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Challenges of Trauma: Migration, Integration, and the Role of Cultural Competence

With two World Wars, a handful of genocides, dozens of dictatorial regimes and innumerable local conflicts, the twentieth century has arguably devastated more lives than any other period of human history. The figure of over 140 million people forcibly uprooted from their homelands – a movement of peoples on a scale not seen for ages – stands prominent among the indicators of human misery. Sadly, the new millennium has seen little reduction in the levels of forced migration. Indeed, over 100 violent conflicts around the world have produced some 44 million currently displaced individuals.¹

But while the scale of the problem has not diminished, recent years have witnessed the emergence of a more refined understanding of the detrimental effects of forced displacement, and the development of mitigating practices and institutions. As articulated in the *Utrecht Guidelines*, a set of policy recommendations endorsed by the United Nations High Commissioner on Refugees in response to the humanitarian catastrophe in the former Yugoslavia, two basic principles underlie the new paradigm.² First – the recognition that forced migration can have a profoundly neg-

ative impact on the psychological well-being of the refugee. Second – that cultural sensitivity is an essential aspect of any measures undertaken to address this problem.

These basic insights are reflected in the definition of refugee integration adopted by the European Council of Refugees and Exiles as a “dynamic, two-way process” that places demands on both the individual refugee and the receiving society. For the refugee, “integration requires a preparedness to adapt to the host society without having to give up one’s own cultural identity.” Meanwhile, the host society must be willing “to adapt public institutions to changes in the population profile, accept and welcome refugees as part of the national community, and take action to facilitate access to resources and decision-making processes.”³

Major European centers have recently seen the emergence of public institutions that emphasize the critical importance of “cultural competence” in addressing the needs of their large and growing populations of migrants and refugees. This article will review some of these novel ideas and practices and discuss the implications of the paradigm of *cultural*

competence for smaller centers like Lithuania, where the social support system for the integration of refugees is still taking shape.

Psychosocial Needs of Refugees

Migration in general, whether forced, voluntary, or some combination of the two, is now widely recognized to put a strain on the migrant's sense of identity. The process of displacement, the loss of home and the effort to create new life in an alien environment place significant psychological pressure on the individual, who is likely to require support from the social services sector of the host country.⁴ In the best of cases, the provision of language and orientation courses, peer support groups, and other routine measures can go a long way to facilitate adaptation. But for a significant percentage of refugees, the reason why they fled their home country involved experiences of a traumatic nature, ranging from domestic abuse to rape to state-inflicted torture. Refugees suffering from post-traumatic stress syndrome (PTSD) pose special challenges to the bureaucracies of host states seeking to provide adequate health services and facilitate socio-cultural integration.

Soldiers were known to have suffered from "shell shock" during World War I, and "combat fatigue" during WWII, and in the 1970s, American psychiatrists first diagnosed Vietnam War veterans with post-traumatic stress disorder. PTSD has since been diagnosed in survivors of traumas ranging from torture to traffic accidents, sexual abuse to earthquakes. It is a severe and ongoing emotional reaction to an extreme psychological trauma, understood as a threat to one's life, serious physical injury, or threat to one's physical or psychological integrity, to a degree that the usual psychological defenses are incapable of coping.⁵

But although the evolution of warfare during the 20th Century was marked first of all by a growing proportion of civilians among the killed and wounded,⁶ the psychological effects of war on civilian populations, and on refugees in particular, have only recently become an issue for international public policy. In the American context, the influx of refugees from Vietnam, Laos and Cambodia during the late 1970s led some psychiatrists to draw parallels between the "shell shock" suffered by soldiers and the mental distress suffered by many refugees.

In 1981, a team of psychiatrists in Boston founded the Indochinese Psychiatry Clinic with the aim of using scientific means to determine the impact of mass violence on people's lives and methods to assist in their recovery. At the time, there was little empirical knowledge regarding the mental health problems of refugees, so the group had to develop novel techniques for diagnosis and treatment. They drew from and combined the insights of two distinct methodologies: a) oral history, based on the testimony of ordinary individuals and b) psychiatric epidemiology, or the study of how a disease spreads through a given population.

Drawing inspiration from the American women's oral history movement, they initiated the Cambodian Women's Oral History Project. This project, which served as a major foundation for the clinical insights and practices of the group, began by collecting the stories of hundreds of ordinary women refugees, and distilling what they call the "phenomenological architecture" of the trauma story. They proceeded to develop, on the basis of these stories, culturally validated screening instruments, or questionnaires, for measuring traumatic experiences and the symptoms of depression and PTSD in refugee populations.⁷

These questionnaires then served as the basis for a novel form of psychiatric epi-

miology, as the group, now called the Harvard Project in Refugee Trauma (HPRT) conducted the first systematic study of the prevalence of trauma among refugee populations on the Thai/Cambodian border. In “Community of Confinement,” HPRT proved the value of what came to be known as the Harvard Trauma Questionnaire, which set the standard for subsequent epidemiological studies of post-conflict situations in Bosnia and Kosovo.⁸

These studies have had an important impact on international policy, which had previously paid little attention to the mental health impact of mass violence. When the UN first organized refugee camps for Cambodian refugees fleeing from Pol Pot’s regime, there was no provision made for the mental health needs of the refugees. But after the publication of “Community of Confinement,” HPRT signed memoranda of understanding with the UNHRC and the World Federation for Mental Health to establish mental health protocols and programs for refugees throughout the world.⁹

Recent studies have quantified the prevalence of PTSD, major depression, or psychotic illnesses among refugees. A systematic review conducted in 2005 revealed that tens of thousands of refugees and former refugees resettled in western countries probably have post-traumatic stress disorder. The study reviewed 20 psychiatric surveys covering a total of 6743 adult refugees from seven countries and found that about one in ten were diagnosed with post-traumatic stress disorder and one in twenty with major depression. This means that refugees resettled in western countries are about ten times more likely to have post-traumatic stress disorder than the general populations in those countries.¹⁰

In the European context, the war in the former Yugoslavia and the massive presence of refugees served as a brutal reminder of reality of war and its effects on a population.

As noted above, the *Utrecht Guidelines* were drafted in 1993 with the participation of the HPRT as a response to the policy challenges posed by this humanitarian catastrophe. They emphasize that victims of forced displacement have specific “psychosocial needs and mental health problems” that must be addressed by programs that are “unstigmatising, culturally sensitive and non-medicalised whenever possible.”¹¹ These principles have since become integrated into the social support systems for refugees across Europe.

Cultural Competence

The notion of cultural competence is central to the new paradigm of refugee integration. The provision of competent and culturally appropriate health care, especially psychotherapy, combined with access to adequate language support, is recognized as one of the most challenging aspects of refugee integration, even in host states with well-developed psychological health care and refugee support systems. In the UK, the National Institute of Clinical Excellence emphasizes that “differences of culture or language should not be an obstacle to the provision of effective trauma-focused psychological interventions.”¹²

Language barriers pose an obstacle to the treatment of trauma at two stages: diagnosis and therapy. As with any illness, timely and accurate diagnosis of PTSD is a critical factor of recovery, and according to a study of refugees in Switzerland, refugees are more likely to be referred to psychological treatment when they either speak the language of the reviewing nurse or are provided with professional interpretation. This study reviewed screening questionnaires administered to asylum-seekers at the time of entry into Switzerland, as well as information pertaining to language use during the interview. It took

note of whether an interpreter was present, the level of training possessed by this interpreter, and the speaking proficiency of the asylum seeker in the language used during the interview. The study discovered that asylum seekers with adequate knowledge of the language or who were provided with professional interpreters are much more likely to report past experience of traumatic events, and the nurses were correspondingly more likely to notice severe psychological symptoms in them, compared to those who had partial or inadequate language ability or who did not have access to a professional interpreter.¹³

The second stage at which language barriers become an issue is during the psychotherapy itself. Cognitive Behavioural Therapy (CBT) is the treatment recommended for traumatized refugees in the UK by the National Institute of Clinical Excellence, and is the predominant form of treatment in Europe and North America.¹⁴ CBT involves a series of meetings between the patient and the therapist that can extend over a period of several months. The sessions consist of dialogue, where the therapist employs various discursive techniques to make the patient feel safe and comfortable enough to discuss his or her emotions, and perhaps even to encourage complex processes of emotional transference as a step towards healing. There is no need to delve into the intricacies of CBT, except to note that the method clearly implies a high degree of communication and mutual understanding between patient and therapist. Linguistic differences pose a real challenge to the success of this dialogical form of treatment.

Professional interpretation services are clearly required to mediate between the patient and therapist, but recent studies have discovered that not just any interpreter will do. The interpreting profession itself has grappled with the specific challenges of interpreting in a social services context and has developed a set of protocols and com-

petencies specific to the sub-discipline of “community interpreting.” This practice is qualitatively different from the mainstream practice of interpreting, which emerged in the post-war era in the context of international conferences and organizations like the Nuremburg Trials and the United Nations. In the UK, for instance, the National Register of Public Service Interpreters has established a code of conduct, professional standards, and qualifications for interpreters working in the area of health care, legal services and local government.¹⁵

The main difference between the community interpreter and the conference interpreter involves the relationship between the interpreter and his or her clients (i.e., patient and therapist), his or her role in managing their interaction, and the potential for conflicting loyalties and expectations. Given the power disparity between the provider and recipient of the public service, the community interpreter is faced with a series of political and personal pressures that are quite far removed from the serene setting of conference interpreting, where discourse is, relatively speaking, an abstract exchange of ideas among rational, comfortable and equal parties.

The profession of community interpreting is still in the process of development, and there is a wide range of opinions over the role of the interpreter and the scope of his or her duties in this context. The default role for the interpreter, preferred by some therapists, is that of a neutral, transparent “conduit” of direct communication between the therapist and patient. The idea is that the interpreter should work in such a way that the dialogue proceeded “as if” the patient and therapist were speaking the same language.

This “transparent” model of community interpretation has recently come under criticism. Hanneke Bot, a psychotherapist specializing in refugee trauma in the Netherlands,

conducted an in-depth study of the process of interpreter-mediated psychotherapy to determine whether this model of “direct interpreting” was actually being followed by the interpreters of Dari and Persian-speaking refugees undergoing psychoanalytical treatment for post-traumatic stress disorder, and whether any deviations from this norm affected the quality of the therapy. She compares the sessions of three separate groups, with each group consisting of a therapist, a patient and an interpreter. The therapists are state-certified specialists with experience in dealing with this type of patient, and the interpreters are all employees of a state-funded interpreter centre and certified to work in the Dutch social-services sector.

In her analysis, Bot argues that deviations from the “direct rule” do not impact upon the quality of the interpretation or the effectiveness of the therapy. She noted the use of the reporting verb as an “explicit space builder” that serves to distance the interpreter from the words rendered, and establishes the status of the interpreter as an independent participant in the three-way interaction. Bot thus suggests that the notion of “direct interpretation” denies the three-party reality of the interaction among patient, therapist and interpreter, and she advocates a “dialogic-interactive” approach that recognizes the role of the interpreter as an active participant in the process.

Bot’s study, and several other investigations into language mediation in the context of mental health strive to underline that there is more to cultural difference than language barriers. There are strong cultural differences in the understanding, expression and treatment of mental illness: “behavior that is typically symptomatic of psychosis according to Western nosology may be indicative of either another mental disorder or of nothing psychiatric whatsoever.” For examples, in some cultures, talking with deceased relatives or

ancestors is considered normative behavior.¹⁶ Moreover, Tribe and Morrissey highlight the depth of the cultural gap between the therapist and the interpreter, and point to the fact that interpreters *de-facto* act as cultural mediators and advocates for the refugees. They suggest that the unique expertise of the interpreter should be used more effectively and not hidden behind a veil of “objectivity.”¹⁷

Arthur Kleinman, a prominent American psychologist specializing in cross-cultural psychiatry, coined the term “explanatory models” to emphasize that every patient perceives and explains his or her illness within the network of a culturally influenced model of health and diseases.¹⁸ In order to establish an effective therapeutic relationship between the psychiatrist and patient, the interpreter must not just translate discrete sentences, but convey the cultural context, the epistemology that underlies the understanding of health and disease of the patient and therapist. What is needed is not simply an interpreter, but a bi-cultural mental health worker who takes an active part in the therapy. This is the approach supported by the Harvard Program in Refugee Trauma, which has developed an entire curriculum for their training needs.¹⁹

Implications for Lithuania

While Lithuania has been notorious through the twentieth century as a source of refugees and migrants both forced and voluntary, it has more recently become a host society for refugees, mostly from the former Soviet Union and Afghanistan. In 2004, Lithuania adopted standard European Union procedures for accepting refugees, and in 2005 it initiated an integration program at the Refugee Reception Centre in Rukla. This program, and related social support services offered by the Lithuanian

government, includes intensive language courses, professional training programs and job-hunting advice.

Over the past few years, several measures have been taken to address both the public environment in which the refugees live as well as their ability to adapt. As noted in a 2007 report prepared by the Commission of the European Communities on migration and integration, the Lithuanian government has placed advertisements in the media to promote understanding of immigration among the public at large, and has amended the code of ethics for journalists and publishers to encourage greater understanding of diversity. For the refugees themselves, the government has organized civic orientation and integration courses on Lithuanian culture and history, and it drafts a personal integration plan for every refugee. Interpretation services are said to be available to refugees, and information about public services is made available in several languages.²⁰

These measures are laudable, but their comprehensiveness remains to be evaluated. For its part, the Vilnius Office of the International Organization for Migration has stated that in its dealings with refugees, it has been able to manage using English and Russian as a common language, and so has not required the services of interpreters.²¹ While interpreting services of one kind or another may be available, Lithuania has no separate system for the training or accreditation of interpreters working in a community context.

Moreover, qualitative studies of the integration process suggest that language barriers and a lack of cultural sensitivity present obstacles to refugees seeking to establish themselves in Lithuania and to access the

full range of social services. According to one refugee from Chechnya: the experience of war is horrible. Someone who did not experience this will never be able to understand it. Of course, we are told that we can go to Lithuanian doctors. But they will not be able to understand us because of the language barrier. Besides, they know very little about refugees (32).²² Many other respondents, especially women and children who form the largest and most vulnerable part of the refugee community, voiced similar opinions. Certainly, the provision of and demand for psychotherapy is a complex issue in the former Soviet Union, as the disciplines of psychiatry and psychology were relatively undeveloped and viewed mistrustfully by the populace, but this evidence suggests that at least some of the refugees may suffer from war or displacement-induced trauma and would take advantage of psychological therapy if it were provided with adequate cultural mediation.

As Lithuania's system for refugee support continues to develop, it will increasingly have to address the hard cases of integrating refugees suffering from post-traumatic stress syndrome. In addressing this and other needs of the small but growing refugee community, there is clearly a role for the concepts and practices of cultural competence. The problem of refugee integration in Lithuania may be relatively insignificant in terms of the quantity of the individuals involved, but the measures undertaken to address their problems, such as the development of the institution of community interpreting, would be valuable in the delivery of a wide range of public services, and make a significant contribution to social cohesion and well-being.

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TRAUMOS IŠŠŪKIAI: MIGRACIJA, INTEGRACIJA IR KULTŪRINĖS KOMPETENCIJOS VAIDMUO

Trauma dažnai yra neatskiriama priverstinės migracijos dalis, kuri trikdo kultūrinę ir socialinę asmens integraciją naujoje aplinkoje. Daugelyje Europos šalių tarpdisciplininiai traumos tyrimai peržengė akademinio diskurso ribas ir yra vis plačiau naudojami insititucijų, dirbančių su priverstiniais migrantais, veikloje. Šis straipsnis apžvelgia naujas idėjas ir praktinės veiklos pavyzdžius,

ypatingą dėmesį skiriant „kultūrinės kompetencijos“ aspektui. Nors Lietuvoje pabėgėlių ir priverstinių migrantų bendruomenė yra nedidelė, naujausios tarptautinės perspektyvos gali padėti ne tik tobulinti dar ganėtinai naują socialinių paslaugų mechanizmą, bet ir skatinti visuomenės toleranciją tautinei ir kultūrinei įvairovei.