RECONSTRUCTING THE NEUTRALITY AND OBJECTIVITY TENET IN COMMUNITY INTERPRETATION: THE CASE OF SYRIAN REFUGEES IN LEBANON

A Thesis

presented to

the Faculty of Humanities

at Notre Dame University-Louaize

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Translation and Interpretation - Translation

by

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MARCH 2022

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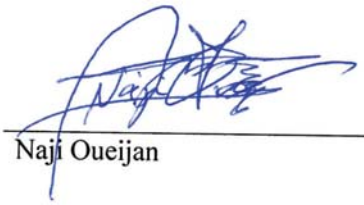

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Acknowledgements

I would like to thank Dr. Maya El Hajj, Chairperson of the Department of English and Translation at Notre Dame University (NDU) for being a true enabler. Dr. El Hajj made me believe in myself and ceaselessly encouraged me to make this work see the light.

To Professor Naji Oueijan, my advisor, I am greateful and fortunate to have him as a guide. He generously mentored and supported me along the journey and brought out the best in me. I owe this success to him as well as my gratitude and respect. I am indebted to Dr. May Akl, who have been part of this journey and a main source of inspiration. She truly inspired me, and I am grateful to the ample support she showed me. I am especially grateful for my family's loving support, and most importantly for my husband. I am extremely thankful to him for his full encouragement and unconditional patience. I also want to dedicate this work to my son, Adam, who was with me during the whole thesis journey.

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Abstract

During and after the war in Syria which erupted in 2011, the Syrian mobility has seen a rapid, large-scale outflow into neighboring countries with Lebanon being on the list of countries to host the largest numbers of Syrian refugees (SR). Many among them ended up living in refugee camps where conditions were and still are dire; consequently, they seek migration through refugees' human agencies and foreign embassies in Lebanon. In light of this situation, community interpreting services have become increasingly required and immigration agencies subsequently have reached out to the Community Interpreter (CI) as an intermediary in the bilingual interviews for refugees who seek resettlement in countries outside Lebanon. Although some attention has been directed towards the role of the CI in similar refugee interviews and from several perspectives, the main focus has been on the controversial question of the neutrality and objectivity tenet. Studies have rarely attempted to approach this question from a psychological perspective. This thesis aims at investigating the role of the CI in interpreter-mediated refugee interviews with a particular emphasis on role conflicts and expectations of the SR's psychological state.

Introduction

War and conflict generate and impose exceptional conditions that are shaped by violence, fear, and psychological traumas, all of which are heavily carried by the refugee to the interview. This is to say that the SR has been the subject of a crime perpetrated by the regime at home or the disputing parties, including possible terrorist groups or militants; thus, the SR has been forced to flee home and all the atrocities of war and to ask for resettlement in a country where there might be a chance for safe and productive life. Having suffered from the hostilities of the war with all the psychological traumas and possible physical disabilities that come with it, the SR resorts to migration as the only alternative to compensate for the inflicted losses.

Strain

This thesis tackles an important layer of the discussion related to the behavior of the SR in the middle of the communicative event. As the communication unfolds, the SR quite often leans to exaggeration to get accepted for migration or shows signs of discomfort, hesitation, or dishonesty. But the motives remain honest regardless of how they have been communicated, because the SR's behavior is justified by social anxiety, fear from the future, and a pressing need to reach safety. In the study carried out in the framework of this thesis, several key factors lie at the basis of the SR's behavior with two main factors emerging. The first is that the interrogating officer/interviewer may demonstrate a harsh or uncompassionate attitude towards the SR on the basis of objectivity and consequently turns the interview setting to a stressful investigation. The

officer becomes a judge with the power to accept or reject the refugee's application. The second is that the SR may be psychologically disturbed by the war, which forcibly intervenes in the communication with all the signs of fear and anxiety that arise to the surface in the refugee's utterances and behavior.

As the communication unfolds, I believe the CI is expected to take the above discussed conditions of the SR into consideration. While the communicative and participatory ground is already complex in interpretation settings, expectations of neutrality and objectivity with regards to the CI in refugee contexts, the complexity of the communication increases. They strain both the CI and the SR; this hinders the fulfilling of the interpretation's communicative goals. Therefore, the CI is expected to assume different roles to maintain the efficiency of the communication roles that may ease the fear and anxiety of the SR and smoothly manage the psychological strain of the parties of the communication's utterances.

Neutrality

In light of the above, this thesis attempts to contest the full neutrality and objectivity tenet in interpreter-mediated refugee interviews and to suggest a reconstructed and less restrained way for CI in managing the communicative event. In other words, this thesis proposes a non-conventional way for treating interpreter-mediated refugee interviews with great sensitivity that rests on a humanistic and psychological approach. The toll that the war has on people should not be overlooked, underestimated, or compromised for the detriment of the traditional, professional guidelines that dictate the behavior of the CI in similar types of interviews. A certain degree of latitude is thus required by both the CI's hiring agencies/embassies to break the traditional perception of the conduit model and allow the CI to act as a coordinator and advocate.

The thesis argues that in interpreter-mediated refugee interviews, the CI cannot be expected to maintain utmost neutrality and objectivity because of the exceptional humanitarian conditions that shape these types of interviews. The thesis thus contends that the traditional or official guidelines of the conduit models that do not take the psychological state of the SR into consideration hinder the need of the CI to act as an advocate, a social agent, a humanitarian assistant, and a supporter, who needs to act beyond merely a neutral conveyor of messages.

Setting

In such interviews, the CI is considered as operating within exceptional settings, which requires exceptional performance, including an alteration of roles; this is only possible when the CI has sufficient knowledge of the basic psychological needs of the refugee. In other words, this thesis will propose a non-conventional role for the CI in refugee status and political asylum interviews in the case of SRs in Lebanon based on a humanistic and psychological approach that takes into consideration the SR's emotional and psychological needs. Accordingly, hiring resettlement agencies or embassies are expected to allow more flexibility in the job of the CI, allowing the interpreter to act as an advocate and supporter, beyond the traditional conduit model that imposes on the interpreter the obligation to abide by the neutrality and objectivity guidelines.

Facts about the Syrian War

Since its inception in 2011, the Syrian Civil War has generated about 207,000 fatalities, among civilians (Statista, 2021), and statisticians have pointed out towards an additional number of documented casualties estimated at around 250,000 among the ranks of combatants from all

the warring parties in the conflict (Reuters, 2021). The Syrian war, in fact, has developed into a conflict of exceptional scale and magnitude on different levels with a significant number of forcibly displaced Syrians registered at nearly 13.5 million—accounting for more than half of the country's population—including 6.8 million Syrians approximately as refugees and asylum-seekers and another 6.7 million people as internally displaced (Reid, 2021).

These figures among a series of other facts are compelling reason for why the Syrian conflict is "unique" and like no other. This was even sustained by Jan Egeland, the former Special Advisor to the UN Special Envoy for Syria Staffan de Mistura in a joint Press Stakeout, who announced that "[t]he Syrian war is unique in two particular ways … [n]umber one, by the blunt force against civilians," affirming that he "know[s] of no other place that is even close to having so many children, families, innocent people being displaced, fleeing for their lives, being killed, being maimed."(Reliefweb, 2018) The second thing that is "unique" about Syria, according to Egeland, is that "it is a place where parties have for a very long time specialized in denying humanitarian access to these civilians."(Reliefweb, 2018)

With nearly 11.1 million people in need of humanitarian assistance in Syria (Reid, 2021), the humanitarian conditions in the country have been alarmingly heading towards unprecedented rates. Consensus has been gathered in that regard (Selmo et. al., 2020; Ogunnowo and Chidozie, 2020; Karim, 2017; Tyyskä, Blower, DeBoer, Kawai, & Walcott, 2017; UNHCR, 2016; Berti, 2015; Thoits, 2011) as was also confirmed by the UN Special Envoy for Syria Staffan de Mistura, who described the situation as "the worst humanitarian tragedy since the Second World War." (GICJ, 2017)

The humanitarian situation in Syria is not the only one that gives ground to consider that the Syrian civil war is unique and exceptional among other wars. Chahine A. Ghais, Professor of

International Relations in the Faculty of Law and Political Science at the Notre Dame University – Louaize, strongly asserts that "Syria is a special case." (2021) Professor Ghais considers that "the Syrian war represents many things and what is mostly remarkable about it is the mixture of complexities that characterize it… it is a new kind of war, a mixture of hybrid wars where weapons are being tested, and then there's the high level of intervention from state and non-state actors that comes into play, which makes it a fierce and violent battlefield." (2021) As shown in a statistics led by the Armed Conflict Location & Event Data Project (ACLED), "the amount of US (2017) and Russian (2016) airstrikes [in Syria] is unprecedented," and in 2014, "the UN Human Rights Office of the High Commissioner has stopped counting fatalities." (Bruijne, 2018) Considering the amount of reported violence when compared to other countries, the same study has shown that "Syria averages 70 violent reported events per day and is currently as violent as all African conflicts plus South Asian fragile countries combined." (Bruijne, 2018) The study also suggests that Kenya and Burundi's lingering unrest, Congo's emerging war, the continuing crises in the Central African Republic, Somalia, both Sudan's, conflict in Nigeria, AQIMS increasing presence in West-Africa and Libya's continuing problems, combined altogether "do not equal the number of clashes and attacks in Syria's conflict." (Bruijne, 2018) When compared to countries-in-war in the Middle East region like Iraq and Yemen, the study has found that "Syria shares a similar violence profile" with these countries, except that actors involved engage in an incredible intensity of violence (Bruijne, 2018). Even when it comes to the presence of foreign fighters on the Syrian ground, a study led by the International Center for the Study of Radicalization and Political Violence (ICSR) has found that nearly 11,000 fighters from 74 nations have participated in the Syrian conflict, which is "a greater number than in 'every other instance of foreign fighter mobilisation since the Afghanistan war in the 1980s'." (Carter, 2014)

Violence exerted against female activists is also the worst of its kind as shown in a report by the Geneva International Centre for Justice (GICJ, 2017); "[f]emale activists are … tortured and harassed in inhuman ways, and are physically and psychologically abused by security officers in order to obtain precious information on the opposition movement." (GICJ, 2017) Almost half a million Syrians have succumbed to violent conflicts in the war so far and more continue to lose their lives as a result of violence and brutality (Selmo et. al., 2020), causing an entire generation to be annihilated (GICJ, 2017).

SRs: An Exceptional Aspect of a Refugee Status

In international law, the term "refugee" refers to "individuals who are outside of their country of origin due to a well-founded fear of persecution based on their race, religion, nationality, membership of a particular social group, or political opinion." (Agic B. et. al., p. 188) By this definition, all refugees alike are classified under the same category of people fleeing their home based on armed conflict or persecution. However, the reasons presented above provide a clear evidence of why this classification proves to be inadequate, if not inaccurate, in the case of SRs. The circumstances shaping the experiences of SRs are obviously exceptional, marked by unprecedented poor humanitarian access, unprecedented magnitude of violence, and massive displacement, foreign fighter mobilization and fatalities at unseen rates. The situation of the SRs thus lends itself to an association between their status as "refugees" and the severity of the circumstances that lie at the basis of this status per se; the purpose of this association is to learn about the adequacy of placing the SRs under such categorization ("refugee" as provided for by the international law), which in this case turns out to be misplaced. Consequently, the SRs are excluded from this universal categorization of "refugees" given that they demonstrate an

exceptional aspect of a refugee status that is unique to them alone, and anything that relates to them must be considered accordingly.

Chantal Chaer, an experienced Lebanese interpreter, working in the interpretation field for nearly 20 years with several agencies in Lebanon, including the United Nations Economic and Social Commission for Western Asia (ESCWA) and the United Nations High Commissioner for Refugees (UNHCR), draws on her extensive experience with Syrian and non-Syrian refugees to confirm manifest dissimilarities between the two categories; her testimony supports the exclusion of SRs from the universal categorization of "refugees". According to Chaer, "one thing is obviously clear about the Syrian refugees: they have much higher needs compared to their Iraqi and Palestinian counterparts," adding that "by comparing the stories of the Syrian refugees with those of the Palestinians' and Iraqis', one can obviously tell how the situation in Syria is much more violent [than in Palestine or Iraq], and that the conditions that the Syrian refugees come from are characterized by higher fear and anxiety levels." (2021) Another dissimilarity as highlighted by Chaer is "the higher rates of mental illnesses that are predominantly detected among the Syrian refugees compared to their non-Syrian counterparts who show much lower vulnerabilities on the psychological level." (2021) Professor Ghais also believes that SRs have endured exceptional hardships in the war: "the use of chemical weapons against civilians in the Syrian capitals is unprecedented and is nothing like in the Afghanistan war, for example, where they were used in attacks directed against the Kurds only." (2021)

SRs in Lebanon: An Additional Layer of Complexity to an Already Dire Situation

The situation of the SRs at large proves to be more alarming and allows to consider their status as refugees from an exceptional perspective compared to their refugee counterparts as

shown in the above. For the purposes of this research, a closer consideration of the SRs' situation in Lebanon is more specifically required. A review of collected facts will demonstrate how the situation of the SRs in Lebanon adds an additional layer of complexity to their already dire situation. One part will be mainly dedicated to discussing their psychological and emotional status; it will later serve as a proof to validate the idea that SRs should be excluded from the common categorization of "refugees" in Lebanon. Subsequently, this will help demonstrate that in refugee status and political asylum interviews in Lebanon, the SRs are ought to receive exceptional treatment based not only on the physiological needs but also on the psychological safety and emotional needs by CIs and resettlement agencies.

At the outset, it is worth having an in-depth look at the context of the SRs' presence in Lebanon to fathom the implications of certain factors on their psychosocial wellbeing. According to reports by the UNHCR, 865,530 SRs are now registered in Lebanon and the number of total Syrians is estimated at nearly 1.5 million (Karasapan & Shah, 2021), "giving it the highest per capita proportion of refugees in the world." (UNHCR, 2021) Lebanon's population is estimated at 6.8 million people and is considered worldwide as "second only to the island of Aruba (population 110,000) and its displaced Venezuelans in the ratio of refugees to the native population." (Karasapan & Shah, 2021) Considering the strain that the Syrian refugee influx has put on the country and its local population, the impact has been devastating, adding to existing challenges that have been wracking havoc on the country before the emergence of the Syrian refugee crisis (Ostrand, 2015). Not to mention as well the Iraqi refugees that the country has been hosting for years around 40,000 refugees other than the Palestinian refugees whose number exceeds 400,000 (Trad & Frangieh, 2007). As a result, the demand on services like education,

health, and infrastructure has considerably risen, making it a struggle for public institutions to cater for the needs of their citizens and the refugees they hosts (Ostrand, 2015).

Legal Restrictions

Syrians in Lebanon are denied the refugee status due to severe legal restrictions imposed by the Lebanese Government, among a series of other restrictions like forbidding the establishment of formal refugee settlements (Kerbage et. al., 2020). In 2015, the Lebanese authorities introduced a series of policies that exacerbated the crisis for Syrians who are seeking refuge into the country (Geha & Talhouk, 2018). Borders' closure, denial of work and employment (under the requirement of a Lebanese sponsor), the enforcement of firm and non-affordable regulations on residency, besides appeals to the UNHCR for the cessation of refugee registration were among the policies that have taken their toll on the Syrians in Lebanon (Nassar & Stel, 2019). Currently, "over 80% of Syrian refugees lack legal residency since Lebanon stopped allowing UNHCR to register Syrians in 2015." (Karasapan & Shah, 2021) Many end up being exploited, detained, or deported if they cannot afford to register outside the UNHCR, which requires them to secure a Lebanese sponsor, get the approval of authorities and pay an annual renewal fee of $200; for most of them, this is unaffordable. Facing the status quo, the SRs on the Lebanese territories end up living in a country where they have no legal framework that enables them to access essential services such as healthcare, education, and employment, which renders their situation highly precarious (Blanchet et. al., 2016) and cause them to live in the fear of being randomly arrested by the police (Hala, et. al. 2020).

Sociopolitical Tension

Professor Ghais explains that "with the presence of Syrian refugees in Lebanon, the country faces an existential danger, due to their large-scale migration, which overburdens the country's infrastructure and depletes its resources," adding **"**compared to the other refugees in Lebanon, "SRs are being used for political ends… this has to do with changing the demographic equation in the country." (2021) Besides this, the Lebanese society seems unable to embrace the integration of SRs within their communities for reasons that are strongly related to the sociopolitical history between the two countries (Hala, et. al. 2020); the Syrians have been in Lebanon for so many years and "[their] prolonged presence in the country has awakened painful memories of the Syrian occupation of Lebanon from 1991 to 2005." (Hala, et. al. 2020) The political discourse has also contributed to arousing the indignation of the public opinion given that Lebanese politicians continue to blame the refugees, mainly the Syrians, for being the cause of instability in the country (Hala, et. al. 2020). This had a negative impact on the local communities in hardly accepting the fact that Syrians are receiving humanitarian support more than the Lebanese people are, considering that the local population has the higher privilege. Incidents were documented on this matter by several non-governmental organizations (NGOs) that have "reported rising tensions between Syrians and Lebanese host communities due to the perception of unfair support for Syrian refugees by the international community compared with poor Lebanese communities." (CARE International, 2018) Syrians continue to be treated as unwelcome outsiders while their Palestinian counterparts have become widely accepted by the Lebanese public. With the arrival of SRs in Lebanon, the Palestinians became to be seen as "'the old refugees,' who, compared to the new 'arrivals', were refugees the Lebanese have grown used to and almost come to regard as part of Lebanese society, in contrast to the Syrians, who were

considered merely “temporary” refugees.” (Andersen, 2016) This identity narrative has been confirmed by Grace Aziz, an Interpreter and Humanitarian Assistant at the International Organization for Migration (IOM). Aziz reported that “Palestinians have been in Lebanon for some times now… one can say that they became part of the country… it’s like it’s their home, but it’s not… they already have their own territories now… their own camps and houses… somehow, they have their own jobs… they are more ‘comfortable’ than the Syrians.” (2021) While the Palestinians have managed to fit in their host community, the SRs are considered as highly subject to discrimination and are prone to physical assault, insults, and bullying in their neighborhood (Hala, et. al. 2020).

Poor Living Conditions

According to estimations, 90% of Syrian refugee households in Lebanon live in extreme poverty in 2021, a rise from 55% in early 2019 (Karasapan & Shah, 2021). As reported by the U.N., “these households are living on less than half the Lebanese minimum wage, roughly $36 monthly and shrinking in real terms.” (Karasapan & Shah, 2021) These figures indicate that SRs in Lebanon are deprived from their most basic needs, including food, safe drinking water, sanitation, health, shelter, education, and employment with 50% of these households suffering from food insecurity in December 2020, a doubling since 2019 (Karasapan & Shah, 2021). Although they receive aid from donors, those refugees continue to live in extreme vulnerability as many among them seeking shelter in tent camps in very remote areas across the country (Andersen, 2016). Tony Antoury, current diplomat at the Lebanese Ministry of Foreign Affairs, shares a valuable insight on this matter, drawing on his previous experience as a Former Field Monitor within the program Collective Site Management and Coordination (CSMC). CSMC has been implemented in several regions across Lebanon by INTERSOS, an Italian, international

NGO that works on the establishment of a wide community-based protection programme targeting refugees, mainly from the Syrian nationality, since 2006. Antoury had been assigned with the regular monitoring and follow up of targeted collective sites for Syrian residents, including the provision of, and access to services in several regions on the Lebanese grounds. When inquired about the humanitarian support offered to those Syrians, Antoury said "It's true that the Syrian refugees [in Lebanon] benefit from services such as the 'Red Card' as we call it; this card is provided by the UNHCR and allows them to access a certain monthly amount of money to make purchases like food and medication. The Card, however, is often insufficient and is barely enough for them to secure their most basic needs." (2021) Sometimes, when services such as education and healthcare are available, the SRs have no or limited access to them partly due their lack of knowledge about the existence of such services or because the registration procedures are very complicated (Hala, et. al. 2020). Additionally, compared to their refugee counterparts, Antoury highlighted that "the Palestinians get to benefit from a specific body that is dedicated to them only, which is UNRWA, whereas the Syrian refugees have been 'included' within these bodies among their refugee counterparts and lack access to a specific body dedicated to them." (2021) Another difference, Antoury stressed, is that "the Palestinian refugees have been residing on the Lebanese territories for a long time since they first arrived in 1948, which allowed them to benefit from several facilities provided by their agency like access to education, hospitalization, and so on, and many among them have jobs now." (2021) Many SRs try to find shelter in a house or an informal refugee settlement, but many of those who make the attempt are home evicted or forced out of the settlement after being dismantlement by the authorities (Ostrand, 2015). Considering the absence of official refugee camps and the difficulty to afford a house as mentioned before (Nassar & Stel, 2019), the job of finding a shelter becomes

a ‘serious concern’ for the SRs who seek refuge in a country like Lebanon; “at the end of 2014, 55 % of the 1,146,405 registered Syrian refugees lived in substandard shelter, mainly in informal settlements, garages, worksites, or unfinished buildings.” (Ostrand, 2015)

Chapter I-Implication on SRs Mental and Psychological Well-being

In the previous sections, I have showcased the reasons that make the situation of Syrians who seek refuge in Lebanon even more complex. Comparing their situation every now and then with their refugee counterparts who live with them under the same roof helped to better understand this reality. In the present chapter, I will discuss the implications of this reality on the mental health and psychosocial well-being of SRs in Lebanon while further elaborating on their situation compared to their refugee counterparts.

Studies have found that higher levels of psychological distress among refugees are associated with higher levels of mental health problems resulting from exposure to traumatic war events (Selmo et. al., 2020). Under the circumstances of the Syrian war, Syrians face higher levels of psychological distress given that they are constantly subject to imprisonment, torture, disappearances, forced displacement, landmines, etc., apart from exposure to munitions, incendiary weapons, and indiscriminately destructive devices as has been mentioned in a 2017 Human Rights Watch report. In 'hot' zones, or areas where exposure is more intense, rates of psychological distress were found to be higher given that the situation is more dangerous and the impact on individuals is correspondingly higher; increased symptom severity has been also linked to living in a hot zone (Selmo et. al., 2020). Besides the traumatic events of war that continue to weigh heavily on them, SRs in Lebanon are subject to several stressors that render their situation as refugees even more difficult with a tremendous influence on their mental health (Selmo et. al., 2020). Major stressors include food insecurity and the lack of medical care (Selmo

et. al., 2020; Fouad et. al., 2021), which constitute a daily challenge for SR communities in Lebanon, adding to the fear of living in uncertainty due to their unknown legal standing (Fouad et. al., 2021). In his Theory of Needs (1943), Abraham Maslow refers to these as human needs established in hierarchy, the first two of which are the Physiological and the Safety needs. This hierarchical partition allows us to closely understand the situation of SRs in Lebanon as affected by these needs which are denied to them. As per Maslow's hierarchy, most of the SR communities in Lebanon lie at the very bottom of needs and are far from reaching the highest level, the Self-Actualization Need. "Human needs arrange themselves in hierarchies of pre-potency. That is to say, the appearance of one need usually rests on the prior satisfaction of another, more pre-potent need." (Maslow, p. 370) Assessing the situation of SRs in Lebanon under this proposition and under Maslow's review of needs, it can be deduced that (1) SRs in Lebanon either seek to gratify their ungratified physiological needs, which are the most pre-potent of all needs (2) or to live in a world that is reliable, safe, and predictable to compensate for the unreliable, unsafe, and unpredictable world they live in as a result of injustice and unfairness inflicted by the war.

While daily stressors and insecurity have been identified to be a major cause of mental health problems, an attempt to reverse this trend is aimed at yielding better psychological conditions in SRs in Lebanon. As the Syrian displacements became more protracted, several NGOs and government agencies have rushed to offer relief aid, including food, fuel, hygiene items and shelter (UNHCR, 2021). Many refugees have reported, however, that they are unable to satisfy their needs due to the lack of humanitarian assistance, which created a "common source of distress" among them (Hala, et. al., 2020).

As previously mentioned, “[w]ar-related traumas, coupled with daily stressors have major implications upon the long-term psychosocial well-being of refugees.” (Fouad, et. al., 2021) Considering the current situation in Lebanon with the daunting economic crisis that crippled the country and paralyzed its institutions, SRs have been pushed down the abyss with 75% of them now living under the poverty line as estimated by The Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR2) (Fouad et. al., 2021). The UNHCR has also reported that since the beginning of the crisis, SRs in Lebanon are losing more the ability to spend on food as “[o]ne-third of adult refugees [have restricted] their food consumption in order to ensure their children can eat and a reported 3/4 refugees [have reduced] the number of daily meals.” (Fouad et. al., 2021) It also reported that the COVID-19 pandemic has further aggravated the vulnerable situation of refugees, asylum-seekers, internally displaced and stateless people across the MENA region (Fouad et. al., 2021), let alone in a country in a state of depression like Lebanon. Based on the UNHCR report, the pandemic has triggered a series of consequences on the mental health of SRs in Lebanon, adding to the daily struggle of dealing with their traumas. These consequences are believed to result in long-term threats to the psychosocial well-being of the SR communities in Lebanon.

The likely perilous journey that refugees endure from their country to the host country and the difficulty to adapt to new environments renders them susceptible to develop psychological conditions, including posttraumatic stress disorder (PTSD) (Ghumman, 2016). According to the UNHCR, refugees in Lebanon are constantly subject to stress, which explains why they develop symptoms that are typically related to them like social distress and PTSD (Fouad, et. al., 2021). Since higher exposure levels generate higher risks of mental illness problems, as previously mentioned, “refugees coming from Aleppo were twice as likely to

present with PTSD as those who came from Homs (Selmo, et. al., 2020), knowing that Aleppo is considered the center of the rebellion and the stronghold of several disputing parties in the conflict. Likewise, given that higher vulnerability to daily stressors is likely to generate more psychosocial disorders, studies have found higher stress levels among refugees dwelling in tents, a natural consequence due to their inability to afford housing (Ghumman, 2016), which constitutes a major daily stressor to SRs in Lebanon.

In 2016, a study has found that 43.9% of SRs in Lebanon suffer from major depression, according to estimations, compared to 6.5% only in pre-war period (Selmo et. al., 2020). In 2017, another study has found that the lifetime prevalence of PTSD among SRs in Lebanon is estimated at 35.4% and the point prevalence at 27.2% (Selmo, et.. al., 2020). With the gradually deteriorating situation in the country, these figures have certainly tended towards a dramatic rise. Adding to the exposure to war traumatic events and the daily struggle to securing livelihood, SRs in Lebanon also face the fear of deportation or eviction and discrimination, which constitute a major source of psychosocial distress (Fouad et. al., 2021). Adding to these fears, the lack of love, affection, and belongingness, which constitute the third pre-ponent need in Maslow's hierarchy (Maslow, 1943). Accordingly, SRs in Lebanon "hunger for affectionate relations …, namely, for a place in [their] group, and [they] will strive with great intensity to achieve this goal." (Maslow, p. 381). The conditions, however, seem to be deterrent no matter how hard these refugees try. In Lebanon more specifically, where SRs lack any legal protection (STJ, 2020), multiple suicide reports have been collected among them in 2020 and an increasingly growing number of occurrences has been filed to inform about threat incidents, including threats to others, family disputes, domestic and sexual violence as well as gender-based violence (SGBV), with increased mental health implications (Fouad et. al., 2021).

For all the reasons above, it is natural to notice higher mental illness rates in SRs seeking safety in Lebanon in particular, which implies the need for an urgent psychosocial response. Accordingly, the Lebanese Ministry of Public Health (MOPH) is working through its Mental Health and Psychosocial Support (MHPSS) Task Force (MOPH, 2021) to offer Mental health and psychosocial support (MHPSS) services for SRs in Lebanon; the UNHCR as well as grassroots and international organizations are also working in collaboration with the MOPH to support and complement the efforts exerted at that level (Fouad et. al., 2021). However, available MHPSS services in Lebanon present several limitations, including the challenge to access the available MHPSS by SRs (Fouad et. al., 2021); another limitation is the large divide that exists between the need to provide MHPSS services for SRs and the quality of the services they receive (Fouad et. al., 2021). MHPSS services are meant to help refugees regain their mental health and psychosocial well-being, a prerequisite to feelings like confidence, strength, achievement, appreciation, recognition, independence, and freedom, which, according to Maslow constitute the basic set of the self-esteem need (Maslow, 1943). In other words, MHPSS services are meant to help refugees satisfy their self-esteem need as per Maslow. However, regardless of their availability, the existence of MHPSS services in Lebanon is not meeting the target, leading to the deconstruction of the self-esteem need.

Psychosocial support is provided on the community level, mainly for women and children, involving entertainment activities and listening sessions. These kinds of activities do have a certain temporary effect on improving the state of mind of the refugees involved but are far from achieving transformative results on the mental health level like addressing persistent traumas or helping refugees recover from PTSD (Antoury, 2021; Aziz, 2021). The need towards addressing PTSD and other mental health conditions in SRs should therefore include a more

powerful response, especially in Lebanon where SRs' mental health is significantly exacerbated by daily stressors. It has been shown that female SRs are at high risk of developing PTSD because of the violence they have been exposed to during the war like rape and other forms of sexual violence along with the ensuing consequences on their mental health and psychosocial wellbeing (Mahmood, 2019; Ghumman, 2016). PTSD is also as prevalent among male SRs in Lebanon as in female SRs (Mahmood, 2019), but most of them refuse or hesitate to receive MHPSS support (Antoury, 2021); hence the need for organizations to work on promoting the importance of MHPSS for affected groups (Aziz, 2021). "Male SRs in Lebanon privately acknowledge the need for help, but the dominant gender stereotypes in both [the Lebanese and Syrian] societies, which require men to be aggressive, non-expressive and unemotional, prevent them from accepting or reaching out to mental health and psychosocial support." (Antoury, 2021) The limitations of psychosocial support to SRs in Lebanon impose the need for a higher response to mental health and psychosocial well-being (Aziz, 2021). "Unfortunately, mental health among SRs in Lebanon does not receive the attention it deserves and the response to mental illness is subsequently lower than it should be… It's there but It's not enough" (Aziz, 2021). Some NGOs in Lebanon are providing focused mental health treatment for SRs, including sessions with psychiatrists, especially for the most severe cases where SRs have been through highly traumatizing experiences like amputations and disabilities (Aziz, 2021). This service however is not much available given that the funds dedicated on this level are very limited (Aziz, 2021). "Donors rather concentrate on channeling their funding towards direct assistance in emergency contexts like in-kind donations or cash funds, and now that NGOs are back to work in an emergency context [in Lebanon], there is very limited attention to mental illness services" (Aziz, 2021).

Key Socio-Economic Factors and Psychological Disabilities in SRs in Lebanon

In this section, I address key socio-economic factors and discuss their influence on the psychological well-being and mental health of SRs in Lebanon while comparing their case to refugees in Canada and America respectively. Here I draw on findings in "Refugees in Host Countries: Psychosocial Aspects and Mental Health" by Agic B. et. al. (2018). The purpose of this comparison is to show how the failure of the system and policies in place to ensure protection to refugees directly affects the mental health and psychological wellbeing of refugees, especially during interrogation settings. To help myself better process the information, I have translated the chapters into Arabic (Translation found in Appendix A). The translations into Arabic are intended to give the CIs, especially those whose A language is Arabic and B language is French, the opportunity to become aware of the significance of becoming acquainted with the psychological theories which may facilitate their understanding of the refugees' emotional and mental situations.

Refugee Employment

With access to employment, people can ensure their survival and continuity; employment, in fact, allows people to generate income and output which helps them satisfy their basic needs such as food and shelter; it also grants them the opportunity to participate in society and feel worth and dignity (International Labour Office, 1979). In the case of refugees, the chapter suggests that finding an employment in the host country helps them overcome their war traumas: "Being granted the right to work and having the capacity to find employment are important in restoring psychological well-being." (Agic et. al., p. 193) It also mentions that

"[e]mployment is one avenue that if meaningful, worthwhile, and challenging can help to reduce the chance for mental illnesses to develop and alleviate present symptoms." (Agic et. al., p. 193) I argue that this suggestion fails to apply in the case of SRs in Lebanon where "almost a third of Syrian refugees in Lebanon's labour market are unemployed," according to a study by the International Labour Organization (ILO) entitled "Assessment of the Impact of Syrian Refugees in Lebanon and their Employment Profile" (ILO, 2014). While the Lebanese citizens and SRs alike are suffering from the same rates of unemployment (ILO, 2014), refugees in Canada have almost the same unemployment rate as Canadians, which is 9% for refugees between 25 and 54, close to that of Canadian-born citizens (6%) (UNHCR, 2021). Additionally, refugees in Canada "contribute to [the] country's economy and are not a burden on Canadian taxpayers as few are unemployed," (UNHCR, 2021) contrary to SRs in Lebanon who overburdened the economy and the labour market (ILO, 2013). According to observations, "the situation for refugees improves as they spend more time in Canada." (UNHCR, 2021) This indicates that the refuge employment situation in Canada allows refugees to overcome their traumatic experiences and improve their mental health and psychological well-being, contrary to SRs in Lebanon where their chances are very low and consequently decreases their physiological and safety needs. Additionally, not only do SRs in Lebanon lack the opportunity to improve their mental health and psychological well-being through employment, but rather the economic situation in the country, along with other social factors, aggravate their existing mental health problems or increases the likelihood of developing them.

Discrimination Against Adolescent Refugees

Exposure to discrimination has a significant impact on refugees' mental health and is engendered by economic and social inequality as well as lacking or degrading healthcare and education services and employment opportunities (Agic et. al., p. 203). In the case of Lebanon, hatred and apartheid against SRs add to these socio-economic factors. As formerly mentioned, "[t]he Syrian occupation of Lebanon [has] left a legacy of hostility towards Syrians among many Lebanese." (Todman, 2021) This enhances the lack of safety and love and belongingness needs among the SR. To draw the comparison, I shall focus on the category of adolescents given their critical age: "adolescents' vulnerability is partially due to role confusion and transformation in responsibilities and identity," (Braun-Lewensohn, 2018). In fact, everyday occurrences of discrimination particularly affect the psychosocial well-being of adolescent refugees (Agic et. al., p. 203; Braun-Lewensohn, 2018) "because of their unique developmental stage" (Braun-Lewensohn, 2018), which may result in feelings of self-worth and severe mental health problems (Agic et. al., p. 203; Braun-Lewensohn, 2018) A study showed that Somali adolescent boy refugees in America who adopt the American identity have less depressive symptoms and the link between depression and discrimination among them is weaker (Agic et. al., p. 203). These findings indicate two things: (1) Somali adolescent boy refugees can fit in the American host communities while embracing a new identity and perhaps new roles in this age transformation phase; (2) the American host communities embrace the integration of Somali adolescent boy refugees, which limits discriminatory practices against them. However, this cannot be valid in the case of Syrian adolescent boy refugees in Lebanon; the long-standing legacy of hatred towards Syrians fueled by the massive influx of SRs into Lebanon who depleted the country's resources and overburdened its infrastructure (Ghais, 2021), prevents the Lebanese host

communities from actually "hosting" Syrians as refugees, embrace their integration, and avoid discriminatory practices against them. This means Syrian adolescent boy refugees cannot fit in the Lebanese host communities because they are not allowed to, neither can they embrace a new identity or role, although it is critically necessary in their age. Consequently, Syrian adolescent boy refugees in Lebanon, unlike Somali adolescent boy refugees in America, are at much higher risk of developing mental illness and psychosocial disorders. It is significant to confirm here that what apples to the Syrian adolescent boy applies to Syrian adolescent girl refugees. At this stage of life, security and belongingness needs are essential to the development of the psychologically balanced grown-ups.

SRs in Lebanon Seeking Refugee Status and Political Asylum and the Role of the Community Interpreter

For people facing conflict and persecution at home, escape is the only way to seek protection and start a new life, including getting reunited with their family members, finding a job, and pursuing education (Phillips, 2015). A safe way to do so would be through resettlement, (Amnesty International), which is the only means of escape through legal entry to a given country (Phillips, 2015). The UNHCR emphasizes that another means of escape would be through false documentation and calls on considering those who adopt it as refugees not illegal immigrants, considering the compelling motives underlying such a decision, including fear of persecution (Phillips, 2015). However, for Syrians who cannot travel legally by plane, sea routes through the Mediterranean may be the only solution no matter how hazardous the journey may be. "Since the Government of Lebanon has maintained that Lebanon cannot be a country of permanent asylum," SRs can only seek resettlement or voluntary repatriation as the only durable

solutions (UNHCR, 2014). It is worth mentioning also, that from Lebanon specifically, the route is long and deadly; yet SRs seeking refuge in Lebanon choose to perish than staying in a country where the situation has dashed any hope for a new life (Rose, 2021). SRs are resettled from Lebanon to countries abroad by organizations such as the International Organization for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR) or through embassies. Prior to approving or rejecting the SR's request for resettlement, the SR is required to meet with an officer, a representative of the resettlement agency, for one or several interviews. Due to language barriers, these interviews are mediated by a CI whose role is to translate the stories of those refugees and ensure a clear and successful communication between the refugee and the interviewing officer. Previous studies of interpretation have depended on the role of CIs in contexts related to refugees and asylum seekers, including SRs, such as resettlement and migration (i.e., Valenta et. al., 2020; Anastasia Atabekova et. al., 2017), healthcare and psychotherapeutic settings (i.e., Wenzel & Drožđek, 2018; Hasdemir, 2018; Tribe, 1999) No studies, however, have examined the role of CIs in the case of SRs in refugee status and asylum interviews from a psychological point of view. Therefore, the current study attempts to investigate the role of CIs in interpreter-mediated refugee interviews in the case of SRs in Lebanon with a particular emphasis on SRs' psychological state. The findings of the study will help suggest a reconstructed and less restrained way for CIs in managing the communication between the SR and the interviewing officer in refugee and asylum seekers' interviews in Lebanon. Finally, the thesis will suggest a specific approach for resettlement agencies and embassies in Lebanon to implement it for use in the case of SRs in Lebanon in these interviews.

Chapter II-Case Study

Recruitment of Participants

My target population consisted of refugees and community interpreters. Data collection has been carried out from December 2020 till November 2021. The work has been slowed down by the spread of the Covid-19 pandemic and by the repeated lockdowns. Gathering data had to be partially done remotely in the context of social distancing for safety reasons. Several modalities have been used in this framework, including face-to-face meetings, phone and video calls, and emails.

Recruitment of SRs

The study used a sample of 100 SRs seeking refuge in Lebanon; their ages range between 17 and 65 males and females. Children had to be excluded from the study as their parents were quite reluctant to allow their children to fill out the questionnaire because of their concerns regarding their children's psychological states. The elderly among them were also excluded due to difficulties in finding volunteers from this category of age. And despite the fact that more SRs were asked to take part in the study, only 100 consented to participate. And although the context of the research and purposes of the study were explained in full, most SRs expressed fears when approached to fill out the questionnaire (e.g., some of them asked if any disclosure of the information required would affect the procedure of their refugee status or political asylum requests; some others had doubts that they were being secretly followed or inquired by their resettlement agencies). The majority of the SR's population is mainly concentrated in the Metn

District, which is one of the most popular areas in Lebanon. Most of them live in very crowded and popular areas in poor conditions. The only inclusion criteria for SRs to have them applied for refugee status or political asylum.

Recruitment of CIs

Only 7 Lebanese interpreters working across different resettlement agencies and embassies in Lebanon volunteered to fill out the questionnaire. The inclusion criteria for CIs was to have a minimum experience of 4 years.

Study Design and Measures: SR's and CIs' Questionnaires

Most of the SRs included in the study were either illiterate or had no knowledge about how to access and use advanced tools such as online questionnaires. A primitive way had to be used whereby questionnaires were typed and printed. Those who were illiterate were met in person and received assistance in filling out the questionnaires; the encounter has been recorded. Refugees who knew how to read and write, received the questionnaire by email. Most of the answers seemed lacking clarity and inquiry was necessary, so refugees were contacted and asked for clarifications. The language used in the SRs' questionnaire was Arabic because most participants acknowledged having very limited or no literacy in English; therefore, I had to translate the answers into English and afterwards the data was analyzed.

The questionnaire is composed of 38 questions and three sections. In the first section, refugees were required to answer personal questions concerning their war experiences, including events before and after displacement, and how the conflict affected them on different levels, mainly the psychological level; the second section comprised questions regarding the interview

with the resettlement agency or embassy, more specifically about the interviewing officer and the effect the officer's attitude on them during the interview, mainly from a psychological point of view (i.e., triggering existing traumas, causing the refugee to experience emotional breakdown or panic attacks or driving the refugee to adopt adaptation mechanisms such as lying, etc.); the third section also comprises questions about the interview but they are more specifically related to the CI and role expectations as perceived by the SRs. (See the questionnaire in Appendix A) It is worth mentioning that "SR in Lebanon" is referred to as "refugee" in the questionnaire and "interview with the SR in refugee status and political asylum in Lebanon" as "refugee interview" or "the interview."

Study Design and **Measures: CIs' Questionnaires**

The questionnaire has been created using an e-tool and was sent to the volunteering interpreters to be filled out; the results were automatically registered in the platform. The questionnaire entitled "Community Interpretation: Role Conflicts and Expectations in the Cases of Syrian Refugees in Lebanon" consisted of 56 questions distributed over three sections. See Appendix B) The first section comprised personal questions about the volunteering CIs and their role in general; in the second section, CIs were required to answer questions about the role they play in refugee status and political asylum interviews with SRs; and in the third section they answered questions related to expectations regarding the role that the interviewing officer plays in these interviews. Same applies to "SR(s) in Lebanon" is referred to as "refugee(s)" in the questionnaire and "interview with the SR in refugee status and political asylum in Lebanon" as "refugee(s) interview" or "the interview".

Data Analysis:

Theme 1: CIs' General Perceptions

Utmost neutrality and objectivity is a prerequisite in the job of CIs even in refugee interviews. Out of the 7 CIs involved, 100% of them were asked by the hiring resettlement agency to maintain utmost objectivity during the questioning session with the refugees; equally, 100% of the CIs involved believed that they should maintain utmost objectivity during the questioning session. Reasons include: "Yes, because as an interpreter my role is only to convey the message without it being affected by my stance, emotions or opinion"; "Yes, it is not my own point of view… I only serve as a liaison because of language barriers"; "You are the voice of the speaker and neutrality is the number one professional standard of interpreters"; "Yes, the interpreter is the facilitator of communication between the 2 parties and is not there to give a subjective opinion"; "Yes, as an interpreter I should not be influenced by emotions or personal prejudices"; "Yes, for the sake of the people being questioned."

Five of the participating CIs thought that their job with refugees was different from their job in other contexts such as courtroom or conference interpreting. Reasons varied and they include: "because of the emotional load these kinds of interviews usually involve (stories of kidnapping, murder, arrest, torture, loss of home and belongings, adventures to escape the war and the fighting, mourning), "as they are more time consuming and emotionally draining; "We have to take the context into consideration… the dire circumstances, and their cognitive levels" because they require interpreters to go the extra mile in maintaining the composure they normally do maintain due to the emotional and possibly distressing content they may come across during an interview with a refugee."

Same results were collected when answering the question of whether the job that includes refugees is humanitarian or not. Five CIs answered: “Yes. It falls within humanitarian relief works, even if this is done indirectly”; “yes, as the CIs are part of the refugee's resettlement process”; “Yes, I am trying to help a human being communicate with another and tell his/her story”; “yes, I think it is humanitarian in the sense that interpretation gives the voiceless a voice”; and “yes, because at the end of the day, their future is on line during these interviews. They either get refugee status or not.”

Although most of the CIs involved believed that working with refugees was different than other settings, only 2 CIs think that working in refugee contexts grant them the ability to be more than just a neutral converter of messages. They believed that an interpreter is supposed to be only a neutral convertor of messages against 3 CIs who thought that neutrality changes according to the situation, including “the space given to the interpreter by the interviewer.”

This explains why 4 of the participating CIs don’t feel like they have to juggle between different roles while in refugee contexts, reiterating the requirement of neutrality and objectivity, against 1 CI believing that this is the case “because you feel that the destiny of these people lies within your hands” and 2 CIs considering that this applies in some cases, for example when “the refugee sees me as his/her savior to convey the messages. I should be open to fulfill the needs of both the interviewer and interviewee.”

Almost similar results have been collected when CIs were asked if they feel like they must play the role of a psychologist and a CI at the same time with 28.6% answering with a yes against 71.4% who answered with a no. For CIs who detected signs of hesitation, exaggeration, or dishonesty in the refugee’s behavior, all of them indicated that the refugee’s behavior is not of concern to them so, which makes them stick to the job. When asked if they ever wanted to make

an exceptional decision to help the refugee, 4 CIs have ruled out any possibility to make such a decision while 1 CI said that she wouldn't do so unless she feels the refugee wants her to step in; a second CI said that sometimes she answers the officer's questions in a private conversation, while a third CI said that she'd show the refugee that she can be trusted in conveying the information and that the refugee's feelings, emotions, and point of view do matter to her.

One CI participant's input on how CIs would help the refugees during the interview came as follow: "Let's say I noticed the refugee is quite uneasy, in this case, I can inform the officer of the matter and he/she can verbally reassure the refugee that this is a safe environment and that they have nothing to fear. It is extremely important for the refugee to hear that message of reassurance from the officer because it affects them differently when coming from a foreigner who doesn't speak their language via the interpreter who actually does. They need to know that the officer is the one reassuring them, and not the interpreter they sometimes unconsciously "take refuge in". At the end of the day, it is only natural for refugees to feel nervous in a setting that could change and shape their entire future."

In order not to step on anybody's toes, it is best that the interpreter does not initiate such a move or any other move directly with the refugee while using the refugee's language. The interpreter rather suggests the move to the officer who would be in direct contact with the refugee and who would decide as to whether or not he/she will be proceeding with that suggestion; after all, the officer should be the one calling the shots in the interview.

Only 2 CI participants agreed that CIs must have enough knowledge of psychology to be able to understand the stress of the refugee during the interview and deal with it.

When asked if the participating CIs would be given the space to intervene on behalf of the refugee to offer help, 71,4% of them said that they would show a reassuring attitude, which gives

the refugee a sense of comfort against 28.6% who asserted that they refused to intervene in the communication whatsoever.

When required to answer if the interviewing officer decides to show a compassionate behavior towards the refugee, 5 CIs have stated that the officer offers sympathy to make the refugee more comfortable when the refugee is stressed out, having an emotional breakdown, suffering from a trauma, or talking about sensitive issues that relate to illness or family. The 2 other CIs said that it depends on the officer's state of mind and the position that the officer occupies.

Theme 2: Perceptions of Refugees Vulnerability

One hundred percent of CIs have acknowledged that they take into consideration the refugee's psychological state during the interview. Close results were collected when asked about the interviewing officer, with 85.7% of CIs stating that the officer does take into consideration the refugee's psychological state during the interview against 14.3 %. In line with these findings, 71.4% of CIs have answered with a yes when asked if they take into consideration the reasons that pushed the refugee to ask for migration during the interview against 28.6% CIs who said they don't. And 71.4% of CIs perceived refugees as vulnerable parties to the communication against 28.6%. This explains why 85.7% of involved CIs believe that the refugee may act in an inferior position to the officer when being interviewed, mainly because the officer has the final say in rejecting or approving the refugee's request (85.7%) or because the refugee might feel like begging for help because there are no other options (14.3%). Also 85.7% out of the 7 CIs have reported noticing common signs of stress or anxiety in the interviewed refugees against 14.3% only; five CIs confirmed they often detected signs of hesitation, exaggeration, or

dishonesty in the refugee's behavior. Answers included "Yes sure. In some cases, it is just clear that they are lying. For example, sometimes the officer asks the same question but in a different way or using different words and you get different answers from the refugee"; "Yes when talking about relatives, children, official documents"; "Yes, … it is very easy sometimes to know that the refugee is exaggerating (doing his best to receive an approval) or lying (by entering into the details of the details); "Such things can be detected when a refugee is trying to lie or cover up gaps or when a refugee is too shy, embarrassed or even afraid to disclose some information." The other 2 CIs considered that they cannot judge such a behavior.

Theme 3: Perceptions of Refugees Reciprocal Attitudes

All CIs have reported that cooperation from all parties is mostly what makes the interview run smoothly for all concerned. One CI response, however, was found to be insightful, considered that a proper layout of the interview as well as a well set-up interview setting that avoids a stressful or intimidating environment are key to helping ensure that the interview goes smoothly for all participants. Three CIs associated the tension that arises during the interview with the emotional state, despair, and vulnerability of the refugee especially due to the "distressful content that the refugee may share," the need to "show as much pain and vulnerability as they can in a short of time," as well as "their worrisome state of mind or their physical condition." And 2 CIs blamed it on the interviewer's attitude, 1 CI on the "lack of responsiveness on the part of the refugee," and 1 CI on the inappropriate attitude that might be seen from any of the two parties involved.

As to aggressiveness, 71.4% of the CIs felt that the officer occasionally acted aggressively towards the refugee and that the interview looked like a police interrogation against

28.6% who asserted that the officer never showed a similar attitude, and the interview was unlike an interrogation, and 85.7% of CIs thought that the officer sometimes asked questions that raised doubt in the refugee's stories against 14.3% who said the officer did not tend to ask questions that raise doubt in the refugee. Instances related to aggressiveness showed by the officer, CIs said, are associated either with the lack of inconsistencies in the stories of the refugees or to the fact that the officer beholds information showing that the refugee is telling lies.

Theme 4: Perceptions of Refugees Experience of Stress and Anxiety

A percentage of 85.7 of the CIs confirmed that the refugees consider the interview as their only way to a safe haven against 14.3% only; this finding explains why 5 out of the 7 CIs asserted that the interview is a stressful interrogation to the refugees, mostly because their destiny and future depend on the interview; one CI blamed the refugee for not being able to determine the objective of the interview and another CI considered that the interview's questions helped refugees to build a better frame to their situation. Also 3 CIs have acknowledged having witnessed an emotional breakdown from the refugee's part especially in cases where the refugee has faced sexual assault or is experiencing trauma. While CIs 3 said to have never witnessed such thing, 1 CI couldn't provide an answer. And 71.4% of the CIs have reported that refugees ask for help during the interview while 100% of them indicated that refugees seek attention or sympathy in these settings; 85.7% of CIs said that loneliness, depression, insecurity, and self-devaluation are commonly expressed by the refugees at the time of the interview; 85.7% said that refugees often mention that they need to be more understood against 14.3% only; 71.4% of CIs have reported that the refugees are suffering from PTSD.

Theme 5: SRs' Perceptions: Sensitivity and Haven Seeking

All 100 refugees involved consider that the conflict stripped them off everything in life, made them loose self-confidence and self-esteem, and had them look for affection and security. 95 out of the 100 participants look for means to satisfy their sense of belongingness and believe that they suffer from trauma due to the war; one example is a refugee who was always afraid of the military uniform because it made him nervous; another refugee who was forced out of her home with her family by one of the terrorist groups said that she felt like being followed the entire time.

Only 3 refugees involved considered that nothing can compensate for what the war had taken away from them against 97 participants who believed that migration can be a chance to compensate for all that they had lost. They also believed that it was their only way to a safe haven. A strikingly low number of 5 refugees acknowledged to had asked for psychological support; one example is the case of a refugee who used to work as an interpreter; another example is that of a schoolteacher, and the other examples relate to mothers who asked support for their traumatized children. For those who never asked for psychological support, the answers were mixed, and the reasons varied; the following are some of the responses made: "All that matters to me is to have my request accepted… this can be the greatest support, not just for me, but to all my family as well"; "I never knew such thing existed… if I did, perhaps I would have asked for support"; "what does it include?"; "I never thought of such thing"; "I don't know where to access this kind of support"; "what for? Would this make my life any better? As long as I'm unemployed and my situation is bad, why would I think or care about psychological support?"; "Not really… I only asked someone to help me find a job once, and I always reach out to agencies for cash and food parcels"; "If I reach out to psychological support would this

make me eat or live better?"; "this kind of support is only secondary compared to my situation… I doubt any of the refugees in my case would give this any importance even if they actually need it"; "I didn't know I can get psychological support, but anyway, even if I did, I wouldn't ask for it… to be honest, are you expecting from a man in our society to seek similar help? What would they say about me?!"

Theme 6: Highly Vulnerability During Interviews

Out of the 100 refugees participating in the questionnaire, 78 of them were very anxious before the interview: "I didn't sleep all night… I've been waiting for this opportunity for 3 or 4 years… it depends on this interview whether I'll be granted the opportunity or not." Fifty-one refugees acknowledged that they were anxious during the interview while 33 said to have been confused and 16 others were calm. One of them said: "Truth is, I was calm because I was so desperate… so, I surrendered to God and placed myself in his hands"; another participant acknowledged that "the officer made me cool down after I've been so worried about how the investigation would go", which was almost a common reason among those who remained calm during the interview. For participating refugees who said to be anxious and confused, they mostly had fears that their request would be rejected because their lives are hinging on that. Fifty-five refugees have acknowledged that they felt the urge to cry or cried while narrating their stories during the interview against 45 who said they stayed strong and resilient. Ninety-two refugees confirmed to have been totally transparent during the interview against 8 who admitted the opposite.

Theme 7: Effect of the Officers' Attitude During Interviews

All 100 refugees acknowledged being worried that the interviewing officer would not like them. A majority of 79 refugees said that the officer was only doing his job, while 16 said that the officer seemed responsive and sympathizing, and only 5 others had the impression that the officer was aggressive and indifferent. For instance, one refugee said, "the officer made me feel as if I'm lying to him the whole time, so I didn't expect him to show support." In other reported examples, however, the refugees confirmed that the officer tried to lighten the mood when they felt uncomfortable or showed kindness and sympathy from the beginning of the interview. A majority of 97 refugees expected the officer to show sympathy given that the officer's final decision will determine the fate of their future and 3 did not expect sympathy or understanding.

Ninety-eight refugees have acknowledged to be annoyed by the fact that their destiny lied within the hands of one person (the officer). Seventy-four refugees said they felt inferior because the final decision was the officer's. When asked if the outcome of the interview came as unpleasing, 19 refugees blamed the resettlement agency for rejecting their refugee status or asylum case, 66 blamed the officer, 7 blamed the interpreter, 5 blamed themselves, and 3 blamed no one considering that this was his/her fate.

Sixty-seven refugees said that the officer's attitude made them nervous, and 33 said it didn't. Nine refugees asserted that the officer indirectly accused them of not telling the truth, while 91 refugees confirmed the opposite: "The officer was asking the same question repeatedly… I was completely honest, but he was very skeptical about me as if he was questioning my credibility"; "the officer didn't say that I'm lying, but it was very obvious from the way he asked the questions that he's not believing me." All refugees involved stated that they would feel more comfortable in providing the information needed if the officer had shown a

reassuring attitude: “Two times during the interview, the officer insisted on asking the same question twice… he disturbed me and made me unsure about myself so I kind of lied”; another reported, “the officer was kind to me and to my son, but I had doubts about myself the entire time… may be the interview itself made me nervous and the fact that the fate of my request depended on it!” One refugee reacted to the officer with lies: “I don’t know why, but I just lied… I didn’t mean to be dishonest, but the officer made me nervous… he asked me the same question three times, and this made me doubt myself.”

Theme 8: Expecting Help from the CI

Eighty-seven refugees asked the help of the CI during the interview while 13 did not; several refugees said that they would want to ask the interpreter to help them, but out of respect for their dignity they did not. Another refugee also acknowledged the need to ask for the interpreter’s help, but the CI was very strict much like the interviewing officer. All refugees involved confirmed having asked the interpreter to tell the interviewing officer about their frustration and insecurity because of what they experienced during and after the war. When refugees were asked about their expectations of the CIs, responses were: “I expect the interpreter to understand what I mean without having to explain and to try and make the officer truly believe my suffering, and that I’m in desperate need of getting accepted for migration”; “the interpreter knows what I want to say so the CI should translating what I mean… disregarding anything I may say that will result in my rejection. … this doesn’t necessarily mean manipulating my stories or inventing stories,” One very interesting case related to a refugee who had worked as an interpreter before the war; she said “as an interpreter, I know that the interpreter has to maintain objectivity in her work… but let’s take into consideration the position of the the refugee and the reasons that pushed that refugee to ask for migration… in this case, the interpreter can

show a bit of sympathy and support"; she continued: "I am aware that the interpreter has to be objective and must not take sides, but in the case of refugees, there must be a certain way to offer help… maybe by closely understanding the refugee's situation and trying our best to explain this to the officer, who should understand why the interview is very important for the refugee." When required to answer if the interpreter is more than just an interpreter, but also a social worker, a majority of 89 refugees answered "yes". Based on the above responses, I move to my argument.

Argument

As mentioned before, this study aims at understanding the perceptions and experiences of both SRs and CIs involved in refugee status and asylum seekers interviews in Lebanon. The findings of the study indicate that several gaps exist between participants' needs and perceptions. On one hand, the former part of this study elucidated the realities that make SRs special refugees among their peers. It becomes clear now that SRs in Lebanon are exceptionally vulnerable due to the war and the daily stressors that add to their already dire situation. They have exceptional humanitarian and psychosocial needs and have developed higher rates of mental illness and psychosocial disabilities. When trying to define the role of CIs in any given setting, it is either "the completely neutral interpreter at one extreme" or the "fully involved interpreter" at the other where the CI has to choose between becoming "an advocate for the service user or a co-worker of the service provider." (Zimányi, p. 58) While hiring, resettlement agencies tend to perceive the CI as a member of their own service team (Zimányi, p. 58), refugees often consider CIs as their own advocates (Holly & Jourdenais, p. 311). Consequently, this thesis suggests an "extended role on the interpreter's part," (Zimányi, p. 58) whereby the CI can be more than just a "translation machine" (Bot, 2005) and can "diverge from impartiality" by "adopting a series of

roles" (Zimányi, p. 59). In this sense, there must be specific determinants to working with SRs in refugee status and political asylum interviews in Lebanon; they require the CI to adopt a different approach, one that goes beyond the "linguistic conduit" (Arocha, 2005), and abides by the tenets of neutrality and objectivity (Zimányi, p. 65), besides takeing into consideration the psychosocial factors that intervene in the course of the interview.

As previously mentioned, most SRs are reluctant or refuse to reach out to MHPSS support for three possible reasons. First, while "[s]tudies have found that Syrians consider stigma a barrier to care," (Hala, et. al. 2020) the SRs in Lebanon continue to face stigma in their communities (McCall, et.. al, 2021) and refuse to access MHPSS services. Second, the spread of "common notions that Arabic-speaking cultures view mental health problems as indications of "craziness" or personal weakness" (Hala, et. al. 2020), constitute an obstacle for SRs, men in particular, to access this kind of services, as was also confirmed by Antoury (2021). And third, many SRs have no knowledge about the existence of such services in Lebanon (Hala, et. al. 2020). This means that CIs must be aware of what they are dealing with; when SRs arrive to the interview, they most probably bring with them a huge load of psychosocial disorders and mental illnesses. The danger of speaking about their traumatizing experiences for the first time in the absence of psychological guidance and support must be seriously taken into consideration by CIs and the hiring agencies. It is also important for CIs and hiring resettlement agencies to keep in mind that tension and stress can have a great impact on the SRs' ability to function normally, and they must be mindful of how important it is to take the SRs needs into account (Neįgaliųjų Veiklos Centras, 2021) The fact that mental disability itself can make the encounter complicated is also to be considered, especially that this "may cause confusion, poor communication, misunderstanding, and at worst, the prospect of a risk of harm to the [mentally] disabled person."

(Naughton, 2021) The CI, who understands the language of both parties, should be given the lead to know how to harmlessly extract the info out of the SR. Especially in cases of highly traumatized SRs including sexual violence or assault, amputations or permanent injuries, and torture, besides the poor living conditions in Lebanon. Hence the CI must show a high degree of sensitivity in rendering the interviewer's questions by choosing the right choice of words and the right tone of voice without risking to inflict any harm on the SR's part. Therefore, the success of the communication in these interviews depends to a great extent on the CI's ability to understand the psychological situation of the refugee and to render the info on both sides without triggering the SR's traumas and fears. This ability requires the CI to have enough awareness of theories of psychology because depending on the effective translation of their stories which is pivotal to the resolution of their application (Amparo & León-Pinilla, 2018), the interview decides the fate of the refugees.

Additionally, showing sympathy to SRs in these interviews does not mean manipulating the information they provide. Rather, the CI sympathizes with the SR with the aim to understand the situation and know how to successfully render it, which can include offering messages of reassurance. In this case, the "translation-machine" model fails to apply "because it assumes that interpreters act robotically, without thinking, because all they need to do is match words." (Hale, p.127) To meet the purpose and act beyond the translation-machine model, "it is crucial [for CIs] to understand how Syrian refugees perceive and describe distress," because the way SRs express themselves is related to the way their thoughts are expressed. (Hala, et. al. 2020) Consequently, the CI becomes able to guide the SR through the interview; first, by detecting and identifying the signs of distress that lie behind the SR's utterances; and second, by rendering those signs in the translation preserving the same impact. For instance, "many Syrians express emotional

difficulties through metaphors that do not easily translate into symptoms in Western-based diagnostic categories," (Hala, et. al. 2020) which makes it hard for the interviewer to understand without the CI's help. Thus, it is very important for the CI not only to help the interviewer understand the direct meaning, but also the implicit meaning of distress that lie behind the SR's utterances. Again, the translation-machine model seems to fail in similar settings, especially that SRs perceive distress "as a legitimate reaction to extreme life circumstances." (Hala, et. al. 2020) This means that sending distress signals is a common, natural phenomenon in these interviews. While SRs seem to "have the burden of proving that they are eligible for asylum," (Amparo & León-Pinilla, 2018) CIs appear to have new roles to play to adapt with this reality beyond the translation-machine.

The CI vs. Robert's Classification of Roles

One way to approach the role of CIs in refugee status or political asylum interviews in the case of SRs in Lebanon is by adopting Roda Robert's classification of the interpreter's roles (1997). All four roles identified by Roberts prove to apply to the case in point. First, the CI plays the role of an Assistant (Roberts, p. 12). The SR in Lebanon has no or limited access to human rights, and the CI makes sure the SR has access to the refugee status or political asylum service. The SR as a service user is also deprived of linguistic rights (Roberts, p. 12); the CI ensures the SR's access to linguistic rights by allowing the opportunity to speak freely and openly during the interview. In this case, the SR may acknowledge for example that the interviewer's attitude is causing stress and preventing the refugee from responding comfortably and with ease. Second, the CI plays the role of a Cultural Broker, ensuring communication between the SR and the interviewing officer while considering cultural considerations. This requires the CI to act beyond

the translation-machine "even to the detriment of the linguistic aspect." (Roberts, p.13) This role is highly needed in the case of SRs in Lebanon; first, SRs in Lebanon prove to show higher levels of mental illnesses; second, the Syrian culture prevent the revealing of underlying psychiatric disorders in Syrians (Hala, et. al. 2020). In fact, "the Syrian culture is equated with behavioral ineptitude, defined by illiteracy and a lack of education" (Hala, et. al. 2020), which makes it hard to detect the SR's mental illnesses. In this case, the CI's involvement is necessary to unveil such disorders and decode the hidden meaning behind the SR's behaviors. Rendering the adequate translation wouldn't be the only outcome of such an attempt, but also, establishing a connection between the interviewer and the SR; this facilitates the approval of the refugee's request by eliminating any potential misunderstanding from the interviewer's part which may have negative result. Hence, the interviewer lacks the capacity to interpret the SR's behavior that is shaped by psychiatric disorders, including the meaning that lies behind it, and as a result, might misinterpret any inconsistencies, hesitation, stuttering or lapses as signs of dishonesty or lies. It is worth mentioning that similar incidents occurred while filling the questionnaires for the SRs involved in the case study. Most of the participants had difficulties understanding the questions or providing proper answers. The repeatedly showed hesitation and had inconsistencies in the information they provided. Third, the role of an advocate is to actively support the service user. (Roberts, p. 13) This role is mainly needed in cases where the interviewer shows a judgmental, aggressive, or arbitrary attitude towards the SR. The CI here should try to compensate for such a behavior by showing the SR a reassuring attitude, explaining to the interviewer that such a behavior threatens the SR's emotional stability during the interview. And four, the role of a conciliator whereby the CI resorts to "conferring privately with parties to the conflict to determine their perceptions of the issues and concerns and then participating in joint

discussions, ensuring that both parties are correctly understood not just in terms of words but also in terms of motives" (Roberts, 1997 p. 14). This role requires the CI to engage in "identifying different intentions" of the communication's parties (Baker, 2010) and complements that of an Advocate, which mainly applies in cases where disputes or tension arise between the SR and the interviewing officer. The CI should explain to the SR that it is the officer's duty to play the role of an investigator and that the SR is required to cooperate and show a responsive behavior. The CI should also explain to the officer that the interview is a stressful situation for the SR who might perceive it as an interrogation between an accused criminal and a judge. In such a situation, the CI should remind the officer that the SR's motives are honest regardless of how they have been communicated.

The CI as a Community Advocate

Adding to Robert's classification of roles, one point which deserves to be discussed, is the issue of trust, which often hinders these interviews and prevent SRs from winning their refugee status or political asylum case. In refugee status or political asylum interviews in the case of SRs in Lebanon, "the refugee mistrusts and is mistrusted as the aid agencies continuously attempt to define [SRs'] eligibility for aid or resettlement based on target or vulnerable group definitions." (Hala, et. al. 2020) To compensate for such a stance, the CI should shift from the role of an Advocate as per Robert's classification of roles to a Community Advocate as per Raval's (Raval, pp. 17–18) whereby "the interpreter represents the community concerns at the level of policy making." (Zimányi, p. 63)

The CI should also try to build mutual trust between the SR and the interviewing officer, which is essential to establishing a successful communication. The CI's involvement is essential

at this level given that SRs may tend to lie during the interview (Hala, et. al. 2020). “If trust is understood as being able to have confidence in a person or a system, lying reveals that refugees have a fundamental lack of trust in the capacities of the humanitarian system and/or the Lebanese Government to help them,” (Hala, et. al. 2020). While institutions expect SRs to say the truth and present credible stories about themselves, SRs “feel forced to adopt behaviors and narratives in line with the agencies’ perceived expectations, even if they do not conform to their usual self.” (Hala, et. al. 2020) Consequently, SRs may resort to lying as an adaptive mechanism as they adjust their behaviors and narratives trying to be eligible for resettlement (Hala, et. al. 2020). This strategy, however, causes the SR to experience distress due to the fear of being discovered (Hala, et. al. 2020), which entails the CI’s involvement on two levels: The first is to work as an advocate for the SR’s adaptive mechanism by mentioning the reasons explained above to the interviewing officer. The second is where the CI tries to prevent the SR from resorting to such a mechanism at the first place by applying a series of techniques and strategies offering a method of communication that brings trust and understanding in very, very difficult circumstances.” (Baker, 2010) Accordingly, CIs engage in organizing the talk between the two participants or participating with their own voices as “active third parties,” (Martínez-Gómez, 2015). They use their “skill in communicating the nuances of what is said” and “interpret the gist of what their interlocutors say rather than translate their utterances closely.” (Baker, 2010) CIs should also be involved in performing activities on both participants’ behalf by “persuading, agreeing, … questioning, claiming, explaining, comforting, denying, coordinating interaction, and so forth.” (Wadensjö, 1999) Wadensjö (1998) suggests that by carrying out these tasks, CIs makes sure not only to relay the talk as “a passive conduit of language” but also to “engage in an *interaction oriented* approach, with the perspective of talk as activity.” (Marks, 2012) Accordingly, the CI

"(1) requests to observe turn-taking order, (2) invitations to start, stop, or continue talking, and (3) requests for solicited but not yet provided information." (Marks, 2012) This allows the interpreter to take control of the communication and guide the SR in the right direction.

Recommendations

This thesis has attempted to reconsider the role of CIs in refugee status and political asylum interviews in the case of SRs in Lebanon. Based on the previously discussed, it provides the recommendations below which are based on a reconstructed version of the neutrality and objectivity tenets that both CIs and hiring resettlement agencies must take into consideration.

I. CIs and Resettlement agencies are required to treat SRs in Lebanon as a special case as a prerequisite to refugee status and political asylum interviews. CIs working with SRs in Lebanon in refugee status and political asylum interviews, are required to embrace different roles as assistants, advocates, cultural brokers, and conciliators beyond the translation machine role. In turn, hiring resettlement agencies are required to allow more latitude and flexibility for CIs in the case of SRs in Lebanon to juggle between different roles beyond the translation machine role.

II. Resettlement agencies and host countries involved in the process related to refugee status and political asylum must embrace a new dimension for their existence in the case of SRs in Lebanon. The lack of a legal framework for SRs in Lebanon, makes it impossible for them to be integrated on the long-term into the Lebanese host society, which explains why "Syrians … perceive UNHCR refugee resettlement as the only definitive solution to their social and mental health problems." (Hala, et. al. 2020) Resettlement agencies and host countries must also take into consideration that in the case of so many SRs, rejecting

the request for refugee status of political asylum is a matter of life and death. Returning home may be the only solution left for so many SRs in Lebanon, especially with the lack of available legal protection and services.

III. CIs working with SRs in refugee status and political asylum interviews in Lebanon are expected to play a key role in paving the way for SRs to compensate for psychosocial losses (Herring, p. 126) in a post-migration setting, which yields positive effects on refugees' mental health and psychosocial well-being. In other terms, the policies and system in place that determine how refugees are received into the country where they will be resettled, as well as the psychosocial opportunities they are offered (Agic B. et. al., 2018) start to have their effect on the SR from the time of the interview onwards.

IV. Resettlement agencies and host countries involved in the process related to refugee status and political asylum must acknowledge the need for SRs in Lebanon to be interviewed based on principles and notions that relate to psychology deficiencies and must implement this to serve as the baseline of the interviews with SRs in Lebanon. "While … migration factors cannot be altered, host countries can make the greatest impact on the mental health trajectories for refugees by addressing the post-migration psychosocial factors" (Agic B. et. al., 2018) which starts at the level of the interview. Accordingly, resettlement agencies and host countries involved in the process must allow the CI to guide the SR through the interview to help guarantee its successful outcome based on the set of roles presented above. It is essential that CIs and interviewers provided by resettlement agencies engage in private encounters prior to meetings with the SRs who are to be interviewed. The purpose of these encounters is to discuss the psychological and intellectual case of every SR to anticipate expectations related to the interview. One

example may include anticipating emotional breakdown or uncontrollable crying in cases of PTSD or severe mental illness.

V. It is fundamental that hiring resettlement agencies provide a standardized Training Program for CIs who work in refugee status and political asylum interviews with SRs in Lebanon. A close consideration of the experiences and needs of SRs in Lebanon must also be embedded in the program to allow CIs to adopt an adaptive approach that conforms with the case of SRs in Lebanon.

1. The Program must be binding for all CIs who work in similar settings and may be divided over sessions as follow:

   Session 1: Introduction to Humanitarian principles, Human rights and refugees law (international and context specific)

   Session 2: Psychological First Aid: techniques and principles to follow when interviewing persons of concern

   Session 3: Dealing with persons in distress: guidance to safe identification and referral of persons at risk to specialized services

   Session 4: Communication skills and language sensitivity: introduction to language and gender-sensitive approaches

   Session 5: client centered approach: putting the SR's best interests at the center of the interview.

2. The Program must offer specialized training by protection specialists allowing CIs to approach SRs harmlessly during the communication, especially in the case of highly distressed individuals. Besides, the program must be built on training CIs on notions

of psychology such as Maslow's and Robert's theories and on specific methods and approaches that are used in mental health and psychosocial settings. This includes:

- Observing, listening, and linking and connecting: the CI first observes signs of distress; second, listens to the exact needs of the SR; and third, links these individuals to information or to other services
- Using comforting and healing statements as well as positive affirmations by communicating empowering words (i.e., you have the right to achieve your goals, you have the capacity to become what you decide to be, etc.)
- Acknowledging feelings (i.e., I hear your concerns; I understand that you are nervous and sad and it's normal to feel this way)
- Applying language sensitivity and inclusiveness so that SRs don't feel subject to discrimination
- Maintaining the dignity, free will, and rights of SR individuals by putting them at the center of interest. This entails respecting SRs' wishes at all times, even if they go against the purpose of the interview (i.e., the CI should ask the interviewer to stop the interview if the SR asks for it; the CI should clearly identify cues of discomfort when a specific question or topic is presented)

3. The Program guidelines and implementation must be discussed between CIs and hiring resettlement agencies prior to their formulation to cover both general dimensions of the CI's role, the psychological dimension and the translational one, and to build cohesion and unanimity on the program between CIs and hiring resettlement agencies.

Conclusion

This thesis has provided a reconstructed role for the CI to play in SRs status and political asylum interviews in Lebanon based on a humanistic and psychological approach that takes into consideration the emotional and psychological needs of SRs in Lebanon. According to this role, the CI is required to take part in the communication from an interaction-oriented approach, allowing interpreters to act as active third parties beyond the neutrality and objectivity guidelines that impose on them the obligation to abide by the translation machine model. As demonstrated in the thesis, SRs in Lebanon have exceptional needs compared to refugees in general. The SRs bring with them to the interview all their fears and traumas resulting from their war experiences and from the daily stressors that they are subject to by seeking refuge status in Lebanon; their psychological and emotional state increase the complexity of their already-dire situation. The interview, thus, is a stressful event and so is the interviewers' attitude. This affects the SR's behavior and utterances during the communication, as they fall under the burdens of their emotional and psychological state before and during their interviews. The danger of speaking about traumatic or painful experiences without psychological guidance and support threatens the SR's mental and psychological stabilityIn other words, considering the factors that shape these interviews, the CI is required to adopt a more dynamic and cooperative approach in dealing with SRs whereby the interpreter juggles between different roles depending on the requirements of the situation. This requires the CI to intervene in the communication to harmlessly extract information out of the SR and safely guide the SR throughout the interview while preventing any

potential risk on the psychological level. This implies that the neutrality and objectivity guidelines can hardly be maintained in the case of SRs in Lebanon in refugee status and political asylum interviews.

Based on the above considerations, this thesis invites CIs and the hiring resettlement agencies and embassies to reconsider the role of the interpreter in Lebanon and to adapt a more humanistic and psychological approach. It also invites researchers and academics in the field of translation and interpretation to reconsider the role of the CI from an interdisciplinary approach, in specific settings that highly require the active involvement of the CI with refugees suffering from traumatic psychological and emotional situations. In the case of SRs,, the two fields of interpretation and psychology are invited to join efforts to provide insights into how to approach the role of the CI in these interviews. Accordingly, the thesis has suggested a two-dimensional role for the CI, who is expected to engage in a series of tasks and activities to make sure that both dimensions are covered. As an interpreter only, the CI will have an acquired capacity to translate the SR's utterances, including the underlying cultural and psychological meanings. Thus an interpreter who has extensive knowledge of psychology techniques, methods and approaches, will have developed an additional professional capacity allowing the CI to guide the SR safely during the interview and to make sure that no harm is caused on the psychological level. This should not mean that the interview should turn into a psychotherapy session or that the interpreter should be a psychotherapist. Rather, the CI and the interview acquire some of the characteristics that are specifically related to psychotherapy.

As all research works have certain limitations, this thesis has it limitation because of the illiteracy of most of the SRs who volunteered to participate in the questionnaire. Efforts have been exerted to help participants answer the questions, but difficulties still existed specifically in

convincing the SRs to participate in the questionnaires; indeed, as most of the SRs have experienced severe interrogations in their own countries and lived under the control of a highly spread undercover official security spies, their first reaction was not to respond to the questions of the questionnaire. One way of overriding this difficulty was to be give them the sense of safety, love and belongingness.

In short, this thesis is intended to make an in-depth contribution to CIs and SRs in Lebanon, a contribution based on an approach where the two disciplines, Translation and Psychology, blend to secure safe and healthy interviews. This stresses the importance of interdisciplinary collaboration, which allows for the evolution of ideas and further advancements across life's domains. Interpreter-mediated refugee interviews should not be based on automated principles but on humanitarian values.

Appendices

Appendix A: Original and Translated Texts

Original Text I

Language Barriers and the Role of Interpreters: A Challenge in the Work with Migrants and Refugees

By Maria Kletečka-Pulker, Sabine Parrag, Boris Drožđek, and Thomas Wenzel

Abstract

The quality of services for migrants and refugees depends to a substantial part on the quality of communication. Particularly in refugees, who usually have no realistic opportunity to acquire the language of the host country before their flight and might be distressed or 59ummarizing, experienced interpreters are required. However, these are frequently not available or not integrated so far in healthcare or legal services. Untrained translators or family members are frequently used instead. The chapter explores legal and medical risks attached to different strategies regarding the use of interpreters and the differences between trained and untrained translators. It further gives an overview of standards and alternatives to address this important challenge in refugee care.

14.1 Introduction

Communication is a key element in human coexistence. When persons involved are refugees, communication is particularly vital due to their vulnerability. It is essential that no language

barriers exist, particularly in situations where individuals face obligations or consequences in legal and medical procedures as a result of their statements. Consequently, for a long time experts have demanded that professional interpreter services should be established for the healthcare and other sectors [1–6].

14.2 Interpreters in Legal Proceedings (Judicial and Executive Branches)

Communication and language are particularly important in legal proceedings. Incomplete or incorrect communication can have significant negative consequences. In asylum proceedings in particular, oral statements provided by the parties involved often constitute the key evidence and are decisive to the outcome of proceedings.

In the following discussion, we will use the European legal framework as an example to demonstrate necessary safeguards. In the EU law, recital 13 of the Council Directive (CD 2005/85/EC) specifies the right to the services of an interpreter [7]. In order to meet the specifications of a “fair trial”, as laid out in article 6, paragraph 3 of the ECHR, EU directive 2010/64/EU lays out the right of every accused to interpretation and translation services during legal proceedings. This directive sets the minimum standards, valid throughout the EU, for the right to interpreting services and translations in criminal proceedings and proceedings relating the execution of the European arrest warrants. This was the first step in a series of measures to set EU-wide minimum standards on procedural rights. The action was followed in 2012 by the directive on the right to information in criminal proceedings. Consequently, professional interpretation and translation are considered to be essential. Due to possible risks associated with actions such as denial of protection and refoulement (e.g. to a state where a person was tortured), the same standards should apply in asylum cases and other legal procedures.

In addition to legal provisions, training standards are necessary to ensure a reliable quality of interpretation and translation services. They must reflect the specific subject areas encountered by an interpreter. The UNHCR has responded by providing a training programme called project QUADA ("Qualitätsvolles Dolmetschen im Asylverfahren", lit. "Quality Interpretation in the Asylum Process")[1] for translators in asylum and other similar cases. Project QUADA is 61ummarizi into 12 learning modules. They include basic information on the legal aspects of protection and the asylum process, ethics, techniques, special challenges, such as working with vulnerable groups, and strategies to protect oneself from psychological impacts while working with 61ummarizing clients. The hand- book and training programme are user-friendly, they 61ummari graphic media, and have been tested in different settings. This project can serve as an important model for capacity building in other areas.

14.3 Interpreters in Migrant and Refugee Healthcare

Many important areas require the aid of translation and interpretation services. One such area is the healthcare sector for which there are few, if any, national regulations regarding this issue. Translation and interpretation services are crucial during mass emergencies and displacements and in larger displaced persons' (DP) camps or similar settings. Often the legal and professional frameworks providing for guide- lines and quality assurance are unclear, or no applicable legal requirements exist for healthcare settings. Vital medical treatments needed in emergencies are usually given priority, and no sanctions might be expected when no professional interpretation or translation is offered, even when legal safeguards might apply. This cannot be considered as an acceptable situation. In host countries, there is often uncertainty and a lack of clarity with regard to who is responsible for bearing the costs of interpretation services. Consequently, mostly

unqualified, ad hoc interpreters, including relatives of patients or multilingual employees, are frequently used in daily practice. Thereby, new media are also employed to provide for professional interpreting via telephone or video conferencing [8]. Both options will be explored later on in this chapter.

Communication problems are not only awkward, time-consuming, and unpleasant for all parties involved, they may also result in inferior support [9] and medical care [10, 11]. Language barriers and barriers to understanding can lead to incorrect care provision, particularly in medical emergency situations. Factors such as class affiliation, lack of health literacy, culturally specific concepts of health and illness, and culturally specific variations in attitudes to prevention and understanding of the role of a healthcare system play here a decisive role [12–15] (see also [16, 17]). Consequently, important information about relevant healthcare services and their benefits/importance in maintaining health is often not adequately transmitted leading to a reduced use of such services. D'Avanzo [18] interviewed a random sample of 75 refugees in a US city and observed an expressed willingness to seek healthcare more frequently if interpreters were available in healthcare facilities and to change healthcare sites in order to gain access to an interpreter. In addition, a lack of mutual understanding may lead to a lower patient adherence or compliance with treatment [19, 20]. Patients may also run an increased risk of being treated differently, e.g. by being more frequently exposed to invasive procedures as compared to non-invasive procedures [21]. Last but not least, lack of sufficient communication gives rise to legal problems in providing comprehensive clarification to patients and in gaining their consent for treatment [22].

14.4 Differences Between Professional and Ad Hoc Interpreters

There are, in general, no guidelines applicable for the settings in which it is not possible to plan the use of interpreters in advance. Therefore, born out of necessity, other solutions are frequently applied in order to establish communication. A special challenge can be observed in, the already mentioned, use of untrained or otherwise ad hoc interpreters [23–26], such as family members or unqualified members of the refugee community. This option may be sometimes hard to avoid due to a lack of access to or unavailability of trained personnel. However, it can be sufficient or even a preferred solution in less sensitive settings, as it involves community members and persons with cultural competence in a shared process. Yet, it is not acceptable in situations where exact and competent communication and confidentiality issues are of paramount interest.

14.5 Professional Interpreters

The assumption that general language competence, which many ad hoc interpreters display, is sufficient for interpreting is one of the primary misunderstandings. Professional interpreters should also possess translational competence [27, 28]. Studies in translation science largely agree that persons lacking a professional back- ground in the subject and without a formal training are not suitable for use as interpreters [29].

It is important to point out that there is a fundamental difference between translation and interpretation. These two terms must be clearly defined first, as they are often incorrectly assumed to be synonymous. The key difference is that “translation [is] the written conversion of a text, whereas interpreting is the oral conversion of the spoken word” [30]. Consequently, interpreting is also used to denote the professional activity, whereas the designation used for lay persons involved in this process is, increasingly, that of a *language mediator* [26].

Professional interpreters are qualified in a series of skills, usually acquired during a tertiary level education. Pöchhacker [27] specifies the three key competences which professional interpreters should acquire: *language competence*, *cultural competence*, and, most importantly, *translational competence*. In addition to mastery of at least two languages (language competence), a professional interpreter must have a thorough understanding of the respective culture, its specific cultural behaviour patterns, and their significance in communicative interactions (cultural competence) (Fig. 14.1).

In many cases, the competence to work as a (professional) interpreter is regarded as sufficient where the first two competences are present. However, the true qualification required in order to 64ummariz the profession is represented by the last of the acquired competences, the translational competence, which "[...] is based on language and cultural competence and includes, above all, the cognitive and linguistic interaction with the particular field of knowledge, specialist area or subject of the communication in question" [27]. Thus, translational competence consists of both interpretation competence, the "ability to convert communication content" (ibid), and interpreter competence, the "ability to behave in a professional manner in an interpreting situation both before and afterwards (pre-/post interaction)" [27].

Translational competence allows interpreters to reproduce precisely and completely all statements, with a summary provided only in agreement with partners in a dialogue. This allows dialogues to be reproduced in the first-person form, literally in the "voice of the other", while an ad hoc interpreter usually uses the third-person form with a frequent use of reporting verbs ("she says") [5]. This competence allows statements of any length to be consecutively interpreted, as professional interpreters are able to draw on the technique of note-taking. However, it is still the

case that shorter statements are always more conducive to direct interaction between parties in a dialogue.

Another key trait of professional interpreters, especially in healthcare ("medical interpreters", MI) [31–33], is their avoidance of expression of personal opinion, commentaries and assessments, and their adherence to the principle of impartiality with respect to the content of a dialogue or a communication partner. In addition, a professionally trained interpreter with a master's degree in the subject is also able to expand his/her specialist vocabulary permanently in order to support interpreting activities [27].

Interpreter impartiality and neutrality are the fundamental principles of the interpreting profession. As any party in a dialogue may regard the interpreter as more partial to its own side, or perceive the interpreter as an advocate on its behalf, the risk of tension within a medical dialogue or legal setting may heighten. As such, it is important to be aware of the potential challenges posed by a triadic and, particularly, by an interpreted dialogue.[2]

The non-verbal aspects of the setting provide a key framework for interaction with clients from different cultures. They may be grouped into:

1. (a) General aspects of a setting, such as seating arrangements, persons involved, cultural habits, and the aim of communication (like personal history taking, treatment, family counselling or legal negotiation).
2. (b) Non-verbal behaviour [35] as a parallel (complementing) information source.
3. I Alternative modes of communication where, for example, printed text must be substituted by other media in case of illiteracy. The latter challenge can be addressed

through materials such as illustrated healthcare tables in order to communicate basic healthcare problems through images.

14.6 Language and Ethnic Background

Transnational displacement aside, even locally displaced populations within a country or region can present with regional differences, different social stratification, or multilanguage settings which can cause substantial challenges. These may lead to difficulties in communication, including misunderstanding of crucial information, incomplete translation/interpretation, irritation, and mistrust. In conflict environments in particular, having a different accent can reduce confidence in interpreters, can be experienced as hostile and arrogant, or may lead to perceiving of disclosure as dangerous. All this impedes conducting an efficient interview or establishing a productive working relationship [36, 37] (see also [16]).

14.7 Specific Aspects of the Work with Refugee People

14.7.1 Culture and Trauma

Limiting the focus to culture as the only decisive factor in a particular form of health behaviour can be reductive and may pose a series of risks. When patients' personal situation is ignored, there exists a danger of stereotypic66ummarizing6666lion overlooking many important factors [38]. Working with refugees, therefore, requires not only a detailed knowledge of their cultural or medical backgrounds but also experience and specific strategies to deal with for example traumatic stress-related issues [39]. This is important as high trauma loads have been demonstrated to result in a higher need for support in communication in medical settings and make access to efficient translation necessary [40]. Further, knowledge of cultural idioms of dis-

tress [41, 42] is required 67ummariziise culture-specific stress or trauma-related symptoms. They should be correctly translated and explained by the interpreter.

Former refugees who become interpreters may be confronted with their own personal history of trauma while doing their work. However, a qualitative study by Johnson with a group of such interpreters in the UK [43] drew attention to the potentially positive aspects of their work for posttraumatic growth. The authors concluded that “A sense of shar67ummarizing6767ion provided a protective backdrop from which the participants could make sense of the personal traumas they had experienced. The role of interpreting was important as it helped maintain cultural identity”. A study by Splevins et al. yielded similar results [44]. The role of interpreters as cultural mediators has also been underlined by many authors (see, e.g., LaMancuso et al.) [45]. On the other side, retraumatisation of such interpreters is a risk factor not to be neglected and should be addressed by proper observation, supervision, and training [46].

Results of a recent meta-analytic review [47] demonstrated no differences in trauma- related psychotherapy outcome between sessions with and without the use of an interpreter. This finding is not easy to interpret and can be perceived either as an argument in favour or as the one against the use of interpreters in this specific setting. Further, Jensen et al. [48] have reported a case study of successful exposure therapy with a torture survivor with the help of an interpreter. More research should be done as the needed quantity of trained psychotherapists being fluent in the languages spoken by their clients, outnumbers by far capacities in both countries of origin and in host countries, even when only level IV interventions from the WHO model (see [49]) are considered.

Confidentiality is yet another key issue that speaks in favour of trained interpreters. Legal or cultural frameworks guaranteeing confidentiality in privileged situations at the levels expected in the EU or the USA, are almost non-existing in most other countries and it cannot therefore be expected from ad hoc interpreters from third countries to follow them. Clients' experiences of persecution may also lead to an—often healthy—mistrust in interpreters from other ethnic or religious groups. Background screening and monitoring of interpreters, particularly those involved in asylum cases, must ensure that they are not only aware of but also respect confidentiality issues and do not report on to home governments because of their political conviction or employment as informants. This problem must be addressed and resolved in order to ensure adequate communication in sensitive situations.

The interpreter's own unresolved personal issues, such as a history of unresolved trauma or interethnic adversities, can lead to distorted or incomplete interpretations, stress or inadequate behaviour (acting out) causing missing appointments, incomplete translation, and aggressive or arrogant behaviour.

Measures to be taken in order to prevent the above-mentioned problems should include:

- – Training (in a system like UNHCR's QUADA described earlier in this chapter, adapted for healthcare settings)
- – Screening of prospective interpreters for prior major problems and vulnerabilities, ethnic or political bias
- – A strategy for preventing problems that includes either intervision or supervision
- – Staff management measures such as rotational or controlled shifts
- – Mutual support and monitoring, possibly including a "buddy" system

- – Low barriers to accessing peer counselling and treatment and avoidance of stigma

14.8 Ad Hoc Interpreters

When an interpreter has no professional training, the term “ad hoc interpreter” is used [26]. Ad hoc interpreters may be divided into several groups. In each case, it must be considered that the translation process involving ad hoc interpreters might lead to incorrect translations, particularly when legal or healthcare vocabulary is unknown to them. Also, in the case of sensitive matters, such as reports on violence, torture, or sexuality, information cannot always be shared or could lead to distress or even indirect trauma or burnout in an ad hoc interpreter. Flores et al. [50] compared interpreter errors and their potential consequences in encounters with professional, ad hoc, and in “no interpreter” settings, and demonstrated that the use of professional interpreters resulted in a significantly lower likelihood of errors.

14.8.1 Children and Adolescents as Language Mediators

The above-mentioned difficulties are particularly present when children have the role of language mediators, as they are highly vulnerable to indirect trauma or in confrontation with age-inadequate subjects. Children might also suffer from being exploited in domestic conflicts. In the presence of children, parents may be hesitant to share information on traumatic events experienced, but also on a culture-dependent range of issues, such as sensitive medical subjects, gender issues, domestic violence, mortality, family problems, or other experiences that might conflict with their role as parents [25, 51–54]. Despite broad consensus on the wide range of problems, the use of children and adolescents as language mediators is often perceived as essential or unavoidable in order to quickly and directly overcome language barriers in everyday

life [55–57]. Furthermore, refusing their assistance would result in huge delays, additional expenditure, and a potential conflict with parents who may perceive inclusion of family members as translators as a good practice even in sensitive settings [57].

Findings from the “video interpretation in healthcare” pilot project published in 2015 indicated that 81% of healthcare professionals (n = 144) in the sample used children as language mediators [56]. Another study concluded that children and adolescents are most frequently used as language mediators in healthcare and social services in Vienna, Austria [58]. Ebden et al. [59] looked into the interpreting ser- vices provided by children and other family members. They concluded that at least 16% of the questions rated as simple were incorrectly interpreted or not interpreted at all. This figure was rising up to 82% for more complex questions. Anatomical terms and symptoms were most often inaccurately or incorrectly interpreted. Furthermore, there were major difficulties in translating specialist terminology, e.g. confusing breathlessness with asthma. Moreover, healthcare personnel had no means of checking whether the information interpreted by language mediators was correct or complete. Most of them had the impression that dialogues had been interpreted by ad hoc interpreters without problems with the content been completely and correctly transmitted. All this leads to a false sense of security in health professionals [25, 60].

Although many studies have demonstrated a degree of risk associated with the use of children and adolescents as interpreters, as well as unreliability of the out- comes, there has been almost no change in the daily practice. In addition, services of foreign language employees and relatives or friends of patients as language mediators have been preferred to those of professional interpreters, as booking a professional interpreter was perceived as time-consuming [61].

It should be noted that multilingual children and adolescents can use their, so- called, “innate” ability to interpret effectively only when the context of a dialogue lies within their linguistic horizons and range of experience [62]. But when interpreting in a medical context or for public authorities, it is particularly easy for a child’s limited horizons to be exceeded. This is usually because they are unable to assign meaning to medical terms in a source language and are then unable to pro- vide a corresponding translation [57, 63, 64]. Parents of bilingual children often tend to hold unrealistic expectations of children’s language competence, unconsciously exposing these children to a high degree of psychological pressure. In contrast, in the, so-called, “protected” contexts, such as conversations at home with friends or acquaintances, or out shopping, this activity can certainly have a positive impact on the child’s personal development [52, 57].

Additionally, using children and adolescents as language mediators can strongly change interfamilial roles and lead to shifts in power relationships. The risk for children and adolescents to suffer from linguistic and psychological overload while being used as language mediators, particularly in unprotected contexts, should not be underestimated. Moreover, the proven increased rate of mistranslations represents a liability risk for the particular institution involved [25, 51, 52, 62].

As the use of children and adolescents may constitute a form of “invisible language work”, it is worth investigating whether this should be regarded as child labour. Ahamer [52] explored this question in detail and compellingly argued that time is a valuable resource: “Although this is an activity undertaken by lay persons – not in terms of professionalism, but in relation to the required expenditure of resources – it represents potential financial savings for institutions and

parents and therefore corresponds to an activity which equates to work". Orellana [65] has also stressed the major contribution made by children and adolescents in their role as interpreters, an activity from which parents or relatives, as well as institutions and society itself, profit. The decisive question is not "whether the children work, but how visible their work is". Taking on this role as interpreter is usually not considered out of the ordinary, and children receive little or no acknowledgement for it. It would be worthwhile taking a differentiated approach to the role children play here rather than viewing them exclusively as beneficiaries of educational and social systems [52]. Accordingly, one could conclude that, working as interpreters, translators, cultural and language mediators, bilingual children and adolescents of parents with a migration background have been making a substantial contribution to the informal health economy for decades, thereby "contributing" significantly to the society even at this young age [57].

From a legal perspective, using children as ad hoc interpreters raises the question of potentially unlawful employment of children, as well as the question of potential threats to child welfare [66]. At this point, it should be stated that children should not be used as interpreters in sensitive settings and that institutions or organizations involved in refugee care should carry the responsibility to provide alternatives, like trained interpreters or video remote interpreting.

14.8.2 Adult Relatives or Third Persons as Language Mediators

The use of adult relatives and multilingual employees without specific training is often problematic as there can be no reliance on the quality and completeness of their translation. Moreover, this type of work is not a part of the multilingual employees' job description. In case that an employee makes an error, this could have ramifications in terms of employment and insurance regulations. These errors might be seen as a lesser risk in emergency situations but

deserve serious consideration in more permanent settings. However, many institutions and NGOs still rely on internal resources in order to overcome language barriers. Implementing this alternative requires a clear regulation of framework conditions (clarification of use, remuneration, courses and advanced training, supervision, legal aspects). It is particularly important to raise awareness that language competence alone is no longer a sufficient qualification for quality interpretation and that interpretation is a highly responsible task involving training, additional time, and emotional distress.

14.8.3 Reverting to a Shared Third Language (e.g. English)

Often attempts are made to use a third, shared language, increasingly English, in communication with patients. A key problem, hereby, is that helpers often hugely overestimate their own foreign language abilities. Switching to a third language is equally problematic for patients for whom this is not a native language either. Consequently, a basic communication problem is simply shifted, and the risk of communication problems increases rather than decreases.

14.8.4 Translated Information Materials

Oral transmission of information can, and should, be supported and complemented with printed material translated into foreign languages. However, supporting materials only serve to complement oral clarification required by law. Attention should be paid to the quality of translated materials as this may vary markedly. Although a very wide range of often high-quality translations are available in many fields, they do not cover all topics yet. Excellent educational material available in different languages can be downloaded free of charge from websites of the Swiss association *Interpret*,[3] as well as of the Austrian Federal Ministry of Health and Women's

Affairs (https://www.bmgf. gv.at/home/Service/Broschueren/), though the range of subjects is limited.

14.8.5 Translation Programmes

Free electronic on- or offline translation programmes are a relatively new tool designed to overcome language barriers. They are easily available, for example, on smartphones used by migrants today as communication hubs. Translation tools may provide assistance, particularly for scarcer languages, and can be quickly and easily used to clari74ummarizing7474lnal queries in a daily medical setting. However, caution should again be exercised, as reliability of these tools is currently limited. It is certainly not advisable to conduct a consent dialogue using a translation programme alone, as there is a clear risk of error due to the nature and limitations of such programmes.

14.9 Professional Solutions: On-Site Interpreters vs. Alternatives

14.9.1 On-Site Interpreters

Finding professional strategies for overcoming language barriers should be given a high priority. The conventional solution is to use a local, professional interpreter, who is qualified based on the principles described earlier. Quite clearly, the advantages gained are directly visible—a barrier-free interpreting. One possible disadvantage may be that the interpreter becomes overburdened by emotional distress or is biased in some cases.

In addition to on-site interpreting, language barriers can be further overcome by using tools such as telephone or video interpreting. The key advantages of these remote solutions are increased temporal and spatial flexibility they facilitate.

14.9.2 Telephone Interpreting

A well-established strategy applied, for instance, in Switzerland and Australia is telephone interpreting. It facilitates access to interpretation services using pre- existing equipment, there75ummarizining technical efforts involved. A recent qualitative study on telephone interpreting from the US draws attention to special considerations in using this tool with refugees [8]. The most important issues reported by the interpreters were (1) the importance of developing trust between the interpreter and the client and that (2) working with refugees requires more attention from the interpreter. Further, in his recent survey Wang [67] took a deeper look at telephone interpreting and the interpreter's perceptions of suitability, remuneration, and quality in healthcare.

14.9.3 Video Interpreting

Compared to other remote methods, video interpreting is the method which simulates the face-to-face situation most precisely by enabling non-verbal communication [68, 69] and by ensuring that cultural aspects expressed in the form of gestures and mimics are not being ignored [69]. Additionally, interpreting visual indicators may explain inconsistencies at the verbal and non-verbal message levels and help preventing misunderstandings. Appropriate non-verbal reactions of the interpreter may have a positive effect on the person whose narrative is being interpreted [68]. This is an important factor in building trust between the interpreter and the client. It also

supports an uninterrupted flow of conversation despite being a remote solution. In situations where a declaration of consent must be obtained, consideration of mimics and gestures is particularly important [68].

Video interpreting, as an innovative means of overcoming language barriers in the healthcare sector, has for a long time been a fixed component of care provision for foreign language patients in several countries including the US. However, it is only recently that steps have been taken to establish a professional video interpreting service in the German-speaking world [56].

As part of the project already mentioned, an Austrian study [56] evaluated the use of professional interpreters integrated into the physician-patient dialogue via video conferencing in a technically uncomplicated manner. The majority of the research sample evaluated the tool as very helpful. Increased efficiency and reliance on the precision of translation were perceived as particularly positive aspects. In addition, it was an ideal means of ensuring neutrality and objectivity of interpretation in terms of spatial and emotional closeness and distance between the interpreter and the patient.

Confidence gained by being able to access correct and complete interpretation played a significant role in increasing employees' satisfaction and in ensuring patient safety. Using a video interpreter allowed employees to complete their tasks to their usual quality standard and, above all, independently of physical presence and avail- ability of a third-party language mediator. Video interpreting received also the highest rating for quick and flexible availability and is perceived as a very good method for overcoming communication barriers in a way that assures quality of translation.

This method may not, however, be the most suitable one for every setting. For scheduled treatments, the use of on-site professional interpreters is the ideal solution as they can be booked in advance. Even where employees, team members, and accompanying persons serving as language mediators are able to cover the interpretation deman77ummarizing7777lnal and institutional framework conditions should guarantee a constant level of quality and safety in the care of patients who do not speak the host countries' language [56].

Last but not least, promising research results, increasing awareness of the problem, and a growing openness to new solutions have provided the opportunity to develop and improve the professional and innovative video interpreting system. Today this system is used by numerous institutions in the healthcare, social, and justice sector in Austria, Germany, and Switzerland and covers approximately 72 different languages. Six hundred qualified interpreters are involved in this network across the EU, offering availability in the core languages for up to 24 h at only 120 s' notice. Since November 2015, video interpreting has been available in the city of Hamburg which chooses a comprehensive container solution to provide refugees with medical care. Germany's first vaccination van for refugees started in Berlin in November 2016 and provides video interpreting, too. In Austria, video interpreting is used to provide medical care in police detention centers, which pre- dominantly house detainees pending deportation and detainees with criminal convictions [70].

14.10 Translation of Standardised Materials

In translation 77ummarizing77sed materials and diagnostic tools, such as medical and psychological questionnaires, culture-specific adaptation and (re)validation is required (also discussed by Wenzel et al. [16]). Particularly for critical issues, a complete revalidation process

has been recommended, including professional translation and validation in a comparable population [71]. A practical alternative has been developed, using common translation—retranslation procedures [72, 73]. These might consist of a simple A-B-A model, which is based on translation by a bilingual, ideally professional, translator. If differences are observed in language A after retranslation, the text should be adapted until the results are sufficiently identical when again retranslated from language B. Care should be taken in choosing bilingual translators. They should belong to the same ethnic group as the person being questioned and should be aware of differences in language used by different social groups. Ideally, they will have a professional understanding of translation sciences and the field/topic in question. Qualitative methods, such as focus groups, can be a relatively simple but efficient tool for improving results and can be con- ducted at the onset or later on to address translation problems.

14.10.1 A Case Example

In a study conducted in former Yugoslavia, we (TW) observed an unusual problem occurring when the Harvard Trauma Questionnaire (HTQ) [71] was applied. While many participants reported that they had been subjected to torture, their specific life circumstances made this finding improbable. A focus group yielded the information that the subjects felt helpless in face of continuous exposure to the hostile and degrading enemy propaganda in public media and have experienced this as torture. While the generally accepted legal definition of torture was obviously not been fulfilled, the results yielded a better understanding of the impact and needs of the patient group in question and avoided misinterpretation of the results.

14.11 Conclusions: Barrier-Free Communication— A Leadership Task

Language and communication are not only essential and fundamental components of every legal process but are also of great importance in almost every area of life, including healthcare. Language barriers are a particular source of error in work with migrants and refugee people, as well as a liability risk, a factor about which the affected professions must particularly be made aware of. Alternatives, like ad hoc interpreters that are used in emergencies, should not become a standard and should be avoided as much as possible due to medical, psychological, and legal risks involved. New approaches like video-based models and training programmes like the UNHCR's QUADA should be further developed and integrated into legal and healthcare systems. Finally, introduction of quality assured measures for overcoming language barriers increases safety of both parties in a dialogue and reduces costs. As a result, all directly or indirectly involved, both interpreters and patients, as well as NGOs, institutions, and authorities responsible for them, can benefit from systematical79ummarizised, professional interpreting services. However, in order to achieve this, "[...] there must be increasing awareness on all sides that using qualified interpreters is not a luxury, but rather a mark of an open society" [74], as demanded by Rasky in an artic79ummarizinging challenges in the present healthcare systems.

Translated Text I

دور المترجمين الفوريين في تسهيل التواصل مع المهاجرين واللاجئين على الرغم من عائق اللغة

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لمحة عامة

يعتمد مستوى الخدمات المقدَّمة للمهاجرين واللاجئين الى حد كبير على نوعية التواصل معهم. و بالتحديد في حالة اللاجئين المكتئبين او المصدومين الذين لا تتسنّى لهم عادةً فرصة تعلُّم لغة البلد المضيف قبل الانتقال اليه، يجب ان يكونوا المترجمين الفوريين ذوي خبرة. لكن أحيانا كثيرة، لا يكونوا المترجمون الفوريون لهم خبرة في الرعاية الصحية والخدمات القانونية، أقلُّه حتى الآن. فيُستبدَلون مرات كثيرة بمترجمين غير مدرَّبين او بأفراد من العائلة. بناء على ذلك، يناقش هذا الفصل المخاطر القانونية والصحية التي ترافق الاستراتيجيات المختلفة المعتمَدة في استخدام المترجمين الفوريين، والفرق بين المترجمين المدرَّبين وغير المدرَّبين. كما انه يعطي فكرة عامة عن معايير وبدائل يمكن اعتمادها لمعالجة هذه المشكلة الكبيرة اثناء الاهتمام باللاجئين.

14.1 المقدمة

يشكل التواصل عاملا أساسيا لتعايش البشر. وعندما يكون الأشخاص المشمولون في عملية التواصل لاجئين، تزيد أهمية التواصل بسبب وضع اللاجئين الحسَّاس. في هذه الحالة يجب إزالة أي عائق لغوي خصوصا عندما يكون الاشخاص المعنيون امام التزامات او عواقب قانونية او صحية نتيجة وضعهم. لذلك يطالب الخبراء منذ فترة طويلة بخدمات مترجمين فوريين محترفين في مجال العناية الصحية ومجالات أخرى.

14.2 المترجمون الفوريون في الاجراءات القانونية (الفرع القضائي والفرع التنفيذي)

تبرز أهمية التواصل واللغة خصوصا في الإجراءات القانونية. فأي نقص او خطأ في التواصل يمكن ان يؤدي الى نتائج سلبية. وفي اجراءات اللجوء السياسي تحديدًا، غالبًا ما تشكِّل الإفادات الشفهية من الأطراف المعنية جزءا من الدليل الأساسي، كما انها تؤدّي دورا حاسما في تحديد نتيجة الإجراءات.

خلال المناقشة التالية، سنستعمل النظام القانوني الأوروبي كمثل يظهر ما هي الضمانات الضرورية. ففي قانون الاتحاد الأوروبي، يحدِّد البند 13 من توجيه المجلس (CD 2005/85/EC) حق الحصول على خدمات مترجم فوري. ومن اجل تحقيق شروط "المحاكمة العادلة"، حسب المادة 6، الفقرة 3 من الاتفاقية الأوروبية لحقوق الإنسان (ECHR)، يذكر التوجيه 2010/64/EU انه من حق كل متَّهَم الحصول على خدمات الترجمة الفورية والخطية خلال الإجراءات القانونية. وبذلك يضع هذا التوجيه الحد الأدنى المعتمَد في الاتحاد الأوروبي لمعايير حَقّ الحصول على خدمات الترجمة الفورية والخطية في الإجراءات الجنائية والإجراءات المتعلقة بتنفيذ مذكِّرات الاعتقال الأوروبية. وكانت هذه اول خطوة من سلسلة تدابير لوضع الحد الأدنى من معايير الحقوق الإجرائية على صعيد الاتحاد الأوروبي. وتَبِع ذلك توجيه سنة 2012 يتعلق بحق الحصول على المعلومات خلال الإجراءات الجنائية. من الواضح اذًا ان الترجمة المحترفة، الفورية والخطية، ضرورية جدًّا. ويجب ان تُعتمَد المعايير نفسها في حالات اللجوء وفي إجراءات قانونية أخرى تجنُّبًا لمخاطر محتمَلة ترافقها اعمال مثل الحرمان من الحماية والإعادة القسرية (مثلا الى حيث كان الشخص يتعرض للتعذيب).

وبالإضافة الى التدابير القانونية، من الضروري أيضا وضع معايير خاصّة بالتدريب على الترجمة للتأكد من ان خدمات الترجمة الفورية والخطية موثوق بها. وهذه المعايير يجب ان تشمل المواضيع المحددة التي سيواجهها المترجم الفوري خلال عمله. وقد استجابت مفوضية الأمم المتحدة للاجئين لهذه الحاجة من خلال وضع برنامج تدريب اسمه مشروع QUADA (“Qualitätsvolles Dolmetschen in Asylverfahren”) الذي يعني حرفيا "الترجمة الفورية الجيدة خلال عملية اللجوء السياسي"، كمرجعٍ للمترجمين العاملين في مجال اللجوء ومجالات أخرى مشابهة. يتألف مشروع QUADA من 12 وحدة تعليمية تشمل معلومات أساسية عن الجوانب القانونية المتعلقة بحماية اللاجئين، وعملية اللجوء السياسي وأخلاقياته وتقنياته وتحدياته الخاصة، كالعمل مع الفئات الضعيفة من المجتمع تمامًا كاللاجئين، بالإضافة الى تقديم طرق محدّدة تسمح للمترجم بحماية نفسه من الأثر النفسي الذي قد ينتج عن العمل مع افراد لا يزالوا يعانون من صدمة نفسية. وجدير بالذكر انه قد تمّ إعداد كتيِّب

الارشادات وبرنامج التدريب الخاصّين بالمشروع بطريقة تسهّل الاستفادة منهما، اذ يستعملان الصور والبيانات وقد تمّت تجربتهما في سياقاتٍ مختلفة. ونظرًا لذلك، فإن مشروع QUADA يمكن ان يشكّل ايضًا نموذجا مهمًّا لبناء القدرات في مجالاتٍ مغايرة للترجمة.

14.3 المترجمون الفوريون في مجال تقديم الرعاية الصحية للمهاجرين واللاجئين

تكثر المجالات المهمة التي تقتضي اللجوء إلى خدمات الترجمة، خطّية اكانت ام فورية. وأحد هذه المجالات هو قطاع الرعاية الصحية حيث تتوفّر القليل من القوانين الوطنية المتعلقة بتقديم خدمة الرعاية الصحية، هذا إن وُجِدَت. فخدمات الترجمة الفورية والخطية مهمة جدا في حالات الطوارئ والتشرُّد الجماعية، وفي مخيمات المشرَّدين او أي أماكن أخرى مماثلة. وفي أغلب الأحيان، لا تؤمّن الأطر القانونية والمهنية التي تنصّ على المبادئ التوجيهية ذات الصلة والمتعلّقة بضمان الجودة المستوى الكافي من الوضوح، او لا تتوفّر المتطلبات القانونية التي تنطبق في مجال الرعاية الصحية. ومع ان الأولوية عادةً ما تعُطى للعلاجات الطبية الضرورية، لا يمكن توقُّع فَرض أية عقوبات في غياب ترجمة محترفة، فورية او خطية، حتى في الحالات التي تنطبق عليها الضمانات القانونية. ولا يمكن لهذا الوضع بان يُعتبر مقبولا. وفي الدول المضيفة، غالبا ما لا يكون واضحا من هي الجهة التي ستتحمّل مسؤولية تكاليف خدمات الترجمة الفورية. نتيجة لذلك، يُستعان أحيانا كثيرة في الممارسات اليومية بمترجمين فوريين غير اكفاء او بأشخاص ليسوا مدرَّبين على الترجمة، بمن فيهم أقرباء المرضى او موظفين يجيدون أكثر من لغة. وبالتالي تُستعمَل أيضا وسائل التواصل الحديثة للحصول على ترجمة فورية محترفة عبر الهاتف او مؤتمرات الفيديو. وسنتوسَّع أكثر في هاتين الوسيلتين لاحقا في هذا الفصل.

يصعِّب وجود مشاكل في التواصل الأمور، ويضيّع الوقت، ويتسبب بعدم الارتياح لجميع الأطراف المعنية. والأسوأ انه قد يؤدّي أيضا الى مستوى أدنى من الدعم والرعاية الصحية. فالعوائق اللغوية والحواجز التي تعيق عمليّة الفهم يمكن ان تؤدي الى تقديم رعاية خاطئة، خصوصا في الحالات الطبية الطارئة. ويمكن لبعض العوامل ان تؤدّي دورًا مؤثّرًا في هذا الخصوص ومن بينها الانتماء الطبقي ونقص او انعدام الإلمام بالصحة وبمفاهيم الصحة والمرض الخاصة بكل مجتمع، والاختلافات الموجودة في كل مجتمع من حيث الأساليب المعتمَدة على صعيد الوقاية وفهم الدور الذي يؤدّيه نظام الرعاية الصحية. نتيجةً لذلك، يتراجع

مستوى استخدام خدمات الرعاية الصحية لانه غالبًا ما يتمّ نقل المعلومات حولها وحول وفوائدها/أهميتها في الحفاظ على الصحة بطريقة غير دقيقة. على سبيل الإيضاح، قابل دافانزو مجموعة من 75 لاجئًا اختيروا عشوائيًّا في مدينة في الولايات المتحدة الأميركية ولاحظ انهم عبَّروا عن استعدادهم الى اللجوء الى الرعاية الصحية بصورة أكثر تواترًا في حال توفُّر مترجمين فوريين في مؤسسات الرعاية الصحية والى الانتقال من مركز عناية صحية الى آخر من اجل الحصول على خدمة مترجم فوري. من جهة أخرى، قد تتراجع مستويات الالتزام بالعلاج لدى المرضى بسبب عدم اكتمال عملية الفهم المتبادل خلال عملية التواصل. وقد تزيد احتمالية تلقّي العلاج غير المناسب لدى المرضى، كالخضوع لعمليات جراحية بنسبة أكبر مقارنةً مع العلاجات غير الجراحية. وأخيرًا وليس آخرًا، يؤدّي عدم توفُّر التواصل بالشكل الكافي إلى المشاكل القانونية من حيث تزويد المرضى بإيضاحٍ كاملٍ متكاملٍ إزاء وضعهم والحصول على موافقتهم لناحية تلقّي العلاج.

14.4 الفرق بين المترجمين الفوريين المدرَّبين وغير المدرَّبين

بشكل عام، لا تنطبق أية إرشادات في الحالات التي يُستحال فيها التخطيط بشكل مسبق لاستخدام مترجم فوري. لذلك، وبسبب الحاجة، غالبا ما تُعتمد حلول أخرى من اجل تحقيق التواصل. وكما ذكرنا سابقا، تنشأ صعوبة كبيرة عند استخدام مترجمين غير مدرَّبين او اشخاص ليسوا مترجمين، مثل افراد من العائلة او اعضاء غير اكفاء في مجتمع اللاجئين. لكن أحيانا، يصعب تفادي هذا الخيار نظرًا لعدم توفُّر اشخاص مدرَّبين او بسبب صعوبة الوصول إليهم وقد يتمّ الاكتفاء به او حتّى تفضيله كحلّ على غيره من الحلول في الحالات التي تُعتبر أقلّ دقّةً من غيرها، لأنه يتضمن أعضاءً وأفرادًا من المجتمع يتمتّعون بالكفاءة الثقافية ضمن عملية مشتركة. إلا ان هذا الخيار يُعتبر غير مقبول في الحالات التي يُشكّل فيها التواصل الدقيق والكفؤ، بالاضافة الى السرية، مسألة ذات أهمية كبرى.

14.5 المترجمون الفوريون المحترفون

يمتلك كثيرون ممن ليسوا مترجمين معرفة عامة باللغة. لكن الافتراض ان هذه المعرفة تكفي لممارسة الترجمة الفورية هو سوء فهم أساسي. فمن الضروري ان يتمتّع المترجم الفوري المحترف بالكفاءات اللازمة في مجال عمله، هذا وتتّفق الدراسات في علم

الترجمة الى حد كبير على انه من غير المناسب استخدام اشخاص يفتقرون الى خلفية مهنية في الموضوع المطروح ولم يتلقوا تدريبا رسميا كمترجمين فوريين.

ومن المهم الإشارة الى الفرق الكبير بين الترجمة الخطية والترجمة الفورية. فيجب تعريف كل منهما بوضوح خصوصا انه في اللغة الإنكليزية غالبا ما تُعتبَر الكلمتان translation (الترجمة الخطية) و interpretation (الترجمة الفورية) مترادفتين، وهذا غير صحيح. فالفرق الأساسي هو ان "الترجمة الخطية [هي] ترجمة النص بطريقة مكتوبة. اما الترجمة الفورية فهي ترجمة شفهية للكلمات التي يجري التفوُّه بها". نتيجةً لذلك، تُستعمَل كلمة interpreting للدلالة أيضا على النشاط المهنيّ. اما الأشخاص العاديون المشمولين في هذه العملية، فيزداد استخدام التسمية *"وسيط لغوي"* للإشارة إليهم.

يتمتّع المترجم الفوريّ المحترف بطيف واسع من المهارات التي عادةً ما يكتسبها في مرحلة التعليم العالي. ويحدِّد بوشهاكر المهارات الأساسية الثلاث التي يجب ان يتمتّع بها المترجم الفوري المحترف وهي: *المهارة اللغوية، المهارة الثقافية*، والأهم، *المهارة في الترجمة*. فبالإضافة الى البراعة في لغتين على الأقل (المهارة اللغوية)، يجب ان يمتلك المترجم الفوري المحترف فهما كاملا لثقافة المجتمع الناطق باللغة التي يترجم إليها وحضارته، وأنماط السلوك الخاصة بهذا المجتمع، وتأثير هذه كلها على التفاعلات التواصلية (المهارة الثقافية).

أحيانا كثيرة، يكفي ان يتمتع الشخص بالمهارتين الأولى والثانية أعلاه كي يُعتبر كفؤا للعمل كمترجم فوري محترف. لكن في الواقع، إن المؤهِّلة المطلوبة لممارسة هذه المهنة تتمثَّل بآخر مهارة من المهارات المكتسَبة، أي المهارة في الترجمة، وهي "[...] مبنيَّة على كفاءة لغوية وثقافية وتشمل، بالدرجة الاولى، التفاعل المعرفي واللغوي مع حقل المعرفة المعيَّن، مجال التخصص، او موضوع التواصل الحاصل". اذًا، تتألف المهارة في الترجمة من مهارة في الترجمة الفورية، أي "القدرة على نقل مضمون التواصل" كما هو (ibid)، ومهارة المترجم الفوري أي "القدرة على التصرف بمهنية في حالة الترجمة الفورية، قبل وبعد (أي قبل التفاعل وبعده)".

يتمكّن المترجم الفوري الذي يمتلك المهارة في الترجمة من نقل كافة الجمل بطريقة كاملة وبدقة، وبإمكانه ايضا أن يقدّم ملخّصًا عن الحوار، طبعًا بعد الاتفاق مع الأشخاص المشاركين فيه. وهذا يسمح للمترجم بأن ينقل الحوار بصيغة المتكلِّم، اي حرفيًّا

"بصوت الشخص الآخر"، في حين ان الأشخاص غير المدرَّبين على الترجمة يستخدمون عادةً ضمير الغائب وغالبًا ما يستعملون أفعال الإبلاغ (مثلاً، "إنها تقول"). وتمكِّن هذه المهارة ايضا المترجم الفوري من نقل الجمل بدقة مهما كان طولها لأن المترجم المحترف قادر على استخدام تقنية تدوين الملاحظات. لكن لا يزال واقعًا ان الجمل القصيرة دائما ما تكون الأكثر ملاءمة في عملية التفاعل المباشر بين الأطراف المشاركة في الحديث.

ومن الميزات الأساسية الأخرى التي يتمتع بها المترجم الفوري المحترف، خصوصا في مجال الرعاية الصحية ("المترجم الفوري الطبي"، MI)، هي تجنُّب المترجم التعبير عن رأيه الشخصي، وعدم المبادرة في تقديم التعليقات والتقييمات، والتزامه بمبادئ الحياد تجاه مضمون الحديث او أحد أطراف التواصل. إضافةً الى ذلك، يتمتّع المترجم الفوري الذي تلقّى تدريبًا محترفًا والحائز على شهادة ماجستير في الموضوع المتناوَل بالقدرة أيضا على توسيع مفرداته المختصة بشكل متواصل كي يدعم النشاطات التي يمارسها في مجال عمله.

ويُعتبر كل من حياد المترجم الفوري وعدم تحيُّزه المبدئان الأساسيان في مهنة الترجمة الفورية. فإذا شعر أحد أطراف الحوار ان المترجم الفوري منحاز اليه او هو بمثابة محامٍ يدافع عنه، يزداد خطر نشوء توتر خلال الحوار المُندرج ضمن سياقٍ طبي او قانوني. لذلك، من المهم ان يتحلّى أطراف الحوار بالوعي الكامل في ما يختص بالتحديات التي قد ترافق الحوار الثلاثي الأطراف، وتحديدا، الحوار المترجَم.

لكن الجوانب الأخرى لسياق الحوار التي لا علاقة لها بالكلام الشفهي، فهي تحدد إطارًا رئيسًا للتفاعل مع الموكلين الذين يتمتّعون بخلفيات ثقافية مختلفة. ويمكن تقسيم هذه الجوانب على الشكل التالي:

- أ – الجوانب العامة لسياق الحوار مثل ترتيبات الجلوس، والأشخاص المشمولين، والعادات الثقافية، والهدف من التواصل (كتدوين المعلومات الشخصية الخاصة بالمريض، والعلاج، والاستشارة العائلية او المفاوضة القانونية).
- ب – السلوك غير اللفظي كمصدر معلومات موازٍ (اي مكمِّل) للمصادر الأخرى

- ج – أنماط بديلة من التواصل حيث يجب، مثلاً، استبدال النص المكتوب بوسيلة أخرى في حالة الأشخاص الأُمّيّين. ويمكن حلّ هذه المشكلة باستخدام جداول مصوَّرة مثلاً، وذلك للتعبير من خلال الصور عن المشاكل الرئيسة التي يتمّ مواجهتها في مجال الرعاية الصحية.

14.6 اللغة والخلفية الإثنية (العِرقية)

ليست الصعوبات حكرًا على التشرُّد العابر للحدود. فحتى تشرُّد السكان ضمن بلدهم او إقليمهم يمكن ان ترافقه اختلافات إقليمية، اختلاف في طبقية المجتمع، او نشوء بيئات تتكلم عدّة لغات مما قد يسبب تحديات كبيرة. وقد يؤدي هذا الى صعوبات في التواصل مثل سوء فهم معلومات مهمّة، وترجمة فورية/خطية ناقصة، وعدم الارتياح، وانعدام الثقة. وإذا كان المترجم الفوري يترجم بلهجةٍ مختلفة عن لهجة اللغة التي يترجم اليها، بخاصةٍ في بيئات النزاع، فقد يؤثّر ذلك على الثقة به، او يُعتبر تصرّفًا عدائيًّا او متكبرًا من قبله، او يؤدي الى اعتبار الإفصاح عن المعلومات أمرًا خطيرًا. وكل ذلك يحول دون إجراء مقابلة فعّالة او إرساء علاقة عمل مثمرة.

14.7 جوانب محدَّدة في العمل مع اللاجئين

14.7.1 الثقافة والصدمة النفسية

التركيز على الثقافة كالعامل الحاسم الوحيد في شكل محدّد من أشكال السلوك الصحي، قد يقلّل من شأن الموضوع ويسبّب مخاطر عدّة. فعندما يُهمَل وضع المريض الشخصي، يبرز خطر التعميم النمطي، مما يؤدّي الى تجاهل عوامل كثيرة مهمة. اذًا، لا يتطلب العمل مع اللاجئين معرفة مفصَّلة عن خلفيّتهم الثقافية والطبية فحسب، بل أيضًا عن تجاربهم في الحياة والاستراتيجيات المحدّدة التي يتّبعونها للتعامل، مثلاً، مع حالات الإجهاد الناتج عن الصدمة النفسية. وهذا أمرٌ مهمّ، اذ قد أُثبت انه في حالات الصدمة النفسية الكبيرة، تزيد الحاجة الى تأمين الدعم في عملية التواصل ضمن الحوارات الطبية ويصبح من الضروري الحصول على ترجمة فعّالة. إضافةً الى ذلك، يُعتبر الإلمام بالمصطلحات الثقافية للألم النفسي أمرًا لا غنى عنه لملاحظة أعراض الإجهاد او الصدمة الخاصة بكل ثقافة. فمن الضروري ان ينقل المترجم الفوري هذه المصطلحات ويشرحها بطريقة صحيحة.

وجدير بالذكر ان المترجمين الفوريين الذين كانوا لاجئين سابقًا قد يضطرّون الى مواجهة ماضيهم الحافل بالصدمات النفسية أثناء قيامهم بعملهم. لكن الدراسة النوعية التي قام بها جونسون على مجموعة من هؤلاء المترجمين في المملكة المتحدة، قد جذبت الانتباه الى النواحي الإيجابية المحتمَلة لعملهم على صعيد النمو في المرحلة ما بعد الصدمة النفسية. وقد استنتج الكتّاب ان "الإحساس المشترك بالأذية نتيجة الوقوع كضحية، قد خلق أساسًا مطمئِنًا يمكن ان ينطلق منه المشاركون في الحوار كي يفهموا التجارب المؤلمة التي قاموا باختبارها شخصيًا. فكان دور الترجمة الفورية مهمًا لأنه ساهم في الحفاظ على الهوية الثقافية". وقد أتت دراسة قام بها سبليفينز وآخرون بنتائج مماثلة. وقد شدد كتّاب كثيرون أيضًا (راجع على سبيل المثال لامانكوسو وآخرون) على دور المترجمين الفوريين كوسطاء ثقافيين. لكن من جهة أخرى، ان تعريض المترجمين الفوريين مرة أخرى للصدمات النفسية هو عامل خطير لا يجب تجاهله ويكمن الحل في المراقبة والإشراف والتدريب الملائمين.

وهنا نتوقف عند نتائج تحليل إحصائي لعدد من الدراسات العلميّة التي تمّ إجراؤها بيَّن انه ليس من اختلاف بين الجلسات التي تلحظ وجود مترجم فوري وتلك التي لا تلحظ وجود مترجم فوري من حيث النتائج التي يتمّ استخلاصها من جلسات العلاج النفسي الخاص بالصدمات النفسيّة. وليس من السهل تفسير هذا الاستنتاج لأنه قد يُستخدم في الوقت عينه كحجَّة إمّا لدعم فكرة اللجوء أو عدم اللجوء إلى مترجم فوري في هذه الحالة بالتحديد. من جهة أخرى، صدر عن جنسن وآخرين تقريرًا عن دراسة حالة فردية حول علاجٍ بالتعرُّض أُجري بنجاح، بمساعدة مترجم فوري، على شخص نجا من التعذيب. ولا بد من القيام بالمزيد من الأبحاث لأنّ العدد المطلوب من المعالجين النفسيين المدرَّبين الذين يجيدون بطلاقة اللغات التي يتكلمها زبائنهم يفوق أكثر بكثير القدرات المتوفّرة في بلدان المنشأ والبلدان المضيفة، حتى عندما تكون العلاجات الوريدية بتدخُّل من نموذج منظمة الصحة العالمية هي الوحيدة التي تؤخذ بعين الاعتبار.

السرية هي عامل أساسي آخر يشهد لصالح المترجمين المدرَّبين. لكن النظامَين القانوني والثقافي اللذين يضمنان السرية في حالات مميزة على المستويات المتوقعة في الاتحاد الأوروبي والولايات المتحدة الأميركية، هما غير متوفّرين تقريبًا في معظم البلدان الأخرى. وعليه، لا يمكن التوقُّع من الأشخاص الذين يُستَعان بهم للترجمة في دول العالم الثالث ان يتبعوا هذين النظامين. كما ان الاضطهاد الذي يتعرض اليه الموكّلين قد يؤدي الى قلّة ثقة، في محلّها، بالمترجمين الذين ينتمون الى مجموعات إثنية او دينية أخرى. وعليه، إنّ التحقيق في خلفية المترجمين الفوريين ومراقبتهم، خصوصًا المترجمين الفوريين الذين يعملون في

قضايا اللجوء السياسي، يجب ان يضمن انهم ليسوا فقط مدركين لأهمية مسألة السرية، بل يحترمونها أيضًا ولا ينقلون المعلومات للحكومات في وطنهم بسبب قناعاتهم السياسية او لأنهم يُستعمَلون كمُخبِرين. فيجب معالجة هذه المشكلة وحلّها لضمان تواصل جيّد في الظروف الحساسة.

وتجدر الإشارة الى ان المشاكل الشخصية العالقة في حياة المترجم الفوري، مثل تاريخ حافل بالصدمات النفسية او نزاعات عِرقية لم يتخطاها بعد، قد تؤدي الى ترجمة فورية مشوَّهة او ناقصة، والإجهاد والسلوك غير المناسب (أي الخارج عن السيطرة) المتسبب بالتغيُّب عن المواعيد، وترجمة خطية ناقصة، وسلوك عدائي او متكبّر.

ان التدابير التي يجب أخذها لتجنّب المشاكل المذكورة أعلاه يجب ان تشمل:

- التدريب (في برنامج مثل QUADA الذي أعدَّته منظمة مفوضية الأمم المتحدة للاجئين وتحدثنا عنه سابقًا في هذا الفصل، مُعَدّ ليناسب حالات الرعاية الصحية)
- التحري عن المترجمين الفوريين المحتَمَلين للكشف عن أية مشاكل جدّية سابقة ونقاط ضعف وتحيُّز إثني او سياسي
- استراتيجية لتجنّب المشاكل تشمل إمّا التدخل او الاشراف
- تدابير على صعيد إدارة شؤون الموظفين، مثل نوبات عمل محدَّدة او بالمداورة
- دعم ومراقبة متبادلان، ربّما بوضع شخصين للعمل معًا، أي استخدام الـ "buddy" system
- تخفيض الحواجز التي تعيق الحصول على نصائح من الزملاء والنقاش معهم وتجنُّب الخجل

14.8 المترجمون غير المدرَّبين

ان المترجم الفوري الذي لم يتلقَّ تدريبًا محترفًا ولكنه يُستدعى للترجمة يُشار اليه باللغة الإنكليزية بعبارة Ad Hoc Interpreter. ويمكن تقسيم هؤلاء المترجمين الفوريين الى عدّة مجموعات. ويجب الأخذ بعين الاعتبار في كل حالة ان عملية الترجمة التي تشمل مترجمين فوريين غير مدرَّبين قد تؤدي الى ترجمة خاطئة، خصوصًا عندما لا تكون المفردات القانونية او الطبية مألوفة لديهم. إضافةً الى ذلك، لا يمكن دائمًا مشاركة المعلومات عندما يتعلّق الأمر بمسائل حساسة كالتقارير حول العنف او التعذيب او الميول الجنسية، وإلاّ سيؤدّي ذلك الى تضايق المترجم الفوري او حتى الى صدمة غير مباشرة او إرهاق. وقد قارنت فلورس

وآخرون بين أخطاء المترجمين الفوريين ونتائجها المحتملة في مواجهات مع مترجمين فوريين محترفين، ومترجمين غير مدرَّبين، وفي ظروف لا يتوفّر فيها مترجمين فوريين، ورأت ان استخدام مترجمين فوريين محترفين يقلّل من احتمالية وقوع الأخطاء.

14.8.1 استخدام الأولاد والمراهقين كوسطاء لغويين

تنوجد المشاكل المذكورة أعلاه بشكل خاص عندما يؤدّي الأولاد دور الوسطاء اللغويين، وذلك لأنهم عرضة لأن يتأثروا بشكل كبير بأية صدمات نفسية غير مباشرة او مواضيع لا تناسب أعمارهم. كما ان الأولاد قد يعانون من استغلالهم في المشاكل العائلية. وقد يتردد الأهل، في وجود الأولاد، في مشاركة معلومات عن اية احداث مأساوية مروا بها. كما انهم قد يترددون في التحدث عن اية مسائل لها علاقة بعادات مجتمعهم، مثل المسائل الطبية الحساسة او التمييز بين الرجل والمرأة او العنف المنزلي او الوفيات او المشاكل العائلية او اية حوادث قد تتعارض مع دورهم كوالدين. وعلى الرغم من الإجماع الكبير على وجود الكثير من المشاكل المتنوعة، لا يزال استخدام الأولاد والمراهقين كوسطاء لغويين يُعتبر أمرًا ضروريًّا او لا يمكن تفاديه في الكثير من الأحيان من أجل تخطّي العوائق اللغوية في الحياة اليومية بطريقة مباشرة وسريعة. كما ان رفض اللجوء اليهم للمساعدة سيؤدي الى حالات تأخّر كبير، وتكاليف إضافية، ومشاكل محتملة مع الأهل الذين يعتبرون ان شَمْل أعضاء العائلة في الترجمة هو تدريب جيّد لهم حتى في الأوضاع الحساسة.

وقد نُشرَت عام 2015 نتائج المشروع التجريبي "الترجمة الفورية عبر الفيديو في الرعاية الصحية" وأشارت الى ان 81% من المختصين في الرعاية الصحية (العدد الكامل: 144 شخصا) المشمولين في العيّنة قاموا باستخدام الأولاد كوسطاء لغويين. كما استخلصت دراسة أخرى ان الأولاد والمراهقين يُستعمَلون في اغلب الأحيان كوسطاء لغويين في مجال الرعاية الصحية والخدمات الاجتماعية في فيينا، النمسا. وقد بحثت إبدن وآخرين في موضوع خدمات الترجمة الفورية التي يقدّمها الأولاد وأفراد العائلة الآخرين. واستنتجت ان 16% على الأقل من الأسئلة التي صُنِّفت على انها بسيطة قد تُرجمت بشكل خاطئ او لم تُترجَم من الأساس. وقد ارتفع هذا الرقم الى 82% في الأسئلة الأكثر تعقيدًا. ففي معظم الأحيان، تُرجمت المصطلحات والأعراض التشريحية بطريقة غير دقيقة او غير صحيحة. كما انه وُجدت صعوبات كبيرة في ترجمة المصطلحات الخاصة باختصاص معيَّن، فجرى مثلاً الخَلط بين ضيق التنفس والربو. أضف الى ذلك ان الموظفين في مجال الرعاية الصحية لم يتمكنوا من التأكد

من صحة المعلومات التي يترجمها الوسطاء اللغويون واكتمالها. ومعظمهم كان لديهم الانطباع ان المترجمين غير المدرَّبين يترجمون الحوار فوريًّا دون اية مشاكل وان المضمون يُنقَل بطريقة كاملة وصحيحة. وكل هذا يؤدي الى شعور المختصين الطبيين باطمئنان مزيَّف.

وعلى الرغم من ان الدراسات قد اشارت الى تعرّض الأولاد والمراهقين لدرجة من الخطورة عند استخدامهم كمترجمين فوريين والى عدم موثوقية ترجمتهم، إلاّ انه لم يتغير أي شيء تقريبًا في الممارسة اليومية. كما انه جرى تفضيل خدمات الموظفين الذين يتكلمون لغة أجنبية وأقرباء او أصدقاء المرضى كوسطاء لغويين على خدمات المترجمين الفوريين المحترفين، على اعتبار ان طلب مترجم فوري محترف يستغرق الكثير من الوقت.

وتجدر الإشارة الى انه يمكن استخدام القدرة "الفطرية" في الترجمة الفورية بطريقة فعّالة لدى الأولاد والمراهقين الذين يتكلمون عدّة لغات فقط عندما يكون سياق الحوار ضمن نطاق قدراتهم اللغوية وخبرتهم. اما في حالة الترجمة الفورية في سياق طبي او امام السلطات الحكومية، فمن السهل تخطّي قدرة الولد المحدودة. فالأولاد عادةً غير قادرين على فهم معنى المصطلحات الطبية في اللغة المصدر، لذلك يعجزون عن ترجمتها. والأهل الذين يجيد أولادهم تكلُّم لغتين، تكون لديهم غالبًا توقّعات غير واقعية بشأن كفاءة أولادهم اللغوية، فيعرِّضونهم بالتالي، عن غير قصد، الى ضغط نفسي كبير. بالمقابل، يمكن ان يشكِّل استخدام الأولاد في الترجمة عاملاً إيجابيًّا في تنمية شخصيتهم إذا كان ذلك ضمن سياقات "محميّة"، إذا جاز التعبير، مثل المحادثات في البيت بين الأصدقاء او المعارف او عند التسوق.

على صعيد آخر، قد يؤدّى استخدام الأولاد والمراهقين كوسطاء لغويين الى تغيير كبير بالأدوار بين أفراد العائلة ويؤدّي الى تحوُّلات في علاقات القوة فيما بينهم. ويجب عدم الاستخفاف بخطر معاناة الأولاد والمراهقين من أعباء لغوية ونفسية تفوق قدرتهم خلال استخدامهم كوسطاء لغويين، خصوصًا في سياقات غير محميّة. هذا وان الارتفاع المثبَت في معدَّل أخطاء الترجمة يشكل خطرًا على الوثوق بالمؤسسة المعنية.

وبما ان استخدام الأولاد والمراهقين قد يمثّل شكلاً من اشكال "العمل اللغوي غير المرئي"، فالتحقيق في هذه المسألة يستحق الجهد لمعرفة ما اذا كان يمكن اعتبار ذلك كعمالة أطفال ام لا. وقد اجاب أهامر عن هذا السؤال بالتفصيل وحاجّ بقوّة ان الوقت

هو من الموارد الثمينة، ذاكرًا: "مع ان هذا النشاط يمارسه أشخاص عاديون، ليس من الناحية المهنية لكن من حيث الإنفاق المطلوب مقابل الموارد، فهو يشكّل طريقة من الطرق للمؤسسات والوالدين لتوفير المال، وبالتالي يطابق نشاطًا يعادل العمل". وقد شدد أوريلانا أيضًا على المساهمة الكبيرة التي يقوم بها الأولاد والمراهقين عند تأديتهم دور المترجم الفوري. فهذا النشاط يستفيد منه الوالدين والأقرباء والمؤسسات والمجتمع ككل. لذلك، فان السؤال المطروح ليس "هل سيعمل الأولاد"، بل "الى أي حد سيكون عملهم مرئيًا". فالقيام بدور المترجم الفوري لا يُعتبر عادةً خارجًا عن المألوف، وبالكاد يحصل الأولاد على عرفان بالجميل لدورهم كمترجمين، هذا ان حصلوا عليه. لذا، من المفيد ان ننظر هنا الى الدور الذي يؤدّونه من منظار مختلف عوضًا عن اعتبارهم كمجرّد اشخاص يستفيدون من نظام التعليم والنظام الاجتماعي. بناءً عليه، نستنتج ان الأولاد والمراهقين الذين يجيدون التحدث بلغتين والذين أحد والديهم او كلاهما من المهاجرين، يساهمون مساهمة كبيرة، منذ عقود، في الاقتصاد الصحي غير الرسمي، من خلال عملهم كمترجمين فوريين، ومترجمين خطيين، ووسطاء ثقافيين ولغويين، وهم يقدّمون بالتالي الكثير للمجتمع حتى في هذه السن الصغيرة.

اما من المنظار القانوني، فاستخدام الأولاد كمترجمين غير مدرَّبين يثير مسألة الاستخدام غير المشروع للأطفال، إضافةً الى المخاطر المحتملة الذي يشكّله ذلك على صحتهم. وتجدر الإشارة هنا الى انه لا ينبغي استخدام الأولاد كمترجمين فوريين في أوضاع حساسة، وان المؤسسات او المنظمات المعنية بالاعتناء باللاجئين يجب ان تتحمل مسؤولية توفير البدائل، كاللجوء الى المترجمين الفوريين المحترفين او استخدام الترجمة الفورية عن بعد عبر الفيديو.

14.8.2 استخدام الاقرباء الراشدين او طرف ثالث كوسطاء لغويين

غالبًا ما تنشأ المشاكل لدى استخدام الأقرباء الراشدين او الموظفين الذين يتكلمون أكثر من لغة والذين لم يتلقّوا التدريب الملائم وذلك لعدم إمكانية الوثوق بنوعيّة ترجمتهم او مدى اكتمالها. كما ان هذا النوع من العمل لا يندرج ضمن الوصف الوظيفي المحدد للموظفين الذين يجيدون التحدّث بلغات عدّة. وفي حال ارتكب اي موظف بخطئٍ ما، قد يكون لذلك تداعيات على صعيد نظام التوظيف ونظام التأمين. وفي حين تُعتبر هذه الأخطاء أقلّ خطورة في الحالات الطارئة، إلاّ انها تستحّق النظر فيها بشكل جدّيّ في الحالات الأكثر دوامًا. غير ان الكثير من بين المؤسسات والمنظمات غير الحكومية لا تزال تعتمد على مصادر داخليّة

لتخطّي عوائق اللغة. لكن تطبيق هذه الطريقة كحلّ بديل يتطلّب تنظيمًا واضحًا للظروف الإطارية (أي تقديم توضيح بشأن الاستخدام والرواتب والأجور والدورات والتدريب المتقدِّم، والإشراف، والجوانب القانونية). ومن المهم بشكل خاص نشر التوعية حول ان الكفاءة اللغوية وحدها لم تعد كافية للحصول على ترجمة فورية جيدة، وان الترجمة الفورية هي مَهمّة ترافقها مسؤولية كبيرة وتشمل الخضوع للتدريب، ووقتًا إضافيا، وألمًا عاطفيًّا.

14.8.3 اللجوء الى لغة ثالثة مشترَكة (كاللغة الإنكليزية)

غالبًا ما تُبذل محاولات عدّة لاستخدام لغة ثالثة مشترَكة بهدف التواصل مع المرضى، ويتزايد استخدام اللغة الإنكليزية في ظروف مماثلة. لكن ثمة مشكلة رئيسة هنا وهي ان الأشخاص الذين يقدِّمون المساعدة غالبًا ما يبالغون في تقدير قدراتهم في اللغة الأجنبية. فاللجوء الى لغة ثالثة في حالة المرضى الذين بالنسبة اليهم هذه اللغة هي ليست اللغة الأم، يسبب المشاكل لهم ايضًا. وبالتالي، لا يشكّل هذا الخيار سوى استبدال مشكلة تواصل أساسية بأخرى، فتزيد احتمالية ظهور المشاكل في التواصل عوضًا عن انخفاضها.

14.8.4 المعلومات المُتَرجمَة

يمكن، لا بل يجب، للترجمة الشفهية للمعلومات ان تُدعَم وتكمَّل بمواد مطبوعة مُترجَمة الى لغات أجنبية. لكن هذه المواد هي فقط لاستكمال التوضيح الشفهي الذي يطلبه القانون. ويجب الانتباه الى نوعية المواد المُتَرجمَة لانها قد تختلف كثيرًا. وبالرغم من توفّر طيف واسع من الترجمات الجيّدة إجمالاً وفي مجالات متعدّدة، إلاّ انها لا تغطّي كافة المواضيع حتى الآن. لكن تتوفّر مواد تعليمية ممتازة بلغات مختلفة يمكن تحميلها مجّانًا من المواقع الالكترونية للجمعية السويسرية *Interpret*، إضافةً الى الموقع الالكتروني للوزارة الاتحادية النمساوية للصحة وشؤون المرأة (https://www.bmgf.gv.at/home/Service/Broschueren) بالرغم من محدودية المواضيع المتوفّرة.

14.8.5 برامج الترجمة

تشكّل البرامج الالكترونية المجانية للترجمة، مع انترنت او بدونه، وسيلة جديدة نسبيًّا صُمِّمت لتخطّي عوائق اللغة وهي متوفّرة بسهولة مثلاً على الهواتف الذكية التي يلجأ اليها المهاجرون اليوم كوسيلة تواصل أساسية. وتُقدّم أدوات الترجمة المساعدة، خصوصًا فيما يتعلّق باللغات النّادرة، ويمكن اعتمادها بسرعة وسهولة لتوضيح استفسارات تنظيمية في الحالات الطبية اليومية. لكن يجب ممارسة الحذر هنا ايضًا لأنه لا يمكن الوثوق بهذه الأدوات إلاّ بشكل محدود حاليًّا. فليس من المحبَّذ، طبعًا، إجراء حوار لأخذ موافقةٍ ما باستخدام برنامج ترجمة حصرًا، لأن حدوث اي خطأ في الترجمة سيشكّل خطرًا جليًّا بسبب طبيعة هذه البرامج ومحدوديتها.

14.9 الحلول المحترفة: المترجمون الفوريون الموجودون شخصيًّا والبدائل

14.9.1 المترجمون الفوريون الموجودون شخصيا

يجب إعطاء أولوية قصوى لإيجاد استراتيجيات ممتازة تساعد على تخطي عوائق اللغة. والحل المتعارف عليه هو استخدام مترجم فوريّ محترف، مَحلّي، ومؤهّل على اساس المبادئ التي قمنا بمناقشتها سابقًا. ومن الواضح تمامًا ان الفوائد التي تنتج عن ذلك يمكن التماسها فورًا، اي ترجمة فورية خالية من العوائق. اما إحدى النتائج السلبية المحتمَلة لذلك، هو ان يرزح المترجم الفوري تحت عبء الألم العاطفي او ان يصبح متحيزًّا في بعض الحالات.

بالإضافة الى تواجد المترجم الفوري شخصيًّا في الموقع المطلوب، يمكن تخطّي العوائق اللغوية باستخدام وسائل كالترجمة عبر الهاتف او الفيديو. ومن أهمّ حسنات هذين الحلَّين عن بُعد هو انهما يوفِّران مرونة متزايدة من حيث الوقت والمكان.

14.9.2 الترجمة الفورية عبر الهاتف

تشكّل الترجمة الفورية عبر الهاتف استراتيجية راسخة تُطبَّق في سويسرا والنمسا على سبيل المثال. فهي تسهِّل الحصول على خدمات الترجمة الفورية باستخدام وسيلة موجودة أساسًا، وبالتالي تقلِّل الجهود التقنية المطلوبة. وفي دراسة نوعيّة أُجريت مؤخّرًا في الولايات المتحدة الأميركية على الترجمة الفورية عبر الهاتف، جرى لفت الانتباه الى بعض الاعتبارات الخاصة في استخدام هذه الوسيلة مع اللاجئين. ومن أهم المسائل التي أبلغ عنها المترجمون الفوريون هي: 1- أهمية تنمية الثقة بين المترجم الفوري

والموكّل، و2- أن العمل مع اللاجئين يتطلّب انتباهًا أكبر من قبل المترجم الفوري. كذلك، في إحصاء قام وانغ بإجراءه مؤخّرًا، فقد تعمَّق في مسألة الترجمة الفورية عبر الهاتف ومفهوم المترجم الفوري لما هو ملائم، ولأمور تتعلّق بالراتب او الأجر وبنوعية الرعاية الصحية.

14.9.3 الترجمة الفورية عبر الفيديو

بالمقارنة مع الوسائل الأخرى عن بُعد، تشبه الترجمة الفورية عبر الفيديو الى حد كبير الحوار وجهًا لوجه لأنها تتيح التواصل غير اللفظي وتضمن عدم تجاهل الجوانب الثقافية التي تعبِّر عنها الإيماءات والمحاكاة. إضافةً الى ذلك، فان فهم المؤشرات البصرية قد يفسر وجود التفاوتات على صعيد الرسالة الشفهية وغير الشفهية ويساهم في تجنّب حدوث اي سوء فهم. كما ان ردّات فعل المترجم الفوري المناسِبة وغير اللفظية قد تؤثر إيجابيًّا على الشخص الذي يُترجَم كلامه فوريًّا. وهذا عامل مهم في بناء الثقة بين المترجم الفوري والموكل. كما انه يساهم في ان يجري التواصل بسلاسة وبدون اية مقاطعة، بالرغم من انه حل عن بُعد. ومن المهم أخذ الإيماءات والمحاكاة بعين الاعتبار خصوصًا في الحالات التي يكون مطلوبًا فيها الحصول على إعلان موافقة.

يشكّل استخدام الترجمة الفورية عبر الفيديو باعتباره وسيلة مبتكرة لتخطي عوائق اللغة في قطاع الرعاية الصحية ومنذ وقت طويل عنصرًا ثابتًا في العناية المزوَّدة للمرضى الذين يتكلّمون لغة أجنبية في عدّة بلدان بما فيها الولايات المتحدة الأميركية. لكن البلدان الناطقة باللغة الألمانية، لم تتّخذ خطوات لترسيخ خدمة الترجمة الفورية عبر الفيديو إلاّ مؤخّرًا.

وكجزءٍ من المشروع الآنف الذكر، قدّمت دراسة نمساوية تقييمًا غير معقّد من الناحية التقنية لعملية اللجوء الى مترجمين فوريين محترفين عبر مؤتمرات الفيديو في الحوارات التي تدور بين الأطباء ومرضاهم. وبحسب عيّنة البحث، فان هذه الوسيلة قد أثبتت عن إفادتها الكبرى. واعتبرت الدراسة ان المستوى المتقدّم من الفعالية في العمل وإمكانية الاعتماد على دقّة الترجمة يشكّلان جانبين إيجابيين بشكل خاص. إضافةً الى ذلك، اعتُبرت هذه الوسيلة الحل الأمثَل في ضمان الحياد والموضوعية في الترجمة الفورية على صعيد المكان والقرب العاطفي والمسافة بين المترجم الفوري والمريض.

وتؤدّي الثقة المُكتسبة من خلال إمكانية الحصول على ترجمة فورية صحيحة وكاملة دورًا مهمًّا في زيادة ارتياح الموظفين وضمان سلامة المريض. فاستخدام المترجم الفوري عبر الفيديو سمح للموظفين بإتمام مهامّهم وفقًا لمعيار الجودة المعتمَد، والأهم من ذلك من دون الاتكال على توفُّر طرف ثالث او وجوده شخصيًّا كي يؤدّي دور الوسيط اللغوي. كما ان الترجمة الفورية عبر الفيديو قد حصلت على أعلى تصنيف من ناحية توفير السرعة والمرونة، وهي تُعتبر وسيلة جيّدة جدًّا لتخطّي حواجز التواصل بطريقة تضمن نوعية الترجمة.

لكن هذه الوسيلة قد لا تكون الأنسب في كافة الحالات. على سبيل المثال، إذا كان موعد العلاج محدد مسبقًا، فالحل الأمثل يكون باستخدام مترجمين فوريين محترفين يتواجدون شخصيًّا، وذلك لإمكانية تحديد موعد معهم بشكل مسبق. وحتى عندما يكون الموظفون، وأعضاء الفريق، والأشخاص الذين يرافقون المريض قادرين على القيام بدور وسيط لغوي وتلبية الحاجة الى مترجم فوري، ينبعي على قوانين المنظمات والمؤسسات ان تضمن مستوى ثابتًا من العناية الجيدة والآمنة للمرضى الذين لا يتكلمون لغة البلدان المضيفة.

وأخيرًا وليس آخرًا، ان النتائج الواعدة للأبحاث، وازدياد الوعي حول المشكلة المعنية، وتزايد الانفتاح على إيجاد حلول جديدة قد أتاح الفرصة لتطوير النظام المحترف والمبتكر للترجمة الفورية عبر الفيديو وتحسينه. وهذا النظام يستعمله اليوم عدد كبير من المؤسسات في قطاع الرعاية الصحية والقطاع الاجتماعي والقطاع القضائي في النمسا، وألمانيا، وسويسرا ويغطّي حوالي 72 لغة مختلفة. وتضمّ هذه الشبكة 600 مترجم فوري كفؤ في جميع أنحاء الاتحاد الأوروبي، وهناك مترجمون للغات الأساسية متوافرين الى حد 24 ساعة في أقل من 120 ثانية من وقت الطلب. ومنذ تشرين الثاني (نوفمبر) 2015، أصبحت الترجمة الفورية عبر الفيديو متوفرة في مدينة هامبرغ التي تستعمل الحاوية الشاملة كَحَلّ لتزويد اللاجئين بالرعاية الصحية. وأوّل شاحنة ألمانية محمَّلة باللقاحات للاجئين بدأت في برلين في تشرين الثاني (نوفمبر) 2016 وقد قامت بتزويد الترجمة الفورية أيضًا. وفي النمسا، تُستعمل الترجمة الفورية عبر الفيديو لتقديم الرعاية الصحية في مراكز الاحتجاز التابعة للشرطة التي تضمّ في الغالب مُحتجَزين ينتظرون ترحيلهم او يواجهون إدانات جنائية.

14.10 ترجمة المواد الموحَّدة

تتطلّب ترجمة المواد الموحَّدة ووسائل التشخيص كالاستبيانات الطبية والنفسية التكيّف مع كل ثقافة والمصادقة على المعلومات او إعادة المصادقة (ناقشها أيضًا ونزل وآخرون). وفي المسائل الحسّاسة بالتّحديد، يُوصى بعملية إعادة مصادَقة كاملة تشمل ترجمة محترفة والتحقق منها ضمن عدد من المجموعات القابلة للمقارنة. وقد تمّ تطوير بديل عمليّ من خلال استخدام عمليات الترجمة وإعادة الترجمة الشائعة. وقد تتألف هذه من نموذج بسيط أ – ب – أ يعتمد على ترجمة مترجم محترف يجيد لغتين. اذا وُجدت اختلافات في اللغة أ بعد إعادة الترجمة، يجب ان يُعدَّل النص الى ان تصبح النتيجة مطابقة بشكل كافٍ عند إعادة ترجمتها مجددًا من اللغة ب. ويجب الانتباه عند اختيار المترجمين الذي يجيدون لغتين. فيجب ان يكونوا من المجموعة الاثنية نفسها التي ينتمي اليها الشخص الذي تُطرَح عليه الأسئلة، وأن يكونوا مدركين لاختلاف اللغة المستعمَلة من قبل فرق اجتماعية مختلفة. وبشكل مثاليّ، سيحصلون على فهم ممتاز لعلوم الترجمة والحقل/الموضوع قيد الترجمة. والأساليب النوعية، مثل مجموعات التركيز، قد تكون بسيطة نسبيًّا لكنها وسيلة فعّالة لتحسين النتائج ويمكن القيام بها في البداية او لاحقًا لمعالجة مشاكل الترجمة.

14.10.1 دراسة حالة

في دراسة أُجريت في يوغوسلافيا السابقة، لاحظنا (TW) مشكلة غريبة عند تطبيق استبيان هارفرد للصدمة النفسية (HTQ). فقد أبلغ معظم المشاركين عن تعرّضهم للتعذيب، لكن ذلك مُستبعَد بالنظر الى ظروف حياتهم. لكن قامت مجموعة تركيز بجمع معلومات من المشاركين تفيد بأنهم شعروا بالعجز حيال تعرضهم المستمر للبروباغندا العدائية والمهينة في وسائل الإعلام، واعتبروا ذلك تعذيبًا. وفي حين ان التعريف القانوني المتعارف عليه لكلمة تعذيب لم يكن موجودًا، فقد سمحت النتائج بتكوين فهمٍ أفضل لما يتعلّق بالأمور التي تؤثّر على مجموعة المرضى هذه ولحاجاتهم، وتفادت فهم النتائج بطريقة خاطئة.

14.11 الاستنتاجات: التواصل بدون عوائق هو مَهمّة قيادية

لا يقتصر دور اللغة والتواصل على كونهما ضروريين وعنصرين أساسيين في كل عملية قانونية فحسب، انما لهما أهميّة قصوى ايضًا في كافة مجالات الحياة تقريبًا، بما فيها الرعاية الصحية. فالعوائق اللغوية تشكّل مصدرًا أساسيًّا للأخطاء في العمل مع المهاجرين واللاجئين وهي تولّد خطر المسؤولية وهو عامل يجب ان يكون المختصّين المعنيين على علمٍ به. أمّا الحلول البديلة،

كاللجوء الى المترجمين غير المدرَّبين المستخدَمين في حالات الطوارئ، فيجب ألاّ تصبح هي المقياس، ويجب تفاديها قدر الإمكان نظرًا لما تشكّله من مخاطر طبية ونفسية وقانونية. والأساليب الجديدة، مثل النماذج على الفيديو وبرامج التدريب كبرنامج QUADA الذي أعدَّته مفوضية الأمم المتحدة للاجئين، يجب ان تُطوَّر أكثر وتُرسَّخ في النظامَين القانوني والرعاية الصحية. وفي النهاية، ان تقديم تدابير نوعيتها مضمونة في سبيل تخطي عوائق اللغة تزيد من حماية طرفيّ الحوار وتقلّل النفقات. نتيجةً لذلك، كل الأطراف المعنية بطريقة مباشرة او غير مباشرة، من مترجمين فوريين ومرضى الى المنظمات غير الحكومية والمؤسسات والسلطات المسؤولة عنهم، ستستفيد من الخدمات المنظمة للترجمة الفورية المحترفة. لكن من أجل تحقيق ذلك، "[...] يجب ان يكون هناك وعي متزايد على كافة الأصعدة بأن استخدام مترجمين مؤهَّلين ليس رفاهية، بل دليل على مجتمع منفتح"، حسبما طالب راسكي في مقال يلخّص الصعوبات الماثلة في أنظمة الرعاية الصحية الحاضرة.

Original Text II

Refugees in Host Countries: Psychosocial Aspects and Mental Health

By Branka Agic, Lisa Andermann, Kwame McKenzie, and Andrew Tuck

Abstract

In the last few years, the number of refugees worldwide has increased significantly, reaching the highest levels ever recorded. As described in the literature, the mental health of refugees is affected by their pre-migration, migration, and post-migration experiences. It is well documented that the circumstances that refugees go through can impact both their physical and mental health. While the pre-migration and migration factors cannot be altered, host countries can make the greatest impact on the mental health trajectories for refugees by addressing the post-migration psychosocial factors. This chapter discusses how certain social factors and policies can affect the psychological well-being and mental health of refugees and asylum seekers in Canada and other developed countries. We will focus on the impact of the seven Ds: detention, denial of employment, dispersal, denial of health care, destitution, delayed decisions on applications, and discrimination. While these are often interrelated issues, they each play a role in the integration of refugees and influence their short- and long-term mental health and well-being. Restricting access to employment or health care and forcing refugees to live in certain areas or in

impoverished circumstances without any certainty of their acceptance all have negative effects on mental health while reducing the likelihood of integrating and developing strong social bonds.

8.1 Introduction

Political violence and turmoil, internal conflicts, and wars have led to a large num- ber of people who have been displaced from their homes and forced to seek refuge in other countries. In the last few years, the number of displaced people has increased significantly, reaching the total highest levels ever recorded in 2015 [1]. The UNHCR reports that there are currently 65 million people displaced worldwide. The majority of these individuals have been internally displaced within their own countries; however, about 24 million people are currently living as refugees or seeking asylum in other countries [1]. The number of refugees has consistently been increasing for years but seems to have slowed in 2015 [1, 2]. Yet, the number of refugees able to return to their country of origin has been trending downward [2]. This puts added strain on host countries, and they in turn need to consider how their policies, strategies, and requirements around entering the country, living and working in the country, and socialization can have an impact on the mental health of refugees within their country in both the short and long term.

"Refugee" is the term commonly used to describe people fleeing their home due to armed conflict or persecution. However, in international law, "refugee" is a very specific term that refers to individuals who are outside of their country of origin due to a well-founded fear of persecution based on their race, religion, nationality, member- ship of a particular social group, or political opinion. Refugees are protected by inter- national law [3]. Asylum seekers or refugee claimants are people who are seeking asylum within a host country and whose request for sanctuary has yet to be deter- mined [4]. These two terms are sometimes used interchangeably,

but refugee claimant is the term used primarily within the Canadian context. Resettled refugees are people who have been granted permanent settlement in another country [5]. They are commonly all called refugees, and the different terms are often used interchangeably.

Most refugees seek protection in countries that border their original home. This is reasonable as these countries are easier to get to due to their proximity to the refugees' home country. Often, although it is not always the case, these host countries are fairly similar to the original country. They are likely to have similar cultures, religions, politics, and histories. While a vast majority of refugees stay in neighboring countries, others take greater risks and attempt a longer journey for a multitude of reasons to developed countries or apply for resettlement to potential host countries to be accepted as a refugee. While some countries like Turkey, Pakistan, or Lebanon have hosted millions of refugees in the past few years [1], other countries, for example, Mexico, that are much further away from the region where most people are currently fleeing also receive asylum seekers and accept refugees annually, just in lower numbers [1]. Recent turmoil in Central America has seen a fivefold spike, from 2012 to 2015, in the number of people from Guatemala, El Salvador, and Honduras seeking refuge in Mexico and the United States [1]. The numbers of refugees and asylum seekers coming to North America as compared to countries in Africa, Asia, and even Europe are less abundant due to the complexity and danger of trying to reach the North American countries from Asia or Africa.

In 2014, there were nearly 900,000 new asylum applications to the "44 industrialized countries"; 30 of these countries reported a rise in asylum applicants during the year [5]. Germany received the largest number of asylum seekers in 2014, an increase by 58% from the previous years, and the seventh consecutive annual increase. The United States, Turkey, and Sweden were the

countries that received the second through fourth highest number of asylum seekers with all four countries seeing large increases over recent years [6]. Most asylum seekers in 2014 to these 44 industrialized countries were from the Syrian Arab Republic. Other countries of note with high levels of people seeking asylum were Iraq, Afghanistan, Serbia, and Kosovo [6]. While industrialized nations have seen increases in refugee applications, refugees, and asylum seekers, the nations hosting the most refugees are in developing regions. The top five countries with the most refugees in 2015 were Turkey, Pakistan, Lebanon, Islamic Republic of Iran, and Ethiopia [1].

While legislation is specific about which refugee groups the international and national laws and rules apply to, this does not necessarily translate into other areas. In the public realm, the different groups are often lumped together as refugees, and the distinctions are not always clear in the academic literature either. Some research clearly defines the group that they are researching; others use generic terms such as migrant or refugee to define different classifications of refugees. In some cases, immigrants are also included in the refugee classification. In recognition of these methodological challenges, we try to be as specific as possible when providing evidence about the effects of the refugee experience on mental health.

Refugee mental health is affected by pre-migration, migration, and post-migration experiences. The difficult circumstances that refugees go through can impact both their physical and mental health. While refugees are more likely to experience some mental health problems than either immigrants or host country residents, overall, most problems will occur in refugee populations at similar levels to host populations [7–9]. It is important to note that only a small portion of refugees with mental health problems require specialized treatment (e.g., from a psychiatrist) and

only a few will develop chronic problems. The estimated rate of mental illness in refugee populations is wide ranging and likely higher among war-affected refugees [7, 9]; these differences are in part linked to the varying social responses [7, 8].

Post-migration experiences can exert enormous influence on the mental health of refugees [10]. Mental health problems limit the potential of the individual both economically and socially and may place greater burdens onto the host country's social institutions [10]. Stresses such as unemployment, poverty, and lack of access to services have an adverse effect on everyone, but migration and resettlement increase the probability of experiencing these stresses [10]. Precarious status, detention, and prolonged status insecurity put additional stress on asylum seekers. Post- migration stressors experienced by refugees, in particular those exposed to pre-migration trauma, have been positively associated with mental disorders [9].

While the pre-migration and migration factors cannot be altered, host countries can make the greatest impact on the mental health trajectories for refugees by addressing the post-migration psychosocial factors. Considering the policies that directly affect how refugees are received and the resources and system in place to respond to refugees can directly affect the long-term mental health of refugees. The way groups are welcomed into a country, the opportunity for sustainable high-quality employment, access to education and training, and initiatives to foster their social inclusion within their community and the larger society are fundamental aspects in reducing social isolation, reducing hopelessness, and producing good mental health.

This chapter discusses how certain social factors and policies affect the psycho- logical well-being and mental health of refugees and asylum seekers in Canada and mainly other developed countries. We will focus on the impact of the seven Ds [11, 12]: detention, denial of

employment, dispersal, denial of health care, destitution, delayed decisions on applications, and discrimination.

8.2 The Seven Ds

8.2.1 Detention

Different countries have different policies and procedures on whom to accept, the process of acceptance, and how refugees or asylum seekers are treated once they've arrived within the country based on a set of criteria which includes security of the nation and human rights. Many developed and developing nations currently have policies or guidelines relating to the detention of asylum seekers at a port of entry or after arrival. These regulations, as well as the treatment of asylum seekers, also differ from country to country.

As examples we outline the regulations in Canada and Australia to emphasize differences and similarities across nations. Detention of asylum seekers, in particular those who have undergone traumatic experiences, can be detrimental to their mental health [13–20] (see also the chapter by den Otter et al. in this book).

8.2.1.1 Canada

In Canada, the Immigration and Refugee Protection Act (IRPA) [4] governs the admission of foreign nationals into the country. Under the IRPA, the Canada Border Services Agency (CBSA) agents may arrest and detain asylum seekers designated as part of an "irregular arrival" if they have reasonable grounds to believe the individual is inadmissible under the IRPA and poses a danger to the public; is unlikely to appear for an examination, an admissibility hearing, or a

removal from Canada; cannot prove their identity; or is part of an irregular arrival as designated by the Minister of Public Safety and Emergency Preparedness. Detained asylum seekers are held in either Immigration Holding Centers (IHCs) or provincial jails. According to the IRPA [4], anyone 16 or older who is detained is held until their case for refugee protection is acknowledged, or the Immigration Division or the Minister orders their release. They do have to receive a review within 48 h of being detained, and this must be reviewed at least once a month. However, there is no defined maximum length of stay, so that essentially a refugee claimant who is detained under the Act can be detained indefinitely [4]. The IRPA specifically states that no attempt be made to detain any minor under the age of 16, except under extraordinary circumstances. Children of detained asylum seekers who are under 16 are either taken away from parents and handed over to provincial child protection services or unofficially detained with their mother in an immigration holding center [21]. In Canada, the UNHCR has full access to all detention centers where asylum seekers are detained.

8.2.1.2 Australia

In Australia, under the Migration Reform Act introduced in 1992, all “unlawful” non- citizens to Australia are required to be detained [22, 23]. The Act ensures that anyone who arrives without “lawful authority” is not allowed to enter Australia until they have satisfactorily completed health, character, and security checks and been granted a visa, or they are removed from the country. Mandatory detention was introduced as a temporary and exceptional measure in response to the wave of “boat people” coming from Indo-China. The maximum time someone can be detained is indefinite and some cases of years-long detention have been documented [23]. The Australian Migration Reform Act has a few notable differences from the Canadian

Immigration and Protection Act: in Australia a detainee is liable to pay the Commonwealth for their detention or removal, and dependent children can also be detained [22].

The Effects of Detention on Mental Health

While the conditions of detention vary considerably within and across countries, often these centers are like prisons (or are actual prisons), with surveillance cam- eras, guards, controlled locks, and fences, and sometimes the centers are located on islands off the mainland of the country [13, 16, 19, 23, 24]. Detention of asylum seekers has been shown to be associated with increased risk of mental health problems and disorders including anxiety, depression, and post-traumatic stress disorder [18, 19, 25]. Exposure to detention can provoke intense fear and anxiety, sleep disturbances, and depressed mood in individuals who have previously experienced torture [18]. Detention often leads to feelings of hopelessness and powerlessness, which can lead to increased substance use [15], worsening mental health, and suicidal ideation and attempts [14–16, 18]. Detention seems to adversely affect the mental health of men and boys more than women and girls [15, 17, 19]. Detention, even short term, has a detrimental impact on the psychosocial well-being of children including developmental delays, diagnosed mental health problems, and suicidal behaviors [26, 27].

Length of stay in detention is directly linked to poor mental health. Nielsen and colleagues [17] studied asylum-seeking children in Denmark. They found that children aged 11–16 who had lived in asylum centers for more than 1 year had a relative risk for mental difficulties 30 times higher than those children who had lived in asylum centers less than a year [17]. Keller et al. [13] followed a number of asylum seekers in the United States over a number of years and found that 70% of participants perceived their mental health worsening during detention; subsequent

analysis correlated this with an association between length of detention and levels of anxiety, depression, and post-traumatic stress disorder which improved for those who were eventually released. Similarly, prolonged detention in Australia [28] has been shown to exert long-term impact on psychosocial well-being in refugees, with the mental health problems persisting after release. Furthermore, the Commonwealth and Immigration Ombudsman found a strong correlation between the rise in the average time in detention and the increase in self-harming behavior [29].

Cleveland and Rousseau [19] examined differences between asylum seekers in detention in Canada and those never detained. They found that the proportion of asylum seekers in detention above clinical cutoffs were significantly higher for post-traumatic stress, depression, and anxiety symptoms than the non-detained group. Symptom levels and the number of cases of mental health problems were found to be significantly higher in the detained group after a relatively short stay in detention, 17.5 median days [19].

Moving Forward

Policies of detention are brought into effect for a number of reasons, including but not limited to security and deterrence of irregular migrants. However, even the most stringent detention policies have been shown not to deter people [30], and as the research shows, detention clearly affects mental health both in the short and long term. In light of the increased interest in detention policies and the increased dis- placement around the world, the UNHCR has been striving to reduce, if not eliminate, the use of detention. In June 2014, UNHCR launched its Global Strategy—Beyond Detention 2014–2019, which aims to support governments to end the detention of asylum seekers and refugees. The strategy lays out three main goals: The strategy

calls for a select group of 12 focus countries to develop national action plans in the first 2 years. As of December 2015, there had been action plans developed for the following countries: the United States, the United Kingdom, Thailand, Lithuania, Israel, Malaysia, Canada, Indonesia, Mexico, Malta, Zambia, and Hungary. The country-specific action plans differ depending on which goal(s) they choose to pursue, the specific objectives and actions to success [30]. For example, ending the detention of children is a key priority of the Canada's NAP with several actions listed under four subgoals: (a) legal and policy framework are in place to ensure that children are not detained, (b) best interests of the child prevail, (c) appropriate alternative reception and care arrangements are available, and (d) child-sensitive screening and referral procedures are in place to refer them to relevant child protection institutions or organizations [31]. In the case of Malta and the United Kingdom, for example, the UNHCR has outlined slightly different routes for ending the detention of children. In Malta in 2014 the government specifically created legislative provisions, and the Prime Minister publicly stated that children should not be in detention, so the UNHCR plans to support the implementation of the policy [32]. The United Kingdom has made progress already toward ending detention of children, but focus is to be placed on short-term holding facilities. Where there are no specific rules in place, the UNHCR will support the government to address this gap [33]. These global strategy and national action plans are only the start of a long process in addressing the issue of negative impacts of detention.

8.2.2 Denial of Employment

Individuals need productive tasks to give them meaning, to create purpose, and to find constructive uses of their time. Employment is one avenue that if meaningful, worthwhile, and

challenging can help to reduce the chance for mental illnesses to develop and alleviate present symptoms. Getting and keeping a job is never an easy task, but it is often made more difficult for refugees based on their status (legal or not) within the host country, recognition of education, and professional degrees from their home country and fluency in the host country's language.

Refugees may at first experience downward employment mobility within a host country. A refugee who is not successful in acquiring work in their field and proving adequately their ability to work within the host country may end up underemployed. Underemployment is employment which is of inferior quality than could be expected given a person's education, skills, and/or experience [34]. This can include temporary, casual, contract, and part-time employment even within the person's field of expertise [34]. Refugee populations, in particular recent arrivals, are less likely to be employed or are underemployed in many host countries. In Canada, for example, some research suggests that refugees are less likely to be in steady employment at a level appropriate to their educational attainment [35]. Overemployment occurs when workers in full-time jobs experience increased pressure, increased workload, longer shifts and hours, as well as demands for high organizational performance with and without increases in compensation for these expectations and demands [36].

8.2.2.1 The "Right to Work"

Being granted the right to work and having the capacity to find employment are important in restoring psychological well-being. While the ability to work is a given right under international law [37], denial to work for refugees, especially asylum seekers, still occurs for certain designations of refugees in some countries. The International Covenant on Economic, Social, and Cultural Rights (ICESCR) recognizes a set of rights that includes the right of everyone to

make a living by work that is freely chosen or accepted with fair wages and equal remuneration for work of equal value and under safe and healthy work conditions [37]. Despite recognition of this law, refugees and asylum seekers sometimes fall into a gray area as their employment rights within a host country are dependent on the policies and legislations that confer certain classifications to different classification of refugees within each country. If they are allowed to work, the policies may also specify how many hours (or weeks) and sometimes where (in the country and/or only in certain industries) they may work. They may be required to prove their ability to speak the host country language, have a set number of hours of experience within the country, and/ or may have difficulty proving their qualifications because of loss of documentation. As examples, we outline the rights to work for refugees and asylum seekers in Canada, Germany, and the United Kingdom.

Canada

Refugees with permanent resident status are allowed to work anywhere in Canada. However, asylum seekers (refugee claimants) may not work in Canada unless authorized to do so [4]. Asylum seekers have to apply for a work permit from Immigration, Refugees and Citizenship Canada (IRCC) and prove they need to work to support themselves. Resettled refugees are provided assistance for up to 12 months from the federal government, or through private sponsors. This support is to help them get established and settled until they can find employment. Refugee claimants have access to social assistance. In their first 4 years in Canada, it has been found that as a group the rate of employment among refugees goes up and the rate of unemployment drops [38]. However, the unemployment rate for those refugees was 29% [38] which was much higher than the unemployment rate in Canada of 6.6% at the same time [39].

Similarly, the percentage of refugee claimants receiving social assistance declines significantly with time in Canada [40].

Germany

In Germany, refugees fall under one of three possible immigration statuses, and these confer different rights and access to the labor market [41]. The permissions and rights to work are laid out in three acts: the Asylum Act, the Residence Act, and the Employment Ordinance [41]. Persons with a residence permit may work with- out restrictions. Applicants who are still in the asylum proceedings (permission to reside) and those with temporary suspension of deportation must obtain work per- mission from their immigration authority and the local employment agency. They can be given permission to work 3 months after the formal asylum application has been filed. However, individuals obliged to live in reception facilities are not allowed to work while living in the facility, which could last for up to 6 months. Asylum seekers from designated safe countries within Member States of the European Union who file for asylum are required to live within the reception facility for the entire asylum process and therefore are not eligible to work [41].

United Kingdom

In the United Kingdom (UK), similar to Canada and Germany, individuals granted convention refugee status are permitted to work, [42]. In contrast asylum seekers generally are not allowed to work. They can apply for permission if they have waited over 12 months for an initial decision on their asylum claim or they have been refused asylum but not received a response to further submissions submitted over 12 months ago and they are not considered responsible for the delays

[43]. If granted permission to work, asylum seekers are only eligible to take jobs from the official shortage occupation lists of the United Kingdom and Scotland [43]. However, they may not be self-employed or start their own business [43, 44].

8.2.2.2 Mental Health and the Relationship to Various States of "Employment"

Employment status has been clearly linked to mental health. Being unemployed is associated with higher levels of anxiety and depression in general populations [45– 47], and high unemployment rates have been associated with suicide patterns [45]. Both underemployment and overemployment have also been linked to levels of stress and depression [36, 48]. In general, individuals who are adequately employed report significantly lower rates of depression than either the unemployed or the underemployed [46]. The relationship between employment and depression is com- plex as people who are depressed are less likely to be employed. However, longitudinal research has shown that the direction of causation from unemployment to illness is greater than illness causing unemployment [45, 46]. Transitioning from employed to either underemployed or unemployment, when controlling for depression at baseline, has been linked to increased depression as compared to staying employed [46].

The effect of employment status on mental health may be greater for some sub- groups of refugees than others. Women and lower-educated individuals are more likely to be unemployed or underemployed [46, 49], and the adverse effects of being unemployed have been noted to be greater in the highly educated refugees [46].

Similar trends around employment and mental health problems from general population studies have been found within refugee groups [50–59]. Having employment (any employment) is better

than being unemployed for the mental health of refugees [52, 55]. A study comparing Somali refugees living in London (UK) and Minneapolis (USA) found much higher rates of depression among refugees in London where participants were more likely to be unemployed; employment status had the highest impact on reducing the odds of major depression [58]. Longitudinal studies conducted with Southeast Asian refugees in Canada found that refugees who were stably employed and people who found jobs between baseline and second follow-up had the best mental health outcomes [50]. On the other hand, refugees who were chronically unemployed or newly unemployed had the worst mental health [50]. Unlike general population studies, this work suggests that depression levels at baseline increased the probability of unemployment at second follow-up [50, 52]. Temporary, part-time, and low-paid work is linked to poorer mental health in refugee populations [9, 57].

8.2.3 Dispersal

Over time numerous countries have implemented policies of dispersion with regard to refugee and/or asylum populations [60–62]. The premise for implementing these policies is usually stated as one of or a combination of the following: spreading the costs across a number of local authorities, achieving better integration, avoiding pressure on housing and social services, deterrence and control, and reducing spatial concentrations of minority ethnic populations [60, 61, 63, 64]. These policies sometimes target asylum seekers and in some cases resettled refugees, and they provide different supports depending on the conceptual framework of the country. Some countries view the welfare responsibility largely as a familial one where ser- vices are provided by volunteer organizations, and other countries provide a welfare safety net to ensure access to services for all refugees [63].

8.2.3.1 Dispersal in Canada and the United Kingdom

Canada

Canada takes a safety net approach, but it does not have designated legislation around dispersal of asylum seekers or refugees. Instead Immigration, Refugees and Citizenship Canada (IRCC) has in place a practice for dispersing government- assisted refugees (GARs), but not refugee claimants or privately sponsored refugees (PSRs) [65]. Refugee claimants in Canada must find their own accommodations until there is a determination on their claim for refugee protection. The sponsoring organization or family is responsible for helping PSRs find accommodations. The main reason for dispersion of GARs in Canada is to share resources. Canada sends refugees to a location within the country where community resources and services will best support their resettlement and integration needs [65]. Officials attempt whenever possible to resettle refugees in communities where relatives or close friends live, if disclosed by potential resettled refugees [65].

Government-assisted refugees (GARS) are met at the airport upon arrival by some- one from one of the federally funded service provider organizations (SPOs). These agents of the SPO have already obtained temporary accommodation for the refugees; they also provide basic orientation to Canada and assist them in finding other settlement services and permanent accommodations [66–69]. Success of this program has been mixed [68]. The support offered by SPO agents is often critical to the integration of refugees in Canada; however, the allotted destinations do not always take into account the requests of refugees. Research suggests that the destination preference of refugees has previously been ignored [66]. The government of Canada attempts to refer GARs to communities that they've requested or as close to their request; how- ever, the

process is complicated in that regions and CIC offices are involved in the normal process and SPOs are located primarily in larger metropolitan cities [65].

The United Kingdom

The United Kingdom introduced legislation in 1999 that created a centralized system of housing and welfare support for asylum seekers [42]. The system was created for the purpose of dispersing asylum seekers to reduce the demand and pressure on housing and resources in London and spreading it throughout the nation [42, 63]. The dispersal system is on a no-choice basis; asylum seekers are not entitled to permanent housing but instead are sent to state-provided housing wherever the government deems and they can be moved multiple times (between about ten major centers) [11, 42, 61–63, 70]. Asylum seekers can refuse dispersal and then they would have to give up the financial support offered by the government, so dispersal may not be compulsory, but it is mandatory for those who cannot support themselves nor have a support system already in place [61]. Individuals granted refugee status who are not dispersed instead can apply for social housing and claim benefits [42].

It has been suggested that this dispersal policy was put in place to accomplish two tasks: (1) deter and control the flow of refugees and (2) disperse the financial burden of asylum seekers across multiple cities and agencies [42, 61, 63]. The dispersal system in the United Kingdom has not been viewed as a successful endeavor for integration of asylum seekers or refugees [42, 61–63, 70]. The condition of the housing situation is often poor, overcrowded, and considered substandard [42, 62]. Once asylum seekers have been given refugee status, they must leave the state- sponsored housing within 28 days, and those who are not priority refugees must find their own housing, with one exception being those dispersed to Scotland [62, 70]. Asylum seekers

granted refugee status in Scotland can move freely to another part of Scotland or the rest of the United Kingdom and still qualify for local authority housing [70].

The Effects of Dispersing on Well-Being

Dispersal practices and policies often result in refugees and asylum seekers experiencing reduced social support, increasing feelings of hopelessness, and increasing isolation. Migrant networks play a critical role in providing support, and advice [60]. Dispersal away from support networks can lead to feelings of powerlessness, fear, and isolation [71]. The instability of housing available through the dispersal program in the United Kingdom for asylum seekers and after receiving refugee status in the United Kingdom has been shown to force them to move frequently, leading them to feel isolated, and they often face harassment and discrimination all of which reduce their likelihood of integration and decrease psychological well- being [42, 62]. Some research also suggests that refugees who were dispersed as asylum seekers in the United Kingdom have higher levels of secondary migration than other refugees [72].

Refugees who are sent to smaller communities in Canada have reported a marked sense of isolation and often have difficulty finding employment for which they are qualified [66, 73]. There seems to be large secondary migration as a means to be closer to family and friends and find employment [66, 67]. Family and friends provide forms of support that the government sources available in Canada cannot adequately provide, such as transportation, childcare, and help in times of illness [66]. While refugees often tend not to stay in small communities, one Canadian study reported that some refugees may decide to stay. Key reasons are the welcoming nature of the community, partnering refugees with a local family as social hosts, and the low

ethnic diversity mean that newcomers are not likely to socialize exclusively with others from their country thereby widening their social ties to the larger community [74].

The UK dispersal policy may contribute directly to increased emotional problems in asylum seekers [72]. However, the link between dispersal practices and diagnosed mental health problems has not been fully explored. The dispersal literature does establish a link between how dispersal reduces social support and increases isolation. Mental health research has clearly shown that there is a detrimental relationship between low social support and mental health problems in refugee populations [9, 75, 76]. Less social support has been associated with more symptoms of Posttraumatic Stress Disorder (PTSD), anxiety [75], and depression [9, 75, 76].

8.2.4 Denied Access to Health Care

Denial of health care for refugees and asylum seekers may depend on changes in government, but legal rights to health care do not always guarantee actual rights and understanding the situation is complex. In some countries, governments provide access to the health-care system for refugees and asylum seekers at multiple levels. In countries such as Canada, the United Kingdom, and Australia where health care is funded by the government, convention refugees often have similar access to citizens; however, not all refugees and asylum seekers are afforded the same rights. Sometimes countries provide limited access for some groups (e.g., vulnerable populations) or to emergency health care, but this multi-tiered system can create uncertainty as both health-care providers and refugees are not sure if they are eligible or for what services they are eligible.

Canada has recently seen its policy around health-care access for refugees change for the better [77]. However, in 2012 changes to the Canadian Interim Federal Health Program essentially removed access to medication coverage, dental care, and vision care for all refugees (except GARs) and refugee claimants from countries that the government deemed safe (i.e., should not be producing refugees) such that they no longer received any health coverage [78, 79]. These changes created a high level of confusion among health-care providers around the coverage available to refugees and refugee claimants [79, 80]. This confusion likely led to refusals and the foregoing of necessary health-care treatment for refugees and claimants [78, 80]. The changes also caused some refugees and claimants to incur significant bills from accessing health care which they were unlikely able to pay [78]. These changes to the Interim Federal Health Program were reversed in 2016 so that refugee claim- ants in Canada can now access basic health-care services and have access to a set of supplemental services during their period of ineligibility for provincial or territorial health-care coverage [77]. These changes make it easier, theoretically, to access health care in coverage. However, because of differences in access and understand- ing that existed before the 2012 changes, they are still likely to continue as refugees and asylum seekers in Canada still face many challenges in accessing health care [81, 82]. Germany restricts access to health care for asylum seekers and refugees [83, 84]. The regulation of the eligibility for and the level of coverage is regulated by the Asylum Seekers' Benefits Act [AsylibLG] [84]. Which services are covered, the process for accessing those services, and the restrictions on refugees and asylum seekers are laid out in the AsylibLG [84]; the health care they receive in Germany has been declared as third class [83]. This exclusion from health care was found to result in higher incident health expenditures than from granting regular access to the needed services in Germany and could not be explained completely by differences in need [84].

Bozorgmehr and Razum [84] found that per capita health expenditures were 40% higher among refugees and asylum seekers with restricted access com- pared to the expenditures in the group of refugees and asylum seekers with regular access in Germany.

Denying access to health care can reduce health-care supports and increase stress and is likely to increase long-term health impacts while leading to the use of costlier health services for refugees. Limiting access to publicly funded health care increases the costs incurred by refugees, the health-care system, and other social institutions [80, 84, 85]. Policies that limit access to health care also places health-care providers in situations where they have to make a moral decision about providing necessary health care to individuals who cannot afford it [80].

8.2.5 Destitution

Refugees and refugee claimants are vulnerable to destitution as they have been forced to flee their country and arrive in host countries with nothing; therefore they are dependent on the host country for their essential living needs [86–88]. It has been suggested that the threat of destitution has been used as a deterrent against asylum seeking and that countries that provide generous provisions are rendered too attractive to seekers [86, 88]. Many forced migrants are in poverty in a monetary sense and therefore often face disadvantages subjectively in terms of housing qual- ity and residential facilities and are socially excluded [87].

Destitution affects many things in the lives of refugees, for example, educational opportunities, language acquisition, and housing which can affect the well-being of refugees and their ability to integrate with the host society. Individuals who are financially unstable have to make decisions, such as—do I first acquire English or find a job to pay for rent? Poverty often affects where we

can live and the state of our environment. This includes the physical structure and environment of our home as well as the social environment such as access to a similar community, family, and friends. Refugees are vulnerable and face exploitation because of destitution [87, 88]. Exploitation and poverty reduce opportunities and reduce availability and accessibility of resources leading to experiences of low mood and sadness, frustration, and discontent [88, 89]. More chronic deprivation can lead to a sense of learned helplessness and antisocial behavior [89]. Poverty is considered a risk factor for mental illness [87, 89, 90]. Poverty is an intricate concept because of its interrelatedness with many other factors [89, 90]. One important factor that is often a result of destitution is poor housing. In Canada, sponsored refugees have reported far lower income levels 4 years after arriving than other immigrants [91]. They are less likely to own a home and more likely to still be living in crowded conditions com- pared to immigrants [91]. This need to share housing leads to a loss of privacy and additional stressors; poor housing conditions can intensify previous traumas and leave refugees open to abuse from other residents [71, 91].

8.2.5.1 The Effects of Poor Housing and the Built Environment on Mental Health

A review of the literature points to a number of associations between housing, the environment, psychosocial factors, and mental well-being [92]. For example, living in high-rise, multiple-unit dwellings has been linked to increased psychological dis- tress in mothers with young children due to increased isolation, reduced chance for children to play, and reduced social networks [92]. Homes in need of repair or with unresponsive landlords are associated with worse mental health [92]. Evans [92] identified three processes (personal control, social support, and restoration) through which the built environment might indirectly affect mental health. When people can

control their environment, they feel better; however, when they are thwarted in this, helplessness can occur. The physical environment is directly linked to recovery from cognitive fatigue and stress. Being exposed to nature has positive outcomes and has been shown to replenish cognitive energy [92].

Factors such as poor-quality housing, lack of control, and lack of social support can help contribute to unstable housing, and hence frequent movement, something which has been noted in refugees and asylum seekers in Canada and the United Kingdom [42, 66, 67, 70, 93]. The constant movement can destabilize social net- works and disrupt the continuity of care [12, 42, 93]. The links between housing, the built environment, and mental health problems for refugees specifically have not been studied extensively. Warfa and colleagues [93] report that residential instability among Somali refugees living in London, England, is seen as stressful and that it compromised the refugees' mental health. Their preoccupation and worry about instability and their limited control were believed to contribute to psychological distress in the Somali refugees [93].

8.2.6 Delayed Decisions

The government of Canada, at the time of writing of this chapter, estimates that the length of time to a final decision on a refugee claimant application already in Canada is 10 months [94]. The current processing times for Offshore Humanitarian Refugees to be accepted as a refugee in Australia (convention refugees and special humanitarian program refugees that are not in Australia) will take 12 months from when the application is submitted until a decision is made [95]. For asylum seekers who are already in Australia to receive Onshore Protection Visas, the Australian government estimates that the time frame to a decision is the same 12 months [95].

These timelines provided by the Australian and Canadian governments are only estimates of the time to process applications. It is important to note that the manner to determine eligibility for refugee status is complex and difficult and will differ from country to country. This stems from the need for decision-makers to have sufficient knowledge of the cultural, social, and political environment of the country of origin, capacity to bear the psychological weight of hearings and the consequent decisions, and an ability to deal with legal issues, both international and local [96].

The government of Germany has previously published statistics on the asylum procedure through the Federal Office for Migration and Refugees [97]. They report that in 2013 nearly 60% of applications for asylum were processed with a decision delivered within 6 months. For those applications in 2012 that were decided beyond appeal, the total duration of the procedure occurred on average within 12.1 months, with nearly half being determined within 6 months and three-quarters were deter- mined within 2 years at that time [97].

The Canadian government also provides estimate times for the process of applications for convention refugees. For individuals applying as a GAR to Canada, the processing time for their application differs depending on where they are applying from. For the majority of countries, the time to application completion is 15 months; however, there is not enough data to determine times for many countries [94]. The shortest processing times for GARS are for those currently in Jordan (1 month) and Lebanon (7 months), while the longest are for applications from individual currently in Ethiopia (46 months) and Kenya (32 months) [94]. For PSRs, the time for processing is about 50 months for applicants from many countries; the pattern for shorter and longer times is similar as it is for GARs with applicants from Jordan taking about 10 months, Lebanon about 8

months, while Ethiopia and Kenya about 73 months and 68 months, respectively [94]. These differences likely result from a prioritization of caseloads that has taken place because of recent conflicts in Syria.

8.2.6.1 Delayed Decision and Well-Being

A review of international studies of the asylum procedure concluded that the process itself is inherently damaging to mental health [98]. Not knowing whether they will be given refugee status, or how long they will wait, can take a toll on individuals. Claimants may fear the decision—that they may be turned down and hence deported back to their country of origin—and this leads to poorer mental health. Uncertainty and temporary protection in Australia has contributed to the risk of ongoing depression, PTSD, and disability related to mental health problems in refugees [28]. Legal status is an important factor in mental health; asylum seekers are more likely to report PTSD and depression/anxiety than recognized refugees in the Netherlands [75]. In both community and clinical samples of asylum seekers, the literature points to high rates of depression, anxiety, and PTSD [98]. The literature also suggests that mental health may deteriorate over time as asylum seekers wait for the outcome of their application [98]. One study of Iraqi asylum seekers in the Netherlands reported that those asylum seekers who had been in the country longer without a decision (more than 2 years) report more worries over the asylum procedure than asylum seekers who have been in the country for less than 6 months [54] for a decision longer (over 2 years) compared to those with a shorter delay in their decision, less than 6 months [54].

8.2.7 Discrimination

Discrimination refers to inequitable or unjust treatment of individuals or groups based on their socially stratified classification, such as race/ethnicity, class, gender, sexuality, ability, age, and/or health status which results in social inequalities. The concept of discrimination focuses on behavior. The definition of discrimination includes “treatment” or “action” that is different for groups of people based on their socially constructed status, which may cause harm or disadvantage. Discrimination is defined on a number of dimensions including direct versus indirect and acute versus chronic [99–105]. A prominent dimension is the level at which discrimination occurs: individual or structural.

Structural discrimination is highly complex. Current conceptualization is not consistent and due to the magnitude of domains, types of discrimination, and the confusing binaries is far from simple to define or measure. If individual discrimination is considered to be an action, then structural discrimination would be in the operation of the system [99]. This does not mean that a government or institution is aiming to discriminate; though the structure may facilitate discrimination, it is the execution of policies and practices that may produce discrimination [99, 100]. It has been suggested that structural discrimination [100, 101] is (1) the practices of institutions rather than the actions of individuals; (2) the results (rather than intent) of indirect practices or direct actions; (3) the outcome of the connected system of practices, policies, and institutions; (4) innately made up of the interconnectedness of institutions and systems; (5) intersecting types and domains of oppression; (6) in part historically and socially constructed; (7) a fluid process that changes over time and space; and (8) justified and maintained, in part, by beliefs that are shared collectively.

8.2.8 Government Policy and Discrimination

Governments often do not specifically set an agenda of discrimination; however, policies have often been identified, by various parties (the media, professionals, advocates of equality and equity, and political opposition), as being discriminatory or discriminate against specific groups (for examples, see [106, 107]). These policies are usually enacted under the auspices of protection, protection of the country's citizenry and its culture. This seems to be in line with public perception in some countries that immigration and asylum policies are not enough and that refugees are taking all of the jobs and reducing the quality of life of the country's citizens [51, 108–110]. There is a culture of "us versus them" (see also the chapter by Vamik Volkan in this book), a fear of the "other," and links to terrorism within the discrimination literature [109–111]. Discrimination is a complex, multilevel phenomenon that is usually only addressed at the individual (perceived discrimination) level in the academic literature.

8.2.9 Discrimination and Mental Health

Government policies on protectionism and deterrence can produce outcomes that result in indirect practices and direct actions that are discriminatory to refugees and asylum seekers [108]. Media depictions also help to shape public perception [61, 109]. These result in oppression, segregation, and hostility (hate crimes) toward newcomers [109, 112]. It has been noted that hate crimes against asylum seekers are justified by the same arguments as other forms of discrimination and are the result of misinformation, frustration, and fear but may be more socially accepted [109]. While structural and institutional discrimination are difficult to measure and assess, individual racism, individual discrimination, and perceived discrimination have been shown to result in a significant psychological toll [54, 113–116].

Many refugees report having experienced everyday discrimination from host country residents and institutions around the world. Common forms of this are employment practices (e.g., not hiring them or firing them because of their race or status), feelings of exploitation, attitudes of a country's residents (e.g., that they are better than you or stereotyping and negative attitudes), and lack of recognition of identity and ability and in health-care settings [51, 93, 114–116]. These everyday discriminations have been associated with symptoms of PTSD and common mental disorders in refugee groups [114–116]. In their study of older Somali refugees liv- ing in Finland [116], depressive symptoms were most common among refugees exposed to everyday discrimination. Mölsä and colleagues [116] concluded that experiences of discrimination and racism formed a substantial risk for mental health problems among Somali refugees living in Finland. These everyday occurrences of discrimination have a psychosocial impact on the well-being of refugees especially adolescents. Continued exposure to discrimination may result in low feelings of self-worth and development of severe mental health problems in adolescent refugees [112, 114]. Adolescent boys and girls may be differentially affected; in a study of Somali refugees in America adolescent boys who adopted more of an American identity were less likely to experience depressive symptoms, and the association between discrimination and depression was weaker [114]. However, for adolescent girls maintaining a strong association with their Somali culture resulted in a similar effect, while they still experienced high levels of discrimination, the effects on depression were less but those who tried to adopt a greater American identity tended to experience discrimination from within their own culture [114].

Individuals who have previously experienced discrimination can provoke emotional responses which may result in heightened stress reaction, mistrust, chronic worry, and rumination [116, 117]. In the long term, this may result in cognitive changes with increased vigilance, anticipation

of discrimination, and adaptations in personal development to avoid opportunities, situations, and places where they may be vulnerable [116, 117]. Discrimination impacts mental health in a number of ways: through socially inflicted trauma (indirect or witnessed), economic and social inequality, decreased mobility (lack of education, or employment opportunities), and inadequate, inappropriate, or degrading medical care [117]. Not all refugees experience discrimination, and not all of those that do will develop mental health problems but discrimination greatly impacts the social and emotional well-being of individuals.

8.3 Potential Avenues for Change: Educating Professionals to Support Refugees

When a country chooses to open its home to accept refugees fleeing from war and conflict, they have often to consider a balance between the humanity of the act and the security and prosperity of their current citizens. They do not strive to worsen or cause mental illness, but sometimes their policies and practices can detrimentally affect the refugees' lives and hence produce mental health problems for them. It is important to recognize that there is a lot that host country governments can do to support refugees, but the responsibility for integration, support, and reduction of mental health problems does not lie solely with governments. Industries, agencies, and individuals within a host country have an obligation to provide a welcoming environment and to provide opportunities and support to refugees. In recognition of this and to bestow the necessary knowledge and expertise to health and settlement professionals, the Refugee Mental Health Project (RMHP) was developed in Ontario, Canada. The RMHP was developed at the Center for Addiction and Mental Health (CAMH) to build settlement, social and health service providers' knowledge, and skills for supporting and promoting refugee mental health and to promote inter-sectoral and inter-professional collaboration.

This project was developed as a follow-up to a national Refugee Mental Health Practices study that identified needs and promising practices in refugee mental health in Canada. This study included an environmental scan, literature review, and in-depth interviews and focus groups with 150 participants in nine provinces across Canada, including refugee clients, settlement workers, program managers, policy- makers, and clinicians [118]. One of the key findings of the study was that building knowledge, skills, and partnerships among service providers is essential to better support complex and changing refugee mental health needs during resettlement. A comprehensive network of service provision would help refugees' access appropriate services when they need them. Health care, social service, and settlement professionals, by being knowledgeable and skilled in this area, can help build the foundation for an effective and sustainable network of service providers promoting refugee mental health during refugees' resettlement in Canada [118].

The findings of the national study were used to develop a guide on promising practices and partnership-building resources for refugee mental health [118] and to inform the refugee mental health capacity-building project. This project includes a self-directed online course on refugee mental health for settlement workers and a version of the same course targeted to health-care providers, a community of practice and a toolkit of resources (www.porticonetwork.ca/web/rmhp). The course covers a wide range of topics including information on refugees in Canada, mental health problems around refugees' experience, information on vulnerable populations, and how to work with interpreters in settlement and health-care settings. This project has met with a high level of success, providing training to over 3500 service providers from 2012 to 2016, and has now expanded nationally. Demand from the settlement sector across Canada consistently exceeds the projects' capacity to offer training.

Project evaluations show improvements in learning, and participants regularly express their gratitude for the opportunity to acquire skills and a stronger appreciation of refugee mental health issues.

8.4 Summary

The seven Ds is a useful framework to review the psychosocial impacts of post- migration stressors on the mental health of refugees. These seven factors can lead to social isolation of refugees, leading to feelings of low self-worth and being unwanted by the host society, increasing hopelessness, and potentially re-traumatizing individuals. In contrast, when social support and positive opportunities are made avail- able in resettlement countries, outcomes can include thriving in the new setting, growth, and resilience.

We recognize that the various classifications of refugees (e.g., convention refugee, asylum seeker) make it difficult to specify differences among the research internationally, also noting that refugees are dealt with differently in different political systems in countries around the world. Refugees who are deemed to be deserving of protection and rights should be treated as such, and exposing them to conditions that cause or worsen social isolation, hopelessness, trauma, and stress increases the chances of mental health problems including suicidal ideation. The evidence presented above points overwhelmingly to the need to improve the post- migration experience for newcomers, as this can mitigate mental health outcomes and offer opportunities for a new life.

Translated Text II

اللاجئين في البلدان المضيفة: الجوانب النفسية والاجتماعية والصحة النفسية

برانكا أجيك، ليزا أندرمان، كاميه ماكنزي، وأندرو تاك

لمحة عامة

في السنوات القليلة الأخيرة، ارتفع عدد اللاجئين حول العالم بشكل ملحوظ ووصل الى اعلى مستويات تمّ تسجيلها في التاريخ. وتتأثّر صحّة اللاجئين النفسية، حسبما تذكر الابحاث، بما يختبرونه قبل الهجرة، خلالها، وبعدها. ومن الحقائق المثبتة هي ان الظروف التي يمرّون بها تؤثر على صحتهم الجسدية والنفسية. وفي حين انه لا يمكن تغيير العوامل المؤثِّرة بمرحلتيّ الهجرة وما قبل الهجرة، إلاّ ان البلدان المضيفة يمكنها ان تُحدث أكبر تأثير في تحديد المسار الذي يسلكه اللاجئين من حيث صحّتهم النفسية من خلال معالجة العوامل النفسية والاجتماعية المؤثِّرة بمرحلة ما بعد الهجرة. وسيناقش هذا الفصل كيف تؤثر بعض العوامل الاجتماعية والسياسات على الرفاه النفسي والصحّة النفسية لدى اللاجئين وطالبي اللجوء السياسي في كندا وغيره من الدول المتقدِّمة.

وسنركّز على سبعة عوامل مهمّة لها تأثير أساسي على هذا الصعيد وهي: الاحتجاز، والحرمان من العمل، والتَّشتيت، والحرمان من الرعاية الصحية، والفقر الحاد، والتأخير في البت بالطلبات، والتمييز. وغالبًا ما تكون هذه المسائل مترابطة، إلاّ ان كل واحدة من بينها تؤدّي دورًا منفصلاً في عملية اندماج اللاجئين وتؤثّر في المدى القريب والبعيد على صحّتهم النفسية وسلامتهم. وفيما يواجه اللاجئون إمكانياتٍ ضيّقة في تأمين فرصة عمل او الحصول على الرعاية الصحية أو يُجبرون على العيش في مناطق معيَّنة او في حالة فقر، ليس من المؤكّد حتّى ان طلبات اللجوء الخاصة بهم سيتمّ القبول بها. هذا كلّه يؤثّر بطريقة سلبية على صحتهم النفسية ويقلّل من فرصهم في الاندماج وتنمية روابط اجتماعية قويّة.

8.1 المقدمة

تشرّد عدد كبير من الأشخاص من بيوتهم وأُجبِروا على اللجوء الى بلدان أخرى بسبب العنف والاضطراب السياسيين، والنزاعات الداخلية، والحروب. وفي السنوات القليلة الأخيرة، ارتفع عدد الأشخاص المشرَّدين بشكل ملحوظ وبلغ عام 2015 أعلى مستويات

من المجموع الذي تمّ تسجيله في التاريخ. ويفيد أحد التقارير الصادرة عن مفوضية الأمم المتحدة لشؤون اللاجئين (UNHCR) ان عدد المشرَّدين حول العالم يبلغ حاليًا 65 مليون شخص، تشرَّدوا بغالبيّتهم ضمن بلادهم. لكن حاليًا، يعيش 24 مليون شخص تقريبًا كلاجئين او كطالبي لجوء سياسي في بلدان أخرى. واستمرّ عدد اللاجئين في الارتفاع بشكلٍ مُطَّرِد على مدى السنوات، لكنّه بدأ يتراجع في العام 2015. غير ان عدد اللاجئين القادرين على العودة الى بلدهم الأم كان يستمرّ في الانخفاض، الأمر الذي فرض عبئًا إضافيًّا على البلدان المضيفة. وهذه البلدان عليها بدورها ان تنظر في التأثير القريب والبعيد الأمد لسياساتها، واستراتيجياتها، وشروطها المتعلقة بدخول البلد والعيش والعمل فيه، فضلاً عن تأثير الحياة الاجتماعية على الصحة النفسية للاجئين الذين يعيشون فيها.

تشكّل كلمة "لاجئ" مصطلح يتمّ استعماله بطريقة شائعة لوصف الأشخاص الذين هربوا من بيوتهم بسبب نزاع مسلَّح او اضطهاد. لكن في القانون الدولي، هي مصطلح محدَّد للغاية يتمّ استخدامه للإشارة الى الأشخاص الذين يعيشون خارج بلدهم الأم بسبب خوف مبرَّر من الاضطهاد على أساس العرق او الدين او الجنسية او الانتماء الى فريق اجتماعي معيَّن او رأي سياسي. ويحظى اللاجئون في هذه الحالة بحماية القانون الدولي. امّا طالبو اللجوء السياسي، فهم اشخاص يسعون الى الحصول على اللجوء في البلد المضيف ولا يزال مصير طلبهم غير معروف. وهذان المصطلحان يُستعَملان أحيانًا كمترادفَين، لكن في السياق الكندي غالبًا ما يتمّ استعمال مصطلح طالب اللجوء. أمّا اللاجئون الذين أُعيد توطينهم، فهم اشخاص قد مُنحوا إقامة دائمة في بلدٍ آخر لكن غالبًا ما يُسمّوا لاجئين، والمصطلحات المختلفة غالبًا ما تُستعمَل كمترادفات.

يعسى اللاجئون بمعظمهم الى الحصول على الحماية في البلدان التي تقع على حدود بلدهم الأم. وهذا أمرٌ منطقي لأن هذه البلدان يسهل الوصول اليها بسبب قربها من البلد الأم. ومع انه ليست هذه هي الحال دائما، إلاّ انه، وفي أحيانٍ كثيرة، تكون هذه البلدان المجاورة مشابهة كثيرًا للبلد الأم. فمن المحتمل ان تكون حضاراتها وأديانها وسياساتها وتاريخها متشابهة. ومع ان الأغلبية الساحقة من اللاجئين يقرّرون العيش في البلدان المجاورة، إلاّ أنّ بعضهم يجازفون بالقيام برحلاتٍ أطول لأسباب متعدّدة ويتّجهون نحو الدول المتقدمة او يقدِّمون طلب إعادة توطينهم للبلدان المضيفة كي يتم القبول بهم كلاجئين. وقامت بعض الدول كتركيا وباكستان ولبنان باستضافة ملايين اللاجئين في السنوات القليلة الماضية. لكن غيره من الدول البعيدة جدًّا عن المنطقة التي يهرب منها حاليًّا معظم الأشخاص، مثل المكسيك، تقوم بدورها بتلقّي طالبي اللجوء السياسي وتقبل اللاجئين بشكل سنوي لكن بأعداد اقل. ونتيجةً للاضطراب الذي حدث مؤخرا في أميركا الوسطى، ازداد عدد الأشخاص الذين يطلبون اللجوء السياسي

في المكسيك والولايات المتحدة والآتين من غواتيمالا والسلفادور وهندوراس بخمسة اضعاف في الفترة بين العامين 2012 و2015. لكن بالمقارنة مع دول أفريقيا وآسيا وحتى أوروبا، يتمّ تسجيل عدد أقلّ من اللاجئين وطالبي اللجوء السياسي المتّجهين نحو اميركا الشمالية. ويعود السبب في ذلك الى ان مستوى التعقيد والخطر اللذين يرافقان محاولة الوصول الى بلاد اميركا الشمالية هو أكبر من تلك التي ترافق محاولة الوصول الى بلاد آسيا او أفريقيا.

وفي العام 2014، تمّ تسجيل حوالي 900,000 طلب لجوء جديد الى "الدول الصناعية الـ 44"، أفادت 30 دولة من بينها بارتفاع لديها في عدد طلبات اللجوء خلال السنة. وتلقَّت ألمانيا أكبر عدد من طالبي اللجوء في العام 2014، اذ شهدت زيادة بنسبة 58% عن السنة التي قبلها، وبالتالي سجلّت سابع زيادة سنوية على التوالي. وجاءت الولايات المتحدة الأميركية وتركيا والسويد في المراتب الثانية الى الرابعة من حيث أكبر عدد من طالبي اللجوء. وقد شهدت هذه الدول الأربعة زيادات هائلة على هذا الصعيد في السنوات الأخيرة. وقد أتى معظم طالبي اللجوء في العام 2014 الوافدين الى هذه الدول الصناعية الـ 44 من الجمهورية العربية السورية. وتمّ تسجيل عدد كبير من طالبي اللجوء الوافدين من بلدان أخرى وهي العراق وأفغانستان وصربيا وكوسوفو. وفي حين شهدت الدول الصناعية زيادات في طلبات اللجوء وتوافد أكبر للاجئين وطالبي اللجوء السياسي، إلاّ ان الدول التي استضافت معظم اللاجئين تقع في المناطق النامية. فالدول التي احتلّت المراتب الخمس الأولى من حيث عدد اللاجئين في العام 2015 هي تركيا وباكستان ولبنان والجمهورية الإسلامية الإيرانية واثيوبيا.

ومع ان القانون يحدد من هي مجموعات اللاجئين التي تطبَّق عليها القوانين والقواعد الدولية والوطنية، إلاّ ان هذا لا يصح بالضرورة في المجالات الأخرى. ففي المجال العام، غالبًا ما يتم إدراج المجموعات على اختلافها تحت خانة اللاجئين، والفروقات ليست دائما واضحة حتى في المؤلفات الأكاديمية. في حين ان بعض الأبحاث تحدد بوضوح من هي المجموعة التي تشكّل محور الدراسة، إلاّ انه في بعض الأبحاث الأخرى يتمّ استخدام مصطلحات عامة مثل مهاجر او لاجئ لتحديد التصنيفات المختلفة المرتبطة باللاجئين. وفي بعض الحالات، يتم إدراج المهاجرين أيضًا ضمن خانة اللاجئين. وإذ نأخذ هذه الصعوبات المنهجية بعين الاعتبار، نحاول قدر الإمكان التزام الدقّة عند تقديم الأدلّة حول تأثير التجارب التي عاشها اللاجئون على صحتهم النفسية.

تتأثر صحة اللاجئين النفسية بما يختبرونه قبل الهجرة، خلالها، وبعدها. و تؤثّر الظروف الصعبة التي يمرّ بها اللاجئون على صحتهم الجسدية والنفسية. ومع ان اللاجئين، بشكل عام، هم أكثر عرضة للمشاكل النفسية مقارنة مع المهاجرين او سكان

البلد المضيف، فإن معظم المشاكل ستظهر ضمن مجموعات اللاجئين بمستويات مماثلة مقارنة بالمشاكل التي ستظهر ضمن مجموعات سكان البلد المضيف. وجدير بالذكر ان عددًا قليلاً فقط من اللاجئين الذين يعانون من مشاكل صحية نفسية يحتاجون الى علاج متخصص (بمساعدة طبيب نفسي على سبيل المثال)، والقليل من بينهم فقط تنمو لديهم مشاكل مزمنة. ويتفاوت المعدل التقريبي للأمراض النفسية عند اللاجئين بشكل كبير وهو اعلى على الأرجح بين اللاجئين المتأثّرين بالحروب. وهذه الاختلافات مرتبطة جزئيا بالاستجابات الاجتماعية المتغيّرة.

يؤثّر ما يختبره اللاجئون بعد الهجرة تأثيرًا كبيرًا على صحتهم النفسية. وتحدّ المشاكل النفسية من قدرة الفرد الاقتصادية والاجتماعية وقد تفرض أعباءً كبيرة على المؤسسات الاجتماعية في البلدان المضيفة. صحيحٌ ان الضغوطات كالبطالة والفقر ونقص الحصول على الخدمات يؤثّر سلبيًّا على الجميع، إلاّ ان الهجرة وإعادة التوطين تزيد احتمال التعرض اليها. كما ان عدم الاستقرار والاحتجاز وعدم الشعور بالأمان لفترات طويلة تفرض ضغوطًا إضافيّة على طالبي اللجوء السياسي. وقد تبيّن ان الضغوطات التي يعيشها اللاجئون بعد الهجرة ترافقها اضطرابات نفسية وذلك بالتحديد في حالة اللاجئين الذين تعرضوا لصدمة في المرحلة ما قبل الهجرة.

وفي حين انه لا يمكن تغيير الظروف التي يعيشها اللاجئون قبل الهجرة وخلالها، بإمكان البلدان المضيفة ان تحدث أكبر تأثير على المسار الذي يسلكه اللاجئين من حيث صحتهم النفسية من خلال معالجة الظروف النفسية والاجتماعية التي يواجهونها بعد الهجرة. فالنظر في السياسات التي تؤثر مباشرة على طريقة استقبال اللاجئين، إضافة الى الموارد والنظام القائم لتلبية اللاجئين يؤثر مباشرةً على صحة اللاجئين النفسية على المدى البعيد. أمّا طريقة استقبال المجموعات في بلد ما وتقديم الوظائف المستدامة والجيدة لها الى جانب توفير التعليم والتدريب والقيام بالمبادرات لتعزيز اندماجها الاجتماعي ضمن جماعاتها والمجتمع الأكبر، فهي تشكّل جوانب أساسية تساهم في تخفيض الانعزال الاجتماعي واليأس وإنماء صحة نفسية جيدة.

سيناقش هذا الفصل كيف تؤثر عوامل اجتماعية معينة وسياسات معينة على الحالة النفسية والصحة النفسية للاجئين وطالبي اللجوء السياسي في كندا ودول متقدمة أخرى بشكل رئيسي، مع التركيز على العوامل السبعة التي أتينا على ذكرها سابقًا، وهي: الاحتجاز، والحرمان من العمل، والتَّشتيت، والحرمان من الرعاية الصحية، والفقر الحاد، والتأخير في البت بالطلبات، والتمييز.

8.2 العوامل السبعة

8.2.1 الاحتجاز

لكلّ بلد سياساته وإجراءاته الخاصة به، يعمل على تطبيقها لتحديد ما اذا سيتمّ القبول بطلب اللجوء لشخصٍ ما ام لا، وكيفية المضي بإجراءات القبول، وطريقة التعامل مع اللاجئين وطالبي اللجوء لدى وصولهم الى البلد المحدد بحسب مجموعة من المعايير المتعلّقة بأمن البلد وحقوق الانسان. ويعمل عدد كبير من الدول المتقدمة والنامية حاليًّا على تطبيق سياسات او توجيهات معيّنة تتعلّق باحتجاز طالبي اللجوء عند أي مدخل للبلد او بعد الوصول اليه. وتختلف هذه القوانين بالإضافة الى طريقة التعامل مع طالبي اللجوء هي أيضًا من بلد الى آخر.

وسوف نستعرض على سبيل المثال القوانين في كل من كندا وأستراليا لإبراز أوجه الاختلافات والتشابه بين البلدين. فاحتجاز طالبي اللجوء قد تُضِرّ بصحّتهم النفسية، خصوصًا من بين الذين قد تعرضوا لظروفٍ تسبّبت لهم بصدمة نفسية. (راجع أيضًا الفصل بكتابة دين أوتر وآخرون في هذا الكتاب.)

8.2.1.1 كندا

في كندا، ينظم قانون الهجرة وحماية اللاجئين (IRPA) دخول الرعايا الأجانب الى البلد. بموجب IRPA، قد يعتقل عملاء وكالة خدمات الحدود الكندية (CBSA) طالبي اللجوء الذين اعتُبروا انهم قد وصلوا الى البلد عبر "دخولٍ غير شرعي" وقد يحتجزوهم. وينطبق هذا التدبير في حال وُجد أساسٌ منطقيٌّ للاعتقاد بان طالب اللجوء ممنوع من الدخول الى البلد بحسب ما ينص عليه ال IRPA واذا ما اعتُبِر انه يشكل خطرًا على المجتمع. ومن بين الأسباب الأخرى التي تستلزم اتخاذ هذا التدبير بموجب ال IRPA هو احتمال عدم تلبية طالب اللجوء الدعوة بالحضور لإجراء فحص معيّن او جلسة استماع بشأن دخول البلد او بترحيل من كندا، او عدم تمكّنه من اثبات هويته، او دخوله بطريقة غير شرعية بحسب تصنيف وزير السلامة العامة والتأهب لحالات الطوارئ. ويتمّ وضع طالبي اللجوء المحتجزين اما في مراكز احتجاز المهاجرين (IHCs) او في سجون المقاطعات. وبحسب IRPA، يبقى كل معتقل عمره 16 سنة وما فوق في الاحتجاز الى ان يتم البت بقضيتة الخاصة بحماية اللاجئين، او لحين ان تصدر الأوامر من شعبة الهجرة او وزير السلامة العامة والتأهب لحالات الطوارئ بإطلاق سراحه. ويجب ان يحصل ايضًا على جلسة تقييمية خلال 48 ساعة من احتجازه وان يتم تقييم ذلك مرة في الشهر على الأقل. لكن لا يتوفّر أي حدّ أقصى لمدّة بقاء المعتقل في الاحتجاز، وذلك بشكل أساسي كي يكون من الممكن احتجاز طالب اللجوء المحتجز بموجب القانون الى اجل غير مسمى. ويذكر ال IRPA بشكل محدد انه لا يجب القيام باية محاولة لاحتجاز أي قاصر تحت عمر ال 16 سنة، الا في ظروف

استثنائية. اما أولاد طالبي اللجوء المحتجزين الذين هم دون الـ 16 سنة، اما يتم إبعادهم عن والديهم وارسالهم الى خدمات حماية الولد في المقاطعة، او يبقون محتجزين بطريقة غير رسمية مع امهاتهم في مركز لاحتجاز المهاجرين. وفي كندا، تتمتّع مفوضية الأمم المتحدة لشؤون اللاجئين بحق الدخول الكامل الى كافة مراكز الاحتجاز حيث يتمّ احتجاز طالبي اللجوء.

8.2.1.2 أستراليا

في استراليا، وبموجب قانون اصلاح الهجرة الذي تم وضعه في العام 1992، يجب احتجاز كل الذين ليسوا مواطنين و"غير شرعيين". ويضمن القانون عدم السماح لاي شخص يصل الى استراليا من دون "اذن قانوني" بدخول البلاد قبل ان يُكمل بصورة مرضية كافة الفحوصات الصحية والشخصية والأمنية الضرورية وان يُمنح تأشيرة دخول، وإلا يتم ترحيله. وقد تم فرض الاحتجاز الالزامي كإجراء مؤقت واستثنائي بسبب موجة "لاجئي القوارب" الآتين من الهند الصينية. وتبقى المدّة القصوى للاحتجاز غير محددة وقد سُجّلت حالات احتُجز فيها الأشخاص لسنوات طويلة. ويتضمّن قانون إصلاح الهجرة الأسترالي اختلافات قليلة ملحوظة عن قانون الهجرة والحماية الكندي: على سبيل المثال، من واجب المحتجَز في استراليا الدفع للكومنولث من اجل احتجازه او ترحيله ويمكن احتجاز الأطفال المُعالين أيضا.

تأثير الاحتجاز على الصحة النفسية

فيما تختلف ظروف الاحتجاز بشكل كبير ضمن البلد الواحد وبين بلدٍ وآخر، غالبًا ما تكون مراكز الاحتجاز متشابهة ؛ فهي كالسجون (او حتى سجون فعلية) وتكون مزودة بكاميرات مراقبة وحراس وأقفال مضبوطة وأسوار، وتقع أحيانًا في جزيرة خارج البر الرئيس للبلد. وقد تبيّن ان احتجاز طالبي اللجوء السياسي يرتبط بازدياد احتمال ظهور المشاكل والاضطرابات النفسية لديهم كالقلق والكآبة واضطراب ما بعد الصدمة. وقد يثير التعرض للاحتجاز الخوف الشديد والقلق لدى الأشخاص الذين تعرضوا سابقًا للتعذيب، إضافةً الى اضطرابات النوم والمزاج الكئيب. فغالبًا ما يولِّد الاحتجاز مشاعر اليأس والعجز التي قد تدفع الشخص الى تعاطي المخدرات بشكل أكبر فضلاً عن تدهور صحته النفسية والتفكير بالانتحار ومحاولة ارتكابه. ويبدو ان الاحتجاز يؤثر سلبيًّا على الصحة النفسية للرجال والصبيان أكثر من النساء والفتيات. ويولّد الاحتجاز، ولو لفترة قصيرة، آثارًا مضرَّة بسلامة الأطفال النفسية والاجتماعية بما فيها تأخر في النمو، ومشاكل يتمّ تشخيصها على صعيد الصحة النفسية، وسلوكيات انتحارية.

وترتبط مدّة البقاء في الاحتجاز بشكل مباشر بسوء الصحة النفسية. فقد أجرى نلسن وزملاؤه دراسة على الأولاد الطالبين اللجوء في الدنمارك ووجدوا ان الأولاد الذين تتراوح أعمارهم بين 11 و16 سنة وعاشوا في مراكز لجوء لأكثر من سنة هم عرضةً

للصعوبات النفسية أكثر بـ 30 مرّة مقارنةً بالأولاد الذين عاشوا في مراكز لجوء لفترة أقل من سنة. وقد قارن كيلر وآخرون بين عدد طالبي اللجوء في الولايات المتحدة وعدد السنين ووجد ان 70% من المشمولين في الدراسة يعتقدون ان صحتهم النفسية قد تراجعت خلال فترة الاحتجاز. وفي التحليل الذي أُجريَ لاحقًا، تمّ ربط هذا الاستنتاج بالعلاقة بين طول فترة الاحتجاز ومستويات القلق والكآبة واضطراب ما بعد الصدمة التي انخفضت عندما تم إطلاق سراح المحتجزين في النهاية. وبصورة مماثلة، تبيّن ان الاحتجاز لفترة طويلة في استراليا قد ترك اثرًا طويل الأمد على سلامة اللاجئين النفسية والاجتماعية علمًا ان مشاكلهم النفسية قد استمرت حتى بعد إطلاق سراحهم. إضافةً الى ذلك، وجد الكومنولث وأمين المظالم لشؤون الهجرة ارتباطًا قويًّا بين ارتفاع معدل فترة الاحتجاز وازدياد السلوك الذي يتمحور حول إيذاء النفس.

وقد درس كليفلاند وروسو الاختلافات بين طالبي اللجوء في الاحتجاز في كندا وبين الأشخاص الذين لم يتعرّضوا للاحتجاز قط. وقد وجدوا ان نسبة طالبي اللجوء المحتجَزين الذين هم بحاجة الى طبيب مختص بسبب اعراض اجهاد ما بعد الصدمة والكآبة والقلق هي اعلى بكثير من المجموعة غير المحتجَزة. وتبيّن ان مستويات الاعراض وعدد حالات المشاكل النفسية هي اعلى بكثير لدى المجموعة المحتجَزة بعد وقت قصير نسبيًّا من البقاء في الاحتجاز، اي 17 يومًا ونصف كرقم متوسط.

التقدم

يتمّ تطبيق سياسات الاحتجاز لعدد من الأسباب التي تشمل على شبيل المثال لا الحصر الأمن ورَدْع المهاجرين غير الشرعيين. لكن تبيّن انه حتى سياسات الاحتجاز الأكثر صرامة غير قادرة على ردع طالبي اللجوء السياسي واللاجئين. وكما تظهر الأبحاث، من الواضح ان الاحتجاز يؤثر على الصحة النفسية على المدى القريب والبعيد. وعلى ضوء الاهتمام المتزايد بسياسات الاحتجاز وازدياد التشرد حول العالم، تجاهد مفوضية الأمم المتحدة لشؤون اللاجئين لتخفيف اللجوء الى عمليات الاحتجاز وحتى وضع حدٍّ له. وفي شهر حزيران (يونيو) من العام 2014، أطلقت مفوضية الأمم المتحدة لشؤون اللاجئين استراتيجيتها العالمية التي سُميت "ما بعد الاحتجاز 2014–2019" وهي تهدف الى دعم الحكومات للحدّ من احتجاز طالبي اللجوء السياسي واللاجئين. وتحدد هذه الاستراتيجية ثلاثة اهداف رئيسة وهي:

"إنهاء احتجاز الأطفال؛

ضمان وجود بدائل عن الاحتجاز في القانون وتطبيقها عمليًّا؛

[و] التأكيد على ان الأوضاع في الاحتجاز، في الحالة التي يكون فيها الاحتجاز ضروريًا ولا مفر منه، مطابقة للمعايير الدولية من خلال جملة أمور من بينها تأمين الدخول الى أماكن احتجاز المهاجرين لمفوضية الأمم المتحدة و/أو شركائها والقيام بالمراقبة بشكلٍ منتظم"، ص: 7.

تدعو هذه الاستراتيجية مجموعة مختارة من 12 دولة يجري التركيز عليها لتنمية خطط عمل دولية في أوّل سنتين. واعتبارًا من شهر كانون الأول (ديسمبر) من العام 2015، تمّ تطوير خطط عمل للدول التالية: الولايات المتحدة والمملكة المتحدة وتايلند وليتوانيا وإسرائيل وماليزيا وكندا واندونيسيا والمكسيك ومالطا وزامبيا وهنغاريا. وتختلف خطط العمل الخاصة بكل دولة حسب الهدف او الأهداف التي تختار ان تسعى اليها وحسب غاياتها المحدّدة وإجراءاتها المعتمدة لتحقيق النجاح. وكمثالٍ على ذلك، يشكّل الحدّ من احتجاز الأطفال إحدى الأولويات الرئيسة لبرنامج العمل الوطني في كندا، بالإضافة الى عدة إجراءات تندرج تحت 4 اهداف فرعية وهي: (أ) تطبيق الإطار القانوني والسياسي لضمان عدم احتجاز الأطفال، (ب) وضع مصلحة الطفل فوق كل اعتبار، (ج) توفير تدابير استقبال واهتمام بديلة ومناسبة، و (د) إجراء تقييم يراعي الطفل ووضع إجراءات خاصّة بالإحالة لتحويل الأطفال الى مؤسسات او هيئات تختصّ بحمايتهم. اما في مالطا والمملكة المتحدة على سبيل المثال، فقد وضعت مفوضية الأمم المتحدة لشؤون اللاجئين طرقًا مختلفة قليلاً عن تلك التي في كندا لوضع حدٍّ لاحتجاز الأطفال. ففي مالطا، وضعت الحكومة عام 2014 أحكامًا تشريعية خدمةً لهذا الهدف بالتحديد وصرَّح رئيس الوزراء علنًا انه لا يجوز احتجاز الأطفال، لذا تخطط مفوضية الأمم المتحدة لشؤون اللاجئين لأن تدعم تنفيذ هذه السياسة. امّا المملكة المتحدة، فلقد أحرزت تقدّمًا بالفعل على صعيد إنهاء احتجاز الأطفال، غير انه يجب التركيز ايضًا على مراكز الاحتجاز القصير الأمد. وبحيث لا توجد قوانين محددة، ستدعم مفوضية الأمم المتحدة لشؤون اللاجئين الحكومة لمساعدتها على معالجة هذه الثغرة. وليست هذه الاستراتيجية العالمية وخطط العمل الدولية إلاّ مجرد بداية عمليّة طويلة لمعالجة مشكلة آثار الاحتجاز السلبية.

8.2.2 الحرمان من العمل

يحتاج البشر الى القيام بمهام منتِجَة كي يجدوا معنى لحياتهم وكي يضعوا هدفًا يسعون اليه ويجدوا طريقة بنَّاءة لاستعمال وقتهم. ويشكّل العمل إحدى الطرق الهادفة والنافعة والتي تمثّل تحدّيًا للأشخاص، لذلك فهو يساعد في تفادي ظهور المشاكل النفسية وتخفيف الأعراض الحالية. لكن بالطبع، فان الحصول على وظيفة والحفاظ عليها ليس بالأمر السهل، إلاّ ان ذلك غالبًا

ما يكون أكثر صعوبةً بالنسبة للاجئين بالنظر الى وضعهم (الشرعي او غير الشرعي) في البلد المضيف، واعترافهم بأهمية تلقّي التعليم، والشهادات العلمية التي حصلوا عليها من بلدهم الأم، وطلاقتهم في لغة البلد المضيف.

قد ينتقل اللاجئون في البداية من وظيفة متدنّية الى أخرى ضمن البلد المضيف. فاللاجئ الذي لا ينجح في إيجاد عمل ضمن مجال اختصاصه ويبرهن عن قدراته على العمل في البلد المضيف قد يواجه من العمالة الناقصة في نهاية المطاف. والعمالة الناقصة هي وظيفة او عمل نوعيته أدنى مما هو متوقع نسبةً الى التعليم الذي تلقّاه الشخص ومقارنةً بمهاراته و/او خبراته المُكتسَبة. وقد يشمل ذلك التوظيف المؤقت، والتوظيف بحسب العرض، والتوظيف بموجب عقد، والتوظيف بدوام جزئي حتى ولو كانت الوظيفة تندرج ضمن مجال خبرة الشخص. أمّا بالنسبة الى اللاجئين الذين قد وصلوا حديثًا الى البلد المضيف بشكلٍ خاص، فلهم حظوظ أقلّ في إيجاد وظيفة لهم في عدد من الدول المُضيفة او قد يجدون عملاً يندرج في خانة العمالة الناقصة. في كندا مثلاً، تشير بعض الأبحاث الى ان اللاجئين لهم حظوظ أقلّ في إيجاد عمل ثابت بمستوى يليق بتحصيلهم العلمي. أمّا العمالة الزائدة، فهي تحصل عندما يختبر العمال بدوام كامل ضغطًا متزايدًا أو أعباء متزايدة أو دوامًا أطول وساعات عمل أكثر، بالإضافة الى مطالب متعلقة بالأداء التنظيمي العالي مع زيادة في الأجر او بدونه كتعويضٍ عن هذه التوقعات او المطالب.

8.2.2.1 "حق العمل"

أن يتمتّع الشخص بحق العمل وامتلاك القدرة لديه على إيجاد عملٍ هما أمران ضروريان لاستعادة الصحة النفسية. وفي حين ان القدرة على العمل هي حق يقرّه القانون الدولي، فان حرمان اللاجئين من العمل، خصوصًا طالبي اللجوء السياسي، لا يزال قائمًا بسبب تصنيفات معينة تصدر بحق اللاجئين في بعض الدول. و يقرّ العهد الدولي الخاص بالحقوق الاقتصادية والاجتماعية والثقافية (ICESCR) مجموعة من الحقوق التي تشمل حق كل شخص في كسب لقمة عيشه من خلال عملٍ يختاره بحرية او يقبل به مقابل أجرٍ عادلٍ واستنادًا الى المساواة في الأجور المدفوعة على أساس التساوي في العمل من حيث القيمة والعمل ضمن ظروفٍ آمنة وصحية. لكن رغم الاعتراف بهذا القانون، يجد اللاجئون وطالبو اللجوء السياسي أنفسهم أحيانًا ضمن ظروفٍ غير واضحة، وذلك عندما تعتمد حقوقهم بالعمل في بلدٍ مضيف على السياسات والقوانين التي تصدر تصنيفات معيّنة لتصنيفٍ مختلفٍ للاجئين في كل بلدٍ. وإذا سُمح لهم بالعمل، قد تحدد السياسات أيضًا عدد ساعات (او أسابيع) العمل وأحيانًا المكان الذي سيعملون فيه (او البلد و/او في قطاعات معينة). وقد يُطلب منهم ان يبرهنوا عن قدرتهم

على التحدّث بلغة البلد المضيف، و/او ان يكون لديهم ساعات محددة من الخبرة في البلد، و/او قد يجدون صعوبة في إثبات مؤهلاتهم بسبب فقدان الوثائق الضرورية. وسنستعرض، على سبيل المثال، حقوق العمل للاجئين وطالبي اللجوء السياسي في كندا وألمانيا والمملكة المتحدة.

حقوق العمل للاجئين وطالبي اللجوء السياسي في كندا

يُسمح للاجئين الحاصلين على الإقامة الدائمة بان يعملوا في أي مكان في كندا على عكس طالبي اللجوء السياسي الذين لا يُسمح لهم بالعمل الا إذا حصلوا على الإذن للقيام بذلك. فينبغي على هؤلاء ان يقدّموا طلبًا لوزارة المواطنة والهجرة الكندية (IRCC) ويثبتوا انهم يحتاجون الى العمل بهدف إعالة أنفسهم. ويحصل اللاجئون الذين أُعيد توطينهم على مساعدة من الحكومة الفدرالية لفترة تصل الى 12 شهرًا، او من كفلاء خاصين. وتهدف هذه المساعدة الى مساعدتهم على الاستقرار الى ان يجدوا وظيفة. و يمكن لطالبي اللجوء السياسي التقدّم بطلب للحصول على مساعدة اجتماعية. وفي السنوات الأربع الأولى التي يقضيها اللاجئين في كندا، تبيّن ان نسبة توظيف اللاجئين كمجموعة ترتفع وأن نسبة البطالة تنخفض. غير ان نسبة البطالة عند هؤلاء اللاجئين قد سُجِّلَت عند 29%، اي أعلى بكثير من نسبة البطالة في كندا التي بلغت 6.6% في الفترة نفسها. بصورةٍ مماثلة، تنخفض في كندا وبشكل كبير نسبة اللاجئين وطالبي اللجوء السياسي الذين يحصلون على دعم اجتماعي بمرور الوقت.

حقوق العمل للاجئين وطالبي اللجوء السياسي في ألمانيا

تعتمد ألمانيا على تصنيف اللاجئين بحسب ثلاث صفات مختلفة خاصّة بالهجرة وهم يُمنحون الحقوق بحسب كل واحدة من بين هذه الصفات، بالإضافة الى حق الدخول الى سوق العمل. والأذونات وحقوق العمل مسطَّرة في ثلاثة قوانين: قانون اللجوء وقانون الإقامة وقانون العمل. ويُسمح للأشخاص الحاصلين على رخصة إقامة بالعمل من دون أية قيود. أمّا مقدِّمو الطلبات الذين لا يزالون في مرحلة إجراءات اللجوء (للحصول على إذن الإقامة) والذين يواجهون تعليقًا مؤقتًا للترحيل، فيجب ان يحصلوا على تصريح العمل من سلطة الهجرة المسؤولة عنهم ووكالة التوظيف المحليّة. وقد يُمنحون تصريحًا بالعمل بعد 3 أشهر من تقديم طلب اللجوء الرسمي. لكن الأشخاص المجبَرين على العيش في مراكز الاستقبال، لا يُسمح لهم بالعمل خلال إقامتهم في هذه المراكز التي قد تصل الى حدّ 6 أشهر. فطالبو اللجوء الوافدين من دول تُعتبر آمنة ومندرجة ضمن الدول

الأعضاء في الاتحاد الأوروبي ويقدِّمون طلب للجوء، يُطلب منهم ان يعيشوا ضمن مركز استقبال طيلة عملية اللجوء وبالتالي هم ليسوا مؤهلين للعمل.

حقوق العمل للاجئين وطالبي اللجوء السياسي في المملكة المتحدة

بصورة مشابهة لكندا وألمانيا، يُسمح في المملكة المتحدة للأشخاص بالعمل اذا ما قد مُنحوا صفة اللاجئ وفقًا للاتفاقية الخاصة باللجوء. بالمقابل، لا يُسمح عادة لطالبي اللجوء السياسي بالعمل لكن يمكن لهم ان يتقدّموا بطلبٍ للحصول على إذن او تصريح إذا كانوا قد انتظروا حوالي 12 شهرًا لصدور قرار أولي بشأن طلب اللجوء الخاص بهم او اذا كان طلب لجوئهم قد رُفض من دون تلقّي اي جواب بخصوص طلبات أخرى قاموا بتقديمها خلال الأشهر الـ 12 الماضية علمًا انهم ليسوا مسؤولين عن هذا التأخير. وفي حال مُنح طالبو اللجوء تصريح العمل، فهم مؤهلون فقط للحصول على وظائف من قوائم النقص المهني الرسمية للمملكة المتحدة واسكتلندا، غير انه لا يُسمح لهم ان بالعمل لحسابهم الخاص او ان يبدأوا بمشروع تجاري خاص.

8.2.2.2 الصحة النفسية وارتباطها بمختلف أوضاع "العمل"

من الواضح وجود ارتباطًا وثيقًا بين العمل والصحة النفسية. فالبطالة تشكّل سببًا أساسيًّا لارتفاع مستويات القلق والكآبة لدى الناس عمومًا بشكل متقدّم عن المستويات العادية، وترتبط معدّلات البطالة المرتفعة بتبلور أنماط الانتحار لدى الأشخاص. وكذلك بالنسبة للعمالة الناقصة والعمالة المفرطة، فقد تمّ ربطهما بمستويات متقدّمة من التوتّر والكآبة. بشكلٍ عام، يسجّل الأشخاص الذين قد تمكّنوا من الحصول على وظيفة ملائمة نسب أدنى بكثير من الكآبة مقارنة بالنسب التي تمّ تسجيلها في حالة العاطلين عن العمل او الذين يعانون من العمالة الناقصة. والعلاقة بين العمل والكآبة معقدة لأن الأشخاص المكتئبين يقل احتمال توظيفهم. لكن البحث الطولي قد أظهر ان البطالة تتسبّب بالمرض أكثر ممّا المرض يتسبّب بالبطالة. وعندما يتوقّف الأشخاص عن العمل ويتنقلون الى كونهم باطلين عن العمل او ناقصي العمالة ، وذلك عند محاولة السيطرة على الكآبة في البداية، فانّ هذا يؤدّي الى ازدياد الكآبة لديهم مقارنة بإذا ما حافظوا على وظائفهم.

قد يؤثر الوضع الوظيفي على الصحة النفسية عند بعض الفئات الفرعية من اللاجئين أكثر مما يؤثر في غيرهم. فالنساء والأشخاص ذات التعليم المتدني هم أكثر عرضة للبطالة او العمالة الناقصة، وقد لوحظ ان الآثار السلبية للبطالة هي أكبر عند اللاجئين الحاصلين على تعليم عال.

وقد وُجدت توجهات مماثلة حول العمل والمشاكل النفسية في دراسات أُجرِيت حول اللاجئين بشكلٍ عام تضمّنت مجموعة من اللاجئين الذين شاركوا فيها لأهداف البحث. فالحصول على عمل (أي عمل) هو أفضل من البطالة لصحة اللاجئين النفسية. فقد وجدت إحدى الدراسات التي أُجريت بهدف المقارنة بين اللاجئين الصوماليين في لندن (في المملكة المتحدة) و اللاجئين الصوماليين في مينيابوليس (في الولايات المتحدة الأميركية) ان مستويات الكآبة عند هؤلاء الذين في لندن هي اعلى بكثير لأن المشمولين في الدراسة كانوا معرضين للبطالة بشكل أكبر. وكان الوضع الوظيفي العامل الأكثر تأثيرًا على تخفيض نسبة احتمال إصابة هؤلاء اللاجئين بالكآبة الحادة. وقد بيّنت إحدى الدراسات الطولية التي أُجريت على لاجئين وافدين من جنوب شرق آسيا ويعيشون في كندا ان اللاجئين الذين كان لديهم عمل ثابت والأشخاص الذين قد وجدوا وظائف بين مرحلة الانطلاق الأساسية والمراجعة في المرحلة الثانية قد حققوا أفضل نتائج تمّ تسجيلها على صعيد الصحة النفسية. بالمقابل، فإن اللاجئين العاطلين عن العمل بشكل مزمن او الذين قد خسروا وظائفهم منذ فترة قصيرة قد سجلوا أسوأ النتائج على صعيد الصحة النفسية. وبعكس الدراسات التي أُجرِيت حول مجموعات اللاجئين بشكلٍ عام، تشير هذه الدراسة الى ان مستويات الكآبة في مرحلة الانطلاق الأساسية قد زادت من احتمال البطالة في المراجعة عند المرحلة الثانية. ويرتبط كل من العمل المؤقت والعمل بدوام جزئي والعمل بأجر منخفض ارتباطًا وثيقًا بصحةٍ نفسيةٍ أكثر ضعفًا عند مجموعات اللاجئين.

8.2.3 التَّشتيت

على مرّ الوقت، عملت عدّة دولٍ على تنفيذ سياسات التّشتيت في ما يتعلّق بمجموعات اللاجئين و/او طالبي اللجوء السياسي. ولتطبيق هذه السياسات، ترتكز هذه الدول على واحدة او مجموعة من الأسس التالية: توزيع التكاليف على عدد من السلطات المحلية، وتحقيق اندماج أفضل، وتجنب الضغط على خدمات الإسكان والخدمات الاجتماعية، والردع والسيطرة، وتخفيض تكاثف المجموعات الأقلية الإثنية في مكان واحد. أحيانًا، تستهدف هذه السياسات طالبي اللجوء السياسي وفي بعض الحالات اللاجئين الذين أُعيد توطينهم، وتقدّم أنواعًا مختلفة من الدعم بحسب الإطار المفاهيمي الذي تعتمده الدولة على هذا الصعيد. وتعتبر بعض الدول ان مسؤولية الرعاية هي الى حد كبير مسؤولية عائلية بحيث تقوم المنظمات الطوعية بتزويد الخدمات، فيما تعمل دول أخرى على تأمين شبكة أمان لتوفير الرعاية وذلك لضمان وصول الخدمات لكافة اللاجئين.

8.2.3.1 التّشتيت في كندا والمملكة المتحدة

كندا

تعتمد كندا نهج شبكة الأمان، لكن ليس لديها قانون محدّد بشأن تشتيت طالبي اللجوء السياسي او اللاجئين. عوضًا عن ذلك، تعتمد وزارة المواطنة والهجرة الكندية (IRCC) طريقة معيّنة لتشتيت اللاجئين المدعومين من الحكومة (GARs)، ولكن ليس لطالبي اللجوء السياسي او اللاجئين الذين ترعاهم جهات من القطاع الخاص (PSRs). فعلى طالبي اللجوء السياسي في كندا ان يؤمنوا مسكنهم الخاص الى ان يصدر القرار بشأن طلب الحصول على حماية اللاجئ. والمنظمة او العائلة التي تكفل اللاجئين الذين يرعاهم القطاع الخاص هي مسؤولة عن مساعدتهم كي يجدوا مسكنًا. والسبب الرئيس لتشتيت اللاجئين المدعومين من الحكومة في كندا هو مشاركة الموارد. فكندا ترسل اللاجئين الى مكان ضمن البلد تكون الموارد والخدمات المقدَّمَة للمجتمعات فيه الأفضل من نوعها لتأمين ما يحتاجون اليه وذلك دعمًا لإعادة توطينهم واندماجهم. ويحاول المسؤولون، حيثما أمكن، ان يعيدوا توطين اللاجئين في مجتمعات تضمّ أقربائهم او أصدقائهم المقربين إذا ما صرّح عن ذلك اللاجئون الذين من المحتمل إعادة توطينهم.

بالنسبة للاجئين المدعومين من الحكومة، فيقابلهم عند وصولهم الى المطار شخصٌ تابعٌ لمنظمات تقديم الخدمات الممولة اتحاديًّا (SPOs). وهذا الشخص يكون قد أمّن مسبقًا مسكنًا مؤقّتًا للاجئين وهو يقوم بتوجيههم حول الأمور الأساسية التي تتعلّق بالبلد ويساعدهم على إيجاد خدمات أخرى لإعادة التوطين بالإضافة الى مسكنٍ دائمٍ. امّا نسبة نجاح هذا البرنامج، فهي متوسطة. فالمساعدة التي تقدمها منظمات تقديم الخدمات التي يجري تمويلها اتحاديًّا، فهي ضرورية لاندماج اللاجئين في كندا؛ لكن الوجهات المختارة لا تتلاءم دائمًا مع طلبات اللاجئين. وتشير الأبحاث الى ان الوجهة المفضلة لدى اللاجئين قد تمّ تجاهلها من قبل. وصحيحٌ ان حكومة كندا تحاول إرسال اللاجئين المدعومين من الحكومة الى المجتمعات التي يطلبونها او الى مجتمعات قريبة جدًّا الى ما يطلبونه، إلاّ ان العمليّة معقّدة لأن المناطق والمكاتب التابعة لدائرة المواطنة والهجرة الكندية (CIC) مشمولين في العملية العادية ومنظمات تقديم الخدمات الممولة اتحاديًّا موجودة بشكل أساسي في المدن الكبرى.

المملكة المتحدة

في العام 1999، أدرجت المملكة المتحدة قرارًا أتى بموجبه إنشاء نظام مركزيّ خاص بتوفير المساكن والدعم الاجتماعي لطالبي اللجوء السياسي. وقد وُضع هذا النظام بهدف تشتيت طالبي اللجوء بغية تخفيض الطلب والضغط على المساكن والموارد في لندن وتوزيعهما على كافة أنحاء البلد. ولا يحق لطالبي اللجوء، بموجب هذا النظام، اختيار مسكنٍ دائمٍ لأنفسهم، بل هم يُرسَلون الى مسكنٍ تقوم الدولة بتوفيره في المكان الذي تختاره، وقد يُطلب منهم الانتقال عدّة مرات (بين 10 مراكز

رئيسة تقريبًا). وقد يرفض طالبو اللجوء التشتيت، غير انه سيتوجب عليهم في هذه الحالة التخلّي عن الدعم المادي الذي تقدّمه لهم الدولة، فلا يكون التشتيت إلزاميًّا ؛ اما الأشخاص الذين لا يقدرون ان يعيلوا أنفسهم وليس لديهم نظام دعم فعّال، فيصبح هذا الأمر إلزاميًّا بالنسبة لهم. والأشخاص الذين يُمنحون صفة اللاجئين وليسوا مشتتين، يمكنهم ان يقدموا طلبًا للحصول على مسكن اجتماعي ويطالبوا بالاستحقاقات.

يُعتقد بأن سياسة التشتيت هذه قد وُضعت لتحقيق هدفين: (1) الردع والسيطرة على تدفق اللاجئين و(2) توزيع العبء المالي لطالبي اللجوء على عدة مدن ووكالات. لكن لم يُعتبر نظام التشتيت في المملكة المتحدة مسعًى ناجحًا لاندماج طالبي اللجوء السياسي او اللاجئين. فعادةً، يكون المسكن في حالة سيئة ومكتظ جدًّا ويُعتبر دون المستوى المطلوب. وعندما يُمنح طالبو اللجوء صفة اللاجئين، يجب عليهم مغادرة المسكن الذي تؤمنه الدولة في غضون 28 يومًا، واللاجئون الذين ليست لهم الأولوية بين أوساط اللاجئين، يجب ان يفتشوا بأنفسهم عن مسكنٍ لهم، باستثناء الذين شُتتوا الى اسكتلندا. فطالبو اللجوء الذين يُمنحون صفة اللاجئين في اسكتلندا، يمكنهم ان يتنقلوا بحرية من منطقة الى أخرى ضمن اسكتلندا او باقي المملكة المتحدة ويبقون مؤهلين للحصول على مسكن من قبل السلطة المحلية.

تأثير التشتيت على الصحة

غالبًا ما تؤثّر ممارسات وسياسات التشتيت بشكل سلبيّ على نسبة الدعم الاجتماعي المُقدَّم للاجئين وطالبي اللجوء السياسي ويؤدّي الى شعور متزايد باليأس وانعزال متزايد. ولشبكات دعم المهاجرين دورًا أساسيًّا في تزويد الدعم والنصح، واذا لم تتوفّر، فان هذا قد يؤدّي الى مشاعر العجز والخوف والانعزال. وفي حال عدم توفّر الاستقرار في المسكن الذي تمّ تقديمه لطالبي اللجوء بعد حصولهم على صفة اللاجئين وذلك في إطار برنامج التشتيت في المملكة المتحدة، فان هذا سيتسبّب لهم بالشعور بالانعزال بالإضافة الى تعرّضهم غالبًا للتحرش والتمييز ممّا يقلّل من احتمالية اندماجهم ويضعف صحتهم النفسية. وتشير بعض الأبحاث أيضًا الى ان اللاجئين الذين قد تشتتوا بصفتهم طالبي لجوء داخل المملكة المتحدة لديهم مستويات هجرة ثانوية اعلى من غيرهم من اللاجئين.

وأفاد اللاجئون الذين أُرسلوا الى مجتمعات أصغر في كندا عن إحساسهم المتواتر بالعزلة، فضلاً عن مواجهتهم للصعوبات في إيجاد عمل يمتلكون مؤهلاته. ويبدو ان الهجرة الثانوية موجودة بشكل كبير وهي تشكّل وسيلة للاقتراب أكثر من العائلة والأصدقاء وإيجاد عمل. فالعائلة والأصدقاء يمثّلون شكلاً من أشكال الدعم التي لا يمكن لموارد الدولة في كندا ان تقوم بتوفيرها

بطريقة مناسبة، مثل المواصلات والاهتمام بالأطفال والمساعدة عند أوقات المرض. وفي حين ان اللاجئين لا يميلون عادةً الى البقاء ضمن مجتمعات صغيرة، أفادت دراسة كندية ان بعض اللاجئين قد يتّخذون قرارًا بالبقاء. وبعض الأسباب الرئيسة لذلك هو الترحيب بهم في هذا المجتمع، ونشوء علاقة شراكة بين اللاجئين وعائلة من العائلات المحلية كمضيفين اجتماعيين لهم، وانخفاض التنوع العرقي الأمر الذي يعني ان الواصلين حديثًا سيقضون الوقت على الأرجح مع أشخاص ليس بالضرورة ان يكونوا من سكان البلد فحسب، ممّا يسهم في توسيع روابطهم الاجتماعية ضمن المجتمع الأكبر.

قد تساهم سياسة التشتيت التي تعتمدها المملكة المتحدة بشكل مباشر في ازدياد المشاكل العاطفية لدى طالبي اللجوء. لكن العلاقة بين ممارسات التشتيت ومشاكل الصحة النفسية المشخَّصة لم يتمّ اكتشافها بشكل كلّيّ بعد. غير ان الدراسات حول التشتيت تربط بين التشتيت وانخفاض الدعم الاجتماعي وازدياد الانعزال. وقد بيّنت أبحاث الصحة النفسية بوضوح وجود علاقة مؤذية بين الدعم الاجتماعي غير الكافي والمشاكل النفسية ضمن مجتمعات اللاجئين. وقد تمّ ربط الانخفاض في الدعم الاجتماعي المقدَّم بازدياد الأعراض المتعلّقة باضطراب ما بعد الصدمة (PTSD) والقلق والكآبة.

8.2.4 الحرمان من الرعاية الصحية

قد يعتمد حرمان اللاجئين وطالبي اللجوء السياسي من خدمات الرعاية الصحية على تغييرات في الحكومة. لكن الحقوق القانونية المتعلّقة بتقديم خدمات الرعاية الصحية لا تضمن دائمًا انه يتمّ منح الحقوق بشكل فعليّ ويصبح فهم الوضع أمرًا معقّدًا. في بعض الدول، تمنح الحكومات اللاجئين وطالبي اللجوء السياسي إمكانية الاستفادة من نظام الرعاية الصحية على مستويات عدّة. في بلدان مثل كندا والمملكة المتحدة وأستراليا، حيث تحظى الرعاية الصحية بتمويلٍ من الحكومة، غالبًا ما يحصل اللاجئون المشمولون باتفاقية على رعاية صحية مشابهة للتي يحصل عليها المواطنون؛ لكن لا تُعطى الحقوق نفسها لجميع اللاجئين وطالبي اللجوء السياسي. أحيانًا، تمنح الدول حق الاستفادة من خدمات الرعاية الصحية لمجموعات محدّدة (كالمجموعات الضعيفة) او حق الحصول على الرعاية الصحية الطارئة. لكن يمكن لهذا النظام المتعدّد المستويات ان يولّد غموضًا لدى مزودي الرعاية الصحية واللاجئين على حدّ سواء، بما انه ليس من الواضح بالنسبة لكليهما اذا ما كانا مؤهّلين للحصول على خدمات الرعاية الصحية او ما هي الخدمات التي يُسمح لهما بالحصول عليها.

شهدت كندا مؤخّرًا تغييرًا نحو الأفضل في سياستها للرعاية الصحية الخاصة باللاجئين. لكن بموجب التغييرات التي طرأت في العام 2012 على البرنامج الكندي المؤقت للصحة الاتحادية، فلم يعد يحق للاجئين (باستثناء الذين يحظون بدعمٍ من

الحكومة) بالحصول على التغطية التي تشمل الدواء والعناية بالأسنان والعناية بالبصر، والأمر سيّان بالنسبة لطالبي اللجوء السياسي الآتين من دولٍ تعتبرها الحكومة آمنة (باعتبار انه لا يُفترَض بها ارسال لاجئين) بحيث لا يحصلون على اية تغطية صحية بعد الآن. وقد أثارت هذه التغييرات الكثير من الضياع بين مزودي الرعاية الصحية حول التغطية المتوفرة للاجئين وطالبي اللجوء السياسي. وآل هذا الضياع على الأرجح الى رفض تزويد الرعاية الصحية والى الوضع المذكور آنفا في ما يتعلق بالرعاية الصحية للاجئين وطالبي اللجوء السياسي. وقد أدّت هذه التغييرات أيضًا الى توجُّب فواتير باهظة على اللاجئين وطالبي اللجوء السياسي بسبب الرعاية الصحية، فواتير لا يقدرون على الأرجح تكبّدها. لكن تمّ عكس هذه التغييرات في البرنامج الكندي المؤقت للصحة الاتحادية في العام 2016، بحيث بات باستطاعة طالبو اللجوء في كندا الحصول على الخدمات الأساسية للرعاية الصحية وعلى خدمات تكميلية خلال الفترة التي لا يُسمح لهم فيها بالحصول على تغطية تكاليف الرعاية الصحية في المقاطعات او الأقاليم. وهذه التغييرات تسهِّل، من الناحية النظرية، الحصول على تغطية تكاليف الرعاية الصحية. لكن، وبسبب الاختلافات في الفهم وإمكانية الحصول على الرعاية الصحية اللذين ظهرا قبل التغييرات التي أُدرجت في العام 2012، لا يزال اللاجئون وطالبو اللجوء السياسي في كندا يواجهون صعوبات كثيرة في الحصول على خدمات الرعاية الصحية.

وفي ألمانيا، تفرض الدولة قيودًا على طالبي اللجوء واللاجئين لناحية الحصول على خدمات الرعاية الصحية. ويخضع النظام الذي يحدد أهليتهم ودرجة التغطية التي يُسمحون بها لقانون استحقاقات طالبي اللجوء السياسي (AsylibLG). فهذا القانون يحدّد اية خدمات تشملها التغطية، وما هي العملية التي يجب اتّباعها للحصول على هذه الخدمات، وما هي القيود المفروضة على اللاجئين وطالبي اللجوء السياسي. وقد تمّ تصنيف الرعاية الصحية التي يحصلون عليها في ألمانيا في الدرجة الثالثة. وتبيّن ان استثناؤهم من خدمات الرعاية الصحية يؤدي الى نفقات ناجمة عن الحوادث الصحية أكثر من النفقات المتعلقة بحصولهم على الخدمات اللازمة بشكل منتظم في ألمانيا، ولم يكن بالإمكان شرح هذا بشكلٍ كاملٍ من خلال الاختلافات في الحاجة. وقد وجد بوزورغمر ورازوم ان النفقات على الصحة للشخص الواحد كانت 40% اعلى عند اللاجئين وطالبي اللجوء السياسي الذين يواجهون قيودًا لناحية حصولهم على الرعاية الصحية بالمقارنة مع مجموعة اللاجئين وطالبي اللجوء السياسي الذين يحق لهم بالحصول على الرعاية الصحية بطريقة عادية في ألمانيا.

يقلّل الحرمان من الحصول على الرعاية الصحية الدعم من هذه الناحية ويزيد من الشعور بالتوتر وهو يزيد، على الأرجح، نشوء المشاكل الصحية على المدى البعيد ويؤدي الى استعمال خدمات صحية أكثر كلفةً للاجئين. ان السماح للاجئين بالحصول فقط على الرعاية الصحية التي تُموَّل بأموال عامّة يزيد من التكاليف المتوجبة عليهم وعلى نظام الرعاية الصحية ومؤسسات اجتماعية أخرى. كما ان السياسات التي تحدّ من الحصول على خدمات الرعاية الصحية، تضع مزوّدي الرعاية الصحية في أوضاع يتوجب عليهم فيها ان يأخذوا قرارًا أخلاقيًّا بشأن تزويد رعاية صحية ضرورية لأشخاص لا يقدرون ان يدفعوا كلفتها.

8.2.5 الفقر الحاد

يُعتبر اللاجئون وطالبو اللجوء السياسي عرضة للفقر الحاد لأنهم قد أُجبروا على الهرب من بلدهم الى البلدان المضيفة فارغي اليدَين. لذلك، فهم يعتمدون على الدولة المضيفة لتأمين حاجاتهم المعيشية الأساسية. وقد تمّت الإشارة الى ان التهديد بالفقر الحاد يُستعمَل كأداةٍ تُثني الشخص عن طلب اللجوء وان الدول التي تزود خدمات سخيّة تُعتبَر مغرية بالنسبة لطالبي اللجوء. وكثيرون ممن أُجبروا على الهجرة، يعانون من فقر مادي، وبالتالي غالبًا ما يواجهون بأنفسهم المساوئ من حيث نوعية المسكن والمراكز السكنية، فيتمّ استبعادهم اجتماعيًّا في أحيانٍ كثيرة.

يؤثر الفقر الحاد على جوانب كثيرة من حياة اللاجئين، من بينها الاستفادة من فرص التعليم واكتساب اللغة وإيجاد مسكن، ممّا يؤثر على سلامتهم وقدرتهم على الاندماج مع المجتمع المضيف. فالأشخاص الذين يعيشون في وضع مادي غير مستقر، يتوجب عليهم ان يأخذوا قرارات معينة مثل: هل أتعلّم الإنكليزية أولاً او أبحث عن وظيفة لأسدد الإيجار؟ فالفقر يؤثّر غالبًا على مكان سكننا ووضع بيئتنا. وهذا يشمل بنية منزلنا وبيئته، بالإضافة الى البيئة الاجتماعية مثل الوصول الى مجتمع مشابه والى العائلة والأصدقاء. واللاجئون حساسون وهم معرّضون للاستغلال بسبب الفقر الحاد. والاستغلال والفقر يقلّلان من الفرص المتوفّرة ومن توافر الموارد والحصول عليها، الأمر الذي يؤدّي الى المزاج السيئ والحزن والإحباط والاستياء. ويؤدي المزيد من الحرمان المزمن الى الإحساس بالعجز المكتسَب والى سلوك معادي للمجتمع. كما يُعتبر الفقر عاملاً خطرًا على الصحة النفسية. وهكذا، فإن الفقر هو مفهوم معقّد نظرًا لارتباطه بعوامل كثيرة أخرى. وثمّة عامل مهم ناتج عن الفقر الحاد وهو المسكن السيئ. ففي كندا، أفادت التقارير بأن اللاجئين الذين لديهم كفلاء، قد سجّلوا بعد أربع سنوات من وصولهم مستويات دخل أقل مقارنةً بغيرهم من المهاجرين. وهناك احتمال أقل ان يمتلكوا بيتًا واحتمال أكبر ان يبقوا في الأماكن المكتظة مقارنة

بالمهاجرين. وتؤدي هذه الحاجة الى مشاركة المسكن الى خسارة الخصوصية، بالإضافة الى عوامل إضافية تسبّب التوتر. فالأوضاع السكنية السيئة تعزز الصدمات السابقة وتجعل اللاجئين عرضة لاعتداء السكان الآخرين عليهم.

8.2.5.1 تأثير البيئة المُنشأة والمسكن السيئ على الصحة النفسية

يشير استعراض بعض المراجع الى وجود ارتباطات متعدّدة بين المسكن والبيئة والعوامل النفسية الاجتماعية والصحة النفسية. فلقد تبيّن، على سبيل المثال، ان العيش في مسكنٍ مؤلّفٍ من عدّة مبانٍ شاهقة يرتبط بازدياد الاضطرابات النفسية عند الأمهات اللواتي أولادهنّ من صغار السن ويعود السبب في ذلك الى الانعزال المتزايد والإمكانية المحدودة لدى الأولاد للعب والشبكات الاجتماعية المضيقة. امّا في الحال التي تكون فيها البيوت بحاجةٍ الى تصليح او التي يكون فيها المالك غير متجاوب، فان هذا يؤدي الى تدهور الصحة النفسية بشكل أسوأ لدى هؤلاء. وقد حدد ايفانس ثلاث عمليات (وهي السيطرة الشخصية والدعم الاجتماعي والتعافي) قد تؤثر من خلالها البيئة المُنشَأة على الصحة النفسية بطريقة غير مباشرة. فعندما يسيطر الأشخاص على بيئتهم، يشعرون بتحسّن. امّا إذا مُنعوا من فعل ذلك فسيشعرون بالعجز. فالبيئة المادية مرتبطة مباشرة بالتعافي من التعب والإجهاد المعرفيّين، اذ ان التواجد ضمن بيئة فيها طبيعة له نتائج إيجابية وهو يعيد الطاقة المعرفية للأشخاص بحسب ما تبيّن.

يمكن لبعض العوامل كالمسكن السيئ وانعدام السيطرة وغياب الدعم الاجتماعي ان تساهم في تجربة غير مستقرة في السكن، وبالتالي الى التنقل المستمرّ من مسكنٍ الى آخر، وهذا ما تمّت ملاحظته لدى اللاجئين وطالبي اللجوء السياسي في كلّ من كندا والمملكة المتحدة. ويمكن ان يزعزع التنقل المستمرّ استقرار الشبكات الالكترونية ويعيق استمرارية خدمات الرعاية. ولم يتمّ إجراء أي دراسة مكثّفة حول الروابط القائمة بين المسكن والبيئة المُشَأة والمشاكل النفسية التي يعاني منها اللاجئين بالتحديد. لكن أفاد تقرير صادر عن وارفا وزملاؤه ان عدم الاستقرار السكني عند اللاجئين الصوماليين الذين يعيشون في لندن في إنكلترا، يسبّب لهم الإجهاد وقد عرَّض صحتهم النفسية للخطر. ويُعتقد بحسب هذا التقرير ان القلق الذي يظهرونه إزاء عدم استقرارهم وإمكانيّتهم المحدودة في السيطرة على الأمور يساهمان في الاضطرابات النفسية التي تنشأ في أوساط اللاجئين الصوماليين.

8.2.6 التأخير في البت بالطلبات

في الوقت الذي كانت تجري فيه كتابة هذا الفصل، قامت الحكومة الكندية بتقدير الفترة التي تستغرقها عمليّة التوصّل الى قرار نهائي بخصوص اي طلب لجوء تقدّم به اي لاجئ يعيش أساسًا في كندا، وتبيّن ان هذه الفترة هي 10 أشهر. وفي استراليا، تستغرق حاليًّا إجراءات اللجوء الإنساني للاجئين الذين يعيشون خارج البلاد (اللاجئين وفقًا لاتفاقية واللاجئين في إطار برنامج إنساني ممّن ليسوا في استراليا) 12 شهرًا منذ القيام بتقديم الطلب لحين صدور القرار بشأنه. اما كي يحصل طالبو اللجوء الذين يعيشون أساسًا في استراليا على تأشيرة حماية على الأراضي الأسترالية، فتقدِّر الحكومة الأسترالية ان الفترة الزمنية هي نفسها، أي 12 شهرا.

هذه الفترات الزمنية التي قدّمتها الحكومتين الأسترالية والكندية هي مجرد تقدير للمدّة التي تستغرقها عمليّة البت بالطلبات. وجدير بالذكر ان الطريقة المعتمدة لتحديد أهلية حصول اللاجئين على صفة لاجئ معقّدة وصعبة وتختلف من بلد الى آخر. وهذا ينبثق عن الحاجة الى ان يتمتّع صانعي القرار بالمعرفة الكافية حول البيئة الحضارية والاجتماعية والسياسية لبلد المنشأ والقدرة على تحمُّل التأثير النفسي القوي لجلسات الاستماع والقرارات المتّخذة بناءً على ذلك وعلى التعامل مع القضايا القانونية الدولية والمحلية.

قامت الحكومة في ألمانيا سابقًا بنشر دراسات إحصائية تتعلّق بإجراءات اللجوء التي تجري عبر المكتب الاتحادي للهجرة واللاجئين. وقد ذكرت انه في العام 2013، جرى البت بـ 60% من طلبات اللجوء وإصدار قرار بشأنها في حوالي 6 أشهر. وبالنسبة الى الطلبات التي تعود للعام 2012 والتي جرى البت فيها بعد الاستئناف، فالمدة الإجمالية للإجراء كمعدل هي ضمن 12.1 شهرًا، ونصف الإجراءات تقريبًا جرى البت فيها خلال 6 أشهر، وثلاث أرباعها في سنتين في ذلك الوقت.

وقد قدّمت الحكومة الكندية أيضًا المعلومات حول فترات زمنية تمّ التوصّل اليها حسب التقديرات تتعلّق بإجراءات طلبات اللاجئين المشمولين باتفاقية. وبالنسبة الى الأشخاص الذين يقدِّمون طلبًا الى كندا كلاجئين يحظون بدعمٍ من الحكومة، فإنّ مدّة النظر في طلبهم تختلف حسب المكان الذي يقدِّمون طلبهم منه. امّا بالنسبة لأغلبية الدول، فالفترة الزمنية التي يستغرقها إنهاء اي طلب هي 15 شهرًا غير انه في حال الكثير من الدول، لا تتوفّر المعلومات الكافية عنها لمعرفة طول المدة. وأقصر فترات زمانية تتعلّق بإجراءات اللاجئين المدعومين من الحكومة تعود للذين يتواجدون حاليًّا في الأردن (اي شهر واحد) ولبنان (اي 7 اشهر)، في حين ان أطول فترات يتمّ نسبها لطلبات الأشخاص المتواجدين حاليًّا في اثيوبيا (اي 46 شهرًا) وكينيا (اي 32 شهرا). اما بالنسبة الى اللاجئين الذين ترعاهم جهات من القطاع الخاص، فالفترة التي تتطلبها الإجراءات قد قُدِّرَت بحوالي

50 شهرًا لمقدِّمي الطلبات من بلدانٍ كثيرة. امّا طول فترة الإجراءات وقصرها، فهي مشابهة لتلك التي يتمّ نسبها الى اللاجئين المدعومين من الحكومة. فبالنسبة لطلبات المقدِّمين من الأردن، فهي تستغرق حوالي 10 أشهر، ومن لبنان حوالي 8 أشهر؛ اما اثيوبيا، فحوالي 73 شهرًا وكينيا 68 شهرًا. وعلى الأرجح، تعود نتيجة هذه الفروقات الى ترتيب القضايا حسب أولوياتها وما حدث جرّاء النزاعات الأخيرة في سوريا.

8.2.6.1 تأثير التأخير في البت على سلامة مقدِّمي الطلبات

توصَّل تقييم أُجري حول الدراسات الدولية المتعلّقة بإجراءات اللجوء الى الاستنتاج بان الإجراء بحد ذاته وبطبيعته مُضرّ بالصحة النفسية. فعدم معرفة الأشخاص اذا ما كانوا سيُمنحون صفة اللاجئين او كم من الوقت سينتظرون لحدوث ذلك، يؤثر عليهم بشكل سلبي. فقد يخاف مقدمّو الطلب من نتيجة القرار ومن ان يُرفَضوا وبالتالي يُرحَّلوا الى بلدهم الأم، وهذا يؤدي الى تدهور صحتهم النفسية بشكل أكبر. فعدم الاستقرار والحماية المؤقتة في أستراليا يساهمان في خطر الإصابة بالكآبة المستمرة واضطراب ما بعد الصدمة والعجز (او الإعاقة) المرتبط بالمشاكل النفسية للاجئين. فالصفة القانونية تشكّل عاملاً مهمًّا للصحة النفسية والدليل على ذلك هو ان طالبي اللجوء في هولندا هم عرضة لاضطراب ما بعد الصدمة والكآبة/القلق أكثر من اللاجئين المعترف بهم. وتفيد التقارير بوجود مستويات عالية من الكآبة والقلق واضطراب ما بعد الصدمة لدى عيّنات طالبي اللجوء المجتمعية والسريرية. كما تشير الى ان الصحة النفسية قد تتدهور بمرور الوقت، فيما يتنظر طالبو اللجوء نتيجة طلباتهم. فثمة دراسة أُجريت على طالبي اللجوء العراقيين في هولندا أفادت بان طالبي اللجوء هؤلاء الذين مضى وقت أطول على وجودهم في البلد (اي أكثر من سنتين) من دون صدور اي قرار بحقّهم كانت لديهم مخاوف بشأن إجراءات اللجوء أكثر من طالبي اللجوء الذين مضت 6 أشهر على وجودهم في البلد. وقد وجدت هذه الدراسة ان طالبي اللجوء الذين ينتظرون قرارًا منذ وقت أطول (اي أكثر من سنتين) يواجهون خطرًا مضاعفًا بالإصابة باضطراب القلق مقارنة بطالبي اللجوء الذين تأخر قرارهم تأخرًا قصيرًا، اي أقل من 6 أشهر.

8.2.7 التمييز

يشير التمييز الى معاملة غير عادلة او ظالمة لأفراد او مجموعات على أساس التصنيف الطبقي الاجتماعي مثل العرق/الإثنية، والطبقة الاجتماعية، والجنس، والهوية الجنسية، والقدرة، والعمر، و/او الوضع الصحي، الأمر الذي يؤدي الى عدم المساواة على العصيد الاجتماعية. ويركّز مفهوم التمييز على السلوك. فتعريف التمييز يشمل "المعاملة" او "التصرف"

الذي يختلف باختلاف المجموعات من الناس على أساس صفتهم المركَّبة اجتماعيًا، مما يؤدي الى الأذية او الضرر. فتعريف التمييز له عدد من الأبعاد، بما فيها المباشر مقابل غير المباشر، والحاد مقابل المزمن. وثمة بُعد بارز هو المستوى الذي يحصل عنده التمييز: الفردي او الهيكلي.

يُعتبر التمييز الهيكلي نوع من أنواع التمييز المعقّدة للغاية. والمفهوم الحالي ليس ثابتًا ومن الصعب جدًّا تحديده او قياسه بسبب حجم المجالات وأنواع التمييز المتعدّدة والثنائيات المحيِّرة. فإذا اعتُبر التمييز الفردي تصرّفًا، عندها سيكون التمييز الهيكلي في تشغيل النظام. وهذا لا يعني ان الحكومة او المؤسسة تهدف الى التمييز. فمع ان الهيكلية القائمة قد تفسح المجال للتمييز، إلاّ ان تنفيذ السياسات والممارسات هو الذي يولِّد التمييز. وقد تمّت الإشارة الى ان التمييز الهيكلي هو (1) ممارسات المؤسسات وليس تصرفات الافراد؛ (2) نتائج (وليس نوايا) ممارسات غير مباشرة او تصرفات مباشرة؛ (3) نتيجة لنظام مترابط من الممارسات والسياسات والمؤسسات؛ (4) مكوَّن داخليًا من ترابط المؤسسات والأنظمة؛ (5) تداخل أنواع ومجالات من القمع؛ (6) مبني، جزئيًا، تاريخيًا واجتماعيًا؛ (7) عملية مرنة تتغير بمرور الوقت؛ (8) مبرَّر ومُصان، جزئيًا، على أساس معتقدات مشتركة جماعيًا.

8.2.8 سياسة الحكومة والتمييز

لا تضع الحكومات غالبًا جدول أعمال يتعلّق بمكافحة التمييز بشكل خاص. غير ان السياسات تُصنَّف أحيانًا كثيرة، من جهات مختلفة (كالإعلام، والخبراء، ودعاة المساواة والإنصاف، والمعارضة السياسية) على انها تمييزية او انها تمارس التمييز ضد مجموعات محدّدة. (انظر الأمثلة في [106، 107].) وعادةً ما تُسنّ هذه السياسات تحت حماية مواطني البلد وحضارته. وهذا يبدو منسجمًا مع نظرة الشعب في بعض البلدان حيث يعتبرون ان سياسات الهجرة واللجوء السياسي ليست كافية وان اللاجئين يستولون على كل الوظائف ويخفّضون مستوى الحياة لمواطني البلد. فتسود ثقافة "نحن مقابل هم" (انظر أيضًا في هذا الكتاب الفصل الذي كتبه فاميك فولكان)، وثقافة الخوف من "الآخر"، ويجري ربط موضوع اللاجئين وطالبي اللجوء السياسي بالإرهاب في المؤلفات التي تتناول موضوع التمييز. فالتمييز ظاهرة معقدة وذات مستويات عدّة وهي لا تُعالج عادةً إلاّ على المستوى الفردي (أي عندما يختبر الشخص الشعور بالتمييز على الصعيد الشخصي) من خلال المواد الأكاديمية.

8.2.9 التمييز والصحة النفسية

قد تولّد سياسات الحكومة في مجال الحمائية والردع نتائج تؤدي الى ممارسات تمييزيّة تمارَس بشكل غير مباشر ضد اللاجئين وطالبي اللجوء السياسي وتصرفات تمييزية تصدر بطريقة مباشرة تجاههم. وتساهم الطريقة التي يصوِّر بها الإعلام الأمور في تحديد التوجّه الذي يسلكه الرأي العام على هذا الصعيد، الأمر الذي يؤدي الى قمع الوافدين الجدد وعزلهم، وممارسة العدائية تجاههم (كارتكاب جرائم الكراهية ضدّهم). وقد لوحظ ان هذه الجرائم المرتكَبَة ضد طالبي اللجوء السياسي تُبرَّر بنفس الحجج المستعملة لتبرير أشكال أخرى من التمييز وهي تأتي نتيجة معلومات مغلوطة وإحباط وخوف، غير انها قد تكون مقبولة أكثر على الصعيد الاجتماعي. وفيما يصعب قياس التمييز الهيكلي والمؤسساتي وتقييمها، تبيّن ان العنصريّة الفرديّة والتمييز الفردي والتمييز الذي يختبره الفرد على الصعيد الشخصي كلها تؤدّي الى تبعات نفسية وخيمة.

أفاد عدد كبير من اللاجئين انهم يتعرضون للتمييز بشكل يوميّ من قبل سكّان البلد المضيف ومؤسساته حول العالم. ومن الأشكال الشائعة لهذا النوع من التمييز هي الممارسات التي تتعلّق بالتوظيف (كعدم توظيفهم او طردهم من العمل بسبب عرقهم او وضعهم)، ومشاعر الاستغلال، وموقف سكّان البلد منهم (كالتعامل معهم على انهم أعلى شأنًا او ممارسة التنميط او إصدار المواقف السلبية إزاءهم)، وعدم الاعتراف بهويتهم وقدراتهم بالطريقة الكافية وتقديم الرعاية الصحية الناقصة. وقد تبيّن ان هذه التصرفات اليومية المبنية على التمييز تترافق مع أعراض اضطراب ما بعد الصدمة واضطرابات نفسية شائعة بين مجموعات اللاجئين. ووجدت دراسةٌ أُجريت على اللاجئين الصوماليين الأكبر سنًّا الذين يعيشون في فنلندا ان اعراض الكآبة كانت أكثر شيوعًا لدى اللاجئين الذين تعرضوا يوميًّا للتمييز. وقد استنتج مولسا وزملاؤه ان التعرض للتمييز والعنصرية قد شكّل خطرًا كبيرًا لناحية نشوء المشاكل النفسية عند اللاجئين الصوماليين الذين يعيشون في فنلندا. فهذه الأحداث اليومية القائمة على التمييز لديها تأثير نفسي اجتماعي على سلامة اللاجئين خصوصًا المراهقين من بينهم. فالتعرض للتمييز بشكل مستمرّ، قد يؤثّر على مشاعر هؤلاء بشكل سلبيّ من حيث تقدير الذات وينمّي المشاكل النفسية الخطيرة لدى اللاجئين المراهقين. وقد يتأثّر المراهقون الشباب بطريقة مختلفة عن المراهقات. ففي دراسة أُجريت على اللاجئين الصوماليين في أميركا، تبيّن ان المراهقين الشباب الذين تبنّوا هوية أميركية كانوا أقل عرضة للإصابة بأعراض الكآبة، وكان الارتباط بين التمييز والكآبة في حالتهم أضعف. أمّا بالنسبة للمراهقات اللواتي حافظن على ارتباط قوي بحضارتهنّ الصومالية، فلقد أدّى هذا الى نتيجة مماثلة، غير انهنّ تعرّضن بالرغم من ذلك لدرجات عالية من التمييز، إلاّ ان التأثير على الكآبة كان أقل في حالتهنّ. لكن المراهقات اللواتي حاولن ان يتبنّين هوية أميركية، فلقد تعرّضن للتمييز من داخل مجتمعهنّ.

بالنسبة للأشخاص الذين قد تعرّضوا سابقًا للتمييز، فقد تصدر عنهم ردات فعل عاطفية تؤدي الى ازدياد ردات الفعل الناجمة عن الإجهاد وقلّة الثقة والقلق المزمن والتركيز على الأمور السلبية في الماضي والحاضر. أمّا على المدى البعيد، فقد يدرك الشخص أهميّة إحداث تغييرٍ على المستوى الفكري مع التزام الحذر بشكل أكبر، واستباق إمكانيّة التعرّض للتمييز، والتكيّف على صعيد النمو الشخصي لتجنّب المناسبات والمواقف والأماكن التي قد يكونوا فيها ضعفاء. ويؤثّر التمييز على الصحة النفسية في عددٍ من الطرق كمن خلال الصدمة النفسية التي يسببها المجتمع (بطريقة غير مباشرة او واضحة)، وعدم المساواة الاقتصادية والاجتماعية، وانخفاض مستوى الحركة ضمن المجتمع (مثل النقص في التعليم او فرص العمل)، والرعاية الصحية غير الكافية او غير المناسبة او المتدهورة. وصحيحٌ ان التمييز لا يطال كافة اللاجئين وان اللاجئين الذين يتعرضون له لا يعانون جميعًا من مشاكل نفسية كنتيجةٍ لذلك، إلاّ انه يؤثّر بشكل كبير على سلامة الأشخاص الاجتماعية والعاطفية.

8.3 سُبُل محتمَلة للتغيير: تعليم المختصين لتمكينهم من مساعدة اللاجئين

عندما تأخذ دولة ما قرارًا بفتح أبوابها أمام اللاجئين الهاربين من الحرب والنزاعات، يجب ان تفكر في إقامة التوازن بين الجانب الإنساني لهذا العمل وأمن المواطنين اللذين يعيشون فيه وازدهارهم. وبالرغم من انها لا تحاول عن قصد إضعاف نفسية اللاجئين او التسبب بأية مشاكل لهم، إلاّ ان سياساتها وممارساتها تضرّ أحيانًا بحياتهم وتسبّب بالتالي المشاكل النفسية لديهم. لذا، من المهم ان يدرك البلد المضيف انه باستطاعة حكومته القيام بالكثير من الأمور لمساعدة اللاجئين. لكن عمليّة الدمج وتقديم المساعدة والعمل على تخفيض المشاكل النفسية لديهم، كلّها مسؤوليات لا تقع على عاتق الحكومة وحدها. فمن واجب القطاعات والوكالات والأفراد ضمن البلد المضيف تأمين بيئة مرحّبة باللاجئين ومنحهم الفرص وتقديم الدعم لهم. وعلى ضوء ذلك، وبغية منح المعرفة والخبرة الضروريتين للمختصين في مجالي الصحة والتوطين، جرى إنشاء مشروع الصحة العقلية للاجئين (RMHP) في أونتاريو في كندا، ضمن مركز الإدمان والصحة العقلية (CAMH) لبناء المستوطنات، والهدف منه تطوير المعرفة الاجتماعية والصحية لدى مزودي الخدمات، وتنمية مهاراتهم لدعم صحة اللاجئين النفسية وتعزيزها، وتشجيع التعاون بين القطاعات وبين المختصين.

تمّ انشاء هذا المشروع كتكملة لدراسة دولية حول ممارسات الصحة النفسية للاجئين التي حددت الحاجات والممارسات الواعدة في مجال صحة اللاجئين النفسية في كندا. وقد شملت هذه الدراسة مسحًا بيئيًّا، واستطلاعًا للرأي، ومقابلات عميقة ومجموعات تركيز مع 150 مشاركًا في 9 مقاطعات في كندا، بمن فيهم لاجئين وعمال توطين ومدراء برامج وواضعي

سياسات وأطباء. وإحدى الاستنتاجات البارزة التي خلُصت اليها الدراسة هي ان بناء المعرفة وتطوير المهارات وإرساء الشراكات بين مزوّدي الخدمات هو أمرٌ ضروريٌّ لدعم أفضل الحاجات المعقدة والمتغيّرة لصحة اللاجئين النفسية خلال عمليّة إعادة توطينهم. فوجود شبكة شاملة من تقديم الخدمات يساعد اللاجئين على الوصول الى الخدمات المناسبة عندما يحتاجون اليها. وعندما يتمتّع المختصون في الرعاية الصحية والخدمة الاجتماعية والتوطين بالمعرفة اللازمة والمهارة الضرورية في مجالهم، فهم يساعدون في بناء الأساس لشبكةٍ فعّالة ومستدامة من مزوّدي الخدمات، ممّا يعزّز بالتالي صحة اللاجئين النفسية خلال إعادة توطينهم في كندا.

تمّ استخدام الاستنتاجات التي توصّلت اليها الدراسة الدولية لتطوير دليلٍ خاص بالممارسات الواعدة وموارد بناء الشراكات في مجال صحة اللاجئين النفسية ولإبلاغ مشروع بناء قدرات الصحة النفسية للاجئين. ويشمل هذا المشروع دورة تدريب ذاتي عبر الانترنت حول صحة اللاجئين النفسية لعمال التوطين ونسخة عن الدورة ذاتها معدَّة خصّيصًا لمزوّدي خدمات الرعاية الصحية، ومجموعة من الممارسات ومجموعة من المصادر التي يتمّ استخدامها كأدوات بحثيّة (www.porticonetwork.ca/web/rmhp). وتغطّي الدورة طيف واسع من المواضيع التي تضمّ معلومات عن اللاجئين في كندا، ومشاكل نفسية حول تجربة اللاجئين، ومعلومات عن الفئات الضعيفة من السكان، وكيفية العمل مع المترجمين الفوريين في أماكن التوطين والرعاية الصحية. وقد لاقى هذا المشروع نجاحًا كبيرًا، موفّرًا التدريب لأكثر من 3500 شخص من مزوّدي الخدمات بين العامين 2012 و 2016، وقد توسّع حاليًّا على الصعيد الدولي. ويستمرّ الطلب من قطاع التوطين في كندا في تخطّي قدرة المشروع على التدريب. وتظهر تقييمات المشروع تقدّمًا في التعلم، ويعبّر المشاركون عن امتنانهم الكبير لهذه الفرصة التي أتاحت لهم اكتساب المهارات في مجال الصحة النفسية للاجئين وتقدير هذه القضايا بشكل أكبر.

8.4 الخلاصة

توفّر العوامل السبعة التي قمنا بمناقشتها إطارًا مفيدًا لمراجعة التأثيرات النفسية والاجتماعية لمسبّبات الإجهاد على صحة اللاجئين النفسية في المرحلة ما بعد الهجرة. ويمكن ان تؤدي هذه العوامل الى عزل اللاجئين اجتماعيًّا، ممّا يولّد فيهم الشعور بعدم تقدير الذات ويجعلهم يشعرون بانه غير مرغوب فيهم ضمن المجتمع المضيف، وبالتالي هذا يزيد من يأسهم ويسبّب لهم الصدمة من جديد. بالمقابل، عندما تتوفّر المساعدة الاجتماعية والفرص الإيجابية في دول إعادة التوطين، يمكن ان تشمل النتائج الازدهار في بيئة جديدة والنمو والتكيف.

نحن ندرك ان التصنيفات المختلفة للاجئين (مثلاً، لاجئ وفقًا لاتفاقية او طالب لجوء سياسي) تجعل من الصعب تحديد الاختلافات بين الأبحاث على الصعيد الدولي. كما تجدر الإشارة الى ان طرق معاملة اللاجئين تختلف من نظام سياسي لآخر في مختلف الدول حول العالم. وينبغي معاملة اللاجئن الذين يُعتبرون مستحقّين للحماية والحقوق على هذا الأساس. أمّا تعريضهم لظروفٍ تسبّب لهم العزل الاجتماعي واليأس والصدمة والإجهاد أو تؤدّي الى تفاقمها، فيزيد من احتمال تعرّضهم للمشاكل النفسية، بما في ذلك الأفكار الانتحارية. وتشير الأدلة المذكورة أعلاه بشكل قاطع الى الحاجة لتحسين تجربة ما بعد الهجرة للوافدين الجدد لأنّ ذلك يخفّف من التداعيات النفسية المترتّبة عليهم ويوفّر لهم فرصًا للتّنعّم بحياةٍ جديدة.

Appendix B: CI Questionnaire Sample

Questionnaire

Community Interpretation: Role Conflicts and Expectations in the Cases of Syrian Refugees in Lebanon

Question
How long have you been working as a CI?

4+ years
8+ years
10+ years

Question
What agency/agencies or organization/s have you worked or are still working with in Lebanon?

…….…….

Question
Does the hiring agency/officer ever ask you to maintain utmost objectivity during the questioning session?

Yes
No

Question
Does the hiring agency/officer expect you to maintain utmost objectivity during the questioning session?

Yes
No

Question
Does the hiring agency/officer ever asked you to sign a paper whereby you pledge to maintain utmost objectivity during the questioning session?

Yes
No

Question
Does the hiring agency/officer ever informed you that you do not have to maintain utmost objectivity during the questioning session?

Yes
No

Question
Do you think you should maintain utmost objectivity during the questioning session?

If yes, please explain why
_____
If no, please explain why
_____

Question
Do you think it better to meet with the officer to get acquainted with the questions asked before the interview takes place?

Definitely
Not necessarily

Question
Do you think it better to meet with the refugee before the actual interview is conducted?

Definitely
Not necessarily

Question
Do you think your job with refugees is specifically different from the job you perform in other contexts such as courtroom or conference interpreting?

Yes
No

Question
Do you think your job with refugees is humanitarian?

If yes, please explain why
If no, please explain why

Question
Do you think that refugee interviews differ from other interpretation settings?
No
Yes (please explain)

Question
In your opinion, what makes the refugee think or ask for migration?

Migration is the refugee's only solution to resettle and recover
Migration is one way for the refugee to access better services

Question
Do you think of the reasons that pushed the refugee to ask for migration?

Yes
No

Question
Do you think of refugees as vulnerable parties of the communication?

Yes
No

Question
Do you take into consideration the refugee's psychological state?

Yes
No

Question
Do you think refugee contexts grant you the ability to be more than just a neutral converter of messages?

If yes, please explain why
If no, please explain why

Question
Do you think in refugee contexts you have to juggle between different roles (conveyor of messages, advocate, coordinator, social agent, humanitarian assistant, etc.)?

If yes, please explain why
If no, please explain why

Question
Do you feel like you have to play the role of a psychologist and CI at the same time?
Yes
No

Question
How would you describe most of the interviews you had?

Neutral
Calm and smooth
Tensed

Very tensed

Question
What makes the interview tensed/very tensed?
…….…….

Question
What makes the interview run smoothly?
…….…….

Question
Do you notice common signs of stress or anxiety in the refugees?

Very often
Never
Sometimes

Question
Do you often detect any signs of hesitation, exaggeration, or dishonesty in the refugee's behavior?

Not really
Yes (please specify when)

Question
If your answer in the previous question is yes, then how do you react to the refugee's behavior?

The refugee's behavior is not of my concern, so I just stick to my job
The refugee's behavior concerns me, so I decide to offer help
If you decide to offer help, what kind of help would you offer? Explain!

Question
Do you think that the presence of a psychologist or a therapist complicates the communication?

Definitely
Not necessarily

Question
If your answer in the previous question is yes, then do you think as CI that you have to have enough knowledge of psychology to deal with or understand the stress of the refugee, knowing you're the only person to understand the languages of both the refugee and the officer?

Yes
No

Question

If you want to offer help and intervene on behalf of the refugee, how do you do so?

I refuse to intervene in the communication whatsoever
I seek to change and/or alter the emitted utterances in the refugee's favor
I show a reassuring attitude, which gives the refugee a sense of comfort
Other… (please specify)

Question
Is there any other way you would rather help the refugee?

Question
Do you think that the rejection or acceptance of the refugee's application is part of your responsibility as a CI?

Yes
No

Question
If the officer rejects the refugee's application, do you think you could have changed the application's fate had you intervened in the communication?

Yes
No

Question
If the refugee would be accepted depending on your intervention in the communication, would you intervene to help? Knowing that migration is the only or most adequate solution for the refugee to have access to a better life.

Yes
No

Question
Does the officer take into consideration the refugee's psychological state?

Yes
No

Question
Is the officer sometimes aware of the refugee's psychological state, yet decides not to show sympathy?

Yes
No

Question
Do you feel that the officer acts aggressively during an interrogation?

Never
Occasionally
Always

Question
Does the officer ask questions that raise doubt in the refugee's stories?

Never
Always
In some cases

Question
Why and when does the officer ask questions that raise doubt in the refugee's stories?

Question
Do the majority of officers you worked with show a compassionate behavior towards the refugee?

Never
Always
Sometimes

Question

In which cases and for which reasons does the officer show a compassionate behavior towards the refugee?

Question
Does the officer's political and religious affiliation influence the questions and decisions made?

Never
Always
Sometimes (in what cases and for which reasons)

Question
Have you ever witnessed prejudice on the side of the officer? If yes! What was your reaction?

_____

Question
Do you feel that the interview for the refugee is a stressful interrogation?

Never
Sometimes (please specify in which case)

Question
Does the refugee act in an inferior position to the officer?

No
Yes
It depends

Question
What makes the refugee act in an inferior manner when being interrogated by an officer?

The fact that the officer has the final say in rejecting or approving the refugee
The fact that the refugee might feel like begging for help because there are no other options

Question
Are there any other reasons that make the refugee act in an inferior manner towards the officer?

Question
If the refugee starts crying, does anyone do anything about it?

Yes, the refugee is offered sympathy
No, the interview carries on like nothing has happened

Question
Have you ever witnessed a breakdown by the refugee during the interview? What was the cause of the breakdown?

_____

Question
Does the refugee ever seek attention or sympathy?

Yes
No

Question
Does the refugee ever speak of experiencing loneliness, depression, insecurity or self-devaluation?

Yes
No

Question
Does the refugee ever speak of in the need for more understanding and/or a listening ear?

Yes
No

Question
Does the refugee ever mention suffering from post-traumatic stress disorders?

Yes
No

Question
Many refugees suffer from post-traumatic stress disorder. Are their interviews conducted with the presence of a psychologist or a therapist?

Yes
No

Question
Does the refugee consider that migration (including the whole process from the interview till the end) is the only way to a safe haven?

Yes
No

Question
Does the refugee ask for your help?

Yes
No

Appendix C: SR Questionnaire Sample

استبيان رأي

الترجمة الفوريّة في سياق المجتمعات:
نزاع الأدوار وتوقّعات الأدوار في حالة اللاجئين السوريين في لبنان

الاسم:
العمر:

سؤال
لدى أي سفارة/منظّمة حاولت أن تقدّم طلب للهجرة وما الذي دفعك للقيام بذلك؟
_____
_____
_____

سؤال
هل تمّ قبول طلب هجرتك؟

- ☐ أجل
- ☐ كلا

سؤال
هل خسرت أحد أفراد عائلتك أو المقرّبين إليك في النزاع؟

- ☐ أجل
- ☐ كلا

سؤال
ما الذي أخذه منك النزاع غير ذلك؟

- ☐ أُصِبتُ بعطل/تشوّه جسديّ
- ☐ فقدت إحدى/كافة ممتلكاتي
- ☐ كل شيء

سؤال
بعد ما عايشته خلال النزاع، هل تبحث عمّا يشعرك بحسّ الانتماء؟

- ☐ أجل
- ☐ كلا

سؤال

هل تعتبر أنّ النزاع قد زعزع ثقتك بنفسك وحرمك من العاطفة والأمان؟

- أجل
- كلا

هل تعتقد أنّك تعاني من صدمة نفسيّة بسبب النزاع؟

- أجل
- كلا

هل حاولت اللجوء إلى أي نوع من المساعدة؟

- كلا
- أجل، المعالجة النفسية
- أجل، طلب عمل/دعم مالي/غيره

سؤال

هل تعتبر أنّ ما حرمك منه النزاع لا يمكن تعويضه؟

- أجل، فليس هنالك ما يعوّض عمّا أخذه منّي النزاع
- الهجرة قد تمنحني فرصة للتعويض عمّا أخذه منّي النزاع

سؤال

هل تعتقد أنّ الهجرة كانت/هي فرصتك الوحيدة للوصول إلى برّ الأمان؟

- أجل
- كلا

سؤال

ما أهميّة مقابلة الهجرة بالنسبة لك؟

- هي مهمّة
- هي مهمّة جدًّا
- هي مصيريّة
- لا تأثير لها على الإطلاق

سؤال

كيف تصف شعورك قبل المقابلة؟

- هادئ
- متحمّس
- قلق

- [ ] مرتبك

سؤال
كيف تصف شعورك خلال المقابلة؟

- [ ] هادئ
- [ ] مرتبك
- [ ] قلق

سؤال
ما الذي قد يشعرك بالقلق والارتباك خلال المقابلة؟

- [ ] ليس هنالك ما قد يقلقني أو يربكني بشأن المقابلة
- [ ] أن يتمّ رفض طلبي

سؤال
هل بكيت/شعرت بالحاجة إلى البكاء في أي مرحلة من المقابلة؟

- [ ] أجل، فسرد الأحداث التي عايشتها جعلني أبكي
- [ ] لم أبكي/أشعر بالحاجة إلى البكاء

سؤال
هل تقلق من ألاّ يستحسنك الضابط الذي يجري المقابلة وبالتالي أن يرفض طلبك؟

- [ ] أجل
- [ ] كلا

سؤال
كيف بدا الضابط خلال المقابلة؟

- [ ] متجاوِب ومتعاطف
- [ ] ملتزم بواجبه لا أكثر
- [ ] غير مبالي
- [ ] متهجّم

سؤال
هل تتوقّع من الضابط أن يظهر لك تعاطفه وتفهّمه إزاء وضعك؟

- [ ] أجل، فقراره النهائي يحدّد مصير مستقبلي
- [ ] كلا، فإن تمّ رفض طلبي، فلا بأس بذلك

سؤال

هل تعتقد أنّه من واجب الضابط أن يظهر لك تعاطفه وتفهّمه إزاء وضعك؟

- أجل، فهو يدرك تمامًا ما الذي أعانيه ومصير حياتي بين يديه
- كلا، لم أفكر بذلك قطّ

سؤال

هل يقلقك أو يزعجك أن يكون مصير طلبك متعلّقًا بشخصٍ واحدٍ (الضابط)؟

- أجل
- كلا

سؤال

هل خاب أملك بالمقابلة أو جرت على عكس ما كنت تتوقّعه؟

- أجل
- كلا

سؤال

إن خاب أملك بالمقابلة، فعل من تضع اللّوم؟

- أجل
- كلا

سؤال

قد تشعرك المقابلة بالضغط النفسي، فهل شعرت بالتردّد والإرباك في أيٍّ من المعلومات التي قدّمتها؟

- كنت متردّدًا ومربكًا طوال الوقت
- كنت متردّدًا ومربكًا في جزءٍ من المقابلة
- لم أتردّد أو أرتبك على الإطلاق

قد يدفعك الضغط النفسي الذي تختبره خلال المقابلة إلى عدم قول الحقيقة بشكلٍ تام، فتظهر وكأنّك لم تكن صادقًا وشفّافًا في كلّ المعلومات التي قدّمتها. فهل حاولت التّلاعب بأيٍّ من المعلومات؟

- أجل، فالضغط النفسي كان كبير
- كلا، التزمت الصدق والشفافية بشكلٍ تامّ

سؤال

هل شعرت أنّك مضطّرٌ إلى عدم قول الحقيقة تامّة بسبب سلوك الضابط؟

- أجل، فلقد أربكني سلوكه
- كلا، لم يربكني سلوكه

سؤال

هل وجّه إليك الضابط اتّهامًا بأنّك لا تقول الحقيقة؟

- أجل
- كلا

سؤال

إذا بدا الضابط متفهّمًا ومتعاطفًا، فهل يساعدك ذلك على التزام الصدق والشفافية؟

- بالطبع
- هذا لا يساعد

سؤال

هل شعرت وكأنّك في موقعٍ أقلّ شأنًا من الضابط أو كأنّك تتوسّله، علمًا أنّ القرار النهائيّ يكمن في يده؟

- أجل
- كلا

سؤال

هل طلبت من المترجم الفوريّ أن يطلب مساعدة الضابط في قبول طلبه؟

- أجل
- كلا

سؤال

هل طلبت من المترجم الفوريّ أن يخبر الضابط عن شعورك بالإحباط والوحدة وعدم الأمان لما عايشته بسبب النزاع؟

- أجل
- كلا

سؤال

هل تتوقّع من المترجم الفوريّ أن يظهر لك الدعم؟

- أجل
- كلا

سؤال

إن أردت من المترجم الفوريّ أن يظهر لك الدعم، فبأيّ طريقة؟

_____
_____
_____

سؤال

هل تعتقد أنّ المترجم الفوريّ يؤدّي دورًا مهمًّا في قبول طلبك أو رفضه؟

- أجل
- كلا

سؤال
هل تعتبر أنّ دور المترجم الفوريّ يتخطّى دوره كمترجم؟

- أجل، فهو أيضًا داعم ومدافع عن حقوق الإنسان وعامل اجتماعي
- كلا، هو مجرّد مترجم

سؤال
هل تتوقّع من المترجم الفوريّ التأثير على الضابط بأي طريقة لجعل طلبك يُقبل؟

- أجل
- كلا

سؤال
هل تتوقّع من المترجم الفوريّ أن يتلاعب بأقوالك لصالحك دعمًا لطلبك؟

- أجل
- كلا

سؤال
إذا لم تستلطف الضابط أو شعرت بأّن سلوكه تجاهك قاسٍ، فهل تُرِد من المترجم الفوريّ أن يقدّم لك الدعم؟

- أجل
- كلا

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