Public Health, Mental Health and Human Rights

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The Example of North Iraq

Edited by

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Julia Beckmann and Thomas Wenzel

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PREFACE I

THERESIA BAUER

MEMBER OF THE STATE PARLIAMENT
OF BADEN-WÜRTTEMBERG, GERMANY

When thousands of refugees came from Iraq to the state of Baden-Württemberg in Germany in 2015 and 2016, we knew immediately that we had to do more than make offers for integration in our country. It seemed just as important to us to initiate projects in the regions affected, to address, or at least mitigate, their causes of flight.

For example, the Kurdistan Region of Iraq, which has more than five million inhabitants, has taken in more than two million internally displaced persons and refugees. This is an enormous challenge for the region and we wanted to provide targeted assistance here. As early as 2015, the state of Baden-Württemberg therefore established a collaborative agreement with the Duhok governorate, which was extended in 2019 during a delegation trip with the former Minister of State, Theresa Schopper, and myself.

Examples of aid initiatives on the ground were a carpet manufactory in Khanke, in which women affected by war and displacement could build their own livelihood, and the construction of a regenerative power supply in the Mam Rashan refugee camp. However, the centerpiece of our relief efforts was a Special Quota Project in which particularly vulnerable women and their children were relocated from northern Iraq to Baden-Württemberg. In 2015 and 2016, we took in around 1,100 particularly vulnerable women and children from Iraq, many of them of the Yazidi faith. These were women who had been held captive and tortured by the terrorist organization Islamic State. They received psychotherapeutic help in Baden-Württemberg and were supported on their way back to a safe life.

As a logical next step, especially following our experiences with the Special Quota Project, an idea developed in late fall 2016 to establish an Institute for Psychotherapy and Psychotraumatology at the University of Duhok, and to set-up a master's degree program in psychotraumatology. I was particularly convinced by the fact that expertise would be built up

locally in northern Iraq to help people there right from the start of the project.

After the urgent need for such an institute was recognized by all sides, everyone involved worked intensively on the design of the institute. After initial drafts in the fall of 2016, a final application was submitted by the Dual University of Baden-Württemberg (DHBW) at the beginning of 2017. It was immediately reviewed and approved by the Ministry of Science. The Institute for Psychotherapy and Psychotraumatology at the University of Duhok was then launched in March 2017.

There is no blueprint for such a project, but the Ministry has recognized expertise in the support and establishment of institutes and study programs in Baden-Württemberg. As such, we were able to build on this knowledge. The project leaders, Professor Kizilhan from the Baden-Württemberg Cooperative State University and Professor Hautzinger from the University of Tübingen, are two distinguished, internationally experienced, and recognized academics who are held in high esteem locally in northern Iraq. The project was also supported by the former governor of Duhok. The administration of the University of Duhok was very committed to the project and took care of the constructional requirements.

Of course, there were challenges in transferring funds from Baden-Württemberg to northern Iraq, with evidence and documentation required under our budgetary law. A very precise documentation and description of the administrative processes was absolutely necessary. When problems arose, the project participants, their budget departments at the universities, and representatives from my office sat down together and worked out solutions. When visas were needed for lecturers from Baden-Württemberg, we supported the visa application process with accompanying letters. In addition, the university administration from Duhok visited us regularly in Stuttgart to report on project progress and problems. During a delegation trip to Duhok in April 2019, we were also able to see the progress of the project, the work in the refugee camps, and the high motivation of the students. Directly experiencing tense situations on the ground, and having conversations with refugees in the camps, showed us how important and correct the decision was to support the project.

The project has achieved more than laying a foundation for care and therapy in a crisis area; it has also broken down cultural skepticism about psychotherapy locally. The people there have learned that altruistic help is available, especially for women and children, who are among the most vulnerable victims of war. We have spoken with local dignitaries and responsible ministers to ensure continuation of the work on site.

During the project, we also had to accept that the project might be interrupted due to war-related interventions. Indeed, in 2018, flights to Erbil were no longer possible because the airport was closed for a short time. Support and teaching then continued digitally. The project with the university and the region of Duhok is not comparable with other projects in Baden-Württemberg. It is a project in a crisis region where people have had to endure existential challenges for years. In addition, the geographical proximity to Islamic State (IS) territory must not be forgotten. Just 70 kilometers from Duhok lies Mosul, a former stronghold of the IS. We would read daily newspapers quite differently and fervently hoped that no project partners were endangered. The "safety first" message was always important and the health of those involved in the project was of great concern to us in Baden-Württemberg.

I hope that the project will inspire many imitators. Every day the news shows more than 80 million people are on the run and suffer harm to body and soul. If we are able to make a significant contribution to solving this problem, I would be very happy. I am very grateful that I was able to support this project and visit it on site.

PREFACE II

PROF. DR. DAWOOD SULEIMAN ATRUSHI

PRESIDENT OF THE UNIVERSITY OF DUHOK

In the aftermath of the Islamic State of Iraq and Syria (ISIS) invasion of the Kurdistan Region of Iraq, with all the tragedies and atrocities they caused to different civilian communities, a huge number of people needed urgent health care support, including mental health care services. Due to years of war and conflict in the region, the health care system had become compromised and there was a lack of mental health professionals to meet the needs of the affected communities. Thankfully, Professor Ilhan Kizilhan had a comprehensive understanding of the context at the time and sought to find a solution or establish an institution in coordination with the University of Duhok to tackle these critical challenges and mental health needs of our region.

Professor Kizilhan played a key role in making a connection between the University of Duhok and the Ministry of Science and Culture in Baden-Württemberg in Germany, to support a project that would have sustainable impact locally, while educating and training mental health professionals in the region. Consequently, the decision to establish the Institute for Psychotherapy and Psychotraumatology (IPP) was made.

This was a great step towards achieving the overall objective of supporting the mental health system in the region, especially in response to the trauma and the tragedies inflicted by ISIS. As the president of the University of Duhok, I appreciated the efforts that Professor Ilhan Kizilhan put into this idea and the project, due to its significant importance. That is why I have decided to make sure that all the support needed by the University of Duhok is provided, to facilitate the implementation of the project here as much as possible.

Before starting the project, we had many meetings with the professors and faculty members from the University of Tübingen, to conduct needs assessments for the requirements of this joint project. The discussion focused on provision of a curriculum that considered a variety of academic aspects from both Germany and the Kurdistan region. The core scientific curriculum of an academic field is almost the same anywhere in the world,

but the delivery can sometimes differ from one country to another. However, we at the University of Duhok are very open to incorporate new teaching and learning methods into our system. We believe that the IPP has succeeded in offering learning and training methods in psychology and psychotraumatology, and we appreciate that.

Therefore, I think that the IPP is a good example of international collaboration in scientific and education fields. A project like this does not only respond to the critical needs of psychology and psychotraumatology. This project may create opportunities for mutual understanding and learning between communities. We at the University of Duhok are thinking about establishing a new project with the German University. For example, we are thinking of establishing a joint B.Sc. degree in Psychology between our university and one of the German universities.

Furthermore, I believe that the IPP is a true example of sustainable development. The project will have a long lasting and community-wide effect for decades to come. Graduates of this institution are local, and will be entering the local system, which will benefit from the knowledge and skills that they have gained during their studies. I believe that the growing need for mental health support and services in this region will be the biggest factor in preserving the IPP in the future.

Before, in the Kurdistan region, patients with psychological problems had to be sent to Europe or outside Kurdistan to get treatment, and they had the problem of applying for a visa. Some of them were asking for refugee status or political asylum, creating problems with organizations abroad. But now we have our own specialists who can treat these people without needing to go abroad.

Having said that, I would like to thank Professor Ilhan Kizilhan, the Institute for Transcultural Health Science, and its associates and network for their efforts and help. Finally, I would like to express my sincere thanks to the Ministry of Science and Culture at State of Baden-Württemberg, the Foreign Ministry in Germany, and the German Academic Exchange Service (DAAD) for their continuous help and support to our university and region in general.

PREFACE III

PROF. DR. MARTIN HAUTZINGER

UNIVERSITY OF TÜBINGEN

What a strange idea: We need more engineers, physicians, soldiers, and administrators, but no psychotherapists. Wrong!

Nobody denies that we need all of these professions, but a large part of the population suffers from psychological problems and need help. In post-war regions, especially in low-income countries, a health care system does not exist, is far from qualified, and requires support. They need psychological experts and psychotherapists to overcome trauma and heal psychological wounds. For example, after the terror of ISIS in 2014 and the war in Syria, many people took refuge in the Kurdistan Region of Iraq (KRI). Many governmental projects and non-Government organizations (NGOs) that work in this region have focused on giving shelter (tents), organizing basic medical services and childcare, and providing short term advice and counseling. But a large proportion of refugees and tortured people suffer with severe mental illness, in particular posttraumatic stress disorder (PTSD) and depression. First line, evidence-based treatment for these disorders is psychotherapy (Cognitive Behavior Therapy (CBT) according to the well-established independent UK National Institute for Clinical Excellence (NICE) guidelines), which is not available in this region.

With our expertise in CBT, and PTSD, implementing training, supervising therapists, and teaching on different academic levels, we convinced our state and federal government, as well as private sponsors, to support the development of an academic program in Kurdistan. It was the University of Duhok who was open for our "educational adventure" by starting the Institute for Psychotherapy and Psychotraumatology (IPP). The IPP's 3-year master's program teaches students who already have a bachelor's degree either in Psychology or Social Work to become professional psychotherapists, with theoretical, diagnostic, and therapeutic competence to treat a wide variety of mental disorders. It was, and still is, our plan to establish sustainable structures for psychotherapy education as well as psychological treatment in the area.

From the beginning, we followed several principles: (a) education in evidence-based psychotherapy, (b) the training should be culture and trauma sensitive, (c) a core group of local professionals should be trained so that they can provide training for further local therapists, (d) the project should be coordinated with local leaders, the local government, health care services, and academic institutions, (e) an outpatient clinic should be established, offering psychotherapy to the public, and (f) research should be encouraged in order to educate clinicians up to doctoral level and provide more information about this region. We are convinced that real sustainability of mental health care programs can best be established by enabling local professionals to become more competent to support their communities.

Now, after almost 10 years we have reached most of these goals. We have already educated 65 psychotherapists, working in regional organizations, clinics, and administrations. They are treating patients, teaching students, and training future psychotherapists. As an extension of the IPP, we have established an outpatient clinic for psychotherapy ("German Clinic for Psychotherapy"), run by a group of our former master's students, where psychotherapy is offered for free. Currently, about 80 patients are seen and treated there. We have qualified a group of psychotherapists as instructors and supervisors to run the academic training at the IPP. A new group of students are now involved in the master's program under the instruction of the local teaching psychotherapists. After graduation, some of our former students became doctoral students, conducting research for their dissertations under our supervision.

It is a pleasure and fills me with gratitude to document our initial ideas, our goals, the (not always smooth) process to reach these goals, and where we are right now, within the chapters of this book. This documentation should help others to build up similar academic programs for the education of psychotherapists. We are convinced that instead of moving patients to countries where successful treatment is available, it is a much better option to educate local mental health workers in evidence-based psychotherapy to help their people in their country.

INTRODUCTION

JAN ILHAN KIZILHAN AND THOMAS WENZEL

In recent decades, many health care systems in high-income countries, such as Germany, Austria, the UK, and the USA, have faced increasing challenges and limitations in offering affordable health care services. This particularly affects groups of the population that depend on free health care. In recent decades, there has been a noticeable decline in the number of available healthcare experts and service providers, leading to insufficient numbers available in many regions.

Challenges in training and recruiting the necessary health care professionals have been observed, not only in the so-called "developing" countries. This has been caused by several factors, including increasing age, insufficient or unattractive working conditions, increased specialization requirements, sophistication and professionalization of the health care systems, and growing populations. The situation presents a challenging future for all health care professionals, their patients, and for public healthcare systems.

The situation is even more critical in the "developing" and low-income countries, which often suffer from a complete lack of free services, educational and training structures, more unattractive working conditions for health care professionals, and a continuous "brain drain" of the already limited number of experts. Further, these challenges are exacerbated by further difficulties in areas affected by war or civil-war, in post-conflict regions, and in larger disaster areas, such as the recent earthquake-affected regions in Turkey and Syria. During and following man-made or natural disasters, there are increased health care needs, especially for mental health care and psychological support. In some of these regions, discrimination, persecution, and even genocide affect some population groups, such as ethnic and religious minorities, more severely than others. Therefore, in addition to pre-existing problems, post-conflict and disaster regions face new problems, and groups with already insufficient access to healthcare may be at the greatest disadvantage.

This book presents the experience, evaluation and "lessons learned" from a large, long-term project that was supported by the German government and other donors and implemented in a collaboration between

German and Kurdish-Iraqi universities and their respective governments and healthcare authorities. This project aimed to address extreme mental health challenges faced in the Kurdish Region of Iraq, which was nearly devastated by war and conflict. So far, most projects addressing similar situations have been short-term, highly limited in scope, and have not focused on building long-term sustainable structures to fit existing environments, resources, and cultures in diverse affected regions.

The global increase in the already mentioned challenging healthcare situations in post-war and catastrophe countries such as Turkey, Syria, Ethiopia, Sudan, and Ukraine underline the need for evidence-based holistic approaches and models. These models should address the complex challenges faced in these catastrophic situations, which threaten whole populations, particularly minority and vulnerable groups. The authors aim therefore to use the aforementioned insights, research results, and "lessons learned" from this major project to offer guidance for the creation of sustainable interdisciplinary projects which can address the needs of populations in similarly affected countries. The book is not limited to summaries and discussions of theoretical research. Rather, alongside a synthesis of the most relevant research, concrete guidelines and sustainable solution models are presented. These have been tested in real-life environments to address public mental health problems in countries affected by conflict or other large-scale disasters.

The book consists of several sections (parts). First, a summary of the state-of-the-art knowledge on the most relevant emerging issues in the context of these challenges. This is followed by an overview of the preparatory analysis of the country and cultural background and context performed in preparation of the pilot project, which may be used as a model for further activities in Iraq and similar countries when addressing psychological health, followed by both a team-based and an external independent evaluation of the project strategy and outcomes. The authors will summarize both general and specific recommendations and tools which have resulted from the research and pilot project in detail. Relevant materials such as questionnaires, a list of team members, and other materials developed in the project are collected in the appendices at the end of the book.

We believe the materials we provide in this book can help develop similar projects and avoid pitfalls in mental health care services within these challenging environments. While the project was developed in a post-war zone, we expect that similar challenges and solutions could apply, albeit with modifications, in regions affected by large-scale natural disasters.

We are grateful for support by:

- Foreign Ministry of Germany
- Ministry for Science and Culture, State of Baden-Württemberg
- State Ministry of Baden-Württemberg
- Ministry for Higher Education, KRI
- German Academic Exchange Services (Deutscher-Akademischer Austauschdienst – DAAD)
- Ministry of Development and Cooperation
- Deutsche Gesellschaft für internationale Zusammenarbeit (GIZ)
- Eric Gustav Adler Stiftung, Germany
- Caritas International
- Schwäbische Zeitung
- Governor of Duhok
- And all network partners in Iraq, Kurdistan, Germany and worldwide

PART 1

AN OVERVIEW OF THE SCIENTIFIC DISCUSSION RELEVANT TO THE PROJECT

CHAPTER 1

MASS VIOLENCE, WAR AREAS, AND THEIR LONG-TERM MENTAL HEALTH IMPACT: FORMS OF DISCRIMINATION, GENOCIDE, AND SEVERE HUMAN RIGHTS VIOLATIONS

THOMAS WENZEL AND REEM ALKSIRI

To better understand the specific needs of different groups, we must consider the many forms of trauma experienced by survivors in diverse situations, as during mass violence, severe human rights violations, war, and civil war. Each type of violence can have different psychological, social, legal, and economic consequences. These consequences can interact in a complex way and require specific strategies to guide adequate interventions. We must also acknowledge hidden forms of violence not always immediately thought of alongside immediate physical violence. These include structural violence, different acts of discrimination, poverty, uneven distribution of resources in large population groups by political actors, the impact of environmental change, and finally, more (or less) "natural" catastrophes and their aftermath. The reaction of survivors or survivor groups might take different forms, which we will cover separately, ranging from post-traumatic growth to severe forms of complex post-traumatic stress disorder and other chronic mental health sequels. This also includes the transgenerational transmission of trauma, that, as seen in Iraq, reflect multiple historical genocides.

Genocide

Let us first look at genocide, as a traumatic event of particular relevance in Iraq. The term "genocide" was first used by the Polish-Jewish lawyer, Raphael Lemkin, in the context of what we refer to as the "Armenian genocide" today, by the Ottomans (and later "Young Turks") (Lemkin &

Bazyler, 2008). This was an event that led to the creation of the United Nations (UN) Anti-Genocide Convention (Convention on the Prevention and Punishment of the Crime of Genocide, adopted 09 December 1948, by General Assembly resolution 260 A (III), and Entry into force: 12 January 1951)[1].

The Convention defines genocide in Article II and lists events associated with it:

> "In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:
> (a) Killing members of the group;
> (b) Causing serious bodily or mental harm to members of the group;
> (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
> (d) Imposing measures intended to prevent births within the group;
> (e) Forcibly transferring children of the group to another group."

It further stipulates:

> "The following acts shall be punishable:
> (a) Genocide;
> (b) Conspiracy to commit genocide;
> (c) Direct and public incitement to commit genocide;
> (d) Attempt to commit genocide;
> (e) Complicity in genocide."

This important Convention, which is clearly defined at first glance, should be upheld by the signatory countries, other countries, UN bodies, and the UN Security Council. However, as recent events have shown, effective implementation of the Convention can be hindered by political interests and legal barriers, especially relating to the interpretation of Article II. This might indicate that the broader original understanding of the definition by Lemkin should be considered and respected. Nevertheless, we do not intend to get into legal details in the context of this book.

Many groups and their advocates have been fighting for their experiences to be recognized as genocides in the UN Convention definition. This process can be long and arduous, and groups may be used as political cards in the games of political players. Examples range from Armenia, to

[1] See https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-prevention-and-punishment-crime-genocide

the Yazidi group in northern Iraq (Kizilhan et al., 2023), the Uighurs in the Xinjiang area of China[2], the Rohingya group to ethnic groups in Dafur (Hagan & Kaiser, 2011), Indigenous people in Australia (Tatz, 2001), and US African- American and First Nations people (Tanne, 2010).

Sometimes, the response of the UN and similar global players is not immediate and efficient, or is inherently constrained by definitions and mandates. In these situations, national third-country parliaments (i.e., in the case of the Yazidi, the German Parliament) or global independent tribunals (i.e., in the Uighur case, the international tribunal[2] based in London) can take a first step to creating awareness of a problem and contributing to justice (Kizilhan & Neumann, 2020) and recognition. This is important not only for prevention, but also for the psychological recovery of the victim groups.

In the context of public health, flexible definitions might be most useful to understand the impact of genocide and, in areas like Iraq, the impact of multiple genocides. We propose the use of the term of "genocidal acts" (any activity that, if seen by itself, might be a common event but might be part of a more long-term genocidal strategy by different perpetrators) and the concept of a "genocidal environment" (i.e., a geographical or sociopolitical area where genocidal acts are frequent over longer periods). As we will discuss later in this chapter, medical categories and models focusing only on individuals might be insufficient to understand the psychological, biological, and social impacts of experiencing genocidal acts. This includes the development of coping strategies and (relative) resilience in some survivors, or the impacts of transgenerational trauma in other instances.

[2] See https://uyghurtribunal.com/

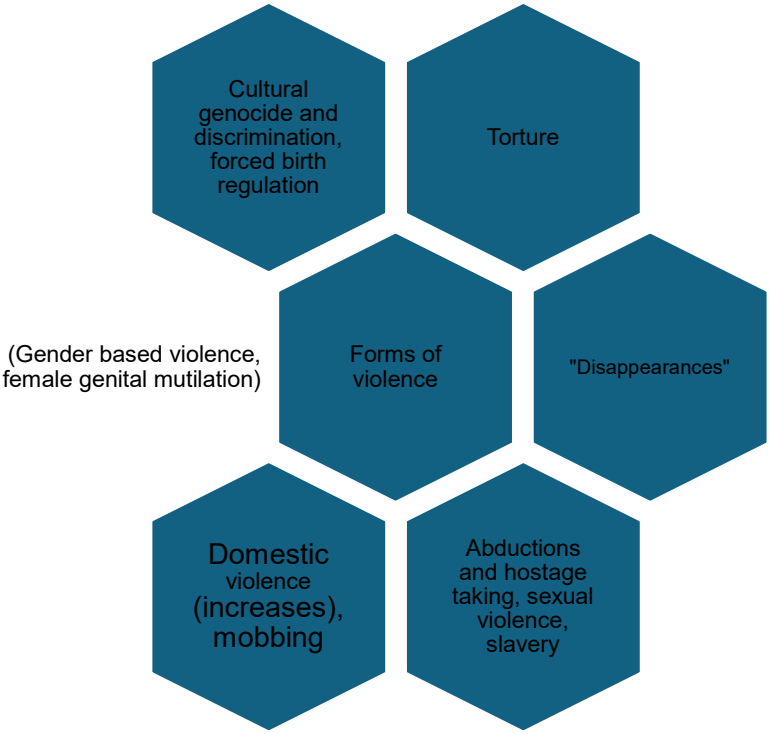

Fig. 1-1 Different forms of violence encountered (not only) in war areas and post-conflict zones

Conducting research under difficult conditions

To understand the impact of mass violence, genocidal acts, or war, we need reliable data to guide interventions and create adequate models which accurately reflect the characteristics of each situation. Science is, and probably always has been, a process that is influenced, controlled, or prohibited by political parties, despite efforts against this by the international scientific community. Efforts to ensure objective science include independent peer review, and research and publication standards. Examples include the COPE guidelines[3] on publication ethics (Committee

[3] See https://publicationethics.org/guidance/Guidelines

on Public, 2000), the World Medical Association's (WMA) Ethical guidelines[4] and specific position statements for medical research, and policies from other international professional umbrella bodies and Non-Governmental organizations (NGOs), such as the European Federation of Psychologists' Association (EFPA)[5].

In Iraq, post-conflict zones, or areas with ongoing conflict, independent research using typical methods can be difficult. However, international institutions, such as the UN or the International Criminal Court (ICC), can actively start investigating legal and other aspects of these situations. Based on their data, they can prepare legal or other interventions. They may still be hindered by challenges such as an impasse in the UN Security Council, which might inhibit their essential functions.

Research about mental health in post-conflict zones, or areas with ongoing conflict, can be especially limited when research approaches come from university settings in safe, high-income countries, without appropriate consideration of the group being studied. Factors which need to be considered include cultural aspects, differences between collective/community-oriented and individual-focused priorities in a society, the existing healthcare culture, gender influences, and prior trauma due to transgenerational transmission of the impact of earlier violence and genocidal acts, for example. Furthermore, appropriate approaches should seek to identify and include local resources for an integrated strategic approach to the research and consequent interventions

If independent legal or scientific investigations are difficult, alternative strategies have been explored to gather data on human rights abuses and their impact on a specific country. These strategies, particularly when combined in an integrative or "triangulated" manner, can provide reasonably reliable understandings of specific situations "on the ground," potentially guiding further investigations or interventions. Effective interventions might also be offered in third (host) countries, where survivors, who might be direct or indirect victims, are alive and able to escape persecution and immediate danger. This support in third countries might include different forms of redress, such as medical treatment and psychotherapy, but also other considerations, including economic support or protection like asylum status, protection against refoulement, and sometimes justice against perpetrators offered by universal jurisdiction principles (International Council on Human Rights Policy, 1999).

[4] See https://www.wma.net/what-we-do/education/medical-ethics-manual/
[5] See https://www.efpa.eu/model-code-ethics

These forms of protection and support are stipulated as obligatory in host countries by international documents such as the UN Convention against Torture and the EU reception directive[6], which defines vulnerable groups that require special consideration and support. Universal jurisdiction has recently been explored as a tool for prosecuting perpetrators in third countries if local authorities do not conduct prompt and effective investigations. However, in "transitional" justice situations, the effectiveness of this strategy might need to be considered, as it may not always offer redress to individual victims. The recent conviction of an Islamic State of Iraq and Syria (ISIS) member in a German court for crimes against a Yazidi girl, based on the principle of universal jurisdiction, highlights the potential for achieving justice in situations like those in Iraq and Syria[7].

Reliable information, independent of potentially false or biased claims in perpetrator countries, must be obtained in different ways to justify such support in third (host) countries or further interventions by international bodies. Medical and psychological examinations, following guidelines of the recently updated UN/WMA Istanbul protocol (Iacopino et al., 2022; Koseoglu, 2022), can provide objective evidence about the impacts of perpetrator actions on survivors. This evidence, combined with testimonies from witnesses and survivors may contribute to this important task. In Iraq, the Investigative Team to Promote Accountability for Crimes Committed by Da'esh/the Islamic State of Iraq and the Levant (ISIL, also known as ISIS) – UNIDAT[8]- fills this void with its independent mandate, despite facing ongoing challenges related to the extension of its authority.

Other strategies for investigation, many developed only recently, might involve the analysis of publicly available documents and sources. For example, analysis of satellite images can document mass graves or torture sites, as seen recently in Ukraine and earlier in China's Xinjiang region[9]. Pictorial evidence and other documents produced by perpetrators themselves, not initially intended for public release, can also be used. Examples of this in-

6 Available from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri= celex%3A32013L0033

7 See https://www.nytimes.com/2021/11/30/world/europe/isis-trial-yazidi-germany.html

8 See https://www.unitad.un.org/

9 See https://www.bbc.com/news/world-europe-61183056 and https://www.rand.org/pubs/articles/2021/chinas-disappeared-uyghurs-what-satellite-images-reveal.html

clude the "Caesar" series in Syria[10], Nazi Germany's concentration camp-related and other relevant documents[11], published documents on torture in Argentina[12], and documents by the former regime of Iraq. These sources can be used to investigate past abuses, which can be important for several reasons: offering therapeutic justice, identifying and prosecuting perpetrators to prevent future threats, safeguarding against recurrence, defining redress - including access to free treatment for victims suffering from the consequences of human rights violations - and informing future reforms

Research in conflict zones and humanitarian disasters still needs to follow ethical standards and consider cultural differences. This issue was recently discussed by Turner and Avison (2003) who highlighted the challenge of ethics in the transcultural context across different societies. They concluded: "A more realistic recognition of multiple moral traditions in pluralist societies would be considerably more skeptic about the contributions that common morality approaches in bioethics can make to resolving contentious moral issues" (Turner & Avison, 2003).

Gender issues

Women face significant challenges due to both historical discrimination and targeted violence in conflict areas. For example, in Iraq, ISIS/DAESH targeted women with brutal violence (Kizilhan, Friedl, et al., 2020). Additionally, they face ongoing discrimination that creates barriers to reintegrating into a normal life, as outlined below.

Key guiding instruments, with a gender lens and focus on women's rights, include the Istanbul Convention[13], which addresses domestic violence, and the Bangkok Rules (UN Rules for the Treatment of Women

[10] https://www.theguardian.com/world/2015/oct/01/they-were-torturing-to-kill-inside-syrias-death-machine-caesar, accessed 5.11.2023

[11] See for example the online collection at https://www.ushmm.org/collections/plan-a-research-visit/electronic-resources/primary-source-databases, accessed 31.1.2024

[12] See https://nsarchive.gwu.edu/briefing-book/southern-cone/2020-07-21/argentinas-house-of-horrors, accessed 31.1.2024

[13] https://www.coe.int/en/web/istanbul-convention, accessed 31.1.2024, not to be confused with the Istanbul declaration on organ transplantation or the UN Istanbul Protocol for Torture related investigations

Prisoners and Non-custodial Measures for Women Offenders)[14]. Women are also becoming increasingly recognized for their important roles as human rights defenders (Correa-Chica et al., 2024; Kabengele Mpinga & Chastonay, 2005). This last development is reflected in the establishment of the International Day of Women Human Rights Defenders[15] and the creation of special institutions and programs within the UN and other organizations. Recent cases, such as the persecution and imprisonment of Prof. Sebnem Korur Fincanci, an internationally renowned forensic expert and human rights defender, highlight the risks faced by this group. Prof. Fincanci has been active in numerous, including Kurdish, areas, such as post-disaster and mass violence contexts, and has served as president of the Turkish Medical Association. Her detention sparked widespread international protests, including from the World Medical Organization (Heisler et al., 2022).

Research projects and proposed interventions must consider gender-related challenges and the needs of all genders, with a special focus on women. Gender has often been neglected in international health and medical research, as seen in examples such as differences in drug metabolism or biorhythms.

The psychosocial and legal concerns of Iraqi women were an important focus in the project presented in this book, and were addressed by gender-specific support actions. Women were not only specific targets of violence in northern Iraq (Al Shawi & Hassen, 2022), but when abducted by ISIS/DAESH terrorist groups, they faced challenges in returning to their communities (Ibrahim et al., 2018; Kizilhan, Friedl, et al., 2020; Kizilhan, Steger, et al., 2020). The traditions of their Yazidi religion prohibit "marriage" or any form of sexual contact with individuals from different groups, even if forced by terrorists like the Sunni oriented ISIS groups. Consequently, returning to their home communities after these traumatic experiences was difficult for Yazidi women, especially as former neighbors, mainly from the Sunni faith, were suspected of colluding with ISIS to identify women to be targeted. These barriers to return home, raised by their faith, had to be addressed in the project through work with local religious leaders who took a lead role in finding solutions to convince community members to respect and reintegrate the returning women sur-

[14] See https://www.unodc.org/pdf/criminal_justice/UN_Rules_for_the_Treatment_of_Women_Prisoners_and_non-custodial_Measures_for_Women_Offenders_Bangkok_Rules.pdf

[15] See https://www.ohchr.org/en/statements/2022/11/international-day-women-human-rights-defenders-statement-united-nations-high

vivors. Despite this, many women choose to remain in "safe" camps to hide their "shame" (Kizilhan, Steger, et al., 2020), and suffer from extreme psychological trauma.

In response to this, the international team working on this project, headed by Professor Kizilhan, organized a rapid extraction project. This project brought female Yazidi survivors of ISIS abduction and abuse to Germany and into a support program. This was provided in a safe country with rapid and unbureaucratic support of the German government, in addition to capacity building and local projects in their home country (Beckmann et al., 2022; Kizilhan & Wenzel, 2020). This example highlights the need for unorthodox, rapid interventions that may be necessary in certain situations. Relocation, despite its controversy, is sometimes the best solution in a crisis, to provide immediate security and aid in the recovery of victims of extreme trauma. Changing perceptions and cultural models can be a slow process within origin countries with gender-biased environments.

The impact of mass violence as a challenge to public healthcare systems

The impact of war and mass violence affects individuals, groups, societies, and health systems as a whole. Therefore, this must be approached as a multilevel challenge when developing projects in war areas, such as northern Iraq.

As we will demonstrate through the description of the pilot project, interventions must be interdisciplinary and multi-level in nature. These interventions should utilize sustainable strategies that are likely to be continued by local stakeholders and teams, especially after international support fades out and shifts to address other emerging crisis areas.

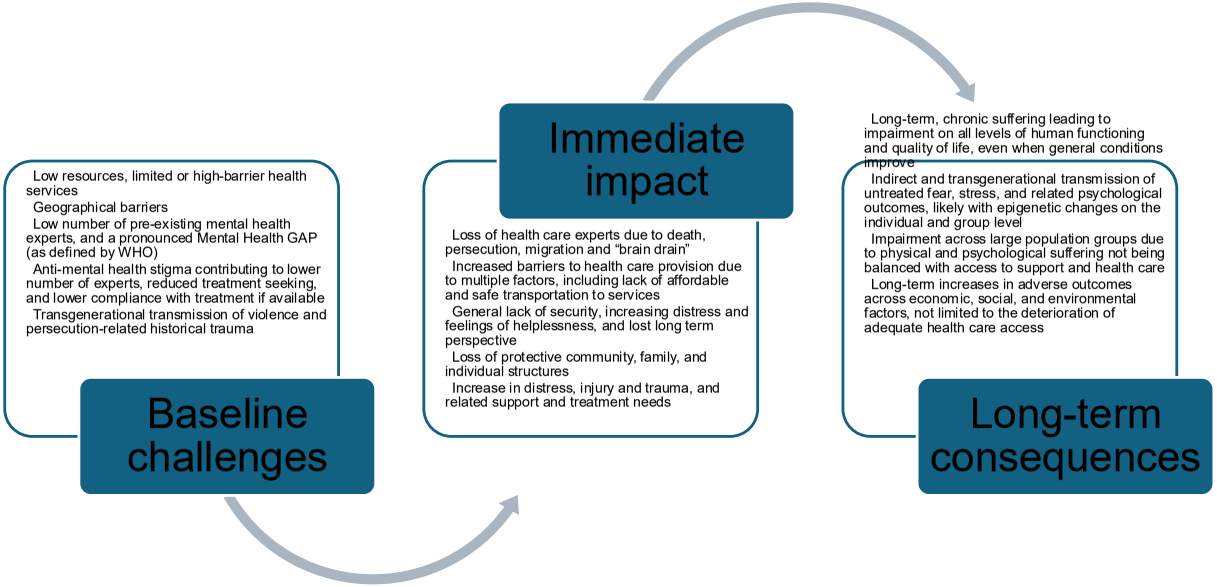

Fig. 1-2 Impact of historical and cultural mass violence on public health care systems and mental health[16]

[16] Reproduced with permission by the authors, from: Oxford Handbook on Violence, Oxford University Press 2024 (in print)

At baseline, before the beginning of atrocities imposed by war and conflict, healthcare systems already face considerable challenges, including low resources, a limited number of trained mental health professionals, geographic and economic barriers to treatment, and unequal access to services for different groups. Stigma against mental health as a health topic, and also against mental health patients and mental health care experts, is also an issue.

From the outset, the limited number of available local healthcare experts in countries like Iraq may have been killed, imprisoned, or forced to flee the country to safer regions, contributing to a “brain drain” of professionals. Only a small number of healthcare professionals may be able to hold out. In addition, it can become more difficult and more dangerous for people to travel to the few service providers left, who may also be overwhelmed and understaffed, as acts of mass violence lead to suffering and distress, especially, but not only, in those already vulnerable and underserved. This can be further aggravated by the interruption or loss of protective factors such as family and community networks. International support efforts may face the same problems and are often neither culture-sensitive nor well-planned and sustainable.

The long-term consequences can be severe, with chronic suffering, increased vulnerability, and potential transgenerational transmission of suffering in large parts of the population (Kizilhan et al., 2023; Kizilhan et al., 2021). Healthcare services can be overwhelmed and not sufficiently staffed by competent experts, while alternative support structures will be slow in rebuilding. The “brain drain” of experts will be difficult to improve. Loss of experts in these settings might be worsened by lack of access to advanced learning and interrupted professional development due to bureaucracy.

As trauma treatment models are often the primary focus in post-conflict regions, we want to provide a short overview of psychological trauma models, treatment options, and support systems, and their fast development over the last decades. Before delving into this, we want to remind the reader not to lose track of the previously described multilevel impact of war and violence. This includes the well-documented WHO mental health (treatment) GAP ("Mental health: WHO minds the GAP," 2010), which remains a significant factor to consider in planning projects in war-torn areas.

History of trauma concepts

Understanding and diagnosing survivors who have been directly or indirectly affected by the previously described forms of violence and human rights violations, or researching the mental health impact of these extreme life events, is more challenging than it might appear at first glance. The diagnostic concept of post-traumatic stress disorder (PTSD) has been recently firmly established through a long and complex process, which we will summarize in this chapter. The development of PTSD as a diagnosis is significant not only in medicine but also for public understanding and most legal systems. However, it is important to approach this development with care, without underestimating the importance of this medical diagnosis.

There are two key issues we want to raise to keep in mind when researching or planning services for survivors of extreme violence. First, PTSD should not receive attention as the only psychological consequence of stress or violence (Penk & Robinowitz, 1989). Second, recent research has on the other hand demonstrated that the basic neuropsychological mechanisms of PTSD are ingrained in the human biological system, probably as a result of evolutionary adaptation to dangerous environments (Baldwin, 2013). In principle, it can therefore be seen as a normal reaction to extreme forms of stress, that is common across all humans and cultures. However, it is important to remember that culture significantly influences how symptoms are shaped and perceived within specific cultural environments. To gain a better understanding of this, we must look back at the history of how PTSD and reactions to extremely distressing life events have been understood in the broadest sense.

Posttraumatic stress in civilian populations

Historically, it was not clearly understood that extreme life events could have specific long-term psychological consequences, even in people without pre-existing vulnerabilities. Most historical accounts trace the beginning of the modern concept of posttraumatic stress to the first railway accidents around 1830. The symptoms were also described as “railway spine”, a term proposed by the UK surgeon Erich Erichsen in 1866, who suggested that symptoms were caused by “concussion of the spine followed by molecular changes” (Harrington, 1996). While descriptions of symptoms in victims of these first railway accidents include what we might now recognize as symptoms of PTSD, many victims also suffered from symptoms we would today rather classify as somatoform or conversion symptoms. These are symptoms that cannot be completely explained

by medically accepted physical mechanisms or by imaging technology. At the time, some authors, as shown by Fischer-Homberg (1970), suspected that victims' claims were motivated by potential financial compensation from railway companies. As a result, illness claims were often discredited or said to be based on fictitious symptoms. This tendency to dismiss victim's psychological suffering as exaggerations has a long history and, in our experience, persists even today (Barrash et al., 2007; Gold, 1998).

At the turn of the 20th century, leading innovators in psychology and psychiatry, notably Sigmund Freud, held ambivalent views about symptoms in their patients. Initially, they attributed symptoms to trauma caused by sexual abuse (Summit, 1989). This concept was later explored by Sandor Ferenczi (Gutierrez-Pelaez & Herrera-Pardo, 2017). Today, these symptoms are likely understood as conversion symptoms, that can respond positively to psychological treatments. However, if we follow the historical development, it is clear that the observation of a link between sexual trauma and later symptoms was not sufficiently pursued or widely accepted in the early days, both within the medical field and the general public, especially in sexual abuse victims (Summit, 1989).

The difficulty of demonstrating the well-established physical and neuropsychological aspects of PTSD in individual victims outside of research settings might contribute to challenges in legal contexts. This includes the brain systems involved in fear and memory, such as the amygdala and hippocampus (Woodward et al., 2006), and even potential anatomical changes in the hippocampus observed in long-term sufferers (Tischler et al., 2006). Challenges arise because demonstrating these aspects can be difficult outside specialized research environments. For example, such limitations can pose difficulties when a PTSD diagnosis has legal implications, such as in asylum cases or the prosecution of perpetrators. Determining appropriate redress and compensation for victims can also be challenging in these situations. Despite these challenges, current scientific knowledge allows us to conclude that post-traumatic stress and trauma spectrum disorders are established medical disorders also in civilians. This remains true even when considering the influence of cultural factors and other variables on how individuals and groups present their suffering.

Returning back to medical history, following the 1830 railway accidents, the next major historical event to highlight the psychological effects of extreme violence on civilians was the establishment of concentration camps by the Nazi regime as part of the Holocaust genocide. This period led to the rediscovery of the idea that extreme life events can cause severe long-term psychological suffering, even in those without any prior vulnerability. The reemergence of this discussion was significant for several