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Health Pluralism: A More Appropriate Alternative to Western Models of Therapy in the Context of the Civil Conflict and Natural Disaster in Sri Lanka?

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This paper considers some dilemmas relating to developing effective assistance with and to people who have lived through extreme events in a civil war and 'post-conflict' context within Sri Lanka. The tsunami which devastated many coastal areas of Sri Lanka in December 2004 and left many people with no homes or livelihood has further affected the country. A major issue is how far the concepts and methods of western psychology and psychiatry are appropriate to radically different cultures and contexts: in particular, how post-conflict and post-disaster psychosocial rehabilitation may depend in complex ways on local specifics and interact or not with biomedical notions of PTSD diagnosis and individual therapy. The relationship between a culture and its healing rituals is a complex one. Cultural, socio-political, existential and personal meanings, expressions and responses to civil war or traumatic events and their aftermath are likely to be mediated by each individual and the context in which they occur. This paper details our findings and offers some suggestions for future practice.

Keywords: health pluralism, civil conflict, natural disaster, Sri Lanka

Introduction

Health pluralism is widely found in Sri Lanka, where the people identified as healers may not always be those to whom this role would be ascribed in the west (Lawrence 2000). Priests and indigenous healers, local rituals and traditions can have an important role in assisting people to deal with the psychological effects of both the prolonged civil war (Somasundaram and Sivayokan 2000) and the tsunami of December 2004. The different communities located within Sri Lanka have a varied range of ways of dealing with distress. By health pluralism, we refer to a multi-layered or diverse range of explanatory health beliefs, and a concomitant wide range of coping

strategies or help-seeking behaviours, as well as a varied range of designated helpers and healers. This paper will argue that working with these individuals and resources may be more appropriate in assisting communities than western models of individual trauma diagnosis and therapy in the context of civil war and its aftermath in Sri Lanka, particularly as this appears to be the preferred option for many people. This is not to say that traditional psychological notions do not have a place, but they may provide only one of a range of possible strategies.

The current research was prompted by a concern that an individualized model of diagnosis and therapy seemed somewhat culturally and resource inappropriate, and was not widely taken up. The author wished to consider how individuals and communities were surviving together, what had helped them cope and what they felt their own needs were, rather than merely offering something which might be inappropriate. It was hoped the research might have pragmatic value, and contribute to the wider debate on these issues in Sri Lanka and beyond. There was also a concern that western models have often been positioned as being 'better' and imbued with a set of privileged values (see Patel *et al.* 2000 for a further discussion of this issue).

How each individual constructs the meaning of events within a civil war is likely to depend on a range of potentially interacting variables, including social, community, spiritual, socio-political and individual factors. How these relate to expressions of coping or distress, and how individuals construct individual or collective narratives may be complex (Tribe 2004).

Socio-political Context

The majority of Sri Lankans (74 per cent) are Sinhalese, mainly Buddhist, while Tamils make up approximately 18 per cent of the population and are mainly Hindu. Tamils form the majority in the north-east of the country. There are also smaller populations of Moors, Malay, Vedda and Burghers (descendants of the European colonialists). Approximately 8 per cent of the population are Christian, including members of all ethnic groups, and 7 per cent are Muslim (*CIA World Factbook*, July 2005).

Sri Lanka has been involved in armed conflict since 1983. Tamil militants, known as the Liberation Tigers of Tamil Eelam (LTTE) or more colloquially the Tamil Tigers, have been fighting the Sri Lankan army for control of the north-east with the aim of creating an autonomous Tamil state there. As a result of military action and violence on both sides, approximately 64,000 men, women and children from all the ethnic groups have lost their lives (Reuters 2006). 1.8 million people were uprooted by the civil war (UNHCR 2003). Although hope rose after a cease-fire was negotiated in February 2002, violence mounted subsequently with significant loss of life, assassinations, reprisals and a 'virtual state of undeclared war in the north east' (National Peace Council of Sri Lanka 2006). Factional splits among the militants led to uncertainty about the future. Further peace talks on implementing the

Ceasefire Agreement took place in February 2006, the first contact between the two sides for three years. At the time of writing, talks were scheduled to take place in Europe at the end of October 2006 with Norwegian facilitation.

In parts of the north and east of the country, where the theatre of war was located, people lived in daily fear of the war and its repercussions. Meanwhile a number of bomb attacks around the capital in the south caused considerable loss of life and injuries as well as damage to property. Finally, when the tsunami devastated three quarters of the coastline in December 2004, 230,000 families lost family members, homes and livelihoods (Save the Children 2006).

Background to the Study

Ideas identified in this paper were generated through over 13 years of psychosocial work, and through training people to assist those with psychological distress caused by organized violence throughout the country. In conjunction with a participant observation methodology, texts and relevant materials were reviewed, ongoing discussions held with colleagues and some semi-structured interviews were conducted. All the main ethnic groups in the civil conflict participated in the study; anybody who wished to participate in the research was welcomed to do so. We have related our findings to the literature in an attempt to maximize the pragmatic value of this piece of work. The quotations given within the text are used to illustrate a theme which was raised by a number of participants, so inclusion was based on a frequency count.

Health Pluralism in Sri Lanka

The psychiatric/psychological infrastructure in Sri Lanka is relatively young. There are approximately 33 psychiatrists and 4 psychologists for a population of 19.5 million. Psychiatrists and psychologists are mainly employed in government hospitals, private practice or universities. Many have trained overseas, although there are six medical schools training psychiatrists, all in urban locations.

The question of the relevance of psychological models developed in the West and their relationship to an Eastern country is a vexing and complicated one. Ayurvedic medicine is practised widely, particularly in the rural areas, and many people may receive allopathic and ayurvedic medicine concurrently (see below).

> I am receiving some treatment from the people at the government hospital, but it is not strong enough, so I am seeing an ayurvedic doctor also, I take all the medicines both of them give me (Mr. S following a traumatic incident).

Ayurvedic medicine is based on the view that disequilibrium causes illness. It has existed for well over 2,000 years (Bhugra 1992). The word *ayurveda*

means 'knowledge of long life', and is a system of healing based on a holistic inclusive and spiritual model. (For further details of the role of the Ayurvedic tradition within Sri Lanka, see Obeyesekere 1976.) In addition, the use of cultural and religious rituals and traditions in dealing with emotional difficulties is widely practised, particularly in rural and war torn parts of the country. Writing about mental health in the Tamil community, Somasundaram and Sivayokan (2000: 26) say:

> If these rituals are not performed in the proper way (e.g. due to disturbed situations, disappearances, remains of the person is not found) there is a greater chance to develop psychosocial problems. Cultural and traditional rituals have a very important role in maintaining and promoting social, family and individual health as well as preventing psychosocial problems from developing.

Siddha, Ayurvedic traditional healers, mediums, astrologers and religious leaders within the community are also consulted for problems or difficulties encountered in life. Western medicine, traditional medicine, the use of rituals and the skills of healers are frequently interwoven in the Sri Lankan context. It is important that any healing practices are conducted in a way that is predicated on cultural context, common health beliefs and locally-identified priorities (Somasundaram and Sivayokan 2000; Tribe 2002). The export of western models of emotional distress and treatment regimes to developing countries has been criticized, particularly in relation to traumatic reactions (Bracken 1998; Summerfield 2000). The authors propose that each model of health and recovery may illuminate the other, and that health pluralism based on locally-identified needs may be the most useful way forward since it appears to be the preferred choice of survivors of the Sri Lankan conflict situation for dealing with psychological distress (Samarasinghe 2002).

One of the research participants working in mental health for a non-governmental organization (NGO) said:

> One traumatized person came for counselling, it did not help at all, but when he completed a ritual he was better. Is this because he believed in it and had no faith in counselling? If you believe in anything it will work (Participant C).

Radley (1994) has stressed the difference between faith in the healer and faith in the treatment. Although religious and cultural practices might not commonly be associated with 'treatment', they can provide a healing function. It might be argued that the division is an arbitrary or semantic one anyway. Helman (1984) has written that the very act of seeking help from a person viewed as a healer/helper may be construed as a ritual in itself.

Having mental health or emotional problems is seen, as in much of the world, as carrying a stigma, but in Sri Lanka the information that an individual has received professional psychological treatment may have wider implications than in the West. For example, the marriage prospects of individuals in the presenting client's family may be badly affected for several

generations (Ranawake 2003). (Owing to the notion of mental illness being due to 'bad blood', this is viewed as the bodily component of bad karma.) In addition, consulting a mental health professional is seldom part of people's help-seeking repertoire, particularly in rural areas.

Several of the research participants noted that many people in a community may be viewed as healers or helpers other than a psychiatrist or psychologist.

> Traditional counselling had been done by the astrologer, the priests, at the various ceremonies, the *thovil* (Hindu) ceremony, or where you get the thread tied, all these things (Sivayogen 1996).

The latter is a common practice, where a thread is tied round the wrist, neck or hips by a Hindu Priest to imbue the wearer with good luck and religious protection.

The anthropologist Lawrence (2000) writes,

> Local healers/oracles/seeresses in Sri Lanka; I believe that one way to initiate alternative programs which assist with forms of healing the injury of war is to educate those who are most popular in these local healing practices (2000: 174).

Landy (1977) claims that, where health pluralism is practised, the cultural and social aspects of treatment may be equally important in relation to choice of treatment and beliefs about outcomes. The explanatory health model held by the patient may well determine where s/he seeks help for emotional or physical pain (Helman 1984). Any health/illness model is likely to contain beliefs about aetiology, epidemiology and cure. Kleinman (1980) has written extensively about the complex relationships between culture, health care and explanatory models. Ideas and beliefs relating to heredity or causality may differ between models. Some may carry notions of spirituality or past 'bad' behaviour. In Sri Lanka, the Buddhist and Hindu concept of 'karma' is very important. This implies an external locus of control, with connotations of blame, the event or psychological state being viewed as an inevitable consequence of behaviour in a previous life, regardless of individual volition or political factors, as though it were pre-ordained. This does not marry well with Western ideas of therapy, internal locus of control and individualistic notions of choice and causality, as shown in the quote from a Sri Lankan mental health worker given below.

> If someone was disturbed they would say this is because of the karma if they are a Buddhist. A Christian might say this is because of the judgement by God or Satan—because they were close or not to God. For example, after a bomb blast. There are things she will not understand, I have a very educated client. She will not come for psychological help, but will come for advice (Participant K).

Rubel (1977) noted that 'folk illnesses' are specific illnesses which people from a particular group appear to suffer, and for which their belief systems

and practices provide an aetiology, diagnosis, prognosis, preventative factors and specific methods of treatment. Examples might be eating disorders in the West, 'amok' in Malaysia, and 'brain fag' in parts of Africa. The assumptions in the West tend to reflect the physical reality and psychological suppositions of the mental health practitioners who live there, and are frequently generalized to the whole world, where they may not always be appropriate. Arguments are also made by some authors for the universality of various syndromes.

Summerfield (2002: 248) writing specifically about mental health claims, says:

> DSM-IV and ICD-10 are not, as some imagine, atheoretical and purely descriptive nosologies with universal validity. They are Western cultural documents, carrying ontological notions of what constitutes a real disorder, epistemological ideas about what counts as scientific evidence, and methodological ideas as to how research should be conducted.

Post-traumatic Stress Disorder (PTSD) may be taken as one example with particular relevance to the issues discussed in this paper. There is a range of views about its robustness as a diagnosis. Some theorists believe PTSD is an inappropriate diagnosis, reflecting a specific cultural context, and should not be exported wholesale, particularly in contexts of war (Summerfield 1999; Bracken and Petty 1999), while Mezzich *et al.* (1999) argue that the Diagnostic Statistical Manual (DSM) does not adequately consider the importance of cultural factors in relation to diagnosis.

However, de Silva (1999), writing on PTSD, notes that there appear to be areas of commonality that are mediated by cultural and other factors while pointing to complex differences to be found within the whole category of PTSD, its relationship to the original traumatic event and other relevant variables. Further research is required to identify the generalizability of PTSD to other contexts and cultures, particularly in a civil war context. For example, in relation to PTSD the assumption that there has been single traumatic event is not usually true in the context of an ongoing civil conflict, where there may be a range of traumatic events currently happening and constant fear of further ones. The literature on type 2 or complex PTSD has started to address this issue (see van der Kolk 1996 or Terr 1994 for a more detailed discussion of this and related issues).

The explanatory models of health held by those offering help or treatment and those requesting it may require careful thought and consideration if misunderstandings are to be minimized. Those requesting and offering help may have very different views of what this help should be; on occasions those receiving 'help' may not have any choice in what that help comprises; they may require advice, help with problem-solving, or other types of interventions, for example financial assistance with rebuilding their homes. Power differentials and dynamics in such situations require constant vigilance and open discussions, as do issues of cultural appropriateness and location. It might be assumed that living under civil war conditions for a period of

20 years may have an effect on individuals and communities. While many survivors will have shown resilience and adaptability, some individuals and families will have found their tremendous losses very difficult to bear.

> Since everyone in this society has been made to experience the terrifying situation and continue suffering, the total effect at the social level can be called collective trauma. For example most people have faced loss due to deaths, displacements, riots, starvation and hunger, destruction etc. (Somasundaram and Sivayokan 2000: 80).

Notions of trust and loyalty may become fragmented or transformed in a situation of civil war. Tribe (1998) has described elsewhere how it may be difficult to know whom to trust, and how suspicion and fear may become normal and functional responses. With long-term peace looking possible, the transition from 20 years of civil war raises a number of issues at individual and community levels.

One Tamil participant living in a largely Sinhalese area said,

> Every day we are getting traumatized, we cannot dress our way, most of the people are controlling themselves to show they are not Tamils, even will turn the radio not to a Tamil station so that people will not know they are Tamils. We have to hide our real identity (Participant T).

While a health worker stated about the people she was working with,

> They have no hope, they are always thinking that they have lost everything. Parents go off their heads, missing, raped, their children never seen again, what is it possible to do, what are any of us to do (Participant P).

The cultural milieu of Sri Lanka differs greatly from that of the West, where most psychological ideas have been based on liberal humanism. Although it has often been assumed that these ideas have universal generality, it is in fact an empirical question how far they retain validity in greatly different contexts of belief and culture. As a Sri Lankan Buddhist monk stated to a colleague, Ms Dissanayake (quoted with her permission):

> The location of the individual at the centre of western morality and cosmology makes it difficult for many to accept that this is, in fact, specific to western culture, and not simply a view of the world as it really is.

Ingleby (1989: 22) writes:

> Yet the norms psychology incorporated were not just ethnocentric: even as a description of modern Western societies, they were highly idealistic. They were not statistical norms, but moral ones.

Henriques *et al.* (1989) have written on this theme, and Kessen (1983) has discussed notions of childhood encapsulated and generalized within psychology as unalterable norms. MacLachlan and Carr (1997) write of the need for Western psychology on occasions to be rejected, or at least not

accepted uncritically, and of the need to develop indigenous psychologies, noting that psychologies developed in different parts of the world may have much to learn from each other.

A Sri Lankan medical colleague considering the relevance of Western psychological models stated to a colleague, as above (quoted with her permission):

> When you ask them the classical . . . the whole thing, the PTSD criteria would be there, but these are all leading questions, this is the other problem. When you ask do you have intrusive memories? One thing is that it is easier to say 'intrusive memory' in English, but trying to put it into Sinhala or Tamil, you see, is very difficult and by the time you have explained all that, they know that they have to answer in the positive. So these are the shortcomings (Sivayogan 1995).

This example illustrates one potential difficulty in attempting to use an aspect of a Western psychological model in a context where health pluralism is prevalent and also in different cultural locations. The inter-relationship between language and meaning, explanatory health beliefs, culture and healing traditions is multi-layered and complex (Tribe and Raval 2003). Fernando (1995) and Tribe (2002) have written about how the methods people use to maintain their psychological equilibrium and find help are in part developed and defined by the cultural, societal and health rules and the meanings they ascribe them. A number of authors have also noted that different cultures define different behaviours or feelings as problematic (Torrey 1972; MacLachlan 1997). Examples of different idioms of distress and health behaviour might include agoraphobia, type A behaviour and eating disorders in the west, *inarun* found among the Yoruba of Nigeria, *quajihaillituq* among the Inuit and *tabacazo* in Chile (MacLachlan 1997).

Western notions of mental health are frequently based on the positivistic philosophical tradition (by this is meant the philosophy of Auguste Comte, who claimed that recognizing only positive facts and observable phenomena was important). These notions may therefore not only be reductionist but also superimpose one set of constructions or a narrative devised in one part of the world onto another culture (Bracken and Petty 1998; Gibbs 1994; Summerfield 2002). Moreover, positivistic approaches have addressed cross-cultural variations, gender, religious and age-related variations as categorical variables, examining the amount of variance rather than looking for different underlying constructions and belief systems.

Political and traditional ideologies may change or co-exist: for example, during the Second World War 'combat fatigue' and 'lack of moral fibre' were 'identified' though these appear to be different constructions of the same phenomenon. Or traditional concepts may be replaced by medico-scientific labelling, for example, 'witchcraft' by 'mental disorder', or the re-categorizing of soldiers' distress in the First World War as 'shell shock' and 'traumatic stress'. Positivists might argue that the latter are examples of progress being made.

The importance of locating emotional difficulties in their socio-political and cultural context has been argued by a number of authors, including Blackwell (1989), Tribe (1998), Kordon *et al.* (1988), Lago and Thompson (1996). In a context of civil conflict, individual and collective identity, ethnicity and political loyalties may more often become intertwined than in other situations, resulting in the expression of traumatic experiences taking many forms.

Furthermore, the politics of war means that psychological traumatization may be constructed as a narrative of 'emotional weakness'. Somasundaram writes:

> For people to be pushed into war, to sacrifice their material, physical, psychological, social and spiritual well-being for a cause determined by others, basic psychological processes have to be activated and manipulated towards this end (Somasundaram 1998: 91).

Research on the psychological effects of war on civilians appears limited (Hauff and Vaglum 1995; Krystal 1995; Waugh 1997). In wartime, pain and suffering are inevitably played down in order to still peoples' doubts about whether it is all worthwhile. Research from around the world shows that any group or government may want to keep hidden any negative psychological effects that the war or civil conflict is having on 'its' side as part of psychological warfare and the politics of war (Levy 1995; Tribe 1998). In Britain during the Second World War, the government apparently went to enormous lengths to uphold the appearance of positive spirit and morale among civilians. This was viewed as a part of the war effort, and resulted in negative perceptions of traumatized individuals (Calder 1991; Freedman 1994). Orner (1997) argues that the British Ministry of Defence continues to deny or hide the potential psychological effects of war, in collusion with veterans' groups. He also writes that physical injuries are continually rated as more serious than psychological injuries, as reflected in compensation payments, acknowledgement and respect by the relevant authorities.

In Sri Lanka assumptions may be made that a particular political viewpoint will be held and that various sacrifices will be willingly undertaken based on ethnic background. In reality, this may not always be the case. Fear may prevent an individual expressing his or her real feelings. The Tamil Tigers have been accused of forcing Tamils either to pay a significant financial levy to them, or to give one of their children as fighters. Stories of similar exhortations taking place in Sri Lanka continue to appear at intervals in the West (Reuters, Nov. 1996). Atrocities carried out by the Sinhalese army and other armed groups are documented in Amnesty International reports (1985, 1996b, 1999). As stated earlier, the socio-political context may affect the way that people react, how individual and collective loyalties may be linked, and how subsequent emotional feelings are expressed.

When the war finally ends, the process of 'normalization' or a return to peace may take some time. One of the research participants noted that it is

perhaps pertinent to consider what a truth commission, as established in South Africa, would uncover, and what role this might play. When such antagonism and loss has been suffered by some members of the two communities, it is difficult to see how the potential long-term effects could easily be dealt with. This is increasingly important as the current cease-fire holds.

> At the end of the war . . . all will need counselling, at the grassroots level. There will be a legacy of hatred and fear, it will be necessary to work with the entire community to sort out the issues. Many arguments will arise otherwise, those who are abroad, they think that the well-to-do people should not have left the country, but should have stayed with us (Participant L).

While the following case provides an example of the importance of attempting to locate emotional difficulties in their socio-political and cultural context, it also illustrates that in a context of civil conflict and war, individual and collective loyalties may become conflictual for an individual and that people's choices may become severely limited in ways that may adversely affect their mental health.

> J was a young man who was carrying out his trade of furniture maker at the edge of his village one day. J and his friends had often shared tales of bravado about what they would do if anyone came to trouble them. When masked and armed men suddenly surrounded him, he did not know at first, which armed group they represented. He was terrified, he lost control of many of his bodily functions. He begged them to tell him what they required and he would do it. They teased him, and said, 'we know who you are, where your family live, (naming various family members), if you don't help us we will see to them and to your shop. We know you don't really support us.' They required him to use his carpentry skills to make them something, he was forced to do this and told not to tell anyone. They told him they would be watching him, and might be back for more 'favours'. J was forced to live with the knowledge that he was providing for a political group he did not support, he did not dare stop but was ashamed that he did not. His previous self-image as a strong and brave independent man had been destroyed. He was also terrified that if one of the other political groupings discovered what he had done, they might extract their own revenge. He was also scared that someone in his village might have seen something and might denounce him. He felt he had no choice. His emotional state slowly deteriorated, he was unable to continue his trade and provide for his family. He eventually fled to Europe where he lived an extremely marginal existence racked with guilt for leaving his elderly parents with no source of income, with very fragile emotional health and worried how his flight might be interpreted by others. He dreamt frequently of returning, but feared to do this.

Stigmatization through Western Labelling?

There is accumulating evidence on longer-term individual and inter-generational consequences of severe war trauma (Davies 1997; Waugh 1997; Hunt 1997; Somasundaram 1998). However, some authors (e.g. Summerfield 2000)

argue that evidence of severe psychological effects might be distorted through being based on clinical samples, while the powers of recovery of individuals and communities have been either underestimated or excluded from the dominant discourse because they do not readily fit a medical paradigm (Bracken 1998; Richman 1998; Summerfield 2002).

As to setting up appropriate services, experience has shown that the 'pathologizing' of certain individuals may lead to secondary stigmatization through their first being seen as having emotional difficulties, and secondly as needing to see a mental health professional (Foster 1989; Schwarzwald *et al.* 1993; Tribe and de Silva 1999). If services are located in a city, travel is difficult for people from rural communities, particularly in a civil conflict situation, with regular road blocks and associated difficulties. An advantage is that this allows people to retain anonymity, although distance may also prevent them getting adequate long-term care. If services go to the villages, this may provide psychological assistance to more people, although they may fear being identified as having difficulties with all the cultural negativities this may bring.

What appears to have been largely ignored are the longer term needs of survivors. Hassan (1994), working with holocaust survivors, argues that many people 'coped' for many years, and refers to the 'symptom free interval'. The needs of the survivors changed as they grew older. This is in line with work from psycho-geriatrics, which shows that as short-term memory diminishes, long-term memories may become more lucid and pressing (Hunt and Robbins 1995; Davies 1997; Waugh 1997). In Sri Lanka resources, even in the short term, are very limited, but after 20 years of civil conflict long-term considerations must not be ignored. The on-going peace process may lead to many changes in the lives of people who have been displaced by the civil war. Although the final outcome is not yet certain, negotiations are continuing. Some people have started leaving the refugee camps and returning to their home areas, but many remain in camps waiting to ensure that the peace holds, and many areas still contain unexploded landmines. War damage to property as well as lack of an established infrastructure has also prevented many displaced people returning home, while in some areas there are disputes over property and land ownership.

It has been claimed that war or civil conflict may have long-term effects on individuals (Brown and Fromm 1986). These may lead to interpersonal friction and perhaps secondary victimization where the individual's family or work colleagues are further affected by the changes. For example, taking away responsibilities previously held by the survivor in an attempt to help him/her, may enhance feelings of helplessness and impotence. This may be heightened when issues of causality and blame are entangled at the individual and community levels. In contrast to this there is evidence (Bracken and Petty 1998) that the individual and community's resilience and powers of survival are often immense and need to be recognized and utilized appropriately.

This is particularly true in a civil conflict context, as in Sri Lanka, when they form part of a wider socio-political or community dynamic.

Cultural and Existential Meaning Within the Civil Conflict Situation

Cultural manifestations and meanings may be numerous, as McQuaide (1989) notes in connection with work conducted with South East Asian clients.

> An emotional problem may have a very different meaning—a meaning not immediately obvious to the Western mind. The emotionally troubled individual may feel that he or she is being punished, and that confiding to a psychotherapist is shaming or betraying the family and the ancestors. Consequently emotional problems may be converted to somatic complaints (McQuaide 1989: 22).

A wide range of traumatic events and subsequent responses are to be found in Sri Lanka, as are beliefs about causality and agency in dealing with them. A Sri Lankan medical practitioner told a colleague, Ms Dissanayake (quoted with her permission):

> If you ask 'Do you attribute that to the bad period, or do you think there is a good period coming up in your horoscope? or something, could have led you from here to there', they will not recognize that as a coping strategy, even if most of them would have used it . . . People will visit soothsayers, or undertake rituals but if you asked them if they had used a coping strategy they would have said no.

Situational Factors

All recorded histories of war document instances of 'normal' moral codes breaking down, and behaviour taking place that in peace time would lead to social censure (Butollo 1996; Figley 1987). In addition to these behaviours commonly associated with war, there may be more subtle examples of behaviour taking place in wartime that can have very negative effects for individuals or communities. An example is given below.

> One of the authors was asked a while ago to see a young woman, C. She was told C had an impressive and brave record in working for respect and human rights in her village located in a civil conflict area. She was widely respected by her community, but disliked by those with political power for her concern for her compatriots' human rights, which it appeared they saw as interfering with their work of war. C had stated that she would rather speak to someone who had no political or ethnic loyalties and who was going to remain in the country for only a short time. When she came into the room, she sat and sobbed, and kept telling me 'it was all over'. Slowly we began to develop some trust and to talk about what was troubling her. It transpired that the local armed personnel had picked her up. I could not understand initially what it was the armed personnel had done, and I continued to encourage her to talk. My formulation, based on a western premise, was that I suspected the armed men had sexually

> abused her and that she felt unable to mention this. She kept repeating, in distress and anger that the armed personnel had stolen her future. It eventually transpired that the army men had not touched her, they had instead sat her on a chair just inside the veranda of their base, but in full view of anyone walking past. They knew this would be interpreted by people walking past as meaning that she had been raped, which would mean, within this cultural frame, that it would be virtually impossible for her family to find her a husband, and might affect the family's position (social and financial) for some time to come. The armed men knew this would destroy her and her family, and any threat they believed she posed would be removed. The family would have no grounds to complain, as the armed men could say she merely sat in a chair on the veranda all day. She decided to leave the country almost immediately, as this seemed a more comfortable option than remaining within.

This case study illustrates how cultural meanings and manifestations within a civil conflict may be misunderstood by outsiders and how a subgroup's social and moral codes may be broken by an opposing group as part of psychological warfare within a civil conflict situation. In this example the armed men knew that by making it appear that C had been raped they would have silenced her as a locally powerful opposition figure, ruined her marriage prospects and brought great shame and embarrassment upon the family.

Therefore socio-political and cultural factors are at work in a number of ways in a civil conflict situation. While assumptions underlying psychological theories may in part reflect the Western context of psychology's development, they may not always adequately reflect the situation of people affected by twenty years of civil conflict in Sri Lanka and the recent tragic tsunami.

Conclusion

In conclusion it would appear that health pluralism is a more appropriate alternative to western models of therapy in the context of the civil conflict and natural disaster in Sri Lanka. The authors contend that each model of health and recovery may offer some mutual illumination, and that health pluralism based on locally-identified needs may be the most useful way forward since it appears to be the preferred choice of survivors of the Sri Lankan conflict situation for dealing with psychological distress. In addition contextual variables and the role of meaning require careful consideration if the needs of those affected by civil conflict and other disasters including the tsunami are to be adequately considered and met. This finding is likely to have wider applicability and relevance in a range of situations throughout the world.

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