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The psychosocial effects of conflict in the Third World

Derek Summerfield

In current armed conflicts around the world, over 90 per cent of casualties are civilians. This article reviews medical and anthropological evidence of the psychosocial effects of extreme experiences such as torture, mutilation, rape, and the violent displacement of communities. The consequences for women and children are considered in particular. The author argues that the social development programmes of non-governmental development organisations should be extended to support social networks and institutions in areas of conflict, and ends by giving guidelines for mental health promoters working in traumatised communities.

INTRODUCTION

According to the UN Department for Disarmament Affairs, there have been around 150 armed conflicts in the Third World since 1945. Twenty million people have died, and at least three times as many injured. In the 1950s the average number of armed conflicts per year was 9, in the 1960s it was 11, and in the 1970s 14. Africa in particular suffered a dramatic escalation in the 1980s, not just in the number but also in the scale of wars, some augmented by famine. In line with these trends, UNHCR recorded 2.5 million war refugees in 1970, 8.3 million in 1980, and currently about 15 million. If the internally displaced are included, the total doubles. Mortality rates during the acute phase of displacement are up to 60 times the expected rates. Eighty per cent of refugees are in non-industrialised countries, many of them among the poorest in the world. Sixty per cent of refugees in Africa receive no assistance.

According to studies undertaken for the International Symposium of Children and War in 1983, 5 per cent of all casualties in the First World War were civilians; the figure for the Second World War was 50 per cent, and that for the Vietnam war was over 80 per cent. In current armed conflicts over 90 per cent of all casualties are civilians, usually from poor rural families. This is the result of deliberate and systematic violence deployed to terrorise whole populations. For instance, 'low intensity warfare' (so called because it is designed to carry low political risks for its progenitors) has been defined by a Colonel in the US Army Special Forces as 'total war at the grassroots level'. Population, not territory, is the target, and through terror the aim is to penetrate into homes, families, and the entire fabric of grassroots social relations, producing demoralisation and paralysis. To this end terror is sown not just randomly, but also through targeted assaults on health workers, teachers and co-operative leaders, those whose work symbolises shared values and aspirations. Torture, mutilation, and summary execution in front of family members have become routine. Recent events in Mozambique show graphically the staggering extent of personal, social, cultural and economic dislocation which can ensue when conflict is pursued along these lines.

THE PSYCHOSOCIAL EFFECTS OF EXTREME EXPERIENCES

Human reactions to environmental stress have been subject to social and medical enquiry since 1900. It is accepted that individuals in all cultures may react to traumatic life events, usually involving loss, with disturbances of psychological and social functioning. Summarising many studies (though mostly in a Western setting), Paykel (1978) concluded that in the months following a traumatic experience, there was a six-fold greater risk of suicide, a two-fold greater risk of a depressive disorder, and a slightly increased risk of a psychotic illness akin to schizophrenia.

For years it was assumed that the emotional effects of disasters, natural or man-made, were short-lived and minimal. This is clearly untrue. A study conducted seven months after an earthquake in Colombia killed 80 per cent of the inhabitants of the town of Armero showed that 55 per cent of the homeless and 45 per cent of primary care attenders had suffered significant emotional disturbance (Lima 1987). In a study of the effects of the Bhopal (India) toxic gas disaster, 23 per cent of 855 primary care attenders were identified by structured interview as having a definite psychiatric disorder (Sethi 1987). The best available comparison of baseline rates in the Third World is a WHO study in four non-industrialised countries which reported that around 14 per cent of primary care attenders had evidence of psychiatric disorder of one kind or another (Harding 1980).

Lifton's eloquent descriptions (1967) of the survivors of overwhelming catastrophe, like the Hiroshima atomic bomb, record how they found themselves changed; they experienced a bond with those who had died, and many had great difficulty in re-establishing trust in others. They had internalised a sense of their own worthlessness and powerlessness, like many survivors of great cruelty. Many felt themselves to be 'contaminated' with guilt, as if they could somehow have averted or ameliorated what happened. This kind of guilt is not typically experienced by the victims of natural disasters.

Over the past two or three decades researchers and clinicians have summarised what they saw and heard in survivors of extreme trauma under titles like *concentration-camp syndrome*, *war neurosis*, *combat exhaustion syndrome*, *survivor syndrome* and, currently, *post-traumatic stress disorder (PTSD)*. In fact the human organism seems to have a relatively limited repertoire of responses to major trauma: sleep disturbance, lability of mood (including sadness and irritability), undue fatigue, poor concentration, and diminished powers of memory are common to all these formulations. These, I suggest, represent core features which probably appear in all cultures. We are concerned here not with transient reactions, but with enduring and frequently incapacitating states of mind and body.

A recent study of 57 Ugandan war refugees (Harrell-Bond 1986) concluded that three quarters suffered an appreciable psychiatric disorder. Psychosomatic symptoms (headaches, general bodily aches, exhaustion even when not doing work) were prominent, as were clinical levels of anxiety and panic attacks. Three of the sample were contemplating suicide, and one had seriously attempted it. There was a close link between depression and the scale of an individual's losses, measured by the number of people in his or her immediate family who had died in the war. The researchers used a cross-culturally validated test during interviews, the Present State Examination. My own work with Nicaraguan rural dwellers who had contended with the effects of 'low intensity' warfare in their daily lives for eight years revealed psychological symptomatology in approximately half of the men and three quarters

of the women (Summerfield 1991b). Symptoms were similar to those in the Ugandan study. In El Salvador, at the height of civil war in 1978–81, psychiatric consultations rose from the eighth to the third most common reason to seek medical attention (Garfield 1985).

Anthropological interest in the stresses facing war refugees is part of a fifty-year debate on the relationship between mental health and migration, voluntary and forced. The literature has discussed the sources of stress in terms of loss and grief, social isolation, loss of status and (where relevant) acculturation stresses and accelerated modernisation. Losses include 'home' in the widest sense, which includes the surrounding landscape as the repository of origin myths, religious symbolism and historical accounts. With its focus on what has been lost, exile or displacement has been likened to a kind of bereavement process. These studies record considerable depression and anxiety, often persistent, psychosomatic ailments, marital and intergenerational conflict, alcohol abuse and antisocial behaviour, frequently directed at women. Single refugees, those from separated families, divorced or widowed women as household heads, and refugees in isolated situations, lacking company or community, have all been identified as being at higher risk. Some of these issues are particularly acute for those stranded in camps for months and years at a time. These refugees must continue to live with the awareness of a decisive change in their status, from active citizen to a marginal person, a war statistic. There is a pervasive feeling of ambiguity inherent in camp life. The future is uncertain and it is hard to make predictions. People feel incompetent and demoralised. Recent WHO-sponsored medical missions to Cambodian camps in Thailand further illustrate why such conditions are inimical to mental health (de Girolamo 1989).

War victims endure multiple traumas: physical privation, injury, torture, incarceration, witnessing torture or massacres, and the death of close family members. For example, Khmer refugees each suffered 16 major trauma events on average, three of which constituted torture by UN criteria. There are also background factors, not least the infectious diseases which flourish in the conditions created by war. In Uganda the AIDS virus has behaved like a terrorising army in its own right, and war-related social breakdown is hastening its spread.

Many studies have indicated that as the overall severity of a disaster or war increased, so did the proportion of the exposed population manifesting psychological disorders. Pre-existing personality factors are obviously capable of shaping the way individuals handle such events, but when there is pervasive mental traumatisation across whole communities, the distinctions between individual and collective traumas may blur. In one report there was no significant difference between ordinary Salvadorean refugees and others who had also been personally tortured, in terms of the severity of psychological symptomatology (Aron 1988). This also seemed true in my study of war-disabled ex-soldiers in Nicaragua (Summerfield 1991a). Similar observations have been made in, for example, the Armero earthquake disaster, mentioned above, and among the victims of politically inspired violence in Northern Ireland. But this area involves complex variables and many studies point the other way, like the Ugandan one cited above.

It is a myth, partly propagated by the slant of media reportage, that in the aftermath of a catastrophe people will be paralysed and helpless or break into panic flight, or that community function is likely to be shattered. Studies of populations under bombardment or siege in Lebanon and elsewhere have demonstrated low

levels of psychological disturbance (Hourani 1986). This partly reflects the way in which emotional needs are overshadowed by the exigencies of immediate survival, at least till later. Human resilience is everywhere evident in the conflict zones of the Third World. Victims of wars are after all normal people, albeit exposed to abnormal forces. It is too easy to oversimplify the state of victimhood, characterising it solely by the psychological and social disturbances which can be documented in those affected. Victimhood is seldom 'pure'. Mazur (1986) notes that war refugees are not just hapless victims who have lost everything, but people who are conscious and active before, during, and after their flight. He questions whether they are helpless or merely labelled so. After all, refugees are survivors.

There is also the question of the effects of sub-nutritional diet on psychosocial functioning, which is particularly relevant in Africa, where war and famine have combined lethally. Evidence accumulated from prisoners of war and refugees in the Second World War suggest that chronic malnutrition contributed to their psychological problems. Hunger can have pervasive effects upon mood, emotional drive, and social behaviour; famine has always been known as a time of violation of normal human ties. Undernourished children can be less responsive and less able to learn. We do not know how much this may add to the effects of institutionalised violence in a country like Guatemala, where up to 80 per cent of the children in some areas are reported to be undernourished.

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD is a formulation increasingly evoked to describe the psychological responses over time, frequently years, following exposure to extreme and unusual traumatic events, commonly wars or catastrophes. It arose out of work with the thousands of US veterans of the Vietnam war, whose unabating emotional difficulties blocked the route back to normal peacetime life. Since then PTSD has been described in the victims of terrorism in Northern Ireland, Chilean victims of torture, Cambodian refugees and others. PTSD encompasses the symptom patterns described above in concentration-camp survivors. Most studies have been conducted in Western countries, and rather more on men than women, and we know very little so far about the proportion of civilians of a particular population in the Third World who would react to conflict by developing PTSD. My pilot study in Nicaragua suggested that many of the major features of PTSD are not uncommon.

The characteristic symptoms of PTSD are thus: recurrent, painful and intrusive recollections of the traumatic events, either in nightmares or in daytime 'flashbacks'. These may be intense enough to feel as if the traumatic event is being re-lived. A disturbed sleep pattern is typical. Another core feature is hypervigilance, often manifested as a tendency to startle easily, even in response to minor cues like small noises. Irritability, restlessness, explosive anger, and feelings of guilt, anxiety and depression may wax and wane. People may try to avoid stimuli that recall the frightening memories, they may feel detached from others, or complain of impaired memory or difficulty in concentrating or completing tasks. Sufferers do not generally experience all features together. PTSD does not of course represent a circumscribed disorder: there is some overlap with the features of chronic bereavement and in particular with depressive illness.

It should be emphasised that PTSD as a descriptive syndrome is generally not meant to include the intense but relatively short-lived emotional distress which is a

natural and immediate reaction to tragedy. Nevertheless, there remain open questions about what might constitute a 'normal' range of responses over time to experiences like being tortured or witnessing the shooting of one's child, and whether underlying psychological vulnerability or the severity of the trauma is the central issue (Green 1985). The onset of PTSD can be delayed for months, or even years: some World War II ex-prisoners still had symptoms 40 years later.

I suggested earlier that disturbances of sleep, proneness to anxiety, lack of energy, and diminished powers of concentration, essentially disturbances of arousal and drive, represented universal elements. What of the subjectively experienced emotions accompanying these indicators of altered body physiology? The emotional distress felt by a victim, and how it is acted out in daily life, will be influenced by individual characteristics, but also by social and cultural factors which help to shape the 'meaning' of the provoking events. For instance, guilt and shame have been prominent themes for US Vietnam war veterans, who came home to find that their society had disavowed the war and was somehow blaming them for it all. Those who had witnessed the massacre of civilians, or participated in the torture of captured Viet Cong suspects, have been especially prone to PTSD. There has been a powerful association between PTSD and self-destructive behaviour: since 1975 the number who have died (by suicide, alcohol and drug abuse, or shoot-outs with police) exceeds the 50,000 who perished in the war itself. Men have had great difficulties in reassuming pre-war roles as husbands, fathers, and stable employees. In marked contrast, 50 per cent of South East Asian refugees in the USA display symptoms of PTSD (and even more are depressed), but there is no associated social dysfunction of such a violent kind (Mollica 1987).

As its name implies, PTSD envisages the trauma or traumas as finite events, completed and receding into the past. But huge numbers of Third World people continue to be exposed to apparently unending war or oppression and must live on in the grip of sustained states of grief, fear and apprehension. While such situations prevail, it is hard to come to terms with loss. For instance, it is hard for a mother to properly mourn a murdered child while her other children continue daily to be at risk of the same fate. And while threat continues, hypervigilance, a core element of PTSD, is actually life-saving behaviour. I think we need an extended formulation of PTSD that encompasses the concept of continuous traumatisation.

I have considered PTSD in some detail, because it is so frequently mentioned in current medical literature. But clearly this kind of 'medical' model cannot address the overall complexity of human response to extreme violence, how people in a particular situation interpret things, how and what they suffer, and how they adapt. These issues are further discussed below, in the section on culture and society.

SOMATISATION

Somatisation (or psychosomatization) is defined, at least by Western clinicians, as the expression of emotional distress in the form of bodily symptoms. Characteristic psychosomatic symptoms include recurrent headaches, widespread bodily pains, unexplained malaise, dizziness, and palpitations. Such complaints are just as real and objective sources of hardship as those that might be caused by physical disease or injury.

Somatization is a worldwide phenomenon. However, it has been regarded as particularly prevalent in cultures in which expression of emotional distress in a

psychological idiom is traditionally inhibited; perhaps these are cultures which place a high value on interpersonal harmony and thus implicitly discourage direct expression of feeling. WHO studies in different Third World countries confirm that psychosomatic symptoms are very common. And published literature on the victims of war in Latin America, Africa and South East Asia all conclude that somatisation is central to the subjective experience and the communication of the distress wrought by violence and disruption.

There has been controversy about the extent to which somatisation can be seen as 'equivalent' to depression and, further, whether it is a Western stereotype that denies the ability of people from non-Western cultures to express themselves in psychological terms. In fact, war victims with psychosomatic complaints often fulfil Western psychiatric criteria for depression and some have PTSD. The dominance of somatisation among Asian patients does not mean that these individuals do not experience depressive feelings or have no psychological insight into their illness; but, some authors suggest, they treat those feelings as secondary to their bodily complaints. Other researchers have found that Indo-Chinese refugees readily discussed their symptoms in psychological terms. In Nicaragua I found that rural peasants clearly understood and expressed the fact that it was the stresses of the war which had generated their somatic complaints, little of which they associated with the pre-war years. Somatisation will also shape the kind of help that is sought. In Nicaragua sufferers were seeking Western (i.e. US) medication, an ironic by-product of the war. In Thai camps for Cambodian refugees, traditional folk healers ('krou khmer') have been effective. This is an area where complex psychocultural realities, not least those of the researchers, are operative.

TORTURE

Torture has been described as a form of bondage by which the torturer ensures that his interventions will last over time. Victims face the protracted psychological problems of other survivors of extreme trauma, including PTSD, psychosomatic ailments, and disturbed body image. The mere act of survival may bring its own guilt, and they must contend with a pervasive sense of anguish and humiliation. Like the survivors of Nazi concentration camps, they must endure what for some is experienced as a catastrophic existential event and rebuild a new personal identity in a world that can never be the same. They may also have lost parts of their body, relatives, work, status and credibility. Spouses and children will have their own reactions. Reports from Chile (CODEPU 1989) convey what a struggle it can be to reconstitute family integrity and openness of communication.

'Disappearances' represent a form of psychological torture for those left behind, and this is intended. Only a fraction of the estimated 60,000 people abducted in Latin America in the past decade have re-appeared subsequently, or had their exact fates established. It is hard to grieve properly for someone who may not be dead, and even after years many families are locked into what has been called 'frozen' mourning. Their emotional limbo is exacerbated when governments – even when restored to more democratic forms as in Uruguay, Chile and Argentina – refuse to expose the whole truth about such acts, or to lift indemnity against prosecution of those responsible (who include doctors). Confronted by a state which holds on to its dark secrets and which seems still to insist that the missing are the guilty ones, it is hard for sufferers to overcome a collective sense of helplessness and insecurity.

WOMEN IN WAR

In the past the division of labour, the allocation of economic obligations within the household unit, and the elaborate protection built into the marriage system gave African women more rights than Western feminists assume. But the economic changes accompanying the colonial era (and continuing since independence) profoundly eroded women's position in society. Most of the responsibility for food production has come to rest with them. Throughout the Third World there seem to be strong links between poverty and households without a male adult. In parts of Central America 50 per cent of households are headed by women. War, drawing in male combatants and disrupting social and economic patterns, brings harsh pressures to bear upon women's central role as provider of physical and emotional sustenance for children and the elderly. They are even more vulnerable when they must take their dependants and flee. Women and small children comprise more than 80 per cent of the population of many refugee camps and settlements. There is concern from various agencies, including WHO and Oxfam, about sexual violence against women in refugee camps, committed either by other refugees or by camp officials who are in a position to apply coercive pressures. In the Thai camps young Khmer women have been attempting suicide. Accepting that there may be gender differences in the expression of emotional distress, several studies show higher levels of anxiety and depression in women than men following both natural disasters and war in the Third World. Women who have been widowed, have lost a child, or have been raped seem more vulnerable to depression and PTSD.

As a phenomenon, rape is linked to the dynamics of power and aggression, rather than to sexuality. It is endemic during war, and is arguably its least scrutinised and documented aspect. Though often seen as the random excesses of poorly controlled soldiers, it would be more accurately viewed as an instrument of subjugation and terrorisation deployed on a more or less systematic basis. In Latin America perhaps the majority of women detained on political grounds by repressive governments over the past two decades have suffered sexual violation or torture, of which 'ordinary' rape is just one form. This has been experienced as an attempt to reduce the woman activist to the status of 'whore', a traditional symbol of shame in a Catholic male-dominated society. In the task of reconstructing their emotional lives, tortured women may face more social and sexual difficulties and be more prone to suicidal tendencies than other women whose experiences of brutality did not include sexual abuse. They may feel constrained to stay silent because of well-founded fears of stigmatisation within their families or wider society. A recent study of 35 Ugandan women raped during the civil wars of the 1980s showed that years later most of them still had repeated nightmares about the event and felt angry, afraid and humiliated. Twenty five per cent now had no contact with men, and two-thirds had no enjoyment from a sexual relationship. Three quarters of them had gynaecological problems, and some were carrying the AIDS virus. Half of them had felt unable to tell their partners (Giller 1991).

CHILDREN IN WAR

'Low intensity' conflict in Angola and Mozambique during the 1980s has demonstrated the consequences for the most vulnerable: the small children. Between 325 and 375 out of every 1,000 children have been dying before the age of 5

(compared to an estimated 185 before these wars), the highest rate in the world. UNICEF estimates that 500,000 extra child deaths have been directly attributable to war-induced destabilisation in these two countries during the decade. The psychosocial effects of unremitting violence and upheaval here and elsewhere can intrude brutally into the normal process of development for an entire generation of children. The stress and insecurity which all children can exhibit when separated from their principal carers, notably parents, is grossly exacerbated by armed hostilities and associated population movements. In Angola, for instance, an estimated 300,000 children have been orphaned or separated from their parents. They may have witnessed the harassment, abduction, torture or murder of parents or siblings, massacres and the destruction of their homes and communities. Older children may themselves be deliberately killed to prevent them being used by opposition forces, tortured, or taken away for sexual or other forms of exploitation. There has been forced drafting of children into armed units in at least 20 countries on three continents. Worsening economic hardship may deepen their feelings of helplessness and insecurity. Children may also be abused, abandoned or neglected by parents or temporary care-givers, themselves under pressure. Uncertainty and tension in a strife-ridden environment intimidate indirectly, and thus the collective fears of parents and those of an entire society are added to the normal fears of children.

War-traumatised children in any culture are fairly similar in their emotional and behavioural patterns, which sometimes alter only after a latent period. Pre-school children may show frequent or continuous crying, clinging dependent behaviour, bedwetting and loss of bowel control, thumb and finger sucking, frequent nightmares and night terrors, as well as unusual fear of actual or imagined objects. They may regress to an earlier developmental stage. Children of early school age can have these features too and be overtly unhappy, nervous, restless, irritable and fearful. There may be self-stimulation such as rocking or head banging. They may not want to eat, or they may have physical complaints – headache, dizziness, abdominal pains – with a psychosomatic basis. They too can regress to behaviour appropriate to a much younger child, in some cases to prolonged muteness or to bed-bound incontinence as if they were babies. They frequently have particular fears: being left alone in a room or sleeping alone, or of situations which carry some reminder of the traumatic events they have witnessed. The social behaviour of traumatised children can be markedly affected, some becoming extremely withdrawn and mistrustful, others loud and aggressive. They may have learning problems. Adolescents can behave similarly, though their responses may also be shaped by whether they have passed the age deemed in their particular culture to mark the onset of adulthood.

War-related themes weave their way implacably into the mental lives of exposed children. A study of 3 – 9 year olds in Lebanon discovered that war was the major topic of conversation for 96 per cent of the children, of play for 86 per cent, and of drawing for 80 per cent (Abu-Nasr 1985). The drawings of Ugandan refugee children show their preoccupation with their experiences of violence, death and starvation: pictures of soldiers shooting their mothers, infants lying bleeding to death, decapitations, dogs eating human corpses, people crouching in the forests with ribs jutting and bellies swollen. A year later these children were still drawing like this, almost always from first-hand experience (Harrell-Bond 1986). There must be distorting influences bearing upon the socialisation of the young in societies where

force appears to be the only means of conflict resolution, and where life seems to be little valued. They too may accommodate themselves to violence. Even very young Ugandan children, when asked about their aspirations for the future, talked of bloody revenge. On the other hand, a UNICEF-funded study of child stress in Uganda interviewed 74 who had been recently evacuated from the Lowero triangle, the 'killing fields' of Uganda. Only two identified with armed aggression, and the rest said that they wanted to help groups like the Red Cross who had helped them (UNICEF 1986). We cannot generalise.

In urban South Africa, politicised black young people often reject the norms of their parents, dismissing their pious hopes for peace as undue capitulation to the apartheid state. Perhaps what is being said implicitly is that parents have failed to protect their children from the oppressive state, so that they must now fend for themselves through activism, including violence. Thus it is that dominant authoritarianism can undermine benign authority, like parenthood. Intergenerational tension of this kind has been described elsewhere. But it is also worth noting that young people picked up at random on police sweeps may be less able to absorb the effects of arbitrary detention and ill treatment than those whose political understanding and commitment affords them a 'meaning' for what has happened to them.

A study of children living in the affected areas of Northern Ireland concluded that psychological disorders increased noticeably during the 1968 riots and violence in Belfast (Fraser 1974). Children aged 11 – 12 in conflict-ridden parts of the Middle East show an increasing incidence of serious psychiatric disorder, including psychosis and depression leading to suicide attempts. A follow-up of Cambodian youngsters, severely traumatised at ages 8 – 12, found that 48 per cent still had PTSD a decade after the events (Kinzie 1989). War can have an all-pervading impact on child development, on the experience of human relations, moral norms and basic attitudes to life.

CULTURE AND SOCIETY

In the colonial era it was impressed upon indigenous peoples that there were different types of knowledge, and that theirs was second-rate. The emotional and social lives of subject peoples were defined in terms of European priorities, and the responsible pursuit of traditional values was usually regarded as evidence of backwardness. Subscribing to the prevailing cultural assumptions, and perhaps also to an implicit belief that mental ill health was part of the price that Judaeo-Christian peoples had to pay for 'civilisation', colonial psychiatrists thought that mental illness was rare in native populations. In the post-independence era, other psychiatric researchers have documented that depressive illness was common, for instance in Africa, and that anxiety in its various forms was as prevalent as in Western societies. But the relativity of knowledge is nowhere more central than in areas encompassing feelings, beliefs, and behaviour, and it has generally been non-psychiatric researchers who have emphasised the limitations of Western categories of mental disorder for organising our comprehension of what those in non-Western cultures experience.

Even concepts like 'stress' and 'coping' are bound by culture and, indeed, by class. Culturally shaped health beliefs, including expectations of the kind of help or healing available, determine to a great extent how distress is experienced,

interpreted, and communicated. And though physical and psychological distress is experienced individually, it often arises from, and is resolved in, a social context. Shared supernatural beliefs frequently carry explanations and antidotes for mental ill health, though such attributions may of course provide a basis for the stigmatisation and neglect of the mentally disturbed. The social nature of illness, often obscured within individualistic Western societies, has been a major theme in the medical anthropology literature over the past 20 years. But despite the complexities of the subject, there do seem to be common denominators in human response to war and disaster, and there is the universality of bereavement as a life event, understood and dealt with by all cultures. There are similarities in the psychological symptoms and adjustment problems shown by Western survivors and by those from widely disparate non-Western cultures, as discussed earlier.

Major events impinge not just upon individuals but at the level of the whole society. Even if war-free, most Third World societies are facing rapid change. The colonial era initiated processes tending to the rupture of cultural continuity, the link between past and present, and these have been continued in the name of modernisation since then. Rural life has been depleted by the drift to the urban centres as the result of crop failures and patterns of unjust land ownership. That traditional family and social structures are under stress as never before is evidenced, for example, by the rapid increase of alcohol-related health, social and economic problems in the Third World. Indeed one study reported that 18 – 40 per cent of high school students in Nigeria were consistently abusing alcohol (Oshodin 1980). The struggle between old and new forms at a time of economic stagnation must render societies vulnerable and volatile. Alienation in the face of Westernisation, which has not delivered what it seemed to promise, can arguably be linked to the rise of Islamic and Hindu fundamentalism in Asia, reactive revivals to reestablish coherence and 'meaning'.

War or civil conflict can be devastating for cultural and social forms. In Uganda and Mozambique huge numbers of destitute and terrorised peoples are haunted by the memories of the relatives they left unburied, and the supernatural sanctions which will follow these lapses of mourning and burial rituals. The Sudan civil war has seen similar society-wide loss of ancestral places and social identity. In Juba none out of 36 refugee adolescents, all aged 16, could write a history of their clan. Many did not know the names of their grandparents or the village their clan came from. Not one could name any traditional social ceremonies. The traditional cycles of animal husbandry have not survived the generalised terror, and most cattle, the major currency for social and cultural interactions related to marriage, rituals, and settlement of disputes, have been lost. As elsewhere, women are left exposed. Young women from rural communities, where prostitution is unheard of, have been driven to engage in this in the overcrowded towns.

Trauma can spawn new forms of expression, or non-expression, which have in common that they defend psychic well-being, to keep terror and horror out, even if such behaviour is not necessarily adaptive in the longer term. Some of the survivors of the Cambodian holocaust of 1975–9, witnesses to the near-total destruction of their cultural identity, have coped so far by adopting what has been described as a 'dummy' personality, a kind of psychological withdrawal or numbing which allows avoidance of the past. Some say they don't remember what happened. Rural people in north-east Brazil have come to experience and express the physical and emotional responses to hunger, extreme poverty, and oppression through the metaphor of

mental disorder ('nervousness'). This is a tragic rationalisation, but in a climate ridden with political violence, it may be safer to be 'ill' than to name directly the causes of their predicament. Chomsky writes that in El Salvador the collective traumatic memory of the massacre of thousands of peasants in 1932 was effective in suppressing dissent for over a generation. As late as 1978, whenever peasants began to talk about their demands, others brought up 1932 again. More recently in El Salvador there has been a striking resurgence of magic practice, from witchcraft to religious sects, among sorely oppressed communities who seem to need to replace lost 'meaning' in their lives. Messianic sects claiming a mythic invulnerability, most notably in Uganda, may be representing something similar.

It does seem that internalised cultural values and traditional family and social role expectations are important in restructuring life after trauma. Adjustment problems in refugees can be ameliorated if they can join a community of others from the same background. This is also true if the culture of the host country is not too different from theirs, presumably because people in an alien cultural milieu are constantly bombarded by messages foreign to them. African refugees in exile are often anxious to revive their old customs as quickly as possible. In Guatemala, Indian leaders see the preservation of their linguistic and cultural forms (to the extent of keeping some of them 'secret') as paramount if they are to continue to resist state terror determined enough to have annihilated 440 of their villages in the early 1980s. Shared ideas about concepts like freedom and justice can obviously provide for coalescence within societies, as when the majority of the population support a 'just' war. I am in no doubt that many Nicaraguans were fortified against the psychological impact of the Contra war by what the revolution meant to them in terms of their history, and the new sense of a national self which it fostered. None the less, in Nicaragua and elsewhere, collective healing after conflict must be more tortuous when both sides have been drawn from the same society.

When catastrophes are as profound as Cambodia's, it will take decades or longer for a society to absorb what has happened. Those who till now have had to keep their memories locked must be enabled to find words to express experiences that were almost literally unspeakable. Some of the old traditions and beliefs will not survive this trial. For individuals, as for a society, things can never be the same and a new world view is needed.

NOTES FOR MENTAL HEALTH PROMOTERS IN TRAUMATISED COMMUNITIES

Who are the most vulnerable? Members of the community are likely to have a good idea of those among them who are most preoccupied with their terrible experiences or who are generally a source of concern. Familiarity with the common presentations of traumatisation, for adults and for children, is needed. It is likely that people without family support, or women who have lost a child or spouse, are more at risk. It has also been shown that feelings of worthlessness, or the feeling that one is unable to play a useful part in life, or the self-perception of poor emotional or physical health status are all strong predictors of psychological disturbance in victims of major trauma. Social dysfunction like self-neglect or child abuse is also a definite indication. These guidelines may also identify the most vulnerable children, because their emotional status during war has been shown to be strongly linked to that of their principal care givers. Children can weather much more if they do not detect

particular panic or depression in their mothers. Further identification of traumatised children may be facilitated by asking questions like: 'Do you know any child who has trouble sleeping at night or who has disturbing dreams/nightmares? Do you know a child who cries a lot or who always seems unhappy or depressed, compared to the others? Do you know a child who won't talk or seems apathetic? Do you know a child who won't play with other children or who fights a lot or plays too roughly? Do you know a child who seems to act strangely compared with other children?'

What about emotional support and healing? In all cultures the healing process occurs through a system of symbols and rituals, verbal and non-verbal, which are grounded in the traditional belief systems of that culture and performed by individuals or groups whose role as healers is sanctioned by that society. Certain qualities of healers and the healing process have been universally identified as central to their efficacy, including communicating the expectation that symptoms can be relieved, conveying a knowledgeable manner, drawing together key persons valued by those in distress, and generating hope for an improved existence. A primary health care worker or mental health promoter who seeks to intervene in traumatised communities needs first to be acceptable to everyone and alert to cultural issues where they arise. A warm, sympathetic and non-judgemental manner is essential, and he or she also needs to be clear that listening means bearing witness, and that this is not a useless activity. It may be very hard for people to communicate their experiences and the worker, whether in a one-to-one interaction or in a group, can help create an enabling atmosphere in which people can share not just the hard facts of their stories, but also their feelings. It is important to allow intense emotion to be expressed without a sense of shame. Signs of helplessness and low self-esteem may emerge, as well as the anger and guilt which are inherent in grieving processes. People may need realistic assurances that their feelings are normal responses to extraordinary events beyond their control and do not reflect personal weakness. Thus through discussion people can come to a better understanding of their feelings or symptoms, including the link between war-related stress and their bodily ailments. Groups, whether focused on discussion or a practical task, also allow individuals to overcome the sense of isolation which so often accompanies serious emotional distress, and can draw strength from the opportunity to give something of value to others. The worker can help people talk through some of their problems, but should not offer instant solutions. Attention can be drawn to the ways in which people are once again bringing their lives within their control.

CONCLUDING COMMENTS

Most conflict in the Third World currently involves terrorisation and deliberate attempts to produce psychosocial injury. Keeping this core psychological dimension in mind affords us better chances for accurate empathy with those affected, for tracing their responses over time, and of course for assisting in the processes of recovery and regeneration.

These psychosocial consequences are part of the record of what actually happened in any particular conflict, no less real or substantial than the statistics about the numbers of dead, homeless, and hungry. Psychological traumatising is an actual experience, and victims everywhere need recognition of this. At the same

time, I think we should focus on traumatisation not primarily as an injury which a particular individual may or may not have sustained, but instead as a *process* or *processes* impinging on social and cultural organisation at various levels: family, community, and society. Assisting a more complete counting of the human costs would be consistent with the objectives of non-governmental organisations (NGOs) in relation to the enhancement of human rights and social justice. Further, the collective testimony of people who have been traditionally voiceless is also a writing of the history of the times. Wars create effects which can far outlast them, and follow-up over years is surely a priority. How will the lives of a generation of Mozambican orphans who witnessed the murder of their parents shape up over the next decade? Monitoring the effects over a long period should be a priority for NGOs and, indeed, of governments themselves.

The business of documenting is also a practical intervention. Just as the gradual recounting of the trauma story may be essential to the individual psychotherapy of a torture victim, so too assisting the process by which the traditionally voiceless come to be heard is of itself empowering. Naturally there must be no unmodified importation of Western psychological 'expertise'. Communities must be understood in terms of their own dominant conceptions of mental health and ill health. Given the variety of forms of co-operative efforts in the Third World, definitions of self-help will vary. Indeed we are often dealing with dynamic situations with traumatised communities actively evolving new forms of self-help and assertion. Community participation can be encouraged, but not prescribed. Local peoples must basically choose their own priorities and be empowered to act on them. The recovery of a sense of autonomy is obviously good for mental health. Thus projects aimed at psychosocial healing would invoke many of the non-material objectives of social development and education as NGOs define them. With raised awareness, previously unanticipated psychosocial benefits may be spotted in apparently unlikely looking projects whose official goals were quite different.

Human rights bodies, churches, or any other organisation able to monitor and document the on-going personal and social impact of conflict need support and encouragement in this function specifically, as well as for the direct assistance they offer victims. And we need to be alive to the ways in which trauma-related mental health work of the kind outlined earlier might be made available to a community, tailored to their particular situation. Mental health training for primary health care workers, the training of refugees as mental health promoters, the preparation of audio-visual material which could be delivered in the schoolroom, clinic, church or other facility, are all approaches to enable individual and collective handling of the core themes: fear, unresolved grief, the problem of disappeared loved ones, stress-related physical ailments, alcohol abuse, abandonment by spouses, sexual abuse, cultural threat, etc.

One universal theme in human responses to extreme events is the crucial role of social networks in aiding recovery. Harrell-Bond (1986) comments that aid has often not been applied to maintaining social institutions. War victims are expected to cope by being appropriately 'social', but may not have the resources to re-establish the real bases of social life. It seems fundamental that anything that can help to reconstitute family and kinship ties, and social and cultural institutions, must be good. There might be opportunities to extend the current range of social development projects to serve these ends. For many peoples there is considerable reparative power in ritual, traditionally central to the struggle to retain the sense that

there is order in the universe. Traditional healers can play a role here. There will be circumstances when early intervention, perhaps on a one-off basis, is needed: the provision of material for burial shrouds obviously qualifies here. There may be healing resources in other socio-cultural forms like music, drama or dance.

Particular groups should be considered for targeting: orphans, the elderly, the physically disabled, those mutilated by torture. Women should be a particular focus because of their heightened vulnerability during war and their central role as providers and nurturers, not least as emotional shields for their children. Projects that target women offer a way in to the mental health of the whole community.

The question of monitoring projects will not always be easy, not least because in the mental health field outcomes may be hard to quantify. Moreover, in dynamic and often unstable situations objectives may shift in mid-project. Means of evaluating progress must be culturally appropriate.

If NGO field staff are to attend more closely to this emotive and pain-ridden realm, they may have to cope with higher levels of stress. They may also have to confront more professional dilemmas and even risks, particularly in countries whose governments directly or indirectly propagate violence, and where community health and social welfare projects are regarded as subversive.

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