

Refugees, torture, and dehumanization

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Background

During the last decade of the twentieth century, mental health professionals in Serbia were faced with large waves of refugees fleeing from armed conflicts in former Yugoslavia. The second large wave started with the conflicts in the Middle East—Iraq, Syria, and Afghanistan—with its peak in 2015, with hundreds of thousands of refugees passing through Serbia. These two large migrations, happening at different moments, were different in many aspects, but it is also true that those groups, their experiences, and their problems could be comparable in many ways. It is thus compelling to ask ourselves, ‘Is there anything that we learned from the refugees of the wars in the ex-Yugoslavia that we can use to provide better mental health to refugees coming to Serbia from other countries?’

Although refugee experience is complex,¹ we intend to focus on traumatic experience, especially torture, i.e. on the treatment of refugees who survived extreme forms of violence. The comparison will be centred on observations that will be briefly summarized here: (i) war conflicts are the cause of displacement of individuals who are highly traumatized, as it seems that violence toward civilians is a weapon of war; (ii) even outside of war and conflict, refugees can and do become victims of human rights abuse, inhuman and degrading treatment, and torture; (iii) violence toward refugees and the breach of their rights can be understood as a consequence of dehumanization, implicitly or explicitly fostered by authorities; (iv) the suffering of refugees cannot be modelled only according to post-traumatic stress disorder (PTSD), as there are other psychological and somatic consequences of traumatic experience; and (v) treatment and the mental health of refugees are inseparable from their human rights, both as a causative factor and as a factor of recovery.

¹ We do not intend here to make difference between refugee, migrant, or asylum seeker, as all of those are legal categories, as we are focusing on a psychological experience of displacement, migration, and possible abuse. In a similar manner, we do not make a distinction between torture as it is defined by the United Nations (UN), which requires that the torturers be state authorities, while in reality a huge number of our clients were tortured by paramilitary or criminal groups. Again we are focusing on the reality of violence and its impact on individuals.

Refugees and war-related violence

Refugees started coming to Serbia as the combats were shifting from Slovenia and Croatia (in 1991), to Bosnia (1992), and, finally, after a short break, from Kosovo (1998–99). Those conflicts caused the displacement of 15.8% of the total population of the Socialist Federal Republic of Yugoslavia, or 33.5% population of countries where conflicts actually took place (Croatia, Bosnia and Herzegovina, and Kosovo) (1). In Serbia, the number of refugees amounted at one moment to almost 10% of the total population (> 700,000), and in 2004 there were more than half a million refugees and internally displaced persons (IDPs), according to UN High Commission for Refugees (UNHCR) reports (1).

Violence toward civilians appeared as one of major characteristics of the war. It is out with the scope of this chapter to argue if this reflects the fact that the type of armed conflict has changed over time, i.e. that ‘old wars’ (wars involving states, in which the main activity is the battle between armies), are superseded by ‘new wars’, which do not involve only states in conflict, but also many different actors, with most violence directed against civilians (2). Violence against civilians in wars in the former Yugoslavia was understood to be in relation to the politics of ‘ethnic cleansing’; it was defined as ‘rendering an area ethnically homogenous by using force or intimidation to remove from a given area persons from another ethnic or religious group’ (3, p. 39). The violence toward members of different ethnic groups can include drastic incidents, such as ‘killings, expulsions, detentions, torture, sexual violence, destruction of property, educational or religious institutions of a certain ethnic group and other means of violence and intimidation’ (3, p. 39). Of course, this violence spread terror and contributed to the mass displacement of population.

An important characteristic of wars in Croatia and Bosnia and Herzegovina was the existence of a large number of prison camps or places of detention. It is very difficult to obtain reliable estimates of the number of imprisoned and tortured, as reports vary in numbers in relation to the source (3, pp. 47–49). A report from the International Committee of the Red Cross (ICRC) mentions ‘over 44,000 detainees, both combatants captured during the fighting and civilians arrested because of their ethnic origins’ (4), who were registered by name by the ICRC during nearly five years of conflict. The same source stated that ‘the belligerents [i.e. all sides in conflict] set up more than 500 places of detention.’

Torture survivors are the group at the highest risk of developing mental disorders among all refugees. Understanding this, in 2000 we set up the Center for Rehabilitation of Torture Victims (CRTV) International Aid Network (IAN), in Belgrade, which still works today and over the years has implemented various programmes for the rehabilitation of torture victims and prevention of torture, funded by the European Commission's European Instrument for Democracy and Human Rights Programme and the UN Voluntary Fund for Victims of Torture as main donors. At the beginning, the CRTV was providing help mostly to refugees from Croatia and Bosnia and Herzegovina who were detained and tortured at some point during the war. Their experiences differed, as did the patterns of torture (5), from forms of torture that are considered 'lighter' to more drastic forms of torture and sexual violence (6).

Violence directed toward civilians, although difficult to comprehend from the point of human morality, appears to have an inherent logic and implicit aims. Most experiences described by our clients could be attributed to 'dehumanizing torture', whose primary aim is to inflict traumatic changes in the personality of the victim, 'to break them as individuals and change them into docile masses' (7, p. 351). As refugees are, by definition, extremely vulnerable and exposed to violence, torture can be directed toward other means. For example, we worked with many male refugees of Serbian ethnicity from Croatia and Bosnia and Herzegovina, who were arrested by the Serbian police after their arrival in Serbia (8). They were arrested in front of their families, assembled in large groups, and transported *manu militari* to a paramilitary unit base, where they were tortured—humiliated, beaten, 'or disciplined'. The main aim was to correct the imbalance between the numbers of armed men in Croatia and in Bosnia, and remedy a 'relative shortage of soldiers as a chronic weakness of the Serbian party' (9, p. 18). This is only one example of the fact that refugees, regardless of their legal status, can become simply goods for the trading during war.

How similar are the experiences of refugees that we are seeing today? We do not yet have solid data from methodologically well-grounded studies, and we must rely on separate reports mainly from civil society organizations (CSOs), individual reports from clients, or from media. My colleagues conducted a brief assessment of randomly selected refugees (10), and recently we completed interviews with another 100 refugees (results not yet published). But even these scarce data can give us an insight into the scope of the disaster.

Wars in Syria and Iraq were extremely vicious and produced large number of refugees, and Iraqis have been leaving their country since the Gulf War in 1991. Afghan refugees started to flee their country at the time of the Soviet invasion (1979), and since then, after several wars, Afghanistan is still torn by conflict and is unsafe (11). Refugees from those three countries formed the main proportion of all those passing through Serbia, but not exclusively. Geographical location determined Serbia's part in the so-called 'Balkan route', which was used for refugees to reach wealthier countries of Europe. In March 2016, the Balkan route was closed to non-European Union citizens without the required documentation. This measure reduced the number of daily arrivals (from an average of 2200 arrivals in mid-February 2016 to an average of 120 in late April 2016) (12). This also prolonged the stay of many thousands of refugees in reception centres organized by the Serbian government. But refugees are still coming into the country and leaving it, most often

using very dangerous smuggling networks. The most recent update from UNHCR (13) for the period between 9 and 22 July 2018 reports 747 newly arrived refugees, asylum seekers, and migrants in Serbia. The structure of the population has changed and most new arrivals were from Pakistan (39%), followed by Afghanistan (29%), Iran (10%), and Iraq (5%), with 17% from Bangladesh, Libya, India, and other countries.

Although not all refugees fleeing war were personally exposed to violence, a lot of them are. In a small pilot study (10), with 205 refugees/migrants (12 females; only 3% from countries other than Syria, Afghanistan, and Iraq) who had settled in informal gathering places or reception centres in Serbia, 29.8% of respondents stated that they had survived some form of torture/ill-treatment in their country of origin. Most Syrians survived some traumatic experiences related to the war that is taking place in their country, mainly bombing, and many were left without a place to live; many have lost close family members, parents, and children. Fear of recruitment and mobilization was also very present, as well as the fear of kidnapping and arrest by the regime. The majority of respondents from Afghanistan were coming from parts of the country that are controlled by the Taliban or Islamic State; many witnessed suicide attacks on the streets; and most of them received death threats from the Taliban or members of other armed groups or were afraid that they would be forced to join militant groups. As with the Afghan group, refugees coming from Iraq have experience of violence from different military groups although the war officially is over.

Refugees and violence in countries of transit

The important finding is that 42% of respondents in this study reported that they had experienced some form of torture or inhumane treatment in the countries of transit, including countries in Europe. It is entirely possible that harsh and sometimes brutal treatment of refugees by officials of those European countries increased after the closure of the Balkan route. Since then, reports from different sources have indicated that the treatment of refugees by border police and other armed forces include systematic physical abuse and torture, followed by expulsions across the border to neighbouring countries. Collective expulsions became a regular practice, as UNHCR was continuously reporting. In the last available UNHCR Serbia Update, 'UNHCR and partners gather reports of 266 collective expulsions: 124 from Croatia (up from 113), followed by 88 from B&H [Bosnia and Herzegovina] (down from 296), 28 from Romania (up from 11) and 26 from Hungary (up from 11)' (13). Existing reports (14–16) describe severe beating of refugees by border police, and use of pepper spray and police dogs who would inflict serious wounds on refugees, who were then forcibly pushed back into Serbia. A study on 992 refugees attending mobile mental health clinics run by *Médecins sans Frontières* (17) reports that 270 (27%) subjects had experienced some trauma in a form of a violent events being perpetrated by a state authorities. A significant percentage (22%, $n = 223$) did have actual signs of physical trauma, and among them were women (11%) and children (13%). Recently, the CRTV published a report (18) on cases of physical abuse of refugees who were pushed back to Serbia, with complete reports by a lawyer, forensic expert, and (for some cases only) a psychologist, according to the Istanbul Protocol (19).

This violence is not just random, but it is systematic violence aimed at preventing other refugees from crossing borders, and discouraging them from trying to enter the country again. This resembles a ‘deterrent torture’: ‘its aim is to discourage or encourage certain activities on the part of the victim or other people, or perhaps both’ and ‘the victims of deterrent torture may be chosen at random. In fact, the more random, the more likely the deterrent effect’ (7, pp. 350–1).

We can add to that reports from individual clients: attacks of armed men against refugee columns and the stealing of their money and possessions; smugglers who kidnap them and keep them imprisoned until they receive ransom; detention in prisons owing to illegal crossings of borders and abuse by police and prison guards; arrests and push-backs to a neighbouring country from which they came, again followed by beatings and abuse, to be repeated in the next attempt to cross the border; attacks and robbery in reception centres by violent groups of refugee men; sexual abuse by state officials or smugglers or other refugees. There are also reports from media: a girl of six killed by a train after officers drove her and her family to the train tracks and ordered them to walk back to Serbia (20); and two 12-year-old migrants were shot by border police after opening fire on a van that refused to stop (21).

What we are witnessing is a gross breach of human rights of thousands of individuals who have been exposed to the most violent, dehumanizing treatment, first in their countries of origin and then during transit, and who should be protected by international laws or at least be helped on the basis of basic human morality. While we are witnessing a great majority of professionals deeply devoted to helping refugees and providing the best possible support for them, we are also seeing cases of violence and inhumane treatment, and that violence has been in most cases carried out by state officials. These incidents illustrate the mechanism of dehumanization that lies beneath concrete violence.

Interpersonal trauma and dehumanization

Dehumanization is a matter of exploration in the social sciences (22), as well as ethics (23). We are using it as a generic term, consistently ingrained in many forms of discrimination against various groups. Dehumanization is quite common during war, as in war propaganda when it is directed against the enemy, but it exists and is operating during peace time—when it works against the mentally ill, sexual minorities, etc., and is called by various names: racism; xenophobia; homophobia; nationalism.

One possible explanation that comes from the psychoanalytical framework observes dehumanization as a schizoid process based on splitting and denial, which functions as a prerequisite of interpersonal violence, while its social effectuation brings destruction and suffering. We may see an individual whose personal attitudes toward immigrants, or the mentally ill, or people living with HIV/AIDS are extremely hostile, and upon a closer look we can see that they stem from his personal conflicts related to his own sexuality and/or aggression, but it is only when social mechanisms and ideologies (implicit or explicit) create a fertile framework for discrimination that this hostile attitude can be transformed into actual violence. This framework can be an official ideology of the state or a group or profession.

The CRTV IAN was engaged in the prevention of torture and degrading and inhuman treatment through monitoring places of detention, i.e. prisons, police stations, psychiatric hospitals, and social asylums, within the activities of the National Preventive Mechanism against torture. Stories of abuse in these institutions changed the picture: torture was no more an issue of war, but something systematic, happening in everyday life and in well-established institutions. Although concrete acts of physical violence were rarely present, we could see everywhere the inhuman, neglectful attitude and practices of professionals, which were, in fact, dehumanizing and which can incrementally lead to inhuman and degrading treatment. Here we come to the important difference between ‘torture proper’, which is usually understood as an infliction of pain, versus neglectful attitude and practices within institutions without concrete physical abuse. We believe that these are just facets of the same mechanism, and that physical torture can happen only within a framework where dehumanization has already taken place.

Refugees today are confronted with endless bureaucratic procedures, years of waiting for asylum with continuing fear of deportation or being placed in camps that are inappropriate for a decent life, like the island of Nauru, where conditions are described as an ‘Australian-made zoo’ (24). There are more subtle indicators of the xenophobia, even among helpers. For example, employees of CSOs working with refugees tend to send them to consult with psychiatrists mostly in cases of aggressive outbursts, either directed outwards or in a form of self-harm. Although not explicit, the underlying idea is that outbursts of anger are something that should be ‘treated’ by psychiatrists, i.e. medicines should be prescribed. Implicit here is the idea of impulses being indicators of madness and the role of the psychiatrist as an agent of social control.

Understanding unconscious dynamics underlying dehumanization can help. Probably the most important notion is that ‘dehumanization is the obverse of empathy’ (25); this means that the individual who is dehumanizing is either genuinely lacking empathy, or he/she has to split his/her own empathic part and deny its victim empathy, for whatever reasons. Our minds can, under pressure, be changed due to defensive mechanisms of splitting and projection of unwanted parts and then the external world becomes inhabited by ‘foreign elements’, which threaten our ordered, ‘clean’ world and purity of our ‘national body’. Bollas speaks about ‘mental contents [which are] regarded as contaminates, and the fascist state of mind idealizes the process of purging itself of what it has contained’ (26, p. 203). Chasseguet-Smirgel explains that intolerance to differences, which leads to discrimination and violence toward minorities, is an expression of the unconscious wish ‘to become one with the body of the Mother’ (27, p. 170); it is also possible to observe, when we are working with clients prone to violence (such as those allied with hate groups), that this is an unconscious wish to evacuate all unwanted feelings stirring from the oedipal situation: jealousy, rivalry, envy, humiliation, etc.

But even more importantly, this projection ‘has the function of squeezing out humanity and preventing human understanding from modifying the cruelty’. Bollas wrote that ‘in object relations terms, humanity is presumably represented or representable by the presence of different capacities of the self (such as empathy, forgiveness, and reparation) which had been squeezed out of the self’ (25, p. 198). In times of social upheaval, creation of the (dehumanized) enemy becomes a systematic enterprise. War propaganda denies any

human characteristics to the enemy; military training does similarly, as its aim is first to dehumanize soldiers in order to create an obedient, dehumanized executor. Refugee men fleeing from Croatia in 1995, who were arrested in 1995 by Milosevic's police, and who were sent for 'military training' to a camp of paramilitary units, were subjected to: 'slapping, kicking, hitting with hard objects, bats or rifle butts, tying up to posts or tree trunks [...] digging trenches and other, often pointless physical activities [...] forcing to carry the rock with the inscription 'Mr Discipline' [...] being placed in dog house and forced to bark' (28, p. 163). It is important to note that this action was organized by the state and would not be possible without state officials, but also without silent witnesses. A similar situation is happening with refugees in Europe now: 'responsible people [...] will be remembered as bystanders and witnesses who failed to help, and who allowed refugees to suffer under dehumanizing conditions while the raucous right carried out its xenophobic practices' (24).

As for the treatment of refugees in Europe now, it is hard not to see dehumanizing processes behind aggressive acts directed toward children, such as a 7-year-old Syrian boy whose arm was broken by a policeman (29). We can wonder if this systematic physical abuse of refugees, combined usually with group push-backs over the border, are indicators of 'a wave of xenophobia fomented by a noisy right wing movement' (24), which translated to the field becomes an agreed-upon routine among state officials who are bearers of an implicit or explicit system of belief that refugees are a danger to society and thus an object of violent measures, which will deter them from crossing the border and keep them away from the country. Is it the indicator that populist propaganda, which depicts refugees as a menace and threat to a country, creates a framework of dehumanization, which works as a prerequisite for a violence toward refugees? Border police (and other officials) thus function as agents defending the country and its population from unwanted intruders; in that picture, refugees' human rights, guaranteed by international treaties, are completely denied.

Dehumanization and torture are extremely noxious experiences, as they have a destructive impact on functions of personality that were developed through interpersonal relationships with caregivers in the first months of life (30). This developmental perspective, i.e. the development of autonomy/maturity, as described in psychoanalytical framework by different concepts like Winnicott's 'transitional phenomena' (31), Anzieu's 'skin-ego' (32), 'cohesive self' (33), and many others, can be used to describe the destructive (regressive) impact of trauma and torture. Thus, we can say that psychological functions developed through an attachment to a secure empathic other were destroyed and that basic safety has been destroyed, and annihilation anxiety now dominates individuals' interpersonal relations, creating a continuous perception of imminent disaster. We can say that this is what torture is all about: the perpetrator is in full control of the victim's body, which could be abused, humiliated, and mutilated. The victim has to abandon his/her pride, dignity, will and autonomy, and—in short—everything that makes us human. Torture through infliction of pain and humiliation effectuate the dehumanization process in the victim—the splitting and dissociation of the 'sense of humanity' is in essence a prerequisite for survival. In extreme cases that we could observe, the consequence can be compared to the 'mortification of self', as

Goffman described defensive transformation of inmates of psychiatric asylums (34, p. 43). Victims of torture appear dramatically changed, withdrawn and isolated, and unable to relate to others, work, or function autonomously. This condition well overcomes existing descriptions of PTSD.

Survivors and PTSD

Extensive use of torture and its consequences have been reported in refugees from the Middle East and Africa (35–37), and there are reports that the experience of torture contributes to poor mental health outcomes in refugees (38). In assessment of clients of the CRTV in 2004, it appears that refugee torture victims (n = 519) not only more often suffered from 'chronic psychiatric disorder' than a control group of non-tortured refugees (n = 346; 17.7% and 4.2%, respectively), but also appeared to have much more frequent 'chronic somatic disease' (20.6% and 13.6%, respectively). Among the tortured group, the highest prevalence was of PTSD (21.1%), depressive disorder (3.9%), and PTSD with depressive disorder (3.9%) (39).

Psychological sequelae of the refugee experience and torture will be huge and have a significant impact on their lives, as we know from many studies done in the past (40). In the psychiatric context, they are usually subsumed under the nosological entity of PTSD, which became the main condition (diagnosis) related to extreme life events and the stress they cause. PTSD has had a profound impact on the treatment of survivors, as it provided a medical and administrative label through which they could be given treatment, recognition, and, finally, compensation for what they have suffered. It had a profound social significance, as it was a kind of confirmation that the suffering a person experiences is a result of his or her traumatic experience related to war or torture.

But the concept of PTSD has other implications as well (see also Chapter 60). With increasing biomedicalization of psychiatry, explanations of even this, by definition an externally induced disorder, shifted toward genetic predispositions that were needed to explain the fact that only a minority of trauma survivors develop PTSD after the exposure. Hypothetical biological markers such as a specific serotonin transporter gene or telomere length are supposedly to be used to differentiate individuals as to vulnerability to stress (41, p. 128). More important is how much biomedicalization in this area can influence modes of treatment.

PTSD was introduced in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition* (DSM-III) in 1980 (42). It came into being as an outcome of different social and political factors, including the needs of veterans of the Vietnam War (43, p. 355). Veterans initiatives were supported by Chaim Shatan and Robert Lifton, who formed a subcommittee on the 'post-Vietnam syndrome' (44, p. 109), in preparation of the DSM-III and, as Shephard tells us, 'an important role in getting to the concept of post-trauma stress [...] was played by [...] Mardi J. Horowitz' (43, p. 367). Combining earlier theories of 'Freud, Janet, Kardiner, Grinker and Spiegel' (43, p. 367), he used the information processing model to come to what would become PTSD in 1980. Andermann et al. make the same point in Chapter 60.

In fact, the concept of traumatic memory, which is unintegrated, intrusive, and emotionally disturbing, relied much on (earlier)

Freud's theories (45), or, more explicitly, the one which he elaborated in 'Studies of hysteria', together with Breuer (46), a paper highly influenced by Charcot's traumatic theory of hysteria (47). There they claim that: '*hysterics suffer mainly from reminiscences*' (italics in original). Although as of 1897, Freud abandoned what later would be called 'seduction theory', after an experience with the Great War, there was a need for a theory of war neuroses that would be incorporated in existing psychoanalytical theories relying mostly on 'sexual conflicts'. In 1918 Ferenczi used this same phrase, translating it into 'the primary axiom of the germinating psycho-analysis' (48). Since that time, many valuable psychoanalytic concepts have been developed, especially those elucidating unconscious processes at the interpersonal level (e.g. theories of thinking, symbolization, and mentalization), which can contribute to our understanding of trauma.

It can be said that PTSD, as is the case with other disorders defined in DSM-III and onwards, contains inherent problems, as it is defined through descriptive methodology, i.e. as a syndrome, consisting of observable signs and symptoms, which actually represent a change of behaviour, either in action or in verbal output. In that sense, it captures only overtly recognizable signs, such as vegetative arousal, or statements of patients confirming emotional suffering related to war experiences. However, some important characteristics are excluded because they cannot be detected through behavioural analysis. Such was the case with feelings of guilt, usually denied by clients, which were part of the criteria for PTSD in DSM-III, as 'guilt about surviving when others were not, or about behaviour required for survival' (42, p. 238), but was excluded in the next edition. Similarly, we can say that it is difficult to imagine treatment of the victim without taking into account the notions of shame, humiliation, anger, hatred, and revenge—and many other disturbing emotions related to trauma. Also, as within the criteria of PTSD, there are only a limited number of signs and symptoms, so there is a possibility that some of the other non-listed forms of suffering will not be recognized as being related to trauma, or can be designated as 'comorbidity'. Increased comorbidity can be a consequence of 'the rule laid down in the construction of DSM-III that the same symptom could not appear in more than one disorder' (49). Thus, a selection of just a few signs and symptoms can lead to neglect of clinical presentations that are, in fact, post-traumatic reactions but are attributed to depression, substance abuse, interpersonal problems, or something else. Moreover, somatic disorders, which we could often see in many refugees and torture survivors is usually not perceived as a post-traumatic condition, but a separate (somatic) entity in total, such as hypertension or diabetes. Fixed and operationalized criteria for PTSD do not take into account dynamic changes in symptoms over time, their dependence on personality (educational and cultural background), and his or her supporting environment.

We can look at the symptoms of PTSD not as a consequence of post-traumatic memory, which is not integrated and is being re-experienced in different forms, but as a consequence of the destruction of the 'capacity for thinking' in Bion's (50) sense, i.e. transforming raw sensory data into mental content, or as a breakdown of the capacity to mentalize (51). We could see that there are varieties of symptoms related to functioning without the capacity to symbolize, which Lecours and Bouchard define as

a level of 'disruptive impulsion', wherein 'drive/affect experiences are neither tolerated nor contained; rather, one finds an uncontrolled direct expression' (51, p. 861). These impulses could be expressed through somatic channels (e.g. multiple somatizations in traumatized patients), motoric expression (e.g. physical activity), in symptomatic actions (e.g. repetition of a traumatic event, self-harm, risky behaviour), imagery (e.g. post-traumatic hallucinations or obsessive thoughts), and verbally (outbursts of anger with shouting, insults, and ruminations) (30). With the collapse of mentalization, layers of representations that form a 'protective shield' against anxieties no longer exist, and the person is continuously overwhelmed by annihilation anxieties that are understood as 'something horrible will happen'. This is the same reason why reminders of trauma function as trauma itself, i.e. causing anxiety, as there is no layer of representations (symbolization) that can help to create the difference. However, a lost capacity for mentalization means that a victim cannot integrate and give meaning to different segments of traumatic experience, which are sometimes too painful. Post-traumatic healing here comes close to the process of impeded mourning, as trauma so often means a loss of someone or something—like trust in others, belief in authorities or groups, and so on. However, mourning is difficult partly because a lack of capacity to mentalize can appear as a disrupted affective regulation. All affects can break into extremes—grief becomes excruciating pain, anger explosive action, and apprehension fear of concrete destructive experiences.

In fact, the original description of 'Post-Vietnam syndrome', published by Shatan in the *New York Times* on 6 May 1972 (52), and later in a separate article (53), depicting problems of Vietnam veterans recounted to him in 'group rap' sessions, did not include anything like intrusive traumatic memory, attempts to avoid remembering, and/or increased arousal in contact with traumatic stimuli. Instead, the main characteristics were: '1) guilt feelings and self-punishment; 2) the feeling of being scapegoated; 3) rage and other violent impulses against indiscriminate targets; 4) combat brutalization and its attendant "psychic numbing"; 5) alienation from one's own feelings and from other people; and 6) doubt about continued ability to love and trust others' (53). It is interesting to see how much papers that appeared just after the war in Vietnam were concerned with interpersonal functioning during adjustment of veterans to civilian life. Shatan described 'alienation' as: 'many veterans find it difficult and painful to feel compassion for others [. . .] because they are frozen into a state of "emotional death". Painful because of the process of thawing their numbed reactions to the death and evil that enveloped them in combat. Unable to forget, unable to endow their Vietnam experience with meaning, they relive it endlessly' (53, p. 647). I believe that here he is describing the dehumanization process that appears to be necessary in combat, but later on contributes to psychological stalemate, which is an obstacle to postwar resocialization. We could see with traumatized people how exacerbations of symptoms can appear at the moments of happiness, for example after the birth of the child. This event would endanger existing defences (in Shatan's words, 'thawing of numbed reactions'), as a person is now compelled to establish an empathic relationship or, in other words, ultimately to *re-humanize* himself/herself, which could be an extremely painful process.

Treatment of refugees as re-humanization

A deficiency of the concept of PTSD in work with survivors of human rights abuses was recognized some time ago (54); as the author of that paper described, the clients, victims of political persecution in Chile, ‘not only react very sensibly to the word disorder but state very clearly that one of the important reasons they feel that they can ask for our help is that we are a human rights institution, not a hospital or an institution for the mentally ill’ (54, p. 104). There is a possibility that for any person, but especially for victims of societal violence, treatment based purely on a biomedical approach might be felt as a further humiliation. The concept of PTSD, as long as it relies on changes in structure and functions of the brain, and at the same time denies the societal context of an individual, will hardly be useful in answering to the needs of survivors.

Exclusion of context, in this case—experience of abuse and torture—reduces the understanding of suffering to some kind of ‘disease’ that dwells in the body and is created by some form of deficit (e.g. constitutional or genetic weakness). Decontextualized, disorders (such as anxiety and depression) are then presented as the *causes* of suffering (instead of the other way around) and ‘have been given the status of first causes, rather like supernatural deities whose own existence requires no explanation’ (55, p. 30). In a very simplified version of events, clinicians will look for predefined symptoms and signs of disorder (e.g. PTSD), and the first interview will now be less oriented toward getting to know the person and his/her troubles, but rather toward verifying symptom patterns—with a checklist or without it (56). Although this is a simplified image, it can give us an insight into the inadequacy of the traditional psychiatric approach to victims of human rights abuses.

We have had an experience that illustrates this point: when we opened a counselling centre for refugees (in 1997) we did not have many clients, as people were very suspicious of the idea of ‘treatment of disorder’. But when we became ‘the Centre’ (in 2000), where they could come and talk not only to psychologists and psychiatrists, but also to a lawyer to get help to obtain their documents, or return to their former property, or see a medical doctor and get medicines free of charge, or schedule an appointment with a specialist, or seek education for their children, the situation changed dramatically. This created a stark contrast to public psychiatric institutions where clients most often could only get medicines and were less often offered hospitalization, if symptoms and suffering were intense. The other probable factor that increased the trust of clients in our services was our willingness to help them in processes in the courts in their claims for compensation for illegal arrest, which were also followed by public appearances and advocacy activities. The idea that there are professionals who recognize the ordeals they suffered at the hands of the state was extremely important and was expressed many times.

Those services, which we called psychosocial assistance (57), were not developed according to some pre-existing plan, but were developed mostly through learning by doing according to the needs of refugees and in collaboration with them and their associations. As services were tailored to the needs of the refugees, during the crisis in 2015 most activities of the CRTV IAN started with mobile team activities with shifting routes and locations depending on the situation on the field. Mobile teams consisted of a medical doctor

and a nurse, who provided sets of interventions labelled ‘medical first aid’, accompanied by a translator and a psychologist, who was responsible for ‘psychosocial first aid’. Later, CRTV IAN organized activities within one of the reception centres (in Bosilegrad), with a strong artistic component, together with the partner organization (30). Families who agreed to participate in the activities started to communicate with each other, developed activities on their own, and were able to participate and share traumatic stories within the therapeutic group. It is highly probable that future activities will continue to have various different components besides psychiatric and psychological help.

Flexibility of services and their organization based on the needs of clients are necessary. Appreciation of context, which in this case is equal to the recognition of human rights abuses, and assistance in a wide spectrum of societal areas will increase the trust of clients and help them adjust to a new community. Recognition of the importance of social interventions is already here: ‘Social programs for refugees have the potential to revive a sense of connectedness, re-establish social networks, and promote self-help activities’ (58). But there is more to that than just the development of specific services in the social field. One can argue that we need to reconsider mental health services—not only for refugees and victims of torture, but also for all those in need of professional assistance, and the priority for those services should be ‘rights-based care and support for mental health’, as elaborated in the Report of the Special Rapporteur on Health (59). To go further in developing this argument would mean going outside of the scope of this chapter, but we are optimistic that the issue of human rights will be, in the near future, inextricably linked to treatment and care of all individuals suffering from mental disorders.

More than to anybody else, this applies to refugees and torture survivors. The very cause of their suffering is an interpersonal trauma which, translated to a legal framework, is a breach of their rights. They are traumatized and displaced, as someone denied their human rights. At the psychological level, if we say that the most destructive factor in the experience of refugees is the dehumanization process, we can look at social interventions as a form of *re-humanization*. First of all, that means protection and safety, by all legal mechanisms and, going back to the psychological level again, this means the creation of psychological space in which a traumatized person can feel safe and start to recover, and give meaning to their experiences, and develop attachments to individuals and objects in a new environment.

Conclusion

Forcible displacement and migration, as seen in wartime, expose our vulnerability to change and our dependence on external, social, and cultural environment, which is probably distributed differently among all of us. Interpersonal violence, as well as systematic and institutionalized abuse and torture, further obliterate the psychological structures that are built and rely on good and protective interpersonal relationships. Interdependence between external (social, cultural), and psychological (interpersonal care transformed into individual strength) functioning should be taken into account when developing models of post-traumatic states and psychological trauma. Moreover, these models can help us build psychosocial

services designed according to the needs of clients, and develop mechanisms for protection of their rights.

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