

# Psychological Responses to War and Atrocity: The Limitations of Current Concepts

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# Psychological Responses to War and Atrocity: The Limitations of Current Concepts

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## Introduction

Over the past 20 years western psychiatrists, psychologists and others have become increasingly interested in the psychological effects of trauma and violence. The inclusion of the concept of Post-Traumatic Stress Disorder (PTSD) in DSM III in 1980<sup>1</sup> was both a result of this increasing interest and a stimulus for further research. The concept has achieved wide acceptance and has been used to describe reactions to trauma in widely different situations including work with both civilian and military casualties of war.<sup>2,3</sup> It is generally assumed that PTSD captures the fundamental psychological disturbance after any particular type of trauma and the earlier concepts of "post-torture syndrome"<sup>4</sup>, "concentration camp syndrome"<sup>5</sup> and "rape trauma syndrome"<sup>6</sup> have all been subsumed within it.

As with other concepts developed in western psychiatry however, it is important to examine what assumptions are involved. Allan Young, a social anthropologist who spent two years observing life at a psychiatric unit specialising in the treatment of combat-related PTSD, points to the ethical assumptions involved in such work.<sup>7</sup> In this paper we analyse some of the cultural assumptions involved in the discourse of PTSD and use this analysis to question its relevance to communities in the non-western world. While empirical studies will no doubt shed some light on these questions, conceptual analysis is also needed so that the results of such studies can be properly interpreted. This is indeed an urgent task because of the extent of trauma resulting from war, political violence and other man-made disasters in Third World countries, affecting largely non-western communities.<sup>8</sup> There is a need for psychiatrists, other medical personnel and lay groups working with such communities to develop an appropriate understanding of the impact of such trauma. The relevance or otherwise of the concept of PTSD to such situations needs to be properly delineated. Approaches to treatment and rehabilitation will in many ways depend on how we respond to these issues.

## Some Prevalent Assumptions in Biomedicine and Psychiatry

Many basic assumptions are contained in the western biomedical approach to illness and distress.<sup>9</sup> As psychiatrists have generally worked from within the horizons of such biomedical discourse, psychiatry, too, operates with such assumptions \* There

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\* Gaines argues that while there are different cultures and ethnopsychologies in the Western world, one particular cultural tradition has come to dominate in the world of medicine and psychiatry. He suggests that "... it is the Northern European Germanic Protestant conception of self and person and its ethnopsychology that are vividly, albeit implicitly, embodied in the US psychiatric voice."<sup>60</sup> This voice is undoubtedly the strongest one within

have been calls recently that great caution be exercised in the dissemination of such biomedical psychiatric knowledge in Third World countries. Higginbotham and Marsella reviewed the undesirable and unforeseen consequences of such dissemination throughout South East Asia.<sup>10</sup> They argue that:

*... investing authority in biomedical reasoning about human problems eliminates explanations of disorder at levels of psychological, political and economic functioning. Consequently, problems with origins in poverty, discrimination, role conflict and so forth are treated medically.*

An ever-expanding literature from medical anthropologists has questioned the cross-validity of many of the diagnoses used in western psychiatry.<sup>11,12</sup> Our experiences with victims of war in Third World<sup>13,14</sup> as well as European<sup>15</sup> settings has led us to question the usefulness of the concept of PTSD, particularly in non-western populations. In this article we pose three questions which reveal some of the underlying assumptions contained within the diagnostic category of PTSD.

1. To what extent does this concept imply a notion of individuality which has its origins in western culture but is by no means universal?
2. To what extent does this concept emphasise the similarities in responses to trauma between different cultural groups, while at the same time underestimating the differences because of an underlying 'universalist' approach to the phenomena of mental disorder?
3. Are the treatment strategies developed in the West, with regard to trauma, i.e. various forms of individual psychotherapy, the best approaches to adopt in non-western societies?

These three questions, and the answers we have put forward, have arisen in the context of our own work with survivors of war and atrocity in Uganda (Bracken and Giller) and Nicaragua (Summerfield), as well as with people from various parts of the world who have sought refuge in the UK. In this paper we use examples from our own work and from other work reported in the literature. We hope to show that a narrow focus on the diagnosis and treatment of PTSD in such situations is inappropriate and may miss the most important determinants of the eventual outcome of such experiences for the people involved.

### **The Discourse of the Individual in Western Psychiatry**

In western thought and culture the concept of the individual plays a pivotal role, shaping and defining political, cultural and medical discourses. Ideas of morality are based on a defence of individual sovereignty and social relationships are often defined as arising from consent and contract between autonomous individuals.<sup>9</sup>

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

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psychiatry in general at present. Its nosology, as outlined in DSM III, is increasingly popular in both Western and Third World countries.

that:

*the western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement, and action organised into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.*<sup>10</sup>

This conception of the individual as existing "prior to society and culture"<sup>9</sup> is also assumed by western medicine and in fact some would argue that biomedicine is currently the central social space where the cause of individualism is being articulated in a bioethical discourse about rights and contracts.<sup>17</sup> Psychiatry has, of course, always focused on the individual. As Nemiah puts it:

*the basic unit of study for the psychiatrist is the individual human being. The proper study of psychiatry, that is, is biography.*<sup>18</sup>

This approach to mental illness is a reflection of a particular cultural perception of individuality and in many non-western cultures the notion of the self, and its relationship to others and to the outside world, is different. The experience and the explanation of illness is therefore also frequently fundamentally different. The intrapsychic is not emphasised and thus plays a comparatively minor role in these less "egocentric"<sup>19</sup> societies. Greater weight is often given to "independent somatic processes, supernatural forces and social relations as causal agents".<sup>20</sup>

Writing about certain cultural beliefs among the Chinese in Taiwan, Kleinman<sup>21</sup> writes that these beliefs invest:

*intimate relationships with more affective significance than one's own thoughts, fantasies, desires and emotions. Family and other close interpersonal relations become a person's paramount interest; coping with them becomes a sign of adult competence, and problems with them are more important to him than other personal problems.*

In such cultures the intrapsychic is not isolated and emphasised as it is in the West and the physical and mental are not separated to the same degree as in western experience. In addition both are generally more integrated with the spiritual realm. In short the cosmological and ontological focus on the individual which is the underlying philosophy of biomedicine is not universally endorsed.

### **Universalism in Western Psychiatry**

Another assumption, closely related in practice to the above, which has been influential in cross-cultural psychiatry is that the forms of mental disorder found in the West are basically the same as those found elsewhere.<sup>22</sup> Not surprisingly studies which have used standardised questionnaires, developed in the West, to assess the prevalence and distribution of mental disorder in other societies have usually managed to confirm this assumption. However the fact that symptoms and signs can be reliably identified in different settings is no guarantee that they mean the same thing in those settings. To assert that they do is to commit what Kleinman calls a 'category fallacy'. This is:

*the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established.*<sup>22</sup>

Such a mistake is made when we assert that some phenomenon is universal simply because we can identify it in different situations. This approach to cross-cultural research implies a traditional empiricist epistemology in which theory is separate from, and does not influence the facts under observation. It assumes that the basic data of psychiatric research i.e. symptoms and syndromes, exist prior to and independent of psychiatric theory. It is only on the basis of such an assumption that one can propose the idea of universally similar categories of mental disorder. Such an approach is difficult to defend given recent developments in our understanding of science.<sup>24</sup> Within this framework phenomena are identified as psychiatric symptoms or syndromes only in the light of some psychiatric theory. It should be of no surprise that we can 'find' the symptoms and syndromes described in western psychiatry in other cultures as well. However it should also be clear that the assertion that they are therefore universal is somewhat "vacuous"<sup>9</sup> at best and dangerous at worst.

### **Limitations to the Use of Western Models of Therapy**

The above assumptions lead in turn to others. Thus it is widely assumed that the therapeutic modalities developed in the West are also appropriate for people suffering mental disorders in other parts of the world. The cultural differences are either ignored or played down.

However, just as the notion that psychiatric disorders are the same cross-culturally is problematic, so too is the idea that therapies are universally appropriate. For example the relevance of various forms of psychotherapy developed in the West to less 'egocentric' societies has been questioned. Connor<sup>25</sup> is able to argue, on the basis of various case examples of successful traditional healing in Bali, that:

*...a crucial component of therapeutic process is communication about the key symbols which operate in the conceptualisation of person.*<sup>25</sup>

As White and Marsella indicate:

*...the use of 'talk therapy' aimed at altering individual behaviour through the individual's 'insight' into his or her own personality is firmly rooted in a conception of the person as a distinct and independent individual, capable of self-transformation in relative isolation from particular social contexts.*<sup>20</sup>

Lock<sup>26</sup> describes how in Japan, where a somewhat different notion of the self (as an inner non-verbalised entity) exists, there is little regard for psychotherapy. In many other societies different conceptions of the self and its relationship to the social and the supernatural also means that explorations of inner emotions and conflicts have less relevance than in the West.<sup>27</sup> In short, helping to alleviate distress by the exploration of intrapsychic cognitions, emotions and conflicts is a form of healing somewhat peculiar to western societies and of doubtful relevance to societies holding different core assumptions about the nature of the self and illness.

In addition it is apparent that healing in a world-wide context is a multi-faceted phenomenon and that the client-professional is only one of many different types of healing relationship. Kleinman<sup>21</sup> argues that in fact such professional encounters account for only a small portion of all healing activities. He argues that most therapeutic activity takes place between the patient and his or her family and friends in what he calls the "popular sector of health care". In other words the experience of illness does not occur in isolation but rather within the context of a whole set of cultural, family and individual values and orientations. These shape the experience of illness itself and determine which therapeutic strategies, if any, will be tried.

When people resort to folk or professional practitioners, their choices are anchored in the cognitive and value orientations of the popular culture. After patients receive treatment, they return to the popular sector to evaluate it and decide what to do next.<sup>21</sup> In deciding on strategies of intervention with regard to different forms of psychological distress it is therefore important to realise that such interventions must be sensitive to the beliefs and practices of the popular sector. This is particularly important in non-western societies where the westernised professional sector is relatively undeveloped and thus has little influence on the ways in which the approaches to different forms of illness are symbolically constructed. In such societies the local understanding of mental illness will be little affected by theories and approaches developed in the West, a situation obviously very different from that in western societies where psychiatry and psychotherapy are discussed daily in the popular media.

### **How These Assumptions Operate in the Concept of PTSD**

We will now turn our attention to the ways in which western psychiatry and psychology have attempted to conceptualise the effects of trauma and violence and examine how the assumptions discussed above operate within this conceptualisation. Most authors in this area acknowledge that there are social and political factors involved in the response to violence.<sup>28,29</sup> However attention is usually focused on factors in the individual and these aspects remain under-theorised.

Since the inclusion of the category of PTSD in the DSM III in 1980 the major debate surrounding the concept has been concerned with the relative importance in its aetiology of premorbid personality and traumatic event. These two variables have been isolated, questions of context have been avoided<sup>30</sup> and researchers have, by and large, adopted a universalist approach assuming that the phenomena associated with trauma in one situation will be similar to those found elsewhere. The self and its relationship with others and with the outside world is usually taken as a 'given' and traumatic events are seen as having an impact on this self and these relationships in isolation from the social, political and cultural context. Likewise treatment approaches based on psychodynamic, behavioural and cognitive models share these 'givens'.

Current conceptualisations of the response to trauma typically focus on intra-psychic events and postulate certain psychological or neurological processes which are understood to be disrupted by the traumatic experience. For example in Horowitz's influential account, trauma is seen to disrupt the individual's life by producing a block in cognitive and emotional processing.<sup>31</sup> This is conceptualised as a purely internal phenomenon located entirely within the confines of the individual self.

Horowitz himself writes:

*Abstracting a general stress response tendency from a wide range in variation in individuals and kinds of stress events, one arrives at the following cognitive and emotional sequence:*

- a Phase of initial realisation that a stress event has occurred, often with a sharply accelerated expression of reactive emotion.
- b Phases of denial and numbness.
- c Mixed phases of denial and intrusive repetition in thought, emotion and/or behaviour.
- d Phase of further ideational and emotional processing, working through, and acceptance (or stable defensive distortion), with a loss of either the denial or the peremptory recollection of the stress event.<sup>31</sup>

While Horowitz acknowledges that there are social, cultural and somatic aspects to the reaction to trauma, his approach is to separate out the cognitive/emotional phenomena and focus upon the latter.<sup>31</sup>

This separation of the psychological from the somatic and the cultural is problematic however, implying as it does that distinctions are easily made between the intrapsychic, the somatic and the interpersonal. As we have seen above, such distinctions are made in the western world but are not widely endorsed in many non-western societies. Somatisation is not dealt with in the DSM III conceptualisation of PTSD which implies that responses to trauma where somatic features predominate are 'atypical'.

A similar situation exists with regard to depression where the somatic presentation is seen as atypical by DSM III. As Kleinman<sup>32</sup> argues however, it is surely irrational and ethnocentric to make out that non-western forms of this disorder are atypical, the form commonly seen in the West being assumed to be the norm.

Furthermore by separating the intrapsychic from other factors, the importance of the social and cultural context in which the traumatic event is situated is systematically underrated. This in turn leads to a reification of the postulated intrapsychic processes, which also come to be accepted as 'givens' of human nature.

In addition to difficulties related to the centrality of the intrapsychic in western accounts of the response to trauma we must also ask if the tendency towards universalism in psychiatric research has meant that there has been a corresponding tendency to emphasise the similarities and ignore the differences in response. Andreasen, in her account of PTSD<sup>33</sup> asserts that:

*...although any given individual may manifest a different complex of symptoms, a single typical complex of symptoms has been repeatedly described after a wide variety of stressors, such as combat, large scale natural catastrophes such as earthquakes, and traumata affecting individuals, such as rape, auto accidents and accidents in the home.*

Horowitz maintains that:

*Human beings are as similar as they are different ... and there seem to be certain, fairly universal conflicts between wishes and realities after stress events such as accidental injuries, illnesses and losses.*<sup>31</sup>

This conclusion is supported by his examination of the literature concerned with trauma ranging from military combat to the response to nuclear bombing, rape, serious illness etc. Horowitz argues that in all these situations the various forms of trauma produce a similar response consisting, basically, of 'intrusive thinking and denial'. By defining these phenomena as the core features of the human response to trauma he is led to propose the basic equivalence of the response to hysterectomy, mental illness, rape, nuclear warfare and being told that one is at increased risk of premature death because of heavy smoking or high blood pressure.

While Horowitz's work is an eloquent argument in favour of some similarity between these situations there is a risk of 'intrusive thinking and denial' becoming a meaningless generality. When researchers assert that they have found these features in so many different situations we are led to ask if they have not found just what they were looking for. His assertion that stress events bring about 'fairly universal conflicts' in individuals is deeply problematic given the variety of human belief systems and values. While the physiology of stress reactions may be reducible to a universal sequence of events, this is clearly not true of cognitions and emotions.

Horowitz's is only one of many existing models of traumatic disorders. However, on examination the models of Freud,<sup>34</sup> Lifton,<sup>35</sup> Kolb and Multalipassi,<sup>36</sup> Krystal,<sup>37</sup> Brett and Ostroff<sup>38</sup> all focus on the intrapsychic and like Horowitz attempt to delineate a 'general response' and thus share the difficulties associated with this approach.

Treatment modalities which focus on this 'general response' are similarly problematic. The meaning and importance of such phenomena as nightmares and vivid memories vary from culture and any treatment which ignores the cultural aspects of these and other phenomena will tend to be unsuccessful.

The political dimension of suffering after torture is an example where therapy which focuses on some 'core syndrome' is not able to address the real needs of the victim. Many people undergo torture because of their political convictions. It has been found that if these convictions are ignored during therapy, such people have difficulty making sense of their experiences. Techniques based solely on a psychodynamic approach to intrusion and denial, or a cognitive/behavioural approach to the same, and which ignore the political, social or cultural context in which these phenomena occur have been shown to be less than adequate. Some therapists have responded to this political aspect by using testimony against the torturers as part of the treatment.<sup>39</sup> and by encouraging a reintegration into the political struggle.

### **An Alternative Framework**

It is not our intention to propose some new universalist model to replace, or try to improve on, PTSD or the other syndromes. We are suggesting that by focusing first on the individual and his/her symptoms there is a tendency to conceptualise the affects of trauma in purely individual and medical terms. Issues of context are seen as secondary

and as being merely 'factors' which impinge on the progress of a now reified psychological or biological process.

In contrast to this we are proposing that issues of context in terms of social, political and cultural realities should be seen as central. By social reality we are referring to such things as family circumstances, available social networks, economic position and employment status. Political reality refers to the individual's engagement, or otherwise, in a political movement, their social position as determined by gender, class and ethnic factors and whether they are the victims of state repression or other forms of organised violence. By the term cultural reality we are referring to such things as linguistic position, spiritual or religious involvement, basic ontological beliefs and concepts of self, community and illness. Obviously there is much overlap between these realities and these terms are used here to provide a framework, not as an attempt to develop a strict categorisation.

These realities structure the individual's response to violence by determining: 1. the semantic environment; and 2. the practical context in which the violence occurs and in which the individual recovers. Again we are not proposing a strict dichotomy between semantic and practical, rather we are attempting to provide a contextual framework in which the effects of violence can be described and compared.

In what follows of this section we would like to illustrate this framework with case vignettes from our own work in Uganda as well as with reports from other parts of the world. The work in Uganda took place in the Luwero Triangle, an area to the north-west of the capital Kampala, which became known as the 'killing fields of Uganda' in the 1980's when hundreds of thousands of civilians were killed in government counter-insurgency operations.<sup>40</sup>

During a three year period spent in Uganda we worked with many survivors in local medical clinics and the case material used here is drawn from this work. (A more extensive discussion of the work in Uganda has been published elsewhere.<sup>13</sup>) Social, political and cultural realities structure the context in which violence is experienced and determine to a greater or lesser degree:

1. the subjective meaning of the violence or trauma
2. the way in which the distress associated with violence is experienced and reported
3. the type and extent of general support available to the individual
4. what type of therapies are available and are appropriate

## **1. The Subjective Meaning of Violence and Trauma**

Within the DSM accounts of PTSD it is assumed that certain frightening events, outside the range of normal experience, will always be psychologically damaging. In other words it has been assumed that certain events can be objectively described as damaging or traumatic. The following cases would suggest otherwise:

**Case 1:** A 40 year old Ugandan man who had been a prominent politician in the past was arrested and brought to an army compound. He was held for seven days. During this time he was beaten and humiliated while being interrogated. After his release he was referred to see one of us (PB) by a friend who assumed that he would be in need of some form of psychiatric help. When interviewed, however, he denied any great distress. He told us that he was a Christian, but that prior to his imprisonment his faith had not meant a great deal to him. While he was in detention he felt a strong identification with the figure of Jesus Christ who had also suffered torture and humiliation. He found that his own suffering and his identification with Christ brought him closer to his religion and since his ordeal the quality of his spiritual life was intensified. He indicated that because of this the overall effect of his experience had been positive for him.

**Case 2:** A 28 year old woman who witnessed her husband being killed by the army was unable to bury his body as she was forced to flee the area immediately with her children, for fear that she herself, would be killed. When she was able to return six months later his body could not be traced. When she was seen by members of our team some five years later she was still haunted by nightmares and feelings of shame because she had not been able to bury her husband according to traditional rites. It was this aspect of her loss that she spoke most about when interviewed and which seemed to cause her most distress.

In both these cases the nature of the trauma and its impact cannot be accounted for without reference to the subjective meaning of the events. This in turn cannot be understood without reference to the cultural context in which the individuals lived and in which the events occurred: for one his religious beliefs meant a positive framework for his suffering; for the other the tragic loss of her husband was compounded by the belief that his soul was not at rest because certain rites had not been performed.

War and organised violence often damage traditional ways of life and cultural institutions. This damage can mean that the events of war are even more traumatic for the individuals who are left without a meaningful framework in which to structure their suffering and live their lives. What has been termed "cultural bereavement"<sup>41</sup> may turn out to be a key determinant of longer-term psychosocial outcomes. In Mozambique fleeing survivors were haunted by the unsettled spirits of their dead relatives, for whom the traditionally prescribed burial rituals could not be enacted.<sup>42</sup> Eisenbruch<sup>41</sup> has described culturally bereaved Cambodians in the USA, who continue to live in the past, are guilty about abandoning homeland and about unfilled obligations to the dead, haunted by painful memories and unable to concentrate on the tasks facing them in an alien society. He points out that young Cambodians in Australia, where there was less pressure to conform and where they were given the chance to practise some traditional ceremonies, did better than those in the USA.

## **2. The Way Distress Associated with Violence is Experienced and Reported**

According to the traditional models of responses to trauma there are certain universal effects of trauma and these are accounted for within the syndrome of PTSD. In Uganda we looked for the symptoms of PTSD and found that while these were often present,

they seldom dominated the person's account of his or her suffering. For example in a series of rape victims the commonest presenting complaints were somatic in nature.<sup>43</sup> These were felt by the women to have stemmed from the rape experience. In a society where fertility is of great importance, subsequent failure to conceive ranked highly amongst presenting complaints. Although on further questioning many admitted to symptoms consistent with a diagnosis of PTSD, very few chose to present with these and instead sought treatment for the somatic problems. These somatic complaints were not just 'epiphenomena', but the way in which these women actually experienced their distress. Interventions had to be structured accordingly with an initial focus on physical therapy and investigation.

**Case 3:** A 25 year old woman was raped by several soldiers. While relatives and neighbours almost certainly knew that her ordeal had happened, before talking to members of our team she had never before discussed what happened nor its consequences for her with anyone else. The rape had taken place approximately four years prior to our interviews with her. She had become convinced that she had developed a venereal disease and reported a foul smelling vaginal discharge. She had attended many medical clinics for this and had received several courses of different antibiotics. Swabs were taken by members of our team and no infection was identified. However it was difficult to reassure her and she was convinced that she had been rendered infertile by the rape and its aftermath. She had not sought marriage because of this.

In Nicaragua studies of war-displaced peasants, all survivors of atrocities, showed that PTSD associated features were common. But in this situation the people were clearly not psychological casualties; they were active and effective in coping with new and difficult circumstances in the face of the continuing threat of further attacks. What they were interested in was peace, so that they could return to their old communities and lands and repair social worlds.<sup>14</sup> In neighbouring El Salvador, the psychologist Martin Baro has written persuasively about the need to analyse the impact of state violence in his country in terms of the relationship between individual and society.<sup>44</sup> He reminds us that what was left traumatised were not just Salvadoran individuals, but Salvadoran society. Jenkins, writing about Salvadoran refugees in North America argues that their fear and anxiety is:

*...framed by bodily experience, knowledge of illness, and the ethnopsychology of emotion within the context of chronic political violence and poverty*

and suggests that:

*...trauma, conceived within a framework of individual psychopathology, cannot account for the global affective consequences of terror and distress.*<sup>45</sup>

### **3. The Type and Extent of General Support Available to Survivors of Violence**

Many situations have been described in the literature where war and violence have not resulted in increased rates of psychiatric breakdown. This has often been explained by reference to an increase in general social support and social cohesiveness in times of war. The observation that suicide rates have dropped dramatically during various wars, the apparent lack of any significant increase in psychiatric morbidity in Northern Ireland during the past 20 years<sup>46</sup> and observations from other war-torn communities<sup>47</sup> are testimony to the fact that factors such as community cohesiveness and political

solidarity determine to a large extent how the traumas of war are experienced and coped with.

**Case 4:** A 52 year old Ugandan man described how he had suffered greatly in prison. He told us about the solidarity felt among the prisoners. Even though they were packed into a small cell so that they could barely breathe and were unable to lie down, he told us that there was no fighting amongst them, that they shared food and looked after one another. He reported that every day all prisoners would pray together. The Muslims learnt the Christian prayers and the Christians learnt the Muslim prayers so that they could worship together. He remarked that it was such things that saved him from despair.

**Case 5:** Another 45 year old man who was tortured during counter-insurgency operations in Luwero had both hands cut off by soldiers and was separated from his wife whom he has never seen or heard of since. A remarkable operation, performed by a surgeon in a rural mission hospital, in which the bones and muscles of his forearm were divided had given him some use in one of the stumps, but apart from this he was totally dependent on his neighbours. He was referred to us a victim of torture but when we interviewed him in his home four years after his traumatic experience he reported no symptoms of PTSD or any other psychiatric syndrome. He remarked that the support and solidarity shown to him by his neighbours had allowed him to return to a fairly normal life. His current difficulties were all of a practical nature.

There are however situations where, for various reasons, this social support or community cohesiveness breaks down. One prime example of this is in the case of women who have been raped in war. In many cultures a woman who has been raped is severely socially stigmatised. This was the case in Uganda and for the victims of rape who we interviewed it was clear that the experience of rape had disrupted their sense of community. Most of them had kept this aspect of their lives secret from others and this fact had often led to feelings of alienation.

**Case 6:** A 34 year old woman with five children had been rejected by her husband because of the fact that she had been raped by two soldiers five years prior to her interview with us. He had turned her off the small holding which she had cultivated. As the rest of her own family had perished or been dispersed in the war, she had to survive on what she could find in the bush until ultimately she found her way to the home of some distant relatives who took her in. Unable to explain what had happened to her because of the shame she felt regarding her circumstances and the fear of further rejection if her plight was known, she relinquished any rights she had to the land and to her children and remained in the position of a servant in her relatives' home. Five years later she was still suffering terrible grief over the loss of her children and had had no other relationship during that period. The lack of support because of social attitudes towards rape and the political position of women at that time in Uganda prevented her from asserting any rights she may have had regarding the custody of her younger children.

We found that the mending of social relations was the most important aspect of the healing process for the women in Luwero. Their response, once they felt it legitimate to talk about rape, was to organise themselves into meeting groups that focused on development projects and not specifically on their experience of rape or post-traumatic

symptoms.

#### 4. The Availability and Relevance of Specific Therapeutic Interventions

As mentioned above, Kleinman<sup>21</sup> has pointed to the fact that healing of any sort is a multifaceted phenomenon. Professional-client encounters are only one type of healing relationship and in most societies, particularly in the Third World, form but a small proportion of the whole. In Third World societies traditional healers (the 'folk' sector of the health care system according to Kleinman) are often more important than the professional sector. The particular relationship between different parts of the health care system will, in any society, be determined by socio-economic, cultural and political factors.<sup>48</sup>

When it comes to dealing with the effects of war and violence there is now a considerable literature which points to the importance of traditional beliefs and healers in the recovery process of both individuals and communities. For example Wilson<sup>49</sup> discusses how traditionally many societies had particular rituals which were performed when people returned from war such as the Sweat Lodge purification ritual (*inipi onikare*) of certain Native American groups. Taussig<sup>50</sup> provides an interesting discussion of the relationship between colonial terror and folk healing among the Indians of the Putumayo river in Colombia.

In the Luwero triangle it was apparent that traditional healers (*abasawo abaganda*) were quite numerous and well attended. One of the authors (PB) was able to observe at first hand the healing practices of a number of healers in the village of Kiziba (towards the centre of the triangle) and to discuss their work with them both individually and together in a group. It was generally agreed that all forms of sickness were more common since the war including cases of madness (*eddalu*), foolishness (*obusiru*) and disturbed behaviour (*akalogojjo*) but they did not recognise a particular post-traumatic syndrome. They gave various reasons for the increased incidence of sickness but one common explanation had to do with the drinking of dirty water during the war years. It was thought that the mixing in the person's body of this contaminated water with clean water drunk after the war had ended and the village water supply was restored was the cause of imbalance and, hence, sickness.

It was apparent that the traditional healers were playing a double role during this period. On the one hand they were providing therapies for sick individuals while on the other hand they functioned as a link with the past and thus contributed to a sense of continuity in the community. The healing activities of the traditional healers depended to a large extent on consultation with the ancient spirits of the tribe (*balubaale*). During a healing session the healer would become possessed by the *lubaale* and pronounce on the cause of the sickness and prescribe a remedy. The ceremony of "settling the *lubaale*"<sup>51</sup> was frequently performed and the *balubaale* Mukasa (spirit of the lake), *Kiwanuka* (spirit of thunder) and *Namalere* were often identified. Shrines to some of the *balubaale* were constructed near to the healer's *ssabo* (a round grass hut used for healing purposes). Interestingly, writing before the destruction of the Luwero triangle in 1970, Orley<sup>51</sup> comments that these ceremonies were considered "a little shameful" by his informants and Mbiti,<sup>52</sup> again writing before the Luwero campaigns, observed an overall decline in the *Balubaale* cults. It was our impression that there was a resurgence in the years after the war, in spite of the considerable expense involved and we found little hesitation in

discussing these matters with us.

**Case 7:** A 19 year old ex-soldier was interviewed in a village medical clinic. He complained of headaches and feeling generally unwell. When interviewed he also spoke about nightmares in which he would see friends of his who had been killed in the war and also some of the people he had killed himself. He was very disturbed by these nightmares and believed that he was being visited by dead spirits. He told us that he had joined the army after his father was killed by a rebel group. He was only 16 years old when he had joined. He left his mother and two sisters behind in the home village. He had spent many months engaged in the wartime fighting and was nearly killed on at least two occasions himself. On one occasion he was hurt when a grenade exploded in front of the army lorry in which he was travelling. He was thrown from the lorry and broke his ankle in two places. Because of this he was discharged from the army on medical grounds. When this happened he returned to his home village. Although his ankle healed well and he was able to walk he still felt ill. He found it difficult to settle back into civilian life and became preoccupied with his nightmares. He was seen by our team on a number of occasions and he also attended a traditional healer in his village who diagnosed that he was being persecuted by harmful spirits (*mayembe*). He prescribed the sacrifice of chicken and certain rituals to be carried out by the patient and his family. The patient felt relieved when these had been performed and also felt closer to his family.

Psychotherapy, as practised in western countries, largely takes the form of an individual client consulting a therapist. In Africa and other Third World settings most therapy directly involves other family members and sometimes the wider community. When it comes to responding to the effects of violence western style psychotherapy can have the effect of 'individualising' the suffering of the person involved. Psychotherapy of this mode might be inappropriate and indeed harmful in more "sociocentric"<sup>19</sup> societies where the individual's recovery is intimately bound up with the recovery of the wider community. This is true for individuals and communities still living in the Third World but also for refugees who are living in western countries.<sup>53</sup>

Thus it is apparent that what will be effective healing for victims of violence, will be largely determined by the cultural and social context. Such factors will also determine what types of healing are available. Indeed Herman<sup>54</sup> makes the point that the therapeutic strategies associated with the western discourse on trauma have only become available because of particular political developments during the past 20 years:

*The systematic study of psychological trauma therefore depends on the support of a political movement. Indeed, whether such study can be pursued or discussed in public is itself a political question. The study of war trauma becomes legitimate only in a context that challenges the sacrifice of young men in war. The study of trauma in sexual and domestic life becomes legitimate only in a context that challenges the subordination of women and children.*<sup>54</sup>

### **The Use of PTSD as Testimony**

It has been suggested that medical formulations such as PTSD are of most value in their use as instruments of testimony against torture and violence. Thus Goldfield et al.<sup>29</sup> argue that:

*The medical verification of injuries caused by torture can provide powerful testimony to its occurrence ... the application of a rigorous medical approach to the patient who has survived torture will not only provide these individuals with the best possible care, but will contribute to the international recognition and eradication of this inhumane practice.*

The need for medical care for victims of torture is not in dispute here. And we agree with Harrell-Bond's contention that an 'over-socialised concept of man' in reference to Third World societies can lead to an underestimating of the individual psychological suffering in times of war and violence.<sup>55</sup> What is in question, however, is the notion that psychological responses to torture and trauma can best be accounted for within the categories developed by western biomedicine. Such an approach plays down the contextual relativity of responses to violence in order that a 'powerful' weapon of testimony can be developed. While we would not dispute the validity of such an approach in some situations, we would suggest that contained therein is the danger not only of medicalising the suffering brought about by torture and trauma, but also of medicalising and 'professionalising' the process of testimony and therefore of the struggle against these forms of violence. There is, of course, a serious dilemma here for mental health workers. Swartz and Levett have discussed this issue with reference to the impact of political repression on the mental health of children in South Africa:

*By pointing to symptom clusters which are verifiable by a range of professional experts (regardless of their ideological orientation) they (progressive professionals) may be able to strengthen the cause of people opposed to current regime, whether by lending scientific credibility to protests against abuses or by more means (such as assisting with damages and compensation claims). On the other hand, progressive professionals are not generally interested in reproducing the elitist and alienating excesses of a mental health industry which is based on assumptions of the type that people respond to hardship with psychopathology, which, in turn, needs to be treated by experts.<sup>56</sup>*

As Foucault has pointed out, all forms of knowledge operate within certain political contexts.<sup>57</sup> Psychiatric nosologies and therapies emerged within the context of a professional struggle for hegemony in the area of madness and mental distress. This struggle is continuing and lay campaigners against torture and violence need to be aware of the implications for them of what Rose<sup>58</sup> has termed "the proliferation of sites for the practice of psychiatry".

## **Conclusions**

Political violence, war and other forms of man-made disaster are particularly prevalent in parts of the Third World. Such traumas add immensely to the health problems of such countries. UNICEF estimate that over half a million infants and children under five years, died between 1980 and 1986 either directly or indirectly as a result of the wars in Mozambique and Angola.<sup>59</sup> In addition to the deaths and physical disabilities caused by such violence, the survivors are left with the psychological and social effects of bereavement, torture, rape, starvation and numerous other forms of trauma. Such countries are often left with shattered health services and consequent dependence on foreign personnel and aid. In the western world there is an increasing effort to provide psychological support to the victims of disasters, hijackings, rape and other forms of

trauma. Such support is now seen as a vital part of the medical response to such happenings.

If we are not aware of the biomedical emphasis which is at the heart of much of modern psychiatry, and the assumptions underlying such an approach, we can all too easily end up imposing an inappropriate understanding of trauma which cannot deal with important social and political dimensions.

All scientific approaches to understanding use metaphors at a very basic level. Certain metaphors underlie the approaches of modern biomedicine and psychiatry. Even though these metaphors may be the source of problems for the conceptualisation of psychiatric illness in the West, at least in this part of the world they are metaphors widely used and endorsed by society. In parts of the world where such forms of understanding are not the norm the introducing of concepts such as PTSD based as it is on a likening of the mind to an 'information processing instrument' may be at best confusing. Fear and suffering are facts of human life that belie simple explanatory models, and attempts to account for them in terms of such models have to be, at most, tentative.

If we ignore these problems, we are at risk of introducing inappropriate treatment models and strategies in our attempt to help the rehabilitation of individuals and communities who are the victims of violence and trauma. In addition, because such models of therapy involve expertise, training and a new 'language', the possibility of creating a new 'expert syndrome' arises and with it the possibility of undermining already existing medical and non-medical approaches to the alleviation of distress caused by organised violence. This in turn may have the effect of undermining local community structures, the very forces which act as 'protective' elements with regard to the effects of trauma and the very structures which need to bear testimony in their own terms.

Our argument is not that the concepts of PTSD and the other syndromes mentioned be abandoned, but rather that their limitations be recognised, and their use in non-western situations approached with caution. We would suggest that the most fundamental principle is that recovery over time is intrinsically linked to reconstruction of social and economic networks, cultural institutions and respect for human rights. Recognising these dynamics will not only assist us in understanding why some victims become psychological casualties but also, perhaps the most resonant question of all, why the large majority do not.

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