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Refugees and coming to terms with trauma: conflicts at the interface between immigration law and psychotherapeutic aid

Abstract
The influx of refugees from the former Yugoslavia not only brought with it new aspects in legislation on immigration, i.e. the so called 'trauma regulations', but also led to changes in the practice of psychotherapy at centres for refugees and victims of torture. The therapeutic and social aspects of working with trauma are connected by 'historical truth', a term coined by Laub (2000), and an understanding of violence as exclusion from human society (Lansen, 2003). Thus, changes in psychotherapeutic work with special reference to violations of human rights will be critically reviewed. My paper on **Refugees and Trauma: Conflicts at the Interface between Immigration Law and Psychotherapeutic Aid** deals with the question as to whether – from a psychological point of view - 'trauma regulations' for refugees increase recognition of refugees' suffering or whether, they rather promote the denial of violence and thus become a mere administrative instrument.

Introduction

In the course of my work as a psychologist with traumatised refugees in Berlin I have been witness to a number of developments in 'trauma regulations' applied to refugees in the Federal Republic of Germany after the end of the war in the former Yugoslavia. I would like to trace these modifications in the legal directives on the protection of traumatised refugees from Bosnia and Kosovo under immigration law which developed out of a process of negotiation between therapists and the Administration. Almost ten years after Dayton and five years after NATO's attack on Serbia, the 'trauma regulations' are still the subject of controversy, since some of the decisions as to what is to happen to the war refugees have yet to be made.[1] Not only are therapists and lawyers negotiating and debating with each other, but the psycho-social centres for refugees and victims of torture themselves are engaged in an internal dialogue on their own self-definition and identity[2], in an attempt to reflect upon the influence of politics on psychological discourse and the understanding of trauma in psycho-social work with refugees. This is an attempt to ensure that the standards that the professionals set themselves for psychotherapeutic work in the context of global violations of human rights are not watered down by the political controversy on immigration or deportation and do not, in the final analysis, work to the disadvantage of the clients. This presentation will discuss the question as to whether from a psychological point of view the 'trauma regulations' lead to recognition of suffering by society or whether they do not in fact support the trend towards a denial of violence and are nothing more than an instrument of the Administration.

In the first section I would like to lay bare the facts. On the one hand I shall present the prevailing political and legal conditions that govern the provision of advice, counselling and social aid to the refugees, while on the other I shall sketch the psychological, psychiatric and psychotherapeutic knowledge that has a major influence on the therapists' professional identities and their own self-definitions of their mission and role. What contradictions and

misunderstandings result from the frequently incompatible positions between the therapeutic and politico-legal levels? They do not arise merely from differing interests. The different meanings of the terms used in the respective legal, clinical and political contexts have implications that necessitate translations from one field to another. Is the current conceptualization of trauma suitable for this transfer?

Traumatisation in codified legislation on immigration

Following the introduction of restrictions into the law on asylum at the beginning of the nineteen nineties, the gap between the circumstances requiring protection and the criteria affording protection grew wider and wider. People who had experienced torture and extreme violence were not able to justify their claim to asylum if they were not threatened with repeated persecution by the state in their countries of origin. As a result of the restrictions wanted by the politicians on the one hand and increasing awareness of violations of human rights among supporters on the other, legal decisions on issues of immigration law came to be dominated by a psychological discourse. The arguments in the asylum applications and decisions were individualised, which meant that impediments to forced removal on grounds of health were used as justification for claims to refugee status. The claim to a deportation waiver is based on the right to life and physical integrity laid down in Article 2, Sub-Section 2 of the German constitution (Basic Law). In such cases it must be established and certified by a clinician that a serious deterioration in the individual's state of health could occur in the event that s/he should be deported to or resident in the country to which s/he is to be removed. The Geneva Convention on Refugees also provides protection from deportation in this event and is partly incorporated in §53.6 (1) of the Aliens Act: "The deportation of an alien to another state may be waived if there is a substantial threat to physical integrity, life or freedom". However, the protection against deportation in cases of concrete risk to the person's bodily integrity and life or liberty was expressed as an optional settlement and thus as a discretionary decision. "Thus refugees having fled from war and civil war, in particular, for whose respective groups no settlement has been made by the Federal Minister of the Interior and who are dependent on protection as an individual refugee fall through the net (Höfling-Semnar, 1995, p. 133)." This was tantamount to an extensive abolition of the protection against deportation granted for specific groups of refugees, which at the beginning of the nineteen nineties had applied in particular to the civil war refugees from the former Yugoslavia, who were correspondingly obliged to leave the country.

Since there were no political guideline decisions on immigration law, the few psychologists who were working with traumatised refugees were increasingly confronted with their clients' fears of deportation and mental crises. They issued health certificates which were successful in slowing down the deportation of traumatised persons. Koch and Winter (2000) expressed the attitude of the therapists in a nutshell: "A therapy that is committed and success-oriented […] cannot remain indifferent to the human rights situation in the survivor's country of origin nor to his or her protection from further persecution by the country of exile. Both are important determinants of the healing process" (p. 455). As the years passed the clinicians working with refugees and their mental complaints became professionalized and a new group of experts was formed. They confronted political decision-makers and the Administration with the concept of traumatisation by drawing attention to the plights of individual refugees. They attempted to carry out consciousness-raising, which did in time lead to some new

insights and also opened up new perspectives within the political and legal decision-making processes.

However, at the 'Land' [*Transl. note*: a ‚Land' (plural 'Länder' or 'Laender') is a German federal state] and federal levels the political will was divided. In November 2000 efforts concentrated on the federal level led to a decision by the Conference of German Ministers of the Interior to grant traumatised civil war refugees from Bosnia and Kosovo permanent leave to remain (in accordance with §32, 30 and §54 of the Aliens Act). Thus for the first time there was a legal basis for classification as a member of the group of 'traumatised' persons from Bosnia and the Kosovo and a catalogue of criteria was included in the directives of the individual 'Laender'.

At the same time as this debate was being carried on at the federal level, at the level of the 'Land' of Berlin stricter requirements were established for the health certificates, which were stringently applied by the Administration and the departments of the Aliens Police. From the point of view of the Administration the group of traumatised refugees was too large. The Aliens Police rejected the applications for leave to remain on the grounds that the traumatisation that the doctors diagnosed was not credible and thus for a time the decision as to whether a refugee was traumatised or not was not left to the doctors and psychologists working in independent practices. Instead, at the end of the nineteen nineties, police physicians examined the refugees themselves and declared them to be not traumatised and in a fit state to be deported. In Berlin, following a dispute between the professional associations and the Administration, this led to the establishment of so-called qualified and recognised "list experts" who were to carry out the examinations in future. Complaints that there were doubts as to the conclusiveness of contents of clinical assessment reports and medical certificates, long processing times for the applications and rejections for formal reasons continued. The directives of the 'Laender'[3] contained legal restrictions which were implemented with the aid of fixed deadlines for date of entry into the country, the start of trauma therapy and established criteria for the psychological clinical assessment reports or medical certificates issued by psychiatrists that were required to prove the 'traumatisation resulting from civil war'. These directives gave rise to numerous debates between the Berlin Ministry of the Interior and the psychosocial centres for refugees.

The role of the psychosocial centres for refugees and victims of torture

As a result of the conflict of interests between the refugees and the state authorities and the constant efforts to mediate between the legal and clinical fields it became necessary constantly to redefine the understanding of trauma[4] and delineate it more precisely in relation to certain points at issue.

Traumatisation as understood by the psychosocial centres is a cumulative[5] process[6] that goes beyond the narrow definitions of the diagnostic manuals. It is not a collection of mental and physical symptoms induced by a traumatic event, but is seen within the respective political, social and biographical contexts before, during and after the person's experience of violence. For instance, in project reports and documentation produced by the psychosocial centres on trauma work with refugees we find passages such as: "If a person's life circumstances continue to be restrictive and frightening this can frequently have a re-activating or even retraumatising effect. In this case a series of traumatic experiences become linked to each other whose effects are mutually reinforcing. The symptoms become chronic and pathological sequelae develop. Traumatisation in war refugees must be seen not only where it arises, but

also where it is maintained" [*Transl. note*: ad hoc translation by the translator of the present article] (Groninger, 2003).

Since the symptoms of trauma were used as a source of evidence for the assessment of grounds for fleeing from political persecution, a shift occurred in the tasks of psychologists and therapists at the treatment centres. With the political mandate of protecting human rights, the treatment centres first became crisis centres, and then soon advanced to medico-legal assessment centres. Being traumatised came to be synonymous with having Posttraumatic Stress Disorder (PTSD), since the diagnosis of PTSD had to be justified in the clinical assessment reports. This resulted in a tendency to one-sidedness and to a fixation on the syndrome of PTSD. The refugees' mental suffering had to be explored painstakingly and with great care, if possible in the course of therapeutic work, and the PTSD confirmed and set down in writing. In the diagnostic and therapeutic sessions it emerged that acceptance by the community and having a safe place to be that is likely to remain so in the future were necessary prerequisites for coming to terms with traumatising violence. Instead of being guaranteed this safety and being able to work through experiences of violence, killing and displacement therapeutically, people were subjected to diagnostic explorations and their traumatising experiences were focused on while they were in possession of only a "toleration permit" (Ger.: *Duldung* – short-term, time-limited leave to remain), were without a secure residence status and had not yet attained control over their symptoms. As a result of the long years of uncertainty regarding their immigration status and the rejections by the Aliens Police, therapists had to carry out frequent repeat explorations and clarify supposedly contradictory statements, so that what should have been a therapeutic process was disrupted by the administrative procedures and the time at which the trauma was to be processed was in fact dictated. The refugees were thus exposed to the risk of constant reactivation of their experiences of dependency and helplessness in the face of terror and that of the experience of dependency and helplessness vis à vis the decision processes of the state authorities. This pressure exerted an influence on the sessions, so that in the worst case the therapeutic relationship assumed the form of a diagnostic observation. It thus became impossible to adhere to basic therapeutic principles, including the separation of the function of expert witness from the function of therapist.

In response to the claims by members of the state authorities that the medical certificates lacked professional expertise and to doubts about their conclusiveness, the psychosocial centres increasingly expanded and refined their professional services. A project group drew up a set of 'Standards for the Medico-Legal Assessment of Psychologically Traumatised Persons' for the compiling of medico-legal expertises and regarding the professional qualifications of the expert witnesses. Further training courses are now based on these standards.

The question as to the assessment of the credibility of the reports, which was raised by the state authorities, the politicians and the courts, had to be examined from the standpoint of the mental health professionals and answers needed to be found. Criteria for "genuine" as opposed to "simulated" PTSD (Birck, 2002) were developed and links to witness psychology were established[7]. Since the presence of PTSD was considered by both clinicians and lawyers to be evidence of persecution, the clinicians were charged with a forensic task. It is not a psychotherapeutic activity to check a client's persecution history for its credibility, since therapists do not as a rule have any reason to doubt the symptoms. Judges at administrative courts, who usually commission psychologists trained in forensic psychology to assess the credibility of witness's statements, assumed that clinicians would undertake such an

assessment. This was not compatible with clinical and diagnostic methods, and thus differing expectations of judges and lawyers on the one hand and clinicians on the other led to misunderstandings on this point and finally to the rejection of applications for leave to remain.

In connection with the different issues of immigration law associated with the criteria for protection against the deportation of traumatised persons and a large number of court cases the clinical discussion was expanded to include questions such as: "What is the risk of suicide in traumatised persons in the event of deportation? What effect does retraumatisation caused by forced repatriation and confrontation with the sites at which the violence took place have on the risk of suicide? Does forced removal result in the traumatic disorder becoming chronic? What are the effects of breaking off of the therapeutic relationship and the lack of available treatment in the country of origin (cf. Reader IPPNW, 2003)? These questions, which are asked in the course of legal proceedings, were followed by corresponding exploratory interviews with the refugees in which the health risks associated with deportation were established and justified by professionals in each individual case.

The therapists of the treatment centres were, as shown by the conferences of the German Association of Psychosocial Centres for Refugees and Victims of Torture (BAFF [*Transl. note:* Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer e.V., BAFF]) were well aware of this "highly ambivalent situation, in which it must be asked whether clinical expertise are not being used to solve problems for which no political solution has been found" (Luebbenau conference, 2004). However, no change in the manner in which trauma was handled in legal rules and legislation seemed to be in sight. It is not surprising that on 20.09.2004 in Luebbenau, despite offers of mediation from all sides, problems in communication arose during the public discussion with a panel of experts including representatives of the Ministry of the Interior, the judiciary and the BAFF. The question as to what effects on health a lack of treatment in the country of origin might have in terms of symptoms becoming chronic and deteriorations in health, which was discussed by this panel and elsewhere, is an example of this ambivalence. From the legal point of view (§53.6) the lack of available treatment services is an important criterion for protection against deportation. The psychological viewpoint to which it led reduced the process of coming to terms with trauma to clinical treatment, which fails to take into account the family and social situations of the traumatised refugees in Germany and also the significance of deportation to the places from which they have been forcibly expelled.

It remains to be seen whether the dialogue on the reciprocal reproaches and different perspectives will continue to break down the fronts and have a positive influence on political decisions and immigration procedures. The therapists complain that the offices of the administrative apparatus, including the judiciary, are places of 'cumulative mistrust', and the administration and the judiciary complain that the psychosocial centres are the 'places of cumulative pity or do-gooding'.

Processing trauma in psychotherapy

To help understand the enmeshment between the therapeutic and political viewpoints I would like to summarize a few general principles of trauma therapy. I am basing my considerations on a cognitive-behavioural therapy conceptualisation and a psychoanalytic approach that was developed in connection with therapeutic work with Holocaust survivors.

Trauma therapies are increasingly using approaches that integrate the different schools of therapy. The methods employed can be divided firstly into supportive and stabilising interventions and secondly into trauma-focused interventions. The goal of the third phase of therapy is to integrate the trauma. Clients can be said to be helped to assign the trauma to its place in the past, where is to be kept under conscious control. A further goal is to help clients regain control over their thoughts, feelings and actions in the here-and-now and to empower them to start using their own resources again for the future. The therapeutic relationship helps survivors to learn to manage their traumas, to put their experiences and how they feel into words and to express it in images.

The theory of cognitive-behavioural trauma therapy assumes that the patient's cognitive processing of the trauma is inadequate. The aim of treatment is to expose the client to the trauma, i.e. to re-activate the traumatic event in the therapeutic setting. The patient is asked to imagine and recall the traumatic event with all its sensory and feeling qualities. With the aid of corrective information the confrontation with the pathological anxiety can create a new memory and alter the fear structure. In the course of several sessions habituation can occur, thus reducing the anxiety. By means of verbalising and symbolising the experience the traumatic experience is assigned to its rightful place in time and thus new memory traces are learned and moments of dissociation can be compensated for cognitively. The PTSD symptoms are then expected to subside (cf. Maercker, 2003).

The time at which exposure or 'debriefing' should take place remains a matter of debate, since exposure does in fact involve a high risk of retraumatisation or reactivation. Petzold (2002) goes so far as to say that the psychotherapeutic methods can have harmful sequelae. There has thus been a call for moderate exposure in which intensive listening is required and the survivors themselves determine the time of exposure. This is the only way that the patient's safety and dignity can be ensured.

‚Cognitive restructuring' includes anxiety management training which alters a person's self image and does not directly modify the organisation of the traumatic memory. With the aid of relaxation, thought stopping, stress inoculation training and cognitive re-interpretation the patient learns to cope with stressful experiences, thus strengthening the self concept and providing control over memories.

The aim of the treatment is to change the negative meaning of the trauma and its sequelae into a more realistic or helpful attitude towards the experiences. The idea is to help the client reduce avoidance of stimuli associated with the trauma and learn to control the intrusions.

The cognitive-behavioural therapy model is based on an approach that is focused on the individual, i.e. conflict or problem-oriented. With the psychoanalytic trauma theories it is easier to take into account the societal context that transcends the individual, so that the process of collective processing of the historical facts can also be reflected upon and discussed. Following Laub (2000) I would like to integrate the social dimension of trauma into this brief excursion into trauma therapy.

Laub places relationship dynamics in the foreground of the psychoanalytic conceptualisation of trauma. He asks how the traumatic event is recounted in the therapeutic process and how testimony of the events can be delivered. Citing Kinston and Cohen (1986) he conveys to us how the foundations of human co-existence are so profoundly disturbed by the experience of

extreme violence that the person's relationship to him- or herself more or less dissolved. As a result the trauma is not experienced as part of the self. Kinston and Cohen speak of overwhelming mental arousal caused by failure of the environment to meet the person's needs, which is so severe that the link between the arousal of a need and the memory image is ruptured.[8] Thus no wish-oriented cathexis and no mental experience of temporality can be established and as a result there is no representation of the experience.[9] Further, the rupture of the empathic attachment to the significant other at the same time means that there is an "inability to sustain an empathic relationship to the self" (p. 862). Knowledge of the trauma therefore breaks down "all barriers of space and time and of self and subjectivity" (p. 69) and speaking is associated with a risk of being reminded of the knowledge of the trauma itself, which could lead to reliving the events and feelings of fear and powerlessness.

How can this hole in the mind be treated? How can it be possible to talk about the traumatic events and bear witness if the event has not yet attained the status of being real, despite its overwhelming reality. For Laub it is a question of a process of psychological transformation which is triggered by the narration. In his view, the narrative develops as it is listened to and heard. In this process the knowledge of the experience is expressed (p. 68) and the traumatic rupture needs to be re-experienced and recognised in the dialogue with an empathic listener and to be re-cathected with libidinous energy so that it can be healed. Thus the knowledge of the trauma, understood as a missing representation, can be transformed into knowledge in the sense of making concrete, although a remnant of the trauma, not-knowing, remains. Remembering together with someone re-establishes the connection between I and Thou and enables the survivor to recreate a relationship to his or her own self (Kinston and Cohen, 1986).

Laub contends that the listener himself becomes a participant in the traumatic event and needs to be familiar with the historical conditions of living and the fear and risks of the reality of the trauma, feel the devastation him- or herself, in order to help the survivor to speak (Laub, 2000, p. 69). In this protected space the survivor can then remember and the experience of the void can be named. Knowing is thus not a fact, but an event made present (p. 74). This, according to Laub, makes it possible to distinguish the trauma from reality and "livable consciousness". Telling the story externalises the "not knowing" as an empty circle and thus reconstructs the knowledge. A space is won back "in which life can continue" (Kinston & Cohen, p. 890). The experience of the void thus loses its power over the person's life decisions.

The psychotherapist not only becomes a listener. In the therapeutic exchange an appeal is also voiced, a demand that the social order be re-instated. Therapists are thus called upon to "bear witness to the dimensions of violence that come to light through individual experience" (Laub & Weine, 1994, p. 1103) - a violence that the authors call "historical truth" and which can only be remembered in fragments. For Laub and Weine the concept of "historical truth" forms a link between individual history and collective history which finds expression in the reports of individuals. The therapist must therefore "take into consideration this interweaving of self and history, going beyond the narrow limits of the diagnosis of individual psychopathology" (p. 1102). They add that when witnessing the therapist must above all assume responsibility (p. 1103/p. 1117). and that the creation of a document, an "objective record", is an opportunity for the survivor to share his or her experiences and "also provides evidence of the historical process of destruction that transcends the personal context" (p. 1118f.).

At this point attention should be drawn to the fact that, to cite De Levita (2003, p. 70), people who suffer from their memories are not able to process these memories alone. This requires an environment that has the courage to take the risk of listening to what happened and to empathise, and conveys this to the survivor. This dialogue is important for the process of coming to terms with the trauma. In addition, the actions of the political actors also play an important role. In the context of the discussion on the late sequelae of the National Socialist persecution Lansen (2003) describes a form of violence that leads to exclusion from human society and consists in people being abandoned by society. For Lansen this violence is an authoritarian rule that oppresses, strips people of their rights and is devoid of all human compassion for others (p. 197). In contrast to the current understanding of trauma, this view of the manifestation of violence focuses on society and draws attention to relationships and those in positions of responsibility, to an implementation that is influenced by actors. In this respect Laub's and Lansen's concepts of violence complement each other. Both draw attention to the fact that the processing of traumata must also take place on a societal and institutional level. In short, acknowledgement by society of individual suffering is an important prerequisite for the re-establishment of 'inner peace'. Thus Rossberg (2003) sees recognition by society of personal suffering as the most effective "therapy" (p. 110).

Recognition or Denial?

In order to evaluate the 'trauma regulations' we shall take a closer look at the significance of the socio-political background for the group of civil war refugees. Like Dan Bar-On, we are looking for "misinterpretations" [10] that have been made in dealing with the traumatised civil war refugees from the former Yugoslavia. The exclusion from the community that became apparent with the repeated rejections of the refugees' applications for leave to remain was achieved by different means than in war. In Germany these decisions are determined by the currently valid legislation. However, refugees, precisely because they are refugees, often find themselves in a jungle of bureaucracy and legislation in which justice generates injustice. One refugee described the lack of a legal, recognised status as follows: "To be in this agony or not to be and to stay or not to stay. And I did not feel as if I were really on earth or really in heaven, as if I didn't belong anywhere. They wanted to expel me from here, but I couldn't go back either." [11]

The goal of psycho-social work[12] with refugees is to receive the people into the community, a community that they have lost as a result of war and violence. This community is supposed to provide protection from further expulsion, the right to work and training and re-establish opportunities for integration and rehabilitation, independence and autonomy, for which a secure right of residence is a prerequisite. Obtaining a settled immigration status thus becomes a key task, not only for the counselling centres, but even more so for the survivors themselves. For them the medical certificate became a symbol of deliverance and help, the only key to escaping hopelessness. The result was that they became even more dependent on their therapists, their symptoms and, in the last analysis, also on their adjudicators.

The question is: what role can Germany play in the process of societal recognition of the refugees' suffering? Does leave to remain in Germany come to take on the valence of reconciliation and pacification, intrapsychically? One could say that the leave to remain that Germany grants a specific group of refugees takes on the function of social recognition of the injustice experienced, in lieu, so to speak (Groninger, 2003).

On the one hand the recognition is offered to the refugees and on the other it is refused. The group of traumatised civil war refugees from the former Yugoslavia are reduced to moving within a frame that is strictly defined by legislation and therapy. These people have to adjust their individual and personal forms of trauma processing to the framework stipulated by the immigration laws. This framework leaves them little room for dialogues, communication or reconciliation outside of the therapeutic context. There are also structural barriers to the re-establishment of financial independence. In my experience, refugees having survived ethnic expulsions have not yet been successful in actively building up a culture of community and affiliation to counteract their traumatisation by means of memory work.[13] The confrontation with the above-mentioned problems with immigration legislation seems to divert the attention from both the individual and the collective processes of coming to terms with conflict and trauma, to prevent them and in the end to contribute to their being shifted on to alternative arenas. Nine years after the conflict in the former Yugoslavia, the immigration problems remain the main topic of conversation in the women's groups. The papers, the stressful, long-winded trek from the medical certificate to the long-term leave to remain (*Ger.* 'Befugnis') remain the centre of attention. Reflections on day-to-day politics in Bosnia or Kosovo or the women's own positive and negative memories of before and after the civil war recede into the background.

If recognition as a refugee were to open up spaces for new perspectives and autonomy the survivors could test and establish their ability to act. This is a precondition for their finally being able to contribute to steps to overcome the conflict between the respective groups in the former Yugoslavia by means of an individual and collective transformation process.

The historical background in Germany may have contributed to the fact that the fronts between the judicial and policing practices on the one hand and the helpers on the other became so rigid and that the compromises that were reached led to the development of settlements, standards and a practice that restricted the people to only narrow limits of behaviour. The expression 'transgenerational identification', introduced by Kogan (1990) and others to describe the process of passing on trauma from generation to generation could be used to explain the split within the society, if we assume that the second and third generations in Germany after the National Socialist era are unconsciously identified with either the perpetrator or the victim side. Henningsen (2002) asks whether the judicial and/or policing practices "serve to defend against a split off, unprocessed trauma". Here she is referring to the inability of German civil servants' to believe the victims' stories, to endure them and to recognize the victims' suffering because their narratives trigger guilt feelings which unconsciously produce effects resulting from an identification with the perpetrator and influence their decisions. Here I would like to add a critical question and that is: whether the 'trauma experts' as well-meaning helpers are not themselves running the risk of becoming enmeshed in a certain form of practice, i.e. the writing of medico-legal assessment reports, and thereby, out of a feeling of guilt, contributing to the production of the identities of victim and helper. The helper identity allows them to promote a process of reparation which becomes problematic when refugees are kept in the victim role and their own opportunities for action are undermined: a practice that in the context of the existing social conditions itself in fact becomes implicated in their traumatisation. Trauma apparently leads to turning away, avoidance behaviour and withdrawal not only on the part of the victims, but also on the part of the bureaucracy and at the same time results in attraction on the part of the system that is supposed to be helping. According to Stoffels (1999) the psychotherapeutic perspective, which is often well-meant, can provoke the survivors with generalising statements. They are persuaded that they are traumatised and have suffered a mental impairment that can be healed by therapy (p. 175). Stoffels cites Jean Améry (1966) and Primo Levi. In "The Drowned and

the Saved" Levi (1988) speaks of "a 'professional greed' with which psychoanalysts pounced on the confused helplessness of the surviving prisoners".

With regard to the issue of the medico-legal assessment reports, Henningsen (2003) points out that the assessment process focuses mainly on the documentation and then cites Laub, adding that undergoing medico-legal assessment can help traumatised people. In the assessment interview a diagnostic objectivity is established which, despite efforts made by individuals to counteract it, remains, in the final analysis, limited to the evaluation of PTSD and once more confronts the patients with feelings of powerlessness. If they were to be 'supported' during the examination it is not certain that the clinical psychological assessment report would not be 'torn up' by the Aliens' Authority or the Administrative Court.

A traumatic experience means complete loss of control. A document which is intended to have a therapeutic effect must help to win back the *focus of control*. The idea that a medical certificate could have such a positive effect is only sustainable if we accept that we are performing balancing acts that can be associated with serious risks and side effects.

The aim of compiling medico-legal assessment reports is to establish certain criteria of PTSD. A search for truth is attempted that misses the essence of the refugees' stressful experiences. The diagnostic categories fail to capture the complexity of a 'man-made disaster' and also reduce the problem for the refugees to a question of "having or not having a symptom".
The assessment situation is a mode of communication that determines the nature of the information and what is observed and creates a distance by means of medical and diagnostic questions. This renders it impossible to convey what happened and for remembering to take place in a shared process). Medico-legal assessment is a legal locus of remembering in which the problem of credibility, lack of trust and the risk of reactivating fear and powerlessness are implicit... The expert witness is neither a listener nor a witness in the general sense of the word. He remains imprisoned in the dilemma of either failing to meet the requirement of scientific objectivity, becoming involved and losing his impartiality, or displaying a cool distance and thus turning the situation into an interrogation of the persons under assessment. The assessment thus destroys the narrative. Clinico-diagnostic knowledge leads to the enactment of a mode of interviewing that produces new power relations and threats. The psychological evaluation of war refugees has nothing to do with recognition of suffering, but is in itself a control system that poses a threat and, by forcing the interviewees to speak, increases dependency and perpetuates subjective suffering, attempting to pour it into a mould.

In the end the reality of the persecution remains undeciphered and is eclipsed by the fight for a settled immigration status. It is precisely in the shaping and establishment of a traumatised subject by diagnostic knowledge and the fact of having to submit to it that the traumatic subject[14] is constituted. If refugees adjust to the practice of immigration law on the one hand and threats of removal on the other, the only options that remain to them are to leave the country or to persist in the sick and traumatised role.

In trauma work with refugees therapists repeatedly have to remind themselves of the field of tension between directives of immigration law and psychotherapeutic aid, reflect upon it and discuss with experts from other disciplines in order to guarantee that they are acting responsibly. The question as to whether social recognition is given in the handling of the processes of traumatisation or whether the survivors' experiences of suffering are denied is central to the evaluation of the political settlements.

Notes

[1] In view of the large number of unrecognised civil war refugees from the former Yugoslavia still remaining in Berlin an appeal for a decision on leave to remain for Berlin was mounted in 2004. It was initiated by the Arbeitskreis Gesundheit und Menschenrechte (AGM, Engl. Working Group on Health and Human Rights), the asylum advisors of the advice centre of the parish of the Holy Cross Church and Asyl in der Kirche (the organisation Asylum in the Church), the Behandlungszentrum fuer Folteropfer (BZFO – *Engl.* Treatment Centre for Victims of Torture), the Berliner Arbeitskreis Ausländerrecht im Republikanischen Anwaltsverein (RAV – *Engl.* Berlin Working Party on Immigration Law in the Republican Lawyer's Association), Suedost Europa Kultur e.V. (*Engl.* South-East Europe Cultural Association), XENION, Psychotherapeutic Counselling Centre for Politically Persecuted Persons and the Chamber of Psychological Psychotherapists and Therapists for Children and Young People in the 'Land' (German state) of Berlin.

[2] Conference of the German Association of Psycho-Social Centres for Refugees and Victims of Torture (Bundesarbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BAFF)) held in Bad Boll in 2003.

[3] The directive file can be viewed at the following internet address: www.rak-berlin.de.

[4] For definitions of the concept of trauma and different models in psychoanalysis and clinical psychology see Ilka Lennertz (2004), available at www.traumaresearch.net/special2006/lennertz.htm.

[5] The basis for this is Hans Keilson's study (1979/1992) on sequential traumatisation in children

[6]. The term 'cumulative traumatisation' was coined by Masud Khan.

[7] Dr. Renate Volbert of the Institute of Forensic Psychiatry (Institut fuer Forensische Psychiatrie) of the Free University, Berlin is now working at her institute on research questions at the interface between the medico-legal assessment of trauma and witness psychology.

[8] According to Freud a „psychic impulse" occurs when a link is created between the *arousal of a need* and the *memory image of that perception of the experience of satisfaction* with help from outside. Freud stated that this new cathexis of the need arousal gave rise to a wish to recreate the perception oneself. From that moment onwards the effective energy acquires movement and a direction, an element of temporality. This was Freud's explanation of the development of mental representation in the form of a wish.

[9] In the psychoanalytic literature various different metaphors such as foreign body, hole (Cohen, 1985), gap (Caruth, 2000), crypt (Abraham and Torok, 1979) or empty circle (Laub, 1998) are used to describe such a state.

[10] Dan Bar-On, an Israeli psychotherapist who works with descendants of victims and perpetrators of the Holocaust, draws attention to whole groups of citizens who were subjected to suffering and pain after their actual traumatic experiences and speaks of serious misinterpretations (1999, 94)

[11] Source: Kathrin Groninger (2001), unpublished diploma thesis

[12] For a definition of the term psycho-social work cf. Becker, D. (2001).

[13] Cf. Anne Lipphard's paper (2004). She investigated the culture and memory work of Jews from Vilna in the post-war diaspora and found surprisingly rich collective cultural activities. See URL www.traumaresearch.net/special2006/lipphardt.htm

[14] Cf. Foucault, M. (1997).

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Short biographical note

Kathrin Groninger was born on 16.12.1975 in Esslingen a. N. She studied psychology at the Free University of Berlin. From 2000-2004 she worked as an associate at the service centre for refugees and immigrants of the *German Red Cross* in Berlin. Since 2003 she has been a member of the commission on custody pending deportation, and has begun training as a psychotherapist at the Institute for Psychological Psychotherapy and Counseling in Berlin (ppt). Kathrin Groninger is now serving as a peace-building worker in the Civil Peace Service of the German Development Service (DED) in Rwanda. With the associate partner Ibuka and *Kanyarwanda*, she is developing and supporting projects dealing with post-conflict trauma and networking between those organizations working in this field.

Recent publication

Kathrin Groninger, J. Rüffer, I. Petzoldova, W. Würflinger, W.: „Manual 1. Psychische und physische Reaktionen von Flüchtlingen nach Kriegs- und Gewalterfahrungen. Über den Umgang mit dem Trauma.“ In: Deutsches Rotes Kreuz (Hg.): *Materialien zur Traumaarbeit mit Flüchtlingen*. Karlsruhe: Loeper-Literaturverlag, 2003.

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