



## Moral injury related to immigration detention on Nauru: a qualitative study

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### ABSTRACT

**Background:** Immigration detention is associated with detrimental mental health outcomes but little is known about the underlying psychological processes. Moral injury, the experience of transgression of moral beliefs, may play an important role.

**Objective:** Our aim was to explore moral injury appraisals and associated mental health outcomes related to immigration detention on Nauru.

**Methods:** In this retrospective study, we conducted in-depth interviews with 13 individuals who had sought refuge in Australia and, due to arriving by boat, had been transferred to immigration detention on Nauru. At the time of the study, they lived in Australia following medical transfer. We used reflexive thematic analysis to develop themes from the data.

**Results:** Major themes included 1) how participants' home country experience and the expectation to get protection led them to seek safety in Australia; 2) how they experienced deprivation, lack of agency, violence, and dehumanization after arrival, with the Australian government seen as the driving force behind these experiences; and 3) how these experiences led to feeling irreparably damaged. The participant statement 'In my country they torture your body but in Australia they kill your mind.' conveyed these three key themes in our analysis.

**Conclusion:** Our findings suggest that moral injury may be one of the processes by which mandatory immigration detention can cause harm. Although refugees returned to Australia from offshore detention may benefit from interventions that specifically target moral injury, collective steps are needed to diminish deterioration of refugee mental health. Our results highlight the potentially deleterious mental health impact of experiencing multiple subtle and substantial transgressions of one's moral frameworks. Policy makers should incorporate moral injury considerations to prevent eroding refugee mental health.

### Daño moral relacionado con la detención migratoria en Nauru: Un estudio cualitativo

**Antecedentes:** La detención de inmigrantes está asociada con resultados perjudiciales en la salud mental, pero se conoce poco acerca de los procesos psicológicos subyacentes. El daño moral y la experiencia de transgredir las creencias morales pueden desempeñar un rol importante.

**Objetivos:** Nuestro objetivo fue explorar las evaluaciones de daño moral y los resultados asociados a la salud mental relacionados con la detención de inmigrantes en Nauru.

**Métodos:** En este estudio retrospectivo, realizamos entrevistas en profundidad a 13 individuos que habían solicitado refugio en Australia y, debido a que llegaron en barco, habían sido transferidos a centros de detención de inmigrantes en Nauru. En el momento del estudio, se encontraban viviendo en Australia tras un traslado médico. Utilizamos un análisis temático reflexivo para desarrollar temas a partir de los datos.

**Resultados:** Los temas principales incluyeron 1) cómo la experiencia del país de origen de los participantes y la expectativa de obtener protección los llevaron a buscar seguridad en Australia; 2) cómo experimentaron la privación, la falta de acción, la violencia, la deshumanización posterior a su llegada, con el gobierno australiano visto como la fuerza impulsora detrás de estas experiencias; y 3) cómo estas experiencias los llevaron a sentirse irreparablemente dañados. La declaración de los participantes 'En mi país torturan tu cuerpo, pero en Australia matan tu mente', transmitió estos tres temas en nuestro análisis.

**Conclusiones:** Nuestros hallazgos sugieren que el daño moral puede ser uno de los mecanismos por los cuales la detención migratoria obligatoria puede causar daño. Sin embargo, los refugiados retornados de la detención en alta mar a Australia pueden beneficiarse de las intervenciones que se enfocan específicamente en el daño moral, se necesitan pasos colectivos para disminuir el deterioro de la salud mental de los refugiados. Nuestros resultados resaltan el

### ARTICLE HISTORY

Received 26 April 2021  
Revised 26 December 2021  
Accepted 4 January 2022

### KEYWORDS

Moral injury; post-migration living difficulties; immigration detention; asylum seeker; refugee mental health; Nauru

### PALABRAS CLAVE

Daño moral; dificultades de vida post-inmigración; detención de inmigrantes; solicitantes de asilo; salud mental de los refugiados; Nauru

### 关键词

道德伤害; 移民后生活困难; 移民拘留; 寻求庇护者; 难民心理健康; 瑙鲁

### HIGHLIGHTS

- We retrospectively investigated moral injury and mental health related to immigration detention on Nauru.
- Participants conveyed the impact of deprivation, lack of agency, violence, and dehumanization.
- Evaluations of their experiences fit with conceptualizations of moral injury.

impacto potencialmente deletéreo en la salud mental de experimentar múltiples transgresiones sutiles y sustanciales de los marcos morales de uno. Los diseñadores de políticas públicas deberían incorporar consideraciones relacionadas al daño moral para prevenir la erosión de la salud mental de los refugiados.

### 瑙鲁移民拘留相关的道德伤害:一项定性研究

**背景:** 移民拘留与不良心理健康结果有关,但对潜在心理过程知之甚少。道德伤害,违反道德信念的经历,可能起着重要的作用。

**目的:** 我们旨在探索与瑙鲁移民拘留相关的道德伤害评估和相关心理健康结果。

**方法:** 在本回溯性研究中,我们对 13 名在澳大利亚寻求庇护并因乘船抵达而被转移到瑙鲁移民拘留所的人进行了深入访谈。在研究期间,他们在医疗转移后住在澳大利亚。我们使用反身主题分析从数据中发掘主题。

**结果:** 主要主题包括 1) 参与者的祖国经历和对获得保护的期望如何引导他们在澳大利亚寻求安全;2) 他们在抵达后如何经历剥夺,缺乏代理,暴力和非非人性化,澳大利亚政府被视为这些经历的背后驱动力;3) 这些经历如何导致感到无法挽回地受害。参与者声明‘在我的国家他们折磨你的身体,但在澳大利亚他们杀死你的思想。’在我们的分析中传达了这三个关键主题。

**结论:** 我们的研究表明,道德伤害可能是强制移民拘留造成伤害的机制之一。尽管从海外拘留返回澳大利亚的难民可能会受益于专门针对道德伤害的干预措施,但需要采取集体措施来减少难民心理健康的恶化。我们的结果强调了经历多次细微和大量对个体道德框架违背的潜在有害心理健康影响。政策制定者应考虑道德伤害,以防止侵蚀难民的心理

## 1. Introduction

The latest UNCHR report shows that over 82 million people have been forced from their homes due to persecution, conflict, and human rights violations (UNHCR, 2021). Most mental health studies conducted with refugees and asylum seekers focus on the psychopathological consequences of trauma, and have found elevated rates of posttraumatic stress disorder (PTSD) and depression (Blackmore, Boyle, & Fazel et al., 2020). However, the forced migration experience also includes aspects beyond pre-, peri-, and post-migration trauma that must be accounted for when considering refugees' and asylum seekers' mental health and in designing mental health interventions. For example, refugees and asylum seekers face substantial post-migration living difficulties (PMLD) in the host community environment that may include discrimination, restricted economic opportunities, separation from family, interpersonal factors, loneliness, as well as factors relating to the asylum process and immigration policies which are associated with negative mental health outcomes (Gleeson, Frost, & Sherwood et al., 2020; Hocking, 2020; Li, Liddell, & Nickerson, 2016; Porter & Haslam, 2005). In their review of the literature, Li and colleagues (2016) found that such post-migration stressors affect the psychological functioning of refugees. Porter and Haslam found similar results in their meta-analysis of 59 studies showing that postdisplacement conditions moderated mental health outcomes (Porter & Haslam, 2005). A further study among refugees in Australia supported these findings (Stuart & Nowosad, 2020). A recent network analysis among refugees and asylum seekers in

Switzerland showed that PMLDs covary with each other in a complex way (Wicki, Spiller, & Schick et al., 2021). While numerous pre- and post-migration factors have been shown to influence refugee mental health, their complex interactions remain mostly unclear; additionally, off-shore immigration detention has not been extensively studied. In order to better understand refugee and asylum seeker mental health in a potential host country context and inform the development of interventions, it is crucial to understand these processes (Schick, Morina, & Mistridis et al., 2018; Schick, Zumwald, & Knöpfli et al., 2016).

### 1.1. Australia-sponsored immigration detention and its consequences

A specific post-migration experience for some of the migrants is immigration detention. In Australia, since 1992, people seeking asylum who arrive ‘unauthorised’ such as by boat have been mandatorily and indefinitely detained in on- or offshore detention facilities, or in ‘community detention’. Offshore ‘processing’ on the remote Pacific Islands of Nauru and Manus Island (Papua New Guinea, PNG) was introduced in 2001, suspended in 2007, and re-introduced in 2012 as a deterrence measure against further unauthorized maritime arrivals. By outsourcing immigration detention and discriminating between forced migrants on the basis of whether they had a valid travel document, Australia has arguably violated its moral and ethical responsibilities defined by international conventions such as The Convention Relating to the Status of Refugees (International Covenant on Civil and

Political Rights; Dehm, 2019; Gleeson & Yacoub, 2021; Sharples, 2021; Sundram & Ventevogel, 2017; UNHCR, 1951). On 19 July 2013, it was determined that all asylum seekers arriving unauthorized in Australia by boat were processed offshore by the Nauruan or PNG authorities. If found to be refugees, they would be permitted to resettle in Nauru or PNG, but not Australia. The Healthcare services in immigration detention were contracted to a private company (International Health and Medical Services) for primary and mental health care. If it was deemed that medical treatment could not be provided on Nauru or PNG, a recommendation for medical evacuation to Australia or another appropriate medical facility could be made but which required approval by the Australian Border Force. After medical evacuation to Australia, individuals currently live in detention centres, community detention, or in the community on a final departure visa, which must be renewed every six months. After treatment in Australia, government policy is to return individuals to Nauru (or PNG). For more background information about the offshore detention centres see Amnesty International (2016); Freyer and McKay (2021).

Long-term indefinite mandatory immigration detention has been shown to be detrimental to child and adult physical and mental health independent of the impact of pre-migration trauma and uncertain asylum status, with studies detailing a corresponding increase in negative mental health consequences with increased time in detention (Mares, 2016; Newman, Proctor, & Dudley, 2013; Robjant, Hassan, & Katona, 2009; Steel, Silove, & Brooks et al., 2006; Sundram & Ventevogel, 2017; Von Werthern, Robjant, & Chui et al., 2018; Young & Gordon, 2016). Rates of self-harm in Australian-sponsored immigration detention centres (off- and onshore) have been found to be 200 times higher than in the mainstream Australian population and four times higher than in asylum seekers living in the community (Hedrick, Armstrong, & Coffey et al., 2019).

### 1.2. Moral injury

A framework that may be useful in understanding some of the effects of immigration detention on mental health is 'moral injury' (Litz et al., 2009; Nickerson, Schnyder, & Bryant et al., 2015). Although originally described as the psychological consequences of moral transgressions in the context of war and military, defining moral injury as betrayal of "what is right" in a high stakes situation (Shay, 1991), the idea has since been substantially broadened. Current conceptions have expanded the definition to encompass the psychological, social, spiritual, biological, and behavioural consequences of violations of moral beliefs (Litz et al., 2009). However, the moral injury literature lacks examination of individuals' moral evaluations

(Molendijk, 2018). The definition of morality includes codes of conduct that are followed by a society, a group, an individual or codes of conduct that are normatively followed by all rational people (Gert & Gert, 2020). Thus, a betrayal of 'what is right' can refer to a breach of individual moral beliefs or normative moral beliefs. An example of normative moral values is the universal declaration of human rights (United Nations General Assembly, 1948). Congruent with this definition of morality and recent research (Hoffman, Liddell, & Bryant et al., 2018; Nickerson, Hoffman, & Schick et al., 2018; Nickerson, Schnyder, Bryant, Schick, Mueller, & Morina, 2015), we conceptualized moral injury as an appraisal of events as violating deeply held moral beliefs (including individual and normative moral beliefs), resulting in a *lasting negative impact* on the person (Hoffman et al., 2018; Litz & Kerig, 2019). Furthermore, moral injury may be divided into two subtypes related to: doing a morally injurious act or failing to do what is morally right; or to being the victim of or witnessing other's morally wrong actions (Litz & Kerig, 2019).

### 1.3. Moral injury in refugees and asylum seekers

Moral injury has been proposed as a relevant construct in non-Western populations (Becker, Gausche-Hill, & Aswegan et al., 2013; Beek & Göpfert, 2012; Jafari, Hosseini, & Bagher Maddah et al., 2019; Torabi, Borhani, & Abbaszadeh et al., 2018). The few studies that have investigated moral injury in refugees and asylum seekers found that moral injury appraisals significantly contribute to adverse mental health outcomes (Hoffman et al., 2018; Hoffman, Liddell, & Bryant et al., 2019; Nickerson et al., 2018, 2015). Such moral injury appraisals have been found to be associated with high levels of PTSD, depression, and post-traumatic anger beyond the impact of pre-migration trauma (Hoffman et al., 2018). Furthermore, moral injury appraisals were positively related to pre-migration trauma exposure in recently resettled refugees (Hoffman et al., 2018).

Whereas moral injury in military samples is typically associated with transgressions of moral beliefs by oneself or feeling betrayed by authorities (Griffin, Purcell, & Burkman et al., 2019), a study investigating profiles of moral injury appraisals in refugees and asylum seekers residing in Australia found that none of the participants suffered solely from morally injurious actions committed by oneself but rather from either morally wrong actions by others or a combination of actions by others and oneself (Hoffman et al., 2019). Experiences beyond trauma such as PMLD, for example family separation and immigration and settlement related concerns have also been found to be associated with combined self- and other-directed

moral injury appraisals in refugees and asylum seekers (Hoffman et al., 2018, 2019; Nickerson et al., 2018). Although possible differences in moral injury outcomes between asylum seekers and refugees were not analysed separately, individuals who suffered mainly from moral transgressions by others (and not by oneself) were more likely to have immigration-related concerns such as insecure visa status or fear of being sent to a detention centre, which is more prevalent in asylum seekers than refugees (Hoffman et al., 2019). There are indications that detention may be experienced as morally injurious. For example, although Cleveland, Kronick, & Gros et al. (2018) did not use a moral injury framework, they found that detained asylum seekers felt humiliated by being treated as criminals (see also Coffey, Kaplan, & Sampson et al., 2010). They suggest that symbolic violence and disempowerment may be the main factors which impair mental health in detained asylum seekers.

#### 1.4. The current study

Building on, and expanding the field of moral injury research, our paper aimed to contribute to an understanding of immigration detention experiences for asylum seekers who arrived in Australia by boat after 12 August 2012. Experiences of asylum seekers who were transferred to immigration detention on Nauru after arriving in Australia by boat have been investigated sparsely, in large part due to a lack of, or highly controlled, access to those living in detention on Nauru (Sundram & Ventevogel, 2017; UNHCR, 2016). We aimed to shed light on asylum seekers' and (by the Nauruan authorities determined) refugees' experiences, in particular related to moral injury, by conducting an in-depth qualitative study with asylum seekers and refugees who had been medically transferred from Nauru to mainland Australia.

## 2. Methods

### 2.1. Design and setting

This qualitative and retrospective study among a clinical sample involved semi-structured, individual interviews as primary data as well as diagnostic assessments. We recruited participants from the Cabrini Asylum Seeker and Refugee Health Hub (Health Hub) in Melbourne, Australia. Cabrini is a non-profit Catholic healthcare service provider. The Health Hub provides both primary medical care and specialist mental health services to asylum seekers and refugees. Prior to starting, the study was approved by the Monash Health Human Research Ethics Committee (Reference Number: HREC/52353/MonH-

2019-168,805) and by the Cabrini Research Governance Office.

### 2.2. Participants

#### 2.2.1. Inclusion criteria

Eligible for this study were adults aged over 18 years who had an experience of Australian-run immigration detention on Nauru after 12 August 2012 and who were subsequently medically evacuated from Nauru to Australia.

#### 2.2.2. Exclusion criteria

We excluded people experiencing acute psychotic symptoms or acute suicidal ideation with plan and intent.

#### 2.2.3. Recruitment procedure

Clinicians of the Health Hub screened the medical records of all active Health Hub patients for inclusion and exclusion criteria. They asked potential participants for their interest in this study and, when this was the case, got permission to pass on their details to the researcher for a further discussion. The clinicians also asked those who were interested whether they wanted the assistance of an interpreter. Clinicians provided a list of 25 eligible and potentially interested participants to SP, who informed them of the study and obtained written consent for participation with the help of certified, external interpreter, where necessary. Interpreters orally translated the consent forms and participant information sheets. Twelve people explicitly or implicitly declined to participate (feeling too distressed, unable to meet or could not be contacted) while 13 agreed to participate.

### 2.3. Qualitative interview

We developed a topic list that included questions about participants' expectations and experiences, including thoughts and emotions as well as outcomes of these experiences (see Appendix 1, supplementary data). The topic list was broadly informed by our reading of previous work on potential aspects of moral injury and post-migration living difficulties (e.g. Molendijk, 2018; Nash, Marino Carper, & Mills et al., 2013; Nickerson et al., 2018; Silove, Sinnerbrink, & Field et al., 1997; Steel, Silove, & Bird et al., 1999; Yeterian, Berke, & Carney et al., 2019). Since the concept 'morality' may be understood differently in different cultures, we refrained from using the word 'moral' and rather referred to 'right' and 'wrong' (that is, what they perceived subjectively as right and wrong) behaviour. We iteratively added questions to the topic lists guided by our initial analysis, for example asking participants

more explicitly about what a typical day on Nauru was like for them. Depending on participants' answers, SP sought clarification, further insight or examples.

#### 2.4. Data collection

Both the semi-structured and diagnostic interviews (M.I.N.I., Sheehan et al., 2014) were conducted by SP, a researcher and clinical psychologist from Switzerland experienced in treatment of severely traumatized refugees. For eight participants, the interviews were conducted with an interpreter (on-site interpreter  $n = 6$ , phone interpreter  $n = 2$ ). The interviews took place at the Health Hub. The interviewer had only a temporary research connection with the Health Hub and was not involved in any clinical work. The average duration of the semi-structured interviews was 55 minutes (range = 41–73 minutes). All but one participant gave permission to audiotape the interviews. We used researcher notes taken during and directly after the interview for analysis for the participant who declined the recording. Participants were given the choice to do the diagnostic interview directly after the semi-structured interview or within the next 21 days, and via face-to-face or phone-interview. The participants were reimbursed with 25AUD for their time. Participants were contacted within the following week after the interviews to ensure that they received their regular or additional mental health support if needed.

SP transcribed the audio recordings verbatim and EA checked the transcripts for accuracy. Identifying details of participants were substituted with words indicating their relationship (e.g. [my daughter] when a child's name was mentioned).

#### 2.5. Data analysis

We used reflexive thematic analysis ('reflexive TA'; Braun & Clarke, 2006, 2019, 2020; Terry, Hayfield, & Clarke et al., 2017) to analyse the data from the semi-structured interviews. Reflexive TA involves six phases, moving from data familiarization via extensive coding and theme development to the eventual write-up of the analysis (see e.g. Braun & Clarke, 2020). Our coding, conducted primarily by SP in collaboration with EA, was both abductive (informed by our reading of the moral injury, betrayal trauma and broader refugee mental health literature) and inductive (grounded in the interview data), and included primarily semantic, 'surface level' codes, complemented to a lesser extent by those that pointed to latent patterns. Each meaningful element in the interviews was coded, generating close to 400 codes, which were organized and re-organized into the pattern described in the results.

To aid coding, we used in NVivo Pro for Mac version 12 as well as the drawing and discussion of multiple thematic maps in the later phases of analysis. The quotations presented within the results section were minimally edited for readability. For additional quotations please see Appendix 2, supplementary data.

Our stance was one of realism, treating participants' experiences as 'real and true to them' (Braun & Clarke, 2006; Pickens & Braun, 2018); in other words, we expected that appraisals would have been similar if we had spoken with other participants with similar experiences. As a team of mental health clinician-researchers, we were particularly aware of the role of intersectionality with the life and challenges encountered by families and individuals seeking safety in Australia, and the human rights violations associated with immigration detention.

### 3. Results

We interviewed nine female ('f') and four male ('m') participants with ages ranging from 21 to 60 (mean = 37.9, SD = 13.5) from diverse backgrounds. Four were from Iran, two from Somalia, two from Nepal, two from Sri Lanka and three from other countries (grouped together to maintain confidentiality). Their religions were Christian ( $n = 3$ ), Muslim ( $n = 4$ ), Hindu ( $n = 4$ ), or other ( $n = 2$ ). Ten out of 13 had refugee status in Nauru (but not Australia) and three were still in the refugee status determination process (as asylum seekers). Seven lived in the community on a Final departure Bridging E visa, five lived in community detention, and one participant had a visa without expiry date. This latter participant (P08m) arrived in Australia before 19 July 2013, enabling him to settle in Australia if his asylum claim was approved (see introduction). All other participants arrived after 19 July 2013, and were therefore to be sent back after their medical condition was treated. Eight out of 13 participants had work rights. Participants spent between 1 and 36 months in Nauru (mean = 14.2, SD = 11.1) and had lived in Australia after medical evacuation for 28 to 64 months (mean = 55.3, SD = 12.3). Two comprised a marital dyad and were interviewed together at their request (P12f and P13m).

#### 3.1. Diagnostic interviews

One participant completed the qualitative but not the diagnostic interview because it made her feel distressed and for two other participants, it was not possible to organize the diagnostic interview. For these three participants, their psychiatrists assessed them and reported their diagnoses. Participants suffered from PTSD ( $n = 10$ ), major depressive disorder ( $n = 9$ ), panic disorder ( $n = 3$ ), and obsessive

compulsive disorder ( $n = 3$ ). Regarding the number of current mental disorders, participants had either no current disorder ( $n = 2$ ), one disorder ( $n = 2$ ), two disorders ( $n = 6$ ), or three or more disorders ( $n = 3$ ). Four participants had suicidal ideation, three had had suicide attempts more than two years prior, and one participant had made a suicide attempt less than two years ago. These results show that our participants exhibited poor mental health.

### 3.2. Qualitative interviews

'In my country they torture your body but in Australia they kill your mind': (P01f) is a participant's statement that conveyed several key themes in our analysis. In this results section, we specifically attend to 1) how participants' home country experience and the expectation of protection led them to risk their life and seek safety in Australia, 2) the experience of deprivation, lack of agency, violence and dehumanization after arrival, with the Australian government seen as the driving force, and 3) how these experiences led to feeling irreparably damaged. Many of our participants stated that the aim for participating for them was that other people will learn about their experiences.

#### 3.3. 1) 'In my country they torture your body' – Risking one's life to find safety in Australia

Participants described that they consciously risked their lives embarking on the dangerous boat journey to Australia because they felt there was no option to stay in their home country. For example, one participant said:

'I'm from [...] They don't let you talk; you can't choose what you want to be. You can't choose your religion. You can't be a feminist. We decided that we didn't have another way and we came by boat. And that's not an easy way to travel. It's very dangerous. So we made the decision to live in a jail or to die to get freedom. We choose to have freedom.' (P02f)

Participants had heard that they would attain safety and therefore expected protection in Australia. Some expected that the Australian government would 'look after them' and be 'welcoming'. Many contrasted their home country experiences of war and persecution with the reception they anticipated. For example, one said that there had been fighting in her country even before she was born and that she came to Australia to have a 'safe life'. Others stated that they came from jail, did not have any safe haven in their home country, and expected safety and protection from the Australian government. In other words, they expected their ordeal to be over once they arrived in Australia.

One participant said that he was overjoyed when he arrived after six days on a boat:

'Oh, it's finished! I survived the water, survived back home [...] to come here in a safe place. Not worried about dying or being killed.' (P07m)

#### 3.4. 2) 'In Australia They Kill Your Mind' – Material Deprivation, Lack of Agency, Dehumanization, and Violence

All participants stated that what they experienced after arriving in Australia was the opposite of what they expected; several of them expressed ongoing disbelief and bitterness. Their reports conveyed experiences of deprivation, lack of agency, violence, and dehumanization. Many regretted coming to Australia and some said they wished they had died on the boat journey.

#### 3.5. 'I Was Staying in My Room because I Didn't Have Any Shoes to Walk.' (P10f) – Material Deprivation and Lack of Agency

Participants felt not only confronted with tough environmental conditions in the detention centre on Nauru, such as living in tents in hot temperatures with high humidity and unhygienic facilities, but also with a lack of privacy and control over their lives, related to a vast set of arbitrarily applied and enforced rules. Having to queue for long periods of time in harsh conditions, with queues simply being disbanded when a timeslot for a service had passed (irrespective of whether people were still waiting), was mentioned frequently, and led to frequent inadequate access to food, internet/phone facilities to contact family, medication, clothing and footwear, and sanitation. For example:

'When we wanted to go to the toilet. Even for the toilet paper, what they do, took some of the papers and saying that "This is your paper. Cannot give more."' (P09m)

'We didn't have enough time to take a shower. Maximum two minutes and there was not enough water. We might still have some shampoo on our head but they would just turn off the tap.' (P06f)

Several participants said that the rules were not suitable for people with mental health difficulties or children because they were too difficult to remember and adhere to, contributing to further deprivation, exacerbation of mental ill-health, and erosion of agency. Lack of adequate medical treatment was mentioned as a particular concern, and participants described diagnostic and treatment failures for serious health conditions. Another element of deprivation was lack of schooling and play or educational materials for children.

The deprivation appeared to have an intentional component to it, with participants feeling that security guards created their own rules or had been trained to act inhumanely, with one stating: ‘When we were in the detention centre, in Nauru or Australia, some officer created their own rules. It was not Australia’s rule it was not the minister who told the person to do so. They did their own rules, which killed our minds.’ (P04f)

### **3.6. ‘They were treating us like animals, even less than animals.’ (P07m) – dehumanization and violence**

Participants described multiple experiences that can be classified as violent and potentially traumatic, and often hinted at further experiences that they felt were too difficult to discuss in the interview. Several participants spoke about being raped or a family member being raped, either in the Nauruan community or by a detention guard, and several female participants spoke about threats of sexual violence, stating that the detention centre was not safe for women and citing sexual harassment by security guards. One of the male participants was physically attacked by people from the Nauruan community, and others stated that they did not feel safe living in the community. Of note, two participants who had been raped in the Nauruan community explicitly blamed the Australian government rather than the local people, one stating:

‘I blame the Australian government instead of the Nauruan government. So, when they attacked [raped] us, who can we blame? Australia. Because Australia they promised us that they will give us a safe place. But it was not. Instead of giving us a safe place they gave us mental sickness, physical sickness. They put us somewhere where we will lose our hope, we will lose our dreams, we will lose our families.’ (P01f).

Violent transit experiences to and from Nauru also featured in participants’ accounts. For example, four participants informed that they witnessed or experienced incidents in the Darwin detention centre where they were held after medical evacuation from Nauru where, in the middle of the night, multiple armed police officers with dogs would invade refugees and asylum seekers’ rooms and violently drag them out. For example:

‘Darwin is hot. I had a very comfortable short [night-]dress for sleep. And in the midnight lots of people came to my room. The police with black uniform. Lots of dogs. And lots of officers. You can’t imagine when you open your eyes and you saw many people just over your head. I don’t remember how they took my husband, very badly. And they took my son. He was three months, he was a baby. And they took him. And because I didn’t want to go, I was scared,

they pulled me maybe one kilometre. They just hold my arm very hard and put me on a floor to get to the bus. And I didn’t have pants. I didn’t have clothes. Everyone was watching me. Lots of men, women, or officer. They took my son for 12 hours when he was breastfed. I didn’t know what was going on. No one explained to me what was happening. Did I do something wrong?’ (P02f)

In this latter experience and in the other accounts of traumatic detention experiences, participants conveyed a sense of having lost their dignity, what they expressed as ‘not being treated as a human being’, which was a strong theme in the interviews. The majority of participants stated this explicitly. For example, they mentioned feeling treated as if they had a contagious disease, which they experienced as very painful:

‘One behaviour from the officers that we didn’t really like and we actually wrote complaints about that. We found it very assaulting and insulting when they used to stand behind the fences and throw bags of clothing to us without even coming over as if we’re ill or sick people or have got something contagious . . . You know, all of us, my friends, my family and I, were so upset about that. We were saying “Do we have a skin condition that you just don’t want to be in contact?”’(P11f)

Multiple participants made an explicit comparison with animals. They felt treated as less than animals, referring to the deprivation to which they were exposed as well as to mistreatment by security guards and other staff. For example, one participant said:

‘We feel as an animal. It’s not what they do to humans. That time, I felt they were looking at me as an animal. But when they transferred me to Australia, I thought, no, I thought wrong because the people have a very nice behaviour with pets. When I went to the shop for the first time, I saw lots of food for dogs or cats. They have got toilets, they have got doctors. They have everything they need. So, we are smaller than that for the people who work in the detention camp or government.’(P02f)

One participant described how she was not treated as a human by doctors because when she asked about her diagnosis and condition, they refused to provide her with any information. Participants emphasized in the interviews that they *were* human beings – the same as others – and that they had the same mind and capabilities.

Many participants felt they were treated inhumanely by guards and commented that security guards behaved dismissively, used abusive language, used handcuffs unnecessarily, were present in excessive numbers for transfers, and hit them. The prison-like detention centres overall were perceived as inhumane, and participants questioned why they were treated like criminals by being placed in such centres.

Feeling dehumanized also included feeling used for political purposes in order to ‘stop the boats’, without any regard for the personal impact. Participants’ language conveyed that, rather than blaming individuals for what they experienced, they blamed the government, the immigration department, and the ‘stop the boats’ policy for their suffering. For example, as mentioned above, most participants focused more on ‘training’ of the guards and systemic – though arbitrary – rules, and contrasted their examples with mentions of individuals who behaved kindly, including making a distinction between the Australian government and Australian citizens, referring to Australian (and Nauruan) people as ‘good people’.

### **3.6.1. 3) The result: ‘I’m completely destroyed – inside and outside’ (P07m)**

Participants mentioned their loss of trust in other people, an inability to feel close to others, and a negative view of the world and themselves. For example, a few participants stated that they were scared of other people because other people reminded them of the detention officers. Other participants were unable to make friends after their experience on Nauru. Participants also reported that after their experience of detention, they felt that ‘they lost themselves’, had been ‘damaged’ or ‘destroyed’:

“Now I don’t know, who am I? I lost myself. Because I’m not that person I was, that person who came to Australia. I was healthy. I was active. I had a hard time but I was happy. But now I can’t laugh, I can’t cry, I can’t work. I can’t study. I’m living in very dark place. (P02f)

Participants felt hopeless due to having lost important years of their lives in detention. This also included the loss of health; they mentioned physical conditions that started or deteriorated in Nauru, such as skin diseases, renal and bladder calculi, various chronic diseases, unnatural hair loss, ear and eye problems, and Alzheimer’s disease. Some felt haunted by questions of guilt (e.g. whether they had done something wrong), or why they were treated so badly. For example:

‘If you don’t want to give me a life, okay kill me and shoot me and I will die one time. Why are you killing my brain? Why are you cutting my heart, every single day? When somebody uses a knife and you die, and when somebody kill you every single day, kill your brain and your mind, it’s totally different. It is better you die one time.’ (P04f)

All but one participant (P08m) raised mental health problems – fear, depression, emotional numbness, sleeping problems, obsessive compulsive behaviours, irritability – or ongoing sadness related to their experiences in detention. The one participant who did not mention mental health problems had, notably, only stayed one month on Nauru compared to 6–36 months (mean = 15.3, SD = 10.9) for the other participants. As

mentioned earlier, he was also the only one allowed to settle in Australia.

Many participants suffered from painful memories related to their experiences in detention, which they were unable to forget. These memories were not only related to traumatic experiences but also to the experiences of deprivation and dehumanisation. For example, one participant stated that whenever she sees a water bottle it reminds her of when an officer on Nauru refused to give her a water bottle when she was pregnant because it was ‘too expensive.’

Participants described that they and their friends were in such despair that self-harm and suicide attempts were common during and after detention on Nauru. Several participants said that they attempted suicide, and the participant-couple said that their 12-year-old daughter had attempted suicide. A few participants attributed their suicide attempts to being raped on Nauru (and receiving no adequate support or treatment) whereas another participant attributed her suicide attempts to feeling dehumanised and hopeless. The participant-couple said that their daughter attempted suicide because schooling was suddenly cancelled with no replacement. Some participants described, often with difficulty, having witnessed friends and acquaintances drinking dangerous chemicals or setting themselves on fire.

Multiple participants mentioned that their current situation still felt very precarious with the fear of being about to lose the right to live in the community, being sent back to Nauru or being detained again. Others referred to how difficult it is to live in Australia with only a 6-month visa, restricted rights, and no governmental support. One participant stated:

‘I’m constantly aware of my actions because I’m afraid that if I do any slight thing wrong they might tell me that “you need to go back to detention”.’ (P11f)

## **4. Discussion**

This qualitative study among asylum seekers and refugees receiving medical care in Australia aimed to better understand the experience of immigration detention on Nauru, in particular in relation to moral injury. All 13 participants temporarily resided in Australia after medical evacuation, 12 of them had no permanent status in Australia and were therefore at constant risk of being sent back. The main themes developed from the qualitative data were 1) participants risked their lives on the journey to Australia because they expected safety; 2) they experienced deprivation, lack of agency, violence and dehumanization after arrival, for which they held the Australian authorities responsible; and 3) these experiences led to feeling irreparably damaged. The participant statement ‘In my country they torture



your body but in Australia they kill your mind.’ conveyed these three key themes in our analysis. In the diagnostic interviews, we found that almost all participants suffered from mental disorders, with most of them having two or more disorders, aligning with findings of increased mental health problems during long-term detention (Hedrick et al., 2019; Sundram & Ventevogel, 2017; Von Werthern et al., 2018; Young & Gordon, 2016). We now discuss participants’ accounts with regard to the field’s current and expanding knowledge of moral injury.

#### **4.1. Participants’ expectations and the relation to moral injury**

Moral injury is ‘a betrayal of what’s right’, a transgression of ‘normative expectations’ or ‘commonly understood social values’ (Shay, 1991, 2014), which includes transgressions of individual or normative moral codes of conduct (Gert & Gert, 2020). A potentially morally injurious event occurs if a person acts, fails to prevent, witnesses or is the victim of acts against deeply held moral beliefs, which also contains witnessing inhumanity (Litz & Kerig, 2019; Litz et al., 2009). Our participants fled war and persecution to seek refuge in a country with the explicit expectation of receiving safety and protection from its government. Many participants stated that they expected protection ‘from the Australian government’, which refers not only to a geographical destination but also to people and a political system, from which the participants trusted they would receive protection. Most likely, this was not just an expectation based on safety considerations but also a moral expectation predicated upon a common understanding of human rights and shared moral values. Participants in our study lived in countries where their rights (and moral beliefs) had been extensively transgressed. They stated that they had different expectations of Australia compared to their home countries. They expected safety and protection, as enshrined in the UN human rights (International Covenant on Civil and Political Rights), ‘The right to liberty and security of the person’, (Article 9, OHCHR, 1966) and therefore a normative expectation for a country that is a signatory to this and other UN human rights instruments. Contrary to their expectations, not only did they not receive protection (act of omission) but they were sent to places where they experienced severe deprivation, violence, and mistreatment (acts of commission; Litz et al., 2009). The experience of being harmed after seeking protection was something that no participant expected, which can also be deemed a normative expectation: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” (Article 7, OHCHR, 1966); ‘Refugees should not be penalised for their

illegal entry or stay. ... Prohibited penalties might include being arbitrarily detained’ (UNHCR, 1951). The dissonance between their experiences and pre-existing moral assumptions aligns with Litz et al. (2009) conceptualization of moral injury.

#### **4.2. Participants’ experience of being treated ‘as less than animals’**

Our study adds to findings of negative changes in core beliefs and feeling humiliated, violated and disempowered after indefinite mandatory immigration detention (Cleveland et al., 2018; Coffey et al., 2010) by suggesting that these changes may be attributable to moral injury appraisals regarding dehumanization by a trusted institution (the Australian government). Almost all participants felt they were not treated as humans and many used the descriptor ‘being treated as less than animals’ in some form. One participant who felt used for political purposes said that it was not ‘human nature’ what the authorities did; it was [the] ‘devil’. Unlike Molendijk (2018)’s moral injury study, where military veterans felt that their belief in right and wrong failed them, for our participants it was their trust and belief in just systems which was betrayed. Their struggle was about being placed in circumstances where moral obligations to others did not appear to apply to them. They felt like members of an ‘out-group’, not as humans, not as animals, but as less than animals. This feeling of exclusion fits with ‘othering’ theories, which explain that forced migrants are depicted in public debates as ‘different’ compared to the people of the host countries. In the case of Australia, this goes as far as depicting them as ‘uninvited guests’, ‘boat people’ and ‘queue jumpers’ (Grove & Zwi, 2006). Miller (2009) argues that diminishing the moral value of another person (that is, dehumanization) is itself a morally injurious action. Dehumanization is associated with ‘moral exclusion’. Moral standards that normally apply to others do not apply for morally excluded individuals; it seems justified to harm them (Opatow, 1990). Aligning with moral injury outcomes, feeling dehumanized is associated with feelings of guilt, shame, sadness, and anger for those experiencing it (Bastian & Haslam, 2011).

Our participants condemned their dehumanizing experiences as unequivocally wrong. This is striking, given that it was the main finding of Molendijk (2018)’s study that moral injury comprised an ethical struggle and moral disorientation about moral values rather than unequivocal transgressions of moral beliefs. However, our participants suffered from transgressions by others whereas participants in Molendijk (2018)’s study were primarily affected by moral transgressions committed by themselves. It might be easier to condemn an action that was done by others as unequivocally wrong compared to an action by oneself.

### **4.3. The outcome – feeling damaged and its relation to moral injury**

Moral injury is conceptualized as a mental and behavioural health outcome consequent to a potentially morally injurious event, which includes also witnessing (or being the victim of) inhumanity (Litz & Kerig, 2019). Our participants experienced grave inhumanity in the form of violence and dehumanization. The appraisal of a morally injurious event (e.g. being treated like an animal or less than an animal) may lead to emotions such as shame or anger. In the case of moral injury, these ‘moral’ emotions can become extremely strong and incapacitating, affecting one’s sense of belonging and identity, with enduring negative self- and other-attributions (Litz & Kerig, 2019). Aligning with this conceptualization, participants in our study made enduring self-attributions such as feeling ‘destroyed’, ‘damaged’, or ‘less human’. This is also in line with Shay’s (1991) observations in Vietnam war veterans who felt ‘being already dead’ after morally injurious experiences. In accordance with what has been described as outcomes of moral injury (Griffin, Worthington, & Danish et al., 2017; Litz et al., 2009; Molendijk, 2018), participants in our study also suffered from loss of trust and closeness to others, emotional numbness, re-experiencing the morally injurious experiences, and guilt.

Self-harming may be part of the chronic impact of moral injury (Litz et al., 2009). There is an extant correlation between suicidal ideation, suicide attempts, and moral injury (Bryan, Bryan, & Morrow et al., 2014; McEwen, Alisic, & Jobson, 2020), although effects tend to be small (McEwen et al., 2020). In our study, several participants reported having attempted suicide themselves or witnessed the act, and one participant explicitly related it to being dehumanized.

### **4.4. Moral injury in the context of institutional betrayal**

In our participants, the perceived agent of the moral transgressions was the (Australian) government. Molendijk (2019) advocates a moral injury theory that not only focuses on the conflict within the individual but also includes conflicts between the individual and political domains. She places moral injury in the context of ‘institutional betrayal’, an expansion of the betrayal trauma theory (Freyd, DePrince, & Dhjm, 2007), which comprises harm caused by institutions to individuals who trust and/or depend on that institution (Smith & Freyd, 2014). After believing they could place all their hopes and trust in Australia, our participants blamed the government for both acts of omission and acts of commission. In this context, it was striking that the two women who were raped in the Nauruan community did

not blame the rapists but rather the Australian government for their failure to protect them.

Hence, our findings further expand moral injury within an institutional betrayal context by incorporating the element of the ‘other’. Our participants were seeking inclusion within a broad political and social institutional context – namely Australia – but instead experienced rejection. This was perceived as a betrayal of their fundamental human rights by the institution, and which compounded their sense of exclusion and dehumanization.

### **4.5. Limitations and strengths**

The first limitation of this study is that the high prevalence of mental disorders in the cohort may have affected the responses of participants. Given the extant literature, it is more likely that their detention experiences caused, precipitated or exacerbated their disorders. However, a qualitative study is unable to resolve this possible interaction. Second, because this is an in-depth qualitative study among a specific group of people, participants who have not had a medical transfer and are still living on Nauru (currently in the community since the detention centre was decommissioned) may have had different accounts and we cannot predict in which way these would have been different. It might have also led to a selection bias so that only individuals with severe mental and/or physical conditions who had a medical transfer and were transferred to the Health Hub were interviewed but not individuals with less severe conditions. Third, participants had been transferred to the Australian mainland more than two years prior; as with all retrospective research, they may have found it difficult to recall certain experiences. Fourth, the language barrier, the use of interpreters and cultural differences might have led to a loss of nuance or a distortion of the results. Finally, several participants stated that they were not able to talk about the especially difficult experiences, which means that important information is likely missing and underscores the importance of continuing research in this domain.

The strength of this study is the rare opportunity to hear from individuals with lived experience of immigration detention on Nauru. Individuals in detention on Nauru are extremely isolated because of highly controlled access to Nauru; visitors from outside (e.g. NGO’s, politicians, researchers, health professionals) are scarce. Even though our participant sample was small, it is the largest sample of adult participants who were detained on Nauru and who participated in person to date. Furthermore, due to the qualitative nature of our study, our participants received a voice to relate what they had experienced.

## Conclusions

Transgressions of moral assumptions, the appraisal of being dehumanized, and associated negative mental health outcomes align with conceptualizations of moral injury (Litz et al., 2009; Shay, 2014). Our study adds to the mounting evidence that indefinite mandatory immigration detention over protracted periods of time and particularly offshore detention has long-lasting negative impacts on mental and physical health beyond experiences of past trauma (Mares, 2016; Newman et al., 2013; Robjant et al., 2009; Steel et al., 2006; Sundram & Ventevogel, 2017; Young & Gordon, 2016) and suggests that moral injury might be one of the processes by which it can cause harm. It further adds to the literature on moral injury in refugees and asylum seekers, which also demonstrates that moral injury is associated with experiences beyond pre-migration trauma such as PMLD (Hoffman et al., 2018, 2019; Nickerson et al., 2018).

Individuals returning from offshore detention may benefit from interventions that target moral injury. Yet, our results suggest that interventions developed to treat moral injury in veterans, which focus on self-forgiveness and/or acceptance (e.g. Griffin et al., 2019, 2017), are less likely to apply to individuals who have experienced immigration detention. Interventions for the latter group should include a focus on restoring the belief in justice and the ability to rebuild trust in others. However, an individual-focused treatment will not suffice, and collective, system-wide steps are needed to address the underlying problems causing deterioration of refugee mental health in indefinite mandatory immigration detention. Clearly, the optimal solution would be to abolish indefinite detention; however, in a grim political climate this may not be tenable. In such circumstances, visibility, transparency and openness to public scrutiny may function as the best preventative or reparative measure against violations described in this study. Furthermore, health services must be accessible for all forced migrants, including individuals with temporary visas, and health care workers should be trained in human rights and transcultural competence. Additionally, public health policies should foster inclusion instead of 'othering' refugees and asylum seekers (Grove & Zwi, 2006). To counteract 'othering', narratives of forced migrants should be more widely available to the public. Our results highlight the potentially deleterious mental health impact of experiencing multiple insidious, as well as substantial, transgressions of one's moral frameworks. The implication of these findings is that host government policies that seek to exclude those seeking asylum through offshore detention result in severe and deleterious mental health outcomes regardless of their intention.

## Acknowledgments

We thank the Health Hub team for support in recruitment, in particular Nicholas Mueller and Giam D'Amico. We also thank Natasha Blucher for sharing her expertise and assistance throughout all aspects of our study. Finally, we thank Tine Molendijk and another anonymous colleague for their expertise and fruitful discussions regarding the conceptualisation of moral injury.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

SP received a grant from the Swiss National Science Foundation (grant number 184612) for a 6-month research stay at the University of Melbourne, which was extended by one month and supported by the Child and Community Wellbeing Unit (Centre for Health Equity). Monash University (SS) funded the reimbursement for participants and the interpreters' costs.

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## Data availability statement

The data that support the findings of this study are available on request from the corresponding author, [SP]. The data are not publicly available because the information could compromise the privacy of research participants.

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