Culturally Competent Responses to the Effects of Armed Conflict on the Well-Being of Refugee Women

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Introduction

Armed conflict is often conceptualized as a gendered activity where fighters are men, and where women and children suffer, often differently and disproportionately. Sadly, "Violence is no longer merely the business of male combatants and trained militaries" (Rajasingham-Senanayake, 2004, p. 145). The postmodern wars and armed conflicts in the Balkans and in Africa that targeted and involved large number of civilians, including women and girls, present a fundamental challenge to how we conceptualize war and peace (Rajasingham-Senanayake, 2004) and analyze the effects of these "new wars" (Kaldor, 1999) on their survivors. Girl soldiers, women suicide bombers and women in battle fatigues carrying guns begin to blur both gender roles and conventional distinctions between military and civilian actors. As evidenced by the violence in Rwanda and Bosnia, for example, civilians can be both victims and perpetrators, sometimes seemingly in equal measure.

The battlefields are no longer the same either. Multicultural urban spaces and villages have replaced traditional combat zones. Neighbors have become enemies. The scale of armed conflict has intensified. Campaigns of organized violence against civilians have increased by 56% since the end of the 1980s (Mack, 2006). This figure supports the popular belief that civilians, including women and children, are increasingly being victimized in the post-Cold war era by perpetrators of political violence. Interestingly, more wars presently end in negotiated agreements rather than victories. This is encouraging news for peacemakers. However, wars that end in negotiated settlements last three times longer than those that end in victories and are nearly twice as likely to restart within a few years (Mack, 2006), rendering survivors more vulnerable to repeated victimization. The new wars where civilians are deliberately targeted have entailed immense disruption and radical transformation of historically multicultural societies (Mamdani, 2001; Rajasingham-Senanayake, 2001a and 2001b) and resulted in large scale forced migration and massive internal displacement.

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The benefits of engendering forced migration discourse and praxis are many. Making gender an integral part of the forced migration discourse allows for one to both identify the vulnerability and emphasize the agency of refugee and internally displaced women. We are all aware of gender-specific vulnerabilities that exist in emergency situations that often render refugee women more susceptible to different dangers, including sexual and gender-based violence, and increased rates of mortality and morbidity. However, these vulnerabilities do not stem solely from biological differences between women and men. They are also affected by social factors. Gender morbidity differences, for example, are "strongly influenced by social context, (. . .) by the position women and men occupy in society, the access each gets to services, and the kind of medical care each receives" (Boelaert et al., 1999, p. 166).

On one hand, refugee women experience increased vulnerabilities, but on another hand, refugee women and girls, even the very young ones, "often have well-developed moral, political, and philosophical understandings of the events in their lives and worlds" (Nordstrom, 1999, p. 78). Refugee women make important, life-and-death decisions at every stage of the migration process, but rarely get asked to be involved in political solutions or peace-building activities. Conceptualizing gender as a relational dimension of human activity and thought allows us to also pay attention to refugee women in different positions within the same society (female heads of households, orphaned girls, rural or urban refugee women) and in relation to different categories of men (husbands, fathers, brothers, spiritual leaders, clan leaders).

Furthermore, the variations among refugee women within the same category – their individual voices and personalities, the strategies they forged vis-à-vis husbands, kinsmen, ritual practitioners – are also central to the engendered forced migration discourse. The engendered discourse is particularly important when designing policy and programmatic responses aimed at alleviating the effect of armed conflict and political violence on women. Much remains to be done, including implementation of policies to improve protection of women and girls affected by armed conflict, assessment of the special needs of refugee and internally displaced women and girls in different countries and contexts, and improvement of systems of care set up to alleviate the consequences of armed conflict on women and girls.

In this chapter I focus on the psycho-social consequences of armed conflict on refugee and internally displaced women and girls. In particular, I discuss the strategies used by the international community to "treat the war" as well as its wounds. As the number of refugees and IDPs increases, so does the number of programs established to provide psychological help for refugees and victims of wartime violence (Bracken et al., 1997a). The expansion of such programs in the West and the considerable zeal with which they are exported to non-Western countries indicates the prominence of mental health concepts and approaches in the forced migration field. Particularly prominent is the discourse of "trauma" as a major articulator of refugees' suffering (Summerfield, 2000, p. 417). This prominence is based on the premise that ethnic cleansing, war, and civil strife constitute mental health emergencies and result in "post-traumatic stress," which has in turn led to the use of treatment modalities based on the Western biomedical model. At the same time,

other models, building on the refugees' own resilience, indigenous coping strategies, and spirituality, are beginning to emerge. I explore the potential of these programs to maintain women's strength and further empower them to deal with the consequences of armed conflict on their own terms.

Vulnerability and Resilience

"The short- and long-term impact assessments of armed conflict on women and girls (and men and boys) have been very scarce and studies focusing on experiences of socio-political violence, collective suffering, and presence of disease and trauma-related disorders are only beginning to emerge in the scientific literature" (Pedersen, 2002, p. 182). It is worth mentioning that a significant number of publications on the psychological impact of political violence are based on studies of victims of terrorist attacks in Western countries (see Difede et al., 1997; Parson 1995; Weisaeth 1993; Abenheim et al. 1992; Shalev 1992; Curran et al., 1990; Cairns and Wilson 1989; Bell et. al., 1988) or are based on studies of refugees or torture victims from Southeast Asia and Central America resettled in North America or Europe (see Mollica et al., 1987, 2004; Beiser, 1988; Beiser et al., 1989; Hauff and Vaglum, 1993). There is a striking absence of studies of the most affected populations in their original locations or those displaced within the region. According to a recent review of 135 studies on the epidemiology of PTSD, only eight studies (or 6%) were conducted in developing countries (Pedersen, 2002).

With few exceptions, existing studies favor a focus on the trauma of an individual, at the expense of research on the suffering of war-affected communities and populations. In *Writing at the Margin: Discourse between Anthropology and Medicine*, Arthur Kleinman (1995, p. 101) points out that suffering is "a universal aspect of human experience in which individuals *and* groups have to undergo or bear certain burdens, troubles and serious wounds to the body and spirit" [my emphasis]. Suffering is inextricably embedded in social contexts. "No matter how true it is that there must be an individual *locus* of suffering, the meaning of suffering arises out of the relations of individuals together in the society, so that in consequence the social fact of suffering is more than a sum of its parts" (Bowker, 1997, p. 363). Allan Young (1997, p. 245) emphasizes the social dimension of suffering in the sense that it is "understood locally, by identifiable groups and communities, in the context of ideas about redemption, merit, responsibility, justice, innocence, expiation. . ." and is "based on social codes (which include moral and religious codes)." John Bowker, author of *Problems of Suffering in Religions of the World* (1970) and *The Meaning of Death* (1991), writes: "while some items of suffering can indeed be isolated and treated in abstraction, this should not distract us from remaining alert to the far wider networks of constraints that contribute causatively to human suffering" (Bowker, 1997, p. 380). In the context of mass displacement of whole communities resulting from armed conflict, it seems particularly important to focus on the suffering of refugee and internally displaced communities.

Some authors suggest that focusing on individuals has resulted in overestimation of the magnitude of psychiatric disability among refugee populations. As Marshal

(Marshal et al., 2005) points out, much of the existing research on refugee mental health has focused on individuals seeking health and social services who may have more severe problems than the general population of refugees (Eisenman et al., 2003; Fernadez et al., 2004; Hinton et al., 2000) or individuals petitioning for political asylum who may be motivated to over report trauma exposure and related psychiatric symptoms (Keller et al., 2003; Laban et al., 2004). Furthermore, research is often conducted while refugees are in refugee camps or shortly after arrival in a resettlement country (Jaranson et al., 2004; Mollica et al., 1993; Turner et al., 2003; Van Ommeren et al., 2001; Weine et al., 1998). Marshall argues that "It is difficult to determine if the psychiatric distress documented in these studies represents an acute condition, which might resolve spontaneously or with a change in circumstances, or whether it reflects a chronic condition that will persist in the absence of a therapeutic intervention." They also stress that many studies of refugee mental health have relied on symptoms screening instruments to assess probable diagnoses and they typically overestimate prevalence (Marshall et al., 2005, p. 572).

In my view, the most overlooked group of women (and men) affected by armed conflict and political violence are the refugees and internally displaced who are doing well. As demonstrated above, the scientific literature focuses almost solely on pathology, few researchers study resilience despite the fact that resilience, not trauma, is at the center of many refugees' survival. Unfortunately, many more researchers, policy makers and service providers are interested in the five to 20% of refugees affected by armed conflict who exhibit symptoms of distress than in the 80% of those who survived political violence and are able to function rather well. While we have a moral obligation to support those who suffer and study risk factors, we also need to understand protective factors in order to maintain the resilience and well-being of those affected by war and prevent possible delayed onset of disabilities stemming from exposure to armed conflict as well as mitigate the effects of post-conflict experiences on the well-being of refugee women and girls.

The Growing Prominence of Medicalized Trauma Programs

Recent years have seen tremendous increase in the number of programs addressing "refugees" "trauma" and "post-traumatic stress" (Bracken et al., 1997; Summerfield, 1999, 2000; Watters, 2001). Indeed, trauma projects are becoming progressively more attractive for Western donors. In early 1995, the European Community Humanitarian Office (ECHO) funded 15 international non-governmental organizations (NGOs) from six European Union member states to establish psychological programs in the former Yugoslavia. A European Community Task Force (ECTF) review noted 185 such projects being implemented by 117 organizations. There were 10 times more projects in Croatia than in Bosnia-Herzegovina, the reason given being the state of the war. Sixty three percent of these projects offered direct psychological services and 54% ran psychologically oriented groups, mostly self-help. Thirty three percent of the projects provided psychiatric services and 63% had staff training programs focusing on war trauma (Summerfield, 1999, p. 1452).

The expansion of such programs in the West – as documented by van Ewijk and Grifhorst (1997) in the Netherlands, Muecke (1992) in the United States, and Watters (2001) in Britain – and their export to non-Western countries – as shown by Foster and Skinner (1990), Gibbs (1994), and Boyden and Gibbs (1996) in reference to South Africa, Mozambique, and Cambodia, respectively – are directly related to what Kleinman calls "medicalization of human suffering" (Kleinman, 1997) and Hughes labels "culture of victimhood" (Hughes, 1994). Bracken relates the proliferation of specialized centers for psychological care of refugees to the "modernist responsibility to act" and "control the disorder provoked by suffering and loss through instituting programs of analysis and therapy" (Bracken et al., 1997, p. 434) "that may eschew critical analysis in favor of pragmatism that proliferates, and adds credence, to bio-medical taxonomies" (Watters, 2001, p. 1710). They argue that the tendency to establish such centers and programs results from the "spectacular growth within Western culture in the power of medical and psychological explanations for the world, and in the pronouncements of mental health professionals" (Bracken et al., 1997, pp. 436–437).

Undeniably, trauma programs have acquired a new prominence in the refugee field. In the mid-1990s, the United Nations Children's Fund (UNICEF) established a National Trauma Program in Rwanda (UNICEF, 1996). The National Trauma Center, headquartered in Kigali, provided intensive therapy for traumatized children and their families. By 1996, over 6,000 "trauma advisors" had been trained in basic trauma alleviation methods. They reportedly assisted 144,000 children (Summerfield, 1999, p. 1451). Similar efforts to train mental health staff were undertaken by the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) in Bosnia and Croatia (Summerfield, 1999).

The prominence of mental health programs in refugee camps, resettlement sites, and detention centers seems to be directly related to the rise in the diagnosis of post-traumatic stress disorder (PTSD) that is considered by many mental health experts a "hidden epidemic" and the most important public health problem in countries recently torn by wars, such as Kosovo, Bosnia-Herzegovina, Croatia, and Rwanda (Agger et al., 1995). These assertions often influence international organizations and governments. Their mental health consultants, psychiatrists Inger Agger and Jardanka Mimica, told WHO and UNHCR that some 700,000 people in Bosnia and Croatia suffered from severe trauma and are in need of urgent treatment, and that local providers are able to address less than one percent of these cases (Agger et al., 1995, 1996). According to UNICEF, "10 million children have been psychologically traumatized by war in the past 10 years and [. . .] psycho-social trauma programs must be a cornerstone of their rehabilitation" (Bracken et al., 1997a, p. 439).

The Medical Model

Medicalization is a widespread tendency to expand the meaning of medical diagnosis and the relevance of medical care. Medicalization refers to the way in which medical jurisdiction now encompasses many problems previously not defined as

medical issues (Williams and Calnan 1996, p. 1609). As a result of medicalization, suffering is transformed into a psychiatric condition. An existential experience of tragedy, human rights abuse, and loss is converted into technical problems that transmogrify its existential roots (Kleinman, 1995, p. 34).

Furthermore, medicalization not only reconstructs human experiences, but also, as Illich (1976), Pupovac (2002), and Summerfield (1999) have argued, the exaltation of biomedicine may actually diminish the capacity of human beings to deal with anxiety and suffering, deny their resilience, render them incapacitated by their dramatic experiences and indefinitely dependent on external actors for their psychosocial survival. Margaret Lock (1997) reminds us about the dangers resulting from contemporary tendency in Western societies to appropriate, through biomedical technology, what was formerly taken as "natural," and thus largely beyond human control. This tendency not only changes our expectations about events such as illness and death, but also our view of suffering. When suffering is defined as a medical problem, it is removed from a public realm and is no longer within the purview or power of ordinary people; rather it is raised to a plane where only professionals – medical or mental healthcare providers – can analyze and discuss it. Moreover, when refugees suffer as a result of political dissidence or generalized political violence, medicalizing their experiences removes the matter from the political and social context that produced their anguish and loss (Wellman, 2000, p. 28).

Social scientists offer different explanations of the causes of medicalization. Some have argued that medicalization is a means of social control that serves the interests of particular powerful social groups such as the ruling capitalist class (Navarro, 1975, 1986; Waitzkin, 1979, 1983). Others agree that medicalization is a form of social control, but argue that it serves a heterogeneous array of interests and institutions – prisons, schools, the family – as well as particular segments of the medical profession (Freidson, 1970; Conrad and Schneider, 1980, 1985; Gabe and Calnan, 1988). Feminist writers stress the ways in which women's bodies and lives have been increasingly medicalized and subjected to control by patriarchal medical profession (Doyal, 1979; Scully and Bart, 1978). Illich (1976) suggests that the medical profession has not only persuaded the public into believing that medical professionals have an effective and valuable body of specialized knowledge and skills, but has also created a dependence through the medicalization of different life events and experiences which has in turn undermined and taken away the public's right to self-determination.

Post-Traumatic Stress Disorder

PTSD was first introduced into the Diagnostic and Statistical Manual of DSM-III (APA, 1980) "to address the need for a common diagnostic category covering a wide range of clinical syndromes associated with a traumatic experience" (Fischman, 1998, p. 28). The diagnosis, originally intended to apply to the aftermath of extraordinary experiences, has been increasingly applied to a wide range of life difficulties

such as crime, complicated childbirth or traffic accidents (Summerfield, 1999). Moreover, the most recent reformulation of PTSD in DSM-IV has included secondary traumatization; e.g., trauma resulting from listening to accounts of torture or war atrocities.

Many consider PTSD, along with depression, the most prevailing psychological disorder among refugees (Turner and Velsen, 1990). Surveys of populations who have experienced violence indicate that between 25 and 75% experience PTSD (Desjaralis et al., 1995). Arcel and colleagues (1995) at the International Rehabilitation Council for Torture Victims in Copenhagen assert that 25–30% of refugees develop PTSD and need the help of skilled mental health professionals. Similarly, Medecins Sans Frontieres (1997) claims that 20% of trauma survivors will not recover without professional assistance and that in refugee situations the morbidity rates are much higher. Many of these statistics stem from biased sampling (Watters, 2001; Silove, 1999). The literature shows that the highest rates of PTSD have been recorded within Western psychiatric clinic populations. For example, between 18 and 53% of Bosnian refugees in treatment presented PTSD symptoms (Mollica et al., 1999). Intermediate rates have been recorded in sampled community groups, and the lowest rates have been identified in epidemiological samples (Silove, 1999). In an epidemiological study Mollica found that only 15% of Cambodians in a refugee camp on the Thai-Cambodian border suffered from PTSD (Mollica et al., 1993).

Recent studies suggest that psychiatric illness among refugees might not be as prevalent as we have been led to believe (Hollifield, 2005, p. 1283). A meta-analysis of interview-based studies of the prevalence of PTSD, major depression, psychotic illness, and generalized anxiety disorder in refugees resettled in Western countries revealed that about one in ten adult refugees has PTSD, about one in 20 has major depression, and about one in 25 has a generalized anxiety disorder (Fazel et al., 2005). These prevalence estimates are much lower than some frequently cited claims based on less reliable estimates (Carlson and Rosser-Hogan, 1991; Watters, 2001). Furthermore, the investigators identified contextual variables that account for some of the heterogeneity of prevalence rates in earlier studies. The variability stemming from these contextual factors is not small. For instance, the reported prevalence of PTSD is 218% higher when non-random sampling is employed (versus random or complete samples), 288% higher when assessments are carried out through an interpreter (versus a bilingual/bicultural interviewer), 322% higher when sample size is small (versus large), and 411% higher when clinical assessment is used (versus a semi-structured interview).

Additionally, there is a continuing debate in the refugee mental health field whether rates of PTSD in survivors of community violence are enduring or transient (Becker et al., 1999; Berthold, 1999), and how well the PTSD diagnosis can assess the multiple effects of trauma (Silove, 1999). Also, high or moderate PTSD prevalence rates do not imply a universal acceptance of the diagnosis. The controversy surrounding PTSD stems from a variety of reasons. The diagnostic use of PTSD has been criticized on the grounds that a universal standard to define trauma leading to marked distress is difficult to formulate (Davidson, 1930 and that the diagnostic

criteria have been subjected to rapid changes (Loughrey, 1992), for its taxonomic inadequacy as a subcategory of anxiety disorders which in turn are classified under mental disorders (Donohue and Elliot, 1992), and for not representing other types of recognized or postulated trauma-related disorders (Davidson, 1993; Kantemir, 1994, p. 400).

Some argue that the term *post*-traumatic stress disorder could not be applied to most refugee women since for most of them traumatic stress is not an isolated incident. There is nothing *post* about post-traumatic stress; many refugee women continue to experience stress even upon resettlement (Willigen, 1992). Others question the use of the term *disorder*, which transforms experiences that are essentially a socio-political problem into medical pathology and implies victimhood, which is not a healthy identity for refugee women. Therapeutically speaking an important clinical goal for refugee women is to find meaning in their experience and assume personal responsibility for their own well-being, and not to live in the role of a victim (Frankl, 1985).

Allodi (1991) suggests that in the case of refugee women who survived torture, the PTSD model reduces what is often a complex human rights and political problem to the level of individual psychology. Ochberg (1989) asserts that trauma experienced by torture survivors is far larger than that encompassed by PTSD. Furthermore, Young argues that "traumatic memory and PTSD are constituted through a researcher's techno-phenomena and styles of scientific reasoning" (1995, p. 10). He also argues that PTSD and its traumatic memory "have been *made* real" (Young, 1995, p. 6) and that "the disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized (and continue to do – my emphasis) these efforts and resources" (Young, 1995, p. 5).

The cultural appropriateness of PTSD as a diagnosis for refugee women is questionable because there is very little knowledge concerning its ethno-cultural aspects (Marsella et al., 1993). Most refugee women currently assessed and treated by Western mental health providers come from non-Western countries and draw upon cosmologies different from those used in the West to explain their suffering, therefore in their worldviews there is little room for a taxonomy which until very recently has been void of the term "culture" (Briody, 1990 in Eisenbruch, 1991). Moreover, what constitutes "disease" in one culture is not necessarily viewed as a disease in another (Engelhardt, 1975).

Trauma literature suggests that PTSD has a worldwide prevalence. However, it is a mistake to assume that because phenomena can be regularly identified in different cultural and social settings, they have the same meaning. Not surprisingly studies which have used standardized questionnaires, developed in the West, to assess the prevalence and distribution of mental disorders in non-western populations usually managed to identify signs and symptoms of diseases under study. The fact that symptoms are easily identifiable in different cultural settings does not guarantee that they mean the same thing in these settings. Kleinman (1987) calls this reasoning a "category fallacy." Assessment of psychiatric illness should begin with the

identification of local phenomenological descriptions of folk diagnoses, which only then can be compared to Western nosology (classification of diseases). For example, while there is a rather extensive body of knowledge about the response to torture among Indochinese patients (Mollica et al., 1987), "ethnographic studies have still to determine if a folk illness caused by torture exists in these cultures, and whether it is similar or vastly different from Western derived PTSD criteria" (Eisenbruch in Mollica and Caspi-Yavin, 1992, p. 265).

Too great a focus on PTSD may also lead to misinterpretation of refugees' desire to tell their stories (Goździak and Tuskan, 2000; Goździak, 2002). Most clinicians operating within the medicalized trauma model view stories of trauma as examples of "working through" the suffering, while many refugee women see them as political testimonies aimed at bringing about justice and fighting human rights abuses. By medicalizing the *sequelae* of basic human responses to oppression, the focus is shifted away from human rights and the prevention of forced migration and associated suffering to the objectifying and politically neutral diagnostic categories of modern medicine (Mollica, 1992, p. 23).

The critique of the medicalized trauma model and the PTSD diagnosis does not dispute the need for services, including medical care, for refugee women. What is in question is the reduction of the refugee experience to a medical condition and the notion that psychological responses to war, torture, oppression can best be accounted for within the categories developed by Western biomedicine and that psychotherapy is the antidote (Bracken et al., 1995; Summerfield, 1999). Moreover, only a minority of refugee women will actually reach the door of a mental health provider. The majority of survivors of war, ethnic cleansing, and other atrocities become survivors without treatment. As McIvor and Turner suggest "it may be as beneficial to look at reasons for this in terms of individual, family and cultural factors as to inquire about what discrete ingredients seem to work in the minority who do seek treatment. Community, political and religious groups probably provide the majority of support and treatment" (1995, p. 709).

Alternative Approaches to Address the Effects of Trauma

The PTSD narrative has often marginalized alternative discourses based on survival, strength and coping in the face of adversity and minimized the role of individual agency or meaning which can have particular significance in armed conflict and civil war (Tribe, 1998, 2004; Bracken and Petty, 1999; Ahearn, 2000). Explanatory health models and idioms of distress held by individuals and communities are likely to be multi-layered and defined by both cultural and social meanings and contexts (MacLachlan, 1997; Tribe, 2002; Bemak et al., 2003). Culturally sensitive responses to the suffering of war affected refugee and internally displaced women should reflect the complex nature of the experiences.

Alternative approaches that have gained currency with ethnic-community based organizations, programs providing assistance to refugee women, and a slowly

increasing number of clinicians focus on the resiliency of refugee women as the best way to address traumatic experiences. Most refugee women do not see themselves as "victims" and have no interest in sharing their stories within the clinical framework. Rather than "conflate the terms of refugee and war victim into a generalized category of traumatized, associated with psycho-pathology" (Eastmond, 1998, p. 179), these newer approaches emphasize the centrality of indigenous coping strategies (including religion and spirituality), linguistic appropriateness, and cultural sensitivity in service provision to refugee women. There has also been increased recognition of the need to address the underlying causes of trauma and not just deal with the symptoms that trauma produces.

In Guatemala, Mozambique, Angola, Rwanda, and South Africa, programs aiming to heal war-affected refugees and IDPs are moving away from one-on-one psychotherapy to traditional community conflict resolution strategies, belief systems, and public truth telling to restore social fabric after community destruction (Bagilishya, 2000; Summerfield, 2000; Bloom, 1998). Newly emerging psycho-social programs are also trying to combine cultural, social, educational, and therapeutic interventions as well as combining individual and group counseling programs.

Indigenous Healing Strategies

In developing countries, traditional healers are a lot more important and plentiful than mental health professionals. For example, "In a population of 19.5 million Sri Lanka has only approximately 33 psychiatrists and three psychologists, very few of them in the conflict zone" (Tribe, 2004, p. 115). It is important, however, to realize that regions lacking western-trained mental health providers are often blessed with a range of indigenous healers who provide important support for individuals, families and communities suffering psychological distress. "These local helpers provide important psychological and practical support and may serve communities in ways that western-trained psychologists and psychiatrists cannot" (Tribe, 2004, p. 115).

Van Der Veer and colleagues report the use of *mediums*, *oracles,* and religious leaders to ameliorate the suffering in Jaffna after the war between the Indian Peacekeeping Force and the Liberation Tigers of Tamil Eelan in the late 1980s (Van Der Veer et al., 2003). Wilson (1989) discusses how traditionally many societies had particular rituals which were performed when people returned from war, for example the Sweat Lodge purification ritual of certain Native American groups. Tausig (1986) provides an interesting analysis of the relationship between colonial terror and folk healing among the Putumayo Indians in Colombia. Patrick Bracken discusses the role of traditional healers in the Luwero Triangle, known as the "killing fields of Uganda" where in the 1980s hundreds of thousands of civilians were killed in government counter-insurgency operations. The traditional healers played a double role in the post-conflict period. "On the one hand they were providing therapies for sick individuals while on the other hand they functioned as a link with the past

and thus contributed to a sense of continuity in the community. The healing activities of the traditional healers depended to a large extent on consultation with the ancient spirits of the tribe" (Bracken et al., 1995, p. 1079). The emphasis on the communal past tapped into protective factors that enabled the healing of both the traumatized individuals and the larger group of survivors.

Amani Trust, a non-governmental organization that rehabilitates survivors of torture and organized violence in western Zimbabwe has recognized the importance of belief systems and has responded to requests by community leaders and families in rural areas for interventions to appease the aggrieved spirits of people who had been murdered and buried in unacceptable graves. In pursuit of a solution to this problem, *Amani* became involved in exhumation and has been involved in longitudinal case studies of the consequences of exhumation and reburial from a cultural, psychological, individual, and group perspectives. "(. . .) the process of exhumation and reburial does physically what psychotherapists in the West do metaphorically – it encourages people to explore their past and see the links with their current experiences. Reburial of murdered individuals often restores psychological, emotional, and historical of the affected communities" (Eppel, 2002, p. 870).

The Role of Religion and Spirituality in Coping with Trauma

Is it possible to turn to religion in times of extreme suffering? During wars it often seems that God has forsaken the suffering. Some war survivors go through life with the cruel words of scripture "My God, my God why have you forsaken me?" on their lips (Matthew 27: 46). Not everybody finds consolation in religion in the time of extreme suffering. Elie Wiesel, writing about his experiences in concentration camps, said that after seeing innocent children burned alive, the "flames consumed my faith forever" and that the experience "murdered my God and my soul" (Wiesel, 1960, p. ix). Many soldiers returning from Vietnam remarked "I lost my soul in Vietnam" (Brende, 1993, p. 325). Others have written about the experience of trauma at the moment when "The spirit went numb" (Mahedy, 1986, p. 32) and soul development stopped (Baker, 1989), and have called it a disorder of hope (van der Kolk, 1988), a spiritual night (Mahedy, 1986, p. 32), and a loss of wholeness (Sinclair, 1993, p. 70, in McBride and Armstrong, 1995, p. 7).

Still others found refuge in God, referred to Him as a Shepherd and a cleft in the rock, and found religious beliefs and ritual helpful in trauma healing. Indeed, many religions not only offer a rationale for suffering, but also provide a community setting in which suffering can become a dignified performance. In Buddhism, suffering is explained as a burden of past *karma*, in Christianity, as a backlash from the original sin, but also as an opportunity for a closer association with the Savior on the Cross, and in Islam, as a God-willed destiny. In some societies healing and religion are inseparable, and medical mores are tied to ritual and theology (Fabrega, 1990). Clinical evidence establishes positive relationship between religious beliefs and behavior and physical and mental health (Larson et al., 1998). The

direct emotional stress-reducing function of religious beliefs is intuitively obvious. "Beliefs in God, saints, faith-healing, and life after death are indeed explicitly recommended by spiritual leaders for the lifting of the hopes and the relief of despair and suffering" (Pepitone, 1994, p. 148).

Refugee women's engagement with religion is often very different from the experiences of refugee men. Research indicates that faced with similar adverse circumstances men and women react differently. A study of prisoners in a Russian labor camp showed that women observed religious rituals and celebrated birthdays, while men fantasized about escape, solved chess problems, and talked incessantly about politics (Weinberg, 1992). Religion operates in compelling, competing, and contradictory ways as it shapes the experiences of refugee women. Religion can be a source of resiliency and facilitate integration, but it can also have a contradictory status in refugee women's lives. The close relationship between core religious beliefs and religious institutions with their associated rituals and customs means that the distinction between these is often overlooked. Refugee women's position within societies is regulated by religious institutions both at the family and community levels. Custom and tradition, often justified on religious grounds, ensure refugee women's conformity to conventional gender roles which can be sources of powerlessness and pain. In particular, notions of fatalism which are integral to many religions, from Hinduism to Orthodox Christianity, can offer comfort to the powerless and an explanation for suffering, while at the same time constrain women (and men) from seeking change.

Suffering has been an inseparable element of many refugees' lives. Religion is thought to help people cope with life's experiences by assigning meaning to events (Kelley, 1972; Roberts and Davidson, 1984). Both Eastern and Western religions may help refugees cope spiritually, cognitively, and emotionally with what has become known as the "survivorship syndrome" (Haines et al. 1980; Fraser and Pecora, 1985–1986; Skinner and Hendricks, 1979). Research also indicates that religious rituals play an instrumental role in trauma healing. One of the recognized effects of religious ritual is to create both sacred time and sacred space, "a moment out-of-time and a place apart, nearer to the supernatural and the center of the universe than to the streets and neighborhoods of everyday. Ritual renews the world by offering an opportunity for participants to step outside of it; it renews time by bringing the past, the present, and the future together" (Wellmeir, 1994, p. 17).

However, in some cultures women are often denied both the knowledge and the practical skills required to initiate rituals. In fact, most human religions, from tribal to dominant religions, have treated women's body, in its gender-specific sexual functions, as impure and polluted and thus to be distanced from sacred spaces and rites dominated by males (Radford Ruether, 1990, p. 7). In many denominations, women are officially barred from ordination and men run the spiritual and administrative affairs of the congregations.

The role of refugee women in formal and informal religious spheres is complicated and calls for a careful analysis of the conditions and ways in which religion both promotes and lowers status of women compared to men and helps to empower women. There is a body of research indicating that organized religions discriminate

against women, both theologically (Carr, 1982; Fiorenza, 1983; Himmelstein, 1986; Weaver, 1986) and institutionally, especially in opportunities for formal leadership (Chavez, 1997; Lehman, 1985; Nason-Clark, 1987; Swidler and Swidler, 1977; Wallace 1975, 1992). Other research suggests that women use religion and religious institutions to argue for equality (Briggs, 1987; Chartlon, 1987; Daly, 1973; Ice, 1987; Royle, 1984; Weaver, 1986; Weidman, 1985). Women also use them as social and physical spaces in which to network with other women and build feminist consciousness (Ammerman, 1997; Hargrove, 1987; Kaufman, 1991; Weaver, 1986; Inter, Lummis and Stokes, 1994; Wuthnow, 1994), and to assert informal power in the practice of unofficial, domestic religion (Brown, 1995; Diaz-Stevens, 1993; Dougherty, 1978; Jacobs, 1996).

Being a refugee – the suffering in wartime, loss of homeland and family members, and the challenges of life in a new country – is for many forced migrants, a spiritual crisis of unparallel severity. The basic spiritual needs – hope, meaning, relatedness, forgiveness or acceptance, and transcendence – are threatened in the forced migration process. The impact of being uprooted is particularly poignant and often very traumatic for refugee women, especially when rape and sexual abuse become commonplace. Unmet spiritual needs put refugee women's integration and well-being at risk. Supporting refugee women's faith is therefore important at every stage of the migration process.

Human Rights and Truth and Reconciliation Approaches

Application of a human rights framework to understanding and responding to refugees' and torture survivors' trauma has also been successful. For example, Argentineans focused their efforts on the identification of victims of political oppression buried in mass graves, while the Grandmothers on the Plaza de Mayo needed to discover the parental background of their grandchildren who had been taken from their tortured and murdered parents and given up for adoption (sometimes to the torturer's family). Both of these efforts were instrumental in the survivors' healing process, but at the same time they achieved major advances in anthropological taxonomy and forensic medicine (Joyce and Stover, 1991 in Mollica, 1992, p. 30) and returned full circle to the human rights framework that constitutes the very beginning of the modern crusade against torture.

In a similar way, truth commissions "allow victims, their relatives and perpetrators to give evidence of human rights abuses, providing an official forum for their accounts. In most instances, truth commissions are also required by their mandate to provide recommendations on steps to prevent a recurrence of such abuses" (http://www.usip.org/library/truth.html). In some cases, the commissions have recommended attention to the needs of those who have been the targets of human rights abuses: "With regard to certain categories of victims, such as amputees, war wounded and victims of sexual violence, the [Sierra Leone Truth and Reconciliation} Commission recommends that they be given free physical (and

where necessary, mental) healthcare for the rest of their lives or to the extent that their injury or disability demands" (Sierra Leone Truth and Reconciliation Commission, 2004).

Khulumani (Zulu for "speaking out") is an example of a program set up in early 1995 within the framework of the Truth and Reconciliation Commission (TRC) in South Africa. Initially, "speaking out" was seen as a linear process in which uncovering the truth would lead to psychological and social healing of individuals providing testimonies (Asmal et al., 1994). However, *Khulumani* not only became a respected program reflecting the "authentic views" of survivors, but also evolved into a forum where survivors learned to "speak out" in a very different register from that initially envisioned when they were asked to "tell their stories." The group used the press to "speak out' and they captured public and television space through organizing high-profile public demonstrations and marches; public healing ceremonies were also held and a play about their stories was developed which they took back into communities as well as overseas. What was initiated as a support network for victims who "spoke out" developed into ways that also contributed to the economic subsistence of its members, mainly women in their late 40s and older (Lykes et al., 2003).

In Guatemala, photography was used to "tell the story of violence" and of women's responses to the war. By speaking out through pictures and storytelling, the Association of Maya Ixil Women-New Dawn (ADIMI) project sought to prevent future violence through creating a public record as well as to build connections with other women in Guatemala and beyond who were engaged in similar processes. Equally importantly, project participants sought new skills and resources to develop economic and psychosocial resources for their communities thereby responding to the material ravages of war (Lykes et al., 2003). The ADMI project was inspired by the work of Chinese rural women, Visual voices: 100 photographs of village China by the Women of Yunnan Province (1995). The two photographic methods used by ADMI, "Photo voice" (Wang 1999; Wang et al., 1996) and "talking pictures" (Bunster and Chancy, 1989), formed a basis for a participatory action research project that resulted in a book about the past and present struggles of Maya women in Guatemala (Women of Photo Voice and Lykes, 2000; Lykes, 2001).

In Colombia, the League of Displaced Women in Cartagena has focused its attention on *afrodesplazadas* (or Afro-displaced women) and has taken the bold step of providing what the state rarely does for displaced Colombians: sturdy new homes, child care, emergency food and psychological and reproductive health counseling. The League has also adopted another mission: preparing for prosecution of gender-based war crimes against various armed groups in Colombia. The Center for Investigation and Popular Education (CINEP), also in Colombia, frustrated that many aspects of political violence, especially cases of torture and disappearance were not being recorded let alone prosecuted, started documenting such crimes. According to the US State Department, CINEP has the most influential database of human rights violations in Colombia (Howe, 2004).

It is important to remember that post-conflict community dialogue programs generally have involved only male representatives of communities and relied on male-dominated traditional reconciliation techniques. International organizations,

national governments and NGOs should "implement reconciliation programs, such as workshops and communal projects that specifically include women" and "incorporate cultural processes that allow women to convey histories" (Shoemaker, 2001).

Ethnography and Participatory Action Research

Much discussion about cultural competence of programs serving refugee women focuses on cultural characteristics of specific refugee populations. Unfortunately, this approach "may develop stereotyped views and assumptions that will not serve them (mental health professionals) well in dealing with individuals" (Thornton Garret, 1995, p. 67). Reliance on normative data may lead to what Ridley and colleagues (2000) call "unintentional racism."

Some utility may be derived from "ethnographies that canvassed concepts of coping styles, and ideas about and reactions to illness generally and mental illness in particular" as well as studies of "cultural beliefs about depression, bereavement, anxiety, and cultural influences on the ways emotions and mental disorders are experienced, including responses to psychiatric treatment" (Kleinman, 1988, p. 148). However, ethnography, including ethnographic methods and underlying epistemology, is the real bridge to multicultural mental health practice with refugees.

The goal of ethnography is to understand another way of life from the native point of view (Spradley, 1979, p. 3) and to grasp the native's point of view, her relation to life, to realize *her* vision of *her* world (Malinowski, 1922, p. 25). "Rather than *studying people*, ethnography means *learning from people*" (Spradley, 1979, p. 3). Ethnography "offers health professionals the opportunity of seeing health and disease through the eyes of patients from a myriad of cultures" (Spradley, 1979, p. iv). In mental health practice, ethnographic methods, including ethnographic interviewing, participant observation, and domain, structural, and taxonomic analyses, can be used to "elicit ethnopsychiatric beliefs of patients and families" and "evaluate the influence of cultural rules on abnormal behavior," as well as to "improve cross-cultural and cross-ethnic communication in the clinical interaction" (Kleinman, 1988, p. 149).

There has been much discussion about the utility of ethnographic methods and theory to the study of refugee mental health, as evidenced by a volume on Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research, edited by Frederick Ahern (2000). There is also a growing discourse on the role of ethnography in clinical practice, including clinical encounters with refugees. Eastmond (2000, pp. 84–85) emphasizes that "An ethnographic approach can also be a vital tool in clinical assessments of treatment, expanding the restricted context of the clinical encounter as well as the bases of the clinician's understanding, thus bridging anthropological and clinical traditions." Given the dynamics of refugee lives, she points out the usefulness of narratives and life stories to elicit "narratives of suffering" (Eastmond, 2000, p. 76). Herbst Robin (1992), Lifton (1993), and

Woodcock (1997) have also discussed how narratives can be used as therapeutic tools.

Arthur Kleinman, a Harvard psychiatrist and medical anthropologist, has been "writing at the margin" of anthropology and medicine for quite some time. He has been exploring the many ways psychiatry could benefit from greater knowledge of the concepts and methods of anthropology and conveying the relevance of cultural perspective for psychiatric practitioners (Kleinman, 1988). Kleinman argues for an ethnographic approach to moral practice in medicine and providing a provocative analysis – using an anthropological perspective – to indicate how biomedical concepts such as "trauma" and PTSD fail to incorporate the social worlds of patients (Kleinman, 1995). He also calls for using ethnography to reconstruct patients' "illness narratives" (Kleinman, 1988a).

Participatory action research is also gaining currency with programs aimed at documenting and addressing human rights violations against women. Women's Rights International (WRI) was founded with the specific purpose of developing methods that can accurately document human rights violations against women. WRI works with rural women living in countries at war using participatory action-oriented research. The women affected by armed conflict or state-sponsored violence choose the research questions, design the survey, and collect the information themselves. In 1995, WRI collaborated with the Women's Health and Development Program at the Mother Patern College of Health Sciences in Monrovia, Liberia, to document the experiences of women during the war. Using community participation research requires enduring commitment and carries substantial risks, but also has the potential for very positive and lasting changes at the local level (Jennings and Swiss 2001).

Psycho-Social Programs

Psycho-social interventions are the latest trend in programming for war and armed conflict-affected refugees. Although psycho-social programs have become a key component of international policy, there is much confusion over their meaning among aid agencies and the concept is under-theorized in academia (Pupavac, 2001, p. 358). The term "psychosocial" is often "used to indicate commitment to non-medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach" (Ommeren et al., 2005, p. 71). However, as some opponents point out "in practice" it [the term "psychosocial"] had become too quickly collapsible into "psycho" (Summerfield, 2005, p. 76). Ager points out that "Activities that come under this label in aid agency documents and NGO reports range from trauma counseling to peace education programs, life skills, self-esteem and empowerment building activities, and sports and recreational pursuits, to name but a few elements. The aims of these programs are to prevent trauma and stressors that negatively affect mental health to the degree possible, and to strengthen the capacity of refugees to cope with the traumas and stressors when prevention fails (Ager, 1993).

The critics of psycho-social approaches stress that "The cornerstone of the international psycho-social model is its assumption of the vulnerability of the individual" (Pupavac, 2001, p. 363). In that regard, the psycho-social interventions do not seem to differ much from the biomedical programs centered on the concept of trauma. Within the psycho-social conceptual framework, refugee and internally displaced women in the global South are deemed to be at a greater risk of psychological dysfunction because of the economic, political, and social insecurities they face. However, as Pupavac argues "a history of insecurity should not be equated with a history of psychological problems or greater susceptibility to psychological breakdown – a distinction that is lost in the international psycho-social model." In fact, the reverse correlation may be true; i.e. communities used to hardship "are likely to be remarkably resilient in the face of adversity." In Pupavac's view, "this factor helps explain why international aid workers, including trauma counselors, appear to be more susceptible to secondary or vicarious trauma than the recipient populations who have experienced primary trauma. It may be noted that counseling as a profession attracts a high percentage of former clients who re-train as counselors; consequently the field includes many individuals with a history of psychological vulnerability. This phenomenon in turn encourages a professional culture that tends to project its own sense of psychological vulnerability on to others" (Pupavac, 2001, p. 363).

Additionally, the psycho-social model "posits life-long or even multi-generational dysfunctionality as individuals who have experienced trauma are considered merely to be "in recovery" or "in remission," never recovered, but ever after haunted by their trauma and at risk for being re-traumatized by their memories" (Pupavac, 2001, p. 365). Summerfield (2005) points out that psycho-social programs are often imported to war-affected or post-conflict contexts because outsiders thought it was a good idea. Most refugee women and children affected by conflict do not: counseling is not a culturally familiar activity, and women affected by armed conflict use all their energy to survive a deepening health and human rights crisis.

Proponents of psychosocial programs emphasize the "dynamic relations between psychological effects (e.g., emotions, behaviors, and memory) and social effects (e.g. altered relations as a result of death, separation, and family and community breakdown). The psycho-social approach "suggests that although people are affected in many ways, three areas in particular are affected: human capacity (i.e., skills, knowledge, and capabilities), social ecology (social connectedness and networks), and culture and values." Women affected by war "need support to enhance both their own and their community's psychosocial well-being by strengthening each of these areas" (Mollica et al., 2004, p. 2062).

The benefits of psycho-social programs are assumed by international aid organizations, rather than backed up by empirical research. The evidence base for specific psycho-social interventions is small. A study by Mollica et al. (2002) of Cambodian refugees at the Thai-Cambodian border showed that environmental conditions – such as opportunity for economically productive activities – reduced psychiatric morbidity in camp residents. In Bosnia and Herzegovina, Agger and Mimica

(1996) recorded positive assessments of services received, with higher ranking of group meetings and shared activities than of individual therapies. Methodologically speaking, assessments using feedback from refugees participating in psycho-social activities have certain limitations (Ager, 2000). On the other hand, initial results of the UN experience with emergency and peace education initiatives aimed at improving social capital seem promising, but need further assessment (UNHCR, 2001; UNESCO, 2001). "The jury is still out as to whether current strategies improve matters" (Scott and Stradling, 2001, p. 126).

Summary and Recommendations

The discussion presented above indicates that recent literature records a robust discussion of the concepts, values, and cultural appropriateness of mental health interventions to reduce the psychological burden of war and armed conflict in resource-poor countries (Bracken et al., 1995; de Vries, 1998; Dyregrov et al., 2002; Mezyey and Robbins, 2001; Pupavac, 2001; Silove et al., 2000; Summerfield, 1999). The PTSD construct and trauma-focused services are the main focus of controversy (Ommeren et al., 2005). The controversy is compounded by the recent development of a new field – introduced by international organizations working in resource-poor countries – that is labeled "psychosocial."

Critics of these concepts and approaches point to medicalization of normal distress and the possible harm of assuming that western models of illness and healing are valid across cultures, while others consider denial of the importance of traumatic stress a professional error and denial of preventable suffering. In an attempt to generate advice on strategies to program designers in war-torn countries, Ommeren and colleagues (2005) have attempted to survey expert opinion. As a result of their survey, the authors have put forth eight principles that should be used in formulating response strategies:

(1) contingency planning before the acute emergency,
(2) assessment before intervention;
(3) use of long-term development perspective;
(4) collaboration with other agencies;
(5) provision of treatment in primary health care settings;
(6) access to services for all;
(7) training and supervision, and
(8) monitoring indicators.

Derrick Silove (2005) and Derek Summerfield (2005) have responded to the proposed principles in two separate essays published in the *Bulletin of the World Health Organization*. In his response, Silove (2005) stresses that these principles "present a radical challenge to those single-issue advocates promoting trauma counseling programs or short-term psychosocial project" (2005, p. 75). Silove points out the

necessity to distinguish between common, self-limiting psychological responses to violence and the persisting reactions that become disabling. He believes that the best therapy for acute stress reaction is social: providing safety, reuniting families, creating effective systems of justice, offering opportunities for work, study, and other productive roles, and re-establishing systems of meaning and cohesion – religious, political, social, and cultural. He also points out the challenges inherent in changing entrenched perspectives and practices of international agencies and donors to give priority to supporting integrated community-based programs that focus on social needs arising from psychological disturbances, rather than special issues or particular diagnoses.

Summerfield (2005), on the other hand, points out the tension in international agencies' – such as the World Health Organization – materials on refugee mental health issues "between the wish to acknowledge local worlds and the wish to promote Western mental health technology as a reproducible toolkit" (2005, p. 76). He reminds us that the Western mental health discourse introduces core components of western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.

What is needed, in my opinion, is support for empirical research, including epidemiological and qualitative studies to assess both the scope of the issues facing women and girls affected by armed conflict and the cultural appropriateness of implemented projects. This research needs to be formulated and packaged in a manner that translates readily into new program designs or policy approaches. More importantly, refugee and internally displaced women must be active participants in the design and implementation of this research and ensuing policy and programmatic recommendations.

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