

THE POISON DICTATES THE ANTIDOTE:

An Evaluation of a Rehabilitation Service for Torture Survivors Seeking International Protection in Ireland

Volume 2 of 2

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List of Tables and Figures

Figure 7 <i>Spirasi's 2022-2025 Strategic Goals</i>	9
Figure 8 <i>The Survivors Model for Rehabilitation</i>	21

Contents

LIST OF TABLES AND FIGURES	2
CONTENTS.....	3
CHAPTER 6: IMPLICATIONS AND CONCLUSIONS	4
6.1 Chapter Overview.....	4
6.2 Summary of Key Findings	4
6.3 Results in Context.....	7
6.3.1 Current Conflict Impacting Ireland’s International Protection Process.....	7
6.3.2 The White Paper.....	8
6.3.3 IRCT Global Standards	9
6.3.4 The Istanbul Protocol	9
6.3.5 Spirasi’s 2022-2025 Strategic Plan	10
6.4 Implications for Theory, Practice, and Policy	11
6.4.1 Contributions to Theory	11
6.4.2 Implications for Practice	23
6.4.3 Implications for Policy	33
6.5 Limitations and Future Research	42
6.6 Recommendations	49
6.7 Conclusion	54
REFERENCES.....	57
APPENDICES	103
Appendix A: Common forms of torture according to the Istanbul Protocol (OHCHR, 2004)	103
Appendix B: Participant Information Leaflet (PIL)	105
Appendix C: Spirasi Consent Form	113
Appendix D: Phase Two Consent Form	123
Appendix E: Interpreter Confidentiality Agreement.....	126
Appendix F: Debriefing Form	127
Appendix G: Ethics Approval Letter	129

Chapter 6: Implications and Conclusions

6.1 Chapter Overview

The following chapter endeavours to present a synthesis of the findings from the current research. It does so by firstly summarising the key findings from this research, then presenting the current context in which these findings need to be considered, and then presenting how the findings from the current research have implications for theory, practice, and policy in the field of torture rehabilitation. Finally, I outline some limitations encountered during the course of this research and possible areas for future research, before presenting a list of recommendations for the implementation of the research findings in real world practice.

6.2 Summary of Key Findings

The aim of this thesis is to carry out an evaluation of a holistic approach to treatment of complex trauma to improve the mental health outcomes of asylum seekers and refugees who have experienced torture. The current research sought to address existing gaps in theory and practice, with the overarching goal of making a significant contribution to knowledge, psychological theory, and practice for asylum seekers and refugees by improving the delivery of services for refugees and asylum seekers who have experienced torture. This overarching aim was achieved through three primary research objectives, which, taken together, address a number of current gaps in the extant literature. Research Objective One was to *explore*

whether the International Trauma Questionnaire (ITQ) is a suitable measure for trauma disorders with a population of torture survivors seeking or having sought asylum in Ireland; and, if so, whether there any differences in diagnostic status for PTSD and CPTSD for men vs women and UNCAT vs non-UNCAT status? The research objective was met and the ICD-11 diagnoses of PTSD and CPTSD, as measured by the ITQ, were successfully validated for use with a cross-cultural group of treatment-seeking torture survivors seeking international protection in Ireland. This was the first study to examine the prevalence of PTSD and CPTSD among a treatment-seeking sample of asylum seekers that had experienced torture and these findings were published in the peer-reviewed journal, *Torture* (Hearn et al., 2021). These results suggest that, aligned to the ICD-11, PTSD and CPTSD are highly prevalent within this population group and that the ITQ offers a simple, valid measure with which to assess PTSD and CPTSD among this culturally diverse group.

Research Objective Two was to *establish if engaging with Spirasi's services is associated with changes in mental health >12 months post initial assessment, and if so, whether this change was mediated by (i) higher levels of engagement with Spirasi's holistic rehabilitation service and/or (ii) a perceived sense of control?* Findings demonstrated high levels of mental distress across all mental health indicators, presenting a complex psychopathology within this population. A reduction in all mental health indicators between Time 1 and Time 2 was observed, but this change only reached statistical significance for levels of PTSD and CPTSD. Despite reductions, high rates of PTSD, CPTSD, Anxiety, Depression and Poor Wellbeing were still observed at both time points. Low levels of engagement were observed across all strands of Spirasi's holistic model and level of engagement failed to show any mediating impact on the change in mental health indicator scores between Time 1 and Time 2. Using sense of control as an additional mediating factor,

no impact was recorded for PTSD, CPTSD, Anxiety or Wellbeing. However, a sense of control, specifically relating to level of perceived constraints, was observed as a mediating factor for the reduction in levels of depression between Time 1 and Time 2. Further to this, findings demonstrate that the lack of control perceived by participants was strongly associated with higher levels of distress at Time 2. In addition, higher levels of distress at Time 1 were associated with a poorer sense of control at Time 2. These findings highlight the complex psychological presentation of this population group. Possible reasons for the observed reduction in psychological distress include spontaneous remission, the role of resilience, and the need for long-term rehabilitation interventions for survivors of torture. Further to this, the impact of certain features within Spirasi's initial assessment process were explored as a possible contributing factor to mental health improvement between Time 1 and Time 2, given the known impact of psychoeducation on trauma rehabilitation. Finally, the role of control was also discussed and taken forward to be further explored in Research Objective Three.

Research Objective Three was to establish *whether, and if so, how survivors of torture seeking international protection perceive Spirasi's rehabilitation services as having contributed to their rehabilitation >12-months following initial introduction to the organisation?* Emerging themes were consistent with current and past research relating to torture, trauma treatment, and holistic rehabilitation. These included themes that had also emerged under research objectives one and two, especially with regards to the role of control, sleep, and access to services. These themes were synthesised in order to propose a new model for rehabilitation for survivors of torture seeking international protection: *The Survivors Model for Rehabilitation*. Findings were discussed in terms of how contributing elements within the design of torture (i.e., power, control, and uncertainty), need to be countered and

included in the rehabilitation approach (i.e., empowerment, choice, and certainty). The model, informed by those with lived experience, represents a novel framework for working safely and effectively with similar populations.

6.3 Results in Context

The implication of these findings towards improved policy and practice must, however, be considered in light of the current context at local, national, and international levels.

6.3.1 Current Conflict Impacting Ireland's International Protection Process

The political climate and areas of conflict on an international level has changed and escalated since I began my research. Currently, two main conflicts are impacting Ireland's response to those seeking international protection, with knock-on effect on services catering to people seeking asylum in Ireland. In 2021, the Taliban took over State control of Afghanistan, and in 2022, Russia invaded Ukraine. These events resulted in mass exodus from Afghanistan and Ukraine, forcibly displacing 2.6 million Afghan refugees and 7.8 million Ukrainian refugees to countries across the world (UNHCR Ireland, 2022a). In response to the Afghanistan crisis, Ireland launched the Afghan Admissions Programme. As of October 2022, no single individual had benefited from the programme and applications remain in limbo, despite ongoing threat to safety and life for people trying to flee

Afghanistan.¹ In February 2022, Ireland responded to the Ukrainian crisis by granting temporary residence status to all Ukrainians arriving in Ireland fleeing the conflict. As of the week ending the 6th of November 2022 there have been 62,425 Personal Public Service Numbers (PPSNs) issued to individuals from Ukraine under the Temporary Protection Directive in Ireland.²

6.3.2 The White Paper

In October 2020, the Irish Government pledged to end Direct Provision³ and in February of 2021 a *White Paper to End Direct Provision and to Establish a New International Protection Support Service* (or ‘The White Paper’) was published by the Department of Children, Equality, Disability, Integration and Youth (Irish Government, 2021). Outlined in the White Paper is a plan on how Ireland would move from the Direct Provision system of asylum accommodation to a more appropriate and transparent international protection procedure, where the rights of international protection applicants are safeguarded, and the government is held to a higher standard of accountability. The White Paper states a commitment to a new system focusing on accommodation, health, education, income support and other supports grounded in human rights and that this system would be ‘distinctively different from the system currently in place’ (Irish Government, 2021, p. 28).

¹ <https://www.irishtimes.com/ireland/social-affairs/2022/10/02/afghans-still-waiting-for-decision-on-relatives-year-after-state-pledge/>

² <https://www.cso.ie/en/releasesandpublications/fp/p-aui/arrivalsfromukraineinirelandseries7/>

³ Government of Ireland, ‘Programme for Government - Our Shared Future’ (29 October 2020) 76.

6.3.3 IRCT Global Standards

In 2020 the IRCT released a set of Global Standards (IRCT, 2020b). Seventeen in total, these standards were developed in collaboration with torture rehabilitation centres worldwide and provide standards to which all rehabilitation centres for torture survivors should adhere to for best practice. The standards, in sum, are: 1. Commitment to victims, 2. Independent services, free from external influence, 3. Safety of victims, 4. Support to families, 5. Access to justice, 6. Intake Processes that allow for ease of access, 7. Access to information, 8. Victim feedback, 9. Victims' participation in rehabilitation, 10. Organisational capacity, 11. Staff safety, 12. Care for staff, 13. Share knowledge, 14. Advocate for rehabilitation funding, 15. Apply the following definition of quality of life: *The subjective well-being of individuals and their communities within their specific social and cultural context in relation to factors such as physical and mental health; family, social and community relations; culture; education; employment; economic security; exposure to physical and psychological violence and freedom; good governance and basic human rights; spiritual life; gender equality and non-discrimination; religious beliefs; legal status; and the natural and living environment*, 16. Evaluate improvements in quality of life, and 17. Documenting global impact.

6.3.4 The Istanbul Protocol

Discussed in detail in section 1.3.7, the Istanbul Protocol (IP) released an amended version in 2022. The updates presented in the new edition of the IP were led by four representatives from civil society organisations (Physicians for Human Rights, the International Rehabilitation Council for Torture Victims, the Human Rights Foundation of

Turkey, and REDRESS) and four core United Nations anti-torture bodies (the Committee against Torture, the Subcommittee on Prevention of Torture, Special Rapporteur on Torture, and the United Nations Voluntary Fund for Victims of Torture). This new version considers important factors relating to the psychological consequences of torture.

6.3.5 Spirasi's 2022-2025 Strategic Plan

Spirasi launched their most recent Strategic Plan in 2022. The main components of this plan are outlined in figure 7 *Spirasi's 2022-2025 Strategic Goals*.

FIGURE 7 SPIRASI'S 2022-2025 STRATEGIC GOALS

In brief, the eight strategic goals for the organisation between 2022 to 2025

Strategic Goal One	Expand service provision to increase access and reduce waiting times for survivors of torture across Ireland
Strategic Goal Two	Increase numbers of clients enrolled in accredited education courses
Strategic Goal Three	Develop and implement an outcome measurement tool
Strategic Goal Four	Redesign our process for gathering ongoing client feedback
Strategic Goal Five	Design, develop and implement an adaptable blended learning training piece on trauma informed care for workers and professionals in the health and social care, education and training, and justice and legal sectors.
Strategic Goal Six	Create an advocacy strategy focussed on issues that affect our clients
Strategic Goal Seven	Develop a three-year fundraising plan to diversify our funding sources and increase the capacity of the organisation to meet the current and increased demand for our services
Strategic Goal Eight:	Improve staff engagement and wellbeing within the organisation

6.4 Implications for Theory, Practice, and Policy

6.4.1 Contributions to Theory

The results of the literature review in Chapter 3 evidenced the need for the inclusion of a complex trauma diagnosis for populations that have experienced torture and/or the refugee experience. While trauma theory has been explored over the last century, and the discussion regarding complex trauma has been acknowledged within therapeutic circles since the 1980's and 1990's (Judith Herman, 1992b), clinical recognition of a complex trauma diagnosis, separate to PTSD, has only been acknowledged recently with the publication of the ICD-11 (2018). Many studies suggest that PTSD is the most prevalent mental health illness among asylum seeking and refugee populations, followed by depression and anxiety (Alpak et al., 2015; Crepet et al., 2017; Georgiadou, Morawa, & Erim, 2017). Accordingly, torture research to date has tended to focus on the diagnostic prevalence of PTSD in the aftermath of torture (James Jaranson, 2001; McColl et al., 2010), with little recognition or acknowledgement of the need to study other diagnoses (C. McFarlane & Kaplan, 2012), including CPTSD. J Jaranson and J Quiroga (2011) note that the prevalence of psychiatric disorders in victims of torture is extremely high, and that torture is the strongest indicator for the development of PTSD and depression within refugee populations. The new adaptation of the Istanbul Protocol, launched in 2022, recognises the ICD-11 diagnosis of CPTSD for the first time (OHCHR, 2022). The IP highlights the difficulty some torture victims may have with expressing their experience and symptoms and suggests it is helpful to use a symptom checklist (OHCHR, 2022; Joseph Westermeyer, Hollifield, Spring, Johnson, & Jaranson, 2011). However, it further notes that while several checklists are available for symptom measurement, none are specific for use with this population and should be evaluated for

cultural appropriateness prior to use as “the lack of standardization for the specific group of reference, the lack of cross-cultural validity, and linguistic differences can severely limit the meaningfulness and reliability of the results” (OHCHR, 2022, p. 127). In the last few years, several studies have endeavoured to validate ICD-11’s PTSD and new CPTSD diagnoses with different populations. My research is the first to validate the ICD-11 PTSD and CPTSD, as well as the use of the ITQ as an appropriate measurement tool for these diagnoses, with a cross-cultural population of torture survivors who were actively in the international protection process i.e., asylum seekers (Hearns et al., 2021). These findings also contribute to diagnostic theory relating to trauma and further the validity of ICD-11 PTSD and CPTSD. Additionally, these findings contribute to theory pertaining to the psychological consequences of torture. The validation of the ITQ, as a new measurement tool for the assessment of trauma, in a cross-cultural population of torture survivors seeking international protection has presented considerable opportunities in terms of diagnostic accuracy for survivors of torture and serious harm, in keeping with recommendations as laid out by the Istanbul Protocol (OHCHR, 2004)(OHCHR, 2022). The validation of the ITQ also directly contributes to Goal 3 of Spirasi’s Strategic Plan (2022-2025) (Spirasi, 2022), which outlines the need and intention to ‘*Develop and implement an outcome measurement tool*’, stating that an outcome measurement tool is required for the purpose of ensuring evidence-based services.

Validation of the ITQ within this population not only contributes significantly to addressing the lack of psychological testing available for this vulnerable population, but more importantly, will contribute to greater care, treatment, and support for survivors of torture and has the potential to pave the way for dissemination of the use of a common measure across other torture rehabilitation centres internationally. The IRCT Global Standards Paragraph 13 highlights the importance of disseminating “information about torture and its effects to

professionals in healthcare and other relevant fields who may come into contact with torture victims” (IRCT, 2020b, p. 3). These standards further go on to state that “information should include available and possible approaches to rehabilitation, the specific needs of torture victims (including early identification, assessment, and timely referrals), trauma-informed care, documentation procedures according to the Istanbul Protocol, and regarding the value of providing rehabilitation to facilitate life after torture” (IRCT, 2020b, p. 3). The publication of the results presented in Chapter 4 in the journal, *Torture* (Hearn et al., 2021), contributes towards ensuring this standard is met.

Another key theoretical implication of the current research is derived from the high prevalence of a multitude of mental health problems within this population. This finding contributes to theory relating to the psychological impact of torture in terms of its complexity and comorbid effects. Consistent with these findings, the IP highlights that the comorbidity between trauma disorders, anxiety, and depression is common in victims of torture. Importantly, the IP states that “it is problematic to assume that PTSD and depressive disorder are two separate disorders with clearly distinguishable aetiologies” (p.122). Findings from the current research present the profile of a typical service-user in Spirasi. Namely, a service-user attending Spirasi will most likely be a male torture survivor, aged between 26-39 years, originating from the continent of Africa, currently seeking international protection in Ireland, with a 50:50 chance of speaking English, who encountered the traumatic event as outlined by the index trauma on the ITQ typically between 1-5 years previous to assessment. Concurrent with other studies conducted with refugee and torture survivor populations (Vallieres et al., 2018; Vang et al., 2019), high rates of PTSD, CPTSD, Anxiety, Depression and Poor Wellbeing were observed among this cohort. Similar rates of trauma diagnoses at initial assessment, for example, were found in participants partaking in RQ1 and RQ2 (72% and 78.7%, respectively). Based on these findings, it can be estimated that approximately three

quarters of service-users attending Spirasi meet the criteria for a diagnostic trauma disorder upon entering the rehabilitation centre. The IP states that while it is important to view symptom complaints in relation to the unique experience and perspective of the victim, it is also important for those evaluating the impact of torture to be familiar with the “most commonly diagnosed disorders among trauma and torture survivors” (p.121).

Findings relating to the role of control in this research, as a key aspect associated to psychological distress, also contributes to torture and trauma theory. Specifically, findings presented in Chapter 4, section 4.3.4, evidence that a sense of control is negatively associated with levels of psychological distress and that regaining a sense of control, especially in relation to perceived constraints, may help reduce levels of depression. My findings in RQ2 demonstrated that perceived constraints and overall lack of control are strongly associated with higher levels of distress. Further to this, higher levels of distress are associated with the experience of higher mental illness symptom prevalence. A lack of control is integral to the design of torture. In Başoğlu (2009)’s four essential characteristics of torture, he speaks of the intentional infliction of distress-inducing stressors which are marked by unpredictability and uncontrollability in attempts to remove control from the victim and induce helplessness. Similarly, Suedfeld (Rees, 1991) and Farber et al. (1957) outline the role of control in what they consider to be the major components of torture: debility, dependency, dread, and disorientation. These four components of torture rely heavily on the use of power-dynamics which purposefully shift the control in favour of the perpetrator and the use of uncertainty and unpredictability as techniques to exacerbate the impact of the torture and the environment. The victim is therefore shrouded in perpetual fear, creating an ongoing perceived lack of safety and control. State-bodies have worked closely with psychologists to develop these mechanisms which ensure the most severe level of psychological impact on the victims (Rees, 1991). The current research findings show that the international protection

systems experienced by asylum seekers in Ireland mirror the uncertainty, unpredictability, and lack of control that is built into the design of torture. Extensive evidence has suggested that unpredictability and uncontrollability generate fear and anxiety (Mineka, 1985; Mineka & Zinbarg, 2006) and play a key role in the development of psychological distress (Gudjonsson & MacKeith, 1982). As outlined by Başoğlu and Paker (1995), situational stress and uncontrollability are at the forefront when it comes to developing traumatic stress after a torture experience.

Findings from all research questions in the current research fed into existing theory relating to torture and trauma rehabilitation. Outlined in Table 30 below, is the framework of existing theory combined with the current research findings, demonstrating how I built towards the generation of a new model for working with survivors of torture.

TABLE 27 *BUILDING ON THEORY*

Building on Theory	
Torture	The themes of control, uncertainty, and power emerged from the theory on torture - most notably in the design of torture. This it can be observed through Başoğlu (2009)'s 'four essential characteristics' of torture i.e., i. intent, ii. purpose, iii. multiple distress-inducing unpredictable and uncontrollable traumatic stressors, and iv. the deliberate implementation of strategies which remove control from the victim and induce helplessness. Suedfeld's major components of torture, known as the four D's, reflect similar themes i.e., i. Debility (control), ii. Dependency (control, power), iii. Dread (uncertainty), and iv. Disorientation (uncertainty, unpredictability) (Rees, 1991). Further to this, Biderman's Chart of Coercion (Biderman, 1973) outlines the methods used in torture, the intended effect, and the purpose. All of which reflect what has been

outlined by Suedfeld (Rees, 1991) and Başoğlu (2009). It can be established then that at the core of torture are methods centring around control, power, and uncertainty, for the purpose of breaking the will of the victim. Perpetrators exert their control by using methods that are purposefully unpredictable (Metin Basoglu & Salcioglu, 2011) to induce anticipatory fear (Metin Basoglu & Salcioglu, 2011) leading to a lack of control in the victim and feelings of helplessness (Forrest, 1999).

Current Research Findings	These themes were reflected in the current research in the findings from RQ3 relating to control/choice, uncertainty/certainty, and power/empowerment, and findings from RQ2 relating to a sense of control and high levels of psychopathology.
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Trauma Theory	The experience of torture is an interpersonal trauma. Similar themes relating to control, uncertainty and power are observed in theory relating to interpersonal trauma. Judith Herman (1992b) relates these themes to in the experience of rape, in which the components of power and loss of control result in intentional psychological trauma for the victim. She further connects these themes to coercive control. She highlights the role of unpredictability in exacerbating levels of psychological distress through the removal of body-autonomy in the victim by the perpetrator. In sum, Judith Herman (1992b) states “The methods of establishing control over another person are based on the systematic repetitive infliction of psychological trauma. They are organised techniques of disempowerment and disconnection. Methods of psychological control are designed to instil terror and helplessness and to destroy the victim’s sense of
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	self in relation to others” (p.77). Further highlighted in the trauma literature are the themes of safety, trust, and relationships. The destruction of trust and the damage to interpersonal relationships is explored at length by Judith Herman (1992b), especially in relation to chronic trauma. Judith Herman (1992b) also speaks of the lack of safety as a consequence of experiencing trauma. These themes have also been highlighted by others working in the field of trauma (J. Briere & Spinazzola, 2009b; C. A. Courtois, 2004; C. A. Courtois, & Ford, J. D. , 2009; Sanderson, 2013; BA van der Kolk et al., 2005).
Current Research Findings	Again, these themes are reflected in findings from the current research. Findings from RQ1 indicate prevalence of CPTSD in those who have experienced chronic or severe trauma, consistent with the literature. Further to this, findings from RQ2 relating to a sense of control are highlighted by Judith Herman (1992b)’s comparison and equation of torture and interpersonal trauma experiences; and findings from RQ3 demonstrate the themes of control, power, uncertainty, safety, trust and relationships in the survivor’s perspective of torture rehabilitation.
Complex Needs	The post-torture impact for those seeking international protection can be complex (M. Bauer et al., 1993; Cunningham & Cunningham, 1997). It can lead to a complex psychopathology and complex psychosocial needs. The existing theory has highlighted that the experience of torture and/or the refugee experience is associated with the development of trauma-related disorders such as PTSD (Metin Başoğlu et al., 1997; Başoğlu et al., 1994; J Jaranson & J Quiroga, 2011; A Maercker & Schützwohl, 1997; Teegen & Vogt, 2002), CPTSD (Vallieres et al., 2018; Vang et al., 2019), Anxiety (Georgiadou et al.,

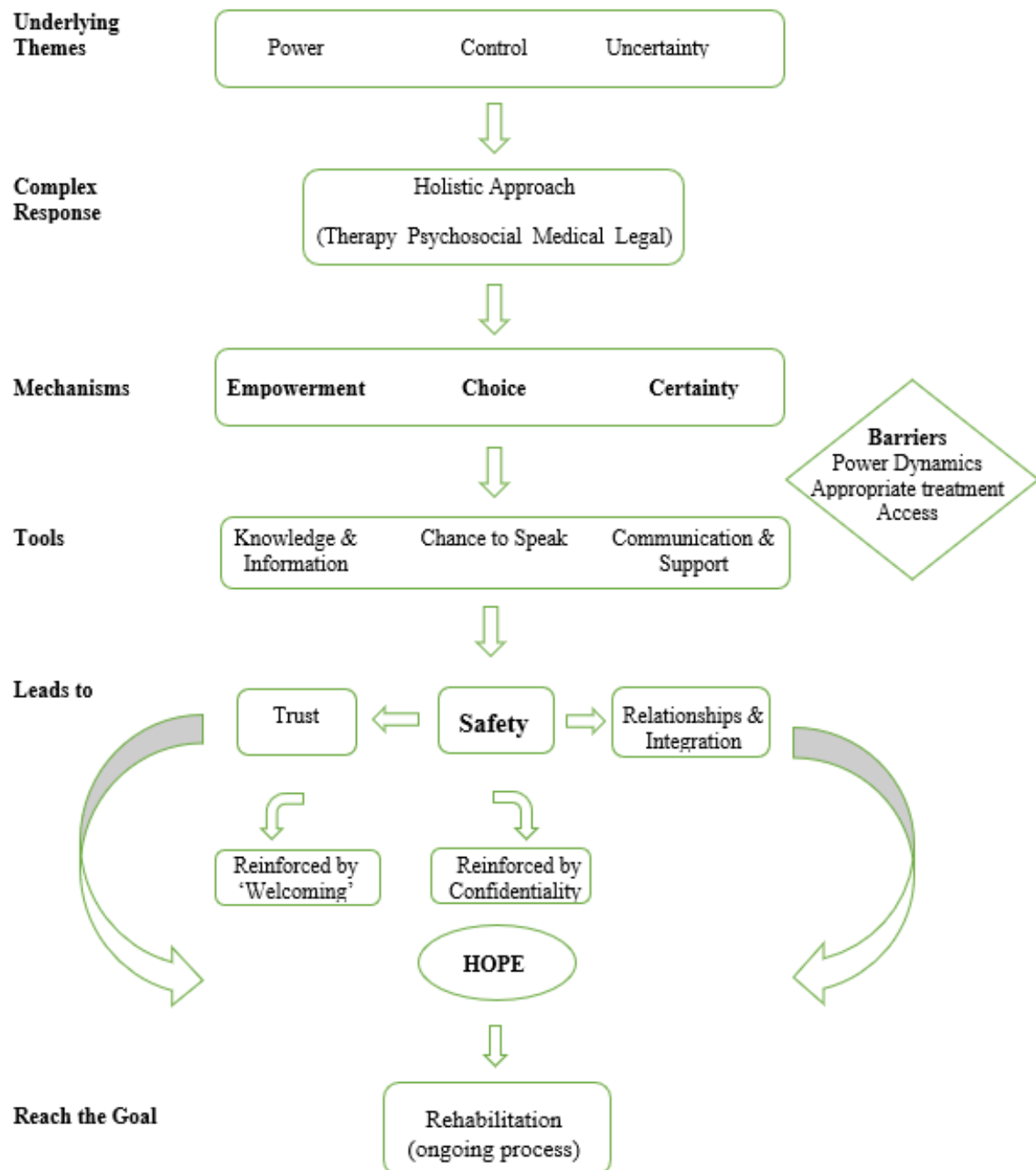
2017; Lindert et al., 2009; A. C. McFarlane & Papay, 1992), Depression (Georgiadou et al., 2017; R. Kessler et al., 1995; Lindert et al., 2009), and many other psychological presentations (Fazel et al., 2005a; Turner & Horst-Unsworth, 1993). Further to this, there is often a high level of comorbidity of disorders (Breslau et al., 1991; Fazel et al., 2005b; Georgiadou et al., 2017; Gros et al., 2010; R. Kessler et al., 1995; D. N. Poole et al., 2018; G. Poole et al., 1997). Complex psychosocial needs require a complex response in the shape of a holistic approach by a multidisciplinary team, according to those working in the field (M Cloitre, 2021; M Cloitre et al., 2011; Freedom from Torture, 2011; IRCT, 2013, 2020b; OSCE, 2018). The response is required to address the biopsychosocial impact of the trauma. Namely, the presenting PTSD symptoms, such as hyperarousal, intrusions, and constrictions, the emotional and relational impact as observed in the DSO symptoms of CPTSD, as well as the impact on functioning at an individual, relational, and social level.

Theory further outlines the longevity of complex trauma and the torture experience (Baker & Basoglu, 1992; Nelson, 1987; Thygesen, 1970), highlighting the requirement for a long-term approach (Carlsson et al., 2005; Carlsson et al., 2006; OSCE, 2018; UNCAT, 2012) to counter the feelings of hopelessness (Crumlish & Bracken, 2011; Danieli, 1988; Gerrity et al., 2001; Peterson & Seligman, 1983) and restore a sense of hope.

Current Research Findings	The current research outlines the high prevalence and complexity of psychology impact from the torture and refugee experience through the finding from RQ1 and RQ2. Finding from RQ2 also highlight the need for a long-term approach to rehabilitation and the psychosocial needs for this population. These are reinforced by the findings in RQ3, where participants spoke about the impact of the psychological symptoms, the long wait times to access services and the ongoing stressors and needs experienced in the host country.
Rehabilitation	Those working in the field of rehabilitation for torture or trauma survivors highlight the themes of choice (L. Eitinger, 1974; Freedom from Torture, 2011; Hearn, 2022; OSCE, 2018), empowerment (Pietrzak, 2018) (Metin Basoglu & Salcioglu, 2011; Freedom from Torture, 2011; Hearn, 2022; Pat Ogden et al., 2006; OSCE, 2018), certainty (Metin Başoğlu & Mineka, 1992; Metin Başoğlu et al., 1997; Başoğlu et al., 1994; Hearn, 2022), safety (Hearn, 2022; Judith Herman, 1992a, 1992b; A Nickerson et al., 2011; Silove, 2013), trust (Hearn, 2022; Judith Herman, 1992b; J Herman & Kallivayalil, 2018; Sanderson, 2013) and rebuilding relationships (Hearn, 2022; Judith Herman, 1992b; J Herman & Kallivayalil, 2018; Lindy, 1996; Pat Ogden et al., 2006), as elements for rehabilitation (Freedom from Torture, 2011; Judith Herman, 1992b). They further note the importance of delivering rehabilitation holistically, in a culturally appropriate manner, with a multidisciplinary team; and that holistic rehabilitation should incorporate psychological, social, medical, and legal needs (Freedom from Torture, 2011; IRCT, 2013; UNCAT, 2012). In order for best practice and the longevity of services, the research literature highlights the need for monitoring and evaluation of these services (J Jaranson & J Quiroga, 2011).

Current Research Findings	These themes and rehabilitation approaches are mirrored in the findings across the current research. Findings from Q1 reflect the need for appropriate diagnosis, evaluation, and monitoring for rehabilitation services and for medico-legal reporting. Findings relating to RQ2 demonstrate how restricted or delayed access to services can hinder this holistic and multidisciplinary approach to rehabilitation, but also highlight the need to integrate a strength-based approach which reinforces resilience, empowerment, and choice for survivors. These themes and observations were further underpinned in findings from RQ3 in relation to important aspects of rehabilitation from the survivor perspective. However, the over-reliance on therapeutic support is strongly evident in figure 5.
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The findings from each research question explored in the current research, informed by the work of Judith Herman (1992b)'s and BA van der Kolk et al. (2005)'s Phase Model approaches, Silove (2013)'s ADAPT Model, and Başoğlu (2009), Metin Basoglu and Salcioglu (2011), and Suedfeld's (Rees, 1991) torture theory, evolves our theoretical understanding of trauma rehabilitation for torture survivors and traumatised refugee populations. Specifically, by exploring themes relating to torture theory and trauma treatment models through the analysis of secondary data from Spirasi's rehabilitation services and through the survivor perspective on rehabilitation, I was able to build on these previous theories across the fields of trauma and torture rehabilitation to propose a new model for rehabilitation, the *Survivors Model for Rehabilitation* (Figure 8).

FIGURE 8 *THE SURVIVORS MODEL FOR REHABILITATION*

This revised model suggests that treatment approaches for torture survivors should focus on rebuilding control and empowerment by ensuring choice and certainty, as theorised by Başoğlu and Şalcıoğlu (2011) and Suedfeld (Rees, 1991), but that this must also be done within the context of safety, and trusting relationships, as theorised by Judith Herman

(1992b) in her Phase Model Approach and Silove (2013) in his ADAPT model. CPTSD is more complex in its development and its symptomology than PTSD. This is reflected in the *Survivors Model for Rehabilitation*, which indicates that treating psychopathology from torture requires a strong foundation of trust and safety with the clinician/organisation. Empowerment, control, and certainty are built into this relationship over time and often requires a long-term, holistic approach. Safety, security, stability and social support have been known to aid rehabilitation after torture; whereas, instability and a lack of justice are known to hinder or negatively affect the outcome of rehabilitation efforts (Gerrity et al., 2001; Silove, 2013). The *Survivors Model for Rehabilitation* outlines the need to integrate a holistic approach which covers psychological, psychosocial, medical, and legal (justice) needs. This new model not only contributes to the existing theory on torture rehabilitation but also furthers theory to reflect a survivor input and perspective, as advocated for within the IRCT's Global Standards, which state in Paragraph 9:

Victims' participation in rehabilitation: Promote the meaningful contribution of victims in service design and delivery, research, decision-making, and governance processes of rehabilitation services through recognition of victims' experience in service development and recruitment processes, open consultative and feedback processes, and other participatory methods that are contextually and situationally appropriate.

Thereby moving away from a Western approach and addressing the colonisation that exists in Western rehabilitation models (P. Bracken et al., 2021; Henrich et al., 2010a), which is explored further in section 6.4.3.

6.4.2 Implications for Practice

CPTSD, as a new diagnostic category for this population, has important implications for treatment modalities and best practice. While the treatment programmes for PTSD have been well-established, reviewed, and agreed upon in academic and professional circles (Forbes, Bisson, Monson, & Berliner, 2020), the current research findings demonstrate a need **for treatment and torture rehabilitation programmes to make alternative options available to those presenting with complex psychological and psychosocial needs.** In other words and given the high prevalence of CPTSD within this population, traditional approaches for the treatment for PTSD may not be the most appropriate or effective among refugee or asylum-seeking populations. Indeed, some of the treatment programmes developed for PTSD (i.e., CBT) have been shown to be less effective in those with more complex trauma experiences (BA van der Kolk et al., 2005) and studies which focus specifically on PTSD for asylum seekers and refugees have failed to find extensive evidence for the effectiveness of PTSD treatment within this population (Birck, 2001, 2004; Carlsson et al., 2005). Patel, Williams, and Kellezi (2018), for example, challenge the suitability of the likes of Eye Movement and Desensitisation Reprocessing (EMDR) and Cognitive Behavioural Therapy (CBT) approaches to PTSD treatment when working with torture survivors. M Cloitre et al. (2011) note that “there are few studies exploring adaptations of, or alternatives to, established PTSD treatments developed specifically for individuals with complex trauma histories and intended to target complex PTSD symptoms” (p. 616). Regarding treatment approaches, studies which carried out a meta-analysis of current commonly used psychotherapies for adults showed less successful treatment for symptoms of CPTSD (Coventry et al., 2020; Thanos Karatzias et al., 2019). In the study by Coventry et al. (2020), for example, psychotherapy approaches known to be effective for PTSD symptoms had less success when focusing on a subgroup of participants who had been impacted by the complex

trauma of war violence. The most effective approaches to working with CPTSD symptoms instead appears to be those which include more than one component so as to address both the PTSD and DSO symptoms (Coventry et al., 2020; Thanos Karatzias et al., 2019) characteristic of CPTSD.

M Cloitre et al. (2011) explored the recommended treatment modalities for Complex PTSD as opposed to PTSD and concluded that there was strong (84%) consensus among experts that a phase-based approach, tailored to address relevant symptoms within the CPTSD criteria, is most appropriate. A review of this approach nearly 20 years later suggested it continues to stand the test of time (C. Courtois & Ford, 2009). This approach is further endorsed by both the National Institute for Clinical Excellence (NICE) and the International Society for Traumatic Stress Studies (ISTSS) (M Cloitre et al., 2011). Whereas complexities emerge when considering appropriate treatment approaches to adult-onset CPTSD in refugee or war/genocide-exposed populations (M Cloitre et al., 2011), a phase-model approach, with an emphasis on beginning with safety-building, which also takes into account the further complexities of family separation, cultural dislocation, and ongoing asylum-crises (Beltran & Silove, 1999), is deemed most appropriate. This approach is further supported in a review by A Nickerson et al. (2011), who found a multimodal approach, which emphasises an initial safety-building/stabilisation phase, as more appropriate than PTSD treatment approaches for refugee populations. Taken together, findings from the current research support the argument that a phase model approach might be more appropriate when working with the complexities of being a torture survivor seeking international protection.

Whereas some studies suggest an improvement in PTSD symptoms through the engagement in short-term therapies (9 and 12 weeks), it has also been noted that survivors diagnosed with CPTSD, or those with ongoing life stressors and poor social supports will require longer term treatment (M Cloitre et al., 2011). Therefore, and given that (i) torture

can cause long-term effects (Eaton, 1982; Nelson, 1987; Thygesen, 1970), (ii) that the long-lasting impact of trauma encountered in the country of origin (or experienced during flight) is associated with stressors related to the host country (Hermansson, Timpka, & Thyberg, 2002), and (iii) the high prevalence of CPTSD within the current research sample found at both time points, there is a need to incorporate a **long-term approach to the rehabilitation of torture survivors seeking international protection**. Long-term approaches are particularly important for the context of Ireland, where the international protection process currently takes an average of five years (UNCERD) and given Birck (2004)'s suggestion that resistance to treatment is impacted by the instability of the international protection process in the host country. Indeed, the clear and complex presentations of participants in the current study are potentially exacerbated by ongoing challenges associated with seeking international protection in Ireland and raises the question as to whether trauma-focused psychotherapy is the correct intervention for survivors of torture and serious harm whilst they are still undergoing the international protection process. Finally, implementing more long-term approaches would ensure consistency with UNCAT's call for "a long-term, integrated approach with specialist services which are readily accessible" (UNCAT, 2012).

The OSCE (2018) state that effective rehabilitation should be "available, appropriate, accessible, and provided in a way that guarantees the safety and personal integrity of the victims, their families and their care-takers". Consistent with this and Paragraph 12 of GC3 in UNCAT stating that rehabilitation services should be "readily accessible", Goal One of Spirasi's Strategic Plan for 2022-2025 relates to providing greater access to services for survivors of torture in Ireland (Spirasi, 2022). Specifically, Spirasi's Strategic Plan (2022-2025) predicted that Spirasi would double their capacity from 250 to 500 new service-users per year in order to respond to the current and future increased demand on the service, further stating that this would allow for a reduction in waiting lists and a more accessible service.

Findings from the current research, however, suggest that the existing structure of Spirasi's holistic rehabilitation model is failing to meet this objective. Namely, access to rehabilitation, even after been accepted into the service, emerged as an issue across both Phase One and Phase Two of the current research, with these long wait times and under-resourcing likely to have a direct impact on service-users (Laban et al., 2007; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Laban et al., 2008). This is highlighted particularly in relation to RQ2 where participants' level of engagement was hindered by long-wait times prior to accessing therapy and other strands of Spirasi's holistic model.

Findings from RQ2 of the current research demonstrate possible comorbidity of mental health disorders among service-users of Spirasi. The holistic rehabilitation approach holds significant promise in addressing the complex challenges faced by torture survivors who are burdened by the comorbidity of trauma disorders, anxiety, and depression (M Cloitre et al., 2011; Freedom from Torture, 2011). This multifaceted approach recognises that the interconnectedness of these conditions requires a comprehensive and integrated intervention strategy. By encompassing physical, psychological, and social dimensions of healing, the holistic approach seeks to restore not only the individual's mental well-being but also their overall sense of self and connection to their environment. For torture survivors grappling with the comorbidity of trauma disorders, anxiety, and depression, the holistic rehabilitation approach provides a framework for tailored interventions. By addressing the core symptoms of each condition while also considering their potential interactions, holistic rehabilitation acknowledges the need for an integrated treatment plan. This approach aims to empower survivors by helping them develop coping skills to manage distress, anxiety, and depressive symptoms, while also fostering resilience to navigate the intricate challenges of their experiences. Moreover, the holistic rehabilitation approach recognises that the impact of torture extends beyond individual psychological distress (Baker & Basoglu, 1992; Ekblad et

al., 1994; Lie, 2002; K. E. Miller & Rasmussen, 2010; R. F. Mollica et al., 1987; Z. Steel et al., 2011). It acknowledges the broader social context in which survivors exist and emphasises community support, empowerment, and reintegration. By addressing the trauma of torture alongside anxiety and depression, and by fostering a sense of belonging and purpose within a rehabilitative community, this approach not only aims to alleviate the symptoms of comorbidity but also promotes a transformative journey toward recovery and renewed quality of life. In essence, the holistic rehabilitation approach offers a well-rounded response to the complex needs of torture survivors facing comorbidity of trauma disorders, anxiety, and depression. By considering the physical, psychological, and social aspects of healing, this approach provides survivors with a comprehensive toolkit to navigate their journey toward recovery, growth, and reconnection with themselves and their communities.

However, despite advertising a holistic approach to rehabilitation, Spirasi's model appears to rely heavily on therapeutic intervention as the main aspect of their rehabilitation model. As evidenced in figure 5 participants in RQ3 referenced therapeutic supports 8 times more frequently than psychosocial supports. Specifically, an overreliance on individual psychotherapy as the pathway to rehabilitation for the service-users is contributing to the delay in accessing rehabilitation for many, while also neglecting the importance of psychosocial support as instrumental to stabilisation and safety-building (Silove, 2013), both of which must be in place before meaningful trauma-processing can take place (Judith Herman, 1992b). This was demonstrated in the current research in RQ2 by the lack of engagement in therapeutic services due to long wait times and a lack of engagement in psychosocial support due to under-resourcing.

Judith Herman (1992b)'s first phase in her Phase Model Approach to trauma treatment is safety building and stabilisation. She speaks about how in order to restore power and control to the survivor a sense of safety must first be established. She goes on to explain

that without a sense of safety being in place, no other therapeutic work will be successful, and it is not ethical to even attempt until a certain level of safety has been reached. This process of safety-building or stabilisation can last for years in those with complex presentations of trauma. Boyles (2017) notes that a part of rebuilding safety in Herman's model is restoring a sense of control. However, a sense of control is difficult to establish when "confronted with the threat of repatriation and when one's life is externally controlled by legal, financial and social constraints" (p. 212), as is the case for the majority of the current research participants who remain in the international protection process in Ireland. Trauma treatments, generally look to address past traumatic events which have led to the development of psychological symptoms causing a level of functional impairment. However, for asylum seekers seeking protection in Ireland, the trauma is ongoing, continuously compounding, and fraught with real time fear and uncertainty.

Studies have shown that trauma-focused treatment is less effective when carried out in those with complex presentations, including the complexity of seeking international protection (Gerger, Munder, & Barth, 2014; Lambert & Alhassoon, 2015; A Nickerson et al., 2011; Robjant & Fazel, 2010). Part of working through trauma is about putting the traumatic incident into a timeline of the past. And whilst the torture or severe harm which was experienced by participants in the current research took place in the past, their asylum journey is an extension of that event and is taking place in the present with a critical impact on the future. Given that the process of seeking international protection is highly unstable in most countries, and that perceived constraints and a lack of control are strongly associated with psychological distress, it is appropriate to question whether survivors are ready to engage in psychotherapeutic work in Spirasi at this point in their rehabilitation journey.

A lack of social support has also been identified as a predisposing factor for developing depression post-torture (Metin Basoglu et al. (1994). Accordingly, a focus on

psychosocial interventions over that of a trauma-focused therapeutic response has been suggested as a more appropriate rehabilitation approach (K. E. Miller & Rasmussen, 2010; K. E. Murray et al., 2010; Papadopoulos, 2007; Derek Summerfield, 1999). Spirasi only recently defined what the service of ‘psychosocial’ means within their services. As outlined in Spirasi’s 2021 ‘Psychosocial Report’, psychosocial “pertains to the influence of social factors on an individual’s mind or behaviour, and to the interrelation of behavioural and social factors”. This report then expands on this understanding by highlighting the connection between psychosocial wellbeing and psychological wellbeing in refugee and asylum-seeking populations (Fazel, Reed, Panter-Brick, & Stein, 2012; Patel, Kellezi, & Williams, 2014; Ryan, Dooley, & Benson, 2008) and describes a recent shift in focus towards researching the psychosocial impact of post-migration impact for asylum seekers and refugees (Li, Liddell, & Nickerson, 2016a; Malm, Tinghög, Narusyte, & Saboonchi, 2020). Consistent with this previous research, Spirasi’s psychosocial team have also noted that the following post-migration factors are likely to have a greater impact on mental health than pre-migration experiences (Chu, Keller, & Rasmussen, 2013; Porter & Haslam, 2005; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011), all of which fall within the realm of psychosocial work: uncertainty relating to asylum application (Bäärnhelm, Laban, Schouler-Ocak, Rousseau, & Kirmayer, 2017; Chu et al., 2013) financial difficulties and unemployment (Beiser & Hou, 2001; Tinghög, Al-Saffar, Carstensen, & Nordenfelt, 2010), accommodation issues (Li, Liddell, & Nickerson, 2016b), social isolation (Gorst-Unsworth & Goldenberg, 1998) and poor social support (Laban, Komproe, Gernaat, & Jong, 2008; Schweitzer et al., 2011). So, while there is a high need for psychosocial support for service-users of Spirasi, according to findings presented in RQ2 and RQ3, therapists seem to disproportionately provide all levels of support (see figure 5). Therefore, Spirasi should specifically revise their activities to

ensure **greater access to psychosocial supports, over and above the access they currently grant to therapeutic supports.**

Given the noted importance of social support in resilience in refugee populations (Siriwardhana et al., 2014), promoting both emotional and informational support, as well as a sense of belonging (Chung et al., 2012; Walther et al., 2021), it is worth considering how social support could be better integrated into the treatment approach of torture rehabilitation centres. One method, termed community resilience (Ungar, 2005), includes building relationships, exercising control, seeking meaning and seeking safety, and is said to create ‘a thicker description of resilience’. These community supports have been shown to be a strong resource in rehabilitation from trauma (Walsh, 2007). Walsh (2007) states “The effects of trauma depend greatly on whether those wounded can seek comfort, reassurance, and safety with others. Strong connections with trust that others will be there for them when needed, counteract feelings of insecurity, hopelessness, and meaninglessness” (p. 208). Similarly, P. J. Bracken et al. (1995) advocate for a collective recovery approach, stating that recovery is linked to the rebuilding of social connections. A number of studies link social support with increased psychological well-being in refugee populations (Ahern et al., 2004; Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006; Schweitzer, Melville, Steel, & Lacherez, 2006). Gorman (2001) posits that treatment approaches with refugees should explore the identity of the individual in the wider social context.

Van der Kolk states, “Social support is not the same as merely being in the presence of others. The critical issue here is reciprocity: being truly heard and seen by the people around us, feeling that we are held in someone else’s mind and heart” (Bessel van der Kolk, 2014, p. 79). When we review Maslow’s ‘Pyramid of Needs’, employing a psychosocial approach as the prime intervention during a survivor’s period of seeking international protection, seems like common-sense. Maslow (1958) theorised that human need can be

viewed as a pyramid with the basic needs of physiological needs and safety at the foundation, followed by psychological needs, capped by self-actualisation. Harlow's modernised version (as referenced in Boyles, 2017) of this model situates safety at the foundation but also has it permeating the higher building blocks within the pyramid of needs. The aim of social work with survivors of torture is to "promote access to rights, choice, stability, safety, and improve wellbeing" (Boyles, 2017, p. 372). Considering supporting literature, findings from the current research suggest that **a strong psychosocial foundation for survivors in the international protection process could pave the way for more effective and timely psychotherapeutic interventions.** This premise is further supported by previous research (K. E. Miller & Rasmussen, 2010) which calls for a more integrative approach to treatment for those in the international protection system, shifting the focus from trauma-focused psychotherapy to more practical psychosocial interventions combined with a focus on stabilisation.

Taken together, these findings have further implications for the assessment process in rehabilitation centres for survivors of torture. As discussed in section 3.3.4 assessing and diagnosing service-users on entry into the service provides a context for the treatment approach, but also provides an opportunity for a survivor to understand the symptoms they have been struggling with, and possibly by which they are being held hostage. This knowledge may provide immediate relief, a reduction of fear, and feelings of hopefulness about the future and may have contributed to the reduction of PTSD and CPTSD levels observed between Time 1 and Time 2 in RQ2 findings. Similarly, and supported by the results presented in section 5.4.3.2, having had the chance to speak to a professional and having them bear witness to the atrocities that were experienced can help restore a human connection; being met with non-judgement and compassion can help rebuild shattered trust in humanity for the survivor. Further to this, being asked what their needs are as a whole person,

in the context of the international protection process, can provide a sense of allyship and comfort in having an advocate. **Spirasi's initial assessment process appears to achieve these steps and should be considered a part of, rather than the start of, their rehabilitation programme.** These findings therefore provide guidance for other rehabilitation centres working with this population to review their own initial assessment procedures.

Results of this research suggest that rehabilitation programmes should integrate more of a focus on sleep treatments for this population. Based on considerable research into the effectiveness of CBT-I versus medication, it is now recommended that CBT-I be the first course of action when dealing with insomnia (M. Smith et al., 2002). Given the overwhelming experience of the participants in relation to sleep difficulties and the plethora of psychological disorders which they are managing, **including a specific focus on improving natural, healthy sleep for survivors should be integrated into the early stages of rehabilitation provided by organisations like Spirasi.** Addressing these needs may give survivors a stronger foundation for which to access current internal coping mechanisms or the stability to build new ones.

Barriers to rehabilitation are expected and often require changes in policy or structures at an organisational level. In terms of Spirasi, policy changes must be first proposed by a member/s of the management team, seeking agreement and feedback among the staff, and then be submitted to the director and the sub-committee from the Board of Management, before being presented to the wider Board of Management for approval. This is a long process and often delays change. However, and as described by the participants themselves in RQ3, in the short term, it is the renewal of hope - rather than full rehabilitation - which gives survivors a sense of progress.

Finally, given the extant literature presented in Chapter 1, the findings through the current research, and the cultural considerations explored in section 1.8.6, the current findings

evidence a need for **a shift in focus in terms of psychological treatment offered to survivors of torture who are seeking international protection**. Mechanisms which promote empowerment, choice, and certainty are important. However, of equal importance is what these mechanisms strive to provide for the service-user, namely, safety, trust, and integration. The *Survivors Model for Rehabilitation* recognises the complex nature of the psychopathology which can result after torture, as well as the context in which many torture survivors present for rehabilitation (i.e., seeking international protection), and advocates for a holistic approach using a multidisciplinary team. According to this proposed model, the aim of any treatment offered by rehabilitation services should therefore be to try to counter the experience of torture by finding ways to empower the survivor, offer choice, and ensure certainty in all their interactions. This should further be achieved through strong communication, providing psychoeducation, and creating a safe, confidential, and judgment-free space to speak. Doing so through a welcoming environment is hypothesised to further foster feelings of safety and trust with the organisation. Furthermore, the relationships built within this context will provide a template for rebuilding connections with others and encourage integration (Hearn, 2022), and restore hope. The end goal, of course, being rehabilitation.

6.4.3 Implications for Policy

Findings from the current research have implications for national policy in Ireland. The combination of findings from the current research and the literature review point to a high level of mental health difficulties experienced by asylum seekers in Ireland due to pre-, transit-, and post-migration trauma experiences, and the resulting requirement for long-term holistic and specialised supports. The current research reflects the long wait times experienced by survivors of torture who are referred to Spirasi, and, from the literature

(Laban et al., 2007; Laban et al., 2004; Laban et al., 2008), the longer an individual is in the process of seeking international protection, without resolution, the higher the potential for deterioration in mental health. For example, higher rates of anxiety and depression were observed in Iraqi asylum seekers seeking international protection in the Netherlands for more than two years in comparison to those in the system for less than six months (Laban et al., 2004). Likewise, the current study also found high rates of PTSD, CPTSD, Anxiety, Depression, and Poor Wellbeing at intake into Spirasi's services, and one year later.

Ireland is a signatory to UNCAT and as such has committed to implementing article 14 of UNCAT regarding the right to rehabilitation. This right is inclusive to all who have suffered torture, regardless of legal status. The considerable delays surrounding the asylum process can result in the application for international protection being left for years in limbo; leaving the asylum-seeker uncertain of the outcome of their protection claim, powerless to move on with their lives, and feeling unsafe. Consequently, and as Silove (2004) writes, "the asylum seeker is trapped in a continuum of threat, loss of control and intensifying feelings of helplessness" (Silove, 2004, p. 60). Indeed, the current research evidenced that asylum seekers in Ireland experience a lack of control, high levels of uncertainty, and disempowerment throughout the international protection process, all of which present barriers to rehabilitation. It is recommended that changes in policy are required to address the long processes existing in Ireland for seeking international protection. If this is not possible, and long-term processes will continue, this research highlights the need for appropriate and accessible support for survivors in this system. This would require a substantial increase in funding to organisations like Spirasi in order to meet the demands on the service and the complex response required to work within best practice with this population. What is required here, therefore, is not an implementation of new policy but a more effective fulfilment of an existing one: *'the right to rehabilitation'* (UNCAT, 2012).

An implementation from the White Paper (Irish Government, 2021) was the provision of vulnerability assessments which are advocated for under the Recast Reception Conditions Directive and the European Communities (Reception Conditions) Regulations 2018 (Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection [2013] OJ L 180/1 and SI No 230/2018 European Communities (Reception Conditions) Regulations 2018.).

According to the Recast Reception Conditions Directive, vulnerable people include; minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection [2013] OJ L 180/1, art 21). The purpose of identifying vulnerable asylum seekers is to enable the provision of appropriate and accessible supports. Under the heading of Mental Health, the White Paper states:

Mental health needs will be identified as part of the general Health Assessment and informed by Vulnerability Assessments. Where applicants have mental health needs, including trauma, they will be referred to healthcare professionals with relevant experience, and this will be done in a culturally sensitive manner with appropriate interpretation services. Once this assessment has been carried out, appropriate community-based care will be initiated, and all relevant information will be communicated to mental health services in a timely manner.

This proposed action plan is welcomed under the findings of the current research. However, although the vulnerability assessments have started to be implemented in the main reception

centre for newly arrived asylum seekers, there has been no increase in funding for specialised mental health services, such as provided in Spirasi, to meet the increased demand from these assessments. Further to this, one of the recommendations of the White Paper was clearing the backlog of unprocessed international protection claims. However, as of October 2022, 11,142 people had applied for international protection in 2022; a 516.6% increase on the figure for the same period in 2021, and does not include the people seeking protection from Ukraine.⁴ Earlier this year (June 2022), the minister for the Department of Children, Equality, Disability, Integration and Youth told the Dáil that the war in Ukraine “had an unavoidable impact on the implementation of the White Paper, as staff in my Department were temporarily diverted to fulfil Ireland’s obligations”.⁵ Policy makers working with those in the international protection process need to be made aware of the high levels of mental health needs present in this population and the importance of ensuring capacity to provide timely, accessible and appropriate rehabilitation services. Given the escalation in international protection applicants and those who are fleeing the Ukrainian conflict who will require mental health supports, **the White Paper needs to be revisited and changes made to ensure the aims laid out within this document can still be met without further delay** while also ensuring that Ireland continues to meet their obligations under UNCAT article 14, the right to rehabilitation. This will require a wider response from government and non-government services across Ireland for appropriate implementation of mental health and integration needs. If Spirasi is to be tasked with meeting the current demand for specialised

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<http://www.ipso.gov.ie/en/IPO/20221110%20IPO%20Monthly%20Website%20Stats%20Oct%202022%20FINAL.pdf/Files/20221110%20IPO%20Monthly%20Website%20Stats%20Oct%202022%20FINAL.pdf>

⁵ <https://www.oireachtas.ie/en/debates/question/2022-07-07/121/>.

support from these populations then considerable resources need to be made available for them to do so in a responsible manner which reflects best practice.

Findings from the current research also have implications for policy on an international level. How torture is defined continues to be a topic of debate within the area of torture and torture rehabilitation (Metin Başoğlu et al., 2007). The current research included participants who had experienced torture as defined by Article 1 of UNCAT and who had experienced serious harm as defined by the Qualification Directive. Participants who fall outside of the strict definition of torture in Spirasi's remit - and were therefore categorised in this research under 'serious harm' - have generally experienced SGBV, as defined by UNCAT GC2. As described in section 3.3.3, women in the current study were more likely to meet a diagnosis for CPTSD (55.8%) compared to men (37.9%), albeit these differences failed to reach statistically significant levels. The high diagnostic levels of CPTSD among those who suffered serious harm, however, lends support to Metin Başoğlu et al. (2007)'s argument for a wider inclusion criterion under UNCAT based on psychological impact, and further supports a need for an inclusion of survivors of sexual and gender-based violence in the area of torture assessment and rehabilitation.

The current research findings also suggest that people who have faced interpersonal violence and disempowerment suffer a level of psychological effect equal to someone who is a victim of torture at the hands of a State agent. Women who are fleeing their home and their country after having experienced gender-based violence on a domestic or community level suffer trauma and stigmatisation. Clear parallels are evidenced between violence inflicted by State actors and gender-based violence by non-State actors when one looks at the form, the intentionality, and severity of the inflicted pain or suffering for a certain purpose: like State torture, gender-based interpersonal violence aims at rendering the victim powerless and under the control of the perpetrator (Report of the Special rapporteur on torture and other cruel,

inhuman or degrading treatment or punishment) (Hearns et al., 2021). Accordingly, the UN Committee against Torture, the body monitoring UNCAT, opted to include gender-based forms of violence by non-State actors into its work under ‘General Comment 2’ and stated in paragraph 18 that States are required to exercise due diligence to prevent, investigate, prosecute, punish and provide remedies for acts of non-State violence, including acts of gender-based violence such as rape, domestic violence, female genital mutilation, and trafficking and that otherwise “its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts” (UNCAT, 1984). While the Committee against Torture has progressed in addressing violence by non-State actors, the World Organisation Against Torture (OMCT) is concerned that the use of UNCAT is still not equal among the sexes, with women often receiving less protection, prevention, or access to rehabilitation services (Hearns et al., 2021). I officially presented finding from RQ1 of the current research, which spoke to the implications of torture across the sexes, to the United National Committee Against Torture at the Office of the High Commissioner of Human Rights on the 4th of December 2018, in keeping with IRCT (2020b) Global Standards Paragraph 13 which highlights the importance of disseminating “information about torture and its effects to professionals in healthcare and other relevant fields who may come into contact with torture victims” (p. 3). The lack of clarity which exists across torture rehabilitation services regarding the remit under UNCAT still prevails, however, and **the findings from the current research further highlight the need to revisit the definition of torture and establish the role of psychological impact within this definition for those tasked with delivering rehabilitation.**

Finally, findings from the current research also have implications for policy development and delivery at a local level (i.e., within Spirasi’s services). The validation of a new measurement tool for the assessment of trauma in a cross-cultural population of torture

survivors seeking international protection has presented considerable opportunities for stronger monitoring and evaluation. In Spirasi's Strategic Plan (2022-2025), Goal Three outlines the need and intention to 'Develop and implement an outcome measurement tool', stating that an outcome measurement tool is required for the purpose of ensuring evidence-based services. James Jaranson (2001) observes that "despite the long history of torture rehabilitation throughout the world, only a small fraction of torture survivors actually receive treatment. Financial support for services never comes close to meeting the need and therefore it is increasingly important for torture rehabilitation centres to demonstrate that the resources are used most efficiently and effectively to help survivors" (Gerrity et al., 2001, p. 100). Moreover, rehabilitation centres must be able to demonstrate the effectiveness of their services. The use of a common, valid measure could also contribute to generating more comparable outcomes across rehabilitation centres, and substantiate the effectiveness of the various treatments being used worldwide (JM Jaranson & J Quiroga, 2011).

Key to service delivery in a human rights context is ensuring services are accessible, affordable, and acceptable (Samuel; Walton et al., 2022). Assessment of services must be carried out to establish these expectations are met and if not, why not. Assessing services requires rehabilitation centres to evaluate (i) clinical impact (ii) treatment effectiveness and (iii) efficiency (J Jaranson & J Quiroga, 2011). Accordingly, the a taskforce, led by David Kinzie of the Oregon Health Sciences University, of senior clinicians across the USA between 2004 and 2006, with the objective of developing quality assurance criteria for torture treatment centres, as well as a research plan to collect treatment outcome data, recommend that: (i) measuring outcomes should be an integral part of care, (ii) assessment must be integrated into the daily routine of programme, and (iii) outcome measurement should be part of a process which includes analysis and reporting of data and improving the quality of care through education and training of the providers (J Jaranson & J Quiroga, 2011). The

European Union ((EU), 2008) has its own set of criteria for evaluating the torture rehabilitation centres it funds which, are somewhat similar to those stated above. These include efficiency, effectiveness, impact, and sustainability. They further emphasise the need for data to be used to improve the quality of service and care for victims of torture accessing treatment. The findings from the current research contribute to these efforts by further evidencing the validity of the ITQ which can be used for the monitoring and evaluation of service impact, providing valuable data relating to the impact of services for reporting and fundraising purposes, and thereby ensuring the continuation of service provision for this vulnerable population.

The findings from the current research demonstrate an over-reliance of individual psychotherapeutic support as the main function in rehabilitation in Spirasi. This, as demonstrated by findings from RQ2, is problematic for the delivery of a holistic model of rehabilitation for this population. This is demonstrative of the Western mindset of valuing individual treatment spaces over group treatment spaces and Western psychology over non-Western psychosocial approaches (Bemak & Chung, 2017; P. Bracken et al., 2021; P. Bracken et al., 1997; Marsella, 2010; Wessells, 1999). There is a need for Spirasi, and organisations like it, to challenge these approaches by questioning how the “assumed superiority of concepts, curricula, and clinical practice guidelines of Euro-American centres, and their enthusiastic export across the globe, has served to divert attention from local moral and cultural worlds” (P. Bracken et al., 2021). P. Bracken et al. (2021) speak to the need for mental health services to move away from a purely Western approach to responding to states of distress and to look towards the differing approaches as seen in ‘ethnopsychiatry’ that can provide alternative narratives that are more collective in nature. In order for this to happen, the relevant stakeholders must be onboard. In Spirasi, stakeholders include the Board of Management, the Director, and the senior management team of Spirasi. However, this

process will require inclusion of all levels of staff and service-users. The inclusion of the voice of the service-user contributes to a more holistic understanding of lived experiences and ensures a multi-level approach to evaluation, further strengthening the possibility of implementation. If recommendations resulting from implementing the research findings are found to work within a real-world setting, ultimately it is the vulnerable population, as well as the service-providers that stand to benefit the most from the research (D. H. Peters, Adam, et al., 2013). The IRCT, in their recent publication, *Global Standards on the Rehabilitation of Victims of Torture* (IRCT, 2020b), note in paragraph 9 of this document the importance of including the voice of the service-user in their rehabilitation. It states:

Promote the meaningful contribution of victims in service design and delivery, research, decision-making, and governance processes of rehabilitation services through recognition of victims' experience in service development and recruitment processes, open consultative and feedback processes, and other participatory methods that are contextually and situationally appropriate (p.3).

Further to this, in paragraph 8, the document emphasises the importance of systematically collecting feedback about the rehabilitation service from the service-user. Specifically, it recommends the need to

establish procedures and mechanisms that enable torture victims to provide ongoing feedback, including upon leaving rehabilitation services, in a language they speak, about the services they receive; for example, through the use of standing service-user engagement mechanisms, victim satisfaction surveys, service evaluations, focus groups, and other participatory mechanisms (P. 3).

Further to this, P. Bracken et al. (2021) advocate for “engagement with research and service development that involves individuals with lived experience” and that a “de-colonised

curriculum will shed light on the dominant mental health research hierarchy that continues to devalue the voices of those with lived experience of mental illness and the mental health system (Faulkner 2017)". The current research provides an example of how by building on the quantitative means of data collection through the cross-culturally validated measurement tools i.e., the ITQ, with the inclusion of the voice of the service-user, rehabilitation services can **generate more appropriate and informed understanding of service-user needs**, as well as direction for rehabilitation with torture survivors in this context.

6.5 Limitations and Future Research

The current research is not without limitations. First, secondary data was used for RQ1 and RQ2. Due to the requirement to use data which was available, there was limited possibility to influence the data collection process, including which variables to include. The inclusion of additional variables, for example level of familial support, external stressors relating to the international protection process, and current coping mechanisms, may have altered the results. Further to this, failing to account for comorbidity was a missed opportunity, not only in terms of theoretical findings but also regarding the null result in RQ2 for level of engagement in Spirasi's services as a mediating factor. Future research could look to explore the mediating impact of engagement while accounting for these factors to establish if it provides clearer data on whether holistic rehabilitation can be measured in this manner.

Second, ethical restrictions prevented the use of a control group. The use of a control group that was not accessing Spirasi's service at all in RQ2 would have allowed for the exploration of whether being accepted and connected to Spirasi, or undergoing the initial assessment process, were contributing factors in the reduction of mental health indicators.

Thirdly, internal processes within Spirasi resulted in changes to the administration of psychological measures during the initial assessments. When rates of PTSD and CPTSD recorded at initial assessment stage in Spirasi are compared across RQ1 and RQ2, there is a notable difference. Higher rates of CPTSD (60%, N = 45) as opposed to PTSD (18.7%, N = 14) in the sample associated with RQ2, compared to PTSD (32.6%, N = 86) and CPTSD (39.4%, N = 104) rates in sample for RQ1. Given that the participant characteristics were similar across both, one possible explanation for this observation is that the participants in RQ2 were assessed by psychotherapists, who had specific training in how to deliver the ITQ in a conforming way, whereas participants in RQ1 were assessed by physicians with no formal training in administering the ITQ. While it is expected that there is always a degree of inconsistency when scales are administered by more than one clinician, service-deliverers need to ensure inconsistencies are at a minimum for diagnostic and monitoring and evaluation purposes. **This points to importance of training and consistency in the delivering of psychological assessment scales in rehabilitation centres.**

Fourth, legal and environmental factors, such as the international protection process, family reunification process, Direct Provision, and stressors relating to the current housing crisis in Ireland, may have had a confounding impact on the results as participants may have been impacted by one or all of these factors at different points throughout the data collection. It has been demonstrated that post-flight trauma can cause additional and cumulative distress (Cheung, 1994; Hauff & Vaglum, 1995; Hermansson, Timpka, & Thyberg, 2002; R. H. Mollica et al., 2001; Sabin et al., 2003; Sandstedt, Carlsson, Hürnquist, & Thyberg, 1992). While the mix of participants at different stages of their protection process in Phase 2 of this research added to the richness of the discussion through the varying perspectives, it would also be interesting to interview participants at a similar stage i.e. 12 months into their process for international protection or 5 years post-receiving refugee status, for example. Controlling

for the confounding factors outlined above, or indeed integrating them, would also make for interesting future research.

A fifth limitation is the use of the Western-developed assessment measures. Despite the cross-cultural validity observed in the validation of the ITQ for assessing PTSD and CPTSD, the IP 2022 cautions viewing a survivor's presentation through a Western-only lens. It notes that while diagnosis can be helpful, symptom presentation must always be considered in the cultural context and that descriptive methods are most useful for this. Moving towards a blended approach might be worth exploring for those working with this population.

Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that psychiatric classifications are generally considered to be based on Western medical concepts and that their application to non-Western populations presents certain difficulties (Patel, 2011; D Summerfield, 2001). It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies (OHCHR, 2022, p. 118).

As such, Western models of psychological distress which were assessed for in the current research might not capture the breath of different culture symptom presentation such as somatisation, which the IP note are highly prevalent:

Pain, headaches, or other physical complaints, with or without objective physical findings, are common problems among torture survivors. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to the physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal

pain and headaches. Headaches are very common among torture survivors and may be due to torture-inflicted injury (head and neck injuries are a common part of torture), as well as being caused or exacerbated by poor sleep patterns, stress and anxiety (OHCHR, 2022, p. 120).

Further to this, despite the cultural diversity of the participants used in RQ1 and RQ2, culture in itself – beyond the noting of the cross-cultural population – was not explored further as a statistical component.

Sixth, when considering limitations, it is also important to consider the subset of torture survivors to whom these findings may not apply. The participants in the current research were treatment-seeking, which already establishes a level of resilience, as discussed in RQ2. Further to this, when analysing complete data sets for RQ2 over Time 1 and Time 2, there was a drop in participants who partook in Time 2. While the reasons for this are unknown, it creates a potential bias in the data given that all included participants were those who had consented to a 12-month review assessment, indicating of a level of engagement with the service. Looking into the reasons for the drop in participation at Time 2 in meditating research studies with this population would be worth exploring further. Further to this, some of the incomplete data sets which were discarded (see Handling of Missing Data, section 2.7.8.1), raise the question of why the psychological measures were not completed and whether this was due to participants becoming highly distressed, or issues of cross-cultural competency. Further to this, as discussed in the findings from RQ1, the role of dissociation may play an important role in complex trauma and as such future research should explore the impact of dissociation, especially in terms of treatment-seeking behaviour.

The seventh and main limitation observed in the current research, however, pertained to the wait times for service-users to access rehabilitation interventions, such as therapy, psychosocial support and/or medical legal assessments (see section 4.2). Specifically, long

wait times to engage in therapeutic services, lack of resources to offer frequent psychosocial intervention, and restricted access to legal reports, resulted in very few interventions offered or utilised by service-users within their first 12 – 15 months in the service. Not only do the long waits to access services run the risk of the service-user deteriorating during this time (Laban et al., 2007; Laban et al., 2004; Laban et al., 2008) but it also prevented appropriate and effective data being gathered for RQ2. Research question 2 (RQ2) of the current research would therefore be worth exploring again when the wait time for access to services has been addressed in Spirasi or carried out in a similar service which is not impeded by this issue. Further to this, future research should explore the impact of a psychosocial-led service with service-users who are undergoing the international protection process to determine whether having psychosocial needs met prior to undergoing trauma processing work makes for a more efficient use of resources and a more appropriate timeline for survivor rehabilitation.

The eighth and final limitation that must be considered for this research is the impact of the Global Covid-19 pandemic. In March 2020, Ireland was put into an official ‘lock-down’ due to the escalation of the Covid-19 Pandemic.⁶ As a result, Spirasi was unable to operate their usual service. Over the months that followed, similar to other mental health services (Shore, Schneck, & Mishkind, 2020), Spirasi moved its services online to facilitate remote working. Whilst a recent meta-analysis (Batastini, Paprzycki, Jones, & MacLean, 2021) of online vs in-person delivery of therapy failed to show any significant difference as measured by symptom reduction, some studies have shown positive and negative results of using online therapy (Lutz et al., 2021). Namely, findings suggest improvements in those accessing therapy online, unless they encounter environmental issues which contribute added stress to trying to access therapy online (e.g., internet difficulties, privacy and confidentiality

⁶ [Gov.ie – Public Health Measures in place until 12 April to prevent spreading COVID-19. www.gov.ie.](https://www.gov.ie/en/public-health-measures-in-place-until-12-april-to-prevent-spreading-covid-19/)

issues, and childcare barriers) (Lutz et al., 2021). Spirasi's move to a remote working model was a slow process. This may have impacted the access of services for many service-users, including participants in the current research. Further to this, online therapy was a new modality for both clinicians in Spirasi and service-users, meaning it may have resulted in a slower building of trust and connection. In addition, given that most of the participants in the current research were living in asylum accommodation during the time of data collection, they may have been experienced some the environmental barriers to engagement (Lutz et al., 2021).

Research carried out on the psychological impact of the Covid-19 pandemic suggest high levels of anxiety and stress (Panchal et al., 2020; United Nations, 2020), depression, insomnia, and PTSD (United Nations, 2020) worldwide (Semo & Frissa, 2020). One study on seven Arab countries (Egypt, Kuwait, Saudi Arabia, Jordan, Algeria, Iraq, and Palestine) indicated that 36.6% adults qualified for a PTSD diagnosis (Shuwiekh et al., 2020). Further to this, a meta-analysis by Cénat et al. (2021) on all studies conducted on the impact of COVID-19 globally (up to May 2020), showed a prevalence of depression at 15.97%, anxiety at 15.15% and PTSD at 21.94%. In a meta-analysis by Vindegaard and Benros (2020), findings showed that during the Covid-19 pandemic pre-existing psychiatric disorders worsened. Further to this, significant clinical depression, anxiety, post-traumatic stress, and suicidal ideation have been recorded in front-line and healthcare workers during the pandemic (Liu, Yang, Zhang, & Liu, 2020; Rossi et al., 2020; Wan, 2020).

Minorities and refugees appear to have been strongly impacted by COVID-19 (Kirby, 2020). A study by Solà-Sales et al. (2021) comparing the impact of the Covid-19 pandemic on migrants vs non-migrants, found that migrant participants indicated worse mental health than non-migrants and, further to this, within the migrant group refugees scored worse. A study by Alpay et al. (2021), with a group of Syrian refugees in Turkey (nearly a quarter of

whom had suffered torture) measured COVID-19 traumatic stress (COVID-19TS), cumulative stressors and traumas, PTSD, depression, and anxiety. Results indicated high levels of trauma within the group and that having suffered torture was a risk factor for being hospitalised for COVID-19. They concluded that COVID-19TS is directly associated with elevated PTSD, depression, and anxiety comorbid symptoms within this population. It has been observed that during the Covid-19 pandemic levels of resilience play a role in general mental health but do not reduce the fear of Covid-19 (Solà-Sales et al., 2021). Given that minorities and refugee populations are over-represented in front-line jobs (Development, 2022), and that participants in the current research were mostly living in asylum accommodation at the time of the current research, it can be posited that economic, environmental, and mental health factors may have contributed to levels of distress for participants, which were not controlled for, and therefore may have impacted results.

With regards to future research, it would be interesting to measure the mental health impact of Ireland's response to the Covid-19 pandemic on those in the international protection process and living in group asylum accommodation. During strict protocols related to the Covid-19 pandemic, frontline workers who were residing in asylum group accommodation were moved into private accommodation spaces. It would be interesting to assess whether the risks and fear associated with being on the frontline were balanced by having access to privacy and a safe(r) living space during that time. In addition, it would be interesting to explore further Alpay et al. (2021)'s findings regarding the link between torture survivors and Covid-19 impact with the inclusion of CPTSD. Finally, a qualitative study on survivors' perspective of online therapy would be helpful in the area of torture rehabilitation. Given that physical access to the service may present issues as a result of location, work, education, and mental or physical disability, having the option for effective online rehabilitation supports would greatly benefit this field.

6.6 Recommendations

Based on these findings a number of key recommendations have been proposed. This is in keeping with the implementation approach undertaken in the current research and the goal of using these research findings as a mechanism for real world change.

Challenge	ACCESS
Context	Greater access to Spirasi's Services on all levels is needed. Participants spoke about the long wait time to enter the service and the subsequent long wait times to receive intervention after initial assessment. Further to this, a number of survivors who fall outside of the category of torture as per UNCAT Article 1 are not granted access to the rehabilitation services best suited to their needs due to Spirasi's strict remit. The findings from the current research further highlight the need to revisit the definition of torture and establish the role of psychological impact within this definition for those tasked with delivering rehabilitation. The long and arduous asylum system is contributing to mental distress for torture survivors in this process in Ireland.
Recommendation	There needs to be greater access to psychosocial supports, over and above the access currently granted to therapeutic supports. Make MLR access available to all service-users. Wider Spirasi's Remit.

	The White Paper needs to be revisited and changes made to ensure the aims laid out within this document can still be met without further delay.
Expected Outcome	There are high levels of psychosocial needs identified within this population of service-users. Stabilisation, as per the Phase Model Approach, can be achieved through regular and appropriate engagement with psychosocial officers, where practical needs relating to the asylum system, and safety-building and empowerment needs can be met through basic psychological first aid. A strong psychosocial foundation for survivors in the international protection process could pave the way for more effective and timely psychotherapeutic interventions. Gaining access to international protection is a high priority for many accessing Spirasi's services and the delay or rejection relating to this causes ongoing and compounding levels of distress. However, only a small percentage of service-users receive an MLR from Spirasi to support their asylum claim. Access to a report, as is their human right (OHCHR, 2022) would support the service-user in seeking justice, as per the Holistic Approach to Rehabilitation (Freedom from Torture, 2011). Spirasi's purpose is to provide rehabilitation to survivors of torture. UNCAT GC2 advocates for the inclusion of SGBV under the definition of torture. My findings demonstrate high levels of psychopathology and

	rehabilitative needs among those who do not fit into the strict definition under Article 1 of UNCAT. Spirasi has to date been discretionary in accepting referrals from those outside of this strict definition. However, if the goal is rehabilitation based on the complexity and severity of need, then there is a case to be made for officially widening the remit to include ‘serious harm’ and SGBV in referral applicants with refugee backgrounds.
Challenge	LONG-TERM NEED
Context	High rates of CPTSD which requires a long-term approach to treatment, as well as complex psychosocial needs exacerbated by the long asylum processes in Ireland, mean that Spirasi’s rehabilitation model must account for long-term need.
Recommendation	Incorporate a long-term approach to the rehabilitation of torture survivors seeking international protection through a more appropriate holistic model of rehabilitation which has psychosocial support at the forefront.
Expected Outcome	Service-users will establish a sense of safety, stability and basic resourcing and coping mechanisms prior to engaging in trauma-therapy work. Making for a more efficient and ethical approach to rehabilitation.
Challenge	WESTERNISED APPROACHES
Context	Spirasi’s model for rehabilitation, while incorporating some non-Western approaches such as trauma-sensitive yoga and Capacitar groupwork, is still heavily reliant on Western-approaches to psychotherapy through the prioritising of individual talk therapy as the main course of treatment.
Recommendation	De-colonisation Process which includes the survivors’ perspective.

Expected Outcome	A more culturally appropriate approach to rehabilitation which creates better engagement and outcomes.
Challenge	RESOURCING
Context	Spirasi's long wait time for accessing services are partly due to under-resourcing. Spirasi is heavily dependent on State, EU, and Religious Funders. The increase in people seeking international protection in Ireland (over 11,000 through the asylum process and over 60,000 from the Ukraine crisis) will inevitably mean an increase in referrals to Spirasi's services. Spirasi's current resources are insufficient to meet the current and future demand for torture rehabilitation.
Recommendation	Implement appropriate monitoring and evaluation systems for the purposes of reporting and funding applications. This should incorporate both quantitative and qualitative mechanisms for M&E. Service-user feedback and involvement in the design of services should be at the forefront. Training of clinicians in the administration of feedback mechanisms is important to ensure consistency. Link with the Department of Children, Equality, Disability, Integration and Youth regarding the implementation of the 'White Paper' and the role Spirasi's services can play within this i.e., the regionalisation of services and access to mental health supports for those who are identified as survivors of torture through the vulnerability assessment.

Expected Outcome	Evidence-based services will not only help to improve the services delivered by Spirasi for their service-users but will also demonstrate impact to funders. Thus, creating a stronger funding proposal. Coordinating with the Department of Children, Equality, Disability, Integration and Youth around the regionalisation of services in line with the new accommodation areas as implemented by the White Paper will ensure greater access to appropriate supports for torture survivors.
Challenge	MODEL FOR HOLISTIC REHABILITATION
Context	Spirasi's holistic model for rehabilitation is proving to be ineffective, due to the over-reliance on individual psychotherapy.
Recommendation	Implement the <i>Survivors Model for Rehabilitation</i>. Findings and the development of <i>Survivors Model for Rehabilitation</i> should be published and shared globally so as to give other rehabilitation centres working with this population the opportunity to implement it within their services, where appropriate. The inclusive of Sleep-specific treatment in the early stages of rehabilitation i.e., CBT-I. Spirasi's initial assessment should be considered a part of, rather than the start of, their rehabilitation programme.

Expected Outcome	As part of its interrogation of current services, and its commitment to the IRCT's recommendation of a survivor-led service, Spirasi should use the model as a guide in developing a new way of delivering holistic rehabilitation. The expected result of which is a more informed and appropriate approach to holistic rehabilitation which accounts for the experience encountered through torture, through interpersonal trauma, and through the refugee experience. Sharing this model across similar organisations may highlight the importance of including a survivor perspective in models of rehabilitation and provide a new context from which to work. A shift in focus in terms of psychological treatment, including a specific focus on improving natural, healthy sleep for survivors will better resource survivors in building resilience. The inclusion of a substantial initial assessment which delivers diagnostic accuracy through the use of the ITQ, followed by psychoeducation to inform and empower the service-user as to how trauma may manifest, while offering short-term solutions regarding coping mechanisms and a treatment pathway, may provide a solid foundation to the rehabilitation journey for the service-user.
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6.7 Conclusion

With the increasing instability and conflict permeating across the world, it is highly likely the current crises resulting in high numbers of forcibly displaced people will not only continue but escalate over the coming years. The rise of far-right propaganda and politics internationally is a cause of concern, especially in relation to maintaining standards around human rights. The refugee population face risks at all stages of their journey, pre-flight, transit, and post-flight. Ireland has long demonstrated their commitment to championing human rights. However, as a nation, we are failing those who seek asylum on multiple levels. The ongoing distress caused by the asylum process and the barriers to accessing appropriate rehabilitation supports mirror the torture and trauma experiences prior to arrival in Ireland. The findings from the current research highlight the severity of psychology distress experienced by torture survivors in the asylum process in Ireland and the high level of complex needs with which they present. Organisations tasked with providing support for this population must find ways of working within best practice and advocate for additional resources to ensure accessibility. The Irish government must recognise their commitment to providing appropriate and accessible rehabilitation to torture survivors as a signatory to the United Nations Convention Against Torture, which affirms the requirement for States to provide “as full a rehabilitation” as possible.

This research endeavoured to explore the rehabilitation of survivors of torture in the international protection system in Ireland through addressing three research questions over two phases, with the findings from each objective informing the methods of the next. The final outcome is the generation of a new model of how to work with survivors of torture who are seeking international protection in a Western rehabilitation setting, the *‘Survivors Model for Rehabilitation’*.

For decades clinicians and researchers alike having been stating that a diagnosis of PTSD is insufficient to capture the impact of compounding or severe effects of the torture

and refugee experiences. In 2018, with the inclusion of a diagnosis for CPTSD in the ICD-11, new opportunities arose to test this theory. The current research provides evidence that CPTSD is highly prevalent in torture survivors subjected to the refugee experience. Thus, validating clinical theory and providing appropriate diagnostic tools for measuring the impact of trauma within this population. This has global-wide implications in terms of treatment approaches across rehabilitation centres for survivors of torture. Further to this, the development of a new model for rehabilitation which incorporates previous theory relating to the mechanisms of torture, the treatment of complex trauma, and the best practice around holistic approaches to rehabilitation, presents rehabilitation centres with a solid framework for working with complex psychological presentations in complex psychosocial settings.

However, the most important aspect of these findings is that this model is developed from the torture survivor's perspective. The theory and findings across all levels of this research indicate that at the core of torture is the intention to use power and uncertainty to control the victim in order generate the highest level of distress. The theory and findings from this research demonstrate that key to rehabilitation, according to survivors in this research, is countering these core mechanisms of torture, through empowering the survivor through the provision of choice, certainty, and connection, thereby restoring a sense of control. In conclusion, the poison may dictate the antidote, but it is the survivor that should dictate the rehabilitation.

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Appendices

Appendix A: Common forms of torture according to the Istanbul Protocol (OHCHR, 2004)

Torture Act	Types	Techniques
Blunt Trauma	Crushing Whipping Beating	Objects used in crushing techniques include rifle butts, pliers, heavy rollers, or the body weight of the perpetrators. Whipping with wires. Beating techniques include: ‘Telefono’ consists of hitting both ears simultaneously with the palms of the hands; ‘Falanga,’ which is the beating of the soles of the feet with a solid object (Shrestha et al., 1998b).
Penetrating Injuries	Gunshot wounds, stabbing (including slashing), limb removal.	Objects used for stabbing can include needles, razor blades, knives, bayonets, glass, scrap metal, and rods. The traumatic removal of tissue and appendages includes the forceful removal of earlobes, hair, and nails. Inserting wire under the nails.
Suspension and Forced Positioning	Stretching limbs apart, prolonged constraint of movement, forced positioning. Suspended by the wrists, or ankles, for varying amounts of time in varying	‘La barra’ consists of tying the wrists to the ankles, keeping the knees completely flexed, and passing a rod under the knees and in front of the elbows, before suspending the victim by lifting the rod (O. V. Rasmussen, 1990). ‘La bandera’ (the flag) consists of tying the victim’s wrists behind their back and then suspending them by the hands.

	positions (H. D. Petersen & O. V. Rasmussen, 1992).	‘The Palestinian suspension’ consists of suspending the victim with one hand facing forward and the other one facing backwards (Skylv, 1992). ‘El quirofano’ consists of suspending the upper half of the victim’s body in the air, while the victim is laying down on their front (O. V. Rasmussen, 1990). Male victims are sometimes subjected to heavy objects being suspended from their genitals.
Burns and Electric Shocks	Chemical, Thermal, and Electrical	Chemical exposure to salt, chilli pepper, gasoline, etc. (in wounds or body cavities). Objects used to inflict burns often include cigarettes, hot irons, gas torches, ice, hot liquids like water and oil, electricity from power outlets or stun guns, acids, and other caustic materials. Electric shock sources tend to be power outlets, portable generators, cattle probes, and stun guns. Electric probes are often placed on sensitive organs, such as earlobes and genitalia.
Asphyxiation	Dry or Wet	Dry ‘submarino’ which consists of covering the victim’s head with a plastic bag. Wet ‘submarino’ consists of the submerging of the victim’s face in fluids, such as dirty water, urine, or excrements. Forcing the victim to inhale chemicals or dust.
Detention Conditions	Environmental conditions or manipulations within the cell.	Small or over-crowded cell, solitary confinement, unhygienic conditions, no access to toilet facilities, irregular or contaminated food and water, exposure to extremes of temperature, denial of privacy, and forced nakedness.

		Deprivation of normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell.
Sexual Torture	Rape, Sexual Assault, Humiliation, Forced Incest, FGM, Mutilation	Digital or penile rape. Rape using objects or the insertion of objects into the vagina and anus, such as the point of a bayonet, sharp sticks, broken bottles, knives, burning wood, and hot oil. Mutilation of sexual organs with knives or razor blades, cutting of the clitoris and other parts of the vagina (Shrestha et al., 1998b)
Psychological Torture	Isolation, debilitation, spatiotemporal disorientation, sensory deprivation, sensory assault, the threat of death or violence, degradation, and pharmacological manipulations (Ojeda, 2008).	Humiliation, such as verbal abuse, performance of humiliating acts. Threats of death, harm to family, imprisonment, mock execution. Threats of attack by animals. Forced betrayals, accentuating feelings of helplessness, exposure to ambiguous situations or contradictory messages. Violation of taboos. Behavioural coercion, forced harm to others through torture or other abuses, forced destruction of property, forced witnessing of torture or atrocities being afflicted on others.

Appendix B: Participant Information Leaflet (PIL)

An evaluation of Spirasi's holistic approach to treatment of complex trauma to improve the mental health outcomes of asylum seekers and refugees who have experienced torture

Participant Information Leaflet



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



Research Study in partnership with Spirasi and the Centre for Global Health, Trinity College, Dublin

Table of Contents

Purpose of this Study.....	1
Your Involvement.....	2
Next Steps.....	3
Your Confidentiality.....	4
Benefits and Risks	5

You were informed during your initial assessment that research is taking place in Spirasi. This is an information booklet outlining a study currently being researched in Spirasi.

Purpose of this Study

This research study is a postgraduate study which will examine the impact of Spirasi's rehabilitation services in treating trauma and promoting well-being in Spirasi clients.

The study will contribute to our understanding of the impact of Spirasi's rehabilitation programmes on trauma in asylum-seekers and refugees, who have experienced torture. It will do this by analysing the pseudo-anonymised data provided by clients at initial assessment and 12-month follow-up assessments in Spirasi. Some participants will also be invited back in 12 months' time to speak about their experience of Spirasi's rehabilitation services.

It is hoped that the study will benefit asylum-seekers and refugees, who have experienced torture by creating a greater understanding of the experiences of clients engaging in Spirasi's rehabilitation programme.

You can withdraw from this study without penalty, and no explanation will be required. Any data collected prior to withdrawing will be destroyed and not used. After May 2021 it may not be possible to remove certain data as it will have been anonymised, processed and ready for publication as part of the larger study.

Your Involvement

- At the information session, the researcher (Aisling) explained to you what will be involved if you decide to take part in this study. It was explained that there are 2 phases to this study.
- **Phase 1:** As part of their process, Spirasi invites all clients to do a follow up assessment after 12 months, using questionnaires you filled in during your first visit. Spirasi does this as part of client-care and data collection. The researcher (Aisling) would like to use this data for research purposes.
- **Phase 2:** A small number of participants who have engaged in Spirasi's rehabilitation programme be invited back for an interview with the researcher (Aisling) to talk about their experience of Spirasi's rehabilitation programme after 12 months. This interview will take place over an online video or audio platform. It will be audio- or video-recorded and transcribed by the researcher (Aisling). This data will be used as part of her study into the effectiveness of Spirasi's rehabilitation services.
- An interpreter will use used, if required.
- The findings will be published as part of a post-graduate study. Your name and any identifiable information will **not be published**, but your anonymous answers may be used to inform future rehabilitation programmes in Spirasi and similar organisations. The overall anonymised findings of the study may be used in academic papers and oral presentations.

Next Steps

- **If you would like to take part in Phase 2 of this study:**
 - You will be invited to attend an online interview with the researcher (Aisling) 12 – 18 months' after your initial assessment.
 - Before you consent to taking part, Aisling will send talk to you about the research aims, goals and requirements over the phone, and send you information via email or post to read. You will also be sent a consent form to review.
 - An interpreter will be booked for you, if required, to talk you through the research aims, goals, and requirements – including the reading through of this information booklet and consent form.
 - The researcher (Aisling) will call you 7 days later to follow up.
 - If you wish to take part, the researcher (Aisling) will ask you to sign a consent form and post it back to the Spirasi office using the stamped addressed envelope supplied.
 - The researcher (Aisling) will then arrange a day and time suitable to you for the online interview to take place.
 - On the day, the researcher (Aisling) will go through what will be involved and answer any questions.
 - You will have the opportunity to change your mind and discontinue the interview at any point in time, regardless of signing the consent form.
 - From beginning to end, the interview should last approximately 50 to 90 minutes.
-



Benefits and Risks

- If you decide to take part in this study, there is no direct benefit for participants. However, it is hoped that the study will benefit future asylum-seekers and refugees, who have experienced torture.
- It will aim do this through creating greater understanding of the experiences of Spirasi clients and through informing future rehabilitation programmes.
- There is a risk that you may find the research procedure distressing. If you feel uncomfortable or distressed at any time, please note that you can reschedule or withdraw from the study completely.
- There will be no penalty for choosing not to continue, and it will not have any effect on the services you receive at Spirasi or in your asylum process.
- If you become distressed, the researcher (Aisling) will stop the interview and either contact a Spirasi therapist/doctor on your behalf or help reduce your distress using her skills as a therapist.
- If the researcher (Aisling) feels that you are unable to meet the requirements of this research or if she feels that it is in your best interest to stop, she has the right to end your participation.

Should you have any questions about this research, please do not hesitate to contact Aisling. She is happy to talk to you about this study over the phone or online video.



Your Confidentiality

- If you would like to take part in this study, all of your information and the answers you provide will be used by the researcher for research purposes only. This means that your information will not be shared with anyone else, other than Spirasi. Spirasi keeps a record of the questionnaire scores for their own data collection purposes.
- Your name will only appear on the consent form which will be stored in paper-format in a locked cabinet, and electronic format in a password-protected client management system.
- If you take part in phase 2 of this study, the audio recording of the interview will be typed out by the researcher (Aisling) and you will be provided with a copy of it. If there is something that you spoke about in the interview that you would like to delete, the researcher will help do this. The storage of this data will be password protected.
- Spirasi does not have any role in the processing of asylum applications by the State; participation in this study will not have any effect on your asylum application.
- The interpreter will be asked to sign a legally binding non-disclosure form for confidentiality purposes. This means that the interpreter cannot speak about anything we discuss.
- There are limits of confidentiality. In certain circumstances, the researcher may need to break confidentiality, due to concern for your well-being or the well-being of another. This is in line with Spirasi's policies related to clinical practice and confidentiality. The researcher will try to inform you in advance if there is a need to break confidentiality.
- You have a right under the Freedom of Information Act to make a formal request for any of your personal information held by the researcher.

Contact

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Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



Spirasi

213 North Circular Rd,
D7

Appendix C: Spirasi Consent Form

Part A: Client Consent To Process Special Data at Assessment

Spirasi: Spirasi is an Irish organisation helping survivors of torture most of whom are asylum seekers, refugees, or other disadvantaged migrant groups. In Spirasi our aim is to provide a holistic rehabilitation to those who have suffered torture, through medical, therapeutic, social and integration support.

Special Information: In recognition of your right to privacy, we are seeking your permission to collect and process your "*Special Information*". This is data revealing:

- your racial or ethnic origin
- political opinions, religious or philosophical beliefs
- trade-union membership
- health-related data
- data concerning your sexual health or sexual orientation
- biometric data processed solely to identify you
- criminal convictions

Your Consent: Spirasi seeks to use your Special Information for the purposes outlined below. You do not have to provide your consent and you may withdraw consent at any time. Where consent is not provided or it is withdrawn we will cease use your special information for the relevant purpose.

Please confirm that you are happy to agree to the following:

- I agree for my special information to be used **by Spirasi** where required to conduct my assessment or to provide or obtain clinical care, social care or related support for me.

YES ☐ NO ☐

- I agree for my special information to be **anonymized for internal and external research and reporting purposes.**

YES ☐ NO ☐

- I agree for my special information including photographs to be used for **preparing reports** where required for **my assessment, care and support** including the preparation of Medico-Legal Report and clinical letters (such as routine feedback letters to my GP).

YES ☐ NO ☐

- I agree to receive consultations with Medical Professionals and other Clinical Team Members using **Secure Video and Audio Consultations**, if necessary, for my **assessment, care and support**.

YES ☐ NO ☐

- I agree that where required for **my assessment, care and support**, Spirasi may share my personal and medical information with **non-Spirasi persons** for the above purposes, such as Health Care Professionals, Social Care Professionals, Legal Professionals, Accommodation Providers and other Agencies related to your care.

YES ☐NO ☐

Should you wish to withdraw your consent at any time, you should contact the Data Protection Officer at info@spirasi.ie; or write to Data Protection Officer, Spirasi, 213 North Circular Road, Phibsborough, Dublin 7. Please note this may impact on our ability to provide our services.

I _____ (*Name of client in block capitals*), agree and consent for my data to be used for the purposes that I have indicated above.

Signed: _____ (*Client*) Date: _____

I _____ (*Name of Interpreter in block capitals*)
 have explained each section of this client consent in _____ (*Insert language*) and the client has acknowledged and confirmed that they understand each section of the form and the choices they have made before signing.

Signed _____ (*Interpreter*) Date:

We are a registered charity (Irish registered charity number 16923) and company (Irish registered company number 476831). Our full name is Spiritan Asylum Services Initiative. Please read our Privacy Notice for full details on how we use personal information.

Part B: Privacy Notice

About Us

We are Spirasi. Within this Privacy Notice 'we' and 'us' means Spirasi. We aim to help those who flee torture and severe trauma through our services.

In order to provide our services to you, we need to use your personal information. We are committed in all our uses of your personal data to protecting and respecting your privacy. This Privacy Notice will tell you about what personal data we collect, how we use your personal data and your right to protect your personal data. If you do not understand any part of this Privacy Notice please ask the Data Protection Officer at info@spirasi.ie; or write to Data Protection Officer, Spirasi, 213 North Circular Road, Phibsborough, Dublin 7.

We are a registered charity (Irish registered charity number: 16923) and company (Irish registered company number: 476831). Our full name is Spiritan Asylum Services Initiative

1. Your Personal & Special Information

Your personal information is any information about you that can be used to identify

you including your name, date of birth, postal address, e-mail address and telephone number.

Certain categories of your personal information are regarded as *special*. Special information includes information relating to an individual's physical or mental health, religious, philosophical or political beliefs, trade union membership, ethnic or racial origin, biometric or genetic data and sexual orientation.

2. What personal information do we collect? Why do we collect it?

Type of Personal Information	Purpose	Legal Basis
Administrative: name, address, contact details (phone, mobile, email), dates of appointments.	To support the administration of our organisation including the provision of services to you and information about services.	This processing is necessary for our legitimate interests in managing Spirasi's charitable activities. You have the right to object to us processing your personal data on this basis.
Medical Record: Individual Health Identifier, date of birth, religions, country of origin, sexual orientation, gender, family history, contact details of next of kin, contact details of carers, asylum application number, PPSN, Medico-	To conduct medical assessments, prepare reports based on medical assessments including the preparation of Medico-Legal and clinical letters.	We will only use your special data where one of the following is satisfied: i. you have explicitly consented ii. it is necessary to protect your vital interests where you are not capable of consenting

Legal reports, photographs, medication details, current and past medical history, laboratory test results, imaging test results and other data required to provide medical data.		iii. it is necessary for medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems as provided by the Data Protection Act 2018. iv. it is necessary for the purposes of providing or obtaining legal advice in connection with legal proceedings, or for the purpose of exercising and defending legal rights.
	To provide or obtain clinical care, social care or related support.	(i) and (iii) as above.
	For research purposes. The purposes and legal basis for which Spirasi processes personal and health research data is available upon request.	We will only use your special data for health research purposes where you have explicitly consented.
3. Who do we share your information with?		
With regard to assessments and your ongoing care and support of our clients, we may share data with the following non-Spirasi persons:		

Health and social care providers	GPs, HSE, hospitals and clinics, occupational therapists, speech and language therapists, social workers, pharmacies, counselling services, hospital laboratories.
Service Providers	Service providers under contract with us including IT providers such as Salesforce and Thesaurus Software.
Other Third Parties	Solicitors, Social Protection, the International Protection Office, Tusla, Reception Integration Agency and accommodation providers such as De Paul Trust.

4. How long do we keep your personal information?

We may retain your Personal Data **indefinitely** for the purposes of providing services to you. We will also retain Personal Data for so long as required by law and for the exercise or defence of legal claims.

For more information, please contact ask the Data Protection Officer at info@spirasi.ie; or write to Data Protection Officer, Spirasi, 213 North Circular Road, Phibsborough, Dublin 7.

5. Transfers of Information

The data that we collect from you may be transferred to, and stored at, destinations both within and outside the European Economic Area (**EEA**), for example, we use an IT provider that is located in the US.

We want to make sure that your personal data is stored and transferred in a way which is secure. We will therefore only transfer data outside of the EEA where it is compliant with the GDPR and the means of transfer provides adequate safeguards in relation to your data. For example, this could be:

by way of a data transfer agreement with a third party, incorporating the current standard contractual clauses adopted by the European Commission for the transfer of

personal data by controllers in the EEA to controllers and processors in jurisdictions without adequate data protection laws; or

by transferring your data to a country where there has been a finding of adequacy by the European Commission in respect of that country's levels of data protection via its legislation; or

where you have explicitly consented to the data transfer.

Where we transfer your personal data outside the EEA and where the country or territory in question does not maintain adequate data protection standards, we will take all reasonable steps to ensure that your data is treated securely and in accordance with this Privacy Notice.

6. Your Rights

You have number of rights in relation to how we use your personal information.

Object	You have a right to object to us processing your personal information where we do so on the basis of our legitimate interests to do so for research purposes.
Withdraw consent	Where we have obtained your consent to process your personal information, you may withdraw this consent at any time. We will cease to use your data for that purpose unless we consider that there is an alternative legal basis to justify our continued processing of your data for this purpose, in which case we will inform you of this condition.
Access	You may ask us for a copy of the information we hold about you at any time, and request us to modify, update or delete such information. If we provide you with access to the information we hold about you, we will not charge you for this unless permitted by law. If you request further copies of this information from us, we may charge you a reasonable administrative cost. Where we are legally permitted to do so, we may refuse your request. If we refuse your request we will always tell you the reasons for doing so.

Deletion	You have the right to request that we "erase" your personal data in certain circumstances. Normally, this right exists where: • It is no longer necessary for us to hold the information for the purpose for which we obtained it; • You have withdrawn your consent to us using your information, and there is no other valid reason for us to continue; • Your information has been processed unlawfully; • It is necessary for the information to be erased in order for us to comply with our obligations under law; or • You object to the processing and we are unable to demonstrate overriding legitimate grounds for our continued processing. We would only be entitled to refuse to comply with your request for erasure in limited circumstances and we will always tell you our reason for doing so. When complying with a valid request for the erasure of data we will take all reasonably practicable steps to delete the relevant data.
Restrict processing	You have the right to request that we restrict our processing of your personal information in certain circumstances, for example if you dispute the accuracy of the personal information that we hold about you or you object to our processing of your personal information for our legitimate interests. If we have shared your personal information with third parties, we will notify them about the restricted processing unless this is impossible or involves disproportionate effort. We will, of course, notify you before lifting any restriction on processing your personal information.
Rectification	You have the right to request that we rectify any inaccurate or incomplete personal data that we hold about you. If we have

	shared this personal data with third parties, we will notify them about the rectification unless this is impossible or involves disproportionate effort. You may also request details of the third parties that we have disclosed the inaccurate or incomplete personal data to. Where we think that it is reasonable for us not to comply with your request, we will explain our reasons for this decision.
Portability	If you wish, you have the right to transfer your personal data between service providers. In effect, this means that you are able to transfer the details we hold on you to another third party. To allow you to do so, we will provide you with your data in a commonly used machine-readable format so that you can transfer the data. Alternatively, we may directly transfer the data for you.
Contact Us	If you wish to exercise any of these rights, please contact us at info@spirasi.ie or call us at (01) 838 9664. We will respond to your request within one month. That period may be extended by two further months where necessary, taking into account the complexity and number of requests. We will inform you of any such extension within one month of receipt of your request. We may request proof of identification to verify your request. We have the right to refuse your request where there is a basis to do so in law, or if it is manifestly unfounded or excessive, or to the extent necessary for important objectives of public interest.
Further information	You also have right to lodge a complaint with the Data Protection Commission or another data protection authority, in particular in the Member State of your residence, place of work or place of an alleged infringement, if you consider that the processing of your personal data infringes the GDPR.

	Further information in respect of your rights is available at the website of the Office of the Data Protection Commission, www.dataprotection.ie .
Changes to how we use your Personal Information	
This Privacy Notice was last updated on 1 September 2020 and may change from time to time. We will use your more recent contact details we have to notify you of material changes.	
7. Contact Us	
If you have any questions about this Privacy Notice or the privacy and/or security of personal information submitted to us, please email the Data Protection Officer at info@spirasi.ie ; write to Data Protection Officer, Spirasi, 213 North Circular Road, Phibsborough, Dublin 7. All requests will be dealt with promptly and efficiently.	

Appendix D: Phase Two Consent Form

UNDERSTANDING THE LONG-TERM OUTCOMES OF ASYLUM SEEKERS AND REFUGEES WHO HAVE EXPERIENCED TORTURE, FOLLOWING PARTICIPATION IN SPIRASI'S REHABILITATION SERVICES

Phase 2: Consent Form – Participant's Copy

Researcher Name: Aisling Hearn

Email Address: hearnsai@tcd.ie

Phone Number: +353 1 838 9664

Supervisor Name: Dr Frederique Vallieres

Email Address: fvallier@tcd.ie

Phone Number: +353 1 896 2130

Research Summary

This research study is a postgraduate study which will examine the impact of the rehabilitation services in Spirasi in treating trauma and promoting well-being in Spirasi clients. The research aim is to explore the associations between the rehabilitation programmes in Spirasi and the psychological effect of torture. The study will contribute to our understanding of the impact of Spirasi's rehabilitation programmes on trauma in asylum-seekers and refugees, who have experienced torture. It will do this by collecting the anonymised data provided by clients at their 6- and 12-month follow-up assessments in Spirasi. It is hoped that the study will benefit asylum-seekers and refugees, who have experienced torture by creating a greater understanding of the experiences of clients engaging in Spirasi's rehabilitation programme.

You will be invited to Spirasi Dublin to attend an interview with the researcher (Aisling). An interpreter will be provided if necessary. This interview will be audio-recorded and later transcribed by the researcher (Aisling).

I _____ consent to participate in the present study.

- I agree that I have been told all the relevant information to do with this research.
- I have read, or have had read to me, the information booklet for this research and I understand the reasons that this research is being carried out.
- I agree that I fully understand that any information I provide will be kept private and confidential and will not be used for any other purposes than outlined in the Participation Information Booklet.
- I acknowledge that if I take part in this research it will not have any effect on the services I receive at Spirasi, either now or in the future.
- I acknowledge that Spirasi does not have any role in the processing of asylum applications by the State and participation in the study will not have any effect on my asylum application.
- I agree that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction.
- I freely and voluntarily agree to be part of this study, though without prejudice to my legal and ethical rights.
- I give my permission for my anonymous information and data to be used in future studies without additional consent and I agree to the publication of the results of this research.
- I understand that I can withdraw from this study at any time and my decision to withdraw will not involve any penalty. I understand that if I withdraw from the study my data will not be used for the purposes of this study and any data stored by the researcher for this purpose will be permanently deleted.
- I have been informed of the limits of confidentiality and am aware that there are certain circumstances in which the researcher may need to break confidentiality. I am aware that this is in line with Spirasi's policy on confidentiality and policies related to clinical practice.
- I understand that I have a right under the Freedom of Information Act to make a formal request for any of my personal information held by the researcher.
- I have received a copy of this agreement.

Name: (Print) _____

Signature: _____

Date:

Principal Investigator's Statement of Responsibility

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that might be involved. I have offered to answer any question and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Name: (Print) _____

Signature: _____

Date:

Appendix E: Interpreter Confidentiality Agreement



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



INTERPRETER CONFIDENTIALITY & NONDISCLOSURE AGREEMENT

I, _____ understand that when employed as an Interpreter, my responsibility is to facilitate communication between two or more parties that do not speak or understand the same language. **All information discussed between the parties is considered to be “confidential”.**

I, agree to hold confidential or proprietary information in trust and confidence and agree that information discussed at a meeting/activity shall be used only for the purposes of conducting such meeting/activity and shall not be used for any other purpose, or disclosed to a third party.

Furthermore, at the conclusion of the meeting/activity, I agree to return all written information (i.e., forms, notes, etc.) provided to me for the purposes of conducting such meeting/activity.

I understand that if I violate this agreement in any way, I will be terminated from the Interpreter list and will no longer be allowed to serve in an interpreter capacity for Spirasi.

AGREED AND ACCEPTED BY:

Interpreter

Date

Researcher

Title

Appendix F: Debriefing Form

Debriefing Sheet

UNDERSTANDING THE LONG-TERM OUTCOMES OF ASYLUM SEEKERS AND REFUGEES, WHO HAVE EXPERIENCED TORTURE, FOLLOWING PARTICIPATION IN SPIRASI'S REHABILITATION SERVICES.

Researcher Name: Aisling Hearn	Supervisor Name: Dr Frederique Vallieres
Email Address: hearnsai@tcd.ie	Email Address: fvallier@tcd.ie
Phone Number: +353 1 838 9664	Phone Number: +353 1 896 2130
School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2	School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2

Thank you for agreeing to participate in this study.

This research study is a postgraduate study which will examine the impact of the rehabilitation services in Spirasi in treating trauma and promoting well-being in Spirasi clients. The research aim is to explore the associations between the rehabilitation programmes in Spirasi and the psychological effect of trauma.

The study will contribute to our understanding of the impact of Spirasi's rehabilitation programmes on trauma in asylum-seekers and refugees, who have experienced torture. It will do this by collecting the anonymised data provided by clients at their 6- and 12-month follow-up assessments in Spirasi.

We invited clients of Spirasi who had consented to participate in this study to attend follow-up assessments at 6 and 12 months. A small number of suitable participants were also invited back for a follow-up interview between 12 and 18 months after their Initial Assessment in Spirasi. The participants in Phase 1 answered 3 questionnaires at follow-up assessments 6 and 12 months after their initial assessment. The participants in phase 2, completed Phase 1 and were invited to attend an interview with the researcher (Aisling) to speak about their experience of Spirasi's rehabilitation services, 12 – 18 months after their Initial Assessment. It is hoped that the results from the study will benefit asylum-seekers and refugees, who have experienced torture, by creating a greater understanding of the experiences of clients engaging in Spirasi's rehabilitation programme.

If you feel especially concerned about how your data will be used in this study or are experiencing any distress as a result of participating in this study, please feel free to contact the researcher (Aisling Hearn) on 01 8389664 or hearnsai@tcd.ie about options for therapeutic support in Spirasi. Alternatively, you could also contact her academic supervisor (Frederique Vallieres) if you have any concerns regarding the wider study or regarding the researcher (Aisling Hearn).

Thank you for your participation in this study. If you have further questions about the study, please contact Aisling Hearn. In addition, if you have any concerns about any aspect of the study, you may contact Dr. Frederique Vallieres, Ph.D., Assistant Professor, Centre for Global Health, Trinity College Dublin, on (01) 896 2130 or fvallier@tcd.ie.

Appendix G: Ethics Approval Letter



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

F.A.O. Aisling Hearn

Approval ID: SPREC112020-31

School of Psychology Research Ethics Committee

29th January 2021

Dear Aisling,

The School of Psychology Research Ethics Committee has reviewed your application entitled "Understanding the long-term Outcomes of asylum seekers and refugees who have experienced torture, following participation in Spirasi's rehabilitation services", and I am pleased to inform you that it was approved.

Please note that you will be required to submit a completed **Project Annual Report Form** on each anniversary of this approval, until such time as the research is complete and the thesis is submitted. The form is available for download from the Ethics section of the School website.

Adverse events associated with the conduct of this research must be reported immediately to the Chair of the Ethics Committee.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Richard Carson'.

Richard Carson
Chair,
School of Psychology Research Ethics Committee