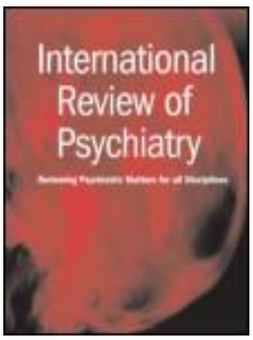

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The question of political neutrality when doing psychosocial work with survivors of political violence

LYNNE JONES

Centre for Family Research, Social and Political Sciences Faculty, University of Cambridge, Cambridge, UK

Sum mary

This paper considers whether a position of political neutrality is either valid or practical when doing psychosocial work with survivors of political violence. The ®rst part reviews the various professional ethical codes that appear to call for neutrality and illustrates some of the problems that have arisen when medical practitioners have identi®ed themselves with a particular political ideology. The contradiction between the demand for neutrality and a commitment to a person's wellbeing is then explored, as are the dif®culties and consequences of sustaining a value free position. The second part of the paper focuses on psychosocial work conducted by humanitarian aid agencies in war zones, in particular Bosnia-Herzegovina. It argues that a tendency to focus on individual psychology while ignoring political and social context may appear to confer neutrality, but will have adverse psychological and political consequences. Case examples are given of attempts to acknowledge political biases while doing psychosocial work. When faced with problems such as genocide and ethnic cleansing, neutrality is not possible. For those doing psychosocial work, political literacy and an acknowledgement of one's subjectivity is essentia l. At the collective level, psychosocial programmes should examine the long-term political consequences of their work as well as the short-term humanitarian impact.

Introduction

Early in 1995, a w om an rang m e to ask m y advice on w orking as a counsellor in Yugoslavia. I told her that she must be m istaken, because I had only w orked in Bosnia and Slovenia. `T hat is w hat I m ean,' she said irritably, `the form er Yugoslavia!' T he ®rst bit of advice I had to offer w as to be tactful and use the country's correct nam e. `W ell I am a therapist,' she said, `not a politician. That sort of thing is really not m y concern.'

The story is not apocryphal, and although perhaps a m inor incident, it is representative of a w idely held view am ongst those doing psychosocial w ork, that in som e way political ignorance confers political neutrality, and that this is desirable. It is these assumptions and the whole question of the vexed relationship between politics and professional practice in this vague and am orphous area called psychosocial work, that w ill be explored in this paper. From the outset it is essential to state that I am not talking about party politics but politics w ith a sm all `p'; that is, our beliefs and practices about the exercise of pow er and governm ent in organized society, m ost of which express underlying moral values. This paper concentrates on the role of the psychiatrist, and the dilem m as raised in this speci®c ®eld. The particular historical experiences of the psychiatric profession mean that the con¯icts and dilem m as that affect all health professionals are m ore sharply de®ned.

Professional ethics and neutrality

In reviewing various ethical codes that guide physicians, one ®nds, for example, the pledges that `whatever houses I may visit I will come for the bene®t of the sick, remaining free of all intentional injustice' (Edelstein, 1967); and `the health of my patient will be my ®rst consideration'; and that `considerations of religion, nationality, race, party politics, or social standing' should not `intervene between my duty and my patient' (Bloch & Chodoff, 1991). There is a more speci®c injunction in the Declaration of Hawaii, produced by the W orld Psychiatric Association in 1983, in response to abuses of psychiatry in the Soviet Union. Section 7 states that `the psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment' (Bloch & Chodoff, 1991).

All of these codes stress that the wellbeing of the individual patient is paramount and comes before any other consideration. This makes sense given the centrality of trust to the doctor±patient relationship. Trust is essential, for without it patients would not wish to abdicate that degree of autonomy that may be necessary for physicians to take any kind of therapeutic action; that is, to put their lives, or at least their wellbeing, in another person's hands. History is replete with examples of what has resulted when doctors have lost sight of the individual and that trust has been abused. Lifton (1986), for

Correspondence to: Dr Lynne Jones, Centre for Family Research, Free School Lane, University of Cambridge, Cambridge CB2 3RF, UK. Tel: 1 44 1223 334510; Fax: 1 44 1223 330574.

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example, has graphically documented how doctors, and in particular psychiatrists, helped to develop, promote and then act upon the `biomedical ideology' that underlay the Nazi project:

> Determined ¼ to intervene therapeutically to attain healing and health for everyone, full of the desire to put themselves primarily at the service of the community and full of the impotent rage over the therapeutic inaccessibility of so many mental patients, psychopaths and habitual criminals [that is Jews], they [the psychiatrists] actually moved from the individual to the `national body' (Volkskorper), to prevent `treatment' (Behandlung) metaphorically: to make extermination (Sonderbehandlung) the perfection of healing (Lifton, 1986).

Lifton's work makes clear that identi®cation with Nazi ideology and the project of national, that is Nordic, rejuvenation and regeneration made it possible for physicians to view genocide as necessary puri®cation and mass killing as `therapy'. Thus he describes an instance reported by the survivor physician Dr Ella Lingens-Reiner, when:

> ¼ pointing to the chimneys in the distance she asked a Nazi doctor, Fritz Klein, `how can you reconcile that, with your (Hippocratic) oath as a doctor?' His answer was, `Of course I am a doctor and I want to preserve life. And out of respect for human life, I would remove a gangrenous appendix from a diseased body. The Jew is the gangrenous appendix in the body of mankind' (Lifton, 1986).

The Nazi practice of achieving mental hygiene through murder is one of the most frightening examples of what can follow from the close identi®cation of a healing project with a particular ideology. Another more recent example comes from the practice of psychiatry in the former Soviet Union. It is worth noting ®rst the difference of emphasis in the Soviet Physicians' Oath which did not demand paramount loyalty to the individual but did include a commitment `to be guided by the principles of Communist morality, ever to bear in mind the high calling of the Soviet physician, and of my responsibility to the people and the Soviet state' (Bloch & Chodoff, 1991). Medical students in the Soviet Union were required to take political studies and `to be well acquainted with the principles of Marxism-Leninism' (Bloch & Chodoff, 1991) and Communist Party membership was an absolute re- quirement if one wished to rise in the medical hierarchy.

Bloch argues that it was this politicization of psychiatry that made abuses possible, in particular the broadening of the diagnosis of schizophrenia to encompass even minor behavioural changes as evidence of the condition. This made it possible to use compulsory hospitalization and treatment as a means of controlling political dissent. Anticipating expulsion, the Soviet Psychiatric Society withdrew from the W orld Psychiatric Association in 1983 and prior to readmission in 1989 acknowledged `¼ that previous political conditions created an environment in which psychiatric abuse occurred for non-medical, including political, reasons' (Bloch & Chodoff, 1991).

These are extreme examples, however they highlight what can happen when doctors, for ideological reasons, put their loyalty to a collective above their loyalty to a patient. Such examples appear to suggest that the solution lies in political neutrality. Yet political neutrality would tend to suggest ethical neutrality, and the fact is that the practice of medicine cannot be either if it is to act out completely the values underlying the codes of conduct. The Hippocratic Oath, for example, states that a doctor should `keep his patients from harm and injustice'. The American Medical Association states that `a physician shall respect the law and also recognize a responsibility to participate in activities contributing to an improved community' (Bloch & Chodoff, 1991). In its annotations for the psychiatric profession, the American Psychiatric Association points out that civil disobedience in protest against social injustice may be acceptable. All these statements suggest a need for public action in pursuit of the wellbeing of the patient and it is hard to see how any such action can be value-free or apolitical. The existence of ethical codes of conduct actually denotes the existence of a framework of values. Dyer (1983) would argue that one of the de®ning characteristics of a profession as opposed to a trade is the existence of such codes. These codes are a clear set of values which underlie its actions and on the basis of which the profession asks for public trust.

Moreover, even those of us fortunate enough to grow up outside the restrictions of a totalitarian state do not grow up in a value-free world. Our attitudes regarding health care, as to whether it is a service or a commodity, our decisions about where and how to practice, what diagnosis to make and what treatment to give, partly re¯ect our scienti®c training, itself not value-free, and partly re¯ect our personal social biographies. This is particularly the case in psychiatry. Therapeutic and resource decisions in Britain, for example, have resulted in the displacement of some chronically mentally ill people, having little access to good quality care either in the community or in institutions, into homelessness or prison.

Value-free psychiatry?

Psychiatrists face political and ethical dilemmas every day. They are in the unique position of not only being doctors but also agents of social control, in that they have the power to deprive individuals of their liberty and treat them against their will, not only for their own good but for the good of the

public as in forensic psychiatry. These powers rest on the psychiatrist's ability to make a diagnosis which, even with current advances in biological psychiatry, is still heavily in¯uenced by cultural and social norms. This is well expressed by Mechanic (1991):

> Because psychiatry deals with deviance in feeling states and behaviour, its conceptions run parallel to societal conceptions of social behaviour, personal worth, and morality. Conceptions of behaviour can be viewed from competing vantage points, and thus they are amenable to varying professional stances. In the absence of clear evidence of aetiology or treatment, personal disturbance can be alternatively viewed as biological in nature, as a result of developmental failures, as a moral crisis, or as a consequence of socioeconomic, social or structural constraints. Remedies may be seen in terms of biological restoration, moral realignment, social conditioning or societal change. Although all these elements may be present in the same situation, the one that the psychiatrist emphasizes has both moral and practical implications. There is no completely neutral stance. Diagnostic and therapeutic judgements have political and social implications.

Take, for example, the diagnosis of conduct disorder. The ICD 10 guidelines (WHO, 1992) de®ne conduct disorder as: `repetitive and persistent pattern of dissocial, aggressive, or de®ant conduct [which] should amount to major violations of age appropriate social expectations.' There is a reminder that it may be symptomatic of other psychiatric conditions and that it is frequently associated with adverse psychosocial environments including unsatisfactory family relationships and failure at school. This is a description of unacceptable social behaviour, as much as it is a psychiatric diagnosis. When unassociated with other psychiatric disorders, there is no de®nitive evidence of biological etiology or effective pharmacological treatment, and the degree to which it is accepted as a psychiatric problem depends entirely on the degree to which psychiatrists see antisocial behaviour as their domain. The practical, social and moral implications of making the diagnosis are clear: the diagnosis may save a child from being excluded from school, because he or she `has a psychiatric problem', and may change sentencing policy in court. It also labels the adolescent, possibly teaches him or her to adopt a sick role as a way to escape responsibility for antisocial acts, and may encourage family and school to see the child as the problem rather than examining their own contributions to the behaviour.

Another diagnosis that to some degree re¯ects social and political attitudes is that of `shell shock', `neurasthenia', or what is now called Post Traumatic Stress Disorder (PTSD). Muller-Hill (1991) argues that during the First World War it was not dif®cult for a German soldier to obtain such a diagnosis. A view then developed that it was paci®st agitation by these `deserters' in army hospitals that resulted in mutiny and German defeat. German psychiatrists in the Second World W ar made a collective decision not to make this diagnosis, or, if necessary, to use the punitive treatment of electric shock.

The degree to which political and moral attitudes to soldiers and their duty in¯uenced treatment in Britain during the First World W ar is also movingly documented in Pat Barker's (1992) fact-based novel, *Regeneration*. In one scene, the psychiatrist Rivers views a session where Lewis Yealland uses electric shocks at increasing voltage to coerce a mute patient back into `full recovery' and ®tness for the Front. This brief episode shows clearly how Yealland's beliefs about the war colour his attitude to the patient, his illness and its treatment. Here the patient Callan tries to break out of the treatment room and Yealland explains to him: `You will leave this room when you are speaking normally. You are a noble fellow and the ideas which come into your mind and make you want to leave me do not present your true self. I know you are anxious to be cured, and you must make every effort to think in the manner characteristic of your true self: a hero of Mons.' Perhaps Callan remembered, as Yealland apparently did not, that Mons had been a defeat. At any rate he went back to the chair.

Later Rivers ponders the value of his own talk-based psychotherapeutic approach:

> He'd found himself wondering once or twice recently what possible meaning the restoration of mental health could have in relation to his work. Normally a cure implies that the patient will no longer engage in behaviour that is clearly self destructive. However, in present circumstances, recovery meant the resumption of activities that were not merely self destructive but positively suicidal. Just as Yealland silenced the unconscious protest of his patients by removing the paralysis, the deafness, the blindness, the muteness that stood between them and the war, so, in an in®nitely more gentle way he silenced his patients; for the stammerings, the nightmares, the tremors, the memory lapses of of®cers were just as much unwitting protest as the grosser maladies of the men (Barker, 1992).

Therapeutic decisions in present day psychiatry are no less value laden, as is re¯ected in the availability of different kinds of care to different populations. The prescribing of different psychotherapies, for example, re¯ects availability and current research interests as much as patient need. Moreover, as London argues:

> Therapists have personal value systems, and it is dif®cult to see how they could possibly form relationships with clients even for the sole purpose of understanding them, never mind helping them,

> without being cognizant of their own values and making implicit comparisons between themselves and their values and those of their clients. The failure to respond in any way to those comparisons, by some process of suspension of his own beliefs, may be possible, but it may also eventually commit the therapist to suspending his interactionÐfor it is hard to see how he can respond to his patient without cognizance of himself, and once aware of his own values, how he can completely withhold communicating them and continue to interact ¼ So-called moral neutrality in the psychotherapist is as much a moral position as any more blatant one. It is from the therapist's side, a libertarian position regardless of how the client sees it. Indeed, in some respects he may justly see it as insidious (London, 1964).

The problem is not solved by a retreat into biological psychiatry, even if one puts aside the growing discussion within the natural sciences on the degree to which subjective factors in¯uence the generation of hypotheses and the selection of data. Even if it is agreed that in some areas of psychiatry it is possible to make a diagnosis and decisions about therapy purely on the basis of the person's symptoms and signs and our scienti®c knowledge (Gilbert & Mulkay, 1984). By deliberately ignoring the political and social context in which these symptoms and signs have emerged, we may actively contribute to an environment that is harmful to the individual. This is the position of the doctor who binds the wounds of a political detainee but does not inquire how the wounds were in¯icted; or of the prison doctor who checks on the wellbeing of a prisoner due for capital punishment or subject to torture, and when asked to declare a patient ®t, does not ask `®t for what?'

Bloch (1991) argues that the vast majority of psychiatrists in the former Soviet Union were apolitical and probably tried to avoid political cases, but they conformed to the system `using rationalization and denial to avoid their entrapment in ethical dilemmas'. Lifton (1986) points to a class of Nazi doctor who were not active ideologues but adopted a `technologized professional identity' (`I am a professional healer and nothing else, in no way responsible for Auschwitz; so I go along with it and heal when I can'). These doctors felt it was their job to alleviate suffering in whatever environment they found themselves. And in Auschwitz the alleviation of suffering could be thought to include mass killing.

Psychosocial work

It would appear that the dangers of using one's medical calling to promote a particular ideology are not avoided by pretending that one works in an ethical and political vacuum. Indeed, the attempt at neutrality may appear to outsiders as complicity with political injustice. In examining the particular concerns that arise when doing psychosocial work during a war, it seems pertinent to give the *Oxford English Dictionary* (1989) de®nition of psychosocial:

> Pertaining to the in¯uence of social factors on an individual's mind or behaviour, and to the interrelation of behavioural and social factors; also more widely, pertaining to the interrelation of mind and society in human development.

Its ®rst use was by the sociologist F. W. Moore, who stated that: `¼ there are also psychosocial phenomena such as language, customs, rights, religion, etc. arising from the action of social elements with or upon the individual mind' (*Oxford English Dictionary*, 1989). Note that the concept is deliberately constructed to embrace the social context. It is also interesting to note the degree to which many contemporary psychosocial projects could as easily be called psychological projects. W hile they may acknowledge social and political causation, they focus on the psychological impact, and espouse psychological therapies, rather than discuss or engage with the social and political world. This attitude is echoed in the general public's response to the psychosocial problems caused by war, as exempli®ed by the journalist Felicity Arbuthnot (1994) discussing the problems Iraqi children face under sanctions: `Surviving under what is arguably the most draconian embargo in modern times, trauma which could usually be expected to lessen with time is intensifying because of hunger and deprivation. Iraqi children have given up playing games because the games remind them of dead playmates. ¼ In July 1993, the UN Food and Agriculture commission noted ªwith deep concern, the prevalence of several commonly recognized pre-fam ine indicatorsº in Iraq. ¼ All Iraq's children, with a third of the population under 15, need counselling so that normality and childhood can be restored.' Having pointed out that it is sanctions and malnutrition that are prolonging Iraqi children's trauma (malnutrition which might also account for their disinclination to play games), Arbuthnot then calls not for the lifting of sanctions nor provision of food, but for universal counselling to restore normality!

The focus on psychopathology caused by a war is a particularly prevalent form of psychologizing. Thus the construction of the diagnosis of PTSD creates a `disease' from which victims of war may suffer. This appears to offer psychiatrists and other psychological therapists a politically neutral role in alleviating some of the suffering caused by war. Yet the concept of PTSD is one of the more value-laden in psychiatry. This has been well documented by Eisenbruch (1984), Bracken and Summer®eld (1995) and others. They suggest that labelling the symptoms of intrusive imagery, hyper vigilance, avoidance, numbing and sleep disturbance as a universal response to a wide variety of traumas ranging from sexual abuse to natural disasters to wars, exempli®es the ethnocentric and imperialistic tendencies of western psychiatry. As a result, collective

distress is individualized and divorced from the social and political context in which it occurs. The diagnosis of PTSD ignores the fact that many non-western societies do not see the intrapsychic processes of an autonomous and bound individual as their main concern. They place more emphasis on interpersonal relationships and the communal world.

Thus, while the same symptoms may be identi®ed in a variety of traumatic situations they may have quite divergent meanings in different societies. Nightmares, for example, may convey messages from ancestors. Survivor guilt may be seen as an essential preliminary to ritual reparations for the dead. Making the diagnosis of PTSD may pathologize coping strategies that are essential to survival. Hyper vigilance, the ability to distinguish an incoming from an outgoing mortar for example, has meant the difference between life and death in Sarajevo. Numbing and denial may also allow a person to muster the psychological strength necessary for ¯ight and to endure the miseries of refugee camp life as well as make possible courageous acts of non-violent resistance.

In the face of siege and genocide, individuals are encouraged to seek counselling for intrusive images rather than to ®nd ways of responding collectively to a cultural and political assault. Yet these experiences have taken place within the community, and research shows that the maintenance of social ties is protective in the face of traumatic events. Human identity rests on the network of social relations we build around ourselves: the ties of family, work, community, and the emotional bond that we make with our physical environment. It might therefore be argued that the main psychic injury of war is the disruption of those ties, the annihilation of identity through the destruction of the social world. It may be that the greatest improvement in mental health will be achieved by non-psychological interventions that attempt to rebuild the individual's social world, such as community redevelopment and family contact schemes.

Improvement in mental health is certainly not best achieved by ranking individuals in a curious hierarchy of suffering: raped women, traumatized children, the elderly and so on, so that their sense of victimhood is increased and the bonds that hold families and social networks together are loosened. It is interesting to note that the seriously mentally ill, such as chronic schizophrenics, those suffering from dementia, and the learning disabled, are often left out of these hierarchies altogether (Jones, 1995). As Stubbs and Soroya (1994) point out in their review of psychosocial work in Croatia, very few psychosocial projects work with men, unless they have been in concentration camps. They argue that:

> ¼ the categories chosen are not addressed ¼ according to clinical criteria alone; they are always subject to political imperatives. The clearest explanation for `who does what with whom' in terms of psychosocial projects seems to be in terms of the development of a hierarchy of deserving victims, with women and children seen as priorities. A victimology discourse does little to empower these groups and, instead, increases the power of primary de®ners, particularly psychologists.

Preliminary results from the long-term study of the psychosocial effects of war being conducted by the psychiatric department of Kosevo hospital in Sarajevo, show that between 1992 and 1994, 94% of those between the ages of 25±44 were men with stress disorders (Jones, 1995). A possible reason for avoiding a group with such clearly de®ned clinical need is that it allows the therapist to avoid the political issues that would arise during therapy, that is both the client and therapist's beliefs about the war. These professional attitudes do not arise simply from a desire to increase professional dominance. One might argue that the creation of a construct such as PTSD and of psychological therapies such as debrie®ng answers the needs of mental health workers to make an immediate response to suffering, while avoiding the complexities of political and social causation. This helps to maintain detached objectivity that is the professional ideal.

While such questions as `Why did this happen?', `Who did it?' and `How do we stop it?' may not be of great relevance after an earthquake, they are uppermost in the minds of anyone subject to bombardment and ethnic cleansing. Avoiding such questions inhibits the possibility of doing good therapeutic work. The following are some examples of this dilemma. The ®rst example is from work with encamped Bosnian adolescent refugees in Slovenia in the Spring of 1993. At that time, approximately 40 youngsters were living with their families in a camp on the outskirts of Ljubljana. The accommodation consisted of barrack-type huts and there was no schooling. The adolescents were not allowed into town without permission nor did they have any resources. It became increasingly dif®cult to engage the boys in any constructive activity. I was asked to see if they would like to be involved in a group. At my ®rst meeting with the boys, one of the ®rst questions I was asked was: `You're English, I want to know what you think of Douglas Hurd?' I replied that I did not know him personally, `But if you are referring to his policy on Bosnia, I disagree with it, indeed I am deeply asham ed of it, and that is one of the reasons I am here.' The boys appeared to ®nd this response satisfactory and the group was established (Jones, 1994).

During the second week, I arrived to ®nd that the boys had locked themselves in the room designated as a youth club, and were very angry. The camp administrator insisted that once the key was returned, the boys would no longer be allowed to use the room. One response might have been to leave.

However, I was aware that many of the boys came from Srebenica and that their anger could be related to the fact that this town was now under heavy attack, in danger of falling to Bosnian Serb forces. Later, they poured out their grievances: their anger at what was happening in Srebenica, their guilt at not being there, their frustration at the west for not doing anything to help and their anger at the camp administrator for setting limits on them about being loud and noisy. They saw themselves as without a country, home or a clear role, and about to be deprived of the last `territory' they possessed.

It was important at that time to remain problem focused. The boys' personal traumas were not discussed, nor did they show a desire to do so. Indeed, one youngster stated that as they all knew each other's stories, they saw no point in discussing them in the group. Although it is important to note that some did want to tell their stories on an individual basis because they saw themselves as having a public role as `witnesses'. Meanwhile, group time was used to discuss ways, they as a collective, could regain control of at least some aspect of their lives, such as access to their room, and develop conventional negotiating techniques.

In this situation, my honesty and transparency about my own political views helped to establish the trust that made it possible for the group to function. Personal political views were not imposed on the youngsters at any time, nor were they volunteered unless asked. Opaqueness on the part of therapists may increase their own feeling of being in control, but does little to empower the group. A willingness both to discuss and acknowledge one's own political views, and to confront issues of power and authority within the camp that affected them collectively, appeared to be therapeutic. It was outside the con®nes of normal group work.

The second example also comes from group work with health professionals, and involves the kidnapping of a group member by enemy forces in Sarajevo in 1994. Everyone in the group was extremely angry. In addition to discussing their personal feelings of anger, fear and vulnerability, a proportion of the time was also spent discussing what practical and political steps could be taken collectively to obtain their colleague's release, and whether it was appropriate for them to do so. As a British citizen, I was asked to use my in¯uence with the then commander of UN troops in Bosnia. Putting aside the fact that I did not see myself as having any great in¯uence, I was obviously being asked to take a political action on behalf of the group. I agreed to do so, as I had supported and encouraged their discussion of their own actions. Not to do so would have been to abdicate my own moral responsibility to confront a crime, destroy the trust the group had in me, and to increase their own sense of powerlessness and isolation. My agreement to act helped to validate and support their desire to channel their anger into a collective response to a political threat. This kind of action did far more to diminish anxiety and fear than simply focusing on the intrapsychic feelings.

One does not go into a war situation blind. Living in the age of information, one is bound to have some kind of prejudices as to why such events are occurring. W hether acknowledged or not, such prejudices affect one's perception of and response to the very people we try and help. It might therefore be better to acknowledge one's subjectivities. Firstly, if they are acknowledged they are easier to put aside, if necessary, as for example when providing life-saving physical care to people you believe have committed a crime. Secondly, with psychosocial work one engages with the social issues that impact on a person's mental health. Therefore, one has a duty not just to be psychologically sensitive, but also politically literate and well informed; otherwise one cannot fully understand the problems, nor the most effective remedies for our patients. Moreover, attempts to remain neutral in the face of genocide are likely to be construed as tacit collaboration with the aggressor and make any effective therapeutic work impossible. This obviously raises the question of how to work with those one perceives as the perpetrators of such crimes. There is no easy answer except to say that, pretending moral and political neutrality does both them and oneself a disservice. Further, those unacknowledged prejudices will surely in¯uence the interactions and transactions for the worse.

Memory and impunity

There is another reason for stressing the need for political literacy. One of the most frightening aspects of modern warfare is the degree to which the target becomes people's ability to sustain their own version of the truth. This has been well documented by Martin-Baro and also Primo Levi, who quotes Simon Wiesenthal's (1988) memories of SS men cynically admonishing prisoners:

> However this war may end, we have won the war against you; none of you will be left to bear witness, but even if someone were to survive, the world will not believe him. ¼ There will be no certainties because we will destroy the evidence together with you. And even if some proof should remain and some of you survive, people will say that the events you describe are too monstrous to be believed: they will say that they are the exaggerations of Allied propaganda and will believe us who will deny everything and not you. We will be the ones to dictate the history of the Lagers.

This is vividly exempli®ed in the low intensity and dirty wars of Latin America in the last two decades. Thus, in Guatemala the `of®cial story' of the horrifying war against the indigenous population in the early 1980s, in which 30,000 were killed and more than 100,000 disappeared, is of a battle against

Marxist-Leninist subversion. Continuing disappearances and deaths are the work of `criminal elements' and those who argue with this version of events are themselves labelled as subversive, unpatriotic or traumatized and unstable. In Argentina, Kordon (1993) records how:

> The military dictatorship tried to describe the mothers who were reclaiming their disappeared sons as mad, in order to marginalize them from the rest of the population. ¼ In some places one heard such comments as, `Well, poor things, with all that has happened I imagine they need a great deal of psychological help. I have seen them sometimes looking very anxious and nervous.'

The government, by psychologizing the problem, has devalued the alternative versions of events and removed the threat. Moreover, the lack of visible markers such as graves and the impunity of perpetrators of injustice, when added to the perceived risk of challenging the of®cial version, means that individuals learn to, at best, keep their memories private, or worse, to begin to doubt their validity and their own judgement. Nor does it have to be an oppressive government or aggressor state that challenges one's sense of reality. It may be the media and authorities of supposedly neutral states. Here Dzevad Karahasan (1995) recounts his experience of living in western Europe as a Bosnian refugee:

> I arrived in the free and fortunate world and began to feel bewildered, so that now after spending a year in that world, I have come seriously to ask myself and others whether I really exist; whether I experienced what I remember; whether I am a wicked liar and mysti®er falsifying my forty years of life, or perhaps a pitiful patient who believes he remembers something that naturally did not happen, because it could not have happened. I have learned that we in Bosnia were victims not of a crazed chauvinism which managed to ®nd use for a huge decapitated army, in search of a state, and a leader willing to employ itÐbut of our on nature. I have learned that the Bosnia in which I reached (optimistically speaking) my middle age does not exist and never did. ¼ I asked myself if I was mad because I remembered my life the way I had lived it, and thought about my home in the way I did.

Or one can encounter disbelief in one's own friends and family:

> Almost all the survivors, orally or in their written memoirs, remember a dream which frequently recurred during the nights of imprisonment, varied in detail but uniform in its substance. They had returned home and with passion and relief were describing their past sufferings, addressing themselves to a loved one and were not believed, indeed were not even listened to. In the most typical and cruel manner, the interlocutor turned and left in silence (Levi, 1988).

One can again draw some parallels from work with sexually abused children. In many cases, when there are no witnesses, the perpetrator is not prosecuted for lack of evidence. This impunity leaves the child with a feeling of not being believed that increases his or her sense of powerlessness and lack of worth, makes effective therapy dif®cult, and the process of forgiveness and reconciliation impossible. For one cannot forgive what is not acknowledged.

Therapists treating patients who have suffered political abuses such as torture, rape, siege and genocide, will be faced with patients who want to know if their stories are believed, and whether we as therapists are able to provide some degree of validation for the events that have destroyed their lives. In making such a judgement about external reality we will be making a political choice. Therefore, neutrality is not a possibility. If we do believe them they will want to know what actions we and they could take to give such events meaning.

Lykes (1990) wrote that `impunity rewrites the past, purging it of the reign of torture, disappearance, and rape'. And while it protects the perpetrators it interferes with the possibility of both individual and social reparation. Thus we may ®nd that our most effective therapeutic efforts are those which support the patient in any collective effort to bring perpetrators to justice, and that a collective interpretation of events that emphasizes political and social meanings has more use, than one that emphasizes the private intrapsychic meaning. Like the Bosnian adolescent boys discussed previously, our patients see more value in recounting their stories for publication, than telling them in therapy in order to obtain catharsis. For it is publication not therapy that creates history.

The discussion thus far has focused on the question of political neutrality as it arises in the transactions between an individual therapist and a patient. Just as troubling and important are the consequences of whole projects attempting `neutrality'. W hat this `neutrality' actually means is what Stubbs and Soroya (1993) describe as a `notable reluctance on the part of psychosocial projects to criticize or be seen to criticize, powerful or regulatory agencies including the government'. In many cases this results in an active `depoliticization of their work. Often special mental health projects have tended to be developed and promoted at the expense of human rights'. Thus issues such as the lack of economic and political rights, poor physical conditions, arbitrary decision-making by authorities, all of which have an effect on mental health, are not addressed. The irony is that the refugees and displaced populations that such projects serve are there because they are victims of human rights abuses in the ®rst place, and it is depressing to see such projects compound the problem.

Stubbs and Soroya (1993) argue that `psychosocial programmes can be seen as reproducing the de®nitions of the wars developed by the international community'. This was most clearly demonstrated in Bosnia-Herzegovina, where it could be argued that engagement and participation in the humanitarian aid effort contributed to a particular political interpretation of the con¯ict that did more harm than good. This interpretation maintained that all `ethnic factions' were equally to blame for the con¯ict. This doctrine of `equality' allowed outsiders to remain neutral, and was used to justify non-intervention and the imposition of an arms embargo. This interpretation also suggested that `innocent civilians' should be fed, although, take note, not physically protected, until the `warlords' saw sense, and that this required humanitarian aid, plus workers to deliver it, who would themselves be physically protected. An aid effort of this kind would also be useful for managing public opinion at home, by showing that something was being done. The presence of these aid workers, and the troops necessary to protect them, then became a further justi®cation for no military intervention. Military intervention to lift the sieges of the cities `might jeopardize the aid effort'. Thus one could argue that, in this case, humanitarian aid, which includes psychosocial projects, actually prolonged the suffering it was there to alleviate. Social workers working in Sarajevo felt that the majority of their psychological problems would be resolved if western governments would use political and military muscle to lift the siege of the city (Jones, 1995). There is no neutral political framework in which to work, and aid efforts will always have political implications, of which we should be aware so that we can make an informed choice as to what would be in the best interests of the population at risk.

Conclusion

While identi®cation with political ideologies carries enormous dangers, there is no such thing as political neutrality and that to ignore one's own biases and commitments can on occasion be equally dangerous, allowing tacit collaboration with political ills. We are all in¯uenced by our personal histories and our best course of action is to acknowledge our subjectivities. This is particularly important in psychosocial work which, by its nature, cannot ignore social and political context and that attempts to do so by focusing on intrapsychic processes and individual pathology are not in the best interest of the ones we help. Thus, we have a responsibility to be politically literate and open to new information. We should neither impose our views on our patients nor avoid discussion of them, and we should be prepared to work with them, both individually and collectively, to understand, engage with and confront those political and social problems that impact on mental health. Not to do so is likely to undermine the validity of patients' memories and increase their sense of victimhood and disempowerment. In addition, it may compound the human rights abuses from which they have already suffered, resulting in unwitting collaboration with war aims such as genocide. At the collective level, we must examine the political and social implications of our interventions to make sure that they are both the most effective use of resources and that they contribute to long-term as well as short-term wellbeing.

Finally, it is worth considering the following: in its footnotes to the Principles of Medical Ethics, the American Psychiatric Association states that while `psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness [they] should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.' It might appear that what I am advocating is a confusion of these two roles, and that as long as we live up to our duties as citizens there is no need to politicize psychiatry. I have argued that psychiatry is always politicized, in that it is value-laden, and we are better psychiatrists when we are aware of this and look clearly at the political implications of our work. But it should be emphasized that there are always great dangers to compartmentalization. As physicians, if we do not feel bound by the values and responsibilities that protect us as citizens, a commitment to political justice, human rights and the rule of law, we endanger the mental and physical wellbeing not only of our patients but of society as a whole.

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