The work field of torture

Impact assessment study and anthropological reflections

Supplementum No. 1, 2003
The work field of torture –
impact assessment study and anthropological reflections

Copyright:
© International Rehabilitation Council for Torture Victims, IRCT

Editor:
Henrik Marcussen, MD, DMSc

Guest editors:
Kirstine Amris, MD
Julio Arenas, Psychologist

Assistant editor:
Lone Gunilla Curtis, MSc

Publisher:
International Rehabilitation Council for Torture Victims, IRCT
Borgergade 13
P.O. Box 9049
DK-1022 Copenhagen K
Denmark
Phone: +45 33 76 06 00
Fax: +45 33 76 05 00
E-mail: irct@irct.org
http://www.irct.org

Print:
Printed by Scanprint a/s, Viby Jylland, Denmark, 2003

Financial support:
This document has been produced with the financial assistance of the European Union and
the Royal Danish Ministry of Foreign Affairs. The views expressed herein are those of the IRCT
or the authors and can therefore in no way be taken to reflect the official opinion of the
European Commission or the Government of Denmark.

Front page:
Mogens Andersen, Denmark

ISSN 1021-6146
2003

The IRCT Impact Assessment Study (I-V)
Phase I: Outcome of torture rehabilitation at specialised centres
from the clients’ and the health professionals’ perspective
Kirstine Amris, MD, Chief Medical Officer at the International Rehabilitation
Council for Torture Victims & Julio Arenas, Psychologist, Research Coordinator
at the International Rehabilitation Council for Torture Victims

Community-based intervention beyond ‘the clinic in the bush’:
anthropological reflections on armed conflict and community healing
Thomas Pedersen, MA, E.MA in Human Rights and Democratisation,
51 Prospect Park, Flax Street, Belfast BT14 7EH, Northern Ireland.
Thomas Pedersen is a graduate student in the Master’s Programme in Anthropology
at the University of Copenhagen (Denmark). He holds an E.MA in Human Rights
and Democratisation from the University of Padua (Italy), and a BA in Ethnography
and Social Anthropology from the University of Aarhus (Denmark).

This supplement is printed on recycled paper “Cyclus Offset” 70 g/m².
Contents

Editors’ preface ........................................... 5

The IRCT Impact Assessment Study (I-V) – Phase I:
Outcome of torture rehabilitation at specialised
centres from the clients’ and the health professionals’
perspective ............................................. 7
  Stine Amris & Julio Arenas

Community-based intervention beyond ‘the clinic in
the bush’: Anthropological reflections on armed conflict
and community healing ............................... 31
  Thomas Pedersen
Editors’ preface

The World Health Organisation (WHO) has decided that the World Health Report 2004, Health Research: Knowledge for Better Health should involve a careful reflection of how advances in health research lead to improved health and health equity. The WHO is hereby giving increased emphasis to the role of health systems, and attention is focused on the importance of policy-making in achieving effective health systems.

At the same time a growing number of bodies have recognised the importance of health policy-making being research-informed. This developing interest coincides with the extensive efforts being made to increase the implementation of health research findings more generally in the mainstream health care system.

Similarly, new requirements to the work field of torture rehabilitation demands a shift from the idealistic practice of the 1970s and 1980s to a knowledge-based, scientific and academic approach in the years to come. The work field of torture rehabilitation needs to take responsibility, not only for a knowledge-based development of the applied practices within reparation of torture victims, its documentation and prevention activities, but also as an advisory and expert capacity to decision- and policy-makers influencing the agenda.

Production of systematic knowledge based on health, political, and social science is therefore a sine qua non not only for the development of the work field, but also to ensure sustainable funding for the anti-torture work in the future.

As it has been pointed out by Roger Gurr and José Quiroga in Torture, Supplement No. 1/2001: “Approaches to torture rehabilitation. A desk study covering effects, cost-effectiveness, participation, and sustainability”, knowledge about the effectiveness of different treatment approaches and of different models of organisation of service delivery is still to be produced.

As a contribution to the above-mentioned reflections, this supplement to Torture has been dedicated to the reporting of the results of the first phase of the IRCT Impact Assessment Study – a combined qualitative-quantitative, exploratory study conducted in collaboration with IRCT-affiliated rehabilitation centres in Indonesia, Bosnia, Kenya and Guatemala in 2002. In order to widen the perspective on the phenomenon of torture and rehabilitation, the report: “Outcome of torture rehabilitation at specialised centres seen from the clients’ and the health professionals’ perspective” has been combined with: “Community-based intervention "beyond the clinic in the bush": Anthropological reflections on armed conflict and community healing”.

Acknowledgements

We would like to thank the following:

The OAK Foundation for their generous support to the IRCT and IRCT-affiliated rehabilitation centres over the years and for making it possible to conduct the first phase of the Impact Assessment Study.

The clients and staff from Rehabilitation Action for Torture Victims in Aceh (RATA), Banda Aceh, Indonesia; Centre for Torture Victims (CTV), Sarajevo, Bosnia; The Independent Medico-Legal Unit (IMLU), Nairobi, Kenya; and Equipo de Estudios Comunitarios y Acción Psicosocial (ECAP), Guatemala City, Guatemala, for their collaboration and participation in the study.

José Quiroga, MD, Director of Program for Torture Victims, Los Angeles, California, USA; Carlos Madariaga, MD, Psychiatrist, Medical Director of CINTRAS, Chile; Ole Dreier, Ph.D., Professor of Psychology, University of Copenhagen, Denmark, and other colleagues for valuable reflections and discussions related to the Impact Assessment Study.

S.A & J.A

TORTURE Supplementum No. 1, 2003
The IRCT Impact Assessment Study (I-V)

Phase I:
Outcome of torture rehabilitation at specialised centres from the clients' and the health professionals' perspective

Stine Amris, MD, Chief Medical Officer & Julio Arenas, Psychologist, Research Coordinator
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and “point of departure” for the study</td>
<td>9</td>
</tr>
<tr>
<td>Measurement of health and treatment outcome in general health care</td>
<td>9</td>
</tr>
<tr>
<td>Measurement of health</td>
<td>9</td>
</tr>
<tr>
<td>The concept of “social health” in measurement of health</td>
<td>9</td>
</tr>
<tr>
<td>The concept of “quality of life” in measurement of health</td>
<td>10</td>
</tr>
<tr>
<td>Treatment from the patients’ perspective in measurement of health</td>
<td>10</td>
</tr>
<tr>
<td>Applied study designs in treatment outcome research</td>
<td>11</td>
</tr>
<tr>
<td>Measurement of health and treatment outcome in torture rehabilitation</td>
<td>11</td>
</tr>
<tr>
<td>Level of knowledge – “scientific state of the art”</td>
<td>11</td>
</tr>
<tr>
<td>The problem of torture</td>
<td>11</td>
</tr>
<tr>
<td>Health-related consequences of torture</td>
<td>12</td>
</tr>
<tr>
<td>Organisation of treatment</td>
<td>12</td>
</tr>
<tr>
<td>Implications for measurement of health and treatment outcome in torture populations</td>
<td>13</td>
</tr>
<tr>
<td>Aims of the study</td>
<td>13</td>
</tr>
<tr>
<td>Research strategy</td>
<td>14</td>
</tr>
<tr>
<td>Study design</td>
<td>14</td>
</tr>
<tr>
<td>Selection of participating centres</td>
<td>14</td>
</tr>
<tr>
<td>Data collection and methodology</td>
<td>14</td>
</tr>
<tr>
<td>Data sources</td>
<td>14</td>
</tr>
<tr>
<td>Methodology</td>
<td>14</td>
</tr>
<tr>
<td>Interviews with clients</td>
<td>14</td>
</tr>
<tr>
<td>Interviews with health professionals</td>
<td>14</td>
</tr>
<tr>
<td>Selection of informants</td>
<td>14</td>
</tr>
<tr>
<td>Data processing</td>
<td>15</td>
</tr>
<tr>
<td>Quantitative data</td>
<td>15</td>
</tr>
<tr>
<td>Qualitative data</td>
<td>15</td>
</tr>
<tr>
<td>Results and analysis of data</td>
<td>15</td>
</tr>
<tr>
<td>Quantitative data</td>
<td>15</td>
</tr>
<tr>
<td>Description of centres</td>
<td>15</td>
</tr>
<tr>
<td>Characteristics of the target groups</td>
<td>15</td>
</tr>
<tr>
<td>Organisation of service delivery</td>
<td>15</td>
</tr>
<tr>
<td>Organisation of treatment and health professional staffing</td>
<td>15</td>
</tr>
<tr>
<td>Description of informants</td>
<td>16</td>
</tr>
<tr>
<td>Description of the interviewed health professionals</td>
<td>16</td>
</tr>
<tr>
<td>Description of the interviewed clients</td>
<td>17</td>
</tr>
<tr>
<td>Qualitative data</td>
<td>17</td>
</tr>
<tr>
<td>Rehabilitation and outcome of rehabilitation from the clients’ perspective</td>
<td>18</td>
</tr>
<tr>
<td>“To be pointed out”</td>
<td>18</td>
</tr>
<tr>
<td>A social event and the experience of “suddenness”</td>
<td>19</td>
</tr>
<tr>
<td>The presentation of the problem and problem understanding</td>
<td>20</td>
</tr>
<tr>
<td>Sole responsibility and isolation</td>
<td>22</td>
</tr>
<tr>
<td>The relationship to the health professionals and the centre</td>
<td>23</td>
</tr>
<tr>
<td>Rehabilitation as a possibility for development in the process of life</td>
<td>24</td>
</tr>
<tr>
<td>Rehabilitation and outcome of rehabilitation from the health professionals perspective</td>
<td>24</td>
</tr>
<tr>
<td>The clients and problem identification</td>
<td>24</td>
</tr>
<tr>
<td>Working tasks and working conditions</td>
<td>25</td>
</tr>
<tr>
<td>Collaboration and multidisciplinary skills</td>
<td>25</td>
</tr>
<tr>
<td>The clients – successful or not successful</td>
<td>26</td>
</tr>
<tr>
<td>The linkage between theory and clinical practise</td>
<td>27</td>
</tr>
<tr>
<td>Discussion and Perspectives</td>
<td>27</td>
</tr>
<tr>
<td>Implications for future research</td>
<td>28</td>
</tr>
<tr>
<td>Phase II</td>
<td>28</td>
</tr>
<tr>
<td>Phase III</td>
<td>29</td>
</tr>
<tr>
<td>Phase IV</td>
<td>29</td>
</tr>
<tr>
<td>Phase V</td>
<td>29</td>
</tr>
<tr>
<td>References</td>
<td>29</td>
</tr>
</tbody>
</table>
The concept of rehabilitation includes medical and psychosocial rehabilitation of the individual, including rehabilitation as societal and political actor. It also includes public recognition of the criminal atrocity committed — and, eventually, punishment of the perpetrators.

At the level of the community break down of social, political and economical networks are recognised as being consequences of torture and organised violence, affecting dynamic relationships between individuals and the community impeding trauma recovery.

Most rehabilitation centres and programmes have therefore adopted multidisciplinary approaches, linking traditional rehabilitation of individuals and interventions provided at the community level; to the legal and political aspects of torture and are additionally engaged in medico-legal documentation, prevention and advocacy activities.

As of to day, most of the published literature on the consequences of torture and on services provided to torture victims is descriptive. Only few outcome studies exist and these studies have limitations due to the lack of definition of diagnostic criteria; theoretical framework for problem identification and understanding, goal setting in therapy and provided interventions; validation of assessment instruments and identification of relevant outcome indicators.

In a desk study summarising "the scientific state of the art" within torture rehabilitation Gurr & Quiroga point out that knowledge is missing in several areas.

The implications of this lack of knowledge and the resulting lack of scientific evidence within the work field are that no clear and scientifically valid recommendations on the organisation and functioning of rehabilitation services and the interventions they offer in different environments can be put forward. The complexity of contributing factors and the lack of controlled studies mean that decisions have to be made based on simpler evaluation methods and professional judgement.

Establishment of theoretical frameworks based on health, social and political science and linkage of theory with practice within reparation of individual torture victims and within interventions provided at the community level is therefore needed in order to develop the work field.

The IRCT has drafted a long-term research strategy based on a global multi-centre study design. The research strategy comprises 5 phases, which are to be conducted within a time framework of 5 to 6 years (Fig. 1).

The main objective of the overall study is to assess if and how rehabilitation at specialised centres provided in different socio-cultural settings improves the well-being of victims of torture, and based on the achieved knowledge to establish empirically founded "best practise guidelines" for the future clinical work.

Additional outputs will be the identification of outcome indicators, which can be used in outcome monitoring at centres worldwide, and development of instruments to be used in intercultural outcome research.

The first phase - a combined qualitative-quantitative, exploratory study has been conducted in collaboration with IRCT affiliated rehabilitation centres in Indonesia, Bosnia, Kenya and Guatemala in the year 2002. A report, based on the results of the study, has been elaborated and will be accounted for in this paper.

**Measurement of health and treatment outcome in general health care**

Measurement of health and outcome of treatment are in general very complex and the scientific approach - the design of the study, the methodology, the choice of measuring instruments and outcome parameters - implicate a series of conceptual and methodological issues that need to be addressed.

**Measurement of health**

In order to measure health outcome a measure of health status is required, which in turn must be based on a concept of health.

Acceptable definitions of health have been changing throughout history. The past 150 years have led to a shift away from viewing health in terms of survival, through a phase of defining it in terms of absence from disease, onward to an emphasis on positive themes of happiness, social and emotional well-being and quality of life.

There is now broad agreement that the concept of positive health is more than mere absence of disease or disability and implies "completeness" and "full functioning" or "efficiency" of mind and body as well as social adjustment. Beyond this there is not one accepted definition.

Following this broad definition assessment of health status becomes a complex task. Health is to be seen as a construct, which cannot be measured directly. The overall concept of health or change in health status must therefore be measured through a number of indicators defined within the various domains of health.

Additionally there are multiple influences upon patient outcome, which also require a broad model of health. The non-biological factors that can affect recovery and outcome include patient psychology, motivation and adherence to therapy, coping strategies, socio-economic status, availability of health care, social support networks and individual and cultural beliefs and behaviours.

Based on the above mentioned, it is increasingly recognised that measures of "social health" and "quality of life" measures should be included when evaluating health care interventions.

**The concept of "social health" in measurement of health**

Donald C et al have called a broader view of health than the reporting of symptoms, illness and functional ability "social health". They conceptualised social health both as a component of health-status outcomes and, in terms of social support systems that might intervene and modify the effect of the environment and life stress events on physical and mental health. Measurement of social health focuses on the individual and is defined in terms of interpersonal interactions and social participation.

Other authors have also conceptualised social health as a separate component of health status, defining it in terms of the degree to which people function adequately as members of the community.

Lerner noted that health status may be a function of non-health factors external to the individual, such as the environment, the community and significant social groups and recommended that social well-being measures focus on constructs such as role-related coping, family health and social participation. He hypothesised that socially healthy persons would be more able to cope successfully with day-to-day challenges arising from performance of major social roles;
would live in families that are more stable, integrated and cohesive; would be more likely to participate in community activities; and would be more likely to conform to societal norms.

The concept of "quality of life" in measurement of health

"Quality of life" in relation to health is a broader concept than personal health status and also takes e.g. social well-being into account.

There is no consensus about a definition of quality of life. The literature covers a range of components; functional ability, the degree and quality of social and community interaction, psychological well-being, somatic sensation (e.g. pain), and life satisfaction. Health and functional status are just two dimensions of health-related quality of life.

Basically, quality of life is recognised as a concept representing individual responses to the physical, mental and social effects of illness on daily living, which influence the extent to which personal satisfaction with life circumstances can be achieved. It encompasses more than adequate physical well-being, it includes perceptions of well-being, a basic level of satisfaction and a general sense of self-worth.

Treatment from the patients' perspective in measurement of health

Analysis of the patient perspective – patient experiences and patient evaluations – can be incorporated in measurements of health care services and is inarguably important in understanding patients' perception of, and satisfaction with, their health outcome following treatment. Different types of measurements can be applied:
Assessment of behaviours and attitudes, which illustrates the patients' health and disease behaviour including compliance, norms, values, expectations and experiences.

Assessment of patient satisfaction and degree of fulfilment of expectations of the treatment.

Assessment of patients' preferences for treatment in relation to the likely effect on their health and health-related outcome.

There is considerable evidence that patients' assessment of care has important consequences for their health and for the health care they receive. Patients who are dissatisfied with their health care are more likely to engage in activities, which disrupt their medical care, and could compromise their health outcome7.

In this way patients' assessments become not only an evaluation, but also a predictor of health outcome.

Applied study designs in treatment outcome research

Various research designs are available in outcome research, but most often outcome studies are conducted using:

- Randomised controlled trials (efficacy studies) in which the treatment is implemented by the researcher under rigid control and the patient randomly allocated to either treatment or no treatment in a control group, or
- Quasi-experimental study designs assessing treatment as it is applied in the field (effectiveness studies).

The advantages of randomised controlled trials are that the research outcome, with a high degree of possibility, can be attributed to the application of treatment.

Disadvantages are that interventions are provided under tightly controlled and largely artificial experimental conditions, while patients, clinicians and other decision-makers need to know how treatments work in the real world and whether they are cost-effective under routine conditions. Important questions relating to the organisation and delivery of services are additionally rarely addressed in randomised trials8.

Research related to effectiveness rather than efficacy provides therefore a series of advantages, but also disadvantages. The study design involves less manipulation. It is therefore more feasible and provides clinical relevant feedback to treatment providers.

The outcome of the treatment a person receives is however determined by a number of factors. In uncontrolled studies it can therefore be difficult to attribute any difference in outcome to the treatment itself. Improvement may e.g. be explained as spontaneous recovery or related to external events. This threat to the validity of the research outcome, can be ruled out by applying a relevant comparison group.

Measurement of health and treatment outcome in torture rehabilitation

Level of knowledge - “scientific state of the art”

In 2001 Gurr & Quirgao1 published a comprehensive desk study - “Approaches to Torture Rehabilitation” - based on material collected in 1997-1998. Out of more than 400 scanned refereed journals, other journals, books, and unpublished papers 250 were selected for review and included in the study.

In the introduction the authors state: “having done a thorough review of the literature, we are disappointed by how few questions in service provision are answered. In some areas of interest there are virtually nothing available.”

Most of the published literature on the health related sequences of torture and rehabilitation of torture victims is descriptive. Only few clinical outcome studies exist and these studies have limitations due to the lack of: control groups; definition of diagnostic criteria; theoretical framework for problem identification and understanding; goal setting in therapy and provided interventions; validation of assessment instruments and identification of relevant outcome indicators.

In their conclusion Gurr & Quirgao1 pointed out that knowledge is missing in several areas, and put forward the following recommendations for future research:

- Studies of the effectiveness of different models of organisation of torture rehabilitation services
- Studies of the efficacy of different treatment approaches
- Studies of the criteria for successful outcomes in treatment and the duration of achieving these outcomes
- Studies of the cost-effectiveness of the different treatment approaches
- Studies of the cultural influences on the response to trauma
- Studies on how the majority of people, in different cultures, who never receive treatment, cope with their trauma
- Studies on intervention strategies for the prevention of the onset, the reduction of the severity, or prevention of the recurrence of mental health sequelae in torture survivors
- Studies on specific high-risk groups among victims of organised violence, such as women, rape victims, children, orphans, family members, ex-soldiers, etc.
- Studies to separate the medical and psychological sequelae of torture from the sequelae of refugee trauma
- Studies on resilience factors and an elucidation of why not all exposed to severe trauma develop long-lasting conditions
- “Westernised” approaches, i.e. what are the respective advantages and disadvantages of the different approaches
- Studies on the coping strategies of the second generation of torture survivors, and on integrative problems to elucidate how the impact of trauma is transmitted to the next generation.

The implications of this lack of knowledge and the resulting lack of scientific evidence within the work field are that no clear and scientifically valid recommendations on the organisation and functioning of rehabilitation services and the interventions they offer in different environments can be put forward. The complexity of contributing factors and the lack of controlled studies mean, that clinical decisions have to be made based on simpler evaluation methods and professional judgement.

The problem of torture

Torture, as currently understood in international law, involves several elements: the infliction of severe pain (whether physical or psychological) by a perpetrator who acts purposefully and on behalf of the state.

There are several purposes, which torture can serve, but the broad objective includes the maintenance of social control, the defence of ruling values and the suppression and prosecution of political opponents and criminals. Where torture has become institutionalised or where police can act with complete impunity, the threshold at which torture is seen as an appropriate tool can decrease.

Torture and other forms of violence can be perpetrated to assist "ethnic cleansing" - the expulsion of one or more ethnic groups - or more generally to induce in a population a sense of terror.
The targets of torture are a mix of those who have long been recognised as potential victims—foremost, political or military opponents of the ruling power—as well as others who are under-recognised as targets of torture: alleged criminals, the poor and socially marginalised, and ethnic minorities.\(^9\)

Torture practised today is either state policy—the deliberate use of torture with the silent or open support of the government—or it can arise out of ineffective control of law enforcement personnel, including impunity for those who carry out the atrocities, or is practised in conflict zones including members of armed opposition groups.

**Health-related consequences of torture**

Research suggests that the consequences of torture occur in the context of personal attribution of meaning, personality development, and social, political and cultural factors (The Istanbul Protocol, 1999)\(^10\). For this reason one cannot assume that torture has the same outcome in different individuals and in different socio-cultural and political settings.

The health-related consequences of torture are therefore likely to be influenced by many interrelated internal and external factors, including:

- Age and developmental phase of the victim at the time of torture
- Pre-existing personality, genetic and biological vulnerability of the victim
- Prior history of trauma
- Circumstances, severity and duration of torture
- Preparedness for, perception and interpretation of torture by the victim
- Cultural meaning of torture and cultural meaning of symptoms
- The social context before, during and after torture
- Community values and attitudes
- Political factors.

Consequently there are complementary approaches applied by professionals in understanding the impact of torture on the overall concept of health.

The clinical approach utilises a medical and psychological paradigm and relies on clinical history, physical examination, and mental status examination of the individual.

The community approach involves assessment of traumatised groups or populations and focuses on the impact of torture on interrelationships and the “psychosocial health” of the community.

It is scientifically well documented that individual torture victims who are referred to treatment have a broad range of physical, psychological, social and legal problems. Most of the knowledge about the health-related consequences of torture is however based on symptom description and established in western settings focusing on refugee populations\(^11\).\(^11\)

Research related to other dimensions of health than the reporting of symptoms and illness is missing and e.g. systematic information on health-related quality of life including physical and mental functional ability in torture victims is not available.

Physically torture survivors present a variety of symptoms from different body systems, which have been reviewed in several publications. Most of these papers have a listing of symptoms, but no diagnoses. Frequent and typical complaints that are reported even years after torture, are chronic pain related to the musculo-skeletal system, neurological symptoms and irritative symptoms from organ systems\(^12\).

The psychological sequelae of torture are likewise described in terms of listing of symptoms or clusters of symptoms. Despite the variability due to personal, cultural, social and political factors similarities in the psychological symptoms that emerge are described, with the main constellation of symptoms corresponding to those collected into the syndrome labelled as Post-Traumatic Stress Disorder (PTSD). However, the utility of this diagnosis in non-western cultural groups has not been clearly established, although evidence suggests that there are high rates of PTSD and depression symptoms among traumatised refugee populations\(^13\).

Further, cross-cultural research has revealed that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric reactions and disorders. What is considered disordered behaviour, a disease in one culture may not be viewed as pathological in another. Likewise, while some symptoms may be present across different cultures, they may not be the symptoms that concern the individual the most. Therefore, the assessment has to include the individuals’ beliefs about their symptoms, as well as an evaluation of the presence or absence of symptoms\(^13\).

Relatively little is known about the social and economical consequences of torture. Social effects of torture are described in the literature at the level of the individual, the family, the community and the society.

The impact of torture on the “social health” of individuals and within families is described in terms of impairment of role-model coping, interpersonal interactions, and social participation leading to social isolation and stigmatisation, poverty, and family and marital problems.\(^1\)

Flight into exile, displacement and settlement in a new country are additional events that aggravate the social and economical consequences of torture.\(^1\)\(^4\)\(^-\)\(^16\)

At the level of the community breakdown of social, political and economical networks are described as a consequence of torture and other related human rights violation, which may affect the dynamic relationship between individual and community and impede trauma recovery.\(^17\)

**Organisation of treatment**

The complexity of the health-related consequences of torture was recognised very early in the history of treatment. Most rehabilitation centres and programmes have therefore adopted multidisciplinary approaches, offering the clients a combination of medical and psychological services, social counselling as well as legal assistance. The professional staffing may include physicians, psychiatrists, psychologists, counsellors, physiotherapists, social workers, occupational therapists, nurses and lawyers.

Several models of service structure have developed within the work field:

- Integrated centres, where rehabilitation services are provided by a multidisciplinary team at the centre supplemented at some centres by coordinated referral to external experts
- Core centres, supporting and coordinating referral of clients to external experts and networks
- Networks of volunteers or part time staff offering services to torture victims without core support function
- Community based intervention, where services are provided in the field.

Not only the organisation of service delivery, but also the clinical practise vary to a great extent between centres, coun-
ries and regions of the world. Some centres apply a medical approach in assessment and treatment prioritising medical and physical aspects in rehabilitation, other centres are more oriented towards psychosocial needs and treatment models. Some centres focus on rehabilitation of individual torture victims, others provide family and group therapy, some centres offer a combination of individual, family and group therapy and finally some centres work entirely community based.

Given the different social and political contextual settings world-wide the target group also varies between centres. Some centres mainly receive clients from socially marginalised groups or ethnic minorities where torture and violence are randomly targeting whole populations, other centres work with victims of torture targeting selected individuals and in some countries of resettlement rehabilitation centres work strictly with refugee populations.

Since systematic knowledge and scientific evidence is lacking in many areas, it has not been possible to recommend or reach consensus on “best practice guidelines” within rehabilitation of torture victims or within the individual health professional disciplines that contribute in the rehabilitation process. Throughout the years many e.g. psychological treatment approaches have been applied, varying from centre to centre and from health professional to health professional and without concordance in problem understanding, and priority and goal setting in treatment.

Furthermore the “work field of torture” has utilised knowledge and methods developed in other areas e.g. mainstream mental health services and assumed that they would be equally effective in the care of torture survivors.

Establishment of theoretical frameworks based on research, and linkage of clinical practise with theory within rehabilitation of torture victims is therefore needed as well as operational definitions of e.g. torture as a trauma (problem identification and understanding), goal setting in therapy, successful treatment processes, and successful outcome of treatment and recovery.

**Implications for measurement of health and treatment outcome in torture populations**

The complexity of the health-related consequences of torture necessitating a multidisciplinary approach in treatment, and the diversity of interventions provided in different models of service structure makes outcome research a difficult task.

There is a desire within the health professional work field and by all funding agencies for indicators of individual improvement, service quality and utilisation efficiency. Literature – recognising the inadequacy – suggests that the indicators, which can be used are symptom reduction, improvements in functionality, achievements of negotiated treatment goals and consumer satisfaction.

However a prerequisite for developing operational and valid outcome indicators, which can be used in monitoring of rehabilitation services based on the above mentioned, is increased knowledge in several areas:

- Better understanding and definition of the health-related problems caused by torture – the objective of rehabilitation – seen from the torture victims’ as well as the health professionals’ perspective.
- Increased knowledge about individual responses to the physical, mental and social effects of the health-related consequences of torture on activities of daily living – functionality – and other quality of life parameters.
- Increased knowledge about the multiple internal and external modifying factors influencing mental and physical health status and treatment outcome.
- Increased knowledge about the influence of torture and health-related consequences of torture on social support systems within the family and within the community.
- Increased knowledge about the process of rehabilitation – the clinical practise and applied theories, goal setting and expectations from the clients’ as well as the health professionals’ perspective.
- Increased knowledge about the clients’ preferences, perception of and satisfaction with their health outcome following treatment.

Development of intercultural, validated assessment instruments will be a prerequisite for conduction of outcome research establishing efficacy, effectiveness and cost-effectiveness information.

Thus, research applying qualitative as well as quantitative research methodology is needed in several priority areas in order to measure health status and treatment outcome in torture populations.

**AIMS OF THE STUDY**

The current study had 2 overall aims:

1) To describe – based on a phenomenological approach – the outcome of torture rehabilitation as provided at specialised centres and in different socio-cultural settings seen from the clients’ and the health professionals’ perspective.

A series of dependent and independent variables related to centres, clients and health professionals were identified to be elucidated by the study:

**Independent variables:**
- Characteristics of the centre and the frames for the intervention provided by the centre
- Therapists’ characteristics
- Client demographics
- Initial severity and chronicity in the study population.

**Dependent variables related to clients:**
- Definition and understanding of the problem(s) caused by the torture
- Perception of the treatment course and the treatment outcome
- Daily life change
- Future wishes.

**Dependent variables related to health professionals:**
- Definition and understanding of the clients’ problem(s) caused by torture
- Working methods
- Perception of collaboration, tasks and objectives within the work
- Perception of the clients
- Possibilities and limitations in the work
- Relation between clinical practise and theory.

2) To use the obtained knowledge in generating hypothesis to be further elucidated by subsequent qualitative and quantitative research, and to apply the knowledge in the design of such studies.
RESEARCH STRATEGY

Study design

The study was designed as a multi-site study and included 4 rehabilitation centres from 4 different UN regions of the world. This design was applied in order to highlight representativeness and in order to describe study findings across different socio-cultural settings.

Conduction of the study at individual centres took place in close collaboration between the centre and the IRCT research team visiting the centre according to a mutual agreed timetable and Terms of Reference for conduction of the study. The IRCT research team comprised 1 medical doctor and 1 psychologist.

Selection of participating centres

Four well-consolidated centres representing the Asian region, the Central and Eastern European region, the Sub-Saharan African region, and the Latin American region were identified by the research team based on the following criteria:

- Member of the IRCT network
- Location of the centre. Participating centres should be located in different regions of the world
- Age of the centre. Participating centres should be established in or before 1999
- Client characteristics at centres. Clients treated at the centres should be victims of torture or other related human rights violation
- Treatment approach and service delivery. Participating centres should represent different treatment approaches and organisation of service delivery (centre based treatment, community based treatment, referral to external network)
- Staff number and composition. Centres should have a multi-disciplinary staff composition and a minimum of treatment staff.

The following centres from the IRCT network were identified and received written information and invitations to collaborate in the study:

1) Rehabilitation Action for Torture Victims in Aceh (RATA), Banda Aceh, Indonesia, established in 1999
2) Centre for Torture Victims (CTV), Sarajevo, Bosnia-Herzegovina, established in 1997
3) The Independent Medico-Legal Unit (IMLU), Nairobi, Kenya, established in 1995
4) Equipo de Estudios Comunitarios y Accion Psicosocial (ECAP), Guatemala City, Guatemala, established in 1997.

All centres accepted the invitation and were visited by the IRCT research team according to the following timetable:

1) RATA: 25th of June until 11th of July 2002
2) CTV: 28th of July until 4th of August 2002
3) IMLU: 5th of September until 15th of September 2002

Data collection and methodology

Data sources

In order to obtain in-depth insight and in order to describe nuances and contrasting perspectives data collection from several complementary data sources was applied:

- Written sources: review of relevant literature and existing written background material on centres (project proposals, mission reports, annual reports, publications, etc.)
- Interviews, questionnaires and informal communication
- Systematic and sporadic observations made by the research team in the field.

Methodology

A combined quantitative-qualitative methodology was applied in the study:

The quantitative method was based on questionnaires collecting data to be analysed in numerical form. The following questionnaires were developed and implemented:

- A “Centre Questionnaire” to be filled in by the centre staff describing centre characteristics
- A “Health Professional Questionnaire” to be filled in by the interviewed health professionals describing health professional characteristics
- A “Client Information Sheet” to be filled in by centre staff on interviewed clients based on background material from existing client files.

The qualitative method was designed to get an in-depth picture of a relatively small sample of clients and health professionals’ perceptions, experiences and evaluation of treatment courses within rehabilitation of torture victims. The qualitative data was obtained using semi-structured interviews and focus group interviews.

Number of informants to be interviewed was chosen based on recommendations from the literature regarding phenomenological interview-based studies.

Interviews with clients

Semi-structured individual interviews were conducted in a cross-section of 5 clients at each centre. Interview guides applied in the interviews were elaborated to reveal a variety of attitudes, opinions and behaviours among clients within the identified dependent variables to be elucidated by the study.

Focus group interviews were conducted, when appropriate, with the same 5 clients at each centre. Topics to be discussed in the focus group were identified based on the individual interviews.

Interviews with health professionals

Semi-structured individual interviews were likewise conducted in a cross-section of 5 health professionals at each centre. Interview guides applied in the interviews were elaborated to reveal a variety of attitudes and opinions among health professionals within the identified dependent variables to be elucidated by the study.

Focus group interviews were conducted, when appropriate, with the same 5 health professionals at each centre. Topics to be discussed in the focus group were identified based on the individual interviews.

The psychologist from the IRCT research team, using an interpreter if needed, conducted all interviews. Interviews were recorded and transcribed successively at the IRCT.

Selection of informants

Purposeful sampling was applied in the selection and inclusion of informants. The following criteria were used:

Selection of clients:
- Age (18 years of age or older)
- Informed consent and willingness to participate in a recorded interview
- Heterogeneity regarding: age, gender, time framework of the therapeutic course, and problems related to the torture.
The above-mentioned criteria were applied in order to describe differences in perception, understanding, perspectives and experiences among clients.

Selection of health professionals:
- Informed consent and willingness to participate in a recorded interview
- Heterogeneity regarding: age, gender, health professional background, and years of experience within the work field.

The above-mentioned criteria were used in order to describe differences in perception, understanding and experiences among health professionals regarding the clinical practise and the theoretical framework applied in the rehabilitation of torture victims.

Data processing
Quantitative data
Numeric data from Centre Questionnaires, demographic data and other person related data were analysed using simple statistical tests in order to characterise centres, health professionals and clients.

Qualitative data
Processing of the qualitative data was based on a phenomenological approach using "practise portrait" as methodology in the analysis21-23.

RESULTS AND ANALYSIS OF DATA
Quantitative data
The results from the processing of the quantitative data are presented in table format: Centre Questionnaires: Table 1-6. Health Professional Questionnaires: Table 1-10. In the following only selected tables will be presented.

Description of centres
Based on the results from Centre Questionnaires, Health Professional Questionnaires and observations made by the IRCT research team in the field, the frames for the provided rehabilitation services including differences and similarities across participating centres can be described in terms of:
- Characteristics of the target group - the context of torture
- Organisation of service delivery
- Organisation of treatment and health professional staffing
- Characteristics of individual clients treated by the centre.

CHARACTERISTICS OF THE TARGET GROUPS
RATA, CTV, and IMLU reported primary victims of torture as defined by the UN Convention Against Torture as being the target group for the health professional work at the centre.
ECAP reported primary victims of torture as defined by the UN Convention Against Torture and victims of organised violence as defined by WHO as being the target group.

The problem of torture and the context in which the torture takes place also varies across centres:
RATA is especially mandated to treat victims from the so-called "DOM period" - the period from 1989 until 1998 during which a repressive, government supported military regime was executed in Aceh in order to control the political opposition and the liberation movement. Torture and other human rights violation are still extensive in Aceh, perpetrated by the military and randomly targeting and intimidating the broader population.
Torture victims treated at CTV are victims from the war in Bosnia 1992 - 1997, the victims being detained in concentration camps during torture and the perpetrators military personnel of different nationality.
Torture victims treated at IMLU are mainly victims of institutionalised violence perpetrated by law enforcement personnel, the targets of torture being alleged criminals, the poor and socially marginalised.
ECAP's main target group is an ethnic minority - the Mayans - exposed to political repression through decades, culminating in government supported ethnic cleansing and displacement targeting whole communities in the early 1980s.

ORGANISATION OF SERVICE DELIVERY
Based on the inclusion criteria, the 4 participating centres represented different models of service structure:
RATA mainly functions as a core centre - a head quarter - coordinating the health professional work undertaken by 4 field offices situated in different regions of Aceh, including referral of clients to relevant external specialists and other public health care systems. Only a smaller number of clients receives treatment in RATA head quarter itself.
CTV functions as an integrated centre offering services at the centre provided by different health professional specialists.
IMLU mainly functions as a core centre assessing the needs of the clients and coordinate hereafter the referral of clients to a collaborating network of specialised health professionals.
ECAP's health professional work is community based and project oriented. The focus is reconstruction of the collective memory through testimonies, reconstruction of social, cultural and political networks in the communities, and legal justice for the suppressed population.

ORGANISATION OF TREATMENT AND HEALTH PROFESSIONAL STAFFING
As illustrated in Table 1 and Table 2 all centres offer a multidisciplinary assessment of clients either at the centre itself or by referral to various health professional specialists in a collaborating network. At some centres the collaborating network also includes legal advisors.

The organisation of treatment is likewise based on a multidisciplinary approach at all centres, even though the clinical practise and focus of the provided intervention vary across centres.

Two centres reported the combination of physical, psychological and social aspects in rehabilitation to be the most important. One centre prioritised medical and psychological aspects and one centre applied a strictly psychosocial model in assessment as well as in rehabilitation.
At one centre rehabilitation is targeting individuals, families and the community. Two centre focus on rehabilitation of individuals and families, and finally one centre offers individual and community based intervention.
Average duration of treatment and number of treatment sessions also vary across centres, as illustrated in Table 1, with a spread in average duration of treatment from 4 months up till 2 years.

Reflecting limitations and possibilities at individual centres, as well as differences in the organisation of service delivery and priorities within the clinical practise, the staffing at centres also varies to a great extent. As illustrated in Table 2, this variation includes both the number of full time employed staff and the professional composition of the staff. A health professional background however is dominating among full time employed staff across centres comprising 73%.
The majority of the staff in collaborating networks is likewise health professionals, attached to the centres on consultative basis. Only one centre reported the use of volunteers.

Additionally only one centre reported a need for the use of interpreters in their clinical work.

Table 3 describes demographic data of clients referred to treatment at individual centres as reported in the Centre Questionnaires.

The majority of the clients is between 19 and 50 years of age, predominately males in 2 centres, predominately females in 1 centre and in 1 centre the gender distribution among clients is equal.

The social status amongst clients across centres is in general low with high unemployment rates and low levels of education. In one centre 100% of the clients are reported to be peasants, 90% of which are illiterates and 80% widowers.

At all centres except one the referred clients have different ethnic backgrounds.

Table 4 lists the 5 (or more) most frequently applied psychological torture methods reported by referred clients at individual centres.

As illustrated, variation among the reported psychological torture methods across centres exists reflecting the specific context of torture in the different countries, but similarities are also present, with e.g. threats and/or witnessing of torture being reported by all centres.

Table 5 lists the 5 (or more) most frequently applied physical torture methods reported by referred clients at individual centres. All centres report unsystematic beating.

Aside from beatings the clients at CTV most often report atrocities related to deprivation – deprivation of basic needs and restriction of physical activities.

At the rest of the centres the reported torture methods represent systematic, physical torture with sexual assaults and suspension listed by all 3 centres.

Table 6 lists psychological and physical complaints presented by clients at referral across individual centres.

As illustrated, similarities are present in the symptomatology regardless of variance in applied torture methods, context of torture, and social and cultural differences.

All centres report anxiety and depression symptoms as being frequent. Physical sequelae are predominantly pain – headache and pain related to the musculo-skeletal system – reported by all centres.

Description of informants

DESCRIPTION OF THE INTERVIEWED HEALTH PROFESSIONALS

Based on the filled in Health Professional Questionnaires the

<table>
<thead>
<tr>
<th>Services offered at centre/referral</th>
<th>Indonesia RATA</th>
<th>Bosnia CTV</th>
<th>Kenya IMLU</th>
<th>Guatemala ECAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychological</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Counselling</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social counselling</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Legal aid</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Referral to other specialist</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| Treatment targeted at               | Individuals    | Yes        | Yes        | Yes        |
|                                     | Family         | Yes        | Yes        | No         |
|                                     | Community      | Yes        | No         | No         |
|                                     | Others         |            |            |            |

| Decision on treatment based on      | Medical examination | Yes | Yes | Yes | Yes |
|                                     | Psychiatric assessment | Yes | Yes | Yes | Yes |
|                                     | Psychological assessment | Yes | Yes | Yes | Yes |
|                                     | Assessment by counsellor | Yes | Yes | Yes | Yes |
|                                     | Assessment by physiotherapist | Yes | Yes | Yes | Yes |
|                                     | Assessment by social worker | Yes | Yes | Yes | Yes |
|                                     | Assessment by lawyer |            |            |            |
|                                     | Others | Field worker, nurse |            |            |

| Most important part of rehabilitation | Physical | Yes | Yes | Yes | Yes |
|                                     | Psychological | Yes | Yes | Yes | Yes |
|                                     | Social/legal | Yes | Yes | Yes | Yes |
|                                     | Combination | Yes | Yes | Yes | Yes |
|                                     | Others | Psyhosocial assessment |            |            |

| Average duration of treatment        | 24 weeks | 16-18 weeks | 24 weeks | 2 years |
|                                     |          |            |          |        |

| Average number of treatment sessions | 5       | 15-20     | 12       | 48-96       |
|                                     |          |            |          |        |

| Criteria for ending treatment        | Mutual agreement client/health prof. | Yes | Yes | Yes | Yes |
|                                     | Client's initiative | Yes | Yes | Yes | Yes |
|                                     | Health professional's initiative | Yes | Yes | Yes | Yes |
|                                     | Referral elsewhere | Yes | Yes | Yes | Yes |
|                                     | Other | Immigration |            |            |
professional profile of the interviewed health professionals, the current organisation of their clinical practise, and their preferences are presented in table format, Tables 7 and 8.

In total 20 health professionals were interviewed. 17 health professionals were full time employees at the centres, and 3 health professionals employed on consultative basis as part of the collaborating network.

DESCRIPTION OF THE INTERVIEWED CLIENTS
Twenty clients, 8 females and 12 males, were interviewed. Written client files were accessible on 17 of these clients. The following descriptions are based on information from the Client Sheets filled in by health professionals at the individual centres (Fig. 2-7).

The interviewed clients were between 23 and 65 years of age, in average 42.7 years old.
All clients had a low social status and poor backgrounds; 5 being farmers, 4 being employed, 1 being occasionally employed, 5 being unemployed and 2 retired.
The torture took place between 1 and 11 years ago, in average 7.6 years ago. Twelve of the interviewed clients were tortured during confinement/imprisonment, 5 clients at their residents. Duration of confinement/imprisonment varied from 2 days to 15 years, in average 26.2 months.

At the time of the study, the individual clients had been treated from 2 months till 24 months, with an average treatment duration for the whole group of 17.6 months.
Five clients had ended their treatment courses, and 12 clients were still receiving treatment at the time of the study.

Qualitative data
How do the world-wide programmes for the rehabilitation of torture victims operate and are they effective? Who are the consumers and how do they utilise these programmes?
The programmes for the rehabilitation of torture victims are practiced within, and in relation to a social work field. A work field involving different parties with different perspectives according to their positioning in the field: their positioning in relation to the problems, and their positioning in relation to each other.
Consequently, an essential question is to be asked: what is the health professional's perspective and what is the torture

<table>
<thead>
<tr>
<th>Number of full time employees</th>
<th>Indonesia RATA</th>
<th>Bosnia CTV</th>
<th>Kenya IMLU</th>
<th>Guatemala ECAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social workers</td>
<td>24 field</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Legal advisors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Counsellors</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Interpreters</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Admin. personnel</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>7 nurses</td>
<td>1 sociologist</td>
<td>5 health promoters</td>
<td>1 anthropologist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employees on consultative basis</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>&gt;20</td>
<td>2</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Social workers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal advisors</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Counsellors</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Interpreters</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Admin. personnel</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>1 nurse</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of volunteers</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social workers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal advisors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Counsellors</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Interpreters</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Admin. personnel</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Differences staff/client regarding</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td>Information</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Social status</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Country of origin</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you use interpreters on daily basis?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
18 are broken and my teeth were pulled out and broken ( ... ) I and they told me

"I was beaten, I was maltreated, I was raped, I have the bones that are broken and my teeth were pulled out and broken ( ... )"

Since I am not employed I can come here because it is free and I can get that kind of help."

"My husband has been killed and burned and I have been in concentration camp ( ... ) My brother and his wife told me to come here, because I was feeling bad, I was very skinny and was very depressed because I lost my memory when I was in XX (a town)."

"I was beaten severely. And you can see my hands ( ... ) Because I experienced (in the prison) some things that nobody else did and I was black from bruises – like my shoes are now ( ... ) I came here encouraged by other people living in XX (a town). They told me that I must go here and get help. Not only food but also other things in order to survive."

"I contacted the centre through Dr. XX. I contacted him because I had nightmares and I was screaming during my sleep and wetting my bed. He directed me here. Because I didn't have any means to provide necessities for myself ( ... ) I came here because they (health professionals) could pay for my medication."

---

**Table 3. Characteristics of individual clients treated by the centres. Demographic data. Clients treated in the period 1/1/1999 until 31/12/2001.**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Indonesia RATA</th>
<th>Bosnia CTV</th>
<th>Kenya IMLU</th>
<th>Guatemala ECAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>996 (84%)</td>
<td>154 (51%)</td>
<td>594 (85%)</td>
<td>232 (29%)</td>
</tr>
<tr>
<td>Female</td>
<td>193 (16%)</td>
<td>150 (49%)</td>
<td>105 (15%)</td>
<td>558 (71%)</td>
</tr>
<tr>
<td>Age distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤18</td>
<td>29 (3%)</td>
<td>8 (5%)</td>
<td>38 (6%)</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>19-30</td>
<td>967* (97%)</td>
<td>28 (19%)</td>
<td>240 (40%)</td>
<td>20 (52%)</td>
</tr>
<tr>
<td>≥51</td>
<td>52 (36%)</td>
<td>58 (40%)</td>
<td>74 (13%)</td>
<td>19 (8%)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤18</td>
<td>8 (4%)</td>
<td>6 (4%)</td>
<td>9 (9%)</td>
<td></td>
</tr>
<tr>
<td>19-30</td>
<td>185* (96%)</td>
<td>19 (14%)</td>
<td>41 (39%)</td>
<td>28 (53%)</td>
</tr>
<tr>
<td>≥51</td>
<td>66 (47%)</td>
<td>49 (35%)</td>
<td>14 (13%)</td>
<td>84 (15%)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>No information</td>
<td>18,4%</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Married</td>
<td>No information</td>
<td>62,5%</td>
<td>×</td>
<td>20%</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td></td>
<td>4,04%</td>
<td>×</td>
<td>80%</td>
</tr>
<tr>
<td>Widower</td>
<td></td>
<td>11,4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>×</td>
<td>9,9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ or 7 years of school</td>
<td>×</td>
<td>40,7%</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>&gt; 7 years of school</td>
<td></td>
<td>49,5%</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td>Peasants 100%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>50%</td>
<td>82,9%</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td></td>
<td>27,0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled</td>
<td></td>
<td>3,08%</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td></td>
<td>69,9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acehnese: 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bosniaks: 93,9%</td>
<td></td>
<td></td>
<td></td>
<td>Maya Achi: 70%</td>
</tr>
<tr>
<td>Croats: 0,4%</td>
<td></td>
<td></td>
<td></td>
<td>Canjabil</td>
</tr>
<tr>
<td>Albanians: 0,4%</td>
<td></td>
<td></td>
<td></td>
<td>Man</td>
</tr>
<tr>
<td>Serbs: 0,4%</td>
<td></td>
<td></td>
<td></td>
<td>Kambas</td>
</tr>
<tr>
<td>Romas: 1,1%</td>
<td></td>
<td></td>
<td></td>
<td>Pocomchi</td>
</tr>
<tr>
<td>Latvians: 2,6%</td>
<td></td>
<td></td>
<td></td>
<td>No indigina: 5%</td>
</tr>
</tbody>
</table>

* Indicates a positive answer with no specific value.
The chief of my village came to the committee and obtained a list of who are torture victims from the xx period. (...) Thirty persons were all taken to the medical doctor in the community. The medical doctor said that they could not solve my problems so I had to go to a general hospital in the province and the general hospital referred me here."

"They shot my man and they took me to the police to torture me. They started to torture me with bottles in my secret parts. They made my uterus bleed. When I came here I was bleeding. They did different things to me. Yes, a bottle, breathing pepper, do you understand? (...) One day I meet a man in the street and he said to me: 'we saw you were suffering, you must contact a human rights office'. I said: 'what is human rights, I have never heard that before. Where can I find that? And how I can talk with them? I am not good in English'".

A SOCIAL EVENT AND THE EXPERIENCE OF "SUDDENNESS"
An experience of "suddenness" combined with terror and helplessness is believed to be the prevailing reason for help seeking.

"Around 3 a.m. somebody requested me to open the door. I opened for I did not know who was outside. I opened and I met some police officers with guns. They started to slap me; they slapped me a lot and then they were asking me, why did I do that. I was not aware of, what they were asking me. That is when they chained me, put me in handcuffs and escorted me to the police station. When we got there, they told me to get into the cell. At around 3 a.m. there came two police officer and they started beating me and they kicked me in my private parts. I started bleeding. My fellow inmates were complaining so much that they stopped beating me."

Table 4. Most frequently applied psychological torture methods among referred clients.

<table>
<thead>
<tr>
<th>Indonesia</th>
<th>Bosnia</th>
<th>Kenya</th>
<th>Guatemala</th>
</tr>
</thead>
<tbody>
<tr>
<td>RATA</td>
<td>GCTV</td>
<td>IMLU</td>
<td>ECAP</td>
</tr>
<tr>
<td>Threats</td>
<td>Restriction of communication with outside world</td>
<td>Threats of not being able to perform sexually after sexual torture</td>
<td>Witnessing massacres</td>
</tr>
<tr>
<td>Sexual harassment</td>
<td>Restriction of visits from the outside</td>
<td>Sexual harassment</td>
<td>Threats on life</td>
</tr>
<tr>
<td>Intimidation</td>
<td>Forced blind obedience</td>
<td>Separation from family</td>
<td>Not permitted to conduct rituals</td>
</tr>
<tr>
<td>Witness of torture</td>
<td>Threats of being killed or infliction of serious injury</td>
<td>Confinement in small, dark cells</td>
<td>Displacement</td>
</tr>
<tr>
<td>Witness of sexual assaults</td>
<td>Threats of separation from, torture of or killing of family members</td>
<td>Witness of atrocities (rape, beating of others)</td>
<td>Witnessing torture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Forced to become a traitor</td>
</tr>
</tbody>
</table>

Table 5. Most frequently applied physical torture methods among referred clients.

<table>
<thead>
<tr>
<th>Indonesia</th>
<th>Bosnia</th>
<th>Kenya</th>
<th>Guatemala</th>
</tr>
</thead>
<tbody>
<tr>
<td>RATA</td>
<td>GCTV</td>
<td>IMLU</td>
<td>ECAP</td>
</tr>
<tr>
<td>Electrical torture</td>
<td>Restriction of physical activity</td>
<td>Beating</td>
<td>Beating with machetes or sticks</td>
</tr>
<tr>
<td>Sexual torture (rape)</td>
<td>Restriction of access to food and water</td>
<td>Shooting</td>
<td>Sexual violence</td>
</tr>
<tr>
<td>Suspension</td>
<td>Forced to wear inadequate clothes and shoes</td>
<td>Falanga</td>
<td>Burning</td>
</tr>
<tr>
<td>Submersio</td>
<td></td>
<td>Suspension</td>
<td>Submarino</td>
</tr>
<tr>
<td>Beating</td>
<td></td>
<td>Sexual assault</td>
<td>Exposure to inhuman conditions</td>
</tr>
<tr>
<td>Nail torture, burning with cigarettes</td>
<td>Beating</td>
<td></td>
<td>Suspension</td>
</tr>
<tr>
<td>Mutilation (amputation of body parts)</td>
<td>Restriction of access to medical care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TORTURE Supplement No. 1, 2003
The most frequent psychological symptoms

<table>
<thead>
<tr>
<th>Indonesia</th>
<th>Bosnia</th>
<th>Kenya</th>
<th>Guatemala</th>
</tr>
</thead>
<tbody>
<tr>
<td>RATA CTV</td>
<td>IMLU ECAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night mares</td>
<td>Insomnia</td>
<td>Anxiety</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Aggression, lack of control</td>
<td>Psychogenic headache</td>
<td>Depression</td>
<td>“Heart pain”</td>
</tr>
<tr>
<td>Depression</td>
<td>Intolerance and low level of tolerance for frustration in interpersonal relations</td>
<td>Anger</td>
<td>Sadness</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td>Post Traumatic Stress Disorder</td>
<td>Fear of re-experience of trauma/victimisation</td>
</tr>
<tr>
<td>Paranoia</td>
<td>Anxiety</td>
<td>Fear about relationships</td>
<td>Desperation</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Depression</td>
<td></td>
<td>Somatisation</td>
</tr>
<tr>
<td>Changed personality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of beliefs and self-esteem</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The most frequent physical symptoms

<table>
<thead>
<tr>
<th>Indonesia</th>
<th>Bosnia</th>
<th>Kenya</th>
<th>Guatemala</th>
</tr>
</thead>
<tbody>
<tr>
<td>RATA CTV</td>
<td>IMLU ECAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Pain in joints and lower back</td>
<td>Chronic headache</td>
<td>Headache</td>
</tr>
<tr>
<td>Pain in extremities and joints</td>
<td>Headache</td>
<td>Chest pain</td>
<td>Skeletal pain</td>
</tr>
<tr>
<td>Low back pain</td>
<td>Palpitations</td>
<td>Whip marks</td>
<td>Parasthesia</td>
</tr>
<tr>
<td>Headache</td>
<td>Chest pain</td>
<td>Bullet wounds</td>
<td>High/low blood pressure</td>
</tr>
<tr>
<td>Reduced hearing</td>
<td>Visual disturbances</td>
<td>Broken limbs</td>
<td>Gastritis</td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
<td></td>
<td>Chest pain</td>
</tr>
</tbody>
</table>

This suddenness of the event and the induced feeling of terror frighten the clients and a sense of distrust in what the present might bring is therefore a general theme.

The reason for help seeking and the point of departure for the treatment course is therefore, regardless of differences in the nature of the problems and the sequences of events, described as a significant and epoch-making event - a social event in the clients' lives. There are numerous feelings, conflicts and decisions to relate to, which in most clients generate a profound anxiety.

"That experience, for sure, I will not forget in my life. Never in my life ... I will never forget, even today. Even the times I do not want to remember for the terror they imposed."

"I can never forget what I survived. I try, but I can never. It is hard ... I cannot forget this, because the picture, the place, is always there, always ... the worst thing is that I am living close to there and I have to go through that place every day in the bus and I have a feeling that someone will come out and drag me out of the bus, and that I cannot resist."

This social event, taking place in the lives of the clients, furthermore brings about a lot of speculations. Speculations about what happened and why it happened, speculations that hastily lead to speculations about what is wrong with themselves and in particular what is wrong with life.

"I was tortured because these police officers they wanted me to die ... So what did they do? ... I prayed to God for keeping me/to save me: 'it is your son, who came here and died, who was tortured to death'. I normally thank God for that ( ...) I know that God, normally pays/forforges any crime a person does. God always pays/forforges that. So to me, I cannot say that I want to do anything to them, e.g. to those who tortured me. But their time will come, just as it will come for me, you see. But on my side, I can say that, I will not contact them, I will not do this and that. No, what I know that one day they will pay, they will pay ( ...) Since they have ruined my life, forever, God will get revenge for me ... God is there for me, yes, God is there for me, to revenge for me. And I know that will happen."

THE PRESENTATION OF THE PROBLEM AND PROBLEM UNDERSTANDING

The way the problems are presented and described by the clients often reflects some desperation. They feel helpless and experience that they have no possibilities of solving the problems on their own.

"I am in a bad situation. I have no heating and I have no financial means because I am not working ... the situation leads to suicide because it is hard for somebody like me to
"My life characterised by and a question about problems. I come here (centre) and ask for help and I know nothing. Yesterday I was not like this but today I am."

The clients also generate a lot of hypotheses related to their problems. In this way the definition of the problems becomes characterised by and a question about, where the problems are to be placed and who are responsible for solving them.

"My life has changed, since this experience (...) I was arrested, I was tortured, so what will become of my life? Who takes measures against those who tortured me? (...) Yes, I know them well, I know them ... they are still stationed down there."

"I know that you (interviewer) cannot do anything concretely, but that you came to hear about us; and I am not looking anything from you personally. Is there somebody to whom we can show how the situation is? ... We are not eat-
Physical torture methods
Sexual torture including rape
Unsystematic beating, kicking
Systematic beating
Suffocation
Suspension, fixation
Noise exposure
Mutilation, amputation of body parts
Cigarette burns
Gun/machinegun lesions
Deprivation of necessary medical care

Psychological torture methods
Sexual harassment
Witnessing killing and torture of close family members
Witnessing killing and torture of others
Solitary confinement
Threats on life
Forced obedience
Deprivation of basic needs

Fig. 2. Torture methods reported by interviewed clients.

Status at referral

<table>
<thead>
<tr>
<th>Physical problems</th>
<th>Psychological problems</th>
<th>Social problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart problems</td>
<td>Acute PTSD</td>
<td>Loss of family</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Complex PTSD</td>
<td>Loss of property</td>
</tr>
<tr>
<td>Thyroid dysfunction</td>
<td>Depression</td>
<td>Loss of job</td>
</tr>
<tr>
<td>Gynaecological problems</td>
<td>Anxiety</td>
<td>Social isolation</td>
</tr>
<tr>
<td>Urinary dysfunction</td>
<td>No belief in the future</td>
<td>Stigmatisation</td>
</tr>
<tr>
<td>Stomach-ache</td>
<td>Low self-esteem</td>
<td>Social</td>
</tr>
<tr>
<td>Headache</td>
<td>Insomnia</td>
<td>Mental</td>
</tr>
<tr>
<td>Low back pain</td>
<td>Psychosomatic disorder</td>
<td>problems</td>
</tr>
<tr>
<td>Pelvic pain</td>
<td>Intolerance</td>
<td>Family</td>
</tr>
<tr>
<td>Pain in extremities</td>
<td>towards others</td>
<td>problems</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Speaking disturbances</td>
<td>Impaired</td>
</tr>
<tr>
<td>Sensory disturbances</td>
<td>Hallucinations</td>
<td>interrelation-</td>
</tr>
<tr>
<td>Sequela from fractures</td>
<td>Sexual</td>
<td>ship in the</td>
</tr>
<tr>
<td>Sequela from gun wounds</td>
<td>dysfunction</td>
<td>community</td>
</tr>
<tr>
<td>Amputation left leg</td>
<td></td>
<td>Insecure</td>
</tr>
</tbody>
</table>

Fig. 3. At referral the clients presented with the following symptoms/problems, recorded by the health professionals.

Fig. 4. The clients' problems were defined/diagnosed and recorded by the health professionals within the following categories.

Treatment goals

<table>
<thead>
<tr>
<th>Physical dimension</th>
<th>Psychological dimension</th>
<th>Social dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancement of function</td>
<td>Enhancement of function</td>
<td>Enhancement of function</td>
</tr>
<tr>
<td>Symptom reduction</td>
<td>Symptom reduction</td>
<td>Improved social situation</td>
</tr>
<tr>
<td>Pain relief</td>
<td></td>
<td>Return to work</td>
</tr>
</tbody>
</table>

Fig. 5. Treatment goals as reported in Client Sheets.

Clients expectation to treatment

<table>
<thead>
<tr>
<th>Physical dimension</th>
<th>Psychological dimension</th>
<th>Social dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain relief</td>
<td>To be another human being</td>
<td>Increased function in the family</td>
</tr>
<tr>
<td>Improved walking</td>
<td></td>
<td>Increased function in the community</td>
</tr>
<tr>
<td>Increased physical function</td>
<td></td>
<td>Return to work</td>
</tr>
<tr>
<td>To be able to perform sexually</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 6. Clients' expectations to treatment as reported in the Client Sheets.

"I came here (to the centre) in order to try to help myself through conversation, try to be better, but I think the only thing that can make me better is to change the environment and to live somewhere else. I live now in the place where I used to live and people who were there before and who were helping them (the perpetrators) are here. I can see them, I can see them at my workplace and that is a constant traumatisation."

SOLE RESPONSIBILITY AND ISOLATION
A social event has occurred and changed the clients’ circumstances. The foundation for life itself has changed and along with that the clients’ future possibilities have changed.

It is characteristic that the clients and their families, despite the support and co-operation of others, find themselves to be isolated and with the sole responsibility for coping with their crisis and their caring responsibilities.
Right now some of the groups, do not discuss feel that is by Fig problems in a way that they will becau e no one can take responsibility for my family . . .

"I feel somewhat isolated, and also that I am alone. I am just alone. Where do I start, and where do I share my problems of life ... Where do I start and to whom can I just tell my problems in a way that they will really understand me ... that is why actually when I start to think about all those things, I feel that I am mentally disturbed. Yes, very much, very much (...) I am always afraid, and I usually isolate my self from some of the groups, do not discuss things because I do not see any point in telling someone about my problems or about my life in jail."

The clients also express frustration and concern about the future.

"According to me, actually the only way to avoid this kind of frustration is just to leave the country, and go to some other ... Because it is painful and bitter for me when I look back: being a prisoner for no reason and after coming out of jail, no one cares about me ... nobody wants to know about me."

THE RELATIONSHIP TO THE HEALTH PROFESSIONALS AND THE CENTRE

Already at the beginning of the interviews, all clients expressed gratitude and satisfaction with the support and help they received from the health professionals and the centres. The interpersonal relationship with the health professionals and the relation with the centres are seen and understood as a very important factor and a possibility in their daily lives. A factor and a possibility that is also important in relation to the problems they want to solve.

"I am very satisfied with the treatment and support. Yes, I appreciate it very much. If I were to finance those things alone I would not make it. I would not make it. The cost of medicine is too high, so expensive. Operation requires a lot of money, see? So, for me I would not be able to make it, so I appreciate their assistance (...) They are co-operative with their clients."

"They (health professionals) are good people ... and very close to me, and they always talk to me and relieve me, and try to explain to me ... Yes, the doctors, everybody. People understand me here ... I am happy that the centre exists ... Always good things, nothing bad."

The health professionals and the centre are not perceived merely as professionals and an institution that try to solve problems – they are direct and indirect partakers in the lives of the clients.

"The people from the group, and the doctor, are very important, and they are friends now, and we can talk with each other. And some people from the group come to my home ... Yes, the doctor and the group is a very important support in my life, inside and outside."

The health professionals and the centres are otherwise an important acquaintance – an acquaintance that might lead to a change in the clients' socio-economic circumstances.

"XX (health professional) brings a lot of rice and money, yes. And if there is a special day, a big day, then XX gives money to me and also to my family."

This acquaintance and relationship becomes clear during some of the interviews, illustrated by remarks about how the clients feel dependent on the health professionals and the centre.

"I am waiting for XX every (day), looking in the calendar for it to come. It is very good for me ... I like to come here, and I come even if it is not for treatment (...) The clients do what the doctor tells them to, but I would be very disappointed if it (treatment) would stop ... I will stop only if they (health professionals) force me. And if they force me out of the door, I will come in through the window!"

The health professionals and the centre are (after all) a system the clients are dependent on, a system whose attitudes may have a consequence for the clients and their families – and therefore also might mean a difference to their possibilities of development in the society.

The dependency on collaboration and support from the professionals are obvious, but the clients don't seem to mind this "model in service provision".

"The centre exists for the clients and they serve them ... I do everything they (health professionals) say."

The clients' relation with the health professionals and the centres is in this way characterised both by dependency and distance.

A connection between the every day lives of the clients, the health professionals and the centres seems to be missing. This becomes important for the possibilities for mutual cooperation and influence.

"Of course when I come (to the centre) I feel better each time. But when I return to my everyday life there are still some of the problems that I had before, because I feel that a lot of injustices have been done to me and there are still a lot of injustices happening. Because I also depend on this country, and I am very sensitive about it. Maybe my situation would be better if I would not be so sensitive about these injustices."
The interviews have focused on the clients' understanding of and influence on the process of problem identification and definition. It is revealed by the interviews that in some cases, the clients are not aware of the health professional's goals, plans, means and methods. Neither are they aware of, what possibilities and limitations there are in service delivery within the given frames of the centre.

In the interviews the clients present their perception and understanding of the problems, their frustrations and their anger, themes that are often not touched during treatment sessions. In that context the problems as perceived by the clients seem to vanish, they accept that they need to be examined and treated by professionals, and subjects to the provided treatment and the health professional who offers the treatment.

"I always used to be satisfied but lately when I came, I was dissatisfied and they were also dissatisfied because they (health professionals) did not have resources to give anything ... can you maybe tell me something that can ease the situation for the staff here? Some of the clients, me and some other people, come here and cannot understand the situation, so we yell at the staff, and it is very hard for us and for them."

REHABILITATION AS A POSSIBILITY FOR DEVELOPMENT IN THE PROCESS OF LIFE

"The atmosphere here and the people working here mean a lot to our life .... The atmosphere of kindness and understanding, because it is the basis for a person to feel good."

Several of the interviewed clients use the work of the health professionals and the centre as an important opportunity for development in their life. They apply their experiences within their families, in the raising of their children, in their understanding of the dynamics of interrelationships within the community and in order to expand their own potentials.

It is difficult to register changes in the client's personal use of life circumstances, and it is in particular difficult to attribute such changes to an applied health professional intervention. Possible changes must therefore be ascribed the event of rehabilitation combined with other contributing and interrelated life events.

The clients tell in the interviews that during the course of the treatment they start to reflect, change their points of view on things, and wonder about possibilities and relations, which the health professionals put into perspective.

"I feel much better now. Because I feel safe here ... and the professionals understand me ... I can always come here and find a pleasant attitude ... With the other people, the other neighbours I feel very good, and people respect me and I respect other people."

"Now, I am not crying and I am not easily annoyed or frustrated (...) I feel better and not nervous, healthier, and I have a very good relationship with my neighbours."

"Maybe I feel better, because I communicate better with people now, and I talk to different people, and I like to work and do other things."

"I am very satisfied and very grateful. I haven't words to express it. Because I was referred here and I got medicine - you can see here is the prescription from the doctor. I have this problem with pain. 40% of my pain is relieved now, but I am still not able to work."

It is difficult to measure the effect of these conversations/interventions as such, but they might be of great importance to the changes, which the clients themselves introduce into their lives.

Rehabilitation and outcome of rehabilitation from the health professionals' perspective

The clients and problem identification

The health professionals were asked who the clients are.

"The clients are the ones, who have been subjected to torture. They have been taken and tortured, maybe because of their opinion, and sometimes for no apparent reason, and maybe just to make them do something against their will ..."

"They are different, people from concentration camps really hard torture victims, between all the people, the girls and the young maids, younger men, who were hardly tortured, and they have much headaches, spine pains, spine problems, they are very different."

"There are two categories of clients here. There are victims of torture who have been beaten by the police and some who have been e.g. shot by the police. When they are diseased the family members come to us and ask for post mortems. When it is about medical aspects we may have the immediate victim here and deal with him or her directly. If the victim is in hospital maybe we liaise with the family either first of gender or spouse, when they contact us and we get the case."

"I can put the client in two categories. In one group, there are people who are silent and do not talk much. And they always ask if the name and last name will be kept anonymous. People who have suffered a lot ... People who say that they never want to come back to the place that they lived before (...), in the place where the torture happened, where they saw their children being killed or their husbands or women being taken away. People who come here and thank very much for one medication ... The other group is also people who survived torture and lost material goods, but who come here very angry and very furious ... There is this client to whom we always explain every time he comes here, that there are things that we can and cannot do ... This client always starts from the point that 'I am a victim, and that I have to have help' no matter if he has got everything that we can offer ... The first group, would probably say to me: 'You are somebody who wants to help us', and the other group would often say to me: 'You are the one responsible for what is happening to us, we wish you the same.'"

In general the health professionals tell that it is the centre that defines the clients' problems. Additionally the health professionals also review the referring organisation/health professional's points of view and based on these elements a conclusion and a recommendation for treatment are made.

"Most of them we accept, but some we refuse. Because we know, how to sort them out. And what happens if the client comes again now, with different issues? If the first history was related to the direct torture, and this is some other side effect, I try to explain to the client, 'this is what we did, and our area is only torture. Now this is stomach pain, which is not related to that issue, and due to our donor funding, we are not allowed to do this' ... So when you try to ease them back, they still want to go and talk. So it is an area, where it is very complicated. It is an area where psychologically you have to be
ready to deal with all sorts of people. Others they will speak abusive language, others they are donuts, others you really will not understand, because they are afraid to trust you.”

“My first step is debriefing, because it is from debriefing that I will be able to tell what this client actually requires. During the debriefing what I start off with, after knowing each other and creating rapport with the client, I would like the client to relive the situation, just to try and recount the events ... Yes, I am able to define the clients’ problem, because at the end of each – the debriefing also serves as an exploration, which is the intake.”

“Let’s say e.g. that somebody comes with this lack of sleep, how do I define that to him? I tell them, that you know, when you are going through all these torture problems, there was arousal within you. The body or the mind was kind of aroused. And this one is coming with the problems, such as lack of sleep, such as lack of concentration, you know. So I will tell them: ‘That is not because there is something terribly wrong with you, but this is the result of the problem or the result of the torture you went through, this is why this is happening’. But basically during the first session, I am not going to have all that time to explain. It will go step by step until we cover all this, because there are quite a number of these problems ... Now what do I call what I do? I usually call it ‘psychological assessment’ ... When I come to doing my assessment I will do the cognitive side first, then I will go to the social one, the emotional one and then the sexual side also ... And sometimes I use the Harvard Trauma Questionnaire, and I find that one is even easier ... Now afterwards, when I have done that one, I have to do the analyses of this kind of information which I have got. What is the case, I am having here? Is it a PTSD? Is it depression? Is he now being psychotic or is it only just anxiety? So this kind of information will give ...

What do I do? When I ask them, they give me these things and then after I get them, and I know what he is having, I am going to explain to him, that ‘this is what is the problem with you, and you need to be helped with this and that, so you will get your treatment plan, based on what I have found’. These findings will now guide you, as to what methods you are going to use, to help this client.”

WORKING TASKS AND WORKING CONDITIONS

The health professionals were asked about their tasks in relation to the referred clients and their problems. The picture is multifaceted – and the most characteristic about this picture is the multifunction of the staff.

“We must be emphatic, we must be good listeners, we must also be non-judgemental when we are talking to them. We must listen with controlled emotional involvement. If we show this once, then they will see that ‘this person is somebody who I can trust, and I can talk to’.”

“If you work in a community, you must know as much as possible about their language, culture and race. Because all those dynamics affect the relationship and affect the way one can operate in all professions actually.”

“They sometimes ask me to give them also some money, and I say that we only give treatment not money.”

The health professionals recognise that the problems presented by the clients are not only physical or mental by nature, but comprise also economical, social, and legal aspects.

“These people, the torture victims, are people who need a ‘holistic’ management. Sincerely, if you take the torture victim, you know, first of all their problems are not just one. They have psychological problems, they have physical problems, they have social problems, they have legal problems. So if these things could run concurrently that would be good.”

“We are limited financially, and the clients need something for heating in the winter, and they need shoes, and all this costs something financially, and we are limited in that area. Because the clients mainly come for those reasons, they mainly want to solve those problems, the social problems, and the other things are secondary for them, the other kinds of help that we provide. There is no support in the law. They could maybe turn to, that there is no law to support them.”

It seems as if the health professionals initially choose individuals as the object of treatment, but when the problems as well as the foundation for the understanding of these problems change, the object of treatment needs to change and expand as well, and to also include the individual’s social context. It is the health professionals’ task to focus on the clients’ overall situation – which implicates the use of new specialised knowledge.

In the interviews it is clearly demonstrated that one of the health professionals’ tasks is to intervene in social conflicts between human beings, conflicts in which the definition of the problem itself constitutes a social conflict with differences of interests involved.

“We can see that those people (the clients) are living in very bad conditions, in other people’s houses, and in very bad conditions for living. They do not have health insurance, the government is doing nothing to help them, they are left to themselves ... When we speak with them, on the first place they put the providing for the family and for the children to provide for them, for the food, the clothes, for the school, and then other problems – like health problems.”

COLLABORATION AND MULTIDISCIPLINARY SKILLS

The health professionals’ tasks are placed in the middle of, or more accurately covering the whole spectrum of the social dimension. They have tasks related to many different people and institutions and in trying to solve these problems they are likewise dependent on many people.

“I do not see that anything is being done about social problems. They (institutions representing the government) have even told me, after a few recommendations for transition to third countries for the clients, not to do it anymore because it would look like we are sending people out of the country. Although I see that it is the only way for some people who want to go out ... I get a little bit satisfied with the small financial help we can sometime give ... but nothing concrete. There was a conference and a seminar, but I do not see that anything socially, in the social dimension, is done.”

Possessing multidisciplinary skills and the demands for a thorough co-ordination of services and interventions provided by individual health professionals play a central role. The health professionals were asked about their collaborating partners – who they are and who they collaborate the most with.
"I collaborate on sharing experiences with the counsellors, in the professional meetings and supervision, and we just share our experiences... Well in my work I collaborate mostly, it is like the people I have done some work with or where I have gone to raise awareness and so on, it is mostly the communities in the slum, the schools and families."

"We are a team work. We solve all problems together. We exchange experiences and information especially about the clients, and it is very positive and the clients feel that. Also something which is out of the centre, if somebody of us can, we do it for the client."

THE CLIENTS - SUCCESSFUL OR NOT SUCCESSFUL

The problems the health professionals deal with and thereby “solve” are characterised by conflicts in and between human beings, and cannot be solved without the active participation of the involved parties. Some health professionals talk about their frustrations due to lack of “visible” results, lack of possibilities in assisting the clients and insecurity about how the clients are going to cope.

"Concerning the clients, I think that it is the same because the service is the same. Considering the experience of the professional team - it is bigger, but maybe from the experience it is harder because you have more experience, because you know more of the problems, and you can see the old clients coming back again. I started working with what the centre can offer and now I have some experience and the things are the same, and there are some things missing all the time and things are the same as the beginning. It was okay at the beginning before I knew what really were clients' problems and what can I do in their problems. Because I do not know what I knew afterwards. Now the problem for me is bigger because I know what the problems are, and what I can offer to clients and I know that I cannot do much."

"I feel helpless. When you hear so many problems, and me personally, I cannot do much about these problems, but I can maybe refer them to somebody, somebody here or somewhere else, but there are some of the problems that nobody can help them with. There are some things that happened to them that changed their life in a way so that you can never make it better."

"Because the clients’ situation is not solved. I cannot see that anything has been done (by the government) for those people. Because a woman may have lost three of her children and what can I say to her? 'Here is the medication!'"

Other health professionals are more positive in their assessment of the process and the outcome of rehabilitation.

"It is possible (success), it is very possible. Not only because of me, but especially because of the efforts of the group itself, how they try to continue with their lives."

"Seen from my point of view, there are many positive changes that can be observed, changes in the clients' behaviour, changes in their perception of life, changes in their level of participation in important development projects in the community, in their capacity - step by step - to cope with their fear and the silence. Yes, I do consider that there are changes in how the clients - step by step - appropriate different spaces where they are protagonists, "actors". From my point of view these changes are important and visible."

The criteria for finalising the clients are assessed by the individual health professionals from different perspectives and points of view.

"When I decide to stop the treatment, it sometimes depends on how many sessions I was dictated to have with the client... Yes, I really have to do my best to see that at that time I have done what I can do. Or if I find the case still very bad, doctor XX is very understanding and I tell doctor XX: "You see, I do find that I have not mastered this area, the client is not well, now can we give him maybe two or four sessions, to see how this client is.""

"How do I decide to terminate? First of all, I have to prepare the client and I work with the client to come to that also. I will see, that the client has improved in the areas where he was having difficulties... And I also have to know whether he is now doing activities - he has gone back to what he was doing before. And he also feels comfortable; I feel I am okay, and I do not need to keep a client in therapy who is ready to go. But still I do keep an open door. I do tell them, in case of any other thing, yes. But my aim actually is to "empower" them and they live their life."

The health professionals were asked if they could identify some typical causes for a rehabilitation course turning out to be not successful.

"If the client was not ready for therapy. You see, people who just come here they may not themselves have thoughts of going into therapy. So the client may not even come back. In fact it is also difficult to tell whether there has been success or not in that aspect, because the client did not come back again. The client may not come back because he gained insight when he got home, and now he is able to manage his life. So it is not always an indicator that it did not succeed."

"When there is no understanding from the governmental organisations, no understanding by anybody. And sometimes you can see how fast they are to reply that they cannot do anything, that they are not authorised. And they just say that they are not dealing with the clients’ problems and that I should turn to somebody else."

"When there is extreme poverty, when somebody tries to recover, but they cannot recover, and usually what happens, is that they go into depression. I have observed, in my own work with these people, that when there is a lack of social support, when there is poverty, when they is previously not well functioning, before this instance of torture, then they have problems too, in recovering."

"When the clients have unrealistic expectations. They are coming here maybe for a year, and they are still expecting some things we can never give them; I mean like financial support and things like that. And you feel helpless at first because you cannot give them anything, because there is no way that we can help. And after that you feel a little bit, I don’t know, disappointed because you cannot do anything but talk to them, and each time about the same things."

"When the process is very long, and the clients come from different regions, and different doctors examine the clients. This means that it is not the same doctor who is responsible for all supervision and control of the clients. It is difficult then to discuss the development of the clients between the..."
doctors and the field workers who have that duty. Yes it might be difficult, and the results are not effective ... The unsatisfactory results are caused by the long process and also the different opinions and thoughts of the doctors, and the minds of the clients, and also the field workers, who control the clients – they are different. And the clients they have chronic problems, very big problems, so even though we give them a treatment, the result is not satisfactory."

“When the client does not want to take medicine, maybe the lack of support, the lack of family support.”

These statements express the fact that the core of the health professionals' skills and their position in a social work field, is influenced by the polemic that takes place about the clients' problems, the possibilities and responsibilities of solving them.

THE LINKAGE BETWEEN THEORY AND CLINICAL PRACTISE

The majority of the interviewed health professionals tell that they need to develop their own skills and professionalism in order to manage their tasks within the work field. They also express the necessity for the development of norms and standards in order to systematise, describe and understand their clinical practise and based on this to be able to implement theoretical frameworks that do not contradict the clinical needs. They recognise that research and analysis should be part of the practise and a basic activity at centres.

The health professionals were asked if they themselves or the centre apply an explicit theoretical framework, an explicit approach or methodology in the rehabilitation of the torture victims.

“Indirectly maybe, indirectly.”

“I think that we try to adjust to the needs of the clients. Because some of the clients need only supportive psychotherapy and some of the clients need more. It depends. Because in my opinion all people cannot be satisfied with the same therapeutic approach, and some people need something and some people need something else, in the approach, I mean.”

“I like using Rational Emotive Therapy. Cognitive behavioural therapy comes in, and also, I must tell you I am a “eclectic” counsellor or psychotherapist. Depending on the case, I will maybe use one form here another form there, but even in one client I may use several. E.g. I may also use client centred therapy, and this will help me to allow the client to express himself or herself, and I really want to listen, and encourage him to talk ... I also use imaginary, when the clients have these nightmares, you know when they have very scary things, I ask them to change the scene of their dreams. And this one, I find to be very, very powerful. I don't know, but I have really believed in it.”

“You see in a counselling perspective, I am “eclectic”. But within that eclectic model I use the humanistic base, the person centred, so, 'I am interested in you as a person, and I do not judge you'. In that non-judgemental atmosphere the client is able to feel free to self disclose, so instead of explaining who I am, then I request the client to introduce himself or herself, and then I explain to the client how I work: 'this is counselling and in counselling you do not give answers, but we shall work together and get to a solution'. Then I give terms of the contract 'we shall be together for such and such a time' ... Yes, within the humanistic base I am “eclectic”, and then most cases I apply behavioural therapy, because of these images they keep experiencing and the fear they have in them ... So I need to at least “empower” them so that they are assertive enough to know that it is just an image.”

“As long as I have worked here, I have not received any specific training in clinical practise with torture victims or theoretical frameworks. The way I examine the clients, is based on the knowledge I got when I was studying, at the university.”

“I think we have very interesting discussions about theory. These are often very emotional. In those situations it becomes clear that our points of view are quite close. Maybe we have had some problems, the biggest one I think has been related to which theoretical concepts we use to define our practise. As a psychosocial action, intervention, or ...?”

“... I don't think we have any specific common theoretical framework, because each of us have our own theoretical framework, and those are very different and we adhere to those. We have discussed at length and we still stick to it, but we have a common instrument – “the word”; the discourse. 'To create space with the clients, where we are able to share experiences, especially through “the word”. I think that the theoretical framework we have is “the word”, a humanistic approach’.”

The relation between clinical practise and research was also discussed with the health professionals. They were asked, how much they read and to what extent they apply scientific theories and research results in their concrete clinical work.

“I don't really read much. I read a little, I must say, whenever I have the time. The only thing which I find is difficult, is to find time for myself, and sometimes I know it is important, and sometimes I tend to say that I will do it ... I would like to know more.”

“I have never had any chance to exchange views and experiences, and knowing how other centres deal with the torture victims.”

“I read as much as I have access to. You know, because you cannot buy a lot of new things here, you cannot find it, except on the internet, and as much as I know, there is not that much literature on the internet. So I think as much as we receive from anybody, as much as we can get ...”

DISCUSSION AND PERSPECTIVES

The study had two main purposes.

One was to describe – based on a phenomenological approach – the outcome of torture rehabilitation as provided at specialised centres and in different socio-cultural settings seen from the clients' and the health professionals' perspective.

The other was to use the obtained knowledge in generating hypotheses to be elucidated by future qualitative and quantitative research projects.

The participating centres in the current study were selected based on their differences in organisation of service delivery. All centres however applied a multidisciplinary approach in the assessment and treatment of individual clients, but the clinical practise and priorities within the clinical practise varied, reflected in the professional profile and composition of staff across centres.

The torture victims treated by the individual centres
shared many characteristics. They all belonged to poor and socially marginalised populations, were all randomly targeted by the torture, and the majority presented with a multitude of physical, mental and social problems even years after being exposed to the atrocities.

In this explorative study a representative sample of clients and health professionals were interviewed in order to obtain an increased and intercultural understanding of:

- the objective of rehabilitation – problem identification and problem understanding
- the process of rehabilitation – the clinical practise and applied theories, goal setting and expectations from the clients’ as well as from the health professionals’ perspective
- the clients’ preferences, perception of, and satisfaction with their health outcome following rehabilitation.

The results of the study show that the objective of rehabilitation – the problem identification and problem understanding – depend on the professional background and the composition of the staff at centres, as well as the socio-cultural context the individual centres are placed in.

That a broad spectrum of theories, methods and treatment approaches are applied, and that no explicit procedure/method/practise is used to elucidate, uncover and define the multitude of clinical problems presented by the clients.

That the theoretical knowledge and the practical experience available at centres often determine the way individual centres prioritise to organise their clinical practice, but that this practice is also influenced by concrete possibilities and limitations within service provision.

It therefore seems difficult – within rehabilitation as it is practised – to clearly delineate professional tasks, professional competencies and qualifications, and that this diversity of positions and perspectives might influence mutual goal setting in and planning of treatment, and the coordination of overall rehabilitation courses.

The clients present different, but specific physical and psychological problems, problems they invariably relate to the complex social context in which they live.

Expectations to treatment and to the health-related outcome of treatment are very concretely formulated within the physical and the social dimension: pain relief, improved physical function, improved individual function within the family, improved interpersonal relationships in the community, and return to work/being able to provide for the family. These expectations formulated by the clients seems to be in accordance with the stated treatment goals as presented by the centres.

Across centres the interviewed clients expressed a through-going satisfaction with the support, treatment and rehabilitation they were provided. This satisfaction was placed in different dimensions – the psychological, the physical, and/or the social dimension – but represented in general an achievement of self-efficacy. “Empowerment” – especially in relation to the clients’ daily living and future perspectives – does for that reason emerge, as an overall outcome of rehabilitation.

The interviewed health professionals’ possibilities and limitations are formulated in relation to a complex work field. A work field, where many of the physical and psychological problems presented by the clients are perceived to be chronic, and where the health related problems often disperse in the social context – a dimension where most of the health professionals feel limited in providing a sufficient assistance.

Despite the complex character of the work field and the context in which it is practised, the health professionals find their work to be of great importance. They affirm that the services they provide not only have an impact at the narrow clinical level, but also an impact at the societal level. That the mere existence of rehabilitation centres specialised in treatment of torture survivors creates public awareness of “the problem of torture” and contributes to the prevention of torture, and fight against human rights violations.

Implications for future research

The work field of torture is a work field with an applied practice. Research should therefore be relevant, focusing on existing problems and possibilities related to this practice.

Problems related to practice become visible in and are outlined by the field of practice. Knowledge production as well as dissemination and implementation of knowledge should therefore not be driven by an isolated “research practice” seeking to transfer knowledge to the field of practice. It is the field of practice that defines and outlines the character and relevance of problems to be prioritised by research.

Research conducted from “above” and from the “outside” easily fails to capture how actors in the field of practice selectively focus on certain aspects while disregarding others, how they identify and define problems and possibilities, and how they realise or neglect those in the context they act in. All these aspects are pivotal in action/practice- oriented research, which aims at creating knowledge and build competencies allowing the participants themselves to develop their own practice.

The goal of “action research”/“practice research” is to contribute to a systematic description and development of a given practice. The knowledge the research aims at producing is an analysis in and understanding of specific aspects of the practice under study – an insight that makes description of the practice possible and permits further development of the practice.

Given the uniqueness of torture as a trauma, the complexity of the health-related consequences with numerous contributing and modifying factors and the diversity of provided rehabilitation services to torture survivors, outcome research in this area is complex. The scientific approach still implies a series of methodological problems, which need to be solved and the use of combined research methodologies applied in several steps in order to ensure validity of the results.

Qualitative research methodology needs to be applied in order to obtain a better understanding of phenomena such as the objective for rehabilitation (problem identification and problem understanding), the process of rehabilitation, mutual goal setting in and expectations to rehabilitation, and criteria defining a successful outcome.

Qualitative research methodology will likewise be a prerequisite to identify meaningful outcome indicators and in order to develop instruments to be used in successive quantitative outcome research including effectiveness studies of different rehabilitation models, efficacy studies of different treatment approaches and in cost-effectiveness studies.

The IRCT has drafted a long-term research strategy (Fig. 1) within the area and conducted the first in a series of studies, which is accounted for in this report. Based on the status of the existing knowledge base, which includes the results from the current study, additional priority areas have been identified and the following phases included in the long-term research strategy:

Phase II

The objective of the study in the second phase will be to further complement and increase the knowledge obtained in the first
The objective of the fourrh phase will be to define and develop mental and social treatment related quality of life, and to adjust the instrument if needed.

Phase IV

The objective of the fourth phase will be to validate and test the acceptability of the developed multidimensional assessment instrument across cultures and to adjust the instrument if needed.

Psychometric equivalence among instruments in different cultures is satisfied when the psychometric properties of two or more cultural groups are essentially the same. Key issues are comparable reliability, validity and responsiveness. The following will be considered validating the developed outcome assessment instrument across the participating centres:

- Content equivalence
- Criterion equivalence
- Conceptual equivalence
- Semantic equivalence.

Phase V

The objective of the study in the fifth phase will be to establish effectiveness information, conducting a prospective, baseline outcome study including a one-year follow-up applying the developed instrument.

A quasi-experimental study design (effectiveness design) is considered to be the most feasible design for the study. Since it is not ethically possible to randomise torture victims into non-treatment groups, a suitable non-randomised comparison group will therefore be identified to control for internal validity confounding.

As stated in the introduction the expected output of the overall IRCT Impact Assessment Study is to be able to provide the work field of torture with:

- Effectiveness information regarding the rehabilitation of torture survivors in different socio-cultural settings
- Knowledge on empirically validated rehabilitation of torture survivors, which can be used in the establishment of clinical guidelines and in quality development of the clinical practice within the work field
- Relevant and operational outcome indicators, which can be used in outcome monitoring at centres worldwide
- Assessment instruments, which can be used in intercultural outcome research.

REFERENCES

11. Basoglu M, Jaramon J, Mollica R, Kastup M. Torture and men-
Community-based intervention beyond ‘the clinic in the bush’: anthropological reflections on armed conflict and community healing

Thomas Pedersen, BA, MA, E.MA

“In order to fight the beast, you have to know it first, and know it well.”

George Aditjondro (1)
Contents

Beyond the village: where is the community? ........ 33
Beyond the survival of the fittest:
    anthropological perspectives on violence ........ 34
        Diamonds and oil: operational approaches to violence .... 34
        Material losses: “Before the war I had everything” .... 35
        Stars and stripes: cognitive approaches to violence .... 35
        Dehumanisation: “They don’t consider you as a person” 36
Fear and loathing: experimental approaches to violence 36
‘Culture of terror’: “I’m always in fear” ........ 36
‘Geography of fear’: “I’m afraid to go out” ........ 37
Stigmatisation: “There are some people who cannot feel happy when they see you” ........ 37
Breakdown of intimate bonds: “I don’t think that I can live with you any longer” ........ 37
Violation of selfhood: “She didn’t want to talk with anybody” ........ 37
The logic of reciprocity: “One day they will pay for it” ........ 38
The logic of reversal: “Something is upside down, something must be done right” ........ 38
Beyond medication: anthropological perspectives on community healing .......................... 39
    PTSD: when trauma becomes a disease to be cured ........ 39
    Community-based intervention: breaking the cycles of violence .................................. 39
    Enlightenment: the Other as ourselves in other circumstances .................................... 40
    The possibility of ‘rebirth’: a new beginning ................................................................. 40
    Truth-telling: acknowledgement of pain and suffering .................................................. 40
    Politics of recognition and the resumption of everyday life: pragmatic co-existence .......... 41
Conclusions ........................................ 42
Notes ........................................... 43
References ........................................ 43
In understanding health-related consequences of torture, two complementary approaches can be identified within the contemporary ‘work field of torture’: the clinical approach and the community approach. The former “utilises a medical and psychological paradigm and relies on clinical history, physical examination, and mental status examination of the individual”, while the latter “involves assessment of traumatised groups or populations and focuses on the impact of torture on interrelationships and the ‘psychosocial health’ of the community”.

Recognising the complexity of the health-related sequelae of torture, most rehabilitation centres and programmes today provide multidisciplinary treatment approaches, including medical and psychological services, social counselling as well as legal assistance. While some centres concentrate on rehabilitation of individual survivors of torture, and others focus on family and group therapy, there are still others which are modelled entirely on community-based intervention.

As it has been pointed out by Roger Gurr & José Quiroga, knowledge is still to be produced on the effectiveness both of different treatment approaches and of different models of organisation of rehabilitation services. While the production of such knowledge is part of the aim of the ongoing Rehabilitation Impact Assessment Study (2), undertaken by the International Rehabilitation Council for Torture Victims (IRCT), the purpose of the present paper touches upon another but closely related area, namely, the study on intervention strategies for the reduction of the severity of mental health consequences for survivors of violence, that be of armed conflicts or by torture, and for the prevention of the onset or the recurrence of exchanges of violence. This is, at least in the case of torture, an area that constitutes yet another field which has been recommended for future research by Gurr & Quiroga.

The present desk study is an anthropological contribution to such research agenda. The aim of the study is to explore the following two-folded hypothesis:

1) Whereas violence of armed conflicts, including the use of torture, does not solely target individuals but also communities, there is, in terms of community healing and conflict prevention, an outspoken need for community-based interventions in ‘post-conflictual’ settings.

2) Whereas the understanding and treatment of massive trauma should not be restricted to intra-psychic processes of individual survivors of violence, be that of armed conflicts or by torture, it is essential that the comprehension and implementation of community-based intervention move beyond the dominating strategy of delivering rehabilitation services in ‘the bush’.

To argue for the validity of this hypothesis, I will firstly start out by making a point of clarification in terms of shedding light on what makes a community into a community, and thereby enlighten what violence of armed conflicts, including the use of torture, potentially targets on the communal level. Secondly, I will examine the need for community-based interventions in ‘post-conflictual’ settings by outlining three different anthropological approaches to violence (3), identifying causes and effects of the use of violence in the context of armed conflicts. Thirdly, on the grounds of an anthropological critique of the medicalisation of massive trauma (4), I will advocate community healing and conflict prevention in terms of three different community-based intervention strategies, all emphasising intervention in the communal level rather than intervention in the community.

Methodologically speaking, I will primarily make use of anthropological literature on conflict and violence as well as on pain and social suffering. In order to illustrate some of the theoretical points, and thereby to highlight the relevance of an anthropological contribution to the work against torture, I will draw upon empirical data in terms of interview material gathered in 2002 during the first phase of the IRCT Rehabilitation Impact Assessment Study. The interview data were obtained through semi-structured individual interviews as well as through focus group interviews with clients and professionals attached to rehabilitation centres located on three different continents. That is, the interview data were collected respectively in Bosnia and Herzegovina at the Centre for Torture Victims, Most, Sarajevo (CTV), in Indonesia at the Rehabilitation Action for Torture Victims in Aceh (RATA), and in Kenya at The Independent Medico-Legal Unit (IMLU) (5).

BEYOND THE VILLAGE: WHERE IS THE COMMUNITY?

To underscore some of the elements of what it actually is that violence of armed conflicts potentially can devastate on the communal level, and what it actually is that community-based interventions potentially can heal, I will use this section to highlight how community is conceptualised within contemporary anthropology. The question is: what makes a community into a community?

To come up with a clear answer to this is not a simple task. As Vered Amit reminds us, many anthropologists have noticed the ‘slipperiness’ of the notion of ‘community’, “arguing that it is too vague, too variable in its applications and definitions to be of much utility as an analytical tool”.

Anthony P. Cohen points out that ‘community’ has never been a term of lexical precision, nor has there ever been any generally acknowledged theory of community. Sometimes ‘community’ is used synonymously with ‘society’; sometimes it appears to be used to discriminate between ‘us’ and ‘them’.

Nevertheless, Amit claims that it is these very ambiguous features of ‘community’ which help to ensure the persistence of the notion in the academia as well as in the street. Like ‘nation’ and ‘culture’, the term of ‘community’ persists in usage because it evokes a ‘thick’ selection of images, presumptions, and meanings which are likely to have a stronger emotional appeal than a more utilitarian term like ‘group’.

Cohen argues that ‘community’, at any level from the local to the global, designates individuals who supposedly share a condition which they may not even be conscious about; a condition that may not even reach beyond the specific item which people are presumed to share. Indeed, communities may even be without place. ‘Community’ has become “a way of designating that something is shared among a group of people at a time when we no longer assume that anything is necessarily shared”.

In brief, there is not necessarily any convergence of community, place, people, identity, and culture. Hence, as Cohen notes, ‘community’ appears to have become a normative rather than a descriptive term. “Community seems to have remained a compelling idea, perhaps indicating a yearning for a degree of commonality and for a focus on those social features which conjoin people rather than those that divide them”.

In that respect, Cohen seems to be subscribing to the conceptualisation of community within contemporary anthropology and its sister disciplines, which according to Amit, has involved “a marked shift away from community as an actual-
ized social form to an emphasis on community as an idea or quality of sociality". Following on from Benedict Anderson's notion of 'imagined communities', which deliberately de-coupled the idea of community from actual interacting groupings of people, Amit notes that contemporary anthropologists, when referring to 'community', often appear to have in mind an emotionally charged category of social relations.

Notwithstanding Phina Werber's observation that the notion of 'imagined community' has been 'liberating' the concept of community from its previously restricted sociological association with Tönnies' ideal "as a traditional face-to-face collectivity of consociates, bound in amity" (6), Amit claims, in agreement with Fredrik Barth, that communities are not simply the creation of the act of imaging. The construction of communities is fundamentally based on the effort to mobilise social relations.

In this regard, Amit distinguishes between two different logics of collective identification, between two different forms of community, namely, the consociate and the categorical. The former is based on consociate relationships, conceptualised primarily in terms of what is held in common by its members rather than by reference to oppositional categories between insiders and outsiders. Consociate communities, and the identities deriving from them, are constructed through particular forms of social interaction, through the shared experiences of participation in particular associations and events.

In contrast, categorical communities are based on ascribed categorical identities. Whether of gender, race, religion, nationality, or ethnicity, these identities are conceptualised as anterior to the actual social relationships and activities that may be attributed to them. What matters the most is not what 'we' are sharing, but the boundary dividing 'us' from 'them'. The category trumps the relationship, making categorical identities relying heavily on symbolic markers.

In the perspective of a 'post-cultural anthropology', Nigel Rapport argues that rather than amounting to objectivities, categorical communities, or 'cultural communities', as Rapport terms them, are first and foremost the subjective realisations of those who symbolically articulate and animate them at particular times and places. In spite of the extent to which cultural communities may tend to lay absolute claim to individual members' lives, thoughts, feelings, and loyalties, Rapport regards individuals as more than their membership of and participation in cultural communities; individuals are to be seen as coming first ontologically.

Amit adds that the more distanced categorical identities are from actual relationships of intimacy, the more likely it is that cultural communities will be dependent on the invocation of oppositional categories, primordialised notions of moral obligations, and the involvement of some element of force in times of mobilisation.

In other words, while violence of armed conflicts potentially unmakes communities in terms of bringing relationships of consociation and intimacy to an end, the use of violence is at the same time likely to make communities in terms of mobilising social relations based on categorical identities. Violence is in itself an act of categorisation, lethally separating 'us' from 'our' enemies. Whereas nothing seems to divide 'us' more from 'them' than the use of violence, nothing tends to bring 'us' as closely together as times of violent conflict. In facing 'our' common enemy, 'we' come together in expressing 'our' common opposition, while 'we' are likely to perceive any dissidents within 'our' own ranks as traitors who should be dealt with accordingly.

However, as it has implicitly been indicated by the anthropological perspectives on community above, the unmaking of communities is not necessarily a matter of literally wiping out 'the village'. On the contrary, less will do. To 'wound' a community, if not to destroy it altogether, is a matter of attacking the condition of what is shared among the members of the given community, that be, both in terms of consociate and categorical identities. To 'traumatis' a community is a matter of breaking relationships of consociation and intimacy; it is a matter of silencing any intra-communal disension; it is a matter of vandalising or ruining symbolic markers of categorical identities; it is a matter of categorising and targeting individuals on the grounds of ascribed communal identities.

By the same token, at this point it should be clear that to heal a community trough community-based intervention, should at least involve strategies of repairing broken relationships, promoting the freedom of speech, and restoring symbolic markers while decreasing the divide between 'us' and 'them'. Before making a more thorough examination of such strategies, I will first turn to an exploration of the need for community-based interventions in 'post-conflictual' settings by outlining three contemporary anthropological approaches to violence.

BEYOND THE SURVIVAL OF THE FITTEST: ANTHROPOLOGICAL PERSPECTIVES ON VIOLENCE

Jonathan Haas reminds us that violence of armed conflicts can be explained along several dimensions, such as different models of causation, the origins vs. the maintenance systems of violence, and the causes vs. the effects of violence. While models of causation have historically been dominant in evolutionary and functional approaches to violence (8), Ingo W. Schröder & Bettina E. Schmidt observe that it is only the latter approach which continues to be held in common by social scientists researching conflict, violence, and war.

Indeed, Schröder & Schmidt emphasise that, particularly since the 1980s, the field has become increasingly fragmented. Accordingly, Schröder & Schmidt identify three main approaches to violence within current anthropology which they term 'the operational', 'the cognitive', and 'the experimental' approach. Although this distinction might be questioned due to its broad definitions and resulting overlaps, I will, nevertheless, adopt it for analytical purposes in the present paper. I will especially pay attention to the experimental approach, since it is the one of the three approaches, which I have found to be supported the most by the empirical data obtained through the IRCT Impact Assessment Study.

Diamons and oil: operational approaches to violence

The operational approach, as characterised by Schröder & Schmidt, is a theoretical approach which "links violence to general properties of human nature and rationality and to general concepts of social adaptation to material conditions. It aims to explain violent action by comparing structural conditions as causes affecting specific historical conditions". It is an approach, which under the heavy influence of a biological concept of competition, tends to portray violence as resulting from competition for scarce resources.

A noteworthy example of such an approach is provided by Jeffrey A. Sluka, who is subscribing to a 'power-conflict theory' in order to explain why State terror has today become a major and growing world problem. According to Sluka, the power-conflict theory views State terror as resulting from the
strength of the State and the ever increasing concentration of power in the hands of national and international elites. 'Terror States', as Sluka calls them, do not emerge because there is a functional necessity to resort to violence in order to maintain law and order, but rather because elites choose to rely on violence, "believing that it is a rational and cost-effective means to achieve their political-economic ends – namely, to preserve and advance their privilege within the system of social stratification".1

While Sluka reminds us that several anthropologists have emphasised social stratification as "the most dangerous feature of contemporary society",1 Schröder & Schmidt underscore that violence does not inevitably result from competition. On the contrary, conflicts are much more often settled by non-violent means than by violent confrontations. Nevertheless, under specific circumstances, violence may pay; violence may prove to be a highly efficient strategy to influence the outcome of the competition in favour of 'our' own community or group.1

By linking violence to a basic state of conflict, Schröder & Schmidt highlight that they are making three implicit but important statements about the social ramifications of violent practice. Firstly, violence is never totally idiosyncratic; it always expresses some kind of relationship with another party. Secondly, as social action, violence is always associated with instrumental rationality, which is why violence is never completely sense- or meaningless in the eyes of the perpetrators. Thirdly, violence is never a totally isolated act; it is always related to a competitive relationship and therefore a product of a historical process.13

Between the lines it is to be read that from the operational approach, as described by Schröder & Smith, the effects of violence are likely to be measured in terms of gains and losses of resources ranging from power and control over human lives and territory to diamonds and oil. In brief, the result is social stratification, as referred to by Gerald Bermeman, as:

"The fact that some categories of people get more of the valued things in life and others get less; a few get most, and most get the rest. Some live well and long; some live poorly and briefly. There is a ranking, in other words, of access to goods, services and experiences – to what the social theorist Max Weber called 'life chances'. There are national elites and international elites; the national poor and international poor. There are rich nations and poor nations” (9).

Material losses: “Before the war I had everything”
One of the categories of people which tends to get less of the valued things in life is survivors of torture. Many of the torture survivors, who were interviewed for the IRCT Rehabilitation Impact Assessment Study, expressed that they are encumbered by socio-economic problems related to their experiences of being tortured. Several of the survivors have lost their ability to work and are consequently suffering financial losses.

Whereas torture survivors, as a disadvantaged social group, are almost bound to have a negative socio-economic impact on the wider society, the loss of income and/or property is likely to be an enormous burden for the individual survivors. In the words of a Bosnian client at the CTV:

"I was traumatised, and I knew, I had to overcome all these difficulties because before the war I had everything. And now, I knew, I had to fight by myself in order to live because there was no-one else to support me ... and, you know, that to solve this problem, this housing problem ... I had to fight, but, I knew, I had to force myself ...

The case is not that the involved rehabilitation centres do not recognise their clients' socio-economic problems, but the case is from Bosnian and Herzegovina over Indonesia to Kenya that the given centres do not possess the resources to provide any sufficiently socio-economic assistance. As an Indonesian health professional at the RATA points out, "the clients have usually three types of disorders: physical disorders, mental disorders, and also social problems .... the big problems, faced by the clients right now, are social problems (...) But RATA doesn't have the budget for social problems" (10).

A Bosnian health professional at the CTV adds that: "These problems are connected because the clients – if they get any better – they always talk about social problems, and social needs, about the shoes they need, about the clothes they need, about everything they need" (11). This appears to be reflected by an Indonesian RATA client who states that “I'm happy for what the doctor gives to me, but I want more help; I suggest that rice is given to me, because I have the responsibility for my younger sisters” (12).

Stars and stripes: cognitive approaches to violence
Unlike rice, you cannot eat flags for breakfast, although that often tends to be what you are led to believe when applying a cognitive approach to violence. Schröder & Schmidt describe the latter as an approach in which violence is viewed as “first of all culturally constructed, as a representation of cultural values – a fact that accounts for its efficacy on both the discursive and the practical level. Thus, violence is seen as contingent on its cultural meaning and its form of representation”.13

Conflicts are, according to Schröder & Schmidt, mediated by the cultural perception of the given society, community, or group, engendering specific meaning to the conflictual situation. Motivation for acts of violence follows the given cultural interpretation framework that defines the value and relative importance of material and social benefits.13 Hence, cultural meanings associated with violence may impel or induce people to commit acts of violence.

In this context, the performative quality of violent imaginaries plays a lead role. These imaginaries are, following Schröder & Schmidt, either represented through narratives, performances or inscriptions. Through narratives memory of past violence is kept alive in stories, either by glorifying the deeds of 'our' own community or group, or by the perceived injustices 'we' have suffered. Through performances antagonistic relationships are staged, and prototypical images of violence are enacted in public rituals or 'war ceremonies'. Through inscriptions violent imaginaries are inscribed in the cultural landscape as images displayed on banners and murals, or in the visual media.13

In order to carry out acts of violence, Schröder & Schmidt emphasise that perpetrators are in need of violent imaginaries, framing the practice of violence in a code of legitimation which claims the assertion of interests to be related to moral imperatives.13 As David Riches points out in his groundbreaking work on the 'triangle of violence', that is, on the triangular relationship between perpetrators, victims and witnesses, each of the involved parties is likely to appeal to social rules and values, and to invoke justice to be on their side. In brief, the legitimacy of violence is contested; victims and 'dissenting' witnesses are most likely to deem the acts of
violence for illegitimate, while perpetrators and 'consenting' witnesses presumably will argue for the legitimacy of the violent acts.14

Pamela J. Stewart & Andrew Strathern elaborate that violence is praised by some, and condemned by others, because order is a subjective concept. Whether violence creates or destroys order turns on the question of whose order is at stake. Likewise, the perception of what constitutes a violent act may also be subjective. In most cases there is, however, agreement about what an act of violence is, while there tends to be disagreement about whether such an act is appropriate or justifiable.15

Indeed, Schröder & Schmidt claim that "wars are made by those individuals, groups or classes that have the power successfully to represent violence as the appropriate course of action in a given situation".16 As Edmund Leach notes in relation to 'terrorists' and those waging a war against them, each side represents the other's acts of violence as 'barbarism', while they are considering their own use of violence as 'heroic'.17

Still, Schröder & Schmidt argue that historicity is the most important code of representation to legitimate the use of violence. "Wars are fought from memory, and they are often fought over memory, over the power to establish one group's view of the past as the legitimate one".18 Therefore, violence is not only a resource for solving conflicts over material issues, but also "a resource in world making, to assert one group's claim to truth and history against rival claims, with all the social and economic consequences this entails".19

Dehumanisation: "They don't consider you as a person" Historicity is not the only code to legitimise the use of violence. Another one is constituted by the theme of dehumanisation which serves to transform 'our' enemies into radical Others. In the context of the Colombian 'Dirty War', Michael Taussig claims that semantic functions of 'cleansing' are shared by the political assassinations and the process of 'cleaning', i.e. the process in which beggars, sexual minorities, and petty criminals are gunned down in the streets by 'dead squads', and are thereby:

"... creating firm boundaries where only muck exists so that more muck can exist, purifying the public sphere of the polluting powers which the dominant voices of society attribute to the hampa or underworld whose salient political feature lies in its being strategically borderless - invisible yet infiltrating - but decidedly Other; prostitutes, homosexuals, communists, left-wing guerrilleros, beggars, and what I guess we could call the dark threatening mass of the undeserving poor - which, when you think about it, doesn't leave too many people in the upperworld".20

Inspired by Richard Rorty,21 Kirsten Hastrup argues that by categorising entire communities or groups of people as less than human, the 'branded' people are alienated from the human community.22 By dehumanising others as sub-humans or beasts, 'we' are, according to Hastrup, regarding ourselves as prototypes of humanity, as better examples than the Others,23 and thereby, as I will add, excluding the Other from 'our' moral community.

By representing and perceiving other human beings as 'animals', 'barbarians', 'terrorists', or the like, 'we' are likely to be morally capable of striking out against these 'inferior' Others. As David B. Morris observes, "We do not acknowledge the destruction of beings outside our moral community as suffering; we detach ourselves from their pain as it were an incomprehensible behaviour encountered on some Swiftian island".24

In that respect, reflecting on the torture which he was exposed to during his time in prison, a Kenyan client at IMLU states that:

"The beatings, and actually the mocking - that you are mocked by all prison warders - they don't consider you as a person; they just see you as a criminal. And as prescribed by the law, you are supposed to be hanged, but: "We are not going to hang you; we are going to beat you to death". So what actually hurts my heart is the brutality, the brutality of the prison warders, the brutality to Kenyans, or to human beings, who are in the prison as prisoners. That really hurts me" (14).

Fear and loathing: experimental approaches to violence

The brutality, the hurt! Experimental approaches to violence, as identified by Schröder & Schmidt, focus on the subjective qualities of violence. "Violence, here, is highly contingent on individual subjectivities, and its meaning unfolds mainly through the individual's perception of a violent situation".25 Experimental approaches portray violence as something that structures people's everyday lives, even in the absence of an actual state of war.25

In that context, Arthur Kleinman argues that the violence of 'low intensity' warfare is meant to control people through the implied suffering, involving a range of traumas; pain, anguish, fear, loss, grief and the destruction of a coherent and meaningful reality. Images of violence, spectacles of terror, and displays of power, are all used to create helplessness and mistrust. Such techniques of violence are meant to intimidate witnesses, to suppress criticism, and to prevent resistance. In brief, massive trauma is used systematically to silence people through suffering.26

Consequently, as Veena Das and Kleinman note, trust is lost in your known world when access to established contexts and trusted categories disappear in 'the shadow of violence':

"People have to 'unlearn' normal reactions - for instance, they learn how not to respond to cries from the neighbouring house in case their reactions are being watched by the security police or one of the terrorist organizations and are interpreted as sympathy for one or the other political cause. The grounds on which trust in everyday life is built seem to disappear, revealing the ordinary as uncanny (...) there is a feeling of extreme contingency and vulnerability in carrying out everyday activities ... As [E. Valentine] Daniel points out ... yesterday's terrorist could be today's prime minister".27

'Culture of terror': "I'm always in fear"

The horror, the horror! In the eyes of Michael Taussig, the 'space of death' is "important in the creation of meaning and consciousness, nowhere more so than in societies where torture is endemic and where culture of terror flourishes".28 The latter is described by Shuka as:

"an institutionalized system of permanent intimidation of the masses or subordinated communities by the elite, characterized by the use of torture and disappearances and other forms of extra-judicial 'death squad' killings as standard practice. A culture of terror establishes 'collective fear' as a brutal means of social control ... When fear becomes a way of life, as it did in Argentina and Guatemala, a culture of terror has emerged".29

36

TORTURE Supplementum No. 1, 2003
In relation to the Colombian 'Dirty War', Taussig claims that 'the underworld' is a paranoid construction of the ruling class designed as if it was to produce and reproduce a Hobbesian world in which you cannot trust anyone. The Hobbesian fear is a strategic tool of silencing due to the individualisation and unexpectedness of violence: anyone is potentially a target, if he or she is categorised by the 'dead squads' as belonging to 'the underworld'. "There is no officially declared war. No prisoners. No torture. No disappearing. Just silence consuming terror's talk for the main part, scaring people into saying nothing in public that could be construed as critical of the Armed Forces".16

The result is the sound of silence. "Nobody wants to know" as a Kenyan client at IMLU puts it (15). He elaborates:

"In fact, I don't talk much with people, especially not as long as they know the kind of system, you know, the Government, the kind of politics that have been preached to Kenyans, the fear that has been inflicted to Kenyans by the system ... So, I am always in fear, and I usually isolate myself from some of the groups. I don't discuss things because I don't see any point in telling someone about my problems, or about my life in jail, other than he happens to report something" (16).

A Kenyan counsellor at IMLU adds that "there are cases, where the client will just keep shopping around, talking about many, many different things, but these clients mostly have anxiety. The client is not really sure of his safety" (17).

In that respect, another Kenyan IMLU counsellor claims that an indicator of successful rehabilitation is when he can tell that the client is able "to overcome certain fears within him" (18).

'Geography of fear': 'I'm afraid to go out'

Fear and anxiety is not solely associated with a 'culture of terror', but more concretely also with a 'geography of fear'. In the context of long-term intensive conflicts, Dag Jørund Lenning points out that individuals are doing warlike activities as well as living their lives and doing ordinary tasks in 'the shadow of the war'. The conflict becomes the 'normal order of things' in which every individual has to cope with life and find meaning in the violent conflict. Socially speaking, every individual has to relate to the hostile surroundings in terms of avoiding certain areas and people.23

This is also likely to be the case for 'post-conflictual' settings. Survivors of violence, be that of armed conflicts or by torture, are often, if not always, afraid of certain places and people which they associate with the causes of their suffering. In the case of a Bosnian CTV client, she states that; 'I'm still afraid of airplanes and of other things' (19), while an Indonesian client at the RATA says that "I cannot stay in my home village because the military comes and disturbs me" (20). Another Indonesian RATA client explains that: "I cannot walk out; I cannot walk out at all, because there are many soldiers in the surroundings, even in the hills. Yes, there are many soldiers there. Yes, even though they don't hit me, but I'm afraid to go out" (21).

Stigmatisation: "There are some people who cannot feel happy when they see you"

Lenning highlights that in 'the shadow of war' individuals have to relate to the hostile surroundings, not only socially but also culturally in terms of making sense out of the hostilities. In this regard, Arjun Appadurai notes that one of the worst implications of ethnic violence is its distortion of the relationship between daily, inter-ethnic face-to-face interactions and the collective categorical identities forged through images of the global media or through the nation-building practices of the Nation-State.24

Distortion of relationships is not bound alone to the context of inter-ethnic violence. In the case of torture, survivors are likely to be 'branded' by the interest which their torturers have shown in them; survivors tend to be associated with danger and disorder; they tend to be stigmatised within their respective communities. Strikingly, an Indonesian health professional at the RATA claims that her objective is in part that "the clients can be accepted by the community" (22), while a Kenyan client at IMLU explains:

"Once you have been convicted within your area, people begin to suggest that you are not a good man because you have been to prison ... those people, they can hit you; there are some people who can not feel happy when they see you. Especially those relatives, who are still my neighbours, they are not glad to see me" (23).

Breakdown of intimate bonds:

"If I don't think that I can live with you any longer"

While violence of armed conflicts, including the use of torture, is likely to distort some relationships, it is almost bound to bring others to an end. As Kleinman, Das and Margaret Lock point out, violence is a form of social suffering that not only gravely damages subjectivity but also ruins the intersubjective and collective connections of experience.25

In other words: "The experience of suffering is interpersonal, involving lost relationships, the brutal breaking of intimate bonds, collective fear, and an assault on loyalty and respect among family and friends".20 As an Indonesian RATA client explains: "my father was shot at home, and the military raped me in front of my mother. My mother is a torture victim too ... My mother is hanged in front of me. So yes, I was crying" (24). Furthermore, a Kenyan counsellor at IMLU emphasises that he had several cases in which the wife of a torture survivor would come and say, "since you no more have your testicle, I don’t think that I can live with you any longer" (25).

Violation of selfhood: "She didn't want to talk with anybody"

In addition to the intersubjective and collective levels, survivors of violence, be that of armed conflicts or by torture, are also affected on the subjective level. Hasstrup emphasises that the first lesson from the increasing number of anthropological studies on violence and suffering is that violence "hyper-individuates the victim because pain cannot be shared".18

Kleinman, Das & Lock seem to suggest that pain is incommunicable due to its capacity "to isolate sufferers and strip them of cultural resources, especially the resource of language".25 Pain inflicted by violence is, according to Hasstrup, highly localised and bounded by the survivor's body. Therefore, at a certain experimental level, the role of culture is close to being non-existent: "Suffering makes no cultural distinctions but obliterates them all. The individual in terror is just that: an individual in terror; alone, on the edge of speech".18

Indeed, at the subjective level of experiencing violence, Hasstrup observes in accordance with Elaine Scarry, that pain actively destroys language. Such destruction is closely related to the destruction of the subject; "Violation is not simply a transgression of somebody's physical boundaries; at a deeper level it is a violation of selfhood, and hence a de-
struction of the position from which one may speak in first person". 18

Whether it is first and foremost because pain is incommunicable, or simply because the survivor is in fear, or is feeling embarrassed, the result is silence. As a Bosnian health professional at the CTV recalls: "there was an example of a woman who didn’t want to talk... this was a raped woman... she was always silent (...) she didn’t want to talk with anybody..." (26). Reflecting on Aegean communities in Kenya, an IMLU counsellor adds that:

"The sort of things that I talk about, like my brother was hurt and... has become schizophrenic; those are things that they will not talk about; those are family secrets... Africans will share with their neighbours, but these ones won’t. If it is in the family, it stays there... If somebody has been bashed in the prison and becomes a zombie, he is hidden at home because they are seeing it as embarrassing... They are not looking at the health aspect... They are hiding, because they are clearing their face. For them it is an embarrassment" (27).

Moreover, an Indonesian health professional at the RATA observes that "the client’s family will take a decision about the client’s problems and situation because the client cannot talk" (28). A Kenyan IMLU counsellor elaborates that because of the confused situation of the torture survivors, "their stories are distorted. So, cognitively they are not able to say anything, and they are scared, you know" (29). Not surprisingly a Bosnian health professional at the CTV claims that an indicator of successful torture rehabilitation is when the clients “want to talk more, when they want to talk all the time” (30).

The logic of reciprocity: “One day they will pay for it”

While some survivors of violence, be that of armed conflict or by torture, may be rehabilitating through talking, others do not seem to find peace on earth, or in heaven, before their suffering has been revenged. Among the latter is a Kenyan client at IMLU. He makes it clear that: "all I know is that one day they will pay for it (...) Since they have ruined my life, for all the time, God will get revenge for me... God is there for me, to revenge for me. And, I know, that it will happen" (31).

Michael Jackson argues, as in the case of gift-giving, that the conditions of the possibility of violence are inherent in the most elementary and universal experienced form of intersubjectivity, namely, in the logic of reciprocity. That is, the possibility of violence is conditioned by our obligations to give, receive, and repay which govern our relations with those we love as well as with those we hate, providing the rationale for both the giving and the taking of life. 26

Jackson points out that the exchanges of violence are cyclical. The ‘vicious circle’ of violence is sustained by an irminable process kept in motion by the impossibility of the warring parties ever to decide unambiguously when they are even; when an eye has been paid for an eye and a tooth for a tooth. 26 This is why all attacks tend to be carried out as counter-attacks which are again responded to by counter-counter attacks; and this is why acts of violence are often, either implicitly or explicitly, morally justified as ‘vengeance’, ‘retaliation’ or ‘retribution’.

Thus, as noted by Jackson 27 as well as by Allen Feldman 28, violence so to speak takes on ‘a life of its own’ by detaching itself from its initial origins and consequently becomes the condition of its own reproduction. This point is also recognised by Stewart & Strathern who argue that revenge, as a basic impulse, plays an extremely important role in motivating exchanges of violence. Still, contemporary conflicts are often very difficult to settle because modern processes of conflict management rarely take account of revenge and the intrinsic dynamic of violence. 15

The logic of reversal: “Something is upside down, something must be done right.”

Elaborating on the reciprocal logic of violence, Jackson argues that it has often fatal consequences when the moral order collapses due to breakdown in the reciprocal obligations that ideally should obtain between senior and junior persons — that be, between parent and child as well as between ruler and subject, coloniser and colonised, rich and poor. 19 Such breakdowns, either real or imagined, tend, according to Jackson, to be experienced as movements toward death and chaos, as reversals in our life-affirming order of social life. 30

As Hastrup emphasises, violence tends to undermine the subjectivity of the survivors because they are alienated and disorientated by the violent shattering of the moral horizon of good and evil, right and wrong. Following E. Valentine Daniel, Hastrup adds that the survivors’ sense of a linear time and biography is defined by violence. “The moment of shock extends into and disrupts all possible meanings of the present, and defies narrative understanding, where ‘cordance is king’” 18

Against this experienced disorder of things, Jackson underscores that acts of violence take the form of extreme reversals of the social order. Hence, violence is generally driven by ‘our’ need to retake what ‘we’ believe that ‘we’ have been wrongfully deprived and is now owed. 30

Less extreme expressions of this logic of reversal are to be found in the wish for positive change. As one Kenyan IMLU client puts it; “it is bitter and something must be done, something must be done to implement change... Something is upside down, something must be done right” (32). A similar kind of logic appears to be at play when another Kenyan client at IMLU is asked about what he wishes for his life in the future. He replies that: “I wish that I am still young... According to how I have suffered a lot, if I can have a job or experience to get money, to assist my family, I can live very happily” (33).

What is more, the logic of reversal is likely to have trans-generational implications. Inspired by the work of Vamik Volkan on ‘chosen trauma’, Suarez-Orozco & Robben seem to claim that victimised communities ‘choose’ to transform their losses into cultural narratives which become an integral part of the communal identity. 4

In other words, communities may develop representations of themselves as victims of past losses or injustices:

“Past humiliations may be passed on from parent to child, and from one generation to the next. Feelings of shame, helplessness, and loss of self-worth are borne by each generation in the belief that the next generation will undo the past harm and humiliation. Thus, the chosen trauma may threaten a society by burdening future generations with the self-righteous exercise of violence”. 4

While it is arguable whether or not communities are given a choice to choose a trauma, not to mention that cultural communities, in the words of Rapport, “do not possess their own energies, momentum or agency”, 11 Jackson’s intersubjective approach to violence does, nevertheless, appear to suggest that a crucial aspect of communal identities may be struc-
cbnred around historical humilations; around the existential need to right the perceived wrongs of the past.

Suárez-Orozco & Robben conclude that violence of armed conflicts continues to pursue the involved parties "long after the slaughter ends and the peace treaties are signed". This holds true for survivors and their children as well as for perpetrators and witnesses; violence of armed conflicts continues in various ways to shape their inner, interpersonal, and socio-cultural worlds. Still, attempts at 'healing the wounds' largely tend to focus alone on the rehabilitation of the individual body and mind.

BEYOND MEDICATION: ANTHROPOLOGICAL PERSPECTIVES ON COMMUNITY HEALING

As reflected above throughout my exploration of anthropological approaches to violence of armed conflicts, acts of violence tend not alone to target individuals, but also communities. While violence of armed conflicts potentially damages body and psyche, the same holds true for interpersonal relations as well as for the moral and socio-cultural order. Recognising this, Suárez-Orozco & Robben emphasise that the understanding of massive trauma should not be restricted to intra-psychic processes of the individual survivor.2

Today, such a restricted understanding of massive trauma seems, nevertheless, to be the most dominating ground on which rehabilitation services are provided to survivors of violence, be that of armed conflicts or by torture. In order to draw up the rough contours of alternative ways of responding to massive trauma, I will dedicate the remaining pages of this paper to an outline of three different strategies of community-based intervention. In other words, with the point of departure in an anthropological critique of the medicalisation of massive trauma, the purpose of the following pages is to examine anthropological perspectives on community healing.

PTSD: when trauma becomes a disease to be cured

While acknowledging that the construction of the 'Post-Traumatic Stress Disorder' (PTSD) has resulted in significant clinical advances, Suárez-Orozco & Robben criticise the PTSD concept on several grounds. Among these, the most important one is that the application of the PTSD concept is medicalising trauma into a unilinear and decontextualised disorder.4

"The hegemony of the PTSD concept has been so great, and the psychotherapeutic treatment of individuals such a large and important professional practice, that collective manifestations of massive trauma and their impact on the surrounding society continue to be neglected areas of scientific inquiry".4

Kleinman elaborates that the way in which health professionals tend to think and talk about trauma situates it in personal rather than in social dynamics. Psychiatrists and psychologists tend to view violence as an event that can be studied outside of its particular context because of its alleged universal effects on individuals. As a consequence, massive trauma is at large ignored.20

Inspired by Allan Young's cultural analysis of the PTSD construct, Kleinman regards PTSD as a professional personification of violence of armed conflicts, illustrating how social problems are transformed into the problems of individuals, and how, thereby, social traumas are re-figured, for policy and intervention programmes, as psychological and medical pathologies.20

Kleinman argues that the diagnostic criteria for PTSD are mapping distress in the mind of the individual; the social experiences of trauma, resulting from the devastating effects of violence of armed conflicts on families and communities as well as on the routines of everyday life, are made over into personal experiences of suffering. Accordingly, the use of PTSD tends to overlook the fact that the locus, causes, and effects of violence of armed conflicts are predominantly social.20 In brief, medicalisation of massive trauma violates the experience of the trauma; purely medical phrasings distort and neglect the social experiences that survivors undergo.

Taken to its extreme, the medicalisation of massive trauma implies that trauma is treated as a disease which is to be cured. As a case in point, an Indonesian health professional at the RATA states that "We have to provide medicine for the clients until they are fully cured" (34). As Kleinman observes in relation to the diagnostic criteria of the PTSD concept, the underlying idea seems to be that "suffering cannot and should not be endured. It should be brought to an end".20

The same idea tends to be at play in the treatment of traumatic memories as something that are to be 'worked through' and 'erased'.

Again the Indonesian case is illuminating (35). A RATA health professional states that "I can provide activities for the patients every week ( ... ) Maybe by taking medicine she can reduce her problems ... When I go there, she always cry, I don't know why, maybe she remember her husband?" (37).

In this regard, anthropological studies on violence of armed conflicts can make valuable contributions to the foregrounding of what has been removed by the medicalisation of massive trauma, namely, the social context as the chief focus for understanding massive trauma. In addition, Suárez-Orozco & Robben point out that:

"The anthropological contribution to an interdisciplinary study of massive trauma has considerable potential. The work can delineate the dynamic relation between society and trauma because, on the one hand, the social context influences the self-perception and recovery of the traumatized and, on the other, the victims themselves, as a social group, have an influence on the society at large".4

To illustrate the importance of the social context, Suárez-Orozco & Robben compare the homecoming of American Vietnam War veterans and Gulf War I veterans. While the latter were received as patriotic heroes, the former were likely to be ridden with guilt feelings by the nation-wide anti-war protests.4

The point is that different social circumstances cannot but have an effect on the recovery of the traumatised war veterans. Likewise, ranging from social restoration to social disintegration, massive trauma is bound to have an effect on the wider society.4 Once again, it seems manifest that community-based intervention is imperative. Still, the question remains: how to heal a 'wounded' or 'traumatised' community?

Community-based intervention: breaking the cycles of violence

As it has, at least implicitly, been indicated above, in particular by the experimental approaches to violence, community healing implies as a minimum that the use of violence is brought to an end. However, as reflected especially by Jack-
son's intersubjective approach, violence is not solely a matter of rational instrumentality. Violence is not simply a matter of continuing 'politics by other means'. Hence, exchanges of violence are not likely to be brought to an end simply because the contending parties rationally commit themselves to a course of non-violence. While such a commitment may result in a truce, the achievement of a long-lasting peace is unlikely.

Rather, as it follows from Jackson's intersubjective approach, to break the cyclic exchanges of violence, the intersubjective conditions of the possibility of violence have to be challenged. This implies, on the one hand, the challenging of the reciprocal and reversible logic of violence, and on the other, the challenging of the othering processes associated with the violent imaginaries which frame the use of violence in a code of legitimation.

Enlightenment: the Other as ourselves in other circumstances
To challenge the othering processes, preconditioning the possibility of violence, is in the words of Jackson a matter of deconstructing, "both in practice and discourse, the 'abnormal' distance that we believe to exist between ourselves and others, and between 'here' and 'there'".29 To do so, Jackson advocates Hannah Arendt's notion of 'a visiting imagination'.

To train your imagination 'to go visiting' is, according to Jackson's reading of Arendt, to renew and extend the reach of your understanding as outsider. It implies neither a detached knowledge of another's world, nor an empathic blending with another's worldview. It is rather, a method of putting yourself in the place of another, of "interleaving a multiplicity of particular points of view in a way that calls into question all claims for privileged understanding. No matter how abhorrent the view of the Other, it represents a logical possibility for one's Self".26

By blurring categorical boundary lines, 'a visiting imagination' challenges what Primo Levi calls our 'Manichean need' for clarity and simplicity which reduces social relationships to conflicts, and conflicts to duels, duels to 'us' and 'them', friends and enemies, the good and the evil. 'A visiting imagination' is likely to reveal that human beings are not creatures of either/or, but, on the contrary, ambiguous hybrids that make the world a 'grey zone', not black and white.31

To make judgement in such a 'grey world' is, in the words of Jackson, "a way of doing justice to the multiplex and ambiguous character of human reality by regarding others not as inhuman, but as ourselves in other circumstances" — even though those 'others' may include the Adolf Eichmanns of this world.26 This is not an argument for moral relativism but an appeal for making judgement conditional upon understanding, that is, upon putting yourself in the place of another.

Whereas Jackson advocates the ethnographic method as the most challenging terrain for our imagination 'to go visiting' (38), Arendt recommends history,26 while I will add anthropology as well. As the ethnographic method hardly is a realistic option for community-based intervention, I will advocate that historical and anthropological studies of 'the other side' should be prioritised on all levels in national education systems together with the encouragement of cross-community dialogue and exchange programmes.

The possibility of 'rebirth': a new beginning
A renewed understanding of 'the other side' will, however, not do the job alone. In order to reduce the intersubjective conditions of the possibility of violence to the benefit of the possibility of community healing, I will argue that two conditions have to be enhanced, namely, the freedom from vengeance as well as the freedom to remake a world.

This implies first and foremost the promotion of the possibility of 'rebirth'. That is, the promotion of the possibility of the 'miracle of natality', as advocated by Arendt, as the bestowal of hope and faith upon human affairs which fuels any attempt at making a new beginning after a 'rite de passage', be that by reform or revolution, by peace or war.32

However, as illustrated by survivors of torture, less dramatic 'rites de passage' will do. In the words of a Kenyan IMLU client: "it's good, if I have a different start; a new start in a different area" (39). The point is even clearer in the case of a Bosnian client at the CTV who states that: "Now, I feel like a new woman, like reborn, because now I have my apartment, I have my pension, I have a husband, and I have accomplished all that by myself" (40).

In this light it is revealed that in spite of the religious connotations associated with the possibility of 'rebirth', the fresh start is actually of a rather worldly nature. In accordance with this, Das and Kleinman emphasise that the term 'healing' should not retain its conflation of medical and religious action as it tends to do when used in truth commissions. In their eyes, 'healing' means repair as well as transformation into a different moral state.33

Truth-telling: acknowledgment of pain and suffering
Apart from the 'miracle of natality', freedom from vengeance involves the working of a restorative justice, implying that victims and perpetrators come together in redeeming the past as well as in committing themselves to the collective building of a bright new future. Following Jackson's use of Arendt's notions of forgiving and promising, the intersubjective conditions of the possibility of violence are challenged by our faculty to forgive past injustices as well as by our faculty to make and keep promises of future justice.

Forgiving and promising involve, according to Jackson, an active refusal to 'replay' events of an unjust past by repositioning yourself in an imaginary future society of justice which potentially 'annuls' history. This was the hope that the Truth and Reconciliation Commission of South Africa was built on, and it is the hope which should be invoked after every epoch of violent conflict.29

Das & Kleinman suggest that truth commissions may play a decisive role in community 'coping' as a moral procedure in response to violence of armed conflicts when that is said; Das & Kleinman do emphasise that the role of a truth commission cannot account for the continuity of everyday social experience, nor can it alone heal community in terms of repairing social ties and institutions. The role of such a commission turns on its acknowledgement of the pain and suffering of survivors, and the part of perpetrators in causing that pain and suffering, legitimating the collective quest for healing and revitalisation.33

While recognising the naivety of the assumption that forgiveness can be easily earned, Das & Kleinman argue that the establishment of a truth commission is a dramatic effort to provide a public space in which the terror of the past may be articulated and publicly heard. Not that the task of truth commissions is to offer new information, but, rather, that it makes perpetrators as well as survivors become part of the formation of knowledge and truth, whereby it may become possible to create a collective future in which the divided and traumatic past can be inherited.33

Notwithstanding its arguably flawed realisation, the merits of the idea of truth commissions are to be found in the capacity that truth commissions may have to heal, if not reconcile, the contending parties due to the varied testimonies given to the commission by victims and perpetrators alike.
By undermining the simplistic view of the given conflict as one being cast between 'heroes and villains', or between 'victims and perpetrators', the testimonies provide a challenge to the contending parties' mutual 'blame-game'.

As Brandon Hamber reminds us, when we delve deeper into most conflicts, then it soon becomes evident that many parties to the conflict have long and varied histories in which they have had multiple 'roles'; they have both been victims and perpetrators. Likewise, the same message is received when we approach violence as intersubjective which is to say that all violent acts tend to be reactions. Thus, I will argue that reconciliation is about identifying 'us' with 'them'; like 'them', we are victims as well as perpetrators.

This is, however, not to say that all the contending parties have been victims and perpetrators equally, but rather to recognise that all 'sides' have 'played' both 'roles'; the distinction between 'us' and 'them' is not matching the one between 'victims' and 'perpetrators'. As Hamber points out, truth-telling of the past "certainly means engaging in the dirty business of remembering, acknowledging responsibility and even finger-pointing". Truth-telling does not only mean acknowledging who has been suffering, but also acknowledging who has been inflicting the suffering, who is responsible, who is guilty.

In that respect, Duncan Morrow stresses that there will not be any reconciliation before ideologies of communal victimhood give way to the recognition of the harm inflicted by 'our side'. In agreement with the reversible logic of violence, Morrow argues that ideologies of victimhood portray every violent act of 'ours' as acts of defence, and every violent act of 'theirs' as acts of aggression. In brief, if reconciliation is not only to remain a beautiful but distant ideal, 'we' have to recognise that 'we' are, inevitably, not only victims of 'their' violence, but also of 'our' violence to 'them'.

Politics of recognition and the resumption of everyday life: pragmatic co-existence

In contrast to the freedom of vengeance, the freedom to remake a world is, following Das & Kleinman, not as much a matter of forgiveness and redemption as a question of communities experimenting with ways of inhabiting a world together.

Das & Kleinman appear to suggest that in spite of different social and cultural contexts a double movement tends to be necessary to break the cycles of violence:

"At the macro level of the political system it requires the creation of a public space that gives recognition to suffering of survivors and restores some faith in the democratic processes, and at the micro levels of community and family survivors it demands opportunities for everyday life to be resumed." 32

At the political level, Das & Kleinman observe that many of the communities 'coping' with traumatic violence and other forms of social suffering, appear to be engaged in what Charles Taylor has phrased as the 'politics of recognition'. By (re)gaining the capacity to speak for oneself politically, attempts are made at rebuilding communities through the redefinition and re-creation of the political society. 33

The desire for a 'politics of recognition', and its implied re-creation of the political society, seems to be reflected in the case of a Kenyan client at IMLU:

"I know that the system, I know that the set of tribal lines, and that the poverty in Kenya, will never come to an end unless the system is completely changed (...) Some of our rights, some of our basic rights are not considered in the system. Especially the poor people; they are not considered at all, not at all, not at all" (41).

The Kenyan client adds that he does not "want to go back to prison ... I want to be safe ... according to the constitution that governs Kenyans' lives today, I got my rights; I must be respected. The constitution doesn't belong to any politician" (42).

Another striking case in point is provided by a Bosnian health professional at the CTV who claims that fewer clients come to the CTV nowadays because:

"The Government is not doing anything for these people, and they are left to themselves, and they are losing faith in everybody (...) Because none of their problems have been solved, their houses have not been brought back to them, they cannot do anything in the official health system, they have to pay for everything, they don't have money, they are losing faith in the system and in the people" (43).

From the latter case, the link between the political level and the level of the everyday life is manifest. In that respect, Das & Kleinman note that the 'project of re-creating normality' seems to:

"... engage the survivors of collective tragedies in, on the one hand, creating a public space in which the experience of victims and survivors cannot only be represented but also be molded, and, on the other, engaging in repair of relationships in the deep recesses of family, neighbourhood, and community. The recovery of the everyday, resuming the task of living (and not only surviving), asks for a renewed capability to address the future". 33

As illustrated by the case of a Kenyan IMLU client, the 'quest for normality' becomes very difficult when the survivors of violence, be that of armed conflict or by torture, are politically suppressed or, as I will add, socio-economically deprived:

"Now, I had to start pursuing, or, rather, finding a way to put things back to normal (...) What am I supposed to do to put things back to normal? Right now, I am without job; our country, Kenya, is getting strangulated ... who can afford to have money? Right now, I don't know those people ... What am I supposed to do to put things back to normal?" (44)

Whereas the Kenyan client is explicitly planning to leave his country until things settle back to normal, a Bosnian client at the CTV is implicitly stating that she is feeling at home in Sarajevo; "I would never give this town to anybody, because I like to live here with this people ... I like this town because this is my town, I was born here" (45). Here it is almost bound to be a crucial point that the Bosnian client appears to perceive things as returning to their 'normal order':

"When I came here in 1995 everything was ruined, and I was very sad, but then I saw that the things were being rebuilt, and that the people are going back to their flats, and I am very happy to see that, and to see that on television, because everybody should get what is theirs, and I am happy to see that." (46).

Das & Kleinman elaborate that the making of a world, on the level of the everyday life, is "a matter of being able to
recontextualize the narratives of devastation and generate new contexts through which everyday life may become possible. 33 The latter touches upon pragmatic concerns, telling the conflicting parties that "reparation cannot take the form of justice, co-existence is possible only if the past is deliberately set aside" (47). Thus, reconciliation does not necessarily have to be coupled with truth, but may be orientated towards the resumption of everyday life rather than towards justice. Accordingly, Das & Kleinman regard reconciliation as:

"A complex process of reestablishing sociality, in which the differential stakes of not only the perpetrators and victims (different from the vanquished), but also of witnesses and bystanders, must be understood in order for a return to everyday life to become possible." 21

While it may not be possible to repair loss, or to cure pain, for the individual, Das & Kleinman seem to suggest that 'community health' may be measured in terms of sufficient co-operation between the contending parties to allow for the resumption of everyday activities. 33 Hence, to heal a 'wounded' or 'traumatised' community is to unite its divided parties sufficiently closely to allow people to resume their everyday affairs after violence has distorted and broken relationships.

CONCLUSIONS

Recognising that improved knowledge about violence of armed conflicts as well as about treatment of massive trauma does not necessarily entail an improved response in terms of intervention strategies, be that in form of conflict regulation or of rehabilitation services, the desire for such an improvement has, nevertheless, been the key motivator for the present desk study. As quoted initially; "In order to fight the beast, you have to know it first, and know it well". On the pages above, 'the beast' has been taking the shape of violence of armed conflicts, including the use of torture, while strategies for community-based intervention have served as 'the weapon' in the fight against 'the beast'.

Throughout this paper, I have been exploring the validity of my two-folded hypothesis, stating, on the one hand, that there is a distinct need for community-based interventions in 'post-conflictual' settings, and, on the other, that it is of paramount importance that the understanding and implementation of community-based intervention move beyond the dominating strategy of providing rehabilitation services in 'the bush'.

By shedding light on the conceptualisation of community within contemporary anthropology, and by outlining three different anthropological approaches to violence, I have been arguing that there does in fact appear to be an essential need for community-based interventions in 'post-conflictual' settings. Likewise, on the grounds of an anthropological critique of the medicalisation of massive trauma, I have been sketching the contours of anthropological perspectives on community-based intervention strategies, indicating that community healing goes far beyond the delivery of medical rehabilitation services in the field.

I have been substantiating my theoretical arguments, and thereby highlighted the relevance of anthropology to the work against torture, by illustrating several of my theoretical points with empirical data obtained through the IRCT Rehabilitation Impact Assessment Study. In spite of the different contexts, ranging from Bosnian and Herzegovina over Indonesia to Kenya, and in spite of far the most, if not all, the interviewed survivors of torture expressed satisfaction with the provided rehabilitation services the present desk study has by virtue of my anthropological analysis of the interview material strongly suggested that the involved torture survivors appear to be in essential need of rehabilitation beyond medical and psychological treatment, be that of individuals, families, or groups of people. Massive trauma is not a disease to be cured, but a social experience affecting entire communities.

I have been arguing that violence of armed conflicts, as a form of social suffering, does not alone target individuals, but also communities. Violence of armed conflicts is likely to do damage to the individual body and mind as well as to interpersonal relations and the moral and socio-cultural order. This is a point which potentially holds tremendous consequences for the rehabilitation services provided to survivors of violence, be that of armed conflict or by torture.

Unlike the hegemony of the PTSD concept, the anthropological approaches to violence, which have been outlined above, suggest that understanding and treatment of massive trauma should not be restricted to intra-psychic processes of the individual survivors. On the contrary, far from solely being a personal problem, massive trauma is linked to societal problems in need of responses on a communal level.

In the present paper, I have roughly been sketching three responses, that is, three strategies for community-based intervention, aiming at the healing of 'wounded' or 'traumatised' communities. As a minimum such community healing implies the breaking of the cycles of violence. Neither the ideal of reconciliation, nor the pragmatism of peaceful co-existence is likely to be achievable in any way as long as fear and fighting belongs to the order of the day. Likewise, 'peace, love, and understanding' are hard to bring about at gunpoint.

Still, the first strategy for community-based intervention, which I have outlined in this paper, involves educational initiatives in which 'our' understanding of 'the other side' is renewed through the training of our ability to put ourselves in the place of 'the other'. The desired outcome is the deconstruction of the 'abnormal' distance between 'us' and 'them', whereby 'the other' is included in 'our' moral community.

The second and the third strategy both aim at restoring community health in terms of respectively enhancing the freedom from vengeance and the freedom to remake a world. This implies the promotion of the 'miracle of natality' as a matter of encouraging faith and hope in the making of a new beginning after a 'rite de passage'.

While freedom from vengeance involves a fresh start by redeeming the past and binding one another to the collective building of a brave new future, the freedom to remake a world harbours a new beginning by pursuing 'politics of recognition' as well as by establishing sufficient opportunities for everyday life to be resumed.

To facilitate this double movement as well as to create the potential framework for redemption and forgiveness, I have cautiously been advocating the establishment of a Truth and Reconciliation Commission in the spirit of the South African one. Thus, instead of joining the large number of voices within the anti-torture work field in their tires but often 'black and white' calls for bringing about an end to impunity, I have been supporting a restorative justice approach suitable for a 'grey world'.

When that is said, however, I am recognising that truth commissions by no means can be said to have worked out ideally in practice. Hence, I find myself compelled to agree with Das & Kleinman when they declare that "there usually
is no clear-cut victory, no definitive crossing over to safety and renewal. But if that sounds too bleak a conclusion, think of it the other way around: there usually is no complete defeat, no ultimate breakdown and dissolution. 13


The IRCT is a private non-profit foundation, that was created in 1985 by The Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen. The objectives of the foundation is on an international basis to promote the provision of specialized treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally.

To further these goals the IRCT seeks on an international basis:

- to develop and maintain an advocacy programme that accumulates, processes, and disseminates information about torture as well as the consequences and the rehabilitation of torture

- to operate a documentation centre about torture and related topics
- to establish international funding for rehabilitation services and programmes for the prevention of torture
- to promote education and training of relevant professions in the medical as well as social, legal, and ethical aspects of torture
- to encourage the establishment and maintenance of rehabilitation services
- to establish and expand institutional relations in the international effort to abolish the practice of torture, and
- to support all other activities that may contribute to the prevention of torture.