoretical contributions to a sociocultural approach

Given the valuable contributions of the theoretical approach to studying the phenomenon, it is clear that, equally and inversely, there are multiple contributions of studying the phenomenon to the theoretical approach. What are the contributions of studying experiences of potentially traumatic events among victims of torture to the theoretical field of sociocultural psychology? It should be noted that the population itself is unique: a refugee victim of torture may be said in some way to represent “the ideal victim” – destitute, broken, the “most victim of all victims” in a manner of speaking. What they as human beings have experienced is horrifying beyond description. As I have explored in this thesis, experiences of potentially traumatic events may take them to the very limits of their humanness. Yet, exploring the unfolding of individual trajectories over time, we see that development does not stop. In the face of unspeakable horror, human beings develop. They dream, they imagine, they grow. This development inevitably occurs within a rich sociocultural network. Studying this particular population has allowed us to examine how this holds true even in dire circumstances, among all individuals – even those positioned at the miserable bottom of the social, political, and economic ladder. I am grateful for all of the research participants for allowing me to have seen this. It is more than resilience. It is growth.

I return to the case of Jules explored in **chapter eight**. He continued to dream. His ability to create plans, to imagine richly a beautiful future, and even to fall in love in the face of unimaginable obstacles, is remarkable. I return to the case of Mr B explored in **chapter six**. Despite significant physical and psychological suffering, he was able to draw on multiple resources (a cross-European Sudanese network of friends and family, the inspirational writing

of Dale Carnegie, the BBC World News application on his phone) to develop a life for himself beyond his identity as a refugee victim of torture. By exploring the development of individual human beings, even within the most dire circumstances, we see examples of how

“active selves construct their understanding of the world not in ways that slavishly remain faithful to those experiences, but rather in ways that constantly go beyond them. Human beings consistently create novelty both by their actions and by their thinking, using their social environment as a resource for both” (Valsiner & van der Veer, 2012, p. 96).

Perezhivanie as a concept has allowed me to consider further the unique ways in which individual research participants rose to the challenge of mastering their new lives upon arrival in Europe. Through examining the lives of individuals characterized by unthinkable horrors, we are still able to see that:

“Social environment as a source of development of the individual is not something, which exists outside the individual. It exists only when the individual actively participates in this environment, by acting, interacting, interpreting, understanding, recreating and redesigning social situations of development. Social environment determines the developmental trajectory; however, [...] subjectivity, an individual subjective configuration [...] is no less powerful in defining the course of [...] individual unique developmental trajectory than objective characteristics of social environment.” (Fleer et al., 2017, p. 11).

Addressing the research question

I return once more to the research questions identified in **chapter one**, the introduction:

- **Which narratives of trauma circulate among the diverse actors working with refugees within various legal and medical activity systems? How is the diagnostic construct of P.T.S.D. used as a tool within these activity systems?**
- **How do the individual trajectories of individual refugees, diagnosed with P.T.S.D., unfold over time within this sociocultural context?**
- **How is trauma understood and made sense of by individual refugees? How is a diagnosis of P.T.S.D. accepted and understood (or not) by asylum seekers and refugees from culturally diverse populations?**

The notion of the “traumatised refugee” is a complex one. It holds symbolic power. There is a complete narrative behind this tragic figure. Many have seen the images flashed across the media: devastated and impoverished communities, sinking ships, abandoned children, fences and barriers and brutal European regimes attempting to control the influx. There is no denying the brutal reality facing refugees arriving in Europe. The suffering is real, and multifaceted. Trauma does not stop at the border.

However, the results of this research have highlighted the existing tensions among conflicting narratives of trauma circulating among the actors involved. They bring to light the discrepancies in the way in which experiences of potentially traumatic events are understood, and in which narratives of trauma are used across legal and medical activity systems. Broadly speaking, the way in which “trauma” is understood by lawyers is different to that of health professionals such as doctors and psychologists, and again to that of refugee populations themselves. Furthermore, the way in which experiences of potentially traumatic events and their sequelae is i) understood or made sense of and ii) (re)presented in narratives, addressed to other actors across settings, changes to adapt to the context, and changes over time. The use of a diagnosis of P.T.S.D. in particular seems to be unnervingly context-dependant. A doctor may diagnose P.T.S.D. strategically, to inform an individual treatment plan within a medical context, but not to inform the asylum tribunal to assist them in their decision-making process – or vice versa. A lawyer may decide to focus on the “headline” of the potentially traumatic event in representing the narrative to a judge – and encourage a refugee to frame this narrative within a certain way that is most easily understood by the court. Refugees may decide to present the trauma narrative in one way to a psychologist, and in another way to their lawyer. They may go to the psychologist with the explicit intention of receiving a medical certificate attesting to a diagnosis of P.T.S.D. for use in the legal system. They may deny being traumatised altogether – the implicit understanding of “trauma” inherent to a P.T.S.D. diagnosis seemingly too far from their own subjective understanding of what was happening to them. The results indicate that P.T.S.D. as an instrument circulates among the different actors yet with specific meanings and functions within each activity system, and which change over time.

Not only are there multiple tensions associated with such a diversity of narratives of trauma, but there is an inherent hierarchy within medical and legal activity systems which places the knowledge of one group as superior to another. The narratives are not created equal. They are embedded within sociocultural and political structures with very real political, economic, and social consequences for refugees. Within this system, it appears that the medicalized narrative of trauma, as manifested concretely in the diagnosis of P.T.S.D., holds particular political power. Neither the health professionals nor the refugee research participants appeared naïve to the potential benefits of using P.T.S.D. as a cultural tool to be used in the asylum seeking procedure in particular. P.T.S.D. as a diagnosis appears instead to have been used strategically by the various actors in a way that was explicitly interactive, communicative, and purposeful. It is not a politically neutral tool. I return once more to the case of Jules explored in **chapter eight**. He explicitly rehearsed the way in which he was going to narrate his story before the asylum tribunal. He was an actor preparing to take to the stage. He rehearsed “the story that they gave me” as this was the one that was going to “be believed.” That being said, the privileging of western psychiatric knowledge was not necessarily always the case. The majority of professional’s discourse reflect a certain ambivalence in the face of such contradictions. Their relationship to the diagnosis appeared to range on a continuum from complete and unproblematic acceptance of the category of P.T.S.D., to a nuanced, individualised and context dependant use, to a critiquing and problematisation thereof.

The results also clearly highlight the changing nature of the subjective experiences of exposure to potentially traumatic events by individuals over time. For the individual refugee research participants - negotiating complex legal and medical systems had a substantial impact on their mental health. It confirms what is increasingly being highlighted in the literature: there is very little “post” about the post-traumatic stress being experienced by refugee populations in Europe. It seems absurd to focus on the “headline events” of what happened in the country of origin when individuals are struggling to survive – today and every day. Yet it is not a question of “here or there,” “past or present.” No such dichotomies exist. Rather, the potentially traumatic experiences of the past echo the current reality. Trauma begets trauma. As highlighted in the feedback loop model presented in **chapter nine**, the experiences of the past echo current experiences. There are no such clean temporal divisions in the subjective experience of potentially traumatic events. Similarly, there are no clean divisions between the subject and their environment. P.T.S.D. would suggest an impairment, a wound located at the level of the individual. However, in line with a sociocultural perspective, the results of the research have highlighted the dynamic interplay between the individual subjective experiences of potentially traumatic events and the concrete sociocultural environment.

Another issue explored in the thesis concerns that of the use of the diagnosis of P.T.S.D. as a cultural tool: for what, by whom, and for whom? None of the refugee participants in the research were familiar with the concept of P.T.S.D. before being diagnosed with it themselves. What strikes me is the way in which this diagnosis was appropriated and/or contested by various participants. There were a variety of responses to being confronted with this novel, medicalized notion of suffering. For some participants, it appeared as though the notion was so far from their own conceptualisation of what was happening that very little appropriation took place. The diagnosis was something for western health professionals, from western health professionals, that was of very little direct concern or consequence. As such, it was not so much of a rejection of the diagnosis. It was a rendering it irrelevant. For others, it was a useful tool. In this latter case, it seems that the use of the tool lay in its concrete political, legal, and social relevance. It was a tool for use within various medical and legal activity systems—not a personal usefulness as such, but a practical and concrete usefulness in the sociocultural environment. In such cases as these, there similarly seems to have been very little appropriation of the diagnosis at a personal or subjective level among participants. In other words, P.T.S.D. as a cultural tool was used with certain concrete intentions in mind. For example, it was useful to have the diagnosis as evidence of refugee status within the asylum tribunal. The diagnosis was a cultural tool used to act in the world, but not to further a process of psychological rehabilitation, or to make personal sense of suffering. None of the participants seemed to have drawn upon the diagnosis to inform their own personal way of making sense of potentially traumatic events or as a significant factor in their journey to recovery.

It is perhaps understandable that P.T.S.D. be used as a tool by various actors attempting to negotiate the complex procedure that is asking for asylum. It may even perhaps be viewed as a question of the survival of certain refugees. We need, on one hand, to be shocked by the potentially traumatic events – and to bear witness the impact of this on their mental health. To recognise this, in the concrete form of the diagnosis, is imperative. The wounds are real. What

I find more surprising, however, were results indicating the same power struggles playing out in the court playing out in the consultation room. From a personal perspective, it has lead me to reflect on the implication of this for health professionals working with this population. Might refugee patients be rehearsing their trauma stories for the psychologist, as they do for the court? Might they experience being seated in front of a psychologist in the same way as being seated in front of a judge?

I refer back to the words of one participant:

*“The people asking you questions [in the tribunal], it’s like you’re sitting across from a psychologist. They’re professionals who know their work...for the psychologist, it’s a **game**. It’s a **toy**. He asks you questions, and bases his deductions on your response - and the asylum [procedure] itself, it’s the same.”*

His words suggest a deep distrust in mental health professionals. It also highlights how different the subjective experience of being seated in front of a psychologist may be for refugees to that of what we might imagine it to be. For him, the psychologist is similarly playing a game. He himself is a toy in this context, being manipulated by the medical system as much as the legal system. For many V.O.T.s in particular, it sadly seems to echo the deep sense of powerlessness at the hands of an aggressor experienced in their countries of origin. There are inevitably power imbalances inherent to the relationship. There are inevitably differences in how we make sense of trauma, how we narrate trauma to ourselves and others. As there are multiple traumas, there are multiple stories of trauma, and multiple listeners to the stories.

Trust is central to these dynamics. Within the dialogical approach adopted throughout this thesis, trust is considered as positional: “social power holders insist upon a positional monologization of trust...we are assumed to trust institutions [and] all that monologization happens through words -words inserted into specific locations.” (Linell & Marková, 2013, p. xi). Yet, “trust is a dialogical feeling in which the person relies on someone else based on expectation of positive ethical reciprocity...thus trusting psychotherapy, in a macro-sense, implies to trust a distributed institution, in which social roles are established, as well as the generic rules that govern the activity that may reach a legal format” (Salgado, 2013, p. 110). In the consultation room, refugee victims of torture are expected to trust the mental health professional when diagnosed with P.T.S.D. They are socially and institutionally in the (inferior?) position as the patient within this dynamic. For some of the research participants, trust in the mental health professional was a given. For most, however, there was a marked ambivalence around how much the professionals charged with their care could be trusted. I return to the case of Brigitte seen in **chapter seven**. She grappled with whether or not her psychologist’s medicalised or “scientific” interpretation of what she had experienced was true: “apparently there is an explanation that’s different to what I think myself. So I don’t know which to leave or take.” I return to the case of Dilraj seen in **chapter nine**. He was equally ambivalent in trusting the doctor’s diagnosis: “he has written that I’m in very big depression. Actually, I don’t know if I’m in depression or not.” In light of the multitude of potentially traumatic events to which this population has been exposed – all along the migration journey – the lack of trust is not surprising. Indeed, for some, the implicit obligation to trust the professional may prove an impossible task. Being in the privileged and arguably hierarchically

superior position of health professional in relation to refugee “patient” therefore comes with an ethical responsibility to be aware of the discrepancies in trauma narratives, and the power dynamics inherent to this context of which trust is a core component.

What is further worth highlighting in reflecting upon these results is the notion of agency or the will and ability to extend one’s power to act (Clot, 2011; Clot & Béguin, 2004; Clot & Litim, 2008; Kloetzer et al., 2015). None of the research participants—refugees, health professionals, community leaders—were passive in engaging with these legal and medical activity systems. To some degree or another, there was more or less power to act as individual agents. This power extends to the refugee participants themselves. Despite the inevitable imbalances of power characterising these systems, and the multitude of barriers faced, all of the refugee participants found ways to act within the system in order to survive and thrive: rehearsing a speech for the tribunal, disagreeing with a psychologists’ interpretation of their symptoms, actively seeking the support of a local community ... even within the most ostensibly powerless positions, there is a power to act, there is resistance. Research participants, refugee victims of torture, found the will and ability to exert power over a seemingly hopeless situation.

To summarize, these results therefore highlight

- i) the way in which a P.T.S.D. diagnosis is being used strategically as a cultural tool by various actors within medical and legal activity systems put in place to address the large influx of refugees arriving in Europe
- ii) the changing development of experiences of potentially traumatic events over time. This includes the substantial impact of the current (sociocultural, legal, economic, and political) environment on refugee trauma trajectories
- iii) the culturally diverse narratives of trauma informing refugee mental health, which may compete, contradict, or conform to the narrative of trauma inherent to a diagnosis of P.T.S.D. This includes the substantial lack of the use of the P.T.S.D. diagnosis as a resource for personal recovery among participants.
- iv) the ways in which refugee victims of torture manage to draw on multiple resources in order to exert and extend their power to act as active agents, despite being positioned as “victims”

What are the implications of these results for sociocultural psychology? In the next section of this conclusion, I reflect on some possible ways in which these results may lead us to define “trauma,” and better understand potentially traumatic experiences, from within a sociocultural perspective.

Towards a sociocultural definition of trauma

I begin these reflections by returning to psychoanalytic conceptualizations of the term “trauma.” According to Freudian psychodynamic theory, trauma is defined as a frightful experience which overwhelms the psyche to such an extent that images, words or other memories related to the

event are unable to be integrated into the system of representations which structure the experience of the individual (Garland, 2002; Sturm et al., 2007). Within this paradigm, one commonality of trauma experience is the feeling of a chaos of seemingly unutterable experiences collapsing into that “wordless nothing” (Larrabee et al., 2003, p. 354). As eloquently expressed by Lester (2013):

“Pushed to the very precipice of physical and/or psychological annihilation, the bonds that tether a person to the everyday world become stretched, distorted, and even torn; sometimes irreparably so. Such a state of ontological alienation is profoundly distressing. To regain their footing, people often turn to culturally available practices, symbols, and structures to help reorient them to the world” (p. 753).

What the results of the thesis have demonstrated is the mediating impact of narrating potentially traumatic experiences to Others, in processes of recovery. This is because telling a story of a potentially traumatic event or reliving it necessarily occurs in a larger dialogical matrix of narrative and social praxis (Kirmayer, 1996). The communicative function of language as a tool, concrete semiotic and symbolic devices provide the connections to an Other and to one’s Self (Daiute & Lucić, 2010). As such, symbolic elements in socio-cultural practices are resources for repairing ruptures in intersubjectivity. They are lenses through which experiences may be collectively and individually reflected upon. **Language** is central. Cultural representations, carried through language, are considered in their function not only as shared symbols but also as subjectively appropriated and emotionally invested representations (Sturm et al., 2010). It is therefore through language that one is able to constitute and actualize a coherent sense of Self. Furthermore, this can only take place in the context of “interlocution” or “addressivity” (Bakhtin, 1978, 1981, 1986) – towards and with an Other. There is evidently a continual dialogue between the person’s inner world and the socio-cultural context in which internalized configurations or representations of potentially traumatic events are processed (Lemma & Levy, 2004). The critical issue here is that of the notion of reciprocity (Van Der Kolk, 2015) inherent to **social recognition** (Marková, 2016). In order to illustrate the importance of social recognition as a “powerful element for healing in the aftermath of trauma” (Larrabee et al., 2003, p. 353), Larrabee and colleagues refer to the works of Agger (1994) wherein she details her journey through the narratives of forty refugee women. In documenting the healing process among these woman, Agger writes: “In this space they begin to experience the necessary turning point between the wordless nothing dominated by chaotic anxiety and the wordless fellowship given form and expression in the symbol of the circle and its healing ritual” (p. 126). What is interesting to note in her words is the particular value given to “fellowship” as crucial to the healing process of giving “form and expression” to a coherent narrative of trauma.

Zittoun (2004) argues that:

“The embodied quality of experiences is, in its origin, given as a brutal happening. To be apprehended mentally, these experiences have to be linked to semiotic mediations. Mnemonic traces of previous comparable experiences, in their minimal definition or socially shared signs, either previously internalized, or available in one’s environment, have to be attached to them. Semiotic mediation minimally authorizes the grouping of fuzzy embodied impressions and then designate these groups of impressions (by a linguistic term, or also just by attaching them to any image), and eventually to include

them into an articulated sequence in the flow of thinking. Thus, semiotic mediations can allow experience to become part of, and thus transform, other thoughts. Thanks to semiotic mediation, normal elaboration of experiences allows processes of linking and transformation through which they progressively fade in the flows of memories and thinking.” (p. 484).

Reflecting on the process by which semiotic mediation allows for memories of potentially traumatic events to be processed and ultimately stored in the flows of memories and thinking, a traumatic rupture in this very process would lead to the usual semiotic work of making sense, which demands to bind traces of events to other traces, in time and in experience, not taking place. The potentially traumatic events and the actual sphere of experiences are disconnected. Should this prove to be the case, the lack of connection of past and present can also be understood as preventing the emergence of possible futures. From within this dialogical paradigm, this lack of connection to the future is intrinsically linked to a severe disruption of the relational processes by which meaning is dialogically created – the bedrock of which is social recognition. Viewed through the lens of a dialogic systems sensibility, the traumatic world’s slipping away from the categories of meaning can be seen as a severe disruption of those relational processes in which meaning is formed (Sucharov et al., 2007).

Within a sociocultural framework than, **trauma may be defined as that which cannot be elaborated through semiotic means**. I would argue that, implicitly contained within this definition, is the idea that the Self is inextricably connected to the Other, and that it is language which acts as the mediating conduit between the two. Trauma has a social and a cultural dimension. For the transformation of memories of potentially traumatic events into semiotic forms which connects it through language to its rightful place in time, the elaboration needs to be socially situated and “intersubjectively acknowledged” (Zittoun, 2014, p. 485). Here, I refer to a Vygotskian conceptualization of language as a system of signs. This does not necessarily mean that the elaboration needs to be conducted verbally. Language is more than words. Many processes of recovery from potentially traumatic events have resulted from making use of alternative ways in which to elaborate upon the experiences. Drawings, puppets, dolls, sandtrays, to cite a few examples, have all been used to facilitate this process of elaboration in creative ways without depending on words. This was something I observed during my period of participant observation in the V.O.T. centre during the “arts and crafts” groups for women victims of torture. Meaningful processes of elaboration were being undertaken. Narratives of trauma were expressed and shared, using language as a system of signs. All of this without words.

A sociocultural definition of trauma, sees it first and foremost as **relational, intersubjective** experience. It relates to a **crisis** that is situated, negotiated, and sometimes mended in relationships. From this perspective, mental health comes into view as “a problem of social Ecology, which may involve crises of kinship, of relations of reciprocity and obligation, of maintaining proper relations with ancestors, and, importantly, the therapeutic relationships” (Bemme & Kirmayer, 2020, p. 13). Trauma should be seen as a social phenomenon, viewed at communal and societal levels (Daiute, Beykont, Higson-Smith, & Nucci, 2006).

Due to the fact that the experience of trauma unfolds within the complex ecology of sociocultural systems, it is **nonlinear and non-dose dependant**. Being exposed to a “dose” of potentially traumatic event(s) will not result in a directly proportional symptomatic response to these events. Rather, the experience is mediated through *perezhivanie*. The way in which post-traumatic symptoms may manifest is similarly nonlinear: symptoms do not necessarily gradually weaken over time. Furthermore, as explored in **chapter eight**, the suffering is not in direct opposition to aspects of resilience and growth.

A sociocultural understanding of trauma takes into account notions of **temporality**. Social resources provide a time orientation, and, consequently, a self-continuity between past and future (Kadianaki & Zittoun, 2014) necessary for the construction of a coherent narrative, and, ultimately, the Self.

This begs an essential question: **is “refugeehood” necessarily traumatic?** By definition, refugees are people who have faced severe threats in their countries of origin, and many experience violence during their flight or in refugee camps. Disruption of social networks and separation from or loss of family members are common consequences of forced migration and are associated with an increased risk for subsequent mental health problems (Kirmayer, Rousseau, & Measham, 2011). For many refugees who have arguably been exposed to a plethora of potentially traumatic events both before, during and after migration – what is potentially lost is the ability to draw on meaningful socio-cultural symbolic resources to make sense of these events as well as the ear of a listening Other to whom and with whom the process of sense-making of potentially traumatic experiences may be addressed.

Yet, I would argue that the experience of refugeehood, like any experience of migration, and indeed any general human experience, is complex. As much as the thesis has highlighted suffering, my hope is that aspects of growth and development in the face of this suffering have equally been highlighted. In short, the state of “refugeehood” is not necessarily traumatic in and of itself. I would instead return to the above definition of trauma, and argue that experiences of refugeehood may be considered traumatic **when there is no possibility of these experiences being elaborated through semiotic means**. Sadly, this is too often the case. Facing potentially traumatic events, as well as significant ruptures from a sociocultural context in which these events may be made sense of, a vast number of refugees are traumatized by their experiences of migration. We need to bear in mind that it is not only the period before and during migration, but also upon arrival in host communities: a period typically characterized by a social and political marginalization leading to isolation, withdrawal, distrust, non-recognition and rejection, as well as being torn from one’s communal and social fabric.

In this sense, a sociocultural understanding of “**refugeehood**” itself would consider it as a social phenomenon, beyond the “traumatized” isolated figures of individual asylum seekers. Rather, it considers “violent displacements as embedded in geo-political systems mediated by human language” (Daiute et al., 2020, p. 15). Refugeehood, in other words, is an embeddedness in refugee systems. The recent unfolding of the refugee “reception crisis” in Europe is inextricably linked to the development of society as a whole. Responses and reactions to the crisis are

indicators of the maturity of society. Instead of focusing on individual refugees, a sociocultural approach would consider the dynamic interrelatedness of individuals and broader “refugee systems.”

In an attempt to develop a sociocultural understanding of “trauma” (specifically, refugee experiences of potentially traumatic events), two interrelated concepts elaborated upon by Vygotsky merit exploration: **crisis** and **drama**. The two concepts were central to Vygotsky’s work. They became integral to the way in which he conceptualized human development in all of its entirety (Dafermos, 2015). The term “crisis” in general, has a long and complicated history: firstly, in Ancient Greek language, the verb “κρίνειν” means “to separate,” “distinguish,” “judge” or to “decide” (Dafermos, 2013). In these times, it was central to politics. It referred to the making of a decision, a crucial and decisive turning point which could tip the scales in a particular direction: “In ordinary life, ‘crisis’ refers to that point in an event or a series of events which determine it/their outcome(s) and which signals the direction it/they will finally take” (Brockhaus, 1845, p. 399). In his exploration of the term, the historian Koselleck (2006) notes that the concept of crisis in classical Greek fused both subjective and objective spheres, “through which the individual citizen and the community were bound together” (p. 359). He continues by stating that “even while crisis remains open as a cosmic event, it is already taking place within one’s consciousness” (p. 360). For him, “crisis” is “used as a transitional or temporal concept, which, as in a legal trial, leads towards a decision. It indicates that point in time in which a decision is due but has not yet been rendered” (p. 361). It would be interesting, at this juncture, to consider the concept he presents of crisis as an “ongoing trial” (p. 359) associated with a notion of politico-legal justice and decision making, as it pertains to the “crisis” of requesting asylum. Once again, both the “objective” crisis of the asylum decision, and the “subjective crisis” experienced internally by the individual refugee requesting asylum, are inextricably bound. Interestingly, Koselleck continues, “in the case of illness, crisis refers both to the observable condition and to the judgement (*judicium*) about the course of the illness” (p. 360). Crisis, in other words, refers both to the event itself unfolding within the environment, as well as the way in which the individual makes sense of, responds to, perceives/judges the event. It covers equally well “the uniqueness of both the perceived structural transformation and that of each acute moment of decision” (p. 382). Furthermore, Koselleck continues, the concept of crisis later retained an essentially positive connotation with “general possibilities” (p. 395). He refers to the use of the concept by Marx and Engels, for whom “the crisis will make me feel as good as a swim in the ocean” (Engels, 1987, as cited by Koselleck, 2006). In short, “crisis” equally came to symbolize revolution, opening new reinvigorating possibilities.

Let us return to Vygotsky’s understanding of the term. He believed that “crises are not a temporary condition, but the way of inner life” (Vygodskaja & Lifanova, 1999, p. 25). For Vygotsky, the concept of crisis in particular was more than a scientific term, but a way of conceptualizing the potentially traumatic events he encountered in his own life (Dafermos, 2015) linked to personal suffering as well as the social upheaval occurring around him (Hyman, 2012). Four core aspects linked to the way in which he conceptualized the interrelated concepts of crisis and drama are worth highlighting:

- i) they are *inevitable* – an unescapable part of everyday human life
- ii) they relate both to *events and reactions to these events*: both on the macro-level of society, as well as the micro-level of the individual subjective experience
- iii) they *create the conditions for development*
- iv) they contain *possibilities for positive transformation* and restructuring, on an individual and social level

From within this perspective, as noted by Dafermos (2015), “human development becomes possible only on the basis of dynamic, dramatic interrelations between concrete subjects and society that could not be reduced to their external interactions” (p. 21). Vygotsky (1989) himself purported “the dynamic of the personality is drama” (p. 67). The “drama” encountered in daily life, a moving force of development, is both intra-psychologically interpreted by the individual at the same time as being experienced inter-psychologically (Veresov, 2016). The concept of crisis or drama as both the event and the interpretation thereof may also be extended to the macro level of the social, economic, or political. It is why I refer in this thesis to the refugee “reception crisis” rather than simply the “refugee crisis.” The crisis around the mass arrival of people requesting asylum in Europe over the past couple of years relates significantly to the way in which Europe has “received” and responded to this wave of migration.

Dramas and crises, clashes and conflicts, tensions and turbulence, are not only inevitable but necessary for development. How does this relate then, to our understanding of “trauma” from within a sociocultural perspective? I return to the definition of trauma from a sociocultural perspective elaborated above. I would cautiously advance the idea that a drama or crisis encountered in the life of the individual, and refracted through their unique *perezhivanie*, may be considered “traumatic” in the absence of a possibility of these dramas or crises being elaborated through semiotic means. This includes both the “macro” and “micro” dramas (as distinguished by Veresov, 2016) of refugee life: the large scale, terrifying events unfolding on a global scale, as well as the daily struggles inherent to adjusting to life in a host country, for example. What distinguishes trauma from a drama or crisis is our **reaction** to the event, as refracted through **perezhivanie**. Vygotsky purported that “in order to overcome the crisis constructively one has to deal seriously with the problem of meaning or sense” (Pléh, 1988, pg. 409). He emphasised that it was **language** as a tool which could introduce a new dimension of sense making beyond the immediacy of events in the environment (Vygotsky, 1987, first published in 1934). The implications for mental health clinicians working with refugees facing potentially traumatic events are many, and will now be explored.

Implications for mental health clinicians

As summarized by Droždek and colleagues (2020),

“core aims of all psychotherapeutic interventions for survivors of war and violence are to help them to regain control over their lives, restore self-efficacy and a sense of agency, reattach with humanity, give

meaning to traumatic experiences and suffering, and regain hope for the future. These therapy aims go beyond the goals of simply reducing symptoms of PTSD, depression, and other comorbid conditions, although reduction of symptoms and associated suffering are important.” (p. 9).

How may mental health clinicians obtain these aims? What might a sociocultural approach teach us about experiences of potentially traumatic events among refugee populations? I now explore the implications of such a sociocultural understanding of “trauma” for mental health clinicians working with refugee populations.

The role of narrative activity

In this thesis, I defend the view that we are narrative beings, constructing and reconstructing our Selves through stories, locating our biographies and life projects in discursive webs of shared meaning. One consequence of this sociocultural perspective is that understanding the human capacity to produce, think in, and transact with narrative must play a central role in clinical practice. Narrative capacities, skills, practices, and specific content can contribute to the causes, course, and outcomes of psychopathology as well as to processes of coping, resilience, healing, and recovery. Narrating our lives mediates our lives. For refugees, the activity of narrating is a critical part of their “making sense of what is going on in their environment, trying, and sometimes succeeding against great odds to re-create meaningful sustainable life for themselves, for their children, their communities, and natural environments” (Daiute & Gómez, 2014, p. 157).

We do not just speak through language but *use* language to express meaning in context. People use narrating to interact in the world, to figure out what is going on in their environments, how they fit, and sometimes, how to change things (Daiute et al., 2015). The bridging role of language, therefore, should be central to refine the way that clinicians think about how local illness terms, expressions, and explanations relate to the kinds of problems they diagnose and treat. For example, cultural representations of potentially traumatic events and their sequelae held within language may also serve to articulate modes of experience and adaptation that contribute to resilience and well-being in the face of adversity (Lewis-Fernández & Kirmayer, 2019).

Clinicians, through the mediating impact of language as a cultural tool, may play a key role in facilitating narrative activity: assisting the memories of potentially traumatic events to be elaborated upon, made sense of, and placed within a meaningful temporal framework. It is this narrative activity which allows individuals to reconfigure a sense of themselves and their experiences – both of the past, the present, and the future - in order not to remain stuck within the wordless nothing. Through a process of semiotic mediation, we find the words to confront the wordless nothing. It is not only P.T.S.D. which may be used as a cultural tool by mental health clinicians and their refugee clients or patients alike. A sociocultural approach has allowed us to examine the ways in which language *itself* acts as a cultural tool with which to mediate potentially traumatic experiences – for example, in the narrative activity of the psychotherapy session. For many, the therapeutic context itself may function as another cultural tool – the rituals inherent to the therapeutic process unfolding within the session, and developed within

the context of a human relationship, serving to facilitate a process of healing and recovery. Here, I return to Daiute's (2014) definition of a cultural tool as "symbolic process developed in human relations for interacting purposefully in the world" (p. 23). Narrative activity within the psychotherapeutic process exemplifies such purposeful interaction.

The collective cultural frame

At the core of this thesis is the idea that the experiencing of potentially traumatic events has a social and cultural dimension: "the manner in which people understand their afflictions is undoubtedly connected to beliefs about the origins of such afflictions. Such beliefs are central in devising appropriate therapeutic strategies for the alleviation and elimination of the afflictions" (Honwana, 2006, p. 229). This thesis has explored "culture" in all of its dynamic unfolding over time. "Culture" is not static. It changes with experiences of forced migration, and over time, so clinicians should bear in mind the ever-changing local cultural communities and current issues and concerns. They should also be aware of their own personal and professional cultural assumptions (Kirmayer et al., 2011).

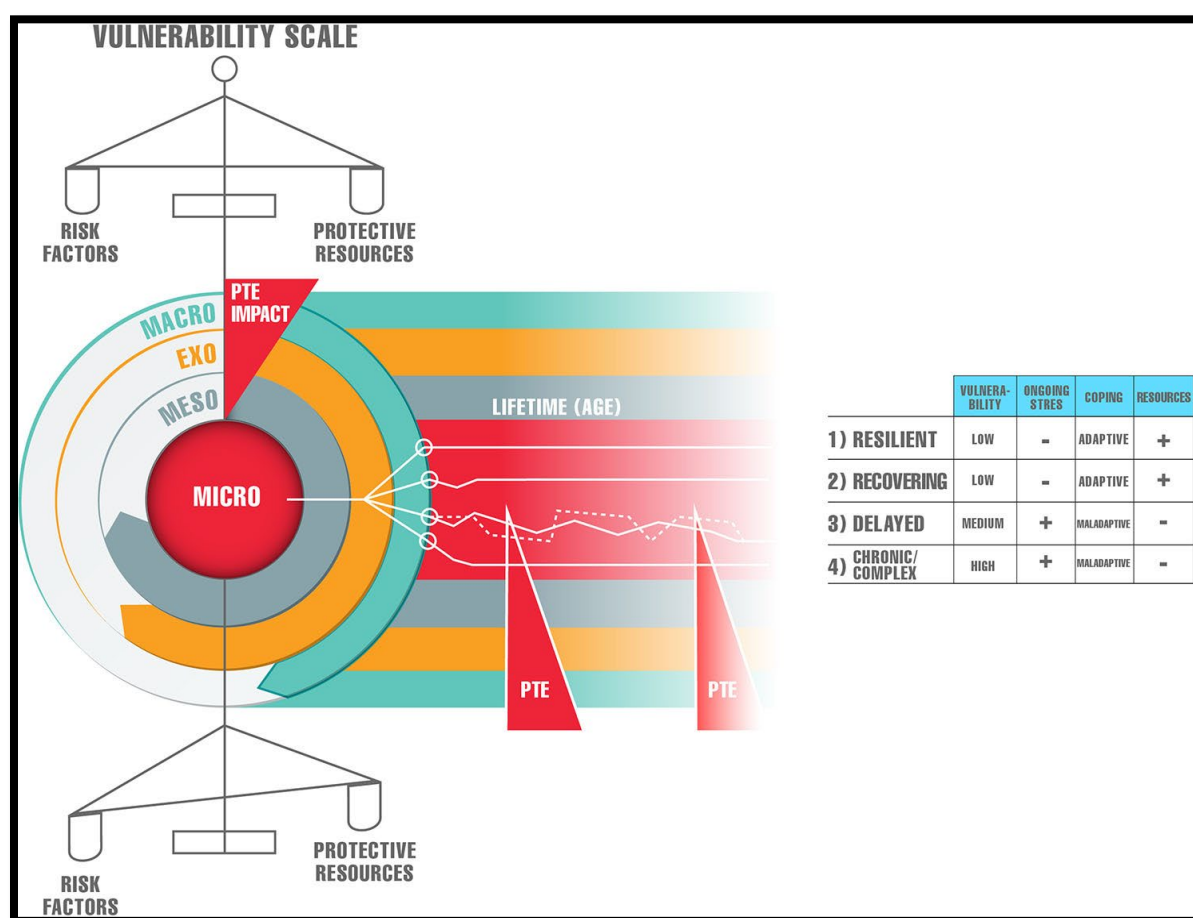
Some key implications for mental health clinicians, arising from a sociocultural exploration of experiences of potentially traumatic events among refugees, is the significant influence of collective histories of colonialism, racism, violence, and exploitation which may influence the development of a working alliance built on trust. People from refugee communities come with their own collective histories, living conditions, and social, moral, and political concerns that form the backdrop of their personal experience of potentially traumatic events. For survivors of torture in particular, the clinical situation may remind them of these potentially traumatic events – the interview leading to a sense of being interrogated, as was the case for some research participants. It is essential that clinicians be aware of the sociocultural issues framing experiences of potentially traumatic events. Such experiences may not be framed by refugee patients or clients as an "illness" as such, but rather seen in terms of the events' social, moral, and political meanings. It is this **cultural framing** which substantially determines processes of healing and recovery, responses to therapy and the risk of psychopathology developing. Ignoring these different cultural framings may lead to a patient or client feeling discriminated against, misunderstood, or simply not believed – interfering with trust and disclosure.

Temporality

A sociocultural approach allows us to

"grasp the dynamics of interactions between resilience, psychological damage, context and time. These interactions are nonlinear, and contingently result in development of psychopathological phenomena when reaching a threshold during a process of accumulating potentially traumatic experiences over a survivors' lifetime" (Drożdek et al., 2020, p. 1).

What is highlighted in the approach is the **nonlinear** nature of the unfolding of experience. A sociocultural approach allows us to view the **dynamic and bi-directional** relationship between the sociocultural context and the individual's internal, subjective experience of potentially traumatic events. As noted in the above quote, Droždek argues that “in order to understand the complexity of this relationship, one should be guided by a string of causation principles and grasp the logic of fluctuation of psychopathology over survivor's life trajectory” (p. 2-3). His model (p. 5) highlights this ever-changing dynamic over time, notably the influence of risk and protective factors within the sociocultural environment having an impact on the trajectory of an individual's mental health:



In exploring the individual trajectories of refugees impacted by potentially traumatic events, the results of the thesis similarly highlight the changing impact of the sociocultural environment (including risk and protective factors) in dynamic interaction with individual mental health, as represented in the above model. This calls into question assumptions of a linear trajectory from the experiencing of potentially traumatic events, to the experiencing of post-traumatic symptoms, to healing and recovery:

“Assumptions about trajectories of actions toward presumed progress also implicate temporality, as in the term ‘resilience in war’ implying that ‘war’ is a temporary interruption and people can/must recover from such interruptions. When people narrate specific times, they interact with historical time, thereby using time to create meaningful connections of contemporary plights and dreams with events over a broader span of time, place, and consequence.” (Daiute & Gómez, 2014, p. 159).

Mental health clinicians need to pay attention to these aspects related to **temporality**. The implications are twofold: firstly, in terms of the nonlinear fluctuation in subjective experiences of potentially traumatic events as noted above, but secondly in understanding the importance of reconstructing a subjectively meaningful temporality within the therapeutic process. For many refugees participating in this research, a significant part of their process of healing and recovery involved the re-establishing of a meaningful “linearity.” In line with the above quote, they indeed “create[d] meaningful connections of contemporary plights and dreams with events over a broader span of time, place, and consequence.”

Part of mediating potentially traumatic events is, through processes of linguistic elaboration, allowing memories of potentially traumatic events to be placed within a meaningful temporal order; in other words, placed alongside other memories of the past so as not to haunt the present, or the (imagined) future. As Daiute and Gómez (2014) have demonstrated among two of their Colombian research participants, Don Paz and Feniks,

“Don Paz’s orientation to the past and Feniks’s orientation to the future interact with the physical and symbolic temporalities limiting their lives and holding possible alternatives. While there’s no perfect past for Don Paz nor an open future for Feniks, using time to imagine options is an important step.” (p. 172).

The authors note that “when people narrate specific times, they interact with historical time, thereby using time to create meaning in relation to contemporary plights and dreams” (p. 163). They show “how people use the cultural tool of imagined time to analyse their circumstances critically and eventually manage those circumstances” (p. 168). Drawing on the work of Ricoeur (1984), they point to how memories, including those of potentially traumatic events, are never set. Rather, the memory of any specific event can differ or appear different depending on the circumstances of recall and sharing. When refugees narrate their experiences of potentially traumatic events, there’s inevitably a “present of past things” (Ricoeur, 1984, p. 9). There is similarly a “present of present things” (Ricoeur, 1984, p. 9), the anchoring perspective of narrating time which expresses the narrative purpose and which is intricately related to the unfolding relationship between refugee and mental health clinician, as well as a “present of future things” (Ricoeur, 1984, p. 9). This projection into the future, they note, is imagined and fluid:

“Considering the diverse meaning of explicit and implicit temporality in terms of the context raises implicit questions to guide investigations about how diverse narrators use time to make sense of situations, considering collective goals, and creating narratives of action” (p. 167).

In the case studies explored in **chapter eight**, this imagination of possible futures was connected to hope. For many of the research participants in this thesis, points of recovery and subsequent growth were inextricably linked to being able to imagine new possible futures. They were also connected to an individual’s ability to “question the inevitability of a certain future narrative” (Daiute & Gómez, 2014, p. 166). These possibilities of imagining and creating new futures formed part and parcel of their power to act – integral to processes of healing and recovery from the experience of potentially traumatic events. In the act of imagining the future, in other words through constructing narratives within hypothetical time, individuals “build on

[their] own story to create a turning point expressing the awful realities of a suspended life, very possibly with no future” (Daiute & Gómez, 2014, p. 171).

In the case of Brigitte (presented in **chapter seven**), elaborating upon her past experiences of potentially traumatic events with her therapist, who provided her with the resources in which to make sense of these events, allowed her to develop new plans for her future. Once she began to accept his “scientific” explanations for her nightmares, for example, she began to associate them with events in her past – and not the present anger of her ancestors as she originally had thought. By thus elaborating upon her experiences in her country of origin, through a process of **semiotic mediation** facilitated by psychotherapy, she was able to construct a new idea of herself (as not being an evil women targeted by her ancestors but as having done what was needed in the circumstances), and imagine a new possible future for herself and her child. In the case of Dilraj, however, he was unable to find the words to narrate his experiences. Without language, in the absence of semiotic mediation, he remained stuck in the wordless nothing. Even within the context of the interview, he constantly narrated events in the past in response to my questions regarding his life in Athens. It is as though he was frozen in time. Feeling deeply misunderstood and disconnected from his new sociocultural context, he eventually returned to his country of origin.

Here, I again return to the point noted above: the experiences of potentially traumatic events are **nonlinear**. While the reconstruction of a meaningful temporality, through semiotic mediation, is integral to processes of healing and recovery from such events, clinicians need to be aware that this is a complex and dynamic process. In analysing Jules’ trajectory in **chapter eight**, article five presents a “loop model” of his possibility to imagine. Imagination in this article is conceptualised as a process which creates “loops” out of the present, here-and-now of experiences connected to the material reality of the current environment. The process is seen as being triggered by some disrupting event, which generates a disjunction from the person’s unfolding experience of the “real” world, and as unfolding as a loop, which eventually comes back to the current, actual experience (Zittoun & Cerchia, 2013). In concluding this thesis, and reflecting upon the implications for mental health clinicians, I would like to revisit this conceptualisation. The loop model presented a linear concept of Jules’ trajectory. It may not go far enough in capturing nonlinearity. It risks “retain[ing] a monocultural vision of linear time, in contrast to less formal unofficial perspectives occurring in everyday life of communities, and emerging movements” (Daiute & Gómez, 2014. p. 172). The reality is far messier than the model could suggest. Experiencing potentially traumatic events may disrupt a coherent sense of linearity. It may break any subjectively meaningful sense of temporality. Clinicians need to be prepared to meet this “temporal chaos.”

One way in which clinicians may pay attention to, and work with, such aspects related to **temporality** is to track nonlinearity within the narrative activity of their refugee clients or patients. Pay attention to the words of the individual in the consulting room:

“The varied use of tense markers [...] and the use of subjunctive in particular provide rich analyses of narrative time. Diverse verbal time markings interact with expected truth and imagination. All narrative

time is symbolic, but past and present time markings imply actual experience, while the range of future, conditional, and possible time markings are more clearly imagined times. Narrated past events appear fixed and true because they are reported as having happened. Future, conditional, and hypothetical events have not occurred, so they are imagined, although often overlooked as such. Present tenses appear fixed in another way, often expressing the position of the narrator. The result of this interplay of time settings is the highlighting of meaning in the narrator's imagined time" (Daiute & Gómez, 2014, p. 170).

Considering aspects of temporality in narrative activity, and the relationship to the experiencing of potentially traumatic events, is particularly relevant for those refugees still waiting on a decision from the asylum tribunal. Many of the individuals who participated in the research waited months, if not years, for a response from the asylum tribunal. They remained held captive by the potentially traumatic events they had experienced in the past. They reported feeling stuck in time. If the experience of potentially traumatic events is understood as a radical disconnect from a meaningful past, present, and future; lengthy asylum delays function as an external mirror to this internal experience. I refer to the moving account of refugeehood provided by Clementine Wamariya (2018) upon arrival in her host country,

*"Time, once again, refused to move in an orderly fashion; the pages of the book lay scattered, unbound. This still happens to me. My life does not feel logical, sequential, or inevitable. There's no sense of action, reaction; no consequence, repercussion; no **plot**" (p. 33)*

Using language as a cultural tool, the role of the mental health clinician is therefore to assist individuals in constructing and reconstructing meaningful **plots** to their lives. A sociocultural exploration has allowed us to explore how this narrative activity serves to re-establish a meaningful linearity between the experience of potentially traumatic experiences of the past, the present, and hopes for the future.

The permeable Self

In exploring the impact of the cultural framework on experiences of potentially traumatic events among refugee clients or patients, one key element for consideration is the various ways in which the cultural framework determines the border or boundary of "self" and "Other." As Tang (2007) notes: "cultures differ regarding their dominant ideas about the ontology of self as well as relationship between self and others, between self and the universe, and between life and death" (p. 129). In **chapter six**, the case of Mr B is given as an example of a research participant who doesn't experience himself so much as an individual but more as having a "family self" based on relational models. The analysis highlights how he frames his experiences of potentially traumatic events within the intersubjective realm of his family network – similar to the South Sudanese research participants presented by Tankink and Richers (2007). Here, it is worth considering that refugee patients or clients from cultural contexts which are more collectivist in orientation may have different degrees of permeability of ego boundaries – in other words, the boundaries between "self" and "Other" may be conceptualised as being more extensive, flexible, or permeable. In clinical practice, this perspective can guide us to a deeper understanding of resilience, healing, and recovery based not only on internal psychology or

biological processes but also equally on social-interactional processes. The implications would be to integrate the knowledge of the individual's life-world, their family, and community as the site of both challenges and resources with which to cope, adapt, heal, and recover.

Universality of experience

Exploring mental health clinicians' work with diverse refugee populations raises questions surrounding the universality of experiences of potentially traumatic events. What is culturally determined and what is universal? It must further be noted that clinicians working with refugee communities face very concrete linguistic barriers. Not only may they be working with translators among populations who don't speak their language – they may be working with individuals for whom there simply are no words for “trauma” or “stress” in their language at all. What are the implications for mediating the experiences of potentially traumatic events in such an instance?

In exploring the exchange between mental health clinicians and refugee victims of torture (for example, as in the case of Brigitte) – what strikes me is the way in which symptoms align with those appearing in the definition of P.T.S.D. found in the D.S.M. V (APA, 2013). However, despite the universal symptoms (in this particular example, experiencing nightmares), the way in which she understands these symptoms are culturally informed. Language plays a key role in mediating this sense making process – in connecting Brigitte's cultural environment (in this case, African traditional spirituality – a worldview wherein ancestors who have passed away may still cast spells on the living) to the way in which she makes sense of and experiences these symptoms. It also fundamentally frames her process of recovery and post-traumatic growth. Believing the nightmares to indicate her ancestor's continual displeasure with her actions, she continues to feel guilty – a feeling that impedes her own sense of Self, and her plans for the future.

The results of this thesis may lead us to consider that, while many of the experiences of potentially traumatic events remain universal, including symptoms indicated in the definition of P.T.S.D., the way in which they are framed is culturally determined. It is this cultural framing which mental health clinicians need to pay attention to, as they accompany their refugee clients or patients in their narrative activity. As noted by Kirmayer (Laurence Kirmayer, 2019),

“Beyond engaging with local contexts, attention to culture can advance social psychiatry by revealing both commonalities and variations in the experience and expression of mental disorders. In addition to improving the validity of clinical assessment and the appropriateness of interventions, cross-cultural comparative methods can identify new strategies for adaptation and recovery rooted in local traditions but potentially translatable and transportable to new contexts.” (p. 31).

Here, Kirmayer refers to the need to “improve the validity” of clinical assessment – not to stop the activity altogether. Despite cultural variations in experiences of potentially traumatic events, he notes that we need to pay attention to “both **commonalities** and variations in the experience and expression of mental disorders” (my emphasis). Elsewhere, he and colleagues have noted

that “understanding suffering in context may also challenge common assumptions about what we assume to be culturally different, but **emerges as similar** across contexts” (Bemme & Kirmayer, 2020) (p. 12) (my emphasis). We are all human beings, and much of our experience as human beings is universal. It is therefore worth reflecting on many of the benefits of a P.T.S.D. diagnosis for refugee patients or clients. For many, there may be a sense of relief in having one’s experience understood. In other words, P.T.S.D. as a cultural tool may provide individuals with a framework in which their experiences may be made sense of. I remember discussing symptoms of P.T.S.D. with a South Sudanese woman who exclaimed with incredulity “but how can you, as a white woman, know that this is what is happening to me?!” It’s possible that at that moment that she had felt seen and understood, that she had been provided with words to explain the “wordless nothing.” Such a framing of her experiences meant that she was neither alone, nor crazy. What she had been experiencing was a “normal” reaction to potentially traumatic events. During my period of participant observation, the psychoeducation sessions using a *boite image* (collection of images centred on symptoms of P.T.S.D.) similarly aimed to “normalise” symptoms. It was a tool to facilitate discussion, and assist the participants of the sessions in making sense of their experiences. Here, it is worth mentioning the role of language in such processes of semiotic mediation. The *boite image* was a cultural tool, based on images rather than words. Without relying on the written word, or indeed a formal language such as English, French, or Arabic, it provided participants with a language as a tool with which to mediate their experiences.

The construct of P.T.S.D. may have some universal applicability, but the focus should be widened to recognize the multiple biosocial, cultural, and political processes that are essential aspects of experiencing potentially traumatic events – as well as resilience and recovery. The experience of these events and related suffering is both personally and socially value-laden:

“The dilemma with the current emphasis on PTSD therefore, is that although the diagnosis may capture a universal pattern of fear conditioning, anxiety, and avoidance behavior, this pattern is only a limited aspect of the range of clinical problems that can be directly related to trauma exposure. Other dimensions of trauma experience have social and cultural meanings and dynamics requiring comparable clinical attention” (Kirmayer et al., 2011, p. 5).

We need to see “beyond the P.T.S.D. paradigm” (Droždek et al., 2020, p. 2), but not disregard it altogether. A key message to be borne in mind is adequately summarized by experts in the *Lancet* commission for global mental health:

“Mental health problems exist along a continuum from mild, time-limited distress to chronic, progressive, and severely disabling conditions. The binary approach to diagnosing mental disorders, although useful for clinical practice, does not accurately reflect the diversity and complexity of mental health needs of individuals or populations.” (Patel et al., 2018, p. 1).

As disease models broaden and care practices become collaboratively stepped, shifted and shared among self, family and friends, community leaders, and medical providers - new conceptual and relational issues arise (Patel et al., 2018). A sociocultural framework allows us to understand the importance not only of a specific Other (for example, a psychotherapist) in this process of recovery and post-traumatic growth, but indeed the role of the entire

sociocultural context as influencing the development of the individual. Narrative use integrates the individual with society (Daiute et al., 2015). In the following section, I therefore explore some implications for mental health and psychosocial (MHPSS) interventions within humanitarian contexts more generally.

Implications for mental health and psychosocial (MHPSS) interventions in humanitarian settings

Increasing awareness of the substantially elevated mental health and psychosocial needs of refugee populations has led to focused interventions for mental health and psychosocial support (MHPSS) for these groups. However, despite growing attention to MHPSS for emergency-displaced populations, there are still major gaps in programming and support. To foster social integration and improve post-traumatic recovery, it is crucial to better understand and address the specific needs of this highly vulnerable population (Schick et al., 2016). In light of the high prevalence of P.T.S.D. symptomatology and given the low uptake of mental care among resettled refugees noted in the literature (Schouler-Ocak et al., 2016; Slewa-Younan et al., 2017), interventions need to consider the myriad of complex and inter-related factors influencing refugee experiences of potentially traumatic events. Such a framework would “connect the risk and protective factors in the material and social conditions of refugees’ post-migration lives to broader social, economic, and political factors” (Hynie, 2018, p. 297). Furthermore, to ensure that psychosocial and mental health needs are met, MHPSS should be integrated as part of a continuum of care that is multi-layered. MHPSS is not the domain of one sector. It needs to be realised through coordinated and complementary actions of a multitude of actors within legal and medical activity systems (Faregh et al., 2019).

I base the following recommendations on a review of the literature, current trends in MHPSS interventions within humanitarian settings, and on the implications of the empirical results of this thesis research:

A community-based response

Trauma is a social as well as an individual phenomenon (Daiute, 2016). The sociocultural context in which we live and the quality of relationships we have are central to our mental wellbeing and contribute to risks of developing mental health problems. This is also true in terms of the social context within humanitarian crises. Furthermore, the contexts, roles, values, and demands produced by cultural communities may be a source of disadvantage, structural violence, and suffering as well as providing opportunities for adaptation, healing, and recovery (Kirmayer, 2018). Sociocultural dynamics are therefore integral to trauma trajectories as both a potential source of trauma as well as a source of healing and recovery. Here, I once more refer to results of the research which highlight the important sociocultural resources which participants drew upon to make sense of potentially traumatic events, to recover from these experiences, and, ultimately, to thrive. In the case of Jules explored in **chapter eight**, for

example, it was the fact of remembering his father's wisdom pertaining to times of hardship, making friends at church, falling in love, and creating plans for the future with family members in France, that facilitated healing.

The focus on the individual in the modern mental health field tends to under-emphasise the importance of social and structural drivers of wellbeing and illness. This calls for strengths and resilience-based approaches to interventions and supports that not only respond to problems, deficits, and prevalence of mental health conditions, but also build on existing strengths and resources within affected communities. We especially need to recognise the role that non-specialists and community members can play. In summary, we need an approach that recognises the sociocultural context of mental health – a perspective that goes beyond a purely individualistic view of treatment and recovery. Rather, as noted by Daiute (2016), focusing on social relations in humanitarian contexts involves building in individual capacities, interactions in communities, and the human right to continue developing these capacities :

“By extending beyond the individual to the individual-in-collective, we [can address] the tensions not only in terms of individual [...] voices, but also in terms of interacting shared narratives, diverse goals and opportunities within and across each context” (p. 132).

This social justice approach, Daiute notes, emphasizes what needs to be done, whereas a trauma approach focuses what has been done. At the levels of public health and policy, a sociocultural perspective on trauma necessitates that we consider the powerful effects of structural violence, migration policies, and social inequality as determinants of health. This involves a recognition that social systems have their own dynamics which can amplify experiences of potentially traumatic events or conversely provide sources of collective resilience (Kirmayer, 2019). Any such community-based response should further heed the mediating influence on language in individual and communal experiences of potentially traumatic events and subsequent recovery. This includes, for example, focussing on and facilitating **collective narrative practices** organizing group activities, a dynamic and potentially transforming process allowing members to create solidarity, to reflect critically, and to imagine life in their own way:

“just as narrative has been created by humans to interact, to solve problems, and to change culture over many civilizations, people across circumstances, including those in the least privileged and powerless situations, use narrating to interpret, to debate, to act, and sometimes to transform extremely challenging and tragic life circumstances” (Colette Daiute & Gómez, 2014) (p. 157).

A culturally relevant response

We need to situate experiences of potentially traumatic events in sociocultural context. Lack of attention to cultural context on the part of providers and decision-makers can lead to mistrust of mental health information and services and reduce motivation to engage with mental healthcare or adhere to treatment (Faregh et al., 2019). Exploring the influence of culture on experiences of potentially traumatic events among refugee populations – both related to their original and current sociocultural context - should be a fundamental consideration in the clinical assessment of this population, as well as the design and delivery of mental health interventions

(Hassan et al., 2015; Kirmayer et al., 2018).

Such attention to culture and context in MHPSS interventions could include, for example, attempts to refine diagnostic criteria (finding the right level of generality and specification to work across cultures), the identification of new diagnostic variants, and the inclusion of more contextual assessments (Kirmayer, 2018). Much headway has been made in this regard over recent years. In the most recent version of the D.S.M. (A.P.A, 2013) the term “cultural concepts of distress” has replaced the outdated terminology of culture-bound syndromes - a change intended to signal a broader, more inclusive understanding of culturally specific distress as something that changes over time and does not represent place-specific “exotica” (Kaiser & Jo Weaver, 2019). It should be noted that integrating culture in mental health services and systems is not just an issue for groups that face specific inequities related to their identity and social position but is central to person-centred healthcare for all. Indeed, the sociocultural perspective adopted throughout this thesis rejects any static or reified notion of “the cultural other ... but with recognition of the developmental, social and political facts of our cultural being” (Kirmayer & Jarvis, 2019, p. 18).

A longitudinal, contextually situated response

Exposure to ongoing stress in an instable environment, together with individual vulnerabilities, coping styles, and limited availability of protective resources, seems responsible for the maintenance of post-traumatic symptoms over the life trajectory, combined with the decline of resilience by increased intensity or continued exposure to potentially traumatic events (Droždek et al., 2020). Mental health and psychosocial support (MHPSS) needs do not remain static over time. They shift and change in response to both the external environment and an individual’s inner resources. This requires a wide range of supports to be offered in the response, based on individual or community needs, and at different stages of a crisis. Long-term, flexible approaches are needed that take into consideration that the mental health needs of refugees may change over time and that trauma trajectories are inextricably intertwined with the changing sociocultural, political, legal, and economic environment. Briefly put, we need not only to focus on “trauma” from an individual, clinical perspective. We need to understand the ways in which it is inherently connected to the macro level of immigration policies affecting migration trajectories over time: delayed asylum trials, unemployment, constantly changing accommodation arrangements, prolonged detention... these factors do not simply “add to” existing experiences of potentially traumatic events, they multiply and compound it through the constantly reinforcing effect of feedback loops – as shown in the case of Dilraj in **chapter nine** (Womersley & Kloetzer, 2018c). What is needed is a “processual reconceptualization of wellbeing and distress” (Kidron, Kotliar, & Kirmayer, 2019) p. 28).

A depathologising response

Diagnosing someone with P.T.S.D. does something in the world. A sociocultural approach to understanding experiences of potentially traumatic events among refugees, as adopted in this thesis, includes considering the concrete legal, political, and social implications of the use of

cultural tools, such as medical diagnoses, on the individual. As succinctly summarized by Kirmayer (2018):

“epistemic practices, including medical diagnosis and treatment, serve to bring particular configurations of distress into being by shaping individuals’ experience and expressions of distress in ways that then receive confirmation through medical attention and intervention. This social response then stabilizes the disease or disorder as a discrete entity and can increase its prevalence” (p. 3).

He notes that calling something a “mental disorder” depends on a series of distinctions: a normative distinction between illness and affliction versus health and wellness; an ontological distinction between afflictions that are bodily, spiritual, or sociomoral and those that are specifically mental; and a pragmatic distinction that ascribes the problem to the domain of psychiatry as a discipline, profession, and social institution. A detailed understanding of the cultural construction and consequences of mental disorders, he continues, therefore requires consideration of the institutional apparatus and circuits of power and knowledge that co-constitute forms of suffering and their treatment. He and colleagues have therefore called for “culture-specific etiology, symptomatology, treatment approaches, and outcomes which diverge from biomedical taxonomies and illness constructs” (Kidron et al., 2019, p. 1).

This is not to say that the diagnosis of P.T.S.D. should be gotten rid of entirely. To the contrary, the diagnosis does have concrete ramifications for the daily life of the individual which may be to their benefit: not only for their personal psychological rehabilitation in terms of making sense of potentially traumatic events, symptoms and post-traumatic recovery, but also in terms of the political, legal, and social impact of the diagnosis. For many participants, the diagnosis was a validation of their suffering. It offered an important means of social recognition. Research by Kidron and colleagues (2019) among Holocaust descendants, for example, reveals how the “emotive scar” left by exposure to potentially traumatic events was seen by respondents as a culturally valorised form of commemorative remembering and worn as an empowering badge of honour. It is, however, necessary to stress the importance of considering P.T.S.D. as a particular cultural tool, within a particular sociocultural environment, understood and used differently by various actors. A sociocultural perspective insists upon the ethical responsibility to consider this concrete impact. This includes paying attention to how and why we diagnose P.T.S.D.

These recommendations are in line with the recent Lancet commission on global mental health and sustainable development (Patel et al., 2018). The commission stresses the fact that psychiatric diagnoses can lead to unhelpful labelling that often oversimplifies and undervalues the complexities of personal circumstances. Moreover, labels can be stigmatizing, and the impact of stigma is often even more burdensome than the symptoms that have led to the diagnosis themselves. Importantly, the commission highlights the need for MHPSS interventions to be based on socioculturally informed narratives of trauma. As an alternative to the categorical diagnostic model, the Lancet commission proposed a staging model, which recognizes opportunities for intervention at all stages of the pathway from well-being to different stages of disorder. In other words, it recommends a rejection of the mental illness-health dichotomy in favour of conceptualising mental health as existing along a continuum and

dynamically changing over time. In other words, it rejects the “deficit” narrative inherent to a pathologising framing of experiences of potentially traumatic events, in favour of a concept considering both “wounds and wellness.”

A resiliency-based, forward-looking response

Given the potentially traumatic impact of forced displacement, as made evident in the results of the thesis, the possibility of healing and growth may seem small in comparison. However, the results also attest to the fact that human beings may be quite capable of restoring their identities and (re)finding their place in the world when given the chance to do so. The results highlight the multiple ways in which refugees may show resilience in the face of exposure to potentially traumatic events. They point to ways that resilience and vulnerability may interact, qualifying one another in the process of meaning making. In other words, they reveal the ways that refugee experiences of potentially traumatic events are embedded in complex networks of personal and collective meaning that may give rise to both resilience and vulnerability. Here, the notion of “resilience” is not a reified psychological state, that can be captured by yet another global measure of health and illness but rather “a hermeneutic process of meaning making that shapes the way that selves and communities experience and respond to distress in order to restore or enhance culturally valorized forms of wellbeing” (Kidron et al., 2019, p. 30). **Resilience** is thus understood from a sociocultural perspective as the capacity of a system to adapt successfully to the challenges that threaten system function, survival, or development. From this perspective, resilience is dynamic. It changes as the capacity for adaptation is distributed across systems. It further depends on the resilience of other systems (Masten, 2014a, 2014b).

This concurrent experience of resilience and vulnerability challenges some key assumptions of “traumatised refugee” narrative. Contrary to the inhuman Narrative of a psychiatric diagnosis, human narratives are “dynamic, subjective, and imaginative of survival, justice, and thriving.” (Daiute & Gómez, 2014, p. 157). Refugees are active agents engaging in the new world in which they find themselves. They are not only patients, victims, seekers of asylum. They are dreamers, planners and doers, family members and friends, with hope for the future. They “interpret their circumstances, interlocutors, and options for making lives in this shifting world order” (Daiute et al., 2020, p. 2). This response involves helping refugees make meaning of their experience, focusing on their strengths, as well as fostering an environment where they are able to meet their basic needs. In a very powerful TED Talk, Luma Mufleh (2017), the founder of a refugee youth program and herself an asylum seeker from the Middle East stated, “Don’t feel sorry for them, believe in them.” So too must we consider experiences of forced migration from a trauma-informed lens, recognizing the unimaginable difficulties refugees have suffered as well as their strengths, resiliency, and capacity for hope (Ringler-Jayanthan *et. al.*, 2020, p. 82). It is as important to consider resilience and wellbeing within local worlds as it is to consider distress (Kaiser & Jo Weaver, 2019), to recognize the strong sense of connection to places left behind while at the same time recognizing the possibilities of a constructive (re)building of connections to people and place (Sampson & Gifford, 2010).

Returning for a brief moment to the theoretical framework of sociocultural psychology informing this thesis, Dafermos (2015) notes that Vygotsky himself developed a theory that opens up new perspectives for the rethinking and overcoming of a crisis. In contrast to dominant psychological theories that describe the actual developmental level and presents forms of human being, the approach illuminates prospective human development. In other words, rather than seeing someone as “traumatised” (static, present), we need to respect and value their potential for growth and development (dynamic, future orientated). Challenging the concept of adaptation, Dafermos notes how Vygotsky proposed the idea of creative, future oriented activity, that “...makes the human being a creature oriented toward the future, creating the future and thus altering his own present” (Dafermos, 2015, p. 21). Elsewhere, Dafermos (2018a) similarly reflects on the link between “crisis” and “creativity” within a sociocultural perspective. Here, he demonstrates how Vygotsky’s theory was developed as an attempt at the conceptualization of crucial issues associated with human development that emerged within the process of societal change: “the future focus, the orientation to what might happen rather than what has already happened constitutes a significant dimension of the human creative agency” (p. 233). Striving to overcome crises, Dafermos argues, people can develop an active, creative, socially oriented activity. While drawing on the idea that individuals’ narrative activity always occurs in social relations, a sociocultural perspective allows us to shift from the assumption that powerful actors impose values on less powerful actors (in this case, refugee victims of torture) to an acknowledgment that people in vulnerable positions can act strategically (Daiute et al., 2020).

A resiliency-based intervention from a sociocultural perspective, therefore, should aim to:

- Foster prosocial bonds at every level
- Integrate systems of care
- Provide opportunities for development
- Support culturally based ceremonies fostering resilience
- Support community engagement and collective action

Limitations and future perspectives: open questions and pathways forward

This research has significant limitations. In concluding this thesis, it is necessary to recognise and reflect on these in order to identify open questions and suggest pathways to future research. Primarily, the research was grounded within a sociocultural methodological framework. This framework privileges depth over breadth. This is a deliberate choice, as explained in **chapter five**. I could not explore the complex and unique interrelations between refugees and their sociocultural context in the unfolding of individual trajectories without delving into the depths of single case studies. As noted by Veresov (2016), the specificity of sociocultural theories is that “they are not generalizations of observable and reproducible empirical facts, but theoretical instruments of studying the process of sociocultural genesis of human consciousness in all its dialectical dynamics and complexity” (p.135). Aspects of environment and aspects of subjective experiences melted into perezhivanie, and represented in perezhivanie, cannot be considered as absolutely internal or absolutely external; they are unmeasurable with absolute

yardstick (Veresov, 2019). The intention was never to take a static snapshot of potentially traumatic events among refugees, as would be the case of larger epidemiological studies examining prevalence rates of P.T.S.D., for example. The investigative approach undertaken – focussing on continual changes in developmental trajectories – may therefore be metaphorically compared to that of a movie, not a photograph.

A thorny dilemma then – often arising in the case of such in-depth, longitudinal work – is the question of generalisability. Dare I make claims as to the implications of this research for clinical interventions on the basis of such a small sample of participants? As interesting as it might be to explore an individual's trajectory in detail, what could the results of such an exploration possibly bring to the larger body of literature contributing to our understanding of refugee experiences of potentially traumatic events? May we identify certain patterns or tendencies across the lives of the participants?

Not only does one limitation relate to the small number of participants, another relates to a potential selection bias in the choice of participants, which cannot be excluded as a limitation. For ethical reasons highlighted in **chapter five**, the refugee victims of torture who participated in this study were carefully selected by the MSF and Babel team working at the V.O.T. centre. Given that this is a highly vulnerable population, this selection and recruitment process was essential. However, this inevitably necessitates a degree of selection bias. Those who were considered by the team to be too psychologically fragile were excluded from the study. There may also have been a bias towards individuals for whom the intervention of the V.O.T. centre was running relatively smoothly, towards individuals bringing encouraging stories of hope, or towards individuals grateful for the work being done by the team for example. However, it is worth repeating that the aim was not to have had a representative sample of participants, but to have explored the unfolding of individual lives in all their messy and painful complexities.

One significant limitation of the study relates to the question of language – the problems inherent in conducting research in contexts where there is no shared or common mother tongue. The interviews were conducted without the use of a translator, in English or in French – neither of which are the first language of many of the participants. This is a significant limitation of the research – and a significant consideration for the analysis of data. In most cases, I felt communication within the interview setting to be “good enough.” Conversation flowed, and there was a felt sense of a common understanding. In some cases, though, this indeed was a significant challenge. I am thinking in particular of one research participant, a Sudanese victim of torture whom I here call “Muhammed.” Despite not being able to speak English fluently, Muhammed appeared to me to derive a sense of pleasure in conversing in English. Having come from a university setting in Sudan before experiencing persecution, torture, and eventually seeking asylum, Muhammed seems to have experienced a sense of pride and enjoyment in engaging in the “intellectual exercise” of talking in English – the activity somehow related to a sense of his identity as a learned intellectual, linked to his past position at the university. Mr B (introduced in **chapter six**) was a similar case – his competence in English a testament to his intellectual curiosity. In both cases, however, their limited ability to speak English fluently, and to express themselves as they would have been able to in Arabic, was a significant limitation.

The shaping of the narrative depends largely on the audience. *How, why, and to whom* is the story told? How much can be tolerated by the listener? A significant limitation relates to the “truthfulness” or accuracy of the accounts given within the specific interview setting. As highlighted throughout the thesis, the way in which narratives are framed is highly context dependant. Was there, for example, a perceived “secondary gain” for the participants, of which I was not aware? What other agendas may have hidden within the context of our research relationship? These questions are linked to the inevitable power dynamics framing the relationship. As much care as I took to represent myself and my research as truthfully as possible, including outlining the potential risks and benefits of participating as well as the limits of my role as a researcher, we cannot deny these dynamics. I am in a powerful and privileged position in relation to participants: a white European, associated with an international NGO, the university researcher and the one asking the questions... It is possible that participants framed the narrative in certain ways for certain real or perceived benefits. These reflections should also be extended to include the ways in which “narratives” of trauma may have competed with “Narratives” within the interview setting.

The above point relates to the various ethical dilemmas unfolding within the context of the interview itself (as a specific narrative genre significantly framed by academic institutions) explored in **chapter ten**. It also relates to the method of analysis. To what extent were the “narratives” of the individual refugees who participated in the research, their unique life stories, informed by, or even “contaminated” so to speak, by Narratives of trauma – scripts circulating among the various actors with whom they came into contact? To what extent did the health professionals I interviewed draw upon institutionalised Narratives of trauma in order to represent their organisation as best as possible as they recounted their own experiences of working with this population? To what extent did refugee leaders similarly draw upon Narratives of trauma to testify to the full extent of the suffering of their community, for possible secondary (humanitarian) gain? A limitation of the thesis, and a possible avenue for future research, is the limited attention provided to an analysis of the actual interview situation itself. A closer reading of the interview situation itself would doubtlessly enhance our understanding of the ways in which different N/narratives of trauma circulate within the context of the refugee reception crisis.

Another limitation of the study relates to the question of gender. Whilst the population of research participants in general reflect a rather equitable gender balance – the population of individual refugee participants tells quite another story. Out of the ten participants, there was only one female. This discrepancy reflects the demographics of the V.O.T. centre in which the research took place. More broadly speaking, it reflects a discrepancy among V.O.T.s in general – who, globally, are overwhelmingly male. This is not to say that worthwhile analyses of gender dynamics may not be explored. One does not need to have an equal number of male and female participants to do so. Indeed, having a predominantly male sample may allow for some interesting reflections on masculinities – more specifically the interplay between potentially traumatic events, the sociocultural context, and issues around masculine identities. In concluding this thesis, however, I am aware of a significant limitation to this study being that

gender dynamics may not have been considered in sufficient detail. This could provide an interesting avenue for future research.

In further reflecting on the body of research participants, I am left with a personal sense of satisfaction in terms of the diversity of perspectives offered. Indeed, participants came from a wide variety of diverse sociocultural backgrounds. The participation of a number of different refugee community leaders in particular was particularly invaluable in this regard (that being said, it is worth mentioning that the intention of this thesis was never that of a “transcultural” comparison, where one particular cultural group is compared to another). However, one of my original intentions was to have the perspectives of lawyers and other professionals working within the asylum tribunal. This group proved difficult to access. Despite my willingness, I was not able to find a lawyer working in this context who was willing to be interviewed. The reason for this reluctance remains unclear, but it is probable that it could be linked to the politically sensitive nature of the question. I do, in **chapter seven**, attempt to offer some reflections on the way in which narratives of trauma are understood and used by this group of professionals. However, this is based on the indirect reports of the other research participants. An interesting future avenue for research would be to explore the understanding, and use, of different concepts related to “trauma” within the asylum tribunal specifically by including legal professionals within the research sample. The question of the use of P.T.S.D. in the asylum tribunal in particular is a complex one – both because of the complexity of the legal system in and of itself as well as the complexity surrounding the various understandings of “trauma,” but also the ethical complexity linked to exploring this issue. Exploring the use of P.T.S.D. in this context would certainly have legal, social, and political ramifications. As researchers, we do have an ethical responsibility to consider the impact of our research in the world.

Lastly, focussing on experiences of exposure to potentially traumatic events and their sequelae (specifically the use of a P.T.S.D. diagnosis), has inevitably been to neglect a focus on sources of resilience and strength. Indeed, a review of the literature reveals that mainstream trauma research has yet adequately to explore everyday experiences of protective factors as they mediate coping, healing, and recovery (Kidron et al., 2019). Many academics have called for additional “naturalistic studies” of everyday lived experience to identify interactions between protective factors, risk of chronic distress (including P.T.S.D.) and resilience (Kidron et al., 2019; Pedersen, Kienzler, & Guzder, 2015). This provides a further direction for future research.

As we “move away from a categorical biomedical model toward dimensional and transdiagnostic approaches” (Bemme & Kirmayer, 2020, p. 3), we should similarly aim to develop more viable, clinically relevant tools for refugee populations, as well as contribute to a more critical, decentered literature on mental health and illness (Kaiser & Jo Weaver, 2019). This includes a focus on the broader structures or forces that are being contested, whether implicitly or explicitly, through the often-conflicting ways in which “trauma” among refugees is understood. In the ways in which we understand and (re)present narratives of refugee trauma, we must be careful to avoid presenting distress as reflecting solely individual psychopathology or equitably distributed distress. This is essential to avoid victim-blaming through a myopic

exploration of only immediate causes of distress (Kaiser & Jo Weaver, 2019). Nowhere is this more relevant than in the context of the current humanitarian crisis of forced displacement.

We need to beware of “priorities and practices [which] amount to a neo-colonial imposition of Western knowledge that threatens traditional and indigenous forms of care and healing” (Bemme & Kirmayer, 2020, p. 4). Furthermore, as argued by Daiute (2017), “defining the problem in individual bodies of those labelled ‘refugees’ averts the analytic gaze from the broader problem, while a focus on ‘refuge’ shifts our gaze to the politics of displacement.” (p. 12). In other words:

“Issues such as poverty, war, oppression, racism, violence, poor education, unemployment, lack of housing, or other forms of structural violence, critics have argued, may be at risk of being further obscured when distress is reconfigured into a psychiatric condition and only addressed downstream” (Bemme & Kirmayer, 2020, p. 11).

Attention to the social and the structural are key means of avoiding these pitfalls. This necessitates a “move away from models dominated by implicit colonial hierarchies, racialized identities, and reified notions of culture as homeostatic or steady-state systems, toward “postcolonial” models of cultures as open, dynamic, heterogeneous, and hybrid social systems that offer individuals resources for self-fashioning and positioning.” (Kirmayer, 2018, p. 9). Furthermore, future work should continue to clarify the mechanisms by which societal tensions and dilemmas are transmuted into individual experiences of potentially traumatic experiences as well as resilience, including the extent to which individuals’ or families’ engagement with narratives of trauma and resilience helps them manage their social predicaments (Lewis-Fernández & Kirmayer, 2019).

My final hope is that this thesis has gone some small way in providing

“a rightful encouragement for clinicians and practitioners to consider the ways in which the implicit and explicit models from which we operate impact our understanding of refugees and limit the ways their stories are told, but also [a] springboard through which we learn to truly hear the stories of refugees as those of hope and resilience. That is to say, the way that we hear stories, the level at which we allow ourselves to be truly moved by them and the way that we choose to respond to them moreover, and the things on which we choose to focus are ultimately directly correlated with healing and restoration in those refugees whom we serve.” (Neace 2020, p. 16).

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Annex I: Consent form for individual participants

Study Title

Socio-cultural manifestations of P.T.S.D. among refugees and asylum seekers in Europe: where is the trauma?

Collaborating institutions

1. University of Neuchâtel - Institut de psychologie et éducation
Faculté des Lettres et sciences humaines
Université de Neuchâtel
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Contact person in case of questions

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Purpose & Procedure

My name is Gail Womersley and I am a doctoral student in the department of Psychology and Education at the University of Neuchâtel. I'm conducting research on how asylum seekers and refugees have responded to the difficult events they have experienced. As a beneficiary of the M.S.F. Victims of Torture Project, I would like to invite you to participate in my research project in order better to understand your experiences. This is because you are in a position to give valuable first-hand information from your own perspective.

If you decide to participate, I will join your health worker during your initial intake interview. I will record the session with a digital audio recorder. I might also ask you permission to speak to other people who know you well to learn more about the impact of trauma on you and your community in general. This could be, for example, a member of your family or someone else in your community.

It is important to know it is your decision to join the study. You do not need to share any information that you don't want to and you can stop at any time. You will be given a false name so that all information will be kept private and no one will know what you said. This is a personal research for academic purposes and is not connected with the government. It will not affect any decision by the authorities to grant you refugee status or not.

It is important that you read and understand the following explanation on why we want to conduct this study. Please make sure that all your questions have been answered to your satisfaction before signing this document.

Eligibility

You will be requested to participate in this study if you are a beneficiary of the M.S.F. Victims of Torture project in Athens

Confidentiality/Benefits/Risks

- The data collected will remain completely anonymous: your name will only be linked to this consent form, and it will not be possible for anybody, including the researchers, to trace your name to any answers you provide us. Your name will NEVER be used in any analysis, or in any databases.
- This file with your consent signature will not be shared with anyone other than the person asking the questions. All consent forms and information on you will be kept under conditions of strict confidentiality.
- Participating in this study will provide us information on the difficulties facing asylum seekers and refugees. Study results may allow us to provide better advice and guidance to people attending our project in the future.
- Other people may find out that you are in the study if they see you sitting with me. We can have the interview at a time and place that suits you, and if you are concerned about being seen, we can stop the interview at any time.
- Participating in this study involves no risks for you and will not in any way affect the care we offer you, which will always remain free of charge.
- Certain questions I ask you might be difficult to answer. You do not have to answer any questions that you do not want to. We can stop the interview at any time if you do not want to continue.
- You will not be reimbursed for taking part in this study.

Right to Refuse

You have the right to refuse to participate in this study. This will by no means have any influence on the care we will offer you at the Victims of Torture Project. If you choose not to participate in this study, you will receive care as is usually done. You can also withdraw from this study at any time you want without any consequences. You are in a position to make a decision if you understand what you have read or if you have had the details explained to you.

Participant Consent Form

I _____ (name) have read and/or have received enough information on the reasons why I am being asked to participate in this study on trauma. I understand that participation in this study is strictly voluntary. I agree to being audio-recorded (choosing not to be audio-recorded will not affect your participation). If you did not adequately understand the information provided, you should not sign right now and ask a cultural mediator to re-explain the information today or at a later date.

☐ I have been offered a copy of the participant information form and consent form to keep if I wish.

☐ **I agree to be audio-recorded**

☐ I agree to participate in this study

Name of participant: _____

Signed at (place): _____ Date: _____

Signature of participant or caretaker: _____

Declaration by researcher

I (name) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter (*sign the declaration below if a cultural mediator is used*).

Signed at (place) on (date)

Signature of researcher

Signature of witness

Declaration by cultural mediator (if a cultural mediator is used)

I (*name*) declare that:

- I assisted the researcher (*name*) to explain the information in this document to (*name of participant/caretaker*)

..... using the language medium of
..... (state which)
- I conveyed a factually correct version of what was related to me
- We encouraged him/her to ask questions and took adequate time to answer them
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered

Signed at (*place*).....on (*date*)

Signature of cultural mediator

Signature of witness

Semi-structured Interview Schedule

First meeting

Please tell me a little bit about yourself

(to prompt if needed: How long have you been in Athens? Legal status? Following up with which professionals? Where are you living and with whom? Family members?)

[NOTE: Participants are encouraged to share their personal history (pre- and peri-migration) – but this is not an obligation]

How is your life at the moment? How are you feeling physically? How are you feeling emotionally (inside)?

What difficulties are you experiencing at the moment?

What adds to your stress?

What is helping you at the moment?

Who is helping you at the moment?

What ideas do you have about a psychiatrist or psychologist?

Have you heard of P.T.S.D.? Trauma? What ideas do you have about this diagnosis?

Do you think a diagnosis of P.T.S.D. could help asylum seekers be granted refugee status?

What do you think is important for professionals working with refugees to understand about trauma?

What do you think is important for the organisation (MSF) to understand about your difficulties?

Subsequent meetings (follow-up)

Since we last met, how have things been for you? What has changed?

How is your life at the moment? How are you feeling physically? How are you feeling emotionally (inside)?

What difficulties are you experiencing at the moment?

What adds to your stress?

What is helping you at the moment?

Who is helping you at the moment?

Annex II: Consent form for interviews with community leaders/representatives and interview schedule

Study Title

Socio-cultural manifestations of P.T.S.D. among refugees and asylum seekers in Europe: where is the trauma?

Collaborating institutions

1. University of Neuchâtel - Institut de psychologie et éducation
Faculté des Lettres et sciences humaines
Université de Neuchâtel
Espace Louis Agassiz 1
CH-2000 Neuchâtel
Switzerland
2. Médecins Sans Frontières – Operational Centre Brussels, 94 Rue Dupré, B1060
Brussels, Belgium, tel. +32-2-4753611

Contact person in case of questions

Gail Womersley
Email: gail.womersley@unine.ch
Tel: +41(0)75 4126455

Purpose & Procedure

My name is Gail Womersley and I am a doctoral student in the department of Psychology and Education at the University of Neuchâtel. I'm conducting research on how asylum seekers and refugees have responded to the difficult events they have experienced. I would like to invite you to participate in my research project in order better to understand your experiences of trauma within your family and your community. This is because you are in a position to give valuable first-hand information from your own perspective.

If you decide to participate, a first interview will be arranged at a time and place of your convenience. The interview will take around an hour and will be very informal. This will be a

chance for us to get to know each other better, and for me to ask you some questions about the difficulties facing the community. There are no right or wrong answers, I am only interested in hearing your story and your point of view. I will record the session with a digital audio recorder.

It is important to know it is your decision to join the study. You do not need to share any information that you don't want to and you can stop at any time. You will be given a false name so that all information will be kept private and no one will know what you said. This is a personal research for academic purposes and is not connected with the government. It will not affect any decision by the authorities to grant you refugee status or not.

It is important that you read and understand the following explanation on why we want to conduct this study. Please make sure that all your questions have been answered to your satisfaction before signing this document.

Confidentiality/Benefits/Risks

- The interview will be completely anonymous: your name will only be linked to this consent form, and it will not be possible for anybody, including the researchers, to trace your name to any answers you provide us. Your name will NEVER be used in any analysis, or in any databases.
- This file with your consent signature will not be shared with anyone other than the person asking the questions. All consent forms and information on you will be kept under conditions of strict confidentiality.
- Participating in this study will provide us information on the difficulties facing asylum seekers and refugees. Study results may allow us to provide better advice and guidance to people attending our project in the future.
- Participating in this study involves no risks for you and will not in any way affect the care we offer you, your family or other members of the community which will always remain free of charge.
- Other people may find out that you are in the study if they see you sitting with me. We can have the interview at a time and place that suits you, and if you are concerned about being seen, we can stop the interview at any time.
- Certain questions I ask you might be difficult to answer. You do not have to answer any questions that you do not want to. We can stop the interview at any time if you do not want to continue.
- You will not be reimbursed for taking part in this study.

Right to Refuse

You have the right to refuse to participate in this study. This will by no means have any influence on the care we will offer you, your family or community at the Victims of Torture Project. You can also withdraw from this study at any time you want without any consequences. You are in a position to make a decision if you understand what you have read or if you have had the details explained to you.

Participant Consent Form

I _____ (name) have read and/or have received enough information on the reasons why I am being asked to participate in this study on trauma. I understand that participation in this study is strictly voluntary. I agree to being audio-recorded (choosing not to be audio-recorded will not affect your participation). *If you did not adequately understand the information provided, you should not sign right now and ask a cultural mediator to re-explain the information today or at a later date.*

☐ I have been offered a copy of the participant information form and consent form to keep if I wish.

☐ **I agree to be audio-recorded**

☐ I agree to participate in this study

Name of participant: _____

Signed at (place): _____ Date: _____

Signature of participant: _____

Declaration by researcher

I (name) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter (*sign the declaration below if an interpreter is used*).

Signed at (place) on (date)

Signature of researcher

Signature of witness

Declaration by cultural mediator (if a cultural mediator is used)

I (*name*) declare that:

- I assisted the researcher (*name*) to explain the information in this document to (*name of participant/caretaker*) using the language medium of (state which)
- I conveyed a factually correct version of what was related to me
- We encouraged him/her to ask questions and took adequate time to answer them
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered

Signed at (*place*).....on (*date*)

Signature of cultural mediator

Signature of witness

Semi-structured Interview Schedule

What are some of the mental health difficulties facing the community?

How have you seen different members of the community experiencing trauma in their lives?

What kind of factors might be helping members of the community cope with stress? What adds to their stress?

What ideas do you have about a psychiatrist or psychologist?

Have you heard of P.T.S.D.? Trauma? What ideas do you have about this diagnosis?

Do you think a diagnosis of P.T.S.D. could help asylum seekers be granted refugee status?

What do you think is important for health professionals working with migrants to understand about trauma?

What do you think is important for the organisation to understand about the psychological problems of the community?

Are there any other questions related to trauma among migrants that you would like to explore?

Annex III: Consent form for interviews with key informants and interview schedule

Study Title

Socio-cultural manifestations of P.T.S.D. among refugees and asylum seekers in Europe: where is the trauma?

Collaborating institutions

1. University of Neuchâtel - Institut de psychologie et éducation
Faculté des Lettres et sciences humaines
Université de Neuchâtel
Espace Louis Agassiz 1
CH-2000 Neuchâtel
Switzerland
2. Médecins Sans Frontières – Operational Centre Brussels, 94 Rue Dupré, B1060
Brussels, Belgium, tel. +32-2-4753611

Contact person in case of questions

Gail Womersley
Email: gail.womersley@unine.ch
Tel: +41(0)75 4126455

Purpose & Procedure

My name is Gail Womersley and I am a doctoral student in the department of Psychology and Education at the University of Neuchâtel. I'm conducting research on how asylum seekers and refugees have responded to the difficult events they have experienced. I would like to invite you to participate in my research project in order better to understand your experiences of working with this population. This is because you are in a position to give valuable first-hand information from your own perspective.

If you decide to participate, a first interview will be arranged at a time and place of your convenience. The interview will take around an hour and will be very informal. This will be a chance for us to get to know each other better, and for me to ask you some questions about the

difficulties you've seen facing the community. There are no right or wrong answers, I am only interested in hearing your story and your point of view. I will record the session with a digital audio recorder.

It is important to know it is your decision to join the study. You do not need to share any information that you don't want to and you can stop at any time. You will be given a false name so that all information will be kept private and no one will know what you said. This is a personal research for academic purposes.

It is important that you read and understand the following explanation on why we want to conduct this study. Please make sure that all your questions have been answered to your satisfaction before signing this document.

Confidentiality/Benefits/Risks

- The interview will be completely anonymous: your name will only be linked to this consent form, and it will not be possible for anybody, including the researchers, to trace your name to any answers you provide us. Your name will NEVER be used in any analysis, or in any databases.
- This file with your consent signature will not be shared with anyone other than the person asking the questions. All consent forms and information on you will be kept under conditions of strict confidentiality.
- Participating in this study will provide us information on the difficulties facing asylum seekers and refugees. Study results may allow us to provide better advice and guidance to people attending our project in the future.
- Participating in this study involves no risks for you and will not in any way affect your position in M.S.F. Your supervisors will not be notified of participation or non-participation in the study.
- Other people may find out that you are in the study if they see you sitting with me. We can have the interview at a time and place that suits you, and if you are concerned about being seen, we can stop the interview at any time.
- Certain questions I ask you might be difficult to answer. You do not have to answer any questions that you do not want to. We can stop the interview at any time if you do not want to continue.
- You will not be reimbursed for taking part in this study.

Right to Refuse

You have the right to refuse to participate in this study. You can also withdraw from this study at any time you want without any consequences. You are in a position to make a decision if you understand what you have read or if you have had the details explained to you.

Participant Consent Form

I _____ (name) have read and/or have received enough information on the reasons why I am being asked to participate in this study on trauma. I understand that participation in this study is strictly voluntary. I agree to being audio-recorded (choosing not to be audio-recorded will not affect your participation).

☐ I have been offered a copy of the participant information form and consent form to keep if I wish.

☐ **I agree to be audio-recorded**

☐ I agree to participate in this study

Name of participant: _____

Signed at (place): _____ Date: _____

Signature of participant: _____

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter (*sign the declaration below if an interpreter is used*).

Signed at (*place*) on (*date*)

Signature of researcher

Signature of witness

Semi-structured Interview Schedule

How would YOU describe the beneficiaries' mental health problems?

How have you seen different beneficiaries experiencing trauma in their lives?

Are there cultural or social factors (for example, language, ethnicity, religion) which make beneficiaries react differently to trauma?

How do/would you describe psychological problems to beneficiaries?

How do the beneficiaries themselves understand trauma, or explain it to you?

What do you see is the main cause of trauma among this population?

What kind of factors might be helping beneficiaries cope with stress? What adds to their stress?

What ideas do you have about a P.T.S.D. diagnosis?

What would lead you to make a diagnosis of P.T.S.D.?

Do you think a diagnosis of P.T.S.D. could help asylum seekers be granted refugee status?

What do you think is important for health professionals working with migrants to understand about trauma?

What do you think is important for the organisation to understand about the psychological problems of beneficiaries?

Are there any other questions related to trauma among migrants that you would like to explore?

Annex IV: Boite image

