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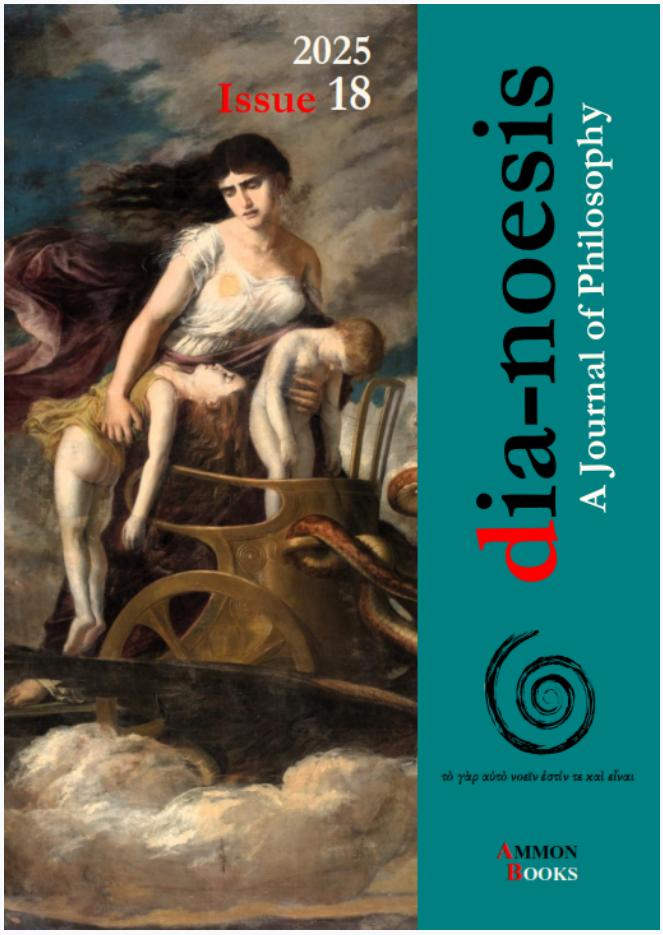
Trauma, Exile, and Cultural Displacement



Bioethics in a skeptical perspective:

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Bioethics in a skeptical perspective: how to *not* always treat trauma during exile and cultural displacement

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Abstract

In today's world, bioethics seems to be the best solution we have in order to sustain a firm and efficient ethical understanding of our suffering world. However, in its good-willed narrative a lot is missing. Many of our fellow human beings carry another cultural and historical awareness than our own. In the context of interaction between the authority of the bioethicist and the needful person of exile or cultural displacement, trauma may indeed not get cured, or even worse, become deeper. As communication between distinct identities is indispensable, both doctor and patient need to re-identify themselves, often securing for each other a certain suspension of knowledge and moral decision.

Keywords: *Bioethics, trauma, exile, cultural displacement, Skepticism*

It was R. M. Hare who suggested that if the moral philosopher cannot help with the problems of medical ethics, he ought to "shut up shop"[1]. This view is aligned with that of those who claim that the bioethical "experience" is absolutely essential in treating problems of all kinds in the medical spectrum but also that it is an innovative strategy that enhances the possibility for theoretical moral philosophy to discover a better mission. The real expectation is that bioethics can move on from a point of empirical observation, along with medical science, to the formation of values[2]; in the bioethical relationship between doctor and patient, this seems highly problematic, if not improper. The main reason is that, because of the nature and the innumerable practicalities of this relationship, it is crucial to bear in mind that there are two personalities involved with strong moral dilemmas that count, not just one, and that one of them is usually in the position of an inferior. This makes the moral outcome even more difficult or significantly less predictable. This happens primarily in cases when trauma, a complicated existential condition, is involved, as the identities of both the patient and doctor may be at risk. To manage such situations, most bioethicists uphold that a deontological approach will suffice[3]. But what happens when neither the patient nor the doctor know what to do? Is deontology adequate or imaginary? Or, otherwise said, is it possible that they have an actual right to become sincere skeptics?

On the face of it, at least the doctor should be no skeptic, for the obvious reason that he is committed to a profession that requires certain knowledge and action that comes from it. While doing his job, a doctor is asked to make decisions, among them moral ones or practical decisions of inherent moral quality, while the patient can retain a more passive acceptance of the facts or of his role. Dragona- Monachou[4] well observes that, because of that,

[1] Hare R. M., *Essays on Bioethics*. Oxford 1993: Oxford Academic, pp. 1-14.

[2] Dragona-Monachou M., *Syghroni Ithiki Philosophia (Contemporary Moral Philosophy).* Athens 1995: Ellinika Grammata, p. 394.

[3] Cf. Veatch R., *A theory of medical ethics*. New York 1981: Basic Books, pp. 316-400.

[4] Dragona-Monachou M., *Syghroni Ithiki Philosophia (Contemporary Moral Philosophy).* Athens 1995: Ellinika Grammata, pp. 378, 390-391.

the conscience of the doctor had better be a moral one, otherwise what his medical action is going to produce will be no other than a personal response to a problem thus dependent on personal morality. To bridge this gap of potential moral narrowness and inefficiency, what seems more plausible is the deontological approach or working within a certain protocol- something that more and more medical practitioners accept with hope turning themselves into believers. However, what the doctor misses by following that is two things: a) the opportunity to enhance his own personal moral identity to a desired degree of perfection, b) the opportunity to do full justice to the particular case of the patient.

Bioethics, a field that examines the ethical implications of biological and medical practices[5], is increasingly relevant to understand the above complexities surrounding trauma, exile and cultural displacement but also is a field where one´s moral identity can be set under certain socratic *elenchus*. Under this prism, the aforementioned phenomena are not simply individual experiences but are deeply intertwined with subsequent and broader social and ethical considerations that affect identity training, health and communal relations. Jotkowitz draws our attention to the fact that it is quite disputable whose ethics we follow when we follow all these bioethical considerations during consultation[6], perhaps violating the right of the person who is exiled or culturally displaced to be heard in his own recognition of himself and of his situation. Similarly, Toulmin maintains that moral enthusiasts may not do a good job when they literally blind themselves to real life situations and problems[7]. Elliott focuses on the parameter that the problem is not that bioethicists believe they have the skills and the knowledge to support their moral decisions but that they represent authority in the nexus of certain bureaucracy which gives an air of the infallible[8]. It comes as no surprise that Jotkowitz, again, describes that "for ethical consultation to fulfill its promise of medicine practiced

[5] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, pp. 31-33.

[6] Jotkowitz A., "Ethics Consultation: Whose Ethics?", *American Journal of Bioethics*, 7:2, 2007, pp. 41-42.

[7] Toulmin S., 1981, "The Tyranny of Principles", *The Hastings Center Report*, 11: 6, 1981, p. 38.

[8] Elliott C., "The tyranny of expertise", in Eckenwiler L. A., Cohn F. G. (Eds), *The Ethics of Bioethics. Mapping the Moral Landscape*. The Johns Hopkins University Press, Baltimore 2007, p. 45.

according to the highest ethical standards, the members of the team must better reflect the religious and cultural values of the patients they are serving"[9]. For this reason, if the identity of the suffering person is to be re-shaped under the new conditions of his exile or displacement, then the related interactive social situations are to be re-shaped as well. Therefore, the intersection of bioethics with trauma, exile and cultural displacement requires thorough exploration of key terms and considerations to understand its implications completely.

The trauma, fundamentally understood, refers to the psychological and emotional response to distressing events. As such, it is related to the idea of one's self, but also to the connections he has developed, i.e. with his sense of belonging. Trauma covers individual and collective experiences, particularly those that affect marginalized groups. Exile, in this perspective, is taken to mean the state of being prohibited from the native country, often as a result of political, social or economic pressures[10]; again, this has to do with a re-formulation of identity, and of the interactions one has with the others as object as well as with himself as object. De Grazia well understands this procedure when he refers to the narrative identity and the process of self-creation[11]. This extends the psychosocial ramifications of the interruption of identity, while exiles fight their sense of belonging and cultural roots. Cultural displacement, meanwhile, implies the loss or alienation of a community of its cultural contexts, which leads to an existential crisis that could complicate identity reconstruction processes. Each of these terms plays a fundamental role in the configuration of experiences of individuals and communities, and examining their intersections reveals how bioethical considerations can provide a framework to understand human dignity, specifically alongside the issue of health. De Zulueta explains how this kind of consideration as active "compassion needs to be able to respond to all the dimensions

[9] Jotkowitz A., "Ethics Consultation: Whose Ethics?", *American Journal of Bioethics*, 7:2, 2007, pp. 41-42.

[10] Cf. Kiritsis D., "Economic Globalization, Society and Education", *Dia-noesis*, 10, 2021, pp. 87-100.

[11] De Gracia D., *Human Identity and Bioethics*. Cambridge 2005: Cambridge University Press, pp. 77-114.

of suffering and to respect the dignity of the person and not slide into pity and condescension"[12].

Studying the intersections of bioethics, trauma, exile and cultural displacement is particularly relevant in various communities, where variable cultural contexts affect perceptions and responses to these problems. For example, the ethical dimensions of providing medical care to traumatized refugees or displaced persons reflect on questions about informed consent, autonomy and the attribution of justice[13]. But also, as Agich demonstrates[14], questions appear regarding what really constitutes the actions, cognition, and perceptions of practitioners. In many cases, traditional bioethical principles must be re-evaluated to accommodate the distinctive needs and cultural nuances of these populations[15]. Respect for cultural diversity becomes imperative, since the ethical standards that appear sufficient within a cultural paradigm may not be applicable to another. Dancy even doubts whether principles are anything else than just generalized mistakes which disfavor the variety of reasons that there are on numerous issues[16]. The question remains though: even if we say respect and awareness sound right (in the sense of being effective), how much are they really feasible?

In addition, the consequences of trauma, exile and cultural displacement on identity are quite profound and influence a lot of related parameters. Many people from displaced communities fight with the integration of their past identities with new, often imposed ones, leading to complex psychosocial challenges and, often, failures. Quite frequently they are feared by local governments or are turned into scapegoats; in this manner, their sense of identity is even more at risk[17]. Bioethical research on these identities reveals not only the individual's struggle to manage himself under the

[12] De Zulueta P. C., "Suffering, Compassion and 'Doing Good Medical Ethics'", *Journal of Medical Ethics*, 41: 1, 2015, p. 89.

[13] Engelhardt H. T., "The search for a global morality: Bioethics, the culture wars and moral diversity", in Engelhardt H. T. (Ed), *Global Bioethics. The Collapse of Consensus*, M & M Scrivener Press, Salem 2006, pp. 18-49.

[14] Agich G. J., "The Question of Method in Ethics Consultation", *American Journal of Bioethics*, 1:4, 2001, pp. 31–41.

[15] Toulmin S., 1981, "The Tyranny of Principles", *The Hastings Center Report*, 11: 6, 1981, pp. 31–39.

[16] Dancy J., *Ethics Without Principles*. Oxford 2004: Clarendon Press.

[17] Vasanthakumar A., *The Ethics of Exile: A Political Theory of Diaspora*. Oxford 2021: Oxford University Press, pp. 1-2.

new terms, but also the collective memory of the communities affected by historical injustices. Once more, identity seems threatened, and the bioethical considerations do not always seem to serve effective solutions. The task lies in finding sensitive and culturally competent approaches that will gradually and in the long run recognize and cherish these identities while promoting health and well-being.

In addition, social perceptions greatly influence the traumatized, exiled or culturally displaced communities. Stigmatization and discrimination can exacerbate pre-existing mental health problems and obstruct access to adequate health resources. Hua et al clarify that "[we can now] identify the presence of institutional racism within international inpatient care; ...and there is evidence that patients experiences of racism within health systems was not isolated to inpatient settings but could in fact occur across the treatment pathway, with implications for how they then experienced their care as inpatients"[18]. These findings by Hua et al, along with the ethical dilemma that surrounds social responses to trauma and displacement, are crucial for bioethical analysis, since they raise questions about the moral responsibilities of health professionals, political leaders and society in general to guarantee equitable care and support.

Participating in an interdisciplinary exploration of these intersections allows a more comprehensive understanding of the ethical dimensions at stake. By recognizing the multifaceted nature of trauma, exile and cultural displacement, bioethics can ideally contribute significantly to improving mental health frameworks and promote social attitudes that cover diversity and resistance to adversity, as long as bioethics examines the factor of feasibility and the influence of its authority. Trauma is a multifaceted psychological response to distressing events, characterized by physical, emotional and cognitive repercussions[19]. It can manifest itself in many ways, covering acute and chronic experiences. Chronic trauma, in particular, stems from prolonged exposure to distressing situations

[18] Hua P., Fenton S. J., Freestone M., Bhui K., Shakoor S., "Ethnic disparities as potential indicators of institutional racism in inpatient care within acute mental health wards: A rapid review, *SSM- Mental Health*, 8, 2025 https://www.sciencedirect.com/journal/ssm-mental-health/vol/8/suppl/C

[19] Regel E., "Mental health and humanitarian crisis: Moral stress in trauma therapy", *Bioethics*, 38, 2024, pp. 811–815.

such as violence, war or continuous social marginalization. Among the displaced communities, the nuances of trauma are even more complicated by factors that intersect, such as cultural dislocation, loss of social support and the struggle for identity in the midst of an agitation. As if this violence was not ominous enough, Cuerda even claims that "Doctors can become a State's instrument of violence. If a totalitarian shift is produced, it is easier for a state-medical class symbiosis to be generated in those countries which have a well-established and bureaucratized sanitary structure"[20].

The causes of trauma in displaced communities usually include not only the immediate consequences of exile - such as violence, persecution or flight - but also the side effects related to resettlement challenges. Frequently finding barriers that make it difficult for those outsiders who seek inclusion[21] to adapt to new environments, including linguistic discrimination, socioeconomic instability, even sexual isolation[22] and erosion of family cultural structures. Minoritized ethnic groups, especially in Western countries, receive unequal treatment resulting in lower quality healthcare and different health outcomes when compared to the wider population, according to Smedley et al[23]. The specific stressors can exacerbate feelings of helplessness, leading to deep impacts on mental health, including anxiety, depression and posttraumatic stress disorder[24]. Zeleke et al demonstrate, in the example of Ethiopia, how "internally displaced people are subjected to many stressors, including poverty, mass and community trauma, individual trauma and the collapse of social support networks, which can result in mental distress, impaired interpersonal relationships, diminished coping

[20] Cuerda E., "Medicine and State Violence", *Conatus*, 4: 2, 2019, p. 259.

[21] Vasanthakumar A., *The Ethics of Exile: A Political Theory of Diaspora*. Oxford 2021: Oxford University Press, p. 9.

[22] Cf. Bauer J. E., "'Mein Feld ist die Welt': On Magnus Hirschfeld's Conception of Exilic Nomadism and the Origins of Sexual Ethnology", *Dia-noesis*, 8, 2020, pp. 7-48.

[23] Smedley B.D., Stith A.Y., Nelson A.R., "The culture of medicine and racial, ethnic and class disparities in health care", *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US), 2003.

[24] Regel E., "Mental health and humanitarian crisis: Moral stress in trauma therapy", *Bioethics*, 38, 2024, pp. 811–815.

abilities, and poor psychosocial well-being"[25]. In addition, trauma can permeate family dynamics, infecting interpersonal relationships among family and community members and changing traditional roles, influencing drastically communal ties and social structures.

The interaction between trauma and identity becomes particularly evident in the context of exile and displacement. Individual identity can be fragmented as individuals deal with past experiences of violence and loss while they seek to adopt new social norms. For many of these people, a critical aspect of their personal identity is dependent on their cultural heritage and their homeland. Being torn apart from the family and homeland environment can instigate an identity crisis, where individuals can feel divided between their historical cultural identities and the pressures to assimilate in the host country, which quite often seems quite hostile to these "intruders". This duality can manifest itself in a constant negotiation or misapprehension of identity, usually leading to feelings of alienation or marginalization.

Regarding collective identity in displaced communities, it can be said that although shared trauma can promote solidarity and a feeling of belonging, it can at the same time perpetuate simultaneous cycles of sadness and collective anxiety. For example, community rituals and narrative practices can serve as mechanisms for processing shared experiences, allowing a collective identity that honors past trauma and promotes resilience. Zeleke et al have found in their research that there are factors such as a collective definition of trauma, collective lived experiences, and collective connection to culture and legacies of healing and resilience[26]. As a result, despite the profound sense of loss, the connection to the community and a culture necessary for healing are indispensable. However, these same narratives can also reinforce victimization by

[25] Zeleke W. A., Wondie Y., Mekonen M. M., Hailu T., Holmes C., Moges M. D., Nenoko G., "The collective narrative of trauma and healing among internally displaced individuals in Ethiopia: a community-based participatory action research inquiry", *BMC Psychiatry,* 25:705, 2025 https://doi.org/10.1186/s12888-025-07043-4

[26] Zeleke W. A., Wondie Y., Mekonen M. M., Hailu T., Holmes C., Moges M. D., Nenoko G., "The collective narrative of trauma and healing among internally displaced individuals in Ethiopia: a community-based participatory action research inquiry", *BMC Psychiatry*, 25:705, 2025 https://doi.org/10.1186/s12888-025-07043-4

complicating individuals with social perceptions of strength and agency.

In addition, the social perceptions of trauma play a critical role in the formation of the trajectories of displaced individuals and communities. External narratives usually frame populations displaced through victimization lenses, which may inadvertently limit their agency and recovery opportunities. Policy formulation and social support systems that ignore the nuances of trauma can further marginalize these communities, reducing their visibility in discussions on mental health and social justice. Downie and Macnaughton observe that the problems of health are not just those of public policy and legislation. The policies which are advocated by public health institutions raise a multitude of ethical issues involving principles of justice utility and individual rights[27]. Approaching these complexities requires a differentiated bioethical structure that takes into account the intergenerational and cultural dimensions of trauma, while seeking to improve the results of health support and promote satisfactory and effective involvement with displaced populations. Exile precipitates profound psychological and social consequences for those who have practically been forced out of their homeland. The act of exile not only interrupts the continuity rooted in cultural heritage but also precipitates a reconfiguration of the self in a foreign context, where the exiled individual fights with constant feelings of loss and isolation. Within this multifaceted experience, bioethical considerations on access to health and mental health support for exiled individuals become fundamental especially since, as Morris upholds, due to the fact that the ethical implications of emotion for bioethics are crucial precisely because medicine engages in devaluation of feeling[28].

The psychological toll of exile is multiple, including stress and posttraumatic stress disorder[29]. Individuals face the frightening challenge of dealing with traumatic memories associated with their

[27] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, p. 107. Cf. Toulmin S., 1981, "The Tyranny of Principles", *The Hastings Center Report*, 11: 6, 1981, pp. 31–39.

[28] Morris D., "Narrative, Ethics and Pain: Thinking with Stories", in Charon R., Montello M. (Eds), *The Role of Narrative in Medical Ethics*. Routledge, New York 2002, p. 209.

[29] Regel E., "Mental health and humanitarian crisis: Moral stress in trauma therapy", *Bioethics*, 38, 2024, pp. 811–815.

homeland, often exacerbated by trauma of their own displacement. In the bioethical context the differentiated experiences of exiled individuals are highly significant and should be dealt with. The ethical principles of bioethics emphasize justice and equity, advise against non-harm, raising questions about the standards of health resources for these populations[30]. Exiled individuals often find barriers to access to appropriate health services, influenced by factors such as immigration status, cultural stigma around mental health and socioeconomic restrictions, emphasizing the need for an ethically responsive health system. Experiences of discrimination and xenophobia contribute to an exacerbated sense of crisis of alienation and identity within such populations. What needs to be highlighted is the ethical obligation to ensure that mental health structures are sensitive to cultural contexts and lived experiences of affected individuals, thus addressing not only doctors, but also the cultural dimensions of trauma.

Unfortunately, traditional models of mental health often fail to understand and analyze properly the collective traumas experienced by exile communities, leading to a disconnection between clinical practice and the realities faced by these populations. Bioethical considerations, therefore, have a role in informing the development of integrative care models that should adopt a holistic understanding of mental health, recognizing the interaction between individual trauma experiences and the broader social and cultural dynamics at stake. Moreover, it is essential to recognize the role of resilience in exiled communities. Ethical structures in bioethics should incorporate narratives of strength and agency[31], recognizing that while exile represents significant challenges, communities often develop innovative coping strategies and forms of solidarity. These aspects of resilience should be reflected in bioethical discourse around mental health care, promoting an asset-based approach that validates and uses existing strengths in exiled populations[32].

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[30] Cf. Churchill L. R., "Are We Professionals? A Critical Look at the Social Role of Bioethicists", *Daedalus*, 128: 4, 1999, p. 253.

[31] Cf. Morris D., "Narrative, Ethics and Pain: Thinking with Stories", in Charon R., Montello M. (Eds), *The Role of Narrative in Medical Ethics*. Routledge, New York 2002, p. 199.

[32] Regel E., "Mental health and humanitarian crisis: Moral stress in trauma therapy", *Bioethics*, 38, 2024, pp. 811–815.

Bioethical considerations around access to health and mental health support illuminate the pressing need for an equitable health system that responds to the complex needs of exiled individuals while they can be assimilated to local communities, contributing to the most effective and culturally sensitive mental health practices. Cultural displacement is a complex phenomenon which fundamentally modifies the fabric of individual and collective identity. Individuals undergoing cultural displacement are often faced with having a type of life that oscillates between their own heritage and the requirements of their new environment. This ongoing compromise imposes significant psychological charges, leading to mental health challenges such as anxiety, depression and identity disorders. The cognitive dissonance felt by displaced persons stems from the interaction between their historical account as members of a specific cultural group and the urgent need to adjust to a potentially disparate societal context. Hence, a crucial aspect of cultural displacement is inherent in the potentiality of identity training. For uprooted individuals from their native country, the nuances of their cultural identity can become obscured, forcing them to face questions of belonging and self-esteem[33]. The loss of cultural symbols, languages and practices - a process called "cultural mourning" - presents a re -evaluation of its place in displaced and host communities. This reassessment is not simply an internal struggle; It has broader implications for community dynamics in what Regel describes as "morally imperfect conditions"[34]. The displaced populations are often marginalized within their new societies, leading to new isolation and, due to that, exacerbation of mental and other health problems. Marginalization can come from the perception of society that biases against their cultural differences, thus promoting an environment of misunderstanding and distrust that complicates or renders impossible social integration.

Besides, further bioethical challenges encountered by displaced people cannot be overlooked. For example, access to mental health resources adapted to specific trauma associated with exile and loss is often inadequate or non-existent; Systemic barriers such as linguistic differences and the lack of culturally competent care more

[33] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, pp. 51-54.

[34] Regel E., "Mental health and humanitarian crisis: Moral stress in trauma therapy", *Bioethics*, 38, 2024, p. 814.

emphasize appropriate therapeutic interventions. However, as Gabrielyan & Suleimenov claim, communication as an objective foundation of ethics between "transpersonal information objects of various types" is vital[35]. Therefore, many displaced people may be reluctant to resort to mental health services due to fears concerning stigma, concerns about confidentiality or previous negative experiences with medical institutions in their country of origin or in the host country. These dilemmas oblige bioethicists to consider the ethical implications of health care provision systems in contexts where social justice and equity are even more urgent; especially because of the fact the complexities of individual experiences need to be recognized and accepted. The development of services that incorporate cultural accounts into therapeutic practices can promote resilience and a feeling of continuity that can alleviate the impact of cultural loss.

Under this prism, it is advisable that cultural displacement should not be a lonely experience based merely on physical relocation; It must be perceived as a multidimensional process that shapes identities and community dynamics. The bioethical implications inherent in this process and the plethora of difficulties in assimilation call for our attention while the displaced individuals combat against their previous identity in a background of trauma and adaptation. But also, as Sermetis shows in his analysis of Sartre, radical freedom, the freedom to choose who a person is going to be for the rest of his life, the freedom to think as he desires, are milestones that cannot be neglected in the existential adventure part of which, here, is the medical process[36]- therefore it is not just the social nexus but also the individual response that counts, the opportunity to protect one's identity by overcoming trauma under his own terms and with no significant external assistance. Tackling these complexities requires an inclusive approach which values the separate cultural identities of displaced people and integrates them while they also make personal efforts to integrate themselves[37].

[35] Gabrielyan O., Suleimenov I., "Objective Foundations of Ethics and Prospects for Its Development: Information and Communication Approach", *Conatus*, 10:1 2025, pp. 111-125.

[36] Sermetis T., "Freedom of Consciousness in Sartre", *Dia-noesis*, 11, 2021, pp. 117-128.

[37] Engelhardt H. T., "The search for a global morality: Bioethics, the culture wars and moral diversity", in Engelhardt H. T. (Ed), *Global Bioethics. The*

Healthcare professionals are obliged to face the challenges of cultural competence, ensuring that informed assistance for trauma recognizes specific experiences and backgrounds of different populations[38]. In the same context Engelhardt argues that so far "bioethics has not managed to produce a generally accepted account of appropriate deportment so as uncontroversially to justify a single account of health care policy and bio law"[39]. In connection with this insurmountable, so far, problem, the traditional therapeutic methods, especially the western ones, can often not be able to resonate with individuals from different cultural contexts. Therefore, the ethical implications of the treatment extend beyond the supply of care; they invite a revaluation of the existing working framework that can inadvertently marginalize the same communities that need assistance.

In many cultures, mental health problems are still a taboo, leading to an inclination to suffer in silence. This cultural stigma is aggravated by external social perceptions, which can further isolate individuals who bring signs of trauma. The implications for the treatment are manifold, since the stigma not only hinders individual recovery efforts, but also perpetuates wider cycles of exclusion and discrimination. But not only that: the political landscapes surrounding the issues of exile and movement complicate access to mental health care. In many cases, displaced people may find themselves in environments without adequate resources for mental health, let alone with several inequalities and health disparities. Ethical obligations in these contexts impose a focus on the defense of fair access to health care, as well as an understanding of how policies can affect mental health support structures. The intersection of trauma, exile and cultural movement requires that healthcare professionals undertake practices that not only deal with symptoms but also consider methodologies for wider sociopolitical contexts and dominant attitudes towards mental health.

Collapse of Consensus, M & M Scrivener Press, Salem 2006, pp. 18-49. Cf. Andorno, R., and G. Boutlas. "Global Bioethics in the Post-Coronavirus Era: A Discussion with Roberto Andorno", *Conatus - Journal of Philosophy*, 7: 1, 2022, pp. 185-00, https://doi.org/10.12681/cjp.27999.

[38] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, pp. 101-106.

[39] Engelhardt H. T., "The search for a global morality: Bioethics, the culture wars and moral diversity", in Engelhardt H. T. (Ed), *Global Bioethics. The Collapse of Consensus*, M & M Scrivener Press, Salem 2006, p. 35.

These perceptions shape not only the way in which individuals who undergo trauma and exile understand their experiences but also dictate their will to ask for help[40]. According to Churchill, the increasing role that Bioethics can play due to its social acceptance is crucial[41]. For example, in various communities, in particular those that are marginalized or under-represented, the intersectionality of stigma surrounding mental health problems and displaced identities can create a number of obstacles to access to care, often intensified by pre-existing prejudices and discriminatory practices.

Cultural insights play a crucial role in training societal perceptions of trauma and exile for those people who are in need. In many cultures, there is a dichotomy between resilience and vulnerability, often celebrating endurance and loneliness while stigmatizing the expression of mental distress. This cultural framing can marginalize those who have undergone trauma or displacement, labeling their experiences as weaknesses rather than valid responses to their extraordinary circumstances. The burden of unresolved trauma can become a collective experience, leading to community hesitation to recognize their respective health needs. In such contexts, trauma is often made invisible thanks to collective adaptation strategies- something that is not so frequent unfortunately. Due to the above, community members may refrain from asking for help, fearing that recognition of their suffering can alienate them from their cultural group. Media representations considerably influence understanding and taking into account trauma and the need to find cure. For example, immigration laws, public opinion or political agendas may regard individuals as threats to society, which perpetuates negative stereotypes that complicate efforts for integration. These stories that happen everywhere nowadays can promote environments in which the search for aid is associated with marginalization or additional rejection, limiting the agency of individuals in the continuation of the necessary support[42].

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[40] Cf. Dancy J., *Ethics Without Principles*. Oxford 2004: Clarendon Press, pp. 34-38.

[41] Churchill L. R., "Are We Professionals? A Critical Look at the Social Role of Bioethicists", *Daedalus*, 128: 4, 1999, p. 254.

[42] Morris D., "Narrative, Ethics and Pain: Thinking with Stories", in Charon R., Montello M. (Eds), *The Role of Narrative in Medical Ethics*. Routledge, New York 2002, pp. 196-213.

As regards the role of mental health institutions and political institutions and their leaders, they are indispensable in the formation of societal perceptions. Professionals and governments must bear in mind that there is now an almost unavoidable and complex interaction of cultural standards in this huge global village, and that individual experiences remain valuable for the regional narratives. If societal stigma is widespread through the Press or politics, health discourse can inadvertently strengthen pre-existing stereotypes, perpetuate trauma and disconnection cycles[43]. Consequently, the call for culturally competent care becomes urgent, emphasizing the need for service providers to consider carefully the multifaceted socio -cultural strata which informs about the identity and experiences of an individual with trauma and displacement.

These stories which are built around trauma and cultural displacement have significant power over the lived experiences of individuals and for this reason they cannot be neglected or frowned upon by locals. Nonetheless, these stories evolve with changes in other societal attitudes. For those affected by trauma and exile, it is essential to reshape their perceptions, without host societies being obsessive about certain views, and to allow to promote environments conducive to recovery. Consequently, the exploration of the way in which bioethics interface with these themes must take into account the broader implications of societal perceptions, the role of stigma and emergency for inclusive accounts which validate the experiences of all individuals confronted with trauma and displacement. In this understanding, bioethics attains a rather unexpected political role for contemporary societies. A fine example can be drawn from the Aboriginal peoples in North America which further highlights the intersection of bioethics, trauma and cultural displacement[44]. The historical trauma endured by these communities, in particular forced assimilation, the dispossession of land and the discrimination that followed, have deep implications on their collective identity and their mental health status. Bioethical

[43] Cf. Mude W., Whitehorne-Smith P., Nyanhanda T., Mwanri L., "The Perceived Social Determinants of Mental Health among African Youth Refugees in South Australia", *Journal of Immigrant and Minority Health*, 27, 2025, pp. 743–750.

[44] Saunt C., *Unworthy republic: the dispossession of Native Americans and the road to Indian territory*. New York 2020: W. W. Norton & Company, passim.

discourse here has an opportunity, a political one actually, to prioritize the indigenous perspectives on health and well-being, which often diverge from classical western medical exemplars. These communities are enthusiastic about their own traditional healing practices; so, one ethical obligation of public health systems could be to incorporate these perspectives into their medical agenda so as to promote healing and resilience while reaffirming the cultural identities that tend to be, otherwise, marginalized[45].

This requires a bioethical approach sensitive to the shades of the formation of identity, recognizing how cultural narratives influence the personal and collective experiences of trauma. Morris maintains that "institutions often cultivate to their advantage the moral twilight that ensues when they devalue individual narratives and emotional knowledge"[46]. He further argues that the continuity of care is lost in our times and patients are not linked anymore so much with a single doctor who is responsible for treating them but with a vast and impersonal number of specialists. Since the face-to-face approach has been jeopardized, it follows that the personal narrative is put at risk. Churchill stresses here that a kind of hazard for patients and their families comes from bioethics consultants who are part of institutional power structures that serve the institutional needs rather than those of the patients[47]. Morris additionally stresses the fact that when we make ethical decisions we do not really choose good over evil. We tend to make a preference on one story over another and thus highlight personal or cultural values of a suffering individual more than others while we try to perform our moral acts[48]. Such understandings highlight the imperative for research and politics to engage with the complexities of culturally informed practices in mental health care. Traditional bioethical models often lack the prerequisites that are necessary to meet the specific needs of different populations affected by trauma.

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[45] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, pp. 91-92.

[46] Morris D., "Narrative, Ethics and Pain: Thinking with Stories", in Charon R., Montello M. (Eds), *The Role of Narrative in Medical Ethics*. Routledge, New York 2002, p. 212.

[47] Churchill L. R., "Are We Professionals? A Critical Look at the Social Role of Bioethicists", *Daedalus*, 128: 4, 1999, pp. 256- 257.

[48] Morris D., "Narrative, Ethics and Pain: Thinking with Stories", in Charon R., Montello M. (Eds), *The Role of Narrative in Medical Ethics*. Routledge, New York 2002, p. 213.

Therefore, there is an urgent need for a change to an inclusive bioethics that incorporates indigenous knowledge systems and culturally relevant therapeutic models to adequately respond to the challenges faced by displaced and traumatized individuals. These models would benefit from an interdisciplinary approach, drawing on cultural studies, social and bioethical psychology to create a holistic understanding of the intersection in question.

In our view, related directly to the above is the problem of definition. As the ancient Skeptic philosopher Sextus Empiricus claims, it is difficult, if not impossible, to have a fair definition of what is good, beneficial etc. In his *Against the Ethicists,* he upholds that a doctor's work is done with brevity, not causing pain and systematically, and this is what differentiates him from a common person[49]. Nonetheless, he explains that every art is possible for people who are capable of practicing it. As in the case of a city of deaf people, no guitar playing is possible, in the same way when people wish to have an *ars vitae* imbued by *phronesis*, it is a problem if they are capable of having it[50]. In this argument Sextus tries to demonstrate that our wishing one thing does not equal with the thesis that we are capable of achieving it. By doing so, he does not want to discourage our pursuing the truth of higher or more ethical things. On the contrary, he wishes to show how urgent it really is to remember that we are not really capable of providing yet all these complex answers that we need, and also that we may be incapable of acting rightly without them. In the same way, a practitioner does not have a solid definition of what is good or bad in all these cases. Therefore, a skeptic suspension of judgment allows more space for both the moral agents that are involved[51], especially since, as Sextus remarks, it is a mistake to believe that the person who suspends judgement and practices *epoche* is not energetic[52]. The stronger point that Sextus presents in this hypothesis is that what the dogmatists consider as evil, i.e., pain, sickness etc, is more easily treated by a Skeptic who is not orientated towards certain goods- the Skeptic does not know what a good is and consequently it is easier for him to bear pain or misfortune[53], regardless whether

[49] Sextus Empiricus, *Against the Ethicists*, 203-206.
[50] Sextus Empiricus, *Against the Ethicists*, 196.
[51] Sextus Empiricus, *Against the Ethicists*, 168.
[52] Sextus Empiricus, *Against the Ethicists*, 162-163.
[53] Sextus Empiricus, *Against the Ethicists*, 147-154.

certain things are considered good or evil depending either on opinion or on need[54]. For Sextus, it is impossible for someone to be eudaimonistic if he assumes that there is something good or evil by nature[55]. The great disparity of opinion regarding good or evil seriously affects the issue of health. According to his theory, there are people who believe that health is the highest good, others who believe that this is not, others also believe that health is only a preferable than a real good[56]. For bioethics this is a consideration that may be more fruitful that futile, at least in the sense that we may not have common definitions a) of what trauma is and b) the gravity of each trauma[57]; even if we managed to have same definitions, they could not be the same for different cultural communities where religion and regional beliefs also play their significant role. In this perspective, it becomes very complex, if not vague, to understand not just what the good is for everyone involved but also if what is considered as good is conducive to a real state of well-being and eudaimonia[58].

Elliott assumes that bioethicists have now trusted themselves and their expertise more than they should[59]. In dealing with bioethical issues, it should be remembered that there are at least two moral personalities included, therefore two moral perspectives to be illuminated and taken into account. The diversity of opinion, the possible lack of consensus on bioethical issues, renders it not only difficult to treat trauma, even in the cases of exile and cultural displacement but also tends to transfer one problem in the place of another, as Sextus comments[60]. In order to cure the trauma of these moral protagonists that exile and displaced people are, the real need of the particular person who receives help may be disguised while it is often related to his sending community which has a certain, very unshakeable view on good and evil. Sextus is cautious when he discusses major aspects of the nature of good,

[54] Sextus Empiricus, *Against the Ethicists*, 141-144.

[55] Sextus Empiricus, *Against the Ethicists*, 144.

[56] Sextus Empiricus, *Against the Ethicists*, 48-49.

[57] Cf. Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, pp. 71-75.

[58] Sextus Empiricus, *Against the Ethicists*, 35-37.

[59] Elliott C., "The tyranny of expertise", in Eckenwiler L. A., Cohn F. G. (Eds), *The Ethics of Bioethics. Mapping the Moral Landscape*. The Johns Hopkins University Press, Baltimore 2007, pp. 43-46.

[60] Sextus Empiricus, *Against the Ethicists*, 133-135.

and subsequently how it is related with (what each of us understands as) eudaimonia. In the same line, Doris suggests that skepticism about persons and their identities is almost unavoidable and that one should carefully examine the things he believes over another person and his current situation[61]. Furthermore, Doris clarifies that "talk of persons involves both descriptive and normative elements" and this interferes gravely with the issues of agency and responsibility[62]. Hence, policies should be developed that actively involve the parties affected by the communities concerned in decision-making processes, ensuring that their items are an integral part of modeling institutional responses. The emphasis should be placed on the development of research methodologies on participatory action that allow communities to articulate their needs and preferences in the formulation of mental health services, allowing some more space for interpretation on previously static models.

As Dragona-Monachou highlights, all the relevant terms need to be philosophically more concise, and they practically, more than anything, need to be clarified[63]. Understanding does not stand alone; it is often a matter of linguistic clarity and theoretical coherence before medical action[64]. What we need here is not an uncritical follow of moral theories that will guide us to a wrong conception of the problem but an honest education that will train us to treat it. Just a linear implementation of rules and bioethical theories is not safe in treating trauma. Churchill even challenges our ability to be trusted when we treat other people through our bioethical prisms by asking: "would we want our own advice?"[65] and by posing part of the ineffective situation in our addressing the wrong problems. It is essential that ethical considerations evolve into tandem with our understanding of these complexities to encourage an inclusive approach that not only addresses the psychological needs of affected individuals but also promotes social justice

[61] Doris J. M., "Skepticism about Persons", *Philosophical Issues*, 19, 2009, pp. 57-58.

[62] Doris J. M., "Skepticism about Persons", *Philosophical Issues*, 19, 2009, pp. 58-59.

[63] Dragona-Monachou M., *Syghroni Ithiki Philosophia (Contemporary Moral Philosophy).* Athens 1995: Ellinika Grammata, p. 386.

[64] Downie R. S., Macnaughton J., *Bioethics and the Humanities. Attitudes and Perceptions*. New York 2007: Routledge, p. 58.

[65] Churchill L. R., "Are We Professionals? A Critical Look at the Social Role of Bioethicists", *Daedalus*, 128: 4, 1999, pp. 262- 265.

and fairness in healing processes, one that seeks truth in effective narratives in their existential setting. As De Zulueta rightly manifests: "Doing good medical ethics involves attending to both the biomedical and existential aspects of illness… Patients' narratives describe existential neglect and how this intensifies suffering"[66]. Through collaborative efforts and the commitment to cultural humility, through solid definitions in our quest of the truth and becoming aware of the limitations of our knowledge about the existential drama of human beings (especially those in exile or cultural displacement), research and future politics can contribute to the development of paintings that honor the dignity and resilience of those who navigate in the intricate realities of what their lives have brought in for them. But true faith should not be shown for the theory; true faith should regard the healing. This is where a certain amount of skepticism seems indispensable and may allow even those circumstances where trauma is not to be treated at all by external factors, despite their bioethical awareness and sensitivity.

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[66] De Zulueta P. C., "Suffering, Compassion and 'Doing Good Medical Ethics'", *Journal of Medical Ethics*, 41: 1, 2015, pp. 87–90.

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