

# **Good Practice in the Care of Victims of Torture**

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**German Association of Psychosocial Centres for Refugees and Victims of Torture  
(BAFF)**

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***We want to dedicate this publication to the survivors of torture – our clients who have had the strength to tell us their stories and the trust to share their life experiences. We have listened to the horrors that they had to go through, but we also feel privileged to have in many cases been witness to the wonderful transformation of destruction into new life.***

BAFF (German Association of Psychosocial Centres for Refugees and Victims of Torture), as the coordinator of the project "Good Practice in the Care for Victims of Torture", would like to thank everybody who has collaborated in developing and preparing this publication.

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Special thanks go to our partners, the five other participating European centres, whose teams have been prepared to critically analyse, document and reflect on their daily work with survivors of torture and have thereby played a key role in making this project possible. Special thanks to

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Thank you all for your professional commitment in being prepared to take the risk of joining us in this pilot project for an inter-institutional self-evaluation. Insightful histories of your centres and inspiring good practice examples prepared by you are the heart of this publication.

The participating organisations express their appreciation to the external evaluators – PD David Becker, International Academy (INA), at the Free University of Berlin, Germany and Professor Brandon Hamber of the University of Ulster in Northern Ireland, who provided their expert guidance in setting up the evaluation framework and helped us to develop the specific methodology for this project.

And we would like to thank the readers of this publication, who, we hope, will ensure that our recommendations for the improvement of procedures regarding victims of torture in Europe are implemented.

Elise Bittenbinder,  
Chairperson of BAFF,  
Psychotherapist with XENION,  
a psycho-social centre for victims of torture in Berlin

# 1. Introduction

*"Torture means destruction of individuals, of families and communities, of hope and of humanity, of soul, mind, psyche, of life.*

*Creation is the opposite of destruction.*

*Creating networks can bring support to our clients, our work and our staff.*

*It helps us to stay sane in the destructive world that our clients have to face – and we with them."*

*(Quotation from the final symposium in Bucharest)*

## 1.1. Background

This publication is based on a project launched by five European Institutions working with survivors of torture and human rights abuses and supported by **the Refugee Fund of the European Commission**. The project's aim was to develop common principles in central issues relating to the care of survivors, and to transmit the findings into **the European Network of Centres for the Care of Torture Victims** to secure synergy effects and sustainability.

The Network of European Treatment and Rehabilitation Centres for Victims of Torture and Human Rights Violations (referred to below as the European Network), was initiated in 2002 by the BAFF (German Association of Psychosocial Centres for Refugees and Victims of Torture) and founded in 2003. Currently, the network brings together around 70 centres or programmes providing healthcare and support to survivors of torture across Europe (defined as the area covered by the Council of Europe).

Between them, the centres have a huge body of experience and knowledge about how to assess and deal with the problems of these vulnerable groups, and consequently it was natural that the idea of creating a network should emerge. A network was seen as an effective way through which initiatives could improve services to their clients, contacts between experts could be strengthened and common principles of good practice be developed. The network's philosophy lies in defining common standards while respecting and fostering the diversity of its members and promoting an interdisciplinary approach.

A few years ago, the Network started working on the development of recommendations in relation to the EU Directives and Guidelines for Initial Health Checks for Most Vulnerable Groups, which the network published in 2004 ([www.european-network.org](http://www.european-network.org)).

The project, which has the title "Developing European standards of documentation, assessment, training, prevention and lobbying in the work with most vulnerable refugee groups (victims of torture and human rights violations) in order to evaluate and facilitate good practice," was developed as a continuation of this line of work.

The project is unprecedented for the European Network: it provides a practical example of inter-country and inter-disciplinary cooperation by bringing together centres working in different European states and specialising in various fields of support. The project is remarkable in that the centres involved have decided to develop best prac-

tice standards by critically evaluating their own work and working together on the results.

## 1.2. Objectives and organisational framework

The project aims to develop a common approach within the EU to the task of addressing the specific needs of vulnerable groups, especially those who have undergone torture or other severe human rights violations. The project took the form of a pilot cooperation between five European institutions:

- XENION: Psychosocial assistance for the politically persecuted (Germany)
- Zebra: Intercultural Centre for Counselling and Therapy (Austria);
- ICAR Foundation: Medical Rehabilitation Centre for Victims of Torture (Romania);
- Primo Levi Association: Treatment and Support for Victims of Torture and Political Violence (France); and
- AMC/Equator (Netherlands).

The project which took place in 2008/9, was coordinated by the German Association of Psychosocial Centres for Refugees and Victims of Torture and consisted of the following steps:

In the **first step** two members of each partner, three members of the steering committee and two evaluators – one internal, one external – participated in a preparatory meeting in Paris in July 2008. Criteria for self-evaluation were developed and responsibilities were discussed with regard to the following topics:

- Intake and documentation, including questions of confidentiality, methods of assessment of refugees' problems and needs, and the complex treatment they require;
- Collaboration with health and social systems, civic society and support communities;
- Prevention work; and
- Lobbying for vulnerable groups, especially victims of torture, and bringing about improvements in decision-making in asylum procedures by the state and the EU.

In the **second step**, each partner carried out a self-evaluation, analysing its own approach with regard to the topics. In the **third step**, the partners set out to develop joint criteria and recommendations for good practice for each of the four topics. For this purpose, an interim meeting took place in Berlin, in January 2009. In the **fourth step**, members of the partner institutions presented the criteria and their recommendations to the European Network Conference in Barcelona in May 2009. In the **fifth step**, the partners held a final symposium in Bucharest in September 2009, at which the results of the project were brought together and common criteria and recommendations for good practice in torture care were finalised.

In the **final step**, project results, criteria and recommendations were documented, and we are proud to present them in this publication. We hope that the criteria and recommendations will be of use to professionals working with torture survivors, help-

ing them to provide a better service to their clients. In addition, we hope our work in the project will have a noticeable impact on decision-making processes, so that legislation will be more effectively implemented, and victims of torture and human rights abuses will find a better and fairer reception in the countries of the EU.

### 1.3. About this publication

This publication has been developed to disseminate examples of good practice in the work of the Treatment and Rehabilitation Centres, to highlight the most pertinent problems in the treatment and support of refugees and victims of torture, and to present recommendations for good practice developed within the project.

This project followed two lines: its goal was to identify examples of good practice, while both taking into account the different contexts of the centres involved and developing common norms and recommendations for this kind of work in Europe. Self-evaluation and critical appraisal of the centres' work were chosen as the methods of achieving this goal. The tension between developing and presenting examples of good practice on the one hand, and critically reflecting on one's own work on the other, was consciously accepted, in order to achieve real and convincing results.

The issue is however difficult and controversial: How do institutions evaluate the effectiveness of their own work and the relevance of their work for the vulnerable refugees who are their beneficiaries?

This publication looks at current central issues regarding the needs and provisions of vulnerable refugees as they were identified, analyzed and discussed among the five institutions. Despite their differing contexts and methods of operation, the centres recognise that comparing their approaches can ensure a more efficient exchange of expertise and professional know-how. This publication documents the information they generated, as well as the process that led to the formulation of criteria and recommendations.

First we outline the **Evaluation Methodology** and provide theoretical background, giving the arguments for using an evaluation method which reflects the specific approaches and the diversity of the institutions.

Next a chapter on the **History and Origins of the Participating Centres** describes the development of each centre in the context of its country and its core approach to treatment and support. That leads to a chapter on **Current Key Learning Issues**, which outlines the common thematic framework which the partners have identified and discussed.

**Examples of Good Practice** reflects critically on the outcome of the discussions and presents an account of both the achievements and the problems which the participating centres face in providing support to victims of torture in Europe. We also analyse the factors that hinder successful help for the survivors.

In the early stages of the project, we came to the conclusion that it would be more consistent with our approach and aims if we referred to "norms and recommendations" rather than "standards." In the following chapter, we document these **Recommendations**. They were developed by the participating institutions as a set of criteria for professional conduct, and are followed by **Challenges for the Future** – highlighting the steps which we feel are necessary if these recommendations are to be translated into sustainable action across Europe.

We hope that the examples, information and recommendations assembled in this publication will help various groups of professionals working in this field to learn about the diversity of approaches and methods applied in the rehabilitation and support of victims of torture. We also hope that some of our suggestions will be taken up, and that our experience will offer a framework for other institutions which need to evaluate and develop their work.

## 2. Methodology

In this EU-funded project, the project partners have set up a common evaluation framework with which to assess their institutional performance. Within the organisations a self-evaluation methodology was used (*internal evaluation*). This was aimed not only at assisting partners to evaluate their own work and improve their practice, but also sought to use a dynamic self-reflexive process to generate norms of common practice and recommendations for the project as a whole. To ensure the project met its wider goals, an *external evaluation* of the project used as its basis the *Outcome Mapping* methodology designed and tested by the International Development Research Centre of Canada, one of the leading organisations in the field of evaluating development work. The *internal evaluation* and *Outcome Mapping* frameworks resulted in a contextual approach to the evaluation process and thus to the project as a whole, which was essential given the diverse nature of the partners' work. To this end, the evaluation focused on the internal capacities and motivation of the participating organisations, along with the external environment that influences their performance, while allowing the project as a whole to be assessed against the goals it set for itself.

In this framework, performance was not defined narrowly. Rather it was defined in terms of mission fulfilment, efficiency, and the extent to which the participating organisations adapted to changing conditions. This definition made self-reflection critical to the entire project. This publication presents the results of the institutional assessment and is based on the discussions which took place during the Team Days and the larger meetings.

### 2.1. Self-evaluation

#### 2.1.1. Why is the method of self-evaluation so central to this project?

Work with victims of torture is difficult and highly demanding for the health care workers involved. Professionals run high risks of burnout and vicarious traumatisation, and often work under a number of social and moral pressures. On top of that, their work is influenced by highly controversial debates in society and politics.

Few areas demonstrate a cross-professional, cross-national and cross-political approach more strongly than that of refugee and asylum policy. It is a meeting ground where many clear and distinctive voices are heard – international law in the form of human rights and refugee legal instruments; domestic law in the form of national aliens law; the voices from the health care system, providing assistance in the context of multiple cultures to ameliorate the after-effects of loss and gross human rights violations; and the voices from politics, where domestic agendas may compete with expectations that the right conditions will be developed for the integration of those who arrive in a new country. And – not to be forgotten – the voices of the citizens.

With so many different realities operating simultaneously across borders, it is difficult to measure and compare the varied work of the centres and institutions providing services. This becomes even more difficult when one wants also to actually utilise the

diversity of the centres and their approaches, and develop a participatory methodology.

So the basic approach needs to be more qualitative than quantitative. But that is the challenge: How can you describe adequately the multi-disciplinary and politically complex situation of the centres and their clients? How can you achieve the development of common norms, when at the same time you have to acknowledge hugely different contexts, diversities which have arisen historically, and their implications for the work?

We have chosen a methodology which first of all accepted the differences and which required each of us to look closely at our own realities and context. And then we shared this "inward view" with the other centres giving ourselves mutual feedback. Following this we discussed the feedback from the other centres in our own institutions. Thus we developed a permanent discussion and reflecting process, both nationally and internationally, in which, by discussing our differences, we began to understand what we all had in common. We documented this process, always using the documentation as a basis for further discussion as well as to verify what had been discussed. In addition, we had two evaluators, one who was guiding and supporting the self-evaluation process, and the other who was evaluating the process from an external position.

### **2.1.2. Some comments on self-evaluation**

Applied in the context of international development work, self-evaluation is an assessment tool which is used to diagnose institutional problems, as a first step in the formulation of improved interventions. Individual organisations have different characters and needs, and so self-assessment is complex. A solid framework is required, which must guide an institution in its own investigations into its performance – from defining its own idea of performance, to setting indicators, and finally to measuring its success. In this project self-evaluation was used not only to benefit the partners in assessing their own work, but as a methodology for extracting common norms and practices, which was a key purpose of the entire project.

The following principles guided the evaluation activities (both internal and external):

- **Evaluation should ensure the participation of those being evaluated.** To be useful, evaluation needs to produce relevant, action-oriented findings. This is fostered by sustained involvement and ownership by the members of the organisation throughout the process.
- **Evaluation processes should develop capacity in evaluative thinking and imply practical empowerment.** Whether those involved are managers, program staff or project partners, evaluation should increase their capacities and comfort with evaluation. Exclusive reliance on external expertise can limit an organisation's ability to be clear and specific about its goals and to learn and apply lessons. Specific strategies can be built into evaluations that are explicitly aimed at fostering these organisational characteristics.
- **Evaluative thinking adds value from the outset of a project or program.** Evaluative thinking can make a project or programme more effective by helping to clarify the results to be achieved, the strategies that will contribute to

their achievement, and the milestones that will demonstrate progress. This is true from design through implementation.

- **Evaluation should meet standards for ethical research and evaluation quality.** In order to ensure the validity of the evaluation findings, accepted social science research methods and procedures should be followed. The quality of evaluation is assessed against four internationally accepted standards: utility, feasibility, accuracy, and propriety.
- **The decision to evaluate should be strategic and not routine.** Evaluation is designed to lead to action and can contribute to decision-making and the formulation of strategy at all levels. To ensure evaluation provides useful findings, the centres must be selective in determining what issues, projects and programs are to be assessed and at what time.
- **Evaluation should be an asset for those being evaluated.** Evaluation can impose a considerable time and resource burden on team members and their participation should not be taken for granted. They should benefit from the process and should have control over the evaluation agenda when they are the intended users.

## 2.2. External evaluation: Outcome Mapping

Outcome mapping (see Earl, Carden and Smutylo, 2001) was chosen as the basis for evaluating the outcome of the evaluation process itself and to clarify goals and activities, as well as progress toward the anticipated results of the project as a whole.

At the heart of the Outcome Mapping methodology is the view that development is accomplished through changes in people's behaviour; therefore, people and organisations are central to the concept of Outcome Mapping. The originality of the methodology lies in its shift away from assessing the macro products of a program (e.g., policy relevance, poverty alleviation, reduced conflict) to focus on changes in the behaviour, relationships, actions, and/or activities of the people and organisations with whom a development program works directly, these the methodology posits can be logically linked to a program's activities.

In this project Outcome Mapping, which was originally developed for use in development work, was not implemented in its entirety. It was instead adapted for the specific task at hand, to be used at the program and organisational levels as a monitoring system and to evaluate on-going or completed processes. A learning-based and user-driven view of evaluation was taken – guided by principles of participation and interactive learning, and encouraging evaluative thinking throughout the process.

The adapted Outcome Mapping process was initialised in the initial project meeting (which took place in the second month of the project in Paris) through a participatory workshop led by the evaluators. At this meeting a series of questions – based on the Outcome Mapping method but not restricted to it – were developed, and these were used to build the evaluative framework. These included: (1) What is the overall vision of the project and what does it want to contribute to? And how will it do so? (2) Who are the program's boundary partners (those it can directly influence)? (3) What are the changes that are being sought with boundary partners? (4) How will the program contribute to the change process? These questions were worked through at the meeting in Paris with the project partners, and the answers in essence documented

what the partners wanted to achieve. These answers were then used to build the evaluative framework.

The evaluative framework consisted of a series of categorised key desired outcomes using the Outcome Mapping framework. This framework then served as the template against which the project was finally evaluated from an external perspective. At the second meeting in Berlin in March 2009 the framework was further tested with project participants, who were asked about how far they had so far come in achieving the outcomes. An evaluation questionnaire was developed and introduced at the final symposium. It was circulated to assist the (self-) evaluation of the partners, as well as to provide information for the overall evaluation of the project.

In addition to the use of the evaluative framework for the external evaluation, a series of other questions, consistent with the Outcome Mapping, were also asked. These were questions that sought to better understand and evaluate good organisational/project practice, i.e. whether the project developed new ideas, opportunities, and resources, or tried to do so; whether it received ongoing feedback from key informants; whether it assessed and potentially (re)designed its products, services, systems, and procedures as a result of the project; whether it created space for feedback from those whom the project seeks to influence; and whether results were being disseminated effectively. The questions were also intended to highlight any innovations coming from the project; and to show whether the project had built in organisational/project reflection during the process.

In addition to this, the external evaluator also considered the wider indicators set out in the project proposal:

- the degree to which the project adhered to the time table;
- the degree to which information flowed between partners;
- the quantity and quality of data collected in all participating centres;
- the efficiency of analysis of data/ usefulness of the result of the project;
- the comprehensiveness of criteria and recommendations developed;
- how many persons were reached through the project;
- whether the relevant target group was reached;
- the content of the feedback from the target groups;
- whether all outputs were achieved (e.g. three meetings, dissemination to European Network, etc.)

Overall the Outcome Mapping framework allowed the group to reach consensus on the macro-level changes they wanted to achieve (and with whom) and the strategies to be employed. It also provided a basis for subsequent discussions among the partners to negotiate program intentions, to help the program develop a monitoring system and to establish an evaluation plan. Outcome Mapping was a useful and appropriate tool to chart goals, activities, and progress toward anticipated results. In addition, the evaluator also assessed the objectives and outputs as laid out in the original proposal.

Broadly speaking the external evaluator found that the objectives of the project were achieved. His report is available on request.

### 2.3. Internal evaluation: self-evaluation as method

Conventional approaches to evaluation focus on a project's objectives and on finding a method (for example interviews) of assessing its impact and outcome – the external evaluation described above had to rely on this method to a degree, although it also tried to develop a more participative self-evaluation method in which partners defined their own goals for the project using the Outcome Mapping methodology, and then these were evaluated by the partners themselves. However, when thinking about social reality, especially from the position of the day-to-day work of the partners, it is important to acknowledge that the social reality is ever changing and complex. Precise evaluation of the relationship between inputs and outcomes is difficult in social processes because there are multiple actors and external influences.

The internal self-evaluation process was guided by the following principles:

- to ensure that the project is carried out with the interests of clients as its main priority;
- to move towards thinking of the complex contribution of the various people involved in a centre's activities;
- to include participation of all team members, partners and organisations as far as possible;
- to focus on empowerment processes and steps towards realistic outcomes; and
- to focus on changes in the behaviour, relationships, actions or activities of the people or organisations with whom the project works directly.

The partners used the self-evaluation process to assess their own work and then derive norms of common practice and a series of recommendations. The following assumptions lay behind the process:

- severe traumatic experiences are complex and ever-changing processes; instead of planning for and expecting short-term specific achievements, it is reasonable to define long-term aims, giving space for evolution and change;
- evaluation should not only focus on work, questions of organisations and the situation of the clients, but it should also allow space for the individual sensitivities of staff members;
- evaluation should not mean only answering questions set from the outside, but must provide the opportunity for participants be actively involved in the process;
- the process of evaluation must consider the specific reality of the project or the centre;
- each project and centre has its unique evolution, and an historical analysis often helps to understand the development of problems and how to deal with them;
- in the process of evaluation all participating partners should have the chance to develop and to reappraise their own opinions and ideas; and
- the documentation of the evaluation process must be accurate, detailed and comprehensible for all parties.

## 2.4. Specific methods: Team Days and feedback loops

The self-evaluation process included three Team Days, each with a specific focus:

- 1<sup>st</sup> Team Day: collecting data, identifying key problems
- 2<sup>nd</sup> Team Day: developing suggestions for solutions
- 3<sup>rd</sup> Team Day: implementing results in the work of the centres

The participating centres carried out their self-evaluation by using a methodology and structure they developed jointly in cooperation with the internal evaluator. This ensured a commonly defined agenda and meant that results could be used for comparative analysis. The discussions and conclusions of the Team Days were documented and presented for discussion in the partner meetings that followed each Team Day (See Appendix 2 for details of the project timetable).

At the Team Days each centre ran thorough and targeted discussions, focussing both on achievements and challenges, and looking for appropriate responses to the problems they identified. In addition to exchanging and analysing data, Team Days helped the centres study the internal dynamic of staff relationships by providing space for interaction between staff from different levels and areas (e.g. clinical and administrative staff). This interdisciplinary strategy allowed for a better exchange of ideas between different groups of professionals and assured a more holistic approach.

Team Days were organised around the issues and topics identified at the partner meetings, thus reflecting the real interests and concerns of the group. While holding to the original structure of the three Team Days, there was room for flexibility, so that issues which emerged at the partner meetings could be taken account of.

The structure and key issues of the Team Days are presented below in their final versions, along with comments from participants. We hope that this detailed presentation will help the reader learn more about the structure and goals of the Team Days and show how the self-evaluation technique works.

**Feedback loops:** The evaluation methodology for the Team Days was presented and explained by the evaluators at the first partner meeting in Paris. This meant that two representatives of each partner and the coordinating organisation had the opportunity to find out more about the suggested methods for self-evaluation and to discuss plans for the first Team Day. After the first Team Days had taken place in each centre, the protocols were made available to all the partners and key issues were discussed in the partner meetings. Additional feedback was given to each centre by the internal evaluator. Another feedback loop was the last Team Day itself: here each centre discussed the feedback it had received from the other centres. Additionally, within each centre a feedback loop was included in that the protocol of the Team Day was fed back to the team for comments and further discussion.

### 2.4.1. Team Day 1 – description of proceedings and major steps

In each centre, two team members led the process of self-evaluation and decided which staff members should take part. As noted above, it had been agreed that staff from different working fields (clinical staff, administration, members of the board, interpreters and freelancers) were to be represented. Approximately 12 members of each centre participated in the first Team Day.

**Team Day 1** included the following steps/issues:

**1. Description of the institution:** one team member read a short description of the institution which was discussed with the team members

**2. Identification of key problematic situations:** each team member described a difficult situation they had experienced, which was then discussed and analysed.

*"Each member of the team who is taking part in the evaluation enters on a fantasy journey (directed fantasy journey). Members of the team consider a situation which arose at work and which they regarded as problematical. They should note the personal feelings which were linked with the situation. Every team member should make an imaginary snapshot of the situation." (Extract from the briefing note given to the centres before the Team Days)*

**3. Empowerment analysis:** starting with a detailed description of a clinical case the team members defined typical problems affecting clients on different levels (individual, group, society). In a second step, objectives were elaborated for the three levels (what should be done?). After that, a realistic perspective of action was developed (what can be done?)

**4. Significant change stories:** each team member wrote and presented a story in which a significant change at work had been achieved.

*Extracts from the Team Day 1 protocols:*

"The proceedings of the Team Day helped the team to identify its core values, and fostered cohesion and motivation of the team." (*Equator, the Netherlands*)

"... Important process for the team of the Rehabilitation centre, because for the first time all colleagues (employees as well as freelances) came together for a working process, which was meant to observe and consider the work from different points of view. It was seen as enriching, interesting and valuable. There was criticism regarding the number of tasks for one day, and there was a wish to have more time for discussions after the exercises, and for more options of exchange and deliberation in this vein beside the usual supervisions." (*Zebra, Austria*)

"Our greatest challenge has always been to gain the confidence of the individual clients and to meet their expectations, and a lot of our extracurricular activities have in fact been necessary to be undertaken to allow us to continue to provide the services to victims we set out to provide." (*ICAR Foundation, Romania*)

"A heated discussion arose over the interpretation of eligibility, reception and assessment of clients and the limitation on the numbers of clients that we can take on for care and treatment. 'We should make sure that all clients get the chance to tell their story and get the best advice' versus 'We do not want to give hope to persons whom we cannot take on for capacity reasons.' There was controversy as to how we use our resources: should we help more clients or build capacity through intensifying fundraising?" (*XENION, Germany*)

"...We have not been able to go too much into the more advanced topics, and I certainly would have liked to do that, yet we are going to stay with our frustration and go on to the analysis of the problems and conflicts that the Institution went through at the level of the individual – in terms of what solutions can be found for our patients on the psychic, material, and political levels, first in a kind of utopian, idealistic manner, and afterwards in a realistic fashion...I am just crossing the waiting room and recognise Mr. S. whom I have known for twenty years, his gaze is searching for me. Twenty years of care giving? To me, he per-

sonifies what torture can do and what one can achieve. Twenty years that have been serving what? When I see him I recall that summer where we all feared he would commit suicide." (*Primo Levi Association, France*)

## 2.4.2. Team Day 2 – description of proceedings and major steps

Based on the report from Team Day 1 and the evaluator's feedback, the teams defined the key issues for their work and developed suggestions for solutions for the problems they had identified.

The central issue for **Team Day 2** was to define concrete activities which the centres wanted to develop and to select the problematic issues they needed to work on. The issues were selected based on the reports from Team Day 1. Team Day 2 also became a logical continuation of the deeper analysis of the issues and included more targeted discussion about their impact on the work of the centres.

*Extracts from the Team Day 2 protocols:*

"The proceedings of the Team Day 2 helped the team to decide to more strictly focus on certain elements of the treatment program, consequent to one major objective of the treatment: empowerment." (*Equator, the Netherlands*)

"Again great interest. At the same time the complexity of our work and the difficulties therein became noticeable. Awareness of how difficult it is to find solutions, also because of the challenging conditions which we, together with our clients, have to face over and over again. As a result, the atmosphere on this day was occasionally also characterised by frustration, sometimes anger and impatience. Nevertheless it was an important process for the team that made it possible to realise and name the effects on everyone of us and the whole team. We learned to handle it better together." (*Zebra, Austria*)

"After discussing each problem the participants selected three key issues they saw as most relevant to their target groups and relating to the specific activities of the organisation... ICAR team members decided to focus on society and policy issues...because positive changes at the political and social level influence internal matters for the better, too." (*ICAR Foundation, Romania*)

"We did a structured review on what XENION can manage financially and in terms of content, and also what resources we have available for it. As a result, we were able to identify gaps and discrepancies and learned to evaluate our internal capacities." (*XENION, Germany*)

"Is working together experienced as a difficulty? 'In any institution, people come into conflict. I don't think that seeing things from this point of view helps to make progress. Behind each guild there are people and sometimes, they disagree. But nothing would be more suspicious than an imaginary harmony.' As someone says it another way: 'The multidisciplinary approach works well here, with all its pitfalls.'" (*Primo Levi Association, France*)

### **2.4.3. Team Day 3 – description of proceedings and major steps**

**Team Day 3** was aimed at making decisions and developing concrete goals for the future. The focus was put on the following questions:

- How can we implement the findings of the Team Days 1 and 2?
- What will our Plan of Action look like?

Team Day 3 was structured in three parts:

- I. European Learning Issues
- II. Plan of Action and Good Practice
- III. Vision for a European Dimension: Final Evaluation

#### **I. European Learning Issues**

The first part of Team Day 3 was used to learn from the other centres. Everybody taking part in the Team Day 3 was required to have read all the Team Day protocols of the other centres plus the feedback from the internal and external evaluators. The moderators (if necessary, together with one or two of their colleagues) were asked to present the basic data gathered from other centres to their team so that everybody had an overview.

#### **II. Plan of Action and Good Practice**

The second part of Team Day 3 was used to set up a Plan of Action and decide on the centre's individual Good Practice.

##### **Plan of Action**

- Identify Problems
- Set Goals
- Decide on Method and Action to take in order to reach the Goals
- Decide on the indicators to be used to measure the success of the Plan of Action

##### **Good Practice**

The task was to decide on how each centre's "Good Practice" should be documented and define how it could be given more visibility.

Each centre identified and described its Good Practice in a written report. These reports were then presented to the other centres at the final meeting in Bucharest, where a major element was the discussion about the Good Practice of each centre.

#### **III. Vision for a European Dimension: Final Evaluation**

In this last part of Team Day 3, the centres discussed their wishes for a European dimension. In particular, they focused on how they see themselves as part of an international team, and what they imagine as strategies for further cooperation.

*Abstracts from the Team Day 3 protocols:*

"All Team Days have clearly served team building. They also triggered new international contacts and plans for further development of the treatment, research and advocacy for our vulnerable and complicated target group." (*Equator, the Netherlands*)

"Similar feedback from the participants as on the previous Team Days. Emphasis of the importance of these days, appreciation of the collective learning process that everyone sees in following this evaluation process. The instructions and guidelines of the evaluators or of the leadership were sometimes seen as a great challenge, but at the same time also as necessary to come to precise results. Especially highlighted and felt as necessary was the variety of the different tasks that also considers the different layers of our work." (*Zebra, Austria*)

"The experience of the three Team Days and their requirements...allowed for a better insight into the organisation, its problems, accomplishments and future directions. Also, the staff had the opportunity to all sit down and discuss issues in depth, which time pressure usually doesn't permit. Finding out about the issues other European rehabilitation centres are dealing with had been an interesting experience for ICAR staff, especially for those who don't interact on a regular basis with professionals from these centres. The idea that you are not alone in your daily struggles is extremely important and somewhat comforting." (*ICAR Foundation, Romania*)

"Because of the precarious situation of the clients, we have always been forced to adopt a very open approach to our work, and there always has to be space for experiments. Although we often see this as a problem, this could be one of our big strengths. If we can develop norms out of this innovatory mentality, we could define basic ideas of good practice. These proposals of norms and good practice can then be compared with those of the other centres in order to find common norms and good practice." (*XENION, Germany*)

"A formidable work of reflection occurred. We don't enhance the value of it enough. To what extent can all this serve lobbying purposes? There are too many people who don't know the problems we encounter, that is, problems that patients and caregivers encounter, in the midst of their interaction. If five other centres have performed the same work, that means that there will be a lot of information, a lot of material gathered." (*Primo Levi Association, France*)

This process might sound complicated – but the process, and the input which the process had into our work, has shown that this methodology was more appropriate to our problems and realities than other evaluation methods we have used in the past. Additionally the feedback showed that the team members, and especially the clinical staff, found the method an extremely helpful way of working effectively on typical problems faced by clients. The methodology also allowed for the partner organisations to learn more about each other's work and best practice. The self-evaluation method meant that the information used for considering similarities and differences was detailed and rigorous, thus allowing for a more nuanced and context-specific set of recommendations. In other words, the methodology facilitated internal empowerment of the partners allowing them to look at some of their own challenges and solve internal problems, but it also facilitated a detailed cross-country view of the work of the project partners.

### 3. Care for vulnerable refugees and victims of torture in Europe

To place the types of services offered by the various partner organisations in context (see chapter 4) it is necessary to make some general comments about the vulnerabilities experienced by refugees and victims of torture in Europe. Our description of the situation is based on the available literature on the subject, as well as on the experiences of the project partners.

There is no longer any controversy over the fact that vulnerable refugees and victims of torture need assistance and treatment to ameliorate the after-effects of loss and gross human rights violations. But domestic political agendas are not always compatible with the kinds of conditions which caregivers and health professionals would like to see. All the same, they are providing care, treatment and rehabilitation facilities in a wide variety of ways. The professional discourse on psychological and physical after-effects of trauma and man-made disasters has come a long way, diagnostic manuals are available and different treatment models have been established.

Intervention is possible and needed on different levels, although the way in which help is given can differ widely. This often depends on how we define adequate support, given that there are a number of persistent complex issues concerning the various forms of insecurity experienced by all refugees (and even more by victims of torture) which cannot be completely solved, but which require systematic consideration and are usually inter-related:

- *Physical insecurity:* Refugees may be exposed to particular risks of physical violence in their countries of exile. There has always been tension between host populations and refugees, complicating the situation of refugees and creating a potential for interpersonal and group conflicts. Both sides often project their insecurity onto the other, while remaining broadly ignorant of their circumstances. Thus refugees are often subject to violent attacks by right-wing extremists and racist groups. Refugees may also feel physically insecure because the prejudices of the local population can lead to a hostile environment; the refugees may feel that the local population have a negative disposition towards them.
- *Psychosocial insecurity:* For many refugees, arrival at their destination is a shocking experience, as they suddenly realise that refuge guarantees them no real security. They feel overwhelmed by the variety of problems they face to survive (e.g. employment, language difficulties, schooling for their children, legal problems, poverty), all of which have to be addressed simultaneously. On the other hand, for the first time, at the place of destination and away from direct threat of those that harmed in the first place, they often become fully aware of the psychological damage they have suffered. The extent of this damage is multiplied by the problems with which they are confronted in the new environment.
- *Legal insecurity:* Refugees are often restricted in their rights of movement and in their access to social and medical services, to employment and credit. Thus they experience several forms of insecurity. Many have a protracted irregular legal status while they wait for a decision on their refugee status. They are not citizens of the country to which they have fled, and thus they lack the protec-

tion of the state and are at particular risk of persecution and social and economic marginalisation.

- *Material insecurity*: Refugees rarely possess many material resources when they come to a country of exile. When they arrive, they may well live a precarious, hand-to-mouth existence, focused on mere survival, especially in the initial stages. They depend on special support programs which themselves suffer from insufficient funding. They lack local social networks and language skills, and are confronted with unknown social and cultural rules and an unfamiliar economic environment. All these combined with their problematic legal status make it unrealistic for them to think of achieving financial security.

As a result of the high degree of insecurity that refugees face, they have been shown to be at increased risk in various ways. They are often likely to be chronically ill, especially when their trauma is complemented with new factors that aggravate their psychological and mental condition. In this case, the mental condition of refugees and their psychosocial problems are highly interconnected: problems stemming from psychological and physical suffering and those stemming from the social conditions in which they find themselves feed on one another.

Refugees thus present a broad range of vulnerabilities that are constantly influenced by the ongoing socio-political process in their home countries, as well as in the countries where they have found asylum. The issue of how we define their suffering in itself influences their well-being. If they are simply defined as "disturbed" or "ill" it can aggravate their situation. If their suffering is only seen as social or political, it ignores their real problems on the individual mental and physical health level. Thus the definitions that are used to describe the problems of refugees themselves can influence their mental health.

These problems on the individual level might include pre-existing problems (mental and health disorders) or conditions induced by crisis, such as grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD). Thus, emergencies tend to amplify pre-existing problems of social injustice and inequality, and, combined with new stress experienced in the country of exile, lead to diverse forms of traumatisation that encompass far more than PTSD – some of it being reflected in the concept of complex PTSD (see Herman, 1992).

Although psychological trauma is generally well understood, there is still no generally accepted view as to appropriate treatment. The concept of PTSD is successful in describing symptoms resulting from a traumatic situation, but an exclusive focus on traumatic stress may lead to the neglect of many other key mental and psychosocial health issues, and tends not to take the contextual and psychosocial and political context adequately into account.

Although we can today call upon highly specialised knowledge and different techniques to determine trauma-relevant disturbances, the professionals in this project agree that methods which focus solely on deficiency, suffering and pathology, and which do not include the **resources** of the person affected, which support his or her well-being and self-determination, are insufficient.

In the context of violence, war and persecution we talk of **psychosocial trauma**. This affects the individual as well as the whole society involved and is never limited to one traumatic event but triggers a process with different sequela.

Hans Keilson's 1992 publication on "*Sequential Traumatisation*" makes clear that trauma must be seen in its social dimension and that any psychotherapeutic treat-

ment of victims of war and political persecution must include this aspect. It follows that attempts at rehabilitation must not only include the past traumatic sequence but also the present terms of coping in exile in a *trans-cultural* context.

Subsequent approaches that do not operate in an **integrative manner** and which do not take into account the social and political context will not be effective.

Services have to include not only medical or psychological provision, but also integrative provision such as structures for mentoring, voluntary work to support integration into the host society, and interventions into civic society and in the political decision-finding processes.

## 4. Services offered by centres

### 4.1. About the Partner Organisations

The five partner organisations engaged in this project have been active for many years, both at national and international level, doing practical clinical work, prevention work and training, as well as using their expertise to lobby health and social systems.

All the centres are non-governmental organisations, including psychotherapists, doctors, psychologists, social workers, lawyers and administrators. Between them, they have substantial knowledge of documentation, assessment, treatment, evaluation and research which they have developed over many years of practical and theoretical commitment to the field.

In order to understand their differences and similarities, each team described its origin and history in written form for the benefit of the others. Each of them did so in a way which itself was characteristic of its identity.

Some points became obvious: XENION in Germany, Zebra in Austria and Primo Levi in France show certain similarities in their structure and method (e.g. offering psychotherapeutic and social services), while Equator in Holland and ICAR in Romania offer a more exclusively medical and psychiatric approach in dealing with their clients. Equator is institutionally linked to the country's health system in a different way from the others.

Among the issues which are relevant to a comparison therefore are whether there is more or less space for psychotherapy or social service, what the role of political action is, and whether political action, when it takes place, has any influence on the way the staff work or on the treatment methods they choose.

#### 4.1.1. Zebra, Austria - A holistic approach to the needs of traumatised people

Zebra, the intercultural consulting and therapy centre, has existed since 1986 as an independent and non-denominational institution in Graz.

The origins: The starting point was an Amnesty International symposium about torture and rehabilitation in 1985, in which many European centres from various countries participated. The various concepts of existing centres were compared and it was agreed that an approach restricted only to medical and clinical aspects was insufficient, leading to the choice of a multiprofessional and interdisciplinary approach, networked with other institutions. In 1986, Zebra was founded with the support of the then mayor of Graz.

Development of services and cooperation: At that time, Zebra was the only institution in Graz that offered professional consultation and care for refugees and migrants. As a result of the precarious legal situation of refugees (i.e. with no proper asylum procedure and with refugees often being detained to await repatriation), the main emphasis was put on the counselling of imprisoned refugees.

In 1990, the first cooperation contract for the counselling of migrants with the Employment Office AMS (Arbeitsmarktservice) was set up. Zebra organised workshops, seminars and meetings on training and education. In 1991 the first "ZEBRATL", a professional journal for asylum and migration issues was published.

From 1997 to 1998, Zebra and several other organisations brought the exhibition "Verbrechen der Wehrmacht" ("Crimes of the Wehrmacht") to Graz and organised a wide variety of seminars and further education events connected with the exhibition. The re-appraisal of the past and the confrontation with Austria's recent history and its involvement in National Socialism have been a significant element in developing political awareness about issues related to the refugees of today.

The outbreak of the war in ex-Yugoslavia saw a wave of refugees coming to Austria, and this led to a greater public recognition of the issue of refugees and concern with their fate. In 1993, Zebra received a request from the province of Styria to provide counselling for Bosnian war refugees.

In 1996, psychotherapeutic treatment was established as an additional service. A psychotherapist was employed and freelance therapists were taken on. Particular emphasis was put on outreach, providing mobile psychotherapeutic treatment in hostels in Styria for refugees from Bosnia and later on from Kosovo. In 1997 Zebra worked with other institutions to provide care for unaccompanied adolescent refugees. In the same year, Zebra opened a second office.

The outreach clinic for migrants developed further and began to offer mother tongue counselling. In cooperation with the AMS, Zebra supported the integration of people searching for work into the employment market. Counselling of asylum seekers focused on legal advice and assistance through the asylum procedure.

Services and activities: In 2002, new premises and cooperations led to restructuring and a new concept. The legal advice service was integrated into the counselling centre; the rehabilitation centre and the therapy team were expanded and new offers such as language promotion were provided.

In recent years, it has become widely understood that traumatised refugees need comprehensive rehabilitation, as a result of both their traumatic experiences and their current situation. Psychotherapy, social work, physiotherapy, as well as medical and psychiatric treatment, are essential parts of our institution. Today, the core team consists of five psychotherapists, a social worker, a consultant psychiatrist, two physiotherapists and a pool of interpreters.

Since 1999, Zebra has been involved in projects funded by the EU within the framework of the EQUAL directives (2003-2007). Among them have been basic education and literacy provision for unaccompanied refugee minors and a project which helps refugees to integrate into the community. From 2005 to 2007 a project called "Improvement and development of treatment and counselling for survivors and victims of torture in Styria" was supported by the EU, which involved intensive cooperation with the "Landeslinik Sigmund Freud." The project was awarded the Styrian prize for human rights in 2007.

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#### **4.1.2. Equator Foundation, the Netherlands – Linking mental health recovery to social integration**

Origins: The Equator treatment program was established in 2003 within the Department of Psychiatry of the Academic Medical Centre at the University of Amsterdam hospital with financial aid from the European Refugee Fund. In 2007 the department chose to focus on a medical-biological psychiatric approach. In May 2009 Equator moved out and became an autonomous agency as the Equator Foundation, and found a new institutional base in the holding foundation Arq, an expert centre for psychological trauma.

General: Equator Foundation provides psychiatric and psychosocial care to survivors of war and political violence and to victims of human trafficking. It applies an approach which simultaneously aims at mental health and social connectedness. In the Amsterdam region, Equator provides day-care and outpatient treatment programs for traumatised refugees. Equator also implements psychosocial support programs in post-conflict areas in Africa. It carries out research into the effectiveness of the aid provided, and considers education, training and development as essential in its mission.

Equator's guiding principles are that mental health care for survivors of war, political violence and human trafficking has to apply an individual trauma perspective as much as a focus on the social aspects of the experiences and current situations of clients, and that expertise gained in aid provision in contexts outside Western Europe has to feed into working methods for migrants in the Netherlands.

Consequently, staff expertise combines the areas of posttraumatic psychopathology, cross-cultural psychiatric diagnostics and treatment, intercultural communication, human rights issues, and social and ideological movements. Through a combination of working for the treatment program in Equator and going on field missions for humanitarian aid organisations some staff members also have international experience working in mental health and psychosocial programs in a variety of low income and post-conflict countries.

Presently the Equator Foundation, in cooperation with national counterparts, carries out community based psychosocial support programs in Rwanda and DR Congo. These programs aim at mental health recovery, social re-bonding and social functioning and include research on their effects. In the past Equator has participated in studies in Tanzania and Zaire (both 1995), Afghanistan (2004) and Sierra Leone (2004), and is currently involved in a worldwide study of humanitarian aid workers (coordinated by CDC and Antares Foundation).

Treatment program: Equator provides psychiatric and psychosocial care for refugees and asylum seekers and victims of human trafficking who suffer trauma-related psychopathology. Treatment methods comprise: individual supportive counselling or trauma-focused psychotherapy (CBT, Narrative Exposure Therapy, Testimony therapy, EMDR), medication, stabilisation groups, psychomotor therapy, psycho-education, information and orientation on Dutch society (group work), language training, individual social and legal counselling, occupational therapy (group), social integration support (individual), and preventive groups (verbal and physical working methods).

The day-care clinic runs a multi-disciplinary and multi-component program 3 days per week. Clients can participate for a maximum period of 6 months. Treatment occurs

largely in group sessions. Psychiatric and psychological treatment components focus on coping with traumatic memories. A main element of the program is shaped by a form of sociotherapy, a therapeutic group approach which has been adapted to the refugee client population – finding a constructive daily routine or prospects for employment after the termination of treatment.

Equator also offers outpatient treatment in the form of a women's group mixing psychiatric and psychological treatment with strategies to foster social integration. The variety of methods applied might be trauma-focused or might address depressive symptoms, or use body-oriented methodologies. Also female victims of trafficking might be referred to the program for diagnostics and treatment if needed.

Number and origin of clients: Over the past years, the average total number of clients included in the program at any point in time was 120. These originated from a broad spectrum of countries in four different continents.

Staff: The Equator team comprises 2 directors (a psychiatrist and an anthropologist/occupational therapist), 2 psychologists, 2 medical doctors, 2 sociotherapists, 2 psychomotor therapists, 1 social worker, 1 occupational therapist, 2 researchers and 1 secretary. Almost all staff work only part-time for Equator.

Boundary partners: Equator Foundation is engaged in a number of activities in cooperation with outside partners such as the Amsterdam Coordination point Human Trafficking (ACM) and the Works Foundation and project (a satellite foundation of Equator Foundation), which aims to act as a bridge taking clients from care-dependency toward social independence and to help traumatised refugees successfully engage in occupational integration. Equator also has its local partners in Rwanda and Congo, with whom it implements psychosocial support programs specifically designed for populations living in post-conflict areas.

Research: Equator carries out academic research projects to evaluate and measure treatment and program outcomes.

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#### **4.1.3. ICAR Foundation – A Romanian human rights initiative in a transitional political climate**

Origins: The ICAR Foundation is a Romanian NGO, created in 1991 and registered in 1992. Its first rehabilitation centre opened in Bucharest in 1993, a second in Iasi in 1995, and a third in Craiova in 1998.

ICAR is still the only institution providing qualified assistance to torture survivors in Romania, i.e. people who fought in Romania for a democratic and open society during the political repression of 1945-1989 and who experienced torture, violence and other inhuman treatment in communist prisons. The foundation's basic goals are to improve the health of these survivors, help them become integrated into a normal social life and prevent future acts of torture. ICAR's demonstration of respect for survivors also represents an important step toward healthy political reconciliation, which the organisation considers the least a society can do for them when their torturers go unpunished.

ICAR started this struggle at a time when, despite an apparent political transition, torture survivors were still ignored and treated with disdain by both the State and much of the population. ICAR succeeded gradually in getting the State to assist in providing first the physical premises for torture treatment centres, and then the right to free medicine prescribed by ICAR physicians only for basic care and services.

This was however much more than a battle for services for torture survivors, or a search for government funding. The State's reluctance to support the needs of torture victims is symptomatic of a much deeper problem of democracy. Torture victims are living in a country where their torturers have escaped with impunity, many still occupying influential positions in society.

In its concern with the long overdue and still unmet need for some form of moral rehabilitation for victims, ICAR opened a court case in 2003 requiring the Romanian State to acknowledge the extensive human rights violations committed by the former communist regime and to make a public apology to the victims of this regime and their families. Supported by an increasing number of civil society organisations and individuals this request led the new centre-right President to establish a Commission for the Analysis of the Communist Dictatorship in Romania in 2006. Based on the Commission's report the President declared the previous regime illegitimate and criminal, and the requested public apology was made to its victims on behalf of the Romanian State.

It has been a long battle which is not yet over, but ICAR's successes to date show the power of persistence and creativity, and the importance of a stubborn unwillingness to give up on the struggle for quality services for its clients.

### **A new group of clients in need of ICAR's services**

Since 2003 ICAR has also provided care to an increasing number refugees arriving in the country who have been victims of torture and ill treatment, and this is gradually changing the focus of its actions. In spite of the fact that special services for such victims are mandatory under EU directives there are no such services available in the Romanian public health system. The result is that these people depend largely on ICAR and international funding for the services they need.

The situation is further complicated by the very limited access to health care which asylum seekers and unemployed refugees and their families enjoy.

Special services have until now been provided only at ICAR's premises in Bucharest and in the Bucharest reception centre to which ICAR has obtained access. ICAR, however, is currently in the process of building capacity to deal with this group on a national basis so that appropriate services can be offered in all the five reception centres for asylum seekers and refugees situated along Romania's external frontiers.

This has immediately faced ICAR with the challenge of convincing the immigration authorities of the urgent need to establish procedures that guarantee early identification of victims among asylum seekers and to finance or at least help to finance the maintenance and necessary expansion of special services to these victims.

This is uphill work, especially since a recent study has shown that most other member states have also failed to implement the EU Directive in question. But ICAR has finally been able to establish a dialogue with the office responsible for the distribution of ERF funds in Romania. In the course of the current project, ICAR was able to expose the staff of the office to a panel of European experts in the rehabilitation field

which helped to get the message across concerning victims' needs and state obligations.

Current number of clients and services: In 2008, ICAR provided 15,113 medical and psychiatric consultations, 1,098 external referrals, 165 psychological and social consultations and 67 legal counselling sessions to over 900 clients. More than 15 cases for reparation are ongoing in Romanian courts assisted by ICAR lawyers. Romanian language classes, cultural orientation sessions and other social events are organised by ICAR staff and its volunteers for refugees and asylum seekers in the reception centres.

### **Unsure future after loss of EU funding**

ICAR's survival is currently seriously threatened by the negative effects of recent policy changes by the European Commission in Brussels, but ICAR's ability to maintain its deeper long-term strategic goal, even while immersed in the daily struggle to find money for urgently-needed care and medicines, provides an example of good organisational practice in care for victims of torture and ill-treatment. New challenges require new solutions; the struggle is ongoing.

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## **4.1.4. XENION, Germany – The starting point is the story and the reality of clients' lives**

### **Origins and history of XENION**

In the 1980s there was no way within the health system in Berlin to provide professional help in overcoming their difficulties for political refugees and victims of torture and human rights abuses. In 1986, this situation led a group of German and foreign doctors, psychologists, social workers and psychotherapists who had been repeatedly confronted with the needs of refugees to found the XENION Association. It was staffed by volunteers and was immediately confronted with a flood of refugees seeking help.

XENION was the first institution for this target group in Berlin, and it had the support of Amnesty international and the medical associations. Ellis Huber (Chair of the German Medical Association) spoke of a milestone and said that *"the Medical Association regrets that, in the year of Berlin's 750th anniversary, the Senate fails to come up to the historic traditions and the historic commitment of the city towards its refugees."*

From the beginning the centre was an interface between health-related provision (including psychosocial, psychological and medical treatment) and approaches to human rights work. This was a logical consequence of its being involved with politically persecuted survivors.

XENION received its first public money from the Berlin Department for Health and Social Services, as well as from the "World Solidarity" Foundation, in 1988. Two years later the European Community became a main financial supporter, guaranteeing its work over years and allowing the Centre to develop. It adopted an integrated

approach, using various coordinated psychotherapeutic and social measures in its work.

In 1991 XENION started a special project for young refugees. In addition to psychotherapy, the young people are offered counselling on vocational training and special measures to prepare them for work. In the same year, XENION entered into a deeper conceptual exchange with similar initiatives in other member states of the European Community.

XENION was one of the first organisations in Germany that forced the discussion on multicultural and multiethnic approaches in psychiatry and the proper use of trained interpreters in that field. In its discourse with the health professional community XENION stood its ground on two points which were highly controversial at the time: firstly, not only those who are themselves survivors or victims can advise and help others, and secondly, psychotherapy and counselling can be done with interpreters if the interpreters are properly trained. The issue of what qualifications are needed to work in a trans-cultural setting led XENION to offer a special training programme for interpreters in 1992 that was unique in Germany.

In 1995 XENION organised a national conference with international speakers in Berlin under the title "Feeling at home once more in the world – fate, change and identity." In 1997 the centre became a founding member of the "Bundesarbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer e.V. or German Association of Psychosocial Centres for Refugees and Victims of Torture (BAFF)", the umbrella body for German psychosocial centres for victims of human rights abuses. In 2004, it hosted an annual BAFF conference with the topic: "The dispute over professional reports: torture victims and refugees from war in the legal machinery". The discussion which ensued in the professional world led to the development of guidelines for professional reports on traumatised refugees, and to the establishment of training courses for doctors, psychologists and psychotherapists in how to draw them up.

Another important element of XENION's concept is the integration of traumatised refugees into the community. Social networking was seen as a bridge towards involvement with the society and as part of the healing process. A mentoring project was founded under which trained volunteer mentors support clients of XENION and other young adult refugees in their daily life. In 2003, XENION started the AKINDA network for legal guardians ("**A**usländische **K**inder in **D**eutschland – **A**llein" – "Foreign Children in Germany – Alone") – organising legal guardians for unaccompanied refugee minors living alone in Berlin.

Since 2005, XENION has been collaborating with the Medical Association and the Psychotherapists' Association in professional training for therapists, psychologists and doctors. It has also started training judges etc.

In 2007, XENION celebrated its 20th anniversary with over 250 guests in the Berlin state parliament building.

Transnational cooperation: a commitment to networking is an important aspect of XENION's transnational exchanges which started in 1991. Among others, XENION collaborated in a German-Bosnian-Kosovan professional exchange in 1998-2000, and since 2005 in an exchange with Chechnya and Russia. More recently it has established links with Poland.

XENION's working concept is to support its clients in issues related to health, social rights and asylum and residence status. It sees itself as a human rights organisation whose objective is not only the treatment and counselling of refugees but also the

provision of help for them to achieve their rights and to live a life which is as independent and integrated as possible. Our working concept puts the individual and his/her story at the centre of its concerns.

Staff: Staff include psychotherapists, a psychiatrist (not in house), social workers, project coordinators, a coordinator for the youth and mentoring project, and administrative staff. Some of them are employed full or part time and some (eight psychotherapists and 16 interpreters) work on a freelance basis. In addition XENION has an IT advisor, a supervisor and an organisation and team developer.

Client statistics in 2008: total number of clients: 209, new registrations: 115, Countries of origin: 18.

The name XENION comes from the Greek and means "hospitality in a foreign place."

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#### **4.1.5. Primo Levi Association, France - Multidisciplinary care and support for victims of torture and political violence**

Origins: The Primo Levi Association was founded 15 years ago by five French NGOs (Amnesty International, French section; ACAT – Christian Action for the Abolition of Torture; Médecins du Monde – Doctors of the World; Juristes sans Frontières – Jurists Beyond Borders; and Trêve, a small group of healthcare professionals who had previously worked with torture victims). The association provided an institutional framework to provide treatment and support for persons who were victims of torture and political violence. By choosing the name of the Italian writer, a survivor of Auschwitz, as the name of our association, we wanted to honour the power of his testimony, the rigor of his ideas and his refusal to accept the existence of inhuman, cruel and degrading treatment. The association established three areas of action; the first – direct treatment and support – provides the content and legitimacy for the other two, which are training and communication activities.

##### **The Primo Levi care centre**

Treatment and support are provided in a multidisciplinary health-care centre. Victims of torture and political violence can receive medical, physiotherapeutic and psychological services, as well as social and legal aid.

Client numbers: The Primo Levi care centre receives and treats more than 300 people from more than 40 countries, regardless of their legal status in France. It carries out annually more than 4,000 consultations of adults, children – including unaccompanied minors – and families who have suffered torture or political violence in their native country and who are now refugees in France.

The staff of the care centre includes: 1 receptionist, 1 person responsible for admissions (intake interviews), 3 half-time general practitioners, a part-time physiotherapist, 6 half-time clinical psychologists (all psychoanalysts), a full-time social worker and full-time lawyer. Every year interns in psychology, social work and law come to work in the centre.

Work ethic: The ethical basis of all activities is the respect for patients: for patients' testimony and experience, their personal rhythm and the time they need to decide

whether or not they decide to speak about traumatic events or the path envisioned for treatment, for their differences, for each persons' individuality (a patient is not just a trauma, his/her life experiences are much more complex).

### The choices that distinguish us:

- **A consecrated setting** – "for victims of torture and political violence," where people see themselves as such: care and support are adapted to the specificities of this group of people and are organised so that patients are at the centre of the treatment.
- **Multidisciplinary approach and team work** – in order to meet the needs of patients on the road to recovery we have established a broad approach and team work including long-term monitoring.
- **Professional interpreters** – even though it implies substantial additional costs, Primo Levi insists on professional interpreters in order to establish quality communication between patients and staff.
- **The choice of psychoanalysis** – the clinical psychologists who work at the Primo Levi Association are all psychoanalysts. Psychoanalysis is a way to listen, but it is also a discourse, a way of addressing patients, to invite them to reclaim their place as subjects and to re-establish contact with other subjects. However, the centre adapts the "classic" psychoanalytical method to correspond to the needs of victims of intentional violence coming for care (face-to-face consultations, a more active presence of the therapist, the possibility of including an interpreter in the therapy sessions ...). On a one-to-one basis, patients take the time to give themselves the right to speak again, and thereby recuperate their place as subjects.
- **Caring for children, adolescents and families** – a change in the profile of adult patients (a growing number of families) and the increased presence of single, unaccompanied minors have led the clinicians to rethink the way in which unaccompanied minors, as well as children who are often present but forgotten by adults, are received at the centre. They are seen directly by a psychotherapist without any preliminary admission interview.
- **Taking the time that is needed** – "standard" trauma doesn't exist. Each person is uniquely affected, depending on his/her past life experiences, character, weaknesses, defences, social support system and many other aspects. The patients guide us. They determine the length of treatment. Nothing can be done without them, or regardless of them. Time is doubtlessly one of the most important assets that a specialised centre such as ours can offer: giving them the time and taking our own time to be available and attentive, to get to the heart of the matter. The Primo Levi Association stands for a qualitative approach that is respectful of patients' temporality.

### Training

We offer training, in France and abroad: in France we train the staff of hostels for asylum seekers and refugees, in Algeria we have trained health workers, in Lebanon the staff at a new care centre for torture victims; we have also trained Chechen teachers and school directors...

Communication: to inform and testify in order to share experiences and to bear witness the association produces publications (*Mémoires*, a quarterly of 16 to 20

pages, a monthly e-letter) and provides internet access to a specialised documentation centre ([www.primolevi.org](http://www.primolevi.org)). We also initiate and participate in media and other types of awareness campaigns to bring relevant issues to the attention of national and international political figures.

Coalition partners: in this context, the Primo Levi association participates in several coalitions: the French coordinating coalition for the right to asylum (CFDA), Observatory on health rights for foreigners (ODSE), European Network of Rehabilitation Centres for Survivors of Torture, Reseda – the French speaking network of care centres.

In 2004, the Primo Levi Association received the **Human Rights prize** awarded by the French Republic in recognition and support of the activity of the care centre.

### **Primo Levi Association**

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## 5. Key issues and challenges

The centres are faced with a series of problems in trying to offer high quality services to their clients, some of which have a clear solution while others do not. The self-evaluation method gave the organisations time and a structure to help elucidate and document some of these challenges. That said, sometimes the problems are intractable or beyond the scope of an individual organisation, the point however of the methodology was to help understand the necessary tensions, recognise unsolvable contradictions and deal with them as adequately as possible. This chapter focuses on the problem areas of this work. The idea is not so much to present solutions but to raise the awareness of the reader towards the problems everybody has to deal with working in this field. To structure this chapter further we differentiated four key areas:

5.1. Political and social problems

5.2. Treatment

5.3. Advocacy

5.4. Organisational issues

### 5.1. Political and social problems

Initially there is always a language problem. The refugees themselves often do not speak the language of the country in which they are seeking asylum, have difficulties in learning it and sometimes for psychological reasons actively reject learning it. On the other hand neither the professionals in the centres nor state officials can be expected to speak the languages of the asylum seekers. Thus interpreters have a very important role but often are not available and, even if they are, given the emotive and complex issues being discussed, many things get lost and confused in the translation process.

Most clients have severe material and financial problems, and suffer from legal restrictions and health insurance limitations. Very often the psychological symptoms they present stay the same or become worse because of the asylum procedure (duration of the process, insecurity, prohibition to work, lack of livelihood). Treatment is very necessary while being constantly facing new threats and difficulties. Furthermore, in structural terms, material and mental problems constantly overlap and normal health security is not a reality.

Their legal situation often increases the insecurity of the clients. Dublin II regulations imply the possibility of refugees being transferred to countries where their living conditions may be much worse, so that such a transfer is seen as a threat. The differences between European countries in this respect are significant. While the Dublin II process is understandable in legal terms, it is socially and psychologically disastrous for the refugees: they are moved around, have no security as to where they can stay, and possibly end up in unacceptable living conditions. This can marginalise them once again, so that they feel penalised by yet another system.

A key issue for refugees is the fact that they are not allowed to work or receive adequate professional training. This makes their marginalisation more profound and, in terms of mental health, implies dependency, devaluation and disempowerment. Finally refugees often have to confront a negative public opinion and some experience direct racism and xenophobia.

For the centres these realities imply the need to act politically while working within the framework of therapy, social work and medical care. It is not that the centres want to be active politically: it makes their work more complicated and hinders them from focussing on work with the clients. But clinical work is impossible when a client's mental health is being damaged by unfavourable living circumstances and by the way he or she is being dealt with by state institutions. This leads to a tension between the basic political and social problems of the refugees and the efforts of the centres to guarantee their basic human right to health and dignity.

## 5.2. Treatment

The therapeutic issues that have to be dealt with when working with refugees are highly complex and this is often underestimated. With claims that there are trauma treatment strategies that can apparently solve any problem in just a couple of sessions, it is difficult for non-specialists to understand why treatment with refugees takes so long. In reality however, there are no quick fixes for the long-term effects of severe torture and social displacement. Very often what treatment can achieve is limited: although treatments help patients survive and manage their lives more or less adequately, they may still continue to feel bad or have bouts of depression. For experts in the field this is no surprise. They know that they are dealing with chronically difficult situations and that effectiveness has to be measured in a different way than when dealing with a simple behavioural problem or a specific physical illness. It is not possible in a document such as this to explain all the therapy related issues in detail but the following list can at least offer the reader some insight into the challenges of treating refugees and asylum seekers who have been tortured:

- Many clients are chronically ill and the initial question is: do we have the right treatment for them?
- High expectations as to the benefits of psychotherapy create a lot of pressure: the clients hope to be freed of their nightmares, fears, flashbacks, panic attacks or suicidal thoughts etc. and the referring organisations expect to see a relatively prompt change in their clients towards a normal life. But those who work at the centres rather find themselves asking the question whether therapeutic intervention has any effect in the context of an insecure life situation.
- Although we can call upon highly differentiated diagnostic manuals and techniques to identify and deal with disturbances which may have been caused by traumatic experience, it is far harder to give emotional and spiritual support which victims of torture and serious human rights abuses need if they are to deal with the enormous suffering and pain to which they have been subjected. The professional discourse faces a dilemma: there is far greater interest in finding out how to cure a disease, than there is willingness to confront the suffering, even if it can only be confronted powerlessly, and to offer support, especially when there is no quick and clean solution in sight.
- In many cases symptoms remain or become worse because of the asylum procedure. For the applicant, the asylum procedure is defined by a basic feeling of insecurity, exacerbated by the impossibility of planning for a future normal life. Although therapists succeed in reducing some symptoms, it's hard for therapists to determine when and how to finalise treatment when victims of torture are in a vulnerable state and are in a position that reinforces their vulnerability.

- A healthy life needs social contacts and a supportive community. The lack of social interaction brought about by restrictions in the asylum process itself may lead to the therapist or other carer becoming "the most important person" in a patient's life – creating a risky dependency.
- It is often impossible for therapists to focus on the task of alleviating trauma. Therapists may have to engage in non-stop crisis intervention, or deal with helping clients deal with the psychosocial consequences of the current instability of their real life rather get at the underlying problems.
- Survivors of torture have experienced the violation of their personal and intimate borders. In therapy it is essential to respect and build up those borders. Because of the pressure on the resources of the centres, they often have to turn people away, rejecting them once more. This inability to help can lead to a feeling of powerlessness in the teams, especially when residence rights for refugees are linked to acceptance in a centre for treatment.
- Ending treatment or social assistance for refugees who have no permanent legal status may lead to deportation for refugees whose permits are limited to the period of their treatment.
- An improvement or decline in a client's mental health is often linked to an improvement or decline in the social situation rather than to treatment or therapy.
- The need for interpreters is an additional challenge and expense for the centres, requiring extra resources and training, and increased coordination.
- Paradoxically, a multidisciplinary team has to set boundaries between the professionals involved in order to function. Teams may include those who have different priorities (such as a medical or a sociopsychological approach), but the boundaries will help ensure respect for differing views.
- Many of the challenges facing centres are due to objective ambivalences in the tasks they face. Should they stabilise and prevent re-traumatisation, or should they work through traumatic material? Should they be sensitive towards cultural difference or does overemphasis of ethnic issues prevent successful integration? Should centres accept all those who come in genuine need of services, or should they reject some in order to treat others better? Such tensions are typical of the teams in the centres, but they reflect the reality of the conditions under which they work
- As a result of countertransference, psychotherapists working with victims of man-made disasters run a risk of becoming a victim among victims, and this can lead to a breakdown in professional routine, burn-out or vicarious traumatisation. Self-protection for the therapist is essential; ensuring that therapists are themselves protected is a leadership challenge in teams with small resources.
- There are certain issues which are taboo in certain centres, and are hard to deal with in all centres. Such issues include: returning people to their home country; working with perpetrators or members of the military; treating clients who are violent or abusive towards themselves or others; or treating clients who have themselves been perpetrators as well as victims. However the issues recur and centres need to develop a culture in which they can be dealt with.

### **5.3. Advocacy**

Since the mental, physical and social well being of refugees depends very immediately not only on themselves but on their surroundings, it is absolutely essential that the centres deal with those surroundings and thus dedicate time to advocacy. Nevertheless there is often not enough time for this because the centres are faced with an extremely high demand for psychological and medical attention from their clients. This means that those who know the problems of the refugees best – the therapists and social workers working with them – have little time to explain publicly what they know. They can do little to make the public take responsibility for enhancing the well-being of the refugees – or at least for not damaging it further. It would be desirable, even necessary to have more time to explain issues to the state institutions, but those involved in this work face a continuous tension between the time dedicated to clients and the time dedicated to advocacy. The problem cannot be solved by everybody trying to do both, nor can it be solved by splitting the tasks up and having professional lobbyists on one side and therapists on the other side. Although there is no clear-cut solution to this issue, advocacy and therapy are two sides of the same coin, and neither should be sacrificed for the other.

There is also tension between the professional neutrality expected in a therapist or a social worker, and the fact that working with refugees necessarily implies being on side in the battle for human rights. In practice, clients often expect that helpers will not be neutral. They expect them to stand unambiguously on their side, and will only trust them if they feel they are actively defending their rights. Many people who have suffered extreme trauma may have difficulty in trusting others, and will require such proofs of commitment. On the other hand clinical work needs a certain trustworthy distance, a level of neutrality that contains the client and does not act for him or her. This dilemma has to be dealt with.

A third dilemma arises in the cooperation with local and national authorities. The state institutions obviously are not the enemy, and it is necessary to cooperate with them to the benefit of the client. At the same time state policy has different aims than a therapist or a medical doctor and, in some cases, state policy can be questionable in terms of the human rights philosophy which underpins it. Treatment centres must protect their independence in order to remain acceptable partners for their clients as well as for the state. This complex and contradictory situation does not have to be a problem but it can become one if the implications are not seen and consciously dealt with as they arise.

### **5.4. Organisational issues**

All institutions suffer certain basic organisational problems that could be solved if they had enough money but resources are limited. This leads to chronic problems which can be summed up as follows:

- Centres are confronted with a heavy workload: there are too many clients who genuinely need help and too few people to provide it;
- Helpers may well become over-involved in their work, feeling the need to protect and take responsibility for clients who reveal life-threatening experiences. They may suffer from stress, frustration and exhaustion, and not have the time to reflect on their work;

- As a result of the pressure, staff may tend to work alone and isolate themselves from the other team members ("I have to solve this alone: the others have also a lot of work...can't bother them..."). They may fail to allow enough time for adequate communication with other team members due to lack of time and resources;
- The centres are a treasure-house of information about torture victims, and this often leads to an expectation that they will be involved in prevention, consciousness raising and lobbying. These tangential tasks are taking up an increasing amount of time and effort, leading to a conflict for staff over whether they should be spending their time on treatment or on possibly more peripheral issues;
- Lack of funding means time has to be invested in fundraising instead of carrying out the organisation's real objectives;
- For many centres, volunteers are an essential part of the team. Ways have to be found to integrate them into trustworthy team structures, since they too have to be able to deal sensitively with intercultural issues and to handle professional standards such as confidentiality;
- In interdisciplinary teams, there may be difficulty in ensuring clarity as to the tasks of those doing different kinds of work (therapy, advocacy, administrative work). However, such clarity is needed to allow staff to fulfil their own role properly.

## 5.5. Summary

Based on the above, we can point to nine key tensions present in the work of the teams:

- Helpers may be powerless in the face of the suffering and pain that have been inflicted on victims of torture. They may have to offer support, even though there is no quick and clean solution in sight;
- The centres are both professional health service providers and interlocutors to civic society, involved as human rights organisations in prevention and consciousness-raising;
- The level of involvement in prevention work and politics has to be balanced with resources for treatment and support;
- Financial sustainability (which may mean accepting money from official sources) has to be balanced with the need to be independent in order to do effective lobbying;
- An interdisciplinary approach should not be at the expense of providing an unambiguous psychotherapeutic space, in spite of pressures to dilute this element;
- Crisis intervention may put pressure on resources for long-term healing;
- The uncertainty under which many refugees live make it difficult to determine when and how therapy should begin and end;
- Burn-out among staff has to be prevented;
- Ambivalences in the host societies, such as cultural difference and the risk of over-emphasising ethnic issues, have to be dealt with.



## 6. Examples of good practice<sup>1</sup>

A core task of the project has been to build networks and thereby enrich each centre's understanding of the others and how they operate. The centres noted that in the process they also understood their own operations better. In this sense the recommendations that will be presented will not be a prescriptive list, but will rather reflect the multiplicity of the various centres' experience, offering an array of options. They will also serve as a way to point out common problems and the different ways in which these have been dealt with.

Chapter 4 has shown how the work of each centre has developed out of a commitment to human rights and how it has been from the start unavoidably linked to political, social and legal issues. The development of their services reflects this clearly. Every attempt to develop treatment of refugees from a limited or one-dimensional perspective is bound to fail in the long term.

Treatment methods that only focus on the traumatic experience itself, or attempts to carry out crisis intervention or stabilisation while the refugees are living in basically unstable conditions, will not meet the needs of the survivors for rehabilitation or their wish to live a normal life. Unstable conditions will mean it will be nearly impossible for them to participate in society in a dignified and self-reliant way. Including the political and social context leads to the adoption of a complex treatment approach, including social and integrative measures. The specialised centres contribute to and help to shape the characteristics of the human rights parameter within the health systems. At the moment in Europe they do this mostly not as part of the health system but as NGOs, suffering from increasing financial difficulties and insecurity. A question which has not yet been solved is how the relationship between the centres and national health care systems should best develop in the future. It is obvious that the cooperation must increase, and that, within the healthcare systems too, capacities must develop that are able to deal with the specific problems of refugees. Yet the specialised knowledge of the centres cannot be transferred so easily into the system; indeed, for many refugees, access to treatment through the centres is not only easier but less burdened with fear. It may continue to make sense to think of complementarities and synergies between the national health care system and the centres, without trying to merge them completely.

### 6.1. XENION - Social work with refugees and victims of torture and human rights abuses

**Dorothee Bruch and Elise Bittenbinder**

#### Key Issues

- Working within the context and with the different dimensions of effective care, especially social containment with the help of psychological support
- The starting point is the story and the reality of the survivors' lives

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<sup>1</sup> The partners in the project have decided to use the term „good practice“ rather than „best practice“.

- Role of expert reports in the asylum procedure and the implications for the psychotherapeutic relationship and treatment program.
- Limits of therapeutic support in a life situation which is basically insecure
- Leaving the strictly therapeutic setting to accompany the client to migration office: moral obligation for human rights defenders or professional compromise?
- How to work and cooperate with decision making bodies in order to prevent social and medical problems

This approach to social work puts the real life situation of the clients at the centre of its concerns. The concept integrates their social, political and cultural relationships into the working procedures and includes both the issues which have led them to leave their country and those which they encounter in exile. The importance of cooperation with social and political decision-makers and the dilemmas which arise will be made clear in a case study.

XENION prepares a thorough social case history which includes not only biographical data but also data relating to the context of the country of origin as well as those of Germany as the country of exile. These include a client's biographical data, personal and political situation in the country of origin, significant ethnic or religious characteristics, personal experience of persecution or violence, traumatic experiences, causes of flight, the conditions under which flight was undertaken, family relationships, family history etc. In addition, information about the individual's current situation in Germany will be noted, including the legal, health, family, financial and residential situation as well as social contacts. Such social contacts may include support organisations or cultural associations which share the client's language, as well as other organisations and resources which will help the individual to lead an independent life.

**"Narrative exploration"** is a central element in the social case history as well as in XENION's further care strategy. Narrative exploration stands at the beginning of the process and ensures that as many dimensions as possible are taken into account in the subsequent process of care and treatment. Further options for treatment are presented clearly to the client and decided on jointly.

The narrative focus ensures that, unlike in the usual social context, it is the individual destiny and not the administrative process which stands in the foreground. Refugees (both in their country of origin and their country of exile) usually experience life as a structure of power and dependency. It is therefore of particular importance that the needs of the client are given priority at registration and at the first consultation. Qualified interpreters are of course made available at this stage.

In individual cases, social counselling may take two to three hours for registration, social case history and initial consultation, or may extend over several years if it is undertaken in conjunction with long-term treatment.

Professional counselling and treatment have to involve the entire social system, and we are networked and cooperate with schools, educational institutions, hospitals and other health provision, social welfare organisation, social institutions, lawyers, asylum and aliens' offices, courts etc.

In addition, XENION acts as a multiplier and a network centre for NGOs by offering training for professionals and voluntary workers, as well as by political lobbying and documentation of human rights abuses and their consequences.

On the one hand XENION must consider the fundamental right to security, health and rehabilitation of extremely vulnerable refugees and victims of torture and human

rights abuses. On the other hand it has to deal with a highly complex residence status procedure as well as with the refugees' living conditions, which are often restrictive and lead to isolation. Such conditions can often be a serious mental strain for people who are psychologically or physically damaged.

Under normal circumstances, a refugee should be called to a hearing within two weeks, at which all the information relevant to an asylum application should be laid out. Normally, information which is brought up later will not be considered, since it will be regarded as having been "deliberately intensified." When a psychological or physical illness or other similar problem is diagnosed in a client, the organisation immediately gets in touch with the person at the asylum authority, the BAMF, who is working on the client's asylum application. Sometimes the official is informed about the treatment process so that an appointment for a hearing can be postponed.

In cases in which traumatised refugees are unable to relate their traumatic experiences as a result of their illness (for example, where the experiences include elements that are perceived as deeply shaming, such as sexual violence), XENION can supply documentation about human rights abuses as described during counselling sessions, so that these may be considered in the asylum application. The setting of an asylum hearing is designed to reach the facts as efficiently as possible, and is not suitable as a place to provide the security needed by clients who are psychologically troubled to enable them to open up.

If refugees can be sensitively prepared for the hearing, the situation may be seen as less threatening. Refugees who feel threatened by the situation may be accompanied by a person they trust, such as a social worker or a lawyer. In such cases, it may be possible for them to report on their experiences without running the risk that they will re-actualise their trauma.

In around 40 percent of the cases XENION deals with, they are asked to provide an expert opinion in the form of a psychological assessment for the BAMF, for the courts or for the commission that deals with individual hardship cases. Such an assessment makes sense where a legal or social issue can be backed up with psychological support, or where questions can be raised which can benefit from further psychological or medical exploration.

In the case of serious psychological illness, assessments may be used to justify a decision to postpone deportation. The BAMF often expects to receive and takes note of such assessments, but it does not commission and pay for them.

### **Case Study: Ms. S. (22), a Kurdish women from Syria**

*In 2002 Ms. S's husband was accused of political involvement, arrested and imprisoned. After his release he went into hiding and his family was subjected to regular house searches from March until he left the country in April 2002. During these house searches Ms. S., who was 5 months pregnant at the time, was tortured and subjected to sexual attacks.*

*She was beaten with belts and once she was sprayed with gas and threats were made that she would be set on fire. Threats were also made that her daughter would be injured. She was – also in the presence of her daughter – raped several times. Although pregnant, she was kicked in the genitals and told that this was done to make her lose her child. A belt was fastened around her stomach and drawn tighter and tighter. Ms. S. was ordered to strip naked and taken outside the house where the villagers spat on her. The humiliation in front of her husband's family in whose house*

*they were living at the time meant that the family could not stand the pressure anymore and made her leave the country. Her husband was still in hiding and followed later.*

*Both policemen and members of the secret service ("muhabarat") took part in the abuse of human rights and torture. Ms. S. has feelings of profound shame and guilt. She broods and suffers from obsessive thoughts. She complains of sleep disturbances and lack of appetite. She also suffers from dissociative states. Following her traumatic experiences of torture and the problems associated with her flight, Ms. S. now has the symptoms of post-traumatic stress disorder (avoidance behaviour, anxiety, flashbacks and stress reactions). She also has reactive depression. Her son, with whom she was 5 months pregnant during the attacks, has serious heart problems and has already had to have three operations. Ms. S. is deeply convinced that his heart problems are a result of the attacks.*

*Ms. S. has also severe problems on the social level. After her experience of violation the relationship with her husband has changed. While he still lovingly cares for the children he has started to be violent towards his wife. The two have never spoken about the abuses which Ms. S. suffered while he was in hiding. "Officially" Mr. S. knows nothing about it. Ms. S. describes that she sometimes hits her children when she cannot control herself anymore. She feels terrible afterwards but seems to be unable to stop it.*

*Ms. S. was originally sent to XENION by her lawyer because she suffered a severe nervous breakdown and the lawyer was unable to talk to her about her reasons for leaving the country and seeking asylum in Germany.*

*In the course of the documentation of her social case history and the narrative exploration (described above) she started to tell parts of her story. The social worker referred her to psychotherapy because Ms. S. had frequently collapsed when trying to tell her story. The social worker also contacted the lawyer to see how the additional information about the abuse and sexual violation could be included in her legal file. Unfortunately the interview at the BAMF had already taken place and Ms. S. had not said anything about the abuse or the rape. This was partly because there was a male interpreter present, partly because her husband was sitting nearby and partly because she simply could not talk about it.*

*On the basis of the social case history, XENION's case conference decided to take on the case and to offer Ms. S. legal and social and psychotherapeutic assistance as well as help with the children. Special care was given to the child with heart problems. For 5 years Ms. S. received regular social assistance. XENION helped her with legal advice, finding adequate housing and schools for the children, finding a language course, a school at which she could get a German degree, a probationary position, and finally in 2007 a job. XENION also helped her through the separation from her husband, including her move into sheltered housing for women.*

*During the exploration, anamnesis and psychotherapeutic treatment sessions Ms. presented a lot of details of her traumatic experiences, from general persecution to physical and psychological attacks amounting to torture, and from the severe problems and hardship in the exile situation to her increasing estrangement from her husband and her educational problems as a result of her stress, pain and anxiety. A professional psychological expert report was compiled by a psychologist – not the psychotherapist who was treating her – in order to describe the effects of her extreme traumatic life experience and the severe mental health problems they had led to.*

*At the request of her lawyer, the social worker started to collaborate with the migration officer in order to review the information given in the first interview. Given that the first interview – with a male interpreter present – was not handled ideally the migration office agreed in 2006 to hold a second interview. However Ms. S. was in no mental condition to go through with it and turned to the psychotherapist for support. It was decided that the psychotherapist should accompany her client in order to support her and to intervene if the mental condition should not allow a continuation of the interview. This decision was taken with the help of external supervision since this extension of the professional support bears the risk of compromising the psychotherapeutic relationship. It has to be handled very carefully and transparently for all parties involved. At the same time, Ms. S.'s involvement in the real-life asylum system was having a major influence on her mental health, and on the chances that the therapeutic process would help her to find a mental balance after the extreme violence she had suffered.*

*XENION as an institution has taken a clear stand on this: it is seen as ethically appropriate for psychotherapists in their function as human rights workers to support their clients with professional reports and as expert witness in court if this should prove necessary.*

*Ms. S. received regular psychotherapy sessions until 2005. She continued to receive psychotherapy on demand until 2007. The children attended a small art therapy unit. She has also been assigned a voluntary worker to give her psychosocial support. Even though her insecure legal situation and the fear of being deported back into the terror significantly influenced the mental conditions of Ms S. and her whole family, her problems did not disappear when a residence permit was issued. The therapeutic process had indeed helped her deal with some of her traumatic experience, but other problems deteriorated. The husband could not cope with the fact that Ms. S. started to learn German and to get some training – while he found himself unable to make progress with integration. Resentment and the "disgrace" (he could not get himself to face it as rape) started to get between husband and wife. Although he knew what had happened, he "preferred" not to know. He also could not forgive himself for the fact that neither he nor his family was able to prevent it. The attempt to include the husband in psychotherapy did not succeed. Although he came at times to sessions, he refused to participate. The relationship deteriorated in 2006/7: Ms. S. was beaten up and had to go to hospital. However it took almost over a year for Ms. S. to come to the decision to separate from her husband.*

*Surprisingly for the XENION team, after the separation Mr. S. came to seek advice on how to handle the separation and later to overcome the loss and start anew. He had previously refrained from learning German or trying to integrate. Since 2007, Mr. S. has been participating in regular psychotherapy sessions and is also seeking social and legal assistance in order to help him with his rights of access to the children and to find a job.*

### **Recommendations**

- It is recommended that the story of the survivors' lives should be the starting point when working with the context and reality of the clients.
- It is recommended that a transparent and participatory system of information and early counselling should be regarded as an essential part of services provided

- It is recommended that systematic counselling be offered early on in order to prevent problems from becoming more acute or chronic
- It is recommended that centres work and cooperate with decision making bodies as part of effective advocacy.
- It is recommended that centres engage in political and social activities such as lobbying to ensure monitoring of human rights
- It is recommended that centres intervene in legal proceedings since the legal process is crucial for an effective support of the healing process
- It is recommended that centres produce professional psychological reports in order to support qualified decisions of the migration office or the courts.

## **6.2. Equator Foundation - Restoration of an individual's psychological and social identity**

**Esther Schoonbeek and Pim Scholte**

### **Key Issues**

- Being a refugee is not an identity. Refugees are individuals as diverse as any other group of people.
- Trauma-related problems or symptoms in refugees can only sometimes be addressed through trauma-focused treatment methods.
- A refugee's social network and social behaviour have a major impact on his or her well-being, and call for attention in treatment.
- Refugees may be treated in mixed gender groups.
- Some traumatised refugees need tertiary care, the provision of which, however, may result in institutionalisation.

Clients as well as professionals who refer clients to the Equator treatment programme repeatedly stress that the way in which Equator staff approach clients is different from what is common in mental health care. This probably relates to our stand that clients should primarily be seen as both fellow humans and unique individuals. Other characteristics, such as being a foreigner, a refugee, or a traumatised person, are secondary to that. This core principle responds to the need of our clients to re-define their social roles and regain respect and dignity.

Tertiary care provision is needed for clients who are mentally severely out of balance. However, the risk of institutionalisation that sometimes seems inevitable can be decreased by utilising a day-care program for only part of the week, and by focussing treatment on integration in society and on the adoption of social roles.

Equator provides a mixed gender day treatment program. From time to time it is debated whether treatment should also be offered in same gender groups, as some clients are reluctant to participate in a mixed gender group. So far experience with the Equator mixed group has been mainly positive. This relates back to the objectives set for the group and the daily atmosphere created: the key element of sociotherapy (the core treatment method) is to provide a safe environment, through transparency, by building mutual trust and setting democratic rules. A homelike living room is the central place in the treatment, where clients get together three days a week in a "substitute family," and where they are stimulated to re-acquire social behaviour and practice alternative roles. Sociotherapists and senior group members function as role models. Clients feel welcome and respected, and discover that it is possible to collaborate in equality with persons of the other sex.

Another dilemma is the sequence of treatment methods: whether to start with trauma-focused therapy or by focusing on stabilisation and on taking up new activities and social roles. It is our experience that clients are often too unbalanced and socially deprived to start focusing on trauma. Addressing daily routines and social contacts through a day-care program may provide a basis for trauma-focused therapy at a later stage. And once this has started, a treatment group of fellow clients may serve as a safe haven to return to after the sessions. Being respected as an individual and

experiencing support from the group, together with the skills which will have been learned, provide a basis for bearing the difficult process of trauma-focused therapy.

## **Case Study**

*J, a 22-year-old woman from Sierra Leone, has been sexually abused for years after fleeing from her country as a young girl. J's parents and two of her brothers were murdered by rebels, and J doesn't know if her sister and her third brother are still alive and where they might be.*

*J started participation in the treatment group of the day-care clinic of Equator, together with mainly male group members. Initially she appeared to be an angry looking girl, quiet, not knowing how to deal with this new environment. When approached in a gentle way she would abandon her angry posture, but then take on a "shy little girl" attitude. She wasn't able to define any expectations or objectives, neither for her treatment nor for her future.*

*During the months in the day-care clinic we stimulated J to be more assertive in the group, to do the things she liked and was good at, and to behave more according to her age. She turned out to be a good cook, and she became a respected group member. She learned to set her own limits and to express herself verbally. Outside the Equator treatment group she got in touch with someone she considered a substitute mother, an Angolan woman whom she had met through the church and who took care of her.*

*After sleeping once with the son of this woman, J got pregnant. She and the father decided to have the baby and to stay together. J moved in with the man and gave birth to a son (whom she initially proposed to name after one of the sociotherapists). The two parents turned out to be good partners and they actually made a great couple. J started taking Dutch language lessons and later took on a part-time job, working with elderly people at their homes.*

*By this time another problem became apparent. After the one time that had resulted in J's pregnancy, the couple hadn't had intercourse ever again. J had had serious flashbacks during the intercourse. Thereafter, whenever her husband approached her, she would become stressed and worried that she would get flashbacks again.*

*Both J and her man were motivated to get this problem solved, so we started partner therapy sessions aiming to improve their sexual relationship. We formulated homework exercises to build mutual trust, understanding and intimacy. In addition, a lot of explanation and information on sexuality and lovemaking was provided. Due to the patience of the man, J's motivation and the love and humour of both partners, the exercises worked well and gradually their sexual intimacy grew and became satisfactory.*

*In one of the later therapy sessions the couple said that J had started telling her man pieces of her past traumatic experiences. He had stimulated her to do so instead of only writing in her diary. J acknowledged that it helped her to process her past and that it felt good to share it. Her man noted that J's stories really moved him, but that he appreciated very much that she shared them and hoped that it helped her to finally leave the past behind.*

## Recommendations

- It is recommended that the uniqueness of each refugee as a human being be acknowledged, thereby respecting personal characteristics and identity and avoiding stereotyping.
- It is recommended that traumatised refugees be treated using a personal approach, taking into account individual circumstances, characteristics, assets and needs. This also applies when using protocolised treatment elements.
- It is recommended that prolonged care be provided to traumatised refugees whenever needed, and that attention also be given to issues not directly related to trauma, flight, or migration whenever it applies.
- It is recommended that it be carefully assessed if there is a need and possibility to use trauma-focused therapy methods, and to be aware that the consequences of trauma may be mitigated through other pathways as well.
- It is recommended efforts should be aimed at reinforcing a client's social network and optimising a client's social behaviour in the psychological treatment of traumatised refugees.
- It is recommended that the use of therapy groups be considered in the treatment of traumatised refugees, as these may provide a temporary substitute family to the client, help restore feelings of trust and dignity, and familiarise clients with the social rules and values of the guest society.
- It is recommended that mixed gender groups be considered in the treatment of traumatised refugees, as these may familiarise clients with the common gender-bound behaviour patterns and interactions of the guest society.
- It is recommended that traumatised refugees be provided with a form of tertiary care whenever needed, and that, to help prevent institutionalisation, a day-care group approach and a focus on social context should be adopted.

## 6.3. Zebra - Professional interpreting in health-care settings

Uta Wedam

### Key Issues

- Access to treatment for traumatised refugees in their mother tongue.
- Need for professional interpreting in health-care settings, especially in psychotherapeutic and psychiatric treatment to ensure an adequate anamnesis.
- Need for appropriate training for interpreters as well as for professionals working with interpreters.
- Clarity about framework requirements and general conditions for interpreters.
- Possibility for supervision and intervision (supervision in a peer group) for interpreters.

In recent years, Zebra has developed and improved its provision of therapy. As an NGO offering provision specifically for traumatised asylum seekers and refugees, Zebra recognises that it cannot always ensure that clients are given appropriate treatment. Access to psychotherapy for refugees is still hardly possible within the usual health-care system. Language barriers are often impossible to overcome. In mental health care and psychotherapeutic and psychiatric treatment, language skills play a major role. There may be difficulties in the anamnesis, and later in treatment, if they are inadequate or nonexistent. In our holistic concept of treatment, we have always tried to consider the importance of language skills and to deal with them by co-operation between disciplines and across methods. Well-trained and experienced interpreters are an essential and permanent part of our team.

Zebra tries also to train interpreters outside our institution who have some knowledge of the field of refugees and migration. In the medical, therapeutic and social context, interpreters are very often needed by clients and by various other organisations to prevent false diagnosis and misunderstandings, and to ensure adequate treatment. From time to time Zebra cooperates on specific projects with the University of Translation and Interpreting in Graz. Furthermore, we are involved in the preparation of a curriculum for healthcare professionals as well as in a three-semester university course on "community interpreting."

### Working with interpreters in a therapeutic context

Interpreters play a very important role in the therapeutic process. Without them, verbal communication would not be possible. They do not only help to interpret, but also to get across the values of the refugees' background and culture. As interpreters "switch" language, refugees "switch" from one culture to another. It is important to create a space in which one can "switch" – at first, it will just be a matter of language, but it will soon move further.

Interpreting is a very complex task, which, if it is done well, requires perfect language skills, knowledge about various cultures and a willingness to deal with the client's problem and situation. This means that only very well trained interpreters should be involved in psychotherapy. They must have both professional translation skills and understand therapeutic work with heavily traumatised people.

Interpreters who are involved in psychotherapy are always confronted with clients' trauma, anguish and agony. It is essential to prepare them for that and to advise them of the likelihood of transference and counter transference.

Clients who have a mental disorder or are psychologically unstable have a particular need to be able to express their feelings in their mother tongue. It helps them retain their dignity if they can talk about issues like pain and distress in a language in which they are fully competent. We need to help the clients to come out of their speechlessness. At the same time, the treatment setting can only be effective if the therapist manages to involve the client in the therapeutic process and to "activate" him. This means all the members of the trio – client, therapist and interpreter – are needed.

The therapist and the interpreter form a team in which both need to be aware of their role and responsibility. The therapist has the overall responsibility, but is dependent on the interpreter without whose assistance and help he or she could not function. The interpreter has to ensure communication on various levels – language, culture, socialisation, religion – and in both directions – from the client to the therapist and from the therapist to the client. The interpreter must perceive the essential issues, must take him- or herself back and act as part of the overall situation.

Most of our interpreters are already qualified, but they are trained by us for the specific setting of psychotherapy, take part in a regular exchange with the care staff, and undergo reflection, intervision (supervision among peers without an external supervisor) and supervision. The interpreter pool is managed and coordinated by a professional interpreter and a therapist. Intervision takes place four times a year, twice with the interpreters alone and twice together with the therapists and social workers. We have interpreters for Russian, Chechen, Turkish, Albanian, Bosnian/Serbian/Croatian, Romanian, Farsi, Bengali, Arabic, French and Mongolian.

If possible, a client's entire treatment is accompanied by the same interpreter, who has to work with the psychotherapist, the psychiatrist, the social worker and if needed with the physiotherapist.

Our training modules include three main areas: firstly, the significance of language, interpreting and intercultural dialogue for the refugees and migrants; secondly, the significance of the psychosocial context, the need for care in ensuring that the meaning intended by clients is truly signified by interpreters, in spite of cultural contextual differences and the relational dynamics between therapist, interpreter and client; and thirdly, the requirements for a satisfying and constructive team work, the framework within which the interpreters work, and professional role perception.

The following case history illustrates the complexity of the possible combinations and the high demands placed on the interpreters.

### **Case Study: Compassion fatigue of interpreter. Therapy process with the help of interpreters**

*The client fled to Austria from a conflict zone. She was referred for psychotherapy by a psychiatric clinic in which she had had in-patient treatment. Possibilities to talk to her adequately in the clinic had been limited. The therapy began with a trained interpreter from her culture. She received psychotropic drugs from our psychiatrist to deal with various symptoms. Among other things, she suffered from sleep disorders with recurring nightmares. She scarcely answered questions about the dreams, saying merely they were about her past. The therapist assumed that her dreams were related to incidents about which she could not yet talk. She told her that it might be*

helpful to talk about the terrible pictures, memories and thoughts, to get rid of troubling things, so that she could create a distance to the past. She said it is possible to share incidences with others. Since the client had already had a positive experience with the therapy and there was mutual trust, she was able to tell the therapist that she knew this, but that she did not want to talk about it for the time being. After five months, when she had already become psychologically stable, she asked the therapist to organise another interpreter for her. She said she appreciated the current interpreter very much but she wanted to talk about something about which she could not talk with an interpreter from her own cultural background. The therapist assumed a violent incident such as rape. She asked her cautiously and received confirmation.

Rape is a very touchy and shameful topic, a taboo. Even in our liberal and tolerant culture, barriers exist that make it difficult to talk about it. However in our culture, women who are raped are less likely to be ostracised in public or repudiated by the family, as is the case in some other communities. Women from such communities often find it impossible to talk about their experiences to anyone, whether male or female, family or stranger.

The request for a new interpreter was thus not surprising. The therapist organised an interpreter who did not come from the client's cultural background. She informed the client that the new interpreter was not from the same country but came from the culture of the dominant society in her country from which she had fled. The therapist explained to the original interpreter the situation in which traumatised people find themselves: on the one hand, they want to forget and deny their experiences; on the other hand, they want to talk about them and deplore them. The original interpreter was trained and had been advised about the possibility of changes and was able to deal professionally with the unexpected situation. The new interpreter was briefed about the progress of the therapy and was told that the client herself had asked for a change.

The client was then willing to talk, but she said she would only talk once about this incident and that therapist and interpreter should not interrupt her with questions. As she told of a shockingly humiliating rape, her voice and position changed; she cried, sobbed, stuttered, whispered and screamed. After about two hours, she was totally exhausted. The session was a serious challenge for the interpreter, who also had to narrate the story, witnessing the emotional release and pain of the client and putting it into words.

In spite of the client's request, the interpreter asked the therapist during the session whether she could tell the client something personal. The therapist agreed after the interpreter had told her roughly what she wanted to say.

The therapist saw that the interpreter also needed to get rid of pent-up feelings in order to deal with the situation. The interpreter told the client of her distress and her compassion and apologised for the outrage her people had done to her. In this case, this intervention was important for the therapy: the client could feel and accept the interpreter's authenticity and honesty. On another level, the client could perceive herself as a woman who may have had terrible experiences, but who did not lose the respect of the therapist and the interpreter. Both of them became indirect witnesses to the crime, and they never questioned it. Both accepted the outrage to which the client had been exposed and deplored it. This was especially important for the client, since she came from a culture in which this would not be shown openly.

In the course of the session, a space was created in which the client managed to find and share a "language" that made it possible for her to confront what had hitherto

*been inexpressible. She managed to establish a connection between her experiences in the past and her pain in the present as well as between herself and the others.*

*Victims of violence see themselves as alone, tarnished, humiliated in their dignity and excluded from their community; their interpersonal relations are disrupted and their worldview is destroyed. The creation of relationships which assure trust and safety has a central significance in the recovery of self-respect. For the client, the session was the beginning of the integration into her life story of the traumatic incident she had experienced and was a major step in her healing process.*

*The example shows how, in the trio of therapist, interpreter and client, a new form of communication is created and a culture is shared that results directly from the needs expressed. Interpreters have to be made aware of how hard it is for traumatised people to talk. The client needs to find words to express unspeakable experiences.*

*It might appear that the therapeutic team broke the rules in this case. But this example shows the difference between theory and practice – the therapist remains in control, but if the interpreter and the therapist both know the rules, act with appropriate caution, and understand why they take their action, they can develop the confidence to be able to break the rules in order to adapt themselves to the needs of the client.*

*"Those who have experienced it will never know what it was like; those who know will never say; not really, not everything." (Quindeau, 1995, in the aftermath of war and torture; S.8)*

## **Recommendations**

- It is recommended that professional interpreters be employed in health-care settings. In health care, language has a major significance, since it is indispensable in both anamnesis and treatment. Health-care professionals are very often dependent on lay interpreters, such as family members or friends, who do not have the necessary skills. This type of ad-hoc interpreting can neither be accepted from an ethical nor from a legal and professional standpoint.
- It is recommended that interpreters be trained specifically for health care settings, especially if working with traumatised people.
- It is recommended that professionals, especially psychotherapists and psychiatrist, be trained in how to work with interpreters and in how to take responsibility for them.
- It is recommended that interpreters be given the possibility to have an exchange with colleagues and that supervision is facilitated.
- It is recommended that the therapist – while remaining objective towards the client and the therapeutic process – takes a clear stand on who is the perpetrator and who is the victim when working with victims of violence.

## 6.4. ICAR - An organisation using the chance to secure recognition for survivors in the Romanian society

Camelia Doru and Erik Holst

### Key Issues

- Creating space for our clients in a post-conflict society
- Obtaining a public apology for the victims for human rights violations during the communist regime

Work with survivors of torture is always also human rights work and, as a consequence, it has to include advocacy. Advocacy in this context becomes an essential aspect of health work, since posttraumatic health care for victims is closely related to the recognition of their suffering and to the role of the centre in bringing about change in public and political attitude. In this sense the role of the ICAR Foundation is itself the example of good practice.

### Case Study: A unique action with a unique result which may be relevant in a number of other new member countries in the EU

*The political environment in Romania after 1990 obliged the ICAR Foundation to keep a low profile: Its activities had to be conducted discreetly, in order to protect the clients, who were still seen as "enemies of the people."*

*As a result, in its first years, the ICAR Foundation focused on providing specialised medical and psychological services. It left other important issues to one side – issues such as telling the truth about the atrocities of the past; identifying the perpetrators and publicly exposing them; or obtaining moral recognition, legal remedy and reparations for the survivors.*

*However, ICAR soon realised that there was a great need for moral rehabilitation among its clients and it slowly became able to include activities aiming at dealing with the past: Since 1997, ICAR has marked the 26th of June, the UN Day for Victims of Torture, and has addressed a range of issues concerned with a post-dictatorship society, with a special emphasis on truth and justice for victims of gross human rights violations.*

*The involvement of ICAR's target group, in the form of the leadership of the Romanian Association of Former Political Prisoners (AFDPR), in ICAR's strategy and decision making was of crucial importance for its success. A strong alliance with the AFDPR's national and local associations was a key element in the Foundation's development, especially taking into account that the group was understandably suspicious and reluctant to open itself to outsiders. ICAR also entered into alliances with other civil society organisations.*

*After more than 10 years of existence ICAR felt that the moment for moral reparation had come, and in 2003 ICAR brought a court case against the Romanian state demanding official recognition of the victims, public apology for past human rights abuses and public exposure of perpetrators.*

*ICAR's initiative should in no way give the impression that this was the only attempt to contribute to justice and reconciliation in post-communist Romania. The following chronology of events will help situate it in its historical context:*

1990 – Under a decree, a modest pension and certain special rights are made available to people politically persecuted by the communist dictatorship between 1945 and 1989.

1991 – The AFDPR files charges against those guilty of crimes and injustices, requesting that they be brought to justice. The case is eventually dismissed based on a strict interpretation of the rules.

1993 – A "Draft law on exposing the former Securitate" is tabled by Senator Constantin Ticu Dumitrescu, President of the AFDPR

1994 – A draft lustration law on "The access to public and political positions for former communist statesmen and members of the oppressive apparatus" is presented to the Parliament but finally rejected in 1996.

1996 – Change of government. The former communists under the leadership of Ion Iliescu lose power to the Democratic Convention under Emil Constantinescu.

1997 – A draft law on the annulment of political convictions during the communist regime is rejected.

1999 – The draft law on exposing the former Securitate proposed in 1993 is passed, albeit in a much diluted form.

2000 - Establishment of The National Council for Studying the Communist Archives (CNSAS).

2003 - ICAR files the civil court action mentioned above. A broad range of civil society organisations, individual victims and personalities from Romania and abroad support the action.

2004 - A website is set up by the historian Livia Dandara, campaigning for a public trial of those who adopted communism and conspired against Romania's interests (1917-1944), introduced it through terror and genocide (1944-1964), organised it as an exploitation, extermination and alienation camp (1964-1989) and finally converted it into a destructive capitalism in order to get rich and avoid responsibility.

2005 - Change of government. The long de facto post-communist domination ends in favour of the D.A. (Justice and Truth) alliance. ICAR sends an open letter to the new Romanian president Traian Basescu asking for moral reparations for the victims of the communist regime. He meets a delegation from the AFDPR and ICAR, and says he will offer an apology if he can do so on a solid documentary basis. The Prime Minister establishes an institute to investigate communist crimes.

2006 - A lustration law temporarily limiting access to some public positions and offices by persons who were part of the communist regime is adopted by the Senate but is postponed sine die in the Chamber of Deputies.

- A broad range of civil society organisations appeal to the president to expose the truth about the communist regime. He establishes a Presidential Commission which publishes a report, providing an authoritative foundation for a political statement.

**- On December 18<sup>th</sup>, in an extraordinary joint session of the two Chambers of the Romanian Parliament, the President delivers his historic declaration condemning the communist regime from 1945-89 as illegitimate and criminal and, on behalf of the Romanian State, offers a public apology to its victims and their families.**

2007 - ICAR supplements its initial 2003 court case with a Strategic Litigation Project, with funding from the United Nation Voluntary Fund for Victims of Torture, to test and

*encourage implementation of international standards of reparation for victims of gross human rights violations*

*To stress the generous spirit of victims of the former regime and their contribution to the cultural development of the country, ICAR commissions a well-known film producer to make a documentary demonstrating the achievements of a number of – by now mostly aged – clients*

*2008 - As part of its contribution to the continued reconciliation process, ICAR organises a seminar on national reconciliation, presenting experiences from other post-conflict or post-dictatorial societies followed by a discussion on their implications for successful national reconciliation in Romania.*

## **Impact**

*The political statement of December 18th 2006 represented a key moment in Romania's progress after 1989. It was a moment which had long been awaited, especially by those who had spent harsh years in prison for defending the traditional, democratic Romanian values. The report of the presidential commission and President Basescu's political statement fulfilled some of the functions that have been fulfilled by truth commissions in other post-dictatorial societies.*

**Moral impact:** *Restoring victims' dignity was by far the most important dimension of the public apology. For more than 60 years, trauma, impunity and lack of reparation had undermined basic principles and beliefs in our society.*

**Emotional and psychological impact:** *There was a huge affective load attached to the apology. The atmosphere in the Romanian Parliament – with most parliamentarians and guests solemnly standing during the President's speech and almost crying, while others showed their opposition by displaying anti-presidential banners – proved that the energies released with the opening of this chapter – a real Pandora's box of recent Romanian history – are enormous.*

**Long-term political impact:** *The statement drew a clear line between current Romanian society and the communist regime.*

**Immediate political effects:** *The attempt four months later to unseat the President by post-communist political forces in Romania demonstrated the continued power of these forces, their resistance to change and to national reconciliation. However, the willingness of the Romanian people to deal with the past was demonstrated in the referendum on the president's removal, which he won decisively in May 2007.*

**Legal impact:** *The political statement of December 18th 2006 led to the introduction of a bill to parliament to remove political crimes from the communist period from criminal records and to allow better access to reparations. This was adopted by the Senate on May 12, 2008 and finally in June 2009 also by the Chamber of Deputies*

**Further necessary steps towards national reconciliation:** *The official apology represents a landmark in a long process of national reconciliation. The way things have evolved after December 18th 2006 in Romania suggests there is still a long and painful process ahead. But, as President Basescu said, only a strong nation can accomplish this process.*

## **Impact of this development on our clients**

**As ICAR fought for the whole group of victims, we prefer to talk about the impact of our action at the group level for our clients, who have experienced up**

**to 20 years of harsh interrogation, torture and detention in prisons, hard labour and concentration camps.**

**At the group level the most important accomplishments were:**

1. *The official condemnation of the communist regime and recognition of its political abuses helped to restore victims' dignity and self-esteem.*
2. *The recognition of their status as political opponents of a criminal regime removed their stigma as "enemies of the people."*
3. *Individuals are now entitled to go to court to have their political sentences annulled and to obtain appropriate reparation.*

*ICAR is now assisting a number of victims to gain reparations in court, and is optimistic about the outcome.*

*"We are happy that our sacrifice was acknowledged, that the truth was revealed and a long chapter of our history is coming to an end. Justice must be done. It is never too late for a country; it may be too late for the victims who didn't live long enough to see it and for perpetrators who escaped unpunished. For our future and for the next generations it is crucial to send a clear message that in our society a crime will always be condemned and never rewarded" (Statement of AFDPR Vice-President, Cristian Dumitrescu, at the National Reconciliation Seminar, 2008).*

## **Recommendations**

- It is recommended that centres seek to collaborate with other human rights organisations as defenders of the right of their clients. They should confront the inability – often combined with unwillingness – of the legal system to find solutions which will restore social calm and heal the scars in societies profoundly traumatised by the abuses of either left-wing or right-wing dictatorial regimes. The challenge is made greater because of the huge number of victims entitled to see justice done, and the large number of perpetrators of human rights violations.
- It is recommended that the wider community – especially the EU Community – should support the role of the centres in reaching this aim. ICAR's experience show that the centres can play a crucial part in the process of social healing – even though no two countries' post conflict situations are identical.
- It is recommended that the European Network for Rehabilitation Centres for Survivors of Torture should inspire further initiatives by centres towards national reconciliation in other former communist societies by underlining the absolute need to break through the prevailing preference for what has been described as "national amnesia" as a "solution" to the problem.
- It is recommended that the European Commission continue financial support to make sure that initiatives such as the one established in 2010 by the "Commission for Study and Evaluation of the Communist Totalitarian Regime in Moldova (1917-1990)," in which hopefully the Memoria rehabilitation centre will be involved, get the support they need.

(The Memoria centre, Chisinau, was established in 2000 with the technical assistance of the ICAR Foundation and financial support of the European Commission and United Nation Voluntary Fund for Victims of Torture)

## **6.5. Primo Levi Association - Treatment and support provided by a multiprofessional team working with an interdisciplinary approach**

**Sibel Agrali**

### **Key Issues**

- For those who have been victims of deliberate violence, such as torture or any other ill treatment, the resulting traumas leave traces that won't necessarily wear away or disappear with time. Indeed, in spite of the time that elapses between the traumatic events and the present, for those involved it's often "as if it were yesterday."
- The symptoms which follow torture and political violence are multiple, complex and deep-rooted. They require an appropriate response: firstly, the specificity of this kind of trauma must be recognised and the effects of deliberate violence must be taken into account. The response should be delivered in a concerted manner by a multidisciplinary team.
- It is the patient who guides us concerning the type of care or support to be offered. We don't have any preconceived ideas, we don't know in advance which services are relevant or how long treatment and support will be necessary.
- Care and support must be offered with continuity in mind.
- Within the therapeutic framework no act or offer is trivial or insignificant.
- Each person, and therefore each patient is unique; treatment, care and support must take into account and respect this singularity, as well as each individual's required pace.

**The Primo Levi care centre has conceived a holistic approach, based on the view that torture and all other intentional violence inflicted in various contexts of political turmoil leave a wide range of interconnected effects upon those who have been victims of such maltreatment. These effects require a coherent interconnected response.**

All those who at some time are required to intervene in treatment or any other aspects of support and advice for the patients of the care centre are considered as caregivers, No caregiver should feel isolated when involved with a patient, he/she should be interrelated to other professionals (caregivers) involved or be able to talk about his/her patient during the weekly team meetings.

Treatment and support for persons traumatised by torture and other political violence requires constant communication and adjustment between all professionals involved, knowing that a great deal of time may be necessary for healing to commence. All the while one must offer containment and accompaniment of such intense suffering

In the care centre a full staff meeting is held once a week to discuss all new admissions, decisions concerning initial referral of patients within the centre, how to deal with treatments posing clinical difficulties, difficult and urgent situations, thematic issues, institutional difficulties. Once a month 3 hours are devoted to team supervision by an outside psychoanalyst who can offer a new view of the clinical and institutional issues that have been raised.

**Case example: Mrs B, a 44 year old mother of seven children from an African country**

*Mrs B, an African woman, 44 at the time a social worker referred her to the Centre in June 2002, has been in France for two years. Mrs B is married and has seven children. She had to leave her husband and children when she left her country following the rapes she suffered in 2000. As an asylum seeker, she was still waiting to be called before the OFPRA authorities who carry out the initial examination of asylum applications. The social worker noted that Mrs B was "very depressed" and "would like to see a psychologist; she has decided to talk about what torments her."*

*Our **intake interviewer** was the first to welcome Mrs B and establish a bond. She compiled the information with the use of an application form and tried to understand what brought her to our centre. The initial interview enables an assessment of what the person needs in terms of care.*

*The patient was put on a waiting list and had to wait two months before she could see a psychologist in November 2002. The intake interviewer had outlined Mrs B's situation during the weekly team meeting, and referred her to an organisation which would help her with her asylum application.*

*During the first two months of treatment, Mrs B only saw the psychologist at the centre. He heard how she was raped in her own home by three soldiers who were looking for her husband. They manhandled her husband first before raping her in front of him and their youngest daughter, aged four. Mrs B has been overwhelmed by feelings of shame ever since, especially as her daughter spoke about the rapes at school and her husband subsequently rejected her. She has been cast out by her community. Her mere presence was a reminder of the events and brought disgrace so that she had to leave. Mrs B is overcome by sadness when thinking about her husband. "What kind of husband would let his wife live so far away and in the cold?" she wonders.*

*Soon after the sessions with her psychologist began she received the notification calling her before the OFPRA officials for an interview. The psychologist referred Mrs B to the centre's **socio-legal worker** in January 2003 to prepare her for her interview. A team meeting allows the psychologist to share his thoughts with the socio-legal worker. The psychologist knew that it was particularly appropriate to refer Mrs B to the centre's socio-legal worker: an older woman, who is very familiar with Africa. The "ties" that Mrs B is building at the centre also help towards the reestablishment of her social fabric.*

*Although the patient said the interview at OFPRA went well, the response was negative. The socio-legal worker helped her lodge an appeal. She also helped her obtain welfare payments and apply for accommodation. After several changes of address, Mrs B eventually found a place in a hostel for asylum seekers, a little far from Paris itself, but the centre pays travel costs for appointments.*

*In the meantime, Mrs B continued avidly to attend her sessions with the psychologist. She slowly started talking about her childhood and how she was raised thinking she was destined to serve others. Mrs B is hard-working, astute and resourceful, but had little formal education.*

*Little by little, as trust increased, Mrs B talked about the physical and somatic effects of the rapes in more detail. She feels tremendous shame. She is convinced that everybody knows what she has undergone, that "it shows." What's more, she persistently has the impression she can smell the soldiers' odour all around her. She sees*

the scene over and over again. It's a "bodily stored memory", a "perpetuation of the branding." These physical problems are accompanied by massive sleep problems. The psychologist suggests that Mrs B should see one of the centre's general practitioners.

After her case is discussed in a team meeting, medical care begins in May 2003, nearly five months after treatment began. Medically, Mrs B shows symptoms of insomnia, continuous flashbacks, pains in the abdomen, anal pains and a haemorrhoidal pathology, combined with lumbago and various other pains. She also has difficulty in breathing as a result of her anxiety. According to the **doctor** (a woman) these symptoms are typical of victims of rape. For several months, the doctor carried out medical tests, trying to reassure the patient and counter her impression that everything inside her has been damaged. The patient told her about the lingering smell of the soldiers. This olfactory disorder actually lasted for quite a number of years. It was triggered by anything and everything: anniversaries, news concerning her country, thinking of her children etc. Mrs B was prescribed antidepressants, sedatives and other medication for her haemorrhoids and digestive problems. Each winter she also undergoes treatment for her asthma. The centre's doctor has become her general practitioner.

Five months after the beginning of treatment and support at the centre, the doctor decided (after having discussed it beforehand with the psychologist) to refer Mrs B to the physiotherapist, to work on her breathing and "thoroughly locked" pelvis.

The **physiotherapist** began seeing Mrs B regularly from January 2004, and began to see the doctor less frequently. The physiotherapist noted indeed that the patient suffers pains in the pelvis, lumbar vertebra, sacrum and shoulder, as well as other "roaming" pains. Her breathing was restricted, leading to coughing fits.

In December 2004, Mrs B's asylum appeal was rejected finally, and she became an "undocumented migrant". She had to leave the hostel and an extremely difficult period began. "If someone harms me tomorrow, I won't be able to defend myself", she said. She had come to France with the hope of being acknowledged as a victim but also of being guaranteed protection for the future.

Despite her hardships, Mrs B still managed to establish ties with people around her. She was often put up by people she had recently met but had the feeling that she was dependent on them. She was never given keys, and had to wait for her hosts to come home in the evening. Without papers, she didn't feel safe. She was unable to make a formal complaint when one of her hosts tried to take advantage of her. The socio-legal worker continued to help her. Mrs B found casual work (housework, mind-ing children), but providing care for other children remind her of her own. Sadness overwhelmed her.

In 2005, the physiotherapist suggests that Mrs B join a small group of women that meet regularly as a relaxation group. Mrs B tells her psychologist that she would also like to speak with other women who have been raped. Her request is discussed and it is decided that the **director of the centre** will see her in order to help her find something appropriate. Although a group was recommended, Mrs B decided not to join. The idea itself seems to have been enough; knowing that other women experienced something similar, that she's not alone.

Initially Mrs B constantly mentioned her husband and the possibility of their reunion, but this expectation gradually subsides.

*Mrs B's case is regularly discussed at team meetings. According to her doctor, medication would be of little use until what happened to her is officially recognised, until she herself is recognised as a victim and "welcomed" and protected in this country.*

*In 2007 a volunteer **jurist**, new to the team, suggested submitting a request for a residence permit on humanitarian grounds. The jurist argued that the fact of the rape was not officially questioned, and that the rejection of asylum status was merely because of an "absence of risk in case of return". Yet Mrs B was deeply traumatised, totally estranged from social and family links, and unable to return home. The **president** of the Primo Levi Association was asked to contact a well-known and influential deputy.*

*Mrs B obtained her residence permit in November 2007. It is not the kind of acknowledgment she expected, but it is a fresh start after many years of uncertainty and bitterness.*

*A new **social worker** helped her with all the procedures that arose from having obtained her papers. The physiotherapist found her a care job and, with a salary, she can apply for council housing.*

*In 2008, the physiotherapist observed improvement in her physical condition. The doctor notices that Mrs B "controls her own body in a much better way." She has plans for future education, which the social worker will help with.*

*The patient managed to get in touch with her children but every time she speaks with one of them on the phone, the symptoms recur (digestive disorders, anal pain...). Mrs B is worried about her 12 year old daughter and would like to bring her over here.*

*On the whole, Mrs B is much better; within the limits which can be expected after such traumatic events. Her social file can be transferred to the regional social worker and Mrs B is less in need of the Primo Levi care centre's support.*

*In the psychologist's point of view, "the work is done" though Mrs B still attends occasional appointments. She regularly likes "to be in touch" to confirm to herself that we are still here and that she still has a place here, if and when necessary. "When she comes round here, she comes to recharge her batteries", says her psychologist, "in the very place of her transformation."*

*Nine members of the Primo Levi Association's team were needed, from the intake interviewer to the centre's director, even including the president of the Association. After seven years of multidisciplinary care and support, Madame B is on the verge of leaving the centre.*

## **Recommendations**

- It is recommended that holistic treatment, care and support be offered to those – adults, children, families – who have been subjected to torture and political violence, scarred by repression. This involves taking into account the medical, physical, psychological aspects, without neglecting the social, cultural and legal needs.
- It is recommended that professions bring their efforts together to work on an institutional level in an inter-disciplinary manner, in order to respond to patients' needs and to contain and reduce their suffering. Each professional's role will be recognised, and respect will be shown for the professional's contribution and the limits of his/her action and support.

- It is recommended that space be provided within the institution for regular clinical exchanges and sharing of experiences for all those who work in such care centres.
- It is recommended that members of staff become fully acquainted with the requirements and constraints of other professions, and that they make known their own requirements and constraints, in order to better appreciate each staff member's framework, and to make space for some flexibility. This means taking the other professional into account in a patient's multidisciplinary treatment. This requires regular exchanges, consultations, and good communication between those concerned.
- It is recommended that people who have been subjected to torture and political violence be dealt with for treatment, care and support regardless of their status. Medical, psychological and socio-legal care and support always makes sense for these persons, if only to break their isolation.
- It is recommended that the professionals who work with these patients provide longer consultations or appointments in order, little by little, to establish basic trust.
- It is recommended that each patient's uniqueness should be respected: taking into account their life story, their various affiliations, language, culture, plans, commitments, their resources and their limits.
- It is recommended that treatment and support be conceived on a possibly long-term basis, and that long-term access be provided.

## 6.6. Summary

These examples of good practice are all very different. They emphasise different aspects of clients' problems and the work done by the teams in advocacy, counselling and treatment. They give examples of how staff are protected, and how the political work which is necessary to support the clinical work is done. They include outreach and participation in civil society, as well as in the judicial system. With all their differences they have a great deal in common, and that allows us to draw certain conclusions which we will present in the next chapter.

# 7. Conclusions and recommendations

## Introduction

It is widely recognised that torture and all other forms of intentional political violence and persecution wreak havoc on the victims, their families and communities. Physical and psychological means are used to trample on social and cultural taboos in order to destroy victims' personality and identity, and their social and political place in society. Such abuse leaves indelible scars, a sense of helplessness, mistrust and, paradoxically, shame. Thus, even after it ceases, torture continues to torture the minds and bodies of the victims, and has long-term repercussions on families and communities.

Organisations which are engaged in the treatment, care and support of victims of torture and their families are essentially working for human rights and human dignity. In such centres, professionals work together to help re-establish identity, security and a possible future for those who have been traumatised at the hands of others.

The destructive forces which these people have faced have to be counteracted by the constructive forces of conscientious professionals. Their work contributes to a better social and political environment for victims and their families.

Standards of assessment, documentation, treatment and training for such work already exist in some European countries. The organisations carrying out this work are mainly non-governmental organisations, which are also involved in training and lobbying in their countries' health and political systems

Their structures and working methods differ historically, as do the capacities of the stakeholders and the strength of their alliances. They also differ in the nature of their interventions in the process of making decisions about asylum policy. We present our conclusions with a clear consciousness of our differences, but also an understanding that we share very basic convictions which have been proven to be relevant in different contexts and thus can be presented here as joint results.

This chapter includes recommendations for treatment strategies (7.1.), for the institutions providing help (7.2.), for cooperation with decision-making bodies (7.3.), and for processes of evaluation (7.4.). We will close this chapter with the Bucharest Declaration (7.5.), which summarises our conclusions and the key norms which in our view should apply to this work all over Europe.

## 7.1. Counselling

### **The client's story: acknowledgement of what is said. Listen to their stories**

Support for survivors of torture or other vulnerable persons must include support for the client's self-determination. The starting point is a narrative exploration which permits clients to tell "their story."

Traumatic experiences should not just be seen as an element in the internal space of the individual. The way in which an individual tells his or her story has an important influence on how he or she works through trauma. There is a social, political and cultural reality to the experience which depends on such factors as the subjective significance of violence and trauma for the individual, the manner in which stress in the

context of violence is experienced, and the nature and extent of social support for the individual in his/her current situation.

### **Quality assessment, documentation and management**

Rehabilitation of victims of human rights abuses must include support for their efforts to obtain their rights in the host society to live a life which is as independent and integrated as possible. The working concept must put the individual and his/her story at the centre of its concerns. Throughout the process from registration to the conclusion of treatment, the experiences of refugees and their suffering have to be taken seriously.

Their social, political and cultural relationships should be integrated into the working procedures, and should include both the issues which have led them to leave their country and those which they encounter in exile.

Case assessments should take into account data relating to a client's country of origin and his/her place in it, details of the flight, and also information about the client's situation in his/her country of exile. Care should be taken to include not only the problems the clients has faced and still faces, but also those elements in the case which could provide support and reinforcement.

Torture is defined by the absolute powerlessness of the victim and absolute power over life and death of the perpetrator. Refugees have usually experienced an accumulation of situations in which they have found themselves helpless in a structure of power that is outside their control. They may well interpret their current dependence and uncertainty as to their future in the light of their experience as a repetition of that relationship of power and humiliation. It is therefore of particular importance that the needs of the client are given priority at registration and at the first consultation. Qualified interpreters should as a matter of course be made available at this stage.

### **A safe and transparent environment for clients**

Medical, psychological and social interventions should not just deal with the individual, but must include both the immediate and wider social environment, including the community and society as a whole. Cooperation with social and political decision-makers is part of an effective work.

In many European countries, there is no procedure to identify vulnerability or to determine the special needs of the vulnerable. This means that one of our functions has to be the identification of our target group out of all those who turn up on our doorsteps. As a result the centres' social counselling service often has to help vulnerable clients make a case before the authorities for the provision of services to which they are entitled. Social counselling should concentrate on how refugees and the authorities interact, bearing in mind that language, culture, social rules and structure are often complex and alien. Refugees should receive help in applying for welfare provision and in their contacts with social work departments, job centres and aliens' offices. At the same time, the centres should offer training for the staff of such organisations in inter-cultural competence and the consequences of traumatisation.

All in all, effective counselling and treatment have to involve the entire social system, to which end we should be networked with schools, educational institutions, hospitals and other health providers, social welfare organisation, social institutions, lawyers, asylum and aliens' offices, courts, etc.

## **Protection of the rights of clients and advocating for their rights**

Information about rights and legal assistance may be crucial for the client's chances of social integration. Rehabilitation centres should therefore make appropriate information available to their clients in all relevant languages and either provide direct legal assistance or facilitate contact with organisations providing such services.

Centres should monitor the progress of legal procedures in which their clients are involved and intervene as needed.

Where legislation or regulations are not being properly implemented, centres should consider litigation to expose the failure of judiciary or administrative agencies.

Where the law does not guarantee international standards, centres should intervene with the government or the parliament to improve legislation.

Centres will need to mobilise the media in these cases.

## **7.2. Institutions providing services**

### **Identity**

It is recommended that rehabilitation centres should reflect on and discuss their work and their identity. Organisations are founded under specific conditions, and they undergo changes as they offer more services and employ more staff. They are also affected by changes in their social environment and in the legal conditions under which they operate. The relationship between treatment and advocacy will always have to be tested to see if it fits the current situation.

### **Necessity for a multidisciplinary approach**

It is recommended that treatment, care and support for victims of torture and political violence be carried out in a multi-disciplinary fashion. The consequences of political violence are complex and deep-rooted, and require a holistic, multi-disciplinary response, taking into account physical, psychological, social, cultural and legal issues, in order to contain and reduce suffering. When required, trained professional interpreters should be available

### **Established working methods**

It is recommended that centres apply methods which have been proved to be effective through practice or academic research, and they should aim to provide their own evidence of effectiveness. It should be recognised that evidence from non-refugee populations may not be applicable for refugees. At the same time, the uniqueness of each refugee should be acknowledged and stereotyping avoided.

### **Staff care and support**

It is recommended that centres should have an active policy to prevent or mitigate the effects of stress in staff. The problem should be monitored, and staff should receive continuing emotional and practical support as well as help with crises. The nature of the work easily leads to high levels of stress, vicarious traumatisation, ambivalent positioning, compassion fatigue or burnout in individuals, and to fragmentation of

teams and high turnover of personnel. Intercollegial and external support, which should be available for all levels of the organisation, can reduce these risks.

### **Interpreting**

It is recommended to work with professional interpreters. Language is indispensable in both anamnesis and treatment. Health-care professionals are very often dependent on lay interpreters such as family members or friends, who may not have the necessary skills. This is not acceptable, ethically or legally.

## **7.3. Decision making bodies**

### **Transparent cooperation and dialogue with public institutions**

Refugees have to deal with highly complex residence status procedures as well as with living conditions which are often restrictive and lead to isolation. Such conditions can often be a serious mental strain for people who are psychologically or physically damaged.

If refugees are unable to relate their traumatic experiences as a result of their illness (for example, where the experiences include elements that are perceived as deeply shaming, such as sexual violence), centres should work to ensure that documentation about the human rights abuses they have suffered as described during counselling sessions be considered as evidence in the asylum application.

When refugees have suffered persecution or torture at the hands of the authorities in their country, they may well approach the asylum authorities with considerable mistrust. They are unable to lay out their case in full, since they may also fear that the information they reveal may be forwarded to other authorities such as the police or the secret services. Such mistrust may be based on their experiences back home, but may also be one of the symptoms of their illness.

Expert opinions in the form of a psychological assessment are an important tool in the process of helping clients express themselves in the asylum process. Centres should work to ensure that the authorities call for such an assessment where questions are raised which can benefit from further psychological or medical exploration.

The centres should collaborate with the asylum authorities while making sure that they maintain a certain distance from them, in order to provide a safe space for their clients, and also in order to continue to be able to act as a human rights lobby within the health system.

### **Necessity for justice in the healing process**

A number of European countries have experienced totalitarian regimes. Their societies have been traumatised, and they now have to find ways of restoring social calm and healing the scars. A common problem for these countries has been the huge number of victims, the large number of perpetrators and the inability of the judicial systems to cope with this challenge. The documentation of individual cases is part of the healing work contributed by the centres. But they have to raise public awareness in a way that will ensure the protection of the survivors as well as that of their own team members.

The centres have a unique position, in that they have been trusted with the survivors' history. They help recover and preserve society's collective memory of gross human rights violations and they make these accessible to current and future generations. In this way, centres can promote a national debate regarding reconciliation and the need to guarantee that such violations never happen again. They should be supported in their attempts to obtain public apologies for the victims of human rights.

## **7.4. Quality assessment and development**

### **Supervision is no luxury: it is key to preventing burnout**

Supervision (and to a lesser extent organisational development) should be an obligatory part of all services dealing with victims of violence. It should be provided on a regular basis by an external supervisor (or coach/evaluator in the case of organisational development). This is in order to provide a safe space for regular reflection to prevent burnout and vicarious traumatising.

### **Evaluation**

Many centres have reached a stage of development in which it is no longer enough to rely on their founding principles as upholders of human rights and supporters of refugees. They need to ask themselves how effectively their systems provide the services their target group needs. Evaluation can help them find the answers. We would hesitate to recommend a specific method, but the centres involved in this project found that the method they used, and which is described in Chapter 3, gave them the framework and the freedom they needed to gain insight into their effectiveness. This methodology, premised on self-evaluation, was empowering and also gave organisations control over the evaluation process. To this end, it was a learning opportunity rather than a task aimed merely at passing judgement on the partners and their work.

### **Self-critical reflection on processes and structures within the team:**

In most of the centres, the members of the teams have to work together in providing a multi-disciplinary service to the clients. They need to reflect on the nature of their work as a team in order to ensure that their services are coordinated and mutually supportive.

All centres have to face problems, and many of them are recurrent. Centres should work together to find solutions for the problems that the team members themselves identify as typical. They need to work across their hierarchical structures and across the various disciplines, since all members of the team contribute to its success or failure. This in itself will help build up the team. Again, the centres involved in this project found the method they used helped them, since it had the advantage that the team had to carry out the process itself. Structural weaknesses were acknowledged by all participants and are increasingly taken into account.

### **Diversity and interconnection**

The individual centres have developed their own know-how, which is largely appropriate for the conditions they face. But they can also learn from the experiences of other centres, which face different problems. They are all part of an effort that spans

Europe. Connecting with other European partners can create solidarity between staff members in different centres, especially when they realise that some of their problems are familiar to others. The centres involved in this project found that the European perspective added power to the network. Increasing collaboration strengthened the resilience of the staff in the teams, and will provide a dynamic element for the future, which may help prevent personal or institutional collapse.

Sometimes systems get stuck in their own reflections – for example, European Directives require that vulnerable refugees be identified. There are different models for doing this all over Europe, and it would be worthwhile bringing these together, filtering out examples of good practice and developing pan-European norms. Networking as a way of building good practice is therefore recommended.

## **7.5. Bucharest Declaration**

At the final symposium, the partners issued a declaration to affirm the key norms and principles which they developed over the lifetime of the project. The declaration summarises the principles and standards the partners feel are essential for effective care of those who have been victims of torture, whether they are refugees or citizens in their own country.

### **Bucharest Declaration**

*Considering* that torture and other cruel, inhuman or degrading treatment or punishment are prohibited in international human rights and humanitarian law, and that in spite of this it is still practiced in many countries – even in some member countries of the Council of Europe,

*And* that, as a consequence, increasing numbers of victims of torture, inhuman or degrading treatment or punishment are found in all European countries, either as victims of domestic state abuse or as refugees from repressive regimes elsewhere,

*And* that victims of torture have special problems and needs and are entitled to reparation from the state responsible – including the means for as full rehabilitation as possible,

*And* that special services for victims of torture in most European countries are provided exclusively by non-governmental centres without or with very limited funding by local and/or national authorities,

*And having regard* to the European Commission's Reception Directive, the Qualification Directive, the Evaluation Report and Green Paper on the future Common European Asylum System, as well as the Declaration of Bratislava containing special provisions for victims of torture among migrants,

*And based* on the experience of five European institutions working extensively in the field and on an intensive exchange and evaluation between them,

We recommend the following:

### **Rights and protection for victims of torture and human right abuses in society**

The centres need to promote – in collaboration with other human and refugee rights actors – a positive image of their target group and advocate for their rights as refugees and victims of torture. Centres should work as watchdogs to protect the rights of survivors of torture and to ensure they can live a life in self-determination and dignity.

## **Protection and integration for victims of torture and human right abuses in public services**

Staff in public services have to be encouraged to become more aware of the special needs and rights of victims of torture and ill treatment. This is particularly important in those services which mainly deal with refugees, but it is also significant in other public services where staff may have to deal with such victims. Effective partnerships with NGOs and other service delivery partners are also essential to enhancing public services; such partnerships should be encouraged and existing networks built upon (also see below on critical partnerships).

## **Safeguarding secure space for rehabilitation for victims of torture and human right abuses in dedicated centres characterised by transparency**

The centres should offer respect for the victims' suffering and willingness to listen. The centres must provide assurance of full confidentiality. The victims should be made aware of the availability of the various services in the multidisciplinary team and that they have the right to decline any particular service. Avenues for raising grievances about services should also be made known to them.

## **Secure rehabilitation characterised by cultural sensitivity**

The centres are at the forefront in having to ensure sensitivity towards cultural difference, but they want to avoid overemphasis of ethnic issues, which could prevent successful integration.

## **Awareness of social ambivalence**

The centres have to deal with the ambivalences which are present in the host society: for example, society generally accepts the need to protect refugees who need protection, while public opinion also wants to control the input of refugees into Europe. By bringing such ambivalent attitudes to public attention, centres help ensure that the contradictions in much political thinking on these issues are opened up.

## **Ensuring interdisciplinary approach involving collaboration and communication in multidisciplinary teams**

Comprehensive rehabilitation of victims involves professionals with a number of diagnostic and therapeutic competencies. Medical, psychological, physiotherapeutic, social and legal professionals as well as community activists have to cooperate closely and demonstrate mutual understanding of each other's role to ensure the best treatment for victims.

## **Safeguarding and protecting staff**

Staff run the risk of burn out and vicarious or secondary traumatisation, and the centres must take appropriate measures to ensure their professional integrity and stability.

### **Ensuring the independence of publicly funded specialised rehabilitation centres for victims of torture and ill treatment**

We recommend that public financial support be made available for the maintenance and further development of specialised multidisciplinary centres for torture victims as a necessary complement to the general national health and social care system.

The capacity of services for this target group should be sufficient to meet the needs of all such patients on a state's territory – partly through an increase in the capacity and number of specialised centres and partly through an increase in the capacity of the general health and social care system to deal with such patients. Such a development could be made possible through a critical partnership between the centres and the general health and social care system. The centres help to shape the human rights parameters in the health system; the specific role they play in civic society has to be recognised, as they bear witness to human rights abuses and take action to prevent them.

### **Securing context-driven support which recognises the social and political influences on clients' health**

We recognise that the treatment of torture survivors requires contextualised services and that their mental and physical health cannot be divorced from the context and conditions in which they live. Services must therefore not only treat the symptoms and manifestations of torture; they must also address the social conditions of refugees and asylum seekers (e.g. poverty, lack of clarity about legal status, language difficulties) insofar as these continue to affect the victims' psychological and medical status. Advocacy work should be seen as essential to treatment. Such work should be grounded in international human rights standards.

### **Securing professionally trained interpreters as integrated members of the multidisciplinary rehabilitation team**

We recognise that working with interpreters in psychotherapy with victims of torture is an art that requires training for both the interpreter and the counsellor, therapist or doctor in order to be effective and unambiguous.

## 8. Challenges for the future

The origins and the history of the different centres shows that they were developed by health professionals and activists out of a commitment to human rights. From the start they were concerned about political, social and legal issues as well as about the provision of health services which were not adequately provided by national health systems. It was important for the founders to be able to bear witness of human rights abuses, and that commitment continues in that the specialised centres still help to shape the human rights parameter in the health systems. To this end, it is widely accepted by the project partners, based on decades of experience, that it is not enough to deal just with the health of torture victims. Their distress is often largely due to the unjust systems under which they have suffered. Part of the healing process is the process of reconciliation. The answers to their health problems are often also found in the human rights field. This is a tension which cannot always be solved, but remains a challenge for the victims and healthcare professionals alike.

**Psychologisation of clients' situation:** As a result of the stigma still attached to mental health care services the world over, and bearing in mind that problems may well stem from political and social causes, many clients are reluctant to attend mainstream health and medical services. They do not want to be seen primarily as having psychological problems. For this reason they often prefer to come to centres, such as those of the partners, which offer a range of support. Routinely they tell staff that they feel secure because the centres are seen as human rights organisations and not merely health service providers. Such services see their suffering in a political context and not as their individual psychological problem.

The centres are mostly organised as independent non-governmental organisations with limited support from local or regional authorities. Unfortunately, their precarious financial situation often leads to considerable pressure on staff in terms of workload and moral responsibility.

**As a result of this the project clearly pointed to two areas that should be further studied:**

**First:** The issue of how to help staff contribute effectively to the work of the centres by avoiding burn-out and secondary traumatisation needs to be addressed. A closer study into **staff care** could effectively be done using a participatory evaluation and research model, as described in Chapter 2. Using this model of self-evaluation professionals would feel safe to share their views, and the research itself could be problem-solving. Here again, the involvement of a number of centres in different countries would provide valuable input and give the study the quality of diversity which it would need to be generally applicable.

**Second:** There are already studies which show how far organisations meet criteria of best practice, but they do not provide data on the effectiveness of the methods used. **An inventory of care and treatment methods**, based on an in-depth study, would be a very useful tool for professionals working in the field and a relevant reference work for NGOs and community services as well as governmental bodies.

Another issue that needs clarification is the definition of "**vulnerability**". The centres are involved in identifying and setting up programs for the most vulnerable, but, although EU directives refer to this group, they do not offer a legal or psychological

definition of the term. That makes it difficult to define their special needs and convey them to the health system.

### **Capacity for change:**

Having to handle "intercultural experience" every day, having to react to different cultures and varied individual and group values, as well as having to be informed about a variety of political and ethical realities, it is not surprising that, from the start, the centres have had to be very flexible. Additionally, the precarious situation of the clients – reflected in the precarious situation of the centres – needs to be balanced by resilience and the ability to react to changes in ways which do not lead to collapse either of the health of clients, or of the services which are offered to them. The centres have always had to react dynamically to avoid stagnation or collapse, and offer high quality services in a difficult context.

Reacting to change is an important skill for all services which provide care for victims of torture. Networking is an essential way of dealing with diversity. **Diversity and interconnection** are what make a system resilient. We need to use these skills for collaboration in the field of research and also to increase expertise in dealing with victims of torture in difficult parts of the world. Diversity in the centres has arisen naturally out of a confrontation with the diversity of their clients, and diversity across regions was at the heart of our project. The issue now is how to transfer this dynamic quality to other centres and services. The knowledge generated in the project therefore needs to be disseminated.

### **Dissemination and research based on practical experience:**

What this project demonstrated clearly was that there is no lack of expertise in the field, but that there is rather a lack of dissemination of this expertise. The centres have developed their competence over the years, but they have not had the means to do research and to disseminate the skills they have developed. That expertise, gained over 25 years experience in the field, would be extremely fruitful if it could be made available to all who work with victims of torture and human rights abuses, so that those who have suffered in the past can enter their lives in exile with restored hope. This project has been one small attempt to begin this process.

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## Annex 2 – Project timetable

Activity	Objective
<b>BAFF national meeting</b> (Berlin, June 2008)	As BAFF is an umbrella organisation of 27 centres, it was a necessary prerequisite of the project to hold a national meeting in Germany in order to plan the implementation of the project activities and the inclusion of the German Centres.
<b>Preparatory meeting</b> (Paris, October 2008)	Two members of each partner institution (one from Zebra, Austria), three members of the coordinating organisation and one internal evaluator participated in a preparatory meeting, where criteria of self-evaluation were developed and responsibilities were discussed.
<b>Self-evaluation – Team Day 1</b> (Participating Centres, Aug. – Dec. 2008)	All participating Centres analysed in a self-evaluative process their own material in reference to the selected topics.
<b>Interim Meeting</b> (Berlin, March 2009)	In an interim meeting, results of the self-evaluation (Team Day 1) were discussed. Further proceedings, analysis of data and development of common criteria and recommendations were agreed upon.
<b>Analysis of data and development of criteria and recommendations – Team Day 2</b> (Participating Centres, Feb. – Apr. 2009)	Institutions analyzed the data collected and developed joint criteria and recommendations for good practice for each of the selected topics.
<b>European Network Meeting</b> (Barcelona, May 2009)	Results of the Team Days 2 (criteria and recommendations developed) were presented to the European Network of Rehabilitation Centres for Survivors of Torture as a model for self-evaluation and trans-national research approaches. Other members of the Network and other European NGOs thus profited from the project findings.
<b>Making decisions and developing concrete goals for the future – Team Day 3</b> (Participating Centres, Jun. – Aug. 2009)	Institutions discussed the learning issues, developed the plan of action to address the issues and problems identified in the previous stages of self-evaluation. They also discussed their good practice examples (Team Days 3) and possible actions for further cooperation within the European dimension.
<b>Final symposium</b> (Bucharest, Oct. 2009)	Project partners brought together the results of the project. Common criteria and recommendations for good practice in torture care were reviewed and jointly agreed upon.
<b>Dissemination of findings</b>	The partners collaborate in bringing the findings together in a publication that will disseminate the results as well as the method used beyond the project's lifetime.