

A clinician's perspectives on refugee trauma recovery and resettlement

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Acknowledgments to many but especially to Dr Jane Herlihy...
All data on numbers of refugees taken from recent UNHCR reports...

Clinical Practice in a Context

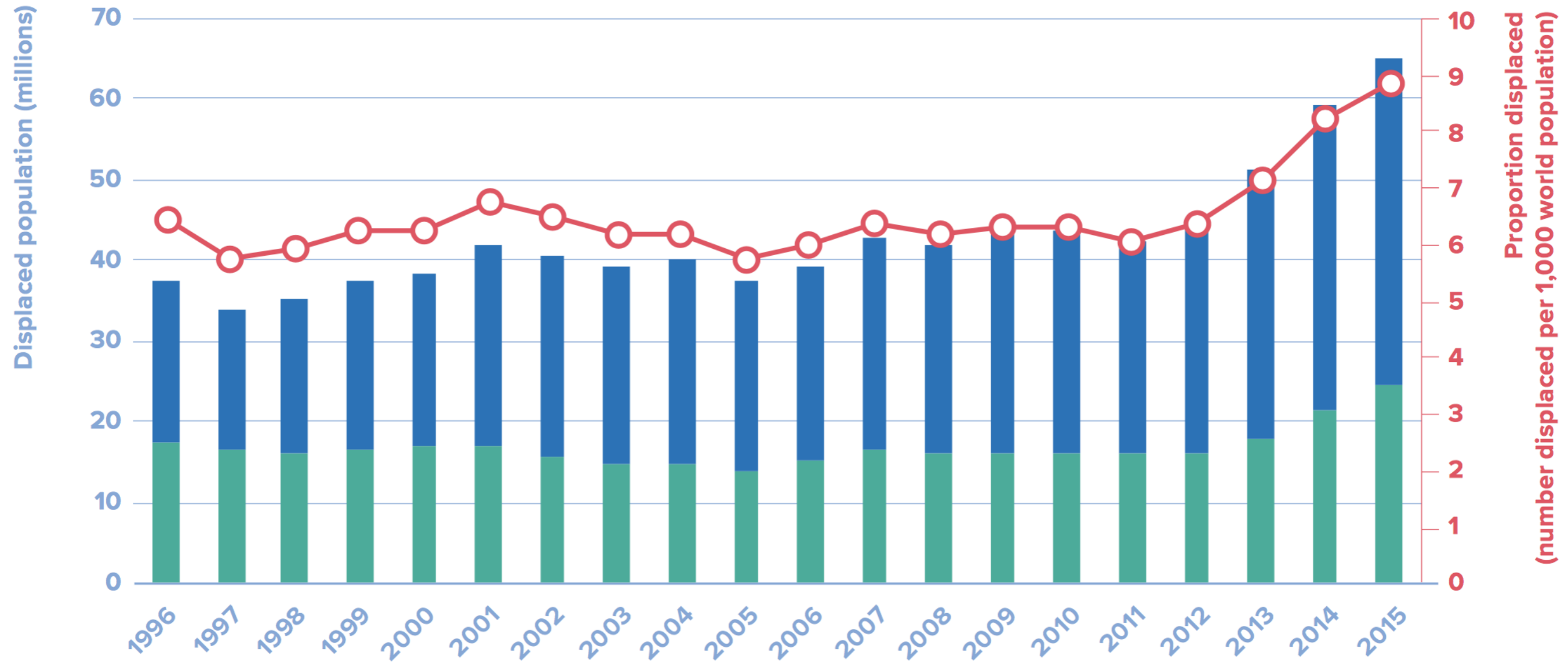
“The world is less violent than it has ever been”
(Obama, 2016). Fewer conflicts and a tendency to be
more localised?

Yet year on year there are increasing numbers of
people displaced by war and violence, including state
violence and torture.

Refugees and asylum-seekers

Internally displaced persons

Proportion displaced



UNHCR

Policy Failures

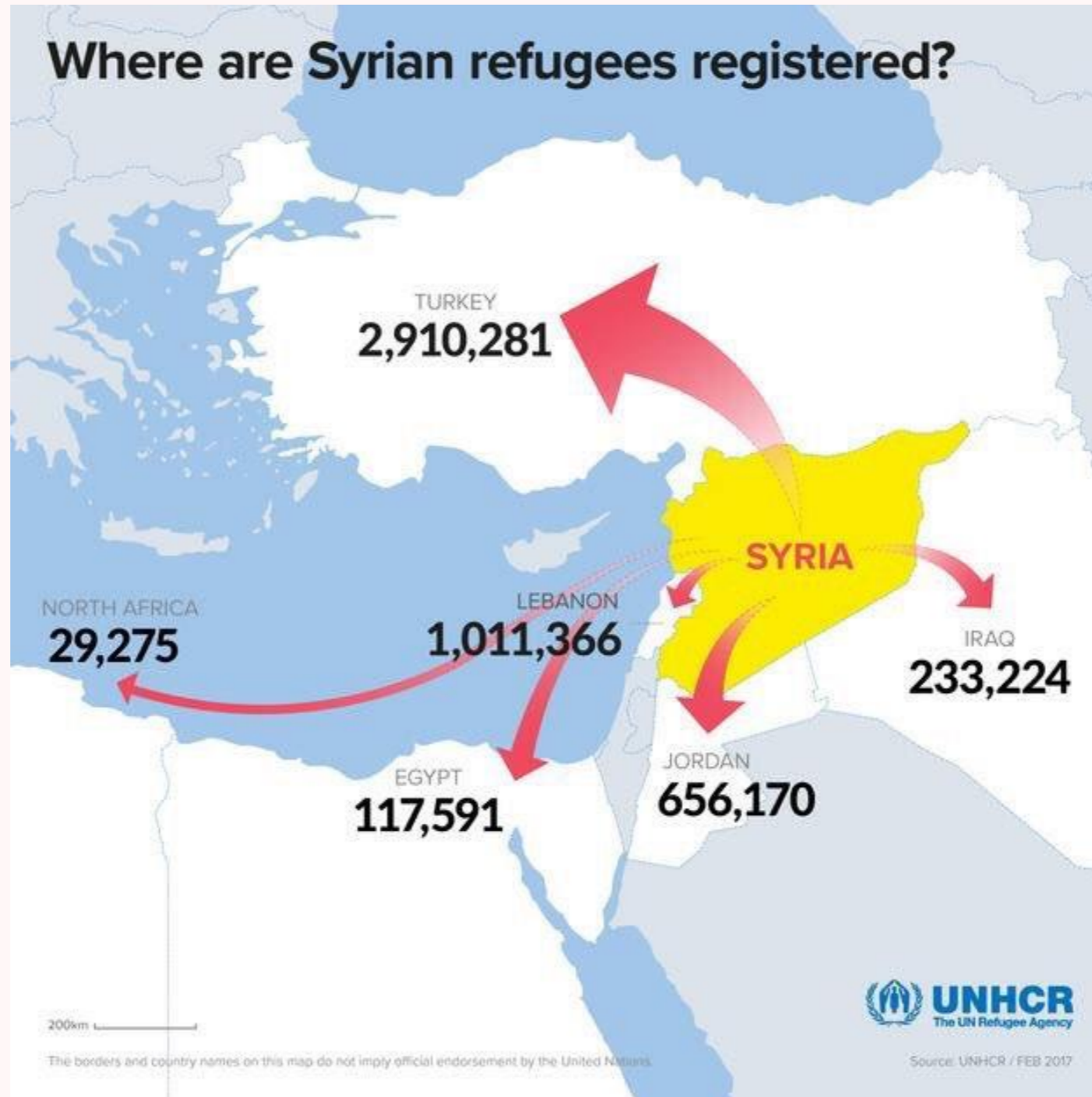
Failure to address the root causes of global migration

Biggest load falls on some of the poorest countries

Nationalist policies (America first, Brexit etc) leading to increasing policies of deterrence?

Inherent subjectivity in asylum decision making

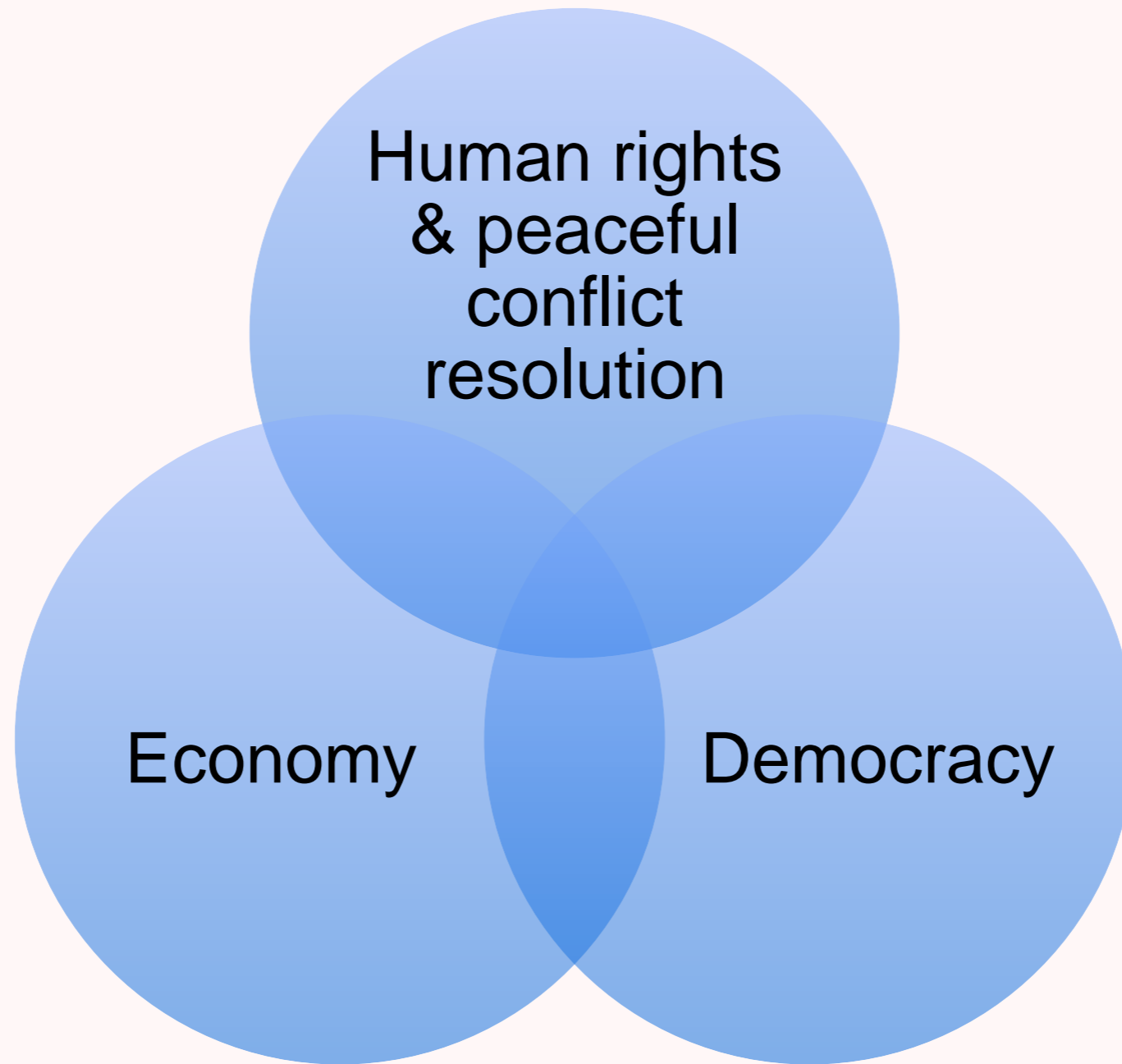
Global Migration



Causes of Migration

- Economic Factors: increases in per capita income *reduce* asylum seekers travelling to Europe.
- Autocracy: moves towards autocracy *increase* asylum seekers travelling to Europe.
- If Western European countries want to tackle the root causes, they need to foster policies “that promote economic development, democracy, respect for human rights and peaceful conflict resolution”.

Neumayer, 2005



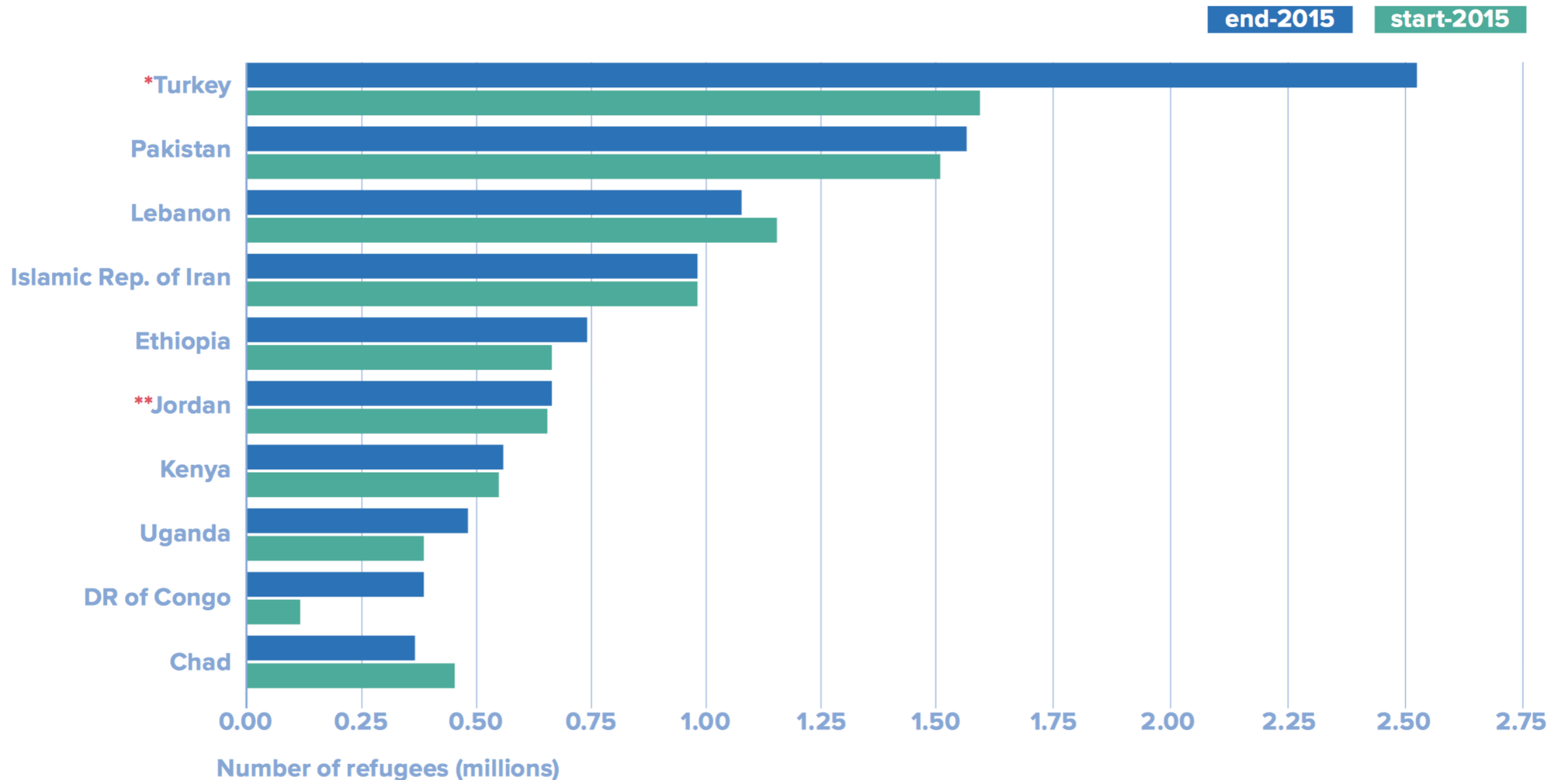
Human rights
& peaceful
conflict
resolution

Economy

Democracy

Where the load falls

Fig.3 Major refugee-hosting countries | 2014 - 2015 (end-year)



Policy Failures

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Political Ideologies

- **Impartialists** believe that people have certain rights based on their humanity alone, and states have obligations to consider these in their policies. States are seen as cosmopolitan, international moral agents, responsible not only for the interests of its own citizens, but also with certain duties towards the wider 'human community'
- **Partialists** emphasise the importance of the links between the state and its citizens, seeing states as under no obligation to anyone outside their citizenship and as morally justified in prioritising and privileging their own citizens over outsiders.

Fletcher, 2008

Trans-Mediterranean migration: partialism vs impartialism



Mediterranean Deaths

- 3,771 deaths reported for the whole of 2015 – of at least 1,015,078 people crossing the Mediterranean (1 in 269).
- By October 2016, at least 3,740 lives reported lost (presumed dead) in spite of fewer crossings standing at 327,800 (1 in 88).
- On the Central Mediterranean route between Libya and Italy, (late 2016) the likelihood of dying was even higher (1 in 47).

Deterrence

- British policies of deterrence over 35 years
 - visa regulations,
 - fines for carriers,
 - benefits changes,
 - changes in rules for legal support etc.
- Mare Nostrum to Operation Triton
- EU deal with Turkey
- Hungarian plan to detain all asylum seekers
- etc, etc...

Policy Failures

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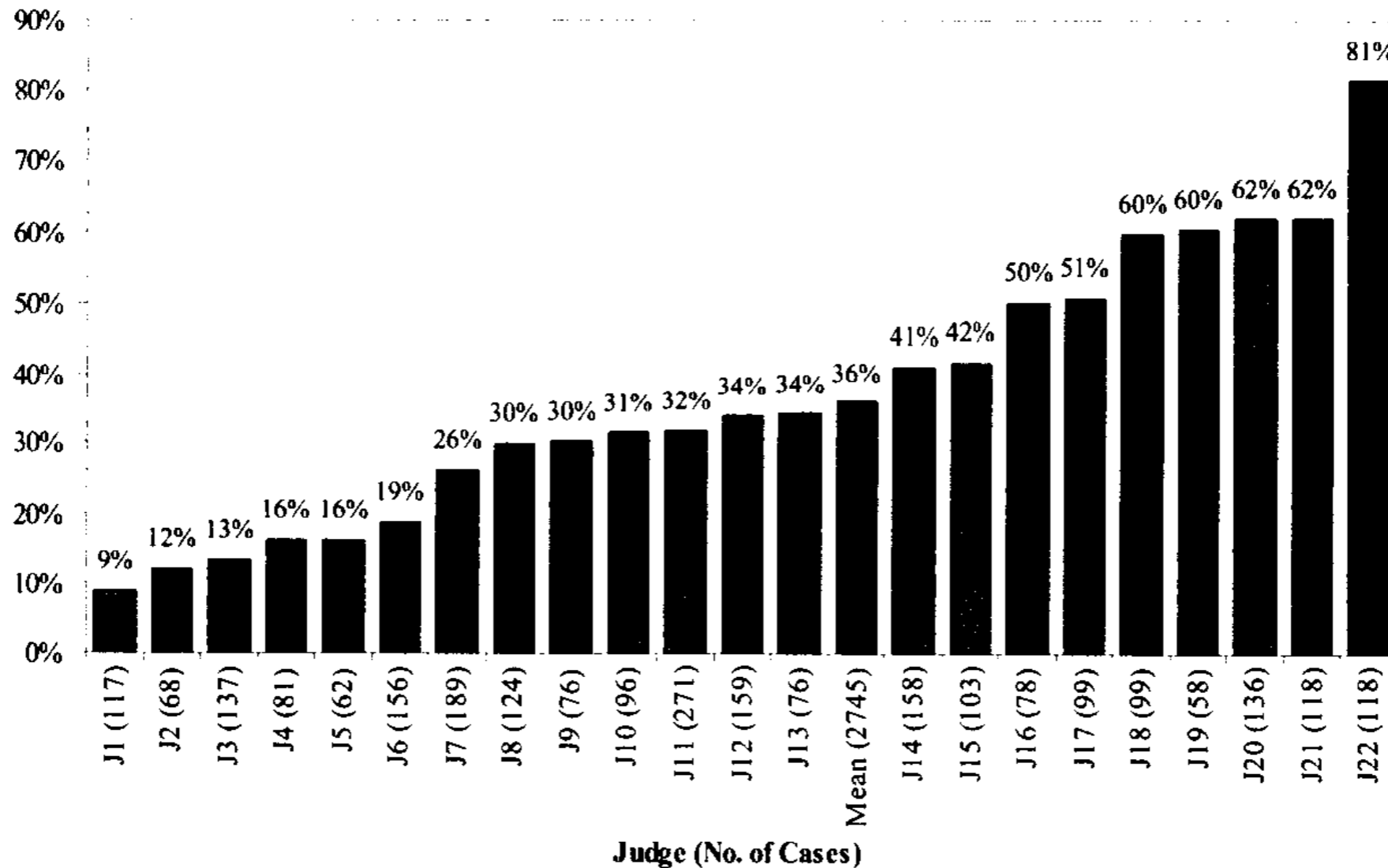
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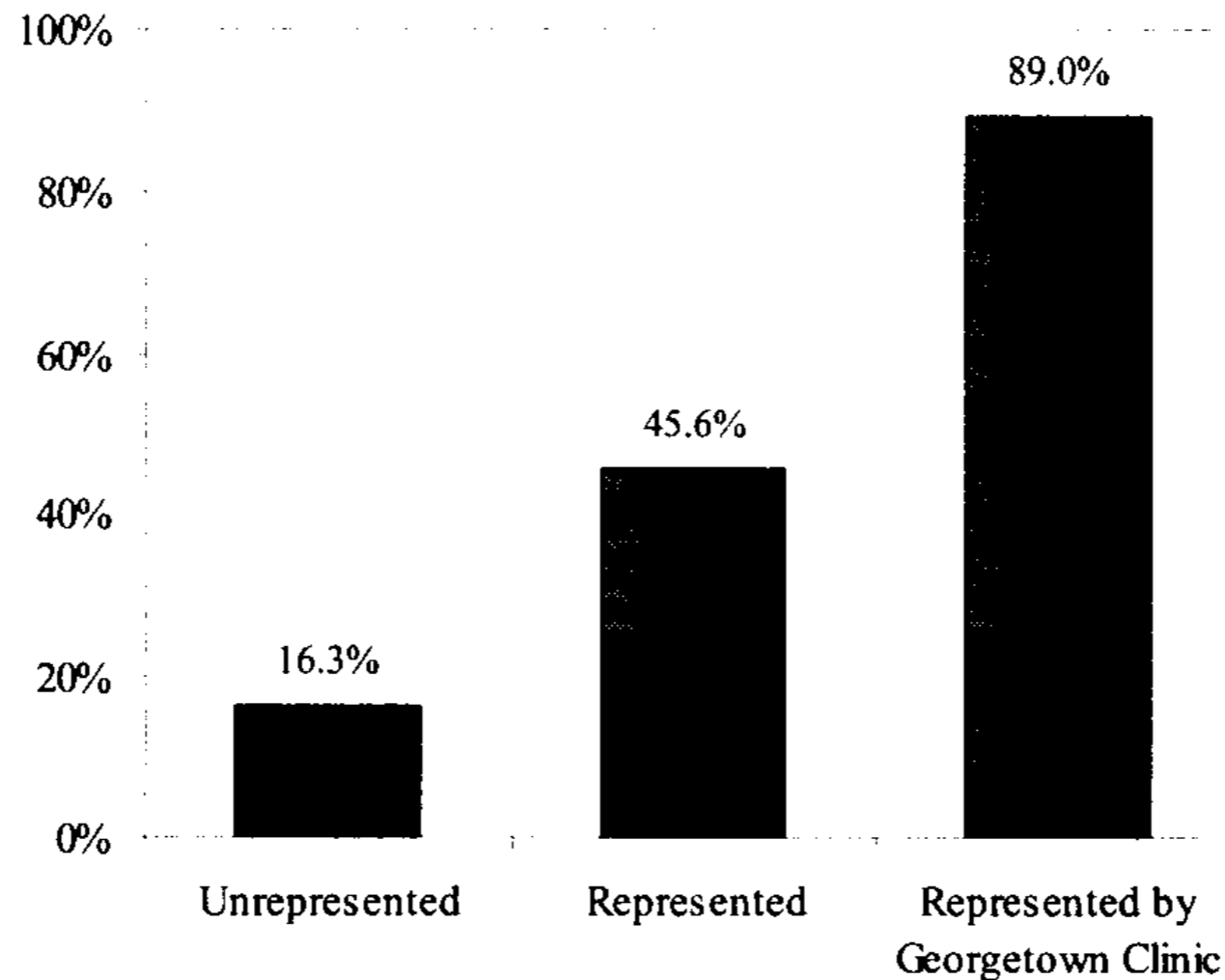
Refugee Roulette (USA)

Figure 27. Judges' Grant Rates in Chinese Cases—Los Angeles



Legal Representation

Figure 29. Relationship Between Representation and Grant Rates



Asylum in Western Europe

- Substantial variation in recognition rates in Western Europe for asylum claims from the same countries.
- No evidence of convergence over the period 1980 to 1999.
- Recognition rates for full refugee status are lower in times of high unemployment and if many asylum seekers from the same country of origin have already applied.

Neumayer, 2005

Clinical Challenges

- Why should refugees trust us as health professionals?
- Paradigm conflicts?
 - Who decides what matters?
 - Trauma vs Culture?
 - Treatment vs Community Development?
 - Post-migration stressors?
- How do we know what works and for whom?
- Phased treatments for people at risk?
- How do we help deliver care to the large and increasing numbers of refugees in developing countries?

Trust me, I'm a doctor!

Lots of reasons for torture and state organised violence.

Perhaps the one thing an autocratic leader most wants to avoid is a lively and active opposition. They want fear rather than conflict?

Torture is a powerful symbolic representation of betrayal. If everyone in the target community knows one or two people that have been tortured and released, how likely are they to *trust* other people, friends, allies, politicians, in opposition?

Why should we be trusted?

Listening

- John Hinton (1980) spoke to 80 patients with terminal cancer (mean time to death was 10 weeks).
 - He did not ask direct questions about outlook.
 - 66% told him that they knew they would soon die.
 - Only 36% had shown to staff that they knew their condition.
 - Patients wanted to protect the staff!
-
- So the way we react, the questions we ask, our capacity to focus on the interview – are all important.

Therapeutic Relationship Issues

(examples)

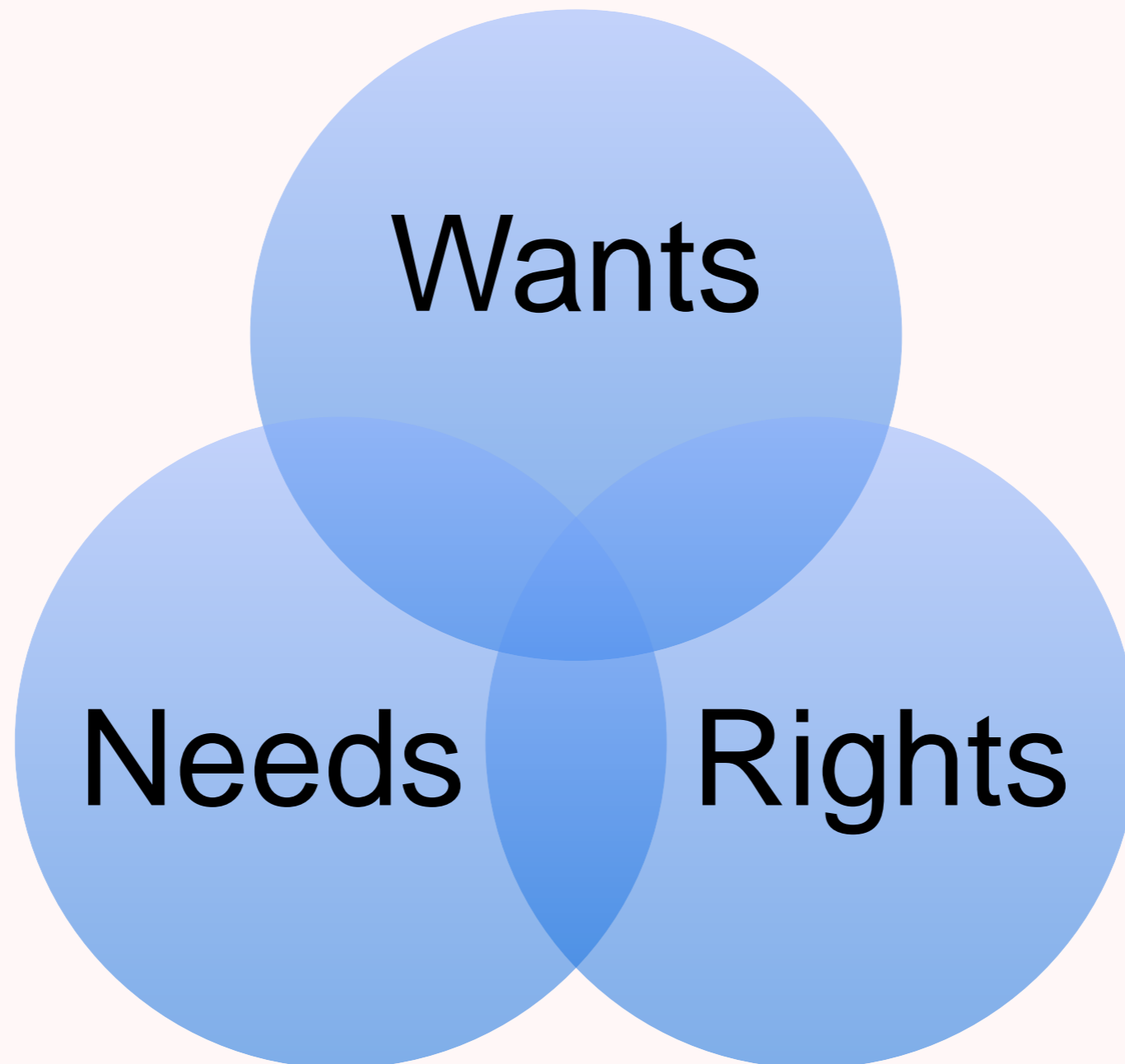
Refugee:

- Toleration of the intimacy of the therapeutic relationship
- Finding a safe space in which there is trust and positive regard.

Therapist:

- Vulnerability (how could I possibly survive something like this?),
- Impotence (how can I prevent this refugee, someone I believe to have been severely tortured, being returned to their country),
- Doubt (how can I fit this in to my previous religious or world view?)
- Horror (how to take in accounts of severe torture).
- Avoidance (I don't want to hear this today).

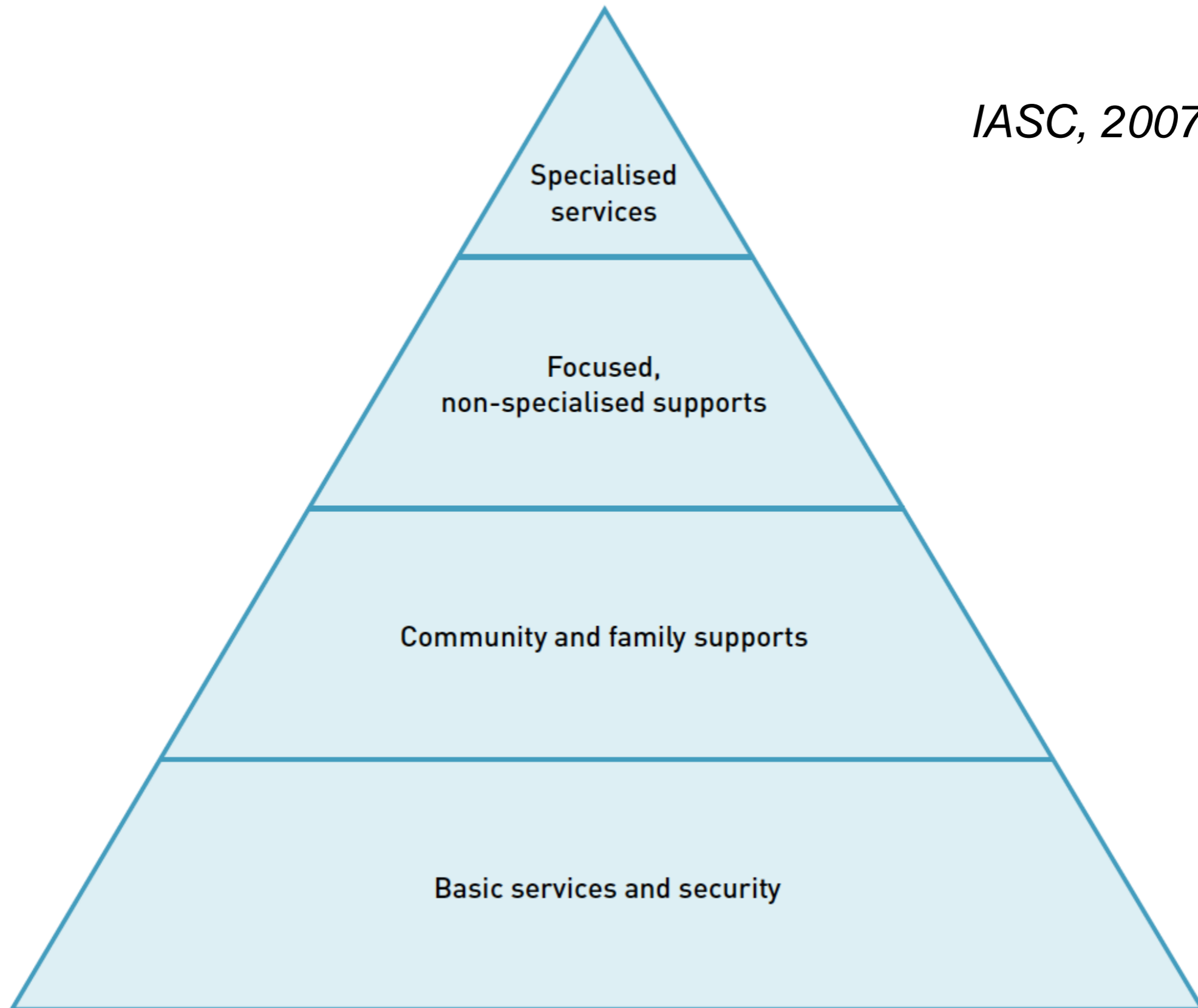
Who decides what matters?



Intervention Paradigms

- Being a refugee is not a diagnosis.
- So why do we have specialist services for refugees?
 - Is it their high risk of trauma,
or something about the type of trauma (torture etc)?
 - Is it that refugees present from a different culture?
(integration vs multiculturalism?)
 - Is it something to do with displacement and separation?
 - Is it something to do with the feelings they evoke in us?
 - Or is it just a matter of politics and budgets?
- How does that shape what we do?

IASC, 2007



What works and for whom?

- How do we investigate this issue? Ethics of research versus treatment?
- Technical difficulties?
 - RCT versus open studies (we are such nice people ...)
 - Stability of access to study group
 - Statistical power
 - Standardisation of instruments
 - Phased interventions
- What is a good outcome? Setting the bar.
- Generalisability from one population to another?
 - Applicability of interventions in different contexts

Phasing Treatments

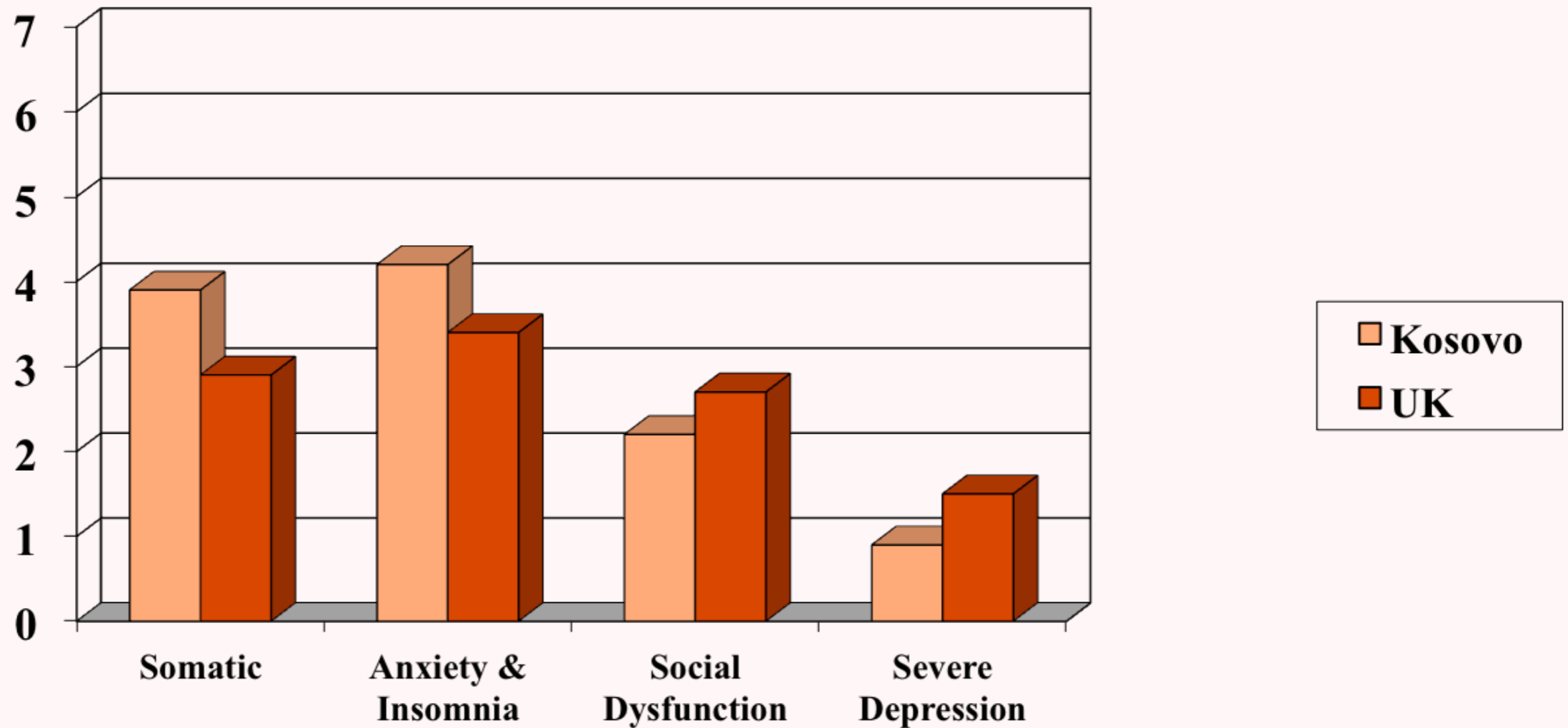
- RECOVERY UNFOLDS in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life.
- Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex.

Herman, Trauma and Recovery

Some conclusions?

- Underpinning human rights agenda in all we do. Important to listen (hard) to the wants of each person we see. Therapeutic relationship.
- Complementary rather than conflictual role of different approaches. Rights vs Needs vs Wants.... Phased Interventions.... Need to establish not just what works but what works for whom.
- Importance of researchers in developed countries rigorously investigating methods – not least to develop strategies to help large refugee populations elsewhere.

Refugees and Returnees



GHQ-28 subscales: comparison between our UK refugee series (n=842) and Barbara Lopes Cardozo et al's community sample in Kosovo (n=1358).