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A

BEYOND CARE AND CONTROL: THERAPEUTIC INTERVENTIONS FOR SURVIVORS OF TORTURE AND REFUGEE TRAUMA

by

KELLY A. McKINNEY

A dissertation submitted to the Graduate Faculty in Anthropology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

2003

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This manuscript has been read and accepted for the Graduate Faculty in Anthropology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy

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Abstract

BEYOND CARE AND CONTROL: THERAPEUTIC INTERVENTIONS FOR SURVIVORS OF TORTURE AND REFUGEE TRAUMA

by

Kelly A. McKinney

Advisor: Professor Shirley Lindenbaum

This dissertation is based on fieldwork conducted in New York City and Copenhagen. From my research interviewing clinicians and spending time in psychosocial programs that provide psychological and social services to survivors of political violence, I explore what happens when Western psychological expertise takes as its concern suffering caused from torture, war or other human rights abuses. The clients participating in these psychosocial programs come from all parts of the world, and psychological knowledge and therapeutic practices have had to address cultural differences as well as the implications of the political causes of trauma.

Often social science theory has framed critiques of psychological interventions in terms of psychologization. This type of critique assumes that psychology depoliticizes, dehistoricizes and individualizes. It is argued that psychological explanations reduce complex social, political and historical processes to psychological mechanisms and can place the burden of change on the victims. Though these critiques are important, what I examine is how the practices of psychology work in and through the capacities of

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individuals to enable them to become autonomous, empowered and self-determining citizen/selves. The structuring and productive aspects of psychological techniques, and their relationship to governance in liberal democracies, is thus one focus of my analysis. I also explore the tensions and dilemmas that emerge when bodies and minds are the focus of intervention, and when memory and trauma become a political issue in therapy. My multi-sited approach has also allowed me to examine the proliferation of trauma interventions from a transnational perspective.

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I would like to dedicate this work to Rukija Ademovic and to all others who have endured political violence.

Kelly A. McKinney
Brooklyn
May 2003

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Introduction:
Background, Methods, and Theoretical and Conceptual Issues

Introduction

This study is concerned with what happens when a particular type of human suffering and the human beings who are the sufferers become defined as problems for those disciplines "with the prefix *psy*--psychology, psychiatry, psychotherapy, and psychoanalysis" (Rose 1996:10; italics my own).[1] For many social problems, such as delinquency or substance abuse, but also for the mundane concerns of everyday life, such as child-rearing, the "psy" disciplines have played a crucial role in defining and knowing the objects of knowledge, producing various types of techniques to manage and address practical concerns, and drawing the contours of normality (Ibid). In the last quarter century, survivors of torture and refugee trauma have been constituted as a new problem for "psy." Psychological concern has centered upon the mental suffering resulting from the horrors and atrocities visited upon these individuals, and the kinds of obstacles and constraints, both psychological and social, that are presented as these individuals try to adjust to life as newcomers in countries of resettlement. By constituting the problems in these terms and acting upon them in systematic and rational ways, "psy" has enabled new ways of thinking and acting: it has both fostered the emergence of particular kinds of relationships between professionals, clients, and the community, and created conditions for transformations in subjectivities. By looking at the productive or structuring functions of psychological interventions for survivors of torture and refugee trauma, this study does not take as its primary goal the evaluation of psychosocial programs for this

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population, nor does it take the view that the psychological sciences act merely as modes of social control or to legitimate structures of social domination. Rather, it looks at what has been made possible by these interventions, and at what kinds of tensions and dilemmas have been created within and by the psychological practices and expert knowledge that constitute this developing field.[2]

Based on research conducted over a period of twelve months during the years 1999 and 2000, this study focuses on psychological expertise and the therapeutic practices in psychosocial programs for survivors of torture and refugee trauma. The particular programs I studied, in New York City and Copenhagen, provide psychological and social services to individuals from all parts of the world who have survived war, terror, torture, or other human rights violations. As individuals and their families try to create some kind of life for themselves in the countries where they have sought refuge or to which they have been relocated, these programs help them to address their psychological suffering and obtain the social services they need.

---

[1] The term "psy" refers to the heterogeneous and dispersed disciplines, practices, and technologies that have emerged from psychology and psychiatry. "Psy" does not refer to some sort of organized, unified, or unitary program.

[2] To be clear, this study is not about political violence nor is it about the experiences of torture survivors, refugees, and victims of war. Readers should turn to publications by Amnesty International, Human Rights Watch, and other human rights NGO's to receive up-to-date reports on conditions around the world. There has also been a recent surge in anthropological research devoted to political violence that can be consulted. The outpouring of this scholarship can be attributed to: the social movements of the late 1960's, such as the student protests against the Vietnam War and the relatively uncensored media coverage of its carnage; the proliferation of regimes of terror in Latin America and other Third World countries; the contributions of post-colonial, post-structuralist, and feminist theories to an understanding of otherness, subjectivity, subjugation and embodiment; and, the fact that with increasing frequency anthropologists find themselves in contexts where violence and social disintegration permeate the "culture" they are studying.

Notable works by anthropologists and other scholars on political violence include, but are by no means limited to these examples: Bunster-Burroto 1986; Feldman 1991, 1997; Linke 1996; Maalki 1995; Nordstrom and Martin 1992; Lifton 1967; Krohn-Hansen 1994; Aretxaga 1995; Kleinman 1995; Stiglmayer 1994; Seifert 1996; Das 1995, 1997; Robben and Suárez-Orozco 2000; Warren 1993; Green 1994; Taussig 1984; Corradi et al. 1992; Abbink 1995; Mason and Krane 1989; Coronil and Skurski 1991; Daniel 1996; Scheper-Hughes 1992a; Asad 1997; Nordstrom and Robben 1995; Sluka 2000; Taylor 1997; Walter 1969.

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This study explores the complex and challenging issues of a rapidly growing field that is still in its formative stages. In a span of just thirty years, approximately two-hundred permanent psychosocial programs for survivors of torture and refugee trauma have been established worldwide (Iacopino 1998; Branigin 2000). In the United States, approximately twenty of these programs are now in operation. Many programs are located in First World areas of resettlement, such as the United States, Canada, England, Australia, or Scandinavia, but a substantial number of others have been established in areas, often in the Third World or poorer countries, where collective violence is or has been part of daily life. In addition, it is now routine for psychological experts to be deployed to war-torn regions of the world to provide crisis intervention to traumatized war victims as part of humanitarian aid packages. Many of these trauma teams represent mobile extensions of already established psychosocial centers in Western countries, while others are formed by donor and other non-governmental organizations (NGO's) not directly affiliated with existing treatment programs. More recently, the strategy for psychosocial trauma programs abroad has been to move away from a model of emergency humanitarian aid to a more long-term model of development and democracy-building.

Accompanying the rapid spread of psychosocial programs for survivors of political violence is a globally growing network of psychological experts, consultants, and donors, along with proliferating numbers of training and certification programs, professional conferences, books, articles, and scholarly journals addressing the problems of refugees, torture, and trauma. In the past eight to ten years, the field has seen its greatest expansion.

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The concerns of this study are timely because of their relationship to recent historical events, namely, the terrorist attacks against the United States on 11 September 2001. Citizens in the United States have been subjected to terror and losses that are all too familiar for clients in psychosocial programs for survivors of torture and refugee trauma. One of the dominant responses to the distress of persons affected by these events has been led by mental health professionals, especially those specializing in "trauma." In the New York City area, several psychological professionals who work with survivors of political violence have been instrumental in organizing efforts to provide systematic mental health interventions to individuals experiencing post-9/11 traumatic stress. Thus the kinds of meanings ascribed to these events and the sorts of psychological modes of dealing with political violence and loss that had been more localized are now finding new sites of application in the larger cultural landscape.

Origins and Aims of the Dissertation

One day in 1996 while drinking my coffee and reading the newspaper in my Brooklyn apartment, I came across the headline "A Promising Medical Specialty Emerges to Help Torture Victims" (Goleman 1996). The word "torture" jumped out at me from the page, spurring me to read on. The author of the article described the "worldwide spread of a fledgling field," a "grisly specialty," and "the need for special training for doctors and for treatment centers for torture victims" (Ibid). Statistics were cited about the rapid growth of treatment centers, with claims that there were ninety-nine worldwide and plans for many more. The author discussed a bill being considered in the United States Congress that would establish funding for an epidemiological study on torture victims, cities where treatment centers existed, different kinds of research in the

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field of torture studies, and specific types of torture. A Danish doctor, Inge Genefke, was interviewed, as was a patient from the treatment center she established, the Rehabilitation and Research Centre for Victims of Torture (RCT).[3] The last third of the article provided descriptions of torture's devastating psychological effects. The author stated that for the torture victims, "the deepest scars were emotional," explaining that many individuals who were tortured exhibit a form of post-traumatic stress disorder (Ibid). Psychological treatment was aimed at helping victims reduce their post-traumatic stress symptoms, deal with their overwhelming feelings of guilt, fear, grief, and shame, and regain trust and the ability to participate more fully in society.

I tried to imagine what these programs must be like. Are they in hospitals? Are they like community mental health centers? Who are the clients? How do survivors even find these programs? I wondered how traditional talk therapy could be used with people from different backgrounds, especially when therapy seemed to be a particularly Western practice, and even in the West, directed mostly toward white, educated, urban people.[4] I thought how limited psychotherapy seemed as an intervention in the face of the immense horror of collective violence and the worldwide practice of terror and war. I also felt slightly unsettled by the whole idea of a new "grisly specialty," wondering what it meant for the discipline of psychology to claim as its own a new problem and a new population, and to designate another group of people as trauma survivors. Finally, the article also made me consider the suffering of torture survivors and refugees. Of course I knew people were tortured, I knew people were victimized by war, but victims became less

[3] I will refer to the psychological interventions for survivors of torture and refugee trauma as the "torture treatment field."

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abstract to me as I wondered how they could even continue living after such horror and loss. I wondered what it could mean, in their case, to "recover" or "heal."

Many of my questions about this new therapeutic specialty were oriented by an interest in the psychological sciences as forms of expertise in our society. I was curious about how psychology as a social science could intersect with the massive problems of human rights violations and political violence, and how conventional Western psychological theories and practices could be shaped to address the suffering of a tremendously heterogeneous group of people. I found myself thinking critically about the mental health professionals and their own understanding of their work, the expert knowledges they were developing, how they imagined their relationships to their clients, and what ideologies and institutional structures were in place at the actual rehabilitation centers. In other words, I was interested in "studying up" (Hyndmann 2000).

My interest in "studying up" and the types of questions I originally raised were certainly informed by my own participation in the professional world of psychology and by the kind of humanistic training I had received. In the 1980s, I was a casemanager in a community mental health center and a caseworker in a residential program. In both settings I worked with chronically mentally ill adults who were frequently in and out of the hospital, unable to live by themselves or hold any job for an extended period of time, and off and on psychotropic medication. These were the types of individuals who were the subjects of Sue Estroff's work on chronicity (1985). After these eye-opening experiences, I received a master's degree in psychology from a program grounded in existential-phenomenology, a school of thought that grew in opposition to Anglo-

[4] The other dominant group of Americans who undergo psychotherapy or counseling are the poor, who demonstrate they cannot "responsibly" conduct their lives.

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American positivistic and ego-centered psychology. Ironically, from being engaged in a philosophical tradition and academic community that more or less denounced many mainstream American psychological practices, I moved to being a research associate to the Task Force Chair of the group putting together the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). The DSM series is published by the American Psychiatric Association and is the definitive handbook on psychiatric diagnosis, listing all recognized diagnoses with their defining criteria. This manual exemplifies the medical model of psychiatry.[5] In addition, I worked as a research assistant in a psychiatry department at a large teaching hospital, and also practiced psychotherapy with clients on an individual basis at a psychotherapy training institute.

When I began this study, I was certain that as an anthropologist and as a former student of an alternative tradition of psychology, I had within my means certain analytical or critical tools that would enable me to demonstrate how "psy's" general disposition toward self-critical hermeneutics permitted certain failures or predictable patterns in its practices. For example, I assumed that torture treatment observed at best a naïve recognition of cultural difference, did not question the epistemological foundation of psychiatric categories such as PTSD, did not examine its own relationship to the production of uneven relations of power, and took a more or less neutral position when it came to questions of politics and social injustice. I imagined that the recipients of mental health services for trauma were a disenfranchised group of people who were subjected to and objectified by the well-meaning but hegemonic practices of elite Western

[5] For a recent critique of the medical model of psychiatry and the DSM-IV in light of the terror attacks in the United States, see Greenspan (2003). For an example of an anthropological critique of the DSM, see Gaines (1992).

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psychological experts. However, three issues emerged during the course of my research that enabled me to conceptualize this study in ways that I had not originally anticipated.

First, as I became involved in my research, I found that many of the psychological practices in torture treatment did not bend to the ready critiques I acquired from my training in "psy" and anthropology. The development of the field of torture treatment has been characterized by an ongoing internal critique of its practices that owes much to anthropology (e.g. Summerfield 1995, 1996, 1997, 1998 1999; Silove et al. 1999; Bracken, Giller and Summerfield 1995; Bracken and Petty 1998; Bracken 2002).[6] This was not a therapeutic field that indiscriminately labeled people with psychiatric diagnoses, or assumed that Western psychological experts had the final word on what is best for survivors of political violence. As this discussion will demonstrate, this field has developed out of particular views and practices that challenge conventional forms of therapeutic practice and the usual types of social critique which have been aimed at the psychological sciences.

Second, I was introduced to the work of Nikolas Rose, whose studies on "psy" emerged out of Foucault's analysis of governmentality.[7] Governmentality, described by Foucault as a problem of rule that emerged in the 1600s, signified a transformation of the state in which power depended on knowing and governing the individual at a distance. Strategies and tactics were developed that could address these problems of rule; these included the 'invention' and regulation of populations and the development of an "apparatus of security" which addresses itself to "a series of possible and probable

[6] Kleinman (1995) devotes a chapter to the "politics of trauma" that consolidates the positions taken by critics of the torture treatment field.

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events" (Gordon 1991:23). Further, the science of political economy emerged along with the isolation of the "economy as a specific sector of reality" (Foucault 1991:102). A complex of specialized knowledges developed that could regulate and manage different sectors of society through dispersed forms of power that were not directly coercive, but were distributed through the biological and productive capacities of populations and individuals. A governmentality analysis locates psychological expertise as a crucial link between processes of subjectification and the problems of liberal democratic rule. It provides a way of conceptualizing psychological expertise in terms of what it has made thinkable, "practicable," and knowable not simply as an individualizing but also social array of heterogeneous techniques, strategies and forms of knowledge (Rose 1996). Psychology works in and through the capacities of the persons whose subjectivity is formed and regulated by liberal ideals of freedom and autonomy (Ibid).

Third, I became interested in questions about trauma and memory, and in how the Cartesian dichotomy of body and mind is addressed in therapeutic theory and practice. These concerns added another dimension to this study's conceptual framework. In thinking about trauma, memory, the body, and the mind, I began looking more closely at the theories and clinical practices of psychological experts. I discovered that specific kinds of tensions and contradictions develop when memory becomes both a therapeutic and political vehicle for change, and when the body/mind dichotomy becomes a focus of treating trauma. My interest in these concerns generated forms of analysis that do not necessarily contradict a governmentality analysis, yet do not problematize psychology in the manner that a governmentality approach does. The relationship between these

[7] I am indebted to Andrew Jefferson, a graduate student whom I met in Copenhagen, for introducing me to the work of Nikolas Rose, a former teacher of his at Goldsmith's College in London.

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different problematizations is inexact, but both shed light on what the field of torture treatment is like and what it has made possible.

The Psychosocial Approach to Political Trauma

as Medicalization and Psychologization

I will here present an overview of the critiques that have formed the basis of expert knowledge in the field of torture treatment, many of which in their most basic form have been echoed in social science discourse in discussions of various phenomena such as childbirth or population control ((Kleinman, Das and Lock 1997; Kleinman 1995; Fraser 1995; Morsy 1995).

First, critiques have been raised regarding what is commonly referred to as "medicalization" or in the case of mental health practices, "psychologization." It has been argued that when distress is transformed under the terms and practices of biomedicine or the psychological sciences, the social, political and economic causes of torture and collective violence are displaced or neutralized. This means that the causes and consequences of political violence become technical problems, rather than political issues with social causes; in other words, psychologization results in de-politicization. Opponents of psychologization also argue that when distress is located in the psyche of an individual, the individual is rendered an autonomous unit distinct from collective experiences of distress which derive their meaning within a specific matrix of social, economic, and political forces. The individual becomes the abstract locus of intervention, and personal recovery or individual healing becomes the goal of treatment (Bracken and Petty 1998). Psychology, this critique posits, therefore individualizes.

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Moreover, it has been argued that the suffering in response to collective violence has come to be defined not just in the idioms of psychology but in terms of psycho*pathology* as if grief, nightmares, despondency, or anxiety are pathological responses to war and torture (Summerfield 1999). Furthermore, through focusing on symptoms and pathology, it has been pointed out that less attention is then paid to resiliency or non-symptomatic responses. By emphasizing pathology, psychological expertise distorts the overall picture of human response to trauma, conceiving people as victims rather than survivors. It has been suggested that most people actually do manage in some way not to become "symptomatic" and are able to rebuild their lives and communities (Ibid).

Pathologizing trauma has been authorized in the form of a psychiatric diagnosis, Post Traumatic Stress Disorder (PTSD), a category that has been under critical attack on many grounds. For example, Summerfield (1999) has argued that PTSD is a distinctly social, cultural and historical construction, even though its applications and the discourse supporting (all of which are based on the idea that traumatic response has a primarily biological foundation) assume that it is timeless and universal. Summerfield has pointed out that PTSD symptoms may in fact be evident cross-culturally but that the *meanings* of those "symptoms" may be entirely different for different individuals or groups (Ibid). He has also suggested that Western psychiatric categories such as PTSD are associated with Western forms of healing, such as debriefing or talk therapy, which are also of questionable efficacy when applied cross-culturally (Ibid). Further, counseling or psychotherapy implies a certain configuration of self that has the capacity to work on itself as an autonomous and introspective ego-centric unit. This notion of self and its self-

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practices may be completely alien to individuals in non-Western "socio-centric" cultures (Bracken 1998). And finally, it has been claimed that people from different cultures may not express their distress in ways that are recognizable to Western-trained mental health professionals. Different "culturally endorsed" expressions of distress may be, for example, "couched in a somatic idiom," evading the gaze or comprehension of Western clinicians (Ibid: 121).

While PTSD plays a role in processes of individualization, the assumption of PTSD's universality as a psychiatric category permits the construction of traumatic stress as a public health problem and an "epidemic" (Silove et al 1991). Thus the problem lies not only with individual sufferers: the unit of intervention has been enlarged to include entire populations where people are either at-risk for becoming symptomatic or already are. It has been posited that the effect of this is, among other things, a "reductionist medicalisation that assigns a sick role on...a large scale and indiscriminate basis" (Summerfield 1998; 1999).

It has also been argued that exporting therapeutic trauma interventions from the West to non-Western countries may lead to the devaluation, destruction, or displacement of local resources for coping with crisis (Summerfield 1998; Bracken 1998). By replacing local or indigenous systems of healing with foreign modalities and professionals, it is thought that a kind of cultural imperialism develops which results in dependency and disempowerment for aid recipients. The application of the "bread and counselling" model of humanitarian aid packages that became popular in the 1990s may be one example of short-term aid provision that ultimately serves the interests of imperial powers (Summerfield 1998). It has also been observed that few recipients of trauma interventions

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have actually expressed a need for them (Ibid). Related to this is the critique of professional interests, which asserts that a "trauma industry" has promoted the professional careers of a handful of Western elites and sheds light on how the knowledges created in the trauma treatment field are considered expert, thus maintaining and legitimizing certain relations of social domination and subordination (Killen 1999).

Some of the critiques just described bear a family resemblance by their suggestion that psychological sciences create or legitimize certain relations of domination and subordination. There are many sub-categories of this critique, including those which seeks to explain the psychological disciplines in terms of interests, from professional interests to those of nation-states (Rose 1996:45). The perspective that the trauma field has taken on the character of an "industry" and that exporting trauma interventions amounts to a humanitarian form of cultural imperialism are two examples of the critique of interests. It is assumed in this critique that somehow psychology enables one group or individual to have power over another, by creating and legitimating hegemonic forms of knowledge and social differentiation. But power's uneven distribution rarely emerges as an explicit and deliberate program of control. In that sense it is perhaps even more insidious because the consensus that characterizes hegemony may be forged without awareness or overt coercion. Critical medical anthropology, which examines the "social production of medical knowledge" and the "contribution of hegemonic ideology to the maintenance and reproduction of structures of oppression" and "the functions of medicine in social control and the appropriation of power" represents this strand of critique in cultural anthropology (Singer 1990). Feminist social science has similarly

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examined the role of biomedical authority in the subordination of women (e.g., Ehrenreich and English 1979; Martin 1987).

Another significant critical viewpoint in the torture treatment discourse challenges the truth claims of psychological sciences on the basis that the epistemological foundations for those claims, grounded as they are in positivism, are then thought to be independent of the social, cultural, and historical context in which they have emerged. For example, as noted above, Summerfield questions the status of PTSD as a timeless and universal construct, and Bracken culturally relativizes certain notions of the self that are assumed by Western psychological theories or constructs such as PTSD. Like many medical anthropologists, these critics would claim that psychology, insofar as it is a form of biomedicine, does not have some privileged access to truth, but should be treated as a culturally and historically situated ethno-medicine (e.g., Desjarlais, Eisenberg, Good and Kleinman 1995; Kleinman 1995; Young 1982; Good 1992, 1994; Good and Good 1993; Gaines 1992; Nichter 1992; Hopper 1991; Kleinman and Good 1985; Obeyesekere 1985).

In sum, the arguments presented against psychologization maintain that psychologizing processes depoliticize, dehistoricize, and individualize. When suffering from political violence is translated into a psychological problem, the political nature of oppression and terror is obscured. It is argued that the historical specificity of all the different forms, locations, and meanings of collective violence are lost by the universalizing and individualizing reductions of psychologization. Psychological explanations for social problems have long been attacked by anthropologists, especially in the traditions of political economy, either because psychological explanations are insufficient or, more significantly, because those explanations reduce complex social,

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political, and historical processes to psychological mechanisms (Scheper-Hughes 1992a; 1992b). Psychologization is presumed to mystify the social and political origins of collective violence and suffering, to exclude other forms of suffering (such as the suffering resulting from poverty), and can place the burden of change on the victims. This form of critique assumes that the domain of psychological knowledge, technical practices of psychology, and categories of thought and truth that dominate psychology somehow are separate from a domain called the political. It is thought that psychologization acts to undermine the potential for political action and therefore the emancipatory possibilities for the oppressed.

That critiques have been generated within the mental health field of torture treatment (not from marginal, radical or peripheral places) and have been an integral feature in the development of mainstream practices in this field suggests an acceptance, particularly since the 1960's, of changing views of the social authority and practices of psychological expertise. Put together, these different forms of critique represent important avenues for questioning and challenging naturalized assumptions in the West that grant psychological explanations and the workings of the psychological sciences certain kinds of privilege. I would like to suggest that some of these critiques, though differing in emphasis and details, all share certain presuppositions that should be considered for further thought.

The Psychosocial Approach to Trauma as Governmentality

For the purposes of this study, the most important unifying feature of the critiques outlined above is that which places a moral and ethical premium on preserving and fostering the freedom of the subjects of psychological expertise. By freedom, I am

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referring to an aggregate of concepts such as rights, autonomy, self-determination, agency, and empowerment that have been constitutive of subjects and citizens of governance through liberal democratic rule (Rose 1996; Dean 1999; Cruikshank 1999). Rose has suggested that freedom has come to be identified with autonomy, or the "capacity to realize one's desires...[and] to fulfill one's potential through one's own endeavors, to determine the course of one's own existence through acts of choice" (1999:84). Freedom, it was suggested by these critiques, can be denied or encroached upon when psychological theories and techniques make people into victims, into the pathological or sick, or into the colonized. Imposing care on people who do not express a need for it, or not taking into account cultural differences or the historical and social context of suffering, are subtle ways to deny freedom. Psychologization also threatens to obstruct the possibility for freedom that can be attained through what is often assumed to be the best means for ending oppression and violence: political action.

But as this study will illustrate, the critiques presented above do not exist outside certain governmental practices that in fact depend upon the very agency and capacity for freedom of subjects that they suggest are being repressed by the psychological sciences. Indeed, these critiques are part of what Dean has termed "programmes of empowerment" which have set the standard for many different social service projects that aim to help the disempowered to "cast off their status as victims and actively participate in the transformation of their condition" since the 1960s (1999:65). Following Dean, I argue that these critiques, or similar ones produced by anthropology that aim to empower the disenfranchised by analytically highlighting agency, are themselves part of "contemporary practices of governance...that have come to rely upon the agency of the

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governed themselves" (1999:67).[8] The *authority* of psychological expertise lies in its ability to furnish an array of techniques that do not impose some kind of model that alienates the subject of expertise or that legitimates uneven relations of power through subtle coercion, but that work in and through the subject's capacity for autonomy, empowerment, and self-determination (Rose 1996). This study shows how the practices of psychosocial centers for survivors of torture and refugee trauma are linked to broader "programmes of empowerment" through participatory and user-right's based models of service provision and treatment that enlist both the "experts" and the clients in projects of autonomy and self-determination through self-governance.

Governmentality and "Psy"

For Rose (1996) a working definition for 'government' is the "more or less methodical and rationally reflected 'way of doing things,' or 'art,' for acting on the actions of individuals, taken either singly or collectively, so as to shape, guide, correct and modify the ways in which they conduct themselves" (29). Dean (1999) explains that a governmentality analysis "...asks questions concerned with how we govern and how we are governed, and with the relation between the government of ourselves, the government of others, and the government of the state" (2). Governmentality serves "...as a way of conceptualizing all those more or less rationalized programs, strategies, and tactics for the 'conduct of conduct...'" (Rose 1996:29).[9] Problematizing certain

[8]Any analysis of governmentality, whether it be by Rose, Dean or myself, is also generated within the same governmental practices as other theories. A governmentality analysis does not occupy a privileged theoretical vantage point. In other words, a governmentality analysis does not lie outside of the conditions that make it possible.

[9] Mitchell Dean, in *Governmentality: Power and Rule in Modern Society* (1999), a kind of primer on governmentality, offers a review of the literature in this area of study. Scholars who have problematized different domains through a governmentality analysis have examined topics such as education, poverty, the law, and psychology. For Dean's complete list of references, see his introductory chapter.

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social phenomena as governmental questions allows for analytic movement between individuals, populations, and the state; from the level of how the self should act upon itself or conduct itself in relation to itself, to how the state should conduct itself in relation to its citizens. A governmentality analysis enables investigations into the harnessing, distribution and dispersal of power (that is simultaneously repressive and productive) from bodies and psyches to institutions and state policy.

One of the central features of liberal democratic societies is "governmentality," or "conducting conduct," through expertise (Rose 1996:12). Rose argues that heterogeneous practices of "psy" expertise have played, in varying intensities and in different configurations, a significant historical function in Western Europe and North America since the nineteenth century in terms of the government of the *self* (Ibid:11). He argues that "psy" occupies a unique place in contemporary liberal democratic societies in relation to the other human sciences because of its central role in processes of subjectification, the shaping of individual conduct and its contributions to the emphasis upon the self we see today. "Conducting conduct" through psychological expertise and the wide ranging dispersal and social absorption of psychological techniques have encouraged the formation of free, autonomous, choosing subject/citizens, a condition "vital to the governability of liberal democracy," according to Rose (1996:11). Rose makes the claim that "psy" has, in fact, been "intrinsically linked with transformations in the exercise of political power in contemporary liberal democracies" (1996:13). The selves to which Rose refers are no other than the selves that we call our own—they are not illusory, fabricated, or contrived selves produced by psychological expertise that function to mask some transcendental subject waiting to have the veils of mystification

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lifted. Selves, he posits, are not foundational but made and remade by ongoing, reflexive, self-making activities, the shape of which have been dependent on the psychological disciplines and techniques and the demands of specific localities and spaces (Ibid:3; Rose 1999:xx). Yet, Rose cautions, to study "psy's" relationship to the governance of selves should not be so "...much a matter of holding psychology responsible for the 'social construction of subjectivity' as of seeing the ways in which the knowledges and techniques of the psychosciences have been bound up with a profound alteration in our politicoethical rationales and practices" (1996:99).

A governmentality approach recognizes that "...subjectivity is itself a matter of the technologizing of the human..."and that "human capacities are...inevitably and inescapably technologized" (Barry, Osbourne and Rose 1996:13). Further, for the most part, "psy" practices, it is argued, are not part of some intentional, rationalized program to brainwash citizens,[10] nor do they compose a cohesive, singular, monolithic force, nor can they be reduced to their capacity for governance or the "conduct of conduct." "Psy," to the extent that it *supports governmental practices* does not operate "...just to control, subdue, discipline, normalize or reform..." but also shapes desires and aspirations and works to form individuals who are"...more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, empowered..." (Rose 1996:12). In its links to mental health facilities, schools, prisons, courtrooms, in the popular media, and in the workplace, as the inventor of the normal person and the organizer of practices

[10] Governmentality also functions in totalitarian regimes, if not differently. Furthermore, "psy" technologies can be used to produce terror, torture and subjugation as both Rose (1996) and Dean (1999) have pointed out.

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of everyday life,[11] "psy" governs individuals "in terms of their freedom" (Ibid: 16). As Rose states, "...we have been bound into relationships with new authorities, which are more profoundly subjectifying because they appear to emanate from our individual desires to fulfill ourselves in our everyday lives, to craft our personalities, to discover who we really are" (Ibid:17). Rose goes as far to suggest that "psy's" presence in processes of subjectification today is so pervasive that a certain kind of homogenization or unification is occurring where humans are being shaped as "...selves with autonomy, choice, and self-responsibility, equipped with a psychology aspiring to self-fulfillment, actually or potentially running their lives as some kind of enterprise" (1996: 33). This he attributes in part to "psy's" "generosity":

> By their 'generosity' I mean that, contrary to conventional views of the exclusivity of professional knowledge, psy has been happy, indeed eager, to 'give itself away'—to lend its vocabularies, explanations, and types of judgment to other professional groups and to implant them within its clients. The psy disciplines, partly as a consequence of their heterogeneity and lack of a single paradigm, have acquired a peculiar penetrative capacity in relation to the practices for the conduct of conduct. They have not only been able to supply a whole variety of models of selfhood but also to provide practicable recipes for action...(Ibid).

Thus, not only have the techniques of psychology been handed over to experts in domains outside the disciplinary boundaries of the psychological sciences but those techniques have been integrally linked to our own self projects. "Psy" has become so much part of our ways of thinking, feeling, being, and experiencing that "it is has become impossible to conceive of personhood, to experience one's own or another's personhood, or to govern oneself or others without psy" (Rose 1996:4).

[11] One only has to turn to the self-help section in any bookstore to see the vast range of everyday life concerns that have become problematized by "psy"– from relationships to handling personal finances.

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Rose (1996) outlines three specific ways in which psychological expertise is related to liberal democratic forms of government that should be noted. They are "rationality, privacy and autonomy" (99). In terms of rationality, and this was also posited by Foucault in *Discipline and Punish* (1977) in his discussion about the panopticon and disciplinary rule, power is to be exercised rationally, not arbitrarily, and is to be calculating and justifiable. Governance through "psy" is authorized by its status as a science and therefore its claims to truth which are based upon neutral, objective, disinterested, measurable, and quantifiable problems and technical solutions. Regimes of truth based on rationality thus, as Rose suggests "...opens up a vast and auspicious territory that expertise—authority grounded in a claim to truthful knowledge and efficacious technique—can colonize" (Ibid).

"Psy's" relationship to that realm of the "private," one of those spaces that are created in liberal democratic regimes to be "outside of the formal scope of authority" and generally thought to include the market, civil society and the family—are spaces where "psy" expertise can link the management of the political regime to the management of private subjects (Rose 1996:99). As Rose states:

> The Janus face of expertise enables it to operate as a relay between government and privacy—its claims to truth and efficacy appealing, on the one hand, to governments searching for their answers to their problems of regulating economic, industrial, or familial life and, on the other hand, to those in authority over these private spaces, be they industrialists or parents, attempting to manage their own private affairs efficaciously (Ibid:100).

Social spaces, such as the school or the workspace, can be governed and managed through psychological technologies so they can operate better for the good of those

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authorities governing the state, but also benefit those who govern and who are governed in these so-called private domains.[12]

Regarding the relationship of "psy" to autonomy, Rose describes how liberal democratic regimes depend upon the regulation of autonomous or free subjects, individuals who have the capacity to regulate and exercise their freedom through their own abilities to make choices. Individuals are to be organized into "...'free individuals' upon whom liberalism depends for its political legitimacy and functionality..." (Rose 1996:100). It is here that Rose's crucial point about the relationship between liberal democracies, individuals, freedom and governmentality should be made. According to Rose, "...in the history of power relations in liberal and democratic regimes, the government of others has always been linked to a certain way in which 'free' individuals are enjoined to govern themselves as subjects simultaneously of liberty and of responsibility..." (1996:12). Rule is dependent on the idea that its subjects are capable of responsible self-government through regulation that will allow for the exercise of individual freedom, liberty, and autonomy. The conditions for individuals to actualize their capacity for freedom are ideally provided without recourse to injunctions and threats of dictatorial, coercive, totalitarian control. "Psy" plays a critical role in shaping the capacities for freedom:

> The technologies of psychology gain their social power in liberal democracies because they share this ethic of competent autonomous selfhood, and because they promise to sustain, respect, and restore selfhood to citizens of such polities. They constitute technologies of individuality for the production and regulation of the individual who is 'free to choose' (Rose 1996:100).

[12] In addition to the Habermasian type of distinction made between the private and public, there is also the sphere of the intimate which can be both public and private but is also categorically different from them. Psychotherapy and torture are intimate activities, and are perhaps unique in how they collapse the boundaries between the public and private.

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Expert knowledges defined by scientific or rational truths have been crucial for organizing and regulating populations by knowing those populations, and mobilizing and instrumentalizing the capacities of those populations (Foucault 1980). As stated previously, Rose (1996) argues that psychological expertise emerged as a unique mode of authority in modern liberal democratic societies in relation to the other human sciences because of psychology's ability to shape, know and govern individuals at the level of subjectivity. Psychological technologies play a central role in knowing, organizing and intervening into populations too so they can better self-regulate, but what is more important for the concerns of this study is how those technologies enable individuals to shape their conduct in specific ways that will enhance their capacity for exercising their freedom as citizens, thus benefiting themselves and society (Foucault 1980). Governance through psychological expertise in psychosocial programs for survivors of torture and refugee trauma represents the governance of liberal society to the extent that authority is exerted without coercion and that the limits of state and professional authority are negotiated in terms of the liberty of individuals. Psychological technologies in these programs operate in terms of rights and freedoms of the clients, and enhance those rights and freedoms *through* the aspirations and goals of the clients. The authority of psychological experts and their knowledge in these programs depends upon the voluntary and active participation of 'clients' for whom the achievement of greater empowerment and self-determination is the goal.

Because the clients of these programs come from diverse cultural backgrounds, and also may have fled from regimes of sovereign rule, the tasks of managing difference

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and fostering good mental health and social adjustment have special significance insofar as psychosocial programs for survivors of political violence are enrolled in the activation of selves capable of freely and actively participating in practices of citizenship under liberal democratic governmental rule. Enhancement of autonomy and freedom is also an important goal in therapeutic practices because those are precisely the capacities that are thought to have been stolen or violated through terror, torture and war. Thus, critical junctures are formed between "psy" expertise, liberal democracy, and certain kinds of political subjects and selves that make the study of the field of torture treatment compelling and illuminating.

Governmentality: the State, "Psy," and Moral and Ethical Dimensions

Typically, social theory identifies governance (and resistance) with electoral politics and the state. Foucault argues that the "institutions, procedures, analyses and reflections, the calculations and tactics" of governmentality may coincide with the concerns of 'politics' in the traditional sense of the term, or of the state (1991:102). However, one of Foucault's contributions to social theory lies in his rethinking of power and its location in relation to the state. His analysis of governmentality is a challenge to:

> overvaluing the problem of the state, one which is paradoxical because apparently reductionistic: it is the form of analysis which consists in reducing the state to a certain number of functions, such as the development of productive forces and the reproduction of relations of production, and yet this reductionist vision of the relative importance of the state's role nevertheless renders it absolutely essential as a target needing to be attacked and a privileged position to be occupied (Ibid:103).

Foucault suggests a more dynamic and complex model where the nature of the state changes in relation to shifting techniques and practices of governmentality.

Governmentality

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> ...is at once internal and external to the state, since it is the tactics of government which make possible the continual definition and redefinition of what is within the competence of the state and what is not, the public versus the private, and so on; thus the state can only be understood in its survival and its limits on the basis of the general tactics of governmentality (Ibid:103).

When Foucault speaks of the "continual definition and redefinition of what is within the competence of the state and what is not" in liberal democratic societies he is referring in part to the tension maintained between governing too much and governing too little, a tension sustained by "a restless and dissatisfied ethos of recurrent critique of state reason and politics" that defines liberalism (Barry et al. 1996:8). This tension results in a constant relocation of the boundaries of the state and what we typically think of as the political with other domains, e.g. "the private" or "civil society," resulting in "shifting zones for the coordination, codification, and legitimation of some of the complex and diverse array of practices for the government of conduct that exist at a particular time and place" (Rose 1996:12). Foucault tried to establish "the perspective of a multiple regime of governmentality" that "contribute[s] towards the relativization of the notional boundary between state and society" (Gordon 1991:36). These larger tensions and shifting boundaries appear locally in the field of torture treatment in the form of ongoing debates that question the limits and conditions of the professional authority of clinicians in relation to the freedom or autonomy of clients, i.e., the survivors of torture and refugee trauma who are treated.

It should also be noted that ways of "conducting conduct" have both moral and ethical dimensions. They are moral insofar as there is some kind of reflection on what people 'ought' to do, and the sense that there are ways to conduct oneself in relation to one's self or to others that are "...good, virtuous, appropriate, responsible" (Dean 1999).

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By providing rational and therefore disinterested justification for its authority, "psy" operates within a particular ethical discourse that enables it to make determinations about responsibilities, and what is good or bad, or right or wrong, for the experts and for the clients.

"Psy," in its "governmental" capacities is also ethical when ethics is taken to mean "the domain of specific types of practical advice as to how one should concern oneself with oneself, make oneself the subject of solicitude and attention, conduct oneself in the various aspects of one's everyday existence" (Rose 1996:30).[13] Psychological expertise, according to Rose, exercises its power on "an internal truth, one essential to each individual person over whom it is exercised" through both rational and ethical means (Ibid: 92). It is not simply that psychological expertise offers techniques to simplify, order, and systematize but that it appeals on the basis of ethical practices that can improve one's life. One example of this meaning of "ethical" in the field of torture treatment would be the prescriptions, circulated in the form of books, articles, workshops and trainings, about how the clinicians should take care of themselves, i.e., practice their own self-care. It is believed that caretakers too may suffer and need to manage their own feelings of traumatic stress or burn-out, so "psy" dispenses clear, practical, concrete advice on administering self-care. It is the responsibility of the clinicians to concern themselves with their own self-care by practicing the prescribed techniques (Rose 1996). Moreover, therapeutic enrollment for clients is based on the dispensation and acceptance of practical advice, reasoning, and techniques for "mak[ing] oneself the subject of solicitude and attention." It is through therapeutic involvement and improved self-

[13] Rose notes that this concept of ethics was first described by Foucault.

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governance that suffering may be diminished and the conditions, both psychological and material, of their lives may be improved.

What I am suggesting here is that questions about psychological expertise and the development of the field of torture treatment should not be posed as the problem of "psychologization" but as evidence of new forms of "governmentalization."[14]

The Psychosocial Approach to Trauma as a Science of Memory

In addition to scholarship produced on the role of "psy" knowledges in connection with contemporary "governmental" strategies, recent scholarly work that focuses on the place and uses of "trauma" and "memory" in contemporary Western society provides a foundation for this dissertation. Young (1995) published an extraordinary book that provides both a history of trauma and an ethnographic account of how PTSD is "made real" in an inpatient treatment program for Vietnam veterans. PTSD, according to Young, is a problem of memory. What he accomplished in this book, besides constructing a fascinating and meticulous history of PTSD, is to show how, and not why, an "invention" like PTSD *materializes* and becomes a social reality. It is not enough to say that PTSD is a social construction; Young demonstrates how a psychiatric construct is "...glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources (1995:5).

Hacking (1995) and Antze (1996) both have examined the recent multiple personality epidemic from the perspective that this new diagnosis and the kinds of subjectivities it makes possible are in their essence about memory and identity. Hacking's work consists of a genealogy of "memoro-politics" to show that multiple personality

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disorder (MPD) is linked to the emergence of the "sciences of memory," those knowledges that were created simultaneously with memory's migration to its present position as the "scientific stand-in for the soul" (1996). According to Hacking's schema, it was in the late nineteenth century that memoro-politics assumed a third angle in a triangle also consisting of Foucault's "anatomo-politics" and "bio-politics" or those power/knowledges concerned with 'life' (Ibid:72). Moreover, according to Hacking, "Trauma took the leap from body to mind just over a century ago, exactly when multiple personality emerged in France, and during the time when the sciences of memory were coming into being"(Ibid:183). MPD, either experientially or diagnostically was not historically possible until a "conceptual space" was created "for the idea of multiplicity" (1995:179) which has since then converged with "a growing bond, in popular awareness, between child abuse and perverse family sex" (Ibid:42). This bond is the crux of the trauma, the trauma that is the source and cause of MPD; it is that trauma that is to be discovered with the help of experts and special techniques. According to Hacking, the invention of "[m]ultiple personality provided a new way to be an unhappy person" (1995:236).

Hacking describes the politics surrounding MPD which have been most clearly manifested in polarizing debates about the veracity of memories. He examines how the False Memory Syndrome Foundation and its affiliates claim that frequently, memories of heinous sexual abuse are implanted by "ideologically committed therapists" (1996:67). Ensuing accusations and public disclosures on the part of the misled and manipulated clients have torn families apart and damaged social and professional relationships. This group is struggling with the clinicians and sufferers of MPD who have embraced the

[14] I thank Vincent Crapanzano for articulating this for me.

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reality and salience of recovered memories of former sexual abuse. Those on this side "denounce the false memory syndrome organizations as support groups for child molesters" (1996:68). Although a great deal is obviously at stake in these battles, Hacking reminds us that these struggles are waged on "...the bodies of young women with psychological problems," an insight that is often eclipsed in the drama of debate (Ibid:68).

Memory wars, large and small, are fought on the terrain of suffering bodies, from nationalist struggles to those at the level of personal identity. We see this in the case of discourses on treating torture survivors, where the "sciences of memory" are always fundamentally and essentially political. For example, in American torture treatment discourses, certain psychoanalytic concepts about memory and trauma have been submerged, marginalized or excluded, especially those theories which suggest traumatic memories are anything but recollections or reports of fixed, determinate, external, historical events. This hegemonic model of memory produces a plurality of effects, including the imperative that the torture victim perform the responsibility of being a reliable witness to atrocities and also that living verbal testimony is given primacy over other expressions of historical memory. In Chapter Seven, this topic will be further explored by focusing on what has been termed the "trauma story."

Social Suffering, Bodies and Selves

Though this study does not position social suffering at the center of its analysis, it does intersect with recent anthropological studies that have concerned themselves with violence, suffering, and healing, most notably the important trilogy of edited volumes

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specifically addressing these problems.[15] The first volume, *Social Suffering* (1997) is most relevant to the present discussion, addressing social experiences of different forms of violence, from structural forms (Farmer 1997), to the Holocaust (Langer 1997), to violence against women in India (Das 1997); the cultural representations of such, and; the "political and professional processes" that "powerfully shape the responses to types of social suffering" (Kleinman, Das and Lock 1997: xii). It is with the latter concern, "political and professional processes" that "powerfully shape the responses to types of social suffering" that this ethnography will most obviously intersect with these projects. The present study will also converge with the aims of this edited volume by showing how in discourses of torture treatment "the moral and the political are inseparable from the medical," (Ibid: xviii) and that "bureaucratic mediation...remakes suffering much as it remakes social life" especially, as the editors claim, the bureaucratic mediation of medicine (Ibid: xx). Like these authors, I demonstrate that processes of bureaucratic mediation and psychological/medical intervention into suffering transforms the meanings and experience of suffering, from a collective level to the level of individual subjectivity, and that intervention is not just a techno-rational process to eradicate or ease suffering but has a constitutive function in defining the contours of suffering.

Other anthropological literature has addressed social suffering by explicitly attempting to wed concerns and theories of medical anthropology to research on collective violence and suffering. In 1998, *Medical Anthropology Quarterly* (12:1) published a special issue on violence and suffering that focuses on both how violence targets and works on and through bodies, and how experiences and expressions of

[15] They are: *Social Suffering* (Kleinman, Das, and Lock 1997); *Violence and Subjectivity* (Das, Kleinman, Ramphele, and Reynolds 2000) and; *Remaking A World* (Das, Kleinman, Lock, Ramphele, and Reynolds

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suffering and distress are socially and individually embodied (Green 1998:4). The editor claims that a problematization of bodies and embodiment that gives primacy to, or at least emphasizes the body as a phenomenological ground for experience, is the point at which medical anthropology intersects with the anthropology of violence. Other recent scholarly literature has strategically located embodiment as a foundational ground and demonstrates how, by taking pain and suffering as a point of departure, distinctions between mind and body, emotions and cognition, representation and reality, and language and experience are broken down (Csordas 1994; Frykman, Seremetakis and Everet 1998; Scarry 1985).

This literature represents one trajectory of a whole host of research and writings on the body and bodily practices that have been produced in recent years, problematizing what was presumed to be an ontologically stable and obdurate, intransigent, material entity (e.g. Lock 1993; Butler 1993; Grosz 1994). It has been suggested that this privilege given to the body, its cultural expressions as well as its theorizations, signifies its importance as one of the last remaining sites for some kind of fixed point of reference and ground for identity and truth in an increasingly fragmented, contradictory, rapidly changing, globalizing world where traditional frames of reference no longer hold currency. Some scholars lament this focus, suggesting that identity movements and politics that rely on the emancipatory potentials of bodily expression and discourse personalize and individualize, and therefore reduce and obfuscate the larger political and economic forces that make possible and also limit their potential (Turner 1994).

In Foucault's *The History of Sexuality*, Volume I, a discussion on the disciplinization of the corporeal body and populations or what Foucault calls "bio-power"

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or "power over life" represents a way of thinking about bodies that is particularly important for this study, especially his concepts of anatomo-politics and bio-politics (1980:139). Anatomo-politics refers to the disciplining of the body as an object of performance— understanding and maximizing its efficiency, usefulness, and capabilities. Bio-politics refers to the regulatory controls of the population, the "species body" that was described in this chapter's section on governmentality (Ibid). Bio-politics of the population would include knowledges about and intervention into "...biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can make these vary" (Ibid). For Foucault, "[t]he disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed" (1980:139).

This study focuses on how political violence *and* torture treatment are directed toward the body-- individual bodies, which are "the primary site for the expression of the subject" (Adams 1998:16),-- bodies as populations, and also the social body (Lock 1993). Bodies are the object of violence and the object of healing, and there has been an intensification of investigation of how to maximize harm to bodies and to repair them, where the knowledges produced in these two domains are mutually implied and interconnected. Thus the body becomes central to understanding torture treatment discourses.

Today in the United States and Denmark clinicians have become extremely interested in cultivating therapies that integrate mind and body; these therapies claim that trauma lives in the body, that trauma is "embodied" and traditional talk therapies are insufficient as methods to truly reach the core of suffering. Failures up to this point in

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treatment, it is claimed, can be attributed to privileging cognition, emotional functioning, verbalization and narrative over the other modes of expression of trauma, such as embodied modes. These therapies do not seek to privilege the body over the mind, but to see the body/mind connection as a unity and not a dualism--to see persons as wholes and to treat them as such. There are a number of such therapies in circulation today that conform to these 'new' ideas about the mind and body which will be more closely examined in subsequent chapters.

The self, similar to the mind and body, has been an enduring experiential category and also an analytical problem. Contemporary Western academic theory is rich with discussion on whether the self is multiple, de-centered, empty, saturated or fragmentary, or whether the distinction made between the Western self as atomized, autonomous, and individualized and the self of other societies as socio-centric or more fluid is useful or even true in some sense of the word (e.g. Cushman 1990; Geertz 1984; Schweder and Bourne 1984; Lasch 1979; Kondo; Gergen 1991; Lifton 1993). This study will depend first on the idea that "the self" as we know and live it is not foundational or transcendent, but is historically and culturally produced, practiced, reiterated, and represented. It is in the context of contemporary Western European and North American societies that this study will be focused, where the self has been made into a singular preoccupation, saturated and indeed to a certain extent even constituted in psychological discourse, and instrumentally important in terms of governmentality (Rose 1996). The self is simultaneously subject and object, cultivated as an object of concern as well the subject of concern. We have been taught that care of the self, or today's management of the self is the moral responsibility of the individual. This does not mean that the individual self is

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autonomous, though the ideal of autonomy provides an ethical basis for "psy's" authority. This study is concerned with ways in which the self works on itself, often with expert guidance, that allows it to be free and responsibly self-determining in relation to others. It is a particular orientation to the self that is stake here.

In analyzing practices of torture treatment, I will show that to work on the psychological self requires a certain regard of the self to itself. Ideals of the self, such as the valorization of self-empowerment promoted by clinicians, must be taught to and practiced by the clients for treatment to be successful.

Selection of the Site and Methods

When I spoke with one of my academic mentors about my ideas for a project about these new "torture treatment centers," he directed me to his wife, a clinical psychologist who fortuitously was involved with evaluating and treating survivors of torture and refugee trauma in the New York City metropolitan area. "Diane"[16] was my first entrée into the local torture treatment community, and it was through her that I made the initial contacts necessary to develop this dissertation study. In the summer of 1997, I conducted exploratory fieldwork at the "City Hospital" program for survivors of torture and refugee trauma in New York City to determine the potential viability of doing research on this topic. I did not return to City Hospital for the dissertation study though my research there had been productive, instead spending my time at another psychosocial program for survivors of torture and refugee trauma, The Haven, which is located in one of the outer boroughs of New York City. I went to the Haven several times a week for a

[16] In the interests of confidentiality, I will use pseudonyms for psychosocial programs and also for informants. However, in the case of the RCT, because it is a well-known public institution as is its leader, Inge Genefke, I will frequently refer to both the RCT and Genefke by name. I will, however, use pseudonyms for clinicians I may have interviewed at the RCT.

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number of months to observe the everyday practices in the program and to speak with the staff there about their work. I wanted to get a sense of what one of these psychosocial programs is like from the ground level, and to learn how local forms of expert knowledge and practice were indeed locally situated and therefore unique, but also how they were linked to forms of expertise and practice that were being exchanged on a transnational scale. Because the Haven was a young program in 1999, and its design and philosophy provided an alternative to the City Hospital model, I felt it was an opportune time and also an ideal place to explore some of my research ideas. But because of my objective to describe broader linkages and themes, I traveled across sites and utilized other sources of empirical data such as that from textual materials, and from professional trainings and conferences I attended and interviews I conducted with various professionals who did not work in the Haven. This study therefore is not an institutional ethnography in the conventional sense.

Furthermore, this study is not an interactionist study of encounters between clients and professionals. This is so because of the specific questions I created that directed the aim of the ethnographic lens, but also a matter of circumstance and the kinds of external parameters that were erected by institutional agents. At the Haven I was not permitted to observe any psychotherapy sessions, or most encounters that the casemanagers or counselors[17] had with their clients. Client visits were usually conducted with the door closed. The therapeutic relationship was considered sacred, and my presence in that space would have been a violation. I did however accompany the casemanagers off site for the

[17] I will use the terms "casemanager" or "counselor" interchangeably, following the changing usage of those terms at the Haven. However, "casemanager" implies that the professional must "manage" many cases. This is the language of social service provision. "Counselor" implies a more intimate and clinical relationship of the professional to the client that is less service-based than therapeutically based.

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purpose of meeting with a few of their clients (with the clients' permission) on rounds of "home visits," and also conducted interviews with ten Haven clients.

Despite not being able to observe supervision meetings between counselors and clinical supervisors, I was permitted to attend staff meetings, where many of the concerns and tensions manifested in professional practices at the Haven were organized and made visible for study.

The five male and five female Haven clients I interviewed were selected by their casemanagers and ranged widely in age, educational background, nationality, ethnicity and English fluency. For each of them, I had a few questions that I tried to ask that were about their experiences as refugees in the United States and how they were getting along. I asked some of them if they had been in psychotherapy and if not, if they would be open to it. I did not always ask the same questions, and often followed the interests, abilities to sustain an interview format, time constraints, and attention spans of the clients in structuring the interviews. These interviews were either conducted at the Haven, at restaurants, or in people's homes with the accompaniment of the client's casemanager. For a few of the clients, I depended on the casemanagers to translate for me. Some of the interviews I audiotaped and others I did not, depending on the client's wishes and also on my own assessment of the interview situation. For example, one client was visibly upset when I met with her. She was angry about her employment situation and also worried about her gravely ill sister back home. She told her casemanager and me that her sister would soon die without a life-saving operation. I listened to the client express her feelings of helplessness and rage, because she herself was barely making ends meet in New York and could not send enough money to finance the surgery. For some reason,

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this client still wanted to continue with the interview even in her disturbed emotional state. I decided, and I think wisely, not to ask her if I could tape- record our discussion.

I had to assure the Institutional Review Board (IRB) office at my institution and the Haven staff that I would not ask the clients anything that could upset them, such as questions about their past traumatic experiences. Nonetheless, some participants voluntarily provided me with accounts of their war-time or torture experiences. Often they would ask me for assistance in getting jobs, writing their resumes, or other matters such as reading official documents, which I attempted to provide.

Besides journeying to the Haven a few days a week, I also attended professional conferences, lectures, and trainings on topics such as trauma or the detention system for asylum seekers. In addition, I volunteered as a "visitor" for asylum-seekers at the Elizabeth Detention Center in Elizabeth, New Jersey. I also interviewed immigration lawyers and refugee resettlement workers.

My forays outside the walls of the Haven included a three-month trip to Denmark where I interviewed psychological professionals and visited other psychosocial programs. This journey was made in the hopes of gaining a richer historical understanding of the development of the field, and to again further the aim of rendering some kind of description of the expert knowledge and problematizations that have emerged within a transnational field of practice. Time and again when I read media articles or research literature on torture survivors, certain names and institutions were mentioned. This led me to think that some kind of dominant discourse(s) existed in the field that could be traced back to Denmark. In particular, I was interested in the RCT and figures like Inge

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Genefke who were considered "pioneers" in this "fledgling field," and wanted to interview them for their perspectives on the field's development.

In Copenhagen, I spent much of my time at the RCT, a large human rights NGO and torture treatment center. There, I was kindly granted permission to share the student office in the Research Department with a few Danish graduate students who were doing their own graduate work on various topics related to trauma, torture and rehabilitation. The students were all friendly and helpful, and it was easy for me to feel accepted and welcomed in the institution and also intellectually stimulated. If I was not in the student office at the RCT or out conducting interviews, I would be downstairs in the Documentation Centre, a library specializing in torture related materials, reading and copying articles on torture, refugees and trauma.

In addition, I visited three other Danish psychosocial programs for survivors of torture and interviewed staff at those programs. I also interviewed staff and "users" at a social center for asylum seekers called the Kultur Hus (Culture House). Furthermore, with another graduate student, I was able to visit Sandholm, the main transition detention camp for asylum seekers in Denmark and in the countryside near Copenhagen. Normally a high security facility, Danish Red Cross officials approved our visit there. We were able to interview two staff members, and also received a tour of the grounds. As all the Danes I interviewed and with whom I spoke about my project spoke excellent English, I conducted all my research in English.

The approach I took to my Copenhagen fieldwork was different from the one I took at the Haven. I was not incorporated into the daily workings of the institution, although my presence at the RCT on an almost daily basis did allow me to observe and

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be part of activities I would not have been part of if I had just come there to interview staff. In general, most of my work was directed toward contacting clinicians, setting up interviews, and doing interviews, and also gathering and reading publications. Some of my contacts were made by cold calling, or calling clinicians without having a referral. Other contacts were made through referrals. For the most part, I encountered a spirit of volunteerism and openness from the clinicians I interviewed in Copenhagen. The professionals with whom I spoke were generous and thoughtful, and with the exception of a few, seemed interested in talking with me. I felt that my goals in Denmark were clear-cut as was my role, and that sense of clarity, as well as a set departure date, allowed me to approach my fieldwork more systematically and efficiently than I had in the States. However, because of the short time I was in Denmark, the types of data I collected, and the nature of my relationship to institutions there, the data I have are of a different type and not always comparable to the data I gathered in the United States. Thus, the kind of comparative analysis I can produce is inexact.

My methods for collecting data included conducting semi-structured interviews, usually audio-taped with accompanying handwritten notes. I also noted my own observations and experiences while attending trainings, meetings, and other group events where I did not interview individuals. In Denmark, I interviewed clinicians formally usually for one to two hours, and covered questions about their experiences in the field, about what changes they have seen in treatment approaches, their theoretical orientation and therapeutic practices, and what they believed would best help torture survivors and refugees. When I interviewed professionals such as refugee resettlement workers and lawyers in the United States, I was able to clarify some questions I had about the different

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categories of refugees, immigration laws, entitlements, and detention laws, in addition to asking these professionals about their work.

Thus this study, composed of descriptions and analysis pertaining to one site (the Haven) shares some features of other institutional studies. But it also draws from other sources of data, such as discursive materials, to form a particular focus and analysis that is concerned with how theories and practices of psychological professionals make certain kinds of governmental solutions possible across sites and national boundaries as well.

Organization of this Study

I have divided this study into three sections. Section I, which includes the next three chapters, provides a conceptual, historical, and descriptive overview of the field of torture treatment and describes institutional conditions, histories and people at different sites. Chapter One, "A Brief History of Torture Treatment" furnishes a conceptual background on different trajectories that have formed to compose dominant discourses in torture treatment. This chapter will look at Latin American, Danish medical, refugee mental health, and humanitarian psychosocial models as the primary influences for shaping contemporary practices and expert knowledge in the field. Chapter Two, "A Comparative Analysis of Programs in the United States and Denmark" focuses on the Haven in New York and the RCT in Copenhagen to illustrate the different therapeutic practices and ideologies that emerged in these different geographical settings and historical periods. This chapter provides contextual information on American and Danish national policies regarding asylum, torture survivors, and refugees, and also on how the different trajectories described in Chapter One emerge, link and are adapted in local settings. It also demonstrates the globalization of certain governmental strategies. The

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third chapter, "The Haven," departs from the rest of the study because it emphasizes description and is less concerned with theoretical issues. I have intended in this particular chapter to provide a picture of staff at the Haven and their work, and also brief portraits of some Haven clients so the reader can imagine more fully a place and people in which therapeutic theory and practice in the field of torture treatment are made possible and meaningful.

Section II (Chapters Four and Five) concerns itself with the Haven, and how governance of both the clinicians and the clients there was fostered through psychological techniques. Chapter Four, "Governance through Culture" illustrates how culture has been instrumentalized in psychological practices to manage a heterogeneous client base. "Culture" was also used to enable both clients and staff to self-govern, activating their capacities to act as autonomous and self-determining subjects. Chapter Five, "Constructing Need" explores how "need" was defined and made manageable through therapeutic practices such as the intake interview, paper technologies such as the client dossier, and community meetings where refugees expressed what they needed. The tensions between the "psychological" and the "social" dimensions of the psychosocial model of service provision will be discussed in this chapter.

The final section, Section III, contains Chapters Six and Seven. Chapter Six, "Body, Mind, Embodiment" explores the history of therapeutic theories and practices through a conceptual framework that organizes the development of the field in terms of representations of the body, mind and embodiment. Chapter Seven, "The Trauma Story" examines how memory, narrative, history and politics find their nexus in a construct called the "trauma story." Both of these chapters also reinforce my argument that

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psychology and governmental practices are crucially linked in eliciting empowered, responsible, and self-governing selves.

The conclusion summarizes the study's main themes, and also discusses the implications of growing mental health interventions in a global landscape of terror.

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Section I

A conceptual and historical overview of the field of torture treatment and descriptions of different programs.

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Chapter 1:
A Brief History of Torture Treatment

Introduction

This chapter will provide a brief overview of the international development of centers and therapies for treating torture survivors. It will show that out of specific cultural and historical sites, different frameworks of theory and practice emerged, interlocked, and overlapped with other frameworks to construct the torture treatment field as it appears today. As this chapter will illustrate, much of the expert knowledge in this field is Western in origin, evolving out of transnational connections made among elite Western mental health professionals who share a common language and epistemological assumptions. This discussion will serve as a foundation for understanding the frameworks embraced by the Haven and other centers, and the critical discourses that have accompanied their emergence, that will be presented in later chapters of this study.

To organize this material, I have divided the torture treatment field into four basic trajectories: 1) Latin American Psychoanalytic; 2) Refugee Resettlement and Mental Health; 3) Danish Medical Model; and 4) Psychosocial Programs Abroad. Each of these will be examined in turn in this chapter.

1) Latin American Psychoanalytic

A significant, yet sometimes under-acknowledged trajectory of torture treatment emerged in Latin America. Nancy Hollander (1997) has written a comprehensive, if romanticized, account of this history upon which the following general description of this trajectory is based.[1]

[1] I would also recommend Agger and Jensen (1996) for further information on this history. These authors focus specifically on Chilean mental health professionals.

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In her study, Hollander focuses on a group of ten psychoanalysts and psychologists from Argentina, Chile and Uruguay whose politically-informed psychological theories and practices grew out of the social crises and extreme political and economic conditions that they and their patients faced during the 1960's, 1970's and early 1980's. During this period, virtually the entire Southern Cone experienced political and economic instability, popular protests and demonstrations, and insurgent and state-sponsored violence. A backlash of state repression, executed not in the name of war but in the name of national security, resulted in the disappearance, torture and murder of thousands of people. As terror systematically permeated every corner of society to defeat the enemy "within," fear, confusion, paranoia, helplessness, and hypervigilance absolutized the power of military rule (Taylor 1997). At the same time, tremendous economic repression further disempowered much of the populace in these countries:

> The terrorist state imposed economic policies that favored the elite groups at the expense of the popular classes whose traditional avenues for seeking economic redistribution had been smashed. The World Bank and the International Monetary Fund, along with U.S. neoliberal economic advisors, imposed harsh measures to attract foreign and international loans. (Hollander 1997:97)

According to international law, nation-states may exercise their right to self-determination and autonomy by invoking sovereign measures such as the Doctrine of National Security. But regimes of terror do not occur without the collusion of the international community. The extent to which the United States fostered austerity measures in the Southern Cone during this period, and its overt and covert political and military activities that promoted repression throughout Latin America, are well-established (Suárez-Orozco 1992; Huggins 1998). Because of a trend toward greater transparency, previously classified documents are now available to corroborate earlier

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sources of evidence which combined prove, for example, that the United States backed the military coup against Allende in Chile and supported Pinochet's regime. It is also a matter of public record that U.S. military experts trained many leaders of Latin American military juntas at the School of the Americas. Many of these students were trained in the finer points of the art of torture (Edelman 1996; Cohn, Thompson, and Matthews 1997; Weiner 1997). I have added this level of historical detail in this section because many regimes of terror, civil wars, periods of political instability, and humanitarian crises involve a certain degree of complicity from the U.S. government.

It was in this environment of repression and terror, fostered further by silence, denial, and collusion by the international community, that psychologists and psychoanalysts, already a prominent intellectual force in the Southern Cone, made important contributions to today's treatment of torture victims and set an example for other clinicians who faced human rights issues in their practice. Moving beyond the conservative reductionism of behaviorist psychology and psychiatry which were, at that time, gaining popularity as a reaction against the excesses of bourgeois psychoanalysis, and the likewise conservative orthodoxy of institutionalized psychoanalysis,[2] these Latin American clinicians embraced perspectives that recognized structural oppression, class relations, collective experience, and their own place within these systems. Although how each clinician integrated politics into clinical practice was slightly different, the clinicians Hollander featured had in common a commitment to critically change their practice from

[2] It must be noted that not all clinicians during this time were engaged in resistance to state-sponsored terror. Some of them were in fact directly involved in its production. Lucia Villela (1997) traces how respected psychoanalytic institutions and analysts in Brazil denied that any analysts were actively participating in the state apparatus of violence and oppression when there was evidence directly contradicting their claims. One analytic candidate at an analytic training institute in fact "worked at the so-called House of Death in Petropolis, a mountain resort near Rio de Janeiro, in a detention facility where political prisoners were questioned."

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the supposedly neutral, apolitical, individualizing stance of psychology to a stance which wed radicalism with mental health. According to Hollander,

> From their point of view, there was essentially no contradiction between Freud and Marx. Indeed, they sought a convergence between a psychoanalytic theory of the unconscious roots of mental anguish and a Marxist theory of the economic origins of social violence and exploitative class relations as the basis for a praxis bent on combatting both. The[se] individuals...have striven to understand the interrelationship between alienated personal existence and alienated social relations, between individual anomie and social oppression, and between individual mental health and collective empowerment (1997:17).

Unfortunately, the ideological commitment these clinicians made could not fully protect them from being traumatized. The toll that terror was taking on these clinicians' patients, and also on themselves, was painfully evident, with the clinician's suffering compounded by the additional burden and responsibility they were shouldering as healers in this context. Many of these clinicians also put their own lives on the line by continuing with their private practices, and more dangerously, risking their safety by treating torture victims, people who had family members disappeared, and political activists. Some clinicians that Hollander featured were personally affected by terror and had to flee their countries at the threat of death. In Argentina, psychoanalysis was seen as subversive and Jewish, and thus analysts in that country were directly targeted during the dictatorship.

However, even clinicians who were exiled did not leave behind their political commitment but continued with their professional activities. For example, Marie Langer, a prominent Argentine psychoanalyst, fled Argentina, established herself in exile in Mexico City and then traveled to Nicaragua where she was instrumental in forming progressive community mental health programs. There was therefore some dissemination of radicalized psychological practices from South to Central America. It was also in exile

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that many clinicians brought new ideas to places in the world for the most part untouched by trauma and terror. For instance, in Copenhagen, a program for torture survivors, refugees and immigrants was established in 1985 by Chilean refugees that has maintained the political viewpoints of its founders.

Relegated to a footnote in Hollander's study is Ignacio Martín-Baró, a social psychologist and Jesuit who lived in El Salvador. Martín-Baró studied, wrote, and lectured about the social-psychological effects of terror, and his work has been influential and well-regarded because of the groundbreaking analyses he made about the relationship between political violence and its collective psychological effects. Choosing not to go into exile, Martín-Baró was tragically assassinated in 1989 (along with seven others) by a military battalion that was trained by the United States.[3] Martín-Baró continues to be revered as a martyr, and his intellectual contributions to psychology as well have inspired other professionals and activists working with survivors of political violence.

Hollander uses the term "liberation psychology" as an umbrella term for the different radicalized psychologies she documents. She notes that this term was originally coined, in fact, by Martín-Baró and is a spin on the phrase "liberation theology." The subtitle of her book, *Liberation Psychology in Latin America*, suggests a comprehensive account of radicalized psychologies encompassing all the disparate countries of Latin America. However, the history of psychoanalysis and psychology she portrays is limited to the Southern Cone, where psychoanalysis in particular played a stronger role in bourgeois life than it did in Central America. The political violence that occurred in the Southern Cone also took on particular forms that were similar to, but also distinctively

[3] For a view of his work, Hollander recommends Aron and Corne (1994).

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different from the types of political violence that appeared in Central America. Because of the diverse and distinctive national histories in Latin America, it is somewhat misleading to generalize as both Hollander and I have done to call this trajectory "Latin American."

Indeed, Søren Jensen explained to me that when he and Inger Agger did research on their book about Chilean mental health professionals, the clinicians they interviewed objected to Jensen and Agger's idea that there was something called the "Chilean model." Likewise, I am sure that Danish clinicians would deny that there is something called the "Danish model" of torture treatment. Thus, the four-trajectory schema I have created in this chapter probably imposes a more homogenizing order on a reality that may be conceptualized differently by the people who actually are working in the field.

Nonetheless, there were some important contributions that the "Latin American" mental health professionals made to the field of torture treatment. They developed psychoanalytic conceptions of what happens on a collective level to people living in regimes of terror, thus expanding theory outside the narrow focus of individual experience. They also pursued analyses of the transference and counter-transference issues that frequently appear during treatment with patients who have been tortured or who have otherwise suffered from political violence. Because of the circumstances in which they worked, these clinicians also developed non-traditional practices. They used legal testimony as a therapeutic tool, gave ongoing clinical support to political groups such as the Mothers of the Plaza de Mayo, and also traveled to patients' homes and other meeting places to have clandestine sessions with individuals and groups. These clinicians

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also were aware of the destructive group dynamics that may occur within mental health organizations that provide treatment to victims of political violence.

Although the Latin American torture treatment trajectory has had an evident impact on the directions of current clinical practice and research in the United States and Western Europe, its significance is not always apparent by surveying the literature published in English in the field. This may be due to several factors: much of the literature has not been translated from Spanish into English; the historical and cultural conditions under which resettlement countries are providing treatment are very different from those out of which emerged "liberation psychology;" many mental health professionals are not receptive either to Marxism or psychoanalysis, and; Latin American clinicians did not have the resources, nor perhaps the intention, to widely disseminate and reproduce their approaches.

2) Refugee Resettlement and Mental Health

The second trajectory forming the torture treatment field, "Refugee Resettlement and Mental Health" has been centered primarily in Australia, the United States and Canada. As these countries have historically allowed significant influxes of immigrants and refugees across their borders, refugee management has become a highly developed governmental system. Here I will focus on the American system, where refugee resettlement involves the coordination of many different agencies, both state and private, in a process that frequently begins in refugee camps in a "second country" of settlement, or in countries adjacent to or near the country of conflict from which victims have fled. Representatives from the United Nations (UN), with the aid of other governmental agencies and non-governmental organizations (NGO's), are responsible for screening

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refugees and making the necessary legal arrangements with the Immigration and Naturalization Service (INS) and other governing bodies. When all the paperwork is filled out and sponsorship agreements made, the selected refugees then embark on the journey to their "third country" of settlement.[4] When the refugees arrive, they are then processed through the domestic resettlement apparatus. In the United States, the official refugee resettlement process usually ends when refugees have exhausted their resettlement entitlements after about one year or so. Individuals who have received political asylum after escaping to the United States illegally, therefore bypassing the officially designated refugee system, may also become part of the refugee resettlement apparatus when they are legal.

In the United States, resettlement services such as assistance with housing, medical care, job training, English classes, and dealing with the INS, are delivered by private agencies contracted by the federal government called Voluntary Assistance Groups (VOLAGS). Some of these agencies are large national agencies, frequently religious organizations, such as Catholic Charities and Lutheran Family Services, with local branches located throughout the United States and abroad. Others are locally based mutual assistance programs. "Mutual assistance program" is a technical and legal term for organizations that are peer-run, civic associations, refugee- or ethnically-based, where more than fifty percent of the representatives on the board are from that peer group. The thrust of these different types of resettlement agencies has been to deliver concrete services that are intended to enable refugees to assimilate and become productive citizens in their countries of resettlement.

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[4] Some refugees may even have four countries of settlement.

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Caseworkers in resettlement agencies may be refugees themselves and, like social service caseworkers in general, are often low-paid and responsible for large caseloads of clients. They are not clinical professionals, and usually have minimal education or prior training. During periods when large numbers of refugees need to be processed through the resettlement system, which happened, for example, several years ago during the Kosovo crisis, the already limited resources these agencies possess can be greatly strained, and the caseworkers are prone to becoming overwhelmed and burned-out. Recruitment and retention of refugee resettlement caseworkers can thus be a concern for these agencies.[5]

This trajectory of torture treatment, like the "Latin American Psychoanalytic," is political in the sense that its service providers are sensitive to social injustices—those injustices faced by refugees in the process of "adapting" to countries of resettlement. Caseworkers in this service arena are aware of the kind of political, economic and social obstacles such as racial discrimination, lack of affordable housing, language barriers, availability of jobs and so on that make it extremely difficult for many refugees to become securely established. Further, because refugee resettlement workers need to be well-informed about refugee entitlements and also INS law and procedures, they are familiar with government bureaucracies and also the conservative anti-immigrant, anti-refugee laws and arbitrary practices that characterize the contradictions of American humanitarianism. Some resettlement workers have taken on a visible advocacy role, and have politically organized to protest injustices in the system by lobbying local and national governmental authorities for INS reforms.

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[5] With the events of 11 September 2001, the United States suspended filling its yearly refugee quotas. Many refugee resettlement workers have been let go because of this.

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More recently, the refugee resettlement trajectory has taken a distinctly psychological turn by focusing on the special needs of refugees who have "suffered extreme experiences of torture and trauma" (Aristotle 2000). It has been argued that because of experiences of extreme violence, certain individuals may exhibit debilitating and intractable symptoms of traumatic stress that should be distinguished from the usual "adjustment" problems seen in the refugee population. This subgroup of individuals, it is posited, require the intervention of specialized expertise. There have been, therefore, extensive efforts to link more traditional resettlement practices with mental health services. In the United States, the Office of Refugee Resettlement established a special program, the National Technical Assistance project, which is mandated to train refugee resettlement workers and others who deal with refugees to recognize signs of severe traumatization and to put referral networks in place to assist these individuals (ORR 1999).

On the one hand, proponents of making mental health a higher priority in the U.S. refugee resettlement system have argued that their movement recognizes forms of suffering that had been previously ignored in the refugee population. This movement also acknowledges that refugee resettlement caseworkers may experience vicarious traumatization because of the intensity of their work with traumatized clients, and that they too should receive special services to protect their mental health. On the other hand, opponents of the refugee mental health movement have argued that it "medicalizes" social problems. They have expressed concern that the concrete and material realities of refugee life in the resettlement process may become less important than psychological conditions and past traumas. These opponents have also observed that the "expert"

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knowledge produced on refugee mental health has emerged out of clinical work and research done on trauma by psychologists, psychiatrists and other mental health professionals, and not from the work of refugee resettlement workers who have been on the front-line in providing services to this population. From their perspective, expert knowledge about trauma is a production of elite, armchair doctors whose goals devalue the knowledge of the refugee resettlement caseworkers and their professional status.

The refugee resettlement and mental health movements have contributed a distinctly culturally-sensitive approach to service provision in the broader field of torture treatment. This trajectory has also provided models of community-based care. (Aristotle 2000, Morris and Silove 1992, Reid and Strong 1987, Canadian Task Force on Mental Health Issues 1988). For the clinicians working in more "medical model" settings such as those which will be discussed in the next section, the refugee resettlement trajectory has also helped to foster the development of an approach that is both psychological *and* social, or "psychosocial."

3) Danish Medical Model

Compared to the "Latin American Psychoanalytic" and "Refugee Resettlement and Mental Health" trajectories, the Danish model is distinctly medical. Historically, this trajectory finds its roots in the early 1970's when Amnesty International (AI) enlisted a group of medical doctors to aid them in their efforts to document torture. According to Inge Genefke, a Danish neurologist, she and other volunteer doctors from Denmark were some of the first physicians to firmly establish a relationship between the medical community and human rights activism. Genefke and other doctors performed examinations of torture survivors to verify that these individuals had in fact been tortured

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and then later began to provide treatment for them. The first group of torture survivors the Danish medical group treated consisted of Chilean refugees who had fled to Denmark, and Greek torture survivors who were residing in Greece. From these first efforts, in just a matter of a year, the AI medical group expanded to include approximately 4,000 doctors from 34 countries (Genefke 1986).

From documentation of torture methods and the physical and psychological effects of torture, the focus shifted toward "rehabilitation" of torture survivors. In 1979 Danish physicians in Copenhagen founded a small treatment program at Rigshospitalet, the university teaching hospital. Shortly thereafter they obtained accommodations in a new building separate from the hospital, becoming an autonomous program specifically designed to rehabilitate torture victims: the Rehabilitation and Research Centre for Torture Victims (RCT).[6] Established in 1982, the RCT became one of the first treatment centres in the world that specialized in torture treatment, along with centers in London and Toronto[7] which were also formed by medical groups affiliated with AI. All of these programs received some money from government agencies and the United Nations Voluntary Fund for Torture Victims, but their existence depended mostly on private funding.

The RCT was dedicated to promoting itself as a standard for other centers and took a leading role in getting funding for and developing similar clinically-based centers around the world. The doctors and other clinicians at the RCT made extensive efforts to

[6] In the late eighties, the RCT was divided into two divisions that were to function separately, but in reality did not. One division was devoted to international advocacy, publishing and creating new treatment centers (IRCT) and the other to domestic clinical practice (RCT). In this discussion, to avoid the confusion and distraction of too many acronyms, I will usually refer to the two organizations as the RCT unless it seems crucially important to distinguish them.

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claim their expertise in treatment, research and advocacy internationally, and both Inge Genefke and the RCT possess almost global brand-name recognition in the field of torture treatment.[8] The clinical rehabilitation model has been replicated across the world, including in the United States as seen for example in New York's "City Hospital" program for survivors of torture.

Many of the centers began with a narrow and specific objective (especially if they were receiving funding from the UN Voluntary Fund for Torture Victims), which was to treat torture victims who were defined according to the UN definition of torture. The Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment of 1984 (IRCT 1999) states that

> For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful.

Thus, the torture survivor seen in many of these centers, especially in the early 1980's, fit a general profile: usually a male, often in his 20's or 30's who had been imprisoned or otherwise interned, usually by his own government, and subjected to different forms of

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[7] These are the Centre for Victims of Torture (CVT) and the Canadian Centre for the Rehabilitation of Victims of Torture (CCVT) respectively.

[8] In the course of my research I found that the RCT and its clinicians were referenced in the torture treatment literature, and in the popular press, innumerable times. The ubiquity of the RCT presence had both positive and negative connotations. For citizens in Denmark, the RCT became a symbol of Danish humanitarianism. This was true also for some clients in other countries who received services from RCT-affiliated programs. For many clinicians within Denmark and also clinicians in other areas of the world, the RCT came to represent cultural imperialism and arrogance.

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torture—from beatings to electrocution to isolation. Many of the torture victims seen by the original Danish group were, not surprisingly, also political activists. Over time, however, the client profile has changed and expanded to include non-political civilians who have been traumatized by war or low-level conflict. The more inclusive client population encompasses any survivors of refugee trauma or collective violence, and not just victims of the UN definition of torture. Yet, certain donors still insist on restricting their funding to torture survivors.

Medical-based torture treatment centers are usually centralized, meaning there is one specific site that clients go to for treatment. If the center is hospital-affiliated, on-site medical examinations, physical rehabilitation and referrals to specialists will be made. If not hospital-affiliated, most centers concern themselves with rehabilitation of the psyche, and provide individual, group and family psychotherapy. Psychotherapy is conducted in the therapist's office, and therapists rely on mainstay approaches such as cognitive-behavioral therapy, psychodynamic approaches, and family systems therapy. Over the years, most of these centers found that they also had to offer some kind of assistance, or at least referrals, for legal matters, housing concerns, food stamps, and so forth. Medical doctors and Ph.D.'s often establish and direct these centers, and the staff usually consists of highly-trained and certified psychotherapists and physiotherapists. At hospital-based centers, medical residents and interns, and clinical psychology interns, may provide medical care and psychotherapy to clients to fulfill training requirements. Few staff are 'lay people,' like the caseworkers who work at refugee resettlement agencies, except for administrative staff. The professional qualifications of the staff depend, however, on the particular program and the kinds of services provided.

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Some of these centers and their leaders have assumed a high public profile. They have come to dominate academic or professional conferences and authorship of publications in peer-reviewed journals and edited volumes. Media coverage of the field of torture treatment almost inevitably focuses on the most visible and established clinicians and centers in the field, and not on smaller or more experimental programs. Many of these centers further establish their dominance and visibility through training and educating other professionals who may come into contact with torture survivors, such as refugee resettlement workers or medical staff in clinics that see a large number of immigrants and refugees. Though these centers have been influential advocates in reforming international and domestic legislation and policy on human rights issues, their basic institutional structures and the professionalization of the field have lent an air of conservatism to their practices. For example, few physicians or psychologists working in one of these centers in Euro-America would ever take the more radical ideological positions of their Latin American colleagues.

4) Psychosocial Programs Abroad

The fourth trajectory in the field of torture treatment consists of the development of psychosocial trauma programs which have been set up in areas where organized violence is taking place, or in "post-conflict societies," rather than in Western countries of resettlement.[9] This form of intervention has stirred up the greatest controversy of the four torture treatment trajectories described in this chapter, and deserves its own proper study.

[9] Community-intervention models for dealing with trauma have also appeared in South Africa post-apartheid. These programs have not been exported but were locally developed by domestic mental health workers. Nevertheless, their development was made possible by transnational flows of information, knowledge and training about trauma-based interventions.

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As a precursor to the early-and mid-1990's creation of psychosocial programs abroad, the RCT established RCT-affiliated torture treatment programs all over the world, as was mentioned above. According to a 1996 report that the Danish Ministry of Foreign Affairs prepared on the RCT and its sister organization, the IRCT, the program "supports activities in more than 50 countries and has a yearly turnover of more than DKK 20 million, which constitutes 2/3 of the total turnover of the RCT and the IRCT." [10] A typical program, for example, was the one established in Kuwait during the Gulf War that was staffed by Danish psychologists from the RCT and Kuwaiti mental health professionals trained by them. It was modeled after the structure and practices of the RCT in Copenhagen, as were many of these RCT-affiliated programs. Critics of the RCT exportation model have claimed that the underlying goal seemed to be empire through global mass-production of centers, with no regard to local conditions or recognition of the possibility that humanitarianism could also be a form of imperialism. Today, the picture at the RCT has changed, mostly because of harsh criticism leveled by mental health professionals in Denmark and elsewhere regarding the RCT's imperial ambitions. Furthermore, a series of critical evaluations that were conducted by the Danish government about the RCT's strategies, institutional structure, and use of funds forced the RCT to reevaluate its whole export model strategy. Today, many reformations in the organization have modified the relationship that the RCT has with its affiliated centers. However, many of the original RCT-affiliated programs continue to function and also have maintained a supportive relationship with the Copenhagen center.

[10] With December 2002 exchange rates, that would be 2,825,820 USD.

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The RCT export model has positively influenced the kind of psychosocial model of intervention that dominates the field today, mostly in terms of the lessons learned from its weaknesses.

Agger and Mimica (1996) claim that in 1991, international psychosocial assistance was inaugurated when the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and the United Nations High Commissioner for Refugees (UNHRC) began making recommendations about the necessity for addressing mental health issues of displaced and traumatized people. [11] According to several sources,[12] these recommendations were fueled by the work of European and American feminists, journalists, and celebrities[13] who publicized the plight of Bosnian women raped by Serbian soldiers during the Bosnian war. The widespread use of rape as a weapon in this war shocked and outraged the Western world, and aid money began pouring in specifically for helping the scores of rape victims cope with their trauma.[14] NGO's were created to manage donor money, and programs to help these women were implemented. As the war continued, three developments led to the transformation of these programs.

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[11] Agger and Mimica published a report (1996) based on an evaluation they conducted that provides a history of psychosocial assistance and humanitarian aid in the former Yugoslavia. See also Agger, Jareg, Herzberg, Mimica and Rebien's 1999 evaluation that provides further background and description of psychosocial programs abroad.

[12] This includes individuals who work in the field of humanitarian relief with whom I had personal communication and also reports generated by Agger and her colleagues (1996, 1999) cited above.

[13] One individual who was providing humanitarian assistance at the time recounted a story to me about the former wife of a famous aging British rock star. This celebrity flew into Bosnia during the war to help the cause of women who were raped. Her demands for comfortable accommodations, chauffeuring, and other special privileges reflected how self-serving celebrities, political causes, the media and humanitarian crises can be linked together.

[14] It was suggested to me by a few sources that the numbers of women raped were widely exaggerated by Western fact-finders and media. One clinician reported to me that the originally estimated 60,000 women who were raped was more likely about 1,000-2,000. This is not to say that rape did not occur as a widespread strategy of war in Bosnia, or that women's suffering, which is all too often rendered invisible,

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First, it became clear that for various reasons, many of these women were not interested in receiving psychological treatment in the form of individual and group psychotherapy. It became evident that "psychological needs" were perhaps not perceived in the way Western donors had imagined, and that programs needed to consider providing other services or interventions to address those needs, or other needs entirely, to ensure the continuation of their funding and survival. Second, outside NGO's observed the success of existing community-generated cultural programs, and began incorporating those cultural strategies into their own programs. For example, theatre and sports projects were popular cultural projects that became psychosocial "interventions" when adapted by the psychosocial assistance model. Third, it was discovered that rape victims were not the only people traumatized in this war: many men, children and families were traumatized as well. Psychological approaches did not need to be eliminated, but could be expanded to include a wider range of clients. The programs therefore transformed to help men, women, children, and families address both psychological and social needs.[15]

The Bosnian war paved the way for today's routine implementation of psychosocial programs during humanitarian emergencies. Typically, psychosocial

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should not be made visible, but that even liberal media and political interests influence how wars and suffering are represented.

[15] Claire, one of the Haven casemanagers, described to me the humanitarian work she had done in Iraq, Rumania, Rwanda, and Bosnia. She told me, "We didn't even hear about 'trauma' or PTSD until 1994 or so in Bosnia. Before, people talked about 'emergency needs,' and there was not so much business talking about psychological needs. The debate at that time was about emergency aid versus development." Prior to the infiltration of all the outside trauma groups that came into Bosnia, Claire explained, the people of Bosnia "organized themselves to resist;" they had what they called "mental resistance," and spontaneously created schools, sports clubs and cultural events, and met with each other in people's homes. This "work saved them," Claire said. She described how some people would walk miles without food just to teach an underground class. Claire knew actors who continued to perform, and theatre projects that carried on while the Sarajevo was besieged. According to Claire, at a certain point the "outside groups started coming in, the NGO's started coming in, copying these groups, adding PTSD and trauma." The Bosnians who did not flee and the grassroots organizers of mental resistance were "tired, exhausted. They were eager to accept·

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programs are either funded by international NGO's or by international governmental bodies, such as the Norwegian Ministry of Foreign Affairs.[16] Usually, these programs try to make links or establish "partnerships" with local NGO's, and if possible, the local government, in the "host" country. However, in some cases it does appear that humanitarian, development, and democracy-building projects create a web of governance that is more international than local.[17]

Although the emphasis on either "psychological" or "social" services in the psychosocial hybrid may be slightly different depending on the program, a basic premise connects them: people, collectively and individually, are "traumatized" by their war experiences and require some combination of mental health services and social support, in addition to receiving standard humanitarian aid such as food and medicine. It has been argued that in the past, humanitarian aid initiatives for complex emergencies overlooked the extreme psychological trauma of the beneficiaries. Food and medicine were not enough to address suffering and the extreme psychological devastation that can accompany war. By not addressing the psychic wounds of the communities, it was thought these efforts were not as effective in both the short-term and long-term as they could have been. Thus, it is now believed that intervention into psychic damage is a requisite condition for rebuilding the society in the present, and also for preventing violence from occurring again in the future, but that it might not be appropriate for these psychological interventions to take the traditional form of Western psychotherapy. In

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funding. So then the locals started implementing more programs, psychosocial programs. Sometimes even the best and the brightest were co-opted, some people even took the money to finance their departure."

[16] Other organizations include the IRCT/RCT, the International Rescue Committee (IRC), Médecins Sans Frontieres (MSF), USAID, UNICEF, and International Organization for Migration (IOM).

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addition to some form of psychological intervention and cultural projects, psychosocial programs frequently include education projects about human rights, conflict-resolution training, and community-building activities.

Since the war in Bosnia, psychosocial trauma programs continue to appeal to donors and large sums of money have gone toward supporting them. [18] Some critics of these projects whom I interviewed suggest that their proliferation is donor-driven. By this it is meant that psychosocial programs have developed not because there is a "need" for them, but because the availability of funds drives their production. Individuals and organizations, whether international or local, tend to seize opportunities for funding by developing proposals to fit donor criteria and then constructing programs to legitimate the need for them. Whether or not this is true in this case, donor-driven programs are not a new problem, nor are they specific to this particular field. International NGO discourse includes the slang acronym, "DDNGO," or "donor-driven NGO."

Individuals working within the international aid community have also questioned the way in which some programs are established willy-nilly without conducting a proper "needs assessments" first, "program evaluations" at the end, or having "sustainability" or "capacity-building" plans for the "beneficiaries" or "shareholders." [19] These critics are not opposed to the programs per se, but feel that many of these programs are being established without the proper strategic planning or professional expertise that would

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[17] The ruling elite of the countries receiving aid usually manage to establish and run the local NGO's that "partner" with the international NGO's, thus maintaining existing power structures.

[18] I have also heard mentioned that the priority given to helping the average person who has been "traumatized" has been at the cost of neglecting the chronically mentally ill--psychiatric patients who were hospitalized or schizophrenics living in the community in areas like Bosnia. These people have been forgotten and have had to survive under deplorable conditions.

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enable these programs to be successful. These programs, it is believed, are being run irresponsibly and without the kind of rigor or accountability that are demanded in today's international NGO market. However, conducting needs assessments and evaluations are not enough to ensure responsible professional conduct. During the Kosovo crisis, an army of NGO's descended upon the populace to provide trauma-related psychosocial support. These groups were poised and ready to go at the first hints of conflict.[20] It was reported to me by one psychiatrist that as many as two hundred psychosocial projects were initiated, and that international NGO workers from the different projects were aggressively conducting needs assessments with the local communities. Some Kosovar war victims were interviewed numerous times by different NGO's during that frantic needs assessment period. Evidently, the different NGO's withheld information from one another in this process, driving the competitive fervor for dominance in the psychosocial field to an even greater pitch.[21]

Summerfield, who was introduced in the previous chapter, writes critically about the rapid emergence and reproduction of the psychosocial model of intervention in the cases of Bosnia, Croatia, and Rwanda (1999). He uses the evaluations produced by Inger Agger and her colleagues, which I have cited in this chapter, as a device to reveal unexamined Western assumptions that underlie the psychosocial model, and to warn

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[19] These "critics" include mental health professionals both in the United States and Denmark I interviewed for this study, or whose books and articles I have read, such as contributors to a collection edited by Bracken and Petty (1998), and Derek Summerfield.

[20] This assertion reflects the views of several informants but is also confirmed by the timing of the NGO services.

[21] These kinds of estimates and also descriptions of what goes on in the field are often produced by people who have major interests at stake and are within the field themselves. It is quite possible that some of this information may be exaggerated, but I think also that there is a definite and wide-spread expansion of psychosocial intervention taking place that is inseparable from power, politics and corruption.

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about the possible destructive social implications of the widespread application of biomedical interventions in the context of war. Similar to Summerfield, some informants for this study have observed that Western mental health experts sent to complex humanitarian emergency situations often have a superficial understanding of local cultural, social and political conditions and lack professional experience in dealing with crisis zones. For instance, during the wars in Bosnia and Kosovo, clinicians from the West, whose only professional experience with war trauma had been in treating patients within Western medical-model settings, traveled to those areas and gave crash-course trainings to local professionals and lay people on "trauma." The clinicians taught the locals about PTSD, debriefing, the sequelae of trauma, and intervention techniques, and then returned home. Presumably, these clinicians met a "need" and fulfilled a humanitarian goal, but people with whom I spoke who were critics of this de-contextualized approach question its cross-cultural relevance or value in crisis situations where other needs may be more urgent. For the clinicians, these training experiences were exciting and rewarding, but the true benefits for war victims is questionable. The self-serving aspect of some of these interventions was magnified when some of these clinicians, upon returning from two-week stints "in the field," then claimed to be "experts" on humanitarian issues and war trauma.

It is not necessarily the case that mental health aid is not desired or accepted by local recipients of service, as even Summerfield points out (1999). War victims and host countries are often desperate for any kind of assistance, at least initially, and wish to have the involvement of Western powers in their crises. However, they may not have much choice in terms of what aid they receive, so they may end up receiving mental health

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interventions whether or not they ask for them. Nonetheless, humanitarian aid workers have observed that local recipients usually creatively transform whatever help they get and use Western resources in unintended ways.[22] As a professional from the RCT explained, "People adapt programs to their setting and actually do what they want. The donor cannot always know what people are doing. If it were just some kind of simplistic transplant or system export model, these programs just couldn't succeed." Further, local mental health professionals who have not fled their countries may feel grossly unprepared for and overwhelmed by the mental health needs of their suffering compatriots. These mental health professionals already assume the biases and epistemological truths of Western psychiatric knowledge, and readily embrace the PTSD and trauma training and professional support that is offered to them. It is precisely those types of Western psychiatric interventions which are hungrily accepted by local mental health professionals that are the basis for critique by liberal Western mental health professionals.[23] Kleinman (1980:32) speaks to the irony of this situation and how the

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[22] Fokko de Vries, a former coordinator for Médecins sans Frontieres-Holland and a consultant for the European Humanitarian Office (ECHO) in Bosnia, wrote in the *Lancet* that psychosocial assistance was offered to "the Bosnian Serbs, but Ljiljana Karadzic, wife of war-crimes suspect of Radovan Karaddzic and self-appointed president of the non-recognised Bosnian Serb Red Cross, turned down the offer by saying, "We Serbs don't have mental health problems." Dictatorial regimes don't like mental health programmes which are perceived as a threat" (1998). This quotation comes from an essay that was a response to a letter Derek Summerfield wrote (1997).

[23] This is a generalization. Each local setting produces a different set of relations between the imported psychological expertise and international humanitarian aid apparatus with local communities. For example, one informant told me that it was

> "deeply offensive to a Yugoslavian psychiatrist to be told he wasn't Western. If a British or American came in and said "don't you feel sort of invaded by these Westerners coming in with all their Western methods?" they would feel very angry because they consider themselves Western. They are reading the same [material]. They are having some difficulty getting ahold of some books right now because of their financial situation but they read exactly the same books and in many ways in the psychological field they are much advanced in psychoanalysis than the Danish are, for example. They are very close to Vienna and Italy so this whole tradition in central Europe and the Austro-Hungarian influence is strong. And at the opposite the Yugoslavian mental health professionals say "Look, we are not black, we are not Africans." Actually that was not a nice thing to say, it was very racist. Because they consider that [to be African or non-Western] to be

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"bias of many health professionals in developing societies" is to "[copy] am idealized model of professional care in technologically advanced societies." Summerfield too discusses how non-Western mental health workers "look to the West for peer group fraternity and approval, and for possibilities for academic publication and further education. They see their familiarity with the dominant frameworks and concepts as a basis for their professional standing and credibility. This may put them nearer to Western colleagues but further from the communities they serve" (1999:1558). Thus, it could be argued that the exportation of Western mental health interventions may appear to benefit the communities to which they are directed insofar as they are accepted by local mental health professionals, yet ultimately they only serve the professional interests of elite groups, therefore reproducing power differentials and failing to benefit the target population.

Western mental health interventions and the establishment of psychosocial programs may also provide the foothold and impetus for reform of psychiatric practices and the establishment of a community mental health infrastructure in war-torn countries. For instance, it may be the case that because of few resources, or certain cultural and social conditions, less "humane" or "antiquated" psychiatric techniques, such as confinement, physical restraints and heavy sedation, could be changed with outside support and training. Because certain practices are indigenous or local does not necessarily mean they are "good."

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something very inferior. They felt bad about this whole invasion of aid projects in the way they felt it violated their pride or something like that. They had been a highly developed country before the war and never needed to ask anybody for help. In that way the projects were insensitive but not the methods."

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Conclusion

In the past twenty-five years, global flows of professional experts, scientific knowledge, and clinical practices in torture treatment and refugee mental health have formed complex networks of transnational exchange. I have presented evidence in this chapter to show that psychological and psychiatric discourses that frame and define events as "traumatic" are spreading globally and shaping the range of possible responses to certain events and providing a ground on which people can experience and make meaning of these events for themselves. However, as Breslau (2000) observed in his work on the globalization of psychiatric responses to disaster, the globalization of a transnational discourse does not erase difference through "homogenization" but rather forms specific junctures at which the local and the global are constitutively linked. At these junctures can be seen the reconstitution of cultural identities, the framing of historical events in specific ways, and the reconfiguring (and also reproducing) of relations of power (Ibid). Caution should therefore be exercised so that the kind of homogenization that is being criticized is not simply a product of a critical discourse that homogenizes and totalizes.

The torture treatment field that continues to shift and change today has emerged from the different ideologies, practices, theories, and institutional structures that were largely defined by the four trajectories described above. In the next chapters, the Haven's community-based, psychosocial model of intervention used in New York City and the approaches in various programs in Copenhagen will further suggest how locally situated practices have emerged from, and also have contributed to transnational flows.

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Chapter 2:
A Comparative Analysis of Programs in the United States and Denmark

Introduction

In the last chapter I provided a broad overview of four different trajectories of expert knowledge that have contributed to the formation, and have in turn been formed by, institutions such as the Haven or the RCT and the individuals who work in them. The present chapter will first look at the recent historical and political contexts in Denmark and the United States in regard to humanitarian aid, refugees and asylum seekers. I will then describe the RCT, the Haven, and several torture treatment programs in Copenhagen to provide a closer look at different institutional structures and to compare practices within their respective national contexts. This discussion will furnish a more finely detailed perspective on the trajectories that were described in the previous chapter, and also provide background material for discussions in coming chapters.

The research methods I employed in the United States and Denmark were slightly different, and as I mentioned in the Introduction, produced plural forms of data. I did not spend the same amount of time at the RCT or at other torture treatment centers in Copenhagen as I did at the Haven, nor was I integrated into their everyday clinical and institutional activities to the same extent. The data I gathered in Denmark were primarily from interviews and discursive materials. From research in New York I have at my disposal a mixture of data from observation, interviews, texts, and first-hand experiences. Further, the RCT and other Danish programs were in existence long before I visited them, while I had contact with Ed and the Haven since that program's infancy.

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Part I: Denmark and the United States: Humanitarianism, Refugees and Asylum Seekers

Humanitarian Boulevard

Upon arriving in Denmark, I conducted my first clinician interviews with Marlene, a psychologist, and Brigit, a physiotherapist. They both worked at a small torture treatment program. I was still rather disoriented from the time change and being in a new place. I had absolutely no mental map of Copenhagen, and was desperately in need of advice about how to make further contacts for my research. After our interview in the charming apartment-like office space where clients are seen, Marlene and Brigit helpfully gave me ideas and leads, both mentioning that their program was only one of several human rights NGO's on that particular street. After Marlene told me that the RCT was one of those NGO's, Brigit made an ironic comment about "Victims Street" that led to this exchange:

Marlene: Or Care of Victims Street.

Kelly: Or Torture Street.

Marlene: Or Solace Street.

Brigit: Or the Consolation Street.

Marlene: Borgergade means citizen, so Citizen's Street also works well.

I was thus introduced to the street nicknamed "Humanitarian Boulevard," Danish hospitality and humor, and the torture treatment community in Copenhagen, the capital of Denmark. With a population of less than 1.5 million people and proportionally few immigrants or refugees, in 1999 Copenhagen had 5 torture treatment programs, and one of them, the RCT, was one of the first of its kind in the world (Bendure and Friary

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1999:115). The RCT also has a branch in Jutland, the peninsula that directly connects Denmark to the land mass of Western Europe and a region which is slightly different culturally than Zealand, the island where Copenhagen is located. Thus in a small country of approximately 5.3 million people, where only 4.5 percent of the population is comprised of foreign nationals, there are a total of six rehabilitation centers for torture survivors, or one for every 883,333 citizens (Ibid: 32).

According to U.S. census data, New York City has a population of over 8 million people, 35 percent of whom are foreign born. Yet it only has two psychosocial programs for survivors of torture and refugee trauma, the Haven and City Hospital. Both of these programs were established nearly fifteen years after the RCT. There is also a human rights clinic that provides medical and psychological examinations and evaluations for asylum seekers. It is not, however, a rehabilitation center. With the U.S. population now standing at 290,133,273 people, there are approximately twenty-five torture treatment centers in this country, or about one center for every 11,600,000 people (U.S. Census Bureau 2003). These centers are located in cities including San Francisco, Boston, Chicago, Los Angeles, Denver, Eugene, Baltimore, and Dallas. Peter Dross, the deputy director of the Center for Victims of Torture (CVT) in Minneapolis estimated in 1996 that 200,000 to 400,000 survivors of torture were living in the United States, and "that as many as a third of those who seek political asylum in the United States each year are torture victims" (Goleman: 1996). In 1998, there were claims that 500,000 torture survivors reside in the United States (U.S. DHHS: 1998).

In 2000, Denmark contributed 9.36 USD per capita to international refugee aid agencies, ranking it only second to Norway. The United States, by contrast, spent 1.40

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USD, ranking it 9th in the top twenty contributing nations. In terms of actual dollars spent on contributions, the United States ranks first, spending 387.1 million USD, whereas Denmark spent 49.6 million USD per year ranking it 9th (U.S. Committee for Refugees 2000). Americans can boast about their largess because of the size of the contributions they make, but Danes would argue that the true measure of humanitarianism is based on per capita spending. Whether or not either country can claim moral superiority in this case becomes less relevant when one considers some of the other policies both countries have embraced regarding refugees or political asylees within their borders.

Denmark

Denmark closed its door to immigration in the early 1970's, but a small number of refugees and asylum seekers continue to be resettled there each year. The numbers remain quite low, however, and even with the additional numbers of "guestworkers" who immigrated to Denmark in the 60's from countries such as Turkey and Pakistan, "[f]ewer than 5 percent of Denmark's 5.3 million people are foreigners, a smaller proportion than in many European countries" (New York Times Editorial: 2002). Many immigrants and refugees have been ghettoized in special housing projects, and the labor market remains stratified by race or whatever other markers signify the subordinated other to ethnic Danes. It has been extremely difficult for ethnic minorities to fulfill any dreams they may have of upward mobility or equality in Danish society (Nordisk Ministerräd:1996; Hummelgaard et al:1995; Jeppesen 1995). As an asylum seeker from Mauritania described to me:

> Yeah, it's not a very kind country in Denmark. I don't think so. I feel that it's not very open. It's not very open compared to other countries where you have a mixture of people and cultures. But here there is the pure race and they have to stay that way. You are out and you are always out. Even if you are a citizen it's like "he is not a Dane." It's difficult,

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you know I think about it, I think about myself and if I stay here in this country and what will happen to my children if I have children, they will never be Danes. So it is difficult to say, OK, I will live this way, I am going to live in this country. You will still be a foreigner after fifty years and so will your children if they are not white...

Refugees who come into the country through the UN quota system, of which in the year 2000 there were 464, are immediately entered into the Danish resettlement or integration system (U.S. Committee for Refugees 2001). Persons seeking political asylum are managed by the Danish Red Cross, which is contracted by the state to run refugee camps. In 2000, 10,077 individuals filed applications for asylum (Ibid). Asylum seekers are first detained in Sandholm, a central camp or "receiving center," where they are basically imprisoned, interviewed and observed before being transferred to one of several refugee camps, some of which are called "refugee villages," located throughout the country. I visited Sandholm, took a tour of the grounds including the military-like dorms and small school there, and interviewed two Red Cross workers.[1] Despite the concertina wire around part of the facility, and the starkness of the camp, the asylum seekers are allowed to come and go as they please as long as they obey certain curfews. The grounds are well-kept, families are kept together, and the workers seem kind. By law, the asylum seekers should be processed out of Sandholm within fourteen days because it is supposed to function as a screening and processing center, and not as a residence. Some cases took much longer than the fourteen days, and on average the length of stay was about a month.

While living in the assigned refugee villages or camps, political asylum seekers receive a small allowance which allows them to take public transportation, visit friends,

[1] Because of some sensationalized press that cast a negative light on the asylum seekers rather than the detention center, as well as criticisms the center encountered from more liberal constituencies, the state and the Danish Red Cross tightly regulate Sandholm's communication with the media and other outside agents. I did not learn until I was at Sandholm how my visit there was exceptional, and that rarely do they let outsiders inside unless on official business. I noted that a large sign was posted rather ominously right

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go shopping, or, if they are in a camp within commuting distance, travel to the Kultur Hus in Copenhagen, a special cultural center for asylum seekers.[2] The Danish Red Cross provides these individuals with medical care and psychological care, and educational and recreational activities for the many months or even years it may take for their asylum claim to be processed. However, during this period these individuals are not allowed to work, and basically cannot begin to integrate themselves into Danish society until they receive final word on their cases. These centers came under harsh scrutiny in the 90's when several asylum seekers committed suicide, resulting in a number of reforms. Yet even in 1999, the state punished asylum seekers who committed rule infractions by taking away their modest allowances, but making sure they still ate by allocating them brown bag meals. Nevertheless, the workers in these camps consider the camps "humanitarian spaces," and as employees of the Danish Red Cross, their mission and ideology sometimes oppose those of the Danish state.

In November 2001, Danish citizens voted in a right-wing majority to parliament. This shocked many on the left, as this was the first time since 1920 that the Liberal Party held more seats in parliament than the Social Democrats. What is also significant about this election is that both parties centered their platforms on tightening immigration laws. Both parties were in agreement about a perceived need to crack down on the immigrants who supposedly exploit Denmark's generous social welfare system and who are at the root of social problems such as increases in crime. The Liberal Party promised to immediately change the laws, whereas the Social Democrats made the political misstep

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outside the detention center that prohibited taking photographs inside. Supposedly this was for the protection of the asylum seekers, but it also served to protect the asylum center.

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of taking a more cautious position, saying they wanted to examine the issues further before enacting new policies. It has been suggested that the events of September 11,th 2001 provided the Liberal Democrats with further justification for their harsh immigration platform, ensuring their success (Reuters 2001). At the same time Denmark's borders may have become more porous as a result of joining the European Union, they have also been tightened, barring many whom need refuge from crossing them.[3] Those on the left speak of "Fortress Denmark."

However, social problems that are so prominent in the United States, such as poverty and violence, appear in less extreme forms and with less frequency in Denmark. In general, the Danish state has tried to take care of its citizens' basic needs from cradle to grave, and the citizens have in turn shared this more collective sense of responsibility. Danish citizens might complain about their health care system—the long waits, mediocre care, bureaucratic obstacles and co-payments—but they still benefit from a state ethos that sees health care as a public responsibility (COWI:1996). Daycare is also provided by the state, as is university education. University students are even given a small monthly stipend for living costs while they are in school. The quality of life there for even the most marginalized citizens has been remarkably decent in many respects. To the regret of many Danes with whom I spoke, neo-liberalism's seductive pull, globalization, and a

[2] There is a small underground economy for some asylum seekers that includes organized crime and working under the table. The Sandholm workers reported that there had been some problems at the camp with Bosnian refugee men who were purported to be involved in criminal activities.

[3] I had conversations with a number of Danes who described concern for the ethnic Danish population's falling fertility rate, and expressed the need for fresh labor to support the country's tax base. These individuals said Denmark needed more immigration to prevent labor shortages, and to ensure that they will be taken care of in their old age. If there is a labor crisis, I would imagine that Denmark's doors will probably open to select groups, as they were during the 60's when guestworkers were encouraged to enter the country during its major modernization period.

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significant shift to the political right has changed and continues to change Denmark's once cherished progressive social and political system.

The United States

The United States differs from Denmark in innumerable ways, the most obvious of which is the sheer size of its population and territory. Further, millions of immigrants have come to the United States and been essential to its social and economic success, and though there is a white, European-descended majority, the country does not come close to having Denmark's ethnic or racial homogeneity. In 2000, the United States resettled 72,500 refugees, and recorded applications for 48,054 asylum cases, sizable numbers compared to the much smaller Danish figures mentioned above (U.S. Committee for Refugees (USCR) 2002). [4] However, like Denmark, recent changes in immigration policy have negatively affected refugees seeking resettlement..

In 1996 under the Clinton Administration, restrictive immigration laws were passed that had a significant impact on asylum seekers and other immigrants. These laws were not the product of reactionary conservative forces, but reflected the general conservatism and anti-immigrant sentiment of both the Democratic and Republican parties. One provision under the new law, "expedited removal," meant that asylum seekers without proper documentation who were not immediately turned away at points of entry, such as airports, were now to be mandatorily detained.[5] In other words, they were imprisoned. Furthermore, untrained INS inspectors at airports and other ports of

[4] One asylum case does not necessarily equal one individual. A family can constitute one asylum case. Also, the Clinton Administration had reduced the numbers of refugees accepted into the country from the Reagan Administration's 200,000 down to 70,000 (Benesch and Guerrero 2001).

[5] Cubans who arrive here by plane are not subjected to the expedited removal laws (Lawyers Committee for Human Rights (LCHR) 1999). This report as well as other publications (e.g. Hughes and Liebaut 1997) and

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entry had the right, which had once been granted to judges, to determine whether or not a person had a well-founded fear and to summarily deport that person if deemed appropriate.[6]

Prior to these laws, unless the undocumented group of asylum seekers stopped at borders were considered a danger to the community or flight risks, they were released on parole, but still required to fulfill their obligation to establish legal residency in this country by going through the proper asylum process. Simon (1998) has described the mass detention of immigrants as part of a larger recent trend, where governance for some groups has been increasingly sought through confinement or incarceration. He suggests that this technology of rule may have been intensified as a response to contemporary "flows of global capital and labor" which have become "a challenge to the stability of American cities" (603).

With the enforcement of the 1996 laws, not only were asylum seekers summarily detained, but frequently they were not granted parole even after they "established a credible fear of persecution and are accordingly no longer subject to the expedited removal proceedings" (LCHR 1999:19-20). Although the national INS office produced official guidelines for parole and encouraged local officials to exercise the parole option, it still "...has a long and well-documented history of failing to parole asylum seekers effectively and consistently" (Ibid:23). The lack of enforcement is partly due to the way the INS was structured and the power afforded to district and regional directors. According to Simon,

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numerous newspaper articles (e.g. Tulsky 2001) are available to the public and provide a detailed overview of the laws and their adverse consequences.

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> [t]he district director is a fascinating blend of imperial prelate and local representative to the national government. Although subject to the ultimate authority of the president and attorney general, the district directors retain great discretion regarding how those policies will be exercised. In their exercise of authority they have traditionally sought to serve the needs of local elites (1998:594).

Those asylum seekers crossing national borders in New York have been most unfortunate because the "New York INS district is among the most restrictive in the U.S." (LCHR 1999: 27). In New Jersey, parole was a much greater possibility for asylum seekers until the INS District Director, Andrea J. Quarantillo, decided in 1998 to radically reverse her more liberal paroling policy. One unnamed informant explained the reversal:

> ...after a period of time she cracked down on that and we brought this repeatedly to her attention and finally she said, "I was looking at my statistics and the numbers were going up in my airport and not in JFK, and the implication was that the smugglers were perceiving this as a sieve and this was becoming part of a smuggling ring.

For both New York and New Jersey, in 1999 parole for detainees hovered around 20-25% which was the lowest parole rate in the country (Ibid:27-30).

Detained asylum seekers in the United States are treated like criminal prisoners except they do not even have the rights of criminals. They do not have the "right" to legal counsel and depend on the social conscience of lawyers and other certified professionals to take on their cases, either on a pro bono basis or through an agency that has funding to provide free or very low cost legal counsel to detainees. In addition, the asylum seeker carries the burden of proof, and federal rules of evidence do not apply to them. In a sense, rather than being presumed innocent, the asylum seeker is presumed guilty and must prove his innocence, or need for asylum. And, because detention centers are not really prisons, they also are not bound to the same standards of practice or oversight as criminal

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[6] There is another category of asylum seekers, those who are already in the U.S. and have proper identification. They have to apply for asylum within one year of their arrival in the country, and are not

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prisons (Simon 1998: 579). Yet, the INS contracts private prison corporations to run these facilities. Certainly, private prison corporations, which comprise one of the fastest growing industries in the United States, are not the same as the Danish Red Cross.

I visited the detention center in Elizabeth, New Jersey, several times as a volunteer "visitor" for detainees. I was part of volunteer program that recruited people from the community to travel to the detention centers to befriend and visit a detainee there. At the time, this volunteer program was run by the Jesuit Refugee Service, which provided a van for us to travel there on Saturday mornings. The detention building is completely non-descript, blending in with countless square miles of industrial buildings, thus spatializing the isolation and invisibility of this population. Extensive security measures are observed with all visitors.

The three hundred Elizabeth detainees wore orange jumpsuits, and for the women that meant pants even if this was against their religion. The detainees were punished with solitary confinement for infractions like praying at night when they should be in bed, as was one detainee with whom I spoke. The toilet and showers had open stalls and it was reported that the guards watch while detainees shower and clean themselves (Phipps 2000:22). Medical and dental care was reported to be poor. Detainees could make phone calls only by purchasing outrageously expensive phone cards issued by the prison corporation. Visitors were allowed only on the weekends and only for one hour. Visits took place in a big room, where there was a bulletproof glass partition between the detainee and his or her visitor. Conversation was transmitted through static telephone connections. The detainees were not allowed to go outside but did have "outdoor recreation" in a large room with skylights. While I was conducting my fieldwork, Bible

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detained. These are called "affirmative cases."

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study, English classes and pastoral care conducted by the Jesuit Refugee Service were suspended because the detainees talked about their detention experiences. This was deemed too subversive, according to INS officials. Quarantillo explained that the JRS "broke the covenant that had been reached with the INS." The JRS program, she said "was initiated to provide detainees with a positive outlet for their energies that would not deal with detention issues"(Hedges 2000).

The confusing legal process, made even more confusing by the fact that many detainees do not speak English and must rely on interpreters, was filled with numerous interviews, postponements, delays and sometimes appeals. If at some point the detainee was transferred to a criminal prison, such as the one in York, Pennsylvania because of "bed shortages," the whole legal process would be interrupted and even stopped until a new local lawyer can be found.

Many asylees have claimed that having no time limit on the determination of their fate is like a form of torture. Further, there is no guarantee that they will be granted asylum, and the threat of deportation and perhaps certain death makes the uncertainty almost unbearable. This is true both in Denmark and the United States. In Copenhagen, I interviewed one asylum seeker whose case was in appeal, and whose fate continued to be uncertain after three and a half years. He regretted even seeking refuge in Denmark. A significant number of clients in the Haven program had been detained, some of them for up to two years in local detention centers before they were granted asylum. Others had been detained even longer.

Since 1995, several hunger strikes have been held by detainees in Elizabeth protesting conditions in the center and the parole process. Periodically, detainees resort to

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this tradition of protest, with the most recent protest occurring in January 2003. They have not been alone in their protests, as many human rights-oriented organizations have increasingly applied pressure on the state to reform its practices. The local print media in the metropolitan area, especially the Bergen Record and Newark Star Ledger in New Jersey, have provided continuous sympathetic coverage of refugee and detainment issues.

Post 9/11

I conducted research for this project in 1999 and 2000, never anticipating that something like the terrorists attacks of September 11th would happen which could so drastically change the immigration apparatus in the United States. The system has gone from bad to worse in many respects, a situation that is all the more unfortunate because right before September 11,th certain important and long overdue reforms were being made in the INS with some immigration laws undergoing reexamination. Immediately after September 11th, the American government swiftly took steps to make immigration and the INS important domains for enacting national security measures, and enveloped the system in anti-terrorism control. September 11th provided an opportunity for politicians to place blame on the United States' supposedly liberal open-door policy toward refugees and asylum seekers. It was insinuated that because of lax policies, Americans had been practically handing out invitations to terrorists. The UN refugee quota system immediately ground to a halt, while approximately 20,000 refugees who had been pre-selected and were waiting to come to the United States were stranded, many of them languishing in refugee camps. It was pointed out that "ironically, now that Americans are concerned that some non-citizens entering the United States may pose a threat, we are excluding only the group that has been most carefully screened (Benesch and Guerrero

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2001). Furthermore, over 1,000 people, primarily Arab and Muslim men, were rounded up and taken into custody by the U.S. government without due process, ostensibly because of their suspected links to terrorism. These arrests were done secretly, and family members of these individuals were not informed of the detainees' whereabouts nor even if these individuals were in fact being detained. Names of these individuals were not publicly released, and some of these individuals were immediately deported for various minor crimes, such as lapsed visas or traffic violations (Donohoe 2001). Friends and family members of detained individuals in the New York/New Jersey area organized themselves and protested these gross violations of civil liberties, calling the state's methods "disappearances." Not surprisingly, many of the detained men were released when it was determined that they had no involvement in terrorist activities.

In addition, racial profiling and detention of Arabs and Muslims has increasingly involved the participation of the police.

Amazingly, when the Homeland Security Bill was signed by the President 25 November 2002, the 110 year old Immigration and Naturalization Service was abolished and replaced by two new agencies that will be divisions of the enormous Department of Homeland Security (Solomon 2002). One agency, the Bureau of Border Security, will be responsible for immigration law enforcement. The other agency, the Bureau of Immigration and Citizenship Services, will "process work authorization, residency, and citizenship applications" (Nicaragua Solidarity Network 2002). Advocates for immigrants and refugees are greatly concerned about the larger implications of this restructuring and also anticipate horrible backlogs, processing delays, and deportations in

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the new system (Logan 2002; Solomon 2002). It is predicted that dismantling and reorganizing the INS may take one or two years (Solomon 2002).

In December 2002, under the authorization of Attorney General John Ashcroft, the INS began implementing the National Security Entry-Exit Registration System (NSEERS) which requires specified nonimmigrant males from 20 countries to report to a designated INS office where they will be "photographed, fingerprinted, and interrogated" (Goldman 2003). Furthermore, information is collected about the "individual's credit card, bank account, and video card numbers, and for those on student visas, on affiliation with campus and political and religious groups and names of roommates" (Feingold, Kennedy and Conyers 2002). Countries on the list include Iran, Iraq, Sudan, Syria, and Libya, with another 15 predominately Muslim countries rounding it out. This is the second wave of roundups, detentions, and deportations since 9/11. Again, these measures have generated panic, uncertainty and outrage in the communities affected.

With the war in Iraq, the near certainty of future terrorist attacks, the increasing militarization of this country, and the shift to the right happening in many Western nations, it may be true that state sympathy toward refugees and asylum seekers will continue to wane in both the United States and Denmark. However, certain humanitarian interventions, and in particular, programs for survivors of torture and refugee trauma continue to exist in Denmark, and in the United States, they are flourishing with state and private support. The second part of this chapter will explore torture treatment centers in the United States and Denmark.

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Part II: The RCT, the Haven, and other Programs

The RCT

A rather ugly 1960's or 1970's style black glass and metal modern building on "Humanitarian Boulevard" houses the RCT and its companion organization, the IRCT. One must be authorized to enter the building by the receptionist who activates the quiet swoosh mechanism that opens the front doors. The first floor is composed of the reception area, some administrative and research offices, a big kitchen, the canteen with candelabras on the tables, and the Documentation Centre. On the second floor, the RCT has its rehabilitation offices, where the clients come to see their therapists, doctors, and social workers. Also on the second floor are administrative offices, a meeting room, the student research office, and other offices for the research, communications, and international departments. The third floor is mostly for the IRCT and is where Inge Genefke has her office. This floor also contains various RCT offices.

In 1988, the RCT made a decision to split itself into two and officially established a new arm called the International Rehabilitation Council for Torture Victims (IRCT). With the split, the IRCT became the international arm focused on advocacy, international legislation, producing publications such as the journal *Torture*, and the development of torture treatment centers around the world. The RCT became the domestic rehabilitation arm—its primary function was to provide medical and psychological treatment services and to conduct research. However, separating the two divisions was not fully formalized until the late 90's, and even with plans for changing the names of the two organizations to further enforce their individual autonomy, the two often remain identified as one by both staff and the public. As I mentioned by footnote in

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the last chapter, I don't want to confuse the reader with too many acronyms or details about the intricacies between the two programs, and will usually refer to the organization as the RCT unless it's important that I differentiate the two.

By the mid-nineties the RCT had become a large, highly visible organization with not only an expensively staffed rehabilitation center but also many RCT affiliates around the world. The organization was at this time and is in fact still one of the largest NGO's in Denmark, employing over sixty people in 1996 (COWI 1996). In the rehabilitation wing alone, there were approximately 13 full-time clinical professionals. In 1994 and 1995, the average combined support for the IRCT and RCT was approximately 30 million DKK per year. With today's exchange rates (but not adjusting for inflation), that would be approximately 3,750,000 USD. The operating budget for this organization far exceeds that of the Haven program, which, during the time I conducted my fieldwork there, had only five full-time staff and a budget of less than 300,000 USD.

Medical and psychological services for survivors of torture and refugee trauma were not provided as part of the Danish national health care system and required some sort of payment for service delivery. The RCT was unusual among the different Copenhagen torture treatment centers because services were privately and publicly funded. The RCT has been so well-supported by the Danish government and its Ministry of Foreign Affairs Development Office (Danida), the UN Voluntary Fund, the Democracy Fund, the European Union, Danish public subsidy, and private foundation money that it has been able to see clients at no fee (Ibid 44). This has been a mark of distinction for the RCT according to several staff there, and is a policy they do not want

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to change despite the fact it means that there are long waiting lists for clients, some of whom have had to wait over two years for treatment.

On average, sixty clients are treated at the RCT each year, most of whom fit the UN definition of torture and all of whom have full legal status in Denmark. These rules are bent somewhat as the RCT also treats family members of the torture survivor or primary client. Other centers in Copenhagen see clients who are not strictly torture survivors, but who are refugees and also immigrants. These other centers will also treat asylum seekers, or those who are not legal residents of Denmark. Many of the RCT clients are Iraqi men or men from other Middle Eastern countries who have been severely tortured, and I was told that these clients are often more traumatized than the clients seen in other Copenhagen treatment facilities.

Charges for services are reimbursed by the municipalities, state subsidies, the EU, the referral agency (such as the Danish Red Cross), or sometimes by grants and private donations at Danish programs other than the RCT. Clients in these centers will not be seen if there is not some method of payment, but clients themselves do not pay. Haven clients and clients at other programs in the United States also do not personally pay for services. Danish municipalities determine how much money they want to spend on each client. Often, this sum does not cover the full amount of sessions that are needed for a course of treatment. Danish clinicians and support staff find their time and energy eaten up from tracking down and fighting for reimbursements, much like health care providers in the United States, a task made all the more frustrating because other populations in Denmark have a full-range of mental health services available to them paid for by the state.

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The rehabilitation staff at the RCT were nearly all ethnic Danes. Other centers in Copenhagen had slightly more ethnically diverse treatment teams, but none of them observed the bi-cultural model of refugee mental health practice that is so popular in the United States. This may be because of the basic homogeneity of the Danish population and cultural differences between the two countries. All the Danish programs employ translators who are specially trained and certified by the state, and translation services were much more organized in Copenhagen than they were in New York during my fieldwork period.

Medical/Torture Model vs. Psychological/Human Rights Model

One of the many Danish clinicians I interviewed was a psychiatrist who had been involved in the torture treatment and refugee health community in Copenhagen for several years. He described to me some of the professional conflicts and ideological schisms of the 1980's that were centered around the RCT and that came to play an influential role in defining the Danish torture treatment community seen today. It is a fascinating and tumultuous history with the villains, heroes, intrigues, and back-stabbings of either a Shakespeare play or a modern soap opera, depending on one's perspective, the uglier details of which I will spare the reader. "Dr. Jergen" is in his late 50's, tall, handsome, charismatic, articulate, and cosmopolitan. He worked as a community health psychiatrist in the 1980's at a large municipal hospital where he created a "transcultural team" and in 1999 was the Chair of Psychiatry at another municipal hospital, while also traveling around the world doing lectures and consultant work as a trauma expert. Dr. Jergen embraced what he called a "human rights framework" that encompassed all categories of survivors of political violence, not just victims of state-sponsored torture.

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He and his former wife had also traveled to Chile, where they studied the clinical theories and practices that Chilean mental health professionals had developed to deal with torture and terror. He was greatly inspired by their work and their courage, and adopted the "testimony method" which he applied to clients in the Danish context. Dr. Jergen was instrumental in bridging together the Latin American with the Danish medical trajectories that were described in the last chapter.

Dr. Jergen explained that in the 1980's, he and his colleagues at the hospital "created a team of professionals trying to learn about this, refugees, transcultural issues, allying with the Danish Refugee Council and the Red Cross, trying to set up a community service." He was also a consultant at a torture treatment center in Copenhagen that broke off from the RCT, and working at asylum centers "especially when there were severe cases of PTSD or psychotic patients." Dr. Jergen said that he and his team were seeing asylum seekers from places such as Kazakhstan, and they "didn't know what to do about them"...

I asked who does know about this? And I called the RCT and they said they did not want to consult on these questions because you couldn't refer patients there if they were asylum seekers. Why? Because they would be "cheating" to get their asylum case proved...So why shouldn't they help? We had people coming here in heavy crisis from whatever had happened filled up with nightmares and whatever and we said we hadn't got a clue on how to handle these people and then we have this world famous institution within reach and they have no wish to help. And they take how many patients a year? Like 60 and then it takes about 80-90% of the money each year is channeled to [tape unclear]. So its overluxurious and there were people there getting a lot of money for long-term psychotherapy and most of them at the time hadn't a clue about psychotherapy so they were talking to them, talking with them. I mean imagine "Dr.Andersen" making psychotherapy. She is terrible. So there is psychotherapy and then there are these doctors coming in from Amnesty looking at their feet, talking about their falanga[7] and what happened to them. Of course it was not bad what they were doing but it was intrusive. So we had in the hospital four or five times as many patients, refugees, as they would see in their famous centre and there was not allocated a single cent for any of this kind of work.

[7] A common form of torture that involves beating the sensitive soles of the feet.

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A big conflict that created a division was this whole medicalization track versus a focus on torture survivors and refugees on a much broader spectrum with a human rights and psychotherapeutic perspective... none of them had any training or psychotherapeutic background or anything...

The RCT approach Dr. Jergen describes is medically-centered—Dr. Genefke was a neurologist by training and not a psychotherapist. As I mentioned in the previous chapter and will elaborate upon in Chapter Six, during its formative years the RCT focused a great deal on the physical and neurological effects of torture, and on documenting torture for Amnesty International. The RCT did hire two psychologists for their treatment team and psychotherapy was a major part of the treatment package, but Dr. Jergen explained to me that the RCT psychologists disagreed with the narrow focus and unsophisticated methods of treatment as well as the narrow definition of victim that were espoused. These two psychologists became engaged in rather hideous battles with neurologist Genefke and her medical doctor colleagues, resulting in bitterness that lasted for years afterward. One of the RCT psychologists left the RCT to join other psychologists in starting a new program in Copenhagen for survivors of torture and refugee trauma called Oasis. The other also quit, and went on to write about the "psychopathology" within institutions that treat victims of political violence.[8]

The RCT was a formidable force in terms of its political connections to the Danish government, its public image, and the power of its leader, and to challenge the ideological or professional authority of its founders was tantamount to treason or heresy.

[8]This psychologist wrote about the kinds of violence that mental health professionals working with torture survivors inflict upon themselves and each other (Bustos 1988). It has been suggested that working with traumatized people traumatizes, and because of the violence and suffering at the heart of treatment, clinicians and service providers themselves may act out unconscious fantasies and feelings. Often these fantasies and feelings are manifested in processes parallel to those of the torture and terror dynamic. This means that institutional group dynamics may reflect processes that parallel what occurs between perpetrators and victims.

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The RCT symbolically functioned as a sort of feared and hated, yet admired and envied tyrannical parent to the local Danish clinicians in the torture treatment field. As Dr. Jergen explained, "I think professionally it should have been questioned, but the response of Genefke was to say that 'people could be for or against refugees, but everybody was against torture.' So for fundraising and PR they were successful at the same time they were so seduced by their own strategy that they isolated themselves professionally from the field."[9] Dr. Jergen publicly challenged the RCT in an article he published in an "intellectual newpaper," telling me, "when I was criticizing the RCT, it was like I was criticizing the queen and the Little Mermaid." Though Dr. Jergen and many clinicians I interviewed were highly critical of the RCT's practices during this time period, at the same time they also expressed tremendous admiration for the many things Genefke and the RCT had accomplished in fighting against torture, "the greatest threat to democracy" according to Genefke.

Dr. Jergen enjoyed his own high stature in the psychiatric community in Denmark, and certainly came to many of his ideas independently of the RCT, but the development and elaboration of his own approach and ideology seemed also to be fueled in opposition to the RCT approach. The other torture treatment centers in Copenhagen implemented after the RCT's inauguration also defined their approaches in opposition to the RCT.[10]

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[9] I was told that a nickname for the RCT was *PR*CT.

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Oasis

Dr. Jergen mentioned that one of the disenchanted psychologists who left the RCT helped to establish another treatment program in 1987 called *Oasis*. I visited Oasis, located in a relatively "poorer" section of Copenhagen. It's a neighborhood in which many immigrants live, a little more desolate, run-down and dirtier than other areas in which I had traveled in the city. Tell-tale signs of urban disaffection—graffiti—marked building walls, and there was actually some litter in a vacant lot. The Oasis program is located in an office building on a main street near a metro station. It occupies two floors. Security measures are taken there as they are at the RCT, so one cannot just enter the office as a stranger off the street. I was reminded of the RCT when I saw the design of the offices and their furnishings—clean, bright and simple. Eleven clinical staff work at Oasis, and the program sees 90-100 clients a year.

This program was founded on principles that were a direct rejection of the ideology and practices of the RCT, and also were a reflection of the socialist ethos in Danish society. I spoke with several people who described to me, partly critically and partly nostagically, about the kind of socialism that was a thriving part of Denmark's recent social and political history. "Collective leadership and democratization were very important in Copenhagen," an RCT staff person told me, and institutions and individual people adopted experimental practices following these ideas. A physiotherapist who immigrated to Denmark from the Middle East during the 70's described her impressions of how feminism, part of the socialist project, was at its height during this period: "Women didn't wear make-up and they all wore the same kind of clothes and everybody

[10] There was also a small psychosocial program for young people called TTT that was not a full service torture treatment program and not included in consortium activities with the other Copenhagen programs.

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wanted to be the same and equal." Two clinicians I interviewed both spoke about the feminist movement, and their participation in it. These kinds of political and social values are still embedded in Danish society, and many of the founding members of the different torture treatment programs in Copenhagen were of the generation when these ideas and practices were most alive. I think some clinicians became even more committed to their socialist ideals because of the types of torture survivors they were treating in those early years. Many of the clients were political activists from South America who had risked their lives for social justice. As one psychologist remarked, "I was very impressed with them. I spoke Spanish with them because I had learned to speak some Spanish when I had spent some time in Cuba. I learned a lot from them, like you couldn't isolate torture from its higher meanings."

Oasis's founders rejected a vertical organizational hierarchy and instead opted to create a horizontal one, where all decisions were reached democratically. After the despotism of the RCT leadership, the Oasis opted to have *no* leader. All activities were to take place with the awareness and agreement of all staff members. One of the founders described the organization as a "collective," a "grassroots organization," where everyone received the same wages whether they were "cleaning house or doing psychotherapy." Maintaining this structure became more and more difficult as the organization grew because responsibilities were divided equally with no "delegation of tasks," and every decision had to be reached by consensus. Eventually, Oasis decided to try hiring a leader who evidently wasn't able to handle the job and was fired after one year. According to this clinician, the next leader who happened to be "quite clever" also had difficulties, declaring to the Oasis staff, "this institution cannot be led." Eventually, over a period of

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many years the organization was able to install a leader and also create a hierarchical structure that worked.

From the outset, Oasis clinicians institutionalized the use of outside consultants to help them reflect on their own practices and dynamics. This was an important new feature in torture treatment programs and was a direct result of the interpersonal disasters that had occurred at the RCT. Many of the clinicians I interviewed in Copenhagen stressed to me the importance of supervision for staff and consultation from outside contractors, and felt that their work could not be done otherwise. Practices of psychologically reflective group work were not an integral part of the self-care package that the Haven adopted, as I will show in Chapter Four.

Etica

Two psychiatrists whom had been quite close to Genefke during the turbulent years at the RCT finally were drawn into battle with her as well, and broke away from the RCT to start a program called *Etica* in 1989. Somehow, the two founders and leaders of Etica never were able to make themselves available for an interview while I was in Denmark although two other clinicians there were. Etica has only six full time clinical staff members. All the other staff work as affiliated consultants which keeps the program's overhead lower than other programs. Etica's offices are in one of Copenhagen's many big old stone and brick buildings with arched entrances leading into hidden cobble-stoned courtyards. An apartment was used for the Etica program, and rather converting it into a sterile clinical office, the directors retained the features and furniture of a regular apartment, including a kitchen and dining room with a long table in it that is used for meetings or other activities.

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The Etica program sees about 50-60 clients a year, most of whom are male. Clients can be asylum seekers or survivors of refugee trauma. More recently, Etica has expanded the scope of its services by providing treatment to traumatized Danes whose trauma does not have to be the result of some kind of political violence. It is the only program that is now organizing itself more around trauma than survivors of torture and refugee trauma.

CEPAR

Established in 1985 by Chilean exiles who trained to become psychologists, CEPAR distinguishes itself from the other centers because of its political ideology and because its leaders were not native Danes. It is associated with another organization established in Belgium by Latin American exiles called COLAT. The founders of CEPAR viewed the problems of their clients mostly in terms of the effects of flight and exile and what it means to be a minority immigrant or refugee in a closed, homogenous society like Denmark's. They did not just treat torture survivors but anyone who has faced forced migration as a refugee or as an immigrant. For the founders, many of the traumas that people experience are not only a result of the huge losses they have incurred from war, persecution or torture, but are from trying to adjust "to a minority position in society in terms of culture and language," and from exposure to "discrimination and difficulties in finding employment" (RCT: 1998). These psychologists were interested in recognizing the structural problems in society and how those related to the mental health of their clients. Their work shares many of the assumptions and goals of the kind of liberation psychologies developed in Latin America that were described in the previous chapter.

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CEPAR is located in a neighborhood of Copenhagen recognized for the mélange of immigrants, students and bohemians who make it their home. It's in a building not dissimilar to Etica's, and I found the space warm and soothing, with its dark wood, and rich yellow orange walls. CEPAR is one of the only Danish programs to call itself a "psychosocial" program, thus aligning itself with programs such as the Haven which recognize the significance of social structure and social needs. As with other Danish programs, there is a predominance of male clients from the Middle East, but in recent years there has been a visible increase in the number of children and young people treated.

For many years Oasis, Etica, and CEPAR had little to do with the RCT, or with each other for that matter, at least on any kind of formal or organized basis. Marlene remarked that as Copenhagen is on an island, so too were each of the torture treatment programs in Copenhagen. The RCT had a particularly bad reputation that took many years to overcome, and most of the centers were not interested in collaborating with them though clinicians in different programs were friendly with one another on an individual basis. However, by 1999, the four major programs in Copenhagen participated in a consortium and began meeting together on a regular basis. One of their major concerns was how they could get more reimbursement for their services. Furthermore, by 1999, there were many new clinicians working in Copenhagen whom were distanced from the original feuds and schisms. Most were aware of this history, but did not feel it was relevant to their present work.

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New York City

I will now shift to 1997 and New York City, where much of what was going on in torture treatment centered on Ed and the newly created Haven program, and Dr. Kantor, Dr. Stein, and Dr. Eli who were three directors of the torture rehabilitation program at City Hospital. There was also a program in the Bronx, affiliated with a large city hospital, that trained medical doctors in identifying human rights abuses and preparing medical evaluations for asylum cases. The director of this program had some media visibility and positioned himself as a medical advocate for those suffering human rights abuses. However, during this period, this program was pushed to the sidelines as the Haven and City Hospital programs ascended to power.

Neither the Haven nor City Hospital devoted as much time or energy to advocacy and lobbying as the RCT did, and neither had anywhere near the RCT's international influence or presence. Nor did these two programs ideologically split over the inclusion criteria for clients. For both programs, any money received from the UN Voluntary Fund for Victims of Torture could only go to legal refugees or torture survivors, but funding from other sources could be spent for any victim of collective violence. There was one interesting exception, however. In 1997 when it was discovered that Abner Louima had been tortured by New York City police, the City Hospital did not offer to treat him because part of their funding and support was from the city. Presumably, it would have been too politically complicated. Louima wasn't treated at the Haven either, but Ed made a point of letting me know that it would not exclude someone like Louima.

By the mid-late nineties, there was much greater consciousness of the fact that torture is practiced world-wide, a development partly indebted to a globally growing

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human rights platform for social change. For the Haven and City Hospital, the task of proving torture had taken a specific turn, and was not about proving to the world that torture is a widespread practice, but was directed primarily toward providing medical and psychological affidavits for individual asylum cases. Furthermore, the medical model was less medical at City Hospital than it was for the RCT. Psychotherapy provided by trained clinicians for "trauma" was the City Hospital program's forte, and any medical or somatic treatment that the clients needed, such as physiotherapy, were to be coordinated by the team but not provided by it. City Hospital also did not have nurses on its staff like the RCT.

The epistemological framework underlying politicized medicine at City Hospital was also slightly different than the RCT's. The kind of scientific objectivity and universalism presupposed in much of the RCT's work had been joined, but not replaced by, more self-reflexivity and particularism at City Hospital. Those forms of knowledge that were de-valued in the RCT model, the "subjective, symbolic, and cultural" (Adams 1998:21) were increasingly becoming what legitimized good practice, not just at the Haven and City Hospital but internationally.

I was conducting pre-dissertation fieldwork at City Hospital during this period (1997) and would occasionally see Ed at staff meetings there. The three directors at City Hospital were all young for their high-level professional positions--in their late thirties and early 40's—and ambitious. I witnessed Ed and these doctors jockeying for position and also enacting an ideological struggle symbolized as the psychosocial refugee resettlement approach[11] versus a more medically-centered one. I observed the drama

[11] To further complicate matters, as I mentioned in the last chapter, there is also a division between those providing basic refugee resettlement services like job placement and ESL classes, and those providing

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unfold during City Hospital staff meetings, and also had conversations with Ed about what he perceived was going on. My impression is that though part of the struggle did stem from basic differences in ideology, orientation, and approaches, much of it also seemed to emanate from territorial and professional interests.

During a conversation with a bright and articulate refugee resettlement worker, a series of anecdotes were related to me about how these two "worlds" were coming together. "Bridgette" describes how for a time there was simply a lack of communication between the different service providers:

I remember once sitting around a table when a light suddenly went off in Dr. Kantor's head [a City Hospital director] and he realized there is a whole funding stream, there is the Office of Refugee Resettlement, there is funding, there's dollars, you know, and wow we are part of this greater community. And that was the beginning of them thinking, "maybe we should go after this kind of funding too." And so it's been a good thing for them and it's been a good thing for us. And that's another reason why Ed was so key, because he was in both worlds. He had come from the refugee resettlement world and background and so he knew what resettlement agencies did and the importance of them...but I remember at the beginning it was so frustrating because I would sit here and I would have City Hospital's number and I knew that they existed theoretically, but it was like picking up the phone and calling Sloan Kettering or something. I had no entrée. It was intimidating. And again, nobody was trying to make it that way. They were trying to do their thing, doing it well with their population but there was very little collaboration.

Bridgette also described how, as the two worlds made efforts to connect, there was some animosity felt, especially by those in refugee resettlement:

There was a group here in NYC called the "Traumatic Stress Association." I remember receiving a flier from them and opening it and thinking "who are these people?" How are they working with refugees?" You know when you come from a non-academic position and are dealing with refugees' lives and you see the names of the people and the workshops they are offering and the people who are there, it's like worlds colliding. You sometimes feel like they are in an elitist, exclusive circle that is self-perpetuating, incestuous. We should all be more integrated.

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refugee mental health services. I interviewed a special project director at the Immigration and Refugee Services of America (IRSA) who told me that within the refugee resettlement community there are individuals who are wary about the emphasis on refugee *mental* health. According to this source there have been many advisory committee discussions about the trend toward "medicalization." Thus the conversation about "medicalization" not only pitted refugee resettlement/refugee mental health practitioners against medical model practitioners, but also has created tensions within the refugee administration community.

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When City Hospital became aware of new vistas for funding, and the advantages of forming an alliance with the Haven, the two programs began an uneasy collaboration that including writing grant proposals together, sharing funding, making referrals to one another, and also conducting trainings and workshops together for local professionals who came into contact with survivors of torture and refugee trauma. By the time I began doing my dissertation fieldwork, the two programs still felt some mistrust and animosity toward one another, but their many differences from 1997 were diminishing. Indeed, I was quite surprised to learn that one of the more difficult directors of the City Hospital program, Dr. Stein, was now a consultant for the Haven and would be at their weekly staff meetings and collaborate on various projects with them. If this were not enough, I was also astonished to learn that Dr. Stein and Dr. Kantor, the two main founders of the City Hospital, had a feud which led to Dr. Stein's resignation from their program. As I reflect on the problems that the Haven and City Hospital had during their formative years, I am reminded of what Dr. Jergen had told me that the RCT's struggles. He told me those struggles were only really interesting insofar as he has observed the same kind of intense feuding and acrimonious professional divorces occur in programs that treat survivors of torture and refugee trauma all over the world.

By 1999 in the United States, on a local, national and international level, professionals representing the refugee resettlement and the medical model or "trauma"-centered trajectories were appearing more and more frequently at the same conferences, trainings, and workshops, and speaking about the same topics and issues. An academic-type trauma clinician was as likely to speak about "adjustment issues" as a refugee

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mental health person was, or be as quick to critique PTSD as his refugee resettlement neighbor. Practices were becoming increasingly standardized, homogenized, and professionalized in the areas of refugee mental health and torture rehabilitation. It was now, according to IRSA's Senior Program Director, "about best practices and standard of care." Indeed, rather than "worlds colliding," the ruling metaphors were coalition-building, collaboration, networking, partnerships, expansion, consolidation, and coordination.[12]

State Influence on Torture Treatment in Denmark

Two important interventions were made during the mid-late 90's at the RCT. One was an assessment conducted in 1996 and the other, a desk-study written in 1998.

The first assessment stemmed from the Ministry of Foreign Affairs, Development Department's (DANIDA) 1993 mandate that "calls for the undertaking of a capacity assessment of major Danish NGO's before Danida will enter into a framework agreement with the NGO in question" (COWI 1996). This assessment, a management consultant evaluation, was basically intended to clean up and make transparent and auditable the practices at the RCT before any more state money was spent on the organization. The RCT had three years in which it could make the changes DANIDA recommended, but in the meantime would receive funding on the condition that they were demonstrating proper effort in meeting DANIDA's new expectations.

One of DANIDA's most significant recommendations was that the RCT and the IRCT needed to really split into two fully autonomous organizations. The IRCT was to continue its networking activities, advocacy, fundraising and support to dozens of

[12] However, professional conferences and publications, and high-level administrative positions were still dominated by Ph.D's and M.D.'s.

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international treatment centers around the world with significantly more transparency. By implementing this separation, it was hoped that certain conflicts of interest and misuse of funds would be eliminated.

The desk study was not directly related to the RCT but signified a shift in the field more generally. This study is a qualitative review that does not so much evaluate as survey the current state of torture treatment, raising questions for further investigation. Representing a critical look at how torture treatment on an international basis had developed in terms of service provision, this study asks whether those "services" actually "meet the needs" of their beneficiaries and whether these approaches are "sustainable" in the long-term (DANIDA: 1998).

These two interventions emblematize important transformations in torture treatment at the RCT and also in the larger, international contexts of torture treatment. The recommendations from the first report align with strategies characteristic of recent global economic and political restructuring and neo-liberal strategies of performance-based entrepreneurialism. Non-profit organizations today have transformed their operating models into for-profit models of businesses or corporations, where service is the commodity. Just a few years after the RCT's assessment and across the Atlantic, the agency of which the Haven was part, the "Community Care Center" (CCC) also underwent significant changes, including the hiring of a new director, significant organizational restructuring, and changing its name and image. The former name of the agency had the word "victim" in it which did not stand well with the idea of the active, resilient, and surviving social service consumers it served, or with its new active, striving, confident institutional image.

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Marketized social service emphasizes outcomes, self-monitoring, cost-effectiveness, competition, quality control, user-rights, and choice, all in the name of delivering excellent care. As one psychologist at the RCT remarked about this shift, "Cost/benefit results are to be made observable. It's not just at the RCT but many social services like health and education are being measured like corporate firms now." Or, as an RCT secretary remarked, "We are now more like organizations that sell and buy." Thus, torture treatment is not just about helping suffering people but is also about manufacturing a product which is called "service." A new discourse of entrepreneurialism has been conjoined with humanitarianism. And in the case of the RCT, not only did humanitarianism take on a more commercial face, but the Danish state took a much more definitive role in torture treatment's future there.[13]

I visited the RCT just three years after DANIDA made their sweeping recommendations. According to what people told me, many changes, especially those that improved leadership style, "were for the best." I was struck in hearing how narratives about the RCT's past leadership problems were couched in both the languages of psychology and of management consulting by some staff members within the organization. No longer was it the case that despotism and backstabbing were caused by narcissistic leaders and primitive psychological responses to dealing with torture and traumatization—the explanation given by clinicians who left the organization before the evaluations-- but that, according to staff who had gone through the evaluation process or who were new hires, the RCT's location of power around one leader and ad-hoc decision

[13] It was reported to me by a staff member at the Danish Refugee Council that there had been in fact more collective interest expressed by the different torture treatment centers in Copenhagen to conduct research and to share their findings with the other treatment providers. An initiative was taken by the Danish Refugee Council to encourage the centers to work together on research projects—most research to date had

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making was also "...characteristic of first generation organizations headed by founding leaders" (COWI 23). According to the COWI consultants, certain features correspond to first and second generation organizations. The goal was to move the RCT to a second-generation organizational structure. RCT staff members echoed this rationale for the RCT's problems and new direction. As one staff person remarked: "In the beginning, this institution was just trying to survive and get recognition. This organization fits into the stages of organizational development." Or as another said: "We had a leader with a strong personality who created this organization. Those are the kind of people that have certain qualities of leadership and can go through a lot difficulties to get things done but maybe with harsh rules. Organizations grow like that and then people split off."

Other changes came at a cost to staff morale and also produced new types of divisions, programmatically and between staff. With the restructuring, the research department was given an infusion of support and privilege, but the head researcher also felt new pressures. Even the researchers were now supposed to quantify everything they did in terms of output, accomplish certain research goals in a set time period and somehow demonstrate measurable success in treatment protocols. The treatment department too, and perhaps even more so, had a hard time with the new changes. To get money from DANIDA, all efforts of the treatment department now were to go toward developing models of treatment that could be used in the international partnerships the RCT established. The RCT's clinical work was now subsumed by the goals to develop better methods for helping people in the RCT's international programs, because DANIDA was a *development* agency. Many clinicians, especially those who had been

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only been conducted by the RCT. However, even though the state was encouraging more research, most programs were unable to pursue any kind of intensive research because of a lack of funding.

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with the RCT the longest, perceived this new rationale as a devaluation of their work. Clinicians found themselves being asked to take on new administrative tasks and training activities and were also now responsible for participating in projects with the international partners. For some clinicians, this expansion of their responsibilities stretched them to the limits of their own capacities. They were, after all, trained to be clinicians, were dedicated to their clinical calling, and did not have the professional training or vocational desire to take on these new roles. Now the joke around the office was that staff no longer worked for the RCT but for DANIDA.

Under the conditions set forth by DANIDA, the RCT also hired a whole new group of people with international experience to reform and develop the RCT's international operations. Many of these new staff members were young, energetic, bright, assertive, immersed in the discourse of international development, and had international field experience with organizations such as the UN. Their academic disciplines included law, economy, anthropology, and international affairs. A staff member outside this department told me they were known as the "fast-talkers."

The new RCT had affiliations with programs around the world as did the IRCT, but only eight rather than scores, and of a different nature. The RCT formed "partnerships" with programs in locations such as Central America and Sri Lanka, Bangladesh, Gaza, and Albania. The strategy for the RCT now was to promote international development and "democracy-building," to get to the causes and help "prevent" human rights abuses rather than to deal with the effects, and to broaden definitions of political violence to include "collective violence" (Mikkelsen 1998).

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Psychological understandings and tools were unequivocally linked to achieving these goals. This was the essence of the new psychosocial program.

Police and prison officer's training in human rights was one sort of project that the RCT was developing with a few of their partners. In Guatemala, the RCT worked closely with the Catholic Church, which one of my informants remarked was "the shadow government there," focusing on psychosocial aspects of the community for strengthening a "culture of human rights," and also dealing with past "trauma." One of the projects included conducting exhumations. Thus in Guatemala, the focus was less on prevention and more on the effects of thirty years of war. In other programs, the focus was more on prevention and the future. As one staff member pointed out, "What we help develop really depends on the reality of each context. It would be suicide to do the same thing in each place." Interventions were to be individually tailored to the specific context—no more one-size fits all strategy. And rather than unilateralism, the RCT approach was bi- and better yet, multi-lateral. Further, interventions were to be conceived in terms of long-term sustainability, flexibility and eventual "independence" for the partner from the framework agreement with DANIDA and the RCT. The RCT's role was to facilitate these processes, not to impose. In the words of one of the RCT's international staff or "fast talkers":

> We respect local processes but we must follow DANIDA rules. We make joint decisions with the partners. It is a joint effort where we make recommendations. We are there to be instruments but the ownership is theirs. You need a certain amount of distance for a partnership and we are trying to create that. You can develop sustainable projects if there is a sense of public ownership...We want them to help us help them...sometimes the locals need someone to walk with them...

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Along with these new strategies for intervention, needs assessments (to find out what the communities need), impact assessments (how does the intervention impact on the community?), and evaluations (is this approach working from a cost/benefits perspective?) from outside consultants were now part of the total development assistance package. DANIDA spent a great deal of money hiring expert consultants to do full evaluations of these different partnership projects, sharing the results and recommendations with the local partners.

In this paradigm of social intervention, activities are to be made calculable and comparable for the optimization of performance (Dean 1999: 173). The "ownership" or self-empowerment model that links outside agents with local, self-managing, community-centered sites is very much in line with the precepts of entrepreneurial modes of governance (Ibid:172). Self-determination is valorized, where new regulatory controls emerge as the users of a service are constructed as having agency and voice to communicate and "own" their 'needs.' In the words of Dean,

> Needs formation is no longer a matter of the scientifically informed production of truth by professionals employed under the welfare state; it is allowed to enter into a space of negotiated settlement conducted in the name of user rights. From below, agency and voice of users and carers enter into contestation with professional practice and knowledge. From above, the rights of consumers and users becomes the criteria for the evaluation of performance of professionals and a technique by which authorities can be open to a rich source of innovation and critical information about changing demographics, markets and environments (1999:169-170).

Combined, all these changes at the RCT signify new forms of professional practice and expert knowledge that depend on a marketization of service, construction of greater powers of "agency" for clients and also a move away from the dominance of one

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particular truth (medicine's scientific objectivity) toward more flexible and pluralistic forms of truth. These shifts in production and consumption of torture treatment expertise and clinical practice at the RCT in the 1990's were also occurring in the United States and in other Western European and North American contexts. These configurations of intervention were evident at the Haven, and will be the subject of analysis in Chapters Four and Five.

State Influence in the United States

Senator Paul Wellstone of Minnesota, a long-time friend and supporter of the CVT in Minneapolis, had been one of the most active lobbyists for the plight of torture survivors in the United States and was instrumental in putting torture on the radar screen of the federal government. He garnered, with the help of former Senator Rod Grams (R-M), and Congressmen Christopher Smith (R-NJ) and Tom Lantos (D-CA), bi-partisan support for the Torture Victims Relief Act that was passed by Congress in 1998 (Amnesty International 1998). As Ed once remarked, "This is an issue that both conservative Republicans like Jesse Helms and progressive Democrats like Wellstone could agree upon."

The 1998 Torture Victims Relief Act "outlines a comprehensive federal strategy for providing critical assistance to refugees who are torture survivors in the United States and abroad by providing funding for torture rehabilitation programs that have long been chronically under-funded " (Ibid). This bill authorized 5 million USD for FY (fiscal year) 1999 and 7.5 million USD FY 2000 for the Department of Health and Human Services to assist treatment programs for torture survivors in the United States. In addition, it authorized 3 million USD (the Clinton administration increased this to 5 million USD) as

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the U.S. contribution to the United Nations Voluntary Fund for Victims of Torture (UN Voluntary Fund) for FY 1999 and FY 2000 (Amnesty International). Another 5 million for FY 1999 and $7.5 million for FY 2000 was also authorized for the U.S. Agency for International Development to assist foreign torture treatment programs.

In 1999, the Torture Victims Relief Reauthorization Act of 1999 was passed which provided additional funding for the fiscal years 2001, 2002, and 2003 in the sum of 25 million USD. It increased the funding for domestic and foreign treatment centers to 10 million USD respectively, and allowed 5 million USD to again be contributed to the UN Voluntary Fund (Ibid). It is now 2003 and efforts are being made to extend the act for two more years (Center for Victims of Torture 2003).

Originally, Wellstone's bill was also intended to ease certain immigration restrictions, strengthen protection procedures for torture survivors, and mandate specialized training for U.S. consular and INS personnel (Survivors International 1998). But the original bill was whittled down—the immigration reform part was excised leaving the less controversial provisions for torture rehabilitation and training. However, Wellstone's efforts, along with the efforts of others, did have some impact on immigration reform. On 22 March 1999, a ruling was passed that "formally implemented U.S. obligations under an international treaty provision designed to protect persons from being returned to countries where they face torture" (U.S. Department of Justice 1999). Under this ruling, if someone seeking asylum in the United States has exhausted all legal avenues, with all appeals denied, the claimant may ask for Article 3 protection which bars an alien from being deported if they can prove they will face torture upon return. This is a

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course of last resort for some asylum seekers.[14] Furthermore, Wellstone and immigration reform activists were instrumental in encouraging pre-9/11 efforts on the part of the INS to better train their workers to follow the law and to treat aliens more humanely.

The provisions of the definition of torture (18 U.S.C. 2340 (1)) contained in the Torture Victim Relief Acts are as follows :

> 'torture' means an act committed by a person under the color of the law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions)upon another person within his custody or physical control.

The law goes on to say that torture includes "...prolonged *mental harm* caused by or resulting from": "rape and other forms of *sexual violence*," "*threats*" of infliction of pain or suffering, "*mind-altering substances* or other procedures calculated to disrupt profoundly the senses or the *personality*," "the threat of imminent death," and the threat or application of the above to *others* (U.S. Department of Health and Human Services 2000; emphasis my own).

The definition of torture above is both restrictive in terms of who can be considered perpetrators or victims and expansive in regard to some of the types of violence and the effects of violence that it allows. It restricts the perpetrator to those operating under the "color of the law" which implies state-sanctioned terror, or violence that falls under international laws about how warfare should be conducted (e.g. soldier against soldier). It excludes the kinds of atrocities committed during war-time or in low-level conflicts against civilians by perpetrators who are not operating "under the color of the law," and in effect excludes countless refugees who have suffered greatly.

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[14] This ruling has perturbed some lawmakers who argue that even asylum seekers who have been torturers themselves cannot be deported because of Article 3.

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As many torture treatment centers had broadened their definition of political violence to include survivors of refugee trauma, choosing this more narrow definition seems rather odd.[15] These exclusions thus were perhaps a political and moral compromise for the legislators who constructed the bill—to broaden the categories of inclusion could have potentially alarmed certain more conservative members of Congress and sent up a red flag so the bill would not pass. Basically, broadening the definition would have meant including all refugees, opening the door for difficult questions like 'Who is a refugee?' and 'At what point is an immigrant actually a refugee?' It would seem that to get a bill like this passed, it must be presented in a contained and non-threatening manner. Like Inge Genefke said, "people could be for or against refugees, but everybody was against torture."

Restrictive on the one hand, on the other this law's concept of torture pointedly includes certain kinds of violence and suffering that expands the definition of victim. Most importantly for this discussion is the focus on mental suffering as an effect of violence, which in past international legislation was not given so much weight. The concept of mental suggested here is also highly psychological. The mental/psychological is reinforced by including "threats" rather than direct physical harm to oneself. These threats and harm can also happen to "others;" violence does not have to be enacted upon a direct recipient but can be made at a distance and bridged by a mental connection. The mental is further emphasized by mention of "mind-altering substances" and "personality."

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[15] During a staff meeting at the Haven, we discussed the definition of torture employed in this law and in the Request for Proposals (RFP). One staff member remarked, "Refugee resettlement people first talked in terms of refugees, but then when the question of torture money came up, they all changed their tune and said they worked with victims of torture."

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Why the legislators explicitly included "sexual violence" as a distinct category is not immediately clear, as it seems it would be adequately covered as one of many strategies to inflict mental or physical harm. Although this provision applies to both men and women, this criterion implies sexual violence against women. I would suggest that the feminist advocacy efforts during the war in Bosnia which were described in the last chapter may have had direct policy implications such as this, though I do not have any direct evidence to support such a view. This inclusion is significant also because the universal figure of the torture survivor has historically been imagined as male. The figure of the woman as a victim of torture is now part of the public imaginary and codified into federal law.

Provisions of this legislation regarding the actual disbursement and administration funds are three-fold. The first area of funding is allotted toward treatment centers in the United States. The RFP that followed this legislation states that funds will be available for the following activities:

> (1) services for the rehabilitation of victims of torture, including treatment of the physical and psychological effects of torture; (2) social and legal services for victims of torture; (3) research and training for health care providers outside of the treatment centers (Department of Health and Human Services (DHH) 2000).

The first provision basically endorses the current model of medical and psychological treatment centers by wanting to fund centers that already exist. As the grant review criteria require that the application "clearly demonstrates experience with and knowledge of victims of torture and an assessment of their presence in the proposed geographic are of service" who could better fulfill this requirement than existing torture treatment

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centers? (Ibid). One refugee resettlement advocate even said to me about this funding, "Aren't they giving out like 20 grants and aren't there like 20 centers?"[16]

The second criterion reflects a blending between the refugee resettlement and medical approaches. Programs are prescribed to tackle legal issues such as immigration status and social problems such as unemployment, along with psycho-medical issues. According to the RFP, social services "are also extremely important and correlate with successful psychosocial adjustment and well-being" (Ibid). The third area of funding is for research and training for non-domestic treatment centers and any domestic health care providers.[17] The Torture Victims Relief Act RFP also encourages applicants to submit proposals that will show plans for providing a "broad menu of services" and "comprehensive services" by forming "collaborative relationships" and "partnerships" with other programs.

In sum, with the passing of the Torture Victim's Relief Act, the government is not asking for innovative, new approaches, but is authorizing and legitimizing the status quo and the dominant practices of torture treatment. The state is not only endorsing the notion

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[16] The actual numbers this informant gave are not accurate but nevertheless, his comments reflect the kind of pervasive cynicism that exists in this professional arena.

[17] The RFP does not devote much attention to specifying what kind of research they are promoting, thus suggesting that research is not a priority of this RFP. This could be so because of research funding that already been set aside by the NIMH for torture treatment research. In April 1997, a conference called "Survivors of Torture: Improving Our Understanding" in Washington, DC (sponsored by the NIMH, Senator Paul Wellstone, the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Office of Refugee Resettlement (ORR)) made recommendations for research. The NIMH released an RFA on Mental Health Research for Survivors of Torture and Related Trauma in February 1998. Funds available for this RFA were approximately $1.2 million. The NIMH also established a working group on the Mental Health Consequences of Torture and Related Trauma to develop a formal scientific report on the topic and organized programmatic resources for questions on research about torture, violence, and trauma. In addition, the ORR and the Substance Abuse and Mental Health Services Administration have joined with the NIMH to provide funding and services for refugees who are survivors of torture.

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that torture survivors suffer psychological harm necessitating psychological intervention, but has written this into the *law*. And, although it is widely accepted that good mental health is predicated on meeting social needs, the whole point of the Torture Victim's Relief Act is to direct more attention and funding to the emotional and psychological effects of torture.

The Torture Victim's Relief Act states that torture survivors "...should be provided with the rehabilitation services which would enable them to become productive members of our communities" (DHHS 2000). Here, a direct line is drawn between mental health interventions and the formation of citizens—"productive members of our communities." Rehabilitation, or experts helping the self of the torture survivor to work on itself toward some ideal of normativity (i.e. "productive members of our communities") enables these citizens-in-progress to become self-responsible so they can contribute freely and productively to the society of which they are now part. With these acts, significant new links have been forged between suffering, the minds and bodies of torture survivors, the expertise of "psy" disciplines, and the state. Governance of torture survivors now occurs in a space that is not entirely social or political. It is a space of intimacy but also a space that is codified into law. With these new linkages, governance of torture survivors has intensified, yet it would be a mistake to think of this as the spread of social control. Instead, the management of the modern state is made possible through the production of "psy" knowledge and new forms of self-governance that enable responsible citizenship for refugees and torture survivors.

When the eagerly awaited RFP for the Torture Victim's Relief Act finally came out, Ed and the Haven mobilized their forces. There were many meetings, emails, and

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phone calls that led to the organization of a local consortium with different agencies and programs. The grant proposal they submitted demonstrated plans for a "menu" of "more comprehensive services." The plans included providing more "outreach" to develop "community-centered resources" and "collaborative projects" and also training for medical and mental health professionals in refugee "trauma." The consortium also proposed to develop new services and expand already existing ones, including "care management, social adjustment counseling, accompaniment, information and referral, social services, legal services," and clinical services (Duff 2000). In addition, they planned for an evaluation of their services which was to be conducted through the CCC. As was also seen in the RCT, evaluation becomes inseparable from service provision. Part of the evaluation process was to include conducting a "needs assessment" of the intended recipients of service. It should be noted that needs assessments are customarily conducted *before* implementing new services and programs.

In 2000, the New York metropolitan consortium received approval for funding for approximately 500,000 USD per year for three years.

Denmark, client independence, and training

Municipal social service agencies were the primary referral source for clients at the RCT and the other Danish torture treatment programs. I was told that torture treatment clients were often those who had a hard time "complying" with the conditions set forth by the state to receive benefits. Like the welfare-to-work programs in the United States, refugees in Denmark also had to demonstrate their own capacity for self-governance by actively working toward their own independence in state-mandated activities. Clients who ended up in torture treatment programs were often those who had

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the most difficulties succeeding in job training programs or Danish language classes and presented various other adjustment problems.

In 1999, an "integration" law passed in Denmark that in essence restructured the entire refugee resettlement apparatus toward a de-centralized approach which placed the burden of responsibility more on each municipality. Prior to this law, individuals were first placed in refugee camps and cared for by the Danish Red Cross. When individuals were granted asylum they were then put under the supervision of a Danish Refugee Council caseworker who oversaw the disbursement of benefits and made sure the refugee had proper housing, language classes, food, and so forth for a period of eighteen months. With the new law, the refugees went from being under the jurisdiction of the Danish Red Cross straight to the local municipalities or local authorities in the regular social service system for a period of three years. The Danish Refugee Council was no longer responsible for refugee care which had been one of their primary activities as an agency. Six hundred Danish Refugee Council workers were laid off because of these changes. The refugees also were being required to follow the entire rigorous, thirty hour per week program of job-seeking, language classes, and skills training. Psychosocial care in Denmark is also bound to citizenship.[18]

This restructuring meant that refugees could not settle anywhere in Denmark that they wanted—they were to be evenly distributed through the country presumably to offset the pattern of high concentration of refugee groups which was thought to contribute to ghettoization and the erection of barriers to assimilation.

[18] This was explained to me by the director of this Danish Refugee Council project, who was also a psychologist at Oasis at one point.

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One of the problems with this restructuring, according to a director at the Danish Refugee Council (which happened to be located on Humanitarian Boulevard), was that many refugees had been "traumatized" and were unable to cope with all the changes and huge demands being placed on them. Additionally, the social workers in the municipalities were not familiar with the refugee population and their particular needs and problems. It was the Danish Refugee Council's new responsibility to train the municipal social service workers in refugee resettlement and also to educate them about *trauma*. Training and educating workers about "trauma" had become a key project for the new Danish Refugee Council. They were also trying to reform curricula for doctors, psychologists, and physiotherapists to include education on refugees and traumatization, facilitate research on survivors of torture and refugee trauma, and also create and implement training programs for language interpreters to work in psychosocial programs for torture survivors. The Danish Refugee Council was also doing a full-scale report on the overall organization of all available services for traumatized refugees in the country. Thus "psy's generosity" allowed new links to be made between the discourses of psychological expertise and non-therapeutic environments, reconfiguring these domains as both therapeutic and citizen-producing (Rose 1998).

Conclusion

This chapter furnishes a description of recent immigration and refugee policies in Denmark and the United States, the development and character of several torture treatment programs in Denmark and the United States, and contemporary configurations of "psy" expertise, neo-liberal strategies for governance, and citizen-making. I would suggest that certain forms of governance, made possible through refugee resettlement,

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humanitarian aid, development and democracy-building activities, are increasingly being linked to the techniques and vocabularly of psychology. This contemporary trend was illustrated through the examples of the RCT's international projects, the Torture Victim's Relief Act, and the restructuring of the Danish Refugee Council.

This chapter also has pointed to some of the contradictions and inconsistencies that define humanitarianism in both Denmark and the United States. For example, there is public and private support in both countries for torture treatment programs, at the same time there is reluctance to open doors to refugees and survivors of torture. A further irony, especially for the United States as a major imperial power, is that certain foreign policy and economic measures are producing the very instability, violence and displacement that creates refugees and other victims of political violence in the first place. A tragic circular production of cause and cure is made evident that will probably only intensify in the coming years.

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Chapter 3:
The Haven

Introduction

This chapter describes the Haven's organizational background, physical environment, and the work of its staff to illuminate certain structural and cultural features of the program that will be the subject of greater focus in the following chapters of this study. It will illustrate one of the distinguishing features of the Haven, the cultural diversity of its geographical location and staff and clients, to demonstrate the Haven's uniqueness in this regard. This cultural diversity is of key ideological and structural importance, and is the center of analysis in Chapter Four. In this chapter, a picture of the core staff of the program, who are mostly bi-cultural, and a sample of five Haven clients are rendered. The reader meets Ed, the Haven's Anglo-American director; Emil, the Serbian-Bosnian clinical director; Slavenka, a Bosnian-Croat casemanager; Marie, an Ethiopian casemanager; Isabela, a Guatemalan casemanager; Sanja, a Bosnian casemanager; and Claire, a French student intern. The reader is also introduced to Eva and Queen, two Liberian refugees; Hamid, a Kurdish torture survivor; Mohammed, a human rights lawyer from an Islamic country; and Meliha, a Bosnian refugee.[1] By describing these clients, I aim to suggest how varied the Haven's client population is, the different needs Haven clients may have, and the different relationships clients have to Haven staff and the program. The clients with whom I spoke were vividly different people, yet common experiences suggest that certain existential and structural facts have shaped all of their lives in ways that also connect them. This is true also for the bi-cultural casemanagers.

[1] These names are all pseudonyms.

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This chapter is also intended to breathe life into the discursive analyses to follow. The production of expert knowledge about culture, about client needs, about different types of therapies, and about trauma; the debates about the psychosocial model, and; the kinds of therapeutic practices that have been developed in the field of torture treatment, all of which will be analyzed in this study, are human activities. Much of the data for this study has emerged out of my interactions with people, and out of observations I have made of the work that they do. The discursive productions and clinical practices I have chosen to discuss are also specific to the localities and temporal junctures of my fieldwork settings and research time period. No matter how abstract or theoretical this discussion may at times appear, much of the shape it has taken is a direct result of my lived experiences with the clinicians and clients who are at its heart, and in specific settings in which we talked, joked, ate, and worked. It is important for the reader to be able to visualize or otherwise sense the concrete reality that is this study's foundation.

I begin this chapter with a brief overview of the larger organization of which the Haven is part and some descriptive statistics. Descriptions of the Haven's location, offices, workday atmosphere, and the Haven staff follow. I then describe the work of the Haven staff. Concluding are portraits of five Haven clients.

Agency Overview and Haven Background

The Haven was established under the umbrella of the "Community Care Center (CCC),"[2] a large agency that provides support and promotes justice for victims of crime and abuse. During the period of my fieldwork, the CCC operated with over 800 staff members and an annual budget close to 35 million USD from both public and private funds, with approximately 75 programs in community offices, courts, police precincts,

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shelters and schools. In the metropolitan area, the CCC had an established presence as a social service agency. Commuters may have noticed advertisements posted in subway cars for the CCC's immigration hotline and domestic abuse programs. After the city contracted the CCC to take a leading role helping victims in the aftermath of the events of 11 September 2001, the agency's name and reputation gained further exposure and recognition.

Beginning in the early nineties, one of the directors at the CCC began laying the groundwork for a psychosocial program for survivors of torture and refugee trauma. However, it was not until 1997 that she was able to procure adequate funding, most of which was granted through the Office of Refugee Resettlement (ORR), to open the Haven and to hire Ed as the program director.

Under Ed's direction, the Haven's practices were modeled after a refugee mental health framework developed in the United States, Canada, and Australia during the mid-to-late 1970's that was described in Chapter One. The 1991 publication of an Office of Refugee Resettlement (ORR) handbook created to assist refugee advocates and mental health service providers symbolized the formalization of this "refugee mental health" framework in the United States. This handbook describes various refugee programs in the United States, and offers guidelines for program development out of what were considered successful and desirable elements in these programs (U.S. Dept. Health 1991). Though no mandates were in place to dictate the direction that psychosocial programs for survivors of torture or refugee trauma should take, the Haven approach was closely aligned with five guidelines for refugee mental health programs developed in the ORR handbook. These guidelines are as follows: 1) "Rely on Non-Psychiatric Settings When

[2] The CCC is a pseudonym.

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Possible to Avoid Stigma" (e.g., do home visits); 2) "Develop an Appealing and Non-threatening Clinical Environment" (e.g., invent an appealing name for the program like "The Haven"); 3) "Use a Multidimensional Treatment Approach" (e.g., incorporate ethnic healing methods, social services into treatment); 4) "Encourage a Team Approach Between Bicultural and Professional Staff" (e.g., include bicultural casemanagers in treatment plans); and 5) "Ensure Coordination and Linkages With Other Service Systems" (e.g., make links with hospital, legal aid programs, refugee resettlement agencies, and so forth) (Ibid.). The Haven's approach and ideologies were also influenced by the discourses critiquing psychologization discussed in the Introduction, and Ed's personal interest in the spiritual dimensions of health and well-being.

Teetering on the brink of fiscal collapse right before I began my fieldwork in 1999, the Haven had a last minute reprieve, receiving adequate funding and also the likelihood of future funding that guaranteed, at least for a few years, not only the Haven's survival, but its expansion. The number of staff grew from two casemanagers and a director to three casemanagers, a director, a clinical director and a student clinical intern. The casemanagers and clinical director were all bi-cultural, meaning that they were refugees themselves, from the same ethnic communities as clients, or both. By 2000, the total number of clients seen in the program since its inception was over 220. According to in-house statistics, forty-three percent of these individuals were torture survivors. The remaining forty-seven percent were survivors of "war trauma." Of all clients and their families, thirty-four percent had been referred for psychotherapy and/or medical services (Duff 2000). Individuals seen at the Haven came from a wide range of national and ethnic backgrounds including Bosnians, Kosovar Albanians, Iraqis, Tibetans, Haitians, and Sri

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Lankans. Many more were from Sierra Leone, Liberia, Côte D'Ivoire, Somalia, Ethiopia and other African countries. Less represented were individuals from Asian countries such as China or Cambodia, despite there being a number of Asian refugees or survivors of political violence in New York City. This was partly because clients were recruited on the basis of whether they matched the cultural background or language abilities of the Haven staff. There were no Asian casemanagers during the period in which I did fieldwork, or staff fluent in different Asian languages. Nor did the Haven regularly rely on interpreters at this time. Further, I hypothesize that refugees from some Asian cultures were probably seen more frequently in medical clinics because they presented their distress through what has been described by Western medicine as "somatization," or, they did not seek help from programs such as the Haven because they feared for their safety or immigration status, and did not want to jeopardize those by having contact with official agencies.

The Haven often struggled for both autonomy and support within the structural and ideological contradictions characteristic of many large institutions like the CCC. Granted autonomy insofar as it was responsible for producing a substantial portion of its operating budget, the Haven at the same time was confined by the CCC's procedures and rules, organizational hierarchies, ongoing restructuring, and the bureaucratic inefficiency endemic to such institutions. The Haven was just one of many programs at the CCC that had to constantly negotiate its status within the agency, and this had an impact on the politics and form of the program. Ed, for example, was forced to spend much of his time fundraising with outside donors, or schmoozing or fighting with different CCC staff to get the resources and support the program needed in a competitive environment that by

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its very structure invited divisiveness. His success or failures in this environment affected staff morale and the overall functioning of the Haven program.

Location

Nestled in a densely populated neighborhood of commercial and residential properties, the Haven is just a short walk-- a long city block--from two different stops on major subway lines. One of these subway trains travels on an elevated track and underneath it, darkened even during the sunniest days by heavy, girded metal, runs a heavily trafficked street. Lining the street are what seems like miles of small shops carrying toys, luggage, clothes, phone cards, and electronics, and also restaurants, travel agencies, and phone stores. Unlicensed street vendors sell their wares on the crowded sidewalks. The street is dirty, the people poor. Many of the storekeepers and customers are immigrants from Latin American countries such as Bolivia, El Salvador, Colombia, and Ecuador.

To get from the subway stations to the Haven, one walks away from this particular street and down one of the main thoroughfares of the Indo-Pakistani quarter of the neighborhood. Not only does this street differ ethnically from the other, but also it is lighter and more open. In the warm months, many of the women on the sidewalks wear shimmering saris and brightly colored salwar-kameez. In the winter, I noticed a practical mix of cultures as the women donned Western winter coats, hats, scarves, and boots over their traditional clothes. Walking down this street one passes shops that sell gold jewelry, saris, imported CD's, audio- and videotapes, kitchenware, books and magazines, phone cards, and cell phones. When passing a certain shop, one is gently enveloped in the smoke and smell of incense. Small salons advertise henna tattoos, a practice that became

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for a time fashionable with young American women. A number of grocery stores stocked with imported Indian, Pakistani and Bangladeshi foods and quite a few restaurants from those regions also thrive in the neighborhood. A small movie theatre near one of the subway entrances features Bollywood films, enticing moviegoers with posters of gorgeous Indian movie stars on the walls outside the ticket office.

At the corner of the first major intersection and on the road running perpendicular to this street stands the reddish-brown brick building that houses the Haven program. Flanking the Haven's building on either side, Indian, Bangladeshi, and Pakistani shops continue for about two or more blocks both ways. If one continues going straight past the Haven building, tree-lined residential streets with many middle-class apartment buildings and single- or multi-family homes appear. As with other areas of New York, in a span of just two blocks the demographic composition of the people and physical appearance of the streets and buildings shifts dramatically. Also similar to other areas of New York, immigrants and refugees toil to create lives for themselves in a city which, at best, reduces them to colorful ethnic stereotypes, and at worst, as nameless, faceless and virtually invisible labor supporting the urban economic and social infrastructure (see Sanjek 1998). For many individuals in this and hundreds of other neighborhoods in New York, their struggles and stories remain to be told.

Although Ed usually included a description of the Haven neighborhood's multiculturalism when giving presentations about the Haven, as if to reinforce the Haven's multicultural diversity and therefore suggest its superiority as a psychosocial program for survivors of torture and refugee trauma, many of the Haven clients did not in fact live in the neighborhood. Nor did the casemanagers. Clients and staff dwelled in

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areas all across the city—from the Bronx to Staten Island, and made the necessary journey to the program as they were able.

Almost directly across the street from the building that houses the Haven, a tiny coffee shop sells decent cheap coffee served by friendly young Indian girls. I stopped into this coffee shop many mornings before starting my fieldwork, or in the afternoon when I felt myself becoming drowsy and inattentive.

At different periods during the day clusters of young women in tight clothes speaking Spanish, laughing, and dragging deeply on cigarettes would be standing outside the building where the Haven had its offices. The women appeared to be squeezing in a few moments of conversation and a quick smoke between classes they were taking at the business/secretarial school located on the building's second floor. Inside the main door of the office building was a rather dark lobby to the building's two elevators. The elevators were frequently occupied by students from the business school, an occasional Pakistani or Indian man there on some sort of business, or individuals whom appeared to be immigrants on their way to ESL classes. On the fourth and top floor of the building where the Haven program was located, the elevator doors opened onto starkly lit corridors that wound in and out from the stairs and elevators in a maze-like pattern. Each corridor looked similar, and as I frequently became confused when walking around, I couldn't help but to wonder what it must be like for new Haven clients or other patrons on that floor. In addition to the Haven program, there were also the CCC community branch domestic abuse and ESL programs, as well as offices for Pakistani and Indian lawyers, insurance brokers, travel agents, and other small businesses. Discreetly tucked away a few doors down from the Haven program was a program for Holocaust survivors.

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Its presence explained the occasional elderly person entering or leaving the office at the end of the hall.

On the third floor, which physically resembled the fourth, the CCC had offices for its immigration hotline and legal aid programs.

Because the CCC ran several different programs at this community branch, there were many flows of physical interaction and also service coordination that connected the programs and staff. One flow was channeled through efforts to coordinate services for different clients within the agency, as it was preferred to provide clients with in-house services as much as possible. For example, if a Haven client was in need of legal representation, his/her casemanager could walk downstairs and talk with one of the lawyers at the legal office. If a Haven client needed ESL classes, the casemanager could simply accompany the client down the hall and speak with the ESL staff about enrolling the client in ESL classes there. Likewise, a lawyer in "legal" could refer a client to the Haven if he/she believed that the client could benefit from counseling or other services the Haven offered. Thus, although the different programs operated separately, staff in the various programs worked together and knew each other well.

With the exception of the Haven clinical director's office, staff offices for the Haven program were located in the main office suite along with the CCC community branch director's office, offices for the domestic abuse program, copying machine, supply closet, emergency food pantry, internal mailboxes and reception area. Seven separate offices fit into a rather small space, four of which were occupied by not one but two staff members. Staff milled in and out of the main office suite, sometimes popping into the different offices to chat with workers in those offices. The community branch

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was a homey and informal place even though it was part of a larger institution. Workers dressed casually, and it was not unusual to see children in the office if a worker could not get childcare that day for some reason. However, the casual friendliness and coziness I observed was somewhat belied by staff conflicts and low staff morale of which I was not initially aware until Haven workers informed me. Evidently, CCC downsizing adversely affected the community branch, and there were also power struggles and personality clashes between different personnel as they fought for resources and recognition.

I came to the Haven a few days a week on my own schedule, usually arriving around 9:30 or 10 am. When arriving at the glass door of the main office suite, I would experience a tingle of apprehension before ringing the security buzzer if I saw Altagracia, the office manager, at the front desk. As I was not issued a key to the main office suite, I was made subject to Altagracia's unpredictable moods. Sometimes, reaching down and pressing the buzzer that opened the main office suite door seemed to represent a major inconvenience to her and appeared to require enormous effort. I observed that her petty demands and capricious refusals were not only directed toward me but to domestic abuse and Haven clients, and some of the CCC staff. Altagracia did, however, have the capacity for being friendly and helpful, but it depended on who you were or what her mood was at that moment.

Besides Altagracia's large and ungainly reception desk, the small waiting area contained several institutional-issue chairs, a water cooler against one of the walls, and rather worn carpeting on the floor. On the walls was tacked a poster in Spanish and English about victim's rights, a poster about emergency procedures for choking victims, a poster with stereotypic images of refugees, and informational fliers on community events

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and services. Many of the CCC's domestic violence clients and staff were Latina which explains why the one poster was only in Spanish and English.

Ed, the director of the Haven, occupied an office straight ahead from the main suite door, a plain and modest room with a large window, a desk, shelves and file cabinets. Decorating the walls were symbols of humanitarianism and multi-cultural inclusivity: a South American embroidered tapestry, a print of what appeared to be a Vietnamese man and child with bamboo canes, an African textile wall hanging, and a calligraphy print with a Confucius quotation. There was also a poster of a child's drawing depicting life during wartime. It was Ed's policy to leave his door open unless he was meeting with someone.

Ed used to wear his thinning hair back in a ponytail and seemed much more comfortable in plaid flannel shirts than the suits he wore for important meetings, but as the Haven program expanded, he cut his hair and upgraded his clothes. Ed, in some ways, was caught between the ambition and professionalization necessary for succeeding in the competitive torture treatment market and large conservative institutions, and the left-leaning politics, spiritual beliefs, and life-style practices that had once formed his identity. Prior to his directorship at the Haven, Ed had been an ordained minister, a practicing Buddhist, and a refugee resettlement worker. He then decided to get his master's degree in psychology and launched the Haven, thereby initiating a life trajectory that took him away from his grassroots, pastoral past. Anglo-Saxon and American, Ed had recently married a woman from another country. He had a young stepdaughter and new baby. Ed was in his mid-forties.

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I would wave as I walked by Ed's office to let him know I was there. Usually he seemed to be extremely busy, talking on the phone and working on the computer simultaneously. Stacks of papers, books and files surrounded him, demanding his attention. Ed received innumerable email and phone messages everyday—sometimes I would check voice mail for him at his request and there would be twenty calls just in one morning. He also was in and out of the office frequently and was increasingly spending time off-site at various meetings. On a few occasions I did not see him at all for several consecutive days.

Marie and Slavenka, two of the Haven casemanagers, shared an office two doors down from Ed's. Claire, a social work intern, shared the office next door to theirs with a casemanager from the domestic abuse program named Michelle. In Slavenka and Marie's office, there were two desks, but only one computer. (Neither Slavenka nor Marie, I might add, could use the computer properly, much to the impatience of the directors). Decorations on the walls were few—the walls were bare except for a couple of inspirational sayings, two calendars, a few photographs, and lists of phone numbers. The most outstanding feature in the office was a "Most Wanted" poster of Slobodan Milosevic taped to a high cabinet. A window on the far wall opened onto another brick building across the way. The desks, fake wood and metal, were standard, inexpensive office models. What made the room warm and friendly were the people in it.

Claire and Michelle had a more cluttered office than Slavenka and Marie's. In addition to two big desks, two computers, and a few chairs, there were bookshelves stacked with papers and notebooks and brown cardboard boxes. The room looked as if someone was going to be moving out of it shortly or had recently moved in. Plants and

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posters of dance performances adorned Michelle's side of the room. On and around Claire's desk there were few personal touches to suggest ownership of that space or claims to permanence there. I usually used Claire's desk, or Michelle's, depending on which was unoccupied.

Claire, Slavenka, Marie, and I would often chat in Slavenka and Marie's office, the central meeting place for gossip and socializing. Slavenka, a Bosnian refugee, was in her early fifties. Her typical work outfit consisted of a turtleneck, a scarf smartly tied at the neck, and nice pants. Bright lipstick, which she wore each day, was in her signature reddish-orange color. Her hair was the same hue, only darker. Flirtatious and funny, Slavenka would tell us stories about her days back in Bosnia before the war when she had a "beautiful house with olive and fig trees." Her husband was a "successful doctor" and she a nurse, and they had a "rich and prominent life" with their two boys. I can still distinctly hear her calling people "honey" and "darling" with her heavy Eastern European accent.

Slavenka had recently separated from her husband of thirty years. Older and frailer than Slavenka, her husband finally was unable to cope with life in the United States and returned to their home in Bosnia. Slavenka's two boys, one in his twenties and one in his early thirties, were working and going to university in New York. Although the boys shared an apartment right down the street from Slavenka's place, she felt that she never got to see them—she said they were too busy with their own lives. Beneath the surface of Slavenka's charming and carefree public persona ran an undercurrent of loneliness, frustration, worry, and finally, exhaustion. Slavenka yearned to return to Bosnia, but knew that leaving New York meant that she would be separated from her

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children and returning to a marriage held together now mostly by memories, the children she and her husband had, and the suffering they had endured together. She often spoke about how difficult life was for her in the States, and how the war irrevocably changed her and her outlook on life. Slavenka was caught between past and future, and here and there, knowing that going back would never undo the war years, but also unable to imagine ever feeling at home in New York.

Marie, in her late forties, wore plainer clothes on her petite frame and considerably less make-up than Slavenka. Her usual demeanor was polite and formal, yet not cold-- I felt something I will call maternal warmth when I was in Marie's presence. A characteristic gesture of Marie's would be to clasp her hands together and perform small bows when speaking with others. However, the gentleness and humility she portrayed was occasionally ruffled by frustration or anger, and every once in awhile, a remark or question would reveal her sly sense of humor. Divorced from the father of her children, Marie had been a political activist, organizer, and educator for women's issues in Ethiopia before she came to the States as a refugee. She had no intention of returning to her country.

One of Marie's children, a girl, lived with her while attending college. Another child, a boy, attended university out of town. Marie also had a sister in the Washington, DC area with whom she was close. I observed that Marie, like Slavenka, worried a great deal about her children and finances and also like Slavenka, suffered health problems such as frequent colds, high blood pressure and fatigue. In addition, Marie had begun suffering from dizzy spells. Besides her children and her work in helping others, Marie's

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greatest solace was found in her relationship with God and in the church she attended in the city with others from her country.

Claire, in her early forties, had long, wavy greying hair and often came to work wearing Indian clothes that she had purchased in the neighborhood. Her charming accent, intelligent eyes, warm smile, and physically solid, no-nonsense presence immediately made me want to be her friend. Claire was French, but grew up in Morocco. In addition to speaking French, her Arabic and Spanish were fluent enough that she could get by with them. After working as an international journalist and then as a humanitarian relief worker for most of her adult life, Claire decided to come back to New York City to pursue a master's degree in social work to learn more about the psychological and clinical aspects of the violence and deprivations she encountered with war victims in the field. Working at the Haven was part of an internship to fulfill her MSW degree requirements. Though Claire was not a refugee, her humanitarian work took her to Bosnia, Iraq, Rwanda, and Rumania where she saw violence, suffering, injustice, and cruel necessity played out in extremes. Claire was passionate if not critical about her work at the Haven. She was married and did not have children.

Hired midway through my fieldwork period was another counselor, Isabela, who came to the States as a teenager from Guatemala. She eventually shared an office with Marie. Isabela's mother was disappeared when she was a small child while her father virtually abandoned his family and started another, leaving Isabela to be raised by her older siblings. At one point, Isabela had herself been a Haven client. There primarily to recruit and counsel Spanish-speaking clients, Isabela was shy, intense, and reserved, but also forthcoming and congenial when invited to speak about herself or engaged in

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conversation. In her early thirties and married with a young son and daughter, Isabela wore glasses, her dark hair in a bob, and dressed youthfully. As a newcomer, she was not yet fully integrated into the old-timers' circle of Slavenka, Marie, and Claire. However, Isabela had worked for a different program in the CCC community branch and was friendly with other staff members including Altagracia, who was consistently quite kind to her, much like a good mother to a daughter. For Isabela, as with Slavenka and Marie, obtaining a casemanagement position at the Haven was a measure of great success because professional positions like these were few and far between for refugees and many immigrants.[3]

Also hired toward the end of my fieldwork period was Sanja. Sanja was from the former Yugoslavia, but unlike Slavenka, she came to the States before the war started rather than as a refugee during the war. Nevertheless, she had been separated from most of her family members who were trapped in Bosnia during the war years. Most significantly, her young child was there with her parents. Married with two children, Sanja's greatest asset to the Haven was not her professional background as a pianist, but her connection to the local Bosnian community. Sanja somehow seemed to know everyone and also was able to work the system to get things done. Someone once described Sanja to me as "very street smart." In her early thirties, Sanja's body was angular and her face strong-featured. She wore fashionable yet casual clothes and never came to work without make-up. Sanja struck me as both a sensitive and tough person. Because she was hired toward the end of my fieldwork, I did not have the privilege of

[3] Two labor niches that many newly arrived refugees filled were in the home health aide and security guard industries. Other refugees found jobs in hotels, driving taxis, or in food service. Some individuals, such as Slavenka, were trained professionals in their countries of origin but found there were many barriers in place that prevent refugees from acquiring jobs that reflect their professional training or experience. Slavenka

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getting to know her as well as the other casemanagers, though she was always warm, friendly and helpful.

Down the hall from the main CCC office suite, there was another suite that contained a large, run-down room with a big window. This became the office for Emil, the Haven clinical director. In addition to Emil's office, the suite included a room used for meetings and storage, with a large table and several chairs in it, and miscellaneous items stacked in piles or leaning against its walls. The Haven used this room for its weekly staff meetings. Both the meeting room and Emil's office were also connected to a large room that contained several computers for the computer classes that the CCC conducted through the ESL program. Often, Emil was the only person in this suite, and the location of his office afforded him much more privacy than other CCC staff.

Emil reminded me of a big affectionate teddy bear who generously delivered hugs, kisses, and loud cheerfulness. Sentimental by nature, tears could appear almost as easily as smiles on his broad face. Two of the greatest sources of pleasure in life for Emil were good food and good films. The third was talking about them. In conversing with Emil, I always enjoyed hearing the analogies, metaphors, and quotations from famous people or lines from books and movies that figured his speech.

Emil and his wife had left Belgrade before the war, came to the States and eventually moved to New York where Emil enrolled in an MSW program at one of the universities in the city. They had two young daughters, and like the other Haven staff, were finding it difficult to make ends meet. For Emil, his new role as the Clinical Director was a significant professional advancement because, typically in mental health

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told me depressing stories about when she worked as a home health aide for elderly Russian dementia patients before she was offered her position at the Haven.

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programs, a clinical director has a Ph.D. or in some circumstances, an MSW with extensive clinical and agency experience. In this case, Emil's less prestigious degree and lack of professional experience were expected to be offset by his charismatic personality, passion, and connections with the former Yugoslavian community in New York. Along with the other Haven staff, Emil was strategically hired for his cultural expertise, and also presumably for a certain understanding of the suffering clients may have experienced as refugees or victims of political violence.

I was both a volunteer staff person within the Haven and an anthropologist from outside of it. Like Ed, I am not a refugee and of Western European descent. Ed and I agreed that I would help the Haven establish a volunteer base while there. I did write up a volunteer manual, but for various reasons never got a fully functioning volunteer program off the ground. I also on occasion helped out with different tasks such as doing mass mailings, running the registration tables at workshops, checking Ed's phone messages, photocopying, and taking notes at the community meetings. Admittedly, I preferred sitting around and talking with the casemanangers about their work and lives more than being entangled in the Haven's messy workplace dynamics. Looking back, I think my dual role as both a semi-staff person and as an anthropologist was ambiguous and difficult for me to maintain, and it also created unresolvable questions of trust between my informants and myself. In addition, because proportionally I spent so much more time with the casemanagers rather than with Ed and Emil, I identified more with them than "management" and therefore my perspective comes from their experiences rather than from Ed and Emil's. In fact, during a talk Emil and I had about an incident that happened at a staff meeting, he accused me of being "defensive of the counselors."

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For the CCC community branch staff members outside the Haven program, few had a clear idea about who I was or what I was doing. Most assumed that I was a student intern like Claire, or a volunteer. They knew I was there on a temporary basis, that I didn't have my own desk or a key to the main suite, and that I was not on the payroll, but few were fully cognizant of the fact that I was there as an anthropologist.

The Work: Ed

What did the staff at the Haven do? Ed spent much of his time organizing and conducting trainings in collaboration with a humanitarian NGO for physicians. These trainings were stipulated in a grant agreement and designed to increase healthcare providers' awareness and sensitivity to refugee problems. It was thought that survivors of refugee trauma and torture sought help first and primarily in "physician offices, community mental health centers and medical centers" (Duff and Pease 2001:12) so it was these groups of professionals that were targeted. In addition to conducting local trainings, Ed was also responsible for conducting similar trainings with refugee resettlement and healthcare providers across the United States for a national initiative on refugee mental health.

Ed also organized different workshops, and worked with other programs and individuals in the city to run the yearly UN Torture Day commemoration events. "Networking" with different individuals, agencies, and possible donors and collaborators throughout the city programs was another task of Ed's. Networking was accomplished through email, the telephone and meetings both on- and off-site. In addition, Ed traveled to professional conferences and attended meetings with other providers of services for refugees and torture survivors, both locally and nationally.

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Getting funding for the program was a never-ending concern for Ed and sometimes took precedence over almost all other goals. If there was no money, there would be no program, and almost all funding for the Haven came from "soft money," or time-limited state and private grants. At a certain point during the period in which I did fieldwork, Ed virtually disappeared into grant proposal seclusion. As a corollary to this activity, Ed was often preparing reports for donors, demonstrating to them that the Haven had fulfilled its quarterly and annual goals. These goals would include things such as conducting a certain number of trainings or seeing a certain number of clients in a set period of time.

While Ed devoted much time to expanding the Haven and building "linkages" with other programs, he was also busy as a manager and administrator and would be the first to admit he had a hard time delegating tasks. He implemented procedures, managed the clinical director and the counselors, ran weekly staff meetings, developed new marketing materials, and conducted staff supervision meetings. On occasion, he introduced himself to new Haven clients, but for the most part had little client contact in his daily routine.

The Work: Emil

The Haven program was a psychosocial program, and Ed thought there was a need to develop the "psychological" aspect of the program. Emil's primary responsibility was to strengthen the Haven's clinical services by providing clinical supervision and training to the counselors, conducting psychotherapy, monitoring the counselors and their caseloads, and establishing better alliances with different psychiatrists and psychotherapists in the city to whom clients could be referred. Typical tasks for Emil

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included training the new casemanagers in the intake process, or revising the client intake forms and then making sure they were implemented properly. Emil also devoted time to upgrading his own clinical skills by learning two new techniques for helping trauma survivors that incorporated both cognitive therapy and body therapy. These techniques will be discussed later in this study. Emil also attended various conferences, meetings, and trainings in New York and on occasion, in other parts of the country.

Emil would work in tandem with the casemanagers whose clients received psychotherapy from him. The client would be seen by both of them, and consultation and coordination would be done jointly as a "triadic" model of service.

The Work-Casemangers

Marie, Claire, Slavenka, Isabela, and then later on, Sanja, functioned as the Haven's core service providers. Their job titles at first were "caseworkers" but this was later changed to "*intensive* casemanagers" as a way to acknowledge the full range of services they provided and the emotional challenges of their work. In the course of daily Haven routines and discussions, the casemanagers were just as often referred to as "counselors" as casemanagers, even though this was not their official CCC title. Of the casemanagers' responsibilities, most were organized around clients and included making referrals, performing supportive counseling, conducting home visits, doing outreach, and completing paperwork. Some of the casemanagers also had special projects they worked on. For example, Marie was responsible for organizing community meetings with different ethnic/national refugee groups in the city.

The casemanagers were responsible for taking advantage of professional development opportunities, such as taking the certificate course at the "Trauma Studies

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Program,"[4] at a local university. They did not have to pay for this training because it was part of an agreement with Dr. Stein, the part-time clinical consultant at the Haven. Dr. Stein was one of the founders of the City Hospital torture treatment program, but left that program to become the founder and director of the Trauma Studies Program. The casemanagers also attended various CCC trainings on topics such as child abuse, rape and counseling.

The casemanagers had weekly supervision meetings with the clinical director as well as weekly staff meetings with the whole team. Sometimes they were required to present cases at these meetings. For these "case conferences," the casemanagers selected a client from their caseload whose situation was clinically problematic. The team then assisted the casemanager in making decisions about what clinical interventions would be best to take in relation to this client. Dr. Stein's expertise was important during this type of clinical discussion.

As the need arose, casemanagers were also asked to work on different projects by the director and clinical director. For example, they assisted Ed in preparing for the UN Torture Day events or training workshops.

The Casemanager's Work in Greater Detail

The number of clients the casemanagers had at any given time varied. For many months after Isabela started, she had only two clients. In terms of "outreach" or getting new clients, she felt that she was "up against a wall" despite all the phone calls she had made, letters to churches she had sent, and visits she had made to different Latin American community organizations in the neighborhood. According to Marie, she and Tomás (a former casemanager) had always been worried about outreach and how to find

[4] This is a pseudonym.

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and attract clients. She told Isabela that "it could take six months or even a year" to start getting a flow, rather than a trickle, of clients. Claire had six clients. Marie at one point had forty clients, and at another, sixteen. Some of the clients were infrequently seen by the casemanagers and retained in the caseload by a monthly phone call. Others required more intensive care and more frequent contacts. Therefore, the number of clients itself does not give a complete picture of the casemanagement workload.

"Accompanying," the term in psychosocial parlance for going with clients to places such as the doctor's office or a social service agency, was a significant service that the counselors provided and took a large portion of their time each week. Marie had many clients she visited in Staten Island who were elderly and whom she also "accompanied." Marie told me if "the clients are young and you tell them the directions and everything they can make it to the Haven or wherever they need to go. If they have a problem, they can still call me." Some clients therefore are considered to be capable of self-sufficiency, especially if they are young, and do not receive the same amount of accompanying as others.

Isabela related to me, "I am lucky with my clients because most people in the city speak Spanish. But yes, I go with some of them to accompany them." By this she means that because a significant portion of New York's population is Hispanic, many social service agencies have bi-lingual staff to accommodate this demographic reality. Yet, Isabela still feels it is important to accompany some of her clients, mostly to act as an advocate for them. Sanja, on the other hand, accompanied clients " a lot because of the language." Many of Sanja's clients spoke Serbo-Croatian (sometimes called Bosnian) or Albanian, and could not speak English well enough to get around. Some could barely

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speak English at all. I also heard from Sanja and Slavenka that Bosnian clients tended to be more "dependent" than clients from other ethnic groups. By this they meant that Bosnians did not take the initiative to learn English and to take responsibility for their own care, and instead depended on the casemanagers "to do everything" for them.

The casemanagers explained to me that the purpose of accompaniment was not just to accomplish the task at hand, but was an opportunity for the clients and the counselors to get to know each other better, to establish trust, and to facilitate the therapeutic activity called "supportive counseling." Marie had one client from Staten Island whom she accompanied to City Hospital for two years and used accompaniment as a means for supportive counseling. She explained, "I enjoyed hearing her stories and giving her counsel on our way to and from Staten Island." This added benefit of accompaniment was reiterated by Ed during those moments when the casemanagers expressed negative views toward performing the service.

And they did have those moments. I often heard Slavenka, for instance, complaining about accompanying. The casemanagers had a running joke with Slavenka because once, Slavenka unknowingly referred to herself as an "escort girl" to describe her accompanying role. The other casemanagers teased her with this name when she would begin telling a story about a difficult accompanying job she had just done. Below is a narrative of Slavenka's that gives a picture of what a typical accompaniment situation was like from her beleaguered perspective:

I had to meet a client there [at the hospital] who is Kosovar refugee. He had a cardiology appointment at 8:30 am for an echo and then had to see his other doctor after for his lupus. We were there for five hours! It was too much. I didn't eat or drink the whole time and I was nervous and the client was nervous. Seeing two doctors in one day! He had the lab test, urine problem and then the doctor gave him some medicine. From 10 to 1:30 we went to see the lupus doctor. It's ridiculous, that's too much. And then double the work

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because of the transportation time. People ask me to do too many things...Sometimes escort makes me want to quit this job.

Isabela's experiences doing accompaniment were not so stressful. Her narrative illustrates other possible accompaniment scenarios:

I have been lucky because the fellow at public assistance has been very nice. I accompanied one of my clients to the Medicaid office because my client needed an interview. And I went with her and they sent me downstairs to the second floor and the guy was lovely. He was a doll. He was very nice. I was shocked! And then I went with a different client to apply for food stamps and we went to the wrong place and the women happened to be from Panama and she spoke Spanish and my client was very nervous and I said, "Oh do you speak Spanish?" And she said, "yes," and I said "OK, I will go and wait for you" and my client was like, "Don't go" and the woman turned out to be very, very helpful and gave my client a bunch of ideas about things. Wow. She didn't get what she went there for because we went to the wrong place...this woman gave the impression that she would be very rough and I thought "Oh my god she is going to give my client a hard time" but I have been lucky. I do know, I am aware of how some people are. And then I had another client who was from Jamaica and the woman who took care of her was from Nigeria and she was a lovely woman. The only thing was that she spoke on the phone the whole time she took care of us. She was talking to a friend and laughing and I looked at my client like "What's this?"

The casemanagers typically assisted clients in obtaining medical care, taking the subway, or applying for social welfare benefits. Many Haven clients were confused about or unaware of their entitlements and the procedures for obtaining those entitlements in the United States, in addition to the language difficulties they experienced. As anyone knows who has had to go to the Department of Motor Vehicles, the Social Security Administration, or to the welfare office in the United States, dealing with those governmental bureaucracies and the people who work in them can be frustrating. Above, Isabela described how shocked she was by how helpful and kind people were to her and her client. She said she was "lucky." Sanja and Marie both explained how the advocacy component of this service was all the more important because of the institutionalized attitudes and other barriers to getting social services they encountered. Sanja told me:

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Sometimes I feel that if I go with my client and even if she does speak English, I think I fight more for her. Because they cannot express themselves, they have their problems, and they just answer yes or no. But if you go with them and if they [the social service person] says no, you say, "Why not? They have their rights!" Sometimes I really have a hard time over there because of fights, well not really fights...

And Marie added:

Especially in the welfare services, I am sorry to say it but sometimes the casemanagers there are very rough. But if you are very active and act like Americans do...they [the clients] don't have the patience. They really need an advocate.

In addition to accompanying, the casemanagers also made referrals. The Haven did not provide many services that the clients needed such as job readiness training or small business assistance. Because the metropolitan area is vast and the number of different agencies and organizations that the Haven casemanagers needed to contact were many, the casemanagers would sometimes spend many hours tracking down the appropriate referral. Each casemanager cultivated her own respective referral lists, fostered relationships with the contact people at different agencies, and shared this information with the other casemanagers.

The casemanagers also conducted home visits, a "non-stigmatizing setting" for service that set the Haven apart from refugee resettlement agencies and also apart from more "medical model" psychosocial programs for survivors of torture and refugee trauma. Often, the clients who needed accompanying were also the clients who were deemed appropriate for home visits by the casemanagers. This category of client was frequently comprised of the elderly, the infirm, or women who were caretakers. For example, Sanja made home visits to a client who was a new mother and who also, for political and emotional reasons, did not venture freely out into the community. Claire visited a client at her home, a torture survivor from Haiti now living in New York who

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was also a single mother with small children. She was confined to her home by acute anxiety attacks.

In accompanying the casemanagers to a few home visits, I felt that their presence was not an intrusion but actually quite the opposite for the clients we saw. There was a sense of intimacy and familiarity between the casemanager and the client that I wonder would be the same if I were to observe them in the office. Because I was a special guest, I know that the clients probably made a greater effort to be hostesses with the coffee, tea and cookies they presented to the casemanager and me. However, they seemed to be happy to have us there. Although I did not pose this question directly to the clients, it appeared to me that these home visits had become for them more of a social call than a social service call. However, the social service aspect was also an important part of the relationship between the client and casemanager in some home visit situations. Marie recounts a story about her first client at the Haven and how a home visit was used as an important social service intervention:

> My first client was an Ethiopian and she used to work with Mr. Ed and then I took over. She had a problem with her son. He had psychological problems and I tried to help. I think a difference was made. The boy closed his bedroom door and wouldn't see his father, his sister, for about a week. When I went there for a home visit he could not talk to me. I said, "I am an African who lives here and a close family friend. Will you please come out here and talk to me? OK, when you feel like talking please here is my number." After three days he started calling me and he said, "Hello, can I please talk to you?" and I said, "Yes, my son, you are the age of my son already." So he talked to me a couple of times for two months or so. Then we started talking about his goals and as a newcomer he didn't know the language very much and his parents, without being conscious, were not so sensible so I tried to work with the parents, especially with the dad who was very authoritarian. So now he is in Las Vegas and he has his own apartment...I follow up, I like to follow up, he's in Las Vegas and his mom went there two or three times to visit him. She expects him to be married soon.

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Home visits created a space where the public and private co-mingled, where the casemanager was at the same time a friend, an authority, a fellow refugee, and a social worker. It was at this intersection that culture played an important role and familiar hospitality rituals such as preparing and sharing food, and welcoming a guest in the home, were enacted. In Marie's narrative, the home visit she described allowed her to present herself as a family friend, a fellow African, and a wise elder to the son who then was emboldened to call her and avail himself to a "psychosocial intervention." In this case, a personal (a family friend) and cultural (African) appeal made possible the engagement with the psychosocial system. This example also demonstrates the strengths of the bi-cultural model of casemanagement.

In addition to the home visits, casemanagers were also responsible for doing outreach,[5] i.e. recruiting new Haven clients. Marie found many of her clients through her church, and then later by contacts made in the Liberian, Somali, and Sierra Leonian enclaves in the city. She was responsible for setting up "community outreach meetings"

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[5] The rationales for outreach are several. One rationale already mentioned is that client quotas needed to be reached. Different grants demanded that a certain number of clients needed to be seen within a set period of time. Client numbers needed to increase over time, especially with the hiring of new casemanagers. In hiring Isabela, the expectation was that she would seek out new clients for the Haven, increasing client numbers and also establishing a Spanish-speaking client base to fill that particular ethnic, national or cultural niche. This expectation fit into one of the larger goals of the Haven which was to be, as one casemanager remarked, as "multicultural and linguistically diverse" as possible.

Another rationale for outreach is that if the word spread about the Haven, all the different refugees and torture survivors in the city whom, it was projected, were in need of the Haven's services would finally have their needs met. Many psychosocial programs create projections about how many refugees and torture survivors there are (in the city of New York it has been estimated there are 200,000-400,000) and then how many have been traumatized to the extent they need clinical intervention (usually figured to be anywhere from five to thirty-five percent) (Duff and Pease 2000:11). It is thought that the problem, therefore, is not that there are not enough clients, but that there are droves of undiscovered, potential clients in the population who simply do not know that the Haven or other programs even exist. It has also been suggested that there are barriers to these potential clients from seeking help at a torture treatment program. Their access to programs like the Haven are limited by "...cultural beliefs about illness and distress, and language and financial barriers" (Duff and Pease 2000:12). It is in fact often said the psychosocial programs currently in operation could not handle the influx of clients if those barriers to access were overcome.

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with the groups she contacted, which will be described in greater detail in following chapters. Casemanagers also conducted outreach through meetings with refugee resettlement agencies, hospitals, clinics, and other locales where refugees received services, and also by leaving Haven brochures and business cards in restaurants and community-meeting places.

Another important duty for the casemanagers was filling out paperwork. This included providing documentation for the CCC, keeping case files up-to-date, and filling out various application forms or official documents for the clients who needed assistance with such matters. Case files were periodically audited, sometimes by Ed, and at other times by outside evaluators such as donors. In the case files, beyond the eight pages of screening and intake forms that had to be filled out were pages called "weekly tracking forms" and then blank "narrative pages" that both required notation with each client contact.

With all the different kinds of duties the casemanagers performed, the amount of time they spent in their offices varied. If they had a home visit or doctor's appointment with a client in the morning, they would often go straight to that appointment and then come into the office afterward in the afternoon. On the other hand, casemanagers could be in the office for an entire day, making phone calls to clients, following up on referrals, doing paperwork, and also seeing clients for "supportive counseling. " Besides the staff meetings, supervision meetings and other types of mandatory meetings or conferences that occasionally arose, the casemanagers had a good deal of independence in terms of how they managed and structured their time. However, on a weekly basis all

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The third main rationale for outreach is that it presents an opportunity for the casemanagers and the Haven program to find out from the refugee communities themselves what their true "needs" are and to

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casemanagers provided schedules to Emil, Ed and Altagracia describing their time and location, both off- and on-site. These schedules could be changed and modified with little notice.

Because the casemanagers shared office space, they tried to coordinate their schedules to accommodate client appointments. Generally speaking, client appointments were private so it was not unusual for the casemanagers to use someone else's office if it were empty. Staff demonstrated flexibility and cooperation in making do with limited office space. Clients were allowed to drop in to see their casemanagers, but for the most part clients did come to the Haven unless they had an appointment. Many clients were so busy working six days per week at substandard wages that they did not have the time to just stop by, but some did make spontaneous visits. For instance, one of Claire's clients stopped by because he had the day off and wanted to say hello to her. Other clients arrived without notice when they needed assistance in doing something like deciphering an urgent official document. In these cases, the casemanager's office door would probably be left open and the other casemanager would stay in the office. During these more informal visits, casemanagers became acquainted with each other's clients. I, too, had the opportunity to get to know some of the clients in this way.

Other client visits were for "supportive counseling," a form of counseling that can be provided by lay people with minimal training which involves, as Claire said, "listening, providing guidance, and being there" for the client in a compassionate and responsive manner. When the casemanagers performed this service, it could range in intensity from providing a therapeutic context for a client to speak about a horrendously violent and sorrowful story of his traumatic past, to simply acting as an advisor to the

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help them strengthen their communities. This will be discussed further in later chapters.

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client, helping him to decide something like whether or not he should take a certain apartment. Staff explained to me that this is a service that sets the Haven apart from refugee resettlement agencies. A casemanager in a typical refugee resettlement agency would not have the time to sit down and speak with clients about what's going on with them in their lives, to listen to client's hopes and fears, or to identify possible symptoms of post-traumatic stress disorder. Instead, large caseloads (especially at times when some humanitarian crisis was going on that the United States felt warranted opening their doors to an influx of refugees) and extensive responsibilities—such as processing paperwork for eligibility for Medicaid or fighting the INS to get work authorization permits-- usually prohibited refugee resettlement workers from having any "therapeutic time" with clients.

For Marie and Claire, the relationship formed between client and casemanager, where they became more like "counselors" than "casemanagers," made them feel their work was important and worthwhile. Sanja and Isabela were perhaps less interested in the therapeutic relationship and the psychological processes that could be involved in this work. Slavenka told me preferred her work as a nurse in Bosnia, where a medical problem could be "fixed" and then the patient went home healed.

Five Haven Clients

Several of Marie's clients lived in Staten Island in a neighborhood that was a ride by ferry and then by bus from lower Manhattan. She went there on a regular basis to provide home visits to clients or to pick them up for accompaniment to various appointments. This area was the new home for thousands of refugees from war-torn countries in West Africa, and I heard repeated that Staten Island contained the largest Western African settlement in the United States. Roderick, a West African community

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leader, claimed that the largest Liberian community outside of Liberia was located in this borough.

Roderick, an imposing Liberian man in his mid-forties, established a pan-African community center for refugees and their friends and family in the neighborhood. The community center hosted activities such as soccer leagues for youth, music programs, and birthday parties for the elderly, as well as general support whether it be emergency shelter or food, or assistance in obtaining medical or other kinds of care. With the help of Marie, Roderick established a mutually beneficial relationship with the Haven, and participated in different meetings with the program, helped encourage referrals, and allowed the Haven to provide certain psychosocial services at the center such as art therapy sessions for youth. Roderick's organization was considered a showcase example of what enterprising refugees could do if they organized, and Ed and other Haven staff mentioned the organization in meetings with other refugees to give them hope and encouragement in "community-building."

I went with Marie to Staten Island one rainy day, taking the ferry across the choppy grey waters of the New York Harbor. Passing the Statue of Liberty, I wondered what it meant, if anything, to refugees who took the ferry to and from Staten Island on a regular basis. After reaching the shores of Staten Island, Marie and I caught a bus that took us to a small town square. We got off the bus and walked over to the community center to see Roderick. He was not in, but a non-responsive teenager was sitting there watching television. Marie and I looked at some children's drawings on the walls, walked around a bit through the space, and then left.

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Located across the street from the community center was a small restaurant owned and operated by one of Marie's elderly clients. The restaurant front had a tiny take-out window, a plain front door, and a small sign with the restaurant's name, but otherwise the façade did not announce to potential customers that there was a restaurant inside. The interior of the restaurant was dilapidated and sparsely furnished, with a bar area, a TV on loudly, and a few tables. I was told that in the summer the restaurant was too hot and in the winter too cold. Marie brought me there to meet the owner, Portia, and two other women from the neighborhood, Judy and Queen. Here, I will focus on the stories of Portia and Queen.

Portia greeted us in the doorway of the restaurant. She and Marie hugged each other warmly many times as we stepped in. Portia, sixty-five years old, had her small lean body and head wrapped in bright blue African cloth. Although illiterate, elderly, and suffering health problems, she was nevertheless able to open and run a restaurant with a business partner and friend, Orly, who was not available to be interviewed that day. Portia also supplemented her income by selling smoked fish, sometimes with Queen's help, at open markets in the city. I was told that sadly, the restaurant was failing, and eventually, it did close. As Marie and I sat at a table, I watched Portia taking orders from young men coming into the restaurant for take-out (most of the patrons were young African men), answering the phone, cleaning, going back into the kitchen to check on things and yelling at one of Queen's grandsons who had accompanied Queen to the restaurant that day. Queen was back in the kitchen smoking fish during much of our visit, which Portia allowed her to do, and at least once Portia also went back there to yell at her. Portia could not sit still for more than a few moments, and I knew it was difficult for

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her to focus her attention on our interview, "the ethnographer's insistent genre...where every "short" question demands a long, sincere, and relevant answer" (Crapanzano 1992:201). Portia's spoken English was in a dialect I had difficulty understanding, so I depended on Marie to translate for me at times. Portia's story is derived from our interview and from background Marie provided.

Portia's Story

Portia came to the United States from Liberia in 1989 to visit one of her daughters, but could not return because war had started there. She was in the States on a temporary basis but finally applied for asylum three years ago, at which time she began petitioning for family reunification for her husband, children and grandchildren who were living in a refugee camp in Ghana. There were forty-four people from her family she was petitioning to get into the United States. If all went as planned, the first nineteen were to arrive in the States within six months. I asked her why she waited so long to apply for asylum, and now a green card. She replied:

> I have nobody to take care of me, you came to new country, you don't know your way, it's hard. Right now I don't know my way to street. It's hard, but in Africa it's not. You can't read, you can't write, you don't know the train, so the train will carry you and put you down and you will be lost. So I was sent to the hospital and my daughter's friend come to visit me. She told me to apply for green card. I was sick and in the hospital, the Staten Island Hospital, she go visit me. And she asked me, "Do you have a green card?" and I say, "no," so she said, "OK, I will help you, I will try for you."

This friend of Portia's daughter, who luckily was able to help Portia, ended up moving to the Minnesota. Minnesota had become a popular destination for refugees, mostly African and in particular, Somalis. Often, refugees will arrive in New York, settle here for awhile, and then decide to join others from their countries in areas of the United States where life is easier. Thus, even in Minnesota there are now growing pockets of refugee and

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immigrant communities that are making white Midwestern homogeneity a thing of the past. Marie, who met Portia through a Liberian community meeting headed by Roderick, took over in helping Portia with such things as getting Medicaid benefits, and also in helping monitor her health care because of Portia's high blood pressure and diabetes. Portia was at an even greater disadvantage than some refugees because she was illiterate. Marie had taken on a daughterly or granddaughterly role with Portia, and Portia did not fully understand what the Haven program was or how Marie was connected to it as her casemanager. With other Haven clients, it was also sometimes true that the casemanager's role was seen much more in familial terms than as a social service arrangement.

At one point during the interview, the phone rang. It was one of Portia's daughters calling from the refugee camp in Ghana, needing to speak with her. I was rather amazed that one could make a telephone call to America from a refugee camp in Ghana. When Portia took the call, it was clear that the interview was over. While Portia spoke with her daughter, Marie provided me with more background on Portia's situation. She explained that Portia desperately wanted to help her family come here, and would make great sacrifices to make that possible, but as an older woman she also wanted her children here so *they* could take care of *her*. She needed rest. But no matter what happened, as Marie stated, Portia was "a survivor."

Queen's Story

Queen also wore African clothes, and was thin and sturdy like Portia. Her youngest grandson sat quietly at the bar drinking a coke and watching TV while we spoke. A few years older than Portia, Queen too came from Liberia. With Marie's

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occasional assistance, I was able to understand Queen's English better than Portia's. Queen lived in the nearby housing projects and was the guardian of her three grandsons who ranged in age from seven to fifteen. Their father died in the civil war and their mother had disappeared. Queen's husband also died in the war. She and her grandsons had been in the United States for only one year. She was seeking subsidized housing for her and the boys because it was too crowded and uncomfortable for all of them in their current living situation with her sister. According to Marie, Queen and Portia were friends, but Queen was a better friend with Portia's business partner, Orly. Marie said that Queen and Portia fought a lot, but continued to smoke fish together and maintain their friendship.

Queen described her relationship with Marie thus:

It is God the almighty and he sent me a granddaughter and she carried me to the welfare office... OK, the almighty God, he does everything for the best. Because my sponsor, she had left, I didn't have nobody to take me to the welfare, to know my way, I didn't know. So I came across her.

Queen, like Portia, viewed Marie like a granddaughter. She also, like many Haven clients, spoke often about God's will and hand in her fate. Marie regularly visited Queen and checked on her progress with such things as obtaining Social Security Income (SSI) and getting subsidized housing. I asked Queen to tell me about some of the problems she had been facing in the United States. She said:

Now, now yes, now my problem now—I have three grandchildren. OK, the government is helping me because I would have, didn't have, any money to take care of me. You saw me got to welfare office and they are taking care of me. Now they try to help me, they help me with every little thing and thank God [something about grandchildren still in Liberia] and that is problem I am facing now because our country is not, you know, in good condition for living. But for me right now I have no problem because I got enough food and the government is taking care of me. If I don't have clothes, some friends give me clothes and they give the children clothes. They have free school for my children at PS 57, the school they go to.

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As with many refugees, one of the main worries Queen had on her mind was family reunification. Families are dispersed, fragmented, and reconfigured from war, yet those who survive often continue to maintain transnational communications and ties with one another. The desire for reunification was strong with almost all the refugees I had encountered. Queen needed to earn enough money to send to her children and grandchildren who were, like Portia's family, waiting for sponsorship to escape the deprivations and insecurities of a refugee camp in Ghana. Queen had to borrow money for plane fare from the Interfaith Services for herself and her three grandchildren to come here, which she needed to pay back before she could scrape enough money together to sponsor other family members. Interfaith is one of the voluntary organizations (VOLAG's) that help settle refugees in the United States.

During our interview, Queen would keep turning to Marie to tell her different things that I assumed were the types of concerns she would share with Marie during an official home visit. For instance, she said,

I will tell you that Henry [one of her grandchildren] came crying to me, Marie, one day. He came to me and said that people were telling him that we were going to be sent back and I said to him, "No, they are lying. We won't be sent back." He was cryin'...I said, "Not the Americans, the Americans are taking care of us." I said they are joking. He wants to stay here.

Queen told me some of her family history, and how her father was one of many African-Americans who went to post-colonial Liberia to help build the nation. He became a close advisor to the King, was powerful, and had many wives and many children. But after sharing this, I could tell Queen was getting restless. She said to Marie,

So I go to try and do fish now, to fish and smoke. Marie, I have a problem now, my daughter in Ghana. She call me and say she is hungry. Now in the refugee camp it is not easy, you got to buy water and buy everything and now I am worried because she needs

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money. So I smoke fish. The UN, they got water there, but there is a time before the water comes and it could be at 2 in the morning and no one will wake you up. So then in the morning you have to go buy it from the reservoir. And I know how it is because I was there for a year!

Queen and Marie talk about this situation, and then Marie asks Queen about her smoked fish business. Sixty-something year old Queen, from a village in Liberia, would travel to the Fulton Fish Market, buy fish, bring it back to Staten Island where she would smoke it and season it "fine with hot pepper." She then took it back to the fish market in Manhattan but had to sell it "across the street" because she did not have a permit, though she was in the process of applying for one with her fellow entrepreneurs. Queen also found her way to a farm in New Jersey:

In New Jersey, you just take a road, a farm road. We have sweet potato, greens, spinach, we have different things, plenty things there. I saw people going there so I followed them. Marie, if you be afraid of something you can't get nothin' done. And then I will be sick.

Marie assured Queen that she will not get sick, and that she was doing just fine. By this point, Queen was desperate to end the interview so she could get back to smoking fish.

At Barnes and Noble with Hamid

I arranged to meet Hamid, a thirty-four year old Kurdish man from Iran, at the café in one of the ubiquitous Barnes and Noble bookstores in the city. Hamid had short black hair and dark eyes, a squarely built frame, and wore corduroy pants, a button-down shirt, and jacket. His English was halting, and he told me it was frustrating for him to speak like a child because of his limited fluency. As we sipped cappuccino and ate croissants, I noticed that Hamid seemed somewhat uncomfortable chewing. I later found out that he had to have extensive dental work done from damage that was the result of his imprisonment and torture. The discomfort in his mouth, however, did not seem to be a problem that could be fixed as I saw him many months after our first meeting and he still

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slightly winced whilst eating. Hamid's case represents the iconic figure of the male torture survivor traditionally seen in torture treatment programs.

Hamid had three brothers and three sisters, and one of his brothers, who had been a Kurdish guerilla fighter, had been killed fighting Iranian government forces. As a teenager, Hamid was introduced to communism and socialism, and when he was old enough he joined the organization of which his brother had been part, and was stationed in the mountains. This organization then sent him to the university in Tehran to study, at which point he was arrested for demonstrating and "making propaganda." After the leader of the organization was captured and publicly renounced his political ideology, Hamid no longer trusted him or had faith in the organization.

As Hamid had been arrested, after four years he was also released from prison, swiftly and with no warning or due process. He and his family decided that it would be best if he fled the country, so he escaped without a passport during the night over the mountains into Turkey with a guide. He had to pay the guide 1,000 USD for his escape. He said he ran for six hours, then walked for twelve, and was shot at by the police, but arrived safely in Turkey where he stayed in a small village. Someone helped him there, and instructed him to go to another city where there were UN officials. He traveled to that city and explained his situation to the UN, and eventually he was granted political refugee status and was allowed to emigrate to the United States. Hamid said he was in Turkey for eight months and received a small allowance from the UN, and shared an apartment with other refugees. One of his brothers came there to see him and to give him money and clothes.

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Hamid had been in New York for twenty-eight months when I first interviewed him. He shared a Brooklyn apartment with two men from a country neighboring Iran. Hamid worked at a gourmet food store owned by another Kurd for minimum wage with other refugees and immigrants for ten hours a day with no benefits. He woke up at 5 am each morning for work, and then after work tried to attend English classes. Because many people he worked with spoke Spanish, or their English was otherwise limited, Hamid was hampered in improving his English. He also felt he worked so much at such small wages that he had little time or money left over to pursue larger goals, such as attending college.

Hamid found his way to the Haven via a hospitalization at City Hospital for depression. City Hospital's torture treatment program provided intensive psychotherapy for him, and he was referred to the Haven for social services and support. Hamid provides an example of a Haven client whose traumatization manifests itself in a psychologically debilitating way, and who undergoes traditional psychotherapy. Hamid explained this period of his life:

> Last year when I was in depression, when you go to another culture, and I was alone, and my mother died and I liked my mother so much. Last year no one helped me with anything. I think about my family, I am homesick all the time. I was in depression for six-eight months. I called my friend in Switzerland [who was imprisoned and tortured with Hamid in Iran] and told him to come here because I wanted to kill myself. I kept thinking about the past. "Why? Why I ask?" He came here and took me to hospital. He took me to a psychologist. Step-by-step, I change myself in New York. When I had operation [for a hernia] I talked with Claire. She helped me.
>
> Right now, I am a normal person because last year I had a psychology problem. It's horrible you know, all the time I was in the past, not in the now, in the present. All the time walking down the street I had problem with people [bumping into them]. I saw psychologist six months everyday because I had a bad situation. I didn't like anything. I didn't like life. To the doctor I talked about the past and he said, OK, how do you feel now? I told the doctor I had a hard life here in NYC. I sometimes need to just talk to one person. I was working construction, it was hard, I didn't know anybody, no family, no break! In Iran, Thursday and Friday are holiday like Saturday and Sunday and all the family come together in the home and talk about the week. Here I just worked and

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worked and had nobody. When I watched TV I couldn't understand anything. But I tried to change. When Irage came here he told me "When you were in jail you were a powerful person" (because I didn't talk, I told the police I liked my ideas). Everybody in jail liked me. He said "Life is easy here, its' nothing like it was in jail." When I first saw Claire, I didn't want to talk with her, only with Kurdish people. I was in the past. Everyone told me to talk, talk, talk, you need to talk. Four-five psychologists [two were students] sat in room and asked me how I felt. I told them I want to put myself in front of train—but I thought of my family. When my life is difficult I trusted my friend and talked with him in Switzerland.

Two weeks he stayed here and we went to Central Park and bought food and talked about old friends. He said why not select a girlfriend for life, progress in life, in language, to change my bad mind.

Then I saw Emil and Claire and I found new friend. Step-by-step I change my job and make new friends. When I see a friend and talk about my life, I feel relaxed.

Hamid eventually became more estranged from the Kurdish community, and sought company with different girlfriends. He missed his family, but knew he could probably never return to Iran. Though the psychotherapy had prevented him from killing himself, he had episodes where he had altercations with others that put his job in jeopardy. He also seemed unable to make and sustain new friendships, and felt lonely and frustrated. Hamid stopped going to the Haven when Claire finished her internship, even though Emil encouraged him to return to attend a psychotherapy group for male torture survivors.

Mohammed's Story

Mohammed, thin and tall, with elegant hands gracefully gesturing as he spoke, agreed to meet me for an interview at the Haven. I noticed he did not look well; his face was drawn, his eyes would sometimes grow wide as if he had seen something frightening, and the smell of sweat, acrid and penetrating, would sometimes drift over to me as we spoke. Prior to his escape to the United States, Mohammed was an attorney and an advocate for the rights of women and children in a country now enveloped in America's "war against terrorism." His political advocacy work brought him to the attention of the

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international human rights community, and although he was publicly known, he was also concerned about his privacy because of possible threats to the safety of his wife and children back home. He modestly apologized to me for his English, but I found him quite fluent and well spoken.

Mohammed spoke about how his homeland was ruled by feudal warlords who forged a system of corrupt and violent rule. Mohammed's life work was as a crusader for the rights of the poor, women, and children, and because of his activities he was falsely accused of crimes, imprisoned and tortured several times. Not only were the local powers threatened by him, but the husbands of the women and girls he represented "were also a problem." According to Mohammed, one of the typical ways perceived wrongs were righted in his society was through vengeance which was sometimes accomplished through murder by hired assassins. Mohammed explained that these hired assassins were recruited from the ranks of the desperate, usually poverty-stricken men willing to kill in exchange for some payment. Because Mohammed was much loved and respected by some of the poor, including hired assassins, he was warned when his life was in danger, and was somewhat protected.

As the threats to Mohammed and his family intensified, the warlords and police expanded their strategies of terror by targeting the poor people whom Mohammed had helped. The intent was to destroy their solidarity with him. Mohammed decided to leave the country when it became apparent that his work was at the cost of many other people suffering or being in danger. He felt he had become a "burden."

Mohammed came to the States with a visa procured through a Congress person and human rights organization, ostensibly to attend a conference. With 11,000 USD his

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father had given to him before he left, he did not to return to his country after the conference ended. Mohammed had one distant relative in New York who sheltered him and employed him in a repair shop for taxi and limousines. He enrolled in paralegal degree program so he could have a legal visa as a student. As with many foreign-trained professionals, Mohammed's degree, training and experience had no value in the States. After working at the repair shop for awhile, he began working at a Subway (a sandwich chain) to make money to survive. He was not entitled to any government aid because he had not yet been granted asylum. Because of his torture, Mohammed experienced a tremendous amount of pain in his legs that made it nearly unbearable for him to be on his feet all day. During our interview, I observed Mohammed stretch his legs and slightly wince several times, prompting me to ask if he needed to prop up his feet. He said no. It was obvious that he lived with chronic physical pain.

I asked Mohammed how he found the CCC and the Haven. He replied:

> This is so funny. I just a sign on the subway saying CCC and you know sometimes you feel something from the heart, and then I called them and said, "can I volunteer?" So they said you come here and they sent me to the legal department. Then I came to know them and I found that they really helped me.

Mohammed began volunteering in "legal" and Mr. Johnson, a lawyer there, referred him to the Haven because, Mohammed told me,

> I started with a problem with my head. I was losing my memory, I went to hospital...uh it was St. Vincent's Hospital. I went there to the emergency room. It wasn't possible for me to stand there and make sandwiches and they started treating me and they told me I needed MRI. It was $1400 and I certainly could not afford it. So I told Marie I didn't have that much money, just enough money to survive so she referred me to City Hospital: [he points upward]. Yeah there is someone. This CCC did a very good thing, they found a job for me in some law offices.

Mohammed was happy that Mr. Johnson got him a secretarial job at one of the law offices in the Haven building, working for lawyers from his country. He was to begin it

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the next week. Mr. Johnson was also in the process of helping Mohammed apply to human rights programs at law schools such as Harvard and Columbia. I asked Mohammed if he had friends in New York and he replied:

> New York, no. Life is such here that I don't have the time. Go to work, then sleep, then school, work, sleep, school, work, sleep, that's it. I don't have time to make the friend. So this CCC is my only friend. Marie is my friend I would say, the way she treats me....You know, if you talk to someone at least you know you get some relief, you talk about your problems, so at least when I talk to the Haven program I feel relieved.

I spoke with Mohammed in the spring of 2002. He was living in Cambridge, Massachusetts and attending law school in a prestigious human rights program at Harvard University. Though grateful about this incredible turn of events, I know Mohammed was profoundly sad to still be separated from his wife and sons. Mohammed told Emil that if he returned to his country, it would mean the death of one of his sons. Emil asked Mohammed what he meant by that. Mohammed explained that if he returned, he would surely be assassinated. It would then be his eldest son's duty to avenge his father's death. If his son killed his father's assassin, his son would in turn be murdered.

Meliha at Home

Meliha, from Bosnia, arrived in the United States in 1999. I visited her apartment along with her casemanager, Sanja, who acted as our interpreter because Meliha did not speak English. Meliha admitted however that she could understand a little English that she had learned by watching TV. Meliha's first casemanager was Slavenka; her second was Sanja who also happened to be a relative of hers and was her sponsor in coming to the United States from a refugee camp in Germany. Sanja told me that shortly after Meliha's arrival, Meliha was diagnosed with breast cancer and had to be treated for it at a local hospital.

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Meliha's apartment was immaculate. She lived by herself in a Queens neighborhood that was populated by Bosnian refugees like her. Meliha apologized for her home and said she was "poor now," and had much more back in Bosnia. The living room contained a donated couch, a coffee table, chairs, a television which was often left on, and a clock on the wall that was always set on Bosnian time. Meliha brought out strong coffee and cookies for us, and set them on the coffee table. I ask Meliha about her family after she told me that she lived alone and that she had been divorced for fifteen years. She explained to me that her daughter lived in Germany, married an Italian, and had two children. She showed me pictures and said that at every hour she can imagine what her grandchildren must be doing in Europe. Her daughter sent her some money to help support her. After we left Meliha's house, I was surprised to hear from Sanja that Meliha had a son in his early twenties who lived in New York. Sanja explained that he did not see his mother often because he was busy with his girlfriend and with "trying to become American."

Meliha described her time in the refugee camp in Germany, where she and other Bosnian refugees were given an allowance of 150 marks a month. Two to three hundred Bosnian refugees lived in a three-floor building called the "American Soldier's House." Food, such as potatoes and rice, were prepared for them but the refugees were also allowed to prepare their own food, which Meliha tried to do if she had the time. Meliha had lots of friends that she met in the camp, but "the Germans started saying that everyone had to get out of there." Many of the refugees were to be repatriated but Meliha did not go back to Bosnia because her hometown was still held by Serbs. Instead, she and others had to choose their third country of settlement. From a choice of the United States,

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Australia and New Zealand, Meliha chose "America" and was selected to be resettled in Utah. However, Sanja intervened and did the paperwork to sponsor her to come to New York City. When Meliha arrived, she stayed at Sanja's for two months until they found her an apartment. Shortly thereafter, she had a pain in her back and felt sick, was diagnosed with breast cancer and had a mastectomy. Meliha decided not to have chemotherapy because she "did not want to lose [her] hair."

Meliha thought that the Germans were "super." She felt more comfortable in Germany than in the States, which she speculated was because their language was closer to her own—a few words were even the same as Bosnian words, such as the words for milk and ice. Americans too were "no problem, they are super." She thought that Americans felt sorry for her because she was by herself and had been sick. Meliha told me that she felt it was too hard to start her life over again here, She said, "I am in my sixties already. The war, marriage, surgery, it's really hard for me. If I were thirty or forty maybe I could...Sometimes I thank God that my brain still works after all I have been through." Meliha told me that she missed her children, her brother, and her father. Her separation from family and friends was painful. She felt that she and other Bosnians were not welcome anymore in their country because "the Serbs hate us, they hate us as human beings. That's all." At this point in our conversation, Meliha turned to the past and told me about some of her experiences in the war. Tears came to her eyes and her voice broke as she spoke.

She told me that "the worst thing" was when Serb soldiers came to her house. They wanted to move in and she refused. They tortured her for three days and when she was released the house was locked and emptied of all her personal belongings. In telling

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me this, she said, "It feels like it was yesterday." Again, she said, "The worst thing is when they say to you that you must leave your house, the house of your childhood, your parents. It's not yours anymore and you cannot even take anything with you that belongs to you." On December 28, 1993, five soldiers came drunk to Meliha's house and they said "bad things." They came back repeatedly until Meliha took a small bag with underwear and a few things and went to her brother's house.

Meliha also described how five soldiers beat her father (who must have been in his seventies and more likely, in his eighties) and her eldest brother over a period of hours. The soldiers told Meliha that they would kill her father if she didn't leave her house. One soldier had a gun and began to beat her while saying insulting and degrading things about her mother. Her collarbone was broken from the beating. The soldiers warned her if she didn't leave in seven days "there will be a body in the river." She then told me, "No one can understand or imagine our lives back then who wasn't there." Meliha said that life during wartime was "like living in the 18th century"—there were no phones, electricity or running water.

Meliha then switched back to the present and told me more about how kind the people in the hospital were to her. She said she had little contact with Americans except for the people who were involved in her cancer treatment and rehabilitation. Her physical therapist found someone from Albania to translate for Meliha and when the therapist heard Meliha's story, she cried, and since that time was "very nice" to her.

Meliha was curious to hear more about me. She wished me the best of luck with school and asked if I had a husband and children. She told me that the most important

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things in life were to marry a good man and have children to love. "Nothing else really matters" in the end, she said. She invited me to come back and visit her sometime.

As part of the interview, I asked Meliha what she thought of counseling and if she would ever consider it. She said she would, but wondered what counseling could do to help her. She followed this by saying, "If you are alone you are always thinking about what happened to you." I asked her if she knew about other programs or community centers where refugees could come together. She offered that it would be nice to meet people, to talk, and to go out. Meliha explained that when she did see her family, they talked about their memories.

Conclusion

This chapter provided a view of the Haven's environment, structure, and work of its staff, and perhaps more importantly, furnished sketches of the staff and a handful of Haven clients. The multicultural diversity of the staff and clients is significant insofar as that diversity needs to be organized and managed in practical ways, a problem that the Haven faced and which will reappear throughout this study. In addition, the different needs clients may have, and the different relationships Haven clients may enjoy with their casemanagers were also illustrated. However, in introducing the bi-cultural staff and several Haven clients, I intend also to suggest the types of hardships that they have had to weather, and the profundity of the losses they have had to endure. This chapter also bears witness to the human capacity for resilience or faith or whatever it was that enabled these survivors to travel to a farm in New Jersey for vegetables, work at physically demanding jobs while in pain, to seek family reunification against great odds, or to transform their suffering into energy for loving and helping others.

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The next chapter will examine how "culture" fit into the practices and formed expertise at the Haven.

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Section II

How governance of both the clients and clinicians at the Haven was fostered through psychological techniques.

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Chapter 4:
Governance through Culture

> We work in partnership with survivors, honoring the beliefs and traditions of their culture. We engage in a respectful process of on-going dialogue with survivors and their families that leads to a plan for achieving well-being. We seek to create an environment in which survivors can rebuild trusting relationships with others and, at the same time, experience their own self-sufficiency.
>
> We hope to empower survivors to draw on the same inner strength and resilience that helped them though their ordeal of torture, to bring them to a place of healing and wholeness in their present life.
>
> Excerpt from the Haven's mission statement

Introduction

The main criterion for a person's acceptance into the Haven program is that he or she survived political violence. Outside of that single unifying condition, the Haven provided services to individuals who traverse all those sociological categories of difference that have come to grid our social relations: class, race, gender, ethnicity, nationality, sexual orientation, and age. In fact, the more "diverse" the Haven's staff and client population, the better, as this reflected the excellence of the program's technical capabilities and also the program's moral and ethical commitment to being inclusive.[1] The Haven was not isolated in this effort, as for many institutions in contemporary American society the goal to maximize diversity has been increasingly associated with greater authority for expertise. However, striving for this type of diversity at the Haven meant accounting for only one practical level of human difference. To fully address the needs of an individual client, the Haven determined to account for both the sociological or objective categories of difference as well as subjective differences: the individual

[1] Herewith, quotation marks around certain words or phrases indicate that these are quotations from Haven staff or Haven literature unless otherwise indicated. I do not necessarily sight the sources of the quotations, because I consider them to represent the general Haven discourse.

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histories, life experiences, and personalities that also were thought to constitute the self. This is likely true for most therapeutically-oriented social service programs that are in the business of enabling "self"-transformation. Service delivery at the Haven thus depended on properly attending to these two unstable and sometimes intersecting levels of difference in helping clients work toward the goals of "self-sufficiency," "empowerment," "healing," and "wholeness."

However, the Haven was faced with an interesting set of problems that set it apart from many social service programs because the population to which it provided services was, by common standards for measuring diversity, remarkably "diverse." In providing services to people from "radically different backgrounds" with "multifaceted perspectives," in a program where service was about "understanding," how could the Haven understand the people it wanted to help and what were the best ways to help?[2] How could the program serve potential or actual clients when some of them did not even have a command of the English language? And when service workers reflected the diversity of the Haven's clients, how could the program create a work environment that also properly took into account the differences of its workers?

Human difference is a political and social reality and thus a practical problem of the Haven's work. To address the practical problems of difference, the Haven relied on different strategies to organize and thereby care for its diverse and heterogeneous clients and workers. One of its primary strategies was to mobilize discourses of culture. By this I mean "culture" became conceptually animated and valued as an instrument for the development of different techniques that unified, organized, and made intelligible both clients *and* casemanagers in what the program hoped to be a reasonable, humane, and

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caring manner. "Honoring the beliefs and traditions" of the client's "culture" was one avenue the Haven program took in attending to objective or sociological categories and subjective differences between clients. This avenue also supported the formation of a "partnership" between experts and clients.

As Rose points out, "psy" knowledges are not located in some abstract realm of theory, or in the rarefied world of academia, but are grounded in "expertise," in "...the capacity of psychology to provide a corps of trained and credentialed persons claiming special competence in the administration of persons and interpersonal relations, and a body of techniques and procedures claiming to make possible the rational and human management of human resources in industry, the military, and social life more generally" (1996:11). At the Haven program, expertise included the production and application of a "body of techniques and procedures" to manage both the casemanagers and the clients that were not simply imposed from above in a coercive or controlling manner. Instead, "psy" knowledge built into or made possible the noncoercive authority of the Haven to determine what was "best for the clients" or "best for the casemanagers" by drawing on certain knowledges—cultural knowledge, knowledge from personal experiences of suffering or of refugeeness, or other forms of knowledge that are presumed to be inherent in and even constitutive of individual subjectivity--that came from the subjects whose self-governance was in question. Cruikshank's (1999) studies on programs for empowerment of the poor reflect this strategy of governmentality. In these programs, expertise had come to be "dependent upon knowledge of those to be empowered...and often gained through the self-description and self-disclosure of the subject to be empowered" and "a crucial part of knowing the poor was knowing what the poor wanted

[2] These quotations come from a Haven grant proposal.

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and how they defined the needs and conditions of poverty" (Ibid.: 77). Similarly, the Haven developed specific practices which were fashioned to facilitate "empowerment" and "self-determination" by inviting the expression of the casemanagers' and the clients' knowledge of their own needs and interests. These practices included the solicitation and honor of their cultural knowledge.

Philosophically, the authority attributed to methods that solicit forms of self-knowledge toward the goals of greater empowerment and "self-sufficiency," may be traced to older liberal humanist ideals of egalitarianism, the intrinsic worth and dignity of the individual, and the right to "self-determination." The Haven also subscribed to the notion that there are universal human rights accorded to each individual person. It was thought that survivors of collective violence lost those rights or suffered violations of those rights, and that therapeutic intervention should and could help restore those rights. There was therefore an important political dimension to therapeutic activity, where the self was constituted as the sight of political intervention and political liberation. Self-empowerment in these practices did not, as it is sometimes argued, mean a turn away from political or collective engagement toward a narcissistic or solipsistic project of self-improvement, but entailed a specific configuration between the political and personal that constitutes a particular "governmental" strategy in contemporary democratic society (Cruikshank 1999). Further, the expert/client relationship that the Haven favored represented a political activity that redistributed power. Thus certain liberal ideals were practiced at the Haven in forms of therapeutic activities such as "dialogue" that fostered an egalitarian relationship between expert and client and challenged existing social

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hierarchies. "Dialogue" represented one of many methods the Haven practiced to create the "partnership" configuration of expertise.

These philosophical and political discourses and associated therapeutic practices solicited a particular kind of self. It was assumed that the Haven client or casemanager was an active, free, autonomous, and choosing self, capable of self-governance or "self-sufficiency," or has the capacity for optimizing this type of selfhood with the application of a little guidance, education or therapeutic intervention into conduct. It was through the application of certain rational techniques and practical methods that self-determination and empowerment were cultivated; the casemanager or client was "not to be dominated in the interests of power, but to be educated and solicited into a kind of alliance between personal objectives and ambitions and institutionally or socially prized goals or activities" (Rose 1999:12). In other words, governmental techniques "construe these subjects as active participants in their lives" and thus are designed to enable them to maximize their potential to reach "personal objectives and ambitions." (Ibid.:10).

My aim in this chapter, as well as those to follow, is to examine how promoting the casemangers' and the clients' capacity for self-governance through their active and participatory "partnership" provides the ground for the authority of expertise at the Haven. Nonetheless, becoming a client, no matter how egalitarian or voluntary the relationship may be, still entailed entering into "a democratically unaccountable exercise of power in that the relationship is typically initiated by one party seeking power over another" (Cruikshank 1999). It was likewise true that the casemanagers, no matter how much their "input" was valued, were also entwined in uneven relations of power with the Haven directors and larger institutions.

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This chapter will first describe the everyday function of "culture" at the Haven. This will be followed by a case study of a clinical training workshop where cultural and spiritual resources were integrated into treatment. The chapter will close with a description and interpretation of the model of the bicultural counselor, and the significance of self-care practices for the bicultural counselors' self-governance.

Everyday Discourses of Culture at the Haven

It quickly became apparent to me that the Haven's multiculturalism and a discourse of culture were structured into the workplace, functioning as an implicit social framework and also a more explicit preoccupation for all of us. I realized that the Haven was a space where "culture," "cultural difference," and "cross-cultural understanding" were continuously accentuated, negotiated, and reiterated. These concepts together, which I shall call the "discourse of culture," acted similarly to what Crapanzano (1992) refers to as the "Third," a constant yet flexible point of reference or context which permitted some stability in our encounters with one another and of our identities.[3] The discourse of culture's practical, everyday usage in conversation and in non-clinical interactions at the Haven provided a useful social orientation point for staff and myself.

For instance, the Haven casemanagers made jokes that used the discourse of culture. In the American hospitals, governmental offices, commercial workplaces, and schools with which I was familiar, jokes about "culture" were largely unacceptable. Yet at the Haven, it was not uncommon for staff to trade jokes such as the one Slavenka told about the Albanian who complains about his new security guard job because he actually

[3] Crapanzano developed the concept of the Third as a critique of the dyadic relationship analytic. I am using the term in a more general way. I am not arguing that the discourse of culture was the only stabilizing frame at the Haven. In fact, there were others that had maybe even greater influence on conduct, such as the professional context or common therapeutic goals.

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has to sit up and stay awake all day. This type of joking was more or less benign, and kept within certain limits. But just outside the doors of the office, sometimes the rules of etiquette would change. I recall walking down the street one time with Slavenka, Marie, and Claire while on the way to grab a bite to eat during our lunch hour. I was commenting on how I loved the South Asian stores and restaurants in the neighborhood. Slavenka turned to me and mentioned something about how they were "dirty" and said with a certain knowing look, "you know what I mean." This was neither the first nor the last time I heard comments and insinuations like this from Slavenka or from the other casemanagers. Thus there were times when the casemanagers made derogatory comments about other cultures (but usually not about each other's culture, at least in the presence of each other). At those moments I felt rather shocked and disappointed to hear such views expressed, especially because I had the naïve and presumptuous expectation that those who were victimized should not victimize others.[4]

More often though, the casemanagers made cultural jokes about one another or themselves that were affectionate or silly. For example, one day Claire wore a scarf and we traded comments about how "French" she looked in it. Marie once said she liked to eat meat so much because "most Africans do" and from them on that became a running joke amongst us.

Cultural expression, in certain forms, was welcomed and even celebrated in everyday practices in the workplace. These were the kind of cultural expressions that

[4] It seemed that Claire and I were less chauvinistic and bigoted than the casemanagers. Perhaps understandably, Slavenka and Sanja had become prejudiced against Serbs. However, this does not explain why they or Marie had class prejudices, prejudices against darker-skinned people, or against other groups such as gays and lesbians. For Claire and me, cultural differences were not as threatening nor as salient, perhaps because we were educated, white, privileged and American and European. We never experienced a threat to our lives for being a certain ethnicity or nationality and we were also part of a society where one does not openly express certain prejudices.

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define America's multicultural ideal--preparing and eating ethnic food, observing certain holidays, and wearing ethnic clothing. For example, after being notified that she had been promoted to *senior* intensive casemanager, Marie invited the staff to an African restaurant owned by her "people" to celebrate for a late working lunch. We all went there and enjoyed the insider cultural knowledge that Marie imparted to us. She knew the owner and naturally was familiar with all the dishes and the culturally proper way to eat the food. During lunch, Marie would say, in "our culture, this is the way we eat this..." and then would demonstrate for us. She took it upon herself to be our tour guide and also our hostess, a representative of her culture and its customs on our brief culinary journey. We were invited into a sphere of cultural intimacy that included having Marie hand-feed us as a hostess would do in her culture. The conversation at the table that afternoon also drew on the discourse of culture as we discussed such issues as Croatian and Bosnian politics and the problems and joys of culturally-mixed marriages. Our talk self-consciously acknowledged the issue of culture, and the fact that we were all culturally different. Often when we would meet together under these types of circumstances, our conversation revolved around cultural differences and similarities, and other topics that reflected our "diversity."

Sometimes, the discourse of culture enabled a way of describing why another staff person behaved or conducted him/herself unpleasantly. On occasion, if some incident or interpersonal exchange happened that was disturbing, the casemanagers engaged in discussions where they would try to determine whether someone's behavior was due to "culture," or some kind of psychological (e.g., personality) or structural (e.g., work hierarchy) problem, depending on the particular behavior and whose conduct was

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disagreeable. I heard mentioned that Emil was thought to conduct himself in ways that were characteristic of "Serbian men." Slavenka thought that Claire's tendencies to be outspoken, argumentative and passionate in dealing with authority figures at the Haven, while perhaps acceptable in Claire's culture, were considered "insubordinate" and "disrespectful" according to Slavenka's cultural standards. Claire in turn felt that when it came to some of the interpersonal conflicts or disagreements she had with Ed, that "Americans are different. They are more controlled, solution-oriented and basic. They cannot argue and disagree with each other." I would suggest that a cultural explanation could be, at times, a subtly insulting explanation and the final word on a matter.

I too had a few disturbing and perplexing encounters with staff at the Haven that I grappled to comprehend, and following my own cultural tendency, usually attributed to them a psychological explanation. Most vivid for me was during the first few weeks of fieldwork when on several occasions, as I tried to engage Marie in conversation, she avoided some of my questions or shifted the conversation to other mundane topics. In general I did not feel she was responding positively to me and I wondered if she didn't like me or didn't trust me. Finally, one of the casemanagers kindly explained that as "Africans" from Marie's "culture" do not speak about themselves in the "I" or "myself"[5] way that "Americans" do, I should approach Marie in a different or less direct manner to engage her. In hearing this, my own cultural upbringing was made visible to me at once with the recognition of Marie's different cultural upbringing.

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[5] Marie did not refer to herself as a "self" meaning, for example, when I asked her to tell me a little bit about herself and her background, she didn't feel comfortable telling me about "herself" in the specific way I asked. To do so was unseemly to her. She could tell me about her "professional background" though. Furthermore, I noticed Marie also would not directly say, "I am angry at Ed," but would tell a story, almost like an allegory, about some other incident that may have happened to her or others. The story and its telling were Marie's ways of letting others know she was feeling angry and that a situation was unjust. This manner of communication seemed indirect to my "American" sensibility.

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Cross-cultural understanding at the Haven frequently had to be achieved through some kind of verbal exchange and clarification. Sometimes though, cross-cultural understanding was impossible to achieve and the chasm of difference simply had to remain as a fact of our existence together. I certainly felt this way sometimes with Marie. I heard it expressed also that those who inhabit the same culture have an understanding with each other that does not need to be articulated—it is just ineffably there. However, it became clear that just because someone shares a culture with others, it did not necessarily mean that all members of that culture were the same or that one must identify oneself with that culture. Emil, for example, worked hard toward eliminating the divisiveness among "former Yugoslavians" that continues on in post-war New York in both his work and personal life. He told me that he did not even identify himself as "Serbian" until the war and was upset by how this negative identification had been thrust on him.

In the informal exchanges just described, the discourse of culture functioned as something spoken and lived in a mostly non-clinical and spontaneous manner at the Haven. Culture could be connected to many things at the Haven—race, ethnicity, nationality, community, how you think, your sense of self, how you dressed, how you spoke, what you ate—and in this sense it functioned as one of those slippery concepts that defies a precise definition, yet is amazingly flexible and useful for this very lack of precision. It did seem to be something durable or essential which people had as a cluster of traits, propensities, and behaviors, and were inherently in, as a medium through which one experienced one's self and the world. We all shared some vague yet consensual understanding of this, which was sometimes explicitly articulated, and sometimes not. It could even be said that we were ourselves creating a particular culture where cultural

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difference and understanding were valued, and that the discourse of culture was itself producing a certain sort of culture. The discourse of culture was everywhere at the Haven and our awareness of it was heightened but also normalized in this setting.

The discourse of culture practiced among the staff in the manner I have described acted as a convenient and readily acceptable way to encompass and make sense of the many differences of the staff. It provided a shared frame of reference from which a "diverse" group of people could get to know one another and work together. Though much of the knowledge we had about culture came out of our own experiences, I do not think we would have talked about or understood culture at the Haven in the same way if the kind of everyday, informal understanding we had of culture was not also linked to academic or professional discourses on culture, or to the multicultural foundation of the Haven's psychosocial approach and organizational structure. We were in a culturally saturated environment, where the discourses of culture had wide and varied forms, ranging from their everyday use, to their codification in official handbooks, to being the subject of clinical debates. In the following sections, this chapter will move from the everyday use of the discourses of culture to explore how "culture" was harnessed and instrumentalized as a technical device for psychological interventions and as a structure for employing and managing casemanagers.

Culture, Community Knowledge, and Healing

The establishment of cross-cultural methods of healing and culturally sensitive techniques of treatment in American mental health settings are not new and have, in fact, been fairly common practice especially in large urban areas since the early 1970's. Indeed, cultural anthropologists, whose expertise has been in "culture," have been

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working with mental health professionals since that time to develop more culturally sensitive approaches, change public health care policy, and institutionalize "ethnicized" mental health care.[6] Santiago-Irizarry is one such anthropologist. She documented her consulting work in three inpatient treatment programs in New York City that were bicultural and bilingual programs for Hispanics (1996). As Santiago-Irizarry points out, the "ethnically oriented care" that she studied emerged not on its own but along with a pervasive sense of "cultural sensitivity" that "has entered the collective imagination as issue, problem, or solution in many domains of U.S. society" (Ibid:6).

A precedence and supportive context was thus established for culture to be codified in training manuals and standards of practice for the treatment of survivors of torture and refugee trauma. It is now commonly taught that "best practices" in this field include a proper understanding of the "culture" of the clients and their communities. The Immigration and Refugee Services of America's (IRSA) handbook on "best practices," produced by an alliance of psychosocial programs of which the Haven was part, is widely acknowledged as a standard of care. It states, "In order to assist a given group you must seriously consider the cultural context of that group. The more you understand the traditions, values, and beliefs of a community, the better able you will be to establish a trusting, working relationship with that community and to help facilitate their move toward greater self-sufficiency" (2000:62).[7] The handbook goes on to instruct that a

[6] Vincent Crapanzano (personal communication) described his involvement in working with psychoanalysts in New York City to develop more culturally appropriate techniques. According to him, the danger in this approach is that culture becomes essentialized or comes to dominate in such a way that other forms of "listening" or interpretation may be foreclosed, or that culture is applied blindly and bluntly without recognizing the social or biographical context of the individual patient. As Marc Edelman (personal communication) pointed out, what he calls the "social work approach to culture" also may not acknowledge intra-category diversity, e.g. "Hispanics." See Footnote 8 below.

[7] This alliance is called The National Alliance for Multicultural Mental Health.

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proper understanding of a client[8] or community's culture may include familiarity with the following: "the geographical, historical and political context of their homeland," "language," "religion," "social structure," "gender roles and families," "education," "values," "food," "clothing," "festivities," and "names." Furthermore, the clinician should also gain an understanding of the client or community's "attitudes toward mental health," the group's particular refugee experience, and the problems faced by that particular group in the United States (IRSA 2000: 63-64). Just from this prescribed list alone, it seems that what constitutes culture, cross-cultural understanding, and cultural-sensitivity includes an almost inexhaustible set of possible experiences or practices. Be that as it may, knowledge of a few of these areas, such as "mental health attitudes" of a particular refugee group are almost universally considered, at this point, an essential part of the discourse of culture for which effective and competent clinicians are responsible.

The Haven used a refugee community's own knowledge of itself as a culture to create spaces for intervention. By way of introduction to this idea, one example of a method the Haven employed was its creation of culturally- affirming "community meetings" at local restaurants owned and operated by members of refugee communities. The community meeting model will be a focus of the next chapter, but here I would like to suggest that the restaurant setting, a supposedly more natural cultural environment, was used to de-clinicize the encounter, equalize the "exchange" by holding it on the home turf of the community whose adjustment and therefore conduct was at stake, and make it enjoyable as a cross-cultural experience for all involved. At the same time the

[8] To note, the IRSA handbook reminds the practitioner that "each refugee is an individual and may share these experiences and characteristics to a greater or lesser degree. Therefore, in addition to becoming familiar with the following information, we should remember to ask each refugee about their [sic] traditions and experiences, and to listen with care (2000:57). This reminder illustrates the tension always in

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community meeting model allowed for the expression of culturally specific differences of different groups, thus preserving their respective cultural uniqueness, it also lent itself to standardization and replication. The community group meeting became an efficient vehicle for the Haven's goals to assess "community needs" and bore repetition with six different refugee groups. In this example, we can see how culture became a means for the Haven to gain admission to different communities, and to intervene upon them in a noncoercive manner by soliciting knowledge from the communities themselves about their own perceived needs in a culturally comfortable setting.

This discussion will now provide a more detailed look at the use of culture in a case study example.

Training Workshop Case Study

The Haven conducted a workshop to demonstrate techniques for incorporating cultural and spiritual symbols and rituals into mental health interventions. This workshop also provided a forum for different "community leaders" to speak about their own cultural and spiritual beliefs and traditional indigenous methods of healing for the "dominant culture" to hear. Sister Vanessa and Sister Brenda, two Catholic nuns from the Maryknoll Order who lived in Guatemala with Mayan peasants, ran the first part of the workshop. The second part of the workshop included a presentation by an indigenous social activist from El Salvador on the oppression of indigenous peoples there, and then two local refugee community leaders, one of whom was Roderick, spoke about the kinds of cultural resources that could be drawn from to develop the kind of "cross-cultural" model of healing that Ed and other clinicians were promoting. Like the community

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question in "psy" discourses between the objective and subjective levels of difference, and therefore also between the universal and the particular, and between the individual and the collective.

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meetings mentioned above, the latter part of the workshop was significant insofar as it demonstrated how "psy" expertise both invites and depends upon the voluntary participation of or "partnership" with the different cultural communities upon which it intervenes. The latter part of the workshop, as Dr. Stein remarked, was an "intercultural exchange" to show "how different cultures can share and utilize their knowledge together." Rather than focus on this aspect of the workshop, I will describe three of the cross-cultural interventions that Sister Brenda and Sister Vanessa developed. I will demonstrate how both the clinician as a workshop trainee and the survivor as the subject of intervention were being taught through culturally appropriate techniques to take responsibility for their own healing and conduct by reflexive awareness of and intervention into the workings of their internal lives.

The workshop was held on one of the upper floors of a majestic church modeled after a 13th century gothic cathedral in France. The conference rooms of this "interdenominational, interracial, and international" church have high buttressed ceilings, and large lead-paned glass windows that open onto spectacular views of the Hudson River and surrounding city. Because of the physical setting, the topic, and the speakers, there was a rather pervasive spiritual or religious cast to the event. I silently wondered if this all symbolically suggested that transcendence of difference is made possible when multicultural spirituality links itself to psychological expertise.

Professional development and ongoing expertise-building for practitioners in the field of torture treatment is common to clinicians in all "psy" professions. Part of the authority of the clinician depends on participation in expertise-building activities. At the workshop, I noticed in the sea of faces many familiar ones from the rather small

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community of torture treatment and refugee resettlement people in the metropolitan area. Some people who attended were clinical psychologists with extensive training in trauma and psychotherapy, and others were lay people from refugee communities who were not doing clinical work per se. After signing in, receiving name-tags, hearing introductions and preliminary remarks, workshop attendees were broken up into two groups, each led by one of the sisters.

I was assigned to Group A, which was directed by Sister Vanessa. She began by talking about the devastatingly brutal history and politics of the thirty-seven year war in Guatemala. She described how Mayan peasants faced the terror of death squads, rapes, disappearances, burned villages, torture and displacement. (This represents IRSA's recommendation that the clinician should have cultural knowledge about the "geographical, historical and political context of their [client's] homeland"). She described the Mayans in this historical context as a "ball in the middle being kicked back and forth" but emphasized that even though they suffered much in the war and are "very poor, have very little work, and have been pushed off of their land," there is "a light, a fire, part of Mayan culture that burns on." However, chronic alcoholism, domestic violence, and other effects of both past traumatic circumstances and present structural violence continue to afflict the community.

According to Sister Vanessa, the sisters' philosophy for healing or "overcoming trauma" (which she noted does not mean "forgetting history") requires using traditional symbols, metaphors and rituals from Mayan culture in conjunction with clinical or modern knowledge about the effects of "violence, torture, displacement, loss, and separation." Sister Vanessa remarked, "People who are from other cultures need symbols

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from their country they can relate to. Every culture has its symbols that are important to them. We need to seek them out."

Circle of Fire

In this exercise, Group A moved to a quiet room and formed a circle. In the middle of the circle was a lighted candle representing fire, a "source of power that enables us to make change but that can also destroy." Sister Vanessa described how fire in Guatemala was used to destroy houses and to burn people alive and torture them. As a form of torture, fire was used to burn the soles of people's feet. She then explained to us that we were to think of fire as both negative and positive, as both consuming and destroying but also as representing a passion for life and change and transformation. A symbolic connection, Sister Vanessa explained, can be made between "external fire" and "an internal fire" that we all carry within. Everyone was then given a piece of carbon or charcoal which we were to hold in our hands. While listening to music from an American movie soundtrack[9] we were to close our eyes and search for "something within yourself that is very painful." The sisters try to choose music "for the kind of feelings we want them [the survivors] to express." We were then asked to "visualize" the pain, "your own, as far as you can, and not someone else's pain." Then we were to imagine the piece of charcoal as a receptacle for our pain--our pain was to be symbolically transferred to that piece of charcoal. The charcoal was to be transformed—it was no longer just a piece of charcoal but became our painful memory or feeling. Sister Vanessa then had us verbally

[9] The music played at this juncture was from the movie *Philadelphia*, one of the first mainstream Hollywood movies to deal with the "delicate" issue of AIDS in America. It starred Tom Hanks. At the end of this exercise, a participant who was annoyed with much of the "circle of fire" asked why the sisters did not use indigenous music. The sisters replied that they do have some Mayan music they play when they want to create a happy atmosphere but did not have any that could accompany pain. This participant, as well as others, was also shocked and angry that the participants were asked "to go deep within ourselves in

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"share" that pain with the person next to us, and place the charcoal in a bowl by the candle and to speak that pain if we wanted as we did so. With survivors, this healing exercise would have been done with a real fire, not a small candle with a bowl next to it.[10]

Finger-painting

Sister Vanessa described how she and Sister Brenda use "finger-paints" as "a way to help them [survivors] express their feelings. Whatever symbols they use are their own." This is an especially effective medium for survivors who "cannot read or write." "Finger-paints," Sister Vanessa explained, "are a medium for expressing not just sadness but anger and joy. Please don't have the idea that all we deal with is sadness. People can look at their present life, their strengths, what they have survived and find in their spirituality that they have the strength and faith that has enabled them to survive. We use music along with the fingerprints to help them along, to express the feelings. It can be a tremendous relief to express feelings" in this way.[11]

Cosmo Vision

This third exercise will be central to the analysis in this section. In the big room, Sister Vanessa prefaced this exercise with an explanation of the "Cosmo Visión Maya."

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public, in front of virtual strangers, to connect with personal trauma, and then have no processing after the experience."

[10] This intervention is closely related to the testimony method, where in therapy the trauma narrative is transcribed onto a piece of paper by the clinician who both witnesses and signs it. The paper then becomes a document that both symbolizes and contains the trauma, which the survivor can then hold and touch and do with as they please. In this ritual, the survivor's pain becomes objectified and separate from him/her, a document for collective memory and history which is meaningful and effective because of the social context of its production.

[11] Art therapy is a discipline devoted to healing through artistic media. It is thought that working through trauma may be facilitated through non-verbal forms of expressions, and that working with concrete materials may allow children, illiterate people, and others for whom talk therapy is not appropriate to

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She gave us an overview of Mayan cosmology by describing different Mayan symbols, the meaning of particular colors in Mayan culture, the centrality of the "production of corn" in the lives of Mayan peasants, and also the Mayan "spirit of collectivity." Our attention was then directed to the floor, where a four-point structure was assembled with candles, charcoal, flowers, corn, and a jar that represented different things including nature, sun, moon, and stars—meaningful symbols in Mayan cosmology according to Sister Vanessa. She explained how these symbols were made significant in terms of how they were symbols of cultural ideals, or of possibilities for transformation. Sister Vanessa acknowledged that how she explained these symbols to us was similar to, but also slightly different from, the version dispensed to Mayan survivors during an intervention because we were a different audience with different goals. Despite the differences in the two versions, one of the sister's goals was to offer us a glimpse of the therapeutic process with the survivors and what it must be like for them. This is what is called experiential learning.

Along with all those items, each of the four points on the floor had a notecard with a clinical word written on it: "thoughts," "feelings," "action," and "relations." A notecard reading "attitude/spirituality" rested in the center of the structure. In this intervention, the sisters have Mayan survivors talk about some event in their present lives. This is usually a "thought." Sister Vanessa gave us a hypothetical example of a survivor who talks about wanting to hit his child. From there, the sisters would direct the survivor's attention to each of the four "clinical" points, one at a time, and make connections between those points and Mayan symbols. According to Sister Vanessa,

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symbolize their experience. As noted in Chapter Three, the Haven program used art therapists to work with children at Roderick's African community center.

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"every thought that comes to the head has a feeling attached to the heart" but sometimes those connections are lost to awareness. When the survivor is led to the point that says "feeling" it is to help the survivor "separate out feelings of anger and resentment and sadness" because "most of their feelings are sadness." Survivors are often directed toward seeking and identifying their anger, because, she said, "The Church has told people anger is bad. We tell them, no, anger is OK." At this juncture Sister Vanessa remarked that this exercise may be rather simple for us, the attendees, because "you are attuned to this" but when "we work with our people we have to help them with this—we work with whatever they present to us."

The sisters try to "make them [the survivors] conscious of those feelings and then teach them they have choices for action" because sometimes the survivors forget that they have different choices—they don't have to hit their child if they are feeling angry but could instead pause, reflect, and choose a less violent action. Thus, when the survivor is directed to the point that is marked "action," he or she is to consider other possible actions to take rather than the one he or she feels compelled to take. After "action," the survivor is to think about "relations" or how his/her actions would have an impact on their social world. Lastly, the survivor is to think about the spiritual consequences of his/her conduct. For the last point, Mayan survivors are reminded of their "spirit of collectivity" which may have become lost or broken because of the violence and trauma in their lives. The sisters help the survivors in "finding the strength within that connects us to other people."

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Ending the lecture segment, Sister Vanessa exhorted us (as she probably does in some way with the survivors) "to look with hope to the future and have a willingness to reach out to others. We must accompany others to make changes within themselves."

Before breaking up into smaller groups to try this exercise ourselves, we were reminded by Sister Vanessa that we as clinicians "need to understand our own processes" and not just "those of people who are in situations of violence and victims of torture."

With the Sister's supervision, each small group was then instructed to come up with some kind of thought or statement, then write it on a piece of paper and present it to her.[12] One group wrote, "Every group has to have a leader." Sister Vanessa then enjoined this group to relate this "thought" to different "feelings;" group members suggested "ambivalence, confusion, anger, discomfort, angst." From there, she directed the group to the four-point structure, talking them through the process. The ideas the group came up with for "action" and the one for "relations" were related—the group decided it should "discuss" their feelings and thoughts "with others." For the "spiritual" connection or "attitude" to associate with this thought, the group suggested "peacefulness." After going through this exercise with each small group, Sister Vanessa instructed us that "we can use" these techniques "in every moment of our lives."

Contextual Questions

Outside of the frame of this exercise is the total context of the lives of the Mayan peasants and their relationship to the sisters. Forming a backdrop for these interventions

[12] Typically, I dislike group experiential exercises. I do not like what I perceive to be contrived and artificial demands for some kind of authentic response, but I usually grudgingly go along with them to be a cooperative member of the group. Just on the basis of my own experience, I imagine that different survivors may perceive therapeutic interventions in all kinds of ways and that their outward response may not be a proper measure of their authentic participation. One could also psychologically read into the choice that group made for their "thought" and speculate that there may be some underlying resentment toward either the sister or doing this exercise.

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is a complicated, ambiguous and violent history of colonizer/colonized, where the Church has played multiple roles. However, Sister Vanessa and Sister Brenda represent a movement of priests and nuns who have been radicalized and put their lives at risk to help the poor and the oppressed in Latin American countries such as Guatemala. Sister Vanessa and Sister Brenda were less interested in proselytizing and conversion, and certainly were more tolerant of Mayan spiritual and religious beliefs, than the recent waves of evangelical Protestants who have descended upon Latin American countries. It was my impression that the sisters were respected and maybe even loved by members of their communities, and that their immersion in Mayan culture and commitment to living and working with them did grant them some authority on Mayan cosmology.

Governance through Culture

From one standpoint, it could be claimed that these interventions seemed to place more emphasis on the clinical or modern, Western components, than on Mayan symbology and traditional practices. Thus, it could be argued that culture acted simply as a tool, or was used as a bridge to get to the clinical or dominant discourse being espoused. Santiago-Irizarry has described similar practices in ethnicized psychiatry where "ethnicity and culture were rendered as the content and the clinical as form" (1996:17). She suggests that this contributes "to the reproduction of medical primacy" (Ibid). Ong too, in her study of Cambodian refugees, has suggested through her governmentality analysis that ultimately biomedicine contributes to regulating and normalizing Cambodian biopolitical subjects as an underclass (1995). Following this type of analysis, it could be argued that although Mayan culture was summoned in a manner that suggested its value in Guatemala's hoped for pluralistic, democratic society, it was in fact

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"co-opted" by "hegemonic fields of action" in the sisters' interventions, leaving differential relations of power in society unchanged or producing new forms of domination and oppression (Santiago-Irizarry 1996:18). [13] This kind of argument views psychological knowledge in terms of its repressive functions and in its function to legitimate relations of power and domination, but neglects to think about the new ways of thinking, acting, or being these interventions offer, or the kinds of connections being formed "between the aspirations of authorities and the projects of individual lives" (Rose 1999:4).

For the interventions to be effective or to have the type of authority that is today respectable, appeal was made to the survivors' own cultural capacities and aspirations. The success of these interventions depends as it were on cultural knowledge that the survivors already possess or can relate to—the shape of the interventions were not constructed from above but instead created *with* the survivors' own cultural repertoire. This activity constructs a new kind of culture or ritual space, a therapeutic space of practices and techniques, those "political technologies of individuality" (Rose 1999:221) that enlist the participation of survivors in a culturally appropriate self-project. Therapeutic subjects are being taught to work on themselves to heal and improve so they may not be so determined by both material and psychological obstacles that get in the way of having a better life. Who would not want to improve his/her life? The clinical

[13] Santiago-Irizarry's study also includes an interesting and important analysis of how "culture" for Hispanics is not only the "cure" but the source of their problems: "both the source of dysfunction and panacea." Hispanics constitute a population at-risk, more "vulnerable" to mental illness because of factors such as poverty, language barriers, or cultural differences that in fact define their "Hispanicity" thus conflating culture with structural conditions. In the end, Santiago-Irizarry argues that even though the Hispanic clinicians who developed these treatments were using typified representations of themselves toward political purposes, they were in fact "perpetuating the very same representations that position these groups differentially in the society at large," medicalizing culture, and reproducing differential relations of power (1996:18).

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intervention is not there to do away with the spiritual or moral authority the Mayans may live by, or to "co-opt" their culture to "reproduce hegemonic fields of action" but to infuse or reconfigure those authorities in new ways that complement the configurations of governance in contemporary societies.

In this intervention, conditions are being created in which a specific mode of psychologized subjectivity is rendered, one in which an individual is directed to turn inward to locate places within the "head" and "heart" that can be given names and values, that can be known, and by doing so, create a zone of "psychological interiority" (Rose172) for intervention upon the individual as self and the community. In *Cosmo Vision*, Sister Vanessa asks that survivors make some kind of statement or produce a thought for her or the group that may be made available for therapeutic manipulation. This thought could be a memory from the past, but could also be a present concern. This exercise's temporal form does not demand that the survivor turn toward past traumas—present concerns can be a point of entry—but does turn the survivor toward the future to explore what "actions" he/she may take now or at some future point. In this temporal ordering the future is granted great importance—the goal is a better future which depends on the ability of the survivor to responsibly take charge of his/her present life, to make goals, have plans, to manage his/her emotional life in a more organized fashion. The future can now be imagined in a different way for the survivor. By "making connections, or relays, between life problems and seeing self-destructive patterns of conduct" (Stenson 1993:53), the subject can prevent the repetition of the grinding suffering of the present. The idea is that the subject does not have to be a passive recipient of fate's injustice, but can positively transform and in fact has the responsibility to do so, the contours of his/her

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life which in return will help the community and help restore harmony and unity in the cosmos.[14]

However, for the survivors' thought to be valuable or useful, it must somehow be transformed into a "problem" for analysis. This task in itself may be difficult for a Mayan survivor: when "we work with our people we have to help them with this—we work with whatever they present to us." Thus the sisters have to educate the survivor about how to orient him/herself toward his/her own thoughts and then to articulate them in terms of a "problem" to make it workable. This can be done by modeling the proper form a thought should take or by gently molding the survivors' statement into the desired form. From there, the survivor is directed toward distinguishing thoughts from feelings, or to use clinical language, cognitions from affect or emotions, and then to make yet even finer distinctions between different feelings. According to Sister Vanessa, the survivors feel too much of some feelings ("sadness") and too little of others ("anger"). It is not then a matter of general constriction of feeling, but an imbalance of feeling. It is presumed that a full range of feelings exist for the survivors, and the task is to bring those to awareness or "consciousness" so they may be acknowledged, felt, and then contained in a structured form .

"Consciousness" allows for the rational management of "feelings." Rational management of feelings[15] is part of the process that allows the survivor choices in taking proper action. If the survivor is too overwhelmed by feelings like anger, he/she may not

[14]In culture of poverty arguments, there is usually some condemnation of the poor for not being able to adequately plan for the future. They are thought to be guilty of always needing immediate gratification or for only being able to react situationally, as if each situation presented to them becomes a "discrete problem," "requiring a variety of situationally selected and elaborated tactics" (Stenson 1993:65). Does this intervention suggest a genealogical link with the culture of poverty problem"?

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have the ability to recognize different options for action; the horizon of possible actions becomes closed. In this regard, the survivor does not have to begin with a "thought" but could begin the process with a "feeling" such as sadness, and then can mindfully connect with the other points on the structure. Wherever one begins, one ends with relations and spirituality, thus completing the cycle.

The cycle, once it is learned and perfected, is also portable and internalizable, that is to say a certain norm of autonomy is achieved insofar as the survivor will now have the ability to better self-govern, to conduct his/her conduct without some sort of external disciplinary control. We the attendees, as practitioners, are also responsible for a certain kind of self-management through "consciousness." As Sister Vanessa said, we also "need to understand our own processes" and as she anticipated, the practitioners were "more attuned" to these methods of working upon the self. The small groups of practitioners were able to engage in this process with ease, and it was not difficult for them to come up with culturally valued responses. Practitioners appeared to be very good therapeutic subjects with their responses that "action" and "relations" should lead to "discussing" their feelings and thoughts "with others" and that the spiritual attitude they should take is "peacefulness."

However, the usefulness of lessons learned in this exercise extend far beyond a certain kind of therapeutic mastery, or the goal of shaping a therapeutic self. These kind

[15] Can there be such a thing? According to many cognitive/behavioral psychologists, this is indeed possible. However, those in psychoanalytic camps would claim that we as human beings are for the most part "unconscious" and are not under conscious, rational control of ourselves.

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of self-reflective practices are not of some artificial or exotic order, but in fact guide typical self-governing practices of everyday life for so many American selves.[16]

Individualization

One of the apparent paradoxes of psychosocial interventions for survivors of political violence is that many of the therapeutic practices focus on the unit of the individual, or perhaps on the unit of the family, at the same time torture treatment clinicians are highly critical of the so-called individualizing effects of their practices. By individualization, it is meant that the social context of suffering and of healing, and the social, political and economic causes of torture and collective violence are minimized or made irrelevant. In this process, trauma becomes a problem of the individual sufferer and the cure is personal recovery; it "turns experiences into symptoms and ignores the collective aspect of political violence" (Richman 1998:181). Individualization goes hand in hand with psychological interventions which are thought to be "Western" and expert knowledge in the field of torture treatment now prescribes therefore that these interventions should not be applied uncritically to non-Westerners (Bracken and Petty: 1998). Furthermore, it is thought that individualizing also implies a particular notion of personhood-- of an autonomous, egocentric, atomized, bounded self that is not only Western but may also represent the worst of Western values (Bracken 1998: 53).

[16] An article in *Self Magazine* (this is truly the magazine's name) discussed the "ABC's of Happy Thinking" (Peden 2002). The article included a simple strategy suggested by a Duke psychologist for thinking more realistically so one doesn't "get sucked into a spiral of energy-sapping negativity." The technique has six steps, including "focus on the antecedent—the situation that's upsetting you...think about the consequences of your beliefs...develop a plan for dealing with the situation," and so forth. These steps are the basis for cognitive-behavioral self-management techniques that are clinically proven to be some of the most effective techniques for therapeutic self-transformation. However, these techniques are available to anyone and do not require a trip to the shrink's office. One may buy magazines with these techniques near the check-out line in the grocery store, and then read about them while improving one's self at the gym.

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To counter-balance the perceived individualization that occurs through therapeutic intervention, there has been much self-conscious effort placed on fostering community-building and community-healing capacities, to see the atomized, autonomous self as a cultural and historical construction, thus contingent and non-universal, and to think of violence and trauma as collective experiences in a political and historical context. *Cosmo Vision* represents this movement which has now been mainstreamed in torture treatment practices. In *Cosmo Vision*, four components are identified that the sisters included which aim to work against "individualization." First, they draw upon the "collective spirit" of the Mayans, their world-view that all parts of the universe are unified and if one part has been violated or is imbalanced, the whole also suffers. The second is by including "relations" in the four-point structure--all thoughts, feelings, and actions have a relational aspect. The third is by conducting these interventions in group settings. It is not one individual doing therapy with one therapist, but a collective and communal effort, one that is also therefore more "culturally" comfortable and appropriate for Mayan people. The fourth is by acknowledging the history of violence and conflict that has produced personal suffering. Yet despite the fact that all these measures are taken to ensure that individualization is minimized, subjects are still being shaped to work on themselves through specific forms of individual selfhood. In addition, ideas of personal or individual worth, the uniqueness of each individual, and individual rights and dignity are also implied and maintained in these practices. Self-governance techniques that will be discussed in this study always depends on some kind of individual self, and thus promote a particular kind of self-formation no matter how de-individualizing practices may be. Furthermore, by cultivating "collective" forms of organization and promoting

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community interventions, is that not just enlarging the unit which is targeted for calculation and intervention?

Perhaps another useful way to think about these problems is to ask what does it mean to target and intervene into subjectivity in specific ways? I suggest that "psy's" authority and expertise in these matters is constitutive of certain political rationalities and social, economic and political configurations. By thinking in these terms, it is not simply the case that therapeutic interventions are individualizing. As Cruikshank (1999) has remarked in reference to self-esteem therapeutics, they are "not an individualizing activity but one in which the self acting upon itself links it to the project of social good, order, stability" (90-91). I would suggest that in the case of psychosocial programs for survivors of refugee trauma and torture in nation-states such as Guatemala, where regimes of rule were governed through terror and that now aspire to be respected liberal-democratic players in the global political and economic community, the shape of citizenship and everyday lives are changing to make the new regime possible. Rose argues that "[l]iberal democracy, if understood as an art of government and a technology of rule, has long been bound up with the invention of techniques to *constitute* the citizens of a democratic polity with the 'personal' capacities and aspirations necessary to bear the political weight that rests on them. Governing in a liberal-democratic way means governing *through* the freedom and aspirations of subjects rather than in spite of them" (1996:155). It is indirectly through expertise, and in the sisters' case "psy" expertise linked with Mayan spirituality and culture, that "the objectives of 'liberal' government can be brought into alignment with the selves of 'democratic' citizens" (Ibid.). Mayan peasants, I would suggest, as they struggle to heal the wounds of years of collective

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violence, are also learning what it means to be a "citizen" in post-conflict, or more accurately, low-conflict Guatemala, where citizenship entails being a cultural, spiritual, and self-governing subject with a moral commitment to community and collectivity.[17] Similarly, survivors of political violence resettling in the United States learn through culturally-sensitive therapies ways to self-govern and therefore how to practice their new freedom responsibly.

Conclusion to the Workshop

The lessons that Sister Vanessa and Sister Brenda taught at the workshop that day were available for us to "cut and paste." "Take whatever will enable you," Sister Vanessa said, "to help the people you work with to have fuller lives." In the American context, where clients in psychosocial programs for survivors of torture and refugee trauma come from an impressive range of different cultures, the rhetoric of "cross-cultural" integration in service provision now prevails though the actual practice of this model remains varied and inconsistent. However, it is true that the authority of psychological expertise is now bound up with the spiritual and cultural knowledges or resources that are thought to be owned by or to exist within the subjects of its practices. The adequacy of psychological

[17] To support this claim, the sisters told us about one exercise where they asked Mayan women to talk about all the different things that came out of the war. The women's responses were both negative and positive. For example, some women said that they were happy that there are now more human rights offices in Guatemala from all different countries in the world. This suggests that the presence of these organizations has had some kind of impact on their lives. In fact, international human rights organizations are important fixtures in the democracy-building apparatus in "post-conflict societies" and as such are promoting techniques of self-governance through "grass roots" psychosocial interventions similar to ones the sisters developed. Rather than be given a handout, the locals are being given a "hand-up" so they themselves can manage their lives in an independent and self-sustaining way. Both the structure and the work of international NGO's including human rights organizations (the RCT would be but one example) reflect these contemporary rationalities of governmentality. Perhaps, as recent scholarship by Ranjbaran (personal communication) and Pupavac (2001) suggests, civil society and the free market's constitution in and through the international NGO and commercial communities in post-conflict and post-Cold War societies today may even reflect what could be called a new "globalization of governmentality."

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intervention is now measured by their incorporation and by the authority accorded to the individuals who are the recipients of psychosocial services—the configuration of partnership. In the wedding of rational, modern truth of psychological expertise to irrational, spiritual and culture truths, positive knowledge about the subject, or the survivor, now means having knowledge about culture and spirituality, i.e. making those aspects of human existence intelligible, calculable and practicable and by doing so, transforming the field of possible social action. Though I did not personally observe rituals or the use of symbols in interventions during my fieldwork period at the Haven similar to the ones the sisters developed, I did observe other ways that "cultural resources" were mobilized as the next section illustrates.

Bi-cultural Casemanagers

The discussion will now shift from Sisters Vanessa and Sister Brenda to explore another way that culture has been instrumentalized in psychosocial programs for survivors of torture and refugee trauma. One feature that defines the Haven program against or allies it with other psychosocial programs for survivors of torture and refugee trauma, and I use this language because much of this does have to do with contested ideologies, is the use of the bi-cultural model. Bicultural casemanagement has become an important ideological and practical component of what I call the "anti-medical model discourse" in the field of torture treatment insofar as it is thought that employing bi-cultural workers reflects a more "multiculturally sensitive" service package, hence a more progressive and also more effective one. In one of my first discussions with Ed about the Haven, he told me "with the exception of myself, we are all bicultural and all refugees" and then proceeded to spend time describing the cultural backgrounds, language

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proficiency, and history of traumatization for each casemanager. The narrative or image created around bicultural expertise served as a marketing tool and a political position, and a way that the Haven presented itself to itself and to others.

Bicultural Resources

In line with this, the expertise of casemanagers at the Haven was based less on formal education and training and more on the knowledge the casemanagers possessed by virtue of the fact that they came from the same community as the clients to whom they provided services. Bicultural workers were preferred because it was thought they were more able than the typical white, bourgeois, American-born casemanager of doing outreach, identifying needs, preventing problems, and educating their fellow community members (ORR 1991: III.30). Thus, when hiring a new casemanager, the quality Ed most seemed to value was in how the candidate was appropriately bicultural and demonstrated community leadership qualities, rather than on his/her professional background in a clinical or social service arena. Ed felt, and others at the Haven agreed, that the person who was bicultural *and* had the appropriate professional background, however, would be even more ideal. Slavenka, a nurse in her home country, and Marie, trained as a social worker in her country of origin, would fit this ideal. Isabela had some exposure in a social service environment prior to her employment at the Haven, but Sanja had virtually none before starting there. Claire, by contrast, was not a bicultural worker; her capital was based on being a native French speaker, her education, and her professional experience. Because she was only a student intern, Ed made concessions to go outside the bicultural model.

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The three basic cultural resources or forms of cultural knowledge the bicultural worker offered to the Haven consisted of the following: 1) language; 2) culture, and; 3) refugeeness or a history of traumatization from being victimized by collective violence in some way. Language was a kind of cultural knowledge that presented itself in a straightforward, commonsense way—the casemanager was at least bi-, if not multi-lingual, and able to translate. "Culture" generally meant a set of beliefs, practices, an orientation to the world, etc., but it could also mean #3--one's inclusion in a community composed mostly of refugees who by definition have been "traumatized." For #3, the phrase "survivor of refugee trauma" captures the association between refugeeness and traumatization. The bicultural worker knew what it meant to be a refugee, and knew what it meant to suffer from collective violence. Taken together, the bicultural workers' first-hand knowledge of language, culture, refugeeness and trauma were thought to be their contribution in the partnership with "psy" to determine what is best for the clients and what methods would work most effectively to serve client needs.

One of the primary jobs of the bicultural casemanager was to use her cultural knowledge in the role that Ed and others have referred to as a "culture broker."[18] This phrase is catchy and also telling as its language suggests a kind of commercial or market transaction where culture is commodified and consumed "cross-culturally." To be a culture broker meant that the bi-cultural casemanager mediated and translated exchanges between the culture of the other and the dominant culture; the latter was usually conceived of as "American" culture or it could be the professional culture of "psy"

[18] It was pointed out to me by Shirley Lindenbaum (personal communication) that the term "culture broker" has a history existing long before its use at the Haven. She explained that "culture broker" was the term given to anthropologists who were doing applied work, with the expectation that that was what they did. With the reflective turn in anthropology, anthropologists themselves rejected the very possibility of this

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expertise. Accompanying a client to the Medicaid office or reporting to the program about community needs are examples of cultural brokering. However, it was not so easy to be a culture broker. I overheard several conversations where Slavenka, especially, was quite vocal in complaining about the burdens she felt as a casemanager vis-à-vis her own refugeeness and traumatization. Slavenka told me, "I am worried that being a refugee makes it too hard for me to be a counselor. I told Ed when I took the job that I would be too emotional and you know it is true. Sometimes when I hear stories from the clients they remind me of my situation and then I cry after I talk to them. It's too much!" Isabela too, but more quietly and not as often, expressed the difficulties she experienced as a culture broker. She once mentioned that when Ed first talked to her about the job, she felt she "couldn't do it," and after starting the job admitted having "mixed feelings about being a wounded healer. I feel like I really haven't helped myself but now I am helping others. But maybe helping others will also help me." Later in my fieldwork I found that Sanja, like Slavenka, (is this a question of culture or personality?) was also quite willing to openly express how frustrated and upset she felt in working with clients within her own community because of her closeness to them and especially because of their "dependency" on her. She told me "it is so hard, you wouldn't believe, Kelly, to work with my people. They need so much, many of them don't speak English, they don't assimilate. They depend on me too much."

At the same time the culture broker was burdened by cultural sameness, she also experienced the demands of the "dominant" culture. In particular, I am referring less to "American" culture and more to the culture of the Haven and psy expertise. During staff

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role. Yet even today people outside the field still see anthropologists working in applied settings as "culture brokers."

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meetings, Ed spoke to the bicultural casemanagers about their need for greater "professionalization" and their lack of good "office comportment." He also talked about the "resistance" he was observing in their conduct that was manifested, for example, in how the casemanagers were not adhering to the protocol of new intake forms, or their "denial of trauma" evidenced in how they were not encouraging enough clients to undertake psychotherapy. With the authority conferred by his professional and psychological expertise, Ed was telling the casemanagers that they were not properly complying with the model of "psy" expertise he was developing and in doing so, he defined their conduct as problem warranting professional intervention. When the casemanagers appeared to be lacking a sufficient commitment to or identification with the dominant culture, their conduct was constituted as a problem that needed to be addressed.

Talking About Bicultural Counselors

One day Emil invited Claire and me into his office to have lunch with him. While sitting around eating hummus, pita bread, and fruit, we began to talk about the casemanagers and the whole idea of the bicultural model. I said something about the casemanagers that reflected, apparently, my naïve valorization of their biculturalism. Claire quickly questioned my suppositions, and then she and Emil had a spontaneous conversation about the bicultural model. I stopped eating and took notes as I listened to them.

Claire: In terms of refugees, yes, it's good to have people from the communities. But then look at Slavenka and how she has been destroyed. If you are a refugee you have to be careful about counter-transference.

Kelly, don't idealize the sameness. It's complex. Don't romanticize them because you know some people don't even want to talk with the people who are in their community. Also, in some ways you and I are much less prejudiced than Slavenka and

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Marie. Look at food and how they won't eat at the Indian restaurants or try out other places. They want to hold onto their own identity. They become close-minded. They only know their own experience. I think we should have mixed teams. If you have a Bosnian counselor who is a bitch for example, then what's the point of having both be Bosnian? You know Slavenka went to visit Hamid [a client mentioned in Chapter Three] and I know she was acting racist toward him.

Emil: Well, I think the negatives of having a refugee counselor is that whoever works here will experience their own traumas as a refugee. If they don't do self-care, they will contaminate the process, plus they will spill and project feelings onto the client.

They also might feel greater loyalty to the client's community than to the agency. Like they won't accept freely the role of the counselor and also they might not work as well with other community members.

People who become counselors when they were never trained to be, nor did they ever dream about it, they don't have appropriate training and self-care skills and they don't see their lives as being fulfilled by this job. Not being prepared, not really thinking about the different aspects of a heavy, complex job, people then give simple responses to complex questions. They think without nuances and don't put the extra effort into confronting problems.

The level of adjustment the person has to American society is crucial. If they are not adjusted, how helpful can they be? What if they are torn between staying and going back? That can be very destructive.

Another question is: where are they in the grieving process, saying good-bye, accepting new society?

And what are their ideas about ethnic and personal identity? If they are nationalist or not multicultural, than that can be destructive.

But then there is having a sense of a personal mission. Like it's not so important who is who but your personal mission. Your personality can help others and work itself helps you to balance your life—"doing something about it."

If a person is a refugee, their experiences help them to have a recognition of nuances, problems, needs...

Claire: Like "you don't need words to understand..." The nuances about culture and experience are very important advantages. But people who are part of the culture can claim they are 'experts' and then when outsiders challenge them they say "well, you can't possibly understand."

Emil: The suffering of their people is their capital. In multi-culturalism, we all have universals. We are all the same yet different. How to preserve this and balance this?

Claire: With domestic violence, what about having to have been abused yourself to be a good domestic abuse counselor? One of my teachers said to look at similarities in feeling, not experience. Introspection is the key. Just because you are a survivor doesn't mean you are exempt from introspection. And just because you are a refugee doesn't mean you are exempt from training.

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Emil: I think it also depends on the level of commitment. People who actively oppose war or oppression would make better counselors. They are working at a more transcendent level. It's not just political but its personal.

Claire: In spite of what a person has gone through, they can still reach out. That's what I admire the most.

Emil: What was really helpful for you was your decision to go there [to do humanitarian relief work], to help. It was a choice.

Claire: There's a big difference, especially psychologically. I think it would have been good for us to have received counseling. We over-identified. People thought they were the same as the refugees. Some people flipped. We were not the refugees.

[pause, discussion moves to other topics]

Claire: Yes, but talking about culture. ____ would say talking to someone outside of the family, a foreigner, is not organic. So how do we handle this?

Emil: Claire, with family, your role is defined, what you can talk about, what you can't. You can talk about non-threatening things with your family. And how you fit, are you molded by family in rigid system or don't fit. It's different from family to family, tribe to tribe. What if you [the counselor] don't share beliefs of the family?

Claire: Something Diane [a clinical psychologist introduced in the Introduction] said, "you can't always idealize culture because many parts of culture can be oppressive."

Emil: Like what Enid [an African Studies professor] said was good, "I am not for it [female genital mutilation] or against it." One thing is respect for the culture. The other thing is not to support something you don't support. You have to be able to work with the system.

In this conversation, Claire tells us that the bicultural worker may be a "prejudiced," "racist," and "close-minded" one, because they "only know their own experience" and "want to hold onto their own identity." They may in fact not "even want to talk with people who are in their community." Emil too mentions that the question of "ethnic and personal identity" can be an issue if the refugee counselor is "nationalist or not multicultural." "Culture" can be "oppressive;" "you can't always idealize culture." It appears that one of the problems for the bicultural counselor is identifying too much with

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one's own culture which could lead to certain forms of rigidity and even a kind of violence. Too little cultural identification, however, would probably disqualify one from becoming a bicultural worker. From this discussion at least, it does not seem that there is much danger in the bicultural worker identifying too much with the dominant American culture, or the culture of psychological expertise. I also did not observe any bicultural counselors who seemed to overzealously favor the "dominant" culture. Problems seemed to arise therefore when the bicultural counselor did not adequately adopt or identify with the expertise of the dominant culture.

Biculturalism does allow for important "advantages" like recognizing "nuances, problems, needs" and not needing "words to understand." But simply being a member of a certain culture and possessing cultural knowledge does not necessarily qualify one to be an "expert." However, when claims for authority are made on cultural identity based on personal or collective suffering, a particularly powerful form of authority is established. A trump card is laid on the table that says "you can't possibly understand." In the politics of identity, this can become a final impasse in "dialogue."[19]

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[19] The effects of these politics are sometimes complex. As Emil has observed, "the suffering of their people is their capital." The legal system, social service and medical systems "broker" in suffering and mediate recognition, rights, reparations, and services. Suffering does become a form of capital, and maybe one of the few forms available to those for whom so much has been taken away or for whom much was never given. Speaking the language of suffering, proving suffering, and performing suffering have become channels for visibility, recognition, and material support. This does not mean of course that people's suffering is not real, but like Emil, I am acknowledging that it does exist as a form of capital and also that for it to be heard it must be "packaged." Senders (2000) speaks to this issue in a paper on contemporary German repatriation. It is also true in asylum cases where certain evidence must be presented in a particular narrative form when presented to the judge. It was also evident at the Mayan healing workshop, where the indigenous Salvadoran man appealed to the audience for help on behalf of his people in a conventionalized way that I have observed many times in my fieldwork —he wore "traditional" clothing, spoke about the spiritual beliefs of his people and the history of their suffering, and did a ritual burning of herbs—that probably has emerged out of some kind of "market" understanding of how best to solicit an American audience. Marc Edelman (personal communication) directed me to an article by Tilley (2002) which discusses how "indigenous" Salvadorans have "invented" an authentic indigenous identity partly through the adoption of certain terms and practices of the transnational indigenous people's movement (TIPM). Adopting the TIPM discourse and codified norms of indigeneity have enabled Salvadoran "Indians" to gain political recognition and resources.

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In terms of the Haven program, where cultural knowledge was thought to be an essential ingredient in authorizing expert knowledge and where dialogue and free participation were methods to obtain these ingredients, what happened was that certain forms of cultural knowledge were legitimated and others were not--not all forms of cultural knowledge were given equal value, nor were all forms permissible at any given time. So for example, though Marie knew her own culture and the suffering of her people, in the local politics of the Haven program, her contributions to the "dialogue" were sometimes over-ruled by other parties. As a bicultural worker one of her main functions was to translate and mediate between the dominant culture and the culture of the refugee communities, but this was an imperfect process at best. How then was effective translation made possible? How could the bicultural casemanager better master "biculturalism" and not feel re-traumatized or overburdened by her own culture or feel compromised by the demands of the dominant culture? Both Claire and Emil had similar ideas about how to address these questions.

In many clinical environments, whether it be a residential program for chronically mentally ill adults, an outpatient mental health clinic, or a psychosocial program for survivors of torture and refugee trauma, a certain degree of *self*-reflection on the part of the clinicians about their own practices is required. Indeed, the work of the Haven casemanager was not just to help the clients, but to also work on his/her own self with a certain level of seriousness, commitment, and rigor. Similar to Sister Vanessa's comment that clinicians "need to understand [their] own processes," Emil and Claire both agreed that "introspection is key," that bicultural counselors "have to be careful about counter-transference," and that "if they don't do self-care, they will contaminate the process, plus

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they will spill and project feelings onto the client." Again, that vast space of psychological interiority of the self is invoked, where the ambiguities of culture brokering can be managed by "an intensification of the relation to oneself by which one constitutes oneself as the subject of one's acts"(Foucault 1986:41). It is through the pursuit of techniques of disciplined engagement with one's self that responsible agency and therefore effective bicultural casemanagement can be formed.

"Introspection" implies that the self can reflect on it's own experience as a self with an awareness that includes "the experience of recognition by others and the concurrent development of a sense of the fact that others have minds of their own; this capacity involves the ability to conceive of 'realities' other than the immediate one" (Seligman 1999:149). Being able to "self-reflect" or have "self-awareness" in fact is thought by Western psychologists and psychoanalysts to be an essential key to healthy adult functioning, and deficits in this area are correlated with "adult psychopathology" (Ibid). In a clinical situation, self-reflection becomes more sophisticated and specific and requires an ability of the self to examine processes of "counter-transference." In the most simple and broad sense "counter-transference means those "projections of the therapist's own fantasies onto the other person" that are usually "based on unconscious memories and fantasies" which "gratify his [sic] needs rather than the patient's therapeutic endeavors" (Langs 1974:298). Through "training," the casemanagers gain the ability to introspect and to determine when their reactions to a client are distorted because of "counter-transference." I think Claire was referring to clinical training, but I also would suggest training means ongoing self-practice: training the self through practicing on itself and then producing reflections on this process in places where one's process can be

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evaluated, corrected and mirrored-back, such as case conferences and in supervision sessions. This work of the clinical self on itself is not a solitary process of self-reflection but an always social one, where a self speaks to other selves about it's "process," enlisting their self-reflection and participation in the ongoing self work.

Although the Haven offered opportunities for advanced training, such as workshops or in-service training, it was ultimately the responsibility of the casemanager to practice good "self-care," to be aware of counter-transference, to self-reflect, and so on, so she could successfully broker culture. However, "self-care" was not simply a matter of having a handle on counter-transferential reactions. Self-care encompassed an impressive range of projects of the self, as the IRSA handbook explains (2000). The handbook contains pages of detailed prescriptions for "self-care" that leave practically no stone unturned, providing authoritative guidance and instruction for techniques in the ethical practices of life--from the body to the soul, from home to the workplace. In the section on "Self-Care for the Care-Taker," the handbook instructs that, "self-care for the care-taker" requires that the clinician "must first be able to identify signs and symptoms" of "stress and secondary traumatization." This is part and parcel of what is called "stress management" which is one of many "job skills" the clinician should develop. The casemanager is thus asked to assume a managerial position in relation to herself to maximize capacities for self-governance. According to the handbook, stress management skills

> require training and practice. It takes practice to become aware of how you respond to stress and trauma-related stress and what works best for you to reduce this stress. Awareness is not something that can be achieved in a single exercise or event and then crossed of your list of things to do. Instead, it is a continuous process of paying attention to oneself. In particular, it involves paying attention to any changes in yourself,

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> including changes in your feelings, attitudes, beliefs, physical health, and daily activities (87).

One way a casemanager can practice self-care is by going over checklists that have been developed for this very purpose. During one of our staff meetings at the Haven, we each were asked to fill out a self-care checklist. I happened to score low on the section of spiritual health. Or, one may ask oneself pointed questions, such as "do I seem to feel more irritable lately?" and then answer to gauge one's stress level. Obviously, stress management requires constant vigilance of the self, from emotional to bodily functions. An ongoing inner-dialogue must be generated, which takes much training and practice to master. This vigilance allows the casemanager to develop other stress management habits, like "seek[ing] balance among different types of activities, including work, personal and family life, rest and leisure." The handbook encourages clinicians to engage in activities that promote relaxation, and to attend to their physical, mental and spiritual health by getting enough sleep, eating well, exercising, and also having fun.[20] Furthermore, the clinician should also "build connections and supportive relationships with your co-workers, friends, family and community." In terms of the workplace, this means that "structured, planned opportunities" should be established "to talk about stress and secondary traumatization," including support groups, having "de-briefings" after "facing a crisis, critical incident, or difficult situation at work," and seeking professional help if necessary.

If the bicultural counselor has adequately and properly responded to instructions by practicing these rational techniques of self-management, it is thought that problems

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such as Slavenka's "destruction" and eventual departure from the Haven could potentially have been avoided. Likewise it may be true that Marie's belief that her clients do not want psychotherapy, which was one of the main sources of conflict she had with Ed and Emil, could be re-examined and re-defined in terms of her own "counter-transference" with her clients. A connection could thus form between Marie's "culture" and the "culture" of psy expertise, so that Marie could see that perhaps because of her over-identification with her culture, she was blind to her client's needs for therapy. In these ways, we observe that not only are the subjects of therapeutic governance intervened upon, i.e. the clients, but that those who exercise authority over others therapeutically-- the clinicians—are also intervened upon with rational technologies that legitimate their professional authority as clinicians (Rose 1994).

It is believed that greater organizational health and harmony can be achieved when the casemanangers practice appropriate self-care and when the organization itself institutionalizes self-care practices. With training and practice, the bicultural counselors could learn to "see their lives as being fulfilled by this job" rather than "not being prepared, not really thinking about the different aspects of a heavy, complex, job," giving "simple responses to complex questions" and not putting the "extra effort into confronting problems." It is the program's responsibility in turn to provide the appropriate means for taking care of the workers so they do not become ill or burned-out from the difficult work they do. Self-care, as an assemblage of rational, practical techniques aligns the cultural values, objectives, and aspirations of the program with those of its workers.

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[20] The IRSA handbook also has a whole section which discusses how the refugee worker can promote "mental health and well-being" of the refugees they help. This includes advice for the refugee worker on

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Since the late 1990's, self-care for the care-providers has been given more and more emphasis, evidenced by the increasing numbers of workshops and lectures conducted on self-care. But how self-care is actually formalized and institutionalized in different programs varies. In Denmark, most programs for torture survivors have incorporated self-care into the work of the staff by hiring outside consultants for reflective team-building exercises and clinical consultation. At the Haven, self-care was talked about often and thought to be an essential and important part of the clinical work by the directors, yet when I conducted my fieldwork self-care was not integrated into the program. There was one exception. At one of our weekly staff meetings, Ed conducted an in-service training on self-care that closely followed the guidelines for diagnosing "stress" and practicing stress management set forth by the IRSA handbook. Ed said that this was to be the beginning of a formalized course of self-care for the program's staff, to be followed by periodic reflections on self-care for all the staff during staff meetings. For more than a year after this in-service training, the subject was not brought up again. Self-care eventually was reintroduced into the staff meetings and also in one-hour sessions every other week that were devoted to "progressive relaxation exercises" and a technique called "emotional self management" for the casemanagers.

Emil explained to me that for fifteen minutes in the beginning of every other staff meeting, staff were encouraged to speak about whatever was on their minds. They were to unburden themselves of the emotional load they were carrying because of the stressfulness of their work in a "non-judgmental and appropriate environment." This portion of the staff meeting was called "feelings." For the first attempt at "feelings" Emil reported that staff talked "blah, blah blah," and then Ed took a call on his cell phone. The

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guiding clients about proper exercise, diet, tobacco and alcohol use, and sexuality.

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second time, "people were not feeling comfortable and did not really talk." At the third, Emil "broke into tears" and talked about a young client he had been seeing whose experiences of violence and suffering had an extraordinary impact on him. During the fourth attempt, Emil said that staff "didn't speak so much, but people took the time to get back into themselves" before moving on to administrative matters and other items on the staff meeting agenda. This demonstrated more progress in the program's "self-care" project according to Emil.

The casemanagers also reported to me that they were allowed to take "mental health days" for self-care.

However, for the most part, self-care was promoted by the concern that the staff showed toward each other in informal, everyday ways rather than from institutionalized self-care practices. It appeared that the program was not fulfilling its presumed responsibility to integrate "structured, planned opportunities" for staff self-care which is to say, the program was not taking itself as an object of reflection and solicitude in the specific ways prescribed for proper self-governance. Who though was responsible for conducting the conduct of the program besides the directors whose own conduct included conducting the program itself? It did not appear that the casemanagers had the authority to conduct the conduct of Ed and Emil in this regard, and perhaps they were not interested in doing so because they had their own means of practicing self-care that seemed to work for them perhaps better than Ed and Emil's exercises.

When I first began my fieldwork at the Haven, I was struck by how close and affectionate Marie, Slavenka, and Claire were with each other. They often went out to lunch together if their schedules permitted, and had much knowledge about each other's

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lives outside of work. To my eyes their bonds seemed so strong that I thought they had known each other for years rather than mere months. When they had free moments together in the office, we would all sit and chat as women and friends, often talking about romantic interests, children, our health, work, and life in New York. We laughed a lot and I am embarrassed to say, on two occasions we were reprimanded for being too loud. As the casemanagers explained to me, they tried to take care of each other. According to Marie, "We are close, close friends. We are ourselves, you know [refugees], we came from other countries and we support each other. And we are women."

The informal gatherings of the casemanagers seemed to serve as ventilation sessions for that construct referred to as "stress." They also functioned to nurture and foster social bonding between the workers which, according to the IRSA handbook, is an important component of self -care and stress management. The casemanagers discussed their lives and work with each other and got some relief through commiseration, genuine caring, mutual support, and laughter.

The IRSA handbook did not make recommendations for pay scales and salaries for bicultural clinicians As I mentioned before, the casemanagers were constantly worried about their financial situations and they also showed physical signs of stress. During informal exchanges among the casemanagers, there would be many entreaties from the well casemanagers to the ailing ones telling them to slow down, relax, and see the doctor for certain persistent maladies. The Haven staff, including the directors, were always encouraging Marie to see the doctor about her quiet illnesses, but she seemed to be in the habit of neglecting her own health, or not practicing appropriate self-care. I often heard

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staff encouraging each other to take it easy and try to take care of themselves better. As Slavenka remarked:

> Ed is always worried for me. He can tell that I am tired. He has training in psychotherapy, well, not really, but he has training and he could tell that something was bothering me. He always tells me to take care of myself, to take time for myself. That I do not do but maybe it's time.

The toll on Slavenka eventually became too much—the heaviness of her past and the many worries of the present contributed to her decision to leave the Haven and also the country so she could return to Bosnia. Slavenka was not only frequently physically sick, but she was also "burned-out." The trials and tribulations of her job as a bicultural counselor were overwhelming to her in addition to all the other grief in her life, to the point that her self-care took the form of leaving.

Conclusion

This chapter opens with the problem of human difference, and specifically the problem of how psychosocial programs such as the Haven can administer to the diverse groups of people to whom they provide service. The discourses of culture as they were used in everyday life at the Haven, as cultural resources for healing, or as embodied in the figure of the bicultural counselor, became ways in which psychological expertise enabled the formations of distinct kinds of selves, intersubjectivity, and the configuration of partnership. Culture became part of the overall therapeutic endeavor to enlist people to understand themselves and others and to help the suffering heal themselves. It enabled clinicians and workers to become better-adjusted, more effective, and more fulfilled. By intervening into conduct in particular ways that cultivate the capacities of the self to relate to itself as a responsible agent, or as a "resilient," "resourceful," "cultural" subject,

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"psy" expertise at the Haven structured a social world where "achieving well-being" and experiencing "self-sufficiency" were both thinkable and desirable.

Being a bicultural counselor was a tough job, and the workers were caught in a situation where there was tremendous responsibility placed on each of them to practice their self-care responsibly. Self-care required an intensification of self-reflective practices, self-vigilance, and adherence to prescriptions for daily living. Intensifying the labor of self-care also could, paradoxically, free the bicultural counselors from the burdens of stress and conflict, and offered them more autonomy from the rule and external disciplinary control of the directors. Self-care, as with many practices of self-governance, entail simultaneously repressive and productive forces.

The discourse of culture at the Haven was characterized by an acceptance that something called "culture" exists, and that this "thing" is important to know about so it can be used in treatment. The reification of culture I described in this setting typifies the understanding and usage of "culture" in American mental health programs, which in a footnote I said has been referred to as the "social work" approach to culture. This approach attempts to relativize "culture," is sensitive to differential relations of power and fits into the "partnership" configuration of expertise, but also echoes the modernist tradition that identifies "culture" with notions of the exotic other, fixes culture(s) as distinct, enduring, and essential, glosses over individual and intra-group difference, and enables the formation of certain relations of domination and subordination which have lately become apparent in identity politics. In the mental health field, "culture" as a category has not been subjected to the same kind of interrogation that it has been in the discipline of anthropology, where culture is not simply a conceptual or theoretical issue

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but also a highly contested historical and political one (Kuper 1999; Rapport and Overing 2000; Abu-Lughod 1990). However, it is difficult to imagine how the field of torture treatment could account for the particular differences of clients without resorting to some kind of conceptual framework that fixes and categorizes those differences in some form.

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Chapter 5:
Constructing Need

> Organizations concerned with refugee assistance and protection need to come up with concrete ways to encourage more effective refugee participation. At a minimum, service providers should seek input from members of the refugee community. Preferably, refugees themselves should assume the lead in determining which services are needed and how they should be provided.
>
> Susan Forbes Martin (1994:79)

> An important component of the Haven program is finding out what people need, not telling them what they need.
>
> Ed, Director of the Haven

Introduction

One of the key questions that organized the work at the Haven could be posed thus: What do clients need? This chapter will consider psychosocial strategies for managing survivors of torture and refugee trauma that address the question of "need" and the notion that both knowing and meeting needs will help survivors heal and become self-sufficient, empowered selves and citizens. "Need" in the context of service provision at the Haven was not self-evident but the result of negotiated, contested and shifting assemblages of practices, techniques, and understandings that produced, fixed and framed need into workable forms.

A significant portion of the Haven's activities were centered on producing knowledge about need. This happened at the level of the client and casemanager relationship where discovering what clients need and determining what actions to take to meet those needs was established through a "partnership" process. The Haven also administered to larger groups of refugees, which it called "communities," in the dual effort to both conduct needs assessments and to foster healing by shaping and enhancing the community-building capacities of its refugee partners. Technical practices at the

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Haven that constructed and defined need made subjects of need visible and knowable in specific ways, organized much of the everyday work of the casemanagers, and shaped and defined the relationships between the casemanagers and the Haven clients.

This chapter is divided into four sections, beginning with a discussion of unconventional needs in the words of an Ethiopian man who was recently granted asylum in the United States. The second section is an analysis of the intake interview, the individual client dossier, and the relationship that individuals form with their counselors in the process of becoming a "client with needs" that suggests ways in which unconventional needs are translated into service. How communities of refugees find themselves participating in the discourse of needs with service providers, based on data drawn from community meetings, is considered in the third section. The fourth and final section takes as its point of departure a weekly staff meeting. While I was conducting my research, one of the Haven's most sorely contested issues was about "psychological" versus "social" needs. This staff meeting dramatically crystallized the debate over the two main types of needs which together form the core of the psychosocial model.

Section I. Unconventional Needs

Henok, an asylee[1] in his early forties and a former labor organizer, teacher, and researcher from Ethiopia, escaped his country after repeated torture, harassment, and threatened deportation. Leaving his wife and children behind to escape what were life-threatening conditions, he found himself combating new forces as he tried to establish

[1] *Asylee* is a term for a person who has been granted political asylum and now has legal resident status in his/her country of resettlement. An *asylum seeker* is a person who has made it across national borders and is in the *process* of obtaining legal permission to stay in the country based on prior and potential future persecution. Henok entered the United States legally with a special visa, then declared he wanted asylum because of credible fear of harm that would befall him if he returned to Ethiopia. Both asylees and asylum seekers are subsumed under the larger category of refugees.

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himself in New York. Henok's distress, pain and weariness were palpable as I sat and talked with him, but he still was able to speak with clarity about his frustrations:

I came here last year in September 1999, OK? Last June now for three months I have to wait for my work authorization. It's a very slow process for a social security number. During this time I try to contact some of these offices, like the Haven, human rights organizations, City Hospital, Catholic Charities and so on, well actually that was not my expectation at all, you know. As a political asylum seeker we most of the time are looking for better help, OK, if you get what I am trying to say. These organizations may not be well equipped, staffed, have budgets, but most anybody who is a political asylum seeker or who is, let's say, a refugee, all we need are basic necessities. We need food. We need to feed ourselves. None of these organizations are in a position to do that—it's surprising. We need to have shelter—none of these organizations are in a position to help us with this matter. We need transportation—none of them are in a position to do that. We need to have our papers for job and immigration is a very, very slow process—we cannot do anything about that—it's a long and tiring process, but that's different. But the organizations who have a model helping political asylees and refugees, what are they going to do, what consultation are they going to do for a man who is participating? We are not looking for big things but small things for us. For one thing, we left our families, we were harassed, tortured, mental and physical torture.

Can I tell you something? In Ethiopia there was a drought for a long time, people were starving, but are you surprised to hear that for the last 40 years I have never starved, I am not starved, but when I reach the U.S. I began to starve. Yeah, its paradoxical, it is here for the first time that I found myself starving, for the first time I got sick for the first time, mentally, I was so embarrassed I had to wait for immigration and I couldn't find a job and I tried to go to different organizations who are in charge of political asylees. Even one organization told me now that I am living with one of my relatives in Long Island to come to Manhattan to feed myself once a day. It was Catholic Charities or something. Can you imagine? That coming from Long Island it is two and a half hours to feed myself once a day in Manhattan? And I just told him that if I had the money to come here to Manhattan I would eat there in Long Island with that money. So I don't think that these organizations address the need[2] of the asylee or refugee as they should, as they should. How can you treat a person who was tortured much and who has left his family and deal with all trauma without feeding him first, giving him shelter, why you are treated in here, I was thinking of family, I was thinking of my transportation, I was thinking of everything, what kind of treatment for torture? Do you want psychological treatment or psychotherapy? Just asking me my answer is yes but my brain is not there, my brain is somewhere so if they say choose psychological treatment I choose nothing because you didn't target my physical suffering first. How can they treat it in here? So that's a real

[2] Henok seems quite familiar with the service industry's discourse of needs. This may be because he himself worked with NGO's and in educational and service-oriented programs that probably practiced service provision or because he has been a recipient of such. Built into user-rights oriented service is a paradox where the recipient is also empowered to critique the service provision. Henok turns the language and logic of "need" into a tool of critique.

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problem and the other point is that there are some organizations that help you get medical treatment, very good, but that takes you two months! I was tortured and I had problem with my heels and I had a sciatica problem at home and they were torturing my leg with the sciatic problem so I had pain very much. I just told them, please give me treatment. You know what they said to me? They gave me an appointment for two months. Again I suffered a lot for two months and after two months they said I have to go back for more treatment.

They made me wait two months. So you see, have you been, OK, that's my problem. You can wait. But what about if you have been tortured, a torture case. When you ask for political asylum you are asking for nothing, we are tortured, we were harassed, we had so many problems, OK, so if it's a torture case, a sickness that came from harassment in the prison you have to be treated for that. If you give a long appointment you may give us an appointment after months but that means you have elongated our suffering at least three times. If you ask me to wait two months that means you have decided I will suffer for two more months.

They must address these problems. They have to sit down and revise their programs and have them address correctly these people: What are we giving them? Did we address or simply ask them to come here and talk with them and then give them a token, is that what we are going to do with these people? Before they start on their program they have to sit down and address our needs, OK? It doesn't matter that they have to address all our needs, but if one of them can address one of our needs that's nice. Instead of trying to address so many things because that you cannot do, OK? So if it's to feed us, so feed us. Is it to find us a job, find us a job, if it's to help us to expedite our immigration process, just focus on that, OK? Is it to give us treatment, then give us immediate treatment because we are suffering. If it's for psychotherapy then take us immediately, tomorrow. Because a man who is suffering, its horrible. If you are suffering, people in here I am sorry to say in Western countries most of them they don't have extended family system so you cannot live with someone for long, it's difficult so we have to get the knowledge ourselves to get something to help us to be on our own.

I include Henok's story not as an evaluation of the existing service system, but to show how grinding life can be for some refugees, and to illustrate how need under such extraordinary circumstances is thrown into relief as a problem of survival with urgent force for Henok and others like him. Not all political asylees in New York face the same conditions that Henok does, but his situation is far from unusual. Even those refugees pre-selected and sanctioned by the UN and domestic refugee quota systems, who may indeed have more assistance in the resettlement process than asylum seekers because they

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are managed through an official and organized resettlement system,[3] may nonetheless still suffer many of the same hardships as asylum seekers. How many and which refugees are accepted into the country, domestic politics, Western strategic interests in the context of international policy and diplomacy, and social stratification predicated on race, gender, and class play a role in differential refugee experiences. Some refugees and asylum seekers may have the benefits of family and community support that others don't. Some refugees are embraced by the country of resettlement with sympathy and concern while others are not. In the United States, "popular" refugees would include Bosnian, Kosovar, Russian Jewish, and Cuban refugees. However, there are also "unpopular" refugees which include many Haitian, African, and Chinese refugees (Gibney 2000). Henok, though educated, had some of the social markers of an "unpopular" refugee because he is dark-skinned and African.[4]

Given these structural conditions, the situation for most refugees, whether they be asylees or official refugees, black or white, educated or non-literate, is indescribably difficult *especially* in the city of New York. There is a tremendous lack of affordable housing and many other problems that make life painfully difficult for the disenfranchised. "These people have nothing," Marie explained, "They live in the most developed country in the world with undeveloped conditions. Yes, refugees are very strong. They are not just survivors but victors. But they need *everything*. They sleep on the floor without blankets. One woman needs shoes and coats for her grandchildren."

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[3] The refugee resettlement process is far from satisfactory both for those providing service and those receiving it. A refugee resettlement agency such as Catholic Charities may find itself inundated with a surge of refugees and face shortages of personnel and other resources. With an overload of cases, the casemanagers of these agencies may find themselves making referrals to the Haven for services like legal because they do not have the capacity to meet the demands of the clients.

[4] However, he is probably regarded more highly as an African than an African-American man would be.

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Claire remarked, "There are huge language issues. Many refugees cannot speak English. The worst is for those who are alone here. If they have family, the family can help them out. Some of them are really in shock, like in a cloud. There is a survival needs crisis in the United States."

Henok found himself starving for the first time in New York after surviving droughts that killed millions in Ethiopia. Here, "in the most developed country in the world," Fenok was without basic necessities such as food, a job, permanent housing, work papers, money, and medical treatment.[5] He was torn away from his family and friends, and suffering profoundly from the separation. He suffered too from his past torture experiences. Marie says her clients "need *everything*." Need here is existential and fundamental in a way that is inconceivable for many Americans,[6] where the struggles, profound suffering, and unconventional needs of refugees render visible the profound injustices of the world.

Henok's crisis and the urgent needs of others like him also present practical problems that require accommodating "unconventional needs" into service provision. As Henok stated, programs like the Haven "must address these problems, they have to sit down and revise their programs and have them address correctly these people."

Section II. Translating Need into Service

For the service providing institutions that have the responsibility of managing survivors of torture and refugee trauma who have "nothing," zones of intervention have

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[5] Contrast this with Denmark where refugees and asylum seekers have all their basic material needs met. However, those refugees suffer a different malaise, one stemming from uncertainty about their future, lack of meaningful and purposeful activity, and social barriers to assimilation. Many Danish refugees would jump at the chance to work, or to be able to strive for something.

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emerged where "need" has been transformed into a technical vocabulary and logic that orients a range of strategies, techniques and codes of practice. Need has become an administrative and clinical problem, requiring definition and quantification, where needs are to be "assessed," "identified," "addressed," and "met." The objectives and goals of service are formulated in terms of meeting client needs, where working with clients means discovering the particularities of each client's needs and then demonstrating in accountable forms professional effectiveness based on meeting those needs. In these practices, though need has indeed become operationalized, it is not a static entity but part of changing relations of service provision at a local level and in relation to larger rationalities of governance.

Psychosocial programs for survivors of torture and refugee trauma base themselves on the premise that there are basically two kinds of needs that all human beings "need" to have met to achieve a proper sense of well-being and adaptive functioning.[7] There are "psychological" or mental health needs, and concrete, material or "social" needs, hence the term "psychosocial." Programmatically, service provision at the Haven divided itself along the lines of these two types of needs—referrals made for ESL classes, housing, legal, family, and medical services were considered services for "social" needs and supportive counseling or psychotherapy were available for "psychological" needs. The Haven considered itself a program that aimed to balance the two types of needs through the structure of its service provision. The model allowed that the

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[6] Of course, there are many others in America for whom "need" is also fundamental in many of the ways described for refugees. However, refugees and for example, homeless people, though needing some of the same basic things, also have particular needs.

[7] The lines drawn between these two types of need run parallel to the two types of human rights that were valued most by communist/socialist and capitalist/democratic regimes of rule respectively. Communist

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psychological should be given just as much weight as the social, and though one side may be addressed before the other, neither alone is sufficient to achieve what may be called well-being. However, the distinction made between these two types of needs was not as straightforward as first appears. Part of the work of the Haven service providers was articulating the differences and also the overlap between these two needs, a process that indicated how contested and unstable the two categories in fact were. For instance, it was thought that when a casemanager accompanied a client to the office of social services, this activity not only fulfilled a social need but a psychological one—accompaniment served a "therapeutic" as well as a social function. Finding shelter for a client also served a psychological need—the need for a sense of "safety"—which clinicians referred to as the first step in the healing process for traumatized refugees (Herman 1992). Indeed, many activities that the casemanagers engaged in with clients were "therapeutic," according to Ed, "but not necessarily psychotherapy." One place though where a marked distinction was made between these two types of needs was in terms of professional roles and status; those workers who provided services for "psychological" needs usually enjoyed greater professional recognition, status and authority than those who provided services for "social" needs.

An Aside: Spiritual Needs

At the Haven, there was also a special category of "spiritual needs" or the "needs of the spirit, the real and inner person" that Ed inserted into the service discourse. These were neither social nor psychological needs. Spiritual needs were talked about as a different type, and the intention of insisting on a third category of need was Ed's

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regimes emphasized the importance of having social needs met—food, clothing, shelter, education, medical and care, and for democratic regimes, civil rights such as the right to free speech were valorized.

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contribution to the critique of medicalization. Psychological needs could intersect with spiritual needs, but the category of the psychological also had the potential for reinforcing a biomedical viewpoint of suffering. For Ed, psychological and social aspects of functioning did not exhaust the full expression of humanity, and his own spiritual background supported this position. By including a spiritual dimension in service, Ed reinstated a category of needs that could resacralize secular, modern social service responses to suffering. However, spiritual needs were not formalized in the practices at the Haven to the extent that the psychological or social needs were and will therefore, for the purposes of discussion in this chapter, receive much less attention.

Generally speaking though, as suggested in the last chapter, promoting and including clients' spiritual needs in service provision was desirable because it was thought that spirituality and religiosity were strong "cultural" traits for many refugees, and that cultural-sensitivity was important for effective and respectful service provision. In the Haven's client intake forms, this was codified in a section on cognitive/emotional functioning, which for Liberians and Sierra Leonians was partially measured by an "ability to seek comfort/rely upon one's religion"(see Appendix IV). In terms of one-on-one relationships with clients, I have some evidence to show that clinicians or service providers for whom religion or spirituality were important in their own lives created therapeutic relationships with clients where the so-called spiritual aspects of existence were openly acknowledged and used in treatment. At a refugee resettlement program I visited, one spiritually-minded coordinator said, "I was always surprised to see how quickly and honestly I would be talking to people [clients] about God." At the Haven,

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Marie in particular was known to be religious and her interactions with clients frequently invoked God, faith, her church, and so on:

> I tell clients that I believe that in this country if you work very hard, keep your eyes and ears open and your mind thinking, you can make it. You need to make friends, talk with people, and with the help of God, always with the help of God, things will work out... I am a Christian, a very devout Christian...I have always been and my whole family is Christian. I am an Orthodox Christian. If it's God's will for it to be, it will be. If it's not God's will, it will not be.

God and spirituality seemed to emerge very naturally in conversations with clients, and it was my impression from talking with Christian and Muslim clients that many had faith in God and held religious beliefs[8] that helped explain their suffering and gave meaning to their lives. Many clients also found "community" in the churches or mosques of which they were members, and for many refugees finding a church or mosque was one of the first things they did upon arrival in the United States.

Spirituality and religion also have been part of the VOLAG apparatus. Many refugee agencies are run by religious groups such as Catholic Charities, Lutheran Family Services, the Jesuit Refugee Service or the American Friends Service Committee. Though these agencies are in fact committed to providing non-religious based service and are contracted by the government, they nonetheless are religious organizations. What impact this has on the clients of these programs is a question further research could answer.

God and social assimilation, religion and psychology, and faith and hard work were mixed together rather seamlessly in Marie's therapeutic discourse. For many clients

[8] Some clients, especially political activists, were avowedly atheistic. I did not personally speak to any refugees who had lost faith because of the violence they had suffered, though accounts from Holocaust survivors indicate that this is possible. For some Holocaust survivors, the atrocities they experienced led them to conclude that they were living in a God-less universe.

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at the Haven,[9] a combination of psychological expertise thrown together with religion (which often took the form of fatalism) was not at all contradictory, and in fact the two worked well together in solidifying the client/counselor relationship, and in enhancing the client's capacity for better self-governance.[10]

Defining Need-Beginning the Screening Process

A potential new client, who finds the Haven through friends, acquaintances, lawyers, outreach efforts, or refugee resettlement programs, will likely make the first call to the program. Already, by actively seeking out and choosing a service provider that is authorized to provide services for the empowerment and self-determination he lacks, the client is demonstrating his capacity for empowerment and self-determination (Dean

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[9] As this study does not examine the actual relationships casemanagers have with their clients, I cannot describe exactly how spirituality or religious beliefs were entwined in the therapeutic process. Nor is there data to show if some clinicians have offended or put off clients by invoking God or other religious beliefs.

[10] The spiritual needs and beliefs of the clinicians presented a slightly different story. Spiritual needs of the professionals working in the field of torture treatment was a slightly dangerous topic of discussion, and not often acknowledged or accepted to the extent it was for the clients. A refugee resettlement coordinator worker explained :

> I know why I do this work and it's because of the clients. I feel honored by their stories...I was always surprised to see how quickly and honestly I would be talking to people [clients] about God. In this culture you are crazy if you do. I get self-affirmation from working with the clients and at first I was embarrassed about this, knowing that I was getting some self-knowledge from this...Our work has to be spiritually fulfilling. You can find meaning in it...what you are furthering, your meaning, you can be an atheist or whatever but most refugee workers have a strong faith in humanity. Part of what we are doing is finding meaning...
>
> We've decided to come out of the closet about this and people are relieved that we can finally really talk about spirituality. Like we have had workshops at conferences and twenty-five people might attend...many people say it's the best workshop they have ever attended because it was something that they were already living...

Ed and other like-minded practitioners have made "spirituality" part of the professional discourse by "com[ing] out of the closet" but it is still somewhat taboo, and it certainly is not appropriate to discuss spirituality in certain contexts and in certain ways because, as the worker above explained, in "this culture you are crazy if you do." Spirituality needs to be professionalized for it to become a safe topic to explore, as for instance in a workshop that is expressly about working with refugees and spirituality or in treatises on self-care that include prescriptions for attending to spiritual needs. Furthermore, although in specific contexts it may be appropriate to talk about one's "spirituality" it is usually not as acceptable to talk about one's "religion" or God. In a staff meeting with clinicians, it would not, for instance, be acceptable to refer to Jesus Christ.

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1999).[11] If the potential client is known to the program or casemanagers, such as a client who is referred to the program through Marie's church or an acquaintance made through outreach efforts, he may not have to go through the process of doing a telephone screening but could simply call to make the appointment. Otherwise, a brief screening process occurs over the phone that establishes whether or not the individual is eligible for services at the Haven. If the person meets the main criterion to be a Haven client-- that he is indeed a survivor of torture or refugee trauma and is interested in receiving services-- then an appointment will be made. During the screening call, some basic information is gathered, such as the person's name, contact information, presenting problem, ethnicity, and spoken languages that will then be used in assigning the client to the appropriate casemanager. Screening information will also be used at a later date when periodic descriptive statistics are generated to represent the Haven program's activities and progress. Thus the screening call initiates the official relationship between the participant and the program, begins the inscription process for that particular individual, and also constitutes the first step in individualizing and making that person knowable as a client.

As was discussed in the last chapter, the problem of providing service to such a diverse array of clients had to be addressed in practical ways. One way to deal with this problem was to pre-select clients by recruiting them through outreach efforts that were aimed at specific refugee groups. Many of these refugee groups were matched to the bi-cultural counselors by similarities in language, ethnicity or nationality. Matching culture, ethnicity or nationality was one diversity management strategy, but sometimes potential clients were referred or self-referred to the program who did not speak English and whose

[11] For the sake of consistency, clients will be referred to by the masculine pronoun and casemanagers by the feminine pronoun.

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native language did not match the language proficiencies of the casemanagers. In these cases, if the potential client had friends or relatives who could translate for them they could still be accepted into the program, as the Haven wanted to avoid turning people away. Which casemanager should be assigned to those clients depended on situated and context-specific judgments of the staff, and not on hard and fast rules. For instance, the casemanager with the lightest caseload at the moment, or perhaps a casemanager who had already seen a client from that ethnic or national group would take the assignment.

By shaping the range of clients who were seen in the program through these particular methods, the Haven created limits and restrictions that defined the clients by categories like ethnicity or language abilities, giving some order and manageability to the ongoing and unwieldy practical problem of diversity. By doing so, certain sociological categories of difference, such as ethnicity, were reinforced in Haven practices.

The Intake Interview

When a new client arrives for the intake interview, he is taken into the private office of the casemanager and seated across a table from her or at the side of her desk.[12] In front of the casemanager lies a client folder filled with blank forms, opened and ready for writing a "psychosocial biography" of the client (Erikson 1969:403). The intake interview may take anywhere from one half hour to almost two hours. According to Isabela, "It depends on how much they [the client] want to talk and what they are willing to share with us for the first time." Occasionally a client may have reservations about submitting information to the casemanager that will be put into writing, and will voice a concern that his dossier could be used against him, either at the hands of his own

[12] Most but not all intakes are conducted in the office. Occasionally, a casemanager will do the intake at a client's home if, for instance, the client is not able to negotiate the subways or is ill.

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government, the American government, or by other parties that could inflict harm on him. According to Ed, since confidentiality is a concept with which many clients are not familiar, it necessitates an explanation that is both educational and reassuring. Clients are told what confidentiality means and that "confidentiality is your right in America." Claire explained, however, that as most refugees have become accustomed to visiting social service agencies and having interviews with authorities, in practice many clients are "indifferent" to the concept of confidentiality and do not in fact have reservations about submitting personal information.

Some of the information gathered is written in the client file while the interview is taking place and other information is entered after the interview. For instance, if the client launches into his "trauma story" before the section of the interview that specifically addresses trauma, the casemanager will allow the client to speak, and then will later go back to the trauma forms and fill them out. During this process, though there is the imperative to fill out forms with efficiency, there is also the imperative to preserve the client's "dignity," to help him feel "safe," and to establish "trust." In balancing these demands, the casemanager is authorized to use her judgment in conducting the interview in the order and manner she deems appropriate.

Clients are told beforehand that they do not have to talk about their trauma if they do not want to, nor are they required to answer any particular questions. Casemanagers are taught to stop the interview at any point if the client feels "uncomfortable." Though by law the files are available to the clients for their perusal, clients at the Haven, even if they are for whatever reason interested in seeing the contents, were not known to exercise this right.

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Inscription

During the intake interview, what is called a "psychosocial assessment" is performed, where the casemanagers read the client specific questions from printed forms. These questions ask about the client's medical and psychiatric history, trauma history, functioning, symptoms, and "priority needs." Inscribed in codified and standardized forms, materializing the subjectivity of the client and transforming the inchoateness of his experience and virtually inexhaustible needs into a calculable and manageable scheme, this individualizing technique "objectifies" the client. Yet the process of the interview also allows for the shaping of the relationship between the casemanager and the client, and presents the first significant opportunity for enrolling the client in the subjectifying project of self-work that will lead to greater self-sufficiency and self-determination. It is both of these techniques, inscription and interviewing, that will now be considered.

This discussion will examine three types of forms in the individual case file: the trauma history, the service plan, and the participant contract. The trauma history forms are significant because they were designed for and represent the inscription of a specific population: clients who have been traumatized through political violence. The service plan, an essential and familiar dossier component for any type of client who receives services under a casemanagement model is important here because the Haven has developed forms that specifically reflect its model of cross-cultural sensitivity and the promotion of self-determination for its clients. The participant contract forms present an example of self-governing requirements of the partnership configuration of "psy" expertise.

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The Trauma History Forms

The "trauma history" forms, like other forms in the dossier, have been borrowed, modified or reproduced from other institutions (see Appendices I, II, and III for reproductions of the trauma history forms). The Haven adopted theirs from other rehabilitation centers for survivors of torture and refugee trauma. Latour and Woolgar (1986) describe how paper technologies in scientific laboratories function to transform certain material substances into another material form, and where much of the scientific activity they observed was oriented toward the production of formal written documents. They suggest that scientific practice can be thought of as a literary endeavor, where the inscription is part of a rhetorical process that persuades order and authority to emerge from the messiness and disorder of practice. Certain aspects of scientific production thus are rendered invisible or irrelevant.[13] Likewise, the indeterminacy of a client's experience and subjectivity becomes ordered through dossier inscription in particular ways, giving privilege to a construct of "trauma" as a perceptual grid for visualizing and knowing who these persons are and making other life contingencies invisible (Rose:113). Documentary practices also have a reflexive function in the sense that they shape what can be seen, known and acted upon and therefore organize the ongoing work of service provision. These paper technologies, as they are constructed, circulated, accumulated and reproduced, also allow for communication among different "sites of calculation," enabling the "coordination and regulation of large numbers of persons" (Rose 109). They also combine with other devices and practices to yield a population of "traumatized" persons with specific "needs."

[13] A similar argument has been presented by Clifford and Marcus about ethnography (1986). Indeed, the dissertation is also an inscription device.

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Traumatic Events

I am separating the trauma history forms into two categories, calling one traumatic events and the other traumatic experiences. For traumatic events, the "Trauma History" forms comprise the first questionnaires (see Appendix I). The casemanager is asked to fill out questions about the specific types of violence the participant has experienced. Written instructions on the form say "when relevant, please include the date, duration, and place of events." There are ten different questions on this page, including, "Is participant experiencing ongoing separation from family members?"; "Did participant see dead bodies?"; "Did participant experience physical violence by authorities or persons acting in official capacity?" and; "Has participant experienced trauma since coming to the U.S.?"

Also under the heading of traumatic events is another page. This one asks about "types of torture" from an inventory list of fifty-one "types of torture" along with a blank space for "others (specify)" that the client may have experienced (see Appendix II). Indicated on the form are instructions to the casemanager, "Please circle all items mentioned by the participant." Types of torture are numbered and arranged alphabetically and include "acid treatment," "asphyxiation," "biting," "chili powder," "electrical shocks," "gunshot," and "injection/pharmacological treatment."

Falling under the category of traumatic experience is a page on "symptomatology," instructing the casemanager to "Please circle all items mentioned by the participant" (see Appendix III). A list of twenty-two psychological symptoms is given, such as "distressing memories of the event," "feeling that event is re-occurring," "nightmares related to event," "sleep difficulties," and "restlessness." There is also a

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"physical sequelae" checklist that includes an inventory of injuries resulting from violence such as "broken bones," "burns," "joint pain," "loss of hearing," "skin discoloration," and "others." There are thirteen items in this list.

The trauma section finishes with "Means of Survival: What helped you survive?" and includes twelve different approaches that helped the client survive. These include "faith in divinity/religious beliefs," "family," "political beliefs/commitment to a cause," "will to survive," "luck/chance/fate," "anger/desire for revenge," and "cooperation with torturers."

Transforming Trauma

The trauma history component of the dossier frames and thus transforms violence and suffering into traumatic events, and traumatic experiences into psychological "symptoms" and "physical sequelae." Among its many functions, the trauma section shapes the client's memory around a certain narrativization of trauma that excludes other ways of organizing memories, and inscribes violence into a series of discrete, quantifiable external events. The trauma history section explicitly dwells on the past and present psychosocial biography of the client, "...concentrat[ing] on those moments in the past that seem to point logically to the present illness, as if to indicate that this outcome was almost inevitable" (Erikson 1969:403). This history also serves to "verify" that the client is a "proper subject" of care and intervention at the Haven program by providing evidence that the client is in fact a survivor of refugee trauma (Ibid). It is by re-constructing the client's past in this manner that the client's "needs" and future are also made visible and calculable in the present. If, for example, the client shows evidence of exposure to traumatic events and also presents "symptoms," the casemanager would then

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have an account to validate that the client has "psychological needs." And, if the client has "physical sequelae" of torture, this would count as evidence to support the assessment that the client has "social needs" warranting medical care. If these needs are not met, the client is "at-risk" for probable difficulties in the future.

These inventories are not psychometric measures or assessments, where a particular score would indicate a certain level of distress or pathology, or where meeting certain criteria defines a psychiatric diagnosis such as PTSD. Many of these symptoms however do fit the official diagnostic criteria for PTSD, but because of its anti-medical model ideology, the Haven did not use this form for the purposes of psychiatric diagnosis. Instead, the symptoms were considered more like trans-cultural responses to trauma, universal indicators of traumatic suffering (not determined by culture influences) that had a heuristic value. They helped the casemanager have a better idea of the types and severity of the client's suffering. This aided the casemanager in the process of discovering and servicing need without completely "medicalizing" the client's suffering. Nevertheless, the shadow of PTSD is indelibly cast on these inventories, suggesting a "persistent euphemization of the disease concept" (Breslau 2000:190) and also fixing the etiological link between causes (traumatic events or hearing about traumatic events) and disorder (traumatic experience) that in fact distinguishes PTSD from all other DSM-IV psychiatric diagnoses. In addition to euphemizing the disease concept, this symptom checklist also unwittingly undermines the Haven's goal to be "culturally sensitive" by universalizing the symptoms. There are culturally sensitive measures in existence that other centers for torture rehabilitation have developed and used. For example, specific measures for people from some Asian "cultures" have been designed to capture clinical

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depression and other symptoms of psychological distress that are expressed through somatic complaints.[14]

The Haven's use of these inventories fosters an indirect method of assessment, where the casemanager reads the inventory lists and interprets the items as signs which point both to the cause (torture) and to the solution (services). Interpreting these signs correctly reveals truths about "needs" for clients that they themselves may not be aware or be able to articulate directly. The hermeneutics of these inventories may require a certain degree of professional know-how. So for example, if a client experienced multiple traumatic events but reports few symptoms, the casemanager could take this to mean that a client is incredibly resilient and may not "need" psychotherapy. It could also mean that the client is not yet manifesting traumatic symptoms that may in all probability appear at a later date. According to "psy" professionals, traumatic symptoms can be postponed, so the "need" for prophylactic psychological care could be interpreted from this configuration of signs. These signs could also mean that the client is not fully disclosing the truth about his experience, perhaps for reasons of shame or a lack of trust. These clients may therefore "need" to work on developing a solid relationship with the Haven staff that will enable them to verbalize their distress.

Many clients may be cognizant of their own suffering like Henok who said "my brain is not there, my brain is somewhere." But the client may not be aware that he has "symptoms" nor that he has "psychological needs." It is then incumbent upon the Haven staff to educate the client who may not know about mental health about what mental

[14] For example, Kinzie and his colleagues (1982) developed a depression rating scale for Vietnamese refugees.

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health means, and to let the clients know that his "psychological needs" can be met through services at the Haven.

The section on "Means of Survival" presents another sort of device for developing a coherent picture of "needs" that looks toward the client's own capacity to "survive" and to make meaning. This section forms a picture of an active survivor, rather than a passive victim. By asking how the participant understands how he survived, the contingency of survival becomes non-contingent; the narrative produced in the forms and elicited from the client transfigures contingency into history. Resilient and victorious survivors possess the capacity not only to make meaning and history, but because of those capacities they are also able to overcome the obstacles they face in the present. For some clients, like the many who have indicated that their religious beliefs helped them to survive, the "means of survival" can be revived and instrumentalized for the present difficult circumstances they face, enabling them to move toward a better future. Thus for some clients, the "needs of the spirit" can be revealed and met in this moment of intervention.

As the client discusses his service plan with the casemanager, the casemanager can refer to the client's individual strengths and help him to mobilize them as a potent force for changing his present conditions. He may not "need" certain outside interventions in the future because he already possesses, perhaps unbeknownst to him, the capacity to help himself.

The Service Plan

The "service plan" is a regular feature of psychosocial casemanagement. Today, social service provision is defined by practices that produce goals and outcomes in

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elaborate regulatory systems of accountability. Auditing technologies pervade not only private for-profit industry, but the non-profit and public sectors as well, providing a whole new range of practices that allow for governance at a distance (Rose 1996:73). The service plan is an inscription device that both constitutes and represents the goal-oriented and measurable and therefore auditable approach to care.

At the Haven, the dossier's "service plan" includes an entire page of small-point font instructions for the casemanager explaining how to do the service plan properly. Designed to be "culturally-sensitive," the service plan includes a mix of "assessments by the counselor," assessments of "functioning" done "in collaboration with the client," and an assessment "co-created with the client and then rated by the counselor" (see Appendix IV for service plan). Thus, this section of the intake process reflects a mode of interaction between the client and casemanager that empowers the client through collaboration and participation, and thus initiates him into the same kind of active engagement in his own life that will also be the goals of service.

The first section of the service plan asks for ratings about "cultural expectations of cognitive/emotional functioning" and the "ability to feel that one is doing well in life (self-esteem)." Four "cultural" categories are represented on this form, including Ethiopians, Liberians, Bosnians, and Sierra Leonians. If the client does not fall into one of these "four cultural groups" a "generic form" is used. So for example, if the client is Ethiopian, he is asked to rate on a scale from "great difficulty" to "no difficulty" how well he fares, in the present, in regard to cultural expectations of his group. Expectations for an Ethiopian client would include the: 1) ability to engage socially with others; 2) ability to help others; 3) ability to seek help from priests and/or elders; and 4) ability to

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share one's problems with family, relatives, neighbors, or close friends. Presumably, these are culturally desirable "abilities,"[15] and would be familiar to and also valuable to the client.

The next question asks about "self-esteem," or the "feeling that one is doing well in life" and here the client rates how he thinks he functions on this axis. The casemanagers' instructions for the self-esteem section of the intake interview includes a statement recognizing that different selves, depending on their culture, may esteem themselves either more "individually-oriented," or more "community-oriented," or "interdependent." A section at the bottom of this service plan page asks the client another question about self-esteem. It has the client rate his self-esteem or the "feeling that one is doing well in life" on whether it is based more on a personal/individual assessment of self-esteem or on a social or community-centered assessment of such. It is possible that the client could rate himself in the middle of these two ends of the spectrum, which would mean that his self-esteem is based both on ego and socio-centric influences, but it is a forced choice question (like most questions in the intake forms) leaving no choice for being neither.

In the next part, the casemanager is asked to fill out her "impression" of the client's "cognitive/emotional functioning." This section includes five areas of functioning: 1) ability to maintain stable relationships with friends/partners; 2) ability to maintain steady employment; 3) ability to discuss trauma story with counselor; 4) ability

[15] This section was developed out of a "needs assessment" project that the Haven program conducted in conjunction with cultural community "partners." I was not doing fieldwork at the time the project was in progress. These "culturally-sensitive" approaches of emotional/cognitive functioning run the risk of being too general (each cultural group has a measure for "ability to engage socially with others"), and too specific (out of all possible cultural expectations, norms, and ideals, why were just four picked and why those four?). The cross-culturally sensitive section in the intake intends to allow for cultural differences and to de-universalize norms, but another normative and homogenizing scale is being constructed to take its place.

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to concentrate; 5) ability to have short-term recall. Again, the scale runs from "great difficulty" to "no difficulty."[16]

After completing these scales, the client is asked to rate his own five expectations for cognitive/emotional functioning. These five expectations are not already listed on the forms but are to be created within the service plan process by the client and casemanager together. According to the instructions, "This part is specifically for cognitive/emotional functioning, not for concrete services (asylum, financial, work, job, etc.)...This section will represent how the client sees his/her problems and what s/he wants to achieve psychologically." This represents an instance where the difference between the "psychological" and the "social" in the Haven psychosocial model is explicitly defined. Examples of "typical items" that the client could wish for himself are provided in the instructions and include "I'd like to sleep comfortably," "I'd like to feel happy," or "I'd like to be hopeful about my future."[17]

The final section of the service plan calls for a "Plan of Action" and is to be done "collaboratively with the client." Again, there are blank spaces for five "plans" that will

[16] The casemanagers reported that when reviewing these sections with the clients every two-three months as per the service plan protocol, they did see an improvement on the scales of cognitive/emotional functioning.

[17] Isabela and Sanja explained that many of their clients "don't get" this section. "Even when I explain it to them a few times," Isabela said, "they look at me like, what?" However, there are some clients who do understand and respond easily to the section. Sanja also described how some of her clients "laugh" when they are asked to rate themselves on the scales of "great difficulty" to "no difficulty" for measures of cognitive/emotional functioning. She explained that it is "very hard to translate what some of these things mean" to clients, not just in terms of language but of culture. Haven casemanagers told me that if clients are educated professionals, the clients may find it easier to relate to the intake process and service plan, and also that they may occasionally use some of the vocabulary and categories that are used by service providers. For example, some clients understand the category of PTSD and in fact use it to describe their own experience. However, it would be a rare event to hear a client talk about his "cognitive/emotional functioning." In addition, clients who become politically active as torture survivors and who identify themselves as such are likely to experience a certain transformation of identity that happens through adopting or internalizing certain aspects of the therapeutic language and framework. Of the different refugees I encountered, Isabela seemed to have most fully adopted a form of therapeutic torture survivor discourse; she was a member of a survivor-based advocacy group and was also a casemanager.

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"reflect the services that will be offered to the client, including necessary referrals." These services encompass all possible psychological and social services that the program may offer or refer for. The "service plan" maps out the direction of "service," and is the final and also probably the most important product of the interview.

The Participant Contract

The participant contract consists of four "responsibilities" the Haven client must adhere to receive services, and four "responsibilities" that the Haven staff agrees to uphold as a contract of service provision (see Appendix V). For the client, these responsibilities include accepting "all social service referrals," and attending "all appointments made on their behalf." For the Haven staff, responsibilities include guiding the "development of the service plan," and making "timely and responsible social service referrals." "Rights" for the Haven participants and staff include the "right to terminate the working relationship on non-compliance" of any of those responsibilities. The Haven client also has the "right" to call a meeting with the counselor's supervisor, if he has a "grievance." At the bottom of the form is a space for the client's name, date, and signature. However, there are no lines for the Haven staff to sign.

Discussion of the Service Plan and Contract

Four important observations can be made about this section. The first is that the client is being taught to consider himself a "cultural" and also a "social" being with certain moral obligations to his cultural group, and also obligations to identify himself in particular ways with this group. Deficiencies in these areas could be for many reasons,[18]

[18] Some clients have in fact consciously distanced themselves from their communities because of political or social reasons. One client with whom I spoke does not want to associate himself with his community because of his past affiliations with a certain political party that was at odds with the religion-based politics of his ethnic group. Another client has mixed feelings about her "community" partly out of shame and the

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but the assumption seems to be that extreme experiences of violence and dislocation may lead to many symptoms (or lacks) that would include deficiencies in being a good group member. One of the concerns of treatment is to foster certain culturally appropriate practices of social and intersubjective relating.

Though this section of the dossier assumes that the group and the individual self are intimately related and "interdependent,' it is the individual self who has the responsibility and "need" to work on itself to fulfill cultural expectations and also to build community participation. The psychological ethic of autonomy gains its authority in terms of self-obligation to the greater good. As with the individual, for communities, too, the goal is greater self-sufficiency, self-determination, and freedom from dependency on expertise and social welfare service. Implied here is the idea that by strengthening community ties between individuals and the collective, a kind of organically occurring healing process will take place that will not require expert intervention. In fact, I have heard different psychological professionals in the field of torture treatment say that they ultimately would like community-building to happen without expert assistance, and that paradoxically their professional goal is to no longer be in business.

Thus, in this part of the service plan, the individual is at once autonomous or "individualized," readily evident even in the fact that this is his own individual service plan, and also socially obligated in morally specifically ways.[19]

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fear of her community's judgment of her because she was raped. One client did not want to associate with her community because if her clan was known, it could put her sister and aunt back home in danger. We can see that an individual's relationship with community may be extremely complex and ambivalent. In the context of service provision, the casemanagers would exercise their capacity to look at each individual case as unique, and would not force "community" upon any client. An evaluation would be made to determine whether or not the client's distancing from his community required therapeutic intervention.

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Secondly, a certain kind of subjectivity is being invited, that of a psychological self that can reflect on itself, on "feelings," on "self-esteem," and on "individual expectations of cognitive/emotional functioning." Even the abilities "to engage socially with others," or "to help others" are forms of conduct that are of psychological concern and thus available to psychological intervention. Here, therapeutic techniques teach the client not only how to consider himself an autonomous self, but the client becomes a central locus in shaping his life, allowing him to declare himself an "I," to say "I want to be happy," and to become identical with that "I" that speaks (Rose 1996:96). He is given the choice to decide what he wants for himself and what he "needs," whether it be to "get rid of nightmares" or "feel more hopeful about [his] future." In this instance, the client's relationship with expertise enables him to organize his desires and aspirations, to discover his needs, and to join his own ethical self-practices with psychological practices, evaluations, and language (Ibid: 95). The client is enabled to do work on him-self so he can get what he "needs."

Third, a curious measure of cognitive/emotional functioning is included in the casemanager's "impressions" of such: the "ability to discuss trauma story with counselor." The aim and "need" for the client is both to remember and to tell, presupposing that there is some thing called the "trauma story" that exists for each client and is potentially available for articulation. With the normativizing inclusion of this aspect of functioning--the client "needs" to tell his story to achieve maximum levels of emotional/cognitive functioning-- an imperative for public disclosure is declared where the client must produce a particular account of himself to another. This imperative

[19] Furthermore, certain kinds of "functioning" are normativized, like the "ability to have short-term recall" or "maintain steady employment" that reflect the social and cultural expectations of Haven staff and

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suggests that there is a traumatized, narrating self, and that this self can materialize within a properly constructed social context of telling and hearing. The traumatized self and the narrativization of trauma will be further discussed in Chapter Seven.

The fourth observation I would like to make regards a certain kind of relationship between the program and the client that is established in this section and more generally in the user-rights social service provision we see practiced today. As the same time the Haven is organized from "above" by what Dean (1999:169) calls the "technologies of performance" which include those techniques that demand a form of social service provision based on maximization of calculable performance such as audits, outcomes assessments, accountability, etc., the program is also governed from "below" by "technologies of agency," where the "instruments of 'voice' and 'representation'" are utilized, "by which the claims of user groups can enter into the negotiation of their own needs" (Ibid:168). In the process of doing the intake interview, the client is empowered to express what he wants, wishes for, or "needs" and is in fact *required* by signing the "participant contract" to "participate in development of a service plan." The contract thus requires that the client practice certain forms of self-determining, self-governance to receive services from the Haven. By signing this contract, the client is demonstrating that he both understands and agrees to the terms of his partnership with the Haven, and is freely and by his own volition claiming a stake in his service plan and thus his future. The client is engaged in practicing a "technique of agency," where partnership demands that he be an active, free and self-managing agent by, paradoxically, subjecting himself to the conditions set forth by expertise. The client freely avails himself to his own improvement

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perhaps as well as the "dominant culture."

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and advancement, and is also, by participating in this process, actively engaged in rendering his individuality.

The client is also partaking in the "ethos of negotiated intersubjectivity" (Dean1999:168) that has become familiar in American life, where many relationships are to be contracted, transparent, and consensual. Like the practices of institutions, relationships between people are also to be in a sense auditable. This document represents a form of risk reduction in the sense that it anticipates the possibility of breaches of trust, and codifies and legalizes the relationship. Trust becomes inviolable through inscription.[20]

Similar to finishing a puzzle, the pieces of client needs come together with the services the Haven provides in the service plan. The final "service plan" creates a set of objectives for service that will either meet "social" or "psychological" needs that the program is authorized to address, thus ordering and managing need. The casemanager is obliged to help bring the client from his current state to a state of more independence, self-sufficiency and self-determination by following the service plan and meeting its objectives in collaboration with the client.[21] The service plan and its accomplishment

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[20] Deborah Gordon describes how "Western morality is dedicated to defending the sovereignty of the individual and to ensuring freedom from interference, equal treatment, and opportunity for development. This support is expressed through a language of "rights" and "justice."...In such a context, ideal social relationships are those which rise out of consent and contract between two individuals, a model that is growing quickly in medicine. Honesty and communication that support equality rather than hierarchy take on a particular value" (1988:19-56). This model of consent and contract reminds me of a lecture where Juliet Flower McConnell (1997) described contracts sold at Good Vibrations, a well-known sex toy shop in San Francisco. These contracts are written documents signed by participants before they engage in s & m, or sado-masochistic sex, that inscribe mutual consent and trust between parties. McConnell suggested that the sexual activity that the people engage in is not what is perverse but the idea that trust can be absolutely guaranteed is. Without digressing into a discussion of Lacan's notion of the psychic structure of the pervert, what is relevant for this discussion is that this contractual way of relating-- appealing to the law to define and contain the desire of the other--extends even into the realm of private sexual practices.

[21] The Haven casemanagers described how "newcomers" or refugees or asylum seekers who recently arrived often have "high expectations" about getting the services they need. These clients expect that

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therefore also function to demonstrate the competence and authority of the personnel who are responsible for its production.

Section III. Community Meetings and Need

Governance and Community Empowerment

The Haven considered itself a "community-focused" program where the role of expertise, according to Ed, is not to just help the individual but the community. "Psychological health," said Ed, "is also a matter of community, families, and not just the individual and how those are affected by violence and relocation." Relying on an idea of a reciprocal relationship between the individual and the community, Ed's model for the Haven includes practices that assume that in other "cultures," the self may have a more "interdependent" relationship to the community. As Ed remarked at the Somali community meeting, "We are aware that in other cultures the sense of self is not an atom encased in a shell but is more permeable." Because of this, the Haven is obliged, as a cross-culturally sensitive service provider, to encourage the reproduction of culturally-different forms of self and community and to not impose normative rules for these relationships from the dominant culture. Furthermore, because "Torture and targeted war is [sic] aimed at the social fabric, destroying communities, not just individuals," intervention should not be exacted just at the level of the individual, but at the level of community. Expertise is there to help because as Ed remarked, "People need a sense of support to mend disintegration of community."

Ed's vision for the Haven as a community-building service stems from recent neo-liberal rationalities of governance (that appeal to both the Right and the Left) where

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"everything will be worked out immediately" and they don't understand that "it takes time" to get decent shelter or a job. These clients sometimes become upset or frustrated with the Haven program.

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"technologies of agency" extend to communities for whom intervention is targeted. Community here, imagined as either given (e.g. the "Sierra Leonian community") or as something needing to be built (also the "Sierra Leonian community") is a "resultant of a detailed work of political construction. It is an attempt to stabilize and normalize particular sets of relations and practices and to establish relatively continuous regimes of authority. It works on the much more open and fluid identifications that characterize contemporary forms of sociality..." (Dean 1999:170). Community, in these practices, becomes part of a landscape of plural forms of governance, where communities, individuals, support groups, and grass-roots programs, all created around notions of empowerment and self-determination, make alliances, links and "partnerships" with experts, service providers, and other governing institutions. In this configuration, community self-empowerment may lead to political activism and engagement in democratic practices of citizenship that also critique, challenge and reform professional and governmental practices.[22] Exercising "techniques of agency" allows participants in the community meetings and also individual clients and casemanagers to question and challenge the Haven's expertise in providing service based on "need."

The Haven's goals to foster community and individual empowerment and self-determination reflect a "critique of professional expertise and knowledge" and in particular a rejection of a paternalistic and subjugating relationship of power between expertise and the subject's of expert intervention (Ibid:154). As Ed declared in the Sierra Leonian community meeting, "we do not claim to be experts."

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[22] One interesting problem with community development around ethnic identity is that it could lead to the same kind of identity-driven violence that helped foment the political violence from which refugees had to flee in the first place. For Ed, "community" thus carries an image of tolerance and pluralism rather than extremism or fundamentalism, but these could be different sides of the same coin.

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Community and Need: A "Dialogue"

A regular feature of Marie's work activities was to conduct "outreach" through organizing "community meetings" with different refugee groups in the city.[23] I attended three of these meetings with Ethiopian, Sierra Leonian and Somali groups, and acted as the official minutes keeper of these events. The Ethiopian and Sierra Leonian meetings were held at two ethnic restaurants in the city and attended by approximately thirty and twenty people respectively. Many of the Ethiopian participants were from Marie's church or came there through direct contact with her, ranging from elders to young college students. Most of the participants of the Sierra Leonian community meeting were members of a grass-roots organization initiated and led by Sierra Leonian refugee women. The Somali meeting, conducted in a large classroom at a local college where one of the Somali community leaders was a professor, was catered by a Somali restaurateur and attended by about fifteen people. This meeting in particular was a rather momentous occasion because, it was explained, this was one of the first times that Somali refugees living in New York, fragmented and divided into warring "clans," were able to put their differences aside and come together in the first tentative steps toward "community-building." At all three meetings, there were a slightly greater number of men than women, and also the men tended to speak a bit more than the women. This was especially true at the Somali community meeting with the exception of the professor who spoke a great deal. Marie explained that the larger representation of men had to do with the fact that women have to stay at home with the children and the elderly.

[23] Rather than spending time discussing how outreach was also about marketing, making a sales pitch, and client recruitment, this discussion will focus on "need" and community-building functions.

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Each meeting began with brief introductions by Marie, the outreach liaison, followed by a speech by Ed. Ed's speech varied little from meeting to meeting. He would describe the Haven and the Haven's relationship to the community, discuss "needs," and then relate some anecdote about a personal connection he had with that particular refugee group. From there, individuals from the community stated their "needs" and also asked questions of the Haven representatives. The Haven staff, in turn, clarified what services the Haven could or could not offer, and tried to answer questions. At the end, Marie or Ed would conclude the meeting by inviting everyone to begin eating.[24]

In this setting as in many settings at the Haven, ideally it was through the community's explanations of what their culture is like and what they "need" that the shape of an intervention was to be guided. Speech was given primacy in these exchanges, and to be intelligible, it had to take appropriate forms. In this context, parameters were set with a certain degree of flexibility that determined what was legitimate speech, and reference to a certain kind of "needs" discourse had to be shared by both the Haven staff and the community that allowed for effective communication.[25] English speaking members of the community and those best at speaking in the language of "needs," or who were the most articulate in the language of the dominant culture were accorded the most authority as representatives of their cultural community. For example, those refugees who were in the country longer, who had advanced degrees, who worked in social services or

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[24] At each meeting, there were always a few individuals who spoke little, perhaps because they could not speak English. They also did not seem to be fully aware of what was going on. Other individuals, especially at the Ethiopian community meeting, arrived when the food was being served. I couldn't help but to wonder if some of these people were encouraged to attend by their community leaders just so they could be fed.

[25] Likewise, many of those people who attended the meetings were already engaged in a process of becoming visible and active citizens. There were countless other refugees who did not attend these

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who were most comfortable in a leadership role were most adept at speaking about need. Henok, who was not at the Ethiopian community meeting, would certainly have been a dominant voice in articulating his community's needs. Fratoli, who worked for a refugee resettlement agency, and Male Speaker B, who has lived in the United States longer than other refugees at the meeting, will stand out from the other attendees in the following transcripts from the Ethiopian community meeting. These minutes were created from handwritten notes and are not transcripts from tape-recordings. Here is an excerpt from Ed and Marie's introductory remarks:

Ed: The Haven is part of the CCC, an organization advocating for the rights of people victimized by crime. The Haven is a program primarily for refugees funded through the Office of Refugee Resettlement. In the 3 years of the program, we have seen people from 25 different countries. The office is located in _____. The Haven was originally intended to be outreach oriented--we wanted to move away from staying in our offices. Many of the clients are Bosnian, many are African, especially from western Africa--Liberians and Sierra Leonians. I had the privilege of meeting Marie and she enabled us to make contact with Orthodox and Evangelical churches for referrals.

The Haven helps with referrals for housing, language and legal services. We try to meet those needs but we are also here to listen. We do not claim to be experts. We want to listen to the voices of the communities because that is how we learn what we need to do to help. We are participants with you and we are fortunate to have a representative of the community working with you and us.

The Haven is a psychosocial program—the spiritual, psychological, social, and physical are all part of our overall health as human beings, what make you a whole person. We see refugees, people seeking political asylum, those with no status. If they have needs from the experience of migration we will do our level best to meet them. We will try our best to dialogue, be involved, make links, network. We want to be able to refer to people who care. We have no agenda except to talk, share concerns, then eat. I will now give the floor to Marie.

Marie: I want to turn the floor to you. Please give us ideas, we want to be of help, we are at your disposable within limits.

Ed: One more thing—thirteen years ago I did refugee resettlement in _____and I did a community meeting with Ethiopian refugees here in New York City. There were about

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meetings, who were not visible as partners of service provision. Psychosocial governance certainly does not reach all refugees in the same ways.

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10,000 Ethiopian refugees here then. The issue was mental and emotional health. The question was how to connect people with that kind of service. We didn't have that then. Instead it was different disciplines dealing with different things—traumatic experiences and adjustment.

Ed and Marie present their roles as "participants" with the communities. Not only is the client/community a participant in service provision, but so is the service provider. The Haven staff portray themselves as listeners, as helpers, as non-experts, who can engage in "dialogue," and have "no agenda" except "to talk" and "share concerns." The Haven enjoins the community not as a soulless, bureaucratic, psychosocial refugee management service provider, but as a caring, compassionate group of people reaching out to equals. At the same time, however, the Haven also called the meeting to provide service as an organization that can "meet needs," "provide referrals," "make links, and "network" with communities who are in need of assistance in gaining greater empowerment and self-determination.

To note, Ed added another "need" in his introduction: "physical" needs, which are usually subsumed under the category of social needs. I would suggest that Ed's attempts to be as "holistic" as possible opens the door for creating more and more "needs."

Making Needs Knowable

To meet needs, the Haven needs to listen to the voices of those in need so needs can become knowable and visible. According to the Haven approach, the shape of service was to be need-driven.

I will now provide the rest of the Ethiopian community meeting minutes to illustrate the flow and format of these community-meeting exchanges. Each meeting had it's own particular flavor and concerns, but I want to include one meeting in its entirety to highlight some issues of concern:

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Ed: I am very aware that we are not talking to a newly arrived people. You have associations, sense of community, advocacy for community. We are here to listen. What are your needs?

Fartoli (an Ethiopian refugee who works at Catholic Charities): Employment.

Claire: When you say employment, do you mean they are not satisfied with their job or they do not have one?

Fartoli: Two things: either the person had a profession in Ethiopia and they cannot get a comparable job here or they only have maybe a high school education, speak no English, and can get only low paying jobs.

Here, Marie encourages the community to draw on its own "resources" to problem-solve

and establishes the community as "expert" in it's own self-governance:

Marie: How have people solved the problem of employment?

Male speaker A: I took English classes which led to employment but I am not satisfied with my job. I do want to be associated with a community.

Male speaker B: To address the question of employment: First for newcomers there are problems associated with the immigration process. You need referrals which refugees don't have. Ninety – nine point nine-nine per cent of those educated need recertification here but don't have the time or the money to get certified. They are worried about feeding their families. This transition, losing everything, can lead to psychological problems. People need training for marketable skills. This can affect generations when you cannot afford, for example, better schools for your children. Proper orientation and training should be given—like for computers. Can refugees get that? Can you influence the government? People can only get physical work which is not bad necessarily but leaving persecution you hope for a better life. How can refugees afford medical insurance? Medical care might be better here but who has access to it? Employment affects everyone. Education and training are most important.

In the process of immigration, once you leave you are disconnected. For example in the Sudan and Somalia, there is no communication there, they are war torn and there is almost no way of communicating. You don't know if your friends and family are alive or dead. You need to fill out forms that say "alive or dead" about your relatives, and you don't know because you don't even know their address which you must fill out on the form. Family reunion problems are major. Then there is the long bureaucratic process for obtaining citizenship and the INS. It took my son five years to get his citizenship. To get a green card and all the immigration paperwork—even when you go through the whole process if you get someone new processing your paperwork they may tell you to start all over again. The bureaucracy and the INS—can your organization get Congress to address this?

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And health, the government has withdrawn Medicaid and Medicare, it's not like how it used to be. Most people are not insured and medical costs are skyrocketing. I am a single parent and I drove a cab fourteen hours a day and had to pay for housing and food, but I couldn't get medical insurance because it was a question of priority. Both my kids went to college.

Ed: Regarding the recertification issue. _____ once had a program to help people with this but they no longer do. They tried to get people immediately into a job which was closer to what they did or they at least tried to get them more interesting jobs. We cannot do job placement but we can try to dig out what is available. We have time for that.

Regarding legal services, we are linked to the Immigration Coalition and sometimes our advocacy efforts bear fruit, sometimes they don't. They take buses to Albany and Washington to lobby. We are part of that and you are, too. We do have legal services available, mostly for political asylum, but what about the whole naturalization process? ....We are also connected to other legal services and can try to find a good fit. There is the New York Immigration Hotline at the CCC. The counselors speak 14 different languages to answer questions that you don't need to ask a lawyer about.

Regarding health care, there is Child Health Plus and hopefully Family Health plus will pass. Maybe we should organize with the Coalition to lobby.

Male Speaker B: One final point, the question of housing. We see homeless people and take them to shelters. But to get an apartment you need a down payment and security deposit which are out of the question for immigrants. We can apply for Section 8 but it can take a very long time, years.

Ed: We are able to help getting public assistance and we have worked with homeless people and have been lucky enough to find them housing.

Mr. M (a representative from a local refugee service agency for Africans which will be called AS): The AS Program serves only asylees and refugees but we can give out loans of $900 for housing with no interest. They can pay it back in 3 or 4 installments.

Marie: Housing is a very critical problem in this city. To qualify for housing one needs to be employed so you can show that you can pay monthly rent. Many refugees in Staten Island live in very congested conditions. At worst, we have to send people to shelters.

Ed: It's the most vexing issue, even more than health care maybe. Most subsidized housing is for people with chronic disabilities (mental) or who are HIV positive. We do have a small fund at the Haven for people who need a little money for a deposit, food, clothes. If you know of people in detention, there are groups dedicated to their needs, like finding housing. I know people working on getting a house for people newly released, a transitional living situation for about a year. It will serve as a springboard for people

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when they are released. It's physically and psychologically damaging to lose your home from immigration and then be homeless here.

Marie: I want to reiterate that we do have a small client fund.

Speaker B: Worst problems are housing and getting a family to be reunited. I don't know what we can do about it except maybe advocacy.

Ed: One organization, _____will stick their neck out to locate and reunite family members. They have a regional office in Nairobi to help communicate about specific cases. This has been a problem in Africa for years. We Westerners have our ideas about what is a family and what a family should be. We will try our best to work with people who can make a dent in the bureaucracy over there.

Fartoli: Yesterday, the President's talk—he says we are prospering. But so many people are poor! Can the Haven offer us high quality services? We want to be strong economically and learn how to invest in the stock market. Can the Haven be a little radical and give us higher quality information? Not just a little money but advice on investments?

Marie: We are a psychosocial agency, we would love to upgrade the conditions of refugees, but we have our limits.

Ed: It is a question of community development, too. No one agency can do the uplifting. It's about organizing. Liberians in Staten Island had a dream of building a community center. One man worked with youth, they got funding from the ORR, African Immigration Community Center—their dream has been realized. They linked with others who knew how to try to get this money. This is an example of where a refugee community can take charge.

Marie: Unity is power. We must get organized to make our dreams a reality.

Mr. M: I am from the "AS Agency" and want people to be aware that there are 23 million people in Africa, especially sub-Saharan Africa, who have HIV or AIDS. I want to urge my fellow Africans to get tested for HIV or if you know of people who have it our agencies provide services and treatment.

Fartoli: For family reunification, Catholic Charities are working with the INS. We have fliers for people.

Ms.A: I am relatively new here in this country. Most of the questions have to do with legal immigrants. I am illegal, and need help with employment and housing. Can you help people like me?

Ed: With political asylum seekers, we try to offer legal services and emotional support in dealing with the fact that many doors are closed. Even when you can work, many

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agencies will not train you because they wait for a second authorization paper. In terms of housing, I am linked with people who are coming out of detention and can link you with them. There is money for this, but it's what and how to proceed. In terms of employment, if you are undocumented, the best you can do is work under the table.

Fartoli: We (Catholic Charities) do green cards and English classes.

Mr. D (lawyer from AS): We are limited because our services are funded for HIV people. When we have time, we can help other Africans. If you have friends or family members who are sick, we can get treatment. There are new drugs so you can survive now, 10-15 years. For African and Caribbean immigrants, we can provide legal services and some counseling if we have time.

Mr. M.: Some lawyers will say, "You give me $5,000 and I will get you a green card." Our agency can give you free legal consult so you know what's really possible.

Marie: Anything from the university people?

University students: No.

Marie: Next time you must speak a lot.

Male Speaker B: Thank you sister for hooking us up. Can you get us compiled information for where to go, how to go?

Jeanine (Director of CCC community branch): We have resource guides... We also have the Immigration Hotline and you can call them for information on various programs.

Marie: Thank you, Miss Jeanine.

Miss Jeanine now actively educates and engages the community in practices of good

citizenship. This makes visible the ongoing process through which citizens are shaped out

of refugees:

Jeanine: How many of you have heard of Census 2000? It will count EVERYONE in this country, legal and illegal. It's so important to be counted so the government can see how schools, hospitals, etc. should get funding. There is no reference to the INS—the INS knows nothing about this, it's confidential. But down the road you can use your census application to document that you were here in this country at this time. Please know that this is important for your status.

You need to learn how to work here in this country, in this work culture. You can get training at our agency right now—English classes and computer skills. Don't wait until you get your authorization to get trained.

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Ed: If you have suffered through war or have been violated by torture please refer to us because we can offer psychological and medical services for free.

Claire: We are now starting English conversation classes with your friends. This is good because sometimes other ESL classes are very large.

Marie thanks everyone in Amharic. Eating commences.

Intervening and Community-Building

Community meetings were designed to function not only as exercises in "needs assessment," or as knowledge producing activities, but were also "community-building" exercises for the good of the community toward their own held goals of self-sufficiency. "Community-building" was being both modeled and actualized in a non-coercive manner in this setting that shaped both present and it was hoped, future conduct. In community-meetings, community is mobilized as a valued unifying device for the organization and management of many different cultures and individuals and constitutes a particularly viable form of social organization for independent, self-determining, and self-sufficient governance.

It was believed that the Ethiopian community was already somewhat unified and organized; as Ed said, "I am very aware that we are not talking to a newly arrived people. You have associations, sense of community, advocacy for community." The emphasis in the Ethiopian community meeting was probably less a community-building intervention than it was for the Somali community. Yet Ed did speak about "community development," and "organizing," because "[n]o one agency can do the uplifting." He described how the Liberians have "realized" "their dream" by "link[ing] with those who knew how to try to get this money." This is what happens when a refugee community "can take charge." Marie, too, said "Unity is power. We must get organized to make our

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dreams a reality." The image of community-building being promoted here is one which requires a form of self-sufficiency that is about linkages and dialogue, where experts and lay people work together in the project of empowerment, self-determination, and democratic citizenship.

Techniques of Agency

I conclude this section on community needs by looking at "techniques of agency," where the subjects of need negotiate and challenge expertise within the discourse of need. For example, as Fartoli said above:

> Yesterday, the President's talk—he says we are prospering. But so many people are poor! Can the Haven offer us high quality services? We want to be strong economically and learn how to invest in the stock market. Can the Haven be a little radical and give us higher quality information? Not just a little money but advice on investments?

Fartoli was using sarcasm to make social commentary, challenging the kinds of conventionalized service provision that composes the terrain of refugee management. Like many refugees, she has an acute awareness of the stratified social and economic realities of which she is part and into which she has been slotted. At the Somali meeting, the professor also challenged the Haven:

> Also you should hire people like us for your agency and other social service agencies, we have qualified professionals.

Another Somali critiqued the emphasis on psychological healing that characterizes psychosocial programs for survivors of torture and refugee trauma:

> Most people in detention who need services do not speak the English language. When someone like Claire visits, she does not speak the Somali language. Maybe you can help us get a pool of people who speak the language? We need an ongoing program, an infrastructure, not just healing a wound.

During the community-meetings, the refugees employed technologies of agency to articulate their needs to expertise. The communities said they needed help for asylum

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seekers and for people in detention, for employment and re-certification, and for housing. Some refugees mentioned that access to good medical care, re-uniting families, interpreters, and help with small businesses were also needs. A Sierra Leonian man who worked in social services said that in addressing employment, refugees "need empowerment, through training programs." I will now enter into the discourse of needs, and exercise a technique of agency by observing that if one were to listen to what the communities need, it is services to meet what the social service agencies call social or concrete needs. At the Sierra Leonian meeting, one of the leaders of the Sierra Leonian grass-roots organization said, "I know when Marie came to me, I was like what do you want from us? But I know that we can work together. One thing we would like from you are concrete services...housing, employment, health care." Participants in the three community meetings I attended did not say they "needed" trauma counseling or psychotherapy, which brings this chapter to the fourth section.

Section IV: Psychological vs. Social Needs

This section examines another aspect of the construction of need at the Haven. The Haven casemanagers practiced "dialogue" with the directors by openly questioning the increasing emphasis on serving "psychological needs" at the program. This debate was organized specifically in terms of the "need" for psychotherapy for clients, and in general centered on the programmatic focus on the clinical component of the Haven's activities.

The casemanagers were not clinical professionals, but their authority was supported by the day-to-day encounters they had with clients-- providing a supportive presence in their clients' lives, making referrals for them, and accompanying them to

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medical appointments. They were also authorities, as bicultural workers, on cultural differences between their clients and the program's agendas, and it was on one issue that the casemanagers were usually in agreement: it may not be culturally appropriate for some clients to be referred to psychotherapy. According to some of the casemanagers, psychotherapy could be stigmatizing, harmful, or a completely foreign concept to the client, and it should not be *imposed* on them as an intervention. The casemanagers also argued that meeting social needs should come first, and when those needs are met, psychological needs will either also be satisfied without clinical intervention, or, if psychological problems still exist, a secure foundation will have been built so the client could then address his psychological needs. Furthermore, the casemanagers expressed some worry because they did not know what their own limits should be as therapeutic professionals. They wondered how to recognize when clients should be referred to psychotherapy, at one point counseling becomes psychotherapy, or when their own lack of clinical training become a problem in the client/casemanager relationship.

Marie and Claire were the two casemanagers most interested in the question of "need" and in challenging the authority of Ed and Emil's judgments about the dispensation of psychotherapy. Sanja, Slavenka, and Isabela did not openly debate the issue, and quietly handled their cases in whatever manner they chose fit. In this excerpt from transcripts of a staff meeting, the debate about psychological needs versus social needs was aired. The clinical support network which is referred to in the meeting is a loosely organized group of psychological professionals who volunteered their expertise to the Haven:

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Claire: I want to know about asking the clinical support people about when a client needs therapy, when do you draw the line? Can we call the clinical support and ask them for advice, consultation?

Ed: We need to be clear that clinical support clinicians are not doing supervision—they are just there for support.

Emil: You can come to me for clinical support

Ed: I agree, but yes, supervision is an issue.

Marie: Have these people been formally included in the clinical support network?

Ed: *Emil* is the liaison clinically. You cannot just call these people for consultation! We want the counselor to be part of a clinical team where the counselor will actually attend sessions with the client and therapist. We don't want this to be a dyad. Do you know what a dyad is? It's two people, like a triad is three people.

Claire: Oh yes, I think it's very important that the counselor be part of the session. But what if the client doesn't want to be in psychotherapy?

Ed: It's about self-determination of the client whether or not they want psychotherapy.

Emil: A client's reluctance for psychotherapy is always legitimate. We want to create network of highly committed and highly professional clinicians, not some alienated idiot but someone who knows and someone who cares.

Marie: If the counselors are doing their job, if the client is satisfied, then why refer them to psychotherapy? Clients from Africa do not go to psychotherapy. In fact, psychiatrists can destroy their being. We need to handle it well and good in taking a client to psychotherapy.

Claire: What is the boundary within our work when we should refer them to psychotherapy?

Ed: It's up to the client if they ask for it.

Claire: But in all my work almost no client asks for psychotherapy nor wants it.

Ed: We run the risk in our model of minimizing the question of psychotherapy to the point of missing an opportunity to let someone really express themselves. [Turns to Marie] Perhaps you should think about when you are a culture broker speaking from the dominant culture about what psychotherapy is.

Claire: If the client wants to see a therapist, many would prefer to see a psychiatrist for medication, for relief of symptoms. The concept of talking about themselves is very

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foreign to many clients, including in my culture we were taught it was bad to talk about yourself.

(Others around the table agreed this was true of many different cultures.)

Ed: There's a continuum between psychotherapy and counseling. Even though we are counselors we do provide what can be considered psychotherapy.

Claire: Many clients feel extremely guilty about something and it may take years for them to feel comfortable talking about it and to just send them to someone new, like Emil or someone else, and tell them to open up....

Ed: There is no coercion going on here. No one is forcing anyone to do anything. That's why the counselor should go to the therapist with the client.

Marie: In many countries, holding your sorrow is a sense of strength.

Ed: That's why we (the Haven staff) need more education about what we are doing here.

Marie: Ethiopians, Somalis, Eritreans are all similar culturally—holding in is to be strong.

Ed: Well, many of the Africans I have worked with *were* open to psychotherapy. It depends what group you are talking about.

Marie: Yes, the upper-class Ethiopians are familiar with psychotherapy and more open to it.

Ed: Let's have Betty [a consultant trainer attending the staff meeting] speak to this:

Betty: Two things...one, when you first speak with a client tell them that at some point they may be speaking to someone else also. It's also how you put it. If you say "speak to someone" rather than "psychotherapy" they may be more open to it. Two, listen to yourself, your own inner voice, when you get the feeling like oooh I am over my head, I don't know what to do here, then maybe the client needs psychotherapy.

Ed: Until the clinical support network is in place, call Emil, Dr. Stein (he's getting paid enough for his services), or Betty, who is not getting paid. In Mozambique, people are taught to forget, not to remember, or remember but to move on—that's why the repatriation efforts of the UN could occur there. Neil Boothby wrote about this...

Emil: We'll see what the future holds in this society for their method...!

Through this narrative, the question of "psychological need" is contested on a number of grounds. One consists of programmatic needs and the needs of the field of torture

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treatment. For instance, the Haven program "needs" funding which for the most part has become available from sources that promote and endorse "psychological" intervention. I am not suggesting that there is some kind of linear, donor-driven process where funding determines the shape of services or the course of research, but that funding is inextricably linked with professional interests and the authority given to certain types of expert knowledge. Trauma and mental health needs are in fact what define psychosocial programs like the Haven and that distinguish them from other types of social services for refugees. Thus the torture treatment field "needs" traumatized refugees and torture survivors with mental health needs and the ongoing existence of these programs depends on continuing to find and help these individuals.

Another ground for debate is composed of the authority of those with clinical expertise, like Betty, Ed, or Emil, against the authority of the bicultural casemanagers and the clients that they see. In this narrative, both Claire and Marie argue that their clients rarely voluntarily ask for psychotherapy. The casemanagers speak here from positions that have been authorized for knowing clients, from the expertise that comes from working closely and intimately with the clients and, at least in the case of Marie, from the knowledge of what cultural others may need by virtue of being a refugee oneself. Marie claims that Africans do not need talk therapy because "holding in is to be strong." Claire, too, speaks to cultural differences by saying, "The concept of talking about themselves is very foreign to many clients, including in my culture we were taught it was bad to talk about yourself." However, Ed also practices his authority to speak from his own intimate knowledge of clients, and asserts that some Africans are open to psychotherapy, thereby

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challenging Marie's cultural homogenization of "Ethiopians, Somalis, Eritreans" and therefore her claims for privileged knowledge.

In this exchange, Ed also argues that the supportive counseling that the casemanagers provide is, de facto, psychotherapy, although at other times I heard him insist that there is a difference between counseling and psychotherapy that should be observed and respected. However, in practice, there were moments when psychotherapy and a visit to the psychopharmacologist were indicated, and it was with situated and context-specific judgments that the qualitative difference between counseling and psychotherapy was produced. The "boundary" between supportive counseling and psychotherapy was not fixed, codified or quantified. However, to reduce ambiguity and to produce more consensus in this decision-making process, Ed asserts that the Haven staff "need more education about what we are doing here."

Embedded in, yet also outside of this narrative are the "user's" voices, the subjects of need, the clients. As Henok remarked in the beginning of this chapter:

> How can you treat a person who was tortured much and who has left his family and deal with all trauma without feeding him first, giving him shelter, why you are treated in here, I was thinking of family, I was thinking of my transportation, I was thinking of everything, what kind of treatment for torture? Do you want psychological treatment or psychotherapy? Just asking me my answer is yes but my brain is not there, my brain is somewhere so if they say choose psychological treatment I choose nothing because you didn't target my physical suffering first. How can they treat it in here?"

Other clients, too, with whom I spoke, were not opposed to psychotherapy per se, but many expressed an over-riding concern about having their immediate concrete needs met. A few clients articulated extreme gratitude for the psychotherapy[26] they did receive, and felt it helped them at a time when they desperately needed it. Hamid, introduced in

[26] It is was unclear from my data if the clients felt gratitude for the actual psychotherapy they received or for the relationship they established with their psychotherapists. It was probably a mixture of both.

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Chapter Three, underwent psychotherapy and reported that it helped him. Some clients were however quite opposed to psychotherapy, like one of Marie's clients who actually left the program when it was suggested to her that she needed it. Then there were those clients who were not interested in talk therapy but in medication: "If the client wants to see a therapist, many would prefer to see a psychiatrist for medication, for relief of symptoms." Some clients preferred to see a doctor who would take a paternalistic role, tell them what to do and give them a pill to take. They preferred the "medical model approach" to psychological care that the Haven ideology opposed.

One of the fundamental tensions in this section, and in the chapter in general, reflects the balance upon which liberal democracies are constituted: that between governing too little and governing too much (Burchell, Gordon and Miller 1991). On the one hand, the Haven needs to respect the "self-determining" capacity of the client by allowing him to say what he needs and to provide the services he wants without "coercion." On the other hand, if for example the casemanager does not suggest psychotherapy or persuade the client to get the psychological help he needs, "We run the risk in our model of minimizing the question of psychotherapy to the point of missing an opportunity to let someone really express themselves." Thus governing too much or too little is part of a constantly monitored and calibrated process in trying to provide an environment conducive for the clients, taken as individuals or communities, to maximize their own capacities for self-governance. To silence the client so he cannot express what he needs, deciding that a client does not need or want psychotherapy when he really does need it, or not properly educating the client about his need for service like psychotherapy when he could benefit from it, may all tip the delicate scales of proper liberal governance.

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As this chapter has demonstrated, it is possible that the client does not necessarily know what he "needs" because he has no point of reference to which he could relate his need, and the clinical staff must therefore frame his needs in terms he can relate to that will coincide with the service available: "It's also how you put it. If you say "speak to someone" rather than "psychotherapy" they may be more open to it." In addition, coercion is avoided when clients are persuaded to undertake psychotherapy with the accompaniment of their casemanagers in the process—the casemanager can function to mediate and transform the psychotherapeutic relationship from the threatening and stigmatizing "dyad" to the friendly and alternative "triad."

Conclusion

Section I in this chapter began with a narrative from Henok, who described the appalling conditions of his life as an asylee in New York City. Henok's "needs" were fundamental and immense as they are for many refugees who have made their way to the United States. How unconventional needs like Henok's could be translated into the conventional needs of service provision became one of the dominant themes in the following sections in this chapter.

Section II examined the intake process and forms in the client dossier to demonstrate how needs are made both knowable and serviceable at the Haven, and to show how a particular relationship of the client to his social service provider and to the larger social world of which he is part is shaped in the process of becoming a client. The individual is in one sense "the arbiter and author of his own recovery" to quote Dr. Stein, but is not only an autonomous and singular self-determining agent, client, self or citizen. The Haven helps to form morally and culturally acceptable relationships between the

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individual, community, and service providers that rely on certain contractual obligations to the self and others. This section also offered a picture of how social suffering becomes transformed through professional intervention in the discussion of the trauma history forms (Kleinman 1991). So too the subjectivity of the client is transformed as it is inscribed into something contained and durable. As Rose provocatively remarks, the "thought object is much more concrete, far more real than its elusive 'real' referent" (1996:1050). This section also looked at how "technologies of performance" and "technologies of agency" can both coincide with and contradict one another.

The third section considered the community meeting, again showing how needs can be rendered knowable and also available to intervention in the same gesture. "Community," like "needs" is a construct not given but made, and in this section the process of "dialogue" and "community-building" reveals how aspirations can be aligned between the subjects of intervention and the interventions and political rationalities to which they are linked.

The fourth section considered the ongoing debate among the Haven staff between "psychological" and "social" needs of the clients. It suggested that determining and meeting needs is a politically unstable process for the staff and for the clients, requiring a balance between governing too little and governing too much, and also illustrated ways that "psychological" needs and meeting those needs could be temporarily fixed, stabilized and facilitated in practice.

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Section III

Discourses of the body, mind, narrative, memory, history and politics.

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Chapter 6:
Body, Mind, Embodiment

Introduction

The focus of analysis will now shift from ways psychological expertise and governance were shaped locally at the Haven to examine theories and therapies that the clinical professionals in the field of torture treatment have developed, paying particular attention to American and Danish productions of expert knowledge. The next two chapters will analyze how concepts of the body, mind, memory, and narrative have been linked to contemporary discourses on trauma and the political reality of collective violence within the domain of clinical practice. These chapters will also illustrate how certain practices of self-governance have been made possible through the therapeutic regimes described.

From the beginnings of torture treatment in the 1970s to the field's contemporary practices twenty-five years later, representations and conceptualizations of the body and the mind in the discursive productions of expert knowledge and clinical practices have undergone significant changes. This chapter will consider three phases in the history of torture treatment that, I suggest, can be linked to different representations and conceptualizations of the body and mind. I am designating these three phases by the terms "body," "mind," and "embodiment," each of which will be considered in turn. As with many cultural transformations, aspects of practice and assumptions in one historical period can be embedded in and take on new meanings in the next or remain relatively unchanged. Rhodes borrowed the image of the pentimento to describe how layers of psychiatric history exist "in a state of tension, shifting according to context, coexisting with practitioners as contradictory or alternative ways of thinking...lending a complex

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and often confusing texture" in the emergency psychiatric unit she studied (1993:131-132). This image of a more dynamic and layered "state of tension" best characterizes the contexts of real practice in the field of torture treatment, yet this chapter's aim is not to describe these layers. Rather, it will identify and describe certain clusters of practices and representations.

The Body

In the 1970s, the Danish Medical Group that was the precursor to the RCT was formed to support Amnesty International (AI) in its efforts to verify that a number of Chilean and Greek individuals had suffered torture. The Danish Medical Group lent its medical expertise by conducting a series of examinations and studies on these individuals, "prov[ing] that there were early as well as late sequelae of torture," and thus bolstering AI's claims that torture had actually occurred (Ortmann et al 1987:161). These first medically-based investigations into torture included the establishment of protocols and procedures for performing medical exams, neurological exams, and dental exams of the victims. More specialized studies were also conducted to examine endocrine and hormonal changes in the body that were connected with impaired sexual functioning seen in torture victims; the effects of falanga, a type of torture where the sensitive soles of the feet are beaten, and; changes in vision that could be the result of torture (Danish Medical Group 1979). Case histories were taken that were specifically directed toward the patient's torture experiences and included questions about the number of arrests, number of internments, prison conditions, "details of the nature, localization and duration of the immediately visible injuries," state of health while imprisoned, present symptoms, "knowledge of torture methods," and so on (Ibid). It was hoped that the combination of

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the case history and the medical investigations could help establish a link between *specific* torture methods with *specific* torture sequelae. It was thought that this link, the "concrete exemplification of the torture," was the key to establishing the most irrefutable and objective evidence of torture possible, "bordering on proof" (Ibid). Searching for this link became an unwavering focus for the Danish torture treatment professionals during this period.

Careful attention was paid to the surface of the victim's body, and the doctor was to describe, measure, and document all scars and irregularities from head to toe. Photographing the body was "useful ...as a means of illustrating reports of torture and abuse" (Allodi 1991:6). Doctors also looked inside of the mouth, the ears, and other orifices of the victims for signs of damage. X-ray machines and brain-scanning devices and other imaging techniques enhanced the visual apparatus of the physician. Clinical chemistry techniques and other "micro-methods" such as skin biopsies and serum and urine analyses entailed investigations into the inside workings of the body. These techniques could detect whether a scar was caused by an electrical burn or another kind of burn, or whether traumatic muscle destruction had occurred because of severe physical trauma (Danish Medical Group 1979; Allodi 1991:6).

Mental sequelae of torture were also documented. Initially, these symptoms were not emphasized in the protocols, and were in a completely separate category from the physical sequelae of torture. Perhaps this was because these were softer signs of torture's effects. Clinicians did observe that mental sequelae came "later" in the post-torture sequence, and that also, mental sequelae appeared to be "the worst ones" (Danish Medical Group 1979, Ortmann et al 1987: 163).

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Even after the Danish Medical Group officially became the RCT and began treating or "rehabilitating" torture victims, the preoccupation with identifying signs of torture and "nosographic description" (classifying physical and mental sequelae of torture), and creating lists and descriptions of torture methods continued (Ibid). Dr. Larsen, a doctor in the "somatic department" at the RCT, spoke to me about her predecessor there, who "was into details...examining each little joint and registering if it were loose or tight and she did it for the whole body." This doctor allegedly kept volume after volume of notebooks on her findings. And even more recently, the quest for "concrete exemplification" continues. Dr.Larsen, though critical of some aspects of the RCT's former practices and her predecessor, was herself keenly interested in establishing a protocol that would provide what she hopes will be nearly irrefutable proof that falanga has occurred. "We need some kind of gold standard, " Dr. Larsen explained to me as she leaned forward in her office chair, her blue eyes growing brighter. "They can tell me if they had falanga, but I want an objective way to find out. If we establish a protocol, than we can determine worldwide if people had falanga. This evidence of torture is very important for asylum seekers—it's a good thing for the documentation of their torture."

During the RCT's infancy, the center's preoccupation with concrete exemplification was amplified with Inge Genefke's pursuit of the "torture syndrome." The "torture syndrome" (which has never been proven and the pursuit of which has since been abandoned) was a syndrome characterized by pronounced mental symptoms of a neuro-psychiatric nature. These symptoms included anxiety, insomnia, restlessness, nightmares, impaired memory, concentration difficulties, and sexual disturbances. It was thought to be similar to the "concentration camp syndrome" and the "war-sailor

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syndrome" primarily because of the belated nature of the mental symptoms (Genefke and Aalund 1983). The RCT clinicians optimistically believed that the syndrome's existence as some kind of organic entity could definitively prove torture occurred and also that its discovery would lead the way to a cure of torture's effects. Interestingly, the RCT discourse at this time did not include PTSD despite the fact that the American Psychiatric Association established PTSD's official diagnostic existence in 1980, and the "torture syndrome" and PTSD share some of the same genealogical roots as well as symptoms (Young 1995; Leys 2000). Perhaps the newness of the diagnosis and the specifically American context of its origins, paired with the RCT's isolationist and imperialist tendencies, prevented PTSD from being readily adopted into the RCT's medical practices.

Many of the RCT's earlier publications reflect the sort of obsessive documentary impulses I am suggesting here. Professional articles from this time period typically begin with an account of the historical origins of the RCT, with much of the remaining portion of the texts devoted to descriptions of physical and mental torture methods, and physical and mental sequelae. Even as attention was increasingly directed toward other concerns, such as treating mental sequelae through psychotherapy, this pattern of describing torture and sequelae was continually repeated in publication after publication (Ortmann et al 1987; Lunde 1982; Genefeke and Aalund 1982).

What sort of object of knowledge were these early torture treatment discourses constructing? A complex and contradictory web of moral, political and medical discourses formed the outlines of the new category of the "torture victim." However, though a certain social category was emerging and solidifying, its content shifted and its

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relationship to other forces was also unstable and changing because this object of knowledge presented itself as a *problem*—a problem of knowledge, of social injustice, of responsibility, of care, of otherness. For instance, the tortured person during this earlier period was not called a survivor, but a victim, as the kind of empowering survivor discourse and ethic of victim's rights which has become so familiar today in Western society was only emergent at this time. Though the shift in identity, language, and modes of governmentality had not yet been organized around empowered survivor-hood, the RCT patient, though referred to as a torture victim, was seen and acted upon as both a *victim* and a *survivor*. Conduct and procedures at the RCT starkly registered the clients' dual nature, with the medical care often vacillating back and forth between treating the torture victim as either the vulnerable victim or the invincible freedom fighter; the torture victim was either broken, damaged, delicate and fragile, needing tender handling and protection, or a strong, robust, freedom fighter for whom coddling would be an insult. The category of torture survivor was one internally fractured and ambiguous.

At the same time, the category of the torture survivor became increasingly idealized, purified, and abstract, as the RCT devoted many of its practices, from administrative to clinical, to reiterating the difference between the torture survivor and all other categories of victims, such as refugees (Malkki 1995a; 1995b). The RCT refused to treat asylum seekers whose legal status was uncertain, or refugees who were victims of forms of collective violence outside of state-sponsored torture. Dr. Jergen had mentioned his opinion on this matter. He said, "I think they were afraid of being polluted by refugees in general. As long as you keep the strict focus on torture and not get into this whole discussion about Left and Right and human rights, but make a clean medical story,

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then its easier to do fundraising and to promote your own case." The RCT's intensively medical and scientific approach to torture documentation and treatment, and its more "pure" category of victim, was linked to a specific political agenda. Genefke herself claims, "people could be for or against refugees, but everybody was against torture." Or, as a staff member at the RCT said to me, "Torture is one of the few human rights abuses that is absolute." Because the RCT's bio/physiological model based itself on principles of scientific neutrality, objectivity and the "inviolability of medical facts" that are thought to be independent of the social and cultural circumstances around their production, and the victim of treatment was a torture survivor and not a polluting refugee, the RCT was better able to accomplish its political mission (Adams 1998:160-62).

Yet the obsessive quality of the clinical activities at the RCT, and the need to purify the category of the victim seemed to reach excessively beyond a political agenda. The RCT's rigidity and fetishization of the torture victim and his body may also have served as a way to ward off the taint of violence and contamination that are thought to be symbolically transmitted to those who treat victims of violence. Fear of contamination may have been especially powerful during this historical period because the torture treatment field was so new. A clinician I interviewed expressed this latter point thus, "It's no longer so taboo. Working with victims of torture and trauma. Before, if you have read Judith Herman's work, it was stigmatizing. There was contamination involved." Medicalizing torture in the way the RCT did sanitized—not in the sense that it sanitized the violence, but it helped keep the clinicians clean from the contamination that they could feel on themselves or that was felt by others around them.[1] What they were doing

[1] An anthropologist working on violence once told me that he has experienced this kind of contamination himself in the way other academics have responded to him and his work.

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was "clinical" and in the name of science. The medical gaze drew boundaries. Intimacy was controlled. Distancing gestures were created. The doctors at the RCT were human rights warriors fighting for democracy on behalf of those who were tortured, but to take off the white coat and stethoscope could have rendered them vulnerable to contamination.

Together, these contradictions, ambiguities and ambivalences suggest how the category symbolically formed a dark nexus of uncertainty that revealed the porousness of boundaries and the possibility of horror and atrocity. The torture victim also symbolized a call to ethical action.

In terms of the medical object being formed, the medical gaze actively and thoroughly scrutinized the torture victim's entire body, from the surface of the skin, to its orifices, to the chemicals in its blood, rendering the body a passive or subordinated object to be known. This was a medicalized and scientifically knowable body, a body with a nervous system, a locomotor system, flesh, pain receptors, hormones, neurotransmitters, muscles, tendons, bones, "a physiochemical machine, all of whose functions can be described in biological terms" (Kirmayer 1988:59). In this scheme, the body was the privileged site of knowability and the psychological processes of the mind were significant to the extent they could be explained by or explain the biologized or organic brain. Over time, the body increasingly availed itself to a certain kind of knowability to the point that a torture survivor could be identified simply by looking at him. A training manual for new counselors at the RCT included information on how to identify torture survivors by their general appearance:

> The appearance of a survivor is often marked by a "bad" posture, with shoulders up and head down as if the person is making an excuse for his existence. He appears sad, in pain, and in many cases there is little eye

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> contact. These changes in appearance are caused by low self-esteem, lack of trust in other and physical pain (Staehr and Staehr 1995:29).

However, the body was not only a physiochemical machine. Framing the RCT's medical practices were two mutually implicated questions with moral, political and legal import: "Did this person really suffer torture?" and, "How can we prove it?" These questions lingered, sustained, and confounded the medical investigations, even after treatment rather than documentation became the focus of medical practice. Questions about the "truth" of torture, and the doubt and uncertainty contained in these questions were linked to practices of "verification," making the tortured body into inscribed corporeality, a body holding truth in flesh in a code that needed to be made intelligible (Appadurai 1998).[2] It was as if the truth told by the body was more reliable, more trustworthy, of greater power, than the torture survivor's words, his own testimony to the violence inflicted upon him. Yet at the same time, words were also necessary for sealing tight some kind of "concrete exemplification of torture." Narrative wrapped itself like an invisible cord around the corporeal materiality of the body's truth, both part of the body's truth but also separate from it, necessary yet not sufficient.

Scarry (1985) and Valentine (1994) speak about how the pain of the other that is inflicted though torture is "doubted," and in Valentine's study, even victims who were tortured themselves doubted the torture of the person who was imprisoned and tortured in the next cell. At the RCT, it was thought that "doubt" about torture could be overcome by

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[2] Here I am making an inversion like the ones that will be discussed below. Appadurai developed the notion of "verification" as a way to analyze the form of atrocities that has been perpetrated in recent instances of ethnic violence. He aims to explain why recent violence has involved such graphic methods as evisceration or driving stakes up through the anus and out of the mouths of victims by suggesting that ethnic otherness is produced in and through these acts. In other words, these bodily violations somehow both substantiate and therefore also verify the enemy.

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scientific "proof," that somehow scientific evidence could pronounce the truth that could not be seen or heard in other ways. Perhaps the truth of torture, of violence so horrific that to some it is unspeakable, exceeded the limits of belief, and also revealed the potential for perpetration by oneself or others. Perhaps, as Antze and Lambek have suggested, "the increasing burden put upon the individual body to serve as the sole site of memory" contributed to the reinforcement of these practices (1996:xiii). According to these authors, a crisis of memory characterizes the late twentieth century, where the

> "...increasing dissolution of the social *milieu* (a dissolution that can be understood as a function of the cumulative effects of capitalism) leaves us with only one fixed point of reference, the *lieu* or site provided by our own bodies. Trauma becomes an obvious case in point. Medical discourse has reinforced and reified this state of affairs, individualizing memory, physiologizing it, rendering it the province of a narrow body of experts...As index of the past, and hence guarantor of the reality of the present, the body is called upon to provide signs of import. Photographs, personal artifacts, and signs of aging play their part, but they are not particularly compelling. Experts seek evidence of psychic and bodily trauma by means of interrogation, confession, hypnotic regression, lie detector tests, brain scans, physical probing, and similar techniques (1996:xii).

Driven as they were by the need for establishing objective certainty, practices of verification at the RCT became virtually ritualistic with the implementation of rigid protocols, guidelines, rules, and documentation. Perhaps the ritualization of medical documentation and healing practices was also symbolically and legally tied to torture victims' claims for asylum in countries of resettlement. Appadurai (1998) synthesizes recent scholarship on ethnic violence that describes the common "tropes" of "deception, treachery, betrayal, imposture, and secrecy" that are imputed to the ethnic other, and the need for "categorical certainty" that is associated with ethnic violence (234). In terms of asylum, a situation is presented where borders are opened and vulnerable, and the ethnic

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other threatens the purity of the Danish people with pollution or contamination. Thus, rituals of verification organized around the body serve to root out false claims of identity, or false stories of persecution to produce a level of "certainty" that the other will not be dangerous or contaminate the purity within borders (Daniel and Knudsen 1995).

A mostly symbolic but nonetheless captivating relationship, mediated and forged by the torture victim, emerges between torture treatment clinicians and torturers as well. In a macabre fashion, the torture clinicians and torturers became engaged, one in healing and one in harming, yet evolving together with awareness of the tactics and methods of the other. As the RCT's work progressed, for example, proving torture became even more difficult. Several people with whom I spoke reported that torturers more and more frequently were using methods that "did not leave marks." Psychological torture such as mock executions or deprivation,[3] or physical torture such as falanga[4] executed without "breaking the skin" but still crippling the victim, were becoming more commonplace torture methods.

The torturers and torture treatment clinicians were also joined in other ways. For both sides, the tortured body became a political tool: for the clinicians, in the fight against torture, for the torturers, in their quest for power. Many torture situations included (and still do) the participation of medical professionals who act as consultants to the torturers, monitoring the vital signs of victims, administering injections, and generally aiding the torturers in the goal to maximize pain in the victim without causing death. Medical

[3] Torture considered here is different from the kind of ethnic violence that occurred with Tutsis and Hutus, or in other conflicts like in Sierra Leone where bodies were dismembered, eviscerated, mutilated and on display. If torture victims in Chile or Argentina ended up being badly damaged by torture, they were usually killed and the bodies were often, but not always, disposed of without leaving a trace. The victims were "disappeared."

[4] To remind the reader, falanga is a type of torture where the sensitive soles of the feet are beaten.

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complicity of this sort has been well documented (e.g., Iacopino et al. 1996; London et al. 1996). Further, medical metaphors,[5] images, and accoutrements have been widely employed in the torture theatre such as the "operating table," and "the mad dentist" (Scarry 1985:42). Rehabilitation and torture also share some of the same methods and techniques that work on the body similarly but toward different ends, e.g., the use of electrical devices, probes, extractions, injections, and drugs. Elaine Scarry describes this as the "inversion of medicine":

> Whether medicine merely provides the equipment or the name for a form of torture, whether the doctor ever was a doctor or has only assumed a role, whether he designs the form of torture used, inflicts the brutality himself, assists the process by healing the person so he can again be tortured, or legitimizes the process by the masquerade of aid, the institution of medicine like that of justice is deconstructed, unmade by being made at once an actual agent of the pain and a demonstration of the effects of pain on human consciousness (1985:42).

The "inversion of medicine" has been paralleled by an inversion of psychotherapy. For instance, the techniques of the "confession," "one of the main rituals we rely on for the production of truth" are used both in psychotherapy, to reveal the secret truth of the trauma story, and in torture, to extract whatever "truth" the victim was thought to conceal, with the two processes uncomfortably mirroring one another (Foucault 1980:59). Clinicians doing torture treatment observed the "perversion" of psychotherapy in torture:

> ...modern torture is often directed primarily at destroying the psychic integrity of the individual...The sophisticated techniques used are often perversions of the principles which underlie psychotherapy, namely the heightening of the person's level of awareness, loosening previously held beliefs and assumptions and fostering an emotionally charged relationship with the perpetrators (Silove et al 1991:482).

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[5] I have also heard torture described as an epidemic, as in "the world faces a modern epidemic of torture" (Silove, Tarn, and Reid 1991) and also as the "cancer of democracy."

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As time passed, practices of verification were increasingly combined with practices of treatment, including psychotherapy, but similar kinds of ritualistic devotion to the patients and their bodies remained. For example, the RCT model had many rules for handling clients, including the cardinal rule that any procedure that reminded the victim of the torture was to be assiduously avoided. Doctors and nurses therefore were not to wear white coats or uniforms. The physical setting was also important:

> The environment and interior of the villas have been made as homelike as possible; the examination and therapy rooms resemble the living room of an ordinary home. The reception room is comfortable, and there is a children's playcorner. The outer framework is an integral part of the treatment. A clinical and institution-like environment might easily revive memories of prison and torture and thus keep victims of torture from coming (Ortmann et al 1987:164).

Further, medication was not used. In the words of a psychiatrist, Erik, who worked at RCT: "Six to eight years ago medication was a forbidden word. This is because there was so much of a focus on torture. It was thought of as an insult to the client, like you have been horribly beaten, let me give you some medicine." Thus, it was thought that if someone braved and survived torture, a pill to help him with his pain denied the profundity of his experience and his resiliency.

Dr. Larsen spoke about how treatment was conducted in the somatic department at the RCT, where there was an almost "religious relationship" between the clinicians and the victims:

> We had always given individual physiotherapy in here. They [the RCT doctors] always said they [the torture victims] couldn't be trained in groups and I always said that's nonsense, of course they could. They thought the torture victims were paranoid and afraid and they couldn't talk the language and they needed their own interpreters and they wouldn't be together with many people...when I started here the whole thing, it was like this religious relationship. For instance, all this stuff was written down by Dr. Pedersen, like you weren't allowed to stand behind the torture victim when you were doing your examination. And I thought how the hell am I supposed to examine a person's back if I

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am not allowed to stand behind them? And you were not allowed to make pain. I cannot do a proper examination without asking does this hurt? Does this hurt? Does it hurt when you bend forward? It was also said you could not do research with torture victims because that would be unethical. But they would very much like to participate. When you explain to them what is going to happen and you explain the purpose, they feel very much like they have been through all this for some kind of purpose, at least they might be able to help someone else. They are very strong people. Oh, and we were not allowed to give electrical pain treatment. There are very few of the torture victims that won't accept the electrical pain treatment when you explain to them what it is.

Oddly enough, the meticulous hyper-attention given to procedures that would protect the fragile victim was also inverted through the psychotherapeutic techniques that the RCT practiced at this time. These techniques took the victim back to his torture experience in painful ways. Indeed, "[t]he point of departure for psychotherapy is the torture which the person has been exposed to" (Ortmann et al 1987:165). The original RCT model for psychotherapy was almost like a surgeon making an incision into the client's mind and removing or readjusting negative memories and feelings. It was as if the mind was matter that could be operated on by words and other techniques, where the victim as body was tough and unyielding, rather than fragile and weak. Dr. Jergen described these methods as " promoting a certain kind of bulldoze approach to cut the evil out and if you didn't want to talk about it then little by little they would make it come out..."

The rationale and techniques of the "cut the evil out" RCT brand of psychotherapy were described thus by its practitioners:

> We seek to make the client recall and describe all details of the torture. We try to make him/her understand the purpose of torture, to recognize that all responsibility and guilt must be rightly placed with the torturers, that torture victims cannot be held responsible for what they said or did during torture...We encourage the torture victim to express suppressed feelings of anger, grief, hatred and rage—feelings experienced during torture but had to be hidden. We encourage the victim to see the torture as a thing of the past—for him to forget it is impossible. During this process we try to restore the identity of the person and make him focus on the future (Ortmann et al:1987:165).

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However, guiding the victim through this process was not at all easy:

> Talking about torture arouses strong resistance. It is painful, almost as torture revived—revival of something that the torture victim would much rather forget. So he will try to avoid talking about it. But his resistance may be broken down. It may take a long time and call for patience and many explanations, but above all, it requires the establishment of confidence and trust. Once the resistance is broken down, the treatment is really incredibly easy (Ibid).

Sometimes, the clinicians needed to resort to methods other than talk therapy to achieve the desired effects: "We use a number of methods, for example, drawing therapy, role playing, and presentation of special pictorial material, such as watercolors illustrating torture situations" (Kastrup et al: 342). Talk therapy, though the preferred method for overcoming resistance, could not always be counted on and the RCT clinicians pragmatically practiced other means to reach their goals.

The Mind

In a 1991 publication written by Australian clinicians, specific reference is made to the therapeutic methods employed by the RCT group of doctors (Silove et al 1991:485-486). In this publication, the Australian authors referred to the RCT group as "some influential therapists" (485) and used quotations from two RCT publications, including one from which I have quoted extensively, to demonstrate and criticize the "strong conviction held by many therapists that the key focus of psychotherapy should be the "uncovering" of suppressed memories and feelings concerning the torture experience" (486). The specific passages the authors quoted were ones in which the RCT doctors explicitly describe, for a professional audience, their "bulldoze approach" to psychotherapy. The Australian authors were careful to give the RCT doctors the courtesy of professional disclaimers, and cushioned their criticism by allowing that: a) the

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translation from Danish to English may have distort the intended meaning of the passages quoted and; b) it was "possible that the wording of these passages was unintended and elsewhere these same authors have emphasized both the need for therapists to avoid any interventions which may bear similarities to the torture experience and the importance of attending to survivors' wider social and family difficulties" (486). It is obvious, however, that the Australian authors were highly critical of the RCT approach, and used it as a platform from which they could launch their own ideas about what kind of treatment torture survivors and refugees should have.

Besides reflecting the ideas and perspective of a particular group of clinicians, the Australian article also represented larger transformations in torture treatment. In torture treatment discourses by this time, the metaphors of the "physiochemical body" and the surgical model of the mind of the RCT model were giving way to what I will call the "psychological mind" or simply the "mind." Psychotherapy had become the dominant rehabilitative modality, and psychologists and other therapists were more highly represented than medical doctors in the field. Psychotherapy now was about treating "trauma," and PTSD had become a widely accepted diagnostic category though its actual use varied with different treatment programs and clinicians. The "psychological mind" featured not only intrapsychic forces but was also distinctly socially and culturally-oriented, and included the social, cultural and political context of the client's pre-treatment life as well as that of their present condition. Clinicians in the field were becoming increasingly concerned with a trend described as "medicalization" and a reliance on "talk therapy," and so were turning their attention to the traumatic effects beyond the torture experience to migration and resettlement, as well as to cultural

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differences, and to the "social" needs of the clients (Silove et al 1991). Medical care, which had been a significant part of the RCT's rehabilitation package, was now relegated under the category of "social" needs of clients, seen as a requisite to addressing the psychic trauma of the survivors, and frequently provided outside of rehabilitation centers rather than in them. Medical care included physiotherapy for the musculo-skeletal sequelae of torture or any other treatment clients might need for torture-related sequelae or for general health concerns. Furthermore, the distinctions previously drawn between torture survivors and survivors of collective violence or refugee trauma were being questioned and in some cases discarded. The split object in the discourses of the RCT, the victim/survivor, was shifting to form the concept of the "active," "empowered," and "resilient" "survivor." These shifts have all been described in various chapters of this study.

Though the object of knowledge, the torture survivor, had become much more multi-faceted and "active" in these discourses, what is significant is that the "psychological mind" rose above others to become the site of knowability and intervention. In this clinical discourse, torture is described as destroying the integrity and even the self of the victim. It cuts deeper to the core than any physical wound. The "mind" or "psyche" has long been thought in Western culture to be closest to the soul or spirit of the individual, the essence of one's being. Torture takes aim at this essence. Clinically speaking, torture

> ... is a tactic in which "terror has no limit." However, the inducement of panic and pain are but means to an end. Torture has as its ultimate purpose to reduce the individual to primitive levels of helplessness and confusion. What the survivor learns is to suppress one's feeling, to distrust oneself and one's worldview and to dissociate from one's own experience. This exploitive process has been described as one of moral and personal

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> coercion or of personality reversal. In brief, torture aims to shatter the psychological structure of the self as the most basic level of personal identity (Gonsalves et al 1993:354).

Torture, however, cannot be isolated from a more total regime of terror. Most clinicians would describe torture both in its individual effects and also in its impact on society, populations, or collectives, much in the way the Latin American clinicians in Chapter One conceived of torture: "The social effect of torture is to create a reign of fear in the form of state terrorism. Torture attacks the very core of society by creating a rule of might rather than a rule of law. No one is safe in an environment in which basic human rights are not respected" (Gonslaves et al. 1993: 354). Torture, it was believed, is not just about a relationship between a victim and his or her individual torturers, but is used as tactic to permeate, violate, and destroy the core integrity of the collective and the social-psychological mechanisms that enable societal cohesion and healthy functioning.

Most torture treatment centers during this period were best known for the counseling and psychotherapy they provided for individuals and for families to help repair and restore "shattered" selves and "psychic integrity." "Psychic pain" was at the center of the survivor's distress, and though one could reach the psychic pain through means other than psychotherapy, such as helping an individual find a job, it was still the *psychological* core of the survivor that ultimately mattered most. Language, which had been a somewhat unreliable source of evidence in the RCT physiochemical body model, became the primary medium for producing truth in the phase of the psychological mind.

Torture treatment at this juncture maintained a certain kind of mind/body dualism that rests on some of the same assumptions underlying the "physiochemical body" phase, mainly the view that there is a biological substratum with its own laws and regularities

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that is the province of science and biomedicine. For example, in a most conventional practice of Western mind/body dualism, clients were sent to medical doctors for "physical" complaints that were thought to be outside the domain of psychological expertise. However, even here the distinction between mind and body was problematized, because some groups of clients were thought to "somatize," or to have "psychosomatic disorders" meaning either their problems could not be detected through biomedical diagnostic technology, or, their problems, such as gastro-intestinal upset, were thought to stem from "stress" and were therefore related to psychological factors. These grey areas of distress exposed the limits of biomedicine and therefore the assumptions underpinning Western notions about the physiochemical, biological, and universal body. Doctors confronted with distress that resisted biomedical epistemological certainty would frequently translate symptoms into some kind of Western psychiatric disorder, like depression, or into some kind of explanation of "cultural differences" that would lead to talk therapy (psychological help) or referral for some kind of more "culturally appropriate" healing (Ong 1995).

PTSD

PTSD, a psychiatric construct supported by an outpouring of scientific research, is interesting for what it reveals about some of the complex ways the mind/body dualism was manifested in psychological practices during the phase of the "mind." PTSD allows that symptoms of psychic trauma, such as hyperarousal, nightmares, recurrent and intrusive recollections, intense psychological distress when one is reminded of the traumatic experience, sleep problems, uncontrollable anger, and avoidance and numbing have a biological foundation. (American Psychiatric Association 1994). The

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psychobiological and scientific basis for the disorder universalizes, validates, organizes and simplifies the experiences of torture survivors, but the way clinicians used and still use PTSD does not necessarily reduce the mind to a passive, mechanical, biological body.[6] A kind of mind/body dualism is sustained in practice where the biological body does not engulf or threaten the existence of the "psychological mind" but can give credence to or complement certain psychological theories and practices when used strategically.

So for example, psychotherapists (including psychiatrists) with whom I spoke in both the United States and Denmark overwhelmingly remarked that they often do use PTSD as an explanation for their client's mental difficulties, but want to resist buying into the idea of it being a "mental illness." They used PTSD in novel, practical ways to avoid biological reductionism and "medicalization" which in turn also ensured the legitimacy and primacy of the "psychological mind" and psychotherapy. A few general ways that the clinicians used PTSD are represented below:

> I work with a model of post-trauma. People with trauma can't consciously take in everything that happens in a scene so some of it is repressed. Then when they are in exile, flashbacks, intrusive thoughts start happening. We tell them it's a natural process and help them to understand the process. We can talk, draw, whatever, to understand their symptoms and so they are not afraid. I tell them you are not going to get better very soon. It takes time, but it helps if you understand what you are experiencing like PTSD and to know that's how your body responds and that flashbacks are part of memories.
>
> Pers, therapist

> We don't use the diagnosis as such, but we use the symptoms and the dynamics. We don't use the criteria like does this person have A and B and C...sometimes or often we find it is an explanation of their difficulties and how they are reacting and it's helpful to have a background, not an illness frame of reference but a political frame of reference, a human rights frame of reference...I would take my explanation from the human rights violations they have been exposed to and that anyone would suffer some consequences from being exposed to that extent of violations they have been exposed to. And then try to form some kind of explanation of how they react and show how it keeps repeating

[6] For a full accounting of the biologization of psychiatry and the history of PTSD, see Young 1995.

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itself even though now they are safe. That would be the beginning. The body is not registering that they are safe now and keeps repeating intrusive thoughts, nightmares, these experiences are not being integrated enough in the sense of the bodily felt security and safety.

Søren, therapist

PTSD is a useful diagnosis but not perfect. It's a useful working diagnosis and the DSM-IV diagnosis is quite good, but it's important to not only focus on PTSD. You have to look at a bigger picture of the client. Oskar, psychiatrist

Ulla, another Danish therapist, shows clients a "diagram" of what happens to someone exposed to traumatic "stressors"---PTSD. She said that this "normalizes" things for the clients and the visual representation can be used "cross-culturally." "PTSD," she said, is "useful" as a "structure" or "concept."

The Danish therapists I interviewed employed PTSD in a practical and flexible manner. PTSD was used to help clients understand that they were not going "crazy" and to make them see the all-important "connection" between their past and present experiences. It also served as a guideline for clinicians. This was true also at the Haven, where talk about PTSD was usually reserved for discussing clients who were the "most traumatized," who had "symptoms" that couldn't be alleviated by counseling or other means, and whose "social functioning" was impaired. For this group of clients, the marked difficulties that fit some of the criteria of PTSD were called "symptoms." However, for those clients who were not so distressed, their issues were frequently referred to as "problems" or would be stated matter-of-factly in the form: "My client is having nightmares." Those clients who did have pronounced "symptoms" were often referred to a psychiatrist for an evaluation and if indicated were put on medication to reduce those symptoms. The clinicians at the Haven rarely used the term PTSD with clients though they did use a form of the "symptoms and dynamics" approach similar to

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the Danish clinician above. The Haven staff employed PTSD to reassure a client that he was having a "normal response to extreme situations."

An explanation and description of PTSD was invariably included in the training sessions that Ed and the City Hospital doctors conducted with professionals who in their daily work came into contact with refugees and torture survivors. Often in these lectures, there would be mention of the hippocampus or amygdala or other parts of the body within a brief discussion of the relationship of brain functioning to trauma, but the emphasis was placed more on describing the cognitive or affective effects of trauma, and the "processing" and "working through" of trauma and traumatic memories and symptoms. Speaking about PTSD seemed to be a necessary component of a proper expert overview about survivors of torture and collective violence, but it was not the centerpiece for training others about client suffering.

PTSD was also commonly used in forensic contexts and for billing and funding purposes.[7] "The best things we got from the medical model were for legal purposes and to get funding," Ulla remarked. For example, at a New York training seminar for psychologists who were interested in doing psychological evaluations of individuals seeking political asylum, the lecturing psychologist explained, "I look at the boring criteria of the DSM-IV and stress-related disorders and memorize the inclusion criteria before I do an interview." The asylum seeker's "narrative" is "extracted for any information that can be made into diagnostic criteria." The evaluations are to be "totally about the DSM-IV. You should go through each criteria, line by line, and match that with

[7] With Vietnam veterans, the diagnosis of PTSD has been used in compensation claims. For survivors of torture and refugee trauma, there are not the same kind of compensation mechanisms in place, so the clients do not have much to gain by claiming they have PTSD. The diagnosis has not entered the discourse with this population the way it has for U.S. war veterans.

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an aspect of the person's narrative." At the end of the interview, "we want a credible write-up of their experience which is clinically informed." Thus the scientifically-grounded, biological foundation of PTSD gives authority to asylum claims in the eyes of the law. Following the PTSD criteria to the letter, and removing the jagged edges and excesses of the client's experience (actions which would be contrary to the ideology of psychotherapy), were the prescribed directions for producing asylum evaluations.

The other areas in which a PTSD diagnosis gains validation are in epidemiological studies that suggest incidence and prevalence of PTSD in populations. The data collected in these studies can be used to acquire funding from donors or for political purposes. For instance, if researchers can demonstrate that 20% of a population is suffering PTSD from some kind of event, then public and private spending can be justified for helping those people. Operationalizing and quantifying "trauma" in terms of PTSD also allows for comparison across individuals, groups and events as well as providing outcome measures. Medical journal articles providing research findings on collective violence or political trauma frequently rely on the PTSD diagnostic category and employ the transnational nomenclature and positivist framework of the DSM-IV and the psychiatric sciences.

Furthermore, PTSD works for insurance and disability claims that require a DSM-IV diagnostic code. Often, clinicians will not worry about "medicalizing" a client's condition if it means that an insurance company or the state will reimburse charges for psychotherapy. This is usually done in the client's best interests, where ten sessions of psychotherapy are shamefully insufficient for helping a client.

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However, rather than being tied to the shorter tether of the PTSD construct, clinicians enjoyed the greater freedom afforded by the concept of "trauma." "Trauma" had become the all-encompassing framework for understanding what happens to the mind, body, and society before, during and after traumatic events or experiences. Rather than obeying the limits imposed by the narrow confines of a biological construct such as PTSD, "trauma" was a psychological formulation with wide-ranging forms and mobile points of application. In my fieldwork, I rarely heard the term PTSD used, but the word "trauma" was generously spread through the clinical talk of experts. For therapists, "psychic trauma" and "traumatic memories" were the substance of their work. A distinctly psychological mapping was made possible by trauma and its offspring (vicarious traumatization, secondary traumatization, and re-traumatization) that linked together political violence, the clients (as body, mind, community, social fabric, spirit) and the caregivers. Trauma loosened but did not completely break the moorings of PTSD's biological foundation. The biological foundations for understanding suffering bodies remain, but trauma allowed for greater intensification of psychological interventions in torture treatment and was instrumental in organizing the work and discourse of clinicians.

"Psychic trauma" was commonly understood to be associated with changes in the nervous system and the brain, but access to it and repairing it was to happen for the most part through speech or some other form of symbolization. It is primarily the cognitive and affective domains of the human subject that constitute the phase of the "mind" and it is at those two domains that psychotherapy is to be directed, whether it be family systems, psychodynamic, cognitive-behavioral, or existential therapy. The mind or soul of

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survivors was at the center of intervention, even when incorporating culturally appropriate symbols or rituals or the social, political, and cultural context of the client.

Embodiment

A 2001 flier for a clinical training, "The Embodiment of Resiliency: The Body's Call to Heal in the Face of Trauma" contained the following description:

> Trauma is not an event, but an experience that lives in the body. After the body registers a traumatic experience, it immediately activates its own process of returning back to a state of balance and equilibrium. If this is not possible, because of inadequate internal or external resources, the trauma continues to reside in the body, and informs and shapes the individual's perceptions and experiences.
>
> The body is the site of all human experience, from the mundane to the sacred and from the satisfying to the terrifying. Resilient bodies literally and metaphorically process life experiences fluidly. Trauma, however, imposes a block or barrier to the body's innate ability to integrate experience and therefore challenges the inherent grace and fluidity of the body. Trauma can freeze the body in time and space and thus prevent or impair movement and subsequent reorganization.

This flier reflects a more recent emphasis in torture treatment on "embodiment." A plethora of new techniques and theories have emerged, reorganizing the way the mind and body are conceptualized by situating the "body" at the center of human experience. This body is not the tortured medical body of the RCT. Nor do "perceptions and experiences" exist primarily as components of the psychological "mind." The body has become the "site" or the ground for experience and subjectivity—the mind and body have joined together in "embodiment." Trauma is thought to register at the embodied self, not just the "body" or the "mind," and the persistence of traumatic memory even with the application of techniques such as psychotherapy, medication, or other interventions is thought to suggest the existence of this phenomenon of "embodied" trauma.

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Bessel van der Kolk,[8] a leading trauma researcher and clinician of international renown declared at a lecture in Copenhagen, "It's the body, body, body. Most therapists are good at connecting affect with cognition, but what is missing is the third part, the bodily sensations...you cannot continue to do the work you've always done. It just doesn't work." There are "new ways of doing things," he said, that are about "leaving Vienna." According to van der Kolk, trauma has a direct impact on the body, a claim he supports by brain imaging research which has looked at the changes in the hippocampus, a part of the brain associated with memory; Broca's area, which is associated with language; and the visual area of the brain.[9] To put some of van der Kolk's various theories in broad terms, when a traumatic event happens it is not immediately languaged, "the first impact is visual, affective, tactile but not narrative;" it is registered non-narratively in the body. The "memory" then gets fixed in the brain (and also the neuro-hormonal-chemical system) in a manner that prevents it from being dislodged through language. One theory posited for how this disconnection happens is that brain lateralization make some of the functions of the left hemisphere, such as organizing, problem-solving, symbolizing, and categorizing unavailable to the functions of right hemisphere, such as expression and comprehension of nonverbal and affective activities, and of "essences." According to van der Kolk, "trauma is located in the right hemisphere

[8] Bessel van der Kolk, M.D. is based in Boston and frequently lectures in the United States and abroad. His work is widely cited, and he shares a close professional alliance with Cathy Caruth, a humanities scholar who has wed her literary work on trauma with his biomedical theories on trauma, and Peter Levine, a clinician working on embodied therapies for trauma victims. In June 2000, Dr. Jergen invited van der Kolk to speak at the hospital in the outskirts of Copenhagen where Dr. Jergen was the head of psychiatry. Van der Kolk's visit happened near the end of my fieldwork expedition in Denmark, and after hearing him speak several times in the United States, I was curious to hear him speak in a Danish context. I felt I had come full circle by listening to an American doing a lecture in Denmark, and seeing collected in a large auditorium that day nearly all the Danish clinicians I had interviewed for my project.

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and unavailable to the organizing processes of the left." The task of therapy is "making the right hemisphere communicate with the left." Flashbacks and other traumatic memories will continue until they can be released and somehow transformed and reintegrated, but sometimes "talking" just doesn't help.

Trauma also hits the body at a neuro-hormonal level. For example, some trauma survivors are thought to have a higher incidence of autoimmunological problems. Van der Kolk reported at his lecture that there is a significant correlation between childhood incest and lupus in women. According to van der Kolk, the immune system "overremembers and overreacts to stressors. The immune system begins to attack itself, so that the cellular and psychological phenomena are actually similar." Traumatic memory is ingrained in the body even if the mind does not "remember: "the body keeps score" and the "body remembers as the mind may not."[10]

Language, the cornerstone of psychotherapy, still plays a key role in van der Kolk's theories for treatment. For him, "narrative memory is an active and constructive social act. Memory depends on the context of relationships. " "Ultimately, " he claims, "psychotherapy is the way to go. People have to be able to communicate their internal experience." Also essential for "effective therapy" is the "relationship" between client and therapist. By this van der Kolk is referring to the commonly held idea that healing is also a product of the quality of the relationship between the client and therapist, and the

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[9] Here my intention is not to provide an overview or analysis of van der Kolk's research or his theories. For this, readers may refer to Ruth Leys' critical work (2000) or Young (1995).

[10] This would be the case for victims who "dissociate" during their traumatic experience. The traumatic event happens but is not experienced, received in recognizable form, or assimilated. The trauma then plagues the body, but the victim may not have consciousness of the event. See Leys's (2000) critique of van der Kolk's rejection of the idea of "repression."

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reparative nature of this relationship can be as significant as any fancy professional techniques.

However, van der Kolk provocatively claims ambivalence both about talk therapy and the therapeutic "relationship." Words he states, "are a double-edged sword," and a "miracle and a tyranny." Since using new body therapies that rely less on the "tyranny of talking about it," van der Kolk likens himself to a "plumber... fixing clogged up toilets." He describes how when employing the technique of EMDR (Eye Movement Desensitization and Reprocessing, which will be described below), "some patients treat me more like a dentist. They respect me but don't necessarily like me. There are no warm, fuzzy feelings there. Patients just come in and pay me to do the work."

EMDR

Van der Kolk recommends a combination of talk therapy with some kind of body therapy.[11] He also advocates using other therapeutic modes such as drawing because "some trauma victims are much better at visual representations." So too did the early RCT clinicians. One body therapy technique that has become popular in the past few years with mainstream American therapists and is highly recommended by van der Kolk is EMDR. At the Haven, Emil was trained in the technique and used it on clients. Danish therapists I interviewed did not use this technique, although they had heard of it. A Danish therapist remarked that part of this reluctance may be due to the American-style hype and marketing of the technique: "I think the process of marketing has disadvantages in the Danish culture. The marketing used in America does not work in here. You know

[11] For example, van der Kolk believes that self-defense classes can be helpful for rape victims. Body therapies like that are about "empowerment...getting power back in their bodies...you need to teach women who have been raped so they don't dissociate." According to van der Kolk, women also need to be

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you have to pay a lot of money for this step [of EMDR training] and then you have to pay more for the next step." The transnational exchange of expert knowledge has enabled Danish clinicians to become aware of this technique, but it has been rejected mostly because of a cultural distaste for the "American" methods in which it has been disseminated, i.e. sold.

In the States, this technique's proliferation and eager acceptance has not happened without controversy. Some therapists claim it is "cultish" or that it is little more than a new type of hypnosis. Part of the controversy stems from the fact that researchers do not understand how it works, although there have been some hypotheses put forth such as the idea that EMDR enables communication between the two hemispheres of the brain.

This technique has different variations and can be modified with different clients, but basically the procedure is as follows: the client is asked to think and talk about something that brings fear, anxiety, or bad feelings. The therapist then asks the client to rate on a scale of 1-10 how disturbing the feeling or memory is. The client then talks more, and the therapist will check in with him by saying, "Where are you right now?" or "How are you doing?" or another similar prompt. The client will respond, and then either he speaks more or the therapist will stop the client and start doing a hand movement back and forth in front of the client's eyes that the client should track with his eyes. Or, the therapist will make alternating rhythmic sounds, like snapping fingers while moving the hand back and forth like a metronome, or will clap a hand on top of one thigh, then the other. The therapist will then ask the client again about what's coming up for him, how he is feeling, what he is thinking, and so on, then stop the client and again do the

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taught how to defend and protect themselves. These may be "vulnerable" women who have "points of vulnerabilty" who need to "be in their bodies, focused, centered" and "stay in their minds."

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rhythmic, alternating motions. Often a client may say something like, "My heart is beating fast. I feel a knot in my stomach," which the therapist will follow by asking him to "say more," or "describe further what that is like." This connects the client verbally and reflectively to his bodily sensations. Another round of rhythmic movement then follows. The therapist will periodically ask the client to rate how he feels on the 1-10 scale, and if the procedure is working, the numbers will decrease through the session. Afterwards, clients have reported feeling "different," "calmer," and can speak about their memories as "just" memories. In other words, rather than "reexperiencing," the client "remembers."

Van der Kolk claims that a patient with "complex trauma" who had been in psychotherapy for thirteen years was improved after just three sessions of EMDR. He has become a "convert" to the technique. Emil too has seen "amazing results" with survivors of torture and refugee trauma although it is true that not all clients respond to the treatment. Some do not want it, perhaps because they do not want to "relive" their pain, or maybe because the technique itself sounds rather dubious. On how to handle the reluctant client, Emil says, "this is a technique that can help them with pain...I use the metaphor of a broken arm. It healed but not correctly and you still feel prolonged low intensity pain. EMDR is a process where you are going to break the arm again and help it to heal correctly. Put it in a cast. We focus on symptoms, using the metaphor of cleaning the house of the soul." The cleaning involves "getting rid of debris, to cleanse and purify. The roof will still be there and sometimes it will rain but the inside of the house will still be protected."

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Emil's persuasive rhetorical strategy depends on two metaphors. In the first, a part of the physical, corporeal body—the arm--becomes the metaphor for the site of the traumatic wound. The metaphor of the "arm" may serve as a vehicle for the clients to understand the process where what is broken can be fixed, as would be the case with a broken arm and a medical procedure. Further, what is broken can be seen—a broken arm can be seen in a way that a broken mind cannot. It is also a pain that clients can imagine. Emil also uses the metaphor of "cleaning the house of the soul" where the house implies the body, yet is not the body. I would suggest Emil uses metaphors outside those of science not just toward a pragmatic end—getting a client to accept the therapy-- but that he is attempting to speak about "embodiment" when the dualistic language of mind and body are inadequate.

Thought Field Therapy and Emotional Self-Management

Emil also utilized a therapeutic technique called Emotional Self-Management (ESM). ESM and Thought Field Therapy (TFT) are related therapies that use Eastern healing philosophies based on energy systems and meridian points, techniques of accupressure, and cognitive therapy. ESM has three "phases:" 1) "working on negative emotion;" 2) "focusing on formulating a goal statement;" and 3) "creating imagery of achieving a goal." Like EMDR, in ESM a client is asked to think about a troubling issue, thought, feeling, image, or fear, and also to rate the intensity of the unpleasantness of it on a scale from 1-10. This scale is called the Subjective Unit of Distress Scale (SUDS). A "sequence" is then performed that affects different meridian points and energy flows in the body. Specific sequences have been designed to go with specific problems. A client may be asked to hum, roll her eyes around, breathe twenty-four times while sitting

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relaxed in a chair with one leg crossed over the other at the ankle ("balanced breathing"), or do "polarity reversals." "Polarity reversals" require the client to recite a set of 12 statements, which are like affirmations, three times. For each set of 12 statements, during the first ten, the client rubs a particular spot on the chest. The eleventh statement is accompanied by tapping under the nose and the twelth by tapping under the lip. The client can also perform "tapping sequences," of which there are twenty depending on the specific problem.

For helping "anticipatory anxiety," the client taps the eyebrow, under the nose, under the lip, under the eye, the collarbone, under the arm, the collarbone, and under the eye, while stating, "my anxiety." The sequence also includes other exercises, like the eye roll. Once sequences are learned, clients can use them at home.

Emil described one client's experience with the ESM "protocols for headaches and anxiety."

> She was able to bring negative emotions to zero. We [he and the client's casemanager] copied the material and gave it to her so she could do these at home. The session lasted two hours. We met two days later in the same place.
>
> She reported that she had slept better and felt better. She came with more confidence as she felt she could control her headaches and anxiety in a way that influenced some of her symptoms. We did additional sets of Emotional-Self Management. We all did it together, saying the affirmations together.

According to Emil, "ESM can do no harm. You can use it for everyone, all ages, gender, class, etc. We use it before court, INS interviews, etc. It helps to decrease the level of anticipatory anxiety. Before INS interviews this is especially helpful because it is one of the most important meetings of the client's life."[12]

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[12] Whenever I spoke with Emil about my dissertation stress, he would try to get me to learn some ESM sequences.

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Cynthia, a therapist who practices and has taught TFT (the main difference between ESM and TFT is that TFT does not include statements and polarity reversals) believes that TFT can work well for refugees because it is "easily translated" across cultures; "it can be taught using photos," the clients "don't have to share their stories;" "it is concrete and portable;" and it is a "self-healing way to beat the perpetrator."

Emil explains that, "In EMDR there is a sense of spiritual ritual. You can feel the negative energy being released. It's very moving." ESM and TFT bring together the "body, mind and spirit." Clinicians training in these methods have been asked to "suspend your paradigm of how things work in the world and come to this with curiosity." These treatments add mystery and inexplicability to what is considered rational, scientific practice, but as with other therapies of torture treatment, these therapies are also about giving "control" back to the clients, who can learn how to "manage" themselves better, through "self-healing." Cynthia said TFT is a way clients "can put themselves together." "People have choices," Emil explained. "They are in charge of their lives even if they are not in the driver's seat. We are the cab drivers. We'll drive wherever they want to go. We can offer our skills (e.g., this is a one-way street, can't go this way)...We should work with what is available, what the client is giving to us."

Pain Theory

A shift in emphasis to a form of "embodiment" has also happened in another setting of treatment—the *physical* rehabilitation of survivors of torture. Dr. Larsen's area of expertise is in pain and pain management, and prior to her work with torture survivors at the RCT, she had done extensive research with patients who have "fibromyalgia," a

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mystifying condition where individuals experience chronic, unspecified pain. With fibromylagia patients, Dr. Larsen explained to me, there is a group who can point to an illness like the flu, or an injury like whiplash, which marked the onset of their chronic pain, but there is another group for whom the cause is unknown. For the second group, some evidence suggests that "trauma," such as "physical and sexual abuse," may be connected with fibromylagia. This connection has been supported by research on PTSD that looks at its "biological basis," like "hormonal changes," and a "genetic predisposition" to it. Dr. Larsen made the important discovery that torture survivors share remarkable similarities to fibromyalgia patients which has reoriented the way the clients in physical rehabilitation at the RCT are now being viewed and treated.

Dr. Larsen describes, in lay person's terms, her observations of the similarities between the pain of torture and fibromyalgia, recent theories on "pain" and how "pain" has oriented her approach:

> And today a lot of those chronic pain syndromes of the locomotor systems, for instance fibromyalgia, it's not the muscles, it's the pain system. It's the nerve system that transmits pain signals that is very plastic and changes. A huge amount of acute pain or pain over a long period can make the nervous system change and these changes can be irreversible. So you have a pain system which is now hyperactive. I think that is what is wrong with our torture victims because they actually look like fibromyalgia patients. They have a lot of physical symptoms they describe as muscle and joint pain and then they have a lot neurological symptoms like needles and pins and numbness and hypersensitivity---you cannot touch them. They are hypersensitive and the fibromyalgia patients are the same and they also have a lot of irritative symptoms from their organ systems-- irritative bladder, irritative bowel, all kind of lung and heart symptoms
>
> ...in the literature that you read about torture and the physical sequelae, it's always written that these symptoms must be psychosomatic because when you examine the bowel, bladder, heart or lungs, there are no findings. But I think the problem is that we have been looking in the wrong places because today you believe that these symptoms, like in the bowel, bladder, heart, are hypersensitivity in the pain system. Of course you cannot find lesions in the organs as such. So this is not psychosomatic, we are just not good enough.

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...The problem is, I think, that this hypersensitivity of the pain system is the bodily response to a lot of different traumas in this. It's not necessarily the cause that's the same but the response is. The torture survivors have the same bowel, bladder, lungs, heart symptoms as fibromyalgia and they also have neurogenic pain, the nerve lesions that can cause chronic pain due to the same changes in the pain system. And they have it very much when they have been beaten and the nerve endings have been damaged. You have a tremendous amount of nerve endings in your feet, your feet are extremely highly developed organs made for walking and you can scan the surface when you are walking, you don't need to "see" the surface when you are walking, and all this has been destroyed with torture victims. They have to use their eyesight to guide them when they walk. Diabetes patients have this too...

You cannot cure nerve pain. Torture victims have unspecific symptoms all over. But if you look at back pain and shoulder pain and headaches and whatever, you can find this in many other patients.

Dr. Larsen goes on to describe some current torture methods, and their effects:

... I think before and now if you are a doctor you think if you had a torture victim you should see scars and fractures and a lot of things, loose shoulders, and you don't. Maybe one of the reasons is that the really mutilated have been put out and I think that intentionally they develop methods that leave few signs. In India for instance they have a method called the "gardener" they have this in Punjab. They use big wooden sticks that they roll on corn to crush it. Now they take the torture victim and put him on the ground and they take this big stick and maybe one or two torturers stand on it and they roll it on the thighs and they crush the muscle fibers but don't go over the bones or tear the skin. They beat you in places where they won't make holes in the skin, soft places. I saw one torture victim whose muscle fibers had been crushed and he had a big spot I could actually feel it. But they are not able to walk very well. If you are a good torturer when you do falanga the skin will not break.

Another thing is the shoulders after suspension. You can hang people in different positions but this one [demonstrates the position for me]...if they do this you will have nerve damage and neurogenic pain for the rest of your life. With neurogenic pain they have it all the time. It's very difficult to examine them clinically. Before we treated the victims as if they had tendinitis and impingement which they don't and so we had them do stretching exercises but now we have them do strengthening exercises. Now we are monitoring the treatment effects.

Dr. Larsen makes the connection between a patient who has been tortured and the typical pain patient, and explains the approach to torture treatment with this new conceptualization:

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...Since we now think of torture victims as pain patients, we cannot use pain as an indicator of treatment because they will always have pain and we know that. Instead of looking at little parts, we look at whole body function. So the goal of physiotherapy today is not to get rid of pain or restore their bodily functioning as they were before the torture, but we want them to live a good life with the disability and pain they end up with. We train function, we try to get better their body function as a whole. We do a lot of exercises for better conditioning, rowing machine, bicycling, we have this treadmill and then we do exercises with special equipment called medical therapy training that helps circulation, coordination, strength and endurance. For most of our torture victims the strength and endurance takes a lot of weight and repetitions and their pain is too great for that so we focus more on coordination and circulation. It's like, before we had this Norwegian equipment like in fitness centres, you sit in these big machines and have limited movement and its working on strength. If someone has problems walking, it's not just about strengthening their thigh muscles but it's also about balance and coordination, the function of the muscle groups together. If you want to learn people how to walk, you walk them. If you want to learn people how to do stairs, have them do stairs. So what we do now, if they have problems elevating their arms, I would have them elevate their arms in a way that causes the least pain. So we threw out all the old equipment.

In this narrative, Dr. Larsen describes how "irritative" bowel, bladder, heart and lungs had previously been classified as "psychosomatic" disorders by doctors. However, the error of the diagnosis of "psychosomatic" she attributes not to the limits of the epistemological foundations of biomedicine but to the failure of technology: "we are just not good enough," "the problem is that we have been looking in the wrong places." It is with scientific advancement that the tortured body is no longer seen as a locomotor system, with joints, ligaments, muscle injuries, "scars and fractures," and "lesions" but as a "pain system," a highly sensitive, "plastic" and changeable system of "signals," neurons, nerve endings, and chemicals. The hard body with localized parts, organized through the visually directed biomedical gaze has been replaced with a "hyperactive," "transmit[ting]" "system," where "unspecific symptoms...are all over," where "[i]nstead of looking at little parts, we look at whole body function."

Dr. Larsen asserts, "We now think of torture survivors as pain patients." Where "pain" had once been a symptom, "an indicator of treatment," it was now the

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overarching, defining characteristic for the object of knowledge, the torture survivor. These pained bodies, embodiments of pain, cannot be "cured" because pain defines their very nature, so the goal for treatment, Dr. Larsen explained, is for "them to live a good life with the disability and pain they end up with."

She describes how clients respond to the pain model:

> Some of the torture victims have very high expectations when they come to the RCT and then they are angry and frustrated when the physiotherapists tell them they will not be cured and that they need to accept their chronic problem. So sometimes it takes time, but it's also a relief for them because professionals are taking them seriously and not telling them they are cracked in the head. Some of them are very worried that they are going to end up in wheelchairs and we need to reassure them that this is not so. They will have periods of good and bad pain.

However encompassing the explanation of the pained body may be, for Dr. Larsen the body and mind are still dichotomized, yet paradoxically are also thought to be inseparable and undifferentiated:

> All of the patients we see are also in psychotherapy. But we can never really know what is physiological and what is psychological. We cannot separate these treatment modalities and even for research, it would be unethical to give them one or another.

Relaxation Pedagogy

The last type of "embodied" therapy this chapter will explore is what a therapist called "relaxation pedagogy." Lise, a "body therapist" and Helle, a psychologist, work at a psychosocial program for immigrants and refugees in Copenhagen. They described how they started offering "a different kind of treatment" beginning in 1995 at a time when the center "thought it was time to focus on the body, too." Lise and Helle often work together as a team, and "try to be very precise in how we work together, as a method" which Helle describes below:

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Actually we have studied for each other in detail what we do in each session, how the clients react and how we think about what the clients are showing us. We discuss this with each other and try to analyse what's going on in my room and with Lise and we try to understand what's going on with the client from these two different groups. It's been very integral to the treatment and we wrote up a case study that we presented at a conference. We tried to really to separate our approaches which is really rather anti-trendy because mostly psychologists and body therapists work closely together and we separate it. For us it's very interesting to clearly define our roles. We work more closely together but our boundaries are more defined. For others, it's more mixed up. Of course you can say superficially, body and psyche goes together and you can't separate it but to do treatment, to know what you are doing you must separate it. We are trying to argue more with our colleagues about this. We are looking forward to having more intense discussions with our colleagues about it.

Helle and Lise's approach is "anti-trendy," because they are rigorously defending the separation between the mind and body and their respective professional roles. It is by maintaining the dichotomy, they claim, that they are actually able to "work more closely together" than other clinicians, for whom "it's more mixed up." I would suggest that part of what they are responding to by their "anti-trendy" approach is the surprising ease in which clinicians now claim that the mind, body and spirit all go together holistically. Sometimes this rhetoric borders on quasi-New Age spiritualism, or seems to be employed mostly for promoting the professional self-interest of certain clinicians. In my observations the discourse of embodiment has definitely become "trendy," and it is understandable that some clinicians would react to this development.[13] How Lise and Helle have chosen to react through their methods and ideology reflect particularly interesting ideas of the mind's relationship to the body.

When Lise first told me what she did, I thought that she was a physiotherapist, but she explained that she had received special training in a specific type of body therapy called Eutony Pedagogy. This is a "pedagogical" therapy meaning that the client is a "pupil," and an "active agent," whose task is to gain more self-knowledge through

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directed bodily experiences. The therapy consists of directed movements and forms of touch either with the therapist's hands or with objects like small balls, wooden boards or cushions. With these different touches and movements, the client is to be "present" to what is going on and to notice and articulate how his body is able to accomplish movements and how he feels with each procedure. This treatment aims to help the client gain some kind of awareness or "felt" perception of his body and therefore of himself and even "life" as a "whole," rather than as dissociated parts. Lise explains further:

It's a Danish education I have that's not physiotherapist. It's a way that has developed in the past fifty years. I can say the difference in the simplest way: the physiotherapist works with the doctor. The doctor finds a problem and the physiotherapist takes care of it. I work with the psychologist and supplement the work of the psychologist. It's about consciousness, anchoring, sensation and to see this as a process of the person's whole life, there is not something here that needs to be "cured" or that this pain must go away. We call it relaxation pedagogy. It's to learn a new way to have a dialogue with your body. We are very different than physiotherapist. We can see that we don't know how to treat the very severe effects of torture. There are some things we don't know about. But the main problem is the dissociated body and also with the physiotherapists, they don't know how to handle this either. We face the same problems but we have different ways of dealing with it...

People say psychosomatic is an integration between the mind and body but to me it's still a cut between the two. The doctors usually think it is psychological but I say no, it's there in the body...

You don't have the feeling of you being your body. This is the feeling that basically they all have, because in order to survive they had to dissociate, and they have a dissociated mind, too. So when people come to me and I ask, what is the pain, what is the problem, they talk like this: I have pain here and then I have pain in my stomach and then in my head and I have this tone in my ear and I can't sleep at night. That's because they are dissociated. They don't have focus and they can't keep focus anywhere. So my idea is to try to help the person focus and to see the whole body as one thing and then to see a part of the body as part that influences the whole. It's to help the person see their body as whole and then to give some kind of understanding of why this is so. Most people have been to doctors and the doctors cannot find anything. Sometimes the clients are afraid to say anything to the doctor because they are afraid it's so serious, like they have cancer or something and they are going to die or they think they are crazy. So it's trying to find out what they themselves think is wrong...

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[13] It is also "trendy" to do community-based work.

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... many of them have that sleepy feeling in their arms and they lack tonus, they drop things suddenly and they think it is their nervous system that is collapsing. But we always go back to how they can cope and we go over the body again and again to get a common understanding of what the problem is. Some clients think it won't work, and they insist they need an operation, but we try to build a common culture together for understandings. This is an experience-based therapy.

Lise describes how the body, like the mind, becomes "dissociated" through traumatic experience, and how it is through a process of re-education that the connectedness and wholeness of the body can re-emerge. The model of the traumatized mind that "dissociates" and needs reintegration (similar in some respects to what van der Kolk described) has been applied to the body. A healthy state of embodiment has been broken with torture, but with the help of the body therapist, the client learns how to gain "consciousness, anchoring, sensation" back into his body, to "focus," to "cope," and to "get a common understanding of what the problem is." Language is integral to this process, allowing the therapist and the client to "build a common culture together for understandings" but also so the client can "create dialogue with [his] body." The mind and the body are brought into a new relationship that is constructed through language, where the mind and body learn to speak to one another again, yet maintain their respective autonomy. It is as if the client's mind and body become sites of agency and volition, where the mind and body can relearn to communicate by a central or executive self whose directed self-reflection promotes greater self-governance of these different self parts without dominating them. These parts need to be activated and empowered for the therapy to work. The reflective presencing and communication between self parts mimetically reflects the structure of the client/pedagogue relationship, as well as the relationship in the phase of the "mind" between the self, cognition and affect that have

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come to characterize certain modes of governmentality discussed in previous chapters of this study.

Conclusion

Many other body therapies have been developed and used with survivors of torture and refugee trauma in the past few years, each with its particular theories and methods. Despite their differences, all of these approaches have in common some kind of understanding that talk therapy doesn't always work with survivors of torture and refugee trauma, and also that the ways intervention has been divided up between psychological therapies for the mind and traditional biomedical approaches to the body haven't always succeeded. One tension that continues to vex clinicians in the torture treatment field is the play between cultural difference and universalism. Biological views of the body and psychological models of the mind both assume some kind of universal "hardwiring" that underlines cultural difference, yet in clinical practice the presupposed universalism is always called into question. The most recent methods to overcome and transcend the problem of cultural difference are the body therapies, which give primacy to a notion of embodiment that prefigures the overlays of culture, history, and biography.

This chapter has demonstrated that expert knowledge in the field of torture treatment has both transnational and local dimensions. Peter Levine, an American clinician and recent collaborator with van der Kolk, has developed an "embodied" treatment method based on what he calls "somatic experiencing" that I did not discuss in this chapter. According to Levine, the flight or fight response is activated when an animal faces danger or a traumatic event. This is a basic survival mechanism. However, it is thought that the nervous system of people who have traumatic symptoms has been stuck

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in this survival mode. This stuckness is centered in the deepest, most primitive parts of the brain, the "reptilian brain" where thought and emotions cannot penetrate. To discharge all those survival energies that have been activated but are stuck, therapy must get to the body's instinctive "felt sense," by "awakening the tiger" within. Peter Levine's work was mentioned by several Danish therapists with great respect and admiration, although my sense is that he was not nearly as popular in the States. The Haven staff were introduced to Levine's work at the Trauma Studies Center, and Emil and Claire both told me that some of Levine's approaches were not their cup of tea, rejecting them mostly based on a dislike of Levine's personality. At one Danish treatment center I visited, some of the therapists have trained with students of Levine and were enthusiastically trying to incorporate some of his methods. We can see that as the cross-pollination of expert knowledge and therapeutic practices occurs transnationally, the particularities of those knowledges and practices influence and are also transformed in different local settings.

Clinicians who practice contemporary interventions in the field of torture treatment do not share the singularly-focused approach to the "body" that the RCT did in its early years, nor do they march forth with the same kind of triumphalist spirit that guided many of the RCT's practices. A plurality of interventions now exist simultaneously, and rather than "cure," Dr. Larsen, Emil, Lise, Helle and other Danish and American clinicians maintain that the best they can offer is to help clients "cope," and "emotionally self-manage," to become "empowered" by "remembering" rather than "reexperciencing" and to gain "better functioning" so they will be better able to live with their "pain." At the same time these techniques seem to be used with success to help

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survivors of torture with their "trauma," a new type of self-governing has also emerged through "embodied" treatments. Many of the techniques are "portable" and designed for the clients to use on themselves, such as those practices which promote mindfulness of bodily sensations and tapping and affirmations. These treatments foster the client's independence and autonomy, and enable ideal forms of self-governance. It is not simply that the treatments result in increased empowerment, the way in which an operation could cure some kind of physical wound, but that the activity of the therapies themselves are self-empowering. To embark on a therapeutic regime is a reflexive activity which cultivates a certain self-formation. As with many psychological therapies, these methods give "prominence...to the norm of autonomy and the promise of achieving it under a regime of rational management of existence" (Rose 1996:97).

Clinicians remain hopeful even in the face of their understanding that some pain cannot be removed, especially physical pain but also psychic pain, and that at best clients must learn to live in and with their pain. Emil speaks to how "hope" sustains his work, and I believe the sentiments he conveys would be shared by other clinicians in this field:

> I feel really good about the atmosphere that my colleagues and I create, and the issue of hope is crucial. We are not here to change the past. That is not our job. We have to remember that and be disciplined in our way. We do not want to throw the boat over but want to keep balance, and like that English boy, Churchill said in 1940, "We are never, never gonna surrender" to the torturers of our clients.

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Chapter 8:
The Trauma Story

Introduction

In preceding chapters, I described how psychological interventions directed toward survivors of torture and refugee trauma were in many ways constructed through what Dean terms a "programme of empowerment" (1999:69). [1] This "programme" shaped critiques that did not undermine the truth claims made by the torture treatment field, but on the contrary, allowed the field to transform and expand its "points of application" (Rose 1999:10). Specific kinds of critiques associated with the program of empowerment—critiques directed toward the individualizing, de-politicizing, and ultimately disempowering processes thought to be connected with conventional Western medico-psychological techniques and assumptions—enabled new practices and points of application, such as the *community*, to emerge.

Clinicians adopted several approaches that were thought to counter the individualizing and de-politicizing effects of conventional Western therapy. Initiating community-building activities was one such approach. In addition, clinicians acquired and applied knowledge about the social, cultural and political position of the client, and integrated cultural and symbolic rituals familiar to the client and the client's community with Western forms of healing. Psychosocial programs for survivors of torture and refugee trauma also made a point not to neglect the significance of immediate social needs when considering the psychological aspects of functioning and effects of trauma. Further, clinicians formalized through specific techniques of therapeutic practice and service delivery the notion that active and resilient *survivors* and not *victims* suffered and

[1] *Trauma* refers to psychic injury and to psychic suffering.

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survived political violence. Similarly, the term *client* was not just a euphemism for patient. A client was defined as an active consumer of service and co-participant in meeting the psychosocial service contract of empowerment.

However much a certain tradition of Western psychology has been transformed through torture treatment's program of empowerment, the field continues to be stabilized and ordered by a medico-psychological concept of "trauma" and a constellation of notions and practices that drive psychological intervention and psychological ways of framing experience. Summerfield has observed that

> [o]ne of the features of 20th century Western culture—particularly in the last 50 years—has been the way medicine and psychology have displaced religion as the source of explanations for the vicissitudes of life, and of the vocabulary of distress. These new understandings have become part of the shared beliefs of contemporary Western culture and thus come to be experienced as natural and self-evident. Terms like stress, trauma and emotional scarring have come into commonplace usage by the general public, used both metaphorically and as an indication for professional help (1999:1449).

Psychosocial programs for survivors of torture and refugee trauma have been constituted with the understandings that political violence often leaves psychic pain or "trauma"; that "trauma" is a mental health issue; and that the appropriate interventions for "trauma" are based on psychological expertise. As Summerfield noted, it has become difficult for us in contemporary Western society to imagine that one wouldn't be traumatized and need psychological help if one endured extreme forms of political violence such as torture, rape, murder, dismemberment, or other atrocities (Ibid). However, as with many assumptions in torture treatment, even those "self-evident" assumptions have been questioned as the field evolves.

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This chapter will take as its point of departure something called the *trauma story*. Though the trauma story, like the other strategies, techniques and practices already described derives in part from a program of empowerment, the aim of this chapter is not to focus on this particular aspect of its functioning. Rather, this chapter will examine how the trauma story gives meaning to and structures relationships between the self of the sufferer and his[2] suffering, and also between the client and the psychological expert. The trauma story is also pivotal in making meaningful connections between the survivor, the psychological expert, society, and history.

The Trauma Story

On the outgoing telephone message of the Haven program, Ed says, "We want to hear your story." The "story" to which Ed refers may mean the story of the client's situation, his circumstances, his "needs," and so forth, in other words, the story of who the client is in terms of services to be provided. However, there is another story implied: the "trauma story," a specific personal narrative that I will identify and discuss using a theoretical framework based on the work of Paul Antze and Michael Lambek (1996).

The trauma story is a narrative that grows out of and gives form to memory. Memory is dialogically constructed through the vehicle of the trauma story—it is a story, and as such needs to be told, a structure that assumes at least a listener and a narrator (Ibid.:xv).[3] In clinical practice, it is often assumed that every client holds this memory, a memory that both disrupts the continuity of identity or self (the trauma as discontinuity)

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[2] As indicated in previous chapters, I have given clients and survivors masculine pronouns, and the counselors and clinicians female pronouns, unless I specify otherwise.

[3] In previous chapters, I described Crapanzano's suggestion that dyadic relationships are actually triadic. According to Crapanzano, there is always a Third, (e.g. language), that makes the dyadic relationship possible. Crapanzano also suggests (personal communication) that in telling the trauma story, an

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and also grounds the survivor's identity or self (part of who I am is the trauma I remember and the trauma story I may tell). The trauma story is a unique form of autobiography, but the notion that autobiographical narrative defines and expresses the self and identity is not. Dominant views in the West assume that identity, memory, narrative, and selfhood are intrinsically connected (Ibid). As with each of our stories, the survivors' stories "have individuated characters; memory is organized around an intrinsic, essential subject, whether an individual I or collective we..." (Lambek and Antze 1996:xvii). Memory, in the form of the trauma story as it is practiced and understood in torture treatment, "...serves as both a phenomenological ground of identity (as when we know implicitly who we are and the circumstances that have made us so) and the means for explicit identity construction (as when we search our memories in order to understand ourselves or when we offer particular stories about ourselves in order to make a certain kind of impression)" (Ibid.:xvi). The primary concern of torture treatment is in the latter service of memory, as a "means for explicit identity construction."

The trauma story created significant gravitational pull in the activities of the casemanagers and other clinicians at the Haven, and also, I found, for the clinicians at psychosocial programs for survivors of torture and refugee trauma in Copenhagen. Akin to the PTSD treatment program on which Young based his study, at the Haven and other torture treatment programs there was the presumption "that every patient conceals a narrative, his pathogenic secret"(Young 1995:227). However, unlike the Veteran's Administration's PTSD program Young discussed, the torture treatment centers I studied

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interlocutory process occurs that determines the form, shape and even production of a certain kind of narrative.

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did not have a public mandate to create a distinctive treatment program with specific therapeutic techniques and procedures based on a concept of PTSD, nor was the assumption that the traumatic memory must be therapeutically disclosed institutionalized (Ibid.:184-185).[4] Yet, in the early years of clinical practice at the RCT that were discussed in the last chapter, there was a strong conviction that the trauma story had to be told for a successful treatment outcome. Obtaining that story from the client was an activity that required the therapist to persevere, devise ingenious methods, and practice tough love. Since that time views on the trauma story and how to address it have shifted, though there is usually little doubt that it does potentially exist in some form.

More recent discourses pertaining to the trauma story have been organized by a discussion based on two inter-related questions: 1) Where is the trauma located--in the mind, body, social relationships, or history? and; 2) How should the trauma story be addressed in treatment? With the increasing acceptance of embodied therapies and the idea that culturally different survivors may not relate to the talking cure, the trauma story's narrative dimension has been called into question. Even so, the therapeutic, moral and political importance given to narrative practice still dominates therapeutic discourses.

The performance of the trauma story could be thought of as a variant of the confession, a ubiquitous and enduring Western ritual that "we rely on for the production of truth," according to Foucault (1980:59). The confession, he writes,

> ...has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling, with the greatest precision, what is most difficult to

[4] Further, the patients in the clinic Young studied were American veterans, while programs for survivors of torture and refugee trauma serve heterogeneous client populations.

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> tell. One confesses in public and in private, to one's parents, one's educators, one's doctor, to those one loves; one admits to oneself, in pleasure and in pain, things it would be impossible to tell anyone else, the things people write books about (1980:59).

Rose claims that the confession "...has been the most versatile and most transferable" technology, "able to travel easily from one locale to another" (1996:96). This observation has been borne out for survivors of torture and refugee trauma who are if anything confessing subjects across a variety of sites. In the domain of justice, the asylum seeker must testify to the INS,[5] psychologists, legal representatives, and judges; in therapeutic domains the client tells his "trauma story" to the casemanager or therapist; and in public domains such as museums, video projects and commemorations like the UN Torture Day, the survivor gives "testimony" and "bears witness" to the perpetration of political violence and to his suffering. And of course, in the domain of political violence the survivor may have had to "confess" to his torturers.

The memory contained in the trauma story, at least at the Haven, became encased in narrative practice. Lambek and Antze have recovered the memory embedded in confessional practices by making memory central to their analysis (1996:xxx). They make the radical suggestion that "Foucault's study of the history of sexuality might well have been about the discourses of memory: the substance of confession, after all, is memory, and the technique of memory is frequently confession" (Ibid). Hacking, in describing the genealogy of what he has termed "memoro-politics," remarks how humanist, anti-scientific ideology shifted "sciences of memory" from their associations with neurology, anatomy, and so on, to the "doctrine that memory should be thought of as narrative." He claims, in fact, that "the metaphor for memory is narrative" (1995:251). In

[5] Immigration and Naturalization Service.

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clinical practice at the Haven, the application of scientific knowledge about the neuro-anatomo-physio-chemical workings of trauma and memory, or therapies directed toward embodied trauma, were typically secondary to the production of the trauma story and the narrative imperative.

The Haven and the Trauma Story

In the chapter that examined how *need* is constructed at the Haven, I described how the trauma story was an essential component of the intake interview there. Two pages of the intake interview were devoted to eliciting the memories of traumatic experience, along with a measure of "functioning" based on the client's "ability to discuss trauma history with counselor." The measure came with an expectation that if the client produced a low score at intake, treatment would enable the therapeutic disclosure of the trauma story, thus improving the client's "score" and therefore his overall "functioning." Formalizing the trauma story in this manner reinforced its potential and an expectation of its production. However, anticipation was to be tempered by restraint. It was "up to the client" to reveal his traumatic memories through narrative. The client did not have to describe anything about his traumatic past if he did not want to. This was stressed both to the casemanagers when they were trained for the intake interview, and also to the client before the intake process began.

The intake interview was just one area in which ideology about the trauma story was made manifest at the Haven. Other situations, such as staff meetings where the casemanagers and the clinical/administrative directors discussed clinical issues, also presented opportunities for producing and reproducing trauma story ideology as will be shown below. It appeared that concerns about the trauma story were critically linked to

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questions about the degree to which service would be psychologically-focused and also about which therapeutic techniques would be used at the Haven. These questions formed part of the ongoing discussion the casemanagers had with Ed and Emil about psychological needs versus social needs, and also about the appropriateness of psychotherapy for the culturally different clients the program served. At the center of these debates was a concern about what should happen and what it means when the trauma story was or was not presented during the course of treatment or service provision.

The Staff Meeting: Resistance and Countertransference

At one Haven staff meeting, Emil did an in-service training on "resistance" and "countertransference." We all sat around the table in the meeting room, and I for one fully expected a routine presentation, and not what was to follow. The discussion was based on a professional article that all the staff were assigned to read prior to the meeting.[6] This article presented the results of a study conducted with a group of therapists who had worked with Holocaust survivors. The author of the article, Yael Danieli, is a trauma therapist perhaps best known for her clinical work with Holocaust survivors and also for the supervision and training she has provided to clinicians who treat traumatized clients. Emil, Ed, and the casemanagers were all personally familiar with Danieli as she was a fixture in the local trauma community. They were also, therefore, familiar with Danieli's mission to make people deal with trauma by confronting them with it. Part of Emil's purpose in conducting this in-service training was to employ moral and, to a lesser extent, theoretical leverage as a means to make the

[6] The 1984 article in question is titled "Psychotherapists' participation in the conspiracy of silence about the Holocaust."

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"resistant" casemanagers comply with the new rules and procedures that placed greater emphasis on clinical aspects of service at the Haven. The hidden agenda of this training slowly became apparent to me, and I could detect the tensions in the room heighten as the casemanagers too became aware of the subtext. As this discussion will show, changing the conduct of the casemanagers was a problem with few implications outside of the Haven setting, but the moral weight Emil attached to staff non-compliance was enormous.[7]

Emil opened the training by explaining to staff that "transference are feelings that a client has toward a therapist, social worker, or casemanager," and "countertransference are the feelings that a therapist has toward her client." Countertransference feelings are not just "compassion" but "feelings that are unhelpful and harmful to the client." Ed added that "these feelings are not necessarily based in reality, but may be images, fantasies from your past, and your history." A clinician's countertransferential reactions with clients who have been exposed to violence, explained Emil, are prone to types of "resistance" to their clients' trauma, such as "indifference, avoidance, and denial."[8]

The following are excerpts from Emil's presentation as he continued to describe what happens when countertransference becomes "resistance:"

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[7] The narrative taken from Emil's in-service training is based on handwritten notes. The discussion among the other Haven staff members following Emil's in-service was transcribed from audiotape. My transcriptions in this chapter remain true to the language of the speakers, many for whom English was not their first language.

[8] The concepts of transference and countertransference were part of the clinical vocabulary at the Haven and at other torture treatment programs. Used clinically, the concepts function to domesticate the complexity of the relationship between the therapist and client and also distance the clinician from the recounting and the horror of hearing the trauma story. This is true at the same time these concepts are thought to reveal and make transparent and present the process of interlocution. The concepts of transference and countertransference can also be used in a more facile way, and act to give a name to what is experienced between a client and therapist.

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It is important to get back to the story of the survivor. It must be told to be integrated. For the therapist not to listen is a secondary traumatization. It is very important to listen. I would like to read one short quotation from Terence Des Pres: "to hear him is met by the need to ignore him"—to join the "conspiracy of silence." Mourning, grief and loss are all part of recovery and without integration, healing is impossible. We need to encourage and incorporate healing, mourning, grief and loss. Each person has an internal need to be heard and to tell his story. It's not only their material needs so we want to have a holistic approach here. Ignoring significant aspects of a client's trauma is hurtful and disrespectful. We need to create a holding environment, and I hope we can go in that direction in the future.

[Resistance would include] if the therapist forgot something the client told them, if they switched to another theme, if they felt bored with the same story over and over. The therapist may feel guilt also because they didn't suffer like the client. This could lead to a dysfunctional position where the client would be encouraged to call at anytime, where the boundaries would get blurred.

...the powerfulness of the evil and tragedy that happened to the survivor, perhaps talking about it could be potentially shameful for the client. The survivor has the fear that the therapist will somehow not respond, or that they cannot bear the evil of the event that was experienced, and in different ways the therapist conveys that message.

It is very important to pay attention to the language that is used. For example, if a survivor talks about how his whole family was murdered and then the therapist uses the term "died" instead of murdered—this is a very important distinction that was missed!

If we see the person as a victim rather than a survivor, victim implies that nothing can be done or changed, and it denies the capacity of survival and the pre- and post-experiences of the person. This is just another way of avoiding reality.

And pain, if people did not feel pain or suffering, or didn't need help, they wouldn't come for help. To not address their pain would be not only disrespectful to them but also to those who have died.

Emil then finished the presentation and asked the staff to respond.

Claire: Well, my feelings about this...if we don't address basic material needs, what the clients need, then we are participating in the "conspiracy of silence."

Dr. Stein: What do you mean?

Claire: Material needs are a priority. If they are hungry, you cannot tell them, "What about your trauma?" They need first to learn to trust you.

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Dr. Stein: This is what Judith Herman says about the first need of a client is to establish safety. Once that is addressed then you can move on to remembering, mourning and reconnection.

Marie: May I say something? There is a gentleman from my country, who said to me, "A lot has happened to me and I will tell you about it someday. But first I must get a job. Then I will tell you." I told him, "I am here for you." I picked him up at the train station, and provided him with a good quiet place to speak and feel comfortable. This is what we have been doing throughout, and just because I am from this man's country doesn't mean I am an expert. We don't want to tell them we know they have "feelings."

Claire: Yes, if anything, we have provided a very conducive climate for the clients to open up. It is genuine and comes from the heart.

Dr. Stein:...You need to discover the client's hierarchy of needs... And also, it's different for each person because some people want to talk, they really need to talk. And they need to know that you are going to be able to listen to them, and they need to have that trust before they can do other things. But then some people need to take care of some things like getting a job to feel grounded. They need to feel grounded before they can talk about some of the more painful things. And even when they talk about it, it can be overwhelming for them and they need to go back and ground themselves.

The staff discussion continued in the same vein, with Emil and Ed debating with Marie

and Claire about the definition of psychosocial intervention and about how they approach

the work that they do at the Haven.

Ed: Yeah, and I would add that the flipside, you know, of somebody who is telling you that they are hungry and you are telling them you want them to talk about their pain, their trauma, is, you know, having a scenario of someone who wants to talk about their pain and you want to get them some food you know...

Claire: Yeah, but I think that's a really unlikely scenario.

Ed: [Talking over Claire] You know, "I want to talk with you about my pain" but you saying "I want to get you a job." OK, do you see what I am saying, you can miss, it's like two ships passing in the night.

Claire: Yes, yes of course and we know that this is an issue for resettlement agencies for lack of time because the resettlement worker has no time, he's got to process cases and he cannot hear that. So that's what we do.

Ed: Right, right and as the person who has created this program, I have struggled with this point a lot, and the fact of the matter is that I have come to the conclusion that if, as Dr. Stein was saying, we don't treat people as individuals, OK, and we are not

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perceptively listening and you know we go in with any assumptions on our part about their needs, about the framework in which they are going to address their needs, we may miss some very critical things. I see the Haven as very much a marriage if you will of, you know, the more psychosocial vantage point as it were and you know this issue of how to work with trauma, OK, it's not that one takes precedence over the other but that there's a dialogue, there is an interplay between the two, very much so. So I have a question that's related to this, you know, do you buy it, what Danieli's talking about?

Claire: You know, I think you have to put it in context, this was written about 20 years ago and this was basically part of her graduate studies about Holocaust survivors but I think that now, I think we know now about treating them. I give her a lot of credit for that but I think that now it's a question of how to approach it, not what it is. You know for me it's like, wow, I cannot believe that people who call themselves therapists would not want to hear the story from a Holocaust survivor. You know I don't know who she did this research with.

I conclude the staff meeting with a remark by Dr. Stein:

Dr. Stein: Well, you know, there is a whole denial about trauma in general, not just in refugees, but in so many other areas, the denials and silences that exist in the mental health field.

Trauma, Memory, Narrative and the Conspiracy of Silence

The Haven does not have a set protocol for treatment, nor an over-arching theoretical orientation in regard to *trauma.* Instead, the program has embraced many, sometimes conflicting, assumptions about trauma that are part of the larger pool of knowledge in the torture treatment community. Certainly not all of these assumptions find their articulation in Danieli's work or in a book written by Judith Herman, to whom Dr. Stein referred above, as many also are derived from the latest biological research on PTSD, refugee mental health work, interdisciplinary scholarship on the Jewish Holocaust, and knowledge gained from the clients themselves who use psychosocial services. However, Herman's groundbreaking work on trauma, published in 1992, has become a virtual Bible to clinicians who treat survivors of domestic abuse and incest, as well as those who treat war veterans and survivors of political violence, and plays an

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important role in the American recovery movement. Dr. Stein's clinical approach was especially indebted to Herman's work in a direct way; for example, the recovery stages of "safety, remembering, mourning and reconnection" come directly from Herman's book. But many of Herman's ideas and vocabulary, which she herself may have also borrowed and adopted from others, have taken on a life of their own and been circulated and appropriated by many professionals (and also survivors) without reference to her or her book. For instance, Herman's recommendation that establishing "safety" should be the first step in treatment has become a commonplace notion in therapeutic practice. However, Herman's moral and political stance on "trauma and recovery" is perhaps a much more salient feature of her work than her clinical theories, and also one that many clinicians in this field, including Emil, would acknowledge informs their own sense of professional mission and methods. It is the moral and political position that Herman and other clinicians have taken which will guide the discussion.

With that said, there is, however, a set of clinical assumptions that Emil tacitly drew from in his presentation that should be briefly stated. It is commonly thought that traumatic events can break down the "psychological structures of the self—the image of the body, the internalized image of others, and the values and ideals that lend a person a sense of coherence and purpose" and also the "systems of attachment and meaning that link individual and community" (Herman 1992:51, 93). With trauma, survivors experience a "catastrophic loss of emotional control," a "massive loss of integrity," and "disruptions to their ongoing "symbolization" of life" (Silove et al 1991:482).[9] Although it is agreed that the traumatic event[10] registers differently than a normal event and

[9] Silove et al. noted that they were drawing from Robert J. Lifton in this passage.

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"becomes encoded in an abnormal form of memory" (Herman 1992:37), there is not consensus on how this happens, where the memory is located, or how to address it (see Chapter 6). But there is consensus about typical "symptoms," from intrusive ones, like flashbacks and nightmares; to avoidance symptoms, such as a "restricted range of affect"; to symptoms of "increased arousal" like sleep problems, hyper-vigilance, irritability, and the inability to concentrate (APA 1994:428). Furthermore, somatic complaints, alcoholism, and the perpetration of domestic abuse and other forms of violence are also thought to be signs of trauma and unresolved traumatic memory.

It is believed that troubling traumatic memories need to be brought out into the open and "processed," but in a manner and form that is qualitatively different from fragmented repetition or symbolic reenactment. Thus, there are two primary tasks of psychotherapy which build upon and reinforce one another. One is to enable the survivor to "speak of the unspeakable" by reconstructing and narrating the traumatic memory, thus transforming the memory and releasing the survivor from repetition and fragmentation and overwhelming feelings of guilt, shame, anger, and loss that haunt him. The other is to repair the "systems of attachment and meaning that link individual and community." Through the therapeutic alliance that is formed between the client and clinician, the client can regain a sense of trust and "safety." This can happen as a result of therapeutic interactions between the client and casemanager that are more psychologically-oriented and also by the delivery of services that meet social needs, like getting medical care for

[10] Herman and van der Kolk would make the distinction between complex trauma, and chronic trauma, and an isolated traumatic event. With complex trauma, such as repeated childhood sexual abuse or prolonged captivity, there may be more dissociation and lack of access to memories. Complex trauma also "invades and erodes the personality" whereas one traumatic event may not have such a dramatic impact (Herman 1992:86). However, childhood sexual abuse and imprisonment and torture are also very different forms of "chronic trauma" and have different effects and societal meanings.

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the client or community-building activities. In accomplishing these tasks, it is believed that the survivor can "work through" his trauma, put the past in its proper place in relation to the present, and hopefully create meaningful connections with others.

What Emil made clear in his presentation is that for him, the trauma story "must be told to be integrated." For Herman, too, telling the trauma is essential to the healing process: "[i]n the second stage of recovery, the survivor tells the story of the trauma. She tells it completely, in depth and in detail" (1992:174). The necessity of telling the story, "completely, in depth and in detail" echoes the RCT's original position on the trauma story, although Herman surely would not advocate the aggressive methods the RCT utilized. But it is not the methods or clinical theories regarding the trauma story that make it so consequential. Instead, it is the moral value and politicization of the trauma story that fuels its power. Telling the trauma story in a therapeutic setting is not just about an individual processing his traumatic memory, but is about breaking "the conspiracy of silence," a collective silence that, according to Danieli, allowed the traumatic event to occur, a silence that is complicit with domination, subjugation, and terror. If not broken, the "conspiracy of silence" allows violence to continue. Thus therapy with survivors of political violence is above all an intensely moral and political activity, where

> [t]he therapist is called upon to bear witness to a crime. She must affirm a position of solidarity with the victim. This does not mean a simplistic notion that the victim can do no wrong; rather, it involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice. This affirmation expresses itself in the therapist's daily practice, in her language, and above all her truth-telling without invasion or disguise (Herman 1992:135).

For the conspiracy of silence to be broken, the survivor must tell the story to a witness who, through listening, bears witness to the trauma of the survivor and the traumatic

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historical event. In Emil's opinion, when the casemanagers focus on meeting the social needs of clients at the supposed cost of the client telling the trauma story, they are participating in what amounts to an act of collusion insofar as the casemanagers are not performing their ethical duty to bear witness. The casemanagers are not just being "hurtful and disrespectful" or showing a lack of clinical competence, but are subjecting the clients to "secondary traumatization" and participating in the "conspiracy of silence." They join history in denying the truth of violence and the truth of human suffering. Denying the truth in this way not only harms the living, "but also...those who have died." In this regard, the responsibility of the casemanager to "bear witness" is rather extraordinary.[11]

Added to this responsibility are the perils of "countertransference." Emil's presentation discusses the prevailing notion that while treating survivors of political violence, the clinician must exercise extreme vigilance over countertransferential reactions because all kinds of "resistance" to the "powerfulness of the evil and tragedy that happened to the survivor" may arise. This is especially so because, as Herman writes, "Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as "traumatic countertransference" or "vicarious traumatization[12] (1992:140). Traumatic countertransference can lead to the

[11] In torture treatment, it is not unusual to have interpreters who participate in therapeutic interactions. At the time I conducted research at the Haven, the use of interpreters was not institutionalized. In Denmark, most clinicians were Danish and did not speak the languages their clients spoke and the use of interpreters was quite common. It was explained to me that the interpreters too play a role in witnessing. A Danish therapist said, "With the interpreter, there is a group of three. The interpreter becomes a witness that something is going on. In other societies you have rituals, the interpreter is part of the ritual of therapy and witnessing an unbearable situation. We are the ones doing something but the interpreter listens.

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therapist unwittingly identifying with the perpetrator and sadistically reenacting the victimization of the client, smothering and placating the client with kindness, taking on the role of "rescuer," losing confidence and feeling "helpless," or becoming overcome by anguish and despair (Ibid: 140-147). According to Herman, "traumatic transference and countertransference reactions are inevitable. Inevitably, too, these reactions interfere with the development of a good working relationship. Certain protections are required for the safety of both participants" (147). Søren Jensen, a Danish psychiatrist who commonly lectures to clinicians about working with survivors of political violence, also teaches that no matter how much clinical training and experience one has, working with trauma survivors "will affect you. You will have nightmares, flashbacks and all that, but this is part of life." What can make the contagion more bearable, he offers, is the understanding that what you are doing is "not just a job and that you are working in a context of human rights work."[13]

Key protections from destructive countertransferential reactions include an ongoing clinical supervision relationship where the counselor can "analyze" her feelings and reactions toward her clients, a regime of self-care practices like those described in Chapter 4 ("caring for the caretaker" as they say), and establishing what are called "good boundaries" with clients (Herman 1992:140-147). Good boundaries can be formed through written contracts between the counselor and client and by laying ground-rules about what the counselor can and will do with and for the client. Advanced training like

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[12] The metaphor of contagion persists in trauma discourses. For example, it is believed that trauma can be "transmitted" across generations. Some clinicians, such as Laurie Pearlman, reject the metaphors of contagion and would insist, for example, that vicarious traumatization is not a secondarily transmitted disease, but is rather an empathic encounter that changes us (see McCann and Pearlman 1990).

[13] Jensen spoke to this issue in a training he conducted at the "Trauma Studies" program in New York, March 2000.

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Emil's in-service would be considered another countertransference management technique. Finding greater purpose and transcendent meaning in the clinical work, as Jensen proposed, also protects the clinicians from destructive countertransference.

Though inevitable, if left unmanaged, countertransferential reactions constitute not just clinical failures but failures of witnessing, according to clinicians like Danieli and Emil. But there is a high price to pay for properly bearing witness. In the intersubjective space created in the act of telling and witnessing, the therapist needs to be both present and autonomous for containing and hearing the trauma, but also is required to undergo the effects of "contagion" herself and thus be identified with the trauma. Bearing witness to the trauma is as an act of sacrifice for the cause of truth, demanding a certain loss of identity through merging with the contagion. The therapist's sacrifice allows a transformation from personal suffering to a testimony of social injustice.

Bearing witness is also the responsibility of the client, and to bear witness the client must remember. Thus memory, enveloped in the therapeutic construct of the trauma story, is being explicitly invoked, which Lambek and Antze (1996) suggests announces a "crisis" in identity (xxi). They write, "When identity is not in question, neither is memory" (Ibid). Trauma is thought to rupture both the continuity (where continuity is associated with identity) of the self and the community. The rupture is enlarged by a lack of acknowledgement or denial by others about what happened, and also by the inability of the sufferer to acknowledge or bear witness to his own suffering. Memory then becomes the vehicle through which identity can be reinstated—the trauma story enables the flow between the past and present that trauma has blocked or disrupted. By telling the trauma story in a therapeutic setting, private trauma and personal memory

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are also connected with public and collective memory, enabling the client to reclaim his own position as witness to the truth of what happened and informing a collective identity constituted by a discourse of remembrance (Laub 1995).

The Testimony Method

This brings the discussion to a specific mode of the trauma story that was first "discovered" by accident. Chilean mental health professionals found that when torture victims recounted their stories for legal and political purposes, there was the added benefit of psychological improvement. A therapeutic technique called the "testimony method" was formalized in the late 1970s based on this observation.

The testimony method shares its roots with a specific literary and political genre of testimonial literature produced since the 1960s in Latin America. *Testimonio* has been described as a genre that gives voice to those who have been silenced, bears witness to the historical reality denied by oppressors, and offers some kind of political analysis and also hope for transformation in the future. Much of this literature has emerged out of revolution and periods of human rights violations. It is thought that the act of providing testimony transforms both the author and the collective, and also autobiography and history. In Latin America, women especially have made significant contributions to the development of testimony literature (Gugelberger and Kearney 1991).[14]

In the clinical context, victims of political repression provide a "detailed description of the events leading to their present state of suffering" which is tape-recorded, transcribed, and signed by the patient and his clinician/witness (Cienfuegos and Monelli 1982:48). Testimonies usually contain "fragmented chronological and affective

[14] I would like to thank Marc Edelman (personal communication) for informing me that the history of the testimony method is more complex and older than the clinical literature usually indicates.

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sequences" detailing detention, torture and the victim's pre-trauma history, which need to be told over a series of sessions. Telling and retelling all the fragments is necessary "...so that the traumatic experience may be integrated and understood in the context of the life of each individual" (Ibid). Part of this integration process was intended to enable the victim to repossess and perhaps reactivate the lost love "object" of his former political activism and social commitment (Ibid). In a research study implementing this method, it was found that all of the patients who were asked to agreed to participate, even with the knowledge that partaking in this experiment would probably mean feeling fear and anxiety, and also dredging up feelings such as shame and humiliation (Ibid).

The Chilean testimony method and the formation of Vietnam vets rap groups in the early 1970s represent some of the first instances where an explicit purpose of victim empowerment and political activism was integrated into the conventionally apolitical and neutral domain of talk therapy.[15] Beyond the healing effects for the individual, the testimony method was originally intended to help patients regain a sense of political commitment, to "create a document of historical value for future generations," and also to serve as a legal document. The actual written document functions, as Cienfuegos and Monelli state, as a portable and transferable "memory" (1982:49). It was reported to me by clinicians who use this method today that patients use the documents in different ways. Some want to rewrite the document as their "narrative" changes; some keep it in a drawer; others may hand it to people and say, "This is my story." [16]

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[15] There were also the feminist consciousness raising groups at this time, but psychiatrists or mental health experts did not necessarily lead them. They were more like "self-help" groups yet did have in common with these other therapy groups an explicit political purpose.

[16] As I got to know Slavenka, we talked about her past and what happened to her during the Bosnian war. It was very difficult for her to speak about this at times, and once she handed me a paper and said, "This is my story. If you want to know what happened to me, it's in there." She had handed me the letter of

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In subsequent years, the testimony method was appropriated and elaborated by Danish clinicians Inger Agger and Søren Jensen (1990, 1996; Agger 1993). In separate interviews with Agger and Jensen, each expressed the belief that the impulse to create a narrative out of suffering is a common human response ("it's deeply human," said Agger), and that the testimony method, used judiciously, with "proper guidelines" and in the context of an ongoing therapeutic relationship, can have definite therapeutic effects. Agger seemed to think, more than does Jensen, that the desire to provide testimony is a universal response to trauma, and that because of this it "takes care of the cross-cultural issue." By contrast, Jensen explained to me, "No one has worked systematically to see if testimony works cross-culturally. Political and more religious people seem to do better with testimony because we have found that they are more alike across cultures than compared to individuals within their culture." Agger and Jensen both suggested that perhaps one of the most important healing factors was not necessarily the narrative production, but the "symbolic" activity of externalizing and concretizing the memory on paper. The "memory" becomes an object under the power of its owner. Jensen described this process as "putting the evil on paper and getting rid of it. The person can then take the document under his arm, hand it to people, and reframe what happened by deciding what he wants to do with it." For both Agger and Jensen, creating a special ritual space for the testimony to be performed also gives it its potency (Agger 1993). Jensen explained that "telling the story by itself has no healing without the context" and that for it to have benefits, the testimony must be produced in a shared context of meaning.

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application she wrote to Ed for the casemanagement position at the Haven. Part of her "trauma story" was contained in this letter, which I suppose was included mostly to show why she would be qualified for the position: she was a refugee herself, and also her experiences led to her wanting to help others who had suffered similar experiences. The application letter functioned like a "testimony."

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When instructing new, young doctors in the psychiatry department in which he worked, Jensen described how he tells them to use "the testimony method if you can't do anything else because it creates order out of chaos."

More recently, a group of clinicians in Chicago who work with Bosnian Muslim refugees have employed the testimony method in clinical practice (Weine and Laub 1995; Weine et al. 1998). The leader of this team, Stevan Weine, co-authored an article from their work that deals with narrative, testimony, and historical reality with Dori Laub, a Holocaust survivor, trauma theorist and psychiatrist at Yale. The Weine and Laub collaboration adds an additional link between Holocaust discourses and trauma theory in torture treatment.[17]

Carefully laying out what they believe is the relationship between the individual and history from the perspective of client testimony, the authors of this article focus mostly on the clinician's important role in witnessing "historical reality" in the therapeutic domain. They are interested in how the clinician's participation in the activity of survivor testimony serves as a crucial link in connecting "an individual's personal story and a collective's history" (259).[18] According to these authors:

> Mental health professionals working with these survivors should develop a psychohistorical formulation that addresses: (1) the centrality of narrative of historical realities in the survivors' use of testimony; (2) the

[17] Dr. Stein's approach to "trauma" has been heavily influenced by Holocaust scholars and clinicians, and to the degree he has had a personal impact on shaping the clinical activities at the Haven, the Haven too has adopted some of the Holocaust discourse on trauma directly from him in addition to other sources of influence. However, the Haven has for the most part been an amalgamation of many influences, including the American recovery movement.

[18] Young (1995) discusses the relationship between individual memory and history in the therapeutic practices at the VA hospital: "Day in and day out, therapists labor to transmute the patient's collective memory, a thing that is located in historical events (to which the patients have privileged access), into individual memories, a thing situated in mental events (to which the therapists have privileged access." (221) What is different about the testimony method is that it takes this process one step further: the therapist then takes this individual memory and rejoins it with collective memory and history.

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> significance of survivors' narratives of historical realities as historical documentation; (3) the clinician functioning as a witnessing professional (258).

Thus in addition to having their countertransference reactions under rational control, these authors suggest that clinicians should also be correctly informed about the survivor's historical reality for greater therapeutic understanding, and also be able to perceive and act upon testimony as an important contributor to the documentation of "historical reality" (259). Clinicians should consider themselves moral and political agents in documenting history (and also in constructing history by preventing future violence), and not just actors in the "narrowing prisms of individual psychopathology and the psychotherapeutic dyad" (Weine et al 1998:1724). However, Weine and Laub explicitly disagree with Danieli's position that countertransferential reactions of "resistance" in effect deny the historical reality of traumatic events. They instead posit that "[c]linicians' shortcomings in adequately bearing witness to narratives...may be because they are not familiar enough with the therapeutic problems to have developed an appropriate treatment approach," i.e. the "psychohistorical" approach to therapeutic testimony they are promoting (258). Though these authors want to diminish the magnitude of Danieli's condemnation of therapists who exhibit resistance, a certain kind of moral responsibility is nonetheless placed on the clinician; Weine and Laub prescribe that the clinician should use "history" and professional authority as political tools for the prevention of future violence:

> In addition to providing a special kind of listening for the survivors, the witnessing professionals will also function as witnesses themselves, by using their professional knowledge, skills, authority, and connections, to actively transmit the knowledge of historical realities to others. Witnessing professionals believe that their professional responsibility includes the

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> prevention of mass trauma from state-sponsored violence through encouraging appropriate actions (259-260).

Weine and Laub, Danieli, Herman, and Emil share the belief that bearing witness and transmitting the knowledge of historical reality to others can halt future conflict and repression. This belief resonates in the post-Holocaust mantra, "Never again."

According to Weine and Laub, despite the testimony's unique capacity for producing historical truth, it is also subject to "distortions" and "myth, revisionism and ignorance"(251). For example, the authors described how Bosnian survivors spoke about "ancient ethnic hatreds," a myth that they assert is a "defensive strategy that relegates current disturbing events to past history so that the starkness of the current reality does not have to be faced. The myth of ancient hatreds acts as a way of absolving the perpetrators and the complacent bystanders from moral responsibility" (249). To remedy the distortions created in this myth, the clinician "should set an appropriate frame for receiving the survivor's testimony" (258). This would include, in the case of the "myth of ancient hatreds," to know that in fact "until recently Bosnia-Herzegovina was a relatively successful mix of different ethnicities and religions" (249) because with this knowledge, "the clinician is better positioned to help the survivor deal with his total betrayal by people once trusted, and with the traumatic loss of sharing in multiethnic community, culture, tradition, and history" (259). Weine and Laub recommend that the clinician should be aware of her own unquestioned acceptance of myths like this, and that she should consult other sources of historical documentation, such as journalistic and scholarly accounts, and other testimonies to gain a more fair and accurate description of

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historical reality.[19] Clinicians must however be aware of "pseudohistorical journalistic writings" that oversimplify the historical reality and may in fact be propaganda disguised as historical truth (250).

Implications of the Trauma Story

The Haven does not employ the testimony method although this does not mean that the program would not at some point adopt it. Many of the theoretical, political, and moral beliefs that underpin the testimony method are attached to practices of the "trauma story" instead. Yet when the performance of the trauma story became a demand and focus of service provision at the Haven, a number of different problems arose. Four of these, described below, also deserve attention for the broader implications they present for the global project of torture treatment.

1) *Trauma, Professionalization and Expert Knowledge*

First, that clients are "traumatized" when they suffer traumatic events is an assumption that has been disputed. (Summerfield 1995, 1996, 1997, 1998, 1999; Silove et al 1991; Bracken and Petty 1998) If clients are not traumatized, the logic goes, then why must they tell the trauma story? Emil would argue that most of the clients by virtue of their refugeeness have indeed been "traumatized" in some way, either from their past or their present circumstances, and that they wouldn't be asking for "help" at the Haven if they were not in some kind of psychic pain, even if the help the clients ask for is in addressing social needs. In this context, by stating that someone has been "traumatized"

[19] An interesting "distortion" that Weine and Laub observed was how many clinicians saw the ethnic cleansing in Bosnia as a repeat of the Jewish Holocaust. These authors caution that this association distorts the specificities of historical reality. Weine and Laub also note how the Serbs mobilized their past victimization at the hands of Croatian Nazi collaborators to justify their present acts of violence. Invoking the Holocaust and Nazism has become a strategy in the discourses of victimization and rights in many American contexts as well.

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or in speaking about the "trauma story," Emil has set a whole discourse and chain of associations into motion.

The construct of "trauma" implies a certain kind of expert understanding of suffering; trauma is a medico-psychological term which organizes a collection of assumptions and practices, many of which have been described in this study, that Emil and usually more educated Western clinical professionals accept and reproduce. Dr. Stein exemplifies the model of a professional expert who consumes and produces medico-psychological trauma discourses. Not only did the word "trauma" drop from his lips with routine frequency, but he was a member of a group of elite professionals who establish interdisciplinary trauma studies programs and psychosocial programs for trauma survivors, and who write articles for peer-reviewed journals and present papers at professional conferences on trauma. These discourses are also supported by elite professionals such as journalists and social scientists whose role has sometimes been to question the underlying suppositions and practices of what has been called the "trauma industry" (Killen 2000). As Summerfield observed, trauma discourses are not, however, the sole province of expert knowledge and professionals—they have found their way into collective life in Western society and hence find themselves naturalized by broader cultural practice of their assumptions. A "vocabulary of distress" and ways in which people experience distress have come to be dominated by the discourses of trauma, especially in the United States (Summerfield 1999:1449).

Marie and the other bicultural casemanagers at the Haven usually did not speak the language of trauma theory with their clients, or in professional settings like staff meetings with their colleagues, even after receiving training at the Trauma Studies

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program and in-service trainings like Emil's presentation. Their dealings with clients were less configured by specific technical aspects of expert trauma discourses than by practical experience; the Haven's local rules and practices (many of which were centered upon an anti-medical model approach that would in fact be critical of "medicalizing" suffering), and their own respective cultural backgrounds. Claire presented a slightly different case because she was on the clinical track in her graduate training program and also because she herself was not a bicultural counselor.

In the staff meeting introduced earlier, both Claire and Marie rejected Emil's presumption that they were somehow denying clients the professional/ethical space to tell their trauma stories. On the contrary, as Claire said, "if anything, we have provided a very conducive climate for the clients to open up. It is genuine and comes from the heart." "I picked him up at the train station, and provided him with a good quiet place to speak and feel comfortable," Marie said. "This is what we have been doing throughout, and just because I am from this man's country doesn't mean I am an expert. We don't want to tell them we know they have feelings."[20] At a later point in the staff meeting, Claire spoke further to these matters:

> But you know, what I have found we are given so many treatment approaches. Dr van der Kolk, you know, he is a psychiatrist and neurobiologist, and he said the other day that some people cannot talk about it and talking therapy is of no use because it has affected the Broca. And then I hear of some people saying flooding is the best and then another one saying the eye thing is a fantastic way. You know, we are loaded with different approaches for miracle treatments and we don't even know what is the best, so in the end I am personally feeling confused. My approach is to listen and to try to respond to the client. I don't think that I am a therapist. I am not a therapist but a psychosocial counselor. I will respond to the social, concretely, and I have an ear and compassion.

[20] Marie is referring to the idea that bicultural counselors have some kind of special expertise. On the one hand, the bicultural model espouses the idea that a member of a certain refugee group or cultural community potentially has a better understanding of that group or community. On the other hand, this idea has also been questioned, especially in light of the fact that "expertise" in general is thought to hierarchize and disempower.

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That is the way I define my job. When I feel that just having an ear and compassion doesn't help, I will try to find another way to help.

It appeared that part of what Claire and Marie were responding to was a certain sort of professionalization of suffering and healing. They asserted that openness, genuineness, and empathy could guide their work and that sophisticated Western expertise on trauma was not necessarily better. This did not mean that they were completely adverse to referring clients to a psychiatrist or another trained clinician if they thought their clients could benefit from the services those professionals were trained to provide. Rather, they questioned the view that clients should be approached with an arsenal of psychological techniques and with the presumption that clients were "traumatized." They also seemed to be questioning certain notions that are presupposed by trauma expertise, but supposedly critiqued by the Haven ideology: that the one serving the client knows better than the client, or that the counselor is in some kind of superior, active position to the more passive and ignorant position of the client. Marie remarked at one point during the staff meeting:

Yes, and you know when clients come to our office they look at that and observe whatever we do, they assess as we also assess and we have to be very careful of our plans and strategy. We should always respect them and go according to their needs and must respect the client's capacity. We observe the clients' gestures, the ideas that come from them. They also do the same thing...[laughter from the group] ...They just do assess us, and we have to be very careful of this.

In speaking with clinicians in Copenhagen who have worked with torture survivors for many years, I found they felt uncertain about the role of expert trauma theory in the relationships they built with clients. A few seasoned clinicians offered the possibility, similar to Claire and Marie, that perhaps simply being a good listener and a decent, empathic person with some knowledge of what the client may have experienced had

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more therapeutic value than any highly technical trauma interventions. Yet at the same time, these clinicians were not willing to dismiss their expert trauma theory or professional authority. A mixture of skepticism, pragmatism and political commitment sustained their clinical practice. As one clinician said to me, "Between us, don't tell anybody this, but I think it is the quality of the relationship, and because of your knowledge of post-traumatic stress and of how ordinary human decency has been violated, you treat this person in a certain way. I think this is the most common healing factor. And then on top of this may come, for some people, the integrating of the trauma." A former clinician who now considers herself a sociologist was convinced that therapeutic trauma interventions, like psychotherapy, are culturally relative and work by the same mechanisms as other successful healing rituals. Certain universal "healing factors" have more significance than the details of all the culturally different variations and techniques; for the person to "believe" in the healing power of a technique was, according to this expert, the most important factor. She said,

> I do very much agree with the Kleinman perspective. What works are the same fundamental factors so what we call psychotherapy here is our indigenous method. So if people don't believe in it, it doesn't work. To apply our method to people who don't know about it or haven't heard about it, it probably won't work. The types of "psychotherapy" that are carried out in traditional healing rituals are just as good and work just as well and are just as therapeutic.

Two other Danish clinicians, Erik and Lone, suggested that the interventions the torture treatment field has developed may not be the best approaches. They both believed that this was, however, an empirical question, and that with more research, such as research on treatment outcomes, it was possible that treatment could be improved. "I am open to almost anything," Erik said, "maybe even that what we are doing doesn't really help. There is very little documentation or research on what we do."

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A largely unanswerable set of questions, but some of the most important ones, remain. Clients might not think of or relate to their casemanagers or therapists as specially trained clinicians in trauma theory, but more as friends and family members. For instance, many of Marie's clients relate to her as if she is an aunt, sister, or granddaughter, and call her by those names. That sense of "kinship" probably does not come so much from the concrete services she helps them receive, or from therapeutic techniques she employs, but from a certain agreed upon way of relating that draws upon cultural sources other than the "cultures" of social service or therapy.[21] Thus, if Marie refuses to take a position as a trauma expert and her clients do not regard her as such, what does it mean for them to tell her about their suffering and what has happened to them? Are they telling her their "trauma story" or something else? Is she being the properly witnessing professional she should be? When does the "deeply human" response to violence, the speaking of suffering and injustice, become the "trauma story?" When does listening to someone and helping him become "therapeutic?"

2) The Trauma Story: to speak or not to speak, when and if ever

During the Haven staff meeting, Dr. Stein reiterated some points that were common knowledge for the casemanagers:

> It's different for each person because some people want to talk; they really need to talk. And they need to know that you are going to be able to listen to them, and they need to have that trust before they can do other things. But then some people need to take care of some things like getting a job to feel grounded. They need to feel grounded before they can talk about some of the more painful things. And even when they talk about it, it can be overwhelming for them, and they need to go back and ground themselves.

[21] In Chapter Three, I described how two of Marie's clients regarded her as a granddaughter. Another client differentiated between Claire, who was his "friend" and a psychologist who he saw who was not a friend but a psychologist. Thus the relationships that are constructed between clinicians and clients are not necessarily strictly clinical and can be fluidly defined.

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Dr. Stein described how each person that counselors may encounter differs in the timing of the trauma story and the degree of "trust" the client feels. The barometer of trust is closely aligned with that of "safety" (Herman 1991). Some clients "really need to talk" before they can address other matters in their lives. Sometimes, the casemanagers explained, even in the first meeting the client will tell the casemanager his trauma story, and also reveal that what he has told he has never told to anyone else before. In the United States, clients may be accustomed to being treated as administrative categories, where it is not that the professionals who process their cases lack compassion, but that they do not have the time or resources simply to talk and listen. This is true also for refugees in Denmark. One Danish psychologist described how for some clients meeting with a clinician can have remarkable effects because "...for many people this is the first time that an official Dane asked them, "how is your life? How are things going?"

Some clients take a longer period of time to feel a sufficient amount of trust with their casemanagers to tell the trauma story. Trust can be fostered by the casemanager's demonstration of responsiveness to the person's psychological and social needs. Some clients must first take care of social needs, "like getting a job" before they can "feel grounded" enough to tell their trauma story. The last situation was the case for Marie's client, who said to her, "A lot has happened to me and I will tell you about it someday. But first I must get a job. Then I will tell you."

It is assumed that the client has a trauma story that is not about his present circumstances but his past; that he will tell the story when he feels ready; and that the clinician has the professional responsibility to manage the trauma story for him. The clinician is responsible for providing an atmosphere that will elicit the story, but not force

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it, and also for controlling the telling of the story so the client does not become "overwhelmed." Clinicians are instructed to perform a technique called "triation." Dr. Stein explained that this means monitoring the "doses" of the trauma story, as if it were a kind of medicine. Clients "need to deal with the trauma event in small, just small doses so they can integrate it because if they just talk about the whole thing they can become overwhelmed...and dysfunctional and depressed." Generally, it is agreed that the more the trauma story is narrated, the better.

However, there is the danger that if certain conditions are present, the client may produce an invalid or non-therapeutic trauma story: "If patients feel under pressure to reveal their traumatic histories, they may recount the details of the torture in a mechanical and seemingly emotionless and detached manner" (Silove et al 1991: 487). It is the job of the counselor not to "pressure" the clients to tell their trauma story, and also, it seems, to be able to detect when the telling of the trauma story is not transformative or therapeutic. Certain kinds of emotional expressiveness that accompany the telling of the trauma story are thought to indicate therapeutic authenticity.[22] The importance of linking a set of appropriate emotional expressions to the trauma story is a subset of the general maxim that linking affect with cognition is one of the most essential conditions for psychotherapeutic transformation.

Torture treatment clinicians have claimed that the demand for telling the trauma story places too much emphasis on past traumatic events when the client's present circumstances may be more relevant and equally or even more traumatic than past

[22] In handling asylum cases, legal representatives may sometimes coach asylum seekers about how they should emote in ways that will be most convincing to the INS judge. If asylum seekers do not emote in a proper manner, the judge may doubt the credibility of their stories. This is true even when the legal

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traumatic events (Silove et al 1991). Trauma, it is argued, should be conceived of as "continuous" rather than "post;" this would not only describe more accurately the experience of clients, but may also orient the clinician away from a more narrow psychological view of trauma to the social and political conditions of the client's present life (Ibid: 485). Silove et al. (1991) suggest that the clinician should not presume to know what has been most traumatic or significant for a survivor of political violence, or what any particular experience, such as torture, has meant to him. Other clinicians and researchers like Bessel van der Kolk suggest that telling the trauma story may not be a therapeutic possibility for some clients until trauma has been dislodged from or processed through their bodies. In addition, some clinicians assert that not all clients should tell their trauma stories because to do so could be psychologically destructive rather than healing, or that it simply is not necessary, i.e., that a person, even after suffering atrocities, is not "traumatized" and can make a life for himself without telling his trauma story:

> It is important to recognize therefore that while all survivors of torture or organized persecution are compelled to make an adaptation to their traumatic experiences, many are able to do so without necessarily incurring chronic psychiatric morbidity...Some survivors create a system of defences which, although fragile, supports them through most of their lives. All they may need at times of stress when their "armour" is penetrated is to receive brief but well focussed help to repair it. Horowitz has pointed out that some victims of overwhelming disaster are irreversibly damaged, so that recounting the trauma story only serves to relive the horror rather than to overcome it. Levi, who committed much of his life to examining his personal experiences as an Auschwitz survivor, concluded that those who experienced imprisonment (in Auschwitz), and, more generally, all persons who have gone through harsh experiences, are divided into two distinct categories: those who remain silent and those who speak (Silove et al. 1991:488).

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representatives explain to the judge that numbness and detachment may in fact be significant indicators that that person has been traumatized.

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Primo Levi's pronouncement provokes thought because it is not confined by the discourses of therapeutic normativity. He speaks from the position of one who survived horror, suggesting that categories, rules, judgments, or demands, such as the idea that one *should* do something with one's traumatic experience like tell the trauma story, are inapplicable, irrelevant or meaningless. Surviving atrocity places a person in a world separate from others, where one only has two choices, if these even can be considered choices: to remain silent or to speak.

Some clinicians believe that telling the trauma story in a therapeutic setting is *culturally* inappropriate for some clients. Further, there is an important gender dimension involved. With the war in Bosnia, using rape as a direct weapon of war resulted in many rape victims many of whom did not want to speak about their experiences despite the encouragement of Western mental health professionals. For some of these women, the shame of their rape was something they could bear better than the emotional and social consequences of sharing their stories of being raped.[23] Agger (1993) describes her experiences working with refugee women who have been raped, tortured, and suffered other forms of violence, and argues for the necessity of co-creating a new cultural space where telling the story is permitted.

Below, a Danish therapist speaks to gender issues, and explains that whether or not to tell the trauma story could also be based on what she called "cultural philosophy":

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[23] The issue of shame takes many forms. In a talk given at the Trauma Studies center in New York, "Dr. Jergen" described how torture survivors may be able to tell the story of their torture, but the most painful area of shame for them is in how they ended up "talking" to the torturers. Some torture survivors would almost rather die than admit that they had been broken by torture and denounced and betrayed best friends and family members. Dr. Stein then explained that political activists in regimes of terror in Latin American knew that if captured, their fellow activists would probably betray them, so there were plans in place to accommodate that probability. According to Dr. Stein, handbooks were also created and passed around that instructed political activists on what to do when arrested and tortured. For example, they were

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With Arabic people, what's unsaid hasn't happened. Women don't tell about rapes because when you tell about it it becomes real and the shame and all that happens. Peter Elsass, a professor of psychology here in Copenhagen writes about this. It has been a big challenge for psychologists and the tradition. All the ways around the trauma. It ends up that the clients do tell but it's not the idea that telling is the relief but that something else is happening even though I don't know what. But if you are Christian and tell your sins, then everything is fine. Then of course the telling is helpful.

This therapist also suggests that:

Some people also don't want to talk because to forget is better. And this is psychologically true. It's not good to always remember everything that's happened, but maybe when the memories are troubling you there are problems.

By saying to "forget is better," perhaps this therapist means that to a certain extent, living life after experiencing atrocity can only happen with some sort of forgetting, and remembering always entails some forms of forgetting. This therapist does not seem to be attaching the kind of moral or political value to telling the trauma story that others have prescribed. I am left wondering about what forgetting can mean in the wake of political violence and atrocity. Can we imagine forgetting in ways that don't mean denying or disavowing? What could it mean for a collectivity to forget? Who can decide what should be remembered and what should be forgotten? Can we think of forgetting without some idea of the "return of the repressed" or the idea that the trauma will always return? Can we disentangle forgetting from the need for justice and accountability?

For the most part, clinicians in the field of torture treatment do not actively chase the trauma story in the therapeutic relationship, but let the clients talk about what they want and then respond to what the clients say and need. Some clients talk almost exclusively about their present life concerns, such as their worries about family members back home who are still in danger, or about practical matters like finding gainful

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instructed on how to fake the motions of being electrocuted. Dr. Jergen felt that these retrospective stories of organized resistance make things seem much more organized than they really were.

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employment. For some clinicians, this can be a satisfactory therapeutic course. In the case of the Haven, because the casemanagers' work was simultaneously geared toward providing supportive counseling *and* helping their clients meet social needs, there was more room for the possibility that the clients may not tell the trauma story. Nonetheless, Emil would insist that there should be room enough. Isabela described how some clients were not interested in receiving the psychological services the program offers and may not, therefore, be inclined to share their trauma story in a therapeutically transformative manner:

> Well, I think my last month's three cases they all came in wanting legal. At that moment they don't come in thinking about anything else except "I want asylum, I want asylum," that's it, that's it and sometimes you try to explain to them, you know, you can work on the asylum. It's a long process, and then after that we can continue together and you can have supportive counseling. They say, "Oh, I don't want that, I just want asylum, I just want to work on my asylum." And that's it. In the past I kept some cases open and tried to work with them, but once they have what they want, they just walk off and don't look back.

However, as the Haven staff meeting illustrated, while the Haven maintained a critical position on practices that overemphasize the psychological aspects of individual functioning, and followed the program mandate that service provision is defined by what the clients say they need, the trauma story was retained as an important potential facet of treatment. So, while Isabela had been taught to follow the needs expressed by the client, and for some clients that may mean their need for asylum, she was also caught in a bind. She may have failed to issue a proper therapeutic invitation to these clients, a failure which could signify her own unconscious resistance to their trauma.

For professionals who provide more intensive psychotherapy with survivors of torture and refugee trauma than the kind of supportive counseling the casemanagers at the

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Haven provide, the trauma story's centrality is maintained, even as its therapeutic necessity is being questioned. A Danish therapist summed up the typical situation for a clinician today in the field of torture treatment that brings together many of the contradictions and ambiguities already covered, including a sense of uncertainty about whether the absence of the trauma story signifies some kind of therapeutic failure. Here is an excerpt from our interview:

SM: The idea of needing to go to the trauma story was never an idea at our program. You could go back but you should titrate it very carefully and not overwhelm the person. So there is some principle that we do agree upon in this house: don't overwhelm the person with the traumatic material. Go slow and sort of soft.

KM: Do you think that the goal is the same, that the trauma needs to be talked about in some way or experienced again in some way to be integrated?

SM: The last thing does not necessarily mean it has to be talked about. There has to be some process, in some way or another, in some ways with words and in another ways on a physical and experiential level, but some processing does have to take place. For these people, their inner world is so chaotic and painful so to be successful you need to help them modulate their inner states in a more efficient way so they can sleep more better, or whatever.

KM: And what about their present day traumas?

SM: It could be interesting to count how many sentences are their present day and how many are the other. A lot of work is helping client establish themselves here in a safe and secure way. That is the ground for everything else. So you shouldn't go into traumatic situation until you handle that first. Sometimes we will never go back to the traumatic material. You can never be sure. You are always feeling that insecurity though that if you don't go back to the traumatic material, is that in the interest of the client or yourself? You will always have the position of not knowing and try to be open as possible to what you feel intuitively would be the best path for the client and it's more or less following after the client. Few of us would take chances on this because you don't want to run the risk of the person to leave the room in a psychotic state. This is not an exaggeration but a real risk. So the work here will be more so that the person feels grounded in his own body and grounded in a way so he can handle things.

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3) Truth and Memory

In Western society, memory often is defined or evaluated along the poles of whether it is "accurate or inaccurate" (Lambek 1996:238). As Lambek suggests, it is difficult for us to conceive of memory in other terms such as "subtle, tactful or reasonable, well or poorly crafted, elegantly or clumsily performed...justified or unjustified" (Ibid). Many scholars, such as Obesekeyere (1981), Lambek and Antze (1996), and Kirmayer (1996), to name just a few, have suggested that framing memory along the accurate/inaccurate poles reflects a tendency in Western culture to deny the role of fantasy or the imagination in many cultural practices including, as Kirmayer pointed out, formulations about "psychological development." Lambek and Antze describe what they call these "literalist" interpretations of memory as a kind of "assault on fantasy" (1996:xxviii). These authors claim that, however, it is not simply the case that fantasy is denied or "suppressed" in contemporary Western society as Obesekeyere maintains, but that fantasy is "actively distorted by being treated as though it were literal." "Acknowledged fantasy, of course," they write, "is far from absent in North America, but its production is largely monopolized by the mass media and circulated in commoditized forms" (Ibid:xxxiv).

The accurate/inaccurate dichotomy has generated moral precepts and boundaries, where doubting the "accuracy" of memory/testimony of survivors of any kind of violence is indeed tantamount to joining the conspiracy of silence as Danieli has argued. Memory debates structured around all different kinds of trauma have become rigidly polarized and volatile; there is perhaps no better example of this in North America than the politics surrounding memories of childhood sexual abuse, where survivors and their advocates

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have pitted themselves against groups that question so-called recovered memories (Hacking 1995).[24] For survivors of torture and refugee trauma, the stakes are also high. It has been suggested that

> [o]ne of the fundamental fears experienced by survivors of torture and organized violence, both at the time of the trauma, but even long thereafter, is that their stories will not be fully comprehended or worse still, that their testimony will not be believed (Silove et al. 1991: 488).

This fear is itself a form of terror, which becomes realized when in fact people sometimes do not believe the horrors that survivors describe. The doubt and fear that survivors feel when they imagine the reception of their trauma stories can be compounded when official truth, such as the truth of the state or dictatorship responsible for their torture, completely denies or negates their version of reality. Appeals to experience and to the veracity of memory may constitute perhaps some of the only means survivors have for communicating their suffering and demanding some kind of accountability for, or at least validation of, the violence committed against them, no matter how fragile or unstable those means may be. Memory's supposed accuracy lies in a social field where political agency for victims and their advocates is made possible. However, when the juridical discourses that compose this field, constructed as they are by certain notions that have to do with fact, evidence, and truth, are combined with therapeutic and psychological discourses that question memory's relationship to 'truth,' an unstable hybrid discourse is formed. The trauma story is caught in the webs of this hybrid discourse.

Ruth Leys, a historian of trauma, has taken on some of the contradictions, conflations and inconsistencies that arise when trauma is associated with an idea of literal

[24] Much has been written about Freud and his abandonment of the seduction theory that I will not reiterate here. For further references on this subject, see Leys (2000:19).

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memory (1996, 2000). In her recent book, *Trauma: A Genealogy* (2000), Leys provides a critical (and harsh) reading of the works of two influential trauma theorists, Caruth and van der Kolk. She takes on their claims about trauma, literal forms of memory, narrative and witnessing. Leys seems keenly intent on attacking Caruth whose post-structuralist work on trauma has been informed by van der Kolk's scientific theories and research findings on the topic. According to Leys's reading of Caruth, Caruth recognizes that trauma ruptures the possibility of representation; trauma is fundamentally incomprehensible, unreadable, inscrutable and inaccessible. However, the symptoms of psychic trauma, such as flashbacks or nightmares, are thought to be "literally and timelessly encapsulated in a special memory system" (254) as the trauma itself. These engravings or icons of external events are not representations, however, but exist unassimilated or symbolically integrated; hence they are outside history.

Again, according to Leys's reading of Caruth, in telling the trauma story, the testimony of the traumatized subject can only be languaged, but languaging the trauma entails a loss of the truth of the trauma. And, for the listener, the trauma itself can only be fully witnessed paradoxically "when the referential function of words begins to break down" (268). Then, it is not the record of the event that is witnessed, but instead the trauma itself is transmitted, thus maintaining the purity of the trauma. Leys remarks, "The transmission of the unrepresentable—a transmission imagined by Caruth as simultaneously an ineluctable process of infection and involving an ethical obligation on the part of the listener—therefore implicates those of us who were not there by making us, as Dori Laub has put it, participants and coowners of the traumatic event" (267-269). This is another version of the transmission, witnessing and contagion process described

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by Herman and Laub, and also thereby linked as well to the ethical rationales for telling the trauma story or using the testimony method put forth above.

One of the consequences of the reasoning that maintains a notion of trauma's "purity" such as Caruth's, is that trauma may take on a sublime or transcendent character. La Capra has described this as the "sacrilization" of trauma.[25] He writes, "I have speculated that the sublime may itself be construed as a secular displacement of the sacred in the form of a radically transcendent, inaccessible, unrepresentable other (including the alterity of radical evil) (2001:93). La Capra has explained that trauma has functioned to reoccupy the spaces left open by the absence of religion, and this has been true not only for trauma scholars but also for social groups for whom identity becomes founded on this idea. LaCapra's intervention into this discourse is to differentiate between "absence," a transhistorical and structural form of trauma, and those highly determinate events that entail memory and testimony which are historical forms of trauma. He claims that the transhistorical sense of "absence" often becomes confused with "loss" in psychic life, and similarly that the transhistorical and historical forms of trauma often become "transposed in fantasy." Anxieties, vulnerabilities, and the assumption of loss generated out of transhistorical absence are ascribed to other people (the enemy), myths of originary events, and ideas of true identity (or "being" or "truth" as LaCapra maintains) which in turn can fuel the kind of violence and traumatization that characterizes many political conflicts, such as the Israel/Palestine situation, or systems of social oppression familiar to all of us.

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[25] This is taken from an unpublished lecture LaCapra delivered at the CUNY Graduate Center, May 2002. Many of these ideas can be found in books LaCapra has published: *Writing History, Writing Trauma* (2001), *Representing the Holocaust: History, Theory, Trauma* (1984), *History and Memory after Auschwitz* (1994), and his forthcoming, *Between Witnessing and Testimony.*

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Bringing the discussion back to clinicians who treat survivors of torture and refugee trauma, the literal nature of memory upon which the trauma story rests is consumed by inconsistencies and contradictions paralleling Caruth and van der Kolk's theories. At the same time that memory is thought to be some kind of chronicle of an external event that a person experienced, clinicians also understand that memory is often not at all a faithfully recorded representation of the "truth" by an individual witness, but an ongoing construction of fantasy, feelings, and experience--a highly plastic and socially framed process. It is also understood that memory can be highly impressionistic with many gaps and holes, a highlight of certain experiences and an erasure of others, and that a lack of coherence in narrative memory (fragmentation, repression and dissociation) is indeed thought to be constitutive of traumatic memory. And returning to Weine and Laub who speak about how testimony should be used to construct historical reality, the purity of the historical reality from which testimony derives may in fact be tainted by distortions or myths.

Yet for both Weine and Laub, it appears that distortions or myths do not call into question the possibility of historical "truth," but that true historical reality can be rightfully revealed when one dutifully corrects these distortions and myths. The same is true for the "trauma story," for which its mutability does not threaten the integrity of the one true historical reality it represents or its potential resemblance to that reality—changes in memory are believed to be successive approximations toward a more accurate description of what really happened. It is assumed that with each change in the narration of the trauma story, adding bits and pieces, recovering fragments, etc., the fashioning of the story into an increasingly coherent narrative also means that it more and more

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resembles the external event. The fit between the memory and the event becomes even tighter when the story is put into chronological order. The cultural beliefs in the veracity of memory and in the singular truth of historical reality are constituted and reaffirmed together in this process.

In therapeutic practice, the contradictions produced within the accurate/inaccurate poles of memory do not compromise an Enlightenment faith in the possibility of truth and historical progress. The moral and political value of the trauma story's performance transcends the contradictions or ambiguities that evolve when the trauma story is associated with literal memory. According to Leys, underlying the trauma story's function as a testimony to historical reality and as a vehicle for bearing witness is

> ....a powerfully entrenched, if undertheorized, commitment to the redemptive authority of history—even if that commitment is tempered by an awareness of the difficulty of historical reconstruction. For Herman and for the modern "recovery movement" generally, even if the victim of trauma *could* be cured without obtaining historical insight into the origins of her distress, such a cure would not be morally acceptable. Rather she must be helped to speak the horrifying truth of her past—to "speak of the unspeakable"—because telling that truth to herself and others has not merely a personal therapeutic but a collective value as well. It is because personal testimony concerning the past is inherently political and collective that the narration of the remembered trauma is so important" (1996:123).

When the "commitment to the redemptive authority of history" becomes tied to the trauma story, the trauma story may become too closely aligned with accuracy, literalness and facticity. This consequence reflects what LaCapra has referred to as the "conflation between the traumatizing event and experience."[26] LaCapra suggests that trauma theory should keep the traumatizing event, experience, and memory "distinct but problematic."

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[26] From LaCapra's lecture at the CUNY Graduate Center, May 2002.

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Even with the explicitly acknowledged value placed on connecting the individual with the collective in torture treatment, the narration of the trauma story in the therapeutic setting at the same time enables what Mauss has described as the Western conceptualization of persons, "unique jural and moral persons bearing individual rights and responsibilities and each quite distinct from the other." (Antze and Lambek 1996:xxi). The trauma story potentially "places tremendous weight upon individuals to seek the sources of identity within themselves, via memory, albeit as shaped by collective narratives and the knowledge of experts" and can therefore function as a shaping vehicle for the jural person (Ibid). In the process of therapeutic transformation, memory in the form of the trauma story plays a role in eliciting certain forms of personhood, the jural person, which is culturally and socially specific. The construct of the jural person, in the West, finds reiteration in the construction of the legal concept of the person and citizen as well. Thus, the performance of the trauma story may indeed cut across cultural difference, but is also embedded in and derives its meaning from a context within Western countries of resettlement that conceptualize personhood and selfhood in culturally specific ways. These ways are also importantly connected to specific modes of governance.

Acts of rememberance, such as telling the trauma story, provide a transport to openness and new possibilities. But the practice of the trauma story may also affect a kind of closure for both the victim and the listener. The trauma story represents a cultural form that allows both "acting out and acting through" (La Capra 2001:36). Like flashbacks, the trauma story can become a memory that keeps the trauma alive through a kind of frozen repetition that is imprisoning, especially when the trauma story becomes

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linked with a particular identity of victimhood. By the same token, the trauma story can also be liberating and restorative, as it allows the survivor to receive recognition for what has happened to him, and releases the hold the past has on his present and future life. For the listener or the one who bears witness, the trauma story's contagion can overwhelm, excite or numb in ways that can result in something akin to "acting out" or the more positive, "acting through." For the witnessing professional, attention to countertransference and an ethical and political commitment pave the road for "acting through."

4) Fantasy, perpetrators, and victims

I interviewed a New York-based trauma expert, Martha Bragin, whose doctoral dissertation (book forthcoming) argues for the reintegration of fantasy and the unconscious in clinical treatment of trauma survivors (2000).[27] Using Kleinian psychoanalysis as a springboard for her thesis, Bragin claims that unconscious aggressive, rageful, sadistic, and destructive fantasies of the victims have been eliminated from most clinical practices of torture treatment and generally by the American recovery movement. According to Bragin, these aspects of human nature have become taboo (at least when talking about "innocent" victims) in the same way sexuality was taboo when Freud wrote about hysteria. Yet while "violence is everywhere" and publicly discussed, she writes, "its acknowledgement as a normal part of human psychological existence is little in evidence" (Ibid:1).

[27] Bragin has her doctorate in clinical social work, and has worked for many years in the juvenile justice system in the United States. She also has extensive experience working with survivors of political violence in psychosocial programs abroad, and in particular has been interested in the experiences of children. She believes that "working through" traumatic experience by addressing aggressive fantasy can be done cross-culturally and collectively through organized ritual and play.

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From these premises, Bragin has made many interesting claims. For instance, the guilt that many survivors experience may not simply derive from the fact that the victim survived whereas others did not, but because the violence experienced activates aggressive and "unforgivable" fantasies or memories of aggression. Similarly, she asserts that

> Exposure to extreme violence, rather than feeling overwhelmingly foreign, in fact feels frighteningly familiar to survivors. This sense of familiarity is the result of an unconscious awareness of similar material in phantasy early in life. Sights of death and dismemberment in particular, and scenarios of sadism and torture as well, represent enactments in the real world of the early aggressive phantasy that, according to Klein, is universal in human development and repressed by the end of the first year of life (9).

Bragin also argues that ignoring the complex interplay between the fantasies of the victim and external events results in rendering the victim passive and an object, rather than a subject, of historical events. Bragin's claims that we all have aggressive fantasies and the capacity for aggression call into question what LaCapra terms "the grid of victimization" that separates perpetrators from victims, and witnesses from bystanders.[28] Acknowledging the "commonality" of aggression breaks down artificial and compromised subject positions that have been perpetuated by some trauma discourses, such as the kind of sacrilizing of trauma that LaCapra described. The lack of recognition of fantasy, particularly aggressive fantasy, Bartok suggests, has resulted in moral and psychological absolutism and, I would add, sanctimoniousness on the part of some professionals and victims. Reflecting on countertransference is one technique that makes it possible for the aggression of the listener to be acknowledged, but the politicization of countertransference and the call to bear witness shifts therapeutic practice to another

[28] From LaCapra's 2002 lecture.

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register where the clinician becomes a "witnessing professional" and the client, a heroic and innocent survivor. The ideology that grids victimization in this way has been institutionalized in centers for survivors of torture and refugee trauma across the United States. In a consortium agreement, American centers have prohibited the treatment of "perpetrators."

For the PTSD treatment program that Young studied, it was assumed that the patients committed atrocities and that telling their trauma stories included speaking about the violence they perpetrated (1995). The Vietnam vets in the program were both victims and perpetrators. At the Haven, this kind of ambiguity or mixing of categories was not tolerated, and if the staff in the program felt that someone met the criteria of a "perpetrator," that person was referred elsewhere (although according to Emil this happened on only one or two occasions). When I asked him, "What about a soldier who committed atrocities but was also a victim himself?" he said that the Haven would not accept that person. On one occasion, the Haven was presented with a case that was not so clear-cut. The program decided in the end to treat this person, whose victimhood was established on the basis of the fact that he had been a "child" soldier.

Serbians who presented themselves as potential clients posed a rather sticky problem for the program because of the strong anti-Serbian sentiment there, but these individuals were accepted if they could establish that they were not directly involved in committing violent acts. One casemanager would not take on Serbian clients, and her position on this matter was for the most part accommodated by the program .

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Emil, protective of the Haven and his position there, was reluctant to say much more about this policy, but he did convey to me that he felt this policy reduced and simplified the complexity of reality.

Conclusion

Mirroring the clinical practices of torture treatment, this chapter revolved around the "trauma story." The discussion touched upon topics such as memory, history, and truth, but in closing, I want to return to what Agger called the "deeply human" response to suffering traumatic events. For the most part, individuals who become clients in psychosocial programs for survivors of torture and refugee trauma do in fact tell their "story" at some point or another, in some form or another, in a context where they feel heard and recognized by another person. Of the millions of people who have survived political violence, this study captures only a small sample, but I agree with the idea that the impulse to narrate or symbolize traumatic experience does run deep, as so it seems does the desire, at least in Western academe, to theorize about what that means.

The trauma story represents another therapeutic technique that aims to politicize medico-psychological discourses and to empower both the victims and the clinicians who treat them. It provides a framework for survivors to make sense of their suffering, to order their experience, and to connect their personal experiences of suffering with collective and historical processes. It also gives clinicians a way to move from paralyzing feelings of impotence, hopelessness, rage or sadness in the face of atrocity, horror, and abjection, to a place where their activities have moral and political significance, giving them a greater sense of efficacy and agency. However, with its productive and structuring capacities, the politicization of the trauma story has also entailed the foreclosure of other

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possibilities. As this discussion reveals, when a notion of literal memory is privileged, contradictions and problems beset therapeutic practices and theories. When literal memory is associated with a concept of trauma's purity, trauma may become sacrilized. The sacrilization of trauma conflates fantasy and external reality, and may result in producing a foundational, and perhaps ultimately destructive, source of identity. When therapists embrace the idea that their clients' stories are the literal representations of external events, and avoid the possibilities that the form of traumatic memories are derived also from fantasy, and more specifically from aggressive fantasy, the grid of victimization emerges, where innocence and guilt, good and evil, and victims and perpetrators are boldly and unambiguously rendered.

Some clinicians had hoped the trauma story could serve as a way to resolve the problem of cultural difference, but as this discussion illustrates, it does not accomplish this task. Telling the trauma story under the conditions and in the forms promoted in these therapeutic discourses does not work for everyone. The trauma story also represents another attempt to reduce the tension and the division between the individual and the collective, but in trying to do so demonstrates the embeddedness of these binaries in Western thinking and cultural practice.

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Conclusion

In this study, I have provided descriptions of the transnational production of expert knowledge and local analyses of clinical practices in New York and Copenhagen for a relatively new specialty in the psychological disciplines: the therapeutic treatment of survivors of torture and refugee trauma. The field of torture treatment has not been the subject of anthropological study to the best of my knowledge yet, as I have demonstrated, many of the internal critiques produced within this emerging field have been greatly influenced by anthropological theory and scholarship. What I have tried to argue in this discussion is that the critiques produced within the torture treatment field and within the discipline of anthropology, and specifically those critiques which evaluate "psy" in terms of subordination, domination, and agency, have been constituted with certain "governmental" strategies. Simply stated, these governmental strategies have to do with constructing "empowerment" and "self-determination" for individual selves and communities.

As I mentioned in the Introduction, a governmentality analysis such as the one I have created has been structured by those same governmental strategies. Nonetheless, I would posit that a governmentality analysis provides a perspective that can enhance anthropological scholarship by opening new lines of thinking and possibilities for analysis.

What has intrigued me about the field of torture treatment besides the new governmental alignments being formed between "psy," selves, and liberal democratic rule is how "psy" has had to address the problem of difference. The organizing feature for this new population of survivors of torture and refugee trauma is that its members have

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all endured some kind of political violence. It is also assumed that this population has suffered some kind of psychologically traumatic effects from that violence. Other than those similarities, the individuals composing this population are racially, ethnically, nationally and culturally diverse. Further, this population differs across gender, age, class, and sexual orientation lines, as well as the particularities of individual biography. As this study has shown, psychosocial programs for survivors of torture and refugee trauma have had to face the challenge of addressing difference, and in doing so have developed different strategies and techniques. To manage difference, "psy" expertise has instrumentalized "culture," defined service by "need," elaborated on techniques of the confession, and developed new "embodied" therapies, all of which also enjoin the subjects of intervention in their own empowerment.

Because of the heterogeneity of this population and also the political roots of its "pathology," I would posit that at a most practical level, "psy" has had to reflect upon and also transform its practices to help the people it intends to help, thus setting it apart from other "psy" specialties. By using the example of the field of torture treatment, I also want to suggest more generally that "psy" knowledges are practical, and that the power they distribute has a material nature, from inscription devices to bodily practices.

Certain related tensions exist in the production of expert knowledge about survivors of torture and refugee trauma. On the one hand, "psy's" positivistic basis allows universals to be perceived, measured and predicted. Criteria for PTSD, measures of social functioning, and culturally appropriate scales for depression and anxiety simultaneously provide evidence for and construct a scientific foundation for the assumption that some kind of traumatic stress follows exposure to political violence, and

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that the solutions are therefore different kinds of therapeutic interventions. On the other hand, the sheer diversity of the population, the political causes of trauma, and the resistance of therapeutic subjects to the "talking cure" have challenged the hegemony of Western positivism and the psychological idiom.

In addition, there is also the tension between the individual and the collective. The autonomous unit of the individual self is the primary focus of therapeutic intervention, at the same time "psy" expertise asserts that because political violence targets groups, the Western individual self is culturally relative, and "community-building" works best to address the effects of large-scale political violence, individualizing practices should be identified and avoided. Further, the tension between psychological needs and social needs in the torture treatment discourse continues to challenge the dominance of conventional psychological approaches. Many treatment programs that were once more "medically"-centered have increasingly incorporated social services in their treatment packages. The psychosocial model of intervention tries to bridge the psychological and social, but as the practices at the Haven illustrated, an uneasy alliance exists between these two "needs."

As I described in Chapter 6, in the past several years there has been growing interest in more "embodied" therapies, such as EMDR, eutony pedagogy, and ESM that both challenge and also complement the mainstays of treatment: talk therapy, addressing social needs, and community-building. It has become fairly standard clinical theory that "working through" trauma may require some kind of adjustment to the body to dislodge and process the trauma, and that embodied therapies can sometimes transcend the problem of cultural difference when talk therapy cannot. Future research might be done

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on how these "embodied" therapies intersect with existing models of treatment, and how evidence is being built to prove their efficacy.

It would also be fruitful for further research to look at how clients come to understand their suffering as they become therapeutic subjects, and how they relate these new understandings to the historical and social circumstances of their persecution and life circumstances.

Trauma and 9/11

After I had spent many months writing this dissertation, the terrorist attacks of September 11th happened. I suddenly felt that my whole study would be awkwardly demarcated by a pre- and post-9/11 reality. The shock, grief, and fear that others and I were experiencing did not prevent me from feeling a sense of urgency to enter the field again so I could study and document responses to the terror, and in particular the responses of psychological experts. From conversations I had with several clinical professionals in the New York City torture treatment community immediately after 9/11, I was aware that the local experts on trauma had quickly mobilized and were trying to organize mental health interventions. Many psychologists, social workers, psychiatrists, and counselors volunteered their services at Ground Zero, hospitals, schools, community centers, fire stations, and police stations, or went to hotels where surviving employees and family members of those employees who were killed in the World Trade Center were encouraged by their companies to congregate for mental health support. Some of the clinicians eventually were turned away because the ratio of clinicians to help seekers was so large. The best and worst sides of the "psy" profession were evident during this time. While many clinicians had the most sincere intentions, old rivalries and petty territorial

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feuds were inflamed, and I was told that trauma experts who have been featured in this present study fought each other for funding and authority in the name of helping the traumatized.

I also became aware that different refugee communities in New York were organizing to help themselves with the "retraumatization" they were experiencing because of the attacks, and at least one group had enlisted the assistance of mental health professionals. As I described in Chapter 2, shortly after the attacks the government started to round-up Muslim men (and some women) for questioning. There were also threats and hate crimes directed at different Middle Eastern and Muslim communities in New York, and mental health interventions were provided to these communities as well.

In the days, weeks, and months after 9/11, the mental health apparatus grew and was institutionalized. Officials made predictions about how many people in the population would experience PTSD, and what the long- and short-term effects would be from such an event. Needs assessments were conducted to garner federal funding, and New York mental health professionals estimated that 520,000 people would develop PTSD and another 3.1 million residents would experience "substantial emotional distress" (Goode and Eakin 2002). Two grants were funded by the Federal Emergency Management Agency (FEMA) for a total of $154.7 million for metropolitan area mental health support based on these estimates (Ibid). Research projects were quickly implemented, and I myself filled out questionnaires for two research studies designed to measure the psychological effects of the September 11th events.

Experts from the Oklahoma City bombing were called in to help with crisis intervention, as they had prior experience in handling such large-scale terrorist attacks,

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and mid-Western Red Cross volunteers worked side-by-side with New Yorkers in providing services to victims. Professional advice was dispensed through the television and other media informing everyday people about the signs of PTSD, how to prevent it, and how to talk to one's children about what happened. People who had never thought of going to a psychotherapist before sought counseling, and I can only imagine the increase in prescriptions that were written for anti-depressants or other psychopharmacological products.

The FEMA funding led to the establishment of "Project Liberty," a citywide program that provided free psychological services to anyone suffering distress from 9/11. The CCC was one of the leading agencies in the city managing Project Liberty, and I knew that the Haven had received some money from this project. Project Liberty's motto is "Feel free to feel better." When I first heard that on a public service announcement, I realized that so much of what I had written actually had great bearing on current events, and that it wasn't necessary for me to rush into the field with all the other social scientists trying to make sense of what happened. The project, name and motto linked freedom to nation and nationalism, citizenship, psychology, terror, and projects of the self. According to the Bush administration, liberty and freedom are what the enemy despises about our nation and wants to destroy, and to feel better was one way, besides shopping, that the common citizen could fight the enemy. Project Liberty's motto suggests that one should feel free to work on oneself to feel better, and working on the self also allows one to feel free. By practicing freedom, one is practicing responsible citizenship, and also participating in democracy. Further, the discourse of trauma and therapeutic recovery became a significant framework for understanding the events of September 11,th and

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political rhetoric was filled with a blend of therapeutic language, Biblical imagery and Christian prayer, and nationalism. I thus realized that the governmental configurations that I had described in this study were transforming and in turn being transformed by the social world, and that the events of September 11th provided support for the kind of analysis I tried to construct in this study rather than undermined it.

The issues that I raised in Chapters 6 and 7, which were concerned with the intersection of bodies, minds, trauma, memory and politics, could also have bearing on our post-9/11 world. What could make future study different is the fact that the terror of 9/11 was directed toward "us," and thus the relationship between the psychological professional, the victim, and the perpetrator would be different. The "grid of victimization" may appear in new variations, and this could have implications for the direction therapies take, the political position clinicians embrace, and practices of memory. I would also suggest that "psy" expertise has become part of the national security project, and has been and will continue to play a role in maintaining order, stability, and consensus with the increased militarization of the state.

Imminent future terrorist attacks and the war with Iraq will continue to change our perception of ourselves, our neighbors, and the rest of the world, in addition to our views on violence and civil rights. The issue of torture appeared in American public discourse after September 11th, and debates were raised about whether or not torture by law enforcement officials could be justified to extract information from terrorists. The fact that this question even arose was alarming, and demonstrates how perceptions of justified and unjustified violence can shift. Already, the American government is violating international law, as the United States often does, by torturing the prisoners of war held

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in Guantánomo Bay and by detaining other POW's in countries where torture is commonly practiced (Press 2003).

Lastly, as I mentioned in Chapter 2, the situation for refugees and asylum seekers will only grow worse if terror against the West continues, and if American hegemony and foreign policy based on unilateralism prevails. Borders will be tightened even further, and it is difficult to imagine that America's defense of democracy will truly improve the lives of those people who are oppressed and displaced. People will continue to risk their lives and even die crossing oceans, deserts and mountains fleeing from intolerable conditions.

Against this bleak scenario is another, which is about how the routine and mundane aspects of life continue, and that despite the state of the world, many Americans are busy making babies, working, buying new homes, shopping at the mall, watching TV, and eating fast food. I would suggest that the quotidian aspects of existence have been organized by "psy" perhaps even more so than the calamitous. That the clients seen in therapeutic programs for survivors of torture and refugee trauma need to see their own selves as the locus of agency and power, and that self-determination and empowerment are made possible by working on the self, simply demonstrates a certain therapeutic ethic that we all live by. We are all being enjoined to work on ourselves, and our self-practices reflexively enable the selves that we are. "Psy" furnishes techniques that allow us to consider and act upon ourselves as ongoing projects of improvement and autonomy. An intensification of certain self-practices, whether it be controlling and monitoring one's diet, going to the gym, or having more positive thoughts enables us to have more "freedom" from external control. Thus the techniques of self-work that the clients are

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taught include them in normative practices of independence, self-determination and responsibility.

I will conclude this study with a eulogy to three people who have died since I began writing it.

After returning to Bosnia, Slavenka began rebuilding her life again in her old home, and was even starting to reconcile with her husband. She kept in touch with Emil and Sanja, and I spoke with her on the phone when she made a visit to NYC to see her sons. She told me that things were improving, but she still did not know if she wanted to stay in Bosnia for the rest of her life. She laughingly told me to keep her in mind if she returned to New York and needed a job. In the spring of 2002, Slavenka was hanging her laundry out on her terrace in Bosnia when she had a stroke. She fell and did not regain consciousness before she died. She was 54 years old.

In May 2001, "Sister Brenda" was murdered in Guatemala. Her killers remain at large.

In the fall of 2002, Senator Paul Wellstone died in a plane crash. The cause of the crash has not been determined.

We cannot measure what impact on others these three made during their lives, but I feel that they all devoted themselves to helping others in some form. As I knew Slavenka personally, her death affected me the most. Emil called me to let me know what happened, and he was deeply shaken by the loss. So too were Slavenka's former clients. When I spoke with Emil and Claire about Slavenka, we all felt that somehow her death was precipitated by the trauma she endured. We felt that her suffering was in her body, that it had become *embodied*, and that it had exacted an irreversible toll on her. We also felt that she had been cheated of a bit of peace that she deserved after all that she had

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been through. I am grateful for knowing her, and am indebted to her for the many contributions she made to this study.

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Appendices

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APPENDIX I Intake/Assessment Forms

Name:_____ Date:_____
Interviewer:_____

Trauma History: (*When relevant, please include the date, duration, and place of the event*)

Reason for Torture: (1) ethnicity (2) gender (3) political opinion or party
(4) religion (5) other_____

Is participant experiencing ongoing separation from family members?

Did participant experience violence political imprisonment, jail, concentration camps, or reeducation camp?

Did participant experience physical violence by authorities or persons acting in official capacity?

Did participant witness violence against other persons (adults/children)?

Did participant see dead bodies?

Was participant forced to work against his/her will?

Did participant experience natural disasters?

Has participant experienced domestic violence?

Has participant experienced trauma since coming to the US?

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APPENDIX II

Name:_____ Date:_____
Interviewer:_____

Intake/Assessment Interview Part II

Symptomatology: (*Please circle all items mentioned by the participant*)

(1) Distressing memories of the event
(2) Feeling that event is reoccuring
(3) Nightmares related to the event
(4) Distress when presented with cues
(5) Physical reactivity to cues of the event
(6) Effort to avoid thoughts of the event
(7) Effort to avoid reminders (places, people)
(8) Forgetting keys aspects of event
(9) Restricted range of affect
(10) Feeling detached from others
(11) Decreased participation in significant activities
(12) Sense of foreshortened future
(13) Feelings of identity/personality change
(14) Sleep difficulties
(15) Memory/concentration difficulties
(16) Hypervigilance
(17) Irritability
(18) Exaggerated startled response
(19) Angry spells
(20) Helplessness
(21) Restlessness
(22) Shaking/Trembling
(23) Other_____

Types of Physical Sequelae: (*Please circle all items mentioned by the participant*)

(1) Broken bones
(2) Burns
(3) Disfiguration of body parts
(4) Increased skin sensitivity
(5) Joint pain
(6) Loss of body parts
(7) Loss of eye sight
(8) Loss of hearing
(9) Loss of skin sensitivity
(10) Malnutrition
(11) Scars
(12) Skin discoloration
(13) Other (specify)_____
_____

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APPENDIX III

Name:_____ Date:_____
Interviewer:_____

Types of Torture: *(Please circles all items mentioned by the participant)*

(1) Acid
(2) Alternating gentle/rough treatment
(3) Asphyxiation
(4) Beating
(5) Beating with batons
(6) Biting
(7) Blindfolding
(8) Bombing
(9) Burdening
(10) Burning
(11) Chili powder
(12) Cigarette burn
(13) Confinement in a small place
(14) Cutting
(15) Denial of privacy
(16) Dental maltreatment
(17) Electrical shocks
(18) Exposure to loud music
(19) Falanga
(20) Genital mutilation
(21) Gun shot
(22) Hair pulling
(23) Imprisonment
(24) Injection/pharmacological treatment
(25) Isolation
(26) Kicking
(27) Maltreatment of genitals
(28) Maltreatment of injuries
(29) Mock prosecution [sic]
(30) Mutilation
(31) Needling
(32) Prevention of personal hygiene
(33) Prevention of urination/defecation
(34) Prolonged forced position (standing, squatting, etc.)
(35) Rape/Sexual humiliation
(36) Rope bondage
(37) Sleep deprivation
(38) Starvation
(39) Strapping
(40) Stretching of body parts
(41) Submarino
(42) Suspension
(43) Threats against family/friends
(44) Threats of death
(45) Threats of future torture
(46) Walking on foreign bodies (broken glass, bullets, etc.)
(47) Water deprivation
(48) Water treatment
(49) Whipping
(50) Witnessing of others being tortured
(51) Work camps
(52) Others (specify)_____
_____

Means of Survival

What helped you survive? *(Please circle all items mentioned by participant)*

(1) Faith in a divinity/Religious beliefs
(2) Family
(3) Political beliefs/Commitment to a cause
(4) Will to survive
(5) Luck/Chance/Fate
(6) Anger/Desire for revenge
(7) Humor/Irony
(8) Emotional distancing/Escapism/ Dissociation
(9) Cooperation with torturers
(10) Deception of torturers (tricks, mind games, etc.)
(11) Other prisoners
(12) Physical exercise
(13) Other, please list _____
_____

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APPENDIX IV

Name:_____ Date:_____

Interviewer:_____

Service Plan
[See the instructions on the last page of this form]

Great Difficulty	Difficulty	Some Difficulty	Little Difficulty	No Difficulty
1	2	3	4	5

CULTURAL EXPECTATIONS OF COGNITIVE/EMOTIONAL FUNCTIONING
[For the first four blank items, use the items in the following subsections for specific cultural groups]

1._____	1	2	3	4	5
2._____	1	2	3	4	5
3._____	1	2	3	4	5
4._____	1	2	3	4	5
5. Ability to feel that one is doing well in life (self-esteem)*	1	2	3	4	5

FOR ETHIOPIANS:
1) Ability to engage socially with others [lack of isolation, withdrawal]
2) Ability to help others [being concerned and responsive to others' needs]
3) Ability to seek help from priests and/or elders
4) Ability to share one's problems with family, relatives, neighbors, or close friends

FOR LIBERIANS:
1) Ability to engage socially with others [lack of isolation, withdrawal]
2) Ability to discuss how one confronted the trauma [genuine sharing of one's trauma story]
3) Ability to seek comfort/rely upon one's religion
4) Ability to maintain familial love and closeness

FOR BOSNIANS:
1) Ability to engage socially with others [lack of isolation, withdrawal]
2) Ability to refrain from constant/excessive/compulsive discussion of trauma
3) Ability to joke about trauma ["Joking" can be an effective coping mechanism as it provides the necessary distancing from the traumatic situation and thus facilitates the emotional processing of the trauma. Differentiate between genuine joking (healthy distancing) and nervous joking (denial; minimizing; wishful thinking)]
4) Commits to national/religious identity

FOR SIERRA LEONIANS:
1) Ability to engage socially with others [lack of isolation, withdrawal]
2) Ability to discuss how one confronted the trauma [genuine sharing of one's trauma story]
3) Ability to seek comfort/rely upon one's religion
4) Ability to maintain form solidarity with friends/neighbors/relatives

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APPENDIX IV –continued–

(*) How does the client assess his/her self-esteem? Through:

oneself				**community**
1	**2**	**3**	**4**	**5**

Overall impression of cognitive/emotional functioning

1. Ability to maintain stable relationships with friends and partners	1	2	3	4	5
2. Ability to maintain steady employment.	1	2	3	4	5
3. Ability to discuss trauma history with counselor.	1	2	3	4	5
4. Ability to concentrate.	1	2	3	4	5
5. Ability to have short-term recall.	1	2	3	4	5

Individual expectations of cognitive/emotional functioning

1._____	1	2	3	4	5
2._____	1	2	3	4	5
3._____	1	2	3	4	5
4._____	1	2	3	4	5
5._____	1	2	3	4	5

Plan of action (done collaboratively with the participant)

1._____
2._____
3._____
4._____
5._____

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APPENDIX V

Participant-Contract—The Haven

The Haven and the people it serves enter into understanding of participant and program rights and responsibilities. Participants' rights and responsibilities are as follows:

For a period of six months, the participant agrees to:

--accept all social service referrals
--attend all appointments made on their behalf
--participate in development of a service plan
--attend regularly scheduled counseling sessions, either individual or group

For a period of six months, staff of the Haven agrees to:

--guide development of the client service plan
--make timely and responsible social service referrals
--attend all appointments with the participants as mutually determined to be needed
--schedule and conduct regular counseling sessions, either individual or group

The six-(6) month period of service will be subject to review at the fifth (5) month. At that time the decision will be made whether the case will be closed or continued because of ongoing need for another six-(6) month period. Either participant or counselor has the right to terminate the working relationship based on non-compliance with the above understanding. If the client wishes to continue to work with the Haven, but has a grievance, he/she should request a meeting with the counselor's supervisor.

I,_____, fully understand the rights and responsibilities as outlined, and I agree to abide by them.

_____
(Date)

_____
(Participant's signature)

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