Critical Evidence: The Politics of Trauma in French Asylum Policies

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Abstract However obvious it might seem today that victims of persecutions suffer from psychological consequences of the violence inflicted on them, its political implications are a recent phenomenon. In the last decade, asylum seekers in France, as in other European countries, have been more and more often subject to demands of psychiatric expertise to prove the cogency of their claim to the status of refugee. This social innovation results from the convergence of two processes: on the one hand, the rapid decline in the legitimacy of asylum, leading to increasing expectations for evidence to establish the reality of persecutions; on the other hand, the emergence of trauma as a nosographical category legitimizing the traces of violence. At the crossroads of these two histories, a social field, mainly occupied by NGOs, has developed to answer this new need for proof from state institutions, with an increasing specialization on victims of torture and on psychic trauma, the two dimensions being partially independent. The final paradox is, however, that in a context of generalized suspicion toward refugees, the recognition of trauma at a collective level is counterbalanced by its limited impact on the evaluation of individual cases. [asylum, refugees, trauma, psychiatric expertise, immigration, France]

The importance of the true confession does not reside in its being a correct and certain report of a process. It resides rather in the special consequences which can be drawn from a confession whose truth is guaranteed by the special criteria of truthfulness.
—Ludwig Wittgenstein, Philosophical Investigations
Half the people requesting political asylum have been victims of violence or abuse in their country of origin. For psychological and therapeutic as well as juridical and political reasons, the question of trauma thus plays a crucial and complex role in the care of the exiled. Treatment should respect psychological suffering which cannot be put into words. Yet, in today’s crisis of political asylum, this suffering is called upon by the judiciary to express itself and provide “proof” of persecution. [Veisse 2004]

So reads the introduction to the chapter “Trauma and Torture” of a practical guide for assistance to migrants and foreigners. This guide was recently published by the main French NGO in the field, the Medical Committee for the Exiled (Comité médical pour les exilés [COMEDÉ]), under the patronage of two public institutions, the National Institute for Prevention and Health Education (Institut national de la prévention et de l’éducation pour la santé) and the General Direction of Health (Direction générale de la santé). It stresses simultaneously the importance of psychic trauma in the experience of asylum seekers and the contradiction most sharply felt by those who help them between the need for treatment and the obligation to attest.

The psychological mark left on individuals by the violence they endured is indeed not only a symptom requiring the attention of psychologists and psychiatrists but has also become evidence, if not demanded, at least expected by the administrations in charge of deciding who will or will not be admitted to political asylum. Therefore, mental health professionals are not only solicited for taking care of victims of torture but are also as experts in trauma who can presumably provide proof that persecutions did occur, thus justifying the status of refugee.

That direct or indirect victims of violence suffer from psychological consequences is internationally acknowledged. The fact has been consecrated by the category of trauma and established through a substantial body of scientific literature (Wilson and Drozdek 2004). But what has become obvious today is actually a recent innovation inscribed in a dual temporality with, on the one hand, the formation (a little over a century ago) of a nosological entity, first known as “traumatic neurosis” and, later, renamed “posttraumatic stress disorder” (PTSD), providing a medical frame in which to think out the effects of violence (Leys 2000), and, on the other hand, during the past decade, the inscription of this medical frame in asylum policies (Ager 1993). In other words, the recognition of the existence of psychological traces left by events.
responsible for a person’s exile and requiring the intervention of specialists in the host country is historically defined. Twenty years ago, in France, refugees rarely saw a psychologist and the NGOs never raised the question of trauma in the defense of asylum.

In studies on mental health problems related to asylum, most authors stress the necessity of paying attention to the traumas themselves (Watters 2001), while, on the contrary, others criticize the dangers of reducing traumatic experience exclusively to its psychic dimension (Summerfield 1999). One crucial issue, however, has received less attention, and that is how traumas have been drawn into the new system of proof wherein the body and mind are made to attest to violence endured. To establish the well-foundedness of the claims of asylum seekers to refugee status, both physical scars (Fassin and d’Halluin 2005) and also psychic traces are to be sought.

If one wants to understand this evolution, one must consider the recent history of political asylum. This history is specific to Western countries, where the status of refugee is individually solicited, whereas in Africa and Asia refugees are mainly treated collectively in camps. The paradox being that giving asylum is represented as a major issue for Europe and North America, but not for the Third World where, ironically, one finds greater numbers of refugees. During the last three decades, the loss of legitimacy for refugees in France and the subordination of their recognition to the logics of immigration control have led to a guaranteed “right” of protection by their host country as established by the Geneva Convention of 1951 becoming a charitable “obligation” only dependent on the good will of each state (Simmel 2001). It is in this context, in which suspicion toward asylum seekers increasingly prevails, that the quest for evidence has intensified and posttraumatic sequels have taken on growing importance for demonstrating that violence has indeed occurred.

This political—therefore not merely nosographic—innovation represented by trauma has contributed to structuring the field of assistance to asylum seekers, in the framework of what Vanessa Pupavac (2001) has called “therapeutic governance.” In fact, support given to immigrants and to refugees has spurred, especially since the 1950s, considerable action on the part of NGOs, often in conflict, sometimes in partnership with the French state (Mathieu 2002). To national policies that have become progressively more restrictive concerning both economic migration and political asylum, these organizations have offered
resistance, the most spectacular demonstration of which was mobilization in favor of undocumented immigrants (mouvement des sans-papiers, Siméant 1998) in the 1990s.

Parallel to the juridical construction of these political causes (Gaïti and Israël 2003), which has permitted some improvement in legislation during this period, another process entailing medicalization was at work for the defense of individual cases (Conrad and Schneider 1980). A series of struggles took place to obtain free medical assistance for undocumented migrants, give residence permits to those suffering from serious illnesses, and take into consideration the psychological sequels of exile (Fassin and Rechtman 2005). The appearance of trauma on this scene, however, initiated a particular social-psychological dynamic. On one side, psychology (as knowledge) has become a privileged form for apprehending social problems, and on the other, psychologists (as professionals) have been called on to play an ever greater role in their resolution (Rose 1989). The mobilization of NGOs on the issue of asylum proceeded from these different logics creating a heterogeneous set of processes fraught with political tensions and ethical conflicts.

These issues, including the place occupied by trauma in public discourse about the suffering of refugees, and the debates that suffering provokes within the organizations themselves do not, however, permit us to predict how effective this category will be in the practical management of individual asylum seekers. One may even reasonably assume that there is a considerable gap between the supposed medical legitimacy of trauma and its social uses, and one must therefore analyze the concrete experience of those who manage asylum. This suggests an investigation into what might be called the “pragmatics of trauma.” On the side of the NGOs, this means understanding to what extent their members do what they say and say what they do in matters of taking care of and accounting for trauma (Young 1995). On the side of state agencies, it implies evaluating the extent to which observing the psychological traces of violence shakes the judgment practices of the bureaucrats charged with deciding what to do about each asylum seeker (Herzfeld 1992). In other words, we want to analyze how much of the rhetoric translates into practice.

How to assess and interpret the increasing invocation of trauma to establish the evidence of violence necessary to the recognition of refugees? Following Michel Foucault (2004), we consider this process an innovation of “governmentality,”
that is, in the governing of asylum seekers. Proving through trauma represents a new “technology” permitting the investigation of the biography (and the semiology thereof) of the persons aspiring to refugee status, supposedly to evaluate more adequately the reliability of their claims. By delving into the “wounds of the soul,” to quote the title of a special issue of the journal Médecins du monde (1999), the exploration of their past has two functions—therapeutic (because it leads to psychological treatment) and institutional (because it allows a story to be validated by civil servants). Body and mind become central to these processes not only through the superficial scars left by torture and brutality but also through marks left in the depths of the psyche. Recognizing trauma then stems from an attempt to extract the “truth” of the person through clinical work thanks to which what was buried deep down is supposedly revealed. To the suspect narrative of persecutions, these policies prefer the uncontested evidence of their psychic mark. To the discredited word of the asylum seekers, they substitute the legitimizing expertise of the mental health professional.

To address these issues, we have carried on an ethnographic study of the social field of asylum in France. We conducted interviews of 20 medical doctors, psychiatrists, and psychologists in the four principal NGOs working in this domain in early 2000: the Françoise Minkowska Center; COMEDE, the Association for the Victims of Repression in Exile (Association pour les victimes de la répression en exil [AVRE]), and the Primo Levi Center. We also consulted the websites of these organizations, the journals they publish, the annual reports they produce. In the case of COMEDE, we were allowed access to their archives that gave us the opportunity to analyze 200 medical certificates randomly selected over a period of 20 years. Considering that this organization remains by far the most important structure of medical and social assistance for foreigners and particularly for asylum seekers, these empirical data are significant with 80,000 persons seen in 25 years and 8,300 certificates issued over this period. Four interviews were also conducted with the persons in charge of the decision concerning refugee status: two are from the French Office for the Protection of Refugees and Stateless People (Office français de protection des réfugiés et des apatrides [OFPRA]), which corresponds to the first level of evaluation of claims; two are assessors with mandates from the High Commission for Refugees within the Commission of Appeal for Refugees (Commission des recours pour les réfugiés [CRR]), which represents the second level of decision
about asylum seekers. Finally, long-term participant-observation was carried out over two years within two organizations to account for the everyday management of asylum: one specialized in medical care (COMEDe) and the other in juridical assistance, Service œcuménique d’entraide (CIMADE), a Protestant aid organization.

Although our study is limited to France, where we did our fieldwork, the exchanges and discussions we have had with members of other NGOs within the European Network of Treatment and Rehabilitation Centers for Victims of Torture indicate that the problems and dilemmas we analyze in France are inscribed in a much wider European context with similar legal and institutional constraints, but with somewhat diverse political and moral debates and responses.

In the following pages, we will first analyze the historical shift in the role of trauma in political asylum policies in France. We will see how trauma moved from suspect to recognized status while asylum was becoming more and more illegitimate. The encounter of the two opposed processes accounts for the increasing place of trauma in the clinic of asylum. Subsequently, we will analyze the confrontation of ethical and political stances concerning the certification of trauma among the four main organizations involved in the medical and psychological care of asylum seekers. We will describe how tensions between expertise and activism develop as the social field of psychotraumatology structures itself differentiating the two domains of exile and torture. Finally, we will discuss the paradox of critical psychic evidence when it comes to practice. On the one hand, the collective added value of trauma is by now infused into asylum policies. On the other hand, the individual efficacy of the invisible trace as reliable proof remains limited with regard to administrative expectations. In other words, one is ready to believe in the truth delivered by trauma when it refers to a general fact about persecution but much less when it comes to the particular cases of the persecuted.

**Displacing Suspicion**

The principle of precaution means that a person claiming to have been raped or tortured should be acknowledged as such. Why then ask a specialist to confirm the truth of what the patient has endured? With what observable elements can a doctor substantiate his/her intimate conviction, since the traces are no longer there?
So writes Sibel Agrali (2004), director of the Primo Levi Center specializing in aid to torture and violence victims. In fact confirming psychic trauma does make sense in this dual framework of necessity and constraint. On the one hand, it is required because doubt has been cast on the truthfulness of individual accounts and experts are being asked to provide conclusive evidence. Among all the possible experts (one could indeed imagine calling on other specialists, e.g., historians, anthropologists, or jurists), physicians and psychologists are the ones most solicited: it is supposed that only the body and psyche, to which they have privileged access, can reveal the ultimate proof of torture or violence. On the other hand, it is because the physical signs tend to fade away (and torturers do their best to avoid leaving traces on their victims that might be used as evidence in future trials for crimes against humanity) that psychic signs have taken on the importance they have now. When the body cannot attest, they are, it is claimed, as indelible as they are invisible.

The decisive moment when the test of truth is played out for the applicant for refugee status is thus the point in which two collective histories intersect. The first is the history of how, not only within psychiatry but also in the common sense, trauma became a legitimate category for understanding misfortune. The second is the history of the decline of asylum as a legitimate category justifying the protection of the international community and the inclusion of the refugees in the undifferentiated flow of immigration increasingly submitted to a logic of xenophobic suspicion. Those are the two histories that we must now consider.

Trauma as a category of social import appears in the second part of the 19th century, because of two series of dramatic events: train accidents and wars (Hacking 1999). In such contexts, it is from the beginning ambivalent: on the one hand, suffering because of a reputedly traumatic experience is acknowledged as such; but, on the other hand, there are suspected secondary benefits, whether financial, when reparations are expected, or, in cases in which soldiers are involved, being exempted from returning to the front. During World War I, psychiatrists, especially on the German side, argued bitterly over the best way to interpret states of shock or posttraumatic sequels: for some, it was mere simulation, and the treatment was to dissuade victims, best done by electrotherapy; others thought unconscious mechanisms were at work, sometimes reminiscent of previous experiences (Brunner 2000). But under both hypotheses, the ideological climate prevailing among psychiatrists as well as among the military was one of distrust. The way trauma was considered then was part of a
“clinic of suspicion” (Rechtman 2005). Moreover, the psychopathological reference, included in the emerging field of psychoanalysis, was the idea of hysteria that also contributed to the discredit of traumatic neurosis. This veil of suspicion regarding responses to violent events remains more or less the same throughout the first half of the 20th century.

As is well known the turning point in the history of trauma was the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (American Psychiatric Association 1980), which turned PTSD into a nosological entity in its own right. This was the result of the encounter, during the 1970s in the United States, of two social groups with psychiatrists involved in the making of a new classification in mental health. The first developed a national network around the semiology of mental disorders evidenced by Vietnam veterans compared to those of the survivors of the Holocaust and of Hiroshima; it thus established a first list of symptoms and criteria of posttraumatic conditions. The second caught hold of the clinical picture of women who had been victims of rape and of children who had suffered from incest; sexual abuse, largely concealed until then, started to be acknowledged as an important source of trauma. The emblematic figure of Sarah Haley, who played an important part in the creation of posttraumatic stress disorder, is often evoked as illustrating this intersection, since she herself was both the daughter of a WWII veteran and a victim of incest as a child (Young 1995). This nosographical innovation considered from social and medical history perspectives reveals a double caesura in the genealogy of trauma (Rechtman 2002). First, the connection was made between military and civilian contexts or, more precisely, trauma henceforward transcended the question of the nature of the event, public or private, collective or individual, thus paving the way to a generalization of the category. Second, putting together in the same clinical entity military men having experienced, witnessed, or performed atrocities and female or childhood victims of sexual violence inaugurates a new moral career for trauma, authorizing an inversion of the stigma and ending the age of suspicion.

In the 1990s, whereas French-dominant segments of psychiatry offered strong resistance to the classification imported from North America, trauma, washed of its original sin, became a legitimate reference that social agents in a variety of situations—from terrorist attacks to plane crashes and industrial accidents—could and continue to call on to legitimize a cause or claim recognition with
the help of self-proclaimed specialists of psychotraumatology (Fassin and Rechtman 2007). It is in this context that trauma also appears as a new social resource for refugees who are asked by civil servants of OFPRA or CRR as well as lawyers who defend them to see psychiatrists to attest to the persecution they have endured.

The history of refugees, until the 1990s, paralleled the history of trauma, in the geometric sense of two lines that never meet. Asylum offered to the foreigner belongs to a tradition as old as it is ambiguous, which philology illustrates when underlining the linguistic kinship between hospes and hostis, respectively hospitality and hostility (Benveniste 1969). To limit ourselves to modern France, asylum was written into the Rights of Man in the Constitution of 1793, already then in a context in which the foreigner generated both generous and distrustful reactions (Wahnich 1997). Throughout all the 19th century, during each conflict occurring in the European states in the making, this ambiguity was regularly reactivated and invariably ended with defeated enemies expelled or forced to flee. It is at the start of the 20th century that the huge waves of refugees following WWI, and even more the Russian Revolution, gave rise to the High Commission for Refugees created by the League of Nations in 1921 (Marrus 1985). This was the beginning of the international administration of refugees with whom the legal terminology of the times associated stateless people and whom Hannah Arendt was to call “the most symptomatic group in contemporary politics” (1958:277).

After World War II, because of their numbers but also because of the shame that weighed them down, the question of “displaced persons” became one of the most delicate that the victorious countries had to deal with, mainly through the United Nations Relief and Rehabilitation Agency and the International Refugee Organization (Cohen 2000). The Geneva Convention, that officially established the right to political asylum in 1951, extended full recognition to the victims of persecution and legitimated sentiments of solidarity toward them. However in the negotiations leading to its signature as well as in the arrangements that were to follow, a tension was clearly demarcated between the revival of humanism inspired by the horrors of the war and the demands of a Realpolitik most of all preoccupied with the states’ intérêt bien compris (Noiriel 1991). This means that, contrarily to what is often said, there has never been a Golden Age for refugees. Always, in practice, asylum has come second to nations’ economies and securities.
That is the dominant logic explaining the dangers that have threatened the status of refugees in Europe in the past 30 years, not so much from a legal as from a practical point of view: less than the attacks, although they are real, on the spirit of the Geneva Convention, it is above all the conditions of its application that most effectively shake its foundations and produce the present-day “crisis of political asylum” (Legoux 1995) all over Europe. In the early 1970s, asylum seekers were few in France, the more so, since there were relatively few obstacles to entering the country, it was simpler and quicker for a victim of political violence to obtain a work contract than to request refugee status. In 1974, the year that labor immigration was suspended in France, only 2,000 asylum seekers were counted. Two years later, as immigration control was being implemented, there were already 15,000. Fifteen years after the borders were closed, their numbers had risen to over 61,000.

The institutions did not immediately adjust to this new reality. The OFPRA, in charge of the evaluation of the situation of the asylum seekers, was quickly swamped. Out of synchrony with the times, the French state reacted according to two distinct logics. One aimed at reinforcing the bureaucratic system by increasing the number of employees so as to accelerate the procedures. The other tended to stiffen the checking procedures to reduce the proportion of people granted political asylum. Thus, the proportion of applicants obtaining the right to asylum fell from 90 percent in 1974 to 28 percent in 1989; in the following decade, it continued to fall and was down to 17 percent in 2004, corresponding to nine percent in the first instance by OFPRA plus eight percent on appeal with CRR (OFPRA 2005:16). At the same time, the social advantages won between 1974 and 1985, concerning notably authorization to work and aid for housing, were progressively suppressed from 1989 on, leading to an increasingly precarious situation for asylum seekers who were relegated to the status of welfare beneficiaries (Brachet 2002). From this point on candidates to refugee status are increasingly discredited and vulnerable.

The set of measures that in two decades totally warped the reality and meaning of political asylum only became socially acceptable because at the same time the image of the refugee was radically transformed. Still strongly legitimate in the 1970s through the heroic figure of the exiled Chilean and the tragic representation of the boat people from Vietnam, that image rapidly deteriorated as the asylum seekers became mainly sub-Saharan Africans and Kurds, Afghans and Kosovars: feelings of solidarity and compassion gave way to suspicion often
mixed with racist prejudices. Although the majority of refugees in the world live in Asia and Africa, asylum became the central issue in European debates as if the presence of refugees was threatening the demographic or economic equilibrium of the continent. The obsession with the false refugee haunted institutions in charge of managing asylum. The narrative, which until then had been the cornerstone of proof, no longer sufficed. Marks—physical first, then psychological—began to be sought to uphold declarations of abuse. That is the context in which the experts of trauma—psychiatrists and, to a lesser extent, psychologists—were called on to intervene.

Therefore, to say like Shoshana Felman (1995) that we live in “a post-traumatic century,” suggests two levels of reality at the same time. First, the events of the 20th century are recognized as having been particularly traumatic. Secondly, trauma has become by the end of the 20th century the framework within which those events are thinkable. There thus exists a twofold history of trauma: the history of the facts and the history of their construction. Refugees embody both (Malkki 1995). They are historically the products of the century’s violence. They can claim to belong to a historically constructed category. Moreover, they are at the intersection of two opposite developments: asylum’s loss of legitimacy and trauma’s gain of it. For at the same time as the generous idea of asylum lost its social recognition, trauma conquered it. Refugees thus slid from one to the other. It remains to be seen what uses professionals made of this shift in the concrete situations that confronted them, specifically to consider the practitioners of the NGOs who receive the asylum seekers, care for them medically and psychologically, and often fill out the medical certificates meant to evaluate their cases as applicants for refugee status.

Activists as Experts

Primo Levi Center grew out of dissidence in the Avre. I think that at that time, there were psychologists who thought that the general practitioners should stick to their function and that psychologists alone should take care of refugees . . . That was the argument given later, because it’s more elegant to say: “we took sides with respect to a doctrine” rather than: “we fought over who was to have the power.” There were Mrs. X and Mrs. Y and both women wanted power, the first didn’t want to let it go, and the other wanted to get it. The fight crystallized around the fact that X was a doctor and had a medico-psychological view of things and that Y was a psychologist and had a psycho-medical view of things. [physician, AVRE, July 2002]
Those are the terms, used by one of our interviewees, to explain the split of AVRE in 1994 giving birth to the Primo Levi Center—both organizations are dedicated to victims of torture and persecution. If our informant is to be believed, the conflicts at the source of the schism concerned both the role of psychology in the care of asylum seekers (what she calls the “doctrine”) and the place of the psychologists within the institution (what she sums up as “power”). This sort of tension is definitely not unprecedented among NGOs working in the field; at the origin of conflicts, there are often differences in ideology as well as competition for resources. However, the tensions and passions arising in this difficult institutional context (Delouvin 2000) can only be understood when related to the moral dilemmas specific to the management of asylum seekers (Graham 2003). The cause of the refugees implies emotional involvement. The expert’s word (expressed particularly in the certificates transmitted to the authorities in charge with evaluating the validity of the asylum seeker’s claim) is inseparable from the activist’s action (as manifested through demonstrations and petitions, noisy interventions in public places or more discreet ones in the offices of the state administration).

The history of how the combination of activism and expertise emerged allows us to realize how the question of trauma is concretely posed to the asylum seeker, and how it both constructs and divides the network of NGOs. We can sketch the broad contours of the picture by looking at the four NGOs that today appear as the inevitable protagonists of the state in this field. All four are situated in Paris or its immediate surroundings, related to the fact that most asylum seekers reside in the capital and its poor suburban neighborhoods. The important position they occupy in the field is linked because of their recognized competence; most refugees either spontaneously come to them through their own networks or are oriented toward them by other organizations, lawyers or even administration. The Minkowska Center played a pioneer role in the aftermath of World War II by giving mental health care to East European refugees. The COMEDE was created with a more medical and social orientation almost three decades later in the context of the exile of Latin Americans fleeing Argentinean and Chilean dictatorship. The AVRE was born as a dissident group within the latter, more specifically preoccupied by issues of torture and persecutions, in particular after the discovery of Guinean prisons. Finally the Primo Levi Center was founded by psychologists and psychiatrists, some related to Kurdish emigration, who left the previous organization considering their approach was insufficiently accepted.
In this history, two processes are thus at work simultaneously. First, new preoccupations with psychic trauma increasingly converged (and stand out as a distinctive factor in the field of mental health generally speaking). Second, this activity concentrated more and more specifically on asylum seekers and victims of torture (rather than on immigrants or foreigners in general). These two trends, reflecting what is happening in society as a whole, as we have seen, participated in building up the field of what can be designated as the psychotraumatology of refugees, that is, a social space structuring positions around issues of knowledge and action (Bourdieu 1980). This field developed rather independently at the frontier of the two fields of mental health and immigration, from which most NGO actors come. As has been shown in other voluntary associations, especially those concerning AIDS, in which activists have been inspired by science (Epstein 1996), doctors and psychologists in the field of psychotraumatology depend—although not in the same way—on their expertise to support their activism. Briefly presenting these four organizations will allow a comprehension of the political and moral issues within the new field around the question of trauma.

The Françoise Minkowska Center, created in 1951 by Dr. Eugène Minkowski and a Polish psychiatrist to provide social and psychological assistance to displaced persons after World War II, is a pioneer in the field of mental health for foreigners. It was founded in the context of the signing of the Geneva Convention and the establishment of the High Commission for Refugees, which both happened the same year. The center focused primarily on refugees from Eastern Europe who were often Jewish and survivors of the Nazi concentration camps. Supported at the start by the Social Service of Aid to Emigrants (Service social d’aide aux émigrants [SSAE]), it later received the help of several large private associations, mainly CIMADE and a Catholic aid organization (Secours catholique), and also the support of public institutions like the Services of Mental Hygiene.

From the start, the issue of language was essential to the clinical practice: consultations were in French, German, Russian, and Polish. Later on, adjusting to the successive waves of immigration, the center specialized in languages associated with the peak moments of the migratory waves: 1964, for Spanish; 1965, for Portuguese; 1972, for North Africans; 1979, for Turks. Two more geographically defined areas of consultation were opened in 1975: one for the South-East Asian refugees, the other for those arriving from sub-Saharan Africa.
Thus, although counseling espoused the universal horizon of the exile experience, the process was founded on the principle of cultural differentiation, of which linguistic specialization is the strongest sign. Today, foreign patients are sent to this center from all over the Paris region, because it is known as the only place where people from North Africa will be listened to in Arabic and where those from Mali will be able to speak in Bambara or Soninke. This attention to the linguistic—and cultural—background of the immigrants and refugees is often described as “clinic of exile” (Benslama 2004), that is, focused on the subjective singularities of each patient—in radical opposition to the radical culturalism of ethnopsychiatry.

In the history of the center, trauma only emerges in filigree, just as the asylum seeker appears as only one of the possible figures of otherness, and the mental health specialists speak of “the foreigner’s psychological suffering, whether immigrant or refugee” (Center Françoise Minkowski n.d.). If over the past few years, it has become necessary to take into account the fact that trauma has entered the nosography of psychiatry, “the modus operandi has not changed, and beyond intellectual debates what remains is clinical practice” (psychiatrist, Minkowska, May 2003). The Minkowska Center has above all stayed a generalist’s center of mental health conceived in the interest of all foreigners and immigrants whatever their story. Or, rather, precisely because they supposedly all share similar histories, it is a center designed for all wounds inflicted by displacement.

Founded much later, that is, in 1979, COMEDE has as its main objective providing foreigners access to health care and social protection. Mental health is only one facet, and even a rather secondary one from a quantitative point of view, because it only accounts for 6 percent of the consultations provided. Although its creation is essentially because of members of Amnesty International and of the CIMADE, and although its independence in relation to the state and its institutions is strongly claimed, it has maintained close and frequent connections with the French Administration: its offices are lent by the Paris public hospitals; approximately 90 percent of its budget consists in public funding, notably allocated by the Ministries of Social Affairs, of Public Health and of Foreign Affairs; its guide is published thanks to a partnership between the General Direction of Health and the National Institute for Prevention and Health Education; and the association is the principal provider of medical certificates for OFPRA and CRR. Whereas the Minkowska Center was originally
founded for those who had escaped from the Nazi concentration camps and was connected to the presence of psychiatrists who, like their patients, were mainly Eastern Europeans, the birth of COMEDE is narrowly associated with the Latin American repressions and the presence of psychologists from Chili and Argentina.

Of course, the profile of the persons coming to consult followed the migratory waves and international conflicts, but it has also been marked by the effects of immigration and asylum policies. The proportion of illegal immigrants has thus grown as has the number of applicants for refugee status. Beyond these changes, however, the vocabulary has varied little and, although the name of the association’s bulletin has gone from Words of Exile (Mots d’exil) to the homophonic Pains of Exile (Maux d’exil), the way of looking at a patient’s experience has remained since its founding closely linked to the metaphorical idea of the “traumas of exile” considered as having more than simply a psychological dimension. Thus, “exile means loss of a family, of a social and professional identity and of cultural and emotional references” (COMEDE 2003). The approach has therefore remained generalist both by refusing to separate persons having undergone violence from other migrants and by recommending medical and social rather than purely psychological treatment. This continuity was precisely the reason for the split that took place in the organization, leading to the birth of AVRE:

Part of the personnel wanted to concentrate exclusively on torture victims by picking them out at the time of arrival. But most of the Board of Administrators wanted to stick to what has always been our policy: holistic care that allows patients to say that they have a sore throat before telling us, when they feel more confident, that they had a traumatic experience. [doctor, COMEDE, July 2002]

The members of the organizations who found themselves in the minority therefore left to start up a new group.

The AVRE was thus founded in 1984 by a general practitioner dissident of COMEDE as she returned from a mission in Guinea, where she had participated with Doctors without Borders (Médecins sans frontières) in setting up a health care unit for the survivors of Sékou Touré’s camps. Convinced by her experience in West Africa that a condition specific to victims of torture exists, not only with respect to other migrants but also compared with other asylum
seekers, she created a structure exclusively dedicated for those patients. In the years that followed, the association also opened a clinic in Paris and developed its actions in several Third World countries. Its dual national and international identity allows it to receive both state support and funding from the United Nations. Its links with the French authorities have had concrete ramifications in a series of symbolic acts: the association was awarded the first French Republic's Human Rights prize; its director was made Knight of the Légion d'honneur; the Prime Minister included her in the National Human Rights Consultative Commission; the General Direction of Health offered her chairmanship of a workshop. Yet, although AVRE is the first French organization specifically oriented toward torture victims, it has paradoxically not placed trauma at the center of its preoccupations. The talk group that it set up has even made it a rule not to bring up the past, to “keep to its role as listener and avoid the two pitfalls which are the denial of horror and the fascination that it can engender” (Montazani and Irago 2000:7). More than trauma as such, torture is at the heart of testimony and denunciation at AVRE. What is more, at the health care center, psychological consulting only accounts for 10 percent of the consultations (AVRE 2005). Although within the association doctors and psychologists are almost on a par, contrary to COMEDE, in which the latter are a minority, the former continue to play the leading role, especially as those who decide the institution’s policies, and also by receiving and orientating patients. The doctors even consider themselves as psychologists:

I improvise myself as a therapist. I can practice both psychotherapy and medicine. People come to consult. They have nightmares because they’re not well. I tell them: “listen, we’ll talk it over, but first I’ll prescribe a little something to stop that.” This is magic side of medicine. [physician, AVRE, July 2002]

For this medical doctor, experience counts more than diplomas and psychology comes more from sensibility than from training.

The marginal position of psychology in the organization is precisely what spurred the separation that gave rise to the Primo Levi Center in 1994. Of the 11 AVRE dissidents, seven decided to launch a new group. They were supported by Doctors of the World (Médecins du monde), Law Specialists without Borders (Juristes sans frontières), and Christians for the Abolition of Torture (Action des chrétiens pour l’abolition de la torture). For reasons related both to the evolution of the political situation in Turkey during that
period and because privileged ties existed between some AVRE members and human rights activists from this country, Kurds made up a good part of the consulting activity at the beginning. With time, the profile of nationalities involved changed, and, ten years later, Africans in particular from the Democratic Congo Republic represent over two-thirds of the center’s new patients.

The association is almost totally financed by public funds, two-thirds of which come from the European Union and the United Nations and one third from the French state and the Ile-de-France Region. More critical than AVRE with respect to the ever more restrictive public policy on political asylum, the Primo Levi Center was nevertheless also awarded the French Republic’s Human Rights prize. In its struggle against torture, the organization consistently deals with “the indelible and inexpressible traces” that constitute “suffering subjects” (D’Elia 2003:14). For its members, “the specificity of our action is closely linked to taking into account the patients’ double trauma: repression in the country of origin and its natural extension, exile” (Association Primo Levi n.d.). Not only are there more psychologists here, they also have a more central role in the health care activity and even in the collective life of the organization. Thus, while the patient’s medical and social situation is part of evaluation and resolution, psychotherapy is firmly established at the heart of the center’s activity:

Our approach is specific because trauma has shattered the person’s life, it is a fracture caused by vicious violence intending to humiliate, degrade, even eliminate the person. We must make them realize that here they are understood and safe. We recognize their status as victims and the trauma they have lived through. [psychotherapist, Primo Levi, June 1997, interview reported in Cottrant 1997]

This specialization sometimes goes as far as refusing to acknowledge the mental disorders of persons having endured persecution when it is shown that the symptoms existed prior to their experience of oppression: these patients are then considered to be concerned by the ordinary structures of mental health and are reoriented accordingly.

The history of these four organizations, although it does not cover the entire psychotraumatic field of medical care for refugees, includes its two main structural elements: one is psychological expertise, the other political activism. A specialization has progressively set in following a double axis that picks out a category (victims of persecutions) from among the group of immigrants and
attributes increasing importance to a psychological category attributed to them (trauma). In the younger associations (AVRE and Primo Levi), this logic has led to placing the specific experience of violence above all the other ones, particularly the more general experience of exile, which on the contrary was paramount in the older associations (Minkowska and COMEDE). All these NGOs, however, share the same universalistic horizon, whether it be the experience of violence or of exile that relates all the members of the different diasporas. This does not mean that they do not take into account cultural features and identities of their patients that have practical consequences in terms of adapting the consultations to linguistic constraints in particular. But they definitely distance themselves from radical ethnopsychiatry à la française, which, especially in the Center Georges Devereux, is built around the principle of incommunicability of cultures (Fassin 1999): for its founder, Tobie Nathan, immigrants should be kept in “ghettos” to preserve their tradition and public schools should be denounced for exposing their children to the “whitening” of their minds.

However, these organizations entertain a complex relationship with public authorities, in particular the French state. They receive from it a considerable part of their resources and in some cases have privileged relationships with it. At the same time they must demonstrate their independence since its administration is always suspected of manipulation to legitimize their restrictive immigration and asylum policies. In this respect, we must distinguish the organizations that are critical of the French government and the European institutions—although one of them continues to work with the institutions in charge of refugee administration (COMEDE), while the other hesitated to depart from the practice of medical certification (Primo Levi)—and the associations less directly involved in political combats—either because they prefer concentrating on clinical work (Minkowska), or because they make other struggles their priority, particularly the fight against torture and its impunity (AVRE). Beyond their political differences, these NGOs also belong to coalitions (Groupe Europe 2001) that try to influence public policy by participating in the Coordination for the Right to Political Asylum created in 2001.

The activist experts who little by little built up this field, especially during the 1980s and 1990s, have thus brought to the fore a new semantic constellation of otherness, associating political asylum and exile, violence and trauma, an emergent configuration that differs from that current during the 1960s and 1970s.
when the reference was mainly immigration and integration, labor and exploitation. A change in the state of the world but also of the way the world is constructed has taken place. But how does this evolution translate into practice? We will now focus on one aspect of this practice, the certification through trauma, probably less important in terms of time spent when compared with rehabilitation and treatment, but certainly the most crucial in terms of ethical and political issues and, therefore, of emotional involvement.

**Searching Traces**

Generally speaking, judges give more credence to physical than to psychological traces. They are more palpable. It is perhaps just the accounting that seems simpler in the case of physical rather than psychological sequels. But it all depends. If you are in front of someone who cannot express him or herself because of bad treatment, a certificate concerning the psychological sequels is very important. [judge, Paris, August 2002]

This is how a judge appointed by the High Commission for Refugees to sit on the Commission of Appeal spoke of the importance of the certification of trauma in the decision to grant refugee status. The ambiguity of the procedure stems from the fact that it means certifying something that everyone agrees about in principle—experiencing traumatic events potentially has psychological effects in the long run—but that remains for the most part short of what is usually admitted as proof—in the sense that the trace is invisible, depending in fine on the combined effects of the persecution narrative and the clinical examination.

Trauma encompasses all at once the omnipresent discourse on violence and the intangible reality of its trace on the psyche. As one of the AVRE members puts it,

psychological stigmata remain, for what they are worth, but there is always that tiny uncertainty. And this has to be put in the certificate, which is not easy: Sometimes you are not really comfortable with it. But in the end, you try to answer as best you can what is being asked of you. [physician, AVRE, October 2002]

A therapist of the Minkowska Center echoes this opinion:

With regard to the North African migrant refugee populations, there is a way of putting the problem that does not fool us. Partly it is social recrimination and a bad feeling which do not necessarily correspond to what the law intended. I myself deal with that by looking at the pathology’s trajectory.
What I write on the certificate concerns what I pinpointed as the element justifying that the person receives treatment. But it is all rather vague. [psychiatrist, Minkowska, May 2003]

In other words, doubt assails even the certificates’ authors who are precisely those who defend the idea of political asylum. In their double position within the association where they work, activists must know how to be convincing even if as experts they hesitate. Indeed, they cannot ignore that their diagnosis rests almost exclusively on an anamnnesis, that is, on words. That is naturally the case with all psychiatric or psychological practice of expertise, but tension takes on a singular dimension when the benefits for attesting to alleged symptoms are potentially so great for the person involved. Whereas the body brings proof through its materiality (Fassin 2001), the psyche only exists through the patient’s words and through the specialist’s categories. Scars can be seen and touched, psychic trauma is invisible. But this weakness is also its strength, for where trauma is concerned, as with suffering more generally, a social investment also implies a moral evaluation (Young 1997): its clinical vagueness facilitates translating a personal conviction into a psychiatric diagnosis that will provide evidence for the administration.

Psychic trauma as it is used today to decide about granting political asylum is thus caught between two forms of politics. There is the trace of the past recognized through clinical investigation. Here the work of the expert in charge of validating the trauma institutes a particular mode of “memoro-politics” (Hacking 1995) that lends an ever greater importance to the psychological treatment of the past. However, by conferring on suffering a moral meaning that opens the door to refugee status, the role of activists in favor of asylum also becomes part of an “ethico-politics” (Rose 1999) in the sense that in the last instance such activists adapt a sense of generosity that resists an increasingly repressive public authority.

It is on this fine line between memory and ethics that the associations must carefully tread. In front of the officers of OFPRA and the judges of the Commission of Appeal who, as the organizations protest, constantly call on them to certify traumas, they do their best to articulate expertise and activism, to help the asylum seekers individually without harming their cause collectively. The collaboration between justice and psychology around trauma fits into a larger picture as well, since in 2004 the psychotherapists of the Primo Levi Center...
even began to train judges of the International Criminal Tribunal at The Hague (Henriques 2004). However, the positions of the organizations in this struggle differ considerably.

Some of them use the certificates pragmatically. Because the administration demands evidence and since the patients need certificates, both are given what they ask for. In these conditions, the certificate stirs up neither debates in the organizations nor doubts among the professionals. In spite of their other differences, the Minkowska Center and AVRE share this same approach on this topic:

I know I am being asked for the accepted formula. If it must be added, I add it. If I feel there is something that ethically comes from psychic suffering and that, as a psychiatrist, I consider it needs appropriate care, I write that in too. If as a citizen and as a humanitarian, who knows what assistance means generally speaking, I feel that, by staying legal and respecting the deontology a doctor is supposed to observe when certifying something, my certificate is going to become an important element for the lawyers or the patient to claim a right, I have no qualms. At first, it is the professional functioning; secondarily, it is the person who understands the society we live in. It is certificate or death [psychiatrist, Minkowska, May 2003]

While separating the psychiatrist, who may not be absolutely convinced of what is being certified but is sure that the suffering is real, from the citizen, who knows what the consequences of the certificate will be even though he is against the way it is handled by the administration, our interlocutor declares he has no remorse about producing the precious document: its functional value must be taken into account the same as its medical significance.

Other organizations take a political stand concerning what is at stake in medical certification in general and psychological evaluation in particular. The fact that the administration with the power to deliver refugee status demands certificates is both a way of delegating their responsibility and a way of compromising the organizations. It is part of a process that discredits political asylum, members of these organizations believe, because the applicant's narrative, completed by what is known of the country of origin, is no longer enough: The professional's word is needed to express the scars on the body and on the psyche. That is where COMEDE and the Primo Levi Center stand. They constantly denounce the “myth of proof” as being a sign that the right to political asylum
is vanishing and just as often discuss “strike of the certificates” as a form of resistance:

We use it as a last resort. We would seriously consider it if we felt that on the whole the certificate does more harm than good. I think it is not impossible that someday we will decide to stop doing it. But it will only work if everyone goes along with it. I don’t know a single doctor in our association, now nor in the past, who didn’t have problems with it. I’d even go so far as to say that it’s the foremost dilemma for beginners. All doctors go through the same stages. At first, it is extreme but then everyone makes up their own ethics on how to deal with it. [physician, COMEDE, November 2002]

Both organizations criticize the certificate, but actually deciding to interrupt issuing them was the breaking point when, in 2002, the Primo Levi Center announced that they would no longer deliver certificates and tried to get the other NGOs to follow. During a stormy meeting, the Primo Levi Center found itself isolated on a political line that was supposed to put pressure on the state administration or at least to put an end to what the center considered unacceptable collaboration with a policy clearly opposed to the spirit of asylum. But this spectacular announcement appeared to be only a rhetorical threat. Even in the Primo Levi Center, the decision was never implemented.

The Strength of Weak Evidence

Beyond the official position thus adopted by each association, taking trauma into account in the certificates raises the issue of professional authority and competence. Medical doctors are considered to possess requisite authority and their professional expertise is involved in many other fields as well, such as occupational injuries (Dodier 1993), but they do not possess the psychological competence for the diagnosis of trauma, even though some physicians, at AVRE especially, say they “improvise as psychotherapists.” Conversely, the competence of psychologists is recognized and justifies their increasing involvement in the management of social disorders (Fassin 2004), but their professional authority is debated, in particular at COMEDE, where this distinction is easily accepted by the psychologists who say that “it is the doctor and the doctor alone who must write the certificate.” Finally for the psychiatrists, they have theoretically both authority and competence, but the only organization where they practice, the Minkowska Center, is marginally involved
in recognizing political asylum and issues few certificates for the state administration. There is thus a sharp discrepancy between the growing importance of trauma in the discourse on the asylum seekers and the narrow space in which this discourse operates in the writing of certificates, as well as between the developing psychotraumatic specialization in the field of asylum and its very modest implementation in the procedures of recognition of refugees. This statement can be confirmed by the result of the complementary examination carried out at COMEDE of 200 medical certificates (50 randomly selected every 5 years). Analyzing in particular the trends over the last decade, two phenomena can be seen.

First, there is a decline in the psychological and psychiatric qualifications indicated on the certificates: in 1992, 6 diagnoses (most often “reactive depression”) and 13 symptoms (generally “sleep troubles”) figured on 50 certificates (representing 38 percent); in 2002, only 3 diagnostics (“post-traumatic neurosis”) and 4 symptoms (“nightmares”) figured on 50 certificates (representing 14 percent). Remarkably, this latter proportion in the sample is higher than that of patients seen by psychologists that only account for 7 percent of the center’s total clinical activity but lower than the 28 percent of the 1,217 persons registered that same year who were considered as suffering from “psycho-trauma” (COMEDE, Activity Report, 2003).

The combination of these figures demonstrates that trauma, diagnosed in nearly one out of four patients by physicians, seldom ends up being taken in charge by a specialist (only one psychological case out of five sees a psychologist) and is often not included in a certificate addressed to the state institutions (half of the supposed psychotrauma ends up in a certificate). Without overestimating the meaning of these small figures, the differences point clearly enough to the limited value of psychological problems for the doctors (because they are inconsistently referred to psychologists) and the little credit given to their being effective as a proof (because they are not necessarily mentioned in certificates) when compared to physical scars that are described in great detail in 100 percent of the documents.

Second, unspecific designations have been replaced by expressions clearly associated with trauma. Doctors used to mention ordinary psychiatric diagnoses, such as: “reactive depression and secondary anxiety due to events experienced in his country” (1992, file no. 30: Angolan man badly burnt and beaten).
Now they speak the language of psychotraumatology, even if it is not completely orthodox in the light of international classifications, for instance: “post-traumatic neurosis with a very marked anxious and depressive state” (2002, file no. 34: Kurdish woman beaten and raped). In the same vein, banal symptoms were previously described, like: “does not sleep well and has trouble remembering, which he explains by the events experienced in his country” (1992, file no. 14: a beaten and wounded man from Sri Lanka). Conversely, today, signs certifying the existence of a state of post-traumatic stress are listed, as an example: “frequent nightmares and recurrent thoughts concerning the events she lived through” (2002, file no. 19: Bangladeshi woman beaten and raped). The change from reactive depression to posttraumatic neurosis and from insomnia to nightmares may seem negligible. However, considering that the psychiatric reference has become omnipresent in the social world, this shift permits one to connect violent events to specific clinical symptoms and, thus, contributes to validating the request for political asylum.

The recent developments in the treatment of certificates is part of the normalization process of certifying practices, implemented by COMEDE and aimed at making the certificates more homogenous and also more convincing. Models have been established and instructions have been given to reduce the narrative that tells about the violence endured and augment the clinical report of the scars observed, thus solidly backing up the medical conclusions and sidestepping possible impressionistic judgments. Ten years ago, the following report could be made: “The present worrisome and precarious social situation can only aggravate the patient’s condition, especially as he must also receive psychological treatment” (1992, file no. 39: a man from Sri Lanka, beaten and burnt). Today such statements have been done away with because they are imprecise (“worrisome”), unspecific (“precarious”), and thus considered too weak as evidence to bear up the application (the symptoms are too vague), or even counterproductive given the definition of asylum (the economic argument is disqualified at the outset). It is now preferable to write, for a case similar to the previous: “Symptoms of post-traumatic neurosis (agoraphobia, insomnia, nightmares) that demand psychological treatment” (2002, file no. 12: a man from Sri Lanka, beaten and wounded).

Thus, the general logic prevailing when establishing a certificate is, on the one hand, to diminish the psychological component certifying the truthfulness of the claim, because it is considered insufficiently demonstrative, and on the
other hand, to limit what is included to trauma, which is the remaining hard core of the psychic evidence. It is nevertheless remarkable that contrary to what can be observed in other countries, none of the scales available to evaluate post-traumatic syndromes are used (Newman et al. 1996) any more at COMEDE than by the other organizations in charge of receiving asylum seekers and torture victims. No systematic investigation is carried out to objectify what constitutes the psychological trace of violence. In France, an individual's destiny depends on the physician's (sometimes the psychologist's or the psychiatrist's) intuition, and most of the time these professionals remain hesitant in their use of trauma as evidence for asylum.

Conclusion

There was a time, not so long ago, when it was assumed that the applicant for refugee status was telling the truth. To be more precise, there was no test of validity in the asylum process. One was not too strict about the narrative and nobody thought of questioning the body or soul to spot the traces of persecution or of the danger the person had experienced. At that time, the economy needed hands to pursue the growth of the nation and refugees were seen as future immigrant workers. Some years later, when the transformations of the modes of production made immigration undesirable, asylum seekers became less welcome. The means to discourage them were multiplied both at the borders where it was possible to turn them away even before they had had time to make their application for refugee status and, inside the country, making their potential status less enviable by restricting the social benefits.

But that was not enough. It was also necessary in the late 20th century to make it the applicant's fault if the conditions of asylum worsened. The fact that the proportion of refugees recognized among the applicants was divided by five was not put down to more restrictive policies or to political asylum being confused with the management of immigration, but to the fact there were more and more "false" refugees. Once doubt had been cast on the narrative, it became necessary to prove its veracity. Documents turned out to be insufficient. Indeed they contained limited information concerning the political situation in the various countries (diplomatic reports lack precision), or even no information, when it came to the material proof that might bear out the applicant's declarations (executioners and torturers do not certify their acts). That is why the body and mind, presumed to have conserved the stigmata of the past, were
asked to attest to the critical events: the body with its scars, the mind with its wounds.

In the new context, doctors working with immigrants have been increasingly confronted with refugees (rather than workers) and with requests for medical certificates (rather than health care). Psychiatrists first, then psychologists, have progressively taken into account a suffering that is not only the result of exile but also the reason one is applying for asylum: persecutions in one’s country. Clinicians and therapists have become, often against their will, experts as well as activists. Psychic trauma, recently canonized, has become a plus-value in which physical traces of violence are absent. Whereas the detailed description of bodily scars certifies but impoverishes, the psychic symptoms of suffering supposedly reveal the “truth” of experience. In the first case, violence is superficially inscribed. In the second, it is deeply embodied.

Trauma thus conveys veracity, as long as it is placed in a certain general framework or presented in experts’ terms. As soon as one returns from the general to the particular, however, the evidence weakens. Recognizing its importance at a collective and abstract level, the officers of OFPRA as well as the judges of the Commission of Appeal, however, find claims to trauma less convincing than marks left on the body when deciding on individual and concrete cases. The asylum activists—experts anticipate such restrictive interpretations: some have made trauma into a secondary criterion, others refuse to certify it, and still others limit its applications. Paradoxically, it is where violence or danger have left the most profound mark—in the psyche—that it ends up being the least convincing for the administration as well as, in the end, for the activists and ultimately for the applicants themselves. Psychic trauma thus says less about a refugee’s “truth” than about the “truth” of political asylum in France.

In one of the last interviews he gave before his death, Michel Foucault (1994) insisted on how much the “ethos” of a time articulates “games of power” and “games of truth”. The extortion of “truth” from bodies and minds to attest experiences of suffering has become a predominant way of exerting power in contemporary societies.

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