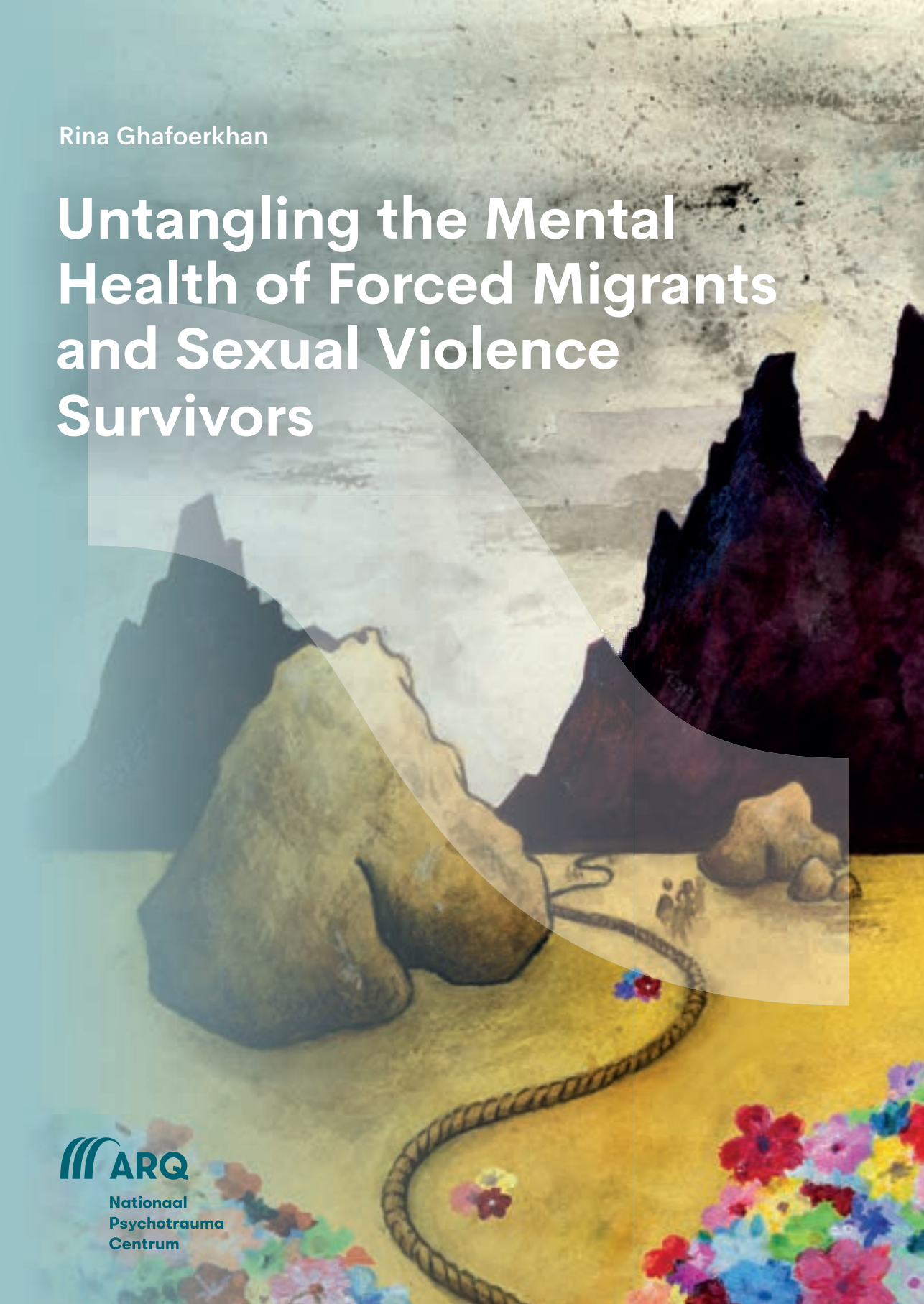
Rina Ghafoerkhan

Untangling the Mental Health of Forced Migrants and Sexual Violence Survivors



ARQ
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Rina Shairaghatoen Ghafoerkhan

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Untangling the Mental Health of Forced Migrants and Sexual Violence Survivors

Het ontwarren van de mentale gezondheid van gedwongen migranten en overlevenden van seksueel geweld

(met een samenvatting in het Nederlands)

Proefschrift

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door

Rina Shairaghatoen Ghafoerkhan

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Vanuit verschillende hoeken van het land zijn mannen en vrouwen bij elkaar gebracht, die vader, moeder, zoon en vrouw hebben moeten verlaten, ook hun woongebied. Tot nu toe heeft een ieder geleefd volgens de regels van de Dharma, maar toen ze in Calcutta aankwamen, hebben ze hun Dharma verlaten. Niemand onder de mensen kon herkennen wie van de hoge en wie van de lage kasten waren. Een ieder kon worden vergeleken met de laagste kaste (Shudra); de Dharma werd met de grond gelijk gemaakt.

Munshi Rahman Khan, 1891

Uit het dagboek van mijn over- overgrootvader die onder valse voorwendselen India moest verlaten om op door Nederland gestolen grond, bekend als Suriname, te werken als contractarbeider.

Khan, M. R., Hira, S., & Khan, M. R. (2003). *Het dagboek van Munshi Rahman Khan*. Amrit.

PREFACE

In today's world, which is increasingly interconnected and turbulent, the number of forced migrants is continuously growing. Several of these individuals carry the burden of immense psychological traumas, including sexual violence and trafficking. In the aftermath of these experiences, some may develop psychopathology that necessitates mental healthcare. However, how to best understand and address psychopathology amongst forced migrants continues to be a topic of debate.

For over a decade, Rina Ghafoerkhan has worked as both a researcher and a clinician at ARQ National Psychotrauma Centre. Her dissertation illustrates the strength of integrating clinical experience with scientific research and is rooted in Ghafoerkhan's clinical work and bearing witness to patients' narratives. The research questions addressed in this dissertation were initiated and developed in close collaboration with therapists. For instance, they observed that sexual violence and trafficking survivors were often at risk of sexual revictimization, yet there was a gap addressing this issue in treatment. Consequently, Ghafoerkhan and her colleagues developed and evaluated a body-oriented module designed to mitigate the risk of sexual revictimization. The evaluation of this module is presented in this dissertation and shows promising results.

At our centre clinicians and traumatised forced migrants are addressing psychopathology amidst challenging circumstances. For instance, forced migrants may encounter numerous post-migration difficulties. This raised the question of whether these circumstances might impact forced migrants' engagement in Narrative Exposure Therapy. Surprisingly, in this dissertation, Ghafoerkhan and her colleagues conclude that daily stressors and emotional dysregulation do not appear to hinder treatment response or its course. These findings may serve as encouragement for clinicians to initiate and persist in the provision of trauma-focused therapies amongst forced migrant populations.

In this dissertation, various conceptualisations applied to forced migrants' (traumatic) experiences are scrutinised through multidisciplinary exchange. Part of this research took place within an international research consortium led by the University of Edinburgh, which focused on improving health at the intersection of gender and protracted displacement settings. Our international department, ARQ International, proudly took part in this consortium along with other European and African non-governmental organisations and universities.

At ARQ National Psychotrauma Centre, we have a long-standing history of addressing the mental health needs of traumatised populations. We, therefore, are honoured to present the dissertation before you, aimed at advancing our understanding of the mental health needs and treatment of forced migrants, with particular attention to those who have suffered sexual violence and trafficking. I trust that you will find this dissertation to be an engaging read. I hope it may spark academic discourse, deepen our comprehension of the mental health needs of forced migrants, and ultimately contribute to the well-being of those affected.

Melina Kappeyne van de Coppello-Rakic
Chair of the Board of Directors

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CHAPTER 1

General Introduction

Over the last years, our daily dose of news has been dominated by the so-called "refugee crisis" and shocking accounts of sexual violence. Through this dissertation we aim to make a contribution at the juncture of these contemporary issues from a mental health perspective. In two parts, we will focus on the mental health and trauma-focused therapies for forced migrants, including survivors of sexual violence and trafficking. We will reflect on the legitimacy of legal definitions of (conflict-related) sexual violence, untangle the diversity of sex trafficking experiences, propose ways to mitigate sexual revictimisation, explore various conceptualisations of "neglected mental health conditions", and examine the relevance of daily stressors and emotion dysregulation in understanding changes in posttraumatic stress symptoms and treatment adherence.

Societies are becoming more globalised as movements of people and goods continue to increase (Institute of Medicine [US] Forum on Microbial Threats, 2006). For some, unfortunately, these movements are forced due to persecution, conflict, violence and other human rights violations in their countries of origin. Forced movement puts people at further risk of sexual violence and trafficking (Boskovic & Jankovic, 2023; Latham-Sprinkle et al., 2019). Nowadays, conflicts often become protracted and more people are on the move than ever before (von Einsiedel, 2017). The United Nations High Commissioner for Refugees (UNHCR; 2023) reports that, worldwide, 108.4 million people are currently forcibly displaced, and according to the Global Slavery Index 6.3 million are forced into commercial sexual exploitation (Walk Free, 2023). These numbers are staggeringly high, especially when imagining the immense suffering of each of these people. Moreover, forecasts for the coming decades are grim, as more people are expected to be displaced due to rising global inequality, protracted conflicts, and climate change (Ahmed et al., 2019; Policinski & Kuzmanovic, 2019, United Nations Framework Convention on Climate Change, 2022). Through often horrendous journeys, some of these people will find their way to Europe and may seek mental healthcare. In the context of cross-cultural encounters between mental health professionals and people who have seen the worst of humanity, new challenges arise in understanding and addressing the (mental health) needs of this growing population.

LABELLING THE STUDY POPULATIONS

In this dissertation we address the mental health of "forced migrants", and "survivors of sexual violence and trafficking", mainly residing in the Netherlands. These labels are clearly not mutually exclusive, as survivors of sexual violence and trafficking are highly prevalent amongst forced migrants. Also, survivors of sexual violence and trafficking included in this dissertation's studies have a migrant background, and the vast majority are forced migrants. Labels attributed to this dissertation's study populations establish their status, rights, access to protection, services, and asylum. However, these labels are compelled by national legislation and international law, and affected by the tense political field around these populations (Zetter, 2007). We propose that mental health perspectives could advance reflections on the legal labelling of forced migrants, although the literature on this exchange is rare. In this section we will share the rationale for our

choice of terminology to situate this dissertation's findings, and reflect on the discord between legal labels and the lived realities of the study populations.

COMPLEXITIES IN DEFINING PEOPLE IN TERMS OF LEGAL LABELS

First, how to label those who forcibly left their homes, mostly from the Global South, and found their way to Europe? UNHCR (2016) makes a clear distinction between "refugees", those with the right to seek asylum and international protection from persecution and violence, and "migrants", those who move mainly to improve their lives economically. This was recently reiterated by UNHCR's Assistant High Commissioner for Protection on social media stating (Triggs, 2023): "Refugees are not migrants. Migrants are not refugees. All have rights that must be respected, but we should not conflate the two."

Second, how to label those who left home and whose bodies were used or sold in forced sexual acts? The labels for what they lived through are numerous: "human trafficking", "sex trafficking", "sexual exploitation", "forced sex work", "trafficking in human beings", "modern slavery", "conflict-related sexual violence", and "sexual and gender-based violence". In the Netherlands, this labelling is strongly influenced by legal frameworks, which has major consequences for people's lives. Persons identified as (potential) victims of human trafficking are entitled to reflection and recovery, protection, access to care, and shelter under the so-called "B8 procedure" of the Dutch immigration law (albeit for a limited period of three months and thereafter only when their criminal case is ongoing; Vreemdelingencirculaire 2000 (B), B8/3). However, for forced migrants these cases rarely led to prosecution, and most survivors end up in general asylum seekers procedures (Amnesty International, 2023).

These legal definitions are justified based on obligations the Netherlands has to follow applicable international and European law, partially centered around the question: "Who has the right to protection and residence?" Yet, these definitions fail to reflect the diversity of people residing in Dutch asylum seekers centers and specialised shelters for human trafficking survivors. Here we encounter a multifaceted and broad range of personal histories, journeys, and hopes for the future amongst people on the move (Jannesari et al., 2020; Pijnenburg & Rijken, 2021). Some of these people will need and seek mental health support within Dutch clinics (e.g., Laban et al., 2007).

From a mental health perspective it hardly matters to pinpoint a sole reason for migration, or to categorise sexual traumas through the lens of legal frameworks. Personal stories demonstrate the incredible difficultly in doing so, and reveal the difficulty in untangling these definitions. How to categorise a man who fled his country during times of conflict, but mainly because he had studied calligraphy and had no hope of finding a job in a war-torn society? Or a woman who escaped an extremely violent husband, left her country to save her life, and ended up being sexually exploited by a Libyan smuggler?

Beyond these personal stories, socioeconomic issues are core drivers of migration. For instance, food scarcity due to changing weather conditions and inequality and poverty due to capitalist endeavors have been identified as root causes of conflict and political unrest

(Benatar, 1998; Richards et al., 2021). Likewise, patriarchal norms, social inequality, and financial dependency have been brought forward as core drivers of various types of sexual violence against women, men and those of diverse sexuality or gender identities (Davies & True, 2015; Kreft, 2023; Manjoo & Nadj, 2015). This further underlines the complexity in defining people by their reason for migration (i.e., for economic reasons or due to persecution and violence), or by the specificities of their experienced sexual violence.

"VICTIMS" OR "SURVIVORS" OF SEXUAL VIOLENCE?

During the period in which the work described in this dissertation was done, the use of the term "victim" has lost ground; instead, the term "survivor" has emerged to describe those who have suffered sexual violence and trafficking. It is suggested that the term "survivor" represents greater agency and potential for recovery, rather than the disempowering and passive term "victim" (National Sexual Assault Kit Initiative, 2015; Papendick & Bohner, 2017). However, in ongoing public debates the term "survivor" has been critiqued for undermining one's suffering, and enforcing a societal expectation to "grow" after trauma. (Donegan, 2020; Sehgal, 2016). Moreover, the American Psychiatric Association (2021) guide on inclusive language suggests avoiding these terms all together, and advices to use person-first (i.e., person who experienced sexual violence), rather than identity-first language (i.e., survivor of sexual violence). Finally, those who lived sexual violence conveyed that the term "victim" might serve their benefit in receiving care, or emphasising their credibility during legal procedures (Schwark & Bohner, 2019).

TERMINOLOGY APPLIED IN THIS DISSERTATION

In light of the above, in this dissertation we mainly use the umbrella term "forced migrants", and additionally the term "survivors of sexual violence and trafficking". By using these terms we hope to encompass a wide range of migrants who fled their countries of origin and seek specialised mental health support in the Netherlands. In some instances throughout this dissertation more specific terms, i.e., "(internally) displaced people", "refugees", "trafficking in human beings", "sex trafficking" or "sexual and gender-based violence", are better suited and applied.

THE LIVED EXPERIENCES OF THE STUDY POPULATION

People are condemned to the place and time in which they are born. For many forced migrants this means encountering prolonged hardship, oppression and multiple adversities throughout their lives (Theisen-Womersley, 2021). In this section we will give a brief overview of potentially traumatic (sexual) experiences forced migrants may have faced or still face in order to situate the mental health needs addressed in this dissertation. Despite the vast body of literature on this topic, in-depth explorations of sex trafficking experiences have received less attention.

TRAUMA EXPOSURE PRE-, PERI- AND POSTMIGRATION

Most forced migrants leave their homes with little preparation and financial means, and in great fear and uncertainty. They leave behind all that is familiar, including loved ones and sometimes young children. Their exposure levels to potentially traumatic events vary greatly (Sigvardsdotter et al., 2016), and intersect with their (pre-migration) social standing, marginalised positions, and disruptions of social fabric during war-time (Scholte & Ager, 2014; Walker & Vearey, 2022). Human rights violations particularly take place in times of conflict, including torture, political imprisonment, weaponised violence, sexual violence, mass murders, bombing, looting, abduction, and child soldiering (Human Rights Watch, 2023; Sigvardsdotter et al., 2016). Some additionally face violence, inequality, imprisonment, rape, torture, or killings, because of their *sexual orientation and gender identity expression* (SOGIE; Nilsson et al., 2021).

Peri-migration, forced migrants are vulnerable to (sexual) violence, and women, girls, and those with diverse SOGIEs are disproportionately targeted by traffickers (Buckinx et al., 2022, Vu et al., 2014). In their pursuit of security, they may face further human rights violations by European policies, for instance, by governments' attempts to discourage migration by the use of immigration detention, and by a lack of preparedness and inhumane living conditions in shelters (Human Rights Council, 2023; Médecins sans Frontières, 2023). When resettled in the Global North migrants' vulnerability for sexual violence and trafficking is increased once again by their lack of resources, uncertain residential status, (un)awareness of their legal rights, and language barriers (International Organization for Migration, 2019).

EXPERIENCES OF SEX TRAFFICKING BEYOND THE SURFACE

Victim-perpetrator dichotomies and rape myths, for instance portrayed in the media, shape what we expect sexual violence to look like (Grubb & Turner, 2012; Merken & James, 2020). Such stereotypes perpetuate a victimhood hierarchy, validating some as "real victims", i.e. a young, non-intoxicated, appropriately dressed female who is assaulted by an unknown attacker, resists the assault, and immediately reports to the police, while discrediting the narratives of others (Boukli & Renz, 2019; Hockett et al., 2016).This is particularly true for sex trafficking, where the victims are often portrait as vulnerable, forced into sex work by being locked up or by use of physical force (Zhang, 2009). The perpetrator is often portrayed as a "loverboy", masculine, violent, and physically attractive (Merodio et al., 2020).

Yet, these stereotypes fail to capture the complexity of sex trafficking experiences, and might lead to an identification gap by law enforcement or healthcare professionals (Mapp et al., 2016; Yakushko, 2009). In turn, this might prevent survivors from receiving services or care, and misjudge their suffering. In reality, the majority of rape survivors experience "tonic immobility", where they do not "fight back", and are unable to move (De La Torre Laso, 2023). Moreover, some survivors might be in an intimate relationship with their perpetrator, be accustomed to threats and violence, or consider their current exploitative situation an improvement to prior life experiences (Casassa et al., 2022; Chambers et al., 2022). These realities complicate the identification of sex trafficking survivors, and may lead to survivors questioning the validity of their victimhood. The literature

on the diversity of sex trafficking experiences is scarce and their various dynamics of control are poorly understood (Bryan, 2016; Iglesias-Rios et al., 2020; Merodio et al., 2020; Silverman et al., 2007).

POTENTIALLY TRAUMATIC EVENTS AMONGST FORCED MIGRANTS IN THE NETHERLANDS

Overall, forced migrants residing in the Netherlands may have encountered accumulative potentially traumatic events, including repeated sexual violence. These experiences may impact the mental health of forced migrants and some may develop psychopathology, such as posttraumatic stress disorder (PTSD). Notably, experiences of sex trafficking may surpass common assumptions and their heterogeneity needs further consideration.

THE MENTAL HEALTH OF THE STUDY POPULATION

In this section we will first provide an overview of the literature on mental illness prevalence rates among refugees, asylum seekers, and survivors of sexual violence and trafficking. We will focus mainly on (sexual) psychotrauma related suffering and PTSD as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013). To conclude we will outline common critiques of a “trauma” and “PTSD” lens to describe the suffering of forced migrant populations.

MENTAL HEALTH PROBLEMS PREVALENCE RATES

There is a vast body of research on the prevalence of DSM-5 defined mental illnesses amongst refugees, asylum seekers, and displaced people (e.g., Blackmore et al., 2020; Mesa-Vieira et al., 2022; Porter & Haslam, 2005). The prevalence rates of studies incorporated in these meta-analyses show great variability and several methodological challenges. Henkelman et al. (2020) conducted a meta-analysis amongst 14.882 refugees resettled in high-income countries and found substantial prevalence rates for self-reported or diagnosed anxiety (13 to 42%), depression (30 to 40%), and PTSD (29 to 37%). Interestingly, they found that these prevalence rates were high even when compared to other populations living in conflict or war settings. They suggested that adversities peri- or post-migration might explain this difference. Another meta-analyses by Patanè et al. (2022) found similar results amongst 11.053 clinically diagnosed refugees and asylum seekers worldwide. Studies focused on Dutch refugee samples found similar reported PTSD rates (e.g., Gerritsen et al., 2006; Lamkaddem et al., 2014).

Literature on the mental health of survivors of conflict-related sexual violence or sex trafficking is far more scarce. García-Vázquez and Meneses-Falcón (2023) found varying prevalence rates for PTSD (13-77%), depression (12-88.7%), suicidal ideation (5.2- 45%), and anxiety disorders (10- 97.7%) when reviewing 39 studies. Evans et al. (2022) found higher prevalence for complex PTSD (41%) than for PTSD (14%) amongst 342 survivors of modern slavery and human trafficking in the UK. Ba and Bhopal (2017) conducted a meta-analyses on the mental health of civilians

who have experienced war-related sexual violence in 14 studies, they found great variation in prevalence rates for PTSD (3.1–75.9%), anxiety (6.9–75%), and depression (8.8–76.5%). No studies have reported on PTSD prevalence rates of survivors of sexual violence and trafficking residing in the Netherlands yet. Despite difficulties in comparing the samples above, it may be presumed that PTSD is prominently present amongst forced migrants and survivors of sexual violence and trafficking, including those residing in the Netherlands. As a result these people may seek treatment within Dutch mental healthcare to alleviate their mental health suffering.

CRITIQUES OF "TRAUMA" AND "PTSD" TERMINOLOGY APPLIED TO FORCED MIGRANTS

Forced migrants seeking mental health treatment in the Netherlands will encounter biomedical explanatory models (Zorginstituut Nederland, 2018), and there their mental health suffering will be categorised by use of the DSM-5 (American Psychiatric Association, 2013). As a result, this dissertation mostly engages with this framework. However, since the terms "trauma" and "PTSD" have been applied to forced migrant populations, conflict and war, their use has been scrutinised and critiqued (e.g., Fassin & Rechtman, 2009; Summerfield, 1999). For instance, it is said that forced migrants have become too heavily framed as "traumatised populations" suffering from PTSD (Miller et al., 2006). This focus on individual neglected trauma is believed to take attention away from the broader sociopolitical context as causes of suffering (Matthies-Boon, 2018; Torre, 2023). Second, framing the mental health issues linked to "traumatised populations" as "neglected" or "disgarded" calls for action. In most cases, this means biomedical explanatory models of mental health developed in the Global North are "exported" to the Global South (Cox & Webb, 2015). These practices, where experts originating from the Global North train locals in medialised and decontextualised frameworks, are critiqued for their post-colonial echoes (Beresford & Rose, 2023). Final, it is proposed that a dominant biomedical frame might undermine local idioms of distress, suppress ancestral, religious or spiritual knowledge, or deny a broader prioritisation for wellbeing (Kirmayer et al., 2014; Mendenhall, & Kim, 2021; Rose & Kalathil, 2019). How conceptualisations of "neglected mental health conditions" are understood and applied when addressing the needs of forced migrants remains an outstanding question.

CHALLENGES AND GAPS IN MENTAL HEALTHCARE PROVISION IN THE NETHERLANDS

For some forced migrants their psychological suffering will outweigh their personal or social resources, and they might seek mental healthcare in the Netherlands. We start this section by highlighting a treatment gap in addressing the risk of sexual revictimisation amongst survivors of sexual violence and trafficking. In this dissertation we propose a role for body dysregulation in understanding and mitigating sexual revictimisation risk. We then briefly outline the evidence base for trauma-focused therapies amongst forced migrants, in particular Narrative Exposure Therapy (NET; Schauer et al., 2011). In this dissertation we will address obstacles forced migrants might

face when engaging in NET. We conclude this section by introducing the potential hindrance of daily stressors and/or difficulties in emotion regulation to NET treatment response and adherence.

SEXUAL REVICTIMISATION: THE POTENTIAL ROLE OF BODY DYSREGULATION

Amongst the populations addressed in this dissertation repeated sexual violence is not uncommon (National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children, 2021). For instance, one might have experienced sexual abuse as a child, forced (child) marriage as a teenager, and sex trafficking during migration to Europe. When entering mental healthcare, survivors may convey statements such as: "It is like I am cursed, why does this keep happening to me?", or "I just freeze when someone approaches me in the street". Yet, sexual revictimisation risk has received little attention within mental healthcare, and pinpointing its underling psychological mechanisms is complicated (Breitenbecher, 2001; Classen et al., 2005).

Trauma is often a bodily phenomenon, it is the physical body that notices pain during torture, that is penetrated during rape, or that has an immensely strong heartbeat while hearing the impact of bombs (Van der Kolk, 2015). During trauma and its aftermath, the immense stress levels are regulated by the body (Sherin & Nemeroff, 2011) and memories of traumatic events become fragmented (Kearney et al., 2023). In line with PTSD criteria (American Psychiatric Association, 2013) trauma (partially) manifests itself via physical and emotional reactions (e.g., being easily startled, feeling emotionally numb, or having difficulty experiencing positive emotions). Furthermore, one's ability to notice and respond to body signs, needs, emotions, and boundaries may become dysregulated. This could lead to difficulties in sleep, eating, emotion regulation, and interpersonal functioning (Kearney & Lanius, 2022; Lanius et al., 2015; Van der Kolk, 2013). Moreover, states of hypoarousal (e.g., numbness or dissociation) or hyperarousal (e.g., restlessness or aggravation), may prevent one from sensing and responding to threat and put one at higher risk for (sexual) revictimisation (Messman-Moore & Brown, 2006; Messman-Moore et al., 2010; Risser et al., 2006). Body-based conceptualisations of trauma are understudied in general, and amongst forced migrants in particular (O'Brien & Charura, 2022; Schaeffer & Cornelius-White, 2021; Van de Kamp et al., 2019). However, given the prolonged, and often early-onset, traumas forced migrants face, their bodies are likely impacted as outlined above. A body-based framework could provide crucial insights into comprehending and mitigating the risk of sexual revictimisation.

THE EVIDENCE BASE FOR NET AND OTHER TRAUMA-FOCUSED THERAPIES

NET was developed over 20 years ago as a short-term manualised approach for the treatment of PTSD resulting from organised violence. From the start the effectiveness of NET was studied by researchers and practitioners from German universities and the non-governmental organisation victim's voice (Schauer et al., 2011). When this dissertation was initiated the evidence-base for NET was emerging, although the method was also criticised (Mundt et al., 2014; Neuner et al., 2014). Over the years various meta-analyses evaluating mental health treatment for forced migrants endorsed NET (Kip et al., 2020; Nosè et al., 2017; Thompson et al., 2018; Turrini et al., 2017). For survivors of sexual violence and trafficking, (meta-analytic) studies on mental healthcare

provision are rare. Wright et al. (2020) conducted a meta-analysis on interventions to support survivors of modern slavery and included nine studies predominantly covering former soldiers partaking in NET. Conclusions could not be drawn, as they identified a research and treatment gap for this population. Similarly, Tol et al. (2013) reviewed seven studies on psychosocial support for survivors of conflict-related violence, and stated that "an obvious conclusion is that the number of studies conducted does not match the significance of the problem" (p. 7). Given its promise in alleviating PTSD symptoms in displaced populations, NET found its way to Dutch mental healthcare over a decade ago. Here, however, NET practitioners encountered various challenges, such as high no-show and limited treatment adherence, not previously addressed in randomised controlled trails carried out in the Global South (Lely et al., 2019).

THE ROLE OF DAILY STRESSORS DURING TRAUMA-FOCUSED THERAPY

When the term daily stressors was introduced by Miller and Rasmussen (2010) they claimed that trauma-focused approaches fail to consider the influence of stressful social conditions on forced migrants' mental health. This immediately sparked a still ongoing debate (Neuner, 2010) on the prioritisation of either daily stressors or mental health, for PTSD in particular. Later, the relationship between daily stressors and PTSD for forced migrants was further examined, yielding mixed results (Byrow et al., 2022; Hou et al., 2020; Li et al., 2016). For survivors of sex trafficking or conflict-related sexual violence specifically little evidence exists regarding the influence of daily stressors on their wellbeing. One study by Nodzenski et al. (2020) amongst trafficked children and adolescents found that concerns about social ostracisation and maltreatment were associated with various mental health outcomes, including PTSD.

In clinical practice in the Netherlands, the NET treatment process is often disrupted by ongoing daily stressors. These entail either practical issues (e.g., having limited means for travel, needing to take on work as it comes along, not having access to daycare for smaller children, or being relocated between shelters), or psychological problems (e.g., by the impact of human trafficking or asylum procedures, marginalisation, uncertainty about the future, financial uncertainty, or being separated from loved ones). Yet whether higher perceived stress due to these uncontrollable social circumstances actually influences treatment adherence and outcomes is unclear. During the course of this dissertation some studies indeed found daily stressors to interfere with the treatment process (Djelantik et al., 2020; Kaltenbach et al. 2020), whereas other studies did not (Bruhn et al., 2018). Hence, more research is needed to determine if and how daily stressors influence PTSD trauma-focused treatment amongst forced migrants.

THE ROLE OF EMOTION DYSREGULATION DURING TRAUMA-FOCUSED THERAPY

While partaking in NET, forced migrants are asked to label their past and present sensations and emotions while narrating about their major traumatic memories. For some, the exposure to their traumas might outweigh their abilities, resulting in avoidance, no-show, and discontinuation of treatment. In clinical practice, this has led to a pressing question amongst trauma specialists: Should patients be "stabilised" in order to partake and benefit from trauma-focused therapy? Or

can trauma-focused therapy itself be considered a "stabilising" therapy? No formal definition exists of when someone would be considered "stable". In general, the term seems to refer to having little ongoing stressors or current threats, and an ability to self-regulate while staying within a so-called *window of tolerance* of optimal emotional and physical arousal (Ogden et al., 2006; Siegel, 1999). For forced migrants and other traumatized populations alike, reaching a state of stabilisation is not merely a matter of psycho-education, emotional skills training, or improving activities of daily living. Instead, some asylum seekers may spend many years waiting for an outcome of their applications, meanwhile living in uncertainty, fear of being deported, and sometimes in unsafe shelter settings (e.g., for women or those with diverse SOGIEs). In such cases waiting for "stabilisation and safety" could be in vain.

Those who advocate a stabilisation phrase prior to trauma-focused therapy highlight the heterogeneity of PTSD patients and propose a tailor-made approach (Cloitre, 2016). This approach may also apply for forced migrants with complex PTSD (Ter Heide et al., 2016). Those who recommend initiating trauma-focused therapy without a stabilisation phase, argue that there is a lack of evidence demonstrating the effectiveness of a stabilisation phase in reducing PTSD symptoms (Bicanic et al., 2015; De Jongh et al., 2016, 2019; Voorendonk et al., 2020).

Various studies have confirmed the interrelatedness between PTSD and emotion dysregulation amongst refugees (Ehring & Quack, 2010; Specker & Nickerson, 2019) and survivors of sexual violence (Walsh et al., 2012). In other traumatised populations, emotion dysregulation was found to influence the outcomes of trauma-focused treatment (e.g., Sharma-Patel & Brown, 2016). Whether emotional dysregulation might interfere with treatment response or adherence amongst forced migrants remains an outstanding question. During the course of this dissertation, a case study has been published underlining the relevance of this question (Tissue et al., 2023). The case study demonstrates that addressing emotion dysregulation beforehand might support NET engagement and outcomes.

RESEARCH GAPS

As outlined above there are various gaps in our understanding of and evidence on the mental health (treatment) of forced migrants and survivors of sexual violence and trafficking. As compared to forced migrants, the literature on the mental health (treatment) of migrant survivors of sexual violence and trafficking is far more scarce and limited by methodological constraints.

THE NEXUS OF SEXUAL VIOLENCE EXPERIENCES IN TIMES OF CONFLICT

Current legal labelling for survivors of (conflict-related) sexual violence and trafficking greatly influences one's access to care, shelter, and likelihood of obtaining a residency permit. While these regulations are understandable from a legal point of view, their relevance from a mental health perspective is not always clear. Should it matter whether someone is sexually violated or sex trafficked as part of an ongoing conflict? A conceptual multidisciplinary exploration of the

nexus between conflict-related sexual violence and sex trafficking during conflict is currently missing in the existing literature.

UNTANGLING SEX TRAFFICKING EXPERIENCES AND ADDRESSING SEXUAL REVICTIMISATION

At the start of this dissertation, very little was known about the heterogeneity of sex trafficking experiences and the mental health status of survivors, let alone about differential mental healthcare provision. Most literature was focused on the legal domain, concerned broad samples (e.g., inclusive of labour trafficking), or made use of large health surveys amongst shelter populations (Ottisova et al., 2016; Zimmerman & Hossain, 2007). Although these studies provided valuable insights into this understudied population, they offered little guidance for mental health professionals serving this population.

In 2010, the Dutch government started a pilot called *Categorale Opvang voor Slachtoffers van Mensenhandel* (COSM). The aim of this pilot was to provide safety, support and care for human trafficking survivors, mainly women, by offering 50 beds in three specialised shelters. The hope was that by offering these specialised services more survivors would be willing to cooperate with the investigation and prosecution of their traffickers (see Londen & Hagen, 2012). Both in the literature and in the COSM, pilot survivors were mostly addressed as one group: victims of human trafficking. For those working with the population, however, it was evident that the group was very heterogeneous (i.e., in terms of personal histories, sexual orientation, type of sex trafficking experience, and mental health care needs) and often vulnerable to sexual revictimisation. For instance, after receiving trauma-focused treatment, some of these survivors would end up in abusive relationships again or still felt confused about their role in the exploitation.

As a result, several questions arose during multisite exchanges between civil servants, policy makers, mental health professionals, and COSM coordinators. A first question was; which subgroups can be distinguished within the population, and how could we best address their specific mental health needs? A second question was; what puts survivors at-risk for sexual revictimisation, and how could we mitigate this risk within mental care provision? We hypothesised that these vulnerabilities may begin to shift by reconnecting with body sensations and improving confidence in expressing personal boundaries (e.g., Van der Kolk, 2015).

NEGLECTED MENTAL HEALTH CONDITIONS

In a call for funding by the United Kingdom's Research & Innovation (UKRI) programme of international development, applicants were tasked with "identifying key neglected chronic mental health conditions" associated with protracted displacement, conflict, and gendered violence. This task is taken up by a team of psychologists and medical/social anthropologists as part of this dissertation. When trying to operationalise the terminology used by the funder and other agencies: *neglected* and *chronic mental health conditions* many questions arose. These included: "What are neglected chronic mental health conditions?", "Who exactly is neglecting these mental health conditions?", "In which ways are mental health conditions neglected?", and

moreover: “If mental health conditions are neglected, is this a problem?”. Therefore, we will explore how various individuals could engage with the term “neglected mental health conditions” in protracted displacement settings.

PREDICTORS OF CHANGE AND ADHERENCE DURING NET

When engaging in NET, forced migrants might be hindered by the stress of ongoing social circumstances, or difficulties in regulating their emotions. In this dissertation we examine if high perceived daily stress and emotion dysregulation might inhibit treatment response (i.e., reduction in posttraumatic stress symptoms) amongst treatment-seeking traumatised forced migrants. And vice versa, whether improved levels of perceived daily stress and emotion dysregulation explain reductions in posttraumatic stress. Finally, we examine whether pretreatment levels of perceived stress and emotion dysregulation were associated with NET adherence and completion rates.

STUDY SETTINGS

Various gaps in the literature and questions from a clinical practice perspective outlined above were developed and will be addressed at ARQ Centrum’45. This national mental healthcare institute is based in the capital region of the Netherlands. The centre specialises in psychotrauma and serves a broad group of treatment-seeking persons (e.g., asylum seekers, refugees, undocumented people, trafficked people, police officers, and war veterans). NET is one of the main trauma-focused therapies offered. In 2013 first discussions on topics addressed in this dissertation took place at Equator Foundation, Diemen, the Netherlands (now part of ARQ Centrum’45). Equator Foundation offered mental healthcare at the COSM shelters, and this collaboration inspired some of the research questions addressed in this dissertation. Up until today one of ARQ Centrum’45’s multidisciplinary teams offers specialised mental healthcare to (forced) migrant survivors of sexual and SOGIE-related violence, and sex trafficking. During the course of this dissertation, the author has worked both as a researcher and a therapist as part of this team. Through our work, we met human rights lawyers specialised in human trafficking and conflict-related sexual violence. In various discussions we tried to understand each other’s professional backgrounds, identify where these might disagree, and share our joint reflections.

At later stages of this dissertation the opportunity arose to contribute to an international research consortium led by the University of Edinburgh, in collaboration with various (African) research partners, and ARQ International (for more information see: https://displacement.sps.ed.ac.uk/). This research consortium is partially focused on identifying “key neglected chronic mental health conditions” associated with protracted displacement, conflict, and gendered violence.

RESEARCH AIMS AND QUESTIONS

The overall aim of this dissertation is to address several gaps in our understanding of the mental health needs of forced migrants, including survivors of sexual violence and trafficking. We will conduct various empirical studies aimed at questioning conceptualisations, and advancing mental health care provision and policy. There are several research questions this dissertation addresses:

1. What is the nexus between "conflict-related sexual violence" and "sex trafficking during conflict", considering their legal definitions, and the impact of these crimes on the lives of the survivors?
2. What subgroups can be distinguished among survivors with sex trafficking experiences, and what is the role of sociodemographic background, prior traumas, and mental health (treatment) indicators?
3. Is a body-based treatment module aimed at mitigating sexual revictimisation feasible amongst survivors of sexual violence and trafficking?
4. How do relevant actors (i.e., those with lived and/or professional experience of displacement) understand the concept of "neglected mental health disorders" in settings of protracted displacement?
5. How can we understand the interaction between daily stressors, emotion dysregulation, and posttraumatic stress symptoms during trauma-focused therapy?

By addressing these questions, we aim to explore common legal and mental health concepts, offer in-depth insights into (traumatic) experiences, examine predictors of change during trauma-focused treatment, and ultimately contribute to clinical practice for forced migrants and survivors of sexual violence and trafficking.

METHODOLOGY

This dissertation contains one theoretical outline, one study protocol, and five empirical studies, mainly including psychiatric patient populations in the Netherlands. In our theoretical study we aim to advance discussion and develop theory by literature study and interdisciplinary exchange. For our empirical studies we used multiple methods, including quantitative and qualitative approaches, to test the research questions outlined above. Methods included a person-centered approach within a historical cohort study; a multi-method approach in a feasibility study using intra-personal analysis of questionnaires and coding of (group-) interviews; qualitative analyses by coding interviews; and mixture modelling and (logistical) regression analysis in an observational treatment study using questionnaires.

GENERAL OVERVIEW

See Table 1 for an overview of the chapters included in this dissertation. Part one focusses on survivors of sexual violence and trafficking, and contains three chapters. The second section is focused on forced migrants, including those who survived sexual violence and trafficking, and contains four chapters. Finally, **chapter 9** concludes with a summary of the overall main findings, a general discussion and directions for future research.

SECTION 1. SURVIVORS OF SEXUAL VIOLENCE AND TRAFFICKING

In **chapter 2**, we explore, together with human right lawyers, the validity of existing legal frameworks on "trafficking in human beings" and "conflict-related sexual violence". We explored the question: Should it matter from a psychological and legal point-of-view to distinguish between these labels? In **chapter 3** we use latent class analysis to identify subgroups within sex trafficking experiences, amongst a clinical sample of women survivors. Also, we consider whether these subgroups relate to their sociodemographic backgrounds, prior traumas, and mental health (treatment) indicators. Finally, in **chapter 4** we apply a multi-method approach to examine the feasibility of a body-oriented module aimed at sexual revictimisation risk mitigation. Using a Bayesian approach we evaluate the intra-individual course of body awareness, body dissociation and self-efficacy in expressing personal boundaries. Final, the perspectives of sexual violence and trafficking survivors, and the facilitators are taken into account via interviews.

SECTION 2. FORCED MIGRANTS

In **chapter 5** we, together with social and medical anthropologists, focus on the concept of "neglected mental health conditions". We explore how different actors, i.e., those with lived and/or professional experience, interact with the concept of "neglect" in the context of (internal) displacement in Somalia, the Democratic Republic of Congo and South Africa.

The final three chapters are about a study on predictors of change and adherence during NET offered to forced migrants and survivors of sexual violence and trafficking. In **chapter 6** we introduce the study protocol for this study. In **chapter 7**, using latent growth modelling, we consider whether posttraumatic stress, perceived stress, emotion dysregulation, and mood change simultaneously during NET. Also, we apply random-intercept cross-lagged modelling to examine if the changes in these concepts precede changes in posttraumatic stress over the course of treatment. In **chapter 8** we focus on the role of pretreatment levels of perceived stress and emotion dysregulation in understanding NET adherence and completion. We will use logistic and linear regression analyses, while considering posttraumatic stress levels at pretreatment.

Table 1

Overview of Chapters in This Dissertation

Chapter	Topic	Type	Sample	Aims
Section 1. Survivors of sexual violence and trafficking				
2	The nexus between conflict-related sexual violence and sex trafficking	Multidisciplinary theoretical exploration	-	Exploring the nexus between conflict-related sexual violence and sex trafficking from both a legal and a psychological viewpoint.
3	The heterogeneity of sex trafficking experiences	Quantitative approach using latent class analysis	*N* = 337 women adult survivors of sex trafficking	Identifying subgroups within sex trafficking experiences and the interaction with demographic factors, prior traumatic experiences, and mental health (treatment).
4	Sexual revictimisation risk mitigation	Multi-method evaluation, using qualitative analysis and Informative hypotheses testing	*N* = 13 survivors of sexual violence and trafficking	Examining the feasibility of a body-oriented module.
Section 2. Forced Migrants				
5	Neglect of mental health conditions in protracted displacement settings	Multidisciplinary theoretical and qualitative analysis	*N* = 20 people with professional and/or lived experience of displacement	Exploring conceptualisations of "neglect" in relation to mental health at the intersection of gender and protracted displacement.
6	Feasibility and predictors of change during NET	Study protocol	-	-
7	The influence of perceived stress, emotion dysregulation and mood on PTS changes during NET	Quantitative approach using latent growth modelling and random-intercept cross-lagged modelling	*N* = 40 forced migrants who completed NET	Examining potential changes, interrelatedness and temporal relations between PTS, perceived daily stress, emotion dysregulation, and mood during NET.
8	The role of pretreatment emotion dysregulation and perceived stress on NET attendance and completion	Quantitative approach using logistic and linear regression analyses	*N* = 86 forced migrants who started NET	Examining whether baseline levels of perceived daily stress and emotion dysregulation are associated with NET completion and adherence.

Note. NET = Narrative Exposure Therapy. PTS = posttraumatic stress.

REFERENCES

Ahmed, K. J., Haq, S. M. A., & Bartiaux, F. (2019). The nexus between extreme weather events, sexual violence, and early marriage: A study of vulnerable populations in Bangladesh. *Population and Environment*, *40*(3), 303–324. https://doi.org/10.1007/s11111-019-0312-3

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth Edition). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2021). Inclusive language guidelines. https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines.pdf

Amnesty International. (2023). *Seksueel geweld: Blinde vlek in de asielprocedure?* https://www.amnesty.nl/content/uploads/2023/03/AMNL_Rapport_Seksueel-geweld_blinde-vlek.pdf

Ba, I., & Bhopal, R. S. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: A systematic review (1981–2014). *Public Health*, *142*, 121–135. https://doi.org/10.1016/j.puhe.2016.07.019

Benatar, S. R. (1998). Global disparities in health and human rights: A critical commentary. *American Journal of Public Health*, *88*(2), 295–300. https://doi.org/10.2105/AJPH.88.2.295

Beresford, P., & Rose, D. (2023). Decolonising global mental health: The role of Mad Studies. *Cambridge Prisms: Global Mental Health*, 1–21. https://doi.org/10.1017/gmh.2023.21

Bicanic, I., de Jongh, A., & ten Broeke, E. (2015). Stabilisatie in traumabehandeling bij complexe PTSS: Noodzaak of mythe? [Stabilization in trauma-focused treatment in complex PTSD: necessity or myth?]. *Tijdschrift Voor Psychiatry*, *57*(5), 332–339. https://www.tijdschriftvoorpsychiatrie.nl/media/5/57-2015-5-artikel-bicanic.pdf

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLOS Medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Boukli, A., & Renz, F. (2019). Deconstructing the lesbian, gay, bisexual, transgender victim of sex trafficking: Harm, exceptionality and religion–sexuality tensions. *International Review of Victimology*, 25(1), 71–90. https://doi.org/10.1177/0269758018772670

Boskovic, M., & Jankovic, B. (2023). Forced migrations and the risk of human trafficking: In E. Alaverdov & M. W. Bari (Eds.), *Advances in public policy and administration* (pp. 18–36). IGI Global. https://doi.org/10.4018/978-1-6684-6334-5.ch002

Breitenbecher, K. H. (2001). Sexual revictimization among women. *Aggression and Violent Behavior*, *6*(4), 415–432. https://doi.org/10.1016/S1359-1789(00)00014-8

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *Journal of Nervous & Mental Disease*, *206*(1), 61–68. https://doi.org/10.1097/NMD.0000000000000774

Bryan, S. P. & N. (2016). Vulnerability to human trafficking among the Roma population in Serbia: The role of social exclusion and marginalization. In *Human Trafficking*. Routledge.

Buckinx, B., Lata Hogg, C., & Vaughn, L. (2022). *The intersection of conflict-related sexual violence against men, boys, and LGBTQI+ persons and human trafficking*. Liechtenstein Institute on Self-Determination, Princeton University. https://oar.princeton.edu/bitstream/88435/pr10r9m39z/1/1222_CRSV.pdf

Byrow, Y., Liddell, B., O'Donnell, M., Mau, V., McMahon, T., Bryant, R., Benson, G., & Nickerson, A. (2022). Profiles of post-migration stressors and mental health in refugees: A latent class analysis. *Psychiatry Research*, *311*, 114494. https://doi.org/10.1016/j.psychres.2022.114494

Casassa, K., Knight, L., & Mengo, C. (2022). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse*, *23*(3), 969–984. https://doi.org/10.1177/1524838020985542

Chambers, R., Gibson, M., Chaffin, S., Takagi, T., Nguyen, N., & Mears-Clark, T. (2022). Trauma-coerced attachment and Complex PTSD: Informed care for survivors of human trafficking. *Journal of Human Trafficking*, 1–10. https://doi.org/10.1080/23322705.2021.2012386

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, 6(2), 103–129. https://doi.org/10.1177/1524838005275087

Cloitre, M. (2016). Commentary on de Jongh et al. (2016) critique on the ISTSS Complex PTSD Guidelines: Finding the way forward. *Depression and Anxiety*, *33*(5), 355–356. https://doi.org/10.1002/da.22493

Cox, N., & Webb, L. (2015). Poles apart: Does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice? *Sociology of Health & Illness*, *37*(5), 683–697. https://doi.org/10.1111/1467-9566.12230

Davies, S. E., & True, J. (2015). Reframing conflict-related sexual and gender-based violence: Bringing gender analysis back in. *Security Dialogue*, *46*(6), 495–512. https://doi.org/10.1177/0967010615601389

De Jongh, A., Bicanic, I., Matthijssen, S., Amann, B. L., Hofmann, A., Farrell, D., Lee, C. W., & Maxfield, L. (2019). The current status of EMDR therapy involving the treatment of Complex Posttraumatic Stress Disorder. *Journal of EMDR Practice and Research*, *13*(4), 284–290. https://doi.org/10.1891/1933-3196.13.4.284

De Jongh, A., Resick, P. A., Zoellner, L. A., Van Minnen, A., Lee, C. W., Monson, C. M., Foa, E. B., Wheeler, K., Broeke, E. T., Feeny, N., Rauch, S. A. M., Chard, K. M., Mueser, K. T., Sloan, D. M., Van Der Gaag, M., Rothbaum, B. O., Neuner, F., De Roos, C., Hehenkamp, L. M. J., …

Bicanic, I. A. E. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33(5),* 359–369. https://doi.org/10.1002/da.22469

De La Torre Laso, J. (2023). The reality of tonic immobility in victims of sexual violence: "I was paralyzed, I couldn't move." *Trauma, Violence, & Abuse*, 15248380231191232. https://doi.org/10.1177/15248380231191232

Djelantik, A. A. A. M. J., De Heus, A., Kuiper, D., Kleber, R. J., Boelen, P. A., & Smid, G. E. (2020). Post-migration stressors and their association with symptom reduction and non-completion during treatment for traumatic grief in refugees. *Frontiers in Psychiatry*, *11*, 407. https://doi.org/10.3389/fpsyt.2020.00407

Domoney, J., Howard, L. M., Abas, M., Broadbent, M., & Oram, S. (2015). Mental health service responses to human trafficking: A qualitative study of professionals' experiences of providing care. *BMC Psychiatry*, *15*(1), 289. https://doi.org/10.1186/s12888-015-0679-3

Donegan, M. (2020, August 15). *Should we stop calling rape victims "survivors"?* https://www.theguardian.com/commentisfree/2020/aug/15/i-disdain-the-word-survivor-michelle-bowdler-moira-donegan

Ehring, T., & Quack, D. (2010). Emotion regulation difficulties in trauma survivors: The role of trauma type and PTSD symptom severity. *Behavior Therapy*, *41*(4), 587–598. https://doi.org/10.1016/j.beth.2010.04.004

Evans, H., Sadhwani, S., Singh, D. N., Robjant, D. K., & Katona, P. C. (2022). Prevalence of complex post-traumatic stress disorder in survivors of human trafficking and modern slavery: A systematic review. *The European Journal of Psychiatry*, *36*(2), 94–105. https://doi.org/10.1016/j.ejpsy.2022.01.005

Fassin, D., & Rechtman, R. (2009). *The empire of trauma: An inquiry into the condition of victimhood*. Princeton University Press.

García-Vázquez, O., & Meneses-Falcón, C. (2023). What is the impact of human trafficking on the biopsychosocial health of victims: A systematic review. *Journal of Immigrant and Minority Health*. https://doi.org/10.1007/s10903-023-01496-z

Gerritsen, A. A. M., Bramsen, I., Devillé, W., Van Willigen, L. H. M., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *41*(1), 18–26. https://doi.org/10.1007/s00127-005-0003-5

Grubb, A., & Turner, E. (2012). Attribution of blame in rape cases: A review of the impact of rape myth acceptance, gender role conformity and substance use on victim blaming. *Aggression and Violent Behavior*, *17*(5), 443–452. https://doi.org/10.1016/j.avb.2012.06.002

Ter Heide, F. J. J. T., Mooren, T. M., & Kleber, R. J. (2016). Complex PTSD and phased treatment in refugees: A debate piece. *European Journal of Psychotraumatology*, *7*(1), 28687. https://doi.org/10.3402/ejpt.v7.28687

Henkelmann, J.-R., De Best, S., Deckers, C., Jensen, K., Shahab, M., Elzinga, B., & Molendijk, M. (2020). Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: Systematic review and meta-analysis. *BJPsych Open*, *6*(4), e68. https://doi.org/10.1192/bjo.2020.54

Hockett, J. M., Smith, S. J., Klausing, C. D., & Saucier, D. A. (2016). Rape myth consistency and gender differences in perceiving rape victims: A meta-analysis. *Violence Against Women, 22(2),* 139–167. https://doi.org/10.1177/1077801215607359

Hou, W. K., Liu, H., Liang, L., Ho, J., Kim, H., Seong, E., Bonanno, G. A., Hobfoll, S. E., & Hall, B. J. (2020). Everyday life experiences and mental health among conflict-affected forced migrants: A meta-analysis. *Journal of Affective Disorders*, *264*, 50–68. https://doi.org/10.1016/j.jad.2019.11.165

Human Rights Council. (2023). *Human rights of migrants* (A/HRC/54/81). United Nations General Assembly.

Human Rights Watch. (2023). *World report 2023: events of 2022*. https://www.hrw.org/sites/default/files/media_2023/01/World_Report_2023_WEBSPREADS_0.pdf

Iglesias-Rios, L., Harlow, S. D., Burgard, S. A., West, B., Kiss, L., & Zimmerman, C. (2020). Patterns of violence and coercion with mental health among female and male trafficking survivors: A latent class analysis with mixture models. *Epidemiology and Psychiatric Sciences*, *29*, e38. https://doi.org/10.1017/S2045796019000295

Institute of Medicine (US) Forum on Microbial Threats. (2006). A world in motion: The global movement of people, products, pathogens, and power. In *The impact of globalization on infectious disease emergence and control: Exploring the consequences and opportunities: Workshop Summary*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK56593/

International Organization for Migration. (2019). *Mapping report on legal frameworks and assistance available to migrant victims of sexual and gender-based violence (SGBV)*. https://iom-nederland.nl/images/Protect/PROTECT-project-mapping-legal-framework-SGBV.pdf

Jannesari, S., Hatch, S., & Oram, S. (2020). Seeking sanctuary: Rethinking asylum and mental health. *Epidemiology and Psychiatric Sciences*, *29*, e154. https://doi.org/10.1017/S2045796020000669

Kaltenbach, E., Hermenau, K., Schauer, M., Dohrmann, K., Elbert, T., & Schalinski, I. (2020). Trajectories of posttraumatic stress symptoms during and after Narrative Exposure Therapy (NET) in refugees. *BMC Psychiatry*, *20*(1), 312. https://doi.org/10.1186/s12888-020-02720-y

Kearney, B. E., & Lanius, R. A. (2022). The brain-body disconnect: A somatic sensory basis for trauma-related disorders. *Frontiers in Neuroscience*, *16*, 1015749. https://doi.org/10.3389/fnins.2022.1015749

Kearney, B. E., Terpou, B. A., Densmore, M., Shaw, S. B., Théberge, J., Jetly, R., McKinnon, M. C., & Lanius, R. A. (2023). How the body remembers: Examining the default mode and sensorimotor networks during moral injury autobiographical memory retrieval in PTSD. *NeuroImage: Clinical*, *38*, 103426. https://doi.

org/10.1016/j.nicl.2023.103426

Kip, A., Priebe, S., Holling, H., & Morina, N. (2020). Psychological interventions for posttraumatic stress disorder and depression in refugees: A meta-analysis of randomized controlled trials. *Clinical Psychology & Psychotherapy*, *27*(4), 489–503. https://doi.org/10.1002/cpp.2446

Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural psychiatry*, *51*(3), 299–319. https://doi.org/10.1177/1363461514536358

Kreft, A.-K. (2023). "This patriarchal, machista and unequal culture of ours": Obstacles to confronting conflict-related sexual violence. *Social Politics: International Studies in Gender, State & Society*, *30*(2), 654–677. https://doi.org/10.1093/sp/jxac018

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., & De Jong, J. T. V. M. (2007). Prevalence and predictors of health service use among Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *42*(10), 837–844. https://doi.org/10.1007/s00127-007-0240-x

Lamkaddem, M., Stronks, K., Devillé, W. D., Olff, M., Gerritsen, A. A., & Essink-Bot, M.-L. (2014). Course of post-traumatic stress disorder and health care utilisation among resettled refugees in the Netherlands. *BMC Psychiatry*, *14*(1), 90. https://doi.org/10.1186/1471-244X-14-90

Lanius, R. A., Frewen, P. A., Tursich, M., Jetly, R., & McKinnon, M. C. (2015). Restoring large-scale brain networks in PTSD and related disorders: A proposal for neuroscientifically-informed treatment interventions. *European Journal of Psychotraumatology*, *6*(1), 27313. https://doi.org/10.3402/ejpt.v6.27313

Latham-Sprinkle, J., David, F., Bryant, K., & Larsen, J. (2019). *Migrants and their vulnerability to human trafficking, modern slavery and forced labour*. http://hdl.handle.net/1854/LU-8636089

Lely, J. C. G., Smid, G. E., Jongedijk, R. A., W. Knipscheer, J., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: A review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology*, *10*(1), 1550344. https://doi.org/10.1080/20008198.2018.1550344

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

Londen, M. van, & Hagen, L. (2012). Evaluatie van de pilot "Categorale Opvang voor Slachtoffers van Mensenhandel" [Evaluation of the pilot on categorical accommodation and assistance for victims of trafficking in human beings]. *Wetenschappelijk Onderzoek- en Documentatiecentrum, Ministerie van Justitie En Veiligheid*. https://repository.wodc.nl/handle/20.500.12832/123

Manjoo, R., & Nadj, D. (2015). 'Bridging the divide': An interview with Professor Rashida Manjoo, UN Special Rapporteur on violence against women. *Feminist Legal Studies*, *23*(3), 329–347. https://doi.org/10.1007/s10691-015-9303-7

Mapp, S., Hornung, E., D'Almeida, M., & Juhnke, J. (2016). Local law enforcement officers' knowledge of human trafficking: Ability to define, identify, and assist. *Journal of Human Trafficking*, *2*(4), 329–342. https://doi.org/10.1080/23322705.2016.1143764

Matthies-Boon, V. (2018). Towards a critical trauma studies: A response to Felix Lang. *Middle East - Topics & Arguments*, *11*, 159-62. https://doi.org/10.17192/META.2018.11.7812

Médecins Sans Frontières. (2022, September 11). *Crisis bij aanmeldcentrum Ter Apel [Crisis at reception centre Ter Apel]*. https://www.artsenzondergrenzen.nl/projecten/nederland-ter-apel/

Mendenhall, E., & Kim, A. W. (2021). Rethinking idioms of distress and resilience in anthropology and global mental health. In A. R. Dyer, B. A. Kohrt, & P. J. Candilis (Eds.), *Global mental health ethics* (pp. 157–170). Springer International Publishing. https://doi.org/10.1007/978-3-030-66296-7_10

Merken, S., & James, V. (2020). Perpetrating the myth: Exploring media accounts of rape myths on "women's" networks. *Deviant Behavior*, *41*(9), 1176–1191. https://doi.org/10.1080/01639625.2019.1603531

Merodio, G., Duque, E., & Axt Peña, J. C. (2020). They are not Romeo pimps , they are traffickers: Overcoming the socially dominant discourse to prevent the sex trafficking of youth. *Qualitative Inquiry*, 26(8–9), 1010–1018. https://doi.org/10.1177/1077800420938881

Mesa-Vieira, C., Haas, A. D., Buitrago-Garcia, D., Roa-Diaz, Z. M., Minder, B., Gamba, M., Salvador, D., Gomez, D., Lewis, M., Gonzalez-Jaramillo, W. C., Pahud De Mortanges, A., Buttia, C., Muka, T., Trujillo, N., & Franco, O. H. (2022). Mental health of migrants with pre-migration exposure to armed conflict: A systematic review and meta-analysis. *The Lancet Public Health*, *7*(5), e469–e481. https://doi.org/10.1016/S2468-2667(22)00061-5

Messman-Moore, T. L., & Brown, A. L. (2006). Risk perception, rape, and sexual revictimization: A prospective study of college women. *Psychology of Women Quarterly*, *30*(2), 159–172. https://doi.org/10.1111/j.1471-6402.2006.00279.x

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect*, *34*(12), 967–976. https://doi.org/10.1016/j.chiabu.2010.06.004

Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry*, *76*(4), 409–422. https://doi.org/10.1037/0002-9432.76.4.409

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029

Mundt, A. P., Wünsche, P., Heinz, A., & Pross, C. (2014). Evaluating interventions for posttraumatic stress disorder in low and middle income countries: Narrative Exposure Therapy. *Intervention*, *12*(2), 250. https://journals.lww.com/invn/abstract/2014/12020/evalua-

ting_interventions_for_posttraumatic_stress.9.aspx

National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children. (2021). *Slachtoffermonitor mensenhandel 2016-2020 [Victim monitor human trafficking 2016-2020].* Nationaal Rapporteur.

National Sexual Assault Kit Initiative. (2015). *Victim or survivor terminology from investigation through prosecution*. https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf

Neuner, F. (2010). Assisting war-torn populations – Should we prioritize reducing daily stressors to improve mental health? Comment on Miller and Rasmussen (2010). *Social Science & Medicine*, *71*(8), 1381–1384. https://doi.org/10.1016/j.socscimed.2010.06.030

Neuner, F., Schauer, M., & Elbert, T. (2014). On the efficacy of Narrative Exposure Therapy: A reply to Mundt et al. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *12*(2), 267. https://journals.lww.com/invn/abstract/2014/12020/on_the_efficacy_of_narrative_exposure_therapy__a.10.aspx

Nilsson, J. E., Jeevanba, S. B., Molitoris, A., Stratmann, S., & Kubik, R. (2021). Sexual and gender minority refugees and asylum seekers: An arduous journey. In E. M. Lund, C. Burgess, & A. J. Johnson (Eds.), *Violence Against LGBTQ+ Persons* (pp. 231–239). Springer International Publishing. https://doi.org/10.1007/978-3-030-52612-2_18

Nodzenski, M., Kiss, L., Pocock, N. S., Stoeckl, H., Zimmerman, C., & Buller, A. M. (2020). Post-trafficking stressors: The influence of hopes, fears and expectations on the mental health of young trafficking survivors in the Greater Mekong Sub-region. *Child Abuse & Neglect*, *100*, 104067. https://doi.org/10.1016/j.chiabu.2019.104067

Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., Priebe, S., & Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLOS ONE*, *12*(2), e0171030. https://doi.org/10.1371/journal.pone.0171030

O'Brien, C. V., & Charura, D. (2022). Refugees, asylum seekers, and practitioners' perspectives of embodied trauma: A comprehensive scoping review. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0001342

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy* (1st ed). W.W. Norton.

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences*, *25*(4), 317–341. https://doi.org/10.1017/S2045796016000135

Papendick, M., & Bohner, G. (2017). "Passive victim – strong survivor"? Perceived meaning of labels applied to women who were raped. *PLOS ONE*, *12*(5), e0177550. https://doi.org/10.1371/journal.pone.0177550

Patanè, M., Ghane, S., Karyotaki, E., Cuijpers, P., Schoonmade, L., Tarsitani, L., & Sijbrandij, M. (2022). Prevalence of mental disorders in refugees and asylum seekers: A systematic review and meta-analysis. *Global Mental Health*, *9*, 250–263. https://doi.org/10.1017/gmh.2022.29

Pijnenburg, A., & Rijken, C. (2021). Moving beyond refugees and migrants: Reconceptualising the rights of people on the move. *Interventions*, 23(2), 273–293. https://doi.org/10.1080/1369801X.2020.1854107

Policinski, E., & Kuzmanovic, J. (2019). Protracted conflicts: The enduring legacy of endless war. *International Review of the Red Cross*, *101*(912), 965–976. https://doi.org/10.1017/S1816383120000399

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA*, *294*(5), 602. https://doi.org/10.1001/jama.294.5.602

Raghuraman, S., Stuttard, N., & Hunt, N. (2021). Evaluating narrative exposure therapy for post-traumatic stress disorder and depression symptoms: A meta-analysis of the evidence base. *Clinical Psychology & Psychotherapy*, *28*(1), 1–23. https://doi.org/10.1002/cpp.2486

Richards, C. E., Lupton, R. C., & Allwood, J. M. (2021). Re-framing the threat of global warming: An empirical causal loop diagram of climate change, food insecurity and societal collapse. *Climatic Change*, *164*(3–4), 49. https://doi.org/10.1007/s10584-021-02957-w

Risser, H. J., Hetzel-Riggin, M. D., Thomsen, C. J., & McCanne, T. R. (2006). PTSD as a mediator of sexual revictimization: The role of reexperiencing, avoidance, and arousal symptoms. *Journal of Traumatic Stress*, *19*(5), 687–698. https://doi.org/10.1002/jts.20156

Rose, D., & Kalathil, J. (2019). Power, privilege and knowledge: The untenable promise of co-production in mental "health." *Frontiers in Sociology*, *4*, 57. https://doi.org/10.3389/fsoc.2019.00057

Schaeffer, A. J., & Cornelius-White, J. H. D. (2021). Qualitative studies on body-based interventions for refugees: A meta-synthesis. *Body, Movement and Dance in Psychotherapy*, *16*(4), 267–285. https://doi.org/10.1080/17432979.2021.1893810

Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd rev. and expanded ed). Hogrefe.

Scholte, W. F., & Ager, A. K. (2014). Social capital and mental health: Connections and complexities in contexts of post conflict recovery. *Intervention*, *12*(2), 210. https://journals.lww.com/invn/abstract/2014/12020/social_capital_and_mental_health__connections_and.4.aspx

Schwark, S., & Bohner, G. (2019). Sexual violence—"Victim" or "survivor": News images affect explicit and implicit judgments of blame. *Violence Against Women*, *25*(12), 1491–1509. https://doi.org/10.1177/1077801218820202

Sehgal, P. (2016, May 3). *The forced heroism of the 'survivor.'* https://www.nytimes.com/2016/05/08/magazine/the-forced-heroism-of-the-survivor.html

Sharma-Patel, K., & Brown, E. J. (2016). Emotion regulation and self blame as mediators and moderators of

trauma-specific treatment. *Psychology of Violence*, *6*(3), 400–409. https://doi.org/10.1037/vio0000044

Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: The neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience*, *13*(3), 263–278. https://doi.org/10.31887/DCNS.2011.13.2/jsherin

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. Guilford Press.

Sigvardsdotter, E., Vaez, M., Rydholm Hedman, A.-M., & Saboonchi, F. (2016). Prevalence of torture and other war-related traumatic events in forced migrants: A systematic review. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *26*(2), 41–73.

Silverman, J. G., Decker, M. R., Gupta, J., Maheshwari, A., Patel, V., Willis, B. M., & Raj, A. (2007). Experiences of sex trafficking victims in Mumbai, India. *International Journal of Gynecology & Obstetrics*, *97*(3), 221–226. https://doi.org/10.1016/j.ijgo.2006.12.003

Specker, P., & Nickerson, A. (2019). Investigating the relationship between distinctive patterns of emotion regulation, trauma exposure and psychopathology among refugees resettled in Australia: A latent class analysis. *European Journal of Psychotraumatology*, *10*(1), 1661814. https://doi.org/10.1080/20008198.2019.1661814

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, *48*(10), 1449–1462. https://doi.org/10.1016/S0277-9536(98)00450-X

Theisen-Womersley, G. (2021). Trauma and Migration. In G. Theisen-Womersley (Ed.), *Trauma and resilience among displaced populations: A sociocultural exploration* (pp. 29–65). Springer International Publishing. https://doi.org/10.1007/978-3-030-67712-1_2

Thompson, C. T., Vidgen, A., & Roberts, N. P. (2018). Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. *Clinical Psychology Review*, *63*, 66–79. https://doi.org/10.1016/j.cpr.2018.06.006

Tissue, A., Specker, P., Hoffman, J., Uppal, S., Cloitre, M., Neuner, F., O'Donnell, M., & Nickerson, A. (2023). Skills training in affective and interpersonal regulation for refugees integrated with Narrative Exposure Therapy: A case study on the treatment of PTSD and emotion dysregulation for refugees and asylum-seekers. *Clinical Case Studies*, *22*(3), 285–306. https://doi.org/10.1177/15346501221133315

Tol, W. A., Stavrou, V., Greene, M. C., Mergenthaler, C., Van Ommeren, M., & García Moreno, C. (2013). Sexual and gender-based violence in areas of armed conflict: A systematic review of mental health and psychosocial support interventions. *Conflict and Health, 7*(1), 16. https://doi.org/10.1186/1752-1505-7-16

Torre, C. (2023). "Think positive, save a life"? Resilience and mental health interventions as political abandonment in a refugee settlement in Northern Uganda. *Civil Wars*, 1–27. https://doi.org/10.1080/13698249.2023.2209485

Triggs, G. (2023, July 11). *Refugees are not migrants...* https://twitter.com/GillianTriggs/status/1678696617153646592

Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: Umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems*, *11*(1), 51. https://doi.org/10.1186/s13033-017-0156-0

United Nations Framework Convention on Climate Change 2022. (2022). *Dimensions and examples of the gender-differentiated impacts of climate change, the role of women as agents of change and opportunities for women: Synthesis report by the secretariat*. https://unfccc.int/sites/default/files/resource/sbi2022_07.pdf

United Nations High Commissioner for Refugees. (2016, July 11). *UNHCR viewpoint: "Refugee" or "migrant" – Which is right?* https://www.unhcr.org/news/stories/unhcr-viewpoint-refugee-or-migrant-which-right

United Nations High Commissioner for Refugees. (2023). *Global trends forced displacement in 2022*. United Nations High Commissioner for Refugees. https://www.unhcr.org/global-trends-report-2022

Van de Kamp, M. M., Scheffers, M., Hatzmann, J., Emck, C., Cuijpers, P., & Beek, P. J. (2019). Body- and movement-oriented interventions for posttraumatic stress disorder: A systematic review and meta-analysis. *Journal of Traumatic Stress, 32(6),* 967–976. https://doi.org/10.1002/jts.22465

Van der Kolk, B. A. (2015). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin Books.

Von Einsiedel, S. (2017). Civil war trends and the changing nature of armed conflict. *United nations university centre for policy research*, *occasional paper 10*, 1–10.

Voorendonk, E. M., De Jongh, A., Rozendaal, L., & Van Minnen, A. (2020). Trauma-focused treatment outcome for complex PTSD patients: Results of an intensive treatment programme. *European Journal of Psychotraumatology*, *11*(1), 1783955. https://doi.org/10.1080/20008198.2020.1783955

Vreemdelingencirculaire 2000 (B), B8. Humanitair tijdelijk, 3. Slachtoffers en getuige-aangevers van mensenhandel.

Vu, A., Adam, A., Wirtz, A., Pham, K., Rubenstein, L., Glass, N., Beyrer, C., & Singh, S. (2014). The prevalence of sexual violence among female refugees in complex humanitarian emergencies: A systematic review and meta-analysis. *PLoS Currents*. https://doi.org/10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7

Walk Free. (2023). *The global slavery index 2023*. Minderoo Foundation. https://www.walkfree.org/global-slavery-index/

Walker, R., & Vearey, J. (2022). "Let's manage the stressor today" exploring the mental health response to forced migrants in Johannesburg, South Africa. *International Journal of Migration, Health and Social Care*, *19*(1), 1–15. https://doi.org/10.1108/IJMHSC-11-2021-0103

Walsh, K., Galea, S., & Koenen, K. C. (2012). Mechanisms underlying sexual violence exposure and psychosocial sequelae: A theoretical and empirical

review. *Clinical Psychology: Science and Practice*, *19*(3), 260–275. https://doi.org/10.1111/cpsp.12004

Wright, N., Jordan, M., & Lazzarino, R. (2021). Interventions to support the mental health of survivors of modern slavery and human trafficking: A systematic review. *International Journal of Social Psychiatry*, *67*(8), 1026–1034. https://doi.org/10.1177/00207640211039245

Yakushko, O. (2009). Human trafficking: A review for mental health professionals. *International Journal for the Advancement of Counselling*, *31*(3), 158–167. https://doi.org/10.1007/s10447-009-9075-3

Zetter, R. (2007). More labels, fewer refugees: Remaking the refugee label in an era of globalization. *Journal of Refugee Studies*, *20*(2), 172–192. https://doi.org/10.1093/jrs/fem011

Zhang, S. X. (2009). Beyond the 'Natasha' story – A review and critique of current research on sex trafficking. *Global Crime*, *10*(3), 178–195. https://doi.org/10.1080/17440570903079899

Zimmerman, C., & Hossain, M. (2007). Stolen smiles: The physical and mental health consequences of women and adolescents trafficked in Europe. *Nurses Network on Violence against Women International (NNVAWI) Conference*. https://researchonline.lshtm.ac.uk/id/eprint/3753/

Zorginstituut Nederland. (2018). Uitleg aanspraken geneeskundige GGZ op basis van DSM-5 classificatie (No. 2018035084) [Explanation of medical mental health claims based on DSM-5 classification]. Zorginstituut Nederland. https://www.zorginstituutnederland.nl/Verzekerde+zorg/geneeskundige-ggz-zvw/documenten/publicatie/2018/07/10/uitleg-aanspraken-geneeskundige-ggz-op-basis-van-dsm-5-classificatie

SECTION I

Survivors of Sexual Violence and Trafficking

CHAPTER 2

The Nexus Between Conflict-Related Sexual Violence and Trafficking for Sexual Exploitation in Times of Conflict

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ABSTRACT

In its 2018 report on conflict-related sexual violence the United Nations Secretary-General reiterated the importance of addressing the nexus between conflict-related sexual violence and trafficking in human beings for purposes of sexual exploitation in conflict (United Nations Security Council, 2018). In this article we will explore this nexus from a psychological and a legal point of view. During conflict the climate of impunity and the extreme contrast between the mighty and the powerless offers an optimal setting and inevitable ground for sexual violence. In general, but in particular during conflict, being victimised by sexual violence once can put individuals at risk for similar or other forms of sexual re-victimisation. For the victim who endured sexual violence, context hardly matters for its psychological impact. Therefore, in accordance with the United Nations Secretary-General report, from a psychological view there is no justification for a clear-cut distinction between conflict-related sexual violence and trafficking in human beings for purposes of sexual exploitation in conflict. Yet, from a legal perspective, this differentiation does matter: the legal definitions form the basis for the prosecution of perpetrators on the one hand and for access to particular rights for victims on the other. This article should be seen as a first exploration into the nexus between both crimes, when it comes to the impact on the lives of the victims/survivors, the definition of the crimes, and the resulting access to rights for victims/survivors of these crimes.

Keywords
Conflict-related sexual violence, trafficking in human beings, conflict, war, mental health, Palermo protocol

Over the last decade sexual violence has increasingly been recognised as a "weapon of war" in ongoing conflicts. In the 2018 United Nations Secretary-General's report on conflict-related sexual violence (CRSV) it is put forward that credible information regarding the scope and magnitude of CRSV is available for at least 19 countries. A shocking picture emerges from these numbers in the United Nations report, especially when considering the alleged underreporting of CRSV incidents by its victims (Davies & True, 2017). Not only do numbers indicate that CRSV is widespread across the globe, it seems that CRSV is an integral part of conflict. In its 2018 report the United Nations Secretary-General stressed once more the urgency of addressing the nexus between trafficking in human beings (THB) for the purpose of sexual exploitation and CRSV, further to United Nations Security Council Resolutions 2331 (2016) and 2388 (2017b). That is, THB for purposes of sexual exploitation in conflict has been put forward as part of CRSV. According to the United Nations report, CRSV – which may include rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilisation, forced marriage, and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict – encompasses trafficking in persons when committed in situations of conflict for the purpose of sexual exploitation. For example, it is reported that in response to the demand for sexual services by certain Columbian armed groups, drug trafficking cartels have facilitated the sexual exploitation of women and girls. Likewise, fear of rape is frequently cited by female Syrian refugees as a primary factor inducing flight, but the risk of sexual violence, exploitation and trafficking remains high in and around refugee and displaced persons camps, owing to overcrowding, lack of privacy, financial desperation and lawlessness.

In this article we will address (the definitions of) the crimes of CRSV and THB in conflict for the purpose of sexual exploitation in order to explore how these crimes are inter-related from a psychological and a legal point of view. In particular from the victim's perspective it is unclear what the legitimacy of such differentiations is, and, most importantly, how these serve victims in the recognition of their experiences. Based on the few information available, it seems that for some victims, recognition of what has been done to them is important; recognition in the sense that their experiences are explicitly recognised in the crimes for which the accused are charged and prosecuted or in the legal judgements explaining their experiences. For most, if not all victims, access to rights that comes with the recognition of their victimhood is for sure very important.

In this article, first, a narrative of a woman who has experienced both sexual violence in conflict and human trafficking for sexual exploitation will set the scene. Second, the specificity of conflict as a setting for sexual violence and processes for sexual (re)victimisation are outlined, as well as the psychological aspects of experiencing sexual violence. Third, the legal definitions of the crimes will be discussed and analysed on the basis of relevant legal instruments (e.g., Palermo Protocol: United Nations Human Rights office of the High Commissioner, 2000; Rome Statute of the International Criminal Code; International Criminal Court, 2002) and case law (e.g., of the Special Court of Sierra Leone, International Criminal Court) most applicable to these crimes to determine the scope of the definitions and where the nexus begins and where it ends. Finally, it will be discussed why these definitions matter (e.g., fair labelling of victims' experiences and

access to rights). This article should be seen as a first exploration in trying to find the nexus between CRSV and THB in conflict for the purpose of sexual exploitation when it comes to the impact of the crimes on the lives of the victims/survivors, the definition of the crimes, and the resulting access to rights for victims/survivors of these crimes. The hypothesis of this article is that because of the interrelatedness of crimes that victims/survivors may experience in conflict situations, there might be a mismatch between the distinctive legal terminology used for both crimes and the victim's perspective. Experiencing one incidence of sexual violence puts victims at-risk for future sexual revictimisation. Furthermore, when it comes to experiencing sexual violence the context in which this occurs hardly seems to matter.

THE STORY OF BLESSING

Blessing thinks she was born in 1995, in a village in Nigeria. A woman found her in a basket when she was three months old. The woman brought her to an orphanage ran by Christian nuns. She never found out anything about her family; she only grew up with the girls and nuns at the orphanage. At the local school she completed education till grade 3. One day she was told she would no longer go to school, instead she had to help with taking care of other orphans. She was sad to leave school but liked to take care of the children.

In 2013, when Blessing was 18 years old, Boko Haram attacked her village. Houses were burned, people were raped and murdered. Also, the orphanage was set on fire and many girls and nuns were murdered that day. Blessing gathered some younger girls and together they fled into the forest. After running for some days, they encountered another rebel group. At first, they helped the girls with shelter and some food, and the girls felt relieved. They thought they were safe. However, then Blessing was taken aside and asked to take off her clothes. The soldiers jokingly discussed who would have her first. Then the "chief" came in and he told Blessing to put her clothes back on, she would now only be his wife. He carried a gun, so she did not dare to refuse. Then he beat her hard on the head and in her stomach and he raped her. She was a virgin and she was not sure what he did, but it was very painful, and she was bleeding a lot. She stayed with the chief for some months, he offered her protection and food. He had many women and he raped Blessing many times. She also became pregnant once, but she miscarried.

One day she managed to escape; she kept on running deeper into the forest. Finally, she arrived in Chad, at a camp, but they did not have much food there. Blessing stayed for some time. There was an older Nigerian lady taking care of her. After a few weeks the lady introduced Blessing to a white man called John. The man was very nice to her and appeared to be very rich. He owned a bar, where Blessing started to work. One day he said there was a way for Blessing to make more money. He introduced her to two men. She was told about staying in Europe and working as a housekeeper. Blessing agreed to go; she felt that she had little choice, because life was hard in Chad. She left in a truck with the two men and two other women and they travelled to Morocco. It was a tough journey, because it was hot and there was not enough water or food. Finally, they

were brought to Italy.

The two men were very rude to her and beat her. They took her to a house, where there was a woman who told her she had to pay 40,000 euros for the journey. Blessing wanted to earn the money as soon as possible, as she was very scared. Every day men came to have sex with her. The woman threatened to kill her if she would not cooperate. Sometimes Blessing had to do the "rough job", that is sex without a condom, because it raised more money. That is how she got pregnant twice.

The first time the woman gave her an abortion pill, but the second time it turned out she was 5 months pregnant, so abortion was no longer possible. She had to keep working during her pregnancy. After the delivery of her daughter Hope, she stayed at the home of the woman for 2 months. After that, she had to work again and pay an additional 40,000 euros to compensate for the time she did not work. Now the woman threatened to harm Hope to urge Blessing to work more.

One day the woman left the house; Blessing took her chance and ran with her daughter. A man approached her, and she told her story. He was on his way home to the Netherlands. He took her along and dropped her off at a bus station in a city unknown to her. He told her which bus she had to take and so she finally ended up at a reception centre. There she was identified as a victim of human trafficking, and it was acknowledged that she had been sexually exploited. Two weeks later, she was taken to a specialised shelter for victims of human trafficking. There, Blessing and her daughter received practical, legal and psychological support. Blessing pressed charges against her perpetrators, but her case was soon dismissed, due to lack of evidence because the exploitation occurred outside of the Netherlands. She was transferred to an asylum seekers centre. She currently awaits the result of her asylum application.

DYNAMICS OF SEXUAL VIOLENCE IN CONFLICT

From the moment the non-state armed group Boko Haram entered Blessing's life it has been a concatenation of various forms of sexual violence. As illustrated through this narrative, CRSV can come in many forms by various perpetrators, directly or more indirectly linked to conflict. These dynamics will be discussed in more detail below.

THE SETTING AND INTERPLAY BETWEEN ACTORS INVOLVED IN OR VICTIMISED BY CRSV

Most individuals living in low-resource areas, due to poor economic and social circumstances, have a limited say over the course of their lives. This gives rise to feelings of powerlessness and worthlessness and affects future expectations of life. Armed conflicts, most of which take place in low resource areas, sharpen this discrepancy between the relatively powerless and the mighty. This, in combination with state collapse and a climate of impunity, offers an optimal setting and inevitable ground for sexual violence. By its very nature, conflict tears apart societies, social structures, and families, and corrodes justice, bonds, and moral values usually protective against violence. This has many implications, one of which being that in particular the powerless are at

increased risk of falling victim to sexual violence. The powerless are frequently members of a persecuted political, ethnic or religious minority, or are targeted on the basis of actual or perceived sexual orientation and gender identity. In traditional cultures, the increased vulnerability to sexual violence during conflict may only add to a pre-existing perception of marginalised persons and women as less worthy and dignified. Such judgments may imply that there is no need for a respectful approach or consent when engaging in sexual acts. The implicit or sometimes explicit message is that certain persons' lives and bodies are not fully theirs. As underlined in the 2018 United Nations report on conflict-related sexual violence (United Nations Security Council, 2018):

> Although it is increasingly clear that self-reliance, economic empowerment and having a political voice are the most effective forms of protection from sexual violence, desperate families are increasingly resorting to harmful and negative coping mechanisms, including child marriage, polygamy, withdrawal from educational and employment opportunities, transactional sex and/or "survival sex" and commercial sexual exploitation.

Over the last decades the concept of sexual consent has been fiercely debated among scholars (Cowling, 2016). Although there is no consensus on its definition, one common view is that it refers to "free verbal or nonverbal communication of a feeling of willingness" (Jozkowski et al., 2014). This implies that for consent there needs to be freedom to express whether one is willing or not. Even though such freedom is lacking in conflict areas controlled by armed groups victims are often still held accountable and blamed for the CRSV events. More often than not, rather than the perpetrator, it is the victim who is considered as dishonourable and tainted. They are often "treated by their families and communities as if they have committed a crime" (Mollica, 2006). The lack of being able to give consent has also been recognised in the laws and case law by international tribunals, where coercion, coercive circumstances or (threat of) force are important elements to establish for instance, the crime of rape as a crime against humanity or a war crime, rather than the element of "lack of consent", which is generally not an issue in times of conflict (Viseur Sellers, 2007). The introduction of the element "lack of consent" would also mean that it needs to be proven and may only burden the victims of these crimes (Schomburg & Peterson, 2007). In relation to human trafficking similar considerations apply. The Palermo Protocol underlines that the consent of the victim of the exploitation is irrelevant, as long as any of the forcible means to lure someone into a situation of exploitation is used (United Nations Human Rights office of the High Commissioner, 2000). In the case of children, coercion by any of the means does not even have to be proven.

SEXUAL REVICTIMISATION

Considering the case of Blessing, the chain of events in her story are inter-related. Being forced to flee from Boko Haram put her at-risk, she was alone and vulnerable when she encountered the other rebel group. Thereafter residing as a displaced person in Chad with limited resources

available to her put her at risk of exploitation. A vast amount of research shows that people who have been victimised by sexual violence face an increased risk for sexual revictimisation later in life (Classen et al., 2005). Unfortunately, data on the course of sexual revictimisation is lacking in areas of conflict. When considering victims of sexual exploitation in general, including those originating from areas of (post-) conflict, studies show that about one third have experienced sexual abuse prior to the sexual exploitation (Oram et al., 2012). Although it needs more studying, these findings indicate the interrelatedness of various forms of sexual violence.

VICTIMS' PSYCHOLOGICAL STRATEGIES

Sexual violence disrupts a person's expectation of the existence of morality, and the capability to manage one's world. Sexual violence belies such trust, perverts one's relationship to the outside world and may result in general distrust and social detachment. In the setting of conflict, morality and trust have obviously already been corroded. Sexual violence makes this worse, whether experienced in an assault or during exploitation, inducing an even greater loss of basic beliefs and agency.

In such context, with the danger of sexual violence ever lurking, one needs to be constantly on guard. Many will develop strategies to avoid violence or limit its severity. If sexual violence seems inevitable, one may try to partly regain control by pro-actively setting conditions for surrender, e.g., to prevent a group rape by negotiating to only "allow" one rebel soldier to have sex. Or, as in the case of Blessing, to sexually engage with a high-ranking soldier to ensure the provision of basic needs (e.g., food, shelter, protection). One may choose to give one's body to protect others, like close relatives. Also, one may go along with sexual violence, i.e., "not putting up a fight", in hopes that the perpetrator may be less violent. One strategy to escape the dreary living situation is to go along with people pretending to offer a solid income-generating opportunity somewhere else. This way, many ended up being exposed to sexual exploitation. In conflict areas, however, victims are often threatened or brutally forced into such situation, thereby being dehumanised and treated as property for trade.

THE EXPERIENCE OF SEXUAL VIOLENCE

Enduring sexual violence is a horrific experience in many ways. Rape, probably the most frequent form of sexual violence in conflict and situations of exploitation, is far more than an unwanted physical penetration (Kelly, 1988). It entails the involuntary exposure of private body parts, the shattering of self-determination where one values it most, the maculation of one's very locuses of intimacy. Someone else's genital is often used for penetration, an event representing ultimate usurpation. Violence used may be life threatening, and cause pain and damage to body tissues. Several emotions dominate the psychological experiences during and after sexual violence (Ullman et al., 2007). Four of these emotional consequences are outlined below. It may become obvious that emotional responses to sexual violence do not vary much per context. Here, it concerns universal phenomena specifically related to the actual violation of physical integrity,

rather than expressions of distress whose manifestation depends on contextual background – whether this is conflict or exploitation.

FEAR

It is self-evident that any form of sexual violence causes great fear in victims. This fear is felt during the violent experience but can also manifest itself as anticipated fear when there is repeated sexual violence. Sexual violence, while being a violent act in itself, is often accompanied by other physical violence, or the threat of being injured, mutilated or killed (Oram et al, 2012). Extreme fear may also be evoked when perpetrators threaten to abuse close relatives (children, spouses, parents) if the victim does not surrender. As perpetrators' superior force, physical or psychological, mostly makes fighting pointless and fleeing impossible, surrender is often the only option.

A far-reaching but common consequence of fear and powerlessness during sexual violence is the phenomenon of "tonic immobility": an emotionally induced state of complete loss of control over one's body, leading to the inability to make any movement or sound (Kalaf et al., 2017). It is an involuntary response to great threat, seen in animals and humans alike. Although performing reflexively and thus beyond one's control, tonic immobility may later lead to feelings of shame and guilt in victims of sexual violence for "not having offered resistance" (Möller et al., 2017). The latter misunderstanding may also give rise to blaming by others – among whom officials in legal procedures.

Another psychological state often appearing in victims of sexual abuse is that of "dissociation" (Schalinski et al., 2011). It is the involuntary inner mechanism through which elements of an intense experience are kept apart from one's full awareness, in particular from one's awareness of the event's full emotional impact. It thus causes a disruption between the actual reality and one's perceived reality. A dissociative state may be considered as protection against too much emotional intrusion of the mind, therefore being an adaptive psychological response. In later life, however, it may cause problems in several ways (Ross-Gower et al., 1998). First, it leads to the inability to (fully) remember the event in question, which may give rise to disbelief about the abuse(s), e.g., during legal procedures (Tankink & Lambrichts, 2017). For instance, the narrative of victims may be perceived as incoherent and inconsistent due to fragmented memories. Second, stimuli linking to the event in question – whether on a conscious level or not – may either lead to sudden extreme emotions and disturbed behaviour or, in contrast, to a striking emotional flatness and unfocused speech in victims. Stimuli triggering such states may be sensory perceptions like images or smells associated with the event, and certain conversation, topics or questions. Legal procedures around the event may therefore yield emotional states and related behaviours in victims, not rarely misunderstood by, and leading to irritation among the involved officials. With sudden emotional outbursts, the victims' account might be perceived as unreliable. Conversely, victims might share their story with little emotion, which might be wrongly interpreted as an indication that the event did not have much impact.

Extreme levels of fear experienced during sexual violence may disrupt the body's so-called stress system, i.e., the whole of neurobiological mechanisms regulating the response of body and mind to stress. A common consequence of sexual violence is the continuous activation of the

victim's stress system, even after the event (Martinson et al., 2016). An ongoing high tension then results in emotional hyperreactivity, sleeping problems, and physical complaints, and may even develop into mental health disorders, such as a posttraumatic stress disorder.

SHAME

Shame can arise when personal boundaries protecting privacy are threatened or violated and there is risk of loss of dignity. Although shame, like guilt, is mostly thought of as a feeling related to the unveiling of one's own wrongdoing, it can be elicited by any unwanted exposure, including of everything considered private. Shame is an emotional state featuring prominently in victims of sexual violence. Sexual violence may be preceded, accompanied or followed by intentional psychological humiliation of any kind, be it through words or deeds, thereby inducing shame and loss of dignity in the victim.

Other sources of shame are possible physical responses to the sexual violence situation and the very penetration: vaginal lubrication in women, penile erection in men (Bullock & Beckson, 2011). It is common biological knowledge that such phenomena can be elicited by tactile stimulation and similarly by extreme fear. For victims, however, awareness of such body reactions may be highly confusing as they usually express sexual arousal. This may lead to misinterpretation of one's own physical reaction (erection or vaginal lubrication) as a sexual response instead of either a tactile or a fear response, to great uncertainty about "secretly having enjoyed the experience", and to accompanying shame. Another physical response to feelings of shame is tonic immobility and dissociation, as already addressed above (Schultz, 2018).

After sexual violence, shame may urge the victim to silence the event and socially withdraw in order to prevent even more exposure (DeCou et al., 2017). Particularly in non-western cultures, openness about it may have major negative consequences, and often leads to ostracism by the spouse and relatives, social marginalisation, and (for women) not being marriageable any more (Mukanangana et al., 2014; Tankink, 2013). Speaking out may thus lead to a radical loss of social and family life. Silencing the event then becomes the preferred option, leaving the victim to suffer in solitude – and perpetrators to remain untouched.

DISGUST

Forced physical contact or penetration may evoke disgust: a strong feeling of revulsion (Badour et al., 2014). This mostly concerns sensory experiences associated with the abuse, such as the sound of a perpetrator's heavy breathing or body smell, the image of a perpetrators' face or intimate parts, the feeling of his genital or semen inside one's body. The latter in particular can cause a victim to feel soiled and dirty. This feeling may persist long after the actual abuse, despite the fact that the body will have excreted liquids and regenerated tissues quite soon. Aversion of oneself may give rise to long-lasting avoidance of any further intimacy – even with a loved one –, or even worse, to the inability to watch or touch one's own body. It is self-evident that such highly debilitating impacts are direct consequences of a sexual assault itself, regardless of its context.

IDENTITY

One of sexual violence's worst impacts is that it corrodes the feeling of identity. Indeed, identity is based on an inner feeling of continuity and the experience of personal boundaries. Both underlie the perception of oneself (or another person) as an integral and consistent entity. Sexual violence violates this integrity. It shatters the seeming self-evidence of being a delimited creature, an entity, and thereby causes damage to one's image of the self (Clark, 2014; Draucker et al., 2009; Perilloux et al., 2012). Thus, the act of sexual violence entails penetration of both the physical body and the psychological self.

Men who are victims of sexual violence experience broadly similar problems as women. Fear and humiliation are similarly evoked, and so are shame and identity problems. The latter may apply even stronger in patriarchal cultures, where images of masculinity may be more traditional. Shame originating from humiliation and surrender may then be particularly intense in males. Forced penetration often makes victims doubt of their sexual identity, as if the event would have disclosed a concealed homosexuality. The latter idea may be reinforced by shameful awareness of one's penile erection while being raped (see above).

PHYSICAL PROBLEMS AND MENTAL HEALTH DISORDERS

Sexual violence may cause physical damage to the body. This can be the consequence of ruthless manipulation or penetration. In the case of conflict-related sexual violence, damage to the genital area is often caused intentionally in order to inflict pain and destroy a person's dignity and even procreative capacity. Indeed, sexual violence as a weapon of war particularly aims to damage the reproductive functioning of victims, thereby contributing to the extermination of targeted populations (Ba & Bhopal, 2017; McAlpine et al., 2016).

Physical problems resulting from sexual violence may be diverse. Mutilation may evoke great shame and inconvenience due to malformation or dysfunction of organs (e.g., sexual dysfunction, or the unwanted spilling of urine or stool). infections may come with serious symptoms and even be life-threatening (e.g., HIV infection).

Emotional problems may lead to the development of mental disorders, such as a posttraumatic stress disorder, depression, or other psychiatric conditions. Unfortunately, specialist treatment, although obviously indicated, is not always provided, its availability often being determined by a victim's socio-economic or legal position.

CONTEXTUAL FACTORS

The listing above is dreary and may illustrate that the devastating effect of sexual violence on victims is mostly determined by characteristics of the act itself and can vary greatly between individuals. Bearing in mind the case of Blessing, the various acts of CSRV she has encountered are best understood within the same range of experiences rather than separate categories. Certainly, each act of CSRV had its particular setting, dynamics and level of severity, however experiencing the act itself can be considered to have a similar emotional impact. Furthermore, the meaning given to the act by the victim afterwards influences the effect of CRSV. Sexual violence – exposure

and penetration – causes terror, loss of dignity, and shame. This happens in particular when sexual violence is used as a weapon of war and is even harsher when it is a gang rape. Purposeful humiliation and gang rapes happen frequently in situations of sexual exploitation as well. While in common life power and sexuality are implicitly intertwined, conflict presents prime examples of the distortion of this dyad towards sadism. Thus, contextual factors, such as conflict situations, may add particular setting to the experience, however the lasting impact of its intrinsically gruesome nature and its negative emotional sequelae can vary between individuals.

As outlined above, the psychological impact of sexual violence on the victim is severe regardless of the context in which the act took place. The setting of conflict may, however, offer a particular dynamic to the sexual violence. Therefore, there is a need to explore whether the victim's perspective corresponds to the present legal framework for these crimes.

THE SCOPE OF THE LEGAL DEFINITIONS OF CRSV AND THB

WHERE DOES THE NEXUS BETWEEN CRSV AND THB BEGIN?

In light of increasing violent extremism and mass migration, United Nations Security Council (UNSC) Resolution 2331 (2016) underlined the urgency of addressing the nexus between trafficking in persons, (conflict related) sexual violence, terrorism and transnational organised crime; the first of its kind. The UNSC Resolution recognised that (United Nations Security Council, 2016):

> Trafficking in persons in areas affected by armed conflict and post-conflict situations can be for the purpose of various forms of exploitation, including exploitation of the prostitution of others or other forms of sexual exploitation, forced labour, slavery or practices similar to slavery, servitude or the removal of organs.

It further recognised that:

> Trafficking in persons in armed conflict and post-conflict situations can also be associated with sexual violence in conflict and that children in situations of armed conflict and persons displaced by armed conflict, including refugees, can be especially vulnerable to trafficking in persons in armed conflict and to these forms of exploitation.

Thus, the acknowledgment of the nexus between conflict-related sexual violence and trafficking in persons for the purpose of sexual exploitation was unprecedentedly made on the international level with similar resolutions following suit (United Nations Security Council, 2017b).

In order to even better understand this nexus, the United Nations Secretary-General's report on CRSV (2017a) defined the term "conflict-related sexual violence" and held it to encompass

trafficking in persons. In precise terms, the report stated that CRSV referred to:

> Rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilisation, forced marriage, and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict. This link may be evident in the profile of the perpetrator (often affiliated with a State or non-state armed group, including a terrorist entity or network), the profile of the victim (who is frequently an actual or perceived member of a persecuted political, ethnic or religious minority, or is targeted on the basis of actual or perceived sexual orientation and gender identity), the climate of impunity (which is generally associated with State collapse), cross-border consequences (such as displacement or trafficking in persons) and/or violations of the provisions of a ceasefire agreement. The term also encompasses trafficking in persons when committed in situations of conflict for the purpose of sexual violence/exploitation.

Not only does the report make clear that it sees CRSV to encompass trafficking in persons when committed in situations of conflict for the purposes of sexual exploitation, it also stresses the circumstances under which the "conflict" may reveal itself, e.g., in situations of armed group violence, state collapse, cross-border movement or violations of a ceasefire agreement. Indeed, according to the above definition, the CRSV may be either "directly or indirectly" linked to a conflict. When reading the annual reports of the United Nations Secretary-General on conflict-related sexual violence, it becomes clear who the suspects of CRSV, including human trafficking, are, and to what kind of conflict-related situations they are linked. A total of 47 parties have so far been listed by the United Nations Secretary- General with the majority of listed parties being non-state actors, of which seven designated as terrorist groups; other listed parties include national military and police forces (United Nations Security Council, 2018).

CRSV can be random or isolated acts in conflict situations; CRSV can also be a so-called "weapon of war", an integral part of the operations, ideology and economic strategy of the perpetrators thereby forming a threat to international security and peace (United Nations Security Council, 2008). In the 2018 United Nations report, a division is made between sexual violence in conflict-affected settings (e.g., including Afghanistan, Central African Republic, Iraq, Libya), post-conflict settings (e.g., Ivory Coast, Nepal) and other difficult situations (e.g., Burundi, Nigeria), again making clear what kind of conflict situations the United Nations Special Rapporteur has in mind when addressing CRSV and human trafficking in conflict.

The language found in the above-mentioned United Nations Resolutions and reports mirrors the conflict-related sexual violence crimes found in the 1998 Statute of the International Criminal Court (ICC or Court). This Court is based in The Hague, the Netherlands, and has – under certain conditions – the mandate to prosecute the most senior individuals suspected of having committed international crimes, such as genocide, crimes against humanity and war crimes, as of 2002, and

when States themselves are unable or unwilling to do so. The Statute of the ICC provides for an extensive list criminalising conflict-related sexual violence. In Articles 7 and 8 of the Rome Statute, rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation and any other form of sexual violence of comparable gravity are explicitly outlawed as crimes against humanity and war crimes. In addition, persecution against any identifiable group or collective on the ground of gender, and the crime of enslavement (which may include trafficking in persons, in particular women and children), are prohibited as a crime against humanity. Although the Rome Statute definition of genocide does not include specific sexual violence crimes amongst its acts, the ICC's guiding Elements of Crimes do recognise that rape and other forms of sexual violence could be prosecuted as such (under "serious bodily or mental harm"; International Criminal Court, 2011). The sexual and gender-based violence crimes become international crimes only, however, when certain general requirements of the international crimes are fulfilled; i.e., for genocide, there needs to be a specific intent against a particular group; for crimes against humanity, there needs to be a widespread or systematic attack against a civilian population; and for war crimes, there needs to be the presence of an international or non-international armed conflict. Only then can we speak of CRSV; an umbrella term for specific sexual violence crimes that can amount to genocide, crimes against humanity or war crimes.

Thus, apart from the crimes of forced marriage and forced abortion, the conflict-related sexual violence crimes mentioned by the United Nations in its above-mentioned resolutions and reports are partly similar to – and it seems inspired by – the conflict-related sexual violence crimes prohibited in law by the ICC as well as several other international criminal tribunals, such as the Special Court for Sierra Leone (SCSL). Whereas forced marriage and forced abortion are not currently criminalised in law, it should be noted that international criminal tribunals have in the past noted that other sexual and gender-based crimes, such as forced marriage, forced nudity, sexual mutilation, and forced abortion, may constitute international crimes. In fact, the SCSL has successfully prosecuted not only rape and sexual slavery, but also forced marriage as the crime against humanity of an "other inhumane act" (Haenen, 2014).

The question remains: where does conflict-related sexual violence and human trafficking meet? The answer can partly be found in some of the most applicable laws and case law interpreting these laws. When looking specifically at the Statute of the ICC and its Elements of Crimes document, this is in particular the case where it concerns the crimes of "enslavement" (a crime against humanity and a non-specific sexual violence crime) and "sexual slavery" (both a crime against humanity and a war crime and a specific sexual violence crime) as both these two crimes incorporate trafficking in persons. According to Article 7(2)(c) of the Statute of the ICC (2017): "'Enslavement' means the exercise of any or all of the powers attaching to the right of ownership over a person and includes the exercise of such power in the course of trafficking in persons, in particular women and children." The Elements of Crimes further explain that the exercise of power attached to the right of ownership includes the "purchasing, selling, lending or bartering [of] such a person or persons, or by imposing on them a similar deprivation of liberty",

and that this conduct includes trafficking in persons, in particular of women and children.[1] The Elements of Crimes with regard to the crime of sexual slavery are similar to enslavement (and thus may also include trafficking in persons), with the addition that an act of a sexual nature needs to have been committed.[2]

While the Rome Statute and the Elements of Crime encompass trafficking in persons in the crimes of enslavement and sexual slavery, they do not give a further definition of THB. For a definition of "trafficking in persons" one has to look at the Palermo Protocol, which includes the first and internationally recognised definition, which is also referred to by the United Nations Security Council and- the United Nations Secretary General in the relevant resolutions and reports linking THB and CRSV. Article 3 of the Palermo Protocol defines THB as (United Nations Human Rights office of the High Commissioner, 2000):

> The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Trafficking thus requires: (1) an act; (2) a means; and (3) a purpose, that of exploitation. The acts include the recruitment, transportation, transfer, harbouring or receipt of a person. "Means" refers to various ways of distorting the free will of a person (Gallagher, 2010, p. 30; Siller, 2016, p. 417) The final element, the purpose of exploitation, is not well defined: "at minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs". What is precisely meant with these terms is left to national governments to decide. The element of exploitation is one of specific intent ("dolus specialis"). Or as Siller puts it: "It is the actual purpose of the perpetrator, as opposed to the 'practical results' which satisfies the mens rea element. For a situation to be considered as trafficking in persons, the exploitation does not necessarily have to take place. The action taken and the means used must be carried out with the specific intention to exploit" (Siller, 2016, p. 418).

Yet, the question that has more recently been raised is whether "trafficking in persons" (a transnational crime) is either a crime which comes under the crime of enslavement (an international crime)[3], or whether enslavement is only one of the potential exploitative manifestations of

1 A footnote furthermore explains that: 'It is understood that such deprivation of liberty may, in some circumstances, include exacting forced labour or otherwise reducing a person to a servile status as defined in the Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery of 1956. *It is also understood that the conduct described in this element includes trafficking in persons, in particular women and children (italics added).'*

2 Sexual slavery – Elements of Crimes, Article 7(1)(g)-2: '(1) The perpetrator exercised any or all of the powers attaching to the right of ownership over one or more persons, such as by purchasing, selling, lending or bartering such a person or persons, or by imposing on them a similar deprivation of liberty. (2) The perpetrator caused such person or persons to engage in one or more acts of a sexual nature.' It should be noted that it has been argued that the crime of sexual slavery is somewhat redundant as it would also fit under the crime of enslavement (Adams, 2018; Viseur Sellers, 2011).

3 A similar comparison could be made with regard to the crime of sexual slavery.

trafficking as laid down in the Palermo Protocol (Siller, 2016, p. 405-427)? Siller (2015) argues that, seen from an international criminal law perspective, there is a need for judicial clarity and decision in either merging the crimes or distinguishing them. This will involve an analysis as to what constitutes "powers attaching to the right of ownership" (United Nations Human Rights office of the High Commissioner, 2000). According to her, the addition of a separate crime against humanity of trafficking in persons may be the only way to hold individuals accountable under international criminal law. Until that time, however, it appears that traffickers who also engage in the enslavement of their victims in the context of a crime against humanity can be held accountable before international courts and tribunals based on the current interpretation of the crime of enslavement in case law (for case law references, see: Siller, 2016, p. 405-427). In fact, before the ICC, steps are currently underway to investigate whether charges related to trafficking in persons can be made in the situation of Libya (International Criminal Court Prosecutor, 2017). On the other hand, as trafficking in persons is considered a transnational crime with different requirements from enslavement being an international crime (e.g., trafficking does not rely upon the exercise of ownership over a person and could have a defence of consent), it could also be held that trafficking is not slavery and should therefore be removed from the crimes against humanity provision of enslavement.

WHERE DOES THE NEXUS BETWEEN CRSV AND THB END?

Finally, the question to be answered is where the nexus between conflict-related sexual violence and human trafficking ends. Surely, as mentioned above, the reports of the United Nations Secretary-General give some indication, by stating that CRSV includes THB and that CRSV can be either directly or indirectly linked to conflict, and can happen in conflict, post conflict situations and other situations of concern. At the same time, the crime of THB is much broader in scope than as a form of conflict-related sexual violence (section above and the definition of THB in general). The following question is then raised: how long we can still speak of "conflict-related" sexual violence? When should THB for purposes of sexual exploitation still be considered as a form of conflict-related sexual violence, and when should it be seen as a stand-alone crime? In other words, when does the nexus between conflict-related sexual violence and THB end?

It seems as if in literature on the term CRSV no attention has been devoted to the scope of "conflict-related". It may be that this is due to the fact that while CRSV is an umbrella term for all sorts of sexual violence acts related to conflict, it is not a legal term in and of itself. Therefore, there has been no need to define "conflict-related" as an element of the crime of CRSV. Rather, forms of CRSV have been criminalised as discussed above. The term at a minimum implies a direct or indirect correlation to conflict. That CRSV exists beyond conflict situations is reflected in, for instance, the fact that enslavement is also considered a crime against humanity, which can occur in peace time as well. In addition, the United Nations reports cited above speak of conflict and post-conflict situations. This would actually imply that exploitative practices refugees face while fleeing from conflict and that amount to THB might still be considered CRSV. Just as in the narrative of Blessing: her refuge from the conflict and sexual violence actually led her into a

trafficking situation abroad. Her lack of resources and psychological vulnerability put her at risk to enduring future sexual revictimisation. To determine whether trafficking in persons is linked to a particular conflict is sufficiently widespread or systematic to speak of enslavement as a crime against humanity, this is relevant. Traffickers in Libya and Italy, who make use of the migration crisis, can then be prosecuted for enslavement as a crime against humanity. Then, what about the situation when a refugee flees from conflict and arrives at a destination country by his/her own means? Would a trafficking situation in the destination country then still be considered as related to conflict, since the person would not even be in the destination country if it were not for the conflict? While the victims' vulnerable position might be conflict-related, the perpetrators generally have no connection with the conflict anymore. Yet, on the other hand, perpetrators make, most of the time, deliberate use of the consequences of the conflict, by exploiting people who fled and are in a vulnerable position. Therefore, in these situations, THB should be considered as a stand-alone crime. The nexus with the conflict seems to end when the perpetrators are no longer linked, directly or indirectly, to the conflict anymore, although they do benefit from the conflict-related vulnerability of the victims.

SEXUAL VIOLENCE, LEGAL LABELLING AND THEIR IMPACT ON WELLBEING

Why do we bother so much to determine when a situation can be considered as conflict-related sexual violence, including trafficking in persons, or when trafficking can be considered as a stand-alone crime? For whom does this actually matter? Sexual violence has long-term consequences for the victims' wellbeing. At the very least, it impacts one's sense of safety and worldview. In addition, sexual violence may have serious physical and mental health consequences requiring treatment. In principle, victims should have access to (mental) health care for these problems. Currently, the legal labelling determines whether people have access to such services. It legally matters how (and where) certain acts can be prosecuted, and what type of protection is awarded to victims. But it also matters socially/psychologically, for the victims, that the terminology used to define what has happened to them matches their experiences.

RECOGNITION

It may be clear that all aforementioned psychological aspects around sexual violence are common human phenomena, and that emotional responses to abuse are universal. CRSV and THB with the purpose of sexual exploitation are connected phenomena, not only by their intertwined appearance but also by their similar destructive impact on a victim's psychological balance. Both act through humiliation, the shattering of a person's self-determination, the brutal violation of personal boundaries, and a fierce attack on an individual's feeling of identity. It is not hard to imagine how a disturbed feeling of identity and a distorted worldview may have a negative impact on psychological wellbeing and social functioning. Emotional sequalae are severe and

long-lasting, and urge for attention, to start with recognition of victimhood with respect to both kinds of sexual violence. The recognition of harm from sexual violence can mean an important first step to recovery.

LABELLING OF THE CRIME (LEGAL DEFINITIONS) AND ACCESS TO RIGHTS

One of the reasons why (legal) labelling matters is that there are different rights attached to a situation being considered conflict-related sexual violence (not being trafficking) and human trafficking. While there is no such thing as an international CRSV convention, the trafficking framework is well defined and offers (in Europe even far-reaching) protection for victims, beyond protection during criminal proceedings. The Palermo Protocol is ratified by virtually all States and includes specific provisions aimed at protecting victims.[4] Linked to the criminal proceedings, the Palermo Protocol includes the right to information, the right to participation, and the right to compensation (United Nations Human Rights office of the High Commissioner, 2000). Further, it urges States to consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons, including appropriate housing, medical, psychological and material assistance, counselling and information in a language that a victim can understand and employment, educational and training opportunities. In providing these protective mechanisms, States are required to take into account the age, gender and special needs of victims.

After the adoption of the Palermo Protocol in 2003, the protection of THB victims has been elaborated further by the United Nations Human Rights Office of the High Commissioner, as the Palermo Protocol was criticised for its criminal justice response, aimed at prosecuting the perpetrators, rather than a human rights based approach, which puts the victim at the centre of any credible action and thus requires an analysis of human rights violations in the trafficking cycle. Based on the role and obligations of States under international human rights law, the United Nations Office of the High Commissioner for Human Rights (2003) developed "The Recommended Principles on Human Rights and Human Trafficking". The subsequent anti-trafficking documents adopted in Europe have incorporated this human rights-based approach to trafficking, including far-reaching protective mechanisms for victims. First with the adoption of the Council of Europe's Convention on Trafficking and later, for EU countries, with the adoption of the Framework Decision of the EU, which was replaced by the EU Directive on trafficking in 2011.

Let us come back to the example of Blessing, who was exploited both in the conflict zone and Italy, and then managed to escape her situation and ask for asylum in the Netherlands. As soon as there was an indication, based on her story, that she was a presumed victim of trafficking, she was entitled to a temporary residence permit, a place in a shelter for victims of trafficking as a third country national, and access to medical and psychological support. This was the case even though the exploitation did not take place in the Netherlands.[5] If, however, her story had indicated

4 Currently 173 States have ratified the Palermo Protocol (see United Nations Treaty, 2001).

5 It needs to be indicated that when your trafficking situation occurred outside of the Netherlands, this might form an obstacle to building a criminal case against any person implicated in the crime. As the protection is only temporarily not linked to the criminal case, during the reflection and recovery period of 30 days, after that the case might be dismissed and the access to support ended.

that she had been a victim of sexual violence during the conflict, which cannot be considered trafficking in human beings, these protective mechanisms on the national level would not, or rarely, have been available.[6]

THE IMPORTANCE OF (LEGALLY) LABELLING THE CRIME FOR VICTIMS?

There is little empirical research available on how victims of CRSV and THB really think about how the crimes committed against them are legally labelled. Some anecdotal evidence seems to indicate that to a certain degree the labelling of the crimes does matter to victims. For example, a Rwandan victim of sexual violence of the 1994 Genocide against the Tutsi held that she was shocked to find out that the violence committed against her was labelled by the Rwanda Tribunal Judges as a crime against humanity rather than genocide (Kaitesi, 2014). Furthermore, it is not without reason that for centuries women's and human rights organisations have fought hard to have CRSV recognised as crimes rather than by-products of war or criminalised under vaguely formulated provisions such as "outrages upon personal dignity", not doing justice to the harms suffered by the victims of these crimes at all (Askin, 2013). Yet, it is still a different question altogether whether today's specific sexual violence crimes (such as rape and sexual slavery) or non-specific sexual violence crimes such as enslavement) do justice to victims of CRSV and THB. The specific sexual violence crimes recognise the sexual nature of the crimes but the non-specific sexual violence crimes may not. There is a risk that when charging CRSV under the latter category, such as enslavement as a crime against humanity, the sexual violence components are overlooked by the Prosecutor or Judges (Brouwer, 2005; Zawātī, 2014). However, when, for instance, the sexual aspects of the enslavement come explicitly to light in the final Judgment, this may provide sufficient "justice" for victims of these crimes. In order to answer this question properly – to what extent would a CRSV, incorporating THB, judgement be adequately satisfying the victims? – it should therefore be asked to a significant number of actual victims of these crimes. This does not seem to have been done so to date.

CONCLUDING REMARKS AND THE WAY FORWARD

During conflict the climate of impunity and the extreme contrast between the mighty and the powerless set an optimal setting and inevitable ground for sexual violence. In general, but in particular during conflict, a victim of sexual violence can be at risk of similar or other forms of sexual revictimisation. As outlined above, contextual factors, such as (post) conflict, may add particular dynamics to the experience of sexual violence, but retain its intrinsically gruesome nature and negative emotional sequelae. Therefore, from a psychological viewpoint, in line

6 Note that on the international level, before the ICC, where some victims of CRSV can participate or appear as witnesses in the proceedings, certain rights are granted to them, including protection, participation and reparation. In addition, assistance (e.g., socio-economic or psychological support) can even be provided to victims outside the case against a particular accused.

with the 2018 United Nations Secretary-General report, there is no justification for a clear-cut distinction between CRSV and THB for purposes of sexual exploitation in conflict. Based on the few information available, it seems that for some victims, recognition of what has been done to them is important; recognition in the sense that their experiences are explicitly recognised in the crimes for which the accused are charged and prosecuted or in the legal judgements explaining their experiences. For most, if not all victims, whether CRSV or THB related, access to rights that comes with the recognition of their victimhood is definitely very important. More quantitative and qualitative research will need to be done to better understand the victims and survivors' perspective on the nexus of CRSV and THB and its legal and psychological consequences.

AUTHOR CONTRIBUTIONS

RG, PS, EdV, A-MB: Conceptualisation, Writing - Original Draft, Writing - Review & Editing.

NOTE

The case of Blessing was constructed by the authors based on their vast clinical experience in working with sex trafficking victims. The name "Blessing" is fictional, and her story is based on many stories and cannot be traced back to a single person.

REFERENCES

Adams, A. (2018). Sexual slavery: Do we need this crime in addition to enslavement? *Criminal Law Forum*, *29*(2), 279–323. https://doi.org/10.1007/s10609-017-9339-2

Askin, K. (2013). Treatment of sexual violence in armed conflicts: A historical perspective and the way forward. In A-M. de Brouwer et al. *Sexual Violence as an International Crime: Interdisciplinary Approaches* (pp. 21–64). Intersentia.

Ba, I., & Bhopal, R. S. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: A systematic review (1981–2014). *Public Health*, *142*, 121–135. https://doi.org/10.1016/j.puhe.2016.07.019

Badour, C. L., Ojserkis, R., McKay, D., & Feldner, M. T. (2014). Disgust as a unique affective predictor of mental contamination following sexual trauma. *Journal of Anxiety Disorders*, *28*(7), 704–711. https://doi.org/10.1016/j.janxdis.2014.07.007

de Brouwer, A.-M. (2005). *Supranational criminal prosecution of sexual violence: The ICC and the practice of the ICTY and the ICTR*. Intersentia.

Bullock, C. M., & Beckson, M. (2011). Male victims of sexual assault: Phenomenology, psychology, physiology. *The Journal of the American Academy of Psychiatry and the Law*, *39*(2), 197–205.

Clark, J. N. (2014). A crime of identity: Rape and its neglected victims. *Journal of Human Rights*, *13*(2), 146–169. https://doi.org/10.1080/14754835.2014.886952

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, *6*(2), 103–129. https://doi.org/10.1177/1524838005275087

Cowling, M. (2016). *Making sense of sexual content*. Routledge. https://doi.org/10.4324/9781315249995

Davies, S. E., & True, J. (2017). The politics of counting and reporting conflict-related sexual and gender-based violence: The case of Myanmar. *International Feminist Journal of Politics*, *19*(1), 4–21. https://doi.org/10.1080/14616742.2017.1282321

DeCou, C. R., Cole, T. T., Lynch, S. M., Wong, M. M., & Matthews, K. C. (2017). Assault-related shame mediates the association between negative social reactions to disclosure of sexual assault and psychological distress. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(2), 166–172. https://doi.org/10.1037/tra0000186

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: A qualitative metasynthesis. *Research in Nursing & Health*, *32*(4), 366–378. https://doi.org/10.1002/nur.20333

Gallagher, A. (2010). *The international law of human trafficking*. Cambridge University Press.

Haenen, I. (2014). *Force & marriage: The criminalisation of forced marriage in Dutch, English and international criminal law*. Intersentia.

International Criminal Court. (2002). *Rome Statute of the International Criminal Court* (No. 38544). https://www.icc-cpi.int/sites/default/files/RS-Eng.pdf

International Criminal Court. (2011). *Elements of crimes*. Official Journal of the International Criminal Court. https://www.icc-cpi.int/sites/default/files/Publications/Elements-of-Crimes.pdf

International Criminal Court Prosecutor. (2017). *Statement of ICC Prosecutor to the UNSC on the Situation in Libya*.

Jozkowski, K. N., Sanders, S., Peterson, Z. D., Dennis, B., & Reece, M. (2014). Consenting to sexual activity: The development and psychometric assessment of dual measures of consent. *Archives of Sexual Behavior*, *43*(3), 437–450. https://doi.org/10.1007/s10508-013-0225-7

Kaitesi, U. (2014). *Genocidal gender and sexual violence: The legacy of the ICTR, Rwanda's ordinary courts and Gacaca courts*. Intersentia.

Kalaf, J., Coutinho, E. S. F., Vilete, L. M. P., Luz, M. P., Berger, W., Mendlowicz, M., Volchan, E., Andreoli, S. B., Quintana, M. I., De Jesus Mari, J., & Figueira, I. (2017). Sexual trauma is more strongly associated with tonic immobility than other types of trauma – A population based study. *Journal of Affective Disorders*, *215*, 71–76. https://doi.org/10.1016/j.jad.2017.03.009

Kelly, L. (1988). *Surviving sexual violence*. Polity Press; B. Blackwell.

Martinson, A., Craner, J., & Sigmon, S. (2016). Differences in HPA axis reactivity to intimacy in women with and without histories of sexual trauma. *Psychoneuroendocrinology*, *65*, 118–126. https://doi.org/10.1016/j.psyneuen.2015.12.025

McAlpine, A., Hossain, M., & Zimmerman, C. (2016). Sex trafficking and sexual exploitation in settings affected by armed conflicts in Africa, Asia and the Middle East: Systematic review. *BMC International Health and Human Rights*, *16*(1), 34. https://doi.org/10.1186/s12914-016-0107-x

Möller, A., Söndergaard, H. P., & Helström, L. (2017). Tonic immobility during sexual assault - a common reaction predicting post-traumatic stress disorder and severe depression. *Acta Obstetricia et Gynecologica Scandinavica*, *96*(8), 932–938. https://doi.org/10.1111/aogs.13174

Mollica, R. F. (2006). *Healing invisible wounds: Paths to hope and recovery in a violent world* (1st ed). Harcourt.

Mukanangana, F., Moyo, S., Zvoushe, A., & Rusinga, O. (2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *African Journal of Reproductive Health*, *18*(1), 110–122.

Oram, S., Stöckl, H., Busza, J., Howard, L. M., & Zimmerman, C. (2012). Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: Systematic review. *PLoS Medicine*, *9*(5), e1001224. https://doi.org/10.1371/journal.pmed.1001224

Perilloux, C., Duntley, J. D., & Buss, D. M. (2012). The costs of rape. *Archives of Sexual Behavior*, *41*(5), 1099–1106. https://doi.org/10.1007/s10508-011-9863-9

Ross-Gower, J., Waller, G., Tyson, M., & Elliott, P. (1998). Reported sexual abuse and subsequent

psychopathology among women attending psychology clinics: The mediating role of dissociation. *British Journal of Clinical Psychology*, *37*(3), 313–326. https://doi.org/10.1111/j.2044-8260.1998.tb01388.x

Schalinski, I., Elbert, T., & Schauer, M. (2011). Female dissociative responding to extreme sexual violence in a chronic crisis setting: The case of Eastern Congo. *Journal of Traumatic Stress*, *24*(2), 235–238. https://doi.org/10.1002/jts.20631

Schomburg, W., & Peterson, I. (2007). Genuine consent to sexual violence under international criminal law. *American Journal of International Law*, *101*(1), 121–140. https://doi.org/10.1017/S0002930000029560

Schultz, A. L. (2018). *Does dissociation produce shame? An exploration of adults with sexual abuse histories* [Master Thesis, University of Canterbury]. https://ir.canterbury.ac.nz/bitstream/handle/10092/15326/Schultz%2C%20Abbie_MA%20Thesis.pdf?sequence=1

Siller, N. (2015). The prosecution of human traffickers? *European Journal of Comparative Law and Governance*, *2*(3), 236–261. https://doi.org/10.1163/22134514-00203005

Siller, N. (2016). 'Modern Slavery': Does international law distinguish between slavery, enslavement and trafficking? *Journal of International Criminal Justice*, *14*(2), 405–427. https://doi.org/10.1093/jicj/mqv075

Tankink, M. (2013). The silence of South-Sudanese women: Social risks in talking about experiences of sexual violence. *Culture, Health & Sexuality*, *15*(4), 391–403. https://doi.org/10.1080/13691058.2012.752936

Tankink, M., & Lambrichts, R. (2017). Rammelende verklaringen en de vrije wil. Over inconsistente verklaringen en keuzevrijheid bij slachtoffers van seksuele uitbuiting [On inconsistent testimonies and freedom of choice among victims of sexual exploitation]. *Delict En Delinkwent*, *2.1*, 13–25.

Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007). Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. *Psychology of Women Quarterly*, *31*(1), 23–37. https://doi.org/10.1111/j.1471-6402.2007.00328.x

United Nations Human Rights office of the High Commissioner. (2000). *Protocol to prevent, suppress and punish trafficking in persons especially women and children, supplementing the United Nations convention against transnational organized crime* (Resolution 55/25).

United Nations Office of the High Commissioner for Human Rights. (2003). *Recommended principles and guidelines on human rights and human trafficking*. United Nations Office of the High Commissioner for Human Rights. https://www.ohchr.org/sites/default/files/Documents/Publications/Traffickingen.pdf

United Nations Security Council. (2008). *Resolution 1820 (S/RES/1820)*.https://www.un.org/shestandsforpeace/sites/www.un.org.shestandsforpeace/files/unscr_1820_2008_on_wps_english.pdf

United Nations Security Council. (2016). *Resolution 2331 (S/RES/2331)*. https://www.un.org/securitycouncil/s/res/2331-%282016%29

United Nations Security Council. (2017a). *Report of the Secretary-General on conflict-related sexual violence* (UN Document S/2017/249). https://documents-dds-ny.un.org/doc/UNDOC/GEN/N17/084/33/PDF/N1708433.pdf?

OpenElement

United Nations Security Council. (2017b). *Resolution 2388 (S/RES/2388)*. https://www.un.org/securitycouncil/content/sres2388-2017

United Nations Security Council. (2018). *Report of the Secretary-General on conflict-related sexual violence* (S/2018/250). https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/083/25/PDF/N1808325.pdf?

OpenElement

United Nations Treaty series. (2001, May 31). *Protocol against the illicit manufacturing of and trafficking in firearms, their parts and components and ammunition, supplementing the United Nations convention against transnational organized crime*. https://treaties.un.org/Pages/showDetails.aspx?objid=0800000280050d88&clang=_en

Viseur Sellers, P. (2007). The 'appeal' of sexual Violence: Akayesu/Gacumbitsi cases. In ed. K. Stefisyn, *Gender-based Violence in Africa* (pp. 51–103). University of Pretoria.

Viseur Sellers, P. (2011). Wartime female slavery: Enslavement? *Cornell International Law Journal*, *44*(1), 115–143.

Zawātī, H. (2014). *Fair labelling and the dilemma of prosecuting gender-based crimes at the international criminal tribunals*. Oxford University Press.

CHAPTER 3

Identifying Subgroups of Sex Trafficking Survivors and the Intersect With Sociodemographic Background, Traumatic Experiences, and Mental Healthcare

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Ghafoerkhan, R.S., Scholte, W.F., Zondervan-Zwijnenburg, M.A.J., Kiss, L., Boelen, P.A. Identifying subgroups of sex trafficking survivors and the intersect with sociodemographic background, traumatic experiences, and mental healthcare.

ABSTRACT

BACKGROUND

Sex trafficking has detrimental effects on the mental health of survivors. Examining the heterogeneity of sex trafficking experiences can improve the understanding of its control mechanisms and psychological sequelae, and tailoring of mental health services.

OBJECTIVES

The main objective was to identify subgroups of sex trafficking experiences among adult women survivors. Secondary objectives were to examine if sociodemographic factors and prior traumatic experiences predict subgroup membership and if subgroups predict psychosocial impairment, treatment indication, and course of mental health treatment.

METHOD

A historical cohort study was conducted among sex trafficked adult women (N = 337) who sought specialised mental health care at an outpatient clinic in the capital region of the Netherlands. Data for deploying latent class analysis were extracted from electronic medical records.

RESULTS

Two subgroups of sex trafficking experiences were identified. First, a "restricted movement" class (n = 265, 79%) including people who were mainly exploited for less than one year, by a perpetrator they were not in an intimate relationship with, whilst being restricted in their movement. Second, an "interpersonal coercion" class (n = 72, 21%) who were mainly been exploited within an intimate relationship for over a year, and was more likely to be forced by psychological threats and emotional coercion. Survivors born in an African country and those with an uncertain residency status had increased odds of belonging to the "restricted movement" class. All those self-identifying as lesbian belonged to the "restricted movement" class. Members of the "interpersonal coercion" class were less likely to complete mental health treatment.

CONCLUSIONS

Findings encourage a nuanced view of sex trafficking experiences and underline the diversity of its control mechanisms. In particular, findings hint to a distinction between being emotionally coerced into sex trafficking within an intimate relationship and being "locked up" by a non-intimate perpetrator.

Keywords

Sex trafficking, human trafficking, traumatic stress, treatment, latent class analysis

Sex trafficking is a complex, diverse, and widespread human rights violation and a global mental health concern (Ottisova et al., 2016; Zimmerman & Kiss, 2017). For adults, sex trafficking has been defined as an act where people are deceived, threatened, coerced, or being abused because their vulnerability, for the purpose of forced sex work (United Nations: Office on Drugs and Crime, 2004). Various control mechanisms by which sex trafficking can occur are brought forward by this definition, suggesting the inner workings of sex trafficking experiences to differ between survivors (Hoyle et al., 2011; Kleemans, 2011). However, in-depth research on patterns within these control mechanisms and characteristics of sex trafficking experiences amongst adults is scarce (e.g., Iglesias-Rios et al., 2020; Lightowlers et al., 2021; Stöckl et al., 2021). Moreover, in the development of counter-trafficking responses and (mental) health care policy, survivors of sex trafficking are mostly considered to form one group (Kleemans, 2011; Wright et al., 2021). The prevalence of mental health disorders, including posttraumatic stress disorder, amongst survivors of sex trafficking is high (Ottisova et al., 2016). However, there is a scant evidence base on mental health services for survivors and even less of an understanding on best practices for potential diversity among survivors (Wright et al., 2021). Disentangling the heterogeneity of sex trafficking experiences could promote understanding of its mechanisms and tailoring of mental health services accordingly.

The objectives of this study were to (1) identify patterns among women migrant adult survivors in an outpatient mental healthcare setting, based on the sex trafficking characteristics and control mechanisms, (2) examine if sociodemographic factors and prior traumatic experiences were associated with these patterns, and (3) test if these patterns explain psychosocial impairment, treatment indication, and course of mental health treatment. To test these objectives latent class analysis, a person-centred approach that identifies patterns of characteristics, was used (Weller et al., 2020).

METHOD

STUDY SETTING AND DESIGN

A historical cohort study was conducted among adult migrant women who had been sex trafficked and sought post-trafficking mental health care. This study was carried out at an outpatient mental health clinic based in the capital region of the Netherlands. One of its clinical departments specifically serves people with a migrant background who have faced sex trafficking. Upon registration at the study site, patients are informed about the possibility that their (anonymised) medical information might be used for scientific purposes, and are provided the option to opt out. Clinical assessment is carried out by a multidisciplinary team and, when appropriate, a psychiatric diagnosis is established. Accordingly, various treatment modules are offered, aimed at posttraumatic stress symptom reduction and recovery. This includes therapies focused on the (re-) processing of traumatic memories (trauma-focused therapy; TFT).

This department mainly receives referrals of (former) residents of a shelter housing women

migrant survivors of (recent) sex trafficking that mainly occurred in the Netherlands. As a result, the study site's patient population predominantly comprised adult migrant women survivors. Therefore, while acknowledging that sex trafficking cuts across gender identities, age, and nationalities, the present study included only adult migrant women (i.e., sex as assigned at birth and/or gender as self-identified during enrolment at the study-site).

For the purpose of this study, electronic medical records of discharged adult migrant survivors were analysed systematically. Documents available within the medical records were clinical screening reports, intake and assessment reports, treatment evaluations, and discharge letters (directed at general practitioners). All these documents had standardised formats and subheadings. At the study site, access to specific closed medical records was granted to the primary researcher (RG) and research assistants employed for the define purposes of this study. Additionally, the primary researcher (RG) other co-authors of this manuscript (WS, PB) worked as clinicians at the study site. It was confirmed by the Medical Ethical Review Board of Utrecht University (file number: WAG/mb/20/023323) that no further ethical approval was required, given that the medical records were kept primarily for healthcare purposes within the institution and only secondarily for scientific data analyses.

PARTICIPANTS

Women were included in the current study if they were 18 years or older and were considered survivors of sex trafficking (United Nations: Office on Drugs and Crime, 2004). For the purpose of this study sex trafficking was defined as: 1) having been forced to perform sex work, 2) not receiving (sufficient) payment and/or not having access to personal earnings, 3) being deceived, threatened, coerced and/or abused due to a vulnerable position. Women were excluded if they had solely experienced other forms of sexual violence, or were sex workers that reported working by their own choice and overseeing their own earnings, or were survivors of labour exploitation but not sex trafficking.

From the medical records, 402 cases were considered for inclusion, 37 cases were excluded because they did not meet the inclusion criteria, and another 28 cases were excluded because their medical records were incomplete. A total of 337 patients were included in the study and various smaller subsets of this full sample were used for analyses. Table 1 provides descriptive statistics for the full sample and relevant subsets. Most survivors either resided in a specialised shelter or lived independently, were single, and almost half had a child at the time of admission. Regarding their mental health status at admission, a majority suffered from posttraumatic stress disorder (PTSD), about half from a mood disorder, and about half shared having suicidal ideations, or undertook previous suicide attempts. On average their global level of functioning (GAF) scores at admission and discharge indicated "serious symptoms or impairment" (American Psychiatric Association, 2000). Many survivors within the sample did not complete (parts of) the treatment they started. Main reasons for this were changes in their residency status or sex trafficking legal procedure, lack of motivation, or loss of contact between the clinician and the survivor for unknown reasons.

Table 1

Sociodemographic Characteristics and Mental Health of Sample

	n	%
Place of residence at admission		
Specialised shelter for sex trafficking survivors	153	41
Independent living	82	22
Homeless/varying places	37	10
Asylum seeker center	10	3
Marital status at admission[a]		
Single	244	66
Married/partnered	70	19
Divorced/widowed	21	6
Motherhood at admission		
Pregnant	32	9
Has children	37	41
Mental health disorders and complaints at admission[b]		
Posttraumatic stress disorder	264	78
Mood disorders	157	47
Comorbidity (≥2 diagnoses)	56	17
Substance dependency or abuse	105	31
Suicidal ideations or attempts	169	50
Treatment[c]		
Narrative Exposure Therapy	51	15
Eye Movement Desensitisation Therapy	62	18
Trauma-focused psychotherapy - other	40	12
Pharmacotherapy	118	35
Non-completion reasons[d]		
Changes in legal residency status	62	30
Lack of motivation	58	28
Loss of contact with patient	43	21
Referred to psychiatric hospital	23	11
Major life event	18	9
	M	*SD*
Global assessment of function score at admission	52	8
Length of treatment in days [c]	599	540
Global assessment of function score at discharge [c]	54	8

Note. $N = 337$. Patients were on average 29.3 years old ($SD = 7.3$).

[a] Missing data: $n = 135$, 10%.

[b] Missing data: $n = 22$, 1%. Categories might overlap within individual patients.

[c] Subset used of patients that started any form of treatment: $n = 255$, 76%.

[d] Subset used of patients did not complete (parts of) treatments: $n = 204$, 61%.

PROCEDURE

Data extraction was overseen by the primary researcher (RG) and carried out by ten research assistants employed at the study site, at various timepoints between 2016 and 2019. Before commencing data extraction and coding, all assistants were trained by the primary researcher on how to handle and code sensitive medical information. During the data extraction regular meetings were held

between the primary researcher and the assistants. Here, inclusion criteria, operationalisations, and scoring were discussed until consensus was reached. Data were entered into an electronic data file, pseudonymised, and stored in a protected digital environment at the study site, accessible only to the researchers. During final data-analyses an anonymised data file was used.

Potential inclusions were selected by the researchers by reviewing the minutes taken during clinical staff meetings regarding new admissions between January 1, 2009 and August 31, 2019. These minutes were considered for three key search terms: "sexual exploitation", "forced prostitution", "trafficking". If a woman resided in a shelter for survivors of human trafficking she was also considered for inclusion. After inclusion, information of interest was encoded from the medical records into variables. Values were entered as missing when information that was supposed to be available due to the standardised format of the documents had been left blank or incomplete. After completion, ten percent of the medical records were checked at random, blinded from the previous data-entry.

MEASURES

Indicators - Sex Trafficking Characteristics and Control Mechanisms

Sex trafficking characteristics and (control) mechanisms were selected based on previous studies (Casassa et al., 2021; Iglesias-Rios et al., 2020; Kiss et al., 2015; Preble, 2021; van der Watt & Kruger, 2017), and clinical experience within the aforementioned mental health clinic (see Study setting and design). To optimise interpretability of the statistical analyses (i.e., latent class analysis), indicators were dichotomously scored. Notably, if information was not present or not applicable to the patient this was scored as a "no". The following information was extracted from the medical records; whether (0 = "no", 1 = "yes") it was mentioned that the patient (i) experienced multiple distinct periods of sex trafficking (revictimisation); (ii) was in an intimate relationship with the perpetrator(s) (i.e., either a family member or an intimate partner); (iii) had been subjected to sex trafficking for more than one year; (iv) was coerced by psychological threats and/or emotional abuse; (v) was coerced by the use of voodoo rituals; (vi) was threatened with the use of direct or indirect (i.e. to loved ones) physical violence; (vii) was deceived or coerced due to a vulnerable position (e.g., debt bondage, confiscated travel documents, being illegal, being homeless); (viii) was restricted in movement (mainly being locked up); (ix) experienced physical violence; (x) was given drugs; (xi) became pregnant, had a miscarriage or an abortion during the sex trafficking period.

Associations - Sociodemographic Factors and Prior Traumatic Experiences

For the purpose of this study it was considered whether (0 = "no", 1 = "yes") it was mentioned within the medical records that the patient (i) originated from a European (ii) or African country; (iii) had an uncertain residency status (e.g., under the consideration as "victim of human trafficking", ongoing or rejected asylum application, or residing illegally in the Netherlands) as opposed to a permanent residency status (either Dutch/European citizen, or granted refugee status in the Netherlands); (iv) self-identified as lesbian (i.e., other sexual orientations were not found within the medical records).

Regarding prior traumatic experiences it was considered whether (0 = no, 1 = yes) it was mentioned that the patient (v) experienced loss of primary caretakers, by death, separation or otherwise (<18 years); (vi) had been forced into marriage (at any age); (vii) had suffered childhood sexual abuse (<18 years); and (viii) had suffered childhood physical and/or emotional abuse (<18 years).

Distal Outcomes- Psychosocial Impairment, Treatment Indication and Course of Mental Health Treatment

At admission and discharge, each patient was given a "global assessment of functioning score" (GAF-score; American Psychiatric Association, 2000) as a proxy for psychosocial impairment due to their mental health condition. For this study it was considered whether (0 = "no", 1 = "yes") the patient had a GAF-score of 50 or below, a threshold formerly indicating "serious symptoms, or any serious impairment in social, occupational, or school functioning" or worse functioning at intake (i) (American Psychiatric Association, 2000). To establish information regarding treatment indication and the course of mental health treatment, several subsamples were used. First, for each patient it was noted whether (0 = "no", 1 = "yes") trauma-focused therapy (TFT) was indicated at admission (ii). TFT generally consisted of evidence-based methodologies such as Eye-Movement Desensitisation and Reprocessing therapy (EMDR; NICE guideline; Shapiro, 2018) and Narrative Exposure Therapy (NET; Brady et al., 2021; Schauer et al., 2011). Next, among patients for whom TFT was indicated it was considered whether (0 = "no", 1 = "yes") TFT had been started (iii). Finally, for the subset of patients who started TFT, it was examined whether (0 = "no", 1 = "yes") TFT was completed (iv).

STATISTICAL ANALYSES

First, we used latent class analysis to identify classes within sex trafficking characteristics and control mechanisms (Table 2). Latent class analysis is a person-centred approach that identifies patterns of characteristics that distinguish members of one class from those of another (Weller et al., 2020). Classes were added as long as one of the fit measures indicated that more classes would improve the model and the software did not produce errors, which generally indicate under-identification of the model (Nylund et al., 2007). The fit measures under consideration were (a) the Lo-Mendell-Rubin test (LMR), (b) adjusted or Vuong-Lo-Mendell-Rubin test (VLMRt), and (c) bootstrap likelihood ratio test (BLRt), with significant *p*-values justifying the added class. Furthermore, the (adjusted) Bayesian information criterion (aBIC and BIC) and Akaike information criterion (AIC) were evaluated with lower values indicating better fit. When fit measures converged on different models, we (visually) inspected the different solutions in an elbow plot (Figure 1), considering their relations and the stability of the solutions (Nylund et al., 2007). After selection of the classes we inspected the posterior classification probabilities for the most likely latent class membership and the entropy value of the model. Researchers usually aim for entropy values >.80, but this is no strict cut-off (Muthén, 2008). Lastly, interpretability for clinical practice was considered when selecting the final class solution. In this analysis, missing data were handled by means of full information maximum likelihood estimation.

Second, we related the selected class solution to predictors and outcomes (Table 4) through three-step approaches that preserve the classification uncertainty (Asparouhov & Muthén, 2014). The three-step method with class predictors calculates a multinomial logistic regression (i.e., this simplifies to a regular logistic regression in case of a two-class solution) with class membership as the dependent variable. The three-step method for categorical distal outcomes provides us with the probabilities for each outcome category within each class, and an overall Wald's test of association. In the three-step methods, full information maximum likelihood estimation cannot be applied to handle missing data. Instead, the default procedure is to apply listwise deletion. The variable "uncertain residency status" had 10% missing data, other predictors did not have any missing data. The survivors with missing data did not significantly differ from the other survivors on the indicators included in the latent class analysis. For the distal outcomes analysis, several subsets of interest were used, ranging between 37% and 59% of the total sample. We considered the missing data by design too large to apply multiple imputation as a missing data handling method, and applied the default procedure of listwise deletion instead. All analyses were executed in Mplus version 8.6 (Muthén & Muthén, 1998), supported by Mplus Automation package (Hallquist & Wiley, 2018), through R (R Core Team, 2022).

RESULTS

AIM (1) IDENTIFYING PATTERNS WITHIN SEX TRAFFICKING EXPERIENCES

For this analysis the full sample was included (*N* = 337). Indicators entered into the latent class analysis are presented in Table 2, and findings are displayed in Table 3 and Figure 1. The BIC suggests a 2-class solution, as the BIC measure is the most reliable fit statistic for determining optimal class solution (Nylund-Gibson & Choi, 2018; Weller et al., 2020). Inconsistency between various fit statistics is common in latent class analysis (Weller et al., 2020). The AIC points towards a 5-class solution and the aBIC favors a 4-class solution. Upon visual inspection of the elbow plot displaying the fit indices in Figure 1, a "cut" is seen after the 2-class solution. Hereafter the AIC and aBIC still decrease, indicating improved parsimoniousness, however not as steeply as after the 2-class solution. The VLMRt and BLRt p-values indicate improvement of the model up until a 4-class solution. Considering the fit measures and clinical interpretability of the various class solutions, a 2-class model was retained. Finally, the quality of the classification was evaluated using the entropy value and posterior classification probabilities for the most likely latent class membership. For the 2-class model the entropy value was 0.75, which can be considered adequate (Muthén, 2008). The posterior classification probabilities for the most likely latent class membership were 0.83 (class 1) and 0.97 (class 2), which can be considered good values (Nylund-Gibson & Choi, 2018).

Figure 2 and Table 2 display the probabilities for scoring "yes" for each sex trafficking indicator within the 2-class solution. Class 1 (*n* = 265, 79%) was the larger subgroup within this sample. Members of this group had an elevated probability to be exploited by a perpetrator unknown to

them, to be subjected to sex trafficking for less than one year, and to be restricted in their movement. All survivors within the full sample who were threatened by the use of voodoo rituals belonged to this class. Members had a lowered probability of being emotionally coerced. Although this class is characterised by various factors the class was labelled "restricted movement". Class 2 (*n* = 72, 21%) was the smaller subgroup within this sample. Members within this group had an elevated probability of being exploited within an intimate relationship (i.e., family member or intimate partner), of being subjected to sex trafficking during a longer period (>1 year), and of being psychologically threatened or emotionally abused. Members had a lowered probability of being restricted in their movement. This class was labelled "interpersonal coercion". Members of both classes had high probability of experiencing physical violence and threats. One third of members within both classes experienced sex trafficking revictimisation, and another third was deceived or coerced due to a vulnerable position. Members within both classes had low probability of having been given drugs, becoming pregnant, having miscarriages, or abortions during the sex trafficking period.

Table 2

Indicators of Sex Trafficking Experiences Included in the Latent Class Analysis

	Class 1 [a]		Class 2 [a]		Full sample [a]	
	n	%	*n*	%	*n*	%
(i) Did the survivor experience multiple distinct periods of sex trafficking (>1)?	54	20	23	33	77	23
(ii) Was the survivor in an intimate relationship with the perpetrator(s)?	16	6	68	95	84	25
(iii) Was the survivor subjected to sex trafficking for more than one year? [b]	66	36	46	87	112	33
(iv) Was the survivor coerced by psychological threats or emotional abuse by the perpetrator(s)?	16	6	33	46	49	15
(v) Was the survivor coerced by voodoo rituals by the perpetrator(s)?	41	16	0	0	41	12
(vi) Was the survivor threatened with direct or indirect physical violence by the perpetrator(s)?	88	33	32	44	120	36
(vii) Was the survivor deceived or coerced due to a vulnerable position to the perpetrator(s)?	69	26	19	26	88	26
(viii) Was the survivor restricted in her movement by the perpetrator(s)?	198	75	26	36	224	67
(ix) Did the survivor experience physical violence by the perpetrator(s)?	136	51	54	75	190	56
(x) Was the survivor given drugs by the perpetrator(s)?	21	8	14	19	35	10
(xi) Did the survivors go through pregnancies, miscarriages, or abortions?	55	21	15	21	70	21

Note. *N* = 337 for full sample, (*n* = 265 for class 1 "restricted movement", *n* = 72 for class 2 "interpersonal coercion").

[a] Reflects the number and percentage of patients scoring "yes".

[b] Missing data *n* = 98, 29%.

Table 3

Fit Statistics for Varying Size Latent Class Models of Sex Trafficking Indicators

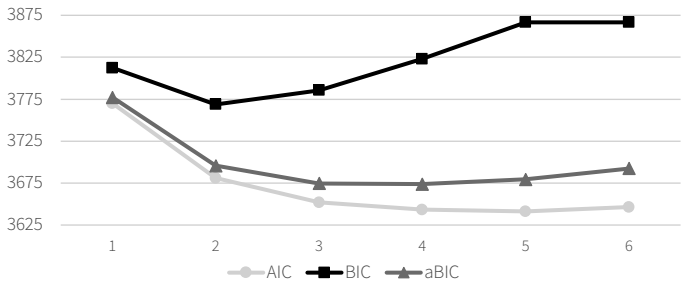
Class	AIC	BIC	aBIC	VLMRt	BLRt	Entropy	Smallest class size
1	3770.20	3812.22	3777.33	NA	NA	NA	377
2	**3680.84**	**3768.70**	**3695.75**	**0.00***	**0.75**	**0.75**	**72**
3	3651.99	3785.69	3674.70	0.00*	0.67	0.67	74
4	3643.38	3822.93	3673.83	0.03**	0.79	0.79	52
5	3641.24	3866.62	3679.46	0.46	0.80	0.80	30
6	3646.35	3866.62	3692.35	0.38	0.83	0.83	27

Note. Solution in bold is selected model. aBIC = Sample-size adjusted Bayesian Information Criteria; AIC = Akaike Information Criteria; BIC = Bayesian Information Criteria; BLRt = Bootstrapped Likelihood Ratio test; VLMRt = Vuong-Lo-Mendell-Rubin likelihood ratio test.

* $p < .01$. ** $p < .05$.

Figure 1

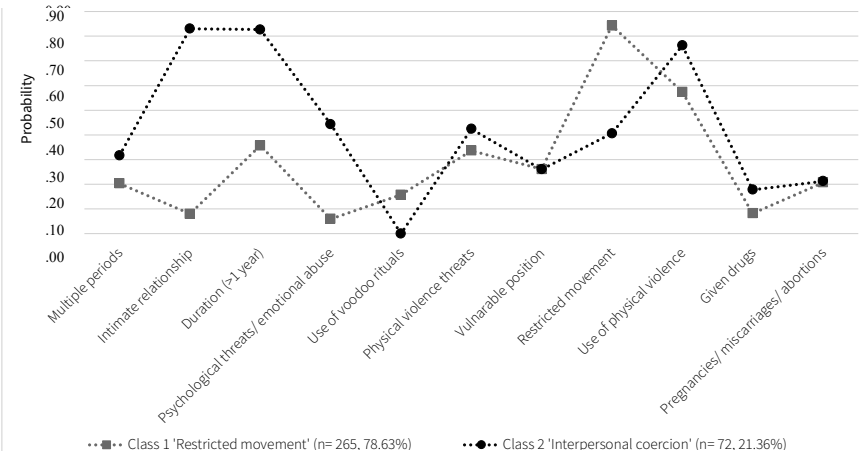
Plot of Fit Statistics for Varying Size Latent Class Models of Sex Trafficking Indicators



Note: *N* = 337. aBIC = Sample-size adjusted Bayesian Information Criteria; AIC = Akaike Information Criteria; BIC = Bayesian Information Criteria.

Figure 2

Response Patterns of Sex Trafficking Characteristics per Latent Class



Note. Reflects probabilities per class for scoring "yes".

AIM (2) TESTING PREDICTORS: SOCIODEMOGRAPHIC FACTORS AND PRIOR TRAUMATIC EXPERIENCES

For this analysis the full name sample was included (*N* = 337). Table 4 displays that about two thirds of the survivors were born in an African country (mainly Nigeria, Uganda, Guinea, and Sierra Leone), against around one fifth being born in a European country (mainly Hungary, Bulgaria, and Romania). Around three-quarters of the sample had an uncertain residency status in the Netherlands. Prior traumatic experiences were highly prevalent (ranging between 18.7% to 64.4%); two third experienced the loss of a primary caretaker before the age of 18 years, about one fifth was forced into marriage, one fifth was sexually abused as a child, and finally, one third experienced physical or emotional abuse as a child.

Table 4

Latent Class Analysis Predictors and Distal Outcomes

	Class 1 [a]		Class 2 [a]		Full sample [a]	
	n	%	*n*	%	*n*	%
Sociodemographic predictors						
Was the survivor born in a European country?	31	12	37	51	68	20
Was the survivor born in an African country?	206	78	19	26	225	67
Does the survivor have an uncertain residency status? [b]	198	84	30	46	228	75
Does the survivor self-identify as lesbian?	49	19	1	1	50	15
Prior trauma predictors						
Did the survivor lose a primary caretaker (<18y)?	180	68	37	51	217	64
Was the survivor forced into marriage?	67	25	7	10	74	22
Did the survivor experience childhood sexual abuse (< 18y)?	46	18	14	20	60	18
Did the survivor experience childhood physical and/or emotional abuse (< 18y)?	25	35	87	33	112	33
Distal outcomes						
Was the GAF-score at admission ≤50? [c]	112	43	28	41	140	43
Was TFT indicated at admission?	129	49	39	54	168	50
Was the indicated TFT started? [d]	98	65	30	65	128	65
Was the indicated TFT completed? [e]	55	57	11	37	66	52

Note. *N* = 337 for full sample, (*n* = 265 for class 1 "restricted movement", *n* = 72 for class 2 "interpersonal coercion"). TFT = trauma-focused therapy.

[a] Reflects the number and percentage of patients scoring "yes".

[b] Missing data *n* = 34, 10%.

[c] Missing data *n* = 8, 2%.

[d] Subset used of patients for whom TFT was indicated *n* = 197, 59%.

[e] Subset used of patients that started TFT *n* = 127, 38%.

Latent class membership was regressed on the predictors shown in Table 4 using the three-step method (Asparouhov & Muthén, 2014). Survivors born in an African country and those having an uncertain residency status had increased odds of belonging to class 1 "restricted movement". Finally, all survivors self-identifying as lesbian belonged to class 1, causing the analysis to produce extreme values. Table 5 shows the estimates, standard deviations, and the odds ratio's 95% confidence intervals of the multinomial logistic regression analysis. Other predictors, including

prior traumatic experiences, did not influence the odds of class membership within the study sample.

Table 5

Multinomial Logistic Regression Analyses of Latent Class Membership (class 1 vs. class 2, with class 1 as reference class) on Sociodemographic Factors and Prior Traumatic Experiences

	Estimate	*SE*	OR 95% CI	
			LL	*UL*
Sociodemographic predictors [a]				
Was the survivor born in a European country?	-0.282	0.616	0.226	2.523
Was the survivor born in an African country?	1.848**	0.630	1.846	21.822
Does the survivor have an uncertain residency status? [b]	-1.620*	0.511	0.073	0.539
Does the survivor identify as lesbian?	-209.586**	NA	NA	NA
Prior trauma predictors [a]				
Did the survivor lose a primary caretaker (<18y)?	0.181	0.498	0.451	3.180
Was the survivor forced into marriage?	0.155	1.111	0.132	10.311
Did the survivor experience childhood sexual abuse (<18y)?	-0.820	0.782	0.095	2.038
Did the survivor experience childhood physical and/or emotional abuse (< 18y)?	0.471	0.492	0.611	4.200

Note. $N = 337$. CI = confidence interval; *LL* = lower limit; OR = Odds Ratio; SE = Standard Error; *UL* = upper limit.
* $p < .01$, ** $p < .05$.
[a] Statistics displayed for answer score "1=yes".

AIM (3) TESTING DISTAL OUTCOMES: PSYCHOSOCIAL IMPAIRMENT, TREATMENT INDICATION, AND COURSE OF MENTAL HEALTH TREATMENT

Various subsets were used for these analyses; table 4 shows the variables that were considered as distal outcomes of class membership. TFT was indicated at admission for about half of the sample; after this treatment indication, about one third of this subset ($n = 197$) started the indicated TFT. Out of the survivors that started TFT, around half of the subset ($n = 127$) completed their treatment. Analyses showed that relatively more patients belonging to class 1 "restricted movement" ($n = 55$, 56.7% within class 1) completed TFT in comparison to those belonging to class 2 "interpersonal coercion" ($n = 11$, 36.7% within class 2; chi-square = 5.73, $p = 0.02$). No differences were found between classes on TFT indication at intake or at the start of TFT; also no differences were found between GAF-scores at admission.

DISCUSSION

This study examined patterns within sex trafficking characteristics and control mechanisms applied, among a clinical sample of adult migrant women survivors in the Netherlands. Findings within this sample highlight the heterogeneous nature of sex trafficking experiences, and indicate two potential patterns worth considering among migrant survivors seeking mental health

assistance. The first entails migrant survivors who were mainly exploited for less than one year, by an unknown perpetrator, whilst being restricted in their movement. They were more likely to originate from an African country and less likely to hold a residency status. All survivors self-identifying as lesbian belonged to this subgroup. A second pattern comprised survivors who mainly were exploited within an intimate relationship for over a year, and were more likely to be forced by psychological threats and emotional coercion. Within our sample these survivors were less likely to complete trauma-focused therapy. The common denominator within the full sample of survivors was the frequent use of physical violence against them, in some cases the occurrence of sex trafficking revictimisation, and in some cases coercion due to a vulnerable position. Finally, prior traumatic events were prevalent within the full sample; here, no differences were found between the identified patterns.

IMPLICATIONS

Study findings reiterate a nuanced view of sex trafficking experiences and underline the complexity and diversity of its control mechanisms and characteristics (Casassa et al., 2021; Hoyle et al., 2011; Iglesias-Rios et al., 2020; Kleemans, 2011; Preble, 2021). In particular, findings hint to a divide between being emotionally coerced into sex trafficking within an intimate relationship and being "locked up" by an unknown perpetrator. Clearly, both dynamics are complex and horrific in their own way and can co-exist within survivors. The relationship between the survivor and the perpetrator and the endured control mechanisms may influence survivor's willingness to disclose and self-identify as a survivor (Verhoeven et al., 2015), the potential psychological sequelae (Abas et al., 2013), and treatment adherence (Yakushko, 2009). For some, (posttraumatic) stress, anxiety and shock might be the most prominent psychological sequalae. This may be exacerbated by fear of retaliation by the perpetrator(s) (Verhoeven et al., 2015; Yakushko, 2009), fear of re-patriation to their country of origin (Domoney et al., 2015), or fear due to being bound by voodoo rituals (van der Watt & Kruger, 2017). Others, because of their attachment to the perpetrator, might paradoxically be prone to feelings of guilt and betrayal towards the perpetrator, and confusion about the validity of their own victimhood (Casassa et al., 2021; Preble, 2021; Verhoeven et al., 2015). Moreover, these psychological sequelae as well as potential social marginalisation (Dahal et al., 2015; Yarwood et al., 2022) can put survivors at risk for sex trafficking revictimisation (Classen et al., 2005; Gordon et al., 2018). Finally, the relationship and endured control mechanisms may influence survivors' identification by health staff and service providers and subsequent access to healthcare, legal justice, and residency status (Domoney et al., 2015; Gordon et al., 2018).

LIMITATIONS AND FUTURE RESEARCH

Several limitations are important to address. First, the use of medical records might have led to underreporting in general and led to incomplete data on some of the a priori variables of interest. Also, the relatively small sample size permitted only a limited number of indicators to be included within the latent class analysis, and might have hindered some important predictors of class membership to be detected. Furthermore, the study site mainly served survivors residing

in shelters offering specialised post-trafficking services. Women residing in these shelters likely represent a specific group of survivors, namely those who were able and willing to "escape", who were identified as "sex trafficking survivors" by service providers, and who were willing to accept (mental healthcare) support (Domoney et al., 2015; Yakushko, 2009; Yarwood et al., 2022). Findings within this study may therefore be limited in their generalisability to a wider population of sex trafficking survivors.

The present study was limited in its ability to capture the influence of various structural "push" factors (e.g., poverty, unemployment, and conflict) on sex trafficking experiences, as these were not routinely recorded within the medical records. These structural factors push in particular socially marginalised people towards potentially dangerous persons and networks facilitating transport between countries and regions (Kuschminder & Triandafyllidou, 2020). It is advisable for future studies to consider such structural factors, as these are key in understanding the complexity and diversity of sex trafficking, and key for the endorsement of (mental) healthcare policies and counter-trafficking efforts (Domoney et al., 2015; Hoyle et al., 2011).

To generalise and substantiate current findings, larger and longitudinal studies examining sex trafficking experiences are needed. It is recommended to include survivors whose experiences go beyond common (public) assumptions about what sex trafficking practices entail (Andrijasevic & Mai, 2016; Hoyle et al., 2011; Kleemans, 2011), so to allow for an inclusive, diverse, and representative sample. Also, other specific subsamples of survivors could be considered for future research, e.g., men (Iglesias-Rios et al., 2020), people identifying as LGBTQI+ (Yarwood et al., 2022), revictimised survivors (Dahal et al., 2015), and samples at the intersect of conflict-related sexual violence and sex trafficking (see chapter 2; Ghafoerkhan et al., 2019). In-depth research among survivors and perpetrators could shed further light on the inner workings of specific control mechanisms, and on possible strategies to mitigate the risk of sex trafficking revictimisation (Hoyle et al., 2011). Distinguishing psychological sequelae specifically associated with various control mechanisms could improve the tailoring of mental healthcare to the specific needs of survivors.

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AUTHOR CONTRIBUTIONS

RG: Conceptualisation, methodology, formal analysis, investigation, writing -original draft, project administration and funding acquisition.

WS: Conceptualisation, writing – review and editing, supervision and funding acquisition.
MZZ: Formal analysis, writing – review and editing, supervision.
LK: Writing – review and editing.
PB: Conceptualisation, writing – review and editing, and supervision.

REFERENCES

Abas, M., Ostrovschi, N. V., Prince, M., Gorceag, V. I., Trigub, C., & Oram, S. (2013). Risk factors for mental disorders in women survivors of human trafficking: A historical cohort study. *BMC Psychiatry*, *13*(1), 204. https://doi.org/10.1186/1471-244X-13-204

American Psychiatric Association (Eds.). (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed., text revision). American Psychiatric Association.

Andrijasevic, R., & Mai, N. (2016). Editorial: Trafficking (in) representations: Understanding the recurring appeal of victimhood and slavery in neoliberal times. *Anti-Trafficking Review*, *7*. https://doi.org/10.14197/atr.20121771

Asparouhov, T., & Muthén, B. (2014). Auxiliary variables in mixture modeling: Three-step approaches using Mplus. *Structural Equation Modeling: A Multidisciplinary Journal*, *21*(3), 329–341. https://doi.org/10.1080/10705511.2014.915181

Brady, F., Chisholm, A., Walsh, E., Ottisova, L., Bevilacqua, L., Mason, C., Werthern, M. von, Cannon, T., Curry, C., Komolafe, K., Robert, R. E., Robjant, K., & Katona, C. (2021). Narrative exposure therapy for survivors of human trafficking: Feasibility randomised controlled trial. *BJPsych Open*, *7*(6). https://doi.org/10.1192/bjo.2021.1029

Casassa, K., Knight, L., & Mengo, C. (2021). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse*, 152483802098554. https://doi.org/10.1177/1524838020985542

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, *6*(2), 103–129. https://doi.org/10.1177/1524838005275087

Dahal, P., Joshi, S. K., & Swahnberg, K. (2015). 'We are looked down upon and rejected socially': a qualitative study on the experiences of trafficking survivors in Nepal. *Global Health Action*, *8*(1), 29267. https://doi.org/10.3402/gha.v8.29267

Domoney, J., Howard, L. M., Abas, M., Broadbent, M., & Oram, S. (2015). Mental health service responses to human trafficking: A qualitative study of professionals' experiences of providing care. *BMC Psychiatry*, *15*(1), 289. https://doi.org/10.1186/s12888-015-0679-3

Ghafoerkhan, R.S., Scholte, W., de Volder, E., & de Brouwer, A.-M. (2019). The nexus between conflict-related sexual violence and trafficking for sexual exploitation in times of conflict. *Journal of Trafficking and Human Exploitation*, *3*(1), 9–33. https://doi.org/10.7590/245227719X15476235096517

Gordon, M., Salami, T., Coverdale, J., & Nguyen, P. T. (2018). Psychiatry's role in the management of human trafficking victims: An integrated care approach. *Journal of Psychiatric Practice*, *24*(2), 79–86. https://doi.org/10.1097/PRA.0000000000000287

Hallquist, M. N., & Wiley, J. F. (2018). MplusAutomation: An R Package for facilitating large-scale latent variable analyses in Mplus. *Structural Equation Modeling: A Multidisciplinary Journal*, *25*(4), 621–638. https://doi.org/10.1080/10705511.2017.1402334

Hoyle, C., Bosworth, M., & Dempsey, M. (2011). Labelling the victims of sex trafficking:

Exploring the borderland between rhetoric and reality. *Social & Legal Studies*, *20*(3), 313-329. https://doi.org/10.1177/0964663911405394

Iglesias-Rios, L., Harlow, S. D., Burgard, S. A., West, B., Kiss, L., & Zimmerman, C. (2020). Patterns of violence and coercion with mental health among female and male trafficking survivors: A latent class analysis with mixture models. *Epidemiology and Psychiatric Sciences*, *29*. https://doi.org/10.1017/S2045796019000295

Kiss, L., Pocock, N. S., Naisanguansri, V., Suos, S., Dickson, B., Thuy, D., Koehler, J., Sirisup, K., Pongrungsee, N., Nguyen, V. A., Borland, R., Dhavan, P., & Zimmerman, C. (2015). Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: An observational cross-sectional study. *The Lancet Global Health*, *3*(3), e154–e161. https://doi.org/10.1016/S2214-109X(15)70016-1

Kleemans, E. R. (2011). Expanding the domain of human trafficking research: Introduction to the special issue on human trafficking. *Trends in Organized Crime*, *14*(2–3), 95–99. https://doi.org/10.1007/s12117-011-9139-8

Kuschminder, K., & Triandafyllidou, A. (2020). Smuggling, trafficking, and extortion: New conceptual and policy challenges on the Libyan route to Europe. *Antipode, 52*(1), 206–226. https://doi.org/10.1111/anti.12579

Lightowlers, C., Broad, R., & Gadd, D. (2021). Victims and suspects of modern slavery: Identifying subgroups using latent class analysis. *Policing: A Journal of Policy and Practice, 15*(2), 1384–1398. https://doi.org/10.1093/police/paaa072

Muthén, B. O. (2008, November 21). Mplus Discussion >> What is a good value of entropy. http://www.statmodel.com/discussion/messages/13/2562.html?1487458497

Muthén, L. K., & Muthén, B. O. (1998, 2017). *Mplus User's Guide Eighth Edition.* https://www.statmodel.com/html_ug.shtml

NICE guideline. (2018, December 5). *Post-traumatic stress disorder*. https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861

Nylund, K. L., Asparouhov, T., & Muthén, B. O. (2007). Deciding on the number of classes in latent class analysis and growth mixture modeling: A monte carlo simulation study. *Structural Equation Modeling: A Multidisciplinary Journal*, *14*(4), 535–569. https://doi.org/10.1080/10705510701575396

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review. *Epidemiology and Psychiatric Sciences*, *25*(4), 317–341. https://doi.org/10.1017/

S2045796016000135
Preble, K. M. (2021). Influence of survivors' entrapment factors and traffickers' characteristics on perceptions of interpersonal social power while being recruited to be trafficked. *Violence Against Women*, *27*(8), 1091–1114. https://doi.org/10.1177/1077801220920376
R Core Team. (2020). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing. https://www.R-project.org/
Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd rev. and expanded ed). Hogrefe.
Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EDMR) therapy: basis principles, protocols, and procedures* (Third edition). The Guilford Press.
Stöckl, H., Fabbri, C., Cook, H., Galez-Davis, C., Grant, N., Lo, Y., Kiss, L., & Zimmerman, C. (2021). Human trafficking and violence: Findings from the largest global dataset of trafficking survivors. *Journal of Migration and Health*, *4*, 100073. https://doi.org/10.1016/j.jmh.2021.100073
United Nations: Office on Drugs and Crime. (2004). *United Nations Convention against Transnational Organized Crime and the Protocols Thereto*. https://www.unodc.org/documents/treaties/UNTOC/Publications/TOC%20Convention/TOCeook e.pdf
Van der Watt, M., & Kruger, B. (2017). Exploring 'juju' and human trafficking: Towards a demystified perspective and response. *South African Review of Sociology*, *48*(2), 70–86. https://doi.org/10.1080/21528586.2016.1222913
Verhoeven, M., van Gestel, B., de Jong, D., & Kleemans, E. (2015). Relationships between suspects and victims of sex trafficking: Exploitation of prostitutes and domestic violence parallels in Dutch trafficking cases. *European Journal on Criminal Policy and Research*, *21*(1), 49–64. https://doi.org/10.1007/s10610-013-9226-2
Weller, B. E., Bowen, N. K., & Faubert, S. J. (2020). Latent class analysis: A guide to best practice. *Journal of Black Psychology*, *46*(4), 287–311. https://doi.org/10.1177/0095798420930932
Wright, N., Jordan, M., & Lazzarino, R. (2021). Interventions to support the mental health of survivors of modern slavery and human trafficking: A systematic review. *International Journal of Social Psychiatry*, *67*(8), 1026–1034. https://doi.org/10.1177/00207640211039245
Yakushko, O. (2009). Human trafficking: A review for mental health professionals. *International Journal for the Advancement of Counselling*, *31*(3), 158–167. https://doi.org/10.1007/s10447-009-9075-3
Yarwood, V., Checchi, F., Lau, K., & Zimmerman, C. (2022). LGBTQI + Migrants: A systematic review and conceptual framework of health, safety and wellbeing during mgration. *International Journal of Environmental Research and Public Health*, *19*(2), 869. https://doi.org/10.3390/ijerph19020869
Zimmerman, C., & Kiss, L. (2017). Human trafficking and exploitation: A global health concern. *PLOS Medicine*, 14(11), e1002437. https://doi.org/10.1371/journal.pmed.1002437

CHAPTER 4

Sexual Revictimisation Risk Mitigation Among Survivors of Sexual Violence and Trafficking: A Multi-Method Feasibility Study of a Body-Oriented Treatment Module

Submitted as:
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ABSTRACT

BACKGROUND

The majority of sexual violence survivors become sexually revictimised, and (forced) migrant populations are at particular risk. Prior research indicates that body disconnect, dissociation, and difficulties in communicating boundaries might be underlying mechanisms of sexual revictimisation. Mental healthcare support disregarding sexual revictimisation may insufficiently address the population's needs.

AIMS

In the current study a novel body-oriented module was considered for its feasibility amongst (forced) migrant survivors of sexual violence and trafficking.

METHOD

Thirteen (forced) migrant sexual violence survivors engaged in the module in an outpatient mental health care setting in the Netherlands. A multi-method approach was applied tapping into patients' and facilitators' perspectives on the feasibility of the module using pre-, during and posttreatment questionnaires, evaluation forms, and (group) interviews.

RESULTS

Patients and facilitators reported treatment outcomes in accordance with the module's aims, and treatment adherence was high. Bayesian informative hypothesis evaluation revealed that, for the majority of patients (58.33%), body awareness and self-efficacy in communicating boundaries increased, while body dissociation simultaneously decreased during treatment.

DISCUSSION

Findings suggest that a body-oriented module for sexual revictimisation risk mitigation is feasible amongst (forced) migrant survivors. Given the small sample size and lack of a control group findings should be interpreted with caution. Various considerations for the module's further clinical implementation and effectiveness research are discussed.

Keywords

Forced migration, sex trafficking, sexual violence, sexual revictimisation, mental health, body-oriented therapy, informative hypothesis testing.

The majority of sexual violence survivors will experience sexual violence again later in life (Classen et al., 2005; Walker et al., 2019). This phenomenon, referred to as "sexual revictimisation", raises the question of how to understand and address this elevated risk. Yet, the risk of sexual revictimisation has received little attention within mental healthcare, especially for (forced) migrant populations (Baba et al., 2023). In the present study we introduce and evaluate a novel body-oriented treatment module. This module is aimed at mitigating the risk of sexual revictimisation amongst (forced) migrant survivors of sexual violence and trafficking, resettled in the Global North.

Migrant populations are at particular high risk for sexual (re-) victimisation and (re-) trafficking (David et al., 2019; International Organization for Migration, 2019; National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children, 2021). As the number of (forced) migrants who seek mental healthcare is disproportionately low, prevalence rates are difficult to establish, especially for male survivors (De Schrijver et al., 2018; International Organization for Migration, 2019; Keygnaert et al., 2012). Mental healthcare provision in the aftermath of sexual violence for (forced) migrants is complicated by various factors. In general, disclosure of sexual violence is infused with shame and stigma in general (Bhuptani & Messman-Moore, 2019), but even more so for (forced) migrant populations (Tankink & Richters, 2007). Furthermore, some (forced) migrants live in uncertainty about their residential status and access to shelter, healthcare, and allowance (Li et al., 2016). Such daily stressors complicate committing to and regularly attending long-term therapies (Byrow et al., 2020; Semmlinger & Ehring, 2022), suggesting short-term therapies may encourage treatment feasibility amongst population. For (forced) migrants resettled in the Global North the risk of sexual revictimisation often runs parallel with their socioeconomic status, resulting in limited financial resources, being unaware of legal rights, or feeling unsafe to approach protective services (Baba et al., 2023; International Organization for Migration, 2019; Rich et al., 2004). Furthermore, asylum seeker centres can be unsafe environments, exacerbating the risk of sexual violence and revictimisation (Keygnaert et al., 2012). Support that disregards these realities may lead to insufficiently addressing the population's needs, and underscores the importance of treatment tailored to (forced) migrants' realities.

Sexual violence is a gross violation of one's dignity, personal space, and physical boundaries (Panzi Foundation, 2019). The aftermath of sexual violence is linked to a wide range of negative short and long term (mental) health outcomes (Dworkin, 2020; Oram, 2019; Ottisova et al., 2016), such as a (complex) posttraumatic stress disorder (PTSD; Dworkin et al., 2023). Survivors may face difficulties in their overall quality of life, including their interpersonal and sexual functioning (Mills & Turnbull, 2004; Rothman et al., 2021). For instance, some may become submissive, discounting their own needs, whereas others may become over-assertive with a fixed control over one's boundaries (Katz et al., 2010; Livingston et al., 2007; Macy, 2007). Such psychological sequelae are compounded by sexual violence starting at a young age (Downing et al., 2021), lasting over an extended period of time (e.g., in the case of sex trafficking; Abas et al., 2013), or being deeply embedded in existing power dynamics in one's community (e.g., marginalisation on the basis of gender, ethnicity, sexual orientation, or gender identity expression; Buss, 2009; Flanders et al., 2023).

Research highlights sexual violence's psychological aftermath as a potential underlying

mechanism for sexual revictimisation (Risser et al., 2006; Scoglio et al., 2021; Ullman & Vasquez, 2015; Walker & Wamser-Nanney, 2023). For instance, disconnecting from one's bodily signs can serve as a survival mechanism by numbing sexual violence's severe impact (Schauer & Elbert, 2010). Yet, when (physical) boundaries are continuously violated one might become disconnected from noticing bodily cues, needs, emotional states, boundaries, or intuition (Burback et al., 2023; Kearney & Lanius, 2022; Messman-Moore & Brown, 2006; Schimmenti & Caretti, 2016). Prior research indicates that lack of body awareness or dissociation may elevate the risk of sexual revictimisation (Risser et al., 2006; Walker & Wamser-Nanney, 2023). For instance, someone may be unable to notice or act on early warning signs of boundaries being crossed in harmful situations (Breitenbecher, 2001; Noll & Grych, 2011). Additionally, one might have unlearned, or may have never had the opportunity to learn how to effectively identity and communicate their personal boundaries (Livingston et al., 2007). As suggested by prior research this may contribute to sexual revictimisation risk in sexual violence survivors (Bockers et al., 2014; Katz et al., 2010; Kelley et al., 2016). These potentially underlying mechanisms of sexual revictimisation have not yet been validated amongst (forced) migrant populations.

Treatment modules focussed on reducing the risk of sexual revictimisation are promising (e.g., Heinrichs & Brühl, 2022; Johnson & Zlotnick, 2006; Messman-Moore & McConnell, 2018; Wolfe, 1996). However, to the best of our knowledge, an evidence base for modules specifically targeting (forced) migrants survivors of (severe/chronic) sexual violence is currently missing (e.g. Robitz et al., 2022). Body awareness, dissociation, and self-efficacy in communication boundaries, hypothesized to mitigate sexual revictimisation, are manifested through the body (Kearney & Lanius, 2022; Noll & Grych, 2011). Thus, staying safe and breaking patterns of victimhood may be best addressed within a body-oriented approach. These types of modules utilize movement, role-play, and bodily experiences, for instance to address the aftermath of trauma (O'Brien & Charura, 2022; Schaeffer & Cornelius-White, 2021; Van der Kamp et al., 2023).

The module evaluated in this study was developed based on the research outlined above and clinical experience at the study site. The module was specifically targeted towards first and second generation (forced) migrants resettled in the Netherlands, who were survivors of severe/chronic forms of sexual violence (e.g., sex trafficking, conflict-related and prolonged childhood sexual abuse). The module highlights four themes using a body-oriented approach: i) (re-) connecting to bodily cues/sensations and emotional states: ii) recognising and expressing personal boundaries: iii) identifying potentially unsafe situations; iv) discussing (potentially harmful) gender norms and responding to potentially unsafe situations.

AIMS

The overarching aim of this study was to examine if patients and facilitators considered the module feasible. Also, it was examined if, over the course of treatment, body awareness and self-efficacy in communicating boundaries increased, while body dissociation scores simultaneously decreased. The following indices were considered: (1) treatment adherence rates, therapist session evaluations and completion rates; (2) patients' pretreatment expectations and posttreatment

evaluations of the module; (3) patients' presession scores on body awareness, body dissociation and self-efficacy in communicating boundaries; and (4) facilitators' reflections on the module. Finally, for this manuscript a fictitious case was presented to offer insight into the target population and treatment process.

METHOD

SETTING AND PATIENTS

This study took place at an outpatient mental health clinic based in the capital region of the Netherlands. In this clinic one multidisciplinary team specifically serves people with a migrant background who have faced sexual violence and/or sex trafficking. In some cases these experiences intersect with violence related to sexual orientation and gender identity expression. Upon referral by a general practitioner psychodiagnostics and treatment are offered aimed at PTSD symptom reduction and personal recovery.

The inclusion period ran between February 2020 and September 2022. Male and female patients (≥ 18 years) within the clinic were considered for inclusion via purposive sampling if they: i) had a history of sex trafficking, or severe/chronic sexual violence; ii) were deemed vulnerable to (sexual) revictimisation as expressed by themselves or as estimated during a multidisciplinary team meeting; iii) gave informed consent for participation in the module and administration of the additional measures and interviews, and allowed researchers access to their medical records. Patients displaying acute crisis, such as acute severe psychosis, persistent substance abuse, or acute suicidality, were excluded.

DESIGN AND ETHICAL APPROVAL

A multi-method approach was applied amongst patients and facilitators using pre-, during and posttreatment questionnaires, evaluation forms, and (group)interviews. Ethical approval for this study was obtained from the Medical Ethics Committee Leiden The Hague Delft in the Netherlands (P17.270). The study was pre-registered at the Dutch Trial register (NL61808.058.17: https://www.toetsingonline.nl/to/ccmo_search.nsf/fABRpop?readform&unids=D707FF3CE1-AFE7D3C125881F00152BB7, NTR7353, July 11th 2018). Additional ethical approval for the group discussion was obtained from the Ethics Review Board of the Faculty of Social and Behavioural Sciences at Utrecht University (21-0460).

INTERVENTION

The module was developed by RG and SB on the basis of vast clinical experience at the study site and a non-systematic literature review. In addition, the manual was evaluated in-depth by various clinicians at the study site and by two experts with lived experience of (forced) migration, sexual violence and/or trafficking, receiving mental healthcare.

The module was offered by eight female facilitators in total: five psychologists, two psychomotor/

movement therapists, and one social worker. An eight hour training was provided by the primary developers (RG and SB), with the support of an expert with lived experience. The module was carried out individually each time by one facilitator over 10 sessions of one hour. Translators (either in-person, via video calling, or via telephone) were available when needed and materials were available in Dutch, English and French.

The module had a body-oriented approach with elements of psycho-education and reflective conversation. The main aims of the module were to promote body awareness, mitigate body disconnect and dissociation, and offer tools to encourage efficacy in communicating boundaries in potentially unsafe situations. The module was specifically tailored to the needs of (forced) migrants. For instance, the vignettes were modified to situations applicable for those living in an asylum seeker shelter. See Table 1 for a brief overview of each session plan. Next to the introductory and closing sessions, the module contained four core themes, each addressed in two consecutive sessions. The first theme, "feeling", was focussed on (re-)connecting to bodily cues/sensations and (re-)gaining awareness of emotional states. The second theme, "autonomy", centred around recognising and expressing personal boundaries. The third theme, "safety", was about identifying and responding to potentially unsafe situations. Finally, the fourth theme, "empowerment", introduced the topic of (potentially harmful) gender roles and potentially unsafe situations in one's daily life specifically.

MEASURES

Facilitators

The following information was derived from the session records: the total number of sessions delivered, treatment adherence during each session, total numbers and reasons for cancellations/ no-shows, total treatment duration, and reasons for drop-out.

Evaluation Form

After each session facilitators filled out an evaluation form. First to indicate whether or not they had completed all elements as described in the manual ("yes" or "no"), and if not, to indicate the reason. Second to respond to the following statements using a visual analogue scale (VAS, 0 = "not at all" to 100 = "very much"): "There was enough time for the session plan"; "The session was a burden to the patient"; "I noticed personal resistance or a lack of trust in the session plan"; "I felt energised/ I looked forward to carrying out the session plan together"; and "I felt the session was useful for the patient".

Group Discussion with Facilitators

A group discussion was held with the facilitators to evaluate the module at the end of the inclusion period. The topic guide for the discussion included evaluations on observed outcomes, in particular with regard to revictimisation risk mitigation, and difficulties encountered when delivering the module.

Patients

Semi-Structured Interview with Patients

Before the start of the module (pretreatment) and after participation in the module (posttreatment) a short semi-structured evaluation interview was held with patients. At pretreatment, patients were asked: "What do you think the module is about?", and "What do you expect to learn during the module?". At posttreatment, patients were asked: "What did you learn during the module?", "What were important topics and/or exercises?", and "What were topics and/or exercises you did not like or did not find useful?".

Questionnaires

Main outcomes of interest, i.e., body awareness, body dissociation, and self-efficacy in communicating boundaries, were measured at the start of each session on a VAS (0 = "not at all" to 100 = "very much"). Given time constraints and in order to minimise the burden on the participants one item per outcome was selected from full scale measures described below. Items best matching the indented treatment outcomes were selected from the full scales. In addition, prior to the start of the module (pretreatment) and after participation in the module (posttreatment) several full-scale measures were administrated for descriptive purposes.

Scale of Body Connection (SBC)

This scale measures body awareness and bodily dissociation in 20 items scored on a 5-point scale (0 = "not at all" to 4 = "all of the time"). As indicated by previous studies, the full scale should not be considered, but rather its two distinct subscales: 1) body awareness (BA; 12 items) and 2) body dissociation (BD; 8 items; Price & Thompson, 2007; Price et al., 2017). For the BA scale a higher score indicates more awareness, and for the BD scale a lower score indicates less body dissociation. The two subscales were administered at pre- and posttreatment for descriptive purposes of the sample. Two items in line with aims of the module were chosen to be administered prior to each session. From the BA subscale: "I listen for information from my body about my emotional state", and from the BD subscale: "My body feels frozen, as though numb, during uncomfortable situations".

Sexual Assault Resistance Self-Efficacy (SA-RSE)

This scale was developed to assess the perceived self-efficacy in response to communicating boundaries in a hypothetical unwanted sexual advance (Littleton & Decker, 2017). For the purpose of this study, one item was selected from the original 16-item self-report scale to match the module's aims: "If someone I know forces me to do something I do not want to do, I feel confident to stop this person", scored on a on a VAS (0 = "not at all" to 100 = "very much"). Higher scores indicate more self-efficacy in communicating boundaries. This single item was administered at pre- and posttreatment, and before each session.

Table 1
Brief Overview of the Session Plans

Session and theme	Aims	Topics and exercises
1. Introduction	Introducing core elements of module. Establishing rapport and therapeutic alliance.	Introduction of emotion regulation and self-regulation. Introducing safety measures during module.
2. Feeling	Distinguishing (un)pleasant body sensations. Recognising tension/ relaxation in the body.	Sensory exercises. Relaxation exercises.
3. Feeling	Recognising and embodying feelings of (un)safety.	Creating a safe space in the room.
4. Autonomy	Recognising non-verbal communication. Learning to express personal boundaries.	Walking exercises. Voice and body language exercises.
5. Autonomy	Exploring grounded standing and resilience.	Grounded standing. Personal space and controlled approach exercises.
6. Safety	Identifying and responding to potentially unsafe situations	Vignettes containing potentially unsafe situations. Psycho-education on sexual revictimisation.
7. Safety	Identifying and responding to potentially unsafe situations in one's daily life. Recognising and embodying feelings of safety (repetition).	Reflective conversation and role-play on a current unsafe situation in one's daily life.
8. Empowerment	Exploring one's own perspective on gender roles and (romantic) relationships.	Reflective conversation on gender roles. Body posture exercises.
9. Empowerment	Practicing setting boundaries in potentially unsafe situations in one's daily life.	Role-play with vignettes and current unsafe situations in one's daily life.
10. Closing	Exploring how to further integrate what has been learned in one's daily life.	Saying goodbye

Posttraumatic Stress Symptoms and Traumatic Load

The Post-Traumatic Stress Checklist – 5 (PCL-5), Life Events Checklist -5 (LEC-5) and Early Trauma Inventory Self Report-Short Form (ETISR-SF) were administered to understand the levels of PTSD symptom severity and the traumatic load within the sample. The PCL-5 assesses the severity of 20 symptoms of PTSD as defined by the DSM-5 on a 5-point scale (U.S. Department of Veterans Affairs, 2022). The measure was administered pre- and posttreatment, as it is considered a suitable measure for monitoring changes in symptoms with good psychometric properties. The summed item scores represent PTSD symptom severity which can vary between 0-80. Research indicates a cut-off score between 31-33 to be indicative of clinically relevant PTSD, and a change score of 10 points as a minimum threshold for determining clinically meaningful improvement (U.S. Department of Veterans Affairs, 2022). The ETISR-SF and LEC–5 were administered at pretreatment to establish the traumatic load within the sample. The ETISR-SF assesses potentially traumatising events as experienced before the age of 18 years old (Bremner et al., 2007). In 27 items the ETISR-SF enquires on a dichotomous scale ("yes" or "no") whether or not someone has lived through general trauma, physical punishment, emotional abuse, or sexual events. The LEC-5 considers the life-time prevalence of 16 types of potentially traumatising events, plus the option for an open-ended response regarding a life event. The respondent is asked to indicate on a 6-point nominal scale whether this event: "happened to me", "witnessed it", "learned about it", "part of my job",

"not sure", or "doesn't apply". Psychometric properties of these measures can be considered good (Bremner et al., 2007).

PROCEDURE

Considering the study's inclusion criteria, patients' eligibility was determined within a multidisciplinary team meeting. After the patient gave informed consent, pretreatment assessment was performed at one week or less prior to the first session. Posttreatment assessment took place directly after the last session, or at a maximum of one week after completion. The questionnaires and interviews were administered in-person by either master-level psychology students, junior researchers, or the primary investigator (RG). Some measures designed as self-report questionnaires were read-out loud by the administrator, given some of the participants' limited vocabulary or reading proficiency. When needed, a translator was available via telephone. On average the assessments lasted 82 minutes for the pretreatment and 47 minutes for posttreatment. Presession assessments during treatment were documented by the facilitators on hardcopy prior to each of the 10 sessions. All data, including minutes taken from the pre- and posttreatment interviews, were entered into a datafile anonymously.

Notably, after the first inclusion, the COVID-19 pandemic broke out worldwide and the study site paused seeing patients on location. The inclusion period was therefore paused from March 2020 and continued in October 2020. The only included patient at the time discontinued treatment after 2 sessions, and was included again later on. Hereafter it was sometimes needed to deviate from the study protocol to conform to the pandemic's regulations. For instance, a small number of meetings were cancelled or held hybrid, due to testing positive for COVID-19, required self-isolation, or schools being closed.

To monitor the treatment process and identify (potential) obstacles in treatment adherence regular exchange between the researchers and facilitators took place. Also, group meetings were held between facilitators to share experiences in applying the module. The module was offered in various languages: Dutch (n = 5), English (n = 5), French using a translator (n = 2), and Lingala using a translator (n = 1). During inclusion parallel interventions were not allowed, apart from ongoing pharmacotherapy or interventions needed in case of acute crisis.

All facilitators (N = 8) were invited to participate in the group discussion held by the primary investigator (RG). Two facilitators conducted only a few sessions before drop-out of their patients and therefore chose not to participate. One facilitator was not able to join due to scheduling difficulties. The discussion was therefore held with five facilitators. Due to COVID-19 regulations this meeting took place via video calling and informed consent was signed digitally. The recorded discussion was transcribed anonymously by a master-level psychologist.

ANALYTIC PLAN

Qualitative Analyses

The minutes taken from the pre- and posttreatment patient's semi-structured interviews (aim 2) were read carefully to capture the voice of each patient and to identify recurrent themes. A

summary of each patient's pre- and posttreatment responses was compiled. The transcripts and recordings for the facilitators' group discussion (aim 4) were read thoroughly, listened back, and thematically analysed (Braun & Clarke, 2022). This analysis was carried out using pre-determined codes and "open-coding" where codes were created and modified during analysis.

Quantitative Analyses

The pre-sessions scores of self-efficacy in communicating boundaries, bodily awareness and dissociation (aim 3) were analysed on an individual level. To gain insight about the course of change in these main outcomes, scores were plotted as a function of the sessions. To test inferences about the course of the main outcomes Bayesian informative hypothesis evaluation was used (Hoijtink, 2012; Hoijtink et al., 2019). This approach had the advantage that inferences about three different outcomes could simultaneously be incorporated into one informative hypothesis (H1) being tested. Specifically, for each individual patient the following course of the main outcomes was hypothesised: body awareness and self-efficacy increased whereas body dissociation simultaneously decreased over the course of treatment (H1). Data were analysed in R Studio version 4.1.1 using the R package bain and restrictor (Gu et al., 2021; van Brabant et al., 2023). For each individual patient the three main outcomes were regressed on the sessions numbers. The informative hypothesis was evaluated using the Posterior Model Probabilities (PMPc) and the weights resulting from the Generalized Order-Restricted Information Criterion (GORICA). Posterior model probabilities quantify the support in the data for the hypothesis specified (H1), the null hypothesis (H0), and their joint complement of the informative and null hypothesis (H2; Hoijtink et al., 2019). The same holds for the GORICA weights (Altinisik et al., 2021).

RESULTS

DESCRIPTIVE STATISTICS

A total of 14 patients were included in this study; one patient dropped out after pretreatment assessment and was excluded from further analyses. See Table 2 for sociodemographic characteristics and an overview of pre- and posttreatment scores for the full sample (N = 13). All patients had experienced a form of chronic or severe sexual violence: sex trafficking, conflict-related sexual violence, abduction with repeated sexual violence, forced marriage that included sexual violence, long-term childhood sexual abuse, and/or sexual violence during sex work. Notably, scores on the ETISR-SF revealed that other types of traumas before the age of 18 years were highly prevalent within the sample, i.e. mainly childhood physical and emotional abuse, domestic violence, and losing a primary caretaker. All patients were diagnosed with PTSD at the study site. At pretreatment, all but one, patients scored clinically on the PCL-5 (M = 53.17, SD = 13.41, range: 25-76). From pre- to post treatment, three out of nine completers showed a clinically meaningful decrease in PTSD symptom severity; four showed a minor decrease or increased severity; for one patient data were missing.

TREATMENT ADHERENCE AND COMPLETION (AIM 1)

See Figure 1 for a flow diagram of the study. Nine patients completed the treatment (64% of the sample) and four patients discontinued treatment (29% of the sample, between 2-8 meetings). For those who completed the module the total length of treatment in days was 120 days (*SD* = 42). In general treatment adherence was high; out of the completers two patients had one or two sessions where the facilitator deviated from the session plan, mainly due to acute daily stressors or time constraints. Likewise, the evaluation form filled out by facilitators on VAS after each session indicated a high level of adherence (*M* = 90.31, *SD* = 8.70). In addition, facilitators experienced having too little time available (*M* = 52.04, *SD* = 11.90), found the module quite a burden to the patients (*M* = 38.18, *SD* = 9.92), viewed the session content as useful (*M* = 73.29, *SD* = 6.56), and finally the facilitators felt little resistance (*M* = 24.44, *SD* = 9.67) and energised (*M* = 73.18, *SD* = 10.18) when delivering the sessions.

Figure 1

Flow Diagram Study, Adapted from CONSORT 2010 Flow Diagram (Schulz et al., 2010)

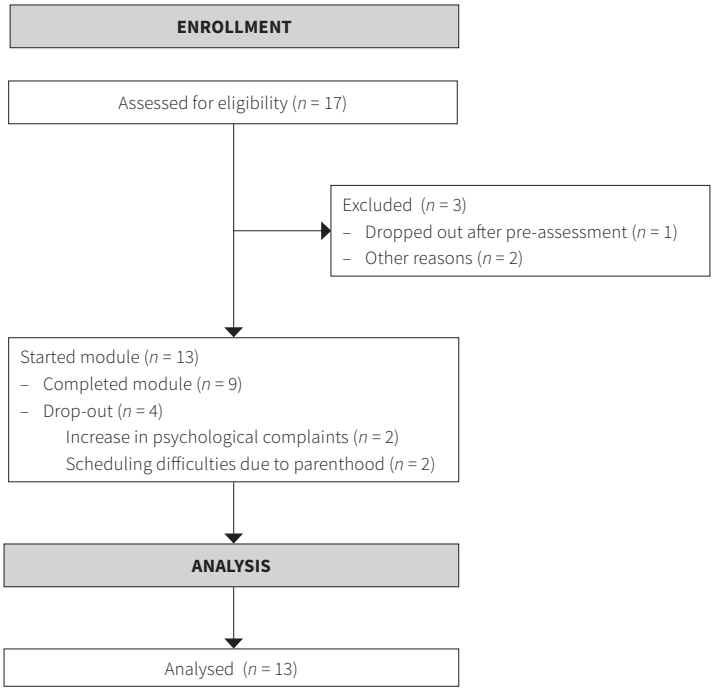


Table 2

Sociodemographic Characteristics and Pre- and Posttreatment Questionnaires

	n	%
Gender		
Female	11	79
Male	2	14
Country of origin		
The Netherlands (second generation migrant)	4	29
Uganda	3	21
Guinee	2	14
Democratic Republic of Congo	1	7
Egypt	1	7
Moldova	1	7
Nigeria	1	7
Sexual orientation		
Heterosexual	8	57
Homosexual	5	36
Place of residence		
Specialised shelter for sex trafficking survivors	6	43
Asylum seeker centre	4	29
Independent living	3	21
Traumatic background [a]		
Survivor of sex trafficking	10	71
Forced marriage	4	29
Other forms of sexual violence	3	21

	Pretreatment		Posttreatment	
	M	*SD*	*M*	*SD*
Body awareness	28.77	8.30	30.44	5.96
Body dissociation	19.50	6.07	17.33	5.20
Self-efficacy in communicating boundaries	38.46	31.09	71.22	26.74
Posttraumatic stress symptoms	53.17	13.41	46.50	12.02
Traumatic load (≤18 years)	17.55	3.45	-	-
Traumatic load (lifetime)	3.23	1.96	-	-

Note. $N = 13$. Patients were on average 29.62 years old ($SD = 8.17$, range: 19-49).

[a] Multiple categories could apply to patients.

Table 3

Overview of Patients' Pretreatment Expectations and Posttreatment Evaluation (*N* = 13)

Patient	Number of sessions	Summary pretreatment interview	Drop-out reason	Summary posttreatment interview
A	10	Understand myself better, learn how to say "no" when things feel wrong.	-	You start to think about your past and what to do to prevent it from happening again. It influences the choices you make, both positive as well as negative choices. I learned to use my voice, I learned I can stop someone with my voice when something happens. I liked the safe place exercise.
B	10	Deal with my emotions I guess. It's therapy, so I will go... I hope to learn a lot from it... I don't know, these questions are too much for me.	-	I learned to listen to my body and to have the courage to say "no". I liked the safe place, the relaxation exercises, grounded standing and personal boundaries. I did not like to talk about my personal life out loud.
C	10	I don't know what I will learn, this treatment is my first time. I understood it can help me trust other people.	-	I believe in myself. I have the courage to say "no" to someone. So "no" is "no" and "yes" is "yes". I am able to laugh, the module gave me positive feelings.
D	10	I think this treatment is about my past and my traumas. I hope to learn how to deal with it better. Other than that I do not know, that is the way I will approach it.	-	I learned what a posture communicates and how you are perceived by others. I did not like the safe place exercise, it was not useful.
E	10	To put my past to rest, to move forward and don't remain stuck in the past. I hope this is what it will bring me.	-	I learned to be strong during the empowerment exercises.
F	10	For women who have been in my situation, who have been a victims of human trafficking, to learn how to recognise certain types [*of people*] and avoid them.	-	I learned to estimate situations better, to have more self-confidence in knowing what is normal and what is not. My feelings came back, they had been shut down for a while. I have become more aware of my feelings, to experience and observe them, rather than to immediately act on them. I did not like the exercise where I had to stand up for myself, it is something I already know how to do.
G	10	I don't know. I cannot move on with life. The thoughts will not go away.	-	I do not see a future for myself and I have no hope, because of what I have lived through. I was nice to talk to the therapist and visit my safe place. I learned to say no.
H	5	I want to be a happy person again. I don't know what I hope to learn.	Acute psychiatric crisis outweighing the aims of the module.	-
I	2	I lost confidence to react. I hope to gain the confidence to say "no" without any explanation.	Difficulties in arranging childcare.	-
J	8	I hope to learn to become strong just as others. I also hope to be able to talk to others without them becoming angry. I don't want to get angry and hurt others.	Increased psychological distress due to a negative refugee application.	-

Table 3

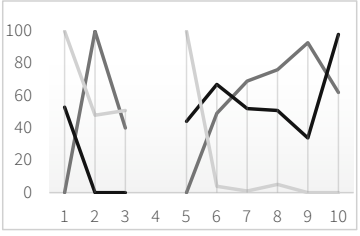
Continued.

Patient	Number of sessions	Summary pretreatment interview	Drop-out reason	Summary posttreatment interview
K	6	Missing data.	Too many daily/ family-related stressors.	-
L	10	It's about safety, I want to be more stable. Not be a mess.	-	Allowing myself to feel what happened, accepting what happened, not avoiding. Not falling into the black hole, embracing the hole and feel everything. I learned to say "no". It was the first time I realised I dissociate, and it is not normal. The controlled approach exercise reminded me of being physically abused as a child.
M	10	Processing, learn how to deal with it all and leave it behind.	-	At the moment I am more positive. I was able to process things and leave it behind. I liked the personal space exercise. I learned about emotions and relaxation. I learned that it is OK to say what I do not like. I learned about boundaries, before I was always afraid of offending people by saying no.

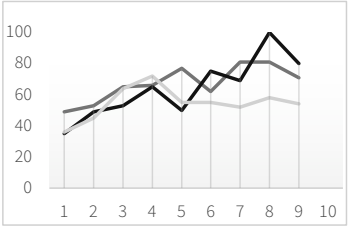
Figure 2

Individual Scores on Weekly Measures (n =12)

Patient A*



Patient B



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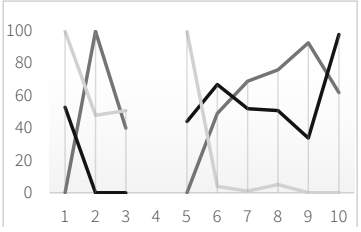

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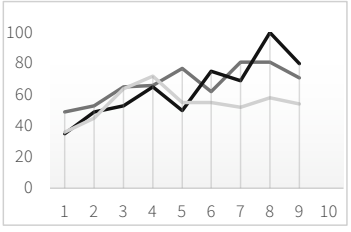

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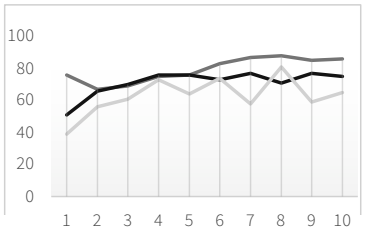

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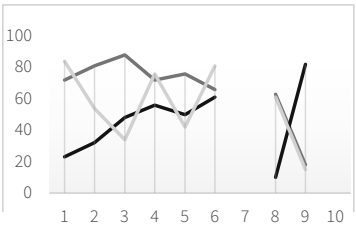

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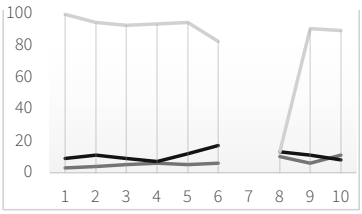

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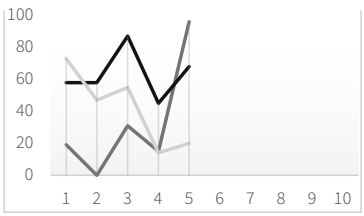

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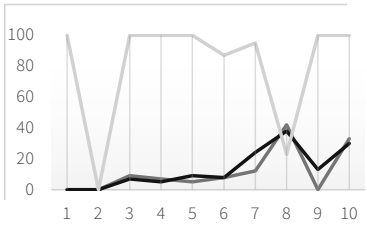

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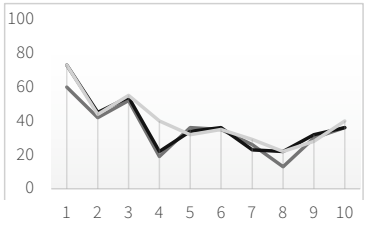

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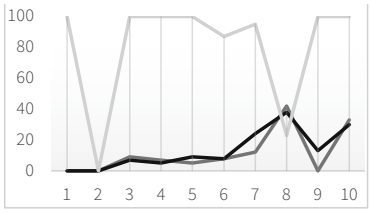
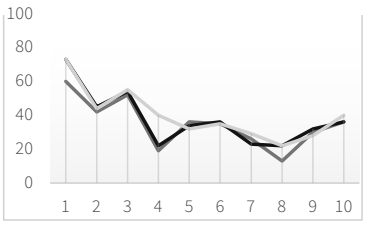


Patient M



Body awareness **Self-efficacy in communicating boundaries** **Body dissociation**

Note. The module aimed towards higher scores of body awareness and self-efficacy in communicating boundaries, and lower scores in body dissociation over the course of treatment.
*Informative hypothesis supported

PATIENTS' PRETREATMENT EXPECTATIONS AND POSTTREATMENT EVALUATION (AIM 2)

Table 3 provides an overview on the total numbers of sessions, reasons for discontinuation, and summaries of the pre- and posttreatment semi-structured interviews per patient. Some patients (B, C, and G) had difficulty formulating an expectation of what they hoped to gain during the module. Others hoped to process their past/traumatic experiences (patients D, E, and M), learn how to set boundaries or say "no" (patients A, F, and I), to regulate emotions or themselves (patients B, L, and J), or to trust other people (patient C). At posttreatment, when probed for what they had learned during the module, patients reported a wide range of outcomes. Many expressed having learned about boundaries, to say "no" or how to stop someone (patients A, B, C, G, L, and M). Others indicated they had learned how to assess a situation for its risks and thus prevent potential harm (patients A and F), had re-evaluated/processed their past (patients A and M), had become more aware of their emotions, feelings and body (patients B, F, L, and M), or experienced more positive emotions (patients C and M). Finally, one patient felt little hope for her future in general and had difficulty formulating what was learned during the module (patient G). There were some exercises that different patients disliked: addressing feelings of safety (patient D), expressing boundaries (patient F), controlled approach (patient L), and finally one patient disliked talking out loud about the personal life (patient B).

PATIENTS' PRESESSION SCORES ON BODY AWARENESS, BODY DISSOCIATION AND SELF-EFFICACY IN COMMUNICATING BOUNDARIES DURING TREATMENT (AIM 3)

Figure 2 displays the individual plots of the outcome measures as a function of the sessions, i.e., body awareness, body dissociation, and self-efficacy in communicating boundaries. To allow for a trajectory of change to be evaluated, only those who followed five or more session were considered (n = 12). As the individual plots revealed some patients' presession scores on body awareness increased over time as hypothesised (Patients C, D, E, F, K, and L), whereas others decreased or did not show any changes (Patients A, B, G, H, J, and M). Self-efficacy in communicating boundaries was expected to increase, which was the case for some (Patients C, D, E, K, L), but not all (Patients A, B, F, G, H, J, and M). Finally, the module aimed to reduce body dissociation, and indeed a decrease can be observed in some plots (Patients A, C, F, H, K, L, M), but not all (Patients B, D, E, G, J). Using posterior model probabilities and the GORICA weights, the informative hypothesis stated a simultaneous increase in body awareness and self-efficacy in communicating boundaries, with a co-occurring decrease in body dissociation. This hypothesis was tested per patient against the null hypothesis (i.e., stating that none of these outcome measures changed over the course of treatment), as well as against the joint complement of the informative and null hypothesis.

As depicted in Table 4, the PMPc of the Bayes Factor and the GORICA weights indicated that for seven patients (58.33% of total sample) the informative hypothesis received substantial support, whereas the support for the null and joint complement of the informative and null hypothesis was rather small. The clinical relevance of these findings for patient G might be questionable. The individual plot shows that although outcomes change in accordance with the informative hypothesis, final scores still remain unfavourable clinically. For three patients (F, J and M) the

results supported the complement hypotheses, namely another model fits the data better. The individual plots reveal this might be due to a sudden drop in gained body awareness (Patient F and M) or an increase in body dissociation, instead of the expected decrease (Patient J). For patient L the analyses were inconclusive, with the results equally favouring the informative and complement hypothesis. As can be seen from the individual plot scores on body dissociation fluctuated over time, perhaps explaining the inconclusive results. Finally, in line with the individual plot of patient B, no changes occurred during treatment and analyses preferred the null hypotheses. Note that, all these Bayesian results are corroborated by the GORICA weights which shows methods robustness of the outcomes.

Table 4

Overview of PMPs and Gorica weights (n = 12)

Patient	Informative hypothesis		Null hypotheses		Joint complement of the informative and null hypothesis	
	PMPc	GORICA weight	PMPc	GORICA weight	PMPc	GORICA weight
A*	.97	.86	.00	.00	.03	.14
B	.04	.17	.73	.77	.22	.06
C*	.98	.81	.00	.00	.02	.19
D*	.79	.81	.00	.00	.21	.19
E*	.75	.80	.00	.00	.25	.20
F	.00	.06	.05	.20	.94	.74
G*	.89	.78	.00	.00	.11	.22
H*	.99	.90	.00	.00	.01	.10
J	.00	.00	.00	.00	1.00	.00
K*	.92	.83	.00	.00	.08	.17
L	.59	.72	.00	.00	.41	.29
M	.05	.68	.04	.11	.91	.74

Note. PMPc = Posterior Model Probabilities of H0, H1, and the complement H2, GORICA weights = weights of H0, H1 and the unconstrained hypothesis Hu.

*Informative hypothesis is supported.

FACILITATORS' EVALUATION OF THE MODULE (AIM 4)

Three themes arose from the group discussion held with facilitators (*n* = 5): "potential working mechanisms of the module", "changes attributed to the module", and "meta-discussions around sexual revictimisation".

Regarding working mechanisms of the module, facilitators appreciated the interactive exercises (e.g., role-play), they believed it built rapport, allowed for active participation and facilitated integration in daily life. It was noted that for survivors of sexual violence, what feels familiar or comfortable might not be safe. Therefore, inviting patients to step slightly out of their comfort zone and practise new behaviour was considered an important element of the module. Gendered behavioural patterns, such as compliance, keeping quiet, and considering others before

oneself came up during sessions, and were considered key topics.

Facilitators attributed various changes to the module: an increased awareness of one's emotions or bodily sensations, recognising and acting on signals of (un)safety, a greater sense of control over one's (negative) feelings or life, having a wider range of behavioural strategies at one's disposal, (re-) gained self-confidence, voicing boundaries, and being able to feel closer to those around them. Subtle changes were noticed in gained confidence, inner strength, seeing someone prosper, or taking on new body postures. Overall, facilitators noted that the integration of gained insights or skills into a patient's life seemed to last.

Several meta-discussions on sexual revictimisation intrigued facilitators. First, while acknowledging the risk of oversimplification, facilitators mentioned two types of patients: those who distance themselves from others with tight personal boundaries, and those who try to regain a sense of control by actively seeking out relationships/ sexual encounters. For the first learning to say "no" was not challenge, rather these patients gained from slowly allowing people within their proximity while feeling safe. For the latter discussions revolved around staying safe and setting boundaries within (sexual) encounters. Second, facilitators struggled with introducing the risk of "sexual revictimisation" without stepping into "victim-blaming". Some facilitators preferred being upfront about the risks in order to exonerate the patient, provide a sense of control, and align with the patient's own fears. One facilitator opposed: "I want to show them the world is a safe place, and this message goes against that…I feel I like am making their world unsafe." Others felt reluctant conveying: "If you behave differently you can prevent victimisation" and questioned if it could be perceived as placing blame.

Lastly, facilitators recognised the complexity in addressing sexual revictimisation. They agreed that patients' risk of revictimisation is often embedded in early developmental patterns and closely linked to contextual factors. They expressed concerns about the inability of the module to address such long-standing patterns and social circumstances. Nevertheless, facilitators argued the module was still able to "plant a seed" or "turn on the volume of intuition" when evaluating potentially harmful situations or recognising safety. More firmly phrased one facilitator said: "It is our duty to reduce such risks, when we are able to. We need to stay away from fatalistic thinking, thinking it is so complex, that we should not even try to address it."

FICTITIOUS CASE

This case is compiled from the collective experiences of facilitators, but does not reflect one patient in particular.

> Ibrahim is a 30-year old man who identifies as homosexual, he was stigmatised by his community from a young age on. He experienced several occurrences of sexual violence and was in a relationship where he was sexually exploited. Often he would comply with any sexual advance to ensure it would be over quickly and to avoid anger towards him. He wanted to learn how to set boundaries when someone initiated sexual contact. On his way to a treatment appointment he was approached in the

metro by someone offering him money for sex. He was taken aback by this and wondered why this person approached him specifically. Ibrahim and his facilitator decided to integrate this event into the "controlled approach exercise". During the exercise the facilitator slowly walked towards Ibrahim with him being in charge of communicating the distance that felt comfortable and safe to him. He decided to use the word "no" to communicate his boundary, and practised with aligning his "no" with his tone of voice and body posture. The exercise was difficult for him, he felt as if he was yelling at the facilitator, was worried to harm the therapeutic relationship and reported feelings of tension. The facilitator reassured Ibrahim. The next session he reflected back on the exercise saying he never considered saying "no" to be an option in interacting with others. Further along in the module he entered the meeting in a cheerful mood. He told the facilitator a friend (sexual partner) texted him to come over late at night, he did not feel like it, he was unsure about himself and felt a lot of tension. However, he finally texted back saying he would rather not meet tonight and the friend texted back saying "no problem". This success, although seemingly small, was a major turning-point for Ibrahim, and a realisation that his "no" could indeed be heard and respected.

DISCUSSION

In this study a novel body-oriented treatment module, aimed at sexual revictimisation risk mitigation was evaluated for its feasibility in a small sample of (forced) migrant survivors of sexual violence and trafficking. Patients' and facilitators' perspectives were captured in various measures (e.g., interviews, questionnaires and evaluation forms) and examined. It can be preliminary concluded that the module is feasible amongst (forced) migrants, and that its further implementation and effectivity are worthwhile to consider. Study findings indicated that treatment completion was acceptable and adherence rates were high. Both patients and facilitators attributed changes to the module that were in line with the intended treatment outcomes. Most prominently, patients expressed gained insight into their personal boundaries, body awareness, (un)safe situations, sense of control, and connection to others. Moreover, analyses revealed that for around two third of patients body awareness/connection as well as efficacy in communicating boundaries were altered in accordance with the module's aims. There were several elements of the module patients disliked, e.g., the controlled approach exercise, the safe place exercise, and speaking about one's personal life. This might resonate with the facilitators' evaluation in which the module was rated to be quite burdensome for patients at times. On the contrary, facilitators also indicated that for the module to be effective, patients might have to step out of their comfort zones or familiarities at times.

Although there is vast body of literature on the risk and potential mechanisms of sexual revictimisation, how to address this risk has received less attention (Classen et al., 2005; Hébert

et al., 2021; Ullman & Vasquez, 2015; Walker & Wamser-Nanney, 2023). Study findings and the module's contents offer insights for clinical practice amongst (forced) migrants. In line with previous literature (Bockers et al., 2014; Katz et al., 2010; Kelley et al., 2016; Risser et al., 2006; Walker & Wamser-Nanney, 2023), the relevance of main outcomes, i.e., body awareness, body dissociation, and efficacy in communicating boundaries, was emphasized by both patients and facilitators. Notably, whilst developing and delivering the module, various alterations were made to specifically serve (forced) migrant survivors of sexual violence and trafficking. First, by allowing for a short-term module, given the difficulty within this population to commit to long-term therapies (Semmlinger & Ehring, 2022). Also, vignettes used in the sessions were modified to the daily reality of (forced) migrants. Finally, as brought forward by the facilitators, the cross-cultural discussions on gendered behavioural patterns, were of particular interest.

This study has several limitations that need to be considered. First, conclusions about the effectivity and generalisability of the module cannot be drawn given the uncontrolled design of the study and its small sample size. Second, patients were only followed during a short period of time. Therefore, no inferences can be made about the actual mitigation of sexual revictimisation risks amongst the study sample, merely of its hypothesised underlying psychological mechanisms. To learn more about actual sexual revictimisation and risk mitigation longitudinal research is needed (Hébert et al., 2021). A final consideration is that the developers of the module were closely engaged during each phase of study, e.g., training, data collection, and monitoring the treatment process. Although this was acknowledged by the researchers and may be seen as a strength, this level of involvement might also have favourably influenced the commitment of facilitators or evoked preferred answers during evaluations and discussions.

Next steps before considering scaling up the implementation of the module should be longitudinal and controlled research within larger and more diverse samples. This would allow further understanding and substantiating potential underlying mechanisms of sexual exploitation targeted within the module, including their assumed contribution to actual sexual revictimisation risk mitigation. Clearly, in the present study not all survivors were completers or responded to the module's intended outcomes. Future research could shed light on how the module could be tailored to the specific needs of various (forced) migrant groups, e.g. SOGIE diverse populations (Martinez & Kelle, 2013) or those who were in an intimate relationship with the perpetrator (Casassa et al., 2022).

The module was found to be feasible within a clinical setting; however, its delivery is recommended only in addition to evidence-based guideline-recommended therapies. Currently, mental health care for sexual violence survivors rarely focusses on sexual revictimisation risk mitigation. As a body-oriented approach was found to be feasible, this might encourage mental health professionals to address sexual revictimisation, whilst acknowledging it is multifaceted and influenced by various contextual factors (e.g., Golo & Eshun, 2019; Levine, 2017; Spangaro et al., 2021). Mental health professionals serving (forced) migrant survivors might consider the following: timing of the module within the treatment process (e.g., prior or after trauma-focussed therapies?); type of professionals and settings by and in which the module could be provided

(e.g., clinical settings only or also by case workers within shelters?); and individual specificities in delivering the module (e.g., those keeping others at distance vs. those actively seeking out sexual encounters). Given the limited evidence base for addressing the mitigation of sexual revictimisation in mental healthcare provision, the current study may be seen as a preliminary exploration of how to address this phenomenon among (forced) migrant populations.

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AUTHOR CONTRIBUTIONS

RG: Conceptualisation, methodology, formal analysis, investigation, writing - original draft, project administration and funding acquisition.
WS: Conceptualisation, methodology, supervision, writing - review & editing, funding acquisition.
SB: Conceptualisation, methodology, writing - review & editing
NvdA: Methodology, formal analysis, supervision, writing - original draft, review & editing.
PB: Conceptualisation, methodology, supervision, writing - review & editing.

REFERENCES

Abas, M., Ostrovschi, N. V., Prince, M., Gorceag, V. I., Trigub, C., & Oram, S. (2013). Risk factors for mental disorders in women survivors of human trafficking: A historical cohort study. *BMC Psychiatry*, *13*(1), 204. https://doi.org/10.1186/1471-244X-13-204

Baba, M., Tipton, C., Danailova-Trainor, G., Morgan, K., & Matthew, R. (2023). Understanding re-trafficking in the United States: Why do we have a revolving door? In M. De Chesnay & D. Sabella (Eds.), *Human Trafficking: A Global Health Emergency* (pp. 149–175). Springer International Publishing. https://doi.org/10.1007/978-3-031-33875-5_11

Bhuptani, P. H., & Messman-Moore, T. L. (2019). Blame and same in sexual assault. In W. T. O'Donohue & P. A. Schewe (Eds.), *Handbook of Sexual Assault and Sexual Assault Prevention* (pp. 309–322). Springer International Publishing. https://doi.org/10.1007/978-3-030-23645-8_18

Bockers, E., Roepke, S., Michael, L., Renneberg, B., & Knaevelsrud, C. (2014). Risk recognition, attachment anxiety, self-efficacy, and state dissociation predict revictimization. *PLoS ONE*, *9*(9), e108206. https://doi.org/10.1371/journal.pone.0108206

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Breitenbecher, K. H. (2001). Sexual revictimization among women. *Aggression and Violent Behavior*, *6*(4), 415–432. https://doi.org/10.1016/S1359-1789(00)00014-8

Bremner, J. D., Bolus, R., & Mayer, E. A. (2007). Psychometric properties of the Early Trauma Inventory–Self Report. *Journal of Nervous & Mental Disease*, *195*(3), 211–218. https://doi.org/10.1097/01.nmd.0000243824.84651.6c

Burback, L., Brémault-Phillips, S., Nijdam, M. J., McFarlane, A., & Vermetten, E. (2023). Treatment of posttraumatic stress disorder: A state-of-the-art review. *Current Neuropharmacology*, *21*. https://doi.org/10.2174/1570159X21666230428091433

Buss, D. E. (2009). Rethinking 'rape as a weapon of war.' *Feminist Legal Studies*, *17*(2), 145–163. https://doi.org/10.1007/s10691-009-9118-5

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Casassa, K., Knight, L., & Mengo, C. (2022). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse, 23*(3), 969–984. https://doi.org/10.1177/1524838020985542

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, *6*(2), 103–129. https://doi.org/10.1177/1524838005275087

David, F., Bryant, K., & Larsen, J. J. (2019). *Migrants and their vulnerability to human trafficking, modern slavery, and forced labor*. International Organization for Migration. https://publications.iom.int

De Schrijver, L., Vander Beken, T., Krahé, B., & Keygnaert, I. (2018). Prevalence of sexual violence in migrants, applicants for international protection, and refugees in Europe: A critical interpretive synthesis of the evidence. *International Journal of Environmental Research and Public Health*, *15*(9), 1979. https://doi.org/10.3390/ijerph15091979

Downing, N. R., Akinlotan, M., & Thornhill, C. W. (2021). The impact of childhood sexual abuse and adverse childhood experiences on adult health related quality of life. *Child Abuse & Neglect*, *120*, 105181. https://doi.org/10.1016/j.chiabu.2021.105181

Dworkin, E. R. (2020). Risk for mental disorders associated with sexual assault: A meta-analysis. *Trauma, Violence, & Abuse*, *21*(5), 1011–1028. https://doi.org/10.1177/1524838018813198

Dworkin, E. R., Jaffe, A. E., Bedard-Gilligan, M., & Fitzpatrick, S. (2023). PTSD in the year following sexual assault: A meta-analysis of prospective studies. *Trauma, Violence, & Abuse*, *24*(2), 497–514. https://doi.org/10.1177/15248380211032213

Flanders, C. E., Tarasoff, L. A., & VanKim, N. (2023). Sexual violence and mental health among young bi+ and lesbian women and gender minoritized people. *Journal of Gay & Lesbian Mental Health*, *27*(4), 483–502. https://doi.org/10.1080/19359705.2022.2072036

Golo, H., K., & Eshun, I. (2019). 'Re-trafficking' in the coastal communities and the Volta Lake of Ghana: Children's rights, agency and intra-household bargaining position. *American Journal of Business and Society*, *4*(4), 97–107.

Gu, X., Hoijtink, H., Mulder, J., & van Lissa, C. (2021). Bain: Bayes factors for informative hypotheses. (Version 0.2.8) [R package]. https://CRAN.R-project.org/package=bain

Hébert, M., Lapierre, A., MacIntosh, H. B., & Ménard, A. D. (2021). A review of mediators in the association between child sexual abuse and revictimization in romantic relationships. *Journal of Child Sexual Abuse*, *30*(4), 385–406. https://doi.org/10.1080/10538712.2020.1801936

Heinrichs, N., & Brühl, A. (2022). Preventing revictimization through a web-based intervention for primary caregivers of youth in care (EMPOWERYOU): Protocol for a randomized factorial trial. *JMIR Research Protocols, 11*(10), e38183. https://doi.org/10.2196/38183

Hoijtink, H. (2012). *Informative hypotheses: Theory and practice for behavioral and social scientists*. Chapman and Hall/CRC.

International Organization for Migration. (2019). *Mapping report on legal frameworks and assistance available to migrant victims of sexual and gender-based violence (SGBV)*. https://iom-nederland.nl/images/Protect/PROTECT-project-mapping-legal-framework-SGBV.pdf

Johnson, D. M., & Zlotnick, C. (2006). A cognitive-behavioral treatment for battered women with PTSD in shelters: Findings from a pilot study. *Journal of Traumatic*

Stress, *19*(4), 559–564. https://doi.org/10.1002/jts.20148

Katz, J., May, P., Sörensen, S., & DelTosta, J. (2010). Sexual revictimization during women's first year of college: Self-blame and sexual refusal assertiveness as possible mechanisms. *Journal of Interpersonal Violence*, *25*(11), 2113–2126. https://doi.org/10.1177/0886260509354515

Kearney, B. E., & Lanius, R. A. (2022). The brain-body disconnect: A somatic sensory basis for trauma-related disorders. *Frontiers in Neuroscience*, *16*, 1015749. https://doi.org/10.3389/fnins.2022.1015749

Kelley, E. L., Orchowski, L. M., & Gidycz, C. A. (2016). Sexual victimization among college women: Role of sexual assertiveness and resistance variables. *Psychology of Violence*, *6*(2), 243–252. https://doi.org/10.1037/a0039407

Keygnaert, I., Vettenburg, N., & Temmerman, M. (2012). Hidden violence is silent rape: Sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Culture, Health & Sexuality*, *14*(5), 505–520. https://doi.org/10.1080/13691058.2012.671961

Levine, J. A. (2017). Mental health issues in survivors of sex trafficking. *Cogent Medicine*, *4*(1), 1278841. https://doi.org/10.1080/2331205X.2017.1278841

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

Littleton, H., & Decker, M. (2017). Predictors of resistance self-efficacy among rape victims and association with revictimization risk: A longitudinal study. *Psychology of Violence*, *7*(4), 583–592. https://doi.org/10.1037/vio0000066

Livingston, J. A., Testa, M., & VanZile-Tamsen, C. (2007). The reciprocal relationship between sexual victimization and sexual assertiveness. *Violence Against Women*, *13*(3), 298–313. https://doi.org/10.1177/1077801206297339

Macy, R. J. (2007). A coping theory framework toward preventing sexual revictimization. *Aggression and Violent Behavior*, *12*(2), 177–192. https://doi.org/10.1016/j.avb.2006.09.002

Martinez, O., & Kelle, G. (2013). Sex trafficking of LGBT individuals: A call for service provision, research, and action. *The International Law News*, *42*(4).

Messman-Moore, T. L., & Brown, A. L. (2006). Risk perception, rape, and sexual revictimization: A prospective study of college women. *Psychology of Women Quarterly*, *30*(2), 159–172. https://doi.org/10.1111/j.1471-6402.2006.00279.x

Messman-Moore, T. L., & McConnell, A. A. (2018). Intervention for sexual revictimization among college women. In *Sexual Assault Risk Reduction and Resistance* (pp. 309–330). Elsevier. https://doi.org/10.1016/B978-0-12-805389-8.00013-X

Mills, B., & Turnbull, G. (2004). Broken hearts and mending bodies: The impact of trauma on intimacy. *Sexual and Relationship Therapy*, *19*(3), 265–289. https://doi.org/10.1080/14681990410001715418

National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children. (2021). *Slachtoffermonitor mensenhandel 2016-2020 [Survivor monitor human trafficking 2016-2020]*. Nationaal Rapporteur.

Noll, J. G., & Grych, J. H. (2011). Read-react-respond: An integrative model for understanding sexual revictimization. *Psychology of Violence*, *1*(3), 202–215. https://doi.org/10.1037/a0023962

O'Brien, C. V., & Charura, D. (2022). Refugees, asylum seekers, and practitioners' perspectives of embodied trauma: A comprehensive scoping review. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0001342

Oram, S. (2019). Sexual violence and mental health. *Epidemiology and Psychiatric Sciences*, *28*(6), 592–593. https://doi.org/10.1017/S2045796019000106

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences*, *25*(4), 317–341. https://doi.org/10.1017/S2045796016000135

Panzi Foundation. (2019). *Handbook: Holistic care for survivors of sexual violence in conflict*. https://mukwegefoundation.org/wp-content/uploads/2019/07/Handbook-Care_for_SV_Survivors-ENG-screen.pdf

Price, C. J., & Thompson, E. A. (2007). Measuring dimensions of body connection: Body awareness and bodily dissociation. *The Journal of Alternative and Complementary Medicine*, *13*(9), 945–953. https://doi.org/10.1089/acm.2007.0537

Price, C. J., Thompson, E. A., & Cheng, S. C. (2017). Scale of Body Connection: A multi-sample construct validation study. *PLOS ONE*, *12*(10), e0184757. https://doi.org/10.1371/journal.pone.0184757

Rich, C. L., Combs-Lane, A. M., Resnick, H. S., & Kilpatrick, D. G. (2004). Child sexual abuse and adult sexual revictimization. In L. J. Koenig, L. S. Doll, A. O'Leary, & W. Pequegnat (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention.* (pp. 49–68). American Psychological Association. https://doi.org/10.1037/10785-003

Risser, H. J., Hetzel- Riggin, M. D., Thomsen, C. J., & McCanne, T. R. (2006). PTSD as a mediator of sexual revictimization: The role of reexperiencing, avoidance, and arousal symptoms. *Journal of Traumatic Stress*, *19*(5), 687–698. https://doi.org/10.1002/jts.20156

Robitz, R., Asera, A., Nguyen, P., Gordon, M., Coverdale, J., Stoklosa, H., & Chisolm-Straker, M. (2022). An annotated bibliography on human trafficking for the mental health clinician. *Journal of Psychiatric Practice*, *28*(3), 218–226.

Rothman, K., Georgia Salivar, E., Roddy, M. K., Hatch, S. G., & Doss, B. D. (2021). Sexual assault among women in college: Immediate and long-term associations with mental health, psychosocial functioning, and romantic relationships. *Journal of Interpersonal Violence*, *36*(19–20), 9600–9622. https://doi.org/10.1177/0886260519870158

Schaeffer, A. J., & Cornelius-White, J. H. D. (2021). Qualitative studies on body-based interventions for refugees: A meta-synthesis. *Body, Movement and Dance in Psychotherapy*, *16*(4), 267–285. https://doi.org/10.1080/17432979.2021.1893810

Schauer, M., & Elbert, T. (2010). Dissociation following traumatic stress: Etiology and treatment. *Zeitschrift für Psychologie / Journal of Psychology*, *218*(2), 109–127. https://doi.org/10.1027/0044-3409/a000018

Schimmenti, A., & Caretti, V. (2016). Linking the overwhelming with the unbearable: Developmental trauma, dissociation, and the disconnected self. *Psychoanalytic Psychology*, *33*(1), 106–128. https://doi.org/10.1037/a0038019

Schulz, K. F., Altman, D. G., & Moher, D. (2010). CONSORT 2010 statement: Updated guidelines for reporting parallel group randomised trials. *Journal of Pharmacology and Pharmacotherapeutics*, *1*(2), 100–107. https://doi.org/10.4103/0976-500X.72352

Scoglio, A. A. J., Kraus, S. W., Saczynski, J., Jooma, S., & Molnar, B. E. (2021). Systematic review of risk and protective factors for revictimization after child sexual abuse. *Trauma, Violence, & Abuse*, *22*(1), 41–53. https://doi.org/10.1177/1524838018823274

Semmlinger, V., & Ehring, T. (2022). Predicting and preventing dropout in research, assessment and treatment with refugees. *Clinical Psychology & Psychotherapy*, *29*(3), 767–782. https://doi.org/10.1002/cpp.2672

Spangaro, J., Toole-Anstey, C., MacPhail, C. L., Rambaldini-Gooding, D. C., Keevers, L., & Garcia-Moreno, C. (2021). The impact of interventions to reduce risk and incidence of intimate partner violence and sexual violence in conflict and post-conflict states and other humanitarian crises in low and middle income countries: A systematic review. *Conflict and Health*, *15*(1), 86. https://doi.org/10.1186/s13031-021-00417-x

Tankink, M., & Richters, A. (2007). Silence as a coping strategy: The case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war. In B. Drožđek & J. P. Wilson (Eds.), *Voices of trauma: Treating psychological trauma across cultures* (pp. 191–210). Springer US.

Ullman, S. E., & Vasquez, A. L. (2015). Mediators of sexual revictimization risk in adult Sexual assault victims. *Journal of Child Sexual Abuse*, *24*(3), 300–314. https://doi.org/10.1080/10538712.2015.1006748

U.S. Department of Veterans Affairs. (2022). *PTSD Checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Van Brabant, L., Kuiper, R., Rosseel, Y., & Dacko, A. (2023). Restriktor. CRAN - Package restriktor (r-project.org).

Van De Kamp, M. M., Scheffers, M., Emck, C., Fokker, T. J., Hatzmann, J., Cuijpers, P., & Beek, P. J. (2023). Body- and movement- oriented interventions for posttraumatic stress disorder: An updated systematic review and meta- analysis. *Journal of Traumatic Stress*, 36, 835–848. https://doi.org/10.1002/jts.22968

Walker, H. E., Freud, J. S., Ellis, R. A., Fraine, S. M., & Wilson, L. C. (2019). The prevalence of sexual revictimization: A meta-analytic review. *Trauma, Violence, & Abuse*, *20*(1), 67–80. https://doi.org/10.1177/1524838017692364

Walker, H. E., & Wamser-Nanney, R. (2023). Revictimization risk factors following childhood maltreatment: A literature review. *Trauma, Violence, & Abuse*, *24*(4), 2319–2332. https://doi.org/10.1177/15248380221093692

Wolfe, D. A. (Ed.). (1996). *The youth relationships manual: A group approach with adolescents for the prevention of woman abuse and the promotion of healthy relationships*. Sage Publications.

SECTION II

Forced Migrants

CHAPTER 5

Concerning "Neglect": Perspectives on the Prioritisation of Mental Health Conditions in Protracted Displacement Contexts

In press:

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ABSTRACT

"Neglect" is a lucrative concept attracting funding and transforming what is prioritised in global mental health. This article unpacks conceptualisations of "neglect" in relation to mental health in the context of a wider project on aiming to improve healthcare at the intersection of gender and protracted displacement amongst Somali and Congolese internally displaced people and refugees. Drawing on interviews with people with professional and/or lived experience of displacement, this article makes three contributions. First, we argue that "neglect" must be considered in the context of differential health priorities and health-seeking behaviours, particularly given the additional challenges associated with disruption to social care networks in protracted displacement contexts. Second, we illustrate "neglect" in light of our respondents' distinctions between overt bodily expressions of distress that are socially disruptive and more internalised expressions of distress that are more socially containable. Third, we unpack the intersectional "neglect" of women and girls by sexual violence's distinctive confluence of social withdrawal with strategies of containment to avoid social disruption.

Keywords

Displacement, mental health, neglect, refugees, sexual and gender based violence

"Neglect" is a key concept in global health discourses and the Sustainable Development Goals, most iconically in the World Health Organization (WHO) response to so-called Neglected Tropical Diseases (NTDs; World Health Organization, 2020), and increasingly also other conditions including mental health (World Health Organization, 2019). Global health and international development funding agencies similarly target "neglected diseases" (Morel, 2003) and "neglected populations" (Manderson et al., 2009). Targeting "neglect" has been prioritised by United Kingdom (UK) international development programmes through various incarnations, most recently in the form of a partnership between the then Department for International Development – now Foreign, Commonwealth & Development Office – and UK Research & Innovation (UKRI) for a programme of international development research via the Global Challenges Research Fund (GCRF). A 2019 UKRI GCRF funding call for projects on development-based approaches to protracted displacement tasked applicants with responding to the challenge of how to expand healthcare systems for displaced people to cover areas that are usually neglected in refugee/IDP settings such as treatment of mental health. In this article we draw on a UKRI GCRF project aiming to improve healthcare at the intersection of gender and protracted displacement to explore conceptualisations of "neglect" in relation to mental health.

Via longstanding debates about universal measures of mental illness versus cultural and social mediation of mental distress (Kleinman, 1988), medical anthropology and transcultural psychiatry have made sustained contributions towards establishing the prevalence, expressions, and burden of mental disorders (Charlson et al., 2022; Kohrt et al., 2015, p. 28). Diagnosis and treatment of mental distress are embedded in cultural concepts of health and illness, and entangled in the social, political, and economic environments in which they are situated. Addressing mental health can be further complicated in displacement contexts, where displaced people, host communities, and local and international healthcare providers will likely have differing priorities and perceptions of need and neglect in relation to health. The prevalence of sexual and gender-based violence (SGBV) and its associated health complications are widely recognised as problems in contexts of conflict and displacement, but differing conceptualisations of the causes and impact of such violence complicate understandings of responsibility and appropriate responses. This can result in the misunderstanding and chronic neglect of the needs of SGBV survivors.

Engaging with insights from medical anthropology and transcultural psychiatry, we articulate why and how different people – with (in some cases overlapping) professional and/or lived experience of migration or displacement – come to understand certain mental health conditions to be "neglected" in protracted displacement contexts. First, we argue that "neglect" must be considered in the context of differential health priorities and health-seeking behaviours, particularly given the additional challenges associated with disruption to social care networks in protracted displacement contexts. Second, we illustrate "neglect" in light of our respondents' distinctions between overt bodily expressions of distress that are socially disruptive and more internalised expressions of distress that are more socially containable. Third, we unpack the intersectional "neglect" of women and girls by sexual violence's distinctive confluence of social withdrawal with strategies of containment to avoid social disruption.

FRAMING NEGLECT IN GLOBAL (MENTAL) HEALTH

International concern for "neglected" diseases can be traced from European anxieties about the perceived dangers of "tropical diseases" in their colonies (Gold, 2021) to the establishment of the "Great Neglected Diseases of Mankind" programme established in the 1970s by the Rockefeller Foundation. This attempt to coordinate interdisciplinary research, development, and technological innovations to address "tropical diseases" lost momentum, and by the end of the twentieth century it was estimated that, globally, less than 10% of spending on health research was dedicated to diseases or conditions that account for 90% of the global disease burden (Morel, 2003). This apparent "market failure" was blamed for producing a "global drug gap" (Morel, 2003), in which drug development and research were overwhelmingly for the benefit of affluent countries. The label of "neglect" drew attention not only to neglected diseases, but also to the neglected populations they primarily affect. As such, NTDs can be understood as "neglected diseases of poverty": they largely affect people who are themselves poor and marginalised in processes of establishing research agendas and public health priorities (Manderson et al., 2009, pp. 283-4). Marginalised populations are not homogenous groups, and experiences of illness and health-seeking behaviour within such groups are intersectional, shaped by factors such gender, race, nationality, and socioeconomic status (Kapilashrami & Hankivsky, 2018). The research, budgetary, and policy focus on HIV/AIDS, TB, and malaria – the so-called "big three" – reinvigorated calls from global health actors to raise the profile of other "neglected" infectious diseases. Underscored by a logic of elimination and eradication, these calls claimed that NTDs should be tackled through increased research, funding, and, ultimately, mass availability of drugs. This approach, it was theorised, would not only improve health, but potentially "make poverty history" (Molyneux et al., 2005; Parker & Allen, 2014).

"Neglect" proved to be a lucrative brand attracting billions of US dollars and transforming global health prioritisation (Parker et al., 2016). The "packaging' of diseases as 'neglected' has powerful moral implications that convey a sense of urgency and the potential to make a difference" (Vanderslott, 2021). In line with arguments about the "anti-politics" of development (Ferguson, 1994) and the "biopolitics" of humanitarianism (Fassin, 2007; Ticktin, 2006), we argue that global health framings of "neglect" as a failure to address fundamental human rights (United Nations 2006, Article 25) can lead to the depoliticisation of interventions on "the neglected" as a "just and moral cause" (Parker & Allen 2014, p. 224). In this discourse it can seem logical to direct resources towards treating the health condition alone (often through drugs) rather than by also addressing the broader social, economic, and political contexts (Singer et al., 2017). This top-down, technical approach arguably neglects the broader inequalities affecting human health and wellbeing. By contrast, Parker et al. (2016) have drawn attention to the inherently social and relational nature of "neglect", producing and reproducing colonial hierarchies of responsibility, prioritisation, and care.

Neglect, as a powerful marker for prioritisation, has seeped beyond infectious diseases and into the broader discourse of global health. The WHO Special Initiative for Mental Health (2019-2023) states that "mental health remains a neglected part of global efforts to improve health"

and highlights the problem of "limited commitment and funding for sustained implementation and the scale-up of services" (World Health Organization, 2019, p. 2). The WHO Comprehensive Mental Health Action Plan 2013-2030 asserts that "action must be taken to address decades of inattention to and underdevelopment of mental health services and systems, human rights abuses and discrimination against people with mental disorders and psychosocial disabilities" (World Health Organization, 2021). Only a tiny fraction of global development assistance for health is dedicated to addressing mental health (Liese et al., 2019). This persistent underfunding perpetuates the prevalence of top-down interventions, as medical professionals and institutions only have capacity to react to acute needs, rather than implement an integrated care model (Walker & Vearey, 2022).

The WHO maintains a list of specified NTDs, but questions remain about which mental health conditions are being neglected and by whom, and about what should be done and by whom. As Pendse et al. (2022, p. 2) note, "colonial power relations have been defining factors for what forms of distress have been validated by clinicians as being "mental illness" and provided care, and what forms of distress have been ignored". One reason for the neglect of mental health in global health programmes could be the relative intangibility and invisibility of mental health symptoms and the attendant challenges of identification and appropriate response, at least in comparison with more visible physical diseases (Kohrt & Mendenhall, 2015, p. 26; Miller et al., 2021). Diverse mental health problems necessitate diverse responses from individuals, families, communities, and mental health professionals. Some problems may require hospitalisation and medication, others might be tied to daily stressors, while still others might exceed mental health frameworks. For instance, as we discuss in this paper, aside from physical or mental trauma, SGBV can result in social shame, stigma, and exclusion, as a result of the complex intersection of social norms concerning sex, gender, ethnicity and the social and economic status of both the perpetrator and the victim. Focusing on the neglect of narrowly defined mental health conditions risks turning a wilfully blind eye to the complex contexts in which such conditions emerged.

RESEARCH CONTEXT AND METHODS

This article's authors are collaborators in a wider UKRI GCRF funded research project on improving healthcare at the intersection of gender and protracted displacement. Our larger consortium comprises research institutes and non-governmental organisations (NGOs) based in Somalia, Democratic Republic of Congo (DRC), Kenya, South Africa, the UK, and the Netherlands, and focuses on Somali and Congolese IDPs and refugees. We selected Somalia and Eastern DRC as key research sites because both have been involved in decades-long protracted conflicts. Somali and Congolese people have faced prolonged exposure to numerous human rights violations, including torture and sexual violence (Human Rights Watch, 2022) and repeated and often protracted internal and external displacement (Internal Displacement Monitoring Centre, 2021; United Nations High Commissioner for Refugees, 2020). Significant displaced populations from

both countries are resettled worldwide, including in our research sites in Kenya, South Africa, and the Netherlands.

DRC and Somalia are both marked by unstable governance and weak health systems. In Eastern DRC the state has remained fragile yet present in the delivery of basic health services (United Nations Office for the Coordination of Humanitarian Affairs, 2022), whereas until 2012 Somalia lacked a functioning state until the establishment of the Federal Government which continues to have limited capacity (United Nations Office for the Coordination of Humanitarian Affairs, 2021). The populations of both sites rely heavily on humanitarian assistance. International agencies and organisations are present in the delivery of health services in DRC (United Nations Office for the Coordination of Humanitarian Affairs, 2022), whereas security problems have limited the presence of foreign actors in Somalia (United Nations Office for the Coordination of Humanitarian Affairs, 2021). Despite vastly different cultural and religious contexts, SGBV is a widespread problem in both countries, and victims are stigmatised through prevailing gender and sexual norms (Jefferson, 2004). The low social status of women and girls is compounded by persistent conflict, insecurity, and displacement.

Displacement is shaped by many factors, including nationality, race, religion, gender, socioeconomic status, countries of transit and settlement, and duration and reasons for displacement. We do not suggest a homogenous experience of displacement, but rather highlight that the diverse and intersectional experiences of displaced people can produce different conceptualisations of health needs and areas of neglect. In this article we explore why and how different people – with (in some cases overlapping) professional and/or lived experience of migration or displacement – come to understand the relevance of the concept of "neglect" in relation to mental health and gendered violence in the protracted displacement contexts of Somalia and the DRC.

Most anthropological research on global mental health has focused on "sufferers" rather than on the perspectives of mental healthcare providers or policy makers (Kohrt & Mendenhall, 2015, p. 44). Thus, the different ways in which mental health professionals and affected populations themselves understand mental health and its neglect in humanitarian settings warrants continuous attention (Tol et al., 2011). We sought neither to artificially delineate professional from experiential knowledge, nor to privilege either professional or experiential perspectives, but instead to incorporate both. Snowballing via professional/social networks and local community-based organisations, we recruited interviewees who met either/both of the following selection criteria: lived experience of migration or displacement from Somalia or the DRC to the Netherlands, and/or relevant professional experience working with Mental Health and Psychosocial Support (MHPSS) and/or gendered violence in the protracted displacement context of our project's focus countries. The latter were psychologists, MHPSS experts, field practitioners, researchers, policymakers, and government officials. These selection criteria allowed us to explore different conceptualisations of "neglect" from various perspectives, including some people with professional expertise, some people with lived experience of migration and displacement, and some people with a wide range of contextualised perspectives from both a professional and personal viewpoint. Out of twenty

interviewees, eight had professional experience alone, five had overlapping professional and personal experience, and seven had personal experience alone.

All Somali and Congolese refugees and migrants in our sample had lived in the Netherlands for at least a decade. The Netherlands hosts around 40,000 people who were born in Somalia, and around 9,000 people who were born in the DRC. Most of these people entered the Netherlands as asylum seekers; others by family reunion or as students. Most Somali migrants fled Somalia's protracted conflict, albeit during different phases, coming to the Netherlands either during the early 1990s or during the mid-2000s. The conflict in Eastern DRC started in 1994 and has resulted in a relatively stable influx of asylum seekers and family reunions in the Netherlands. Government shelters provide accommodation and basic medical services and sometimes mental health services to asylum seekers in the Netherlands. In general, mental health services for migrant populations and cross-cultural knowledge are inadequate and inconsistent, depending on region and resources (Lamkaddem et al., 2014). We did not recruit Somali or Congolese interviewees via mental healthcare services or based on any (in-)direct experience with mental health problems. As confirmed by the Medical Ethical Committee of the Amsterdam Medical Centre, this piece of research did not necessitate medical ethics review in the Netherlands, beyond the project's overarching ethical approval granted by the University of Edinburgh. During interviews, however, some Somali and Congolese interviewees spontaneously disclosed personal experience with mental health problems and/or a comparative perspective on perceptions of mental health(care) in their countries of origin and in the Netherlands.

Between September 2020 and March 2021, four interviewers conducted a total of twenty semi-structured interviews via videocalls averaging an hour each. Interviewees opted for interviews in either Dutch or English, apart from one interviewee who opted for Somali with a translator. In this article we explore a series of recurring themes that emerged from our semi-structured interviews: first, a wide spectrum of health prioritisation and health-seeking behaviours in the context of the additional challenges associated with disruption to social care networks in contexts of protracted displacement; second, interviewees' distinction between overt bodily expressions of distress that are socially disruptive and more internalised expressions of distress; and third, sexual violence's distinctive confluence of social withdrawal strategies of containment to avoid social disruption. This article springs from an interdisciplinary exploration, combining RG, EG's insights from the domain of mental health psychosocial support (MHPSS) alongside DNW, LL and LJ's social and medical anthropology perspectives. Given our specific academic and practitioner backgrounds, we acknowledge that we ourselves may have neglected key information due to our own blind spots.

"NEGLECT" OF MENTAL HEALTH IN DISPLACEMENT CONTEXTS

To what extent do approaches to mental health in displacement contexts replicate decontextualised top-down assumptions about what is neglected and what is needed? Over the past decades

various efforts have been made to develop, implement, and evaluate MHPSS interventions for displaced populations, promote psychosocial wellbeing, and prevent or treat mental disorders (Turrini et al., 2017). A couple of general critiques of mental health approaches – for their focuses on the individual rather than the community and on trauma and posttraumatic stress disorder (PTSD) in particular – resonate strongly in protracted displacement contexts.

First, derived from biomedical models dominant in the global north, an individual-focused approach to mental health research amongst displaced people underplays the social context for mental distress and can attribute problems to individuals rather than to their wider adverse social circumstances (Miller et al., 2006, p. 414; Watters, 2001, pp. 1711-1712). In the context of mental health amongst displaced people, focusing on pre-determined "neglected" conditions potentially risks diverting valuable attention away and thus neglecting the wider social, political, and economic contexts of conflict, protracted displacement, and chronic marginalisation (Matthies-Boon, 2018). Second, focusing on trauma in general and PTSD in particular overlooks that traumatic stress is only one of many possible expressions of distress within a wider range of mental health responses which may consequently remain "neglected" (Miller et al., 2006; Summerfield, 1999, p. 1452-1454).

Research on mental health amongst migrant populations emphasises challenges in relation to communication between patient and mental health professional (Feldman, 2006), migrants' limited use of mental health services due to stigma (Boynton et al., 2010), "ineffective advocacy" (Im et al., 2017), disparate expressions of symptoms (Bettmann et al., 2015), and limited treatment options (Ellis et al., 2010). Notwithstanding valid critiques of exceptionalism concerning mental illness and limited healthcare provision in protracted displacement contexts (Cabot & Ramsay, 2021, p. 288; Summerfield, 1999, pp. 1452-1454), mental health research has shed light on mental health problems and treatment gaps in protracted displacement contexts, even declaring the scope of the problem to represent a "mental health crisis" (Ibrahim et al., 2022). Mental health conditions are prevalent worldwide, but exposure to extreme adversity before, during, and after displacement can exacerbate pre-existing mental health problems and precipitate new mental health problems (Porter & Haslam, 2005, p. 610), as encapsulated by this interview excerpt:

> … the standard dogma or paradigm in refugee mental health is that refugees have mental health problems, just as anyone else has. But the number is increased, or the severity is increased, because of several factors, such as the loss of protective factors, social systems, stable family situations, etc... I think the problems of Somali and Congolese refugees—but I talk more in general, refugees in general—are to some extent the pre-existing disorders that get exacerbated. Because of … the loss of support and the social upheaval and the fact that treatment is not available even though it may have been minimal anyway. But the stability is gone and then you have problems that are caused by events that people have had, but as much in my view, it's not just the events of the past in the country of origin it's as much the problems during the flight and … the problems that refugees have in their ordinary living. So ... which one of those is more important? I can't say, but those

> are important things and all are important. Now, the first group of pre-existing problems are often overlooked and … that's important that people with severe mental disorders—there are not that many, but their suffering is extreme and we can also say more or less confidently that the prevalence is higher than in non-conflict affected populations. (Dutch psychiatrist and mental health adviser in his mid-50s, with over 25 years of experience in conflict and post-conflict settings)

Other interviewees – with professional expertise and lived experience alike – similarly identified several interconnected vulnerabilities associated with displacement that reduce access to treatment. Mental health services might reasonably be described as universally inadequate, underdeveloped, and underfunded (Patel et al., 2016), but several interviewees noted that in protracted displacement contexts, governments and funders tend to prioritise humanitarian interventions that target infrastructures such as primary healthcare, housing, nutrition, and water and sanitation over mental healthcare. Resonating with the literature on "daily stressors" (Miller & Rasmussen, 2010; Walker & Vearey, 2022), interviewees also noted that in contexts of chronic socio-economic marginalisation, displaced people may (need to) prioritise collective wellbeing – protecting and providing for their families – rather than individual mental health. Additionally, hinting at structural neglect, several interviewees noted that this dearth of mental healthcare services results in the burden falling disproportionately on one's kinship, religious, and other social support networks. Finally, displacement is likely to have disrupted those pre-existing social support structures. Consequently, in the words of a Congolese psychiatrist interviewee, "it's very challenging to treat people who having those other problems when they are refugees or when they are depressed because you don't have the social resources that you may have with people who are living in their communities". Thus displacement can both exacerbate intersecting vulnerabilities and simultaneously exacerbate the neglect of mental illness due to the associated reductions in treatment options and opportunities.

Interviewees noted that people predominantly attribute mental health problems to religious and spiritual factors, and consequently initially see religious healing as the preferred treatment. However, they noted that displacement results in the loss of access to socially and spiritually important communal religious spaces, and in the longer term can disrupt knowledge and experience of performing specific rituals to promote mental health and alleviate mental health problems. During her interview, a South African researcher cited her own study finding that some displaced people's cultural traditions had been "demonised" by their host community, with the effect of discouraging them from turning to religious healing practices from their countries of origin. A displaced Somali woman resettled in the Netherlands, told us that "some families are putting pressure on people, "she is sick, bring her to Somalia, Alhamdulillah, bring the children", the pressure that is put by the family is big". This alludes to a strong steer towards familiar healing practices (albeit an option which is not available to everyone for a combination of financial and/or immigration reasons). Notions of "home" are embedded in conceptualisations of health, illness, and healing. Ailments were often understood as forms of religious distress, such as

demon possession, and a result of dislocation from cultural and religious norms. Here, and in other interviews, the importance of remedies that were deemed both culturally and religiously resonant were perceived as most effective, and clearly linked with a perception of displacement as spiritually and physically disruptive.

In common with participants in our wider project's research activities, interviewees frequently mentioned the importance of family and the home as a primary site of support for people in mental distress. This care included both meeting the needs of individuals and containing them within the home so that they cannot be exposed to or cause harm. In discussion of the dual challenges of stigma surrounding people with mental health problems and the limited mental health resources in Somalia, a Somali healthcare worker in his 50's commented "The only cure is to have a good family who will help you with rituals, and will bring you to an Imam, to read you, your body. That is the only cure to deal with people with mental problems". "Home", as a geographical notion and domestic space, is crucial to conceptualisations of illness and care. In Somalia, Islamic healing, where the Qur'an is recited to individuals with perceived "mental problems", is facilitated and at times provided by relatives. The implication is that without good familial support, individuals are at risk of an absence of care and protection from stigma (as discussed further in the following sections).

As noted above, displaced people are already dislocated from their familiar healthcare systems, which can heighten the reliance on kin and other social support networks that are often similarly fragmented. Domestic labour is most frequently performed by women and girls (Federici, 2020), and conceptualisations of normal and pathological behaviour are highly gendered, highlighting the need for an intersectional lens to understand the wider repercussions of illness and caring responsibilities. In contexts of conflict and displacement, women and girls are often left to care for children and the elderly and infirm (Walker, 2015). During her interview, a Korean cultural psychologist noted that displaced women refugees in Kenya often face the "extra duties" and "extra stressors" of providing and caring for their families, which exacerbates mental ill-health. This reliance on gendered domestic labour reveals how forms of care and containment can result from neglected health needs and can further exacerbate structural neglect.

Containment has been deployed as a top-down intervention such as a public health measure to control the spread of infectious disease (e.g., Abney, 2018) or a humanitarian measure to segregate displaced people into camps (e.g., McConnachie, 2016); in both examples, containment is at least as much about protecting those on the outside as it is about protecting those who are being contained. In this article, by contrast, we engage with social containment as an emic concept described by interviewees as an individual or household protection strategy. As we discuss further in the next section, when distress is managed and contained within the home, it is less likely to be identified by the community as a problem to be addressed. Neglecting health needs simultaneously compounds the burden put on those performing (usually unpaid) labour that is required to fill this gap.

THE INTERPLAY BETWEEN NEGLECT AND EXPRESSIONS OF DISTRESS AND SOCIAL DISRUPTION

There is a long trajectory of research on culturally contextual "idioms of distress": socially and culturally resonant means of experiencing and expressing distress in local worlds (Nichter, 2010, p. 405). Beyond socially and culturally resonant terminology (e.g., Carroll, 2004; Greene et al., 2016; Im et al,. 2017), embodied and behavioural expressions of distress are similarly socially and culturally resonant. Most relevant here is the work by Ventevogel et al. (2013) on the identification of two distinctive categories of expressions of distress that resonated – albeit in localised ways – across their field sites in South Sudan, Burundi, and DRC. The first, "severe behavioural and cognitive disturbance", was characterised by "violence", "walking anywhere", "walking naked", "talking nonsense", "collecting rubbish". The second, "sadness and social withdrawal", was characterised by "sadness" and "social isolation".

Interviewees in our study similarly distinguished between distinctive bodily or behavioural expressions of distress and more internalised expressions of distress. However, as we will show, they did not consider that the latter necessarily indicated a health problem. In this section we explore the recognition and prioritisation of socially disruptive bodily or behavioural expressions as reflective of mental illness and the relative containment of more internalised expressions as normalised responses to everyday life. We then examine how these perspectives on what constitutes mental health and illness inform how interviewees categorised certain conditions and not others as "neglected".

When asked about common mental health disorders within the Somali and/or Congolese communities, most interviewees initially described characteristics that evoke Ventevogel et al.'s (2013) first category: conspicuous bodily expressions of distress alongside associated behaviours and decision-making. In the words of a Congolese interviewee:

> You would have mental health problems when you are on the street, and taking off clothes... And you don't make rational decisions anymore, and I don't mean rational decisions in general, but you, like you're going crazy. That's the idea of mental challenge. So, if you still can eat, drink, work, sort of, by yourself, somehow, you're not considered as mentally challenged. So, if you, from my background, from the culture in the Congo, that's what we see. What we expect by the people who are having mental issues. That's the common idea of mental issues. That you're really not able to make rational decisions, like simple decisions, like sleeping on the bed, eating the right food. Like clean food, not just healthy food. You're not able to work, you're not able to put on clothes by yourself. That's the idea of mental challenge. So, it's only when it's at that level. (Congolese financial analyst his mid-30s, resettled in the Netherlands for around 5 years)

There are several points worth unpacking within this quote. First, this interviewee defined mental illness in terms of not being able to take care of oneself on a basic level: eating and drinking, dressing and working. Second, he reflected a common understanding that "mental health issues" are reflected in bodily expressions. Third, he implied that it is only when someone reaches this extreme that they would widely be considered to be suffering from a "mental health problem".

Other interviewees similarly determined that a "mental health problem" would be identifiable when someone no longer appeared to understand or to follow social norms. Once someone has been labelled as "crazy" or "mad", they may encounter marginalisation within their own social milieu. The emphasis placed on explicit outward manifestations of distress exemplifies the popular discourse that stigmatises those who are perceived as "crazy" and indicates why people might be reluctant to discuss their distress within a mental health framework. Social "neglect" is not limited to displaced communities; people suffering from mental health conditions often face discrimination, isolation, and stigmatisation within their communities (Turan et al., 2019). Nevertheless, in the context of displacement, this can compound pre-existing marginalisation and stigmatisation by the host society (Bäärnhielm et al., 2017; Im et al., 2017, p. 645). Additionally, intersections with non-conforming gender identities, sexual orientation, and experiences of sexual violence might put people at further risk of exclusion, stigmatisation, and violence (Larkin, 2019). These prospects make it quite unappealing – either for an individual themselves, or by association with that individual – to be classified as having a mental health problem. In this context, interviewees understood such visible expressions of distress to reflect the failure of protective measures and neglect by the individual's immediate family and wider social structures alike. Several interviewees mentioned that in response to such visible displays of distress, some families might resort to containing the individual within the household.

WHO prevalence studies focus on the mental health burden of internalising problems such as depression, chronic stress, and anxiety. By comparison, none of the interviewees with lived experience of migration or displacement spontaneously described any of the characteristics associated with Ventevogel et al.'s (2013) second category of internalised or covert forms of distress, such as "overthinking", "sadness", or "withdrawal" as mental health problems. A displaced Congolese woman in her early 40s who has been resettled in the Netherlands for around 15 years told us "you know, in Africa we have a lot of problems. We have hunger... But people are not depressed. They don't have depression, so I've never experienced that. Maybe it's there, but I don't know". Several others clarified that the expression of internalised idioms of distress within their communities would not be understood as being a "mental health problem" within their cultural context:

> … mental wellbeing and mental health, it is a void. It is a complete void in Somalia. Regarding language it is also a complete void, and the people are also not aware of it... When your child is a little bit sad, the father is not going to his children, "Are you sad? What are you sad about?" Where, they know, sadness, they know, but they also don't pay any attention to it. Because you also never learned it, to look at oneself. To look and to recognise what he feels at that moment, how they feel.

> People don't pay attention at all. (Somali interpreter in his mid-50s, resettled in the Netherlands for over 25 years)

Other interviewees commented that although some people might discuss their emotions, these would not be understood as mental health problems. A Somali woman in her mid-30s noted "it's not hard to just openly tell people you have nightmares or sadness. That's just normal for Somali people to talk about. They sympathise with each other, but that is not seen as psychological complaints, or signals that one is going crazy". A Somali health researcher in her early 40s observed that "in Somalia, there's a whole range of depressive symptoms, if you will, but then depression in Somalia can be everything, I mean, I think there are six different words that describe that. And not necessarily long-term kind of depression". Together these quotes illustrate that despite ample vocabulary to discuss mental and emotional distress, there are limitations in where these conversations might take place, and how they are understood in relation to mental health problems. This perspective on sadness or distress indicates why people might not identify them as priorities in need of healthcare.

Generally, then, interviewees confirmed Ventevogel et al.'s (2013) ethnographic observations of distinctions between "severe behavioural and cognitive disturbance" and "sadness and social withdrawal". Asking questions about "neglect" allows us additionally to consider the differential implications for formal and informal healthcare. Whereas "sadness and social withdrawal" might be experienced as containable within the household, it might not be experienced as necessitating support beyond the household, and might therefore be particularly susceptible to neglect. By contrast, "severe behavioural and cognitive disturbance" might indicate that an individual's pre-existing support network is unequipped to address their condition which is not containable within the household or even in the wider community, thus calling for some form of external engagement.

> You see, if someone has a mental [health] problem, back home we always say, 'he's crazy' so everything he says doesn't make any sense, you can't follow what he's saying, you can't take him seriously. You can't even talk to him because he doesn't have any significance. He has lost his mind. So, there you go, because of that, he's neglected, he's neglected by everybody, except maybe his family, but possibly even by his family, even other families. So, you see, back home in Congo, we won't put up with you anymore, you are abandoned, you sleep outside, you sleep in garbage cans, you walk around everywhere aimlessly, you eat from garbage cans, things like that. There, if you're walking around when it's getting dark, that's where you will settle down for the night, you sleep midway through your travels, you can sleep under bridges, you sleep everywhere, well you don't have time to wash yourself, you don't have time to communicate, to change clothes you are abandoned, all because someone has fallen ill, because he has a mental [health] problem… People can't deal with it; moreover, we don't have that kind of patience. Back home, if someone gets mentally ill... Maybe the parents may have this kind of patience, but your

> brothers, your sisters, your cousins... they won't put up with you. (Congolese postal worker in his mid-50s, resettled in the Netherlands for around 20 years)

This indicates a perception of a binary between behaviour which is considered "normal" and therefore not a mental health problem, versus behaviour which is considered "crazy" and therefore potentially a mental health problem. This perception of a binary burdens the individual and their informal social networks with the responsibility to handle "sadness and social withdrawal" (which might remain manageable and socially containable) and to prevent "severe behavioural and cognitive disturbance" (which might deteriorate and become socially disruptive). In a context of scarce resources and responsive rather than preventative (international) mental healthcare provision, the effect may be that care providers consider "sadness and social withdrawal" to be relatively responsive to mental healthcare, whereas they

THE NEGLECT OF SEXUAL VIOLENCE AND USE OF SOCIAL CONTAINMENT

Notably, it was only when we asked interviewees with lived experience of migration or displacement specifically about the mental wellbeing of sexual violence survivors that they spontaneously mentioned social withdrawal. Personal experience of sexual violence was not a selection criterion, and we did not probe individual experiences during interviews; rather, they responded to questions about sexual violence in general by reflecting on their professional or social experiences. All interviewees focused predominantly on women and girls as victims (of e.g., female genital cutting, forced marriage, and marital rape), and only a few specifically mentioned men, boys, and LGBTQI+ people as victims. Thus, they reflected a more widespread assumption that SGBV generally concerns violence by men towards women and girls, and our interview material thus compounds the corresponding neglect of other perpetrators and victims of sexual violence.

The gendered perception of women and girls as the victims of male sexual violence was apparent in interviewees' focus on the social significance of female virginity and chastity. Congolese and Somali interviewees alike commented that women would struggle to marry in the future if they were no longer virgins, and that families would likely try to conceal any sexual violations due to the dishonour it would bring to the victim and their wider family. A female Somali interviewee commented,

> … the honour of the family is really important. And when you are a woman or a girl it is sensitive... the social control of the girls is really high... We also have to realise that we are living within a patriarchy community. The women's words are not so big, so we also have our problems. We are less worthy than the men. (Somali sociologist in her mid-60s, resettled in the Netherlands for over a decade)

The pressure to conform to sexual and gender norms is therefore key to understanding how victims and their families react to experiences of sexual violence and conceptualise neglect. Drawing on focus groups in the DRC, Kelly et al. (2012) reported that women and men alike articulated that 'some of the greatest challenges women faced were navigating the shame, humiliation, and ostracisation arising from negative community perceptions of rape survivors' (Kelly et al., 2012, p. 290). Thus, they understood sexual violence as 'not only a physical and psychological problem, but also a problem of social isolation' (Kelly et al., 2012, p. 290). Interviewees in our study similarly identified social exclusion and social isolation– and consequently neglect – as a common outcome of sexual violence. In the words of a male Congolese interviewee in the Netherlands: "Yeah, the mental problem is rejection. You see, it's shame. When she sees that everybody knows that she was raped she becomes ashamed, she's shut turns inwards to herself and deep into her own thoughts". Like several other interviewees, he suggested that – beyond the incident itself – the social response to sexual violence would impact upon the survivor. One thread running clearly though our interviews was the idea that containment is a major concern in the aftermath of sexual violence, and interviewees identified three potential sites for this containment: the individual, the household, and the wider community.

Firstly, in relation to containment within the individual, several interviewees articulated that the victim's fears about other people's responses might disincentivise victims from disclosing sexual violence to others, but that this containment might also result in social isolation. Three interviewees specified that in the aftermath of sexual violence the victim was likely to lose trust – in one's husband, in one's community, in support services – but they didn't assume that this lack of trust indicated mental illness. For instance, a male Congolese interviewee commented, "Should I call it mental health issues? I think trust issues... But I don't know if I would call that depression, really. I think it is one problem, one big problem, that may lead to depression. In general, it's a problem of trust". Thus, the survivor's response was sometimes – but not always – framed as a mental health problem. This indicates that interviewees viewed the interpersonal consequences of sexual violence as distinct from mental health conditions more generally.

Secondly, in relation to containment within the household, interviewees noted that following disclosure, the victim and their family might seek to restrict knowledge about the incident to a select group, in some cases by removing the entire household from the social setting by moving away. When reflecting on the response by the family of someone who had been raped, a female Somali interviewee told us, "they did not do anything, they did not press charges. They moved elsewhere. So it is still a taboo. But in their culture, when somebody within the family is raped, they just do not talk about it". Similarly, when asked about the relationship between mental health and social consequences for survivors of SGBV, a male Congolese psychologist responded that:

> In some cases they isolate themselves or they will be forced to go into exile, another village or into the city where again they don't have the support system. So it's not just the war that displaces these people... So if they can live with it, unless there is physical damage and they need medical treatment, they rather … just

> start over a new life, and hoping nobody will ever know what happened to them. And there is a fear there, because there is always this idea that maybe someone will come from that community, and see her, and identify her.
> (Congolese psychologist in his mid-30s, with around 10 years of professional experience)

Thus, in displacement contexts in which social support networks have already been severed, household containment – either through isolation or through moving away – has the potential to compound pre-existing social isolation. This supports Porter's (2017, p. 68) suggestion that victims of sexual violence might prioritise their own social and economic well-being rather than punishment of the perpetrator.

Thirdly, in relation to containment at a community level via social institutions, other potential responses to sexual violence include transforming the violation into an 'appropriate' sexual interaction through marriage, seeking reparations in the form of compensation, or initiating retributive justice. Such responses resonate with our wider consortium's research findings on treatment pathways indicating that in Somalia a commonplace principal response to sexual violence is families and extended clan networks seeking compensation from the offending parties to the victim's family (Boeyink et al., 2022, p. 8). This implies a framing of sexual violence not only as a mental health concern and physical assault for which the victim might warrant medical attention, but also crucially in terms of as a (dis)honour and justice for which the victim's family should be compensated.

Legal forms of redress for sexual violence are limited in both Somalia and DRC, especially for displaced populations, which also reflects the lower social value of women and girls as intersectionally neglected. Discussing the case of a displaced Somali teenager who had been raped, a female Somali interviewee told us,

> … she actually complained to the camp leaders. And there was an NGO, that NGO helped her, she went to the police station and the guy was caught and, you know, he stayed in jail for two days. And since then, that's when the abuse started. He rapes her constantly. As a punishment. So, you have the rule of law that is not doing its job. The government's not doing their job, you have the NGO, of course they do help, but then they don't look at the consequences. You're not addressing the issue. And that's why women don't come forth, because it's easier. Maybe it happens to you once. And if you keep quiet, then it stops. But then you talk and you get punished. (Somali health researcher in her early 40s, with over 15 years of professional experience)

Sexual violence as a weapon of war and the social implications for survivors reflect norms of gender and sex (Porter, 2017). Where containment, either by the individual or their family, is successful, the problems interviewees identified are in the distress and shame of experiencing

violence. Where containment fails and the social disruption of sexual violence is exposed, the main problem was the social response to the victim and the implications that might have for their (understood as "her") future. These responses cut across categorisations of distress as either potentially overt and socially disruptive or internally expressed withdrawal. This contrast demonstrates the importance of considering social containment in the development and implementation of (mental) healthcare services.

Sexual violence escapes containment when it is understood as a social transgression, which in the context of our research was understood predominantly as sex outwith marriage. Notions of consent were vague, and some interviewees focused instead on the capacity of the individual to be transgressed; for example, sex workers were perceived to regularly engage in socially transgressive sex, and therefore would not be understood as victims. Similarly, marital rape was often not considered rape because it was activity that occurred within the normative context of marriage. The pursuit of compensation by victims' families or marriage to the perpetrator is therefore intended to repair social disruption, rather than address the consequences for the victim as an individual. Two Somali interviewees commented on the vulnerability of women from marginalised minorities, and their limited capacity to seek any form of redress, thus reducing the likelihood that they would tell anyone about the assault. 'Innocent' young girls from 'respectable' social backgrounds were therefore seen as the most legitimate victims.

Porter (2017) emphasises the need to acknowledge the sex in sexual violence, rather than focusing on it exclusively as an act of violence and power. Like daily stressors, sex is a normal aspect of many people's lives. It is the ordinariness of sex, Porter argues, that allows for vagueness in defining rape and challenges in pursuing justice. This makes it harder to identify transgression and therefore easier to neglect violent dimensions that cause harm or illness. The heightened risk of social disruption associated with sexual violence might compound the inclination to overlook the harm it causes the victim in favour of containing and maintaining family honour.

SGBV is a prominent focus of humanitarian responses in protracted displacement contexts. Ticktin (2011, p. 259) prompts us to ask ourselves "at what point identifying sexual violence as special or different (for women in particular) threatens to reproduce notions that see sexual integrity as the most important thing about a woman". To what extent does a humanitarian focus on SGBV come at the expense of the neglect of other health problems (particularly but not exclusively women's health problems)? Echoing Tol et al. (2013), we suggest that a humanitarian focus on the mental health of individual survivors of sexual violence risks neglecting the social implications in contexts where survivors (and their families) prioritise social containment.

CONCLUSIONS

International calls to address neglected mental health conditions require careful consideration, not only of who can define what is or is not neglected, but also what is categorised as a "mental health problem". Echoing long histories of top-down colonial interventions, the concept

of "neglect" is imbued with assumptions firstly about the capacity to know what's best for (marginalised) others and secondly about responsibility to attend to their needs. Our examination of "neglect" illuminates how unaddressed mental health needs among displaced people can exacerbate existing intersectional inequalities.

A focus on "neglected populations" (Manderson et al., 2009), rather than on neglected mental health conditions, demonstrates that neglect (and efforts to address it) is intersectional. Local and global hierarchies of power and marginalisation shape the manifestations, perceptions, and prioritisation of distress and illness, and are therefore crucial to understanding potentially divergent categorisations of "neglect". For instance, the care and containment of those experiencing distress usually takes place within the "home", and is most often performed by women and girls, demonstrating the gendered nature of often unrecognised labour. Similarly, interviewees highlighted that gender, ethnicity, socio-economic status, and the availability of local support networks together inform the forms of social harm experienced by survivors of sexual violence.

Examining what is or is not considered a neglected mental health condition within contexts of protracted displacement can shed light on understandings, experiences, and techniques to cope with illness and distress. Perceptions of distress and the need for containment – or other social, medical, or religious interventions – demonstrate how people in contexts of protracted displacement respond to the structural inequalities that shape their vulnerability to daily stressors, limited healthcare, and the risk of SGBV. These challenges are not unique to displaced populations and are faced by other marginalised or neglected communities, but the likelihood of fractured support networks, precarious immigration status, disruption of spiritual/religious healing practice, and unfamiliarity with available healthcare options can exacerbate these vulnerabilities for displaced populations.

MHPSS providers and beneficiaries might differ in their understanding and associations with the concept of "mental health problems". Interviewees' articulation of mental wellbeing in terms of a binary – "normal" versus "crazy" – contrasts with biomedical mental health frameworks offering a wide range of diagnoses associated with various potential interventions. This mismatch in "mental health" connotations may create a barrier that hinders acceptance by beneficiaries and may therefore undermine the aims and diminish the effectiveness of MHPSS services. Setting mental health priorities and formulating appropriate responses within contexts of protracted displacement will benefit from close collaboration with beneficiaries to avoid reinscribing colonial hierarchies of responsibility, prioritisation, and care. Responding to critiques of MHPSS as individualised, decontextualised, and potentially neglectful of the social contexts of mental health and illness, we therefore advocate for a responsive and integrated approach to mental healthcare in protracted displacement settings.

MHPSS practitioners are part of a wider community of practice that sets the priorities for what is addressed or neglected. Interrogating the framing of specific mental health conditions (and not others) as "neglected" might prompt MHPSS practitioners to reflect on the implications for their roles as mental healthcare professionals. Who gets to decide what to target, and whose perspectives are neglected? What ends up being targeted and why, and consequently what is

being neglected? The call to address “neglected” mental health conditions might appear to be an inherently good and morally worthy pursuit, but it is not apolitical. For instance, given funder prioritisation of specific neglected mental health conditions, it is worth asking ourselves which other mental health conditions are currently being neglected by the fixation within global mental health with scalable and preventative interventions with measurable outcomes, and which other health problems and social implications of SGBV are currently neglected by a humanitarian focus on the individual mental health of sexual violence survivors.

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AUTHOR CONTRIBUTIONS

All authors were involved in conceptualisation, methodology and formal analysis

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LL: Writing - original draft, review & editing, supervision, project administration, funding acquisition.

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REFERENCES

Abney, K. (2018). "Containing" tuberculosis, perpetuating stigma: The materiality of N95 respirator masks. *Anthropology Southern Africa*, *41*(4), 270–283. https://doi.org/10.1080/23323256.2018.1507675

Bäärnhielm, S., Laban, K., Schouler-Ocak, M., Rousseau, C., & Kirmayer, L. J. (2017). Mental health for refugees, asylum seekers and displaced persons: A call for a humanitarian agenda. *Transcultural Psychiatry*, *54*(5–6), 565–574. https://doi.org/10.1177/1363461517747095

Bettmann, J. E., Penney, D., Clarkson Freeman, P., & Lecy, N. (2015). Somali refugees' perceptions of mental illness. *Social Work in Health Care*, *54*(8), 738–757. https://doi.org/10.1080/00981389.2015.1046578

Boeyink, C., Ali-Salad, M. A., Baruti, E. W., Bile, A. S., Falisse, J.-B., Kazamwali, L. M., Mohamoud, S. A., Muganza, H. N., Mukwege, D. M., & Mahmud, A. J. (2022). Pathways to care: IDPs seeking health support and justice for sexual and gender-based violence through social connections in Garowe and Kismayo, Somalia and South Kivu, DRC. *Journal of Migration and Health*, *6*, 100129. https://doi.org/10.1016/j.jmh.2022.100129

Boynton, L., Bentley, J., Jackson, J. C., & Gibbs, T. A. (2010). The role of stigma and state in the mental health of Somalis. *Journal of Psychiatric Practice*, *16*(4), 265–268. https://doi.org/10.1097/01.pra.0000386914.85182.78

Cabot, H., & Ramsay, G. (2021). Deexceptionalizing displacement: An introduction. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, *12*(3), 286–299. https://doi.org/10.1353/hum.2021.0018

Carroll, J. K. (2004). Murug, Waali, and Gini: Expressions of distress in refugees from Somalia. *The Primary Care Companion to The Journal of Clinical Psychiatry*, *06*(03), 119–125. https://doi.org/10.4088/PCC.v06n0303

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. *The Lancet*, *394*(10194), 240–248. https://doi.org/10.1016/S0140-6736(19)30934-1

Ellis, B. H., Lincoln, A. K., Charney, M. E., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Transcultural Psychiatry*, *47*(5), 789–811. https://doi.org/10.1177/1363461510379933

Fassin, D. (2007). Humanitarianism as a politics of life. *Public Culture*, *19*(3), 499–520. https://doi.org/10.1215/08992363-2007-007

Federici, S. (2020). *Revolution at point zero: Housework, reproduction, and feminist struggle* (Second edition, [revised and expanded edition]). PM Press.

Feldman, R. (2006). Primary health care for refugees and asylum seekers: A review of the literature and a framework for services. *Public Health*, *120*(9), 809–816. https://doi.org/10.1016/j.puhe.2006.05.014

Ferguson, J. (1994). *The anti-politics machine: "Development", depoliticization, and bureaucratic power in Lesotho*. University of Minnesota Press.

Gold, M. (2021). Health, migration, and NTDs: An anthropological view. *Medical Anthropology*, *40*(6), 491–496. https://doi.org/10.1080/01459740.2021.1953494

Green, C., Ventevogel, P., & Tol, W. (2016). *Mental health and psychosocial wellbeing in Congolese refugee survivors of gender- based violence: A desk review*. https://www.mhpss.net/toolkit/emergency/resource/mental-health-and-psychosocial-wellbeing-in-congolese-refugee-survivors-of-gender-based-violence-a-desk-review

Human Rights Watch. (2022). *World report 2022: Events of 2021*. https://www.hrw.org/sites/default/files/media_2022/01/World%20Report%202022%20web%20pdf_0.pdf

Ibrahim, M., Rizwan, H., Afzal, M., & Malik, M. R. (2022). Mental health crisis in Somalia: A review and a way forward. *International Journal of Mental Health Systems*, *16*(1), 12. https://doi.org/10.1186/s13033-022-00525-y

Internal Displacement Monitoring Centre. (2021). *Internal displacement in a changing climate*. https://www.internal-displacement.org/global-report/grid2021/#download

Im, H., Ferguson, A., & Hunter, M. (2017). Cultural translation of refugee trauma: Cultural idioms of distress among Somali refugees in displacement. *Transcultural Psychiatry*, *54*(5–6), 626–652. https://doi.org/10.1177/1363461517744989

Jefferson, L. (2004). *In war as in peace: Sexual violence and women's status*. Human Rights Watch Report. https://www.hrw.org/legacy/wr2k4/15.htm

Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, *391*(10140), 2589–2591. https://doi.org/10.1016/S0140-6736(18)31431-4

Kelly, J., Kabanga, J., Cragin, W., Alcayna-Stevens, L., Haider, S., & Vanrooyen, M. J. (2012). 'If your husband doesn't humiliate you, other people won't': Gendered attitudes towards sexual violence in eastern Democratic Republic of Congo. *Global Public Health*, *7*(3), 285–298. https://doi.org/10.1080/17441692.2011.585344

Kirmayer, L. J., & Young, A. (1998). Culture and Somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(4), 420–430. https://doi.org/10.1097/00006842-199807000-00006

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. Free Press ; Collier Macmillan.

Kohrt, B., & Mendenhall, E. (Eds.). (2015). *Global mental health: Anthropological perspectives*. Routledge.

Lamkaddem, M., Stronks, K., Devillé, W. D., Olff, M., Gerritsen, A. A., & Essink-Bot, M.-L. (2014). Course of post-traumatic stress disorder and health care utilisation among resettled refugees in the Netherlands. *BMC*

Psychiatry, *14*(1), 90. https://doi.org/10.1186/1471-244X-14-90

Larkin, B. (2019). Pride and prejudice: LGBTIQ community responses to disaster events worldwide. *Australian Journal of Emergency Management*, *34*(4), 60–66.

Liese, B. H., Gribble, R. S. F., & Wickremsinhe, M. N. (2019). International funding for mental health: A review of the last decade. *International Health*, *11*(5), 361–369. https://doi.org/10.1093/inthealth/ihz040

Manderson, L., Aagaard-Hansen, J., Allotey, P., Gyapong, M., & Sommerfeld, J. (2009). Social research on neglected diseases of poverty: Continuing and emerging themes. *PLoS Neglected Tropical Diseases*, *3*(2), e332. https://doi.org/10.1371/journal.pntd.0000332

Matthies-Boon, V. (2018). Towards a critical trauma studies: A response to Felix Lang. *Middle East - Topics & Arguments*, *11*, 159-62. https://doi.org/10.17192/META.2018.11.7812

McConnachie, K. (2016). Camps of containment: A genealogy of the refugee camp. *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, *7*(3), 397–412. https://doi.org/10.1353/hum.2016.0022

Mendenhall, Emily, and Brandon A. Kohrt, 2015. Anthropological methods in global mental health research, in: Kohrt, Brandon A., and Emily Mendenhall, eds. 2015. *Global Mental Health: Anthropological Perspectives. Anthropology and Global Public Health*. London: Routledge.

Miller, K. E., Jordans, Mark. J. D., Tol, Wietse. A., & Galappatti, A. (2021). A call for greater conceptual clarity in the field of mental health and psychosocial support in humanitarian settings. *Epidemiology and Psychiatric Sciences*, *30*, e5. https://doi.org/10.1017/S2045796020001110

Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry*, *76*(4), 409–422. https://doi.org/10.1037/0002-9432.76.4.409

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, *70*(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029

Molyneux, D. H., Hotez, P. J., & Fenwick, A. (2005). "Rapid-impact interventions": How a policy of integrated control for Africa's neglected tropical diseases could benefit the poor. *PLoS Medicine*, *2*(11), e336. https://doi.org/10.1371/journal.pmed.0020336

Morel, C. M. (2003). Neglected diseases: under-funded research and inadequate health interventions: Can we change this reality? *EMBO Reports*, *4*(S1). https://doi.org/10.1038/sj.embor.embor851

Nichter, M. (2010). Idioms of distress revisited. *Culture, Medicine, and Psychiatry*, *34*(2), 401–416. https://doi.org/10.1007/s11013-010-9179-6

Parker, M., & Allen, T. (2014). De-politicizing parasites: Reflections on attempts to control the control of neglected tropical diseases. *Medical Anthropology*, *33*(3), 223–239. https://doi.org/10.1080/01459740.2013.831414

Parker, M., Polman, K., & Allen, T. (2016). Neglected tropical disease in biosocial perspective. *Journal of Biosocial Science*, *48*(S1), S1–S15. https://doi.org/10.1017/S0021932016000274

Patel, V., Saxena, S., Frankish, H., & Boyce, N. (2016). Sustainable development and global mental health: A Lancet Commission. *The Lancet*, *387*(10024), 1143–1145. https://doi.org/10.1016/S0140-6736(16)00208-7

Pendse, S. R., Nkemelu, D., Bidwell, N. J., Jadhav, S., Pathare, S., De Choudhury, M., & Kumar, N. (2022). From treatment to healing: Envisioning a decolonial digital mental health. *CHI Conference on Human Factors in Computing Systems*, 1–23. https://doi.org/10.1145/3491102.3501982

Porter, H. (2017). *After rape: Violence, justice, and social harmony in Uganda*. Cambridge University Press. https://doi.org/10.1017/9781316841297

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA*, *294*(5), 602. https://doi.org/10.1001/jama.294.5.602

Singer, M., Bulled, N., Ostrach, B., & Mendenhall, E. (2017). Syndemics and the biosocial conception of health. *The Lancet*, *389*(10072), 941–950. https://doi.org/10.1016/S0140-6736(17)30003-X

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, *48*(10), 1449–1462. https://doi.org/10.1016/S0277-9536(98)00450-X

Ticktin, M. (2006). Where ethics and politics meet: The violence of humanitarianism in France. *American Ethnologist, 33*(1), 33–49. http://www.jstor.org/stable/3805315.

Ticktin, M. (2011). The gendered human of humanitarianism: Medicalising and politicising sexual Violence. *Gender & History*, *23*(2), 250–265. https://doi.org/10.1111/j.1468-0424.2011.01637.x

Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Panter-Brick, C., Silove, D., Sondorp, E., Wessells, M., & van Ommeren, M. (2011). Research priorities for mental health and psychosocial support in humanitarian settings. *PLoS Medicine*, *8*(9), e1001096. https://doi.org/10.1371/journal.pmed.1001096

Tol, W. A., Stavrou, V., Greene, M. C., Mergenthaler, C., van Ommeren, M., & García Moreno, C. (2013). Sexual and gender-based violence in areas of armed conflict: A systematic review of mental health and psychosocial support interventions. *Conflict and Health*, *7*(1), 16. https://doi.org/10.1186/1752-1505-7-16

Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., Pescosolido, B., & Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine*, *17*(1), 7. https://doi.org/10.1186/s12916-018-1246-9

Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: Umbrella review of

prevalence and intervention studies. *International Journal of Mental Health Systems*, *11*(1), 51. https://doi.org/10.1186/s13033-017-0156-0

United Nations. (2006). *Convention on the Rights of Persons with Disabilities and Optional Protocol*. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

United Nations High Commissioner for Refugees. (2020). *Global report 2020*. https://reporting.unhcr.org/sites/default/files/gr2020/pdf/GR2020_English_Full_lowres.pdf#_ga=2.54194799.673192728.1653679748-816983163.1653679748

United Nations Office for the Coordination of Humanitarian Affairs. (2021). *Humanitarian response plan Somalia*. https://reliefweb.int/node/3802198

United Nations Office for the Coordination of Humanitarian Affairs. (2022). *Humanitarian needs overview and response plan 2022: Democratic Republic of the Congo*. https://reliefweb.int/report/democratic-republic-congo/democratic-republic-congo-humanitarian-needs-overview-and-response

Vanderslott, S. (2021). *Attention and responsibility in global health: The currency of neglect* (1st ed.). Routledge. https://doi.org/10.4324/9780429355448

Ventevogel, P., Jordans, M., Reis, R., & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health*, *7*(1), 3. https://doi.org/10.1186/1752-1505-7-3

Walker, R. (2015). Negotiating risk: Exploring the experiences of mothers during the conflict in Eastern Sri Lanka. In A. Sgoutas & T. Takseva (Eds.), *Mothers under fire: mothering in conflict areas*. Demeter Press.

Walker, R., & Vearey, J. (2021, September 21). Behind the masks: Mental health, marginalisation and COVID-19. *The Polyphony*. https://thepolyphony.org/2021/09/21/behind-the-masks-mental-health-and-marginalisation-covid-19/

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine*, *52*(11), 1709–1718. https://doi.org/10.1016/S0277-9536(00)00284-7

World Health Organization. (2019). *Special initiative for mental health (2019-2023)*. https://www.who.int/publications/i/item/special-initiative-for-mental-health-(2019-2023)

World Health Organization. (2020). *Ending the neglect to attain the sustainable development goals: A road map for neglected tropical diseases 2021–2030*. World Health Organization. https://apps.who.int/iris/handle/10665/338565

World Health Organization. (2021). *Comprehensive mental health action plan 2013–2030*. World Health Organization. https://apps.who.int/iris/handle/10665/345301

CHAPTER 6

Feasibility and Predictors of Change of Narrative Exposure Therapy for Displaced Populations: A Repeated Measures Design

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ABSTRACT

BACKGROUND

Displaced victims of interpersonal violence, such as refugees, asylum seekers, and victims of sexual exploitation, are growing in numbers and are often suffering from a posttraumatic stress disorder (PTSD). At the same time, these victims are known to benefit less from trauma-focused therapy (TFT) and to be less compliant to treatment. The objective of this paper is to describe the rationale and research protocol of an ongoing trial that aims to evaluate different variables that might influence the feasibility of TFT for the study population. Specifically, perceived daily stress, emotion regulation, and mood are investigated as predictors of change in PTSD symptoms during a trauma-focused therapy (Narrative Exposure Therapy; NET). The feasibility of administering measures tapping these constructs repeatedly during treatment will also be evaluated.

METHODS/DESIGN

Using an observational treatment design, 80 displaced victims of interpersonal violence will be measured before, during, and after partaking in NET. Several questionnaires tapping PTSD plus the aforementioned possible predictors of PTSD change will be administered: Post-Traumatic Stress Disorder Checklist-5, Perceived Stress Scale, Difficulties in Emotion Regulation Scale-18 (pre-test, post-test, and follow-up),subscale impulsivity of the Difficulties in Emotion Regulation Scale-18, Perceived Stress Scale short version, Primary Care Posttraumatic Stress Disorder and a single Mood item (each session). Multilevel modelling will be used to examine the relation between the possible predictors and treatment outcome.

DISCUSSION

The present study is the first to examine the interplay of facilitating and interfering factors possibly impacting treatment feasibility and effectiveness in displaced victims of interpersonal violence with PTSD receiving NET, using repeated measures. The current study can help to improve future treatment based on individual characteristics.

TRIAL REGISTRATION

Netherlands Trial Register: NTR735, July 11, 2018.

Keywords

Refugees, human trafficking, sexual exploitation, posttraumatic stress disorder, narrative exposure therapy, treatment response, feasibility

Worldwide, there is an increase in the number of victims of interpersonal violence who are forced to leave their home country (United Nations High Commissioner for Refugees, 2017). When entering a host country, these displaced persons are usually referred to as either "refugees", "asylum seekers", "trafficked human beings", "illegal immigrants", or "undocumented people", depending on their trauma background and legal status. Mostly these groups overlap in their experience of forced migration, their marginalised social position, and the challenges they encounter. In this paper, we will therefore collectively refer to all such groups as "displaced people".

As a result of assorted traumatic events, like war- and conflict-related violence, sexual violence and exploitation, many of these displaced people suffer from a posttraumatic stress disorder (PTSD) (Fazel et al., 2005; Lindert et al., 2009; Steel et al., 2009; Zimmerman et al., 2006). PTSD symptoms cause a great burden, render people unable to engage in daily activities and put them at risk for revictimisation (Risser et al., 2006). Displaced people suffering from PTSD could therefore benefit from trauma-focused therapy (TFT). TFT is a psychological intervention aiming to decrease PTSD symptoms by fostering the processing of traumatic memories.

Scientific research into TFT for displaced people is scarce. There is evidence that non-refugee traumatized populations benefit more from TFT than traumatized groups with a refugee background (Cusack et al., 2016; Turrini et al., 2019). Moreover, the feasibility of evidence-based therapies within the refugee population is complicated by post-migration obstacles (Slobodin & De Jong, 2015), which can result in low treatment compliance and completion levels. Most likely, the primary focus on PTSD fails to address the broader challenges faced by displaced people (Miller & Rasmussen, 2010). Therefore, more insight is needed into factors affecting treatment response during TFT and conditions for recovery. Identifying factors that undermine the feasibility of TFT for displaced people may help to refine the timing and focus of interventions, and thus improve treatment response.

One key factor that potentially undermines the feasibility of treatment is daily stressors, given their proven association with PTSD symptoms (Chu et al., 2013; Leon et al., 2007, McAlonan et al., 2007). Ongoing daily stressors arising from the immigration process, loss of social network, and impaired functioning resulting from PTSD symptoms negatively impact mental health among the study population (Chu et al., 2013; Laban et al., 2005 Li et al., 2016; Priebe et al., 2016). The burden caused by ongoing daily stressors may impact one's cognitive functioning in several ways (McEwen & Sapolsky, 1995). For example, by occupying the working memory (Luettgau et al., 2018), and thereby reducing the cognitive resources needed to process traumatic events.

While there is evidence for the negative impact of daily stressors and perceived daily stress on treatment for displaced populations, the few present studies have yielded ambiguous results. One study affirmed the negative impact of lack of social support, a daily stressor, when present at the start of treatment on treatment outcome (Buhman et al., 2014). However, a study where clinician-rated daily stressors during treatment could not establish such an impact on treatment (Bruhn et al., 2018). These limited and contradictive findings illustrate the need for more rigorous research on the relation between daily stressors and treatment response within the study population. No study to date has explored the impact of experienced daily stressors while taking part in TFT in

the study population.

Another main factor likely to affect the feasibility of TFT for displaced people is emotion dysregulation, such as insight into, control over, and awareness of one's emotions (e.g., Gratz et al., 2015; Goldin et al., 2014). Several studies have indicated that emotion dysregulation mediates between traumatic events and the development of PTSD in different groups (e.g., Messman-Moore & Bhuptani, 2017), including traumatised refugees (Nickerson et al., 2015). Emotion dysregulation has been identified as a consequence of trauma, and emotional impulsivity in particular as a predictor of future (re)victimisation (Cloitre et al., 1997; Messman-Moore et al., 2010). For TFT to be feasibly applied a person must be able to stay within a dynamic "window of tolerance", a range of affect that can be regulated at that point in time (Siegel, 1999). Consequently, it is expected that the level of emotion regulation at baseline as well as improved control over one's emotions during treatment are both prerequisites for reducing PTSD symptoms (Hien et al., 2017). No study to date has looked into the interplay between emotion regulation and PTSD symptoms while taking part in TFT in the study population.

A final main factor that may affect treatment feasibility is depressed mood, which can be measured as a proxy for depression (Aguilera et al., 2015). Among resettled refugees, the comorbidity rate for PTSD with depression is 44%; for depression with PTSD it is 71% (Fazel et al., 2005). Previous research on TFT shows that higher baseline levels of depression predict poorer treatment response in displaced individuals (Haagen et al., 2017), and therewith undermine the feasibility of treatment. Meanwhile, TFT has proven effectiveness in reducing symptoms of depression in the study population (Nosè et al., 2017). Yet, insight in the interaction between depressed mood and PTSD during treatment is currently lacking.

In an umbrella review of prevalence and intervention studies on common mental disorders in asylum seekers and refugees, Turrini et al. (2017) found that Narrative Exposure Therapy (NET) was the best-supported TFT for reducing PTSD symptoms. In a meta-analysis of NET (Lely et al., 2019), it was found that NET is effective in reducing PTSD and depression symptoms across diverse, predominantly war-affected refugee populations (Schauer et al., 2011). Since it is a first-choice treatment for the study population, NET was chosen as the TFT applied in the present study (Lely et al., 2019).

As outlined above, several factor (e.g., PTSD, perceived daily stress, emotion dysregulation and mood) tend to impact treatment feasibility. However, their interplay during TFT has not yet been examined. Insight in the feasibility of measuring this interplay in a diverse group of displaced individuals following NET, is yet to be established. To best of our knowledge there are no prior treatment studies for which weekly repeated measures have been carried out within the target population. Additionally, the practical execution of examining the interrelatedness between different parameters (e.g., PTSD, perceived daily stress, emotion dysregulation and mood) is based on questionnaires, that are partly adapted for the current study (see methodology section). Consequently, their feasibility within the target population has not been objectified yet.

In the present paper the feasibility, rationale and protocol of an ongoing trial are described. Specifically we aim to identify relevant predictors of PTSD symptom change during and after NET

in 80 displaced victims of interpersonal violence. The primary hypotheses of the study are 1) It is feasible to administer highly repeated measures, within a diverse group of displaced persons. 2) High perceived daily stress, emotion dysregulation, and low mood at baseline and during NET predict higher drop-out, higher no-show, and poorer treatment response of NET (i.e., less PTSD symptom reduction), thus undermining the feasibility of NET; 3) Reduction in perceived daily stress and improvement in emotion regulation, and mood during NET are associated with concurrent reductions in PTSD symptoms during NET; 4) Change in perceived daily stress, emotion dysregulation, and mood during NET predict subsequent changes in PTSD symptoms at later stages of NET. Furthermore, the study aims to establish whether NET contributes to positive aspects of mental health.

METHODS

This study follows a repeated measures observational design with baseline assessments, repeated measures over the course of treatment, and posttreatment assessments. Twelve to sixteen sessions of NET will be provided to all patients included in the study. Various questionnaires will be administered at baseline (T0, pretreatment), one week after NET completion (T1, posttreatment), and 6 weeks after NET completion (T2, follow-up). In addition, assessments to measure potential processes of change will be performed at the start of each NET session. See figure 1 for a detailed overview of the planned design and administered measures.

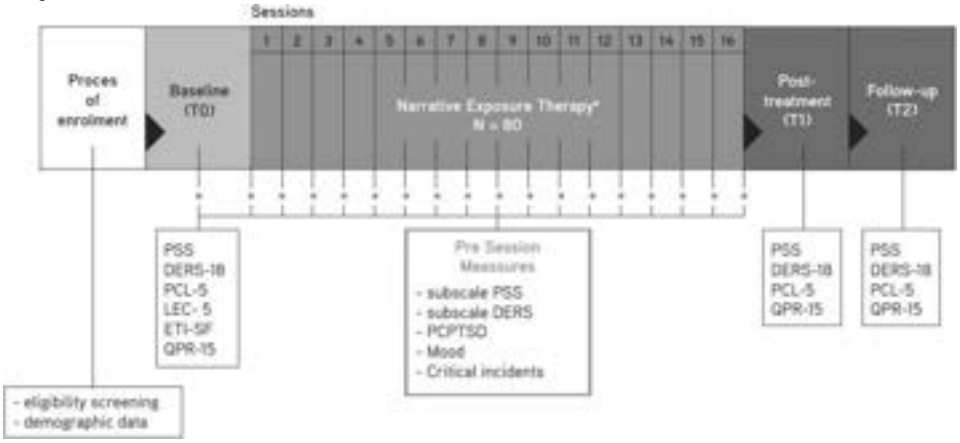
NET will be provided by trained psychologists, psychotherapists, medical doctors, and psychiatrists. Psychologists and master's level psychology students will perform assessments for the study. All involved professionals have extensive experience in working with migrants (in a culturally sensitive manner) and interpreters.

PARTICIPANTS

The study will take place at an outpatient clinic specialised in mental health care for refugees, asylum seekers, victims of sexual exploitation, and otherwise traumatised populations in the Capital region in the Netherlands. The study aims to include 80 participants, in order to detect medium to small effect sizes (Cohen, 1988). Patients are referred to the clinic by a general practitioner or by a partnering social welfare organisation. Patients' background/nationality is diverse; most originate from West Africa, the Middle East, and Eastern Europe. Their legal status varies from having obtained a residence permit or even Dutch citizenship to illegal residence in the country, and they may reside in asylum seekers centres, specialised shelters for victims of sexual exploitation, governmental shelters for illegal persons, or live independently.

Figure 1

Design and Overview of Planned Assessments



Note. Biographical data = gender, age, residence status, etc.; ETI = Early Trauma Inventory- Short Form; DERS-18 = Difficulties in Emotion Regulation Scale-Short Version; LEC-5 = Life Events Checklist for DSM-5; PCL-5 = Post Traumatic Stress Disorder Checklist for DSM-5; PCPTSD = Primary Care Post Traumatic Stress Disorder; PSS = Perceived Stress Scale; QPR-15 = Questionnaire on Process of Recovery-Short Version.

Inclusion Criteria

Patients will be included in the study if they are displaced victims of interpersonal violence, aged 18 years or older; if they have PTSD as a primary diagnosis established by a psychiatrist or clinical psychologist during intake; if individual NET in an outpatient setting has been indicated for them; and if they are cognitively able to give informed consent to participate in the study.

Exclusion Criteria

Patients will be excluded from the study if they display signs of an acute crisis, such as acute suicidality or acute severe psychosis; or suffer from persistent substance abuse. These exclusion criteria are applied because of their expected disturbing influence on the adherence and/or completion of NET.

RECRUITMENT

This is an ongoing treatment trial. The enrolment period is planned to run for 2,5 years from February 2018 to January 2021. Following multi-disciplinary clinical assessment and evaluation, the diagnosis and treatment indication will be discussed with patients. Those who are eligible for enrolment will be informed about the study, and will be invited to participate. This eligibility will be considered as broadly as possible within the inclusion criteria to allow for a representative sample of displaced victims of interpersonal violence. Information about the study aims and objectives, guarantee of anonymisation of data and the fact that participants are free to terminate participation at any moment, will be given orally and provided on paper through an information leaflet. After intake patients are placed on a waiting list for NET, ranging from one to four months.

When patients from the waiting list are invited to start NET, they will once again be informed about the study orally and on paper. Patients will be asked to consider participation over a minimum period of three days. Afterwards they will be contacted by phone or face-to face, and given ample opportunity to ask additional questions. If they indicate willingness to participate in the study, an appointment is made to sign informed consent, and conduct the baseline assessment (T0). Participants are invited to bring someone they trust to this meeting. Participants will be receiving a voucher of 10 euros after the follow-up measurement. If after the first year the aspired total number of participants seems unachievable, prolongation of the enrolment period, and multicentre options will be explored after consultation with the involved medical ethical committee.

INTERVENTION

Narrative Exposure Therapy

NET is an evidence-based short-term psychotherapy targeting PTSD symptoms, specifically appropriate for multiple trauma in divergent cultural settings. For the study population in question the method is found to be feasible (Halvorsen & Stenmark, 2010), and is considered the first choice TFT (Lely et al., 2019). The NET protocol includes 12-16 sessions of individual trauma focused exposure, performed weekly or twice a week by trained mental health professionals. Each session lasts 90-120 minutes, depending on the content of the trauma which is targeted during the session, and the possible involvement of an interpreter. NET aims to create a chronological narrative of a patient's life story, including both traumatic and empowering memories. During each session one or more significant memories (traumatic or empowering) are discussed in great detail. Imaginary exposure, meaning-making, and reprocessing are used to reduce PTSD symptoms. An account of each session is written down by the therapist, which will result in a patient's biography when the therapy has been completed.

Co-Interventions before and during Treatment

When participants cannot immediately start NET, there are no restrictions in psychological or pharmacological interventions received during their waiting period, applied in accordance with national guidelines. Such interventions can be indicated either for symptom management or as a preparation of individual TFT. In addition, individual sessions can be provided in case of (imminent) crisis. From the start of NET onwards, however, no other modules will be provided, unless in case of acute crisis in which the safety of a participant is endangered or he/she is about to harm others. Previously started pharmacological interventions can be continued during NET, however no new pharmacological interventions will be started during NET.

Discontinuation of the Intervention and Drop-Out

Discontinuation of NET will take place if patients so wish or if multi-disciplinary clinical evaluation indicates that continuation is not in the best interest of the patient. If patients wish to stop participating in the study but wish to continue NET, this will be allowed. Patients will be considered dropouts when there are deviations from the NET treatment protocol for more than four consecutive

sessions (i.e., no trauma-focused approach during the sessions or no-show), since in these cases the effectiveness of the treatment offered cannot be assured (Schauer et al., 2011).

MEASUREMENTS

Perceived Stress Scale (PSS) – Full Scale Administered Pre-and Posttreatment

The PSS (Cohen et al., 1983) has been developed to measure the perception of daily stress by assessing how unpredictable, uncontrollable, and overloading patients experience daily life. With 10 items, thoughts and feelings, and the evaluation of daily life in the last month are explored through a 5-point scale ranging from 0 to 4 . Mean scores will be calculated, ranging from 0 to 4. Example item: "In the last month, how often have you been upset because of something that happened unexpectedly?" Administration of the questionnaire takes approximately 10 minutes. Acceptable psychometric properties of the instrument have been established (Cohen et al., 1994).

Subscale Administered Before Each Session

The four items version of the PSS (Lee, 2012) will be administered at the start of each session. These items have proven sensitivity to short term changes in stress (Baer et al., 2012). For the purpose of this study the indicated timespan was changed from "In the last month" to "In the last week" to match the other presessions measures for possible predictors. An example item is: "In the last week, how often have you felt that things were going your way?" These items will be scored on a VAS-scale of exact 10 centimetres by placing a cross on a line from 0 (not at all) to 100 (completely). Mean scores will be calculated, ranging from 0 to 100.

Difficulties in Emotion Regulation Scale Short Version– 18 (DERS) - Full Scale Administered Pre- and Posttreatment

The DERS was developed to measure emotion regulation. The DERS-18 comprises 18 items, and uses a 5-point Likert scale ranging from 1 to 5; it has 6 subscales: nonacceptance of emotional responses; difficulty engaging in goal-directed behaviour; impulse control difficulties; lack of emotional awareness; limited access to emotion regulation strategies; and a lack of emotional clarity. Mean scores will be calculated, ranging from 1 to 5. Example item: "I pay attention to how I feel". Administration of the questionnaire takes approximately 10 minutes. The DERS has high internal consistency, good test-retest reliability, moderate construct, and predictive validity (Victor & Klonsky, 2016).

Subscale "Impulsivity" Administered Before Each Session

As a proxy of emotion regulation the subscale "Impulsivity" will be used, comprising three items from the "Difficulties in Emotion Regulation Scale" (DERS-18; 40). For the purpose of this study the phrase "In the last week I have felt:" was added to match the other presessions measures for possible predictors. Example item: "When I am upset, I become out of control". Items will be scored on a VAS-scale ranging from 0 (not at all) to 100 (completely). Mean scores will be calculated, ranging from 0 to 100.

PTSD Checklist for DSM-5 (PCL-5) - Administered Pre-and Posttreatment

The 20 item PCL-5 is a self-report checklist which measures the presence and severity of the 20 DSM-5 symptoms of PTSD on a 5-point scale (0-4) (e.g., "Trouble remembering important parts of the stressful experience"). Mean scores will be calculated, ranging from 0 to 4. It will be used to indicate PTSD symptom severity pre- and posttreatment. Administration of the questionnaire takes approximately 10 minutes. The instrument has good psychometric quality (Blevins et al., 2015).

Primary Care Posttraumatic Stress Disorder (PCPTSD)- Administered before Each Session

Because a short version of the PCL-5 is unavailable, the five-item Primary Care Posttraumatic Stress Disorder (PCPTSD) checklist was selected to increase the feasibility of the frequently repeated measurements. This questionnaire is used to measure PTSD symptoms (Prins et al., 2016). For the purpose of this study the indicated timespan was changed from "In the past month, have you" to "In the last week" to match the other presessions measures for possible predictors. An example item is: "In the last week did you have nightmares about the event(s) or thoughts about the event(s) when you did not want to?" These items will be scored on a VAS-scale ranging from 0 (not at all) to 100 (extremely). The questionnaire has good psychometric qualities (Prins et al., 2016). Mean scores will be calculated, ranging from 0 to 100.

Mood- Measured before Each Session

Mood will be measured using a validated single item measure (Van Rijsbergen et al., 2012). For the purpose of this study we have altered the item "At the moment I feel" to "In the last week I felt" to make the timespan congruent to the other presession measures for possible predictors. This mood item will be scored on a VAS-scale ranging from 0 (sad) to 100 (happy). Mean scores will be calculated, ranging from 0 to 100.

Critical Incidents

Before each therapy session the client will be asked to report if any relevant personal circumstances have arisen since the last appointment.

Other

Biographical data of patients will be collected (i.e., gender, age, educational level, current residence, legal status, country of birth) to describe the study population.

Questionnaire on Process of Recovery Short Version – 15 (QPR)

The QPR is a 5-point scale (0-4), self-report questionnaire that probes people's recovery and meaningful aspects in the recovery process (e.g., "I feel able to take chances in life."). The QPR-15 consists of 15 items. Mean scores will be calculated, ranging from 0 to 4. The questionnaire has good psychometric properties, and has proven to be associated with quality of life, empowerment, and psychological wellbeing (Law et al., 2014). Administration of the questionnaire lasts approximately 20 minutes. The questionnaire has been selected because it represents psychological wellbeing

beyond the scope of mental health symptoms. The QPR is reliable and valid, and has proven to be associated with quality of life, empowerment and psychological wellbeing (Law et al., 2014).

Early Trauma Inventory – Short Version (ETI-SF)

The ETI-SF was developed to determine potentially traumatic events before and after the age of 18 years old (Bernstein et al., 2003). The ETI-SF comprises 27 items, that assess physical, emotional, and sexual abuse. Items vary between open questions and multiple choice being answered with yes or no. The scale has a range from 0 to 29, with higher scores referring to a higher number of traumatic experiences. Administration of the questionnaire lasts approximately 10 minutes. Its reliability and validity are good (Bremner et al., 2007). The questionnaire has been selected to describe trauma-related features of the study population.

Life Events Checklist (LEC – 5)

The LEC-5 comprises 17 multiple choice items on a 6-point nominal scale (i.e., "happened to me"; "witnessed it"; "learned about it"; "part of my job"; "not sure"; "doesn't apply"). The checklist aims to determine whether someone has ever been exposed to 16 events known to potentially result in PTSD or distress, and one additional event not captured in the first 16 items. In the last part of the LEC-5 respondents are asked which event he/she considers to have had the most impact, followed by 7 questions, both open- and multiple-choice questions, aimed at identifying the characteristics of this event. The scale has a range from 0 to 68, with higher scores referring to a higher number of traumatic experiences. Administration of the questionnaire lasts approximately 20 minutes. The reliability of the LEC-5 is considered to be good (Gray et al., 2004). The questionnaire was selected to describe trauma-related features of the study population.

DATA COLLECTION, MANAGEMENT, AND ANALYSIS

Procedure Presession Measures

During baseline (T0) and at the start of each TFT session the patient's fixed practitioner or a supervised master's level psychology student will administer the thirteen items selected to assess the four abovementioned possible predictors. To avoid an order effect, the sequence of the measures for possible predictors and the order of questions within every measure will change with every session. These measures will only be administered during the treatment period. They will be administered by pen and paper, and are expected to take on average 10 minutes. Questionnaires are translated from their original English version according a forward-backward procedure by two independent native speakers into Dutch, and by professional translators into Arabic, French, Amharic, and Tigrinya. Interpreters will assist for other languages.

Procedure Pre- and Posttreatment

During baseline (T0), posttreatment (T1), and follow-up (T2) measurements, the abovementioned set of questionnaires will be administered. See figure 1 for a detailed overview of the planned time points for assessments. These questionnaires will be administered digitally, and are

expected to take a maximum of 80 minutes. Questionnaires are available in Dutch and English. Given the lack of computer skills and the often limited Dutch and/or English proficiency within the study population, a clinician and interpreter will be available for assistance. Measurements will take place at the treatment location; if preferred, this meeting will be combined with other appointments. After the last assessment participants will receive a voucher of 10 euros.

STATISTICAL ANALYSIS

First, multiple regression analyses and logistic regression analyses will be performed to examine whether high perceived daily stress, emotion dysregulation, and low mood at baseline predict drop-out, no-show, and treatment outcomes. Secondly, the concurrent association between each possible predictor measured prior to each session (i.e., perceived daily stress, emotion regulation, and mood) and PTSD symptoms will be examined using bivariate (multilevel) growth modelling, as multiple observations of the predictor variables and PTSD symptoms (level 1) are nested within individuals (level 2; Snijders & Bosker, 1994). In order to infer that change in the predictor variables leads to change in PTSD symptoms, we will examine the time-line (i.e., temporal precedence) in two ways (Kazdin & Nock, 2003; Kraemer et al., 2000). The dynamic (i.e., temporal) associations will be examined by estimating whether change in PTSD symptoms from the previous week to the current week (t) can be predicted by change of a possible predictor at the previous week (t-1) using multilevel modelling. To examine the time-line of larger shifts instead of week-to-week changes, it will be examined whether the earliest significant decrease in mean levels of each possible predictor (improvement) occurs before the largest reduction in mean levels of PTSD symptoms.

DISCUSSION

Among the growing number of forcibly displaced people worldwide, many are suffering from trauma-related mental health problems. As psychological treatments for displaced persons with PTSD appear to be less successful than for other populations, insight is needed in factors that affect the feasibility of these treatments. However, relevant research is lacking. The ongoing trial presented in this paper is the first to examine the interplay of factors for feasibility and effectiveness of in displaced victims of interpersonal violence receiving NET. More specifically, the impact of perceived daily stress, emotion dysregulation, and disturbed mood on PTSD symptom changes during TFT are examined.

The theoretical basis of NET has been well documented, and its effectiveness has been examined in various studies and contexts (Halvorsen & Stenmark, 2010; Lely et al., 2019; Schauer et al., 2011). Yet, specific factors contributing to positive outcomes or constraining its feasibility are largely unidentified. In the current study, repeated measures will identify various constructs relevant for treatment feasibility and response of NET. Since, to our knowledge, this is the first study to use repeated measures within the target population, findings will additionally provide insight into the feasibility of this method for displaced populations.

As the method requires only minor adaptations to usual treatment proceedings and follows an observational design, participants can be included that might be refused participation in more complex designs (Ross et al., 1999). This allows for conclusions based on a sample representing the intended population with high external validity, which is exceptional for this specific group (Enticott et al., 2017). Although our design favours generalisability of the results, it may reduce the internal validity of the study; for instance, the present design does not allow for the examination of the extent to which observed changes in PTSD can be attributed to NET, but to factors such as natural recovery, bias, or confounders. However, as we aim to study factors promoting or constraining treatment feasibility, a naturalistic design is the most ethical, feasible, and time-efficient design to obtain answers to our research questions. Besides, the reduced internal validity is partially addressed by limiting the possibly confounding role of concurrent treatment.

Evidently, there are factors possibly impacting treatment response. For the purpose of this study repeated measures were selected on the basis of relevant studies (Van Rijsbergen et al., 2012; Victor & Klonsky, 2016), and clinical insights. Thus, the set of questions have been tailored to the specific characteristics of the study population. Conclusions drawn from the study therefore may hold relevant implications in clinical practice for displaced victims of interpersonal violence. Although the chosen subscales support the clinical validity of the study, the PTSD and emotion dysregulation subscales have not been validated as weekly repeated measures.

It is important to note that inclusion for the current study has already started, however, it is planned to run until early 2021. Critically, no data analysis has currently been performed yet. We expect that the findings of this study will contribute to both the scientific and the clinical field. Identifying factors that limit treatment response may in turn inform the development of improved treatment modules that specifically address these blockages. The promotion of self-efficacy or problem-solving skills prior to NET, for example, may decrease perceived daily stress, and its constraining effect on the feasibility of NET. Likewise, promoting emotion regulation prior to NET may intensify its potential supportive role for TFT. Additionally, if these factors have no predictive value for the course of PTSD during treatment, clinicians might be encouraged to offer TFT to patients despite the presence of daily stressors, emotion regulation difficulties, and mood problems. By identifying predictors of treatment response, the current study can enable treatment indications to be tailored to individual characteristics.

Furthermore, exploring these predictors sheds a broader light on the consequences of trauma, beyond a narrow focus on PTSD, and may provide clues for a wider range of relevant treatment foci. In this way, this study responds to the ongoing debate on the emphasis focus of PTSD in designing treatments for displaced populations (Miller & Rasmussen, 2010.

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roles in various stages of drafting the study protocol.

AUTHOR CONTRIBUTIONS

RG: Conceptualisation, methodology, writing -original draft, project administration and funding acquisition.
HvH: Conceptualisation, methodology, writing -original draft, project administration.
WS: Conceptualisation, methodology, supervision, writing - review & editing, funding acquisition.
JvdK: Conceptualisation, writing - review & editing.
JJtH: Conceptualisation, methodology, writing - review & editing.
SdlR: Conceptualisation.
LV: Conceptualisation, writing - review & editing.
ES: Methodology, writing - review & editing.
PB: Conceptualisation, methodology, supervision, writing - review & editing.

REFERENCES

Aguilera, A., Schueller, S. M., & Leykin, Y. (2015). Daily mood ratings via text message as a proxy for clinic based depression assessment. *Journal of Affective Disorders*, *175*, 471–474. https://doi.org/10.1016/j.jad.2015.01.033

Baer, R. A., Carmody, J., & Hunsinger, M. (2012). Weekly change in mindfulness and perceived stress in a mindfulness-based stress reduction program. *Journal of Clinical Psychology*, *68*(7), 755–765. https://doi.org/10.1002/jclp.21865

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., Desmond, D., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse & Neglect*, *27*(2), 169–190. https://doi.org/10.1016/S0145-2134(02)00541-0

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498. https://doi.org/10.1002/jts.22059

Bremner, J. D., Bolus, R., & Mayer, E. A. (2007). Psychometric properties of the early trauma inventory–self report. *Journal of Nervous & Mental Disease*, *195*(3), 211–218. https://doi.org/10.1097/01.nmd.0000243824.84651.6c

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *Journal of Nervous & Mental Disease*, *206*(1), 61–68. https://doi.org/10.1097/NMD.0000000000000774

Buhman, C., Mortensen, E. L., Lundstrøm, S., Ryberg, J., Nordentoft, M., & Ekstrøm, M. (2014). Symptoms, quality of life and level of functioning of traumatized refugees at psychiatric trauma clinic in Copenhagen. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *24*(1), 25–39.

Chu, T., Keller, A. S., & Rasmussen, A. (2013). Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence. *Journal of Immigrant and Minority Health*, *15*(5), 890–897. https://doi.org/10.1007/s10903-012-9696-1

Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self- and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress*, *10*(3), 437–452. https://doi.org/10.1002/jts.2490100309

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed). L. Erlbaum Associates.

Cohen, S., Kamarck, & Mermelstein. (1994). *Perceived stress scale. Measuring stress: A guide for health and social scientists* (pp. 235–283). Mind Garden.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*(4), 385. https://doi.org/10.2307/2136404

Cusack, K., Jonas, D. E., Forneris, C. A., Wines, C., Sonis, J., Middleton, J. C., Feltner, C., Brownley, K. A., Olmsted, K. R., Greenblatt, A., Weil, A., & Gaynes, B. N. (2016). Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review*, *43*, 128–141. https://doi.org/10.1016/j.cpr.2015.10.003

Enticott, J. C., Shawyer, F., Vasi, S., Buck, K., Cheng, I.-H., Russell, G., Kakuma, R., Minas, H., & Meadows, G. (2017). A systematic review of studies with a representative sample of refugees and asylum seekers living in the community for participation in mental health research. *BMC Medical Research Methodology*, *17*(1), 37. https://doi.org/10.1186/s12874-017-0312-x

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, *365*(9467), 1309–1314. https://doi.org/10.1016/S0140-6736(05)61027-6

Goldin, P. R., Lee, I., Ziv, M., Jazaieri, H., Heimberg, R. G., & Gross, J. J. (2014). Trajectories of change in emotion regulation and social anxiety during cognitive-behavioral therapy for social anxiety disorder. *Behaviour Research and Therapy*, *56*, 7–15. https://doi.org/10.1016/j.brat.2014.02.005

Gratz, K. L., Bardeen, J. R., Levy, R., Dixon-Gordon, K. L., & Tull, M. T. (2015). Mechanisms of change in an emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder. *Behaviour Research and Therapy*, *65*, 29–35. https://doi.org/10.1016/j.brat.2014.12.005

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the Life Events Checklist. *Assessment*, *11*(4), 330–341. https://doi.org/10.1177/1073191104269954

Haagen, J. F. G., Ter Heide, F. J. J., Mooren, T. M., Knipscheer, J. W., & Kleber, R. J. (2017). Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis. *British Journal of Clinical Psychology*, *56*(1), 69–83. https://doi.org/10.1111/bjc.12121

Halvorsen, J. Ø., & Stenmark, H. (2010). Narrative exposure therapy for posttraumatic stress disorder in tortured refugees: A preliminary uncontrolled trial. *Scandinavian Journal of Psychology*, *51*(6), 495–502. https://doi.org/10.1111/j.1467-9450.2010.00821.x

Hien, D. A., Lopez-Castro, T., Papini, S., Gorman, B., & Ruglass, L. M. (2017). Emotion dysregulation moderates the effect of cognitive behavior therapy with prolonged exposure for co-occurring PTSD and substance use disorders. *Journal of Anxiety Disorders*, *52*, 53–61. https://doi.org/10.1016/j.janxdis.2017.10.003

Kazdin, A. E., & Nock, M. K. (2003). Delineating mechanisms of change in child and adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry*, *44*(8), 1116–1129. https://doi.org/10.1111/1469-7610.00195

Kraemer, H. C., Yesavage, J. A., Taylor, J. L., & Kupfer, D. (2000). How can we learn about developmental

processes from cross-sectional studies, or can we? *American Journal of Psychiatry*, *157*(2), 163–171. https://doi.org/10.1176/appi.ajp.157.2.163

Laban, C. J., Gernaat, H. B. P. E., Komproe, I. H., Van Der Tweel, I., & De Jong, J. T. V. M. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands: *The Journal of Nervous and Mental Disease*, *193*(12), 825–832. https://doi.org/10.1097/01.nmd.0000188977.44657.1d

Law, H., Neil, S. T., Dunn, G., & Morrison, A. P. (2014). Psychometric properties of the Questionnaire about the Process of Recovery (QPR). *Schizophrenia Research*, *156*(2–3), 184–189. https://doi.org/10.1016/j.schres.2014.04.011

Lee, E.-H. (2012). Review of the psychometric evidence of the perceived stress scale. *Asian Nursing Research*, *6*(4), 121–127. https://doi.org/10.1016/j.anr.2012.08.004

Lely, J. C. G., Smid, G. E., Jongedijk, R. A., W. Knipscheer, J., & Kleber, R. J. (2019). The effectiveness of Narrative Exposure Therapy: A review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology*, *10*(1), 1550344. https://doi.org/10.1080/20008198.2018.1550344

Leon, K. A., Hyre, A. D., Ompad, D., Desalvo, K. B., & Muntner, P. (2007). Perceived stress among a workforce 6 months following hurricane Katrina. *Social Psychiatry and Psychiatric Epidemiology*, *42*(12), 1005–1011. https://doi.org/10.1007/s00127-007-0260-6

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

Lindert, J., Ehrenstein, O. S. V., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees – A systematic review and meta-analysis. *Social Science & Medicine*, *69*(2), 246–257. https://doi.org/10.1016/j.socscimed.2009.04.032

Luettgau, L., Schlagenhauf, F., & Sjoerds, Z. (2018). Acute and past subjective stress influence working memory and related neural substrates. *Psychoneuroendocrinology*, *96*, 25–34. https://doi.org/10.1016/j.psyneuen.2018.05.036

McAlonan, G. M., Lee, A. M., Cheung, V., Cheung, C., Tsang, K. W., Sham, P. C., Chua, S. E., & Wong, J. G. (2007). Immediate and sustained psychological impact of an emerging infectious disease outbreak on health care workers. *The Canadian Journal of Psychiatry*, *52*(4), 241–247. https://doi.org/10.1177/070674370705200406

McEwen, B. S., & Sapolsky, R. M. (1995). Stress and cognitive function. *Current Opinion in Neurobiology*, *5*(2), 205–216. https://doi.org/10.1016/0959-4388(95)80028-X

Messman-Moore, T. L., & Bhuptani, P. H. (2017). A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: An emotion dysregulation perspective. *Clinical Psychology: Science and Practice*, *24*(2), 154–169. https://doi.org/10.1111/cpsp.12193

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect*, *34*(12), 967–976. https://doi.org/10.1016/j.chiabu.2010.06.004

Miller, K. E., & Rasmussen, A. (2010). Mental health and armed conflict: The importance of distinguishing between war exposure and other sources of adversity: A response to Neuner. *Social Science & Medicine*, *71*(8), 1385–1389. https://doi.org/10.1016/j.socscimed.2010.07.020

Nickerson, A., Bryant, R. A., Schnyder, U., Schick, M., Mueller, J., & Morina, N. (2015). Emotion dysregulation mediates the relationship between trauma exposure, post-migration living difficulties and psychological outcomes in traumatized refugees. *Journal of Affective Disorders*, *173*, 185–192. https://doi.org/10.1016/j.jad.2014.10.043

Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., Priebe, S., & Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLOS ONE*, *12*(2), e0171030. https://doi.org/10.1371/journal.pone.0171030

Priebe, S., Giacco, D., & El-Nagib, R. (2016). *Public health aspects of mental health among migrants and refugees: A review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European region*. WHO Regional Office for Europe.

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The primary care PTSD screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, *31*(10), 1206–1211. https://doi.org/10.1007/s11606-016-3703-5

Risser, H. J., Hetzel-Riggin, M. D., Thomsen, C. J., & McCanne, T. R. (2006). PTSD as a mediator of sexual revictimization: The role of reexperiencing, avoidance, and arousal symptoms. *Journal of Traumatic Stress*, *19*(5), 687–698. https://doi.org/10.1002/jts.20156

Ross, S., Grant, A., Counsell, C., Gillespie, W., Russell, I., & Prescott, R. (1999). Barriers to participation in randomised controlled trials. *Journal of Clinical Epidemiology*, *52*(12), 1143–1156. https://doi.org/10.1016/S0895-4356(99)00141-9

Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd rev. and expanded ed). Hogrefe.

Siegel, D. J. (1999). *The developing mind*. Guilford Press.

Slobodin, O., & De Jong, J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*, *61*(1), 17–26. https://doi.org/10.1177/0020764014535752

Snijders, T. A. B., & Bosker, R. J. (1994). Modeled variance in two-level models. *Sociological Methods & Research*, *22*(3), 342–363. https://doi.org/10.1177/0049124194022003004

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to

mass conflict and displacement: A systematic review and meta-analysis. *JAMA*, *302*(5), 537. https://doi.org/10.1001/jama.2009.1132

Turrini, G., Barbui, C., & Nosè, M. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers. *Rivista Sperimentale di Freniatria*, *3*, 51–66. https://doi.org/10.3280/RSF2017-003004

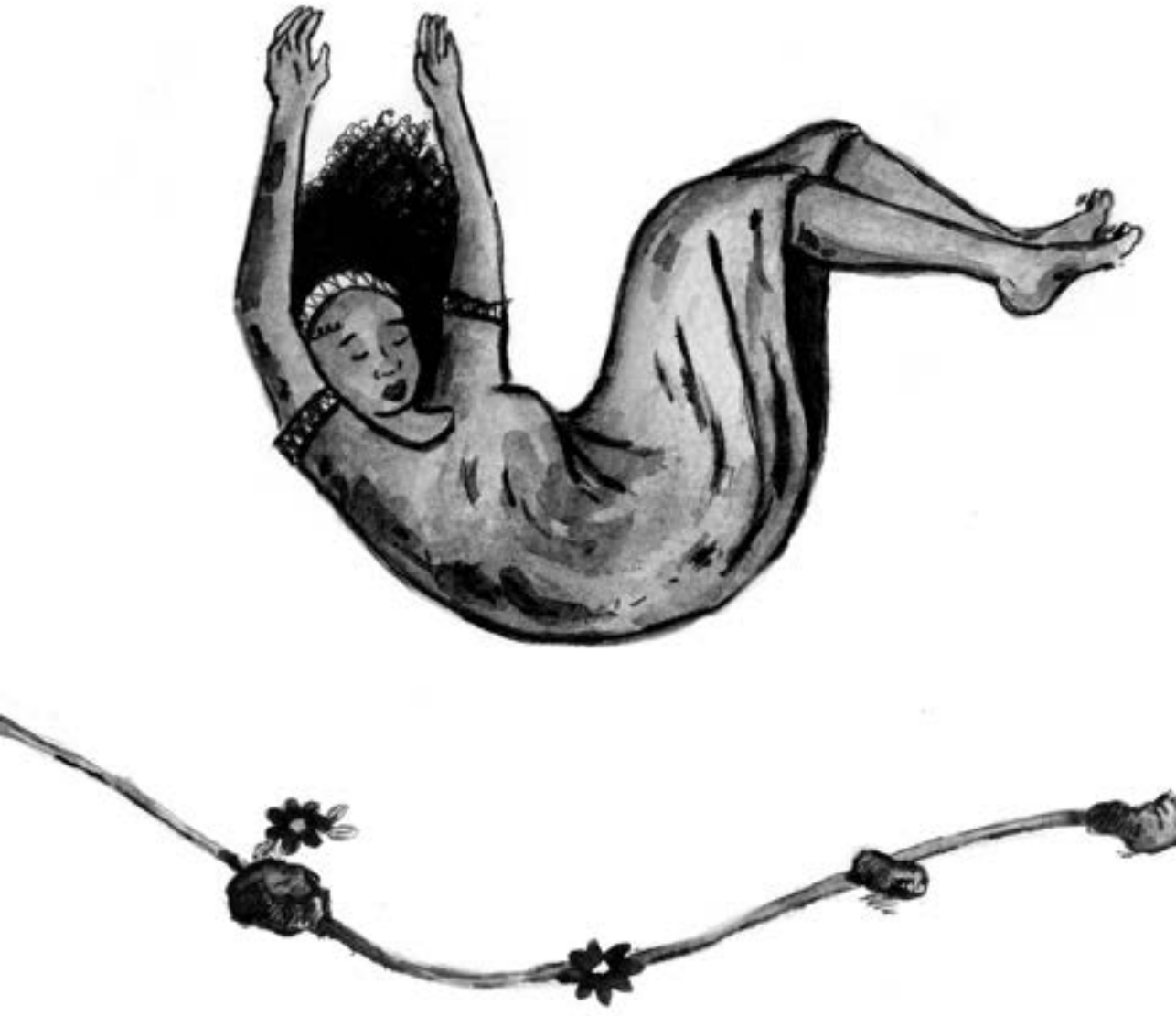
Turrini, G., Purgato, M., Acarturk, C., Anttila, M., Au, T., Ballette, F., Bird, M., Carswell, K., Churchill, R., Cuijpers, P., Hall, J., Hansen, L. J., Kösters, M., Lantta, T., Nosè, M., Ostuzzi, G., Sijbrandij, M., Tedeschi, F., Valimaki, M., … Barbui, C. (2019). Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: Systematic review and meta-analysis. *Epidemiology and Psychiatric Sciences, 28*(4), 376–388. https://doi.org/10.1017/S2045796019000027

United Nations High Commissioner for Refugees. (2017). *Global Trends. Forced displacement in 2016*. https://www.unhcr.org/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html

Van Rijsbergen, G. D., Bockting, C. L. H., Berking, M., Koeter, M. W. J., & Schene, A. H. (2012). Can a one-item mood scale do the trick? Predicting relapse over 5.5-Years in recurrent depression. *PLoS ONE*, *7*(10), e46796. https://doi.org/10.1371/journal.pone.0046796

Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the difficulties in emotion regulation scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment*, *38*(4), 582–589. https://doi.org/10.1007/s10862-016-9547-9

Zimmerman, C., Hossain, M., Yun, K., Roche, B., Morison, L., & Matts, C. (2006). *Stolen smiles: A summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe*. The London School of Hygiene & Tropical Medicine. https://www.icmec.org/wp-content/uploads/2015/10/Stolen-Smiles-Physical-and-Psych-Consequences-of-Traffic-Victims-in-Europe-Zimmerman.pdf



CHAPTER 7

The Relevance of Perceived Daily Stress, Emotion Regulation, and Mood for PTSD Trajectories Among Forced Migrants Receiving Trauma-Focused Therapy

Submitted as:
van Heemstra, H.E.[†], Ghafoerkhan, R.S.[†], Scholte, W.F., van de Schoot, R., & Boelen, P.A. The relevance of perceived daily stress, emotion regulation, and mood for PTSD trajectories among forced migrants receiving trauma-focused therapy.

[†]Both authors contributed equally to this study and manuscript.

ABSTRACT

BACKGROUND

Trauma-focused therapies (TFTs) for forced migrants need optimalization. Post-traumatic stress disorder (PTSD) is partially affected by daily stressors, emotion regulation, and depressive symptoms for this group. It is unclear how these factors affect PTSD trajectories during engagement in TFTs.

AIMS

Aims were (i) to examine changes in post-traumatic stress symptoms (PTS), perceived daily stress, emotion regulation, and depressed mood during Narrative Exposure Therapy (NET), (ii) to determine if these changes are related, and (iii) to establish the temporal relation between emerging trajectories.

METHOD

Eighty-six forced migrants with a diagnosis of PTSD were included. Data from forty participants were eligible for data analysis. Questionnaires were administered every NET session using the Primary Care Post-Traumatic Stress Disorder checklist, the Perceived Stress Scale, the impulsivity subscale of the Difficulties in Emotion Regulation Scale, and a single item for depressed mood. Latent growth modelling and random-intercept cross-lagged modelling were applied, using Bayesian statistics.

RESULTS

NET coincides with improvements in PTS, -3.789 [-5.603, -1.980], perceived daily stress, -3.905 [-5.930, -1.909], and emotion regulation, -3.61 [-6.298, -0.839]. Changes in perceived daily stress and PTS were interrelated, 0.808 [0.495, 0.999], but no lagged effect for perceived daily stress on PTS was found.

LIMITATIONS

The stability of the analytical models was limited by the small sample size. Replication studies with bigger samples are warranted.

CONCLUSIONS

Changes during NET transcend the reduction of PTS, extending to improvements in perceived daily stress and emotion regulation This may encourages clinicians to provide NET to socially burdened individuals.

TRIAL REGISTRATION NUMBER

NL61808.058.17

Keywords

Forced migrants, posttraumatic stress disorder, perceived daily stress, emotion regulation, narrative exposure therapy, treatment response

Forced migrants, including refugees, asylum seekers, and survivors of sex trafficking, are at elevated risk to develop mental health disorders like posttraumatic stress disorder (PTSD; Blackmore et al., 2020). Notwithstanding the evidence-base supporting the effectiveness of psychotherapies for PTSD (Kip et al., 2020) in this growing population (United Nations High Commissioner for Refugees, 2022), many forced migrants remain ill after receiving trauma-focused treatment (TFT; Nosè et al., 2017). Identifying how TFT and PTSD symptoms are impacted by relevant factors could improve treatment response within this population. The current study therefore taps into social and psychological factors that are potentially related to, and even predictive for, trajectories of PTSD during TFT. First, daily stressors, including challenging life circumstances due to the process of migration and resettlement, characterise the experiences of forced migrants. They are an established risk factor for mental health impairments in this group (Nickerson et al., 2022). In one study among refugees, no effect of clinician rated daily stressors on posttreatment PTSD changes was found (Bruhn et al., 2018). Another study established an effect of negative life-events occurring during treatment on PTSD symptoms in the subsequent session, but not on the overall treatment effect (Kaltenbach et al., 2020). These findings question the impact of daily stressors on PTSD treatment response. Second, emotion (dys)regulation is a critical transdiagnostic factor thought to underly the development and persistence of PTSD symptoms (Seligowski et al., 2015), also in forced migrants (Koch et al., 2020). Moreover, research suggests emotion (dys)regulation to be an important mechanism for treatment response amongst PTSD patients (Wisco et al., 2013). For forced migrants suffering from PTSD, living in uncertainty and dealing with daily stressors, emotion regulation skills might be a key factor for benefiting from TFT. Lastly, symptoms of depression are a relevant factor to consider for their influence during TFT, due to their relation with PTSD symptoms among refugees over time (Nickerson et al., 2022). Low PTSD treatment response was found to be predicted by baseline depression severity among refugees (Haagen et al., 2017). Moreover, among other samples PTSD and depression predicted each other's course during TFT (Brown et al., 2018). Hence, depression may be an inhibitory factor for PTSD symptom reduction during TFT.

AIM

The overarching aim of the current study was to examine the relevance of perceived daily stress, emotion regulation, and depressed mood for PTSD symptom change, in a group of forced migrants engaging in a TFT, namely Narrative Exposure Therapy (NET). The following hypotheses were tested:

First, PTSD, perceived daily stress, emotion regulation, and depressed mood improved during NET. Second, changes in PTSD symptoms coincided with changes in perceived daily stress, emotion regulation, and depressed mood during NET. Last, levels of perceived daily stress, emotion regulation, and depressed mood predicted subsequent levels of PTSD symptoms during NET.

METHODS

SETTING AND DESIGN

An uncontrolled observational design was applied, with two types of repeated measures: i) prior to each NET session, and ii) at pretreatment, posttreatment, and 6-week follow-up. The study operationalisation and aims are aligned with the peer-reviewed study protocol (see chapter 6; Ghafoerkhan et al., 2020). The medical ethical comity of Leiden University approved the study and the study was registered at the Dutch Trail register (NL61808.058.17: https://www.toetsingonline.nl/to/ccmo_search.nsf/fABRpop?readform&unids=D707FF3CE1AFE7D3C125881F00152BB7). The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013 (World Medical Association Declaration of Helsinki, 2013). All procedures involving patients were approved by the medical ethical department of the Leiden University Medical Centre, registration number P17.270.

The study was carried out between 2018 and 2022 at ARQ Centrum'45 in the Amsterdam region of the Netherlands. This is an outpatient facility, specialised in the provision of mental health care in the field of trauma-related psychopathology. NET was applied by medical (psychiatrists, psychiatrists in training, and non-specialised medical doctors) and (master-level and post-master-level) psychological professionals. All practitioners were trained in NET. Interpreters were used when necessary.

PARTICIPANTS

Forced migrants who met the following inclusion criteria were invited to participate in the study: i) PTSD as a primary diagnosis established by a licensed mental health professional; ii) a clinical indication for NET as determined by a multidisciplinary team; iii) aged 18 years or older; iv) cognitively able to give informed consent. Exclusion criteria were: i) acute mental health crisis, such as acute severe psychosis, persistent substance abuse, or acute suicidality; ii) previous engagement in TFT less than six months ago. In total $N = 86$ patients gave informed consent for participation, $n = 40$ of whom completed NET according to the study protocol.

QUESTIONNAIRES

Presession Measurements

Four (sub)scales were administered at the start of each NET session, measuring posttraumatic stress symptoms (PTS), perceived daily stress, emotion regulation, and depressed mood, respectively. All items were rated on a VAS-scale ranging from 0 (not at all) to 100 (extremely). To prevent an order effect, the items were listed in a random order that varied for every timepoint. This variation was equal for all participants. Items were originally in English and translated in the following languages: Dutch, Farsi, French, Arabic, Amharic, and Tigrinya.

PTS were assessed through the Primary Care Post-Traumatic Stress Disorder (PCPTSD) checklist. This is a five-item screening tool for PTSD according to the DSM-5, with acceptable psychometric

properties (Bovin et al., 2021; Lathan et al., 2023). The PCPTSD was applied among forced migrants before (Aoun et al., 2018). The original timespan (one month) was adapted to "one week", to concord with the frequency in which the scale was administered in the current study. An example item is: "In the last week did you have nightmares about the event(s) or thoughts about the event(s) when you did not want to?" Mean scores were calculated for the five questions. The Cronbach's alpha for the dataset of this study, as calculated for the first measurement, was good (.71).

Perceived daily stress was measured via the four items version of the Perceived Stress Scale (PSS-4). The scale has acceptable psychometric properties (She et al., 2021) and was proven to be sensitive to fluctuations in daily stress during psychological intervention (Baer et al., 2012). The indicated timespan was changed from "in the last month" into "in the last week" (e.g., "In the last week, how often have you felt that things were going your way?"). Mean scores were calculated for the four items. The PSS-4 had acceptable internal consistency, calculated for the first measurement (Cronbach's alpha = .67).

Emotion regulation was assessed with the three items subscale "impulsivity" of the Difficulties in Emotion Regulation Scale (DERS-18; Victor & Klonsky, 2016) which has good psychometric properties (Hallion et al., 2018). The questionnaire consists of statements, like "When I'm upset I become out of control". "In the last week I have felt" was added to the statements to accord with the other constructs that were measured every session. Average scores of the three items were calculated. The subscale had good internal consistency in the current study, calculated for the first measurement (Cronbach's alpha = .88).

Depressed mood was measured by use of a validated single item (Van Rijsbergen et al., 2012). To accord the timespan of this item with the other items registered every session, the original statement "At the moment I feel" was altered into "In the last week I felt".

Pretreatment and Posttreatment Measures

The PTSD Checklist for DSM-5 (PCL-5; Blevins et al., 2015) was used to measure PTSD symptoms. Internal consistency during baseline was good in this study (Cronbach's alpha .87). The Perceived Stress Scale (PSS; Cohen et al., 1983) was used to measure the extent to which participants experienced their lives as stressful. The internal consistency of this instrument was good at baseline (Cronbach's alpha .71). The DERS-18 (Victor & Klonsky, 2016) was used to measure general emotion regulation. This instrument had good internal consistency during baseline measurements in this study (Cronbach's alpha .78). The Questionnaire on the Process of Recovery Short Version-15 (QPR; Law et al., 2014) was used to measure the patients' perspectives on their stage of personal recovery. The scale had good internal consistency for the current study during baseline (Cronbach's alpha = .87). For a more extensive overview of the mentioned questionnaires see Ghafoerkhan et al. (2020).

INTERVENTION

NET is an evidence supported TFT for forced migrants including refugees (Lely et al., 2019) and victims of human trafficking (Brady et al., 2021). During NET, traumatic, positive, and bereavement-related memories are addressed in chronological order using a "life-line", supported by materials

such as a rope, stones, flowers, and candles. NET is focused on re-processing these memories by integrating their contextual and sensory information and exposing the person to the highly arousing details of the memory. In so doing, the narrative of one's personal life story becomes more coherent and integrated and space is created for reflection. The treatment protocol advises 12-16 sessions with a duration of 90-120 minutes which are performed by professionals trained in NET (Schauer et al., 2011).

PROCEDURE

Patients eligible for participation were informed about the study via their practitioner or a researcher. If they gave written informed consent for participation, NET-practitioners were informed by a researcher about the research protocol which entailed adherence to the NET protocol and the administration of a questionnaire at the beginning of each session. When needed, for example due to time constraints, master level psychology students or psychologists took on this assessment. Additionally, baseline measurements were conducted within the timeframe of one week to immediately before the first NET session. Posttreatment measurements were planned up to one week, and follow-up up to six weeks after the last session. Interpreters were used when participants did not master any of the languages the questionnaires were available in.

The duration of treatment and the total number of sessions varied between participants. This was partly due to practical obstacles interfering with treatment adherence, and partly to the NET protocol, which is determined by the personal lifeline of patients instead of a fixed number of sessions (Schauer et al., 2011). Although the protocol indicates a maximum of 16 sessions, an increase in the total amount of sessions was allowed to suit clinical practice. Participants were excluded from the study and considered drop-out when after 20 sessions no clear treatment end point could be set, based on maximum NET duration in previous research (Siehl et al., 2021). This resulted in a maximum of 23 sessions. Additionally, NET sessions were sometimes cancelled, resulting in an extension of therapy duration in some cases. During NET no other interventions were allowed other than crisis interventions, routine therapy evaluations (standard procedure in the Dutch mental health system), (ongoing) psychopharmacological treatment, and social work consultations.

Since part of the study took place during several phases of the COVID pandemic, in a small number of cases online sessions were allowed and participants remained in the study as long as the majority of the sessions were performed face-to-face.

STATISTICAL ANALYSES

Descriptive statistics were calculated in SPSS for windows, version 27. Independent t-test were performed, using pretreatment measures, to compare completers versus drop-outs at baseline. Change scores from pre- tot posttreatment were calculated and used to describe the sample in terms of PTSD treatment response according to established guidelines (U.S. Department of Veterans Affairs, 2022). Only available data was used, missing data at T0 (DERS 5%, PCL 7%, PSS 2%, QPR5%) and T1 (PCL 3%) were not taken into account.

Furter data analyses were performed in MPlus, version 8.6 (Muthén & Muthén, 1998-2017). Bayesian latent growth modelling (LGM) and random-intercept cross-lagged modelling (RI-CLM) were applied, based on five timepoints. LGM was used to evaluate i) changes in PTS, perceived daily stress, emotion regulation and depressed mood and ii) the interrelatedness of the slopes in PTS, perceived daily stress, emotion regulation and depressed mood during NET. First, changes in the four constructs (i.e., PTS, perceived daily stress, emotion regulation and depressed mood) were analysed over time. To estimate the significance of the trajectories, linear slope estimation was applied and related to the repeated longitudinal measures. Second, changes were matched between PTS and other constructs. For linear models with insufficient fit it was checked whether adding quadratic slopes would improve the model.

Next, RI-CLM was used to analyse cross-lagged associations between PTS and the other constructs. The RI-CLM was applied to account for individual variations in all outcomes (Hamaker et al., 2015). In these analyses it was investigated whether scores of perceived daily stress, emotion regulation, and depressed mood predicted subsequent scores of PTS during NET. Additionally, individual data plots of the trajectories of PTS, perceived daily stress, emotion regulation and mood were made. These plots were used to illustrate how group findings related to the individual trajectories.

Next to the posterior predictive p-value (PPP-value) to evaluate the model fit, several Bayesian alternatives to the classical metrics were used. The required classical cut-off score of > .90 had to be represented in the confidence interval of the Bayesian alternatives of the comparative fit index (CFI), Tucker-Lewis index (TLI). The Bayesian root mean square error of approximation (RMSEA) was considered if the range included < .10.

To deal with the limited sample size, the residual variances of the indicator variables was restricted to be the same over time. Moreover, the coherence in slopes was considered but the intercepts between the factors was fixed. Furthermore, Bayesian estimation was employed, using weakly informative priors covering the entire plausible parameter space on the mean intercept and slope to deal with the small sample size (Van De Schoot et al., 2015).

The "When to worry and how to Avoid the Misuse of Bayesian Statistics checklist" was followed to evaluate convergence (Depaoli & Van De Schoot, 2017). To obtain reliable results, the number of iterations was increased up to the point the potential scale reduction factor was always smaller than 1.05 for all iterations post-burn-in with a minimum of 5000 iterations (times 4 chains) to obtain enough precision for approximating the posterior distribution. Also, all trace plots display the mixing of the four chains, and the results are stable in terms of mean and variance across the entire post-burn-in phase.

Because both the number of sessions and the total treatment duration varied, the analyses were based on an arranged standardised selection of the dataset. Five sessions were selected for each participant at fixed time points. Specifically, data from the first session (T1) and the sessions taking place at 25% (T2), 50% (T3), and 75% (T4) of the treatment time period, and from the last session (T5) were included. This was done to map the changes that participants underwent during the entire treatment process, while allowing for individual variance in treatment duration and

number of treatment sessions. Missing data (7.5 %) were approached by including data of a near session; when these data were not available data of the timepoint in question (T2) remained missing (0.5%).

In our study protocol (Ghafoerkhan et al., 2020) we planned to analyse change scores between timepoints. In the current paper we, however, we chose to apply the RI-CLPM on fixed scores at the five timepoints. Furthermore, due to limited response rates at follow-up (PCL 67%), this timepoint was not taken into account.

A robustness check was done to see if findings based on these data, computed from a standardised selection based on treatment duration, would hold in other selections of the data. Hence, analyses were also performed using two other parts of the data. First, data from the first eight NET sessions were considered. Second, we focused on data from 5 sessions based on the total number of sessions (e.g., the first session, sessions taking place in 25%, 50%, 75% of the total amount of sessions, and the last session). Unfortunately, the fit indices (predictive p-value, CFI, TLI and RMSEA) for these datapoints were insufficient for both selections, and therefore these data approaches were not taken into account.

RESULTS

PARTICIPANTS

In total 40 participants completed NET according to the study protocol, and 46 dropped out. Main reasons for drop-out were more sessions than allowed for in the protocol (*n* = 13), more than 3 consecutive no-shows (*n* = 8), the emotional burden of NET being too high (*n* = 6), withdrawing from the study (*n* = 6), not able or willing to finish baseline measurement (*n* = 4), interference by life circumstances and events (*n* = 3), COVID-19 (*n* = 3), factors relating to the practitioner/institute (*n* = 2), and unmotivated for NET (*n* = 1). No significant differences between completers and drop-outs were found on baseline PCL-5, DERS-18, QPR or PSS scores, using independent t-tests.

The completers' PCL-5 change (baseline to posttreatment) scores revealed that 5% had a clinically meaningful deterioration of at least 10 points increase, 40.5% had a clinically meaningful improvement of at least 10 points decrease, and 54.5% showed no clinically meaningful changes, based on validated cut-of scores (U.S. department of Veteran Affairs, 2022). See Table 1 for the participants' characteristics.

Table 1
Sample Characteristics

	Drop-out			Completers		
	Group %	M (SD)	Range	Group %	M (SD)	Range
Female	45.7			32.5		
Region of origin						
Africa	56.5			67.5		
Middle East	23.9			20		
Eastern Europe	10.9			12		
Other	8.7			0		
Number NET sessions	100	9.35 (8.31)	0-24	100	14.73 (4.05)	8-23
Duration NET in days*	71.7	126.09 (90.31)	0-286	100	150.70 (65.91)	68-352
Baseline scores						
PCL	91.3	54.83 (13.00)	6-79	95	54.24 (11.08)	27-73
DERS	91.3	58.83 (11.42)	28-84	100	57.50 (10.46)	32-78
PSS	95.7	26.34 (5.17)	11-36	100	27.18 (6.21)	14-39
QPR	89.1	33.24 (10.68)	10-55	95	30.24 (11.05)	5-50
Post treatment scores						
PCL				97.5	46.87 (15.45)	14-74
First session scores						
PTS				100	66.21 (16.66)	35.04-100
PSS-4				100	70.32 (20.10)	22.25-100
EMO				100	42.93 (32.07)	0.00-100
Mood				100	76.50 (21.74)	28.00-100
Last session scores						
PTS				100	49.68 (21.74)	0.40-95.40
PSS-4				100	54.70 (25.67)	0.00-100
EMO				100	32.68 (25.96)	0.00-85.33
Mood				100	59.18 (26.09)	0.00-100

Note. $N = 86$, for drop-outs this was $N = 46$, for completers this was $N = 40$. Mean age at start NET was 36.70 ($SD = 10.20$) for drop-outs and 33.53 ($SD = 11.39$) for completers. DERS= Difficulties in Emotion regulation Scale -18; EMO = Subscale 'impulsivity' of the Difficulties in Emotion Regulation Scale; M = mean scores; SD = standard deviation; Mood = Single mood item; NET = Narrative Exposure Treatment; PCL = PTSD Checklist for DSM-5; PSS = Perceived Stress Scale; QPR = Questionnaire on the Process of Recovery Short Version-15 PSS = Perceived Stress Scale (PSS-4); PTS = Primary Care Post-Traumatic Stress Disorder.
*Duration of NET was only calculated for participants who finished T0 and started NET afterwards.

LGM AND RI-CLM

Findings from LGM (Table 2) and RI-CLM (Table 2 and Figure 1) are presented. Fit indices were poor for the following analyses: 1) latent growth models for depressive mood, 2) the interrelatedness of depressive mood with PTS, 3) the interrelatedness of emotion regulation with PTS, 4) the cross-lagged association between depressed mood and PTS, and 5) the cross-lagged association between emotion regulation and PTS. Therefore, outcomes related to these analyses were considered unreliable and not considered further. Adding quadratic slopes to the LGM did not result in sufficient model fit for these outcomes.

LGM revealed that PTS, perceived daily stress, and emotion regulation improved during NET. Additionally, improvements in perceived daily stress and PTS were related. Lastly, the cross-

lagged associations between perceived daily stress and PTS were significant in one occasion, namely lower PTS on T3 significantly predicted lower perceived daily stress on T4.

Table 2

Fit Indices and Outcomes for Multi-Level Models

	PPP-Value	B_RMSEA	B_CFI	B_TLI	Intercept [95% CI]	Slope [95% CI]
Latent growth modelling						
PTS	.51	0.00 to 0.10	0.88 to 1.00	0.92 to 1.00	67.26 [62.55 - 72.10]	-3.79 [-5.60 - 1.98]**
PSS	.21	0.06 to 0.15	0.85 to 0.98	0.90 to 0.99	70.52 [65.32 -75.98]	-3.91 [-5.93 - 1.91]**
EMO	.23	0.00 to 0.15	0.86 to 1.00	0.91 to 1.00	52.38 [43.55 - 61.92]	-3.61 [-6.30 - 0.84]**
Mood	.04	0.13 to 0.19	0.69 to 0.86	0.79 to 0.90	75.80 [69.16 - 82.53]	-4.58 [-7.06 - 1.90]**
PTS with PSS	.17	0.07 to 0.13	0.81 to 0.95	0.83 to 0.95	0.78 [0.46 – 1.00]	0.81 [0.50 – 1.00]**
PTS with EMO	.00	0.14 to 0.18	0.68 to 0.80	0.71 to 0.82	0.59 [0.22 – 0.88]	0.82 [0.45 – 1.00]
PTS with Mood	.01	0.12 to 0.16	0.66 to 0.82	0.69 to 0.83	0.65 [0.26 - 1.00]	0.60 [0.19 - 0.96]
Cross-lagged panel modelling						
PSS on PTS	.45	0.00 to 0.14	0.87 to 1.00	0.82 to 1.00		
EMO on PTS	.13	0.08 to 0.17	0.81 to 0.96	0.73 to 0.94		
Mood on PTS	.07	0.11 to 0.19	0.71 to 0.90	0.60 to 0.87		

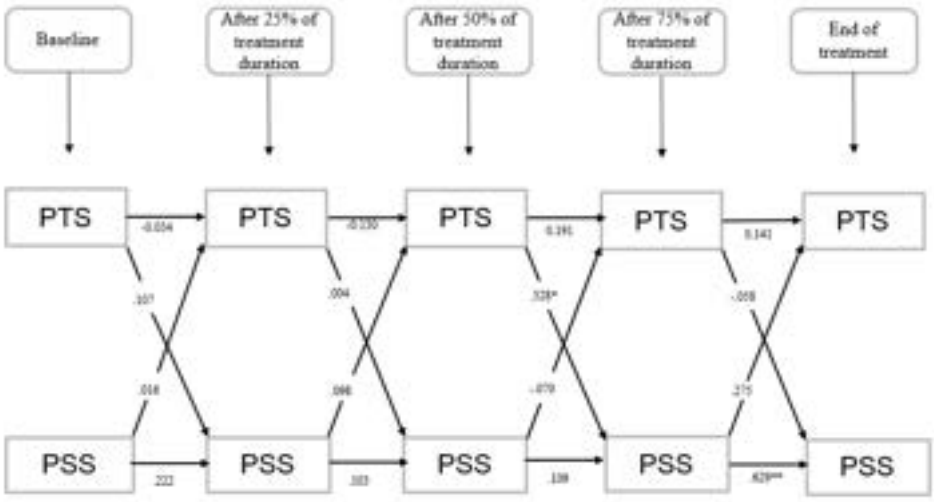
Note. B_CFI = Bayesian Comparative Fit Index; B_RMSE = Bayesian Root Mean Square Error of Approximation; B_TLI = Bayesian Tucker Lewis Index; CI = Confidence Interval; EMO = Subscale 'impulsivity' of the Difficulties in Emotion Regulation Scale; Mood = Single mood item; On = cross lagged association in growth trajectories; PPP-Value = posterior predictive p-value; PSS = Perceived Stress Scale (PSS-4); PTS = Primary Care Post-Traumatic Stress Disorder; With = relation in growth trajectories. * $p < .05$; ** $p < .01$.

INDIVIDUAL DATA PLOTS

The individual data show that the different constructs can appear in different relations. In some cases PTS develops parallel to other constructs, like perceived daily stress (see Figure 2, participant 1). Also, these constructs may develop sequentially in the same direction as PTS. For example, PTS can decrease one timepoint later than perceived daily stress (see Figure 2 participant 2). In other cases no coherence can be observed on face value (see Figure 2 participant 3). Also, it stands out that changes in the different constructs are not always rectilinear and can fluctuate between the different timepoints.

Figure 1

Standardised Autoregressive and Cross-Lagged Coefficients with Random Intercepts Between Perceived Stress and PTS symptoms

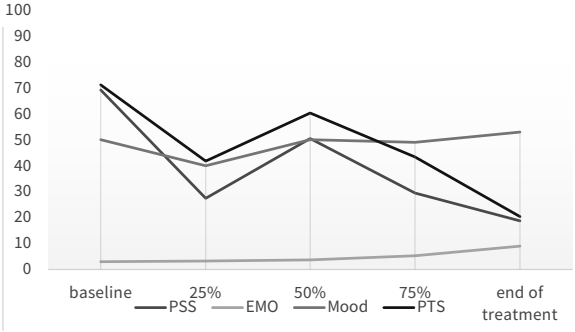


Note. PSS = Perceived Stress Scale (PSS-4); PTS = Primary Care Post-Traumatic Stress Disorder; * $p < .05$; ** $p < .01$.

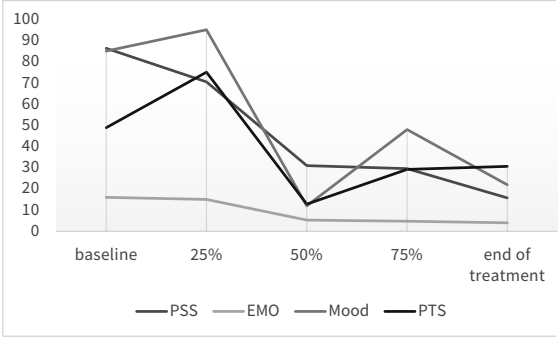
Figure 2

Individual Trajectories of PTS, Perceived Stress, Emotion Regulation and Mood Scores

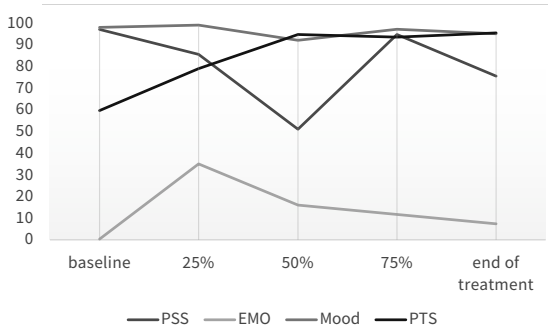
Participant 1. Simultaneous change in changes in PTS and PSS



Participant 2. Sequential order in changes in PTS (timepoint 2- 3) and PSS (timepoint 1- 2).



Participant 3. No face value relation between the changes in PTS and most other constructs



Note. 25% = after 25% of treatment duration; 50% = after 50% of treatment duration; 75% = after 75% of treatment duration. EMO = Subscale "Impulsivity" of the Difficulties in Emotion Regulation Scale; Mood = Single mood item; PTS = Primary Care Post-Traumatic Stress Disorder; PSS = Perceived Stress Scale (PSS-4).

DISCUSSION

MAIN FINDINGS

Our study investigated how PTS, perceived daily stress, emotion regulation, and depressed mood develop during NET, and if trajectories in the latter three constructs are related to trajectories in PTS. In concordance with our hypotheses, all measured constructs changed during the course of NET, although the model fit was inappropriate for depressed mood which therefore could not be interpreted. Considering the individual trajectories, it is clear that changes are not rectilinear for all outcomes. Hence, trajectories are capricious during NET, in line with previous findings on the course of PTS (Kaltenbach et al., 2020). Although NET primarily focusses on changing PTS, the established improvements in perceived daily stress and emotion regulation may be considered as secondary gains. This is relevant since the amount of experienced (Nickerson et al., 2022), as well as problems with emotion regulation (Koch et al., 2020) are prevalent and establish risk factors for PTSD among forced migrants.

Analyses of the associations of PTS and perceived daily stress trajectories revealed that the course of both constructs was related. This indicates that PTS and perceived daily stress undergo comparable changes during NET, in line with our expectations. The strong simultaneous relation between both constructs suggests that perceived daily stress and PTS can overlap. Contrary to our hypothesis, we did not find that perceived daily stress scores predicted subsequent scores of PTS, although the association was pronounced at one timepoint. Several explanations for this finding could be considered. First, levels of perceived daily stress may not determine PTS levels. Both concepts may be driven by other indicators than each other. For example, perceived daily stress and PTS may change as a consequence of treatment without having any impact on each other. A second explanation is that the potential interdependency of these concepts follows another time sequence than applied in the current study, and can only be captured in shorter time lags

(Dormann & Griffin, 2015).

Although findings on the lagged impact of PTS on other outcomes were not included in our study aims, it is noteworthy that PTS significantly predicted perceived daily stress on one timepoint. This indicates that levels of PTS can matter for subsequent levels of perceived daily stress, which is an extra encouragement to alter PTS levels through TFTs among socially burdened individuals.

Unfortunately, our models for exposing interrelatedness in PTS levels with levels of depressed mood and emotion dysregulation did not fit our data. Although no straightforward explanations can be given for this, it could be due to having a too small sample size for the complexity of the model tested. Additionally, considering the individual trajectories, it was observed that the courses of PTS, perceived daily stress, depressed mood, and emotion regulation can be capricious and therewith hard to fit in the applied models.

STRENGTHS AND LIMITATIONS

The current study has several relevant limitations. First, there was a relatively small number of completers, as mentioned above, which diminished the stability of our analytical models and increased the risk of Type II error (Shreffler & Huecker, 2023). Second, observational data were used, without adding a control condition. Hence, it remains unknown to what extent changes in perceived daily stress, emotion regulation and PTS observed in this study can be attributed to the process of NET. Future studies are encouraged to test if the findings hold in larger samples with a control condition. It is also noteworthy that the study had a high drop-out rate and participants dropping out might have shown other patterns of change and relatedness between the constructs. Therefore, our results are limited to forced migrants who are capable of finishing a TFT. In future studies, exploration on the reasons for drop-out and adherence in comparable samples is warranted. Third, the data were collected via self-report questionnaires, increasing the risk of response tendency (Wetzel et al., 2016). Moreover, these questionnaires were applied as VAS-scales which is an innovative but yet unvalidated manner, which increases the risk of measurement errors (Dowrick et al., 2015). Therefore, future work is encouraged to use questionnaires validated for forced migrants with various backgrounds, in replications studies. Fourth, the study was based on clinical and scientific knowledge, but participants' views were not included in the study design. This may have constrained an adequate representation of the participants' needs in the study objectives (Caron-Flinterman et al., 2005). Comparable future studies are recommended to involve participants in designing the study to increase external validity. The study also contains important strengths. The study protocol was designed to allow for a high external validity. The study closely matched clinical practice as carried out at the study site. Furthermore, to the best of our knowledge, this is the first study that collected data on four different relevant outcomes during the course of therapy among forced migrants. Therewith it proves the feasibility of collecting data on multiple outcomes among forced migrants during the therapy. Lastly, the unconfirmed hypotheses of this paper strengthen previous comparable (Kaltenbach et al., 2020) and unexpected (Bruhn, et al, 2018; Schick et al., 2018) results on daily stressors and PTSD after

treatment. Although non-significant findings are unsuitable for confirming null-hypotheses, an accumulation of non-detectable relations gives input for reconsidering expectations. Evidently, future research is warranted to investigate this provoked insecurity regarding the constraining impact of daily stressors on TFT effectivity.

IMPLICATIONS

Findings on group level reveal that changes during trauma-focused therapy transcend a reduction in PTS, extending to improvements in perceived daily and emotion regulation stress. Following this, clinicians are advised to apply NET for traumatised forced migrants, also when they experience their daily lives as stressful and encounter difficulties with controlling emotions. Meanwhile, the individual trajectories point out that improvements can be capricious on all outcomes. Additionally, the interrelatedness of perceived daily stress and PTSD symptomatology was confirmed but there was no evidence for the impact of reduced perceived daily stress on subsequent PTSD symptom reduction. Since evidence within the study does not confirm the potential impeding role of perceived daily stress for PTS trajectories, clinicians are encouraged to provide NET to socially burdened patients.

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AUTHOR CONTRIBUTION

HvH: Conceptualisation, methodology, formal analysis, investigation, writing -original draft, project administration.
RG: Conceptualisation, methodology, formal analysis, investigation, writing - review & editing, project administration and funding acquisition.
WS: Conceptualisation, methodology, supervision, writing - review & editing, funding acquisition.
RvdS: Formal analysis, supervision, writing -original draft, review & editing.
PB: Conceptualisation, methodology, supervision, writing - review & editing.

REFERENCES

Aoun, A., El Gerges, N., & Joundi, A. J. (2018). Posttraumatic stress disorder symptoms and associated risk factors: A cross sectional study among Syrian refugees. *British Journal of Medical Practitioners*, *11*(1), a1106.

Baer, R. A., Carmody, J., & Hunsinger, M. (2012). Weekly change in mindfulness and perceived stress in a mindfulness-based stress reduction program: Weekly change in mindfulness and stress in MBSR. *Journal of Clinical Psychology*, *68*(7), 755–765. https://doi.org/10.1002/jclp.21865

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLOS Medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498. https://doi.org/10.1002/jts.22059

Bovin, M. J., Kimerling, R., Weathers, F. W., Prins, A., Marx, B. P., Post, E. P., & Schnurr, P. P. (2021). Diagnostic accuracy and acceptability of the primary care posttraumatic stress disorder screen for the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) Among US Veterans. *JAMA Network Open*, *4*(2), e2036733. https://doi.org/10.1001/jamanetworkopen.2020.36733

Brady, F., Chisholm, A., Walsh, E., Ottisova, L., Bevilacqua, L., Mason, C., Von Werthern, M., Cannon, T., Curry, C., Komolafe, K., Robert, R. E., Robjant, K., & Katona, C. (2021). Narrative exposure therapy for survivors of human trafficking: Feasibility randomised controlled trial. *BJPsych Open*, *7*(6), e196. https://doi.org/10.1192/bjo.2021.1029

Brown, L. A., Jerud, A., Asnaani, A., Petersen, J., Zang, Y., & Foa, E. B. (2018). Changes in posttraumatic stress disorder (PTSD) and depressive symptoms over the course of prolonged exposure. *Journal of Consulting and Clinical Psychology, 86*(5), 452-463. doi: 10.1037/ccp0000292.

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *Journal of Nervous & Mental Disease*, *206*(1), 61–68. https://doi.org/10.1097/NMD.0000000000000774

Caron-Flinterman, J. F., Broerse, J. E. W., & Bunders, J. F. G. (2005). The experiential knowledge of patients: A new resource for biomedical research? *Social Science & Medicine*, *60*(11), 2575–2584. https://doi.org/10.1016/j.socscimed.2004.11.023

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*(4), 385. https://doi.org/10.2307/2136404

Depaoli, S., & Van De Schoot, R. (2017). Improving transparency and replication in Bayesian statistics: The WAMBS-Checklist. *Psychological Methods*, *22*(2), 240–261. https://doi.org/10.1037/met0000065

Dormann, C., & Griffin, M. A. (2015). Optimal time lags in panel studies. *Psychological Methods*, *20*(4), 489–505. https://doi.org/10.1037/met0000041

Dowrick, A. S., Wootten, A. C., Murphy, D. G., & Costello, A. J. (2015). "We used a validated questionnaire": What does this mean and is it an accurate statement in urologic research? *Urology*, *85*(6), 1304–1310. https://doi.org/10.1016/j.urology.2015.01.046

Ghafoerkhan, R. S., Van Heemstra, H. E., Scholte, W. F., Van Der Kolk, J. R. J., Ter Heide, J. J. F., De La Rie, S. M., Verhaak, L. M., Snippe, E., & Boelen, P. A. (2020). Feasibility and predictors of change of narrative exposure therapy for displaced populations: A repeated measures design. *Pilot and Feasibility Studies*, *6*(1), 69. https://doi.org/10.1186/s40814-020-00613-1

Haagen, J. F. G., Ter Heide, F. J. J., Mooren, T. M., Knipscheer, J. W., & Kleber, R. J. (2017). Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis. *British Journal of Clinical Psychology*, *56*(1), 69–83. https://doi.org/10.1111/bjc.12121

Hallion, L. S., Steinman, S. A., Tolin, D. F., & Diefenbach, G. J. (2018). Psychometric properties of the Difficulties in Emotion Regulation Scale (DERS) and its short forms in adults with emotional disorders. *Frontiers in Psychology*, *9*, 539. https://doi.org/10.3389/fpsyg.2018.00539

Hamaker, E. L., Kuiper, R. M., & Grasman, R. P. P. P. (2015). A critique of the cross-lagged panel model. *Psychological Methods*, *20*(1), 102–116. https://doi.org/10.1037/a0038889

Kaltenbach, E., Hermenau, K., Schauer, M., Dohrmann, K., Elbert, T., & Schalinski, I. (2020). Trajectories of posttraumatic stress symptoms during and after Narrative Exposure Therapy (NET) in refugees. *BMC Psychiatry*, *20*(1), 312. https://doi.org/10.1186/s12888-020-02720-y

Kip, A., Priebe, S., Holling, H., & Morina, N. (2020). Psychological interventions for posttraumatic stress disorder and depression in refugees: A meta-analysis of randomized controlled trials. *Clinical Psychology & Psychotherapy*, *27*(4), 489–503. https://doi.org/10.1002/cpp.2446

Koch, T., Liedl, A., & Ehring, T. (2020). Emotion regulation as a transdiagnostic factor in Afghan refugees. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(3), 235–243. https://doi.org/10.1037/tra0000489

Lathan, E. C., Petri, J. M., Haynes, T., Sonu, S. C., Mekawi, Y., Michopoulos, V., & Powers, A. (2023). Evaluating the performance of the primary care posttraumatic stress disorder screen for DSM-5 (PC-PTSD-5) in a trauma-exposed, socioeconomically vulnerable patient population. *Journal of Clinical Psychology in Medical Settings*. https://doi.org/10.1007/s10880-023-09941-9

Law, H., Neil, S. T., Dunn, G., & Morrison, A. P. (2014). Psychometric properties of the questionnaire about the process of recovery (QPR). *Schizophrenia Research*, *156*(2–3), 184–189. https://doi.org/10.1016/j.schres.2014.04.011

Lely, J. C. G., Smid, G. E., Jongedijk, R. A., W. Knipscheer, J., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: A review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology*, *10*(1), 1550344. https://doi.org/10.1080/20008198.2018.1550344

Muthén, L.K., & Muthén, B.O. (1998-2017). *Mplus User's Guide*. Eighth Edition. Los Angeles, CA: Muthén & Muthén

Nickerson, A., Byrow, Y., O'Donnell, M., Bryant, R. A., Mau, V., McMahon, T., Benson, G., & Liddell, B. J. (2022). Cognitive mechanisms underlying the association between trauma exposure, mental health and social engagement in refugees: A longitudinal investigation. *Journal of Affective Disorders*, *307*, 20–28. https://doi.org/10.1016/j.jad.2022.03.057

Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., Priebe, S., & Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLOS ONE*, *12*(2), e0171030. https://doi.org/10.1371/journal.pone.0171030

Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd rev. and expanded ed). Hogrefe.

Seligowski, A. V., Lee, D. J., Bardeen, J. R., & Orcutt, H. K. (2015). Emotion regulation and posttraumatic stress symptoms: A meta-analysis. *Cognitive Behaviour Therapy*, *44*(2), 87–102. https://doi.org/10.1080/16506073.2014.980753

She, Z., Li, D., Zhang, W., Zhou, N., Xi, J., & Ju, K. (2021). Three versions of the perceived stress scale: Psychometric evaluation in a nationally representative sample of Chinese adults during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, *18*(16), 8312. https://doi.org/10.3390/ijerph18168312

Shreffler, J., & Huecker, M. R. (2023). Type I and Type II errors and statistical power. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK557530/

Siehl, S., Robjant, K., & Crombach, A. (2021). Systematic review and meta-analyses of the long-term efficacy of narrative exposure therapy for adults, children and perpetrators. *Psychotherapy Research*, *31*(6), 695–710. https://doi.org/10.1080/10503307.2020.1847345

Schick, M., Morina, N., Mistridis, P., Schnyder, U., Bryant, R. A., & Nickerson, A. (2018). Changes in post-migration living difficulties predict treatment outcome in traumatized refugees. *Frontiers in Psychiatry*, *9*, 476. https://doi.org/10.3389/fpsyt.2018.00476

United Nations High Commissioner for Refugees. (2022). *Figures at a glance*. https://www.unhcr.org/about-unhcr/who-we-are/figures-glance

U.S. Department of Veterans Affairs. (2022). *PTSD Checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Van De Schoot, R., Broere, J. J., Perryck, K. H., Zondervan-Zwijnenburg, M., & Van Loey, N. E. (2015). Analyzing small data sets using Bayesian estimation: The case of posttraumatic stress symptoms following mechanical ventilation in burn survivors. *European Journal of Psychotraumatology*, *6*(1), 25216. https://doi.org/10.3402/ejpt.v6.25216

Van Rijsbergen, G. D., Bockting, C. L. H., Berking, M., Koeter, M. W. J., & Schene, A. H. (2012). Can a one-item mood scale do the trick? predicting relapse over 5.5-years in recurrent depression. *PLoS ONE*, *7*(10), e46796. https://doi.org/10.1371/journal.pone.0046796

Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the difficulties in emotion regulation scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment*, *38*(4), 582–589. https://doi.org/10.1007/s10862-016-9547-9

World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. (2013). *JAMA*, *310*(20), 2191. https://doi.org/10.1001/jama.2013.281053

Wetzel, E., Böhnke, J. R., & Brown, A. (2016). *Response Biases*. https://kar.kent.ac.uk/49093/1/Response_biases_Final_accepted_version.pdf

Wisco, B. E., Sloan, D. M., & Marx, B. P. (2013). Cognitive emotion regulation and written exposure therapy for posttraumatic stress disorder. *Clinical Psychological Science*, *1*(4), 435–442. https://doi.org/10.1177/2167702613486630

CHAPTER 8

The Role of Baseline Emotion Dysregulation and Perceived Daily Stress in Adherence and Completion of Narrative Exposure Therapy Amongst Forced Migrants

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ABSTRACT

BACKGROUND

Forced migrants living in the Global North are at risk for developing a posttraumatic stress disorder (PTSD). Narrative Exposure Therapy (NET) is an empirically supported treatment for forced migrants suffering from PTSD. However, multiple barriers hinder a consistent commitment and completion of mental health treatment. Identifying which baseline factors contribute to the feasibility of NET could enhance its treatment outcomes.

OBJECTIVE

The first aim was to examine whether baseline levels of perceived daily stress and emotion dysregulation were associated with NET completion. The second aim was to test whether these baseline measures, while considering pretreatment PTSD symptom severity, were associated with NET adherence.

METHOD

An uncontrolled observational study was conducted at an outpatient mental health clinic. Treatment-seeking forced migrants (N = 86) suffering from PTSD were followed while engaging in NET. Pretreatment measures were considered as indicators: perceived stress scale (PSS), difficulties in emotion regulation scale (DERS-18) and PTSD checklist (PCL-5). Information on NET session attendance, protocol adherence and completion was derived from medical records and computed into variables. Analyses were carried out using logistic regression and a two-step hierarchical linear regression analysis.

RESULTS

First, baseline levels of perceived daily stress and emotion dysregulation were not found to be indicative of NET completion rates. Second, analyses showed that baseline perceived daily stress scores significantly indicated treatment adherence. However, when in a second step adding baseline PTSD symptom severity to the model this significance was mitigated. Overall, NET adherence could not be attributed to baseline measures.

CONCLUSIONS

The lack of significant findings could be due to the limited sample size or methodological choices. However, the possibility that these particular baseline factors are not uniquely related to NET treatment completion, session adherence should also be considered for future research and clinical practice.

Keywords

Narrative exposure therapy, forced migrants, posttraumatic stress disorder, emotion regulation, daily stressors, drop-out, treatment completion

Forced migrants living in the Global North form a heterogeneous population, encompassing those seeking refuge from war and conflict, and those who have been trafficked. Over the last years the Netherlands has seen a rapid increase in asylum applications (Asylum Information Database, 2022) next to a constant influx of identified survivors of sex trafficking (National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children, 2021). Prior, during and following migration, most forced migrants face various human rights violations, through exposure to war atrocities, sexual and gender-based violence, torture and (political) confinement (Office of the United Nations High Commissioner for Human Rights, 2021). Moreover, many forced migrants hold marginalised positions throughout their lives, e.g., due to their residential status, ethnicity, gender identity, and/or sexual orientation (Human Rights Counsil, 2023; Hynie, 2018). These ongoing adversities and stressful social circumstances, may exacerbate mental suffering, including posttraumatic stress disorder (PTSD: Gleeson et al., 2020). Narrative Exposure Therapy (NET) is an empirically supported treatment for forced migrants suffering from PTSD (Siehl et al., 2021). However, for this population in particular, multiple barriers hinder a consistent commitment to, and completion of mental health treatment (Byrow et al., 2020). Identifying which factors contribute to the feasibility of NET could enhance treatment outcomes (Semmlinger & Ehring, 2021). To inform clinical practice, the present study considered baseline perceived daily stress and emotion dysregulation as potential indicators of treatment completion and adherence amongst forced migrants, while considering for pretreatment PTSD symptom severity.

Prevalence rates of PTSD amongst forced migrant are high (Patanè et al., 2022), and symptom severity was found to impact treatment course and outcomes (Mitchell et al., 2023). Research confirms the efficacy of NET for forced migrants, yet its feasibility in naturalistic settings has received less attention (Siehl et al., 2021). A meta-analysis on treatment discontinuation amongst PTSD patients showed an overall drop-out rate of 18.28% on average (Imel et al., 2013). However, for NET and forced migrants information on drop-out and adherence are largely unknown (Semmlinger & Ehring, 2022). Discontinuation of treatment before symptom reduction is problematic for various reasons. First of all, for patients themselves dropping out of exposure treatment can cause symptom aggravation, and may increase distrust of mental health services (Semmlinger & Ehring, 2022). Secondly, in the Global North, mental health services for forced migrants are scarce, treatment discontinuation and non-attendance put further (financial) strain on health systems (Nowak et al., 2022).

Once arrived in the Global North, forced migrants face lengthy residential procedures, uncertain living conditions, and limited social embeddedness, while not being able to provide in their own livelihood (Silove et al., 2017; VluchtelingenWerk, 2021). The perceived lack of control or worries about these “daily stressors” can sustain and negatively impact the mental health of forced migrants, including PTSD (Gleeson et al., 2020). As suggested in prior research, daily stressors could potentially impede the course of treatment (Drožđek et al., 2013; Li et al., 2016), for instance through cancelled sessions or necessary deviations from the treatment protocol (Waller, 2009). Indeed therapists are known to be hesitant to initiate treatment with forced migrants (Ter Heide & Smid, 2015). However, prior research on impact of daily stressors on the course of

treatment for forced migrants is inconclusive (Bruhn et al., 2018; Djelantik et al., 2020; Kaltenbach et al. 2020). More research is needed to understand if daily stressors impact treatment completion and adherence for forced migrants is needed.

Emotion dysregulation is an important part of PTSD, and these constructs were found to sustain each other (Seligowski, 2015). To engage in trauma-focused therapy one must be able to handle arousal caused by exposure to traumatic memories (Schauer & Elbert, 2010). For patients with emotion regulation difficulties, tolerating elevated arousal can be particularly challenging and might outweigh their abilities. This could result in increased avoidance, no-show, diminished treatment outcome, and even discontinuation of treatment (Frye & Spates, 2012). It is likely that prior adversities and current social circumstances impede forced migrants' ability to regulate emotions (Ehring & Quack, 2010), and PTSD and emotion dysregulation were found to coincide (Doolan et al., 2017). Although prior studies have underlined the interrelatedness of emotion dysregulation and PTSD treatment outcome (McLean & Foa, 2017), its influence on treatment completion and adherence amongst forced migrants is largely unknown.

The present study was part of a larger research project on processes of change amongst a clinical sample of forced migrants suffering from PTSD (see chapter 6; Ghafoerkhan et al., 2020). The overarching focus of this project was on the interplay between perceived daily stress, emotion dysregulation and mood with PTSD symptom severity during NET. Initial analyses found that while perceived daily stress followed a similar trajectory as PTSD symptom severity during NET, neither could consistently predict the other over time (see chapter 7; van Heemstra et al., submitted). In the present study these concepts were further studied by examining baseline perceived daily stress and emotion dysregulation, for their role in NET adherence and completion, while considering PTSD symptom severity at baseline.

OBJECTIVE

The present study focussed on treatment-seeking forced migrants living in the Netherlands. Those who were diagnosed with PTSD and engaged in NET were followed in a naturalistic clinical setting. The first aim was to examine whether baseline levels of perceived daily stress and emotion dysregulation were indicators of NET completion (aim 1). The second aim was to test whether baseline levels of perceived daily stress and emotion dysregulation were indicators for NET adherence, while accounting for PTSD symptom severity at baseline. Whilst conceptualisations and operationalisation of treatment adherence differ, within this study adherence was defined as a session that was attended by the patient and that took place in line with the NET treatment protocol (Schauer et al., 2011). Information about session attendance and NET protocol adherence was derived from session notes within patients' medical records and calculated into a variable.

METHOD

PATIENTS AND SETTING

This study took place at an outpatient mental health clinic in the capital region of the Netherlands. The clinic's multidisciplinary teams offer mental health services to traumatised asylum seekers, refugees, and survivors of sex trafficking. Upon referral, clinical diagnoses are established in a routine psychiatric assessment at intake. At the study site NET was considered a first-choice treatment for patients who reported multiple traumas at intake and suffered from PTSD. As part of standard care digital session notes are kept, which is a requirement before registering a session into a patient's medical record. For the purposes of this study patients (N = 86) engaging in NET were followed.

Patients' sociodemographic characteristics are presented in Table 1. Patients (≥ 18 years) meeting all of the following criteria were considered for inclusion: i) Forced migrant who has faced interpersonal violence, such as war-, conflict-, sex trafficking, or sexual orientation and gender identity and expression (SOGIE) related violence. ii) PTSD as a primary diagnosis; iii) NET treatment indication; iv) Cognitively able to give consent to participate in the study. Patients were excluded if they: i) Recently (< 6 months ago) completed another trauma-focused therapy; ii) Showed signs of an acute crisis, such as acute suicidality or acute severe psychosis, or suffered from persistent substance abuse.

Table 1

Sociodemographic Information of Patients at Baseline

	Completers		Non-completers		Full sample	
	n	%	*n*	%	*n*	%
Gender						
Woman	41	64	10	46	51	59
Region of origin						
East Africa	19	30	7	32	26	30
West Africa	16	25	6	27	22	26
Middle East	12	20	4	18	17	20
Eastern Europe	8	13	-	-	8	9
Asia	3	5	4	18	7	8
Other	5	8	1	5	6	7
Primary reasons for forced migration[a]						
Conflict/war	18	28	8	36	26	30
Sex trafficking	19	30	3	14	22	26
SOGIE related violence	19	30	9	41	28	33
Other	17	27	6	30	23	27
Highest level of education						
Primary school	24	38	10	46	34	40
Highschool	14	22	4	18	18	21
Higher education	26	41	8	36	34	40

Table 1
Continued.

	Completers		Non-completers		Full sample	
	n	%	*n*	%	*n*	%
Permanent residency[b]	33	52	12	55	45	52
Steady place of residence[c]	30	50	11	50	41	48
Employed/student[d]	18	28	7	32	25	29
In a relationship	21	33	6	27	27	31
Living with children	17	27	8	36	25	29

Note. $N = 86$ ($n = 64$ completers and $n = 22$ non-completers). Participants were on average 34.8 years old ($SD = 10.8$). Participant age and gender did not differ between completers and non-completers. SOGIE= sexual orientation, gender identity-, and expression.
[a] Categories might overlap within individuals
[b] Reflects those who held a Dutch/EU passport or permanent refugee status.
[c] Reflects those who lived in independent housing.
[d] Reflects those who either had steady employment or were full-time students

DESIGN AND ETHICAL APPROVAL

The overarching observational uncontrolled study focussed on predictors of change and feasibility of NET (see chapter 6; Ghafoerkhan et al., 2020 for the study protocol). Ethical approval for the study at large was granted by the Medical Ethics Committee Leiden The Hague Delft in the Netherlands (P17.270). The study was pre-registered at the Dutch Trial register (NL61808.058.17:https://www.toetsingonline.nl/to/ccmo_search.nsf/fABRpop?readform&unids=D707FF3CE1AFE7D3C125881F00152BB7).

INTERVENTION

NET is an individual brief trauma-focused psychotherapy found to be effective in reducing PTSD among refugees, asylum-seekers, and survivors of sex trafficking (Brady et al., 2021; Siehl et al., 2021). During NET traumatic, positive, bereavement, and offender-related experiences are integrated into a patients' life narrative by means of exposure techniques. Important elements of NET are: laying out one's lifeline using symbols like a rope, stones and flowers during the first session, in-depth narration of important (traumatic) life events, and reading back the written life narration during the final session. The NET study protocol recommends between 12 to 16 total number of sessions (Schauer et al., 2011). In the protocol it is stressed that regular attendance during NET is crucial to allow for an optimal processing and in-depth exposure during and in-between sessions. For more information see the NET manual (Schauer et al., 2011).

MEASURES

Treatment Completion

A dichotomous variable was created, patients who completed all elements of the NET protocol were considered completers (1 = "completer"), all others were considered non-completers (0 = "non-completer"). Patients who did not complete the study protocol (i.e., no posttreatment assessment or too many no-shows), but still completed NET outside the study protocol were considered completers. To ensure a representative sample of patients engaging in NET in a naturalistic setting, all completers were considered, regardless of the final number of session or treatment length.

NET Adherence

For treatment completers, session notes entered into patients' medical records by NET therapists were used to obtain information about attendance and protocol adherence. If session notes referred to typical NET elements, such as "laying out the life-line", "exposure", "talking about a stone/flower", or "reading back the life narrative", the session was counted as a "NET session". Alternatively, if session notes lacked such terms, but instead included phrasings such as "unable to perform exposure" or information on other urgent matter, such as "negative outcome asylum procedure" or "escalating conflict in home country", this was counted as a session "non-adherent" to the NET protocol. Finally, if the patient did not show up or cancelled the session at the last-minute it was coded as "non-attendance" of the planned session. From this information, two sum scores were created, one representing the total number of NET sessions in line with the NET protocol, and one representing the total number of non-adherent sessions (either reflecting "non-attendance" or "non-protocol adherence").

Finally, an index representing the total number of true NET sessions, relative to the total number of therapy sessions that were planned was calculated. This ratio variable was created by dividing the total number of NET sessions by the total number of planned NET sessions (that is the sum of total number of NET sessions and total number of missed sessions). Scores ranged between 0-100, with a score of "0" indicating that none of the planned session successfully took place, and a score of "100" indicating that the patient attended all of the planned sessions, and these session took place in line with the NET treatment protocol.

As this study partially took place during the COVID pandemic, sessions missed due to the pandemic's regulations were not considered within this variable. If session notes indicated a session was missed due to a "positive COVID test", "schools closed due to regulations", or "need to self-isolate", etc., this missed session was left out of any of the abovementioned calculations.

Perceived Stress Scale (PSS)

The PSS questionnaire measures perceived stress by assessing how unpredictable, uncontrollable and overloading patients experience their daily lives and stressors during the last month (Cohen et al., 1983). The scale uses 10 items scored on a 5-point Likert scale ranging from 0 = "never" to 4 = "very often". The sum of the total score can range between 0-40, where a higher score indicates higher perceived stress. Scores between 0-13 are considered indicative of "low stress", scores between 14-26 of "moderate stress", and finally scores between 27-40 "high perceived stress". An example item is: "In the last month, how often have you felt confident about your ability to handle your personal problems?" The PSS was found to have acceptable psychometric properties (Lee, 2012), and in this sample had an acceptable Cronbach's alpha of $\alpha = .71$.

Difficulties in Emotion Regulation Scale – Short Version (DERS-18)

The DERS-18 questionnaire measures difficulties in emotion regulation using 18 items scored on a 5-point Likert scale ranging from 1 = "almost never" to 5 = "almost always" (Victor & Klonsky, 2016). The sum of the total score can range between 18-90, where a higher score indicates more

difficulties in emotion regulation. No cut-off scores are provided. An example item is: "When I'm upset, I feel ashamed with myself for feeling that way". The DERS-18 was found to have good psychometric properties (Victor & Klonsky, 2016), and in this sample had an acceptable Cronbach's alpha of α = .78.

PTSD Checklist (PCL-5)

The PCL-5 measures symptom severity of PTSD over the last month using 20 items on a 5-point Likert scale ranging from 0 = "not at all" to 4 = "extremely". The summed total symptom severity score can range between 0-80, where a higher score indicates higher severity of PTSD symptoms. A cut-off score between 31-33 is suggested to be indicative of PTSD (U.S. Department of Veteran Affairs, 2023). An example item is: "In the past month, how much were you bothered by feeling very upset when something reminded you of the stressful experience?". The PCL-5 was found to have good psychometric properties (Blevins et al., 2015) and in this sample had a good Cronbach's alpha of α = .87.

Traumatic Life Events

Two checklists were used to assess traumatic life events: the Life events checklist (LEC-5) and the Early Trauma Inventory Self Report-Short Form (ETISR-SF). The LEC–5 measures life-time prevalence of 16 types of potentially traumatising events, plus the option for an open-ended response regarding a life event. For the worst event the patient is asked follow-up questions on the timing, frequency, and nature of the event. This measure is considered to have good psychometric properties (Gray et al., 2004). The ETISR-SF assesses potentially traumatising events before the age of 18 years old in 27 items (Bremmer et al., 2007), with particular attention to childhood (sexual) abuse. The psychometric properties of this measure can be considered good (Bremmer et al., 2007).

PROCEDURE

Data collection was undertaken between February 2018 and March 2022. When patients met the inclusion criteria, their practitioner or a researcher informed them about the study. Upon willingness to participate, a pretreatment assessment was scheduled from one week prior to the start of NET to right before the start of NET, during which informed consent was signed. Assessments were mainly carried out by the primary researchers (RG, HvH), research assistants/interns, or in some cases by the NET therapists themselves. Due to variations in spoken languages and reading proficiency, the administration of the measures was adapted to the patients' communication needs (e.g., by use of translators). Medical records were monitored by the researchers in order to derive information about the treatment process. The study partially overlapped with the COVID pandemic, during this period for three patients less than 25% of their sessions were held online.

STATISTICAL ANALYSES

Logistic regression analysis was used to test whether baseline emotion dysregulation and perceived stress differentiated between patients who completed NET treatment and those who did not.

Multiple linear regression analysis was used to test whether the NET session adherence ratio was associated with baseline daily stress levels, emotion dysregulation, and PTSD symptom severity. Regression models were evaluated by testing if individual predictors were significantly associated with the NET session adherence ratio, predictors were added to the model in two separate steps. Variables were transformed into standardised scores to allow for meaningful interpretation and comparison, while accounting for differences in normal distributions. Given the small sample size, only a limited number of predictors could be included in the regression models. As overlap between predictors could easily result in collinearity related issues, the Pearson correlations were used. First to test the bivariate relations between the predictors and the NET session adherence ratio, and second to evaluate the degree of overlap between the predictors. Statistical analyses were performed using IBM SPSS Statistics (Version 27).

RESULTS

A total of *N* = 86 patients were initially enrolled. The sample included 35 different countries of origin, mainly Uganda, Nigeria, Syria, and Sierra Leone (Table 1). Patients migrated for various (intersecting) reasons, e.g. needing to leave home because of SOGIE-related violence and during the journey becoming victimised within sex trafficking networks. The LEC-5 indicated that patients experienced an average of *M* = 8.4 (*SD* = 2.6) traumatic life events. Scores on the ETISR-SF further revealed that 61% of the sample experienced childhood sexual abuse, and 94% experienced any form of childhood abuse or neglect before the age of 18 years old.

Table 4 provides an overview of the main study variables. As displayed, mean PSS scores indicated a “moderate stress” level across the sample (Cohen et al., 1983). There are no official cut-off scores provided for the DERS-18; however the mean scores within this sample exceed previous findings amongst patient populations (Fowler et al., 2014). All but one patient scored above the recommended clinical cut-off score on the PCL-5. In general, mean scores indicated a high PTSD symptom severity within the study sample (U.S. Department of Veteran Affairs, 2023).

THE ROLE OF BASELINE PERCEIVED STRESS AND EMOTION DYSREGULATION IN NET COMPLETION

Of the full sample, *n* = 64 completed treatment and *n* = 22 (26%) discontinued treatment. The number of sessions and length of treatment varied greatly (see Table 2). Main reasons for NET drop-out were: the therapy was too high of a burden for the patient (*n* = 7), there were too many other daily stressors/life events (*n* = 6), the therapist was not able to reach the patient anymore (*n* = 2), physical health problems (*n* = 2), the patient did not believe in the effectiveness of the therapy (*n* = 2), for *n* = 3 the reason was unclear from the medical records. As seen in Table 3 logistical regression analyses revealed that none of these baseline measures significantly differentiated between completers and non-completers of NET treatment.

Table 2
Descriptive Statistics NET Treatment Variables

	Completers			Non-completers		
	M	*SD*	Range	*M*	*SD*	Range
Total number of NET sessions	18	7.22	8 – 42	4	5.51	0 – 21
Total number of non-adherent sessions	7	5.80	0 - 25	4	3.92	0 – 15
Total length of treatment in days	211	133	68 – 656	119	136	0 - 448

Note. $N = 86$ ($n = 64$ completers and $n = 22$ non-completers). NET = Narrative Exposure Therapy.

Table 3
Logistic Regression Predicting Treatment Completion (N = 86)

Predictor	*B*	S.E.	Odds ratio	Wald Statistic	*p*
Intercept	.18	1.57			
Perceived daily stress	.05	.06	0.96	.77	.38
Difficulties in emotion regulation	-.00	.03	1.05	.03	.86

THE ROLE OF BASELINE PERCEIVED STRESS, EMOTION DYSREGULATION, AND PTSD SYMPTOM SEVERITY IN NET ADHERENCE

Table 2 provides insight in the number of missed NET sessions. As displayed in Table 4 for completers, on average 73% of the planned NET sessions were attended by the patient and took place in adherence to the NET treatment protocol. Main reasons for non-attendance were: feeling overburdened by the therapy, worsening of psychiatric complaints, physical complaints, lack of day-care for children, changes in living facility/ residential procedure, competing appointments with other service providers, or mandatory naturalisation/language courses. Main reasons for NET non-adherence were: the patient was too dysregulated to initiate therapy, avoidance of the traumatic memory, or major life events or changes in housing/ residential procedure that required urgent attention.

The second aim of this study was to test whether baseline levels of perceived daily stress and emotion dysregulation were indicators for NET adherence, while accounting for PTSD symptom severity at baseline. Table 4 presents the bivariate correlations between the NET adherence ratio and baseline emotion dysregulation, perceived stress, and PTSD symptom severity. The NET session adherence ratio was significantly associated with more severe daily stress and PTSD symptom severity at baseline, but not with baseline emotion dysregulation. The moderate to strong correlations between daily stress, emotion dysregulation, and PTSD symptom severity indicated considerable overlap between these constructs.

Table 5 presents the results of the multiple regression analysis in which the NET session adherence ratio was regressed on baseline daily stress, emotion dysregulation, and PTSD symptom severity. In the first step baseline daily stress and emotion dysregulation were added to the model, accounting for 12.11% of the variance in NET adherence ratio. Baseline daily stress was significantly and positively related to the NET adherence ratio. This indicates that higher levels of daily stress are associated with higher levels of NET adherence to the NET protocol. The association between baseline emotion dysregulation and the NET session adherence ratio was not significant. Because

NET is targeting PTSD symptoms and PTSD symptom severity is also likely to play a role in NET adherence we aimed to adjust the results for baseline PTSD symptom severity. Therefore, baseline PTSD symptom severity was added to the model as a second step, accounting for an additional 2.67% of the variation in the NET session adherence ratio. As can be seen in Table 5, adding PTSD symptom severity to the model resulted in daily stress no longer being a significant predictor of the NET session adherence ratio. This is most likely due to the considerable overlap between the constructs of daily stress levels and PTSD symptom severity at baseline (see Table 4) in combination with the small sample size, causing collinearity in the regression model at this stage.

Table 4

Descriptive Statistics and Correlations between Study Variables

Variable	*n*	*M*	*SD*	1	2	3
1. NET adherence	64	0.73	.15	—		
2. Perceived daily stress	83	26.93	5.43	.37**	—	
3. Emotion dysregulation	82	58.18	10.91	.05	.44**	—
4. PTSD symptom severity	79	55.16	10.80	.31*	.46**	.44**

Note. NET = Narrative Exposure Therapy

[a] Calculated for completers only. The mean (.73) can be interpreted: for 73% of the planned sessions the patient attended the session, and treatment took place in line with the NET protocol.

*$p < .05$. **$p < .01$.

Table 5

Results of the Multiple Linear Regression Analysis in Which the NET Adherence Ration was Regressed on Baseline Daily Stress, Emotion Dysregulation, and PTSD Symptom Severity (n = 64)

Variable	*B*	*SE*	*β*	*p*
Step 1				
Intercept	-.03	.12		
Perceived daily stress	.40	.13	.43	.00
Emotion dysregulation	-.13	.14	-.13	.33
Step 2				
Intercept	.00	.12		
Perceived daily stress	.27	.15	.29	.07
Emotion dysregulation	-.11	.15	-.10	.47
PTSD symptom severity	.19	.15	.20	.19

Note. DERS -18= Difficulties in Emotion Regulation Scale -18; PCL-5 = PTSD Checklist for DSM-5; PSS = Perceived Stress Scale.

DISCUSSION

The present study examined the role of pretreatment perceived daily stress, emotion dysregulation, and PTSD symptom severity, on NET completion and adherence rates amongst a clinical sample of forced migrants. As hypothesised drop-out and non-adherence rates within the sample

were considerable. Yet, surprisingly, analyses showed that none of the baseline measures were significant indicators of NET completion or adherence. These findings suggest that individual levels of perceived stress, emotion dysregulation and PTSD symptom severity at baseline are unrelated to the likelihood of discontinuing treatment or demonstrating lower adherence rates. There are several ways to understand these findings. Most obviously the relatively small sample size or the methodological choices made might have hindered certain relationships to be detected. Alternatively, measures applied might have fallen short in assessing the realities of forced migrants, given that they are based on culturally biased conceptualisations (Bracken et al., 1997). Secondly, as daily stressors and emotion dysregulation are known to fluctuate, dynamic measures may be better suited to capture their influence on the course of treatment. Although these explanations are plausible and could direct future research, the possibility that these particular baseline factors are genuinely unrelated to NET completion and adherence rates is also worth considering.

The study's small sample size and the substantial overlap found between perceived daily stress and PTSD symptom severity may have inhibited the detection of a unique contribution for each concept separately to the treatment course. The intertwined relationship between perceived daily stress and PTSD symptom severity aligns with previous findings (e.g., Minihan et al., 2018), and initial analyses on presession measurements within the study's overarching research project (see chapter 7; van Heemstra et al., submitted). Psychopathology is known to worsen under (acute) stress, and assessing these particular concepts might capture similar areas of functioning (e.g., "lack of control"). Another explanation could be that constructs might unfold each other, making it difficult to untangle each unique influence. For instance, daily stressors may exacerbate pre-existing posttraumatic stress, as uncertainties about one's residential status may trigger feelings of unsafety related to past traumatic experiences. Vice versa, the burden of PTSD complaints might affect one's ability to adequately respond to daily stressors, thus increasing perceived daily stress.

None of the findings supported baseline emotion dysregulation levels as an indicator of the NET treatment course amongst forced migrants. This may contest the notion that emotion regulation difficulties might impair treatment feasibility, but aligns with previous ambiguous findings about this notion (e.g., Gilmore et al., 2020; Van Toorenburg et al., 2020). It is possible that a clinical setting offers holding via regular supportive contact and psycho-education, mitigation pretreatment emotion dysregulation (Helland et al., 2022). This could mean that someone might display high baseline levels of emotion dysregulation, but is still able to flexibly handle difficult moments or high arousal during treatment (Van Toorenburg et al., 2020).

Some additional findings are worth considering. First, in line with previous evidence within naturalistic settings (Kaltenbach et al., 2020), treatment length and total number of sessions needed to complete NET varied greatly, in some cases exceeding the NET protocol's recommendations (Siehl et al., 2021). Second, drop-out rates were found to be higher compared to other traumatised populations (Semmlinger et al., 2021). These findings provide further insight into the feasibility of NET and may inform the potential tailoring of its protocol to naturalistic clinical settings. Finally, in contrast with literature on daily stressors amongst forced migrants,

perceived daily stress levels within this sample was found to be moderate (Cohen et al., 1983). Also higher perceived daily stress was related to higher NET adherence rates, tentatively suggesting that patients who experience more daily stress might feel a greater urge to engage in treatment. These findings might contribute to a growing body of research on the relevance of daily stressors for forced migrants mental healthcare (Li et al., 2016).

This study offers novel insights into the indicative value of baseline measures for the course of treatment amongst forced migrants. However the study was limited by its heterogeneous and relatively small sample. Although this represents the diversity of forced migrants seeking mental healthcare in the Netherlands, the sample might have been too diverse to detect commonalities. To substantiate findings, replication within larger samples of forced migrants, or with a particular focus on specific subgroups (e.g., survivors of sex trafficking, culturally homogenous groups etc.), is needed. Second, although the study's naturalistic setting provides valuable information, it complicates comparing the sample and findings to studies with a more rigorous controlled design. For example, those labelled a "completer" within this sample might vary in terms of their total numbers of sessions and treatment length compared to those considered "completers" within controlled trails. Final, NET therapists might have differed in the quality and comprehensiveness of their note-taking. Therefore, crucial information might have been missing from the medical records, thus affecting the reliability of the outcome variables used.

In conclusion, the current study examined the role of baseline indicators on the feasibility of NET amongst forced migrants. None of selected baseline factors: perceived daily stress, emotion dysregulation and posttraumatic stress symptoms, were found to significantly indicate NET adherence or completion rates. Additional research is needed to substantiate study findings. However, findings might cautiously encourage therapists to continue the provision of trauma-focused therapies, even for patients who experience stressors in their daily lives, or who display difficulties in regulated their emotions at the start of treatment.

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AUTHOR CONTRIBUTIONS

RG: Conceptualisation, methodology, formal analysis, investigation, writing - original draft, project administration and funding acquisition.
HvH: Conceptualisation, methodology, formal analysis, investigation, writing – review & editing, project administration.
WS: Conceptualisation, methodology, supervision, writing - review & editing, funding acquisition.
SG: Conceptualisation, methodology, writing - review & editing
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REFERENCES

Asylum Information Database. (2022). *Country Report: Netherlands*. https://asylumineurope.org/wp-content/uploads/2023/05/AIDA-NL_2022update.pdf

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation: Posttraumatic stress disorder checklist for *DSM-5*. *Journal of Traumatic Stress*, *28*(6), 489–498. https://doi.org/10.1002/jts.22059

Bracken, P., Giller, J. E., & Summerfield, D. (1997). Rethinking mental health work with survivors of wartime violence and refugees. *Journal of Refugee Studies*, *10*(4), 431–442. https://doi.org/10.1093/jrs/10.4.431

Brady, F., Chisholm, A., Walsh, E., Ottisova, L., Bevilacqua, L., Mason, C., Von Werthern, M., Cannon, T., Curry, C., Komolafe, K., Robert, R. E., Robjant, K., & Katona, C. (2021). Narrative exposure therapy for survivors of human trafficking: Feasibility randomised controlled trial. *BJPsych Open*, *7*(6), e196. https://doi.org/10.1192/bjo.2021.1029

Bremner, J. D., Bolus, R., & Mayer, E. A. (2007). Psychometric properties of the early trauma inventory–self report. *Journal of Nervous & Mental Disease*, *195*(3), 211–218. https://doi.org/10.1097/01.nmd.0000243824.84651.6c

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *Journal of Nervous & Mental Disease*, *206*(1), 61–68. https://doi.org/10.1097/NMD.0000000000000774

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*(4), 385. https://doi.org/10.2307/2136404

Djelantik, A. A. A. M. J., De Heus, A., Kuiper, D., Kleber, R. J., Boelen, P. A., & Smid, G. E. (2020). Post-migration stressors and their association with symptom reduction and non-completion during treatment for traumatic grief in refugees. *Frontiers in Psychiatry*, *11*, 407. https://doi.org/10.3389/fpsyt.2020.00407

Doolan, E. L., Bryant, R. A., Liddell, B. J., & Nickerson, A. (2017). The conceptualization of emotion regulation difficulties, and its association with posttraumatic stress symptoms in traumatized refugees. *Journal of Anxiety Disorders*, *50*, 7–14. https://doi.org/10.1016/j.janxdis.2017.04.005

Drožđek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2013). Is legal status impacting outcomes of group therapy for posttraumatic stress disorder with male asylum seekers and refugees from Iran and Afghanistan? *BMC Psychiatry*, *13*(1), 148. https://doi.org/10.1186/1471-244X-13-148

Ehring, T., & Quack, D. (2010). Emotion regulation difficulties in trauma survivors: The role of trauma type and PTSD symptom severity. *Behavior Therapy*, *41*(4), 587–598. https://doi.org/10.1016/j.beth.2010.04.004

Fowler, J. C., Charak, R., Elhai, J. D., Allen, J. G., Frueh, B. C., & Oldham, J. M. (2014). Construct validity and factor structure of the difficulties in emotion regulation scale among adults with severe mental illness. *Journal of Psychiatric Research*, *58*, 175–180. https://doi.org/10.1016/j.jpsychires.2014.07.029

Frye, L. A., & Spates, C. R. (2012). Prolonged exposure, mindfulness, and emotion regulation for the treatment of PTSD. *Clinical Case Studies*, *11*(3), 184–200. https://doi.org/10.1177/1534650112446850

Ghafoerkhan, R. S., van Heemstra, H. E., Scholte, W. F., van der Kolk, J. R. J., ter Heide, J. J.F., de la Rie, S. M., Verhaak, L. M., Snippe, E., & Boelen, P. A. (2020). Feasibility and predictors of change of Narrative Exposure Therapy for displaced populations: A repeated measures design. *Pilot and Feasibility Studies*, *6*(1), 69. https://doi.org/10.1186/s40814-020-00613-1

Gilmore, A. K., Lopez, C., Muzzy, W., Brown, W. J., Grubaugh, A., Oesterle, D. W., & Acierno, R. (2020). Emotion dysregulation predicts dropout from prolonged exposure treatment among women veterans with military sexual trauma-related posttraumatic stress disorder. *Women's Health Issues*, *30*(6), 462–469. https://doi.org/10.1016/j.whi.2020.07.004

Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J., & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: A systematic review. *European Journal of Psychotraumatology*, *11*(1), 1793567. https://doi.org/10.1080/20008198.2020.1793567

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment*, *11*(4), 330–341. https://doi.org/10.1177/1073191104269954

Helland, S. S., Mellblom, A. V., Kjøbli, J., Wentzel-Larsen, T., Espenes, K., Engell, T., & Kirkøen, B. (2022). Elements in mental health interventions associated with effects on emotion regulation in adolescents: A meta-analysis. *Administration and Policy in Mental Health and Mental Health Services Research*, *49*(6), 1004–1018. https://doi.org/10.1007/s10488-022-01213-2

Hynie, M. (2018). Refugee integration: Research and policy. *Peace and Conflict: Journal of Peace Psychology*, *24*(3), 265–276. https://doi.org/10.1037/pac0000326

Human Rights Council. (2023). How to expand and diversify regularization mechanisms and

programmes to enhance the protection of the human rights of migrants. https://documents dds-ny.un.org/doc/UNDOC/GEN/G23/075/40/PDF/G2307540.pdf?OpenElement

Imel, Z. E., Laska, K., Jakcupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *81*(3), 394–404. https://doi.

org/10.1037/a0031474

Kaltenbach, E., Hermenau, K., Schauer, M., Dohrmann, K., Elbert, T., & Schalinski, I. (2020). Trajectories of posttraumatic stress symptoms during and after Narrative Exposure Therapy (NET) in refugees. *BMC Psychiatry*, *20*(1), 312. https://doi.org/10.1186/s12888-020-02720-y

Lee, E.-H. (2012). Review of the psychometric evidence of the perceived stress scale. *Asian Nursing Research*, *6*(4), 121–127. https://doi.org/10.1016/j.anr.2012.08.004

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum Seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

McLean, C. P., & Foa, E. B. (2017). Emotions and emotion regulation in posttraumatic stress disorder. *Current Opinion in Psychology*, *14*, 72–77. https://doi.org/10.1016/j.copsyc.2016.10.006

Minihan, S., Liddell, B. J., Byrow, Y., Bryant, R. A., & Nickerson, A. (2018). Patterns and predictors of posttraumatic stress disorder in refugees: A latent class analysis. *Journal of Affective Disorders*, *232*, 252–259. https://doi.org/10.1016/j.jad.2018.02.010

Mitchell, S., Mitchell, R., Shannon, C., Dorahy, M., & Hanna, D. (2023). Effects of baseline psychological symptom severity on dropout from trauma-focused cognitive behavior therapy for posttraumatic stress disorder: A meta-analysis. *Traumatology*, *29*(2), 112–124. https://doi.org/10.1037/trm0000404

National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children. (2021). *Slachtoffer monitor mensenhandel 2016–2020*. https://www.nationaalrapporteur.nl/mensenhandel/publicaties/rapporten/2021/12/07/slachtoffermonitor-mensenhandel-2016-2020

Nowak, A. C., Namer, Y., & Hornberg, C. (2022). Health care for refugees in Europe: A scoping review. *International Journal of Environmental Research and Public Health*, *19*(3), 1278. https://doi.org/10.3390/ijerph19031278

Office of the United Nations High Commissioner for Human Rights. (2021). *Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations*. https://www.ohchr.org/sites/default/files/Documents/Issues/Migration/PrinciplesAndGuidelines.pdf

Patanè, M., Ghane, S., Karyotaki, E., Cuijpers, P., Schoonmade, L., Tarsitani, L., & Sijbrandij, M. (2022). Prevalence of mental disorders in refugees and asylum seekers: A systematic review and meta-analysis. *Global Mental Health*, *9*, 250–263. https://doi.org/10.1017/gmh.2022.29

Schauer, M., & Elbert, T. (2010). Dissociation following traumatic stress: Etiology and treatment. *Zeitschrift für Psychologie / Journal of Psychology*, *218*(2), 109–127. https://doi.org/10.1027/0044-3409/a000018

Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders* (2nd rev. and expanded ed). Hogrefe.

Seligowski, A. V., Lee, D. J., Bardeen, J. R., & Orcutt, H. K. (2015). Emotion regulation and posttraumatic stress symptoms: A meta-analysis. *Cognitive Behaviour Therapy*, *44*(2), 87–102. https://doi.org/10.1080/16506073.2014.980753

Semmlinger, V., & Ehring, T. (2022). Predicting and preventing dropout in research, assessment and treatment with refugees. *Clinical Psychology & Psychotherapy*, *29*(3), 767–782. https://doi.org/10.1002/cpp.2672

Semmlinger, V., Takano, K., Schumm, H., & Ehring, T. (2021). Dropout from psychological interventions for refugees and asylum seekers: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *89*(9), 717–730. https://doi.org/10.1037/ccp0000681

Siehl, S., Robjant, K., & Crombach, A. (2021). Systematic review and meta-analyses of the long-term efficacy of Narrative Exposure Therapy for adults, children and perpetrators. *Psychotherapy Research*, *31*(6), 695–710. https://doi.org/10.1080/10503307.2020.1847345

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry*, *16*(2), 130–139. https://doi.org/10.1002/wps.20438

Ter Heide, F. J. J., & Smid, G. E. (2015). Difficult to treat? A comparison of the effectiveness of treatment as usual in refugees and non-refugees. *BJPsych Bulletin*, *39*(4), 182–186. https://doi.org/10.1192/pb.bp.114.047928

U.S. Department of Veterans Affairs. (2022). *PTSD Checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

van Heemstra, H. E., Ghafoerkhan, R., Scholte, W. F., van der Schoot, R., & Boelen, P. A. (under review). The relevance of perceived daily stress, emotion regulation and mood for PTSD trajectories among forced migrants receiving trauma focused therapy.

Van Toorenburg, M. M., Sanches, S. A., Linders, B., Rozendaal, L., Voorendonk, E. M., Van Minnen, A., & De Jongh, A. (2020). Do emotion regulation difficulties affect outcome of intensive trauma-focused treatment of patients with severe PTSD? *European Journal of Psychotraumatology*, *11*(1), 1724417. https://doi.org/10.1080/20008198.2020.1724417

Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the difficulties in emotion regulation Scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment*, *38*(4), 582–589. https://doi.org/10.1007/s10862-016-9547-9

VluchtelingenWerk. (2021). *Web van wantrouwen. Hoe de menselijke maat verdwijnt uit het asiel- en integratiebeleid*. https://www.vluchtelingenwerk.nl/sites/default/files/2021-12/VluchtelingenWerk%20Nederland_Web%20van%20Vertrouwen_Juni%202021%20%282%29.pdf

Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy*, *47*(2), 119–127. https://doi.org/10.1016/j.brat.2008.10.018

CHAPTER 9

Summary of Main Findings and General Discussion

In this dissertation our overall aim was to make a contribution to the understanding of the mental health (needs) of forced migrants, in particular for sexual violence and trafficking survivors. The number of people who are forced to migrate due to conflict, war and natural disasters is at an all-time high, and projected to grow in the coming decades (United Nations High Commissioner for Refugees, 2023). Concurrently, this population is likely to face sexual violence and trafficking prior to, during, and after their journeys. Some of these people will find their way to the Netherlands, where they might seek mental health treatment. In this dissertation, we have used various methodologies to explore common legal and mental health concepts, examine the diversity of sex trafficking experiences, address sexual revictimisation risk, and examine predictors of change during trauma-focused treatment for this population. In this final chapter, we will summarise and discuss the main findings, and outline this dissertation's limitations, strengths, implications, and recommendations.

SUMMARY OF MAIN FINDINGS

SECTION 1. SURVIVORS OF SEXUAL VIOLENCE AND TRAFFICKING

The first section was focused on migrant survivors of sexual violence and trafficking and contained three chapters. In **chapter 2** we explored the nexus between labels of "trafficking in human beings" and "conflict-related sexual violence" from a psychological and legal point of view. Accumulative sexual violence is particularly present in settings of ongoing conflict. Its consequences fall disproportionally on survivors, as compared to the perpetrators. We concluded that there seems to be no valid basis for a clear-cut distinction between the two aforementioned labels from a psychological perspective. However, from a legal standpoint, the distinction matters greatly in the chances of prosecuting perpetrators and granting survivors specific rights. This tension underscores the need for collaboration between mental health and legal professionals to accurately recognise and address survivors' experiences of sexual violence during conflict. In **chapter 3** we applied a person-centered approach to identify subgroups within sex trafficking experiences amongst a clinical sample of 337 women adult survivors. We found two subgroups of survivors: 1) those who were restricted in their movement ("locked up") by a non-intimate perpetrator, and 2) those who were mainly emotionally coerced into sex trafficking within an intimate relationship. When considering various associations of these subgroups, we found that being born in an African country, identifying as lesbian, and having a residential uncertainty were more likely within the first subgroup. Furthermore, when examining if these subgroups could predict mental health (treatment) outcomes, we found that discontinuing mental health treatment was more likely within the second subgroup. Finally, in **chapter 4** we used a multi-method approach to examine the feasibility of a novel body-oriented module aimed at mitigating sexual revictimisation amongst 13 (forced) migrant survivors of sexual violence and trafficking. Patients and facilitators attributed changes to the module that were in line with the intended outcomes. Furthermore, Bayesian informative hypothesis evaluation revealed that, for around

two-thirds of patients, body awareness/connection as well as self-efficacy in communicating boundaries improved. We concluded that a body-oriented approach to sexual revictimisation risk mitigation was feasible, and that the module's effectivity and further implementation are worthwhile to consider.

SECTION 2. FORCED MIGRANTS

In the second section, containing four chapters, we focused on the mental health of forced migrants, including those who survived sexual violence and trafficking. In **chapter 5** we explored conceptualisations of "neglect" at the intersect of mental health, gender and protracted displacements. We interviewed 20 people with professional and/or lived experience of displacement. Drawing from insights from medical anthropology and psychology, we concluded that "neglect" must be considered in the context of: i) differential (health) priorities; ii) discrepancies between overt socially disruptive distress and covert socially containable distress; and iii) containment strategies around sexual violence. In **chapter 6** we introduced the protocol for an observational treatment study on adherence and predictors of change during Narrative Exposure Therapy (NET). In this study, NET was offered to forced migrants, including sexual violence and trafficking survivors. All patients were clinically diagnosed with posttraumatic stress disorder (PTSD), in an outpatient mental health clinic in the Netherlands. We considered perceived daily stress, emotion dysregulation, and mood as predictors of change in posttraumatic stress (PTS) during NET. In total, 86 patients were included in the study and 40 patients completed therapy in line with the study protocol. We shared the main findings of this study in the two following chapters. In **chapter 7** we presented the findings on measures administered prior to each NET session. Using Bayesian latent growth modelling and random-intercept cross-lagged modelling, we found that NET coincides with improvements in PTS, perceived daily stress and emotion dysregulation. Notably, the model fit was insufficient for mood. Therefore, no inferences could be made about the role of mood on PTS during NET. Furthermore, although changes in perceived daily stress and PTS were interrelated, they did not consistently predict each other over time. We concluded that, while perceived daily stress and PTS respond to treatment in similar ways, neither seems to be needed for subsequent changes in the other. Lastly in **chapter 8,** we presented findings on the predictive value of perceived daily stress and emotion regulation pretreatment levels on subsequent NET treatment adherence and completion. None of the pretreatment measures were found to predict the completion of NET. At first, pretreatment levels of perceived daily stress appeared to predict NET treatment adherence. However, upon considering pretreatment PTSD symptom severity, this relationship ceased to hold. We concluded that, in the current sample, perceived daily stress and emotion dysregulation were not specifically related to NET treatment completion and adherence.

GENERAL DISCUSSION

IDENTIFICATION AND RECOGNITION OF SEX TRAFFICKING EXPERIENCES

In chapter 2, we delineated how some legal labels might not represent survivors' lived experiences, but affect their lives nonetheless. Criteria as outlined in legal definitions determine whose past (potentially traumatic) experiences get recognised and who might be eligible for (temporary) residence in the Netherlands (Kollen et al., 2022; Rijken et al., 2021). As reiterated by the Dutch National Rapporteur on Human Trafficking and Sexual Violence against Children (2021), sex trafficking survivors' access to protective measures and temporary residential status (after the three month reflection period) are dependent on their cooperation with the criminal proceedings. Consequently, survivors' access to (health)care, support, and shelter relies on identification by law enforcement agencies, and then, after a three months reflection period, on the survivors' willingness to cooperate in investigations and legal proceedings. This poses several issues, including the exclusion of specific survivors who are unable or unwilling to cooperate with law enforcement or in whose cases insufficient evidence is found for the prosecutor to continue the criminal case. Furthermore, it exacerbates inequalities between survivors in their pursuit of justice, due to disparities in their residential status and potential for identification (Rijken et al., 2021). In turn, it further perpetuates the cycle of vulnerability (Maiorano et al., 2023), and potential re-exploitation for these survivors.

Our findings in chapter 3 revealed a particular pattern within sex trafficking experiences that might coincide with residential uncertainty. This pattern involved exploitation by an unknown perpetrator using physical threats and confinement of a relatively shorter duration. The women within this group were mainly from African countries, and some identified as lesbians. This pattern resembles a controversial narrative. In this narrative, an African lesbian woman's sexual orientation is revealed in her country of origin, usually by photos of her and her partner kissing. As a result she faces immense violence and fears for her life and is forced to leave her home. Then someone, usually her sexual partner, connects her to a person who can help her escape her country and supposedly find safety. However, upon arrival in the Netherlands, she is met by someone who forces her into sex work. Often her passport is taken away and she has to earn back the costs for the travel by sex work. After weeks or months of forced sex work, she sees someone has forgotten the key in the front door, she opens the door and manages to escape. She then finds the police and askes for special protection as a survivor of human trafficking.

The validity of this particular narrative has been questioned by the Dutch immigration and naturalisation service (Kollen et al., 2022; Rengers & Kuiper, 2019). Some argued that this narrative might be fabricated and misused to gain access to protection and temporary shelter, since there were many similarities between survivors' testimonies which seldom resulted in prosecution. However, the lack of investigative indicators does not equal a lack of victimhood (Bolhaar, 2019). Similarities within these stories could well indicate structural tactics applied within organised trafficking networks (e.g., as seen in the international investigative operation "Koolvis"; Kamerman & Wittenberg, 2009). In addition, survivors might be unable to share the complex in-depth details of

their experiences, due to threats towards loved ones or personal beliefs like voodoo (Millett-Barrett, 2019). These discussions further underline the discord between the immigration and naturalisation service and investigative mandates, and the lived realities of survivors of sex trafficking.

UNDERSTANDING SEX TRAFFICKING EXPERIENCES BEYOND THE SURFACE

As introduced in chapter 1, the dominant discourse on sex trafficking portrays survivors as vulnerable girls coerced through physical confinement, and perpetrators as dominant violent seducers (Hockett et al., 2016; Merodio et al., 2020; Zhang, 2009). While these narratives may apply to some, the stories shared by survivors are diverse and intricate (Andrijasevic & Mai, 2016; Hoyle et al., 2011; Kleemans, 2011). Some forced migrants may have known their journey or destination would entail sex work, and the type and extent of deceit, violence, and coercion may vary (Vanwesenbeeck, 2013). In chapter 3, we aimed to contribute to this nuance by disentangling the heterogeneity of sex trafficking experiences amongst a clinical sample of women survivors. Consistent with existing literature, we found distinct patterns that may contribute to our understanding of differential psychological consequences, and inform tailored treatment approaches.

We found a pattern of emotional coercion into sex trafficking within an intimate relationship, with high probability of physical violence, and a lower likelihood of physical confinement. These findings link to the phenomenon of "trauma bonding", that has received increased attention over the course of this dissertation (Casassa et al., 2022, 2023a; Reid, 2023). In the context of sex trafficking, this refers to a paradoxical relationship, where the perpetrator threatens the victim's physical and psychological safety, yet exhibits occasional kindness, within a setting where the victim is isolated and unable to leave (Reid et al., 2013). In line with Casassa et al. (2023b), as compared to the other subgroup, we observed an elevated likelihood that these survivors were given drugs, suggesting this may play an important role within this coercive pattern.

We also identified a subgroup primarily consisting of African survivors, who were situated at the intersect of sex trafficking, ongoing residential uncertainty, and for some identifying as lesbian. In the previous section, we outlined the challenging position this group holds in being recognised as survivors of sex trafficking while seeking justice and safety. For them, physical confinement by an unknown perpetrator was the common denominator within their experiences, for some undergoing voodoo rituals as a coercive tactic. This aligns with the necessity for some individuals to flee due to experiences of sexual orientation and gender identity expression (SOGIE) related violence. This often entails using hazardous smuggling routes (Kuschminder & Triandafyllidou, 2020), putting them at-risk for sex trafficking (Martinez & Kelle, 2013; Kollen et al., 2022). As outlined in chapter 5, potentially traumatising events experienced pre- and peri-migration must not be overlooked, given the horrendous testimonies along smuggling routes (Adeyinka et al., 2023).

WHAT IS THE ROLE OF MENTAL HEALTH CARE IN MITIGATING SEXUAL REVICTIMISATION?

The risk for sexual violence and revictimisation amongst forced migrant survivors of sexual violence and trafficking is a global problem (Baba et al., 2023). Thus, comprehending sex trafficking's root causes and effective mitigation strategies necessitates a multidimensional and international

approach (Zimmerman & Kiss, 2017). The risks of sex trafficking and revictimisation are rooted in social determinants, such as global and gender inequality, and political choices in migration policy (Truong & Belen Angeles, 2005; United Nations Office on Drugs and Crime, 2008). Echoing this reality, therapists interviewed in chapter 4 were critical of the role of mental healthcare in addressing sexual revictimisation. Mainly, they were concerned about the scope of a short-term treatment module in mitigating such a complex and deeply rooted phenomenon.

These concerns align with academic debate on the tension between social determinants and mental health in addressing complex matters. For instance Patel (2014, p. 782) states that using social determinants as an argument to disregard the role of mental healthcare "…would be tantamount to telling a woman whose arm has been broken by her violent husband that she should approach political leaders to sort out gender inequalities rather than fixing her arm!". Likewise, one of the therapists in chapter 4 said: "It is our duty to reduce such risks, when we are able to. We need to stay away from fatalistic thinking, thinking it is so complex that we should not even try to address it." Both these quotes oppose a dichotomous or simplistic view in addressing complex matters such as sexual violence and revictimisation. The sad reality is that the risk of sexual violence amongst forced migrants is omnipresent (Hossain et al., 2014; Watts & Zimmerman, 2002), encompassing the likelihood of sexual revictimisation. This urges mental health professionals to acknowledge and address this elevated risk amongst forced migrants, within the scope of their possibilities.

A BODY-ORIENTED APPROACH TO SEXUAL REVICTIMISATION

The literature on sexual revictimisation has grown during the period the work in this dissertation was conducted (e.g., Hébert et al., 2021; Jaffe et al., 2023; Walker et al., 2019). However, literature specifically addressing forced migrant populations remains scarce. Findings in chapter 3 revealed that around 20% of sex trafficking survivors had experienced multiple distinct periods of sex trafficking. In chapter 4, we found a body-orientated approach to be feasible and promising in mitigating sexual revictimisation risk amongst sexual violence survivors. Our conclusion aligned with a growing clinical interest in body-oriented approaches, in part influenced by van der Kolk's (2015), and Ogden's (2015) substantial works. Neurobiological research has confirmed the impact of psychological trauma on the body's stress systems, brain structures, and their functioning (Burback et al., 2023). Yet, there is a need to bridge the gap between this fundamental research, and its implications for body-oriented therapies in mental healthcare (Van De Kamp et al., 2023). Several modules aimed at addressing sexual revictimisation are presented in the literature (e.g., Heinrichs & Brühl, 2022; Johnson & Zlotnick, 2006; Messman-Moore & McConnell, 2018; Wolfe, 1996). However, to the best of our knowledge, none of these are specifically targeted towards forced migrants populations. In the aftermath of trauma staying present-centred poses a challenge, for instance by intrusions or triggers pulling individuals back into the past (Boyd et al., 2018). In chapter 4, we observed that survivors of sexual violence, suffering from post-traumatic stress symptoms, showed an increased bodily presence, awareness, and the ability to assert personal boundaries, while engaging in a body-oriented module. Previous research focused on the body-

oriented modules, reported similar outcomes (Çesko, 2020; Schaeffer & Cornelius-White, 2021). These concepts could be of particular interest in addressing sexual revictimisation, as difficulties in responding to risky situations and body dissociation have long been considered key risk factors (Cloitre et al., 1997; Messman-Moore & Brown, 2006; Walker & Wamser-Nanney, 2023). Although a relatively under-researched area, employing body-oriented approaches amongst forced migrants holds promise for breaking the cycle of victimhood.

THE UNRESOLVED RELATIONSHIP BETWEEN DAILY STRESSORS AND PTSD IN FORCED MIGRANTS

Upon their arrival in the Netherlands, forced migrants' lives become centred around residential procedures, awaiting their outcomes, and transitioning from one shelter to another. This is accompanied by stressors, such as stigmatisation, financial difficulties, family separation, and residential insecurity. Providing mental healthcare for forced migrants is intricately entwined with this challenging social context that impacts undergoing treatment (Semmlinger et al., 2021). In our samples in chapter 3 and 8, around half to three-quarters of patients lived in residential uncertainty, for some despite being in the Netherlands for years. Notably, in chapter 5, managing daily stressors was found to be gendered, for instance by women needing to prioritise collective wellbeing over individual wellbeing. Indeed, in both chapter 4 and 8, we found a lack of daycare and family stressors to be key reasons for discontinuation of treatment. Various studies have underlined the adverse impact of residential uncertainty and daily stressors on forced migrants' mental health, including PTSD (Byrow et al., 2022; Li et al., 2016; Specker et al., 2023).

As outlined in chapter 1, the potentially impeding impact of daily stressors on the course of treatment has been the focus of various studies, leading to overall inconclusive results on its influence (Bruhn et al., 2018; Djelantik et al., 2020; Kaltenbach et al. 2020). Considering session notes examined in chapters 4, 7 and 8 of this dissertation, the hindrance of daily stressors to the course of treatment was reaffirmed. Additionally, using questionnaires in chapter 7, we observed that posttraumatic and daily stress followed a similar trajectory during trauma-focused therapy, perhaps suggesting a potential fundamental stress underlying both constructs. However, a predictive relationship throughout the course of treatment could not be established. In chapter 8, the positive association found between pretreatment perceived daily stress and treatment adherence contradicted our initial expectations. These findings implied that individuals experiencing higher levels of daily stressors prior to treatment, would demonstrate better treatment adherence. This may oppose common assumptions about treating forced migrants, and perceptions derived from session notes. Again, in subsequent analytical steps, this association did not demonstrate predictive significance. Nevertheless, this finding does provide intriguing hypotheses for the association between daily stressors and trauma-focused treatment. For instance, heightened impairment due to daily stressors may increase forced migrants' motivation for treatment. Or therapists may exhibit greater flexibility, or provide more therapeutic holding to those experiencing higher levels of stress. Currently, in the literature and in this dissertation, the relationship between daily stressors and PTSD during trauma-focused therapy remains unresolved.

RETHINKING EMOTION DYSREGULATION DURING TREATMENT FOR FORCED MIGRANTS

In chapter 1, we introduced the ongoing debate around the prioritisation of stabilisation before treatment, and the potential hindrance of emotion dysregulation during trauma-focused therapies. Emotional dysregulation is a prominent complaint categorised under PTSD, especially in cases of (early) interpersonal trauma and complex PTSD (American Psychiatric Association, 2013; Burback et al., 2023). Moreover, emotional dysregulation is considered to be a risk and maintaining factor of PTSD (Burback et al., 2023; Seligowski et al., 2015), including amongst forced migrant populations (e.g., Doolan et al., 2017; Specker et al., 2023). Accordingly, in chapter 7, we found that emotion dysregulation, in particular emotional impulsivity, improves during trauma-focused therapy. However, changes in emotional dysregulation were found to be unrelated to changes in posttraumatic stress symptoms. Furthermore, in chapter 8, pretreatment levels of emotion dysregulation were not found to be associated with treatment discontinuation or adherence. These results align with previous studies that could not establish a link between emotion dysregulation and treatment outcomes for traumatised patients (e.g., Van Toorenburg et al., 2020). One explanation could be that the complex relationship between emotion dysregulation and posttraumatic stress symptoms could not be fully elucidated within the statistical model, suggesting a need for further exploration. Theoretical models on emotional dysregulation (e.g., "window of tolerance"; Ogden et al., 2006) are valued in conceptualising arousal levels in psycho-education, and trauma-focused therapies. However, another hypothesis could be that the framework of emotion dysregulation may be less relevant in explaining treatment outcomes, completion, or adherence amongst forced migrants.

LIMITATIONS AND STRENGTHS

CONCEPTUAL CONSIDERATIONS

Conceptually, the challenge of addressing forced migration and sex trafficking necessitates a multidisciplinary and cross-border approach to address its challenges (Zimmerman & Kiss, 2017). In chapter 2 and 5 of this dissertation, we have collaborated with legal professionals and anthropologists in an attempt to come to an integrated understanding of various conceptualisations. In addition, this dissertation navigates through a spectrum of mental health frameworks, reflective of current debates on global mental health (Bemme & Kirmayer, 2020). For instance, while chapter 5 advocates for a broader and contextualised understanding of wellbeing, chapters 6-8 predominantly immerse in individualised PTSD frameworks to explain forced migrants' suffering. Furthermore, we aimed to challenge simplified conceptualisations of sex trafficking survivors. However, some of the choices made in this dissertation are reinforcing such stereotypes. The study setting in chapters 3 and 4, an outpatient clinic mainly serving treatment-seeking women survivors of sex trafficking, constrained the range of sampling possibilities. This resulted in an emphasis on the suffering and vulnerability of mainly women survivors throughout chapters 2-4. In addition, our sole focus on women survivors in chapter 3 runs the risk

of reinforcing gendered notions of victimhood, disregarding the experiences of male or SOGIE-diverse survivors. Furthermore, the selected indicators of sex trafficking experiences in chapter 3 emphasised ideas about a vulnerable survivor and a single perpetrator. The study was limited in capturing the narrative of a substantial group of survivors who were exploited within trafficking networks (Diviák et al., 2023). Overall, a major omission in this dissertation are the perspectives on perpetrators (Hong & Marine, 2018), for instance on their role in upholding sexual revictimisation.

METHODOLOGICAL CONSIDERATIONS

Methodologically, this dissertation contains uncontrolled cohort studies with small samples of forced migrants seeking specialised mental health care in the Netherlands. The study setting and small samples, limit the findings' generalisability beyond the Netherlands, or beyond clinical samples of forced migrants and sexual violence survivors. The lack of a control group in chapters 4, 7 and 8, limits the ability to assess whether observed associations and changes results from the intervention, a natural course, or other influences. In chapter 4, we addressed this challenge by making use of a multi-method (quantitative and qualitative) and multi-informant (therapist and patient) approach. This allowed for triangulation of findings on the module's feasibility from various perspectives and data sources. In addition, we applied intra-personal analysis to make inferences about treatment feasibility despite the study's limited sample size.

Nonetheless, the small samples have likely impaired the reach of the analyses, and might have prevented certain relationships from being detected (Type II error; Shreffler & Huecker, 2023). As seen in chapter 7, predetermined hypotheses, such as the interplay between depressed mood and PTSD during NET, could not be tested. This was likely due to the complexity of the proposed model outweighing the study's sample size. Similarly, in chapter 8, the contribution of pretreatment perceived daily stress in explaining treatment adherence was diminished upon considering pretreatment PTSD symptom severity. It is plausible that conducting these analyses within a larger sample might enhance the detection of their specific contribution to the course of treatment. All study findings must therefore be interpreted with caution, in order to prevent misinforming clinical practice and policy.

CONTEXTUAL CONSIDERATIONS

A substantial part of the research in this dissertation took place during the COVID-19 pandemic. When news of the pandemic first emerged, all mental health facilities had to suspend in-person visits, leading to interruptions or treatment discontinuation. The challenges brought about by the pandemic revealed pre-existing societal inequalities (Mengesha et al., 2022). For forced migrants in the Netherlands, this often meant increased isolation, a lack of daily activities, and concerns regarding the well-being of family members in environments with limited health resources. Many lacked sufficient Internet access or privacy to continue their treatment remotely online. As society gradually reopened, conducting clinical research entered an unpredictable phase with various lockdowns, cancellations due to positive tests from either the patient or therapist, and disruptions due to school closures, among other factors. Undoubtedly, for a small subset within

chapters 4, 7, and 8, the worldwide pandemic influenced the data collected, research procedures, and treatment outcomes.

Overall, notwithstanding the various limitations of the studies, their major strength was the external validity of the study samples, designs, their implementation process, and eventual findings. Most studies within this dissertation are strongly linked to questions that arose from clinical experience in working with forced migrants. For forced migrants, including sex trafficking survivors, the opportunity to engage in therapy is usually short and rare. They are often relocated between shelters, may lose access to services due to changes in residential status, or will need to prioritise other aspects of their wellbeing as they come along (see chapter 5). Beforehand, we set out to find research designs and analyses able to capture the unruly reality of providing mental healthcare to forced migrants (Djelantik et al., 2022). Evidently, implementing clinical research amongst forced migrants required flexibility. It involved stretching treatment protocols, accommodating no-shows and treatment interruptions, addressing missing data, and allowing variations in treatment duration. As seen in chapter 4 and 8, around a quarter of included patients discontinued treatment, and in chapter 8 one out of four sessions did not take place in line with the treatment protocol. Through our methodological and implementation decisions, we sought to closely mirror the challenging circumstances forced migrants and their therapists encounter while addressing mental well-being.

IMPLICATIONS AND RECOMMENDATIONS

IMPLICATIONS FOR RESEARCH

Cross-Cultural Considerations in Evidence-Based Treatment for Forced Migrants

In this dissertation, one of the main aims was to understand obstacles in treatment feasibility amongst forced migrants. Establishing an evidence base for treating traumatised forced migrants necessitates cross-cultural perspectives, while allowing for therapist's creativity and cultural humility (Bemme & Kirmayer, 2020). Extensive research in transcultural psychiatry and global mental health consistently highlights the diversity in which distress and suffering are expressed across populations and cultures (Lewis-Fernández & Kirmayer, 2019). This is in line with long-standing debates challenging the "cultural universality" of mental health diagnoses (Canino & Alegría, 2008), treatments (Adams & Kivlighan, 2019), and questionnaires (Greene et al., 2023). Therefore, it is crucial to develop quantitative and qualitative assessment tools, capable of capturing culturally specific presentations of distress (de Jong & van Ommeren, 2002). Future research should emphasise a closer integration of forced migrants' explanatory models for distress and healing, and standardised research methodologies to evaluate treatment feasibility and effectiveness for this population.

Disentangling "Sex" and "Sexual Violence"

Is "sex" a good term to use in non-consensual or forced sex acts? Or are these acts better

categorised as forms of oppression, genital torture, violence or injury? These acts are embedded in power dynamics, upholding gender equalities, and marginalisation of SOGIE-diverse people (Hong & Marine, 2018). This became increasingly evident in the aftermath of #METOO movement, as individuals in positions of authority were found to have a long-standing misuse of their power (e.g., religious institutes, entertainment industry, universities, and the military; Erlingsdóttir & Chandra, 2021). Times of war may serve as a particular example to illustrate this point. In these circumstances, the perpetrators often belong to a dominant aggressor group, while the victims are typically from persecuted or oppressed ethnic or religious groups (Buss, 2009). Interestingly, Boesten (2022) describes sexual violence against men in times of war as "…torture practices against men and boys may also be highly sexualised and focus on harming genitals". This suggests that the choice of terminology and ease of applying the label of "sexual violence" to an experience may be gendered (Ticktin, 2011; Zalewski et al., 2018). Future research could further consider the dynamics involved in choosing the terminology for these acts. It might be considered to refrain from conflating the label "sex", implying pleasure, lovemaking, reproduction, or consensual transactions, with dynamics of coercion, exploitation, or forced acts.

Understanding the Impact of Legal Labels and Residential Procedures

The interplay between legal frameworks, lived experiences and mental health outcomes for forced migrants, has been a running thread throughout this dissertation. An outstanding research aim is to increase our understanding of the effects of legal labels and residential procedures on the wellbeing of forced migrants (Rijken et al., 2021). First, future research might focus on the importance of legal recognition for migrant sexual violence survivors, exploring its impact on their overall recovery process. For instance, what does it mean to be acknowledged as a survivor of conflict-related violence by an independent judge, and does this impact one's wellbeing? And vice versa, how does it impact one's wellbeing when a sex trafficking report is being dismissed by law enforcement? Second, practitioners are well aware of the impact of residential uncertainty on forced migrants' mental health, and its hindrance to the treatment process (Norredam et al., 2006). However, there is a need for substantiating the mental health burden imposed by this residential uncertainty (Laban et al., 2008). Furthermore, this could provide valuable insights into its implications for resources and healthcare costs, considering factors such as no-shows and treatment discontinuation.

Understanding the Heterogeneity of Sex Trafficking Experiences

In this dissertation, we sought to understand the diversity of sex trafficking experiences amongst a clinical sample of women survivors. However, there is a depth of intricacies yet to be explored, to gain comprehensive insights in sex trafficking experiences (Iglesias-Rios et al., 2020; Lightowlers et al., 2021). Specifically, a deeper understanding of the association between countries of origin, smuggling routes, and the particular patterns of sex trafficking is needed (Vorrath, 2022). This encompasses a closer examination of the unique circumstances faced by individuals victimised during weaponised conflict, and individuals subjected to SOGIE-related violence. This research

may further explain specificities in the psychological aftermath of sex trafficking, and inform tailored mental health treatments approaches.

Sexual Revictimisation Amongst Forced Migrants From a Mental Health Perspective

There is a growing interest in understanding and addressing the complex drivers of sexual revictimisation, however literature on forced migrant populations considerably lags behind (e.g., Hébert et al., 2021; Jaffe et al., 2023; Walker et al., 2019). This dissertation revealed the potential of improved communication of personal boundaries, and enhanced awareness and connection to body signals. Future research may further explore these constructs as effective strategies to mitigate sexual revictimisation. Furthermore, there is a necessity for in-depth research to identify other factors that contribute to safety after sexual violence amongst diverse samples of survivors.

This dissertation's findings supported a body-oriented approach for the mitigation of sexual revictimisation risk amongst (forced) migrants. In future studies, the module outlined in chapter 4 might be further adapted to specific subgroups (e.g., related to "trauma bonding", and at the intersect of SOGIE-related and sexual violence). Also, more research is needed to test the effectiveness of this module, and its potential for scalability. Finally, there is an overall need for a stronger evidence base for body-oriented work (Van De Kamp et al., 2023), in particular for forced migrants.

IMPLICATIONS FOR CLINICAL PRACTICE

How to Deal with Bearing Witness to Atrocities

Therapists providing mental health treatment to forced migrants bear witness to gross injustices and human right violations. At times, care provision for forced migrants is done under absurd circumstances. For instance, therapists may provide trauma-focussed therapies to persons who are homeless, who may not know if their loved ones are still alive, or whose war experiences are not being validated by a refugee status. Therapists are faced with the reality that sex trafficking perpetrators, or "customers," are rarely convicted, but nonetheless hear continuous gruesome accounts from those who survived their acts. These realities impose a significant burden and responsibility on therapists, both as a professional, and as human being (Ebren et al., 2022). For some therapists, these circumstances might evoke a sense of social responsibility to seek recognition or advocate for the patient populations they serve. How this sense of responsibility might manifest, whether through activism, meaning-making, or other avenues, is a deeply personal choice. Regardless, it is important for each therapist to navigate within this dynamic, and find ways to deal with their role in bearing witness to the narratives of those who have seen the worst of humanity.

Address the Specific Needs of Various Sexual Violence and Trafficking Survivors

The need to consider and address posttraumatic complaints amongst survivors of sexual violence is well established (Chen et al., 2010). However, beyond these well-defined mental health consequences, social exclusion and social isolation may also be considered as outcomes of sexual violence (see chapter 5). Additionally, in chapter 3 nearly half of the survivors were either pregnant or had children. Thus, taking into account the (mental) health needs of these children

and supporting survivors in their roles as in mothers is crucial. Moreover, therapists might consider the distinct psychological consequences, associated with specific sex trafficking experiences (see chapter 3). Stereotypes and preconceived notions about what sexual violence or sex trafficking entails are deeply ingrained in our societies and histories (Mortimer et al., 2019). Therefore, in working with survivors, therapists may need to be vigilant in confronting their own biases (Litam, 2019). This may include informing oneself about dynamics that have received less attention, such as tonic immobility (i.e., paralyses during sexual violence; De La Torre Laso, 2023), or arousal non-concordance (i.e., a physiological genital response, or orgasm during sexual violence; Shin & Salter, 2022). These dynamics may exacerbate psychological suffering, and hinder treatment engagement, since they are often infused with shame (Van Minnen, 2018). Ultimately, recognising and understanding these less acknowledged aspects of sexual violence may exonerate survivors, and disentangle cycles of revictimisation.

For some, their sex trafficking experience might have aligned with dynamics of "trauma bonding", i.e., a paradoxical relationship where intimacy and unsafety are intertwined. A history of (childhood) sexual abuse is considered a likely risk factor for these types of coercive tactics (Casassa et al., 2022). For these survivors the psychological aftermath may involve feelings of self-doubt about one's victimhood, a sense of betrayal towards the perpetrator, and mislabelling of harmful physical and psychological acts as part of a caring relationship (Casassa et al., 2021; Preble, 2021; Verhoeven et al., 2015). This renders survivors particularly vulnerable towards sexual revictimisation. In this dissertation, this pattern was linked to a higher likelihood of treatment discontinuation, underlining the need for tailored treatments (Chambers et al., 2022; Norfleet, 2020). This may involve untangling coercive patterns, potentially rooted in early experiences of unsafety, and re-defining what safety in relationships truly entails.

For other victims, experience of sex trafficking may have been characterised by being locked up by an unknown perpetrator, in some instances coerced by use of voodoo. Offering mental healthcare to this group of survivors necessitates an informed approach. For them, withholding the full truth might be a way to protect loved ones from retaliation (Van der Watt & Kruger, 2017). This could potentially conflict with trauma-focused therapies, which often necessitate a comprehensive recounting of one's past experiences. Additionally, survivors may feel bound to voodoo rituals, which could hinder addressing traumatic memories through trauma-focussed therapies (Millett-Barrett, 2019). Indeed, as brought forward by an interviewee in chapter 5, people may predominantly attribute mental health problems to religious and spiritual factors, and consequently initially see religious healing as the preferred treatment.

Consider the Specific Needs of Those Who Lived SOGIE-Related Violence

All clinical samples in this dissertation comprised a substantial part of individuals identifying as homosexual, all of whom were forced to migrate. Recognising the intersect of various types of potentially traumatising events, e.g., conflict-related, SOGIE-related, and sexual violence, needs attention from therapists (Nilsson et al., 2021). These persons may face accumulative stigmatisation because of their SOGIE diversity, migrant status, and in some cases, because of

sexual violence (Mortimer et al., 2019). Mental healthcare for this population needs an informed approach, and treatments may address lived ostracisation, isolation, and personal questions around self-acceptance and identity (Alessi et al., 2023).

Validate and Address Sexual Revictimisation Risks

Beyond acknowledging accumulative past traumas, therapists working with forced migrant populations should also be aware of future potential (sexual) revictimisation (e.g., Jaffe et al., 2023). Despite its complexities as outlined in the dissertation, addressing this risk should be an integral part of mental healthcare for survivors. This may necessitate a re-evaluation of what recovery means for survivors of sexual violence (Bradby et al., 2023). Addressing psychopathology is crucial, yet understanding how to feel and remain safe in one's daily life after sexual violence is another critical need. What does it entail to heal from sexual trauma, and perhaps work towards a safe and healthy intimate relationship? After trauma-focused therapies, these questions and dialogues within mental healthcare are essential. This might allow survivors to step out of a cycle of victimhood, and reimagine what safety means to them.

Do not Hesitate to Initiate Trauma-Focussed Therapies with Forced Migrants

This dissertation has placed a strong emphasis on the challenging circumstances in which forced migrants and therapists attempt to address mental health needs. Indeed, it is important to acknowledge that the clinical practice with forced migrants may present a different reality than controlled treatment effectiveness studies, and may involve deviations from standardised treatment manuals. Nonetheless, given the high burden and impairment of those suffering from PTSD, we hope this dissertation will encourage therapists to initiate trauma-focussed therapies with forced migrants. Throughout this dissertation, common assumptions on complicating factors in the treatment of forced migrants, such as highly prevalent daily stressors and emotion dysregulation, could not be confirmed. Establishing a cross-cultural therapeutic alliance may enhance the treatment process (Lewis-Fernández et al., 2020). Additionally, individuals with lived experience or cultural mediators can play a significant role in achieving this alliance.

IMPLICATIONS FOR POLICY

Validating Sex Trafficking Experiences Regardless of the Criminal Process

As noted above, there is an inequality between survivors' pursuit of justice and legal residence, and this may impact their wellbeing (Rijken et al., 2021). It may be considered how to further separate the recognition of human trafficking survivors from the outcomes of the criminal process. Indeed, in 2018, an independent multidisciplinary committee were asked for their expert opinion by the Dutch Ministry of Justice and Security. In 59 cases they assessed the plausibility of human trafficking victimhood amongst those whose cases were dismissed by law enforcement (Smit & Klaver, 2019). After a year, this pilot was discontinued, despite its promising results (Knobbout et al., 2019). It is recommended to initiate similar policies and committees, to ensure the justice for and validation of survivors based on their experiences, irrespective of investigative outcomes.

Rethinking the Language of Prioritisation in Addressing Forced Migrants' Mental Health

It is important to consider which language is applied when developing mental health policies, and setting funding priorities (Mills, 2014). In reports and calls for funding terminologies like "neglected mental health conditions" might be used. This language may be influenced by power dynamics, shaping how distress and illness are expressed, perceived, and prioritised. This prioritisation may inadvertently result in the neglect of certain individuals or types of suffering. Additionally, it is important to consider who has a say in prioritisation within mental health policy and action. To prevent reinforcing power dynamics of responsibility and care, it is crucial to involve forced migrants in shaping contextualised and inclusive mental health strategies (Tol et al., 2011, 2023).

The Need for Multi-Sectorial Encounters

Forced migration and sex trafficking are global (health) concerns, requiring multisectoral collaboration and dialogue (Brennan & Nandy, 2001). The realities faced by forced migrants, both globally and in the Netherlands, are inherently political (Costello & Mann, 2020; Houtum & Lucassen, 2016). Global inequalities and climate change, mainly caused by those in the Global North, are key drivers of migration (Benatar, 1998; Richards et al., 2021). Governmental mandates and political choices lie at the core of maintaining situations in which the population is exposed to ongoing human rights violations (Houtum & Lucassen, 2016). For instance, in 2023 the reception of asylum seekers in the Netherlands failed to meet the minimum standards of care, safety and housing (Pharos et al., 2023). International humanitarian organisations, some for the first time in their histories, had to offer emergency healthcare in the Netherlands (Médecins sans Frontières, 2023). Even outside times of crisis, asylum procedures impact (mental) health, for instance due to treatment interruptions related to relocations to another shelter or a lack of meaning, activities, and perspective (Pharos et al., 2023). Mental health perspectives can provide insight into the implications of political choices and inform policy decisions. Multi-sectoral encounters, like between mental and public health professionals, legal professionals, civil servants, and politicians, can foster mutual understanding and lead to integrated approaches in addressing the (mental) health needs of forced migrants.

CONCLUSION

With this dissertation, we intended to contribute to understanding and addressing the mental health needs of forced migrants through several conceptual and empirical studies. In the first part, we found that mental health perspectives on legal labelling of sexual violence in conflict could offer novel insights, that sex trafficking experiences are heterogeneous, and that body-based approaches are feasible in addressing sexual revictimisation risk within mental healthcare. In the second part, we discussed conceptualisations of "neglect" in settings of protracted displacement, and started examined the interrelatedness of daily stressors, emotion dysregulation and posttraumatic stress symptoms for forced migrants engaging in trauma-focused therapy. We

hope that this dissertation enriches the understanding of the mental health needs and treatment approaches for forced migrants and sexual violence survivors, and identifies key areas for future research and action.

REFERENCES

Adams, M. C., & Kivlighan, D. M. (2019). When home is gone: An application of the multicultural orientation framework to enhance clinical practice with refugees of forced migration. *Professional Psychology: Research and Practice*, *50*(3), 176–183. https://doi.org/10.1037/pro0000230

Adeyinka, S., Lietaert, I., & Derluyn, I. (2023). It happened in the desert, in Libya and in Italy: physical and sexual violence experienced by female Nigerian victims of trafficking in Italy. *International Journal of Environmental Research and Public Health*, *20*(5), 4309. https://doi.org/10.3390/ijerph20054309

Alessi, E. J., Kahn, S., Ast, R. S., Cheung, S. P., Lee, E. O. J., & Kim, H. (2023). Learning from practitioners serving LGBTQ+ forced migrants and other diverse groups: Implications for culturally informed affirmative practice. *Journal of the Society for Social Work and Research*, *14*(3), 609–631. https://doi.org/10.1086/716722

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth Edition). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Andrijasevic, R., & Mai, N. (2016). Editorial: Trafficking (in) representations: Understanding the recurring appeal of victimhood and slavery in neoliberal times. *Anti-Trafficking Review*, *7*. https://doi.org/10.14197/atr.20121771

Baba, M., Tipton, C., Danailova-Trainor, G., Morgan, K., & Matthew, R. (2023). Understanding re-Trafficking in the United States: Why do we have a revolving door? In M. De Chesnay & D. Sabella (Eds.), *Human Trafficking: A Global Health Emergency* (pp. 149–175). Springer International Publishing. https://doi.org/10.1007/978-3-031-33875-5_11

Benatar, S. R. (1998). Global disparities in health and human rights: A critical commentary. *American Journal of Public Health*, *88*(2), 295–300. https://doi.org/10.2105/AJPH.88.2.295

Bemme, D., & Kirmayer, L. J. (2020). Global mental health: Interdisciplinary challenges for a field in motion. *Transcultural Psychiatry*, *57*(1), 3–18. https://doi.org/10.1177/1363461519898035

Boesten, J. (2022). Sexual violence as a weapon of war in Ukraine. *BMJ*, o1172. https://doi.org/10.1136/bmj.o1172

Bolhaar, H. (2019, May 6). Onderzoek eerst, dan conclusies. *NRC*.

Boukli, A., & Renz, F. (2019). Deconstructing the lesbian, gay, bisexual, transgender victim of sex trafficking: Harm, exceptionality and religion–sexuality tensions. *International Review of Victimology*, *25*(1), 71–90. https://doi.org/10.1177/0269758018772670

Boyd, J. E., Lanius, R. A., & McKinnon, M. C. (2018). Mindfulness-based treatments for posttraumatic stress disorder: A review of the treatment literature and neurobiological evidence. *Journal of Psychiatry & Neuroscience*, *43*(1), 7–25. https://doi.org/10.1503/jpn.170021

Bradby, H., Papoutsi, A., Hourani, J., Akyuz, S., & Phillimore, J. (2023). Something is (still) missing? Feminist services for forced migrants surviving sexual and gender-based violence in Sweden, Australia, Turkey and the United Kingdom. *Women's Studies International Forum*, *98*, 102697. https://doi.org/10.1016/j.wsif.2023.102697

Brennan, R. J., & Nandy, R. (2001). Complex humanitarian emergencies: A major global health challenge. *Emergency Medicine*, *13*(2), 147–156. https://doi.org/10.1046/j.1442-2026.2001.00203.x

Burback, L., Brémault-Phillips, S., Nijdam, M. J., McFarlane, A., & Vermetten, E. (2023).

Treatment of posttraumatic stress disorder: A state-of-the-art review. *Current Neuropharmacology*, *21*. https://doi.org/10.2174/1570159X21666230428091433

Buss, D. E. (2009). Rethinking 'rape as a weapon of war.' *Feminist Legal Studies*, *17*(2), 145–163. https://doi.org/10.1007/s10691-009-9118-5

Byrow, Y., Liddell, B., O'Donnell, M., Mau, V., McMahon, T., Bryant, R., Benson, G., & Nickerson, A. (2022). Profiles of post-migration stressors and mental health in refugees: A latent class analysis. *Psychiatry Research*, *311*, 114494. https://doi.org/10.1016/j.psychres.2022.114494

Bruhn, M., Rees, S., Mohsin, M., Silove, D., & Carlsson, J. (2018). The range and impact of postmigration stressors during treatment of trauma-affected refugees. *Journal of Nervous & Mental Disease*, *206*(1), 61–68. https://doi.org/10.1097/NMD.0000000000000774

Canino, G., & Alegría, M. (2008). Psychiatric diagnosis – Is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, *49*(3), 237–250. https://doi.org/10.1111/j.1469-7610.2007.01854.x

Casassa, K., Knight, L., & Mengo, C. (2021). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse*, 152483802098554. https://doi.org/10.1177/1524838020985542

Casassa, K., Knight, L., & Mengo, C. (2022). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse*, *23*(3), 969–984. https://doi.org/10.1177/1524838020985542

Casassa, K., Ploss, A., & Karandikar, S. (2023a). "There's a lot missing": Treating survivors of sex trafficking with trauma bonds. *Journal of Social Work*, *23*(5), 838–857. https://doi.org/10.1177/14680173231165930

Casassa, K., Ploss, A., & Karandikar, S. (2023b). "Drugs can be a great coercion": Service providers' perspectives on the relationship between substance use and trauma bonding among survivors of sex trafficking. *Health & Social Work*, *48*(3), 198–208. https://doi.org/10.1093/hsw/hlad011

Çesko, E. (2020). Body oriented work with refugees. *Body, Movement and Dance in Psychotherapy*, *15*(3), 142–155. https://doi.org/10.1080/17432979.2020.1762740

Chambers, R., Gibson, M., Chaffin, S., Takagi, T., Nguyen, N., & Mears-Clark, T. (2022). Trauma-coerced attachment

and complex PTSD: Informed care for survivors of human Trafficking. *Journal of Human Trafficking*, 1–10. https://doi.org/10.1080/23322705.2021.2012386

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime, R. J., Shinozaki, G., Prokop, L. J., & Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings*, 85(7), 618–629. https://doi.org/10.4065/mcp.2009.0583

Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self- and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress*, *10*(3), 437–452. https://doi.org/10.1002/jts.2490100309

Costello, C., & Mann, I. (2020). Border justice: Migration and accountability for human rights violations. *German Law Journal*, *21*(3), 311–334. https://doi.org/10.1017/glj.2020.27

de Jong, J. T. V. M., & Van Ommeren, M. (2002). Toward a culture-informed epidemiology: Combining qualitative and quantitative research in transcultural contexts. *Transcultural Psychiatry, 39*(4), 422–433. https://doi.org/10.1177/136346150203900402

De La Torre Laso, J. (2023). The reality of tonic immobility in victims of sexual violence: "I was paralyzed, I couldn't move." *Trauma, Violence, & Abuse*, 15248380231191232. https://doi.org/10.1177/15248380231191232

Diviák, T., Dijkstra, J. K., Van Der Wijk, F., Oosting, I., & Wolters, G. (2023). Women trafficking networks: Structure and stages of women trafficking in five Dutch small-scale networks. *European Journal of Criminology*, *20*(4), 1506–1528. https://doi.org/10.1177/14773708211053135

Djelantik, A. A. A. M. J., De Heus, A., Kuiper, D., Kleber, R. J., Boelen, P. A., & Smid, G. E. (2020). Post-migration stressors and their association with symptom reduction and non-completion during treatment for traumatic grief in refugees. *Frontiers in Psychiatry*, *11*, 407. https://doi.org/10.3389/fpsyt.2020.00407

Djelantik, A. A. A. M. J., Van Es, C. M., Lahuis, A. M., & Mooren, N. (2022). The challenges of conducting mental health research among resettled refugee populations: An ecological framework from a researchers' perspective. *International Journal of Mental Health*, 1–19. https://doi.org/10.1080/00207411.2022.2069962

Doolan, E. L., Bryant, R. A., Liddell, B. J., & Nickerson, A. (2017). The conceptualization of emotion regulation difficulties, and its association with posttraumatic stress symptoms in traumatized refugees. *Journal of Anxiety Disorders*, *50*, 7–14. https://doi.org/10.1016/j.janxdis.2017.04.005

Ebren, G., Demircioğlu, M., & Çırakoğlu, O. C. (2022). A neglected aspect of refugee relief works: Secondary and vicarious traumatic stress. *Journal of Traumatic Stress*, *35*(3), 891–900. https://doi.org/10.1002/jts.22796

Greene, M. C., Ventevogel, P., Likindikoki, S. L., Bonz, A. G., Turner, R., Rees, S., Misinzo, L., Njau, T., Mbwambo, J. K. K., & Tol, W. A. (2023). Why local concepts matter: Using cultural expressions of distress to explore the construct validity of research instruments to measure mental health problems among Congolese women in Nyarugusu refugee camp. *Transcultural Psychiatry*, *60*(3), 496–507. https://doi.org/10.1177/13634615221122626

Hébert, M., Lapierre, A., MacIntosh, H. B., & Ménard, A. D. (2021). A review of mediators in the association between child sexual abuse and revictimization in romantic relationships. *Journal of Child Sexual Abuse*, *30*(4), 385–406. https://doi.org/10.1080/10538712.2020.1801936

Heinrichs, N., & Brühl, A. (2022). Preventing revictimization through a web-based intervention for primary caregivers of youth in care (EMPOWERYOU): Protocol for a randomized factorial trial. *JMIR Research Protocols*, *11*(10), e38183. https://doi.org/10.2196/38183

Hockett, J. M., Smith, S. J., Klausing, C. D., & Saucier, D. A. (2016). Rape myth consistency and gender differences in perceiving rape victims: A meta-analysis. *Violence Against Women*, *22*(2), 139–167. https://doi.org/10.1177/1077801215607359

Hong, L., & Marine, S. B. (2018). Sexual violence through a social justice paradigm: Framing and applications. *New Directions for Student Services*, *2018*(161), 21–33. https://doi.org/10.1002/ss.20250

Hossain, M., Zimmerman, C., & Watts, C. (2014). Preventing violence against women and girls in conflict. *The Lancet*, *383*(9934), 2021–2022. https://doi.org/10.1016/S0140-6736(14)60964-8

Houtum, H. van, & Lucassen, L. (2016). *Voorbij Fort Europa: een nieuwe visie op migratie*. Uitgeverij Atlas Contact.

Hoyle, C., Bosworth, M., & Dempsey, M. (2011). Labelling the victims of sex trafficking: Exploring the borderland between rhetoric and reality. *Social & Legal Studies*, *20*(3), 313–329. https://doi.org/10.1177/0964663911405394

Iglesias-Rios, L., Harlow, S. D., Burgard, S. A., West, B., Kiss, L., & Zimmerman, C. (2020). Patterns of violence and coercion with mental health among female and male trafficking survivors: A latent class analysis with mixture models. *Epidemiology and Psychiatric Sciences*, *29*, e38. https://doi.org/10.1017/S2045796019000295

Erlingsdóttir, I., & Chandra, G. (Eds.). (2021). *The Routledge handbook of the politics of the #MeToo movement*. Routledge.

Jaffe, A. E., Brockdorf, A. N., Messman, T. L., Gratz, K. L., & DiLillo, D. (2023). Is the risk for sexual revictimization cumulative? A prospective examination. *Women's Health Issues*, *33*(2), 208–214. https://doi.org/10.1016/j.whi.2022.11.007

Johnson, D. M., & Zlotnick, C. (2006). A cognitive—behavioral treatment for battered women with PTSD in shelters: Findings from a pilot study. *Journal of Traumatic Stress*, *19*(4), 559–564. https://doi.org/10.1002/jts.20148

Kamerman, S., & Wittenberg, D. (2009, March 15). Operatie Koolvis [Operation Koolvis]. *NRC Handelsblad*. http://vorige.nrc.nl/achtergrond/article2181306.ece/

Operatie_Koolvis

Kaltenbach, E., Hermenau, K., Schauer, M., Dohrmann, K., Elbert, T., & Schalinski, I. (2020). Trajectories of posttraumatic stress symptoms during and after Narrative Exposure Therapy (NET) in refugees. *BMC Psychiatry*, *20*(1), 312. https://doi.org/10.1186/s12888-020-02720-y

Kleemans, E. R. (2011). Expanding the domain of human trafficking research: Introduction to the special issue on human trafficking. *Trends in Organized Crime*, *14*(2–3), 95–99. https://doi.org/10.1007/s12117-011-9139-8

Knobbout, R. R., Dettmeijer-Vermeulen, C. E., Claassen, A. H., Koopsen, A., van Rij, J. J. M., Rijken, C. R. J. J., & Tankink, M. T. A. (2019). *Nederland laat kans liggen te komen tot een meer mensenrechtelijke benadering van slachtoffers mensenhandel* [The Netherlands is missing out on an opportunity to achieve a more human rights approach to victims of human trafficking]. https://www.comensha.nl/StippWebDLL/Resources/Handlers/DownloadBestand.ashx?ID=1000009782

Kollen, M., Heeringa, A., & Vriezen, V. (2022). *In Europa uitgebuit, nergens beschermd*. Recht in Zicht. https://www.legerdesheils.nl/files/InEuropauitgebuitnergensbeschermd-RechtinZicht-LegerdesHeilsjuni2022.pdf

Kuschminder, K., & Triandafyllidou, A. (2020). Smuggling, trafficking, and extortion: New conceptual and policy challenges on the Libyan route to Europe. *Antipode*, *52*(1), 206–226. https://doi.org/10.1111/anti.12579

Laban, C. J., Komproe, I. H., Gernaat, H. B. P. E., & De Jong, J. T. V. M. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 43*(7), 507–515. https://doi.org/10.1007/s00127-008-0333-1

Lewis-Fernández, R., Aggarwal, N. K., & Kirmayer, L. J. (2020). The cultural formulation interview: Progress to date and future directions. *Transcultural Psychiatry*, *57*(4), 487–496. https://doi.org/10.1177/1363461520938273

Lewis-Fernández, R., & Kirmayer, L. J. (2019). Cultural concepts of distress and psychiatric disorders: Understanding symptom experience and expression in context. *Transcultural Psychiatry*, *56*(4), 786–803. https://doi.org/10.1177/1363461519861795

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

Lightowlers, C., Broad, R., & Gadd, D. (2021). Victims and suspects of modern slavery: Identifying subgroups using latent class analysis. *Policing: A Journal of Policy and Practice*, *15*(2), 1384–1398. https://doi.org/10.1093/police/paaa072

Litam, S. D. A. (2019). She's just a prostitute: The effects of labels on counselor attitudes, empathy, and rape myth acceptance. *The Professional Counselor*, *9*(4), 396–415. https://doi.org/10.15241/sdal.9.4.396

Maiorano, N., Travers, Á., & Vallières, F. (2023). The relationship between rape myths, revictimization by law enforcement, and well-being for victims of sexual assault. *Violence Against Women*, *29*(14), 2873–2890. https://doi.org/10.1177/10778012231196056

Martinez, O., & Kelle, G. (2013). Sex trafficking of LGBT individuals: A call for service provision, research, and Action. *The International Law News*, *42*(4).

Médecins Sans Frontières. (2022, September 11). *Crisis bij aanmeldcentrum Ter Apel [Crisis at reception centre Ter Apel]*. https://www.artsenzondergrenzen.nl/projecten/nederland-ter-apel/

Mengesha, Z., Alloun, E., Weber, D., Smith, M., & Harris, P. (2022). "Lived the pandemic twice": A scoping review of the unequal impact of the COVID-19 pandemic on asylum seekers and undocumented migrants. *International Journal of Environmental Research and Public Health*, *19*(11), 6624. https://doi.org/10.3390/ijerph19116624

Merodio, G., Duque, E., & Axt Peña, J. C. (2020). They are not *Romeo pimps* , they are traffickers: Overcoming the socially dominant discourse to prevent the sex trafficking of youth. *Qualitative Inquiry*, *26*(8–9), 1010–1018. https://doi.org/10.1177/1077800420938881

Messman-Moore, T. L., & Brown, A. L. (2006). Risk perception, rape, and sexual revictimization: A prospective study of college women. *Psychology of Women Quarterly*, *30*(2), 159–172. https://doi.org/10.1111/j.1471-6402.2006.00279.x

Messman-Moore, T. L., & McConnell, A. A. (2018). Intervention for sexual revictimization among college women. In *Sexual Assault Risk Reduction and Resistance* (pp. 309–330). Elsevier. https://doi.org/10.1016/B978-0-12-805389-8.00013-X

Millett-Barrett, J. (2019). Bound by silence: Psychological effects of the traditional oath ceremony used in the sex trafficking of Nigerian women and girls. *Dignity: A Journal on Sexual Exploitation and Violence*, *4*(3). https://doi.org/10.23860/dignity.2019.04.03.03

Mills, C. (2014). *Decolonizing global mental health: The psychiatrization of the majority world*. Routledge, Taylor & Francis Group.

Mortimer, S., Powell, A., & Sandy, L. (2019). 'Typical scripts' and their silences: Exploring myths about sexual violence and LGBTQ people from the perspectives of support workers. *Current Issues in Criminal Justice*, *31*(3), 333–348. https://doi.org/10.1080/10345329.2019.1639287

National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children. (2021). *Slachtoffermonitor Mensenhandel 2016-2020*. Nationaal Rapporteur.

Nilsson, J. E., Jeevanba, S. B., Molitoris, A., Stratmann, S., & Kubik, R. (2021). Sexual and gender minority refugees and asylum seekers: An arduous journey. In E. M. Lund, C. Burgess, & A. J. Johnson (Eds.), *Violence Against LGBTQ+ Persons* (pp. 231–239). Springer International Publishing. https://doi.org/10.1007/978-3-030-52612-2_18

Norfleet, K. D. (2020). *Unwinding the trauma bond: Handbook of 20 group sessions for human trafficking safe houses*. Independently published.

Norredam, M., Mygind, A., & Krasnik, A. (2006). Access to health care for asylum seekers in the European

Union—A comparative study of country policies. *European Journal of Public Health*, *16*(3), 285–289. https://doi.org/10.1093/eurpub/cki191

Ogden, P. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment* (First edition). W.W. Norton & Company.

Patel, V. (2014). Why mental health matters to global health. *Transcultural Psychiatry*, *51*(6), 777–789. https://doi.org/10.1177/1363461514524473

Pharos, Dokters van de Wereld, & het Rode Kruis. (2023). *Zorgen in tijden van crisis, gezondheidszorg in de crisisnoodopvang [Care in times of crisis, healthcare and emergency shelter]*. https://www.pharos.nl/wp-content/uploads/2023/06/Pharos-rapport-CNO_A4_V02_INTERACTIEF.pdf

Preble, K. M. (2021). Influence of survivors' entrapment factors and traffickers' characteristics on perceptions of interpersonal social power while being recruited to be trafficked. *Violence Against Women*, *27*(8), 1091–1114. https://doi.org/10.1177/1077801220920376

Reid, J. A. (2023). Development and evaluation of the trauma bonding scale for adults© in the context of sex trafficking. *American Journal of Criminal Justice*, *48*(4), 945–966. https://doi.org/10.1007/s12103-023-09731-x

Reid, J. A., Haskell, R. A., Dillahunt-Aspillaga, C., & Thor, J. A. (2013). Contemporary review of empirical and clinical studies of trauma bonding in violent or exploitative relationships. *International Journal of Psychology Research*, *8*(1), 37–73.

Rengers, M., & Kuiper, M. (2019, April 23). Meer migranten claimen slachtoffer 'mensenhandel' te zijn. *NRC*. https://www.nrc.nl/nieuws/2019/04/23/meer-migranten-claimen-slachtoffer-mensenhandel-te-zijn-a3957918

Richards, C. E., Lupton, R. C., & Allwood, J. M. (2021). Re-framing the threat of global warming: an empirical causal loop diagram of climate change, food insecurity and societal collapse. *Climatic Change*, *164*(3–4), 49. https://doi.org/10.1007/s10584-021-02957-w

Rijken, C., Khadraoui, L., & Tankink, M. (2021). (Preventing) secondary victimisation of trafficking victims through law enforcement interventions. *Journal of Human Trafficking, Enslavement and Conflict-Related Sexual Violence, 2*(1), 3–25. https://doi.org/10.7590/266644721X16239186251233

Schaeffer, A. J., & Cornelius-White, J. H. D. (2021). Qualitative studies on body-based interventions for refugees: A meta-synthesis. *Body, Movement and Dance in Psychotherapy*, *16*(4), 267–285. https://doi.org/10.1080/17432979.2021.1893810

Seligowski, A. V., Lee, D. J., Bardeen, J. R., & Orcutt, H. K. (2015). Emotion regulation and posttraumatic stress symptoms: A meta-analysis. *Cognitive Behaviour Therapy*, *44*(2), 87–102. https://doi.org/10.1080/16506073.2014.980753

Semmlinger, V., Takano, K., Schumm, H., & Ehring, T. (2021). Dropout from psychological interventions for refugees and asylum seekers: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *89*(9), 717–730. https://doi.org/10.1037/ccp0000681

Shin, H. J., & Salter, M. (2022). Betrayed by my body: survivor experiences of sexual arousal and psychological pleasure during sexual violence. *Journal of Gender-Based Violence*, 1–15. https://doi.org/10.1332/239868021X16430290699192

Shreffler, J., & Huecker, M. R. (2023). Type I and Type II errors and statistical power. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK557530/

Smit, W., & Klaver, J. (2019). *Evaluatie pilot multidisciplinaire advisering slachtofferschap mensenhandel [Evaluation pilot multidisciplinary advise victimhood human trafficking]* (No. 17172). ministerie van Justitie en Veiligheid. https://zoek.officielebekendmakingen.nl/blg-912440.pdf

Specker, P., Liddell, B. J., O'Donnell, M., Bryant, R. A., Mau, V., McMahon, T., Byrow, Y., & Nickerson, A. (2023). The longitudinal association between posttraumatic stress disorder, emotion dysregulation, and postmigration stressors among refugees. *Clinical Psychological Science*, 21677026231164393. https://doi.org/10.1177/21677026231164393

Ticktin, M. (2011). The gendered human of humanitarianism: Medicalising and politicising sexual violence. *Gender & History*, *23*(2), 250–265. https://doi.org/10.1111/j.1468-0424.2011.01637.x

Tol, W. A., Le, P. D., Harrison, S. L., Galappatti, A., Annan, J., Baingana, F. K., Betancourt, T. S., Bizouerne, C., Eaton, J., Engels, M., Hijazi, Z., Horn, R. R., Jordans, M. J. D., Kohrt, B. A., Koyiet, P., Panter-Brick, C., Pluess, M., Rahman, A., Silove, D., … Van Ommeren, M. (2023). Mental health and psychosocial support in humanitarian settings: research priorities for 2021–30. *The Lancet Global Health*, *11*(6), e969–e975. https://doi.org/10.1016/S2214-109X(23)00128-6

Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Panter-Brick, C., Silove, D., Sondorp, E., Wessells, M., & Van Ommeren, M. (2011). Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings. *PLoS Medicine*, *8*(9), e1001096. https://doi.org/10.1371/journal.pmed.1001096

Truong, T.-D., & Belen Angeles, M. (2005). *Searching for best practices to counter human trafficking in Africa: A focus on women and children* (SHS/2005/PI/H/2 REV). United Nations Educational, Scientific and Cultural Organization. https://unesdoc.unesco.org/ark:/48223/pf0000138447

United Nations High Commissioner for Refugees. (2023). *Global trends forced displacement in 2022*. United Nations High Commissioner for Refugees. https://www.unhcr.org/global-trends-report-2022

United Nations Office on Drugs and Crime. (2008). *An introduction to human trafficking: Vulnerability, impact and action*. United Nations Office on Drugs and Crime. https://www.unodc.org/documents/human-trafficking/An_Introduction_to_Human_Trafficking_-_Background_Paper.pdf

Van De Kamp, M. M., Scheffers, M., Emck, C., Fokker, T. J., Hatzmann, J., Cuijpers, P., & Beek, P. J. (2023). Body-and movemen-oriented interventions for posttraumatic stress disorder: An updated systematic review and meta-analysis. *Journal of Traumatic*

Stress, jts.22968. https://doi.org/10.1002/jts.22968
Van der Kolk, B. A. (2015). *The body keeps the score: mind, brain and body in the transformation of trauma*. Penguin Books.
Van Der Watt, M., & Kruger, B. (2017). Exploring 'juju' and human trafficking: Towards a demystified perspective and response. *South African Review of Sociology*, *48*(2), 70–86. https://doi.org/10.1080/21528586.2016.1222913
Van Minnen, A. (2018). *Verlamd van angst: herstellen na seksueel misbruik* (Derde druk.). Boom.
Van Toorenburg, M. M., Sanches, S. A., Linders, B., Rozendaal, L., Voorendonk, E. M., Van Minnen, A., & De Jongh, A. (2020). Do emotion regulation difficulties affect outcome of intensive trauma-focused treatment of patients with severe PTSD? *European Journal of Psychotraumatology*, *11*(1), 1724417. https://doi.org/10.1080/20008198.2020.1724417
Vanwesenbeeck, I. (2013). Prostitution push and pull: Male and female perspectives. *Journal of Sex Research*, *50*(1), 11–16. https://doi.org/10.1080/00224499.2012.696285
Verhoeven, M., van Gestel, B., de Jong, D., & Kleemans, E. (2015). Relationships between suspects and victims of sex trafficking: Exploitation of prostitutes and domestic violence parallels in Dutch trafficking cases. *European Journal on Criminal Policy and Research*, *21*(1), 49–64. https://doi.org/10.1007/s10610-013-9226-2
Vorrath, J. (2022). Peculiarity and persistence of a transregional flow: The evolution of human trafficking for sexual exploitation from Nigeria to Europe. In D. Brombacher, G. Maihold, M.
Walker, H. E., Freud, J. S., Ellis, R. A., Fraine, S. M., & Wilson, L. C. (2019). The prevalence of sexual revictimization: A meta-analytic review. *Trauma, Violence, & Abuse*, *20*(1), 67–80. https://doi.org/10.1177/1524838017692364
Walker, H. E., & Wamser-Nanney, R. (2023). Revictimization risk factors following childhood maltreatment: A literature review. *Trauma, Violence, & Abuse*, *24*(4), 2319–2332. https://doi.org/10.1177/15248380221093692
Watts, C., & Zimmerman, C. (2002). Violence against women: Global scope and magnitude. *The Lancet*, *359*(9313), 1232–1237. https://doi.org/10.1016/S0140-6736(02)08221-1
Wolfe, D. A. (Ed.). (1996). *The youth relationships manual: A group approach with adolescents for the prevention of woman abuse and the promotion of healthy relationships*. Sage Publications.
Zalewski, M., Drumond, P., Prügl, E., & Stern, M. (Eds.). (2018). *Sexual violence against men in global politics*. Routledge, Taylor & Francis Group.
Zhang, S. X. (2009). Beyond the 'Natasha' story – A review and critique of current research on sex trafficking. *Global Crime*, *10*(3), 178–195. https://doi.org/10.1080/17440570903079899
Zimmerman, C., & Kiss, L. (2017). Human trafficking and exploitation: A global health concern. *PLOS Medicine*, *14*(11), e1002437. https://doi.org/10.1371/journal.pmed.1002437

ADDENDUM &

SAMENVATTING
(DUTCH SUMMARY)

In de afgelopen jaren is ons dagelijks nieuws gedomineerd door de zogenaamde "vluchtelingencrisis" en vele onthullingen van grootschalig seksueel geweld. Met deze dissertatie streven we ernaar een bijdrage te leveren op het snijvlak van deze hedendaagse kwesties vanuit een psychologisch perspectief. In **hoofdstuk 1** werd toegelicht dat het overkoepelde doel van deze dissertatie is om enkele hiaten op het gebied van mentale gezondheid en behandeling voor gedwongen migranten te adresseren. We zullen verschillende empirische studies uitvoeren met als doel concepten ter discussie te stellen en de voorziening van geestelijke gezondheidszorg voor de doelgroep te bevorderen. In twee delen zullen we de legitimiteit van wettelijke definities van (conflict-gerelateerd) seksueel geweld bediscussiëren, de diversiteit van seksuele uitbuitingservaringen ontwarren, een lichaamsgerichte benadering voorstellen om het risico op seksuele hertraumatisering te verminderen, verschillende conceptualisaties van "verwaarloosde mentale gezondheid" uiteenzetten, en de relevantie van dagelijkse stress en emotieregulatie onderzoeken in het begrijpen van veranderingen in posttraumatische stresssymptomen en behandelbeloop. Middels aandacht voor deze onderwerpen, streven we ernaar de klinische praktijk voor gedwongen migranten en overlevenden van seksueel geweld en mensenhandel te verbeteren.

SECTIE 1. OVERLEVENDEN VAN SEKSUEEL GEWELD EN MENSENHANDEL

De eerste sectie richtte zich op migranten die slachtoffer zijn geweest van seksueel geweld en mensenhandel, en bevatte drie hoofdstukken. In **hoofdstuk 2** onderzochten we de samenhang tussen de labels 'mensenhandel in tijden van conflict' en 'conflict-gerelateerd seksueel geweld' vanuit een psychologisch en juridisch perspectief. Herhaaldelijk seksueel geweld komt vaak voor in oorlogs- en conflictsituaties en de gevolgen worden veelal gedragen door de slachtoffers. We concludeerden dat er vanuit psychologisch oogpunt geen geldige basis lijkt te zijn voor een duidelijk onderscheid tussen deze twee labels. Echter, vanuit juridisch oogpunt is dit onderscheid van groot belang. Daarbij hebben deze labels invloed op vervolging van daders en het toekennen van specifieke rechten aan slachtoffers. Dit verschil onderstreept de noodzaak van interdisciplinaire uitwisseling, om zo te voldoen aan slachtoffers hun behoefte aan ondersteuning, erkenning en rechtvaardigheid. In **hoofdstuk 3** pasten we latente klasse analyse toe om subgroepen te identificeren binnen ervaringen van seksuele uitbuiting, onder een klinische steekproef van volwassen vrouwelijke overlevenden. We identificeerden twee subgroepen van overlevenden: 1) degenen die beperkt waren in hun bewegingsvrijheid ('opgesloten') door een niet-intieme dader, en 2) degenen die voornamelijk emotioneel werden gemanipuleerd binnen een intieme relatie. Tijdens het onderzoeken van verschillende associaties met deze subgroepen, ontdekten we dat het waarschijnlijker was dat iemand in de eerste subgroep zou vallen als: diegene geboren was in een Afrikaans land, zich identificeerde als lesbienne, en een onzekere verblijfsstatus had. Toen we bekeken of deze subgroepen de uitkomst van behandeling konden voorspellen, vonden we dat mensen in de tweede subgroep vaker met hun behandeling voortijdig verbraken. Ten slotte, in

hoofdstuk 4 gebruikten we een multi-methode benadering om de haalbaarheid van een nieuwe lichaamsgerichte module te onderzoeken. Deze module had als doel het risico op seksuele hertraumatisering te verminderen onder een klinische streekproef van (gedwongen) migranten. Patiënten en begeleiders schreven veranderingen toe aan de module overeenkwamen met de beoogde behandeldoelen. Bovendien vonden we middels Bayesiaanse informatieve hypothese toetsing dat voor ongeveer twee derde van de patiënten lichaamsbewustzijn/-verbinding, evenals effectiviteit in het aangeven van grenzen, tevens veranderde in overeenstemming met de beoogde behandeldoelen. We concludeerden dat een lichaamsgerichte benadering van het verminderen van seksuele hertraumatisering risico's haalbaar was, en dat de effectiviteit van de module en verdere implementatie het overwegen waard zijn.

SECTIE 2. GEDWONGEN MIGRANTEN

In de tweede sectie, bestaande uit vier hoofdstukken, richtten we ons op gedwongen migranten, inclusief degenen die seksueel geweld en mensenhandel hebben overleefd. In **hoofdstuk 5** onderzochten we conceptualisaties van 'verwaarlozing' op het snijvlak van mentale gezondheid, gender en langdurige ontheemding. We interviewden mensen met professionele en/of ervaringsdeskundigheid rondom ontheemding. We concludeerden dat 'verwaarlozing' kan worden beschouwd in de context van: differentiële (gezondheids)prioriteiten; discrepanties tussen openlijk sociaal ontwrichtende stress en verhulde sociaal hanteerbare stress; en strategieën van verbergen van seksueel geweld. In **hoofdstuk 6** introduceerden we het protocol voor een observationele behandelingsstudie naar de voorspellers van verandering tijdens Narratieve Exposure Therapie (NET). In deze studie werd NET aangeboden aan gedwongen migranten gediagnosticeerd met een posttraumatische stressstoornis in de polikliniek van ARQ Centrum'45. We overwogen dagelijkse stress, emotieregulatie en stemming als voorspellers van verandering in posttraumatische stress (PTS) en therapietrouw tijdens NET. In totaal werden er 86 patiënten in de studie geïncludeerd en 40 patiënten voltooiden de therapie in lijn met het studieprotocol. We presenteerden de belangrijkste bevindingen van deze studie in de twee opvolgende hoofdstukken. In **hoofdstuk 7** onderzochten we metingen die voorafgaand aan elke NET-sessie werden afgenomen. Met behulp van Bayesiaanse latente groeimodellen en random-intercept cross-lagged modellen ontdekten we dat NET samenviel met verbeteringen in PTS, dagelijkse stress en emotieregulatie. Hoewel veranderingen in dagelijkse stress en PTS met elkaar samenhingen, voorspelden ze elkaar niet consequent over tijd, geen van beide nodig lijkt te zijn voor veranderingen in het andere construct. Ten slotte onderzochten we in **hoofdstuk 8** de mate waarin dagelijkse stress en emotieregulatie voorafgaand aan de start van NET de uiteindelijke therapietrouw en voltooiing van NET konden voorspellen. Echter, geen van deze maten bleek de voltooiing NET proces te kunnen voorspellen. Dagelijkse stress voorafgaand aan de behandeling leek aanvankelijk therapietrouw tijdens NET te voorspellen. Echter, toen de symptoomernst van de posttraumatische stressstoornis voorafgaand aan behandeling werd meegenomen in het model, hield deze relatie geen stand. We concludeerden dat dagelijkse stress en emotieregulatie niet op een unieke manier gerelateerd lijken te zijn aan de therapietrouw en voltooiing van NET.

In deze dissertatie beoogden we bij te dragen aan het begrip en de benadering van de mentale gezondheid onder gedwongen migranten en overlevenden van seksueel geweld via verschillende conceptuele en empirische studies. In **hoofdstuk 9** werden de belangrijkste bevindingen, beperkingen, sterke punten, implicaties en aanbevelingen van deze dissertatie besproken.

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ABOUT THE AUTHOR & LIST OF PUBLICATIONS/PRESENTATIONS

Rina Ghafoerkhan was born on August 20, 1985, in The Hague, the Netherlands. She obtained her research master degree in Developmental Psychology at Leiden University in 2010. During her studies she volunteered at a grass-root NGO Operation Bobbi Bear in Amanzimtoti, South Africa. She did her clinical internship at ARQ Centrum'45 in Diemen, and wrote her master thesis at the Curium-LUMC in Leiden. Right after her graduation she went to work for the international NGO victim's voice in Gulu, Uganda together with her love Mathijs Hoogstad. Here she served former child soldiers, by offering therapy, trainings and supervision in Narrative Exposure Therapy. Hereafter she worked for Médecins sans Frontières and other (i)NGOs in various (post-)conflict settings for longer and short-term assignments, such as Palestine, Jordan, Lebanon, Pakistan, and Syria. In 2014 she returned to the Netherlands and was teaching at the Child Psychology department of Leiden University. Soon after she started working as a trauma therapist at Equator Foundation. Together with psychiatrist dr. Pim Scholte, she initiated a research proposal on the mental healthcare for (forced) migrant survivors of sex trafficking. In 2016 she started her PhD at ARQ Centrum'45 affiliated with Utrecht University under the supervision of prof. dr. Paul Boelen and dr. Pim Scholte. During this period she continued her clinical work and offered various academic courses, lectures and held presentations at conferences on the mental health of forced migrants and sex trafficking survivors. In addition, she obtained several yoga certificates, including prenatal and trauma sensitive yoga. In January 2023 she was elected editor in chief of *Intervention* journal, an independent scientific journal on mental health and psychosocial support in humanitarian settings. She currently lives in Amsterdam with her husband Mathijs Hoogstad and their two children Luca & India.

SELECTION OF PUBLICATIONS & PRESENTATIONS

Articles in peer reviewed journals

Ghafoerkhan, R.S., Lowe, L., Nieuwe Weme, D., Griede, E., Jeffery, L. (in press). Concerning 'neglect': Perspectives on the prioritisation of mental health conditions in protracted displacement contexts. *Medicine Anthropology Theory*.

Ghafoerkhan, R.S., van Heemstra, H. E., Scholte, W. F., van der Kolk, J. R. J., ter Heide, J. J.F., de la Rie, S. M., Verhaak, L. M., Snippe, E., & Boelen, P. A. (2020). Feasibility and predictors of change of Narrative Exposure Therapy for displaced populations: A repeated measures design. *Pilot and Feasibility Studies*, *6*(1), 69. https://doi.org/10.1186/s40814-020-00613-1

Ghafoerkhan, R.S., Scholte, W.F., de Volder, E., & de Brouwer, A.-M. (2019). The nexus between conflict-related sexual violence and trafficking for sexual exploitation in times of conflict. *Journal of Trafficking and Human Exploitation*, *3*(1), 9–33. https://doi.org/10.7590/245227719X15476235096517

de Wit, K., Begeman, M., Noordkamp, W., Sligte, I.G., Ghafoerkhan, R.S., & Kallen, V.L. (2023). The effect of individual characteristics on susceptibility to aggressive and/or intimidating approaches: Quantifying probability pathways by creating a victimization model, *European Journal of Psychotraumatology, 14*(2). https://doi.org/10.1080/20008066.2023.2263147

Book chapters

Scholte, W. F., Ghafoerkhan, R.S., & Verhaak, L. M. (2021). Identity and resilience in victims of trafficking for sexual exploitation. In B. Maisha, S. Massicotte, & M. Morin (Eds.), *Fostering Resilience Before, During, and After Experiences of Trauma* (1st ed.). Routledge. https://doi.org/10.4324/9781003150855

Scholte, W. F., Verhaak, L.M., Lok, A., & Ghafoerkhan, R.S. (2017). The mental health of trafficked persons. In R. Piotrowicz, C. Rijken, & B. H. Uhl (Eds.), *Routledge Handbook of Human Trafficking* (1st ed., pp. 291- 302). Routledge. https://doi.org/10.4324/9781315709352-23

Ghafoerkhan, R.S., & Hoogstad, M. A. (2016). NET vanuit de bakermat: Uganda. Ervaringen uit de praktijk [NET from its cradle: Uganda. Experiences from the field]. In R. Jongedijk (Ed.), *Levensverhalen en psychotrauma narratieve exposure therapie in theorie en praktijk*. Boom.

Editorials

Board, J. H. E. C. (2020). 'The nexus between human trafficking, enslavement and conflict-related sexual violence is obvious': Views of the editorial board. *Journal of Human Trafficking, Enslavement and Conflict-Related Sexual Violence*, *1.1*, 5-23.

Short publications in non-academic magazines

Rullmann, J., Verhaak, L., & Ghafoerkhan, R.S. (2023). Seksueel geweld en uitbuiting: De verschillende achtergronden van slachtoffers [Sexual violence and exploitation: The different backgrounds of victims]. *Impact Magazine*, *7*(2), 18–21. https://arq.org/sites/default/files/2023-10/Impact%20Magazine%202023-2.pdf

Ghafoerkhan, R.S. (2019). De man met het fietszitje [The man with the bicycle seat]. *InZicht GGD Amsterdam, 5*.

Ghafoerkhan, R. S. (2017). Vikram Patel: Wereldwijde toegang tot geestelijke gezondheidszorg [Vikram Patel: Worldwide access to mental healthcare]. *Impact Magazine, 1* (1), 4–7.

Ghafoerkhan, R.S., & Hoogstad, M.A. (2014). Psychologen zonder grenzen: Dagboek Syrie [Psychologists without borders: Diary Syria]. *De Psycholoog*, *6*, 30–35.

Hoogstad, M.A., & Ghafoerkhan, R.S. (2014). Tackling the aftermath of trauma: The Narrative Exposure Therapy. *Bulletin of the Netherlands Society for Tropical Medicine and International Health*, *52*(2), 14-15.

Ghafoerkhan, R.S., & Hoogstad, M.A. (2013). Opgroeien in een rebellenleger [Growing up in a rebel army]. *Cogiscope.*

Selection of presentations at scientific conferences

Ghafoerkhan, R.S., (2023, September 28). *Sexual revictimisation risk reduction amongst survivors of sexual violence and trafficking: Multi-method feasibility study.* ARQ 50 year conference, Hilversum, the Netherlands.

Ghafoerkhan, R.S. (2022, September 16). *Subgroups of women who were victims of sex trafficking: Characteristics, traumatic background and treatment outcome*. 6th World congress of the World Association of Cultural Psychiatry, Rotterdam, the Netherlands. https://www.wacp2022.org/wp-content/uploads/2022/09/WACP2022-Abstractbook-FINAL.pdf

Ghafoerkhan, R.S., & Lowe, L. (2022, June 10). *Concerning 'neglect': The conceptualisation and prioritisation of mental health conditions in protracted displacement contexts*. Pluralizing Global Mental Health Edinburgh Centre for Medical Anthropology Biennial conference, Edinburgh, Scotland. https://www.edcma.sps.ed.ac.uk/sites/edcma/files/inlineimages/EdCMA_PluralizingGMH_7-6(2).pdf

Ghafoerkhan, R.S. (2019a, October 24). *Victims of sexual exploitation: A historical cohort study*. 6th Global Conference on Violence Against Women, Cape Town, South Africa. https://www.svri.org/forums/forum2019/outline.html

Ghafoerkhan, R.S. (2019b, November 14). *Narrative Exposure Therapy: A reintegrating psychological treatment for multi-traumatized survivors of sexual violence*. 1er congrès de la Chaire Internationale Mukwege, Liege, Belgium. https://www.chaire-mukwege.uliege.be/cms/c_15329160/en/1st-congress

Ghafoerkhan, R.S., Stammel, N., & van Heemstra, H.E. (2019, June 15). *Building an evidence base for trauma-focused therapies for resettled refugees: Results and pitfalls from the field*. 16th European Society for Traumatic Stress Studies Conference, Rotterdam, the Netherlands. https://www.tandfonline.com/doi/full/10.1080/20008198.2019.1613834

Ghafoerkhan, R.S. (2018, December 12). *Sexual exploitation: A historical cohort study within a mental healthcare institute in the Netherlands*. 6th International Conference on the Survivors of Rape, Helsinki, Finland.

Ghafoerkhan, R.S. (2018, June 27). *Meeting the psychological needs of victims of sexual exploitation*. Psychological Health Impact of Trafficking in Human Beings (PHIT) Conference, Tilburg, the Netherlands.

Ghafoerkhan, R.S. (2016, September 30). *Sexual Exploitation: Towards an evidence based and integrated treatment approach*. 5th International Conference on the Survivors of Rape, Stockholm, Sweden.

Rina Ghafoerkhan

Untangling the Mental Health of Forced Migrants and Sexual Violence Survivors

Worldwide, the number of people who are forced to leave their homes due to war, conflict and persecution is increasing. A substantial part of these forced migrants face sexual violence and exploitation. This dissertation aims to make a contribution towards untangling the mental health needs and treatment approaches for this population.

In this dissertation, containing two parts, we deploy multiple methods using quantitative and qualitative approaches. Part one centres specifically around forced migrants who survived sexual violence, such as sex trafficking, conflict-related sexual violence and childhood sexual abuse. In this part, we reflect on the legitimacy of definitions of (conflict-related) sexual violence from a mental health and legal perspective. Additionally, we seek to identify patterns within sex trafficking experiences amongst a clinical sample of survivors and present two subgroups worth considering. Finally, we present a novel body-oriented module to mitigate the increased risk of sexual revictimisation amongst survivors. Using multi-informant and multi-method evaluation we evaluate this module to be feasible in an outpatient mental health clinic.

In part two, we first explore how people with lived and/or professional experience conceptualise 'neglected mental health' in areas of protracted displacement. In the final chapters, we focus on the treatment process of traumatised forced migrants while engaging in Narrative Exposure Therapy. We conclude that daily stressors and emotion dysregulation seem to be of limited relevance in understanding changes in posttraumatic stress symptoms and treatment adherence.

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