Rethinking Mental Health Work with Survivors of Wartime Violence and Refugees

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Of late there has been a proliferation of centres and programmes providing mental health care for refugees and victims of violence. This proliferation has mainly occurred in Western countries, but an increasing number of projects have been delivered to Third World war zones in the name of the treatment of 'war trauma'. Western psychology and psychiatry provide the theoretical and therapeutic tools which are used by most of these projects. This paper argues that because these tools are not value neutral, there are profound ethical problems associated with this work. The insights developed by a number of post-modern theorists are used to provide a framework for discussing these problems.

Introduction

Recent years have seen a great increase in the number of programmes established to provide psychological help for refugees and victims of wartime violence in both Western and non-Western countries. Such programmes have, in the main, shared the conceptual and theoretical framework developed in Western psychology and psychiatry around issues of trauma and stress. These developments appear obviously ethical in nature: what could be more right and proper but to offer counselling and therapy to those who have suffered so terribly at the hands of their fellow men?

In this paper, however, we will argue that to address adequately issues of ethical concern in the mental health care of refugees who have suffered violence requires an understanding of recent developments in the wider area of ethical discourse, in particular the way in which a number of intellectual influences such as feminist and post-colonial critiques have destabilized many traditional notions of morality and order. These influences have played a major role in the development of what we shall refer to as a 'postmodern' perspective. We are aware that the concept of 'postmodernity' and the related concept of 'modernity' are somewhat nebulous and highly contended. In the next section we discuss the meaning of modernism and modernity and later in the paper discuss, at length, the concept of a postmodern ethics. However, at this point it is important to make the following distinction. The term 'postmodernity' is often used to refer to a contemporary social, cultural and political condition, something we simply find ourselves in the midst of. We will use the term in a more positive way to refer to a way of reflecting upon the world and our place within it. In other words, it is a concept of postmodernity as:

... a form of reflection upon and a response to the accumulating signs of the limits and limitations of modernity. Postmodernity as a way of living with the doubts, uncertainties and anxieties which seem increasingly to be a corollary of modernity, the inescapable price to be paid for the gains, the benefits and the pleasures, associated with modernity (Smart 1993: 12).
In this paper we shall examine some of the implications of a postmodern philosophical framework for questions about the mental health care of refugees and survivors of violence. Our basic argument will be that the ethical concerns of the 1970s and 1980s which led to the establishment of special medical and psychotherapeutic centres for the care of victims of torture and other forms of organized violence were themselves, to some extent at least, products of a Eurocentric modernist agenda. In addition we shall argue that the most pressing ethical issue of the present moment is the need to question fundamentally this agenda.

Mental Health Ethics and Work with Victims of Violence

The increased credence attached to the explanatory models of science, and the associated importance given to professionals involved in applying these models, are important examples of what has been called cultural 'modernism'. This term 'modernism', and the associated notion of 'modernity', are used here to refer to the dominant cultural and intellectual agenda at work in industrialized societies during the past few hundred years. It is an agenda framed in the period of the European Enlightenment and developed over the last few centuries in tandem with the economic and social development of Western countries. Modernity involves a valorization of reason and science and a disregard for tradition, religion and disorder. It has also been associated with the rise of humanism and an increasing focus upon individual subjectivity as the source of reason and order. In medicine, psychiatry and social science modernity has been associated with the hegemony enjoyed by positivism as a guiding philosophy over the past two hundred years. Indeed, in the work of Foucault (1971), the emergence of a positivist psychiatry itself can be understood to be a triumph of the modernist vision. In essence psychiatry has sought to convert the human sufferings of madness, misery and alienation into technical problems which can be understood in standardized ways and which are amenable to technical interventions. Such interventions can be formulated in specialized languages and transferred geographically and culturally without difficulty.

The task for the discourse of ethics in this framework is to contemplate the various interests involved when such techniques are being applied. The goal of much current medical ethics discourse is to produce formulae and codified principles to guide this application. In the modernist framework, knowledge and technique are separable from issues of value and morality. Thus traditional psychiatric ethics can be characterized by the following assumptions:-

1. Psychiatric knowledge is similar to medical knowledge in that it is, essentially, applied science. The scientific research upon which it is based is biological, psychological and social.
2. As such, psychiatric knowledge is objective, disinterested and neutral. Psychiatric techniques and therapies are themselves value free.
3. Psychiatric ethics is essentially a rational discourse which clarifies the various values and interests at stake when psychiatric knowledge is being used in particular situations.

In this vision, the possibility that psychiatry itself is a cultural product is not raised. Its classifications, its diagnoses, its therapies are accepted as neutral, and are understood to be separate from questions of ethics. In turn, traditional psychiatric ethics is not concerned to examine underlying assumptions but rather to produce codes of practice.
and to clarify principles of intervention.

The emergence of centres for the psychological treatment of victims of torture and refugees also reflects certain core themes in the modernist agenda. The human pain of war, torture, rape, exile and loss might be seen to constitute the greatest challenge to modernist endeavour; the ultimate quest being to render such suffering amenable to standardized measurement, analysis and intervention. World religions have struggled with the question of pain and suffering for centuries, but in the modernist paradigm this enters the realm of medical and social expertise. Psychiatry has readily responded to the challenge. Using formulations such as Post Traumatic Stress Disorder, and sets of therapies ranging from behavioural to psycho-dynamic, it has, in recent years, focused on the mental health problems of refugees, successfully arguing for special centres, programmes and research in this area.

In this framework, ethical issues become primarily issues of availability. What appeared most obvious and pressing in the 1970s and 80s was the apparent lack of access of refugees and victims of war to medical and psychiatric services. In Western settings the problems were largely seen as linguistic or cultural, preventing the refugees from getting the therapy they seemingly so obviously needed. Such ethical concerns demanded solutions in terms of special programmes. These concerns reverberated with the other cultural preoccupations of Western societies during this period. Thus the increased attention being paid to individual subjectivity has been associated with an ever increasing sense of personal vulnerability. There is now a felt need for counselling and therapy in every corner of life (Rose 1989). This preoccupation with vulnerability served to highlight the apparent scandal that those who had suffered so much were being given so little individual attention.

In other words, it is possible to interpret the emergence of therapeutic centres for refugees and victims of torture as one product of the great modernist project which is aimed at controlling the disorder provoked by suffering and loss through instituting programmes of analysis and therapy. Such programmes are now being exported with considerable zeal to victims of war in non-Western countries. In our experience, the dominant ethical agenda in this work concerns the development of codes of practice: principles of access and intervention which will allow for refugees and others to benefit from progress in the area of psychiatry and psychotherapy.

There are many examples which would suggest that confidence in the modernist programme remains undaunted even now in 1997. However, serious doubts have arisen and there are now pressing reasons, both theoretical and practical, to question modernist assumptions about psychiatry, ethics and the needs of refugees and other victims of war.

Postmodern Ethics

In everyday usage the term 'ethics' has a very wide reference, and it is difficult to give a single definition to which all would subscribe. However, ethical concerns, in general, refer to an attempt to bring some order to judgements of right and wrong, good and bad. Ethics is usually understood to embrace issues of morality and moral judgement. Yet recently this linkage of ethical theory with moral issues, in appearance so obvious, has been called into question. For example, Bauman argues that ethics, not morality, is the concern of 'experts': philosophers, educators and preachers. It is detached from everyday
life. He suggests that:

Ideally, ethics is a code of law that prescribes correct behaviour 'universally'- that is, for all people at all times; one that sets apart good from evil once and for all and for everybody. This is precisely why the spelling out of ethical prescriptions needs to be a job of special people like philosophers, educators and preachers (Bauman 1995:11).

Contemporary ethical theory is, according to Bauman, a product of modernity—a search for rational, universal, foundational ways of understanding the world and determining our place in it. We are now witnessing a major decline in the hold of modernity. Faith in reason, order and science is being rapidly undermined, and postmodern, anti-foundationalist philosophies and ideas are now coming to the fore. Bauman, who overtly embraces the concept of postmodernity, argues that the modernist search for codification, universality and foundations in the area of ethics was actually destructive of the moral impulse. He argues for a 'morality without ethics'. For Bauman postmodernity is not about the 'demise of the ethical' or about the 'substitution of aesthetics for ethics' as is often assumed and sometimes proclaimed. Rather, it is about facing up to the real moral dilemmas which confront us, without recourse to the illusion that there will always be a rational correct solution. For Bauman, modernity was animated by a belief in 'the possibility of a non-ambivalent, non-aporetic ethical code' (the term aporia refers to a contradiction that cannot be overcome, one that results in a conflict that cannot be resolved). He says:

It is the disbelief in such a possibility that is postmodern... The foolproof - universal and unshakably founded - ethical code will never be found; having singed our fingers once too often, we know now what we did not know then, when we embarked on this journey of exploration: that a non-aporetic, non-ambivalent morality, an ethics that is universal and 'objectively founded', is a practical impossibility; perhaps also an oxymoron, a contradiction in terms (Bauman 1993:10).

In his book Political Theory and Postmodernism (1991), White has clarified some of the ethical issues at stake in the modernism/postmodernism debate. White distinguishes two senses of the concept of responsibility, a key term in ethical discussion. The more familiar is a responsibility to act in the world in ways which are justifiable. This is associated with an obligation to acquire reliable knowledge to guide one's actions, and is essentially concerned with issues of practical effectiveness. This sense of moral responsibility is most familiar to us because it is firmly attached to the modernist vision. It requires ethical principles firmly grounded in rational analysis and universally valid. Our suggestion is that the ethical motivation behind many recent mental health programmes for refugees has been a product of just such a responsibility to act.

A postmodernist ethics has gradually emerged from the work of a number of thinkers, perhaps most obviously from the work of Foucault (Bracken 1995). In his writings we find the clearest account of what the other type of responsibility is all about. Much of Foucault's work has been concerned to demonstrate the constructed nature of some of our most established assumptions. Our notions such as selfhood, sexuality and reason are shown in his work to be historically contingent cultural products. We do not experience them as such but rather take them as somehow given. Foucault's aim is to show that the order produced in our lives by such givens is not established without cost. As White indicates, Foucault shares with other postmoderns:
a strong sense of responsibility to expose and track the way our modern cognitive machinery operates to deny the ineradicability of dissonance. The harmony, unity, and clarity promised by this machinery have, for the postmodern, an inevitable cost; and that cost is couched in a language of the Other that is always engendered, devalued, disciplined, and so on, in the infinite search for a more tractable and ordered world (White 1991:20).

Thus emerges the other sense of responsibility; a responsibility to otherness. This involves a concern not to impose order on the world but instead to allow the emergence of other voices and visions, even when this involves increasing complexity and ambivalence.

The notion of a postmodern ethics does not resolve any of the great problems or dilemmas of modernity. However, it can make a claim to greater honesty:

What the postmodern mind is aware of is that there are problems in human and social life with no good solutions, twisted trajectories that cannot be straightened up, ambivalences that are more than linguistic blunders yelling to be corrected, doubts which cannot be legislated out of existence, moral agonies which no reason-dictated recipes can soothe, let alone cure (Bauman 1993:245).

Postmodern ethics is not about a situation where 'anything goes'. It is rather about facing the world without easy recourse to guiding codes or principles. It is about an acceptance that ambivalence and disorder are aspects of life which we should embrace, not just temporary difficulties which need to be overcome by further analysis, or the application of ever more structured ethical systems.

Postmodern thinkers would contend that by focusing on the responsibility to act, traditional ethics has had to:

fix or close down parameters of thought and to ignore or homogenize at least some dimensions of specificity or difference among actors. To act in this sense means inevitably closing off sources of possible insight and treating people as alike for the purpose of making consistent and defensible decisions about alternative courses of action. The modern thinker associates the commitment to this sense of responsibility with self-justification either in the sense of moral-uprightness or pragmatic effectiveness. The postmodern thinker, however, sees a deeper, unacknowledged will to mastery at work here (White 1991:21).

**Psychiatry and Survivors of War**

*Refugees in Western Countries*

The appearance of special programmes for the psychological treatment of refugees and other survivors of war and atrocity has had a number of different, largely unanticipated effects. However, these effects only become visible when one stands back from the modernist responsibility to act discussed above and begins to cultivate an ethical sensibility concerned to avoid an 'ordering' of the experiences of refugees. This has happened at a time when what can be described as a 'culture of victimhood' has emerged within Western society, in which admission to one or another victim group confers
psychological and moral advantages (Hughes 1994). Because of their knowledge, doctors and other professionals have become the prime authenticators of suffering and legitimators of the sick-role and now stand as 'gatekeepers' to many of these victim groups.

In the 20th century there has been a spectacular growth within Western culture in the power of medical and psychological explanations for the world, and in the pronouncements of mental health professionals. Terms like 'depression', 'stress', 'trauma', and 'emotional scarring' have come into common usage by a psychologically-minded general public, frequently denoting candidature for professional help. The concept that some adverse experiences (and the list is lengthening) might have long-term psychological sequelae has come to seem natural and self evident. As with other aspects of Western culture, these trends have been globalizing. For example, Foster and Skinner (1996) describe how former political detainees in South Africa used to frame their stories in terms of themes relevant to their own calling and values: Biblical, legal, political, humanist. But more recent accounts by them have been utilizing the language of psychological effects, indicating how the Western trauma discourse is shaping and regulating experiences of violence.

The development in Western countries of special centres and programmes for the care of refugees who are victims of torture and organized violence has had a number of implications. One of the inherent messages involved in such developments is that the suffering of traumatized refugees is of a 'special nature' and that there is a need for special expertise in caring for such people. This message means that professionals who work with refugees are often moved away from the provision of care, into a role primarily involving the authentification of the effects of torture. In this role it serves the short-term interests of the professionals to further develop the 'special nature' message. This is because their testimony is powerful only to the extent that their expertise is real. If traumatized refugees are not understood to have any specific forms of suffering, then the testimony of sympathetic professionals becomes simply that: sympathetic.

However, this 'special nature' message can increase the sense of 'otherness' associated with the person who has suffered torture. The authors are aware of situations where general practitioners have been afraid to discuss emotional issues with people who have suffered torture because they felt lacking in the 'expertise' to do so. As a result these people were left feeling excluded and stigmatized. In this situation they become narrowly defined as 'torture cases'. Yet most refugees have not survived a single clear-cut traumatic event, but a web of negative (and even some positive) experiences of war or oppressive societies. A torture experience will not necessarily be clearly separable from the other experiences, and some refugees have told us that torture was not the worst thing that had ever happened to them.

Thus professionals can end up in a somewhat distorted role, using a problematic expertise to authenticate victimhood. In turn the asylum seeker referred to such a programme can be led to view him/herself as primarily a victim of torture, requiring special psychological help. This self-identity can become self-perpetuating. The following may serve as an example. Torture has been endemic in Turkey for many years and has been discussed widely. However, it is clear that not all ill treatment there is considered torture by everyone. Kurdish men are routinely assaulted during interrogation at police stations, including beatings on the sole of the feet (falaka). Such
treatment is part of the victimization of this persecuted ethnic group, but it is also evidence of their capacity to endure and resist. When some finally seek asylum in the West, they can find their experiences reconstructed in toto as torture. This may carry a short-term advantage if it generates a medical report which may improve their chances of refugee status. But at the same time, the label carries with it Western ideas of hapless victimhood, and of exquisite and enduring individual mental injury, to which they would not necessarily have subscribed back home. Similar questions were raised in 1994 by Eastmond and her colleagues in Sweden in relation to the reception of refugees from Bosnia:

while the Swedish policy of refugee assistance in the 1970s focused on material support and rapid labour market integration, there was little awareness of psychological needs. Today, there is a growing recognition of such needs and an increase of centres for the care of survivors of organized violence but great problems in integrating refugees into the labour market.

On the basis of their involvement with a group of Bosnian refugees they ask:

whether access to extensive psychological assistance may in fact facilitate creating and maintaining a sick role as traumatized victims and promote helplessness, in the absence of other structures to reconstitute a meaningful life (Eastmond et al. 1994:9).

Apart from the fact that their very existence can promote a sense of victimhood, special programmes also develop and use a knowledge of trauma which is usually located firmly within the framework of Western psychology and psychiatry. As discussed above, these disciplines are very much an aspect of modernist endeavour, premised on the location of distress in separate individuals and using a scientific secular form of understanding. This framework may be constructed on assumptions very different from those of the refugee's own culture. In spite of this, the tendency is for the refugee gradually to see his/her predicament in the terms of the professional discourse. Initially this might seem to be of practical advantage. The refugee wants to appear as intelligible and attractive as possible to the professionals he/she meets. They are seen as significant potential allies at a time when there are few others. Thus he/she may begin to organize and present his/her distress in a 'modern' way (that is, one that fits Western psychological ideas and categories) simply to have his/her suffering recognized. Gradually, however, the tendency is for this culturally consonant framework to become totally adopted by the refugee.

Within the modernist vision this move is unproblematic. It is assumed that the individual is being helped to see his/her problems in a more detached or scientific way. By doing this it is assumed that he/she will be more in control of his/her distress and thus able to cope better. However, in the context of an ethic which seriously values a responsibility to otherness it becomes apparent that this incorporation of a new cultural paradigm in relation to one's suffering can have serious negative consequences. Inherently it involves a loosening of one's ties to the home culture, the very culture whose myths or religious idiom may be important sustaining factors. Eisenbruch (1991), in his elaboration of the concept of 'cultural bereavement', points out that young Cambodian refugees seemed to fare better in Australia that in the US. In Australia there was less pressure to conform to the dominant culture and there were more opportunities to practise traditional ceremonies. In addition, the framework of Western psychology is
highly individualistic. By adopting this framework of understanding, refugees can begin to regard themselves as particular cases. Their current suffering is understood to be the product of their own individual traumas and their own failure to cope. This can also be an isolating influence, undermining the connections between their own suffering and the political or religious struggle from which it emerged. Lastly, adopting this framework, which generally involves an emphasis on the need for therapy or counselling, can lead refugees to undervalue their own capacity for survival and endurance. This tendency resonates with the push towards victimhood discussed above.

**The Export of Western Psychiatry**

The recent 'discovery' of 'war trauma' as an international humanitarian issue is in line with these developments. The Western mental health professional has acquired new prominence in a burgeoning area of operations premised on the understanding that there is a psychological fallout of war for whole populations and that this needs to be addressed in its own right. War is seen as a sort of mental health emergency, with frequent references to post traumatic stress as a 'hidden epidemic'. Agger et al. (1995), who were consultants to the European Community, WHO and UNHCR, claimed that 700,000 people in Bosnia-Hercegovina and Croatia were suffering from severe psychic trauma and in need of urgent treatment, and that local professionals were able to address less than one per cent of these. They warned that post traumatic stress was going to be the most important public health problem in former Yugoslavia over the next generation and beyond. UNICEF claims that 10 million children have been psychologically traumatized by war in the past 10 years and that psycho-social trauma programmes must be a cornerstone of their rehabilitation.

These expansive claims have justified the rush by many agencies to provide psycho-social trauma programmes in many diverse war settings, most notably in Bosnia and Rwanda. Such work has been fashionable enough to command large budgets, despite the paucity of evidence that war-affected people see their mental health as a priority issue to be addressed separately from their other concerns, and still less that they would want it tackled by projects conceived and led by outsiders. Amongst those from whom this 'epidemic' was hidden, it would seem, were those supposedly carrying and incubating it! The direction of the concerns of the vast majority of survivors is not inwards towards their mental lives, but outwards towards their devastated ways of life, social, economic and cultural institutions. These programmes seem to bring a message that mental wellbeing and health is to do with introspection rather than action in the social world (Summerfield 1996).

How do these interventions relate to the questions of justice and reparation which preoccupy victims of organized violence and which, arguably, shape how they process it? One reason for the current popularity amongst Western donors for 'trauma' may be that this focus on the mental rather than the social world of victims generates a relatively pristine, politics-free domain of operations which avoids the more complex and messy problems that wars and refugee crises throw up. The expansive claims mentioned above fit well with a modernist ethic which seeks to avoid such problems and can be seen to emerge directly from a need to 'do something quickly', from a responsibility to act.
Conclusion

The current and widespread moves to establish special centres and programmes for the psychological care of refugees are extremely problematic. Persecution and exile are experiences which cause intense pain and suffering. Those who escape and seek asylum elsewhere deserve support and assistance in a number of ways, including appropriate medical interventions. Above all, however, that such people deserve respect and our interventions should not have the effect of undermining their own knowledge and choices upon which individual and communal ability to survive, struggle and generate new meanings and identities for their lives in exile must be based. The central ethical challenge for those who work in this area is to make this notion of respect the cornerstone of our involvement. Our major contention is that the traditional framework in which psychiatric ethics has been developed is inadequate, in that it separates knowledge and technique from questions of value. Such a separation is currently untenable.

The current fashion for Western agencies developing projects for victims of war abroad begs similar questions. Western psychological concepts are increasingly being presented as if they alone represent the one definitive psychology, assumed to be universally applicable. There is now a considerable literature which would question this assumption (Bracken 1993). As Berry et al. (1992) put it, there is a danger that this dominance will perpetuate the colonial status of the Third World mind. In a previous century, white missionaries from European countries brought another 'truth' to the Third World. These Christian missionaries assumed the superiority of their world vision and travelled abroad with a genuine motivation to improve the spiritual life of various peoples around the world. We now know how destructive and undermining the export of this religious world vision turned out to be for many native people.

It was in an attempt to undo some of this damage that Biko and others formed the Black Consciousness Movement in South Africa. In a paper delivered at a conference of black ministers of religion held in Natal in 1972 Biko said:

it has always been the pattern throughout history that whosoever brings the new order knows it best and is therefore the perpetual teacher of those to whom the new order is being brought. If the white missionaries were 'right' about their God in the eyes of the people, then the African people could only accept whatever these new know-all tutors had to say about life (Biko 1988: 70).

In many ways science and technology have replaced Christianity in Western countries as the dominant way of ordering our thoughts about the world, about life and about death and suffering. The emerging discourse on trauma emerges clearly from this scientific and technological orientation. The challenge to Western NGOs and other agencies dealing with refugees and other victims of violence around the world is to establish ways of supporting people through times of suffering by listening and hearing their different voices in a way that does not impose an alien order. It is a challenge which demands that we work with a spirit of humility about what we can offer, and an acceptance that there is no quick fix or magic bullet that will rid people everywhere of the suffering brought about by violence.
Trauma projects which seek to objectify 'suffering' as an entity apart, converting it into a technical problem to which are applied technical solutions like Western talk therapies, are discounting indigenous knowledge, capacities and priorities (Bracken et al. 1995). Such projects aggrandize the Western expert who defines the problem (e.g. post traumatic stress disorder) and brings the cure; too often it is the same problem and the same cure, whether to Cambodia, Rwanda or elsewhere. These trends also set up dilemmas for indigenous organizations serving war-displaced peoples. Their workers see that the central problem is the broken social world of their people, including poverty and lack of rights, but are finding that it is often easier to obtain funding from Western donors if they portray it as 'trauma' whose antidote is 'counselling'.

One of the guiding principles of medicine since the times of the ancient Greeks has been 'to do no harm'. To work with this principle we must constantly examine our own accepted ways of thinking about the world and constantly question the assumptions from which our practices spring. To engage in such an examination with honesty and without guiding codes would be an example, we believe, of the sort of morality suggested by Bauman or the responsibility to otherness discussed by White. Our argument is that such an examination is what is most urgently needed now in the area of mental health care for refugees.

References


