Abstract

Violence and torture are inextricably linked to medical practice, health, psychological wellbeing and society more broadly. Impacts can be physical, psychological and social, with the potential for sustained implications on survivors and their families and communities (Author, 2023). As such, understanding forms of violence and their multifarious impacts has clear benefits for both practitioners working in medical or psychological practice, and survivors. However, these issues are not centralized in many educational programmes or training.

Drawing on almost two decades of research and critical pedagogy by the author, this article argues for a comprehensive, practical and implementable framework for teaching on violence and border harms. It situates key findings from three empirical research projects. These have focused on support for refugee survivors in the aftermath of conflict, torture and violence, and the entanglements these increasing have with harmful border practices that compound these impacts, as the basis for such interventions.

Reflecting on the development and implementation of a Global Health module embedding research-led teaching, this article documents the strengths and challenges of engaging medical students in social science research and critical pedagogy. Using this as a springboard for practice-based interventions that can address border harms, it documents the development of the 'Supporting Survival' toolkit for practitioners working with refugee survivors of torture and torturous violence. This embeds reflexive learning on definitions of violence, mechanisms for survival as suggested by refugee survivors, barriers to support, and forms of positive practice. The latter of these have been developed by medical practitioners, psychologists, psychotraumatologists and physical

therapists during the projects. In so doing, it calls for the expansion of interdisciplinary teaching as a means of engaging students who will go on to work at the interface of medical practice and trauma, but who are seldom offered the opportunity to access critical social science research.

Keywords

Torture; critical pedagogy; research-led teaching; refugees; border harms, border abolition.

Tables: Table 1: Problems which may develop in the aftermath of torture (adapted from DIGNITY, 2012).

Images:

Image One: Example of cards from each of the four sections of the 'Supporting Survival' toolkit.

1. Introduction

Research increasingly demonstrates that the proliferation of unsafe routes for migration has intensified opportunities for refugees to be subjected to trauma, torture, and violence (Author, 2023; Kuntosch et al, 2024), compounding the impacts of previous experiences of violence, conflict, and/or persecution. Simultaneously, the increasingly hostile environments embedded in many host countries has added further barriers to support in the aftermath of such violence. State enforced reductions in access to healthcare (Soundararajan, 2024), protracted periods of temporal uncertainty in terms of asylum claims and indefinite refugee status, spatial isolation in asylum or detention centres (Bosworth et al, 2024), and narrowing remits for accessing psychological support have combined to create vitriolic conditions for refugee survivors (Abdelhady et al, 2021).

Drawing on almost two decades of research and critical pedagogy by the author, this article argues for a comprehensive, practical, and implementable framework for teaching on violence, border harms, and the impacts of torture. Combining this with an activist scholarship approach, defined as 'politically engaged research aiming to remedy not only the absence of meaningful state intervention in crime and harm, but also expose the role of corporations and the state itself in prosecuting and perpetrating crime and harm' (Author et al, 2023: xxiii).This approach has facilitated a clear means by which research-led teaching can inform practice, reflecting on experience of module development and delivery regarding these issues. The value of embedding knowledge of the physical and psychological impacts of conflict and violence and the lived realities of harsh asylum policies provides opportunities for future medical practitioners to challenge - and on some micro levels thus abolish - harmful impacts of such conditions.

It does so in three stages. Section Two briefly introduces methods and key findings from four research projects based in Northern Europe (Britain, Denmark, and Sweden) undertaken by the author. These explored multiple aspects relevant to critical social sciences: trajectories of violence in the lives of women seeking asylum; impacts of torture and torturous violence; refugee access to perinatal care; immigration detention; and gaps in access to support in the aftermath of violence for refugees. It subsequently highlights the socio-medical impacts of multifarious bordering processes, policies and practices which were found to cause and/or exacerbate harm.

Section Three amalgamates these points to reflect on pedagogic delivery of the above subjects in undergraduate and postgraduate modules, specifically (for the purposes of this article) a case study example of a Global Health module titled 'Violence, Conflict and Forced Migration.' As well as outlining the complexity of delivering to interdisciplinary student audiences, and the strengths and challenges of trauma-informed teaching, it specifically highlights the value of engaging medical students in such modules. As noted, concerns have been raised around quality of medical care for refugee populations (particularly whilst seeking asylum, or without use of the host country's language and poor-quality translation/interpretation services – Boyles, 2017; Sjölund et al, 2009), gaps in support and rehabilitation, and the increasingly insidious entanglement between medicinal access and bordering (Bhatia and Burnett, 2019). As such, this is a key cohort for enacting fundamental rights-centred changes in medical practice. Section Three then centralises this pedagogic experience by exploring perspectives of three students who have gone on to practice medicine in the field, reflecting on ways in which the module enabled former students to engage in positive practice and against border harms.

Section Four draws together the value of research-led teaching with opportunities to implement research findings and module themes in a toolkit to engage wider audiences that reaches beyond the specific programme. As Kleinman argues in the context of radical care:

> ‘By opening up a space of critical self-reflection on our world and ourselves, we can prevent ourselves and others becoming worse people under the pressure of changing conditions. We can protest and resist a dangerous moral ethos in our families, workplaces, and communities and even if we are unsuccessful at changing our local worlds, which is not unlikely, we can keep our moral practices in line with what is right. And that indeed is something worth struggling for, something that can transform others as well’ (Kleinman, 2007: 26).

Subsequently, this section documents the development of a reflexive pedagogic toolkit titled ‘Supporting Survival: a toolkit for supporting refugee survivors of torture and torturous violence.’ Designed by the author in collaboration with the Danish Institute Against Torture, 200 copies have been produced and distributed to non-governmental organizations working with internationally medical staff, psychologists, social workers, and lawyers providing care to refugee survivors and patients.

In all, this article argues for the revision of interdisciplinary teaching as a means of engaging students who will go on to work at the interface of medical practice and trauma, but who are seldom offered the opportunity to access social science research, or indeed evidence-based border abolitionist perspectives (Gilmore Wilson, 2023; Riva et al, 2024). Reflecting Kleinman’s premise around transformation in practice (2007; 2024), I argue

that these approaches in combination have potential to integrate understandings of the social implications and impacts of border harms, structural violence and torture into patient-centred medical practice that can work to abolish harmful manifestations of bordering, if even at a micro level.

2. Research methodologies, key findings, and pedagogic reflections

This section focuses on the methods employed in three of four research projects and introducing key findings that form the border abolitionist and torture abolitionist perspectives underpinning the *Violence, Conflict and Forced Migration* module and how these relate to concerns of medical students and practitioners. The fourth practice-focussed project will be outlined in the Section Four as this centralized research impact and knowledge distribution in collaborative toolkit development.

2.1 Empirical Projects and Methodologies

The first project was a qualitative exploration of institutional approaches to sexual torture in collaboration with the Danish Institute Against Torture, or DIGNITY (2013-2014), a world leading organization working in medical, legal and psychotraumatological responses to torture. Titled 'Unsilencing Sexual Torture', it included 19 in-depth semi-structured interviews with psychotraumatologists, psychologists and lawyers working with survivors of torture in Denmark with the objective of exploring gender specific and informed responses.

The second was a qualitative and activist academic exploration of harm in Northern European asylum systems: Britain, Denmark, and Sweden (2016-2018). Titled 'Gendered

Experiences of Social Harm in Asylum: Exploring State Responses to Persecuted Women in Britain, Denmark and Sweden', it incorporated 74 in-depth semi-structured interviews with psychologists, support workers, detention custody officers, lawyers, advocacy workers and other such social actors working with people seeking asylum in the three case study countries (Britain: n23; Denmark, n: 21; Sweden: n30). The objective was to explore state and organizational responses to women seeking asylum and investigate women's experiences of the asylum process in relation to harmful practices which may have gendered consequences. To gain a deep and woman-centred understanding of the complexity of experiences of seeking asylum, oral history interviews were undertaken focusing on life-long journeys through episodic interviews (Ritchie, 2015: 27) with six women across Britain, Denmark and Sweden: Antonia, Asma, Faiza, Jazmine, Mahira, Nour (see Author, 2019; 2023 for this focus).

The third empirical study was titled 'Unsilencing Sexualized Torture: Identifying and Responding to Sexual Torture Amongst Refugee Survivors of Torture' (2020-2022). It included in-depth interviews with 20 leading practitioners including psychologists, psychotraumatologists, physical therapists and international lawyers to identify and examine how practitioners understand torture, and examples of best practice in response that can be developed to address sexualized violence which may amount to torturous violence. This study was supported by three ideation workshops (Malou Petersson and Lundberg, 2018) that engaged key stakeholders in three torture response organizations which sought to identify best practice for supporting survivors.

These projects have been supplemented by more than 500 hours of ethnographic activist research with women seeking asylum during this period (see Author et al, 2023; Author

and Tombs, 2021). It has included participation in multiple refugee rights organizations, including anti-detention protests, support letter writing campaigns, and weekly support session drop-ins for refugee women in destitution. This approach is situated in an activist academic lens, which is 'a corrective to the dominant logics, narratives and practices of the carceral-corporate-neoliberal state and the multitude of harms it perpetuates' (Author et al, 2023: 11). In relation to this research, it has led to the development of two key practice-based collaborative toolkits: *The Right to Remain Asylum Navigation Board* (see Author and colleague, 2023) and the *Supporting Survival* Toolkit, outlined in depth in Section Four, which highlights examples of positive practice whilst informing on the impacts in relation to care in an era of border harm proliferation.

2.2 Context and key research findings: the foundations of teaching Violence, Conflict and Forced Migration

Violence and torture are inextricably linked to medical practice, health, psychological wellbeing, and society more broadly. Impacts can be physical, psychological, and social, with the potential for sustained implications on survivors and their families and communities (Author, 2023). As such, understanding forms of violence and their multifarious impacts has clear benefits for both practitioners working in medical or psychological practice, and survivors.

Although there is no scope to fully expand on all projects, and to avoid repeating arguments already made in previous books and articles (Author, 2016; 2017; 2021a;

2021b; 2023), it is important to lay foundations before moving to how and why these have been centralized in pedagogic practice. The most pertinent to this article are that:

First, significant barriers to accessing medical and psychological support for refugee survivors of torturous violence were evident in all three case study regions. Many organizations specializing in post-torture support or sexual violence counselling avoided working with people seeking asylum, as the uncertainty of their status is considered too distracting to engage in meaningful therapies. Furthermore, some practitioners stated that beginning psychological support with people seeking asylum only to have them dispersed or removed has potential to cause further harm. Other barriers to support included inadequate funding for specialist services, and the increased dispersal of border control practices into medical care (particularly in the National Health Service in the United Kingdom) meant that some healthcare was unaffordable. Conversely, as such controls have become more commonplace, people in need of medical attention can be deterred from accessing it, although there is ambiguity amongst some medical practitioners around what is and is not available to people seeking asylum. The spatial isolation of asylum housing or detention and deportation centres also reduces capacity for volunteers or practitioners to offer support.

Second, a lack of autonomy in daily life for people seeking asylum, and increased uncertainty for the future for refugee populations more generally, compounds the emotional and psychological impacts of previous subjections to violence. Survivors of torture and torturous violence, including sexualized violence, disproportionately experience anxiety, sleeplessness, nightmares, and other symptoms reflective of trauma responses (Başoğlu et al, 2001; Deps and Charlier, 2020). These are compounded by

micro-level impacts of restrictive policies that increase the likelihood of detention and decrease everyday wellbeing. This uncertainty and insecurity often temporarily supersede people's focus on earlier abuses, the impacts of which can then resurface later in life.

Third, torture and torturous violence are highly gendered, and where organizations focus on narrow legal remits of torture, such as the United Nations Convention Against Torture, and Other Cruel, Inhuman and Degrading Treatment (1984), barriers are created for women in accessing rehabilitative support. For example, more males are detained by states internationally and so are disproportionately targeted for torture in prisons or custody (Einholf, 2018). Conversely, women are disproportionately subjected to torturous violence in domestic or community-based circumstances (Şalcıoğlu and Başoğlu, 2017), sexualized trafficking and in practices such as Female Genital Mutilation, all of which can have the same or similar impacts as torture. It is worth noting that although disparities in experience exists, all groups may be subjected to torture or torturous violence in any of these settings. A recent study (2021) of 2,141 patients referred to DIGNITY between 1982-2009 found that 80% were male, and 20% female (Dalgaard et al, 2021). It also found that the forms of violence inflicted were also gendered, with males more likely to be subjected to beating, suspension and electrical torture, and females to sexualized torture. My research indicated that that narrow definitions of torture may create gendered barriers to torture specific support (Author, 2023).

Finally, and central to the substantive sections of this article, significant knowledge gaps about borders, torture or violence remain in teaching and training for some medical practitioners, psychologists, lawyers and social workers. As will be addressed in Sections Three and Four, the impacts of torture and violence can be socially pervasive and as such

people working outside of specialist fields can still benefit from critical understandings around violence, conflict and forced migration.

3. Teaching against torture: perspectives and pedagogic practice

Having set the empirical groundwork for teaching against torture, this section moves to outline the content, delivery and considerations involved in module development and implementation. It does so from a foundation in critical pedagogy (Giroux, 2010) and draws from abolitionist approaches which see change-making as a central aspect of education rather than a peripheral outcome (Gilmore Wilson, 2023; Riva et al, 2024). To bring practice to life, it includes reflections based on email correspondence about the role of the module 'Violence, Conflict and Forced Migration' from three former students (from my cohort of 2022-2023) who are now medical practitioners. For reference, all agreed to have their quotes included and have asked not to be anonymized.

3.1 Background, learning objectives and justification for interdisciplinary approaches to social science research and medical practice.

The focus of this section is on a module titled 'Violence, Conflict and Forced Migration' developed by the author for Global Health students at the University of Bristol (UK) between 2019-2023. The objectives for students were threefold: to critically understand key approaches to violence and conflict; to ensure that students could demonstrate knowledge of sites of contestation in relation to violence, conflict, and the state; and to understand the impacts on survivors of violence, conflict and forced migration. I originally delivered guest lectures on the harms of the British asylum system and its

impacts on refugee survivors of violence at the Liverpool School of Tropical Medicine (2009/2010) before developing a first iteration of a module for criminology and psychology students at Liverpool John Moores University (2010-2015). It now runs as a Masters module at Lancaster University for law and criminology students (UK).

For those who may work with survivors of torture and violence, the ability to identify and acknowledge forms of violence is a key step toward understanding and thus addressing the impacts of it. This is particularly the case for students who aim to work in conflict regions or displacement areas, however medical students will likely work with survivors at some stage, even if they are not the primary demographic for each budding medical practitioner. Simultaneously, those who have been subjected to torture or torturous violence are also now more commonly confronted with barriers to seeking asylum or long-term safety with refugee status, increases in harmful practices such as immigration detention or a constant threat of deportation, and the compounding of trauma is an increasingly centralized facet of border regimes (Author, 2021a). These are the lived realities of some of the people that practitioners will inevitably engage with. As this section outlines in more depth from student perspectives, knowledge facilitates preparation.

When teaching against torture and violence, providing clarity on forms of violence is essential to ensure people recognize the potential physical, psychological, and social impacts. Students are therefore taught social dimensions of violence, including state violence (Green and Ward, 2004), structural violence (Galtung, 1969; Farmer) and human rights violations, before confronting specific forms of torture and torturous violence. This includes physical, psychological, and sexualized forms of violence and for the purposes

of this module draws from Rejali's internationally recognized seminal work *Torture and Democracy* (2007). In this he outlined uses of violence which included (amongst many other forms) beatings, use of stun guns, the driving of pegs into organs, electric shocks, deprivation of sleep, waterboarding, stress positions, excessive or deprivation of light, sleep deprivation, and holding people in cold rooms or sweatboxes (Rejali, ibid).

This echoes empirical findings from the three research projects in terms of documenting the forms of torture and torturous violence refugee survivors have disclosed to practitioners. Torture does not only travel with torture regimes, but through the trajectories of a survivor's life. Indeed, as one practitioner put it, the impacts of such violence can *wander through lives.* Some of the interviews undertaken across the projects were with people working during conflict or in regimes that had embedded strategies to torture, and some practitioners had also survived them themselves. However, many accounts related to the experiences of people living in Northern European countries, thus were being treated by medical students and psychologists in host communities.

For example, as Sarah, a psychotraumatologist with experience working with survivors in several countries reflected:

> 'People who have been tortured with water boarding, burning cigarettes, noise exposure, people who have witnessed rape of their family members, mothers, fathers, children, wives, you name it. We have people who have been exposed to mock executions, where they hear the click of the gun without being killed. We have people who experienced rape, enforced labour in jails, people who have been forced to drink their own urine.'
> (Psychotraumatologist working with pre-assessed survivors of torture, 2013).

Like other practitioners, Sarah referred to regionality and common techniques, such as the Middle East, although not which specific countries. This globalized sharing of torture, where the forms of torture in one region move across borders and into new areas, is something that resonated with survivors that I met across the multiple projects. These included (though were not limited to) forced prostitution; multiple perpetrator rape; loss of child through abduction by their former partner; burning with cigarettes; repeated beatings; and scalding with hot oil or water. Some abuses had occurred in countries of origin, some during migration, and some whilst seeking asylum or living as undocumented migrants. This I have termed elsewhere as an 'intersectional continuum of violence' (Author, 2017).

3.2 The value of 'knowing violence' and its impacts through trauma-informed pedagogies.

Given the prevalence of violence in many societies, including childhood abuse or sexualized violence, 'knowing torture' is a key objective of modular learning. To 'know' does not require witnessing or graphic visuals, and so they are not included in my modules. This decision is based on the grounds that those affected or even killed have limited or no autonomy over the ongoing use of their imagery; and that students from conflict or refugee backgrounds may themselves have been confronted with violence or familial legacies of torture (see Author, 2023 for further discussion). These points are themselves topics of debates for students who are encouraged in seminars to consider the values and limitations therein (for example, to read from Butler, 2016 and Sontag, 1977 to do so).

Knowing and recognizing forms of violence was subsequently identified as a contributor to positive practice by the three students that I have kept in contact with as they have moved from study to practice. Eliza, for example, has found that:

> 'Going through what types of violence exist, how these can be perpetrated, and the consequences both individually and societally has allowed me to have more consideration of possible issues and needs when walking into a situation with a survivor of violence. Having a background knowledge makes me feel more comfortable within my abilities to respond to violence in a considered and productive way, this confidence is extremely useful in ensuring my patient or client gets the best parts of my practice without any undue or excess stress that may be caused by someone unsure of the situation' (Eliza, medical practitioner and former student in email correspondence, 2024).

That Eliza feels more confident in responding to violence as a direct outcome of learning what it is has, she identifies, actively reduced undue stress that she may have experienced if left without knowledge of such violations.

Students are then encouraged to recognize the potential multifarious impacts from a holistic perspective. Although there is no definitive set of problems which may develop in the aftermath of torture, the *Field Manual on Rehabilitation* developed by the Danish Institute Against Torture is a useful source to begin with (2012). Accordingly, problems or outcomes that can develop are separated into two sections: *body functions, and activities and participation*, as Table One demonstrates.

Insert Table One here.

The formative list allows students to recognize the potential physical and psychological impacts of torture. However, the value of combining medical evidence with social barriers enables practitioners to explore wider issues in the lives of survivors to better understand how the multifarious consequences are relational to other aspects of a survivor's life, as well as their community or family. Former student Aashna, for example, indicated that:

> '[Violence, Conflict and Forced Migration] really developed my perspective on how we approach survivors of violence in medical settings. Nearly everyone goes into medicine motivated by the fundamental "do no harm" principle, so whilst you can usually assume that a healthcare professional would object to all forms of violence, not knowing how to actually discuss some of the intricacies is very common' (Aashna, medical practitioner and former student, in email correspondence, 2024).

Given that many students will not have worked with survivors of torture or torturous violence prior to moving into practice, 'inexperienced students may feel overwhelmed by the case material they encounter either through reading materials or class presentations' (Cunningham, 2004: 307-308). Yet once in practice, there are few ways of buffering between the lived realities or histories of clients or patients, and as such encompassing a space within which students can engage without direct consequence of their own response to patients is not always incorporated into medical training. Amelia highlights the value of learning both violence and borders in her own work:

> 'I feel a lot more confident in approaching histories with patients who may may have migrated and/or experienced violence or persecution. This is both

> in having more knowledge of specific conflicts, but also in knowing the relevant questions about the different types of violence to pose. Being able to ask sensitive questions in a trauma-informed manner can be extraordinarily difficult, but I feel better equipped to think beyond the standard checklist having done this module, especially knowing the long-term impact on a patient's quality of life if these questions are never asked' (Amelia, medical practitioner and former student in email correspondence, 2024).

Although it would be impossible to measure the impacts of teaching about and against torture and violence, the benefits of doing so have potential to outweigh the risks where reflexive and trauma-informed praxis occurs and where, as Kleinman suggests, the concept of care is reintegrated into an otherwise diminishing landscape (2024).

3.3 Encouraging practice-based change in medical settings with people affected by bordering processes.

As outlined in Section Two, research continuously evidences the centrality of harmful border practices on the lives of migrants generally, and survivors of violence specifically. Like most (if not all) countries in the Global North, attempts to reduce refugee intakes in Britain, Denmark and Sweden has incorporated externalizing militaristic borders to Southern Europe, the Middle East, and North Africa (Al-Dayel et al, 2021); decreasing safe routes of travel for people moving further north (Author, 2023); and embedding the removal of freedoms through the proliferation of immigration detention (Bosworth et al, 2024; Global Detention Project, 2024).

Processes of bordering are increasingly bureaucratically embedded through the reduction in many rights, including adequate healthcare (Abdelhady et al, 2020; Docs Not Cops, 2020; Kuntosch et al, 2024; Soundararajan, 2024) and access to post-torture rehabilitative support (Bhatia and Burnett, 2019; Boyles, 2017; Author, 2023; Masmas et al, 2008). To focus on the UK specifically, since that is where the module has been delivered, the National Health Service introduced regulations requiring identity checks for all patients accessing most secondary (or 'non-emergency') care. This includes, but is not limited to, maternity/ante-natal care, paediatrics, and cancer treatment. As Docs not Cops synopsises, 'Trusts are forced to charge upfront those who cannot provide identification to prove their eligibility for NHS treatment. These regulations follow the introduction of a Health Surcharge – paid on top of Visa application fees. Both policies were introduced following the 2014 and 2016 Immigrations Acts.' (Docs Not Cops, 2020). Similar restrictions are increasingly embedded in many host countries.

These structural concerns were already being felt by Aashna, Amelia, and Eliza shortly after they began practice. For example, Aashna identified:

> 'With resources already overstretched, the discussion around migration and refugees in the NHS feels very limited to trying (often unsuccessfully) to organize interpreters for consultations or identifying which groups may be more vulnerable to practices like Female Genital Mutilation or symptoms of functional pain or infectious disease' (email correspondence, 2024).

These are very real barriers to practice for medical practitioners, specifically those working in the National Health Service in the UK which has been in a spiralling crisis (see Kleinman 2024 on broader concerns in medical and psychiatric care). This is an

outcome based in part of the global financial crisis of 2007 and subsequent austerity measures embedded into UK policy from 2020, and in part as the outcome of an ideological drive by successive governments to denationalise the NHS, and open healthcare for corporate trade (see Cooper and Whyte, 2017).

Such toxic combinations – austerity, privatisation (see Kleinman, 2007) and increased border harms – impact on practice for various reasons, some of which Aashna goes on to identify:

> 'It can be so hard to convince someone who has recently come to the UK that they are able to access NHS care and that we should be doing everything we can to facilitate equitable delivery for them. I think this module really highlighted the compounding experiences of violence and the limbo of asylum status, often coupled with inadequate financial and housing support and trying to navigate often a new country, language, and culture. Healthcare staff can find it very difficult to support these patients as many strategies we are used to implementing fall short - such as the recommendation of talking therapies that are not actually culturally informed or trying to motivate someone to completely change their diet when they may be relying on food bank donations' (email correspondence, 2024).

Although these have negative implications for practitioners and patients alike, that Aashna can identify them through her own engagement in learning is the first step in shifting pedagogies which teach against torture, violence and harm from classrooms and lecture theatres to action in practice. This consideration is addressed directly by Amelia,

who is able to clearly identify the links between violence and health, and her ability to shape healthcare delivery based on these:

> ‘During consultations I feel better able to signpost to organizations that may be able to provide support during this difficult process and hope in my future career to advocate to decrease the structural barriers this community experiences. This unit has inspired future career aspirations to both improve the health of communities and decrease barriers to accessing healthcare for those living the consequences of violence’ (email correspondence, 2024).

This final point was reiterated by Eliza, particularly in her direct practice with migrant populations:

> **‘**I think this unit has helped me develop more empathy within my practice. While I always strive to be sympathetic to people’s experiences, learning about the specific issues people forced into migration face through case studies made abstract knowledge of hardships into a more real understanding with context. I think this allows me to approach people with more consideration and understanding about what their needs may be and how to approach these sensitively’ (email correspondence, 2024).

This point – on empathy – is one which has resonated on both sides of the practitioner/client or patient nexus in many aspects of my research (Author, 2014; 2017; 2023) as well as others internationally (Deps and Charlier, 2020; Mohamed Ahmed Magdy Hussein, 2023). On the one hand, the implementation in some places (such as the UK) of time restrictions for client consultations, as well as governmentally enforced

forms of border expansionism into medical practice highlighted above adds significant limitations for medical practitioners, which can cause undue stress through expansive workloads. Meanwhile, survivors of violence seeking asylum can find it difficult to engage consistently even if access is available, since the chaos of asylum reporting systems, issues in affording travel to appointments, language barriers, and at times cultural barriers can all make regular engagement with healthcare systems particularly complex (Deps and Charlier, 2020; Masmas et al, 2008). As Section Four will highlight, these are some issues that have been specifically developed into knowledge sharing and reflexive practice in the 'Supporting Survival' toolkit.

3.4 What is needed to ensure best practice in teaching against torture, trauma, and border harms?

Teaching about any form of violence is complex, wrought with concerns of overstepping student comfort zones and the possibility of unknowingly triggering unwanted memories if survivors of violence are studying the course (Cunningham, 2004; Goddard et al, 2021). Avoiding unnecessary imagery, reminding students that many people may be survivors of violence and thus sensitive discussion is required, and ensuring time and space to debrief at the end of lectures and workshops, or with the lecturer in designated office hours or debrief sessions can all contribute to the maintenance of radical pedagogies whilst reducing the likelihood of negative impact (see also Cunningham, 2004; Kennedy and Scriver, 2016; Goddard et al, 2021).

Because teaching about and against torture and border harms is a complex and sensitive issue, module size is an important consideration. As universities become ever more dependent on student fees and consumer led models of Higher Education in the neoliberal

landscape, increased numbers on elective modules can be problematic. Recognizing if students are affected by content is much more difficult, and as time constraints on workloads proliferate, affect the opportunities made available to embed trauma-informed teaching practice (Goddard et al, 2021; Kennedy and Scriver, 2016) beyond the classroom or office hours. As such, this should be a central consideration when developing such modules, since it has the potential to undermine trauma-informed education as outlined by Goddard et al in terms of 'recognizing the signs and symptoms of trauma' in students, and 'responding' to this recognition (2021: 2-3). Although wellbeing services have increased, meaningful time spent debriefing with students is essential. It is also important that the difference between trauma-informed teaching and counselling is clear to staff and students, as the former does not qualify attempting the latter and indeed has potential to harm. These are key points which require recognition structurally if such pedagogic models are to be implemented.

Finally, those who research and teach on harm, trauma, violence, or torture are not exempt from traumatisation themselves. Compassion fatigue, exhaustion, anxiety, nightmares, and even physical illness can be instigated or compounded when working in this field (Author, 2021b; Cunningham, 2004). Exposure to violence and the impacts thereof are connected to the increase in students since more workshops are required to be held repeatedly covering (and thus exposing the lecturer) to the same narratives of violence repeatedly. Similarly, more assignments are required to be marked which leads to the same issue. Such risks can be reduced by addressing staffing on sensitive modules, limiting student numbers, and/or waiving short turnaround timeframes for marking on violence so that assessors are not continuously exposed to discussions on violence.

In sum, if indeed we are to ensure that radical, abolitionist, research-led and trauma informed teaching is central, if we are to build a meaningful infrastructure for students to address violence, then the wellbeing of those working at the cutting edge of such violations should be structurally and institutionally centralized alongside students and survivors.

4. Learning from teaching: moving critical pedagogy into practice-oriented interventions

Whilst the value of research-led and interdisciplinary modules has been outlined thus far, an obvious limitation is that the content is not inherently accessible for students or practitioners beyond a particular programme. Building upon the positive aspects highlighted by former Global Health students and combining the key research findings that relate to medical and psychological practice and support, I have developed an accessible card-based pedagogical toolkit in collaboration with the Danish Institute against Torture. Now in circulation of 200 copies to support education programmes, non-governmental organizations and grassroot groups, it is titled ‘Supporting Survival: A Toolkit for Supporting Refugee Survivors of Torture and Torturous Violence’. This section outlines the research-led basis for the toolkit content, and the ways in which it has been developed and implemented with the aim of making such approaches accessible to other social scientists working in this interdisciplinary field.

4.1 Developing the Supporting Survival toolkit.

As discussed, the impacts of torture and torturous violence can be invasive, lifelong, and for refugee populations, compounded by harmful bordering processes. However, as with

the dearth of structured education around conflict, violence, torture or refugee rights in medical education, my research and NGO engagement found that those who will likely work with affected groups can struggle with accessing information on forms and impacts of violence, or what barriers there may be to accessing sustained support in the aftermath.

These were key concerns raised by practitioners, including medical doctors, nurses, psychologists, psychotraumatologists and physiotherapists. Alongside time pressures to engage in discussions around their own daily ways of working, the opportunity to reflexively develop practice through education resource was identified as limited. For example, Laura, a Medical Doctor working on the physical assessment and treatment of torture survivors reflected:

> 'I'm not sure what kind of further education type of opportunities I'll have, but that's something I miss and that I hope will be able to be re-implemented, because it gives you a sense of being part of something bigger… Then also just giving you more energy and motivation and inspiration also, hearing about other people, how they're doing their job, and then also being able to see that our patients, even though we know it, that they have similar types of problems and getting different ideas of how we can help them with these problems' (Laura, Denmark, 2021).

To address this gap, I worked in collaboration with three departments of the Danish Institute Against Torture: The Rehabilitation Clinic (led by Nikolai Cerisier Roitmann); the Clinical Research Team; and the Survivor Advisory Board. Throughout April-June 2025, I facilitated three ideation workshops (see Section One) exploring pathways to support and examples of positive practice. These were audio-recorded, transcribed, and

thematically analyzed by the author (Ahmed et al, 2025) to determine survivor and practitioner priorities for knowledge sharing. Key themes included: understanding definitions of violence and their impacts; identifying barriers to support, such as social silencing of violence as well as border related barriers for refugee survivors; identifying positive forms of practice; and centralizing experiences of survival.

Moving research into reflexive practice was a key objective for this aspect of the empirical journey, thus our collaboration decided that a practical toolkit comprising of digestible information would fit the multiple audiences best. To do so, I designed a card set with an accessibly written accompanying 10-point manual. The set has 52 cards and has been divided into four main color-coded themes, plus two information cards for guiding practice:

- *Definitions* is a section which outlines some key terms and relevant conventions that may be useful for survivors, students, and practitioners for understanding complex terms and issues.
- *Surviving violence* draws from survivor and practitioner perspectives about aspects of survival journeys.
- *Barriers to support* identifies issues that can get in the way of accessing support.
- *Embedding positive practice* outlines suggestions from leading practitioners such as psychologists, medical doctors, physiotherapists, and counsellors who work with survivors of torture and torturous violence. This is the main audience this section has been developed for.

Each card can be read individually or in small groups and, as prioritized by survivors and practitioners, aims to inform, challenge myths, share ideas and spark discussion.

Although the information in the cards can be relevant to anyone, some aspects are particularly pertinent for medical students and practitioners (see Image Two). This includes the impacts of torture and torturous violence identified earlier and collated by the Danish Institute Against Torture's Field Rehabilitation Manual (2012). As some medical doctors, nurses, and Global Health students have highlighted in conversation, identifying that physical, psychological, or even neurological problems can be a consequence of such violence is useful to ensure these are part of practitioner consciousness. Three cards specifically address these potential impacts. Similarly, while some aspects of positive practice may be obvious to some people, it often takes extensive experience in gaining such knowledge. A good example of this was advice from a physiotherapist who works on torture-induced pain on the body. Always conscious of his spatial surroundings, he emphasized the need to reduce clutter, in particular anything that can inadvertently resemble instruments of torture or abuse, such as cables (which can be used for whipping, strangulation, hanging or hand tying) and the avoidance of sunlight deprivation when choosing rooms, thus ensuring windows. Other examples included avoiding low hanging lights - a central facet of contemporary Nordic decor - as these can resemble interrogation environments and asking the patient or client where they are comfortable spatially (for example, near a door). Whilst these considerations may be obvious to an experienced practitioner working with survivors of torture, they are not necessarily apparent to everyone.

Insert Image One.

To embed a collaborative and reflexive approach, three sections also include a ‘Reflection Card’ to add participant perspectives, as well as acknowledging that not all will agree on which practices are positive, and many more relevant definitions, barriers and forms of survival exist beyond the scope of 52 cards. In drawing from the consciousness raising method, the collaborative action of talking through each section encourages the sharing of experiences that can otherwise be individualized, with a view of collectively addressing barriers and embedding positive approaches to practice. Central to feminist methods from the 1960s onward, the idea of consciousness raising was ‘to share personal experiences and, together, develop new understandings and analysis about women’s subordinate position and about both social and political issues’ (Hague, 2021, p. 19). This method has proliferated in activist academia, as well as through international social movements where the narrative has the increasingly centralized experience, drawing in the impacts of structural inequalities on individuals, and to highlight disproportionate subjections to harm, as refugee survivors arguably do. When working in combination groups of refugee survivors with practitioners as I have since done as part of a workshop series (November 2025-March 2026), there is also an opportunity for flattening hierarchies in such relationships by sharing perspectives in a space that can aim to collaboratively share knowledge.

The principles developed with students around teaching against torture and torturous violence in the classroom (Section Three) were transferred to the Supporting Survival toolkit, emphasizing sensitivity and mutual respect. The two information cards highlight a minimum code of best practice including that everyone who engages with the process should do so on their own terms; people should be clearly asked if they wish to take part;

participants can acknowledge cultural diversities when approaching sensitive topics; ensuring that participants are aware that sensitive topics are included in this toolkit before beginning discussions or reading; informing participants they can withdraw from discussion or reading at any point; and that a debriefing session by a facilitator can ensure any issues which are impactful or unresolved may be discussed after any workshops or information sessions. It also highlights that good practice to ensure local or regional information on support services is available for survivors or affected families/friends. Everyone is informed that they should not feel they have to read or discuss any topics that they are not comfortable with.

4.2 Strengths and limitations

In combination with the academic literature (Author, 2023) and research-led teaching that bridge the gaps between social science research and medical practice that this article has addressed, the 'Supporting Survival' toolkit offers one example of an interactive critical pedagogy. The manual is clear that it is a tool for reflexive learning and should not be considered a training technique. This, by all accounts, should be left to formal educational practice by qualified practitioners.

While it offers accessible knowledge and consciousness raising, the toolkit is not without limitations. It is currently available only in English which has impacted practitioners working in (for example) parts of Ukraine where psychologists are developing programmes for survivors of torture. This will, we hope, be addressed with future funding for translation. There remain long-term critiques of Westernized practice which do not always translate across cultures and can thus inadvertently replicate hierarchies of medical and psychological discourse (McKee, 1988). Although not a cure-all, I pre-

empted this in some of the cards to highlight that any aspects can be challenged or alternative ideas developed when reflexively using the toolkit.

In his recent work, Kleinman has argued that:

> ‘Caregiving is disappearing from medicine. It is being replaced by a model of treatment that emphasizes institutional efficiency and “throughput” of patients through a system in which they spend relatively little time with doctors and nurses and are seen as a profit-generating source for hospitals’ (2024: 109).

As part of wider combined acts of resistance against this arguably dehumanizing turn, ‘Supporting Survival’ offers an empirically founded blueprint for alternative collaborative practices. Even though the toolkit itself addresses the barriers to medical and psychological support inherent in many asylum systems, it serves as a reminder that the lived complexity of border harms remains tacit for those most affected and - as the toolkit aims to do - allows consideration of what we can individually and collectively do in addressing and abolishing such harms.

5. Conclusion

Torture and torturous violence can have lifelong impacts on the lives of survivors, as well as the families or communities of those affected. Indeed, as this article shows, such violence can be understood as a violation that often goes on to ‘wander through lives,’ impacting at varying points and with multifarious physical, psychological, and even social consequences which can require acute support or long-term rehabilitation.

For survivors of torture and torturous violence who have migrated to or sought asylum in many host countries, these impacts are compounded by increasingly punitive forms of bordering, including special isolation in asylum centres; the harmful proliferation of immigration detention; reduced rights to healthcare; and significant barriers to specialist post-torture support.

Central to my argument in Section Three, there is unique value in embedding research-led critical pedagogies into curriculums studied by students who will go into medical practice. As well as being able to provide trauma-informed platforms for engaging in sensitive and emotionally impactful social issues prior to work with people in clinical settings, introducing future practitioners to the realities of violence ensures they are enabled to engage with or identify the impacts of them. As Eliza reflects:

> 'Many issues within health and policy globally are intrinsically linked to violence, conflict and forced migration. Studying these issues in detail with case studies of the aftermath allows for a deeper understanding of how society can be affected and in turn, how policy can help or hinder development' (email correspondence, 2024).

In contemporary Higher Education in the UK and beyond, academics are encouraged to produce ever more research outcomes, with limited recognition of the value of critical pedagogical practice that can go on to influence the practices of the students we work with. Indeed, it would be impossible to measure. However, engaging medical students in social science research offers unique opportunities to challenge harmful border practices, or address the impacts of torture and torturous violence, well beyond the researcher/educator's own capacity or expertise. This can be considered a micro form of

abolition of harmful border practices, and a challenge to the diminishment of care that Kleinman draws attention to (2024). As Amelia highlights, it can even influence nuanced changes to specialized healthcare that can otherwise (as my own research has shown – Author, 2017) be overlooked or sidelined:

> '[The Violence, Conflict and Forced Migration module] has inspired future career aspirations to both improve the health of communities and decrease barriers to accessing healthcare for those living the consequences of violence. It also encouraged me to apply to the Specialized Foundation Programme as a newly qualified doctor, hoping to study perinatal outcomes in people seeking asylum' (email correspondence, 2024).

As the penultimate section showed through reflections from developing the 'Supporting Survival' toolkit for supporting refugee survivors of torture and torturous violence, empirical findings and pedagogic approaches can be combined and dispersed to wider, even global, practice. Such toolkits can be edited and moulded to suit regional, linguistic, or cultural contexts, acting as a blueprint for those engaged in bridging similar gaps. If teaching against torture, violence and border harms can inform practice in the future work of medical students and subsequently disperse into the lives of more people affected by violence or and bordering, then it is an endeavour worth embarking on.

Bibliography

Abdelhady, D., Gren, N. and Joormann, M. (2020). *Refugees and the violence of welfare bureaucracies in Northern Europe*, Manchester: Manchester University Press.

Ahmed, S.K., Arsalan Mohammed, R.; Nashwan, A. J., Hussein Ibrahim, R., Qadir Abdalla, A., Mohammed M. Ameen, B., Mohammed Khdhir, R. (2025). Using thematic analysis in qualitative research, *Journal of Medicine, Surgery, and Public Health*, 6: 2949-916.

Al-Dayel, N., Anfinson, A. and Anfinson, G. (2021). Captivity, Migration and Power in Libya, *Journal of Human Trafficking,* online first https://doi.org/10.1080/23322705.2021.1908032

Başoğlu, M., Jaranson, J. M., Mollica, R., Kastrup, M. (2001). Torture and mental health. In Gerrity, E., Keane, T. M., Tuma, F. (Eds.), *The mental health consequences of torture*, 35-62, Springer.

Bhatia, M., and Burnett, J. (2019). Torture and the UK's 'War on Asylum': Medical Power and the Culture of Disbelief, in Perocco, F. (ed), *Tortura e Migrazioni, Sapere l'Euopa*, Venice, Italy, 161-180.

Border Violence Monitoring Network (2020). *Annual Torture Report 2020*, available at https://www.borderviolence.eu/wp-content/uploads/Annual-Torture-Report-2020-BVMN.pdf, last accessed 2/11/2021.

Bosworth, M., Fili, A., Louis, M. and Simeonidis, P. (2024). *Detention Landscapes Database: Mapping Violence in Detention*, available at https://detentionlandscapes.uwazi.io/en/, last accessed 6th August 2024.

Boyles, J. (2017). *Psychological Therapies for Survivors of Torture*, Monmouth: PCCS Publishing.

Butler, J. (2016). *Frames of war: when is life grievable?* London: Verso.

Cooper and D. Whyte (2017). *The Violence of Austerity*, London: Pluto Press.

Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatisation in the classroom, *Journal of Social Work Education,* Vol. 40, No. 2: 305-317.

Deps, P. and Charlier, P. (2020). Medical Approach to Refugees: Importance of the Caring Physician, *Annals of Global Health,* 86(1): 1-4.

DIGNITY (2012). *Field Manual on Rehabilitation,* Copenhagen: Danish Institute Against Torture.

Docs Not Cops (2020). *Patients Not Passports – challenging healthcare charging in the NHS*, available at http://www.docsnotcops.co.uk/resources/, last accessed 18/02/2025.

El-Khoury, J., Haidar, R., Barkil-Oteo, A. (2020). Psychological torture: characteristics and impact on mental health, *International Journal of Social Psychiatry,* 67(5):500-506.

Farmer, P. (2004). An Anthropology of structural violence, *Current Anthropology*, 45(3): 205-325.

Galtung, J. (1969). Violence, Peace, and Peace Research, *Journal of Peace Research*, 6(3): 167-191.

Gilmore Wilson, R. (2023). *Abolition Geography: Essays Towards Liberation*, London: Verso.

Giroux, H. A. (2010). Bare pedagogy and the scourge of neoliberalism: rethinking higher education as a democratic public sphere, *The Educational Forum,* 74(3), 184–196.

Global Detention Project, (2024). *Annual Report: Important Victories Amidst Inexorable Expansion*, April 2024, available at https://www.globaldetentionproject.org/annual-report-important-victories-amidst-inexorable-expansion, last accessed 30/01/2025.

Goddard, A., Witten Jones, R., Esposito, D., Janicek, E. (2021). Trauma informed education in nursing: A call for action, *Nurse Education Today,* 101: 1-4.

Green, P. and Ward, T. (2004). *State crime: governments, violence and corruption,* London: Pluto Press.

Hague, G. (2021). *History and memories of the domestic violence movement: We've come further than you think*, Bristol: Bristol University Press.

Kleinman, A. (2007). *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*, Oxford: Oxford University Press.

Kleinman, A. (2024). *Global Mental Health: The View from Social Medicine and Medical Anthropology*, in *Taiwanese Journal of Psychiatry*, 38(3): 107-111.

Kennedy, K.M. and Scriver, S. (2016). Recommendations for teaching upon sensitive topics in forensic legal medicine in the context of medical education pedagogy, *Journal of Forensic and Legal Medicine,* Vol. 44: 192-195.

Kuntosch, J., Ruebsam, M.L., Orsson, J., Orsson, D., Hahnenkamp, K., Hartleib, J., Flessa, S. (2024). Health impact of borders: general reflections and a case study from the Polish-German border, *European Journal of Health Economy*, 25(2):281-292.

Masmas, T.N., Møller, E., Buhmann, C., Bunch, V., Jensen, J.H., Nørregård Hansen, T., Møller Jørgensen, L.; Kjær, C., Mannstaedt, M., Oxholm, A., Skau, J., Theilade, L.,

Worm, L., Ekstrøm, M. (2008). Asylum seekers in Denmark: a study of health status and grade of traumatization of newly arrived asylum seekers, *Torture,* 18(2): 77-86.

McKee, J. (1988). Holistic health and the critique of western medicine, *Social Science & Medicine*, 26(8): 775-784.

Mohamed Ahmed Magdy Hussein, M. (2023). An integrative model of cultural intelligence and empathy for intercultural communication with recent immigrants in healthcare contexts, *Unpublished PhD Thesis*, University of Ottowa, available at https://ruor.uottawa.ca/items/94c1cb37-9436-4c58-b3b1-076bff68f6e0, last accessed 18/02/2025.

Omowumi Babatunde, A. (2018). The Efficacy of Traditional Cultural Practices in the Rehabilitation of Victims of Torture in Nigeria's Niger Delta, *Torture,* 28(3): 31-46.

Petersson, A.M. and Lundberg, J. (2018). Developing an ideation method to be used in cross-functional inter-organizational teams by means of action design research, *Research in Engineering Design,* 29: 433–457.

Rejali, D. (2007). *Torture and Democracy*, USA: Princeton University Press.

Ritchie, D. (2015). *Doing Oral History*, Oxford: Oxford University Press.

Riva, S., Campbell, Whitener, B. and Medien, K. (2024). *Border Abolition Now*, London: Pluto Press.

Şalcıoğlu, E. and Başoğlu, M. (2017). Domestic violence and torture: a theoretical and empirical comparison, in Başoğlu, M. (2017), *Torture and its Definition in International Law,* Oxford: Oxford University Press: 107-135.

Sjölund, B.H., Kastrup, M. and Montgomery, E. (2009). *Rehabilitating Torture Survivors*, *Journal of Rehabilitation Medicine,* 41: 698-698.

Sontag, S. (1977). *On Photography*, London: Penguin.

Soundararajan, M. (2024). *A qualitative examination of policing undocumented migration in the West Midland region: understanding the experiences of undocumented migrants and law enforcement agencies*, Unpublished PhD thesis: Staffordshire University.

United Nations (1984). *United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* available at https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading, last accessed 18/02/2025.