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The Impact of War and Atrocity on Civilian Populations:

Basic Principles for NGO Interventions and a Critique of Psychosocial Trauma Projects

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The Impact of War and Atrocity on Civilian Populations: Basic Principles for NGO Interventions and a Critique of Psychosocial Trauma Projects

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Abstract

Current patterns of violent conflict worldwide mean that over 90% of all casualties are civilian and the terrorisation of whole populations is used as a means of social control. Victims must also endure the deliberate demolition of their economic, social and cultural worlds. How such events are understood is crucial in determining the ways war-affected populations experience and describe them, and the forms of coping and help-seeking brought into play. These are complex and dynamic processes, with outcomes shaped by social, cultural and political forces.

Psychosocial projects drawing on western trauma models have had a sharply increased profile in recent years and this paper offers a critique of this work, using Bosnia and Rwanda as particular examples. The ordinary distress and suffering of war is liable to redefinition as a psychological condition - 'traumatisation' - requiring professional attention or treatment in its own right. For the vast majority, 'traumatisation' is a pseudo-condition. This rather narrow approach risks creating inappropriate sick roles and sidelines a proper incorporation of people's own choices, traditions and skills into strategies for their creative survival. It also aggrandizes the role of western experts and their mental health technology, which is assumed to be universally applicable.

As well as solid background knowledge about the characteristics of modern conflict, international relief workers need to be as informed as possible about the social, cultural and historical dimensions of its impact in the particular locality to be served by a project. A basic premise for effective interventions is the quality of the relationship forged with those we want to assist. From this may flow projects which are based on the priorities of users, do not challenge their own cultural frameworks and interpretations, and hopefully, are able to respond to evolving circumstances and choices.

The core issue is the role of a social world, invariably targeted in conflict and yet embodying the capacity of survivor populations to manage their suffering, adapt and recover: this means a collective, not individualised, focus. The 'psycho-' prefix of psychosocial work is misleading and should be dropped. Emphasis should be placed on social development/rehabilitation principles, to which can be grafted those additional issues thrown up by crises which are man-made rather than natural. In particular, this means an overall approach which locates the quest of victims for rights and justice as a central and not peripheral issue.

The Impact of War and Atrocity on Civilian Populations: Basic Principles for NGO Interventions and a Critique of Psychosocial Trauma Projects

1. An Epidemiology of Modern Conflict

1.1 Overview

There are currently on average at least 50 armed conflicts active in the developing world in any one year. Torture is routine in over 90 countries. 5% of all casualties in World War I were civilians, 50% in World War II, over 80% in the US war in Vietnam, and currently over 90% (UNICEF, 1986). In their 'The State of the World's Children 1996', UNICEF says that in the last 10 years, 2 million children have died in war, a further 4-5 million have been wounded or disabled, 12 million made homeless and 1 million orphaned or separated from parents. At present the United Nations High Commission for Refugees (UNHCR) counts 18 million refugees who have fled across an international border, a sixfold increase on 1970; as many again are internally displaced and often no less destitute. This totals one person in 125 of the entire world population. 90% of all war refugees are in developing countries, many amongst the poorest on earth. 2.5-5% of the refugee population are unaccompanied children.

A key element of modern political violence is the creation of states of terror to penetrate the entire fabric of grassroots social relations, as well as subjective mental life, as a means of social control. It is to these ends that most acts of torture and violence towards civilian populations are directed, rather than to the extracting of information. The mutilated bodies of those abducted by security agents, dumped in a public place, are props in a political theatre meant to stun a whole society. Not only is there little recognition of the distinction between combatant and civilian, or of any obligation to spare women, children and the elderly, but the valued institutions and way of life of a whole population can be targeted. It is depressingly clear that such strategies are highly effective. Mozambique stands as an example for the 1980s: Renamo guerillas sponsored by White South Africa, murdered around 150,000 peasants in cold blood, displaced three million others and left the social

fabric of large areas of the country in tatters. Moreover, in many settings there is an increasingly fine line between political and criminal violence, with security forces involved in unbridled profiteering, black marketing and extortion.

Women in War

Sexual violation is an endemic yet poorly visible facet of violent conflict (Swiss & Giller, 1993). The plight of 200,000 South-East Asian women during World War II, abducted to provide sex 20-30 times per day for Japanese soldiers, has only recently been highlighted in the West. 80% of these 'comfort women' were Korean. For nine months in 1971, after the declaration of independence from Pakistan by Bangladesh and the entry of Pakistani troops to quell the rebellion, it is reliably estimated that between 200,000-400,000 Bengali women, 80% of whom were Muslim, were raped by soldiers (Makiya, 1993). In Mozambique and elsewhere, women have been abducted and effectively enslaved in large numbers. In Iran, detained teenagers executed for political reasons have first been raped, denying them the automatic entry to heaven granted to virgins (Parliamentary Human Rights Group, 1994). Cambodian and Somali women have faced sexual violation before and during flight, and in refugee camps in Thailand and Kenya respectively, sometimes by camp authorities or local police. In India, women community organisers and human rights workers appear to be prime targets for rape. In Iraq under Saddam Hussein, licensed rapists are employed as civil servants by the state and many prisons are reported to have specially equipped rape rooms. In Arab/Islamic culture, the honour of a family is located in the bodies of the women of that family, in their virginity, the clothes they wear and the modesty with which they deport themselves. Most recently, there were the well-publicised systematic rapes of Bosnian Muslim women by Serb militia. Under-reporting of rape by victims is probably universal because of the associated stigma.

The role of women during war has been almost exclusively related to victim status. This has tended to obscure the extent to which women made significant contributions to political struggles in countries such as Eritrea, Ethiopia and Nicaragua. Moreover, the genocide in Rwanda in 1994 has shown women - both educated and peasant - taking up a rather darker role, that of perpetrator (African

Rights 1995).

Assaults on health workers and services

Violations of medical neutrality are a consistent feature worldwide and follow predictably from the way modern war is premised and played out. In Nicaragua, destruction of rural health clinics and targeting of their staff by Contra guerillas was meant to demonstrate that central government could not protect what was valued by its citizens. 300,000 people (15% of the rural population) were left without any healthcare (Garfield & Williams, 1989). Many health workers were forced to operate in clandestine fashion in the countryside, burying their equipment and medicines at night, thus impeding the effectiveness of primary health work, for example immunisation, which depended on advance publicity. In El Salvador, the extra-judicial execution or 'disappearance' of more than 20 health professionals in the first six months of 1980 set the tone for much of the decade. Soldiers made incursions into hospitals and surgeons were assassinated in mid-operation on suspicion that they were prepared to treat 'subversives'. The practice of medicine or community healthcare in rural areas was regarded by the military as linked to subversion, since the health worker was a source of advice and support to the peasant population. The bodies of health workers were left for discovery in a mutilated state - decapitated, castrated or with "EM" (Spanish initials for 'death squad') - carved in their flesh. The purpose of such brutality was clearly to terrorise by example. In Mozambique, 1113 primary health centres, 48% of the national total, were destroyed and looted, leaving two million people without access to healthcare of any kind. Mines were laid around hospitals and in the massacre of 494 people at Homoine in 1987, pregnant women were bayonetted in the maternity unit and other patients kidnapped. 45% of all primary schools were forced to close. More recently, hospitals in Croatia and Bosnia were repeatedly mortared by Serb forces and patients killed; at Vukovar, 261 staff and patients were taken away for execution. In the Occupied Territories, the Israeli army has fired into hospitals and arrested patients, refused to allow seriously ill Palestinians to reach hospitals during curfews, has assaulted, detained and tortured health workers and obstructed delivery of key medicines (Physicians for Human Rights, 1993). The United Nations Relief and Works Association reported that in 1990 alone, Israeli soldiers forcibly entered

its clinics and hospitals 159 times. At Saddam Hospital in Najaf, Iraq in 1991, army troops molested female doctors, murdered patients with knives or threw them out of windows. Other doctors were executed in public by firing squads.

Even international peacekeeping operations are not immune to violations of the Geneva Convention regarding the neutrality of medical services. On 17 March 1993, United Nations forces in Somalia, in pursuit of the warlord General Aideed, deliberately attacked Digfa hospital in Mogadishu. Nine patients were killed and there was extensive destruction of scarcely replaceable equipment and supplies. The hospital was immediately evacuated, decanting hundreds of patients into the war-torn city; it is not known how many more died as a result.

Assaults on culture and ethnicity

Another key dimension is the crushing of the social and cultural institutions which connect a particular people to their history, identity and lived values. Middle East Watch et al (1993) documents that the Iraqi government campaign against their Kurdish population in the 1980s amounted to genocide within the meaning of the Genocide Convention of 1951. This included the use of poison gas - a mixture of mustard and nerve gas - dropped by aircraft, most notoriously on the town of Halabja in 1988, in which 5,000 civilians were killed. In all, 182,000 Iraqi Kurds have disappeared after mass removals in the style of Nazi Germany or Stalinist Russia; most are believed dead. Their villages, with every building razed by explosives, have ceased to exist. Since their invasion in 1977, the Indonesian authorities have murdered an estimated 200,000 East Timorese, an ethnically distinct people. This is nearly one third of the total population. The Pol Pot regime in Cambodia murdered between 1.5 and 3 million people, 20-40% of the total population, in only 4 years from 1975. In a deeply religious land, Buddhist monks were singled out for execution and more than 90% succumbed. So too was anyone found to speak French or even those wearing spectacles, since these were considered marks of the educated and modern. In Guatemala, 440 Indian villages were wiped from the map during the 1980s, regarded by this victimised population as part of a 500 year old attack on their Mayan culture. The Serbs did not invent ethnic cleansing. At least 1.5 million people died in the Sudanese civil war during

the 1980s; repeated large massacres of Dinka civilians were poorly reported in the outside world.

In Turkey, the Kurdish culture and language has long been suppressed and children must speak Turkish in school, a persecution which has fostered violent revolt by Kurdish activists. In South Africa, it was protest against Afrikaans as the medium of education, regarded as the language of the oppressor, which sparked the Soweto riots of 1976 in which around 500 black children were shot dead by the authorities. In Iraq, Saddam Hussein mounted a devastating assault against Shia cultural and religious life in early 1991. Within a few weeks, some 5,000 religious scholars and students from Najaf alone had been arrested and all the religious schools shut down. Many were executed. Mosques and their ancient cemeteries were levelled, the Golden Dome of the Shrine of Ali was hit by artillery fire and the interior ravaged. The cultural offensive against holy sites, seminaries and libraries continued long after the fighting in the cities was over. It is possible that the scale and organised character of the assault has ended a 1,000 year old tradition of religious scholarship and learning, with unpredictable future consequences (Makiya, 1993). In Bosnia, hundreds of mosques have been intentionally destroyed by Serb militia and the educated amongst their prisoners reportedly singled out for execution. So too in Rwanda. When the army took over in Argentina in 1976, their attacks on the progressive professional sector included the burning of books from the university, Freud as well as Marx.

2. The Collective Experience of War and its Socio-cultural Dimensions

Suffering is at the centre of the social order and in this sense is ‘normal’. Violent conflict is part of social experience and memory (Davis, 1992). We should not assume that the stresses of war are necessarily discontinuous with those arising from other sources of social destabilisation, including endemic poverty. This said, a social group is in an extreme predicament if it finds what has happened to it incomprehensible and traditional recipes for handling crisis useless. Meaninglessness leaves people feeling helpless and uncertain what to do. Frequently

at stake are the cultural and social forms which for a particular people define the known world and its values. There are no socially-defined ways of mourning a lost way of life. When all the important structures are targeted - community organisations, trade unions, health and educational institutions, religious leadership - the social fabric may no longer be able to perform its customary role. Suffering must frequently be borne in contexts where socialisation, socially-managed mourning and adaptation are difficult or impossible.

Western debate about experiences such as torture or rape has focused on the psychological effects of what is seen as an extreme violation of individual integrity and identity. This is in line with the western view of the individual as the basic - and autonomous - unit of society, and that our psychological nature is closer to our essence than our social or religious ones. But non-western peoples have different notions of the self in relation to others and the maintenance of harmonious relations within a family and community is generally given more significance than an individual's own thoughts, emotions and aspirations. The cultural emphasis is on dependency and interdependency rather than the autonomy and individualisation on which many western ideas about mental injury are predicated. When conflict so routinely involves the terrorisation or destruction of whole communities, even survivors of individual acts of brutality are likely to register their wounds as social rather than psychological. As the psychologist Martin-Baro (1990) wrote of his own country, what was left traumatised were not just Salvadoran individuals, but Salvadoran society.

Disruption of the traditional cycle of animal husbandry resulting from the Sudanese civil war has brought social breakdown to the pastoralist Southerners. Cattle are crucial to them, being a form of currency not just in trading, but in rituals and disputes. Tribal marriages can no longer be arranged because of dislocation and lack of cattle (the only traditional dowry) and women are driven to prostitution in the towns, something previously unheard of. Because of the endemic killings and rape in the countryside, security conditions have become prime determinants of social behaviour, to the extent that families with noisy children are pushed out. Half this population has been forced to abandon villages regarded as ancestral places, seeking precarious safety in urban areas where their traditional skills are worthless. One

study of teenagers displaced to Juba showed the resulting cultural estrangement and loss of social identity: none could write a history of their clan and many did not even know the names of their grandparents or the village their clan came from. Not one could name any traditional social ceremonies (Panos Institute, 1988).

Many targeted communities must contend with war based on the psychology of terror, one in which to keep silent is an essential survival mode. In El Salvador or Guatemala, terror was intended to be felt, but not named. To give voice to it, to say what had happened, to name the victims or even to be related to them, was to be regarded as subversive and a target for more. Even public utterance of terms like 'health' or 'organisation' was dangerous because the military regarded these as code words for resistance. Concepts of innocence and guilt lose their distinctiveness, no-one can realistically feel safe and it becomes hard to hold on to assumptions about a reasonably predictable world upon which a rationally planned life depends (Zur, 1995). In El Salvador, the collective memory of the massacre of 30,000 peasants in 1932 was effective in suppressing even verbal dissent for over a generation: as late as 1978, whenever peasants began to talk about their social grievances, others brought up 1932 again. These forces make it impossible to properly mourn and honour the murdered and disappeared, reinforce everyone's sense of isolation and mistrust, and interfere with long-held Mayan forms of organising. These include storytelling, which is a traditional psychological resource for them. In Mozambique, Renamo terrorism was clearly intended to instill an incapacitating fear into the population by conjuring up a vision of inhumanity and maniacal devotion to the infliction of suffering which sets them beyond comprehension, outside the realm of social beings and hence beyond social control or even resistance (Wilson, 1992). Fleeing survivors are haunted by the spirits of their dead relatives, for whom the traditionally prescribed burial rituals have not been enacted (Harrell-Bond & Wilson, 1990).

Thus culture is impacted on by war, but it also engages with it. In Mozambique, both the Renamo guerillas and government forces sought to heighten the impact of their military efforts by incorporating traditional sources of ritual power - ancestors' spirits and myths of male invincibility, including ceremonies conferring 'vaccination' against bullets. The rural peasantry did the same thing to bolster their capacity to

resist Renamo violence. Thus a war driven by South Africa's destabilisation policies has been imbued by local understandings and world views, becoming in part a 'war of the spirits'. This spiritual vivification and other cultural shifts may outlast the war, with as yet unknown effects upon the social order. Despite the assault on their way of life, the Guatemalan Mayans have emerged with a strengthened cosmology. The upheavals saw many seek new refuge in the old traditions, shamans and deities. Communities in flight petitioned the mountain spirits for the right to pass through their domain, and to take on a guardian angel role. At the same time, there was a growth in politically conscious grassroots organisations in exile, a preparedness to write, speak and campaign openly whilst remaining on a platform of Mayanness, (Wearne, 1994). The aftermath of war in Uganda has seen an erosion in the power of traditional elders and their wisdom. The refugee experience has undermined their influence since they have not been in a position to negotiate bridewealth payments as of old. There has also been the appointment of ritually insignificant men as government chiefs. One of the reasons why the explanations of affliction offered by the elders were taken less seriously is that the intervention of ancestors, for whom they were interlocutors, was no longer considered to be the problem. Surely the ancestors would not have left people to suffer so much for so long, to witness such atrocities and the death of their children. The ancestors induced suffering for moral purposes, but surely there were malign forces at work here. This meant witchcraft, in the form of young women seen to be possessed by wild and new spirits, including the ghosts of those slaughtered and left to rot in the bush rather than buried in the ordained manner. Witch killing can be seen in terms of the basic social need to make sense of suffering, to enforce social accountability and the emergence of a sustainable mode of communal order (Allen 1995).

Even concepts generally thought of as relatively fixed, such as ethnic identity, have a capacity for fluidity that conflict may particularly mobilise. The collective arousal of a political crisis within a society, where one man's opportunity is another's danger, can cause rapid shifts and polarisations which confound what has gone before. During the years of the former Yugoslavia, its citizens did not routinely feel that their bottom line identification was as 'Serb' or 'Croat' or 'Bosnian Muslim'. There would have been other identities, based on occupation or political affiliation or other role, which were more relevant to daily life than ethnicity. A man might

have seen himself as much as 'carpenter' or 'communist' as he did 'Catholic Croat', yet it was this last which came to define him after the civil war started, whether he liked it or not.

Violent crises constitute positive challenges for some, even if they expect to suffer. Children, too, are not just 'innocent' and passive victims, but also active citizens with values and causes. In Gaza, strong identification with the aspirations of Palestinian nationhood seems to offer psychological protection to children facing high levels of violence from the Israeli army. The more they were exposed to political hardship, the more they deployed active and courageous coping modes (Punamaki & Suleiman, 1990). This did not mean they did not also have fear, grief, nightmares and bedwetting. Similar observations have been made in South Africa about young black activists (Dawes, 1990). In Nicaragua, war-maimed young men were fortified by the belief that they had made a worthwhile sacrifice for the social values at stake in the war and were recognised as such by their society. But such beliefs, and the strength people draw from them in adversity, may change as circumstances change: some of these same men had later been sufficiently disappointed by post-war events to abandon the sense of having suffered in a good cause. They now feared it had all been in vain and for a second time were having to come to terms, different terms, with their physical disability and other losses. On the other hand, it is relevant to the grief of the mother of a 12 year old boy shot dead on the streets of Soweto by a South African policeman that his cause has had a positive outcome in a more egalitarian society, and if there is public acknowledgement of what this struggle cost. Societal validation for those who have suffered is a key theme.

3. The Social Construction of Traumatic Events: the Rise of a Dominant Psychological Idiom within Western Culture

One of the features of 20th century western culture - particularly in the last 50 years - has been a spectacular growth in the power of medical and psychological explanations for the world, a power once dominated by religion. These understandings have become part of the shared beliefs of contemporary western

culture and are accepted as natural and self-evident. Terms such as 'stress', 'trauma' and 'emotional scarring' have become common parlance amongst a psychologically-minded general public, frequently denoting candidature for professional help. Counselling services reach into almost every corner of life. Since many now believe that exposure to, for example, rape or other criminal violence, childhood sexual abuse or even persistent bullying at school may all have enduring or lifelong psychological effects, it seems unthinkable that torture or atrocity should not do this and more to almost all those exposed to them. There is a rapidly expanding trauma field which, through the media, has familiarised the general public with its role as part of the standard response to events involving horror and loss of life. Psychiatric or psychological teams are mobilised after train or plane crashes; in some US cities, it is mandatory for policemen to have what is called critical incident debriefing after shooting incidents, and in Britain, teams of counsellors now arrive almost routinely and immediately at schools if a pupil or teacher has died violently.

There are similar trends abroad. Foster and Skinner (1990) describe how former political detainees in South Africa framed their stories in terms of themes relevant to their own calling and values - biblical, legal, political, humanist. But more recent accounts are utilising the language of psychological effects, indicating how the western trauma discourse is shaping and regulating experiences of violence. The implications of this for the way in which the human costs of war and atrocity worldwide are understood will be discussed in the next section.

The medical diagnosis of 'post traumatic stress disorder' (PTSD) is pivotal here.

Box 1

PTSD

The successor to earlier formulations known as 'shell shock', 'concentration camp syndrome' and 'war neurosis', PTSD was officially classified around 1980 and applied to many US Vietnam war veterans. Criteria for a diagnosis of PTSD can be divided into three groups: liability to re-experience aspects of the original events (in sleep or during the day), avoidance of reminders of the events (or diminished interest in things generally), and increased nervous system arousal (manifesting as sleep problems, irritability, poor concentration, excessive watchfulness, jumpiness etc.).

PTSD was originally meant to apply only to the aftermath of very extreme events - disasters of one kind or another - outside the range of ordinary human experience. But, in line with the trends outlined above, it has also come to be applied to much more everyday adverse events, for example a car accident or foetal death during labour.

Given that in western society the power to legitimise sickness lies largely with doctors, doctor-attested PTSD has emerged as a cornerstone of the compensation industry. A recent editorial in the Journal of the American Medical Association (1995) wryly noted that it was rare to find a psychiatric diagnosis that anyone liked to have, but that PTSD was one of them. It would be unfortunate if PTSD was accepted as a marker for, say, past torture, not only because this is simplistic nonsense but because some victims would fear that unless they could achieve this diagnosis, they might be viewed as not having been tortured as they claim. Similarly, newly demobilised Croatian soldiers cannot obtain a war pension without a diagnosis of PTSD, posing a dilemma for Croatian psychiatrists, because they know there are no job prospects for these men.

4. A Critique of Psychosocial Trauma Projects for War-affected Populations

4.1 Introduction

It is not possible to pinpoint in time the 'discovery' of 'war trauma' or 'post-traumatic stress' as an international humanitarian issue, but it is recent. It marked the significant entry of the western mental health professional - as consultant, trainer, practitioner - to a burgeoning new area of operations premised on the understanding that there was a psychological fall-out of war for whole populations and that this needed to be addressed in its own right. Projects have been either subsumed under the general term 'psychosocial' or more specifically designated as 'trauma' work, rapidly becoming attractive and even fashionable for western donors.

From the outset, some extravagant claims and assumptions have promoted the idea of war as a sort of mental health emergency. There have been repeated quotations in the media about post-traumatic stress as a 'hidden epidemic', suggesting an entity as real and concrete as an infectious agent, and as capable of causing pathology on a large scale. This, then, was not something which would just go away or resolve itself spontaneously. Among those from whom this epidemic was 'hidden' were those directly affected, or 'infected'; some trauma literature has claimed that the sufferer rarely admitted that he or she had the problem. Agger et al (1995) estimated that 700,000 people in Bosnia-Herzegovina and Croatia were suffering from severe psychic trauma, in need of urgent treatment and that in this emergency situation, local professionals were able to address less than 1% of these. They further estimated that there were another 700,000 people with less severe degrees of psychic trauma, and who, in peacetime conditions, would also merit professional help. From the same source, there was a warning that post-traumatic stress was going to be the most important public health problem in former Yugoslavia for a generation and beyond. UNICEF[1] estimates that 10 million children have been psychologically traumatised by war in the past 10 years, and that psychosocial trauma must be a cornerstone of their rehabilitation programmes.

The war in Bosnia and Croatia, more than any other, has attracted a large number of psychosocial projects, with the multilateral agencies and major aid and development organisations well-represented. UNHCR supported nearly 40 projects,

[1] 'State of the World's Children 1996' report. UNICEF.

including kindergarten, vocational classes for adolescents, women's activity and self-help groups, and psychiatric counselling in collective centres. They prioritised the ongoing identification and assessment of vulnerable groups and individuals, naming psychiatric patients, the isolated elderly and the disabled as examples. They also sought to train local staff, whether in education, health or social services, who were considered to be working in situations for which their pre-war training had not equipped them. These staff were viewed as likely to be traumatised themselves.

The World Health Organisation (WHO) had a Mental Health Unit based in their Zagreb area office, describing their objectives as including: the development of comprehensive needs assessments and monitoring systems for rehabilitation work; coordinating the work of NGOs with intergovernmental organisations and the public health system; addressing the skills of healthcare providers and developing methods of evaluation and quality assurance. As specific examples of the work of the Mental Health Unit, they mention the psychosocial rehabilitation of sexually-violated men, the provision of mental health kits (psycho-active medication) and assistance to healthcare providers viewed as being at special risk of work-related traumatisation.

In February 1995, the European Community Humanitarian Organisation (ECHO) was providing financial support for psychosocial work to 15 international NGOs from six European Union member states. A European Community Task Force (ECTF) review noted 185 such projects being implemented by 117 organisations. 68% of these 185 projects offered services designated as social welfare or community development. 63% were offering direct psychological services and 54% ran psychologically-oriented groups, mostly self-help. 33% ran psychiatric services and 63% had staff training programmes, presumably on topics such as war trauma[2]. To date, there has been little rigorous analysis of the conceptual bases and operating practices giving rise to such work.

The other main example I will draw on is Rwanda, perhaps the only war in the

[2] Agger et al. 'Theory and Practice of Psychosocial Projects under War Conditions in Bosnia-Herzegovina and Croatia'. This book, mostly by highly-placed consultants (two are psychiatrists) to ECTF, WHO and UNHCR, reproduces many, if not most, of the working assumptions driving psychological interventions.

1990s to date to rival Bosnia for international attention.

4.2 A review of the concepts and assumptions underpinning trauma work

Whether implicitly or explicitly, most projects are based on some or all of the following assumptions:

I) Experiences of war and atrocity are so extreme that they do not just cause suffering on a large scale, they cause 'traumatisation'

'Traumatisation' is widely used to denote a war-induced psychological, but there is no consistent working definition of the term, even amongst active proponents of the work. Some sources seem to subclassify it on the basis of distance from the provoking events: in *primary traumatisation,* the victims directly experience them, e.g. rape, torture, forced expulsion; those subject to *secondary traumatisation* are close relatives or friends of the victims above; *tertiary traumatisation* supposedly arises in those in contact with the two groups above, for example, witnesses, neighbours, aid workers and therapists. Agger et al (1995) give two examples of cases they see as likely to be traumatised: a woman who witnesses her husband and son abducted at gunpoint, and a man who has his leg amputated after being shot by a sniper. With such indiscriminate and loose definitions available, it is perhaps surprising that their estimate of the numbers affected in Bosnia-Herzegovina and Croatia is only 1.4 million, as noted earlier. They state that the 185 projects were only able to address the tip of the iceberg of need. Psychosocial project proposals elsewhere are similarly replete with comments about the huge traumatised populations to be addressed.

These notions have roots in western assumptions that very adverse events are bound to leave people with a psychological injury. There is no empirical basis for this narrowly pathologising generalisation, one that is capable of distorting the debate on the human costs of war, including those that legitimately relate to ill- health and health services. Suffering or distress - observed or imputed - is objectified, turning it into a technical problem - 'traumatisation' - to which technical solutions are seen to be applicable. Yet, for the vast majority of survivors, 'traumatisation' is a

pseudo-condition; distress or suffering *per se* is *not* psychological disturbance.

ii) There is a universal human response to highly stressful events

With the world's spotlight on the genocide of April-July 1994 in Rwanda, humanitarian agencies flocked to the region. Soon after the earliest flows of destitute refugees away from the killing, a surprising number of NGOs, some with little knowledge of the country, mobilised psychosocial projects to address mass traumatisation. One of these was a well-known international relief agency whose model - known as Emergency PsychoSocial Care - sought to make an early psychological intervention, both to offer immediate relief and as a preventive measure to thwart the later development of more serious mental problems in the exposed population (see also point (vi) below). Their model included the provision of 'psycho-education' for the refugee community and 75,000 copies of a brochure were prepared. Some difficulties were encountered in translation since there was no word for 'stress' in Kinyarwanda and terms such as 'family members' were also problematic since different words were used in different contexts. First a questionnaire was distributed to evaluate baseline knowledge on trauma so that, after distribution of the brochure, they could repeat the questionnaire to see if there had been "an increase in knowledge". The question begged here is: whose knowledge were they talking about, the refugees or the agency's own? The assumption with which they had arrived was that there was a universal trauma response and thus standard knowledge about it.

Once it is accepted that a universal response exists, it is easy to assume that western psychological models and questionnaires can reliably capture this worldwide and that, furthermore, this is what is important about the experience, whether the victim sees it like this or not. This view of trauma as an individual-centred event is in line with the tradition in both western biomedicine and psychology, which is to regard the singular human being as the basic unit of study. But western diagnostic systems, primarily designed to classify diseases rather than people, are highly problematic when applied to diverse non-western survivor populations (Bracken et al 1995; Mollica et al, 1992). The limitations attached to the use of PTSD checklists and other psychological questionnaires in such contexts demonstrate this.

As an example, an international NGO operating in Rwanda and neighbouring refugee camps sent me the results of a psychological questionnaire they had conducted on Rwandans. Their subjects had experienced massacres at close range, and had survived where many of their family members and friends had not. By comparison, there was also a control group of Rwandans who had been further away and not so directly affected by events, some of whom had been out of the country at the time. Several features associated in the West with PTSD casehood were common and seemed significantly more prevalent in the main groups: having bad memories, bad sleep and dreams, feeling sad most days, poor concentration, easily startled and notions about killing oneself. But do these questionnaire items capture the essence of what the subjects themselves feel has been done to them, and reflect their current concerns and aspirations?

It is simplistic to regard victims as mere passive receptacles of negative psychological effects which can be judged 'present' or 'absent'. A checklist of mental state features applied in a war context does not offer a rigorous distinction between subjective distress and objective disorder. Much of the distress experienced and communicated by victims is normal, even adaptive, and is coloured by their own active interpretations and choices. It might be argued that disturbed sleep and nightmares, as an example of a PTSD feature, reflected one facet of a universal human response to traumatic events, but would this take us very far? How many victims think this is important or avoidable? Further, though the literature suggests that PTSD has a worldwide prevalence, it is a mistake to assume that because phenomena can be regularly identified in different social settings, they mean the same thing in those settings. This is what Kleinman (1987) calls a 'category fallacy'. For one person, recurring violent nightmares might be an irrelevance, revealed only by direct questioning; to another, they may indicate a need to visit a health clinic; to a third, they might represent a helpful message from his/her ancestors.

My studies of rural peasants, and of war-wounded ex-combatants in Nicaragua, showed that a diagnosis of PTSD alone is poorly predictive of the capacity to pay the psychological costs of a war, to keep going despite hardship, nor a reliable indicator of a need for psychological treatment (Summerfield and Toser, 1991;

Hume and Summerfield, 1994). Uncritical use of PTSD checklists generates large overestimates of the numbers needing treatment.

It is useful to note the answers given to other questionnaire items in the survey of Rwandans quoted above: 51% of the main group said that they were not sad most days, 77% were interested in activities like work or play, 46% felt they were able to do things as well as before the war, 57% felt that their future seemed good and 75% (remarkably high in the circumstances, it might be argued) felt able to protect family or self. These answers paint a rather more active and resilient picture than the one based only on identification of PTSD features cited earlier. There is a duty to recognise distress, but also to attend to what the people carrying the distress want to signal by it. On the whole, they are directing their attention not inwards, towards their mental processes, but outwards, towards their social world. The trauma field may be in danger of attending only to those cues which match their prior assumptions about the nature of victimhood, and the pre-eminence and universality of a psychological wound.

iii) Large numbers of victims traumatised by war need professional help

Agger et al (1995) caution against over-diagnosis and individualisation of problems which are basically political, but in the next sentence warn that under-diagnosis can lead to the development of long-term chronic disorders. Arcel et al (1995) estimate that 25-30% of refugees develop PTSD and need the help of skilled mental health professionals. However, these sources underestimate the role of socio-cultural and situational factors in shaping outcomes over time, and the limitations of western psychological approaches in non-western contexts. A medical diagnosis, PTSD is held to be a robust enough clinical entity to have a life of its own over time, and one which the sufferer is unlikely to resolve on his or her own.

Thus, the emphasis is on service provision, with the 'expert' and his or her expertise at the centre of things, and the war victim relegated to the role of consumer-patient (Stubbs and Soroya, 1996). It is important to consider whether this may have the effect of increasing an individual's sense of him or herself as passive victim rather than active survivor. This 'official knowledge' will carry a stamp of authority and

thus may unwittingly contribute to further disempowerment. Arcel et al (1995) comment that they had to spend considerable time 'sensitising' refugees to mental health issues, since they were 'too tolerant' of how they were feeling and were not seeking the professional help on offer. Perhaps these people had other problems on their minds, or did not see talk therapy as a familiar and relevant service. I understand that some Sarajevo citizens were irritated by the activities of certain foreign researchers with PTSD checklists at a time when they were struggling to survive under violent siege. As far as the developing world's war zones such as Rwanda are concerned, it seems unlikely that those affected would spontaneously seek psychosocial trauma programmes of the kind that have been imported and delivered to them. The question is: who has the authority to define the problem and whose knowledge is privileged? In this respect, refugees are inevitably at a disadvantage.

There will of course be some, a minority, who do develop clear-cut psychological problems, or even frank mental illness, as a result of the stresses of the conflict and its associated upheavals. In some cases, there will be a prior history of psychological problems and of contact with mental health services. Clearly such people merit particular attention by what remains of mainstream health and social services, or if necessary from the NGO sector. Generally speaking, families and neighbours are well enough aware of most of these.

iv) Western psychological approaches are relevant to violent conflict worldwide. Victims do better if they emotionally ventilate and talk through their experiences

From one culture to another, local traditions and points of view give rise to psychological knowledge, meanings attached to events, and the way help and healing is sought. There is more than one true description of the world. To take one war zone, Cambodia, the taxonomies of traditional healers range across the physical, supernatural and moral realms, and are at odds with the linear causal thought of western practitioners. Yet, the psychological concepts and practices which the expatriate-led psychosocial projects are importing into developing country settings are as western as Coca-Cola. Most projects allude to the duty to acknowledge local

norms and practices, but this is often little more than lip service. It is too easy for NGOs to arrive with an analysis and pre-planned agenda hatched from afar. Rwanda was a particularly telling example of such an approach.

Boothby (1992), whose field experience is from Mozambique, argues that interventions based on western talk therapies, developed in stable and affluent societies, have been largely unsuccessful in unstable and impoverished settings, and where differing cultural contexts prevail. Western explanatory models tend to locate the cause and onus of responsibility within the individual. Social factors may be conceived of as having influence, but in the final analysis it is the individual's response or attitude which is seen to be crucial to outcomes. But, as I illustrated earlier, war is a collective experience and perhaps its primary impact on victims is through their witnessing the destruction of a social world embodying their history, identity and living values. This is not a 'private' injury, being carried by a private individual. Moreover, wars set in train a series of complex evolving events. The understandings attached to them by affected populations, their attitudes and priorities, may also shift with time, and with new pressures or possibilities. Even if we set aside culture, this is an utterly different social context to the one that applies, say, after a disaster in Britain, where survivors of a clear-cut event can recover in an intact and resourced society. War in the developing world is not a 'Hillsborough' football or 'Herald of Free Enterprise' ferry disaster writ large. The notion that war collapses down in the head of an individual survivor to a discrete mental entity, the 'trauma', that can be simply tackled by western counselling or other talk therapy seems largely ridiculous.

As I described earlier, it has come to be accepted within western culture that victims of adverse events should emotionally ventilate and 'work through' what has happened to them. This activity, which is sometimes called psychological debriefing, is seen to be the province of psychologists and counsellors rather than family, friends and colleagues. Some professionals believe that personal recovery cannot properly proceed without this psychological ventilation, so that even if war victims appear to be coping well and reassembling their lives, the 'real' problem lies 'hidden'. The idea that telling one's story may cause 're-traumatisation' unless properly supervised was illustrated by the (unnecessary) concerns at the Hague

tribunals that testimony-giving by Bosnian victims could damage them.

All this naturally tends to emphasise the importance of the trauma field and its expertise. But there is no empirical basis as yet for any of these concepts to be assumed to be generally valid. Indeed, Raphael et al (1995) noted recently that even in western populations there is no objective evidence of the efficacy of psychological debriefing after trauma, but that such services are being widely instituted anyway. We must be doubly cautious about such assumptions in non-western settings, where modes of help-seeking will be influenced by attributions of causation: supernatural, religious, political, and by the physical struggle to survive which must take precedence. There will be familiarity with some aspects of western health services, but this is unlikely to include counselling. Indeed, many non-western cultures have little place for the revelation of intimate material outside a close family circle. Mozambican refugees describe forgetting as their normative means of coping with past difficulties; Ethiopians call this 'active forgetting'.

v) There are vulnerable groups and individuals who need to be specifically targeted for psychological help

Agger et al (1995) have an expansive definition of 'especially vulnerable' in the Bosnian conflict. It comprises: (a) children and adolescents who are orphaned, who have been in concentration camps, have lost a parent or have had their education disrupted by flight and refugee status; (b) women who have been raped, or otherwise tortured, have lost husband, children or home, or are living in mixed marriages; (c) men who were in concentration camps, have witnessed or committed atrocities, or are in mixed marriages; (d) the elderly who have been terrorised, or are without family support or social and health services. This list would seem to draw in a considerable percentage of the total population! A further list, arguably sounder and similar to that of UNHCR, includes those who had pre-war vulnerabilities: the poor and socially-marginalised and people with chronic physical or mental illness or handicaps.

In Bosnia, the highest profile group labelled 'vulnerable' and targeted accordingly were raped women, a topic given a sensationalist slant by much of the international

media. Rape counselling projects were mounted by foreign NGOs or prepared for the reception of women refugees arriving abroad. All these women had experienced multiple events and yet the assumption was made in advance that it would be as 'rape victim' that they primarily defined themselves in their own eyes, and that the counselling would usefully distinguish this from 'bereaved mother', 'widow' or 'refugee'. Arcel et al (1995), who ran several psychosocial projects for women in Croatia, have an extraordinary chapter entitled 'How to recognise a rape victim'. Conceding that a victim might be reluctant to divulge what has happened, they provide a list of symptoms which they see as relatively specific to rape (they are not) and which will supposedly help workers to identify cases so that they can get the rape counselling they are deemed to need. This seems highly presumptuous. There is little medical literature to justify the conviction that rape *per se* is a discrete cause of psychological vulnerability in conditions of war, and that there is a therapy specific and effective enough to justify actively seeking out women who would not normally come forward. What women seek will reflect their own appraisal of their situation: a colleague of mine was told by Bhutanese women refugees, targeted for a rape project, that their overriding concern was the lack of a school in the camp for their children. Moreover, social stigmatisation remains an embedded obstacle in many cultural contexts; avoiding it by staying silent is a pragmatic decision for many. Some of the first Bosnian Muslim women who did speak out, put their rapes in the context of the assault on their culture and ethnic identity.

The other 'vulnerable' group most targeted by relief agencies are 'traumatised children'. But Richman (1993) points out that the emotional well-being of children remains reasonably intact so long as their parents, or other familiar figures, are with them and offer a reasonably coping and stable presence. If this is lost, child well-being may deteriorate rapidly and infant mortality rates rise. The argument is less whether orphans or otherwise unprotected children need attention, so much as whether it is given on a social rather than psychological basis. One rather fashionable group has been called 'child soldiers'. In Liberia, concern by NGO staff that 'child soldiers' had not been 'counselled', threatened to delay their reunion with families and communities. Yet ,from Mozambique comes impressive evidence of the reparative potential of children, abducted into Renamo ranks and forced to kill, once they had been restored to a more normal environment (Boothby, undated).

Save the Children Fund in Mozambique has argued that children should not be seen as a vulnerable group *per se*, and this is echoed elsewhere (Gibbs, 1994).

Trauma models, where the focus is on a particular event ('rape'), or particular population group ('children'), exaggerate the difference between some victims and others, risking disconnecting them from others in their community and from the wider context of their experiences and the meanings they give to them.

vi) Wars represent a mental health emergency: rapid intervention can prevent the development of serious mental problems, as well as subsequent violence and wars

Agger et al (1995) state that lack of attention to trauma issues 'can impact on the next two generations at least, via massive increases in alcohol and drug addiction, suicides, criminal and domestic violence and psychiatric illness. Unresolved traumatic experiences are likely to ignite new hatred and new wars.' Notions of this kind are sometimes, for example, used to 'explain' Israel's cruelty towards the Palestinians in terms of what was done to them by the Nazis. To see society as a kind of extension of the individual human mind, and on this basis, to offer explanations and predictions of the human costs of war in the years and generations to come worldwide, is ridiculous and worrying since no less than consultants to the EC, WHO and UNHCR present this as serious analysis.

Lack of relevant data does not prevent similar prophecies about children caught in war. They are liable to be portrayed as susceptible to problematic relationships and other adjustment problems in the future, including poor learning. Psychological interventions are seen to be required if the brutalising effects of war are not to so impede the formation of their social norms and values as to render them what some have called a 'lost' generation.

Rwanda was certainly a case where NGOs running an 'emergency psychosocial

model' were able to reach refugees in the early aftermath of the catastrophe. Let us transpose the operation to the Jewish Holocaust. A project, planned from afar and deploying unfamiliar conceptual frameworks and practices, is mobilised in mid-1945 to assist those who have just emerged alive from the concentration camps. The project leaders have often not worked in the area before, and perhaps do not know its history. The project is funded, say, for one year. In that time, the project is expected to use largely imported expertise to tackle the 'trauma' of the Holocaust for survivors, not just their personal losses but their sense of what was done to their people as a people. By so doing, it hopes to prevent future mental problems, and to reduce the likelihood that victims will become perpetrators who embrace violence and war. Would not such a proposal seem grossly simplistic and presumptuous, and even throw up ethical questions?

vii) Local workers are overwhelmed and may themselves be traumatised

There is no mistaking the objective pressures on local staff, struggling to maintain war-damaged services and as much under threat as any one else. (Indeed, as mentioned earlier, sometimes under more threat as health and other professionals are often chosen as targets for elimination). Agger et al (1995) claim that teachers, health and social workers and others in Bosnia and Croatia had no experience or training in how to deal with a war situation, and thus there was an emergency need to provide it. As I quoted earlier, their estimate was that local professionals could only cope with 1% of the multitudes deemed to have psychic trauma. An additional justification given is that local workers are held likely to be traumatised themselves, so that they too need help. Not just overworked, and like everyone else, weary, unhappy, apprehensive and sleep-disturbed, but 'traumatised'. These assessments serve to aggrandize the status, knowledge and indeed health of the foreign expert.

It is not for me to speak with authority of the views of local professionals in this situation, but a few points can be made. There is no doubt that in some settings they feel de-skilled in the face of NGO assessments which seem to play down the relevance of their local experience, training and knowledge. Elsewhere, and certainly in Bosnia, professionals were prepared to voice their resentment, and to say that what they wanted were the material resources necessary to keep existing

services functioning, and not imported expertise. In Bosnia, health workers, teachers etc. were paid nothing for several years and pointed out that meeting their salaries was one way to protect the services on which the war-damaged social fabric depended, and that foreign aid should have prioritised this ahead of the plethora of psychosocial projects begun from scratch. Some doctors and other professionals left their posts to work for foreign NGOs - whether as interpreters, field workers, drivers - since this afforded them a proper salary paid in German marks. Who could blame them, but it is surely vital that NGO operations do not unwittingly deplete or distort what remains of mainstream services.

Some Bosnian and Croatian mental health professionals, whose training would have been similar to their opposite numbers in Western Europe and USA, have taken a leading role in psychosocial trauma projects and presumably have not felt that they were being imposed upon them. What about other settings? A colleague at MSF commented to me that local staff often tended to over-endorse western psychology and to play down their own cultural frameworks. Local workers with professional status have, almost by definition, had a largely western training. They look to the West for peer group fraternity and approval, and for possibilities for academic publication and further education. They see their familiarity with the dominant frameworks and concepts as a basis for their professional standing and credibility. This may put them nearer to western colleagues, but further from the communities they serve.

Lastly, there are pragmatic questions. In some devastated war zones, the NGO sector is the only show in town and local workers want a job badly and will fit in with its methods and objectives. They may also modify their approach according to donor preferences: workers in South Africa and the Philippines have told me that the central problem was of course the broken social world of the people they were trying to help, including poverty and lack of rights, but that it seemed easier to obtain funding from western donors if it was portrayed as ‘trauma’ whose antidote was ‘counselling’.

4.3 Evaluation

To date little serious evaluation of psychological interventions and trauma work has been published. Attempts to collate data have been hampered by methodological problems, including a failure to control the many variables at play simultaneously, or based on faulty analogies with single accidents or natural disasters in western countries.

A project premised on 'trauma' as an entity and on the applicability of a mental health technology is going to be evaluated within the same parameters. If a PTSD checklist is deemed to capture what is universal and important, it will naturally be seen as a valid instrument to evaluate outcomes and the 'success' of the endeavour. An expatriate worker on a project for Rwandans recounted the difficulties in gathering information on sleep disturbance (a PTSD feature) when the local population did not consider this a problem. Whether they answered 'yes' or 'no' to it, it was simply a wrong question because it did not tap anything they considered important.

A project, say, to dig wells to provide water for a defined refugee population can be evaluated on a quantitative basis, assuming there is reasonable agreement about the project in the first place. But assessment of success, and value for money, are obviously more problematic when interventions directed at the war-weakened social fabric are not always so concrete. How are needs to be defined and prioritised, and met in a form which allows for evaluation? Again, who decides and after how long? De Waal (1995) concludes that NGO information may be good, but it may literally be worse than useless - it may actually mislead. And in disasters like Rwanda, NGOs may claim 'overwhelming need' for reasons connected to a scramble for image and funds. Moreover, lack of clarity about objectives may bedevil rational evaluation from the start. Once in Rwanda, some NGO workers did not know whether they were there to offer emergency relief or to 'save' the population from genocide.

Evaluation is ideally a continuous process which draws in the feedback of users and workers, complemented where possible by insights from respected figures in the community.

To reiterate, psychological trauma is not like physical trauma: people do not passively register the impact of external forces (unlike, say, a leg hit by a bullet) but engage with them in an active and problem-solving way. Suffering arises from, and is resolved in, a social context. It is not reducible to a universal biomedical entity. The role of social forces is one of the themes of this paper.

5. Basic Principles for Interventions

Western psychological concepts have accompanied the globalisation of western culture and increasingly present as definitive knowledge. There is a danger of an unwitting perpetuation of the colonial status of the Third World mind (Berry et al, 1992). It is a question of power. It would be a painful irony if survivors calculated that their best chance of getting some sort of help lay in presenting in a 'modernised' way, a victim mode in which their knowledge, resourcefulness and, not least rage over injustice, was played down. A narrowly individualised and medicalised discourse about symptoms, cases of PTSD, 'counselling' and 'vulnerable' groups seems of little relevance to the overwhelming majority of those affected worldwide. There is no evidence of the efficacy of interventions in foreign war zones to deliver emergency psychological care as a short-term technical fix, bolstered by fanciful ideas that it may also prevent subsequent mental problems in the exposed population. The current attractiveness to donors of trauma work may not survive a sober analysis, but nor should we underestimate the feistiness of the trauma industry.

The prefix 'psycho-' in psychosocial projects has fostered basic misconceptions and diverted us from the collective focus required. We must look to the pivotal role of a social world, invariably targeted in today's 'total' war and yet still embodying the capacity of survivor populations to manage their suffering, endure and adapt.

If not psychological interventions *per se*, what then? Let me recapitulate by means of a metaphor: the sea represents more to fish than merely the means for biological life. It is their whole world, and embodies what it means to be a fish. Imagine a disaster that tears them from the sea, and survivors coming to rest in a goldfish bowl

filled with tap water. In this environment they can subsist, for this is how they experience it, but it is no world. How can they be helped to get back to the sea, or to begin to turn tap water into something more resembling the sea, and on their terms? For the overwhelming majority of survivors in or near the war-devastated regions of the earth, the task may seem comparable to this.

Orthodox analysis in the international relief sector has held a relatively sharp distinction between relief and development, with disasters which create a need for emergency relief viewed as time-limited interruptions to the favoured task of development work. Duffield (1995) reminds us that in many parts of the world, war is not an extraordinary and short-lived event to be seen as extrinsic to the way a society functions in 'normal' times. It has become a given, something internal that colours the whole web of political, socio-economic and cultural relations across a society. He cites Sudan where the combined effects of an endemic civil war, successive famines and falling income from staple exports have brought it to a state of 'permanent emergency' marked by end-to-end relief operations. All over Africa, resources which might have gone to development work have been diverted to relief operations. (As we have seen, 'trauma' work has used a relief model). There has been less government to government assistance and much more channelled through UN agencies and NGOs, to the extent that NGOs have been replacing the state in the provision of basic welfare services. This gives them considerable clout. What is the backdrop to the increase in the number of ongoing wars from 34 in 1970 to 56 in 1995 (90% internal)? The nation state is under pressure, the poorest 20% in the world are falling ever further behind the top 20%, there are huge numbers of displaced peoples and a global rise in food insecurity. A recent report from the WHO warns of a health catastrophe: life expectancy in the world's poorest countries is likely to fall by the year 2000, one fifth of the 5.6 billion people on earth live in extreme poverty, one third of the world's children are under-nourished and half the global population does not have access to essential drugs (WHO, 1995).

Duffield argues that the social and political economy of permanent emergency is complex and still poorly understood, but will be an important policy issue. There are losers in war, but also winners, who may be an entire social sector or ethnic group, and who take over the assets of the losers. The nature of humanitarian

intervention is itself part of, and a contribution to, the complexity of modern emergencies. What this means is that the conventional paradigms of 'relief' and 'development' will have to be re-thought and that the argument that constructions of 'rape' or 'torture' are decontextualising may in many respects apply to 'war' as well.

Short practical notes on the issues below have been published in Development in Practice (Summerfield, 1995).

5.1 The relationship with users

Firstly, relief practitioners should want their ways of seeing and understanding to be as informed and sophisticated as possible, and able to take account of what happens in social situations which are as frequently in flux as stable.

We must also reflect on our own cultural and personal assumptions - for example, our perception of what torture can be expected to do to someone - which we can carry unexamined into projects and unwittingly impose on those we want to assist, however well-intentioned we are. This paper has been concerned with characterising patterns of recent violent conflict most impinging on the lives of those caught up in it, emphasising the interplay of social and cultural forces. All this is part of the background briefing and pre-operational knowledge which a relief agency, and individual workers, need to bring to bear when planning or evaluating interventions at a particular moment in a particular conflict zone. The initial aim, surely, is to put ourselves as close as possible to the minds of those affected, to maximise our capacity for accurate empathy and enrich our ways of seeing. It is vital that we do not misunderstand people when they express themselves in their own terms. We want as many as possible of the questions we ask to be right in the sense that they tap what the respondents themselves see as important or urgent.

This means a measured information-gathering process which is the antithesis of what happened in Rwanda, for example. Those organisations interested in more than 'hit and run' operations there needed to develop some prior understanding of what the events of 1994 meant. An example of a question too little asked would be

about the place in Hutu and Tutsi social memory of similar inter-ethnic massacres - each costing thousands of lives - in Rwanda and Burundi during the past few decades. What do they remember of those? What did they do then, and how do they think damaged communities mended themselves? Was 1994 different, and if so, why?

What do the users think of us and what we are offering? At a time when they have weakened control over their own lives, they may feel it is in their interest to make themselves intelligible or even attractive to us. We must do our best to establish from them how they really see the effects of interventions in their lives, and with as little contamination as possible by their sense of what we want to hear. A mother may hide the death of one of her children in a refugee camp so that the others have an extra ration of food to share. A Bosnian woman can falsely claim she was raped when this is a passport to a country abroad. The relationship an agency can forge with those in war-torn situations is pivotal, whether it be knowledgeable, unpaternalistic, open, responsive and mutually undeceived. The efficacy of the intervention (whatever it is), and its ability to deliver value for money, must surely be a function of the quality of this relationship over time.

5.2 Social rehabilitation/development

A rehabilitation model that takes into account the whole context of affected populations must be based on the social development approaches which should already constitute good practice in the NGO field, and which aim at a living environment shaped by those who live in it and by processes which act to enhance their capacity to be in charge of their own lives. This means interventions which acknowledge that each situation is *unique*, that *indigenous understandings* are crucial, and whose focus is *community-wide*. This is in contrast to the other broad category of intervention - where the task to be addressed is seen as *standard* and *generalised*, and a *technical* solution is offered to a *targeted* group.

We are talking about a social development agenda with additional perspectives. There are qualitative differences in the impact of a war on its victims compared to, say, an earthquake. When a disaster is man-made rather than a force of nature,

different parts of social memory are mobilised, different attributions and perceptions attached to it, and different questions asked. All this shapes the debate: issues of human rights and social justice and of the impunity of those responsible may be raised and elaborated in new ways. All this can colour the way social rehabilitation principles may usefully be applied in a particular place.

The one point of consensus in medical and anthropological literature on migrant and refugee status concerns the protective function of family and community networks. People also make determined attempts to preserve what they can of their culture and way of life, since these embody what it means to be human and civilised - this is the business of turning tap water into sea water. Thus, what is fundamental for western relief interventions is to aim to augment efforts to stabilise and repair the war-torn social fabric and to allow it to regain some of its traditional capacity to be a source of resilience and problem solving for all. Self-organisation, empowerment, work and training, support to traditional forms of coping and healing: these terms may be truisms in the social development lexicon, but they remind us that people cannot fully regain control of their lives, and recover from war, as mere recipients of charity and care. In Mozambique, the actual physical work of reconstruction following return - such as building houses and planting fields - was considered by local people to be particularly crucial. Aspirations generally include the restoration of health and educational services as a priority; these represent points of reference for this rebuilding, as do other kinds of social and cultural institutions or what remains of them. Ideally, projects from abroad should offer material assistance to mainstream services before they set up parallel ones, though this is against the trend in Africa and is, of course, everywhere problematic when the government itself is the aggressor. People do not necessarily seek simply to restore what they once had to its old state; they recognise that some things may have changed for ever. It is worth commending the role of traditional healers in, for example, Zimbabwe and Cambodia in helping people to lay the war to rest; their value is now being recognised by the WHO (Reynolds, 1990).

There are few prescriptions to be carried from one place to another; solutions need to be local, trading on local skills and priorities and what is possible. Moreover, the context itself may not stand still: war flares in one area of a country, ebbs in another.

Newly displaced people will naturally be preoccupied with issues of security and with hopes for a speedy return to their homes. They may see where they are as provisional and temporary. Later, feeling safer, or because a gloomy realism tells them that the prospects of a return home are slim, they may take stock of their new environment with a more purposeful approach. Can a relationship between a relief agency and users in a particular locality be robust and flexible enough to be able to accommodate such shifts, and their impact on local priorities, without anxiety that plans and budgets are being jeopardised? Lastly, since many wars are ongoing, there is no clear-cut aftermath, no definitive counting of costs and recovery. The basic task here may come down to helping people just to keep going, to endure. All this puts a premium on agencies capable of maintaining a sustained presence in a particular locality.

Over the next few decades post-war reconstruction will have to be increasingly concerned with the question of uncleared mines: the Red Cross estimates that mines kill 800 people and injure thousands every month. In a recent study of 206 communities in Afghanistan, Bosnia, Cambodia and Mozambique, 1 household in 20 reported a mine victim, a third of them dying in the blast; 1 in 10 was a child. Households with a landmine victim were 40% more likely to have difficulty in providing food for the family. 25-87% of households had daily activities affected by landmines. A total of 54,554 animals had been lost, with a minimum cash value of US$200 per household. Without mines, agricultural production in the sample communities could increase by 88-200% in Afghanistan and 135% in Cambodia (Andersson et al, 1995).

Refugee camps, with their emphasis on confinement, control and minimal involvement of residents in decision-making, too often breach the basic principles outlined above. The Thai border camps for Cambodian refugees were particularly like this, and in addition chronically unsafe. Mollica et al (1993) reported that around 80% of residents rated their health as poor or only fair after more than a decade there, felt depressed and had somatic complaints despite access to medical care. It is a telling commentary that known Hutu killers could find their way onto the payroll of aid agencies in the Rwandan camps in Zaire, and continue to organise politically and to threaten and murder residents.

In their work, international relief agency staff are witnesses at close range to other people's suffering, and need to be mindful that this is a privileged position. They are able to offer fraternity and solidarity, to respond in ordinary ways to the tendency of suffering human beings to turn to others. Workers do not have to feel ill-equipped to deal with human distress simply because they are not counsellors trained to deal with 'traumatisation'.

5.3 Rights and justice

In Latin America, refugees might well define their psychosocial needs first and foremost in terms of freedom from oppression. In Guatemala and El Salvador, the presence of foreign NGOs and their staff sometimes conferred protection on victimised communities, since the death squads preferred to do their work away from the eyes of international observers. Some survivors in contact with NGO projects see their personal stories as testimony with a wider human rights purpose. It is significant that in El Salvador people are worried that they have begun to forget all the names of those murdered by the military in the 1980s (Summerfield, 1995). The collated testimonies of survivors represent part of a grassroots history, a counter to the official versions generated by those with power to abuse, and thus a prompt towards public validation of their suffering. As Primo Levi, a survivor of the Jewish Holocaust, wrote of what he had endured: "If understanding is impossible, knowing is imperative". I think it may apply universally that victims suffer more over time when they are denied societal acknowledgement, let alone reparation, for what has been done to them. Relief workers are in a position to collate, translate, publish and distribute such testimonies and, where possible, to present them to war crimes tribunals, truth commissions and governments. Indigenous organisations addressing rights and justice need to be supported; here too their links with overseas agencies or human rights groups may lessen the risk that they will be eliminated.

A striking outcome of the military assault on Guatemalan Mayans and their culture in the 1980s, and a measure of its ultimate failure, has been the emergence of a politically sophisticated movement prepared to communicate and campaign in a modern way without losing touch with the Mayan identity being defended.

History has shown that social reform is the best medicine: it seems imperative that social justice and human rights perspectives should be at the heart of any work with war-affected populations. The more testing question for relief agencies is how far they feel able to take their justice-driven role, particularly when they depend on charitable status. In Bosnia, Rwanda and elsewhere, western governments seem to have used the humanitarian effort as a shield to hide their own mixed motives over serious engagement with the political players and issues. Can agencies confront those with an interest in confining international responses to crises within comfortably humanitarian frameworks at best, and in avoiding the 'difficult' questions? Too frequently these relate to the values of the western-led world order, in which geopolitical and business considerations far outweigh issues of basic rights and justice for millions of the least protected people on earth. Much political violence in the developing world is rooted in gross social inequities. Most victims are the poor and those who speak for them, or members of persecuted ethnic minorities with few advocates in the West. Grossly inequitable patterns of land ownership (eg. in Guatemala, 75% of all land is owned by 2% of landowners), is almost invariable in violent societies. The western multinational economy has an implicit investment in developing country workforces which are leaderless, fragmented and cowed, and thus docile and cheap. Ten years ago, the Brandt report pointed out that the most dynamic transfer of sophisticated technology from rich to poor countries was arms. What is the tacit human rights message accompanying such massive transfers of state-of-the-art weaponry in the name of 'national defence' to those with power to abuse in developing countries? Average per capita expenditure on arms is US$38, compared to US$12 on health (Siward, 1989).

5.4 Education and training issues

The WHO stresses that in developing countries, mental health must be viewed as an integral part of public health and social welfare programmes, not as a separate entity requiring specialised knowledge and skills. Primary health workers, frequently the only network available, may have an important role in fostering discussion of war-related effects within a locally relevant framework, and in assisting in the recognition of those who merit extra attention and support. In this, it is incapacity in day to day functioning, rather than PTSD features alone, which is

the best marker for those who may have a true mental health problem. Some psychologically troubled people do not seek help, and indeed isolate themselves; a certain vigilance and consciousness-raising may be required. The few who commit suicide may well have acted in this way and opportunities to intervene were missed. WHO (1994) have been field testing a manual offering guidance to workers, including refugee camp administrators, on everyday complaints which may be war-related, and on serious mental illness such as psychosis. They suggest liaison with traditional healers. In Latin America, local volunteers have been trained to be what are called mental health promoters in the war-affected communities in which they live. Some initiatives of this kind seem to have been appreciated.

Social workers or other professionals in war zones may seek support, though it is not always clear how much they feel untrained in 'trauma' issues, and how much they want recognition of the huge burdens on them in maintaining some semblance of services. In Bosnia and elsewhere, workers have sometimes been approached by refugees, complaining of headaches, bodily pains, weakness, poor sleep, jumpiness or of being unable to think straight. These complaints are, of course, a form of communication, but it is also helpful to reassure the person that they are basically normal responses to the implacable, and ongoing, stresses of the war, and do not mean that he or she will go crazy. Similarly, children may be pointed out because, for example, they exhibit strong fear in particular situations, generally those which remind them of what has happened: the sound of planes or the sight of a soldier. Others may be cited because they are unusually clinging or fractious, disobedient or poorly concentrating in classes, or bedwetting. These too are common reactions and do not routinely imply something abnormal and a need for therapy. War games are a way in which they process events around them and do not usually mean a 'post-traumatic' problem. In war-torn Beirut, workers used the acronym STOP to remind themselves of what children needed: **S**tructure, **T**ime and **T**alk, **O**rganised activities, **P**arents. Save the Children Fund (1991) have published short manuals for those working with children in war zones. In Mozambique, SCF also sponsored work with teachers on the recognition and management of war- affected children in the classroom. Anything that is pro-family and pro-community will help both young children and adolescents to recover a more positive social reality.

5.5 The question of targeting

I have noted that the targeting of 'child soldiers' (or even 'children') or 'rape' or 'torture' victims for psychological interventions based on a trauma model is not generally justified. So too with 'women', even as we recognise the harsh pressures they face during war, for example, absent menfolk means extra economic pressure or poverty and lack of physical protection, and extra or sole responsibility not just for children but the sick, wounded and elderly. In parts of Central America, 50% of households are headed by a woman and are much more likely to be poor.

Who, then, might be targeted, and for what service? Orphaned and otherwise unprotected children are clearly a priority. The mass orphanhood of Mozambique has almost all been absorbed by extended families and members of former communities or tribal groups. People with physical ill-health or disability are often cited as a 'vulnerable' group, but generalisations are difficult. For example, my own study of war-wounded ex-soldiers in Nicaragua did not indicate that a severe disability - paraplegia, amputation etc. - made subsequent psychological problems more likely. Some of them were certainly candidates for orthopaedic surgery and physical rehabilitation, but all of them prioritised the targeting of appropriate training and work which would more fully restore them to the social mainstream and role of breadwinner (Hume & Summerfield, 1994). In Bosnia, UNHCR nominated those with pre-war physical or mental disabilities, a heterogeneous group whose needs varied from a sudden lack of psychiatric care and medication to physical hardship and neglect after abandonment by fleeing communities. Many of these were elderly. In a rare study of older adults displaced by war and famine in Ethiopia, over half of those aged over 60 years had to be left behind by their families, mostly to die (Godfrey & Kalache, 1989). The particular pattern of circumstances in each war zone demands flexibility in appraising what might constitute a good case for targeting on particular individuals or categories, rather than the general rule of addressing whole communities. These need to be as free as possible of donor fashions.

6. Some Research Questions

What do we know of the costs of the 160 wars since 1945 for those who survived them? Baker (1992) asserts that a body of indigenous writings about such questions does exist, but is rarely translated or published in the West. We need to know more about time-honoured coping patterns mobilised during crisis in a particular society, and what ensues when these too are engulfed by the conflict on the ground. We need longitudinal studies of victimised groups, both non-displaced and under-displaced and refugee conditions which reflect differing economic and social factors, including the extent to which the host culture is accepting or discriminatory. What happens after repatriation, and how is this influenced both by local factors and the attitudes of the government? How can we generate more data to demonstrate that not just peace but justice makes a difference to outcomes? There is still little solid data on those who do develop mental health problems, and the relative influence of pre-war vulnerabilities versus war experiences and exile (Ager, 1993). Research methodologies must emphasise qualitative methods.

The impact of wars experienced as genocidal might usefully be traced through shifts in the collective world view and group identity of survivor populations and their children, and in the socio-cultural and political institutions which represent these. What does it mean to be an Armenian, a Jew or, most recently, an East Timorese, Guatemalan Mayan, Iraqi Kurd or Rwandan Tutsi after attempts to eliminate them as a people, each with its history, culture and place in the world? How does the way they now engage with the world, and with those who offer them help, reflect their bitter knowledge that there are no limits to what can be done to a people without power or allies, and their collective adjustments to minimise the chance of a repeat? How has Vietnam come back collectively from a war that devastated the lives of millions, wrought massive destruction to its infrastructure, and with virtually no aid from the West? This is certainly a case study waiting to be fully documented.

All over the world huge numbers of ordinary, unremarkable people demonstrate a capacity to tenaciously endure, adapt and transcend. To honour this is not to play down what has been done to them and how they have suffered. Theirs is a largely unspectacular example which does not attract media or other attention and analysis, but it begs a resonant question: this is not how or why some individuals become psychological casualties, but how or why the vast majority do not. The oral

testimonies of survivors can offer graphic illustration of their experiences and insight into the processes they brought to bear on them. We need to deploy the wider sensibilities necessary to comprehend war and its aftermath as a complex tragedy and drama played out in public. The work of anthropologists, sociologists, historians and poets in both the West and the developing world, allied to the voices of survivors themselves, can help the humanitarian field get a more richly textured understanding of the range of responses to war and atrocity, outcomes over time, and ultimately to improve assistance programmes.

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Acronyms

ECHO	European Community Humanitarian Organisation
ECTF	European Community Task Force
MSF	Médecins sans Frontières
NGO	Non-Governmental Organisation
PTSD	Post-Traumatic Stress Disorder
SCF	Save the Children Fund
UNHCR	United Nations High Commissioner for Refugies
WHO	World Health Organisation

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