Narratives of Violence in addressing Human Rights Violations

A Plea for an Ethics of Translation in Refugee Mental Health

David Keller

Introduction

In the context of refugee mental health, personal narratives of violence play an essential role in the clinical and therapeutic encounter. They underpin, accompany, and shape the assessment, counseling, and treatment process and take on individual forms. At the same time, the narratives unfolding are often interwoven with accounts of psychological distress, symptoms, and complaints, thereby leading to narratives where the personal experience of illness is closely associated with violence. The coming into being of these narratives rests on a complex set of preconditions and prerequisites, comprising aspects of the setting, social and personal variables, and the interactions between them.

At first, serving as a brief introduction to the field of refugee mental health, the article provides an overview of the potential effects of forced displacement, trauma exposition, and migratory stressors on the psychological situation of asylum applicants. Secondly, it approaches narratives on illness and violence, and their specific coming into being in medical/therapeutic settings. By tracing and describing these different forms of narratives, the article draws attention to the practices of translation that shape their coming into being and materialization. In its concluding section, the article argues that the practices of translation in place that shape the personal narratives of violence and illness, respectively, have profound ethical implications due to the deeply personal meaning attached to them and the vulnerable positioning of its narrators, i.e., refugees seeking protection. Based on these observations, the article argues for an 'ethics of translation' regarding personal narratives of illness and violence and their specific function in addressing human rights violations.

Forced Displacement, Flight, and Mental Health Needs

According to the United Nations High Commissioner for Refugees, the number of people on the flight due to armed conflict, war, humanitarian crises, and human rights violations is on the rise. In its global trends report from June 2023, the UNHCR (2023) estimated that as of the end of 2022, 108.4 million people worldwide faced forced displacement. This number includes different categories: refugees, asylum seekers, internally displaced people, and other populations needing international protection as defined by the UNHCR.[1] From 2021 to the end of 2022, the global number of refugees increased from 27.1 million to 35.3 million, the most significant yearly rise ever documented by the UNHCR.

Generally, forced migration confronts affected individuals and groups with extensive adjustment and coping demands. As studies have shown, forced migration can have substantial effects on a person's mental health situation.[2] Research findings indicate that up to 35 percent

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[1] According to the UNHCR, a "refugee" is a person who has fled their own country because they are at risk of serious human rights violations and persecution and, therefore, have a right to international protection. The term "asylum seeker" refers to a person seeking protection in a third country who has not yet been legally recognized as a refugee. In that regard, the person has to apply and go through the legal process to become an asylee in the country selected (UNHCR 2023).

[2] For a historical overview of the research on refugee mental health, see Silove, Ventevogel, & Rees (2017). The authors point out that the inclusion of "Posttraumatic Stress Disorder" in the third edition of the *Diagnostic and Statistical*

of refugees seeking asylum have experienced severe forms of violence, including torture.[3] Having been exposed to multiple forms of violence is a well-established risk factor for a person's overall health and mental well-being. Besides potential physical damages and consequences for one's bodily health, the experience of severe forms of violence renders an individual more vulnerable to developing post-traumatic stress, anxiety disorders, pain-related disorders, or depression. Thus, as a pretty robust result, a higher prevalence of post-traumatic stress disorder has been documented for refugee populations (WHO 2018, 5; Bryant, Nickerson, Morina, & Liddell 2023).

Furthermore, applying for asylum comes with substantial stressors and challenges: First and foremost, the asylum application interview is demanding, as applicants must provide verbal accounts of their personal reasons for flight. From the authorities' perspective, the personal reasons for seeking refuge should be provided coherently, chronologically, and in detail.[4] As an additional stressor, it usually takes quite a

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Manual of Mental Disorders of the American Psychiatric Association set the base for new research, leading to an upsurge in epidemiological studies in the following decades. The authors define the period between the 1970s and 2000 as the "formative period of the refugee mental health field." (ibid.: 131).

[3] In fact, the reported prevalence of torture exposure among refugees varies, as a systematic assessment proves to be complicated (Campbell 2007; Abu Suhaiban, Grasser, & Javanbakht 2019). The *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity." See UN (1984): Article 1.

[4] This is particularly challenging for applicants with symptoms of post traumatic stress or other mental health conditions. As Herlihy and Turner (2018: 311) point out, "Interviewers and decision-makers base their decisions largely on this account and their appraisal of its credibility."

while to receive an official response to one's application, often leading to an extended period of existential insecurity and worrying about one's future. Furthermore, the ecosocial environment of the host country is not necessarily welcoming. Housing conditions are often burdensome, as temporary shelters might be far away from the city center, are crowded, noisy, or lack privacy. Above all, experiences of discrimination and racism, together with restricted access to financial resources or social benefits, might also take their toll on an asylum applicant's overall health.

Consequently, research conveys an association between traumatic events before migration, post-migratory stressors, and the mental health situation of refugees (e.g., Carlsson & Sonne 2018). Studies have even pointed out that the effect of trauma experienced in one's country of origin is lower on refugee mental health than stressful post-migratory factors (e.g., Li, Liddell, & Nickerson 2016: 82). Thus, besides traumatic events, post-migration stressors account for a substantial amount of psychological distress (e.g., Schick 2019). From a public health perspective, this gives rise to numerous opportunities for intervention but also speaks to the responsibility of the host country to improve the psychological situation of those seeking protection.

Given this situation, there is a need for facilities that provide refugee populations with medical as well as psychological support, including psychotherapeutic treatment. Depending on the host country's health care system and the bureaucratic and legal regulations in place, different structures might be accessible. To take Germany as an example, public health care facilities like hospitals, outpatient clinics, and doctor's offices are also open to asylum seekers.[5] However, this type of

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[5] In Germany, the Asylum Seekers Benefits Act ("Asylbewerberleistungsgeset"") regulates access to health care and the benefits available. § 4 AsylbLG limits medical benefits to acute illness and painful conditions. In chronic illness and disability, treatment benefits may be granted on a case-by-case, discretionary basis (see § 6 AsylbLG). After a waiting period of 36 months, asylum seekers who fall under Section 2 of the Asylum Seekers' Benefits Act are granted access to the same medical benefits as persons with statutory health insurance in Germany.

'standard care' often lacks easy access to language mediation services and support from social workers who can help navigate the complex bureaucratic conditions refugees face in their everyday lives. Furthermore, specialized transcultural and clinical competencies might still be limited when working with service users beyond the 'Global North.' Under these circumstances, psychosocial centers for refugees occupy an important yet unique position within Germany's healthcare landscape. The Association of Psychosocial Centers for Refugees and Victims of Torture (BAfF e.V.) follows a human rights perspective in Germany. It serves as the umbrella organization of currently 48 psychosocial centers across the country, offering support and mental health treatment due to traumatic experiences.[6] As non-governmental organizations that operate primarily with temporary project funds, these centers commit to a holistic approach by offering medical, psychological, and psychosocial help. The centers regularly work with on-site interpreters to bridge language and communication barriers, translating between the health care staff (usually psychologists, social workers, and psychiatrists) and clients/patients. In this vein, the availability of professionally trained translators and cultural mediators is a fundamental prerequisite to making counseling and treatment accessible.

Approaching Narratives in the Realm of Illness and Violence

As scholars in the field of medical humanities have pointed out, the world of medicine, psychotherapy, and counseling is a world of narratives. Generally speaking, all medical, therapeutic, and counseling actors engage to some degree in the production and circulation of narratives. However, it is particularly the patient or client who is "the actual narrator in the treatment room" (Boothe 2009, 55).[7]

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[6] In 2022, the psychosocial centers united in the BAfF supported 25.861 clients. See BAfF (2024): 10.

[7] Translated by the author.

When patients deliver an autobiographical account of their personal illness experience, whether it is oral or written in nature, they produce a genre of "illness narratives" (Hydén (2005/2010, 345). Although very personal and highly individual, these "illness narratives" regularly employ specific structures, stylistic features, and literary tropes. As the psychiatrist and social anthropologist Arthur Kleinman has shown, how patients and clients talk about their health complaints also refers to their respective cultural contexts. These contexts entail local systems of knowledge that shape the perception of symptoms and their attributed meaning. At the same time, the cultural contexts also provide specific illness idioms, thereby influencing the experience of distress (Kleinman 1988/2020, 43f.). Adding to the complex interactions regarding narrative and narrative making, narrative forms in circulation impact the experience of illnesses subjectively and collectively. At the same time, illness influences the narrative form chosen to convey one's perceptions and impressions (Kreitler, Boide, Brendel, & Hommes 2021).

Whether in the doctor's or therapist's office, the emergency room, or at the sickbed — personal "illness narratives" come into being at the very moment when the suffering individual meets the health care professional and begins to tell their story. As Clark and Mishler (1992) emphasize, the stories unfolding are essentially social accomplishments. They depend on complex interactions between the medical professional and the patient/client: "What is included in the story and the way in which it is expressed results from contingencies of that interaction and, in turn, shapes that interaction." The story, thus, "emerges in the context of requests, acknowledgements, expansions, and elaborations. It represents the joint effort of the patient and physician to make coherent sense of a problem within a jointly constructed context of actions and results" (ibid., 367).[8] Also, the emerging narrative is not static or fixed. On the contrary, it might change in relation to treatment response, the course of illness, and other factors (Hydén & Mishler 1999). These observations apply to different medical contexts where encounters between doctors and

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[8] Consequently, speaking of the "patient's story" is misleading to Clark and Mishler, as it masks the collaborative construction at work.

patients take place. In a broader sense, they also pertain to psychotherapy and psychological counseling, as these operate with a comparable logic.[9]

Regarding personal narratives, mental health clinics as well as psychosocial support centers catering to refugees, occupy a similar, yet also particular, space. As a substantial number of refugees with mental distress have been exposed to violence, often in its most severe forms, the emerging "illness narratives" during the encounter often refer to personal experiences of trauma. In that vein, personal narratives of trauma might unfold when asked about the onset and course of symptoms of mental distress, such as insomnia, anxiety, or mood swings. Alternatively, they come into being regarding aspects of bodily health — including functional impairments that make everyday life difficult, sensations of chronic pain, and visible scars, among others. They might come up spontaneously or only after asking rather explicitly about the exposition to events which might render an individual more susceptible to develop the clinical condition of Post Traumatic Stress Disorder.[10] According to the diagnostic categories that are currently in use, a "traumatic event" confronts the individual with "actual or threatened death, serious injury, or sexual violence."[11] The situation or event is "extremely threatening or horrific", including man-made events such as combat, terrorism, and torture, as well as "witnessing the threatened or actual injury or death of others" in a violent manner.[12] In that sense, personal narratives of vi-

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[9] For critical perspectives in this regard, see Strong (2017) as well as Olney (2015).

[10] There are instruments available that explicitly probe for 'traumatic events.' See, for example, *The Life Events Checklist* for DSM-5 (Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane 2013), a self-report measure that assesses the exposure to sixteen incidents that might potentially result in Post Traumatic Stress Disorder.

[11] See APA (2013: 271). Further criteria must be met in order to receive the diagnosis of Post Traumatic Stress Disorder.

[12] In the 11th edition of their *International Classification of Disease*, the World Health Organization defines traumatic events as "Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or hor-

olence might take shape in different situations of the encounter between the clinician and the patient/client and at different stages of the psychotherapeutic treatment or counseling process. The narratives can be very explicit and full of details or, quite the contrary, remain rather general by only referring to something that has happened without going into detail and depth.

From a psychological point of view, speaking about personal experiences of trauma and violence can be quite challenging: The narrator faces the task of recapitulating what they have experienced from their very own perspective, thereby moving from the present to situations of the past that have left a significant mark. In such a situation, the teller might occupy or shift between different positions (e.g., protagonist, witness, victim, survivor). Regarding the nature of the traumatic event, talking about the violence experienced can also reactivate complicated and intense feelings, such as fear, sadness, anger, guilt or shame. Thereby, the experience of torture has particularly profound effects on the individual, as through causing pain and humiliation, the victim's "dehumanization" takes place.[13] In his phenomenological analysis, the anthropologist David Le Breton (2007) points out that torture intends to destroy the whole person, including the feeling of self and identity, as the victim's survival depends totally on the perpetrator's mercy. Besides potential

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rific nature. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g., a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner; and learning about the sudden, unexpected or violent death of a loved one." Other core elements need to be present to qualify for a diagnosis of Post Traumatic Stress Disorder, lasting at least several weeks. These include re-experiencing the traumatic event in the present, deliberate avoidance of reminders, and persistent perceptions of heightened current threat, all leading to a significant impairment. See WHO (2019/2021).

[13] See Jović (2021: 354). Jović also points out that among groups of refugees, survivors of torture face the highest risk of developing psychological disorders. See ibid., p. 352.

bodily injuries, torture survivors might thus suffer from a divided self in permanent pain, feeling broken, without confidence and belief.[14] Basic assumptions about the predictability and comprehensibility of other human beings, one's life, and the future might become shattered, leading to mistrust, alienation, and withdrawal (Pérez-Sales 2020, 447f.). In addition to the psychological challenges of addressing these experiences, it is also often difficult to capture the lived experience by means of language. As the philosopher Donatella di Cesare (2018, 68) describes, there is an "unbridgeable gap" between language and the physical sensations caused by torture. Thus, while torture claims that it forces its victim to speak, it, in fact, silences them. For Di Cesare, talking about the personal experiences is, therefore, a powerful, yet often painful way to liberation: "It is the verbalization of the suffering that undoes the tormentor's power. Even if it makes the memory more acute again, only speech can free the survivor from the cell injected into her by torture, opening the way for escape to beyond."[15] In summary, the experience of torture defies simple representation, as the possibilities of linguistic rendering remain incomplete. At the same time, there seem to be no other possibilities than to approach the reality of torture via its representation in narratives and images (cf. Mühlleitner 2013, 15).

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[14] Regarding the physical impact of torture, see Quiroga and Modvig (2020). The authors differentiate between beatings, positional torture, electric torture, asphyxiation, stabs, cuts, bites, amputations, burns and corrosion, infectious and infesting agents, forced ingestion, infusion or injection, sexual and gender-based torture, deprivation, humiliation, threats, and torture, death, and the punishment of detainees.

[15] See ibid., p. 103. In this sense, some psychotherapeutic approaches aim to transform the personal experience of severe violence into an organized narrative within one's life trajectory. See, for example, "Narrative Exposure Therapy" (Schauer, Neuner, & Elbert 2011), which intents to create a coherent personal story using a lifeline, which is then handed over to the patient in written form.

Narratives about illness and violence

What follows from these observations is that the narratives arising in the settings described above are not simply there. Instead, their emergence and unfolding are based on an interplay of various conditions and factors which might facilitate, impede, or at least influence their coming into being. In direct relation to the accounts of patients and clients, medical and psychotherapeutic settings are also crucial sites where "narratives about illness" gain shape. According to Hydén (2005/2010), these "narratives about illness" comprise different literary products, ranging from medical reports and discharge letters to diagnostic sheets. As they serve specific purposes within the medical and therapeutic sphere, e.g., to organize a follow-up treatment, make a referral to a specialist, and so on, these "narratives about illness" also follow their respective logic, epistemic reasoning, and stylistic elements, including formal requirements established by the professional medical and therapeutic communities. When it comes to diagnostic and treatment reports, for example, the gaze of the medical professional is trained to identify a "disease entity," thereby translating the subjective illness experience of the narrator into a diagnostic category (Kleinman 1988/2020).

Given these different kinds of "narratives about illness," the question arises how the personal and lived experience of the narrator finds representation in these documents. The field of refugee mental health occupies a particular position in this regard, as significant health conditions and personal exposure to violence might also have wide-reaching legal implications when it comes to applying for asylum. In these cases, health professionals can take on entirely different roles: As "professional witnesses" (Herlihy & Turner 2018, 309), they might provide clinical information in a written report comprising symptoms, a diagnosis based on the assessment conducted, a treatment plan, and further recommendations. In other cases, medical practitioners and psychotherapists might act as "independent expert witnesses" (ibid.) without being the treatment provider. This particular role, in most cases commissioned by the courts, comes with additional requirements, like a primary duty to the court.

A vivid example of the intersection between human rights discourse, the legal sphere, and the health care system is Directive 2013/32/EU of the European Union (EU 2013). This Directive recognizes the vulnerability of particular groups of asylum applicants like those with "disability, serious illness, mental disorders or as a consequence of torture, rape or other serious forms of psychological, physical or sexual violence."[16] Member States shall, therefore, assess whether the applicant has special reception needs and specify their nature. Concerning survivors of torture and violence, the members of the European Union "shall ensure that persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment for the damage caused by such acts, in particular access to appropriate medical and psychological treatment or care" (ibid.). On a practical level, the Directive speaks to the necessity of identifying vulnerable individuals among asylum applicants.[17] In the case of mental disorders, physical complaints, or the possible health consequences of torture, this is a task that requires appropriate professional skills from the relevant healthcare professionals.

Furthermore, medical and psychotherapeutic reports might also be requested by patients/clients or lawyers as part of their appeal of a refusal to grant protection. In these documents, the personal narratives of the client/patient play a central role. They give the clinician an impression of how the exposure to violence has affected the narrator's life trajectory, the meaning and significance they attribute to the experience, and to what extent the events have affected the narrator's health. The role of the personal narrative of violence is particularly evident when it comes to the investigation and documentation of torture and other

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[16] See EU (2013), Article 21. The article also includes minors, people with disabilities, the elderly, pregnant women, single parents with minor children, and victims of human trafficking. For a critical analysis of the mobilization of 'vulnerability' in the context of migration policies, see Leboeuf (2022).

[17] In the state of Berlin, Germany, a network of different non-governmental organizations has been established, funded by the Berlin Senate, to support people with special reception needs according to the Reception Directive of the European Union.

forms of severe violence. In this regard, a crucial document and reference work is the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, also called "the Istanbul Protocol." The protocol grew out of an international symposium by the Turkish Medical Association in 1996 on "Medicine and Human Rights" (Furtmayr & Frewer 2010). The first version of the Manual was published in 1999 by a committee of international experts, involving medical professionals, lawyers, psychologists, and human rights monitors (Iacopino et. al. 1999). In the same year, it was also endorsed by the Office of the Human Rights Commissioner of the United Nations (Koseoglu 2022, 89). The latest version, which is also a revised and expanded one, was published in 2022 (OHCHR 2022).

Depending on the context, the protocol can serve different purposes. An important one is the documentation of torture and other forms of inhuman treatment in asylum proceedings. The protocol provides a thorough overview of how to collect psychological as well as physical evidence of alleged torture. While practical guidelines for conducting the investigation form the protocol's core, it also places these guidelines in their broader context by referring to legal norms and standards, procedures of the legal investigation of torture and ill-treatment, and relevant ethical codes.[18] Concerning the actual assessment, the protocol advocates for a dynamic and flexible approach, thereby rejecting a fixed structure. What lies at its heart is the interview, to be conducted with the alleged torture victim in a location "as safe, private and comfortable as possible" (OHCHR 2022, 69). During the interview, the protocol advices asking non-leading questions that allow a "narrative answer" (ibid., 55), starting from the broad scene of the proclaimed incident(s) and then going on to a quite specific account. Conclusively, the clinician should try to obtain "as much detail as possible that is relevant to conducting the assessment" (ibid., 80) by asking questions that allow the person to form a coherent

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[18] This includes relevant ethics of legal professionals, ethical obligations of health professionals, the application of ethical principles in clinical evaluations of torture and ill-treatment, and the case of health professionals with conflicting obligations.

account. In that vein, the protocol points out that "extensive and detailed narratives can provide more information from which to asses the correlation between the allegations and the findings; they frequently provide a sense of 'being there', which adjudicators often consider useful." (ibid.). At the same time, the protocol advises clinicians to apply appropriate interviewing skills to reduce the burden of the assessment and use their clinical competencies to respond to signs of distress in the interviewee before, during, or after the assessment. As the whole process can cause substantial psychological stress to the narrator, the clinician has to strike a delicate balance. To minimize the potential risk of retraumatization, individuals should retain control over their disclosures, particularly "as regards when, how much detail and to whom." (ibid., 70).

Besides the narrative history of the events, the collection of medico-legal evidence of potential torture and maltreatment also requires a medical and psychological examination and the collection of physical evidence from the alleged victim or other persons involved. Finally, the clinician prepares a written report based on all the information and materials collected.[19] When preparing the written report, the personal account is usually being converted to a third-person narrative using conjunctive voice. Regarding the allegations of torture, the report contains a summary of the violence and its circumstances, a chronology of the places of detention and their condition, a narrative account of the ill-treatment in its respective places, and a review of the torture methods employed. Subsequently, the health care professional describes physical symptoms and disabilities and reports the result of the physical examination. In a further step, the report contains a chapter on the interviewee's psychosocial history, including current and past psychological symptoms, a mental status examination, the assessment of social functioning, and, if possible, psychological testing. The report can also contain photographs, body diagrams, diagnostic test results, and consultations.

To arrive at an interpretation of the findings, it is the task of the clinician to conduct correlations regarding the degree of consistency be-

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[19] For a typical outline, see ibid., p. 211f.

tween the allegations of violent maltreatment and the history of physical symptoms (as well as disabilities) and the physical examination findings. This step also includes a correlation of the consistency between the findings with knowledge of torture methods and their potential after-effects. Concerning the psychological evidence, the report also makes claims about the degree of consistency between the psychological findings and the report of alleged torture, among other steps (ibid., 211–212). In the conclusion and recommendations chapter, the clinical expert finally provides a statement on the consistency between all sources of evidence gathered, reiterates the symptoms and disabilities present as a result of the alleged ill-treatment and provides further recommendations.

As this brief overview shows, the process of documentation involves multiple steps, leading to the composition of a complex medico-legal narrative about trauma, violence, and illness. The individual's personal illness and violence narrative plays a prominent role in the developing process. Alongside other evidence, it is often the cornerstone and a central reference point of the coming-into-being of the medico-legal narrative. However, the patient's voice telling about their life, biography, and traumatic history undergoes significant translations during this process.

Towards an Ethics of Translation: Some Preliminary Considerations

As has been shown, personal narratives of illness and violence are quite presuppositional, depending on a whole web of personal, social, and institutional preconditions. To add to the complexity, they also rest upon intricate translation practices. As these practices of translation condition different effects and consequences, and as the actors involved inhabit different positions in terms of power, resources, and agency, they open room for important ethical discussions and reflections.[20] While a thorough analysis of the premises of an ethics of translation is beyond this article, the following observations emphasize the particular importance of reflecting on translation in the context of refugee mental health — especially when this results in the production of written documents to address human rights violations.

Following a broad understanding of translation, a closer look reveals that all actors involved are confronted with different demands to engage in translation practices. On a fundamental level, this is also true for the patient/client: Phenomenologically, the experience of severe violence often comes with a feeling of "Unverfügbarkeit," a sense that there is a gap between one's modalities of expression and the lived experience. The narrator has to find ways to symbolize their personal experiences using words, images, or other means to address them, which is often quite challenging and might feel insufficient. However, the processes of translation in place go beyond the individual's symbolization of personal experiences. Particularly in trans- and intercultural healthcare settings, additional translation tasks are at work, necessitating reflexivity and sensitivity. In these encounters, the client/patient often faces the demand of acting as a translator of their own self and experience. Concerning migration, cultural theorist Doris Bachmann-Medick draws attention to a double dynamic at work. For those affected, this double dynamic often has problematic effects in terms of their subjectivity and agency: "migrants act as definers, but at the same time also belong to the defined, in continually being translated and having to struggle with hegemonic discourses and exclusion" (Bachmann-Medick 2018, 277). Being defined and translated can precipitate far-reaching effects

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[20] The interdisciplinary field of Translation Studies offers promising ideas here. For a general introduction to the ethics of translation, see e.g., Koskinen & Pokorn (2021). For a systematic approach, see Chesterman (2001), who provides an overview of four different models that center on ethical stances toward translation. For example, the literary translator Silvia Kadiu (2019) argues that reflexivity as an ethical practice means making the transformative dimension of translation visible.

in the consulting and treatment room, as medical and psychotherapeutic settings come with clearly defined roles, expectations, and power differentials. This is particularly true in transcultural healthcare. Above all, refugees and asylum seekers often inhabit precarious positions as regards their legal, social, and health status, rendering them highly vulnerable.[21]

The necessity for translation is quite apparent in the case of language barriers. However, when working with language mediation, it is not only about the words being translated. On closer inspection, the obvious duty of the translator proves to be multi-layered, complex, and subtle. Reflecting on this task thus opens up ethical challenges when working with mediation in transcultural healthcare settings.[22] In addition to the efforts of linguistic interpreting, the numerous tasks of "cultural clarification, cultural contextualization, and facilitation of the relationship or connection between the patient and the provider/mental health care system" (Qureshi, Ananyeva, & Collazos 2021, 327) become evident. Being 'the third person' in the treatment and counseling room, language and cultural mediators inhabit a crucial position in negotiating meaning and interpretation (ibid.). This assignment comes with manifold ethical questions, as the discussions and publications on healthcare interpreting ethics testify.[23]

A broad conceptualization of translation underscores that the clinician, being responsible for the overall process of diagnosis and treatment, and being particularly powerful due to the assigned professional status, engages in translatory practices as well: This becomes evident in the construction steps leading to narratives about illness and violence, which build upon the patient's/client's personal narrativization. These narratives operate on the premises of a medico-legal logic, thereby translating the patient's/client's account into the discourse of specific

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21 This also means that mental health care providers often face ethical dilemmas and challenges when working with asylum applicants and refugees. See e.g. Kramer, Olsman, Hoogsteder, & van Willigen (2018); Ekblad (2020).

22 For a general overview of ethics relating to translators, see Pym (2021).

23 For a critical review of healthcare interpreting ethics, see Dean (2021).

disease entities such as Complex Post Traumatic Stress Disorder.[24] Thus, when it comes to the patient's/client's voice, there is the risk of epistemic injustice due to dominant biomedical modes of approaching illnesses in the Global North and making sense of them (cf. Montalt 2021).[25] A clinician's ignorance can thus lead to a whole array of negative consequences, including misunderstandings, pathologizations, and discriminations. In accordance with this, Qureshi, Ananyeva and Collazos (2021, 326) point to the observation that intercultural miscommunication is one of the most frequent reasons of medical malpractice. This scenario ultimately requires communication modes tailored to the individual needs and prerequisites of the client/patient. Concerning the health care professional, this also means exercising particular care in educating the client/patient and ensuring they can make informed decisions based on the information provided. In the case of written reports and medical documents, it is, therefore, of utmost importance to inform about these documents' meaning, relevance, potential, and limitations. The process of back-translation, which plays an essential final step in the preparation and finalization of documents, could also serve as a starting point for a reflexive translation practice, bringing together the clinician, the patient/client, and the translator cum cultural mediator. Within this communicative triad, collaboratively organized translation work can, at best, not only prevent misunderstandings and misjudgments from

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[24] Complex Post Traumatic Stress Disorder has been added to the 11th Edition of the *ICD-11* (WHO 2019/2021), to account for severe cases of psychological distress after repeated, long-lasting or ongoing traumatic events, thereby causing significant dysregulations of emotion, negative beliefs about oneself, and interpersonal difficulties in the surviving individual. For an overview of critical perspectives on the clinical category of trauma, particularly when applied cross-culturally, see Butler & Critelli (2019): 19f.

[25] Carel and Kidd (2014) argue that people who are ill might be more in danger of experiencing testimonial and hermeneutical injusticei n the healthcare landscape. Whereas "testimonial injustice" refers to ascriptions of cognitive, emotional, and behavioral unreliability to patients, thereby othering them, "hermeneutical injustice" considers the difficulties patients might face when they struggle to communicate their experiences.

entering the documentation of human rights violations but also help the patient/client to redevelop a sense of control and agency.[26]

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[26] In a clinical context, retranslations also require particular sensitivity and care, as the recapitulation of experiences of violence can, in turn, cause psychological stress — especially in the case of Post Traumatic Stress Disorder.

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