Journal of Refugee Studies Vol. 31, No. 4 © The Author 2017. Published by Oxford University Press.

doi:10.1093/jrs/fex039 Advance Access publication 7 December 2017

Sleepless Nights because of Ethical Dilemmas in Mental Health Care for Asylum Seekers

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MS received January 2017; revised MS received October 2017

The number of asylum requests in the Netherlands in 2015 was relatively high but comparable to 20 years ago. This article compares the social, political and cultural factors in mental health professionals' ethical dilemmas and reflections in both periods. The data consists of papers from an expert meeting in 1995 on Medical Ethical Standards in Mental Health Care for Refugees, and interviews and focus groups with health professionals on ethical dilemmas in mental health care for asylum seekers in 2015. Using a discursive approach to analyse the data, we found that, in 1995, as well as in 2015, the deliberations of mental health professionals reveal medical, social, cultural and judicial paradigms. In 2015, political factors tend to weigh more heavily than in 1995. We conclude that, in both periods, mental health professionals experience conflicts of values but the context of care for asylum seekers changed.

Keywords: ethical dilemmas, human rights, asylum seekers, mental health, discourse analysis

Introduction

As a result of global turmoil, especially the conflict in Syria in 2015, there has been a substantial increase in the number of asylum seekers entering Europe. Citizens and politicians in various European countries are debating the 'refugee crisis'. This debate highlights feelings that asylum seekers pose an imminent threat to society as well as feelings of embarrassment triggered by the lack of sympathy shown to asylum seekers. This is not the first instance in the recent history of Europe when an increased number of asylum seekers sparked such debates. Similar discussions were prominent during the Balkan crisis: especially in the period 1992–95, when the number of asylum requests in Europe were higher than normal.

In the Netherlands, the number of asylum requests in 1994 (53,000) was comparable to 2015 (58,000). In the intermittent years in the period 1994–2015, the number of requests remained relatively small. There are, however, some signs that, between 1994 and 2015, the debate on the 'refugee crisis' has changed. Both the Netherlands Institute for Human Rights and the Advisory Committee on Migration Affairs in the Netherlands state that more restrictive immigration policies were implemented that jeopardize human rights. These organizations are concerned about the detention of asylum seekers, the restrictive policies concerning family reunification and the criminalization of individuals without legal documentation (Advisory Committee on Migration Affairs 2013).

Many asylum seekers suffer from psychological symptoms (Gerritsen *et al.* 2006). When they receive mental health care, they convey to professionals issues of social injustice, inhumane treatment and the aftermath of conflicts in their lives. As in 1995, mental health professionals in 2015 question the appropriateness of their methods for treatment. Has anything changed in these two decades? Are mental health professionals confronted with the same dilemmas now as then? This article focuses on professional ethical dilemmas and will compare the impact of social and political factors on their moral reflections 20 years ago to those in the present situation.

The results of this study will help to improve the understanding of contextual, societal and socio-historical background of the current debates about asylum seekers. Furthermore, it recognizes ethical dilemmas of mental health care professionals. This is important because these professionals are taking responsibility for the lives of those living in the margins of Western societies and may themselves experience feelings of futility (Brodwin 2013). The ethics of mental health care for asylum seekers seem to be a neglected topic in psychiatry (Bloch and Green 1981/2009). The establishment of guidelines could assist professionals in determining what is at stake when treating asylum seekers in terms of an individual's right to health care services, the goal and methodology of treatment, judicial consequences and societal integration.

Human Rights and Ethical Dilemmas

Asylum seekers have always been a unique group of patients for professionals in mental health care. As a result of their legal status, they live under more extreme and harsher conditions in comparison to other migrants or the indigenous population of a country. These conditions include human rights violations in their country of origin, the hardships of flight and the asylum request investigation, frequent relocations, denial of resident status, detention and unemployment. A relatively high percentage of asylum seekers contend with an array of mental health problems such as anxiety, depression and post-traumatic stress symptoms (Laban and Gernaat 2005; Procter 2005; Gerritsen *et al.* 2006; Toar *et al.* 2009; Coffey *et al.* 2010; Cleveland and Rousseau 2013; Assiri 2014; Goosen *et al.* 2014; Heeren *et al.* 2014; Hocking *et al.* 2015). In comparison to the indigenous Dutch population, there is a higher incidence of suicide and suicidal tendencies amongst asylum seekers (Goosen *et al.* 2011).

Mental health professionals deliberate the nature of their patients' problems and how symptoms should be interpreted and treated. These deliberations are inherent to mental health care in general. With regard to asylum seekers, however, there is limited evidence for most interventions (Adams *et al.* 2004; Slobodin and De Jong 2015). Moreover, social and political developments in asylum seekers' host countries can lead to professional and ethical dilemmas. Whereas a professional dilemma is, for example, the provision of a differential diagnosis or the choice between two equally effective treatments, an ethical dilemma involves a conflict of values.

An example of an ethical dilemma is when professionals negatively impact their patients' asylum process by the inadvertent submission of medical information requested for the judicial process (François *et al.* 2008; Pitman 2010; Gower 2011). Additionally, this information could be used in bringing perpetrators to justice or for the rehabilitation of victims or for developing systems for signalling abuse (British Medical Association 2002: 52). This breaches the issue of trust, as it may prove challenging for asylum seekers to trust medical doctors and psychologists if they have had negative experiences with medical doctors and psychologists in the countries from which they fled. This may have a general effect on the perceptions of asylum seekers towards their mental health professionals (Crosby 2013).

Another ethical dilemma may arise when mental health care professionals are asked by the immigration authorities to provide clinical evaluations or information about treatment of the asylum seeker (Richman 1995). A positive evaluation of the mental health of a patient can be interpreted as an indication that mental health care is no longer needed.

A third example is informed consent. This is achieved by assuring that the patient understands the method and aim of treatment, a promise for the discretionary handling of sensitive medical information and the collection and documentation of data as evidence of abuse or violence. Mental health

professionals are accountable for this discussion with their patients, though cultural assumptions on hierarchy in the doctor–patient relationship can lead to different perceptions of this discussion. At least two related values are at stake: trust in the doctor–patient relationship and transparency about the aims, methods and possible side-effects of treatments.

There are several approaches within which we may understand these ethical dilemmas. Ethical codes of conduct were established to assist health care professionals in making 'good' decisions (British Medical Association 2002). Professional associations in each discipline develop guidelines that include ethical considerations that address professional values such as responsibility, respect, expertise, reliability, justice, safety and collaboration. Another one that is well known is the principle approach, presented by Beauchamp and Childress (1977/2009). This approach consists of four fundamental principles: beneficence (doing good), non-maleficence (doing no harm), respect for autonomy and justice. Several ethicists criticized the universal assumptions of the principle approach, especially the concept of autonomy, arguing that ethics are, as such, contextual (Richters 2002; Malkki 2007), which requires an approach that acknowledges this. More specifically, the ethical dilemmas in mental health care for asylum seekers indicate that we need an approach that acknowledges the socio-political and judicious backgrounds of Western societies.

An approach that acknowledges these backgrounds is a human rights approach. A human rights approach encompasses moral, judicial and political considerations. Its central claim is that individuals should be respected as agents (Forst 2011). Having experienced human rights violations, the vulnerable position of asylum seekers in a new society makes the human rights issue appropriate for analysing their problems (Williams 2005). Such an approach has in common with the ethics of care a focus on vulnerability from a political–ethical point of view (Tronto 1993/2009). A human rights approach implies that the right to the highest attainable standard of health is directly related to other human rights (WHO 2002), suggesting that health care services should be accessible, available, acceptable and of good quality (International Covenant on Economic, Social and Cultural Rights, Article 12, 1966, in WHO 2002). For example, Williams (2005) contended that the right to live free of discrimination, torture and violence, with freedom of speech *and* equal entitlement to health care services, is of paramount importance. This direct relationship becomes visible in the neglect or violation of human rights as well, since it can lead to serious health complications. Diminishing the risk of poor health, on the other hand, may be accomplished through respect for, protection of and the fulfilment of human rights. Furthermore, a human rights approach can be indicative of how health care policies can support, strengthen or jeopardize human rights. From the perspective of professional codes, it is worth mentioning that the British Medical Association (2002) added nine values to the four principles (Beauchamp and Childress 1977/2009), namely commitment, caring, compassion, integrity, competence, spirit of enquiry, confidentiality, responsibility and advocacy.

In summary, our theoretical framework is a human rights framework because it does justice to the moral dimensions of societal, political and judicial domains.

Methodology

Methodologically, we take a critical theory perspective to analyse two different data sets. There are two arguments in using a critical theory perspective. First, unequal positions based on power misbalance lead researchers to a critical approach (Duberley *et al.* 2012). Asylum seekers do not have comparable rights and entitlement to mental health care in comparison to other citizens. In the Netherlands, asylum seekers are entitled to a full range of mental health services; however, due to lack of information or communication problems, they might not utilize these services to the full extent. Researchers using a critical theory perspective are aware of these structural inequalities and have taken them into consideration in developing their methods (Duberley *et al.* 2012).

The second argument to use a critical theory perspective is that it sees the aim of research as empowering the people involved, particularly those in less privileged positions. In both studies, publication of the results were used to assist mental health professionals to find satisfying solutions for professional and ethical dilemmas in the care for asylum seekers.

The critical theory perspective has consequences for the selection of cases, respondents and the methods to analyse the data. The first case is a research project to develop ethical guidelines in mental health care for asylum seekers (Kramer *et al.* 2015). For this project, six mental health professionals were interviewed and five focus groups were formed around different dilemmas. All interviews were recorded and transcribed. The focus groups were documented and minutes were taken of the meeting. A total of 44 mental health professionals were involved in the project (Kramer *et al.* 2015). Respondents were selected on their diverse positions, disciplines and locations. Selecting a variety of respondents, increases the possibility of gathering information that shows controversial and sensitive issues.

The second case is a publication: *Medical Ethical Standards in Mental Health Care for Victims of Organized Violence, Refugees and Displaced Persons* (van Willigen 1998). This publication was the result of a consultation organized by the advisory group on the health situation of refugees and victims of violence of the World Health Organization. The consultation took place October 1995 in Utrecht, the Netherlands. The publication about this consultation includes an extensive introduction, literature study (van Willigen 1998) and contributions of its participants. This is an excellent source for analysis, as the publication is the result of discussions amongst scientists and mental health professionals.

The cases are different in how data is collected. However, we think that a comparison of data in these projects is possible because they had the same kind of origin and the same kind of objective. In both cases, non-governmental

organizations, one for supporting mental health professionals and one for advocating a human rights approach for asylum seekers and refugees, took the initiative to the consultation and to develop guidelines. The data from the 2015 project consists of interviews and focus groups, which makes it possible to use direct quotations of the respondents. The data from the 1995 meeting was published afterwards but includes the original presentations. In both cases, we can refer to individual respondents, who express their opinions about ethical dilemmas in mental health care for asylum seekers, which makes this comparison unique.

The critical theory perspective also had consequences for the method of analysis. To analyse the data, we used discourse analysis (Foucault, in Bryman 2015), which focuses on specific interpretations, controversial meanings and an (over)emphasis on certain elements of asylum seekers' situations. We looked for mention of the social and political context of asylum seekers and refugees and how these references were part of the arguments for ethical decisions made by mental health professionals.

This discourse analysis led to the themes presented in the 'Results' section in which we first describe the themes in the data of 1995, then those in the data of 2015. In the discussion, we focus on differences and similarities between the two cases.

Results

Social and Political Aspects of Ethical Dilemmas in 1995

Four themes arise from the analysis of the 1995 data. Scientists and mental health professionals express concerns about the system of mental health care in general. We interpreted them as concerns about medicalization and a lack of critique of cultures. In their individual relationships with patients with different cultural backgrounds, respondents are concerned about informed consent and autonomy.

Concerns about the Medicalization of Asylum Seekers

Several participants in the European Consultation on Medical Ethical Standards in Mental Health Care for Refugees and Displaced Persons in 1995 were reluctant in identifying the psychological problems of asylum seekers as medical or mental health issues. The interpretation of psychological problems can lead to conflicts between medical, social and political models (Bracken *et al*. 1995; Summerfield 1999). In a medical paradigm, symptoms of asylum seekers are easily understood and classified as, for example, part of a post-traumatic stress disorder. A more critical approach acknowledges that the social and political contexts of the psychological problems are then often ignored. Survivors of human rights violations who testify and press charges against their perpetrators can be 'converted' to patients in need of therapy as a means of (re)processing their traumatic memories. Bracken, Giller and

Summerfield argue that the medical profession has influenced the discussion of moral issues in society:

> Today, medicine is the site where science impacts on the lives of ordinary people most directly. As science has replaced religion as the chief source of explanation about life and birth, illness and death, the social position of medical professionals has become more prominent; they are now centrally involved in many ethical debates (Bracken *et al.*, in van Willigen 1998: 87).

The increased credence attached to the explanatory models of science, and medicine in particular, are examples of what has been called cultural modernism (Bracken *et al.*, in van Willigen 1998). Modernity involves a valorization of reason and science and a disregard of tradition, religion and disorder, which affects society as a whole. Eventually and relevant for this analysis, the modernistic agenda resulted, for example, in the development of special treatment units for refugees. Bracken and his co-authors criticize this development:

> In other words, it is possible to interpret the emergence of therapeutic centres for refugees and victims of torture as one product of the modernist project, aimed at controlling the disorder provoked by suffering and loss by instituting programmes of analysis and therapy. In our experience this is the intellectual context in which most workers in this area operate today. Within such a framework the issue of ethics is about the development of codes of practice: principle of access and intervention which will allow refugees to benefit from progress in the area of psychiatry and psychotherapy (Bracken *et al.*, in van Willigen 1998: 89).

Bracken, Giller and Summerfield were very critical about interpreting problems of refugees as mental health problems. They think the development of special programmes for the psychological treatment of asylum seekers has unanticipated effects. Their major concern is that asylum seekers begin to organize and present their situation in a 'modern' way, in accordance with Western psychological ideas and categories, as a means of having their suffering recognized (Bracken *et al.*, in van Willigen 1998). The incorporation of a new paradigm in relation to one's suffering can have serious negative consequences, like a cultural disconnection or a limited and biased focus on responsibility and (in)competence in dealing with traumatic experiences:

> It inherently involves a loosening of one's ties with the home culture, the very culture whose myths or religious idiom may be important sustaining factors (for their health and well-being).... By adopting this framework, refugees can begin to regard themselves as particular cases, in which current suffering is understood to be the product of their own individual trauma and failure to cope (Bracken *et al.*, in van Willigen 1998: 93).

By adhering to this position, refugees may begin to undervalue their own capacity for survival and endurance. The authors take the discussion about ethical dilemmas in mental health care for asylum seekers to a general level

by contending that not all asylum seekers, as a group, require mental health care services or referrals to the various institutions established for this group. They challenge the health care workers to question the assumptions from which their practice springs (Bracken *et al*., in van Willigen 1998).

Concerns about a lack of critique of cultures: Richters stresses the importance of medical anthropologists in the development of ethics in (mental) health care and highlights the relativity of ethical principles:

> Western health care workers and patients from different cultural traditions call for a special kind of listening. Listening to the patient is rightly perceived as one of the key medical ethical principles. But culturally pluralistic health care settings require extra qualities to allow the kind of listening, interpretation and explanation necessary to ensure valid patient consent. Anthropology can help by translating 'listening to the patient' into 'understanding the patient' (Richters, in van Willigen 1998: 72).

Health practices in different cultures have developed in many ways. Opinions about appropriate (mental) health care show much variety. Richters states that scientists and medical professions from Western countries should refrain from judging other cultural systems or practices because their professional position may be influenced by colonialism and 'Western privilege':

> If one reminds oneself of the often gruesome colonial and imperial past of Western nations, and of the present state of the art of these nations, one may wonder whether we Westerners are the chosen people for such moral evangelization (Richters, in van Willigen 1998: 75).

On the other hand, she argues that critique of cultural (health) practices remains important:

> Cultural anthropologists often take a culturally relativistic stance. That is, they describe things that are different in different cultures, how they are different and why they are different. They describe the cultural framework of presuppositions, values and norms, they show how moral problems are perceived and handled by those whom they affect. But to avoid any ethnocentrism they do not judge the views and practices they describe as good or bad. Though we may praise this considerateness, it blocks any cultural critique (Richters, in van Willigen 1998: 73).

Richters is concerned with Western imperialism in health care and more specifically medical ethics. Her concern is that social systems of refugees who could possibly benefit from Western mental health services could create a disconnect with their 'cultural background'. Bracken, Giller and Summerfield fear this would have an adverse effect on survivors of organized violence. Richters viewed this from another position: some practices are oppressive and the use of these should perhaps be reassessed despite their long-standing acceptance. Questioning and reflecting upon the inherent injustices in one's own cultural heritage may assist in replacing a horrible past with a

future of equality and optimism. Victims of organized violence might want to reconsider cultural practices of suffering and health behaviour in their country of origin:

> As we have seen, questioning the values, norms and customs of other cultures is not by definition a matter of ethnocentrism. Questioning someone's mental make-up is not by definition a matter of trespassing at the border of neutrality that the health care professions are supposed to honour. Questioning neutrality is not by definition trespassing at the border of ethics. On the contrary it could be, and often is, an act in the name of mankind and civilization. Let us admit that refusing neutrality is often heart-breaking, but is the lesser of competing evils (Richters, in van Willigen 1998: 77).

The ethical dimensions Bracken, Giller and Summerfield and Richters discussed are social, cultural and political. The survivor-to-patient transformation is potentially harmful for asylum seekers who engage in Western health care systems, as was described above. On the other hand, too much respect for cultural systems can leave oppressive and unjust practices uncovered.

Concerns about informed consent: A very important ethical rule for health care practitioners is that of informed consent, which obliges doctors, psychiatrists and psychologist to explain the nature of the proposed treatment including its anticipated risks to patients. This is officially regulated by national laws and international codes of ethics in science as well as in health care. In the Netherlands, the Medical Therapy Agreement Bill (Wet Geneeskundige Behandelingsovereenkomst) was passed in April 1995.

Van Leeuwen assumes that informed consent is the result of a social development that takes moral and social values in Western societies into consideration. He defines this as rationalizing behaviour by setting rules. With an agreement of treatment as a prerequisite, a respectful discussion about any kind of treatment is possible between patients and doctors:

> The formal nature of these rules expresses the underlying thought that although individuals may differ in many aspects they are nonetheless socially equal and equally capable of acting as reasonable persons (van Leeuwen, in van Willigen 1998: 53).

Subsequently to the Enlightenment, education, law, trade and traffic are regulated with the premise that people act with reason and can be held accountable for their actions. Medicine and medical morality are among the last domains in which the concept of rationality has been introduced (van Leeuwen, in van Willigen 1998: 56). Medical decisions concerning euthanasia, treatment of psychosis or coma has long been considered the primary responsibility of doctors. The present situation dictates that the health care professional as well as the patient are involved in making rational decisions:

> At the heart of these problems lies the entanglement of morality and the concept of the reasonable person. This concept grants every member of society

> freedom in the sense of non-interference by others as long as the person does no harm to others (van Leeuwen, in van Willigen 1998: 56).

Van Leeuwen thinks that, for patients not born and raised in the West, the concept of informed consent may prove difficult to grasp. They may not experience their physician to be an equal discussion partner or there may be little to no opportunity within the health care system to discuss or consider alternative methods of treatment. Van Leeuwen assumes refugees do not know that personal participation in the treatment process is an option and are perhaps less familiar with the rationalization of behaviour. In addition to 'missing that development', they may also have had experiences in which they felt the doctor's procedures were not in their best interest:

> Refugees do not automatically share Western rationalized values with respect to getting information or negotiating as reasonable persons. Some of them may even recognize in their doctor a representative of the same system they have to fight to get a residence permit; others may expect doctors to act according to the cultural value system they are used to (van Leeuwen, in van Willigen 1998: 58).

Applying the rule of informed consent to refugees requiring mental health services can prove to be a daunting task. Perhaps the doctor/patient equation is unbalanced due to a lack of trust: 'Alienation and the experience of medical assaults and torture can block the establishment of a trusting relationship' (van Leeuwen, in van Willigen 1998: 59).

According to van Leeuwen, cultural values and professional codes of conduct should serve as a catalyst in the decisions physicians make in considering methods of treatment, even if refugees have not been subjected to medical mishaps. Conveying and discussing the concepts of informed consent and autonomy with asylum seekers may prove challenging.

Concerns about autonomy: Autonomy can be described as a personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choices, such as inadequate understanding (Beauchamp and Childress 1977/2009). It relates to the informed consent procedure in which health care professionals, in order to respect patient autonomy, have to inform their patients properly. From a psychological perspective, we could say that an increase in autonomy during adolescence occurs in most societies; however, cultural differences in the family dynamic do occur (Hauff, in van Willigen 1998). Increased autonomy, in relationship to both internal conflict and environment, is often considered a fundamental aim of psychotherapy. Autonomy can be perceived as the direct advancement of one's intentions in interaction with others in situations where one's own interests are at risk (Gullestad 1990, in Hauff, in van Willigen 1998).

Hauff, a psychiatrist, cites a case study with a 19-year-old female patient undergoing psychotherapeutic treatment. The patient recognized, understood and accepted the concept of autonomy. Her parents, who fled Vietnam, are at

odds with their daughter's attitude. Hauff's case study indicates the positive effects psychotherapy has on his patient despite her parents not concurring with either his or their daughter's opinions. He concludes: 'The autonomy of a patient is not a static phenomenon, but an ongoing process involving the person and his relationship with others within a changing sociocultural context' (Hauff, in van Willigen 1998: 68).

In the case of mental health care for refugees, it may prove essential to discuss issues of autonomy explicitly in an attempt to increase the patient's competence and awareness of the psychotherapeutic process (Hauff, in van Willigen 1998: 68):

> Migrants frequently come from societies in the 'South' or 'East', which may have had strong and stable cultural traditions but are now undergoing both a rapid social change and a sociocultural disintegration. They come to societies which they frequently view as culturally 'distant' (Hauff, in van Willigen 1998: 63).

Van Leeuwen and Hauff both address ethical dilemmas in therapeutic relationships with regard to informed consent and autonomy. All agree that involvement in (mental) health care may have serious repercussions in the social relationships of asylum seekers.

In summary, the discursive reasoning of mental health professionals about ethical dilemmas in 1995, as far as is reported in the studied document, shows that asylum seekers are seen as being culturally different and unfamiliar with the Western health care system. This led health care professionals to question how appropriate their framework is in light of treatment of asylum seekers. They also assume that asylum seekers have an undeveloped sense of the concepts of informed consent, doctor/patient relationships and autonomy. In all, mental health professionals feared that the loss of cultural values of their patients may be at jeopardy. Additionally, political factors were only perceived as pertaining to the countries of origin and the connection asylum seekers still had there. The social political framework to analyse the problems of asylum seekers led to a preference for a psycho-social, multidisciplinary approach (van Willigen 1998: 108) in which judicial aspects of the asylum process were not explicitly mentioned.

Social and Political Aspects of Ethical Dilemmas in 2015

A discursive analysis focusing on social and political aspects of the ethical dilemmas of mental health professionals in 2015 can be broken down into three themes. First, the conditions under which asylum seekers live are in themselves a burden that can result in (additional) stress and other psychological symptoms. Second, mental health has become part of the institutional system in which asylum seekers are dealing with different paradigms: medical and legal. A major concern for mental health professionals is how to respond to questions posed by medical advisers from immigration authorities within a

legal paradigm. Third, some mental health professionals question if they should assume a more advocative position.

Concerns about social conditions of asylum seekers: While awaiting the processing of their asylum request, asylum seekers are housed in reception centres with the barest of amenities. They are provided a small living space usually without private sleeping arrangements. They share kitchen and sanitary facilities. They must adhere to the rules and regulations of the facility's security personnel. The noise levels are at best challenging and not conducive for recovering from the flight experience or for coping with the stress subsequent to the experiences which initiated their exodus. Asylum seekers have hardly any rights or opportunities for gainful employment.

Most health care professionals are aware of the conditions under which their clients subsist and express their concerns accordingly. They have doubts about what these conditions mean for the diagnostic process and the choice of a treatment intervention and its effect:

> As long as the asylum seeker is involved in the asylum procedure, there is no stability, social support or respite. Because he lives in a reception centre, with very little privacy, he has nothing to do. Because of this, he is under continuous stress. Sometimes I give the asylum seeker this example: Suppose you're a soccer player. Someone kicks your ankle resulting in an injury. You go to a physiotherapist and he says rest your ankle, do these exercises, maybe get some medication and in a few months your ankle will be fine. But your coach says, no, you have to play and you must. Your injury doesn't get the time required to heal. The therapist can treat you but not your ankle. I seldom see patients recovering from psychological symptoms or disorder during the asylum procedure (R1).

This is especially true when the period of residence in a reception centre is lengthy (sometimes years), when asylum seekers are frequently moved from place to place or when health care is not readily available. Immigration authorities can transfer asylum seekers from a reception centre to a detention centre. In such instances, health care professionals must contact the immigration authorities as to the current location and situation of their patient. According to some mental health practitioners, the social and living conditions of asylum seekers and practices of the Dutch immigration authorities exemplify a lack of compassion and empathy. There appears to be no interest in providing a safe and stable situation, which is a condition for mental health treatment in general and the treatment of trauma in particular:

> I call that social injustice; especially vulnerable people who come to us because they are mentally unstable and require medical attention. They have psychological and sometimes physical problems and lack the basic necessities of life. We take safety and housing for granted. They are moved from place to place. They might even end up in a detention centre or face deportation. This has

> consequences for our treatment. I often experience that treatment is effective but the patient is forced to discontinue against his will, of course (R5).

Asylum seekers are officially entitled to health and mental health care services, but other factors may influence their actual access to these services. For example, they did not receive information about the availability of these services, or they may not be able to obtain the required referral. In addition, they may feel shame or guilt in asking for help with mental health issues, which hinders accessibility of necessary health care:

> The question is whether a person in need gets the care he deserves, assuming the care is available. In every society there are groups that have little to no right to health care services with the perception that they, as a group, are not entitled (R4).

Treating asylum seekers can have an unexpected effect on the emotions of therapists. Their concerns about the situation of their patients, including their patients' social conditions, may cause health care professionals to feel inclined to rescue their patients. However, in their attempts, they inadvertently become personally involved and attached to the degree that they create psychologically stressful situations for themselves. This brings along specific dilemmas:

> The helplessness, the despair and their call for help makes us want to try and find a solution to stop the pain. This can affect me as a therapist as well. Your reaction is to save them and help these people out of their misery but you can't achieve that. So for me, as a therapist, it is important to accept that this is a helpless situation and patients lack the power to change it and that I, as a result, will start feeling helpless in any attempts to do so (R6).

As the result of an indeterminate stay in the reception centres, it is difficult for health care professionals to gauge when, or even whether, psychotherapy or any other trauma reprocessing therapies for their clients can or should be initiated. Moreover, it becomes nearly impossible to set realistic goals for treatment:

> As a professional I experienced that I started something that I couldn't complete. Old emotions surfaced but there was no time to heal. That made me reluctant to start psychotherapeutic sessions even though I realised this person might benefit from them. I focus on the present situation and how to cope with that. That's also effective but the effect is short lived. So you have to learn how to be realistic about the possibilities in this situation. They are in a bad situation and psychotherapy can't produce miracles. Keep your aim low, that's also better for the patient. It's tempting to motivate your patient to achieve much and give him hope, tell him that everything will be all right, but you and your patient may get disappointed (R4).

Summarizing these results, we conclude that the concerns about the social conditions of asylum seekers not only affect the diagnostic and treatment processes of these patients, but also affects mental health care professionals in significant ways.

Concerns about sharing information with third parties: To understand the inherent ethical dilemmas, additional information about the asylum procedure is required. Approximately 50 per cent of all asylum applications in the Netherlands are honoured. From these, half are honoured after one or more subsequent appeals (Immigration and Naturalisation Office 2012). Upon denial of an appeal, the asylum seeker is required to leave the country within four weeks. If the asylum seeker suffers from serious medical problems, it is possible to appeal the decision under Article 64 of the Immigration Law. This request postpones repatriation in light of extenuating medical circumstances. In this instance, the Immigration and Naturalization Office requests their own medical advisers to initiate an inquiry based on information received by the doctor or psychologist/psychiatrist responsible for treatment of the asylum seeker. The medical adviser is responsible for determining the probability of a medical emergency and whether treatment is available in the country of repatriation. The medical adviser then forwards the findings to the Immigration and Naturalization Office who, in turn, makes a decision based on Article 64.

As a result of this procedure, mental health professionals are requested to provide medical information about a specific patient. What and how to report this information to medical advisers from the Immigration and Naturalization Office is a major concern to all professionals we interviewed. They feel the information they provide may impact the decision-making process in the asylum procedure. When they realize the information they provide is subject to rigid immigration policies or may lead to a decision to reject the asylum request, an ethical dilemma arises because the outcome might not be in the best interest of their patient.

The initial dilemma highlights the trepidations mental health practitioners have in providing medical information to medical advisers. If the outcome of the therapeutic treatment is positive, the medical adviser may conclude that treatment has been successful and is no longer necessary. In this instance, a decision based on Article 64 would be negative. However, if the provided information indicates that treatment is not successful, the medical adviser may conclude that further treatment would prove fruitless. Again, a decision based on Article 64 could be negative:

> You find yourself in a catch 22 situation: if the patient improves, which of course is the aim of the treatment, the medical advisor might say: 'Okay, the symptoms are less, we can proceed in returning the person to his country of origin.' But if the medical condition is not improved, the medical advisor might say: 'This treatment is not very effective and won't lead to better results so you can stop and proceed to return as well.' The asylum seeker has to deal with a

> paradox. He wants to get better but then realizes article 64 is no longer applicable in his case and he might have to return. That causes stress and that's why his complaints don't go away (R1).

Mental health professionals question whether the information they provide to medical advisers will be used in the best interest of their patients. Subsequently, some are reluctant in providing any information at all:

> I think it's very tricky, trying to accomplish anything with the medical information. In fact I don't know if my patient is entitled to asylum in the first place and trying to influence the procedure is not my task. My task is to interpret the complaints he has and base my diagnoses and treatment on that (F3).

Sharing information becomes even more conspicuous in the event that the medical adviser submits a request for a suicide risk assessment. In addition to and despite any pre-existing suicidal factors, suicidal behaviour could also be prompted by the threat of repatriation subsequent to a denied asylum request:

> People are often very desperate. Suicidal thoughts and acts are often permanent. That creates a dilemma: how should I assess that? I tell you, it's very complicated when people say: 'I'll kill my child and myself if they sent me back to …'. That assessment is very complicated. Even though I'm trained in the prevention of suicide, which risk can you take and how do you deal with that? It's a very complicated assessment (R5).

Professionals understand that, in such a situation, it is of paramount importance to accurately formulate and precisely document all arguments. In doing so, the medical adviser will have sufficient information upon which to make an assessment. Suicide attempts can then be reviewed in the documentation of the patient's history:

> I do notice that in almost all cases in which I reported that my patient will be too vulnerable to survive in his own country, that was helpful for his case but if I can't come to a conclusion and say with confidence that this is the case, I won't do it (F4).

Conversely, and substantiated by advice received from health care professionals, medical advisers are accountable in the event of an inaccurate assessment of a suicide risk by asylum seekers processed for repatriation. Decisions, and the repercussions thereof, made on the basis of this advice are crucial to all—the mental health care professional, the medical adviser and the asylum seeker.

Advocacy: Mental health professionals may consider taking a stance for asylum seekers as a collective and raising public awareness in an effort to improve the asylum situation and mental health for all. Mental health professionals are divided on the issue of whether to advocate for rights and more comprehensive policies for asylum seekers. For them, it is unclear whether

advocating better policies fall under the auspices of health care professionals and, if so, which disciplines, specifically, would be responsible.

The participants advocating for improved rights felt obliged to communicate the personal stories of asylum seekers to a broader public:

> This topic is very undefined. The question is what therapists can and should do. I personally think that therapists do have a role in advocacy because they talk to the asylum seekers most. Managers don't have that kind of contact. But, this creates tension. I think that justice as a value is very important for most therapists but they don't know how this is achieved. I called the reception centre once to complain about the lack of facilities where my patients could relax. I sent a letter to ask for a better room. This was controversial. I think that we, as professionals, lack the competence to advocate but I do think it's necessary. A lot of other patients are organized and have collective advocators, but asylum seekers represent different disorders and are not well organized. Organizations like the Refugee Council or a special group within mental health care should do more and advocate not only for the right to health but for better circumstances in general (R6).

Some professionals are aware of organizations in the Netherlands where the advocacy for the rights of asylum seekers is contained in their mission statement. Such organizations include the Refugee Council, the Johannes Wier Foundation and the institute for Human Rights and Medical Assessment (iMMO). Advocacy, in itself, does not preclude ethical dilemmas for caregivers; however, a lack of support or no commitment on behalf of management may lead to a conflict of interest. Justice for patients may conflict with loyalty towards the mental health organization.

Thinking about advocacy also affects mental health professionals on a personal level. Some of them mentioned the process of losing their naive idealistic view of Dutch society as multicultural:

> I'm not politically active. When I talk to colleagues who do the same kind of job, you get straight. This is what you can expect when you do this kind of work. You have to accept the facts. A majority of the Dutch population voted for this immigration policy. Deal with it. But things have become less open. At birthday parties I don't tell them I'm working with asylum seekers because they might not feel the same idealism as I do (R2).

In summary, the discursive reasoning of mental health professionals on ethical dilemmas in 2015 shows that asylum seekers are perceived as a vulnerable group because they live with existential uncertainties under challenging conditions. Mental health professionals have trepidations about their role, especially being drawn into the quagmire of the judicial procedure. This concern leads to a crossroad in terms of providing information about the medical condition of their patients and their role as an advocate.

Discussion

What are the various focal points in ethical dilemmas of mental health professionals from 1995 and 2015, and what are the differences and similarities?

An Interpretation of the 1998 Document and the 2015 Data

The mental health professionals cited in the 1998 publication were concerned with the impact of mental health care on the cultural identity and beliefs of asylum seekers. Requesting asylum in a European country and looking for a toehold in their struggle to continue their lives, they came across mental health professionals who could give them the idea that they were not merely survivors of political hardship, but had psychological problems in reprocessing their experiences. From a discursive viewpoint, mental health professionals in 1995 assumed that a medical–psychotherapeutic framework was new to most asylum seekers. Moreover, this train of thought might have diminished a reliance upon their own cultural reservoir in dealing with a tumultuous past.

A second discursive element can be found in the assumption that asylum seekers 'missed' the modernist agenda of the 'West' in the changing thoughts about hierarchical status of mental health professionals. We mentioned the original quotes about West, South and East in the text because it underlines assumptions about the cultural differences of asylum seekers and mental health workers. These cultural differences came to the fore in the concept of informed consent and autonomy. The European Consultation on Ethical Standards in Mental Health Care for Asylum Seekers stated that there should be an increased awareness of these issues. Cultural sensitivity and the awareness of cultural differences between the country of origin and country of settlement should be taken into consideration for the treatment of refugees and displaced persons.

In short, the main ethical dilemma is the result of forcing asylum seekers to fit into a socio-political system in which they lose, from a psychological perspective, their own sources for resilience. In line with the discursive elements of the 'othering' of asylum seekers, mental health professionals in 1995 stress the importance of intercultural training.

In 2015, this cultural concern was not present, but the mental health professionals interviewed are concerned about the impact of the social and political conditions on the lives of asylum seekers. Asylum seekers are perceived as a group that may be negatively impacted by living in a host country in which they face uncertainties and poor social conditions. The impact of the length of stay and relocations in reception centres on mental health symptoms of asylum seekers is substantiated by scientific research (Hallas *et al.* 2007; Goosen *et al.* 2014).

Here, we see a discursive element of framing asylum seekers as a group in which medical and judicial paradigms are intertwined. This leads to questions about the intentions of asylum seekers when seeking mental health care. Is it possible that, besides or even instead of looking for a cure, asylum seekers register with mental health services because their lawyer may be able to use

medical information as extra munition in the asylum request process? Mental health professionals position the help-seeking behaviour of their patients within these social and legal conditions.

In line with the discursive view of asylum seekers as patients in which medical and judicial elements become a hybrid mix, solutions can be sought in disentangling the medical and judicial framework. It may be helpful for professionals to emphasize that they function solely in a medical capacity and are not responsible for decisions made by the Immigration and Naturalization Office based on medical information they provide. As a way forward, more opportunities for reflection on ethical dilemmas are required in an effort to establish and incorporate applicable ethical deliberations.

An Explanation for the Shift in Focus from Cultural to Social and Judicial Aspects

In 1995, the social political context in which mental health care for asylum seekers took place played a role in a preference for a psycho-social, multidisciplinary approach (van Willigen 1998: 108), but judicial aspects were not explicitly mentioned in the contributions of the experts as creating ethical dilemmas. They framed their concerns as medicalization and fear of Western imperialism.

In the 2015 data, compared to the 1998 document, little or no attention is paid to cultural aspects in mental health care for asylum seekers. Treatment of mental health symptoms is less perceived as a cultural dilemma, and treatment itself is self-evident. However, social living conditions are emphasized as part of ethical dilemmas, as well as legal problems. The role of medical information in the asylum request process has increased.

From a human rights perspective, we should mention that equality is a fundamental value, meaning every individual should be respected as agent in a moral, legal and socio-political way (Forst 2011). This equality includes the idea that human beings should be capable of living their lives with dignity (Nussbaum 2006). However, both the 2015 data and the 1998 document run the risk of 'othering' asylum seekers, which strains the value of equality. The 1998 document places asylum seekers in the position of *cultural strangers*, which required—by that time quite positively formulated—cultural training of professionals. The 2015 data shows how asylum seekers are 'othered' judiciously and politically. Within society as a whole, they are sometimes seen as *enemies* that threaten our social and political order and/or steal the resources of the inhabitants. The participating health care professionals often saw asylum seekers as *victims* of these pressing political and judicious conditions. In our view, a human rights perspective requires initially that we do not 'other' asylum seekers or view them as either cultural strangers, enemies or victims, but that we treat them as human beings like ourselves and that we look for commonalities.

In the past 20 years, there have been major fluctuations in the nationalities of asylum seekers, the duration of the asylum procedure, the facilities

provided by the reception centres and the overall political climate. The populist and political discussions in Europe were and are as yet lively.

The political debate in 2015 was more polarized, ranging from people and political parties that want no asylum seekers at all or limit their number to the bare minimum and others who claim it is the obligation of a nation to offer asylum seekers a safe haven.

Political factors and the question of advocacy have become more apparent as doctors or psychologists might be asked by the medical advisers of the immigration authorities to report medical information. Many professionals feel extremely uncomfortable in answering these kind of questions because they feel they have the power to influence the course of the asylum claim of their patient. From the perspective of the mental health professional, providing information to the medical advisers appears brittle and strife-ridden in light of the seemingly strident asylum policies in the Netherlands.

Hesitation about Advocacy

Mental health professionals may have become even more cautious in advocating for the rights and wellbeing of asylum seekers. The controversy among mental health professionals is whether to advocate for the interests of individual patients or asylum seekers as a group. These issues may also be of a non-medical nature. The controversy exists due to these two factors. Despite some organizations having made advocacy their core business and the inherency of advocacy in the responsibilities of mental health professionals, some professionals feel, as yet, unqualified to act in this capacity. Advocacy is hardly addressed or not at all in the professional training of psychologists and psychiatrists.

Under a Magnifying Glass

As a result of the intertwining medical/judicial paradigm, mental health professionals may get the impression that their work and especially reporting the medical condition of their patient to medical advisers of the Immigration and Naturalisation Office are subject to close scrutiny. Respondents often are dismayed at the amount of time required to answer questions by the medical adviser. This is due, in part, to the ethical dilemma of helping their patient and preventing harm by providing incomplete information. Also, the professional may be criticized for partiality, unprofessionalism and the crossing of professional boundaries.

Conclusion

A discursive analysis of the ethical dilemmas of mental health professionals concerned with the care for asylum seekers gathered during a European expert meeting in 1995 and an empirical study in 2015 shows that there is a shift from cultural factors to a broader focus on social, political and legal factors. Mental health professionals often perceive a conflict of values.

Therefore, guidelines have been developed, providing a framework for reflecting on the inherent ethical dilemmas individual care-givers must weigh (Kramer *et al*. 2015). Remaining aligned with professional standards regarding diagnoses and treatment helps, but does not preclude mental health professionals having sleepless nights when they feel they cannot honour different values simultaneously. Mental health professionals should think twice before they decide that asylum seekers are different and/or need to be treated differently. Meanwhile, efforts should be made by mental health care professionals, policy makers and others involved in the care for asylum seekers to be respectful and provide adequate and appropriate care.

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