Expert Translations of Torture and Trauma: A Multisited Ethnography

Monika Weissensteiner – Freelance anthropologist, South Tyrol, Italy

Abstract

This chapter describes and analyses the processes through which some practices of the "global fight against torture" have acquired new meanings and functions in contemporary Europe. Medical and psychological knowledge practices regarding torture are not only intertwined with legal processes of recognition aimed at holding perpetrators accountable, but also with asylum procedures. In many European countries medico-legal and psychological documentation of torture is increasingly used to substantiate asylum applications of victim-survivors seeking international protection. Using my interviews with medical-legal experts, psychologists and lawyers as a point of departure, I will discuss this documentation as a social practice of knowledge production embedded within landscapes of meaning and power. This contribution seeks to reflect upon the epistemologies, the techniques and the ethics through which testimonies of torture are received, read, listened and responded to. How do experts translate an intimate experience to make it recognizable by public institutions? How are legal uncertainty, denial or mistrust dealt with? Contemporary understandings of "trauma" have shaped the recognition of victim-survivors. Data from a multisited ethnographic research project carried out with NGOs who provide support to victim-survivors of torture will be situated within the historical emergence of this documentation practice and its current entanglement with European asylum policy and migration management.

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1. Introduction

> The manufacture of a narrative that is not complicit with the perpetuation of trauma again included, as one of its moments, a war inside language, around the act of naming. […].
>
> For the political and therapeutic task of representation of trauma, the dictionary is the battlefield. (Avelar, 2001, p. 262)

At a public conference entitled "Torture and its consequences"[1] two doctors presented their life-long work on behalf of persons who suffered torture. Justice, awareness raising, prevention and rehabilitation were named by the two doctors as key tasks in the so called "global fight against torture". With reference to the UN definition of torture, which defines torture as "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 […]" (UNCAT, 1984, art. 1), one of the two speakers pointed out: "The question is, what is 'severe'? We think that there are only two persons who can decide what is 'severe': the victims or the doctor. Not the lawyer."

From this description it emerges that medical and psychological knowledge practices regarding torture have become intertwined with legal processes of recognition aimed at holding perpetrators accountable ("justice") and in enabling access to healthcare ("rehabilitation"). And that there are contested opinions over who holds the "truth" over a given pain. Indeed, in the European context medico-legal documentation of torture has recently found growing application within asylum proceedings in the form of expert reports aimed at substantiating asylum applications of persons who suffered torture in their countries of origin and who seek international protection in the EU; or in the individuation of so called "traumatized refugees" in need of care.

1 Public Talk "La tortura y sus consecuencias", 28th of May 2009, Barcelona [tape recorded with permission]. Speakers were one founding member of the International Rehabilitation Council for Torture Victims and one former Rapporteur of the United Nations Committee against Torture and former vice-president of the European Committee for the Prevention of Torture.

Legal recognition of who is considered a refugee, or who a victim-survivor of torture/ill-treatment, relies mostly upon knowledge practices regarding the circumstances and purposes of persecution and torture. Notwithstanding, in the absence of "hard evidence" it is the "fear" and the "pain" of the individual that are increasingly constructed as "epistemological objects": as objects of knowledge production, the body and the mind are perceived as bearing traces of truth. Fear is one criterion in the definition of what constitutes a refugee—a person with "well-founded fear" of persecution (UN General Assembly, 1951). And pain is one criterion of what constitutes torture—"severe pain or suffering, whether physical or mental, […] intentionally inflicted" (UN General Assembly, 1984). However, in international criminal courts and in asylum hearings the oral testimony of victim-survivors is considered "the least credible and most impeachable form of evidence" (Byrne, 2007, p. 614). In asylum proceedings expert reports documenting evidence of ill-treatment/torture are not applied to investigate and prosecute "torture" but instead to corroborate the credibility of a persons' testimony.

In this chapter I want to show how ethnographic research and anthropological theory can help to understand how intimate experiences such as torture and fear of persecution are translated through medico-legal expertise within asylum procedures, as they try to render such experiences recognizable by public institutions. My aim is to describe and to analyse how the "global fight against torture" through documentation practices plays out in asylum procedures. Special attention will be given to the practices and professional identities of the experts who are engaged in providing medico-legal and psychological evidence. I consider the making of these documents as social and cultural practice that takes place within specific historical contexts, which shape their epistemological categories and their meanings. The practices of medico-legal and psychological documentation of torture and related practices of knowledge production are embedded in institutional landscapes of meaning and power, which can be understood as a set-up of discourse and practice, as "boundless of technologies, narrative styles, modes of discourse, and, importantly, erasures and silences" (Saris, 1995, p. 42). How can we understand the "war inside language", the "battlefield" of the

dictionary when it comes to name "trauma" (as in the quote by Idelbar Avelar) or when doctors are called to "decide" over the "severity" of pain (as in the conference quote above)?

My argument is that this expert practice has undergone a change of meaning and power through its application in asylum proceedings and that a closer look into the professional worlds of experts gives insight into the complexities of this practice within contemporary Europe.

My focus has not been to understand the trajectories of victim-survivors or of asylum seekers, but to study "up" and "through" the institutional and epistemological landscapes that condition and shape the way in which testimonies of violence are received and responded to. This writing is based on research carried out between 2007 and 2009[2]. I will draw on ethnographic data from two European countries and situate the findings within ongoing moves to "harmonize" the European asylum system and related policies and practices. In particular, but not exclusively, I have worked with two non-governmental organizations (NGOs) that are providing psychosocial and medico(-legal) support to victim-survivors of torture and of human rights

2 I am thankful to two anonymous reviewers of this contribution, as well as to the editors of this publication, Dorothy Zinn and Elisabeth Tauber, for their reviews and comments on this paper. This chapter is based on ethnographic research (conducted between 2007–2009 as part of a European Joint Master's Program in Anthropology) regarding the production and utilization of medico-legal/psychological documentation of torture and violence within the context of asylum applications in Europe, with particular focus on Ireland and Spain. I thus thank my thesis supervisors Dr. Mark Maguire (NUIM) and Dr. Dan Rodriguez-García (UAB) for their supervision and National University of Ireland, Maynooth (NUIM) for a scholarship. The results of the research can be found in *Torture Evidence on Trial: (missing) scars, "innocent" scars, invisible wounds. Anthropological Reflections on the Documentation of Fear and Violence in European Asylum Procedures*, October 2009, NUIM (unpublished MA thesis). I am also indebted to Dr. Ivo Quaranta from the University of Bologna, who during my first years as anthropology student got me interested in critical medical anthropology and to Gregory Feldman for an e-mail exchange concerning non-local ethnography. I also thank Katherine Whitson, a lawyer and friend from the US, for her English proofreading. A big thank you for many informal chats also goes to various friends who came as refugees to Europe: they were not part of this study, but I dedicate this work to them. Last but not least, I wish to express my deep thanks and gratitude to the professionals who shared their precious time, their experiences, their opinions and feelings with me for the purpose of this study: medical doctors, psychiatrists, psychologists, lawyers. I thank the participating NGOs and professionals, which for reasons of anonymity and confidentiality I have not mentioned in this paper, for enabling me to conduct research in their centres on such a sensitive topic.

abuses. For the argument developed in this chapter, I want to start out with interview excerpts that can serve as an example of how some medical experts and psychologists experience the assessment and report writing for the purpose of producing this documentation.

> Most cases I see are genuine. […] Lately indeed I had one … you can't contradict his story. But what do you do? How do you interpret that in your report? I mean, you don't want to give a report that is going to completely condemn the person. (Interview with a doctor who only recently started doing medico-legal reports and discussed with me her[3] major challenges).

> [Reports] are complex, because you are writing down things that will determinate if a person will get salvation or not! I see it like a salvation. Because if these persons [the adjudicators], for a report will reject or accept someone, this is a responsibility that is too much for one, as psychologist, as a professional. To me this is very complicated. (Interview with a psychologist, who only eventually would write a psychological certificate).

Independent of the actual evidentiary weight given to a report, the responsibility felt by the health-care personnel is significant. "Salvation" or "condemnation" here do not regard the soteriological role of medical practice to transform suffering and achieve salvation. And the moral meaning of their practice might differ from countering impunity and documenting torture for the purpose of holding perpetrators accountable. Here "salvation" and "condemnation" are linked to the responsibility of establishing "the" causal relationship between past violences and their traces on the minds and bodies of asylum applicants, in a context where asylum seekers that fail to appear credible or fail to present enough evidence to support their fear of persecution might receive a negative response to their application. As rejected applicants for international protection, they become illegal and deportable immigrants. As we shall see, these are quite different (institutional) landscapes of meaning and power than those in which this docu-

3 Throughout the text I have used female pronouns when referring to my interview participants.

mentation practice and the related standardized reporting techniques were developed. A doctor, who at the time of the interview had recently started writing medico-legal reports, described the assessment and write-up with the following words:

> We have to be very objective. They could tell you the most horrible story, but sometimes there can be discrepancies. It's kind of hard. And then you have all this information and the wording they want is specific here, `he claims, he alleges´ And then, the person is telling you a story... It gets hard.

In the text making process of writing medico-legal reports, experts are required to use the wording such as "he claims". This wording postulates a distance between what is known to the doctor and what is said by a patient/client and indicates the relationship the expert holds to the testimony (Fassin & d'Halluin, 2005). But some professionals felt that this wording intruded the doctor-patient (or doctor-client) relationship—this was particularly the case for those professionals who in their everyday occupation worked as general health care practitioners (GP) and those who joined an expert-team only recently. As one explained to me, during the anamnesis and examination she would be constantly thinking of how to put that into words later: "How can I say this, how can I type it up?" But as a doctor, she added, it is not important if what the persons says is "true". The main characteristic of a doctor was often described to me as "being able to respond to suffering". One of the reasons for working in this context, according to one doctor, was "sympathy for the injured". Now the task is not the ability to respond to suffering but, as one of the doctors said, the task is to "give an opinion, that this person is suffering as a result: his symptoms are consistent with what he says." The job of the health practitioner becomes a responsibility (response-ability) in terms of making a diagnosis of suffering that establishes the degree of consistency with an alleged event that is deemed to be its origin or cause [etiological event], and of translating her expert opinion into correct text. But sometimes injuries tell multiple stories; sometimes visible injuries are missing.

> [The establishment of consistency] is a kind of a responsibility as well. Because there might be some that appear to be quite okay and they have recovered—extraordinarily well, apparently—from whatever they have gone through in prison and that. So one has to say: well, they seem to have recovered now, even though they have given such a history. You know, you can't blame them for being healthy [doctor laughs, shakes head].

Through these processes, the (in)communicability of torture finds its paths into objectification, becomes (in)translatable. What sort of "responsibility"—to quote the doctor—and "ability to respond" demands a testimony of violence from those who witness it? What does it mean and imply, when medical and psychological knowledge gets entangled in discerning between who is considered a legitimate "refugee" and who indeed falls out of the categories for international protection?

In order to understand these interview excerpts and the experiences of these professionals, it is necessary to trace two story lines that are intertwined in their practices. Therefore, I will first trace the historical development of medico-legal documentation in order to see how the "global fight against torture" through documentation has developed and plays out in different local levels and historical contexts. Within this "history of the present" I will also discuss how the concept of "physical and mental trauma" has shaped the recognition of victim-survivors. With regard to documentation used to substantiate asylum applications, it will then be necessary to briefly discuss the European context of asylum and migration management. The European policy instruments that seek to harmonize asylum practices gave categorical visibility to victim-survivors of torture as "vulnerable persons with special needs" due to trauma (Weissensteiner, 2010). I speak in a generalized way about "Europe" due to the attempt to establish a common European space of international protection and due to the fact that there is evidence that these particular documentation practices have acquired importance in various member states. On the other hand, of course, it is necessary to see how this practice plays out in different national contexts and local levels. In a key article on this subject, published by Didier Fassin and Estelle d'Halluin

(2005), the authors point out that in contemporary France two historical processes converged: on the side of the "refugee category" there is the decline in the legitimacy of asylum and the increased request for evidence to establish the reality of persecution, on the other side there is the emergence of "trauma" within the classification of diseases [as a nosological category], legitimizing the traces of violence. The two authors make eloquently their point: "trauma" says less about the truth of an individualized asylum seeking population, than about the truth of political asylum in Europe. Both categories—"refugee" and "trauma"—are not a-historical, but like other categories they are socially and culturally situated and reconfigured through ongoing processes (cf. Malkki, 1992, 1995; Young, 1995). For researches interested in governmentality (cf. Foucault, 2007; Rose & Miller, 1992; Rabinow & Rose, 2003; Inda, 2006; Shore, Wright & Però, 2011) the relationship between knowledge production and power and the entanglement between expertise and governmental practice has in recent years become an important field of research. Governmental practice relies upon particular forms of knowledge—assemblage of persons, theories, projects, experiments and expertise—from psychology, criminology to social science, that have the subjects to be governed as objects of study. They produce particular ways of thinking and perceiving reality, discerning between what is normal/abnormal, what is true/false, and contemporaneously they provide a know-how to elaborate solutions for management. Anthropological research regarding in some way what I call here the entanglement between medical or psychological knowledge production and the asylum procedure has been undertaken in different national context, like in France (Fassin & d'Halluin, 2005, 2007), the Netherlands (Richter 2004), Canada (Kirmayer, Lemelson & Barad, 2007), Switzerland (Salis Gross, 2004), the UK (Kelly, 2012). Among other issues, the authors highlight the political and ethical conflicts arising from medical, psychological or medico-legal documentation. Different expectations towards the style of medico-legal report writing and their interpretation has also been discussed in the literature (Good, 2004; Rousseau, Crépeau, Foxen & Houle, 2002, Jones & Smith, 2004). This area of research can be situated within a broader study of expert knowledge production (categorical constructions, social conditions of knowledge produc-

tion, expertise), law and indeterminacy and on how uncertainty is dealt with in asylum proceedings (Moore, 2000 [1978], 1994; Yngvesson & Coutin, 2006; Cabot, 2013; Fassin & Rechtman, 2007). From my own ethnographic research that focused in particular on Ireland and Spain (Weissensteiner, 2009), it emerged that the different national contexts in their political, policy, legal and historical dimension influence practices, meanings and implications of this documentation. But also differences in ethos and clinical approach of the involved NGOs and of single professionals shape practice and meaning of this documentation. Notwithstanding notable differences within national realities in the European context, these practices however also have to be viewed and analysed for their "European" dimension and within ongoing moves towards harmonization of asylum policy on EU level.

2. A note on methodology and methods

During my research and prior to conducting interviews with medical experts and psychologists, I spent various months as volunteer and intern mainly at two different NGOs that offer psycho-social and medical support, as well as medico-legal/psychological certification. Participating in everyday activities enabled me to gain insight and understanding of the daily routine and the "issues that mattered" (Riles, 2000) in these centres. One NGO focused primarily on therapy, but occasionally psychological reports were written, the other had started to pay special attention to the application of the Istanbul Protocol and was providing further training and supervision to its (new) medico-legal experts. So, for example, I would interview a medical doctor after having transcribed one of his medico-legal reports. Importantly, the content of this report was not part of my research data. Nor could I use as research data any information I knew about from my work activities in the centre. I was also involved in two annual meetings of the European Network of Rehabilitation Centres for Survivors of Torture. Also, I interviewed lawyers who followed the cases of applicants that had reported being subjected to torture.

Moving research from concrete places and interactions into the realm of European Union [EU] policy and migration management opens up also a methodological question: how can ethnographic research in a "[global world] account for empirical processes that cannot be fully apprehended through participant observation" (Feldman, 2011, p. 33)? My research methods thus draw on recent methodological developments inside anthropology and on the work of anthropologists who have pointed out the necessity to study institutions, documents, policy or to engage in the variety of elements that are intertwined in an apparatus like the EU. As I already mentioned, important theoretical input can be found in works by philosophers, political scientists and anthropologists interested in governmentality and in the knowledge/power nexus. Concerning related methodological aspects, there have been calls of caution not to reduce the object of study to the object of observation (Trouillot, 2001, p. 135). Scholars have proposed to collect data eclectically from a disparate array of sources (Gusterson, 1997, p. 116), such as archives, jurisdiction, documents, policy, laws, newspapers, reports, online-sources (cf. Riles, 2000, 2006; Shore et al., 2011). Without entering into the different nuances of the following methodological concepts (cf. Feldman, for a discussion, 2012), approaches that combine traditional ethnographic methods with a variety of research methods have been defined as "studying-up" (Nader, 1972), as "multisited ethnography" (Marcus, 1995), as "studying through" (Shore et al., 2011), as "nonlocal ethnography" (Feldman, 2011). These approaches highlight the importance to study "bodies that govern human relations rather than to study the governed themselves" (Nader, 1972), without "presuming a vertical hierarchical relation between policy makers determining policy and implementing it on the governed" (Shore et al., 2011, p. 101), but analysing dynamics, conflicts, negotiations between different protagonists over time. This implies necessarily conducting a "multisited ethnography" and rendering ethnography a genealogical approach towards the processes through which certain practices and discourses have come into being. Marcus (1995) highlights the importance of following a particular object, story, metaphor etc. and researching on multiple sites in order to reveal the working of a system. Shore, Wright and Però added "policy" to this list (2011). Feldman (2011) argues that these are also sites

"beyond the locality" when it comes to studying a (migration management) apparatus such as the EU and its discourses that enable, organize and integrate many disparate policy practices, which requires to integrate different methods into an ethnographic methodology.

In my specific case of study, this meant collecting and studying internal and external reports and conference notes drafted by non-governmental-organizations (NGOs) or international organizations (IOs), following and analysing EU policy developments over time in the field of asylum and related reports by a variety of agents, consulting specialized journals and books for medical and legal discourses and debates concerning torture, as well as reviewing a sample of national refugee-status determinations that concerned victim-survivors of torture who applied for international protection. In the main part of this chapter I will therefore integrate fieldwork data from open-ended and semi-structured interviews with data from various sources. I first trace the development of documentation practices regarding torture, before entering into a brief discussion of how victim-survivors of torture gained categorical visibility in EU asylum directives. I then analyse the landscapes of meaning and power in which trauma and expertise on it have emerged as a means for translating violence in order to make it recognizable by public institutions. These institutional landscapes, as pointed out by Saris (1995), can be understood as a set-up of discourse and practice, narratives, but also silences.

3. Torture pain's (in)expressibility and the Istanbul Protocol as a technology of knowledge production

The prohibition of torture is considered to be one of the most fundamental standards of the international community. There has been a notable change in the meanings ascribed to torture over the last hundred years, from being a legitimate judicial procedure to elicit truth, to being considered the worst infraction of the physical, psychological and moral integrity of a human being (Kelly, 2012). However, it was only through a couple of historical moments in the last sixty years—the war in Algeria in the 1950s and 1960s,

the Vietnam war, the military coup in Greece in 1976, a couple of military coups in Latin America—linked with an increased representation in the media, that torture gained public visibility and that with the fall of regimes prosecution became possible (Welsh, 2002; Rejali, 2007; Stover, 2005). In this context the legally binding prohibition of torture, documentation and monitoring have developed, as well as testimonial therapy and first treatment centres. Amnesty International (AI) launched the first international campaign against torture in the early 1970s (AI 1973), as a result of which the first AI Medical Group was established in Denmark.

"At this time, very little was known about torture methods or the physical or psychosocial consequences for torture victims"[4]. According to a founding member of the International Rehabilitation Council for Torture Victims (IRCT) this first study of torture was needed in order to counter impunity, because there was the need "to say that it is real. AI said that we should be able to prove torture. [In court] they were always saying—if there were broken arms or no teeth or eyes taken out […]—that it was the torture victims who did it themselves, it was self-damage"[5]. From the initial aim to document torture for potential legal proceedings, through this first assessment it became evident to the doctors that it was "critical to identify methods to treat and to rehabilitate" victims of torture (ibid). Traces of violence thus need expert translation in order to become "true" signs of violence. And pain as object of knowledge is accessed through a particular way of reading the body and words of survivors in order to make "real", what otherwise is said to be illegible, unrepresentable or simply not true—i.e. non real.

Despite the development of legally binding norms and monitoring entities, torture is still a widespread practice. International experts in law, health and human rights have pushed forward to create the so called Istanbul Protocol (IP), the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

4 http://www.irct.org/about-us/what-is-the-irct/history.aspx [last access 07.10.2014]

5 Public talk "La tortura y sus consecuencias", 28th of May 2009, Barcelona

(OHCHR – UN, 1999 [2004]). Today this is the main instrument for the investigation of torture[6]. It was developed in response to the practices of some governments that challenged or dismissed medical evidence of torture based on clinical assessments and at times called for more "scientific" documentation (Welsh, 2002, p. 14). Expertise is thus not only a particular technology of sight and the medical expert the presumed authority to "decide" about the "severity" of a given pain, but expertise is also an authoritative genre of representation through procedurally correct text-making (Blommaert, 2001). The IP's first aim is the prosecution of perpetrators and the challenge of impunity, but also its use for substantiating asylum applications was envisaged (2004, p. 18). Through the promotion of different non-governmental organizations, the IP has recently found application within European asylum proceedings. In the European context, those who are likely to deny claims or have "downplayed, ignored or even disputed" medical evidence, according to the IRCT (2007), are then not the states that are accused of torturing, but the member states of the European Union. Here legal, medical and psychological fields of knowledge become intertwined with the governmental task to respect international obligations, "European values" and domestic regulations, whilst regulating and managing contemporary migration movements and so-called "mixed flows".

4. European asylum and migration management and victim-survivors of torture as target of care and control

One medical doctor and therapist—who has been working over the last forty years in Europe with victim-survivors of violence and human rights abuses, and who himself was subjected to torture in his home country and was

6 A medico-legal assessment through the IP consists of four elements: the "history taking"; the medical assessment through body inspection, documentation and differentiation between so-called "innocent scars" and torture-consistent evidence; a psychological mental state assessment; and report writing. The aim of the IP assessment is to indicate the degree of consistency between every finding and its alleged cause, whereby, however, the absence of scars or mental distress should not be taken as proof for the non-veracity of a claim and not lead to the conclusion that torture did not happen.

granted asylum in Europe in the 1970s—said to me in an interview: "Back then an open and sensible Europe still existed. [Today] the asylum procedure is not there to grant asylum, but to expulse people".

Notably, in the 1970s asylum seekers and refugees were not asked to prove their claim that they had been subjected to torture in their country of origin, in order to establish their "well-founded fear of persecution". The persons who participated in the first AI medical study of torture with the aim to counter impunity, were already granted refugee status in Denmark. The change that had occurred can also be found in the founding history of the European Network of Rehabilitation Centres for Survivors of Torture in 2003, composed by NGOs supporting victim-survivors of torture in Europe:

> [E]verybody agreed that we needed a European Network because we share a common problem: European countries try to protect their borders against refugees—thus making it impossible for torture victims and victims of severe human rights violations to enter Europe. At the same time European countries are so proud of the fact that Human Rights are their invention and they tell the world how much they do to protect human rights. (Bittenbinder, 2008)

The asylum procedure "to expulse people", as the health care professional quoted before called it, can be seen as part of the procedures which link knowledge and power and differentiate between legitimate receiver of protection and deportable immigrants. They have been standardized in the creation of a Common European Asylum System (CEAS), which has emerged as part of communitarized policy simultaneously addressing asylum, migration management and security measurements, in order to find common solutions to the identified challenge of "a major flow of persons seeking international protection in the EU since the 1990s". The creation of the European Network of Rehabilitation Centres for Survivors of Torture has to be located within this particular historical context. In CEAS related policy papers the image of "mixed flows" emerges as central problematization: flows composed of "both illegal immigrants as well as persons in need of protection" (European Commission, 2007, point 5.3). The asylum procedure has become an instrument and regime of truth of governments to discern between different "cate-

gories" of migrants and their "entitlements" with the effect of using particular forms of verification to establish who is judged to be "truly" a legitimate receiver of protection and who becomes a deportable "failed asylum seeker". In this context documentation of past torture, as a particular technique of verification, has acquired new meanings.

Throughout the policy development and implementation of the establishment of a "harmonized" Common European Asylum System (CEAS)[7] there has been a strong interaction between state and "non-state" institutions like NGOs. As I have described and analysed in detail elsewhere (Weissensteiner, 2010), within CEAS-policy-development victim-survivors of torture have emerged as meaningful target for (non)governmental action in the figure of the "traumatized refugee": as historical reality as well as objects of knowledge, of care and of control. Initially victim-survivors of torture and of violence were given categorical visibility in the Reception Directive, within the classification of "vulnerable persons" with special needs. In contrast to the other groups listed in this category their visibility is least evident: "survivors of torture and ill-treatment—highly traumatized by their experiences—prove very difficult to identify" (IRCT, 2007). NGOs took an active role by pointing out that despite the initial emphasis in the Reception Directive, neither the Qualification Directive nor the Directive on Procedures took into account the special situation of victims of violence. It is in this context that "trauma" has emerged as core symbol within a critique of accelerated asylum procedures, focus on consistency, poorly conducted interviews and rejections of asylum applications due to "lack of credibility". This critique was advanced by a transnational health and human rights NGO lobby. "Practice shows that instead of viewing inaccuracies and inconsistencies as signs of possible medical complications due to acts of persecution,

7 The "Reception Directive" set up standards for reception conditions, the "Directive on Procedures" for asylum procedures and the "Qualification Directive" the criteria for granting international protection. The "Dublin Regulation" and related "Eurodac-Regulation" determine the State responsible for examining an asylum application. Despite the revision of these policy instruments and their disposal into national frameworks, member states up to now still present very heterogeneous realities.

asylum claims are often rejected for being considered 'inconsistent' and for that reason 'manifestly unfounded'"[8].

The interpretation of signs as "incoherence", "inaccuracy", "inconsistency", as "lack of credibility" and thus proof of an illegitimate claim, through the eyes of the expert could be interpreted differently, as being indeed proof of a legitimate claim. The identification of past violence through a diagnosis of health is made in a politically charged environment. Memory—"traumatic memory"—becomes a political battlefield, to use the expression of Idelbar Avelar, with which I opened this chapter. As a lawyer told me in an interview occasion, traumatic memory is not necessarily taken as evidence of past persecution, but "any report is good that states that there is impaired memory. Even if the overall story is credible, I would always include a report that documents memory problems. It is still easy to get a date wrong."

5. Torture "arms races", "battlefields" and "trauma gaps" that matter

During an interview one day sitting in the doctors' room at the NGO where I conducted part of this research, practice showed an even more complex picture. A medical expert exclaimed to me almost complaining: "Expert torturers don't leave marks. Justice needs to understand that". This doctor, who had enough years of work experience to qualify for retirement, had indeed decided to keep working for an NGO as medical doctor conducting both medical assessments to define needs of care as well as producing medical-legal documentation of torture. She strongly believed in her vocation to work on behalf of "the injured" and explained to me her personal and practical difficulties with this documentation practice. In fact, this NGO would produce medical-legal reports at the request of a lawyer on behalf of an asylum applicant or directly at the request of the national Department of

8 http://www.irct.org/investigation-documentation/the-istanbul-protocol/asylum-procedures.aspx [last access 28.06.2015]

Justice. With "Justice" in the quote above, she referred precisely to this national Department of Justice, where the tribunal responsible for processing asylum applications and assessing testimonial and documentary evidence is located.

As the historian Rejali (2007, p. 572) points out, "[W]hen monitors exposed torture to public censure through careful documentation, torturers responded by investing less visible and harder to document techniques". Today, many torture techniques are "clean tortures"[9]: they are meant not to leave any marks at all and so they break down the ability to "show pain", thus rendering the recognition of torture almost impossible. Care is taken not to break the skin.

> Scarry [1985] is right to draw attention to the importance of expression in torture [...but] the inexpressibility that matters politically is not the gap between the brain and the tongue, but between victims and their communities, a gap that is cynically calculated, a gap that shelters a state's legitimacy. (Rejali, 2007, p. 31)

In *The Medical Documentation of Torture* (Peel & Iacopino, 2002), James Welsh writes

> [t]here is a risk that the result of the contest between torturers using less physically damaging torture methods and medical specialists using increasingly sophisticated forensic techniques—a torture "arms race" […]—will be a progressive increase in the burden of proof being placed on medical witnesses. (2002, p. 13)

It thus becomes important to inquire how the global "torture arms race", placing the burden of proof increasingly on the medical witnesses, plays out within asylum proceedings: here, in contrast to criminal proceedings, the

9 Rejali calls physical torture techniques that do not leave any marks "stealth torture" (for example electro-torture, the use of ice, water, spices, sleep deprivation, noise and drugs or clean beating, exhaustion exercises). Unlike "psychological torture" (although this distinction has been challenged), stealth torture is applied physically to the body.

burden of proof should notably be much lower. As a lawyer who presented applications of asylum seekers to the Justice tribunal mentioned above explained to me:

> A good report is one with physical evidence, and psychological. If [the evidence in a report] is only psychological, it is not helpful. [...]. [In] a bad report there are no scars of physical evidence and the report states that the mental state is "consistent" with the account of the applicant. That is challenged by the tribunal.

As torture frequently leaves no physical marks or only nonspecific scars, psychological assessments and psychiatric diagnoses that document "severe mental harm" have gained importance. Initially there was an expectation that a particular "torture syndrome" (AI, 1973) existed. Now physicians agree that there is no medical condition that can be linked to torture. In the absence of a specific torture syndrome, the most frequent psychiatric diagnoses are Post-Traumatic Stress Disorder (PTSD) and major depression (Wenzel, 2007). Questionnaires to objectively "score the trauma" have been developed. However, though the origin of PTSD is found in a traumatic event, there is no causal link between exposure of a "traumatic event" and the development of PTSD. Also, commonly researchers have studies the torture squeal in relation to refugee populations: facing difficult living conditions in the present impacts the possible development and chronification of distress (Wenzel, 2007), while a positive recovery environment could also become a potential factor of resilience (Siltove, 2006).

Kirmayer et al. argue that the construct of PTSD has gained centre stage in the research, writing and clinical intervention due to a variety of factors. "Culturally, the diagnosis of PTSD has been an important move in the struggle to determine accountability for suffering and to seek restitution and redress. By connecting current symptoms and suffering to past events, the diagnosis of PTSD assigns causality and, to some degree, responsibility and blame" (Kirmayer et al., 2007, pp. 1–2). Likewise, Fassin and Rechtman argue that trauma not only causes suffering in need of care, but has also become an (ambiguous) social and moral resource for victims to have their rights recognized, a "tool in the demand for justice" (2007). "Trauma" has had a long

chronological and semiotic migration from its meaning up to the end of the nineteenth century, when it referred exclusively to physical injuries, to its present admission into the "universal" territory of psychiatric entities through its introduction as "post-traumatic stress disorder" (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980). Beside these diachronic changes (cf. Young, 1995), today there are also different constructions of how to understand the effects of violence within the discourse of mental health professionals and there are heated debates between those who adhere to the PTSD model and those who are rather sceptical (Siltove, 2006; Summerfield, 1999). However, as outlined by Bittenbinder (2006), "trauma" can be understood not only as medical and psychiatric category, but also as a psychodynamic process and as a social and political process. The first two Western interpretations tend to localize it as "traumatic memory" within the individual, the latter highlights the socio- and political context of "trauma". "Traumatization"—its origin and its cure—are then not so much an individual issue, but rather a broader process of society. It is, however, the first of these concepts, PTSD, that is often expected to corroborate a claim of past torture in asylum proceedings—some doctors complain, others approve, most make use of it—, due to the particular linear-causal model on which it is based. And it has become necessary to be invoked, to challenge procedural requirements of asylum procedures. As the lawyer quoted before said: "It is still easy to get a date wrong". However, locating "(traumatic) memory" within the individual is just one possible problematization inside *and* outside "trauma" discourse.

Although PTSD is a frequent diagnosis in IP reports, one psychologist reflected upon this diagnostic practice in her NGO: a hint towards the institutional "erasures and silences" and the "war inside language" incorporated in the act of naming: "Can one speak of post-traumatic stress, if the stress is still going on?" Also here the reflection outlined by Avelar at the beginning of this chapter is of relevance, when he refers to the political and therapeutic representation of trauma and the imperative not to be complicit with its perpetuation.

6. Double alliances and heterogeneous voices

NGO-networks argued for the importance of identifying victim-survivors of past persecution in order to guarantee their rights of access to proper treatment and to contribute to the fact finding process in the asylum procedure based on increased and more professional information. They also lobbied to guarantee a legal status of recognition and form of international protection to victim-survivor of torture (Care Full, 2007, Bruin, Reneman & Bloemen, 2006; IRCT, 2007; Parcours d'Exil, 2008) and to implement the Istanbul Protocol in the identification of torture victims. Simultaneous to this public lobby, the application of the IP and the trauma discourse has also been more or less silently opposed or questioned by some NGOs or single professionals. Some speak about a "prostitution of the discipline" or highlight their conflicting position.

> We professionals are in a dilemma: if you write a report you participate in this procedure, if you don´t write it you leave the person even more abandoned. It is complicated.

> It is all so... hard. Because, the [application of the] Istanbul Protocol [to asylum proceedings], was born out of response to a situation in Europe that is deeply traumatizing. The Istanbul Protocol was born out of the necessity to overcome an adversity […]. I am not saying the Protocol itself, don't get me wrong, it is an instrument more, to convince, to argue, but its existence is a shame. […]. It is a shame that one has to use medicine or psychiatry to defend a fundamental right that is written down in the Geneva Convention.

Scholars interested in policy and governmentality have studied how regimes of knowledge and expertise are intertwined with the exercise of power, which aims to know and to govern the wealth, health, happiness—the security—of populations, through control, regulation and care. The application of the IP in asylum proceeding thus presents a specific problematization and possible solution to the states' obligation of allocating care and of assigning protection status: promising to provide the certainty with which the law wrestles. But it is also here that expressions such as "salvation" or "condemnation" find their

social and moral grounding. One could say that experts thus enter a kind of "double alliance", which has been well described by political social scientists Rose and Miller (1992). On the one hand, they ally themselves with political authorities by focusing upon their problems, problematizing new issues and translating political concerns into the vocabulary of their professional discipline. On the other hand, they form alliances with the individuals themselves, translating their daily worries and decisions in a language claiming the power of truth, and teaching them some useful techniques for their conduct (1992, p. 19). The CEAS policy development process through which victim-survivors of torture gained categorical visibility as "vulnerable persons with special needs" due to trauma shows this double alliance. As do to the dilemmas with which I opened up this chapter. However double alliance has entangled NGOs with governmental practices (on anthropological studies of the state, cf. Das & Poole, 2004; Sharma & Gupta, 2006). The following description by a psychotherapist—who worked exclusively in therapy, but for an NGO that also produced medico-legal reports—permits us to grasp on a phenomenological level as lived experience the dilemmas that may arise when linking identification of victim-survivors of torture for therapeutic and for legal purposes. In an interview occasion this psychotherapist explained to me:

> Some people come in, are looking at your files, and wondering: are you in reality part of the "Justice department"? Like, will you have a say in whether they get … [international protection]? There might be that suspicion around who you really are, what you are going to document about them. And where are you going to document it.

The relationship between NGOs and governments in regard to medical or psychological reports and training for government interviewers constitutes a conflicting issue among the providers of expert knowledge, mostly being NGOs offering psychosocial and medical care to victim-survivors of violence (Bittenbinder, 2006). Conflicting positions relate to the ambiguity of what I called the "alliance", as well as to the way that NGOs and single professionals understand and treat "trauma" in their clinical practices. Notably, the psychiatrist who spoke about a "situation in Europe that is deeply trauma-

tizing" put the socio- and political context of "trauma" centre-stage. The origin and the cure of this "traumatization" are then not so much individual but part of social processes, localized not in far-away countries of persecution, but within Europe.

7. Conclusion

My aim has been to see how the "global fight against torture" through documentation plays out in asylum procedures, whereby I paid special attention to the figure of the expert and to understandings of "trauma", as they try to translate intimate experiences to make them recognizable by public institutions. As we saw, it is important not only to look at the documents themselves but consider their "making" as social and cultural practice within a specific historical context, which shapes their epistemological categories and their meanings. Documents are artefacts of institutions (Riles, 2006) and of particular importance in asylum applications and for law practice that seeks certainty. Today applicants need to be "backed by papers" (Yngvesson & Coutin, 2006) to satisfy a certain culture of disbelief that questions an asylum seekers identity and account of the past: "are you really who you say" and "did this really happen to you" (Bohmer & Shuman, 2007). Not only has "the militant doctor" (or compassionate doctor) been turned into an "expert of forensic medicine" through increasingly standardized text making (Fassin & d'Halluin, 2005). The Istanbul Protocol, born out of the need to produce knowledge in order to hold state perpetrators accountable, has acquired new and multiple meanings within the asylum procedure, where it is part of the governmental system aimed at making migration flows manageable and different entitlements differentiable. David Mosse remarks: "[u]ltimately, however, institutions or technologies (national or local) fashioned by expert techniques come to be re-embedded in relations of power that alter their functionality [...]" (Mosse, 2011, p. 5).

How can one do justice, when justice—and the "Justice" (tribunal) quoted before—in the historical realm of the law, demands words and visible signs,

rejects silences or so-called "incoherent" testimonies? When torture is officially denied, silenced, and when testimonies are doubted? Wilson argues that most anthropological studies have concentrated on the relationship between violence and the dialectical unmaking and remaking of life worlds. He calls indeed for more ethnographic studies on how testimonies of violence are conditioned by existing forms for speaking about political violence, since they both constrain and elicit testimony. Anthropological theory can help to understand these processes and "politics of truth-telling" (Wilson, 2003, p. 269), which are conditioned by the institutional landscape in which the naming of violence takes place. As my analysis aimed to highlight, these landscapes of meaning and power are characterized by particular modes of discourse and practices, but also by erasures and silences in the translation and recognition of violence. Violence today is frequently formulated in terms of a human rights violation and and (public) health problem (Richters, 2004; Hastrup, 2003). "Trauma" has become a keyword through with various disciplines approach the experience of violence and its aftermath (Kirmayer et al., 2007) and a defining concept as well as resource for recognizing victimhood (Fassin & Rechtman, 2007). However, as Kelly (2012, p. 5) points out, "although the legal category of torture appears to prioritize individual suffering and cruelty, the turn to law can make it very difficult to recognize specific survivors and perpetrators". A look into national asylum determination decisions shows (Weissensteiner, 2009): applicants were deemed credible if they had significant scars to show and a medico-legal certificate to corroborate their claim, applicants deemed incredible in the absence of scars without taking into account the existence of clean torture techniques, applicants dismissed as incredible in the absence of medical or psychological expert documentation. Here, medico-legal or psychological evidence has gained importance not so much to assess the claim with respect to protection needs, but to ascertain the overall credibility of the applicant.

What sort of "ability to respond"—responsibility—does a testimony of violence demand from those who witness it? Giving the pain a name, naming the violence, and designing a cause, all signifies locating responsibility and reintroducing suffering in a system of shared language and meaning (Good,

1994). But struggling over a name, according to Veena Das, also reflects serious political as well as legal struggles. She argues that "I am in pain" is not an indicative statement, but a claim on the other for acknowledgement, which transforms the task of epistemological recognition into one of ethical acknowledgement (Das, 2007, p. 40, 57). "The victim's greatest certainty, his pain, is paradoxically also the magistrate's locus of doubt. Pain stops at the skin's limit. It is not shareable" (Daniel, 1994, p. 234). Those who are deemed able to translate this experience and make it recognizable to public institutions are then experts. The interview excerpts I quoted at the beginning highlight that for witnesses, documenting torture and trauma involves problems that are ethical, but also epistemological. But they are also legal and political, since a diagnosis of health is taken in politically charged environments.

As Mosse (2011) highlights, focusing on experts and individual actions is frequently read as a negative evaluation. In order to avoid being misunderstood, I want to make explicit that the question here has not been whether "medicalization" of torture and of the asylum procedure could be critiqued on good grounds or, as argued by Wenzel and Kjaer, should be considered as justified for a variety of reasons (Wenzel & Kjaer, 2006, p. 114). Indeed, I explored the conditions that have rendered these knowledge practices possible—and perceived to be necessary—and possible implications of this practice, thereby exploring professional dilemmas as well as the political and the legal domains in which health explanations are addressed with the aim of rendering violence recognizable. My aim has not been to evaluate this practice, but to take the thoughts, concerns and experiences of professionals seriously and to situate their testimonies and practices within the broader context in which they are embedded. Nor is this a claim to substitute or downplay knowledge from other disciplinary fields such as law or medicine. Anthropological theory and ethnographic research can help to explore how the "global fight against torture" becomes real within the conditions of local landscapes. Experts find themselves in a difficult role: while it is nearly impossible to be certain whether or not an individual has been tortured (Peel, 1998)—due to the fact that some forms of torture don´t leave any scars

and most scarring could tell potentially different stories—medical knowledge has nevertheless played an important role in rendering some aspects of violence visible and recognizable by public institutions. However, in the context of migration management these documents acquire new meanings. But there remains a level of uncertainty, especially in asylum proceedings, which needs to be recognized. And there are dimensions of "trauma" silenced by a single post-traumatic-stress discourse. The primary problem is not the participation of experts and organizations that "are trying to rectify today's fundamentally unfair system" (Haagensen, 2007), but the emergence of a system or apparatus that can produce painful effects without breaking skins.

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