14

The Effects of Societal Violence in War and Post-War Contexts

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Since the Second World War, changes in strategic targets, weapon technologies, and combat techniques have led to a significant increase in the number of civilian casualties of war, reaching 90% of total casualties in some cases (Turpin 1998). Social support networks, local economies, and food production systems also erode in such contexts, disproportionately affecting the lives of the most vulnerable people in society, including older people, people with disabilities, lactating women, and children (Pedersen 2002). Additionally, armed conflicts have consistently resulted in large flows of refugees and internally displaced persons. The latest UNHCR Global Trends Report shows that there were 51.2 million forcibly displaced people worldwide at the end of 2013, the highest number since 1989.

Armed conflict and related violence can have devastating and lasting consequences for mental as well as physical health. In 2011, the journal *Nature* published the widely discussed article "Grand Challenges in Global Mental Health," in which the authors—respected scientists and leaders in health policy—consider the mental health situation in states recently emerging from armed conflict or under endemic and protracted violence to be particularly

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R.G. White et al. (eds.), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*, DOI 10.1057/978-1-137-39510-8_14

grave. They state: "Extreme poverty, war and natural disasters affect large swathes of the world, and we still do not fully understand the mechanisms by which mental disorders might be averted or precipitated in those settings" (Collins et al. 2011, p. 30). In order to fill this gap in knowledge, they advocate immediate research and prioritizing of policies for adequate and sustainable interventions. Their call for action is backed by epidemiological surveys that have made strikingly apparent that armed conflicts exacerbate overall rates of mental disorders (Tol et al. 2011). In order to reduce the global burden of mental health conditions, a number of organizations have set out to foster processes of healing and to generate improved mental health policies and services. Much of their work is guided by standardized "evidence-based treatment packages" developed by researchers and clinicians to improve approaches to mental health treatments in war-torn societies.

Such interventions targeting psychological trauma and other ostensibly war-related mental health conditions have not gone unquestioned. In recent years, researchers have produced an extensive body of literature criticizing the inappropriate transfer of Western psychological assumptions to contexts where they may not be meaningful (Bemme and D'souza 2014; Kienzler and Pedersen 2012). Critics argue that such Western conceptions are based on understandings of normality and deviance that focus solely on problems located within the individual and lack a developed conceptual vocabulary for the relational, social, communal, and cultural dimensions and determinants of psychological suffering (Kienzler 2008). Instead, they show that remembering and forgetting traumatic experiences depend on socially and historically contingent memory systems that inscribe trauma not only in the body and the brain but also in the social and political processes that aim to regulate public and private recollection (De Jong, K. et al. 2003; McNally 2003). It is argued that disregarding the importance of sociocultural, political, and economic contexts contributes to reductive understandings of the psychosocial complexities of trauma that rely on potentially ethnocentric diagnostic framings like posttraumatic stress disorder (PTSD) and depression. As a result, advocates of humanitarian psychiatry may fail to acknowledge the role of local patterns and idioms of distress, long-term health effects, psychosocial consequences, help-seeking behavior, and culturally specific approaches to healing (Pedersen 2002).

In this chapter, we will explore the effects of societal violence on people's lives and mental health in war and post-war contexts by introducing key perspectives and debates and highlighting the complex interrelations of trauma-focused pathways, psychosocial pathways, and local expressions of distress. In the process, we do not seek to disregard one or another perspective, but rather aim to illuminate the key insights emerging from the critical debates in the

field and argue for a richer cross-cultural and interdisciplinary understanding of emotional distress in war and post-war situations.

Societal Violence in War and Post-War Contexts

Violence is a social phenomenon and, as such, affects our notions of life and death, good and evil, and sickness and health in manifold and complex ways (Jenkins 1998). Expressions and experiences of violence are increasingly determined and verified by research focusing on physical and psychological trauma, PTSD, and related disorders such as depression and anxiety. While certainly important, these medicalizing approaches often fail to pay attention to the details of the meaning and specific material forms of violence in particular historical and social contexts (Desjarlais et al. 1995). We argue that it is crucial to problematize also the communicative effects, symbolic use, performative quality, and lived experience of violence in order to gain a better understanding of how it is linked to personal and social well-being, and to provide answers to questions concerning the psychological, cultural, and moral consequences of violent acts (Desjarlais and Kleinman 1997).

Violence as means for communication is capable of transmitting messages that devalue or destroy previously held referents, social conventions, and identities (Feldman 1995). For example, Nordstrom's (2004) study about violence in Sierra Leone powerfully highlights the complex symbolic and sociopolitical messages that troops conveyed by cutting off voters' hands and arms in attempting to impose a boycott of the election. The message was obvious: "the voters are 'dis-armed'" (p. 63). In a different context, Taylor (2002) describes how in Rwanda perpetrators frequently inscribed "difference" into the bodies of their adversaries by transforming them into the figures that they were supposed to represent. The violent acts, ranging from stuffing people into latrines to cutting their Achilles tendons at militia roadblocks, were patterned on particular local conceptions of bodily flow and blockage and turned victims into recognizable "Others."

Expressions of violence are always local products, created out of local, regional, and global flows of knowledge and representation. Thus, although violence may be a very personal and subjective experience, "larger social actors such as the state, international organizations, and the global media, as well as transnational flows in finances and people" are all involved in the creation, maintenance, and suppression of violence (Das and Kleinman 2000, p. 2). Linking lived experience with global political economy and inequality has led social scientists to coin the concept of "structural violence." It makes apparent that in war and

post-war contexts militarized violence is connected to other forms of violence—some of them long-standing aspects of global and local political orders, others shaped by more recent global power shifts—including domestic violence as well as structural barriers that take the form of institutional, social, and economic stressors and effectively prevent individuals from achieving tolerable conditions for day-to-day life and survival, let alone their full potential (Panter-Brick et al. 2011; Farmer 2004). Galtung (1985) explains:

> Structural violence was then seen as unintended harm done to human beings (…), as a process, working slowly as the way misery in general, and hunger in particular, erode and finally kill human beings. If it works quickly it is more likely to be noticed and strong positions for and against will build up so that moral stands emerge (p. 146).

As war-related violence tends to be starkly visible, it has the potential to shock people into action and to trigger a flurry of short-term emergency interventions. The everydayness of poverty and exclusion, on the other hand, receive less attention—partly due to the fact that international donor money is lacking to finance longer-term, culturally appropriate, and sustainable interventions. Response to violence is thus not at all a straightforward or morally clear process (Redfield 2013).

To grasp the impact of both political and structural violence on individual lives and entire communities, it is important to move beyond "emergency" that is, death, disease, and trauma, to include the pervasive effects of the destruction of the social fabric of society (Das 2007). Examples of these deep impacts of societal violence in war and post-war settings are receiving growing attention in the academic literature. For instance, Panter-Brick et al. (2011) carefully describe the connections between domestic violence and structural and community violence among Afghan families. They found that interpersonal violence destroyed "family harmony" and solidarity to the point of attempted suicides: "Some adolescents reported having been rushed to hospital after ingesting rat poison, and female caregivers having wanted to throw themselves off the roof 'because of all the beatings'" (p. 360). Respondents in the study clearly highlighted the links connecting interpersonal violence with chronic socioeconomic stressors and acute episodes of political upheaval, insecurity, and violence.

In a different context, Olujic (1998) discusses the parallels between the patterns of everyday dominance and aggression during times of peace and war in Croatia and Bosnia-Herzegovina. According to her, aggression or violence against women was a means by which combatants applied traditional honor/shame ideology to show who controlled "sexual property" and the political

process. By turning women into sociopolitical objects, they effectively denied them their individuality and, related to this, their rights. Das (1996), on the other hand, discusses links between increasing abduction and rape of women and the burgeoning nationalist imaginary of anti-colonial movements in India by tackling the question of "[how it is] that the imagining of the project of nationalism in India came to include the appropriation of bodies of women as objects on which the desire for nationalism could be brutally inscribed and a memory for the future made" (p. 68).

These examples make apparent that within the full range of militarized, political, and structural violence, power relations between perpetrators and victims are negotiated and driven by ideas and imaginaries of identity, fantasy, desire, and reputation (James 2010).

In the following sections, we will focus on the devastating and long-lasting mental health and psychosocial consequences that such forms of societal violence produce, and discuss different disciplinary and interdisciplinary approaches that attempt to understand and improve the well-being of individuals and entire populations emerging from war and violence.

The Effects of Societal Violence on Mental Health

It is widely recognized that violence is a cause of suffering, general ill-health, and mental health problems. Much of the research in recent years sought to establish that the experience of violence in war and post-war contexts leads to traumatic memories, which may result in PTSD, depression, anxiety, and other mental health problems. PTSD in particular has become a "signature injury" functioning as a potent "idiom of distress" (Hautzinger and Scandlyn 2014). Fassin and Rechtman (2009) state, "[T]rauma has become a major signifier of our age," in that we talk about traumatic events such as rape, genocide, torture, slavery, terrorist attacks, and natural disasters in the same way: "one signifier for a plurality of ills signified" (p. xi). However, this is not to say that there is agreement on how violence gets under the skin and how it should be dealt with. In the psychiatric arena, there are growing tensions between different approaches seeking to link exposure to violence to mental health outcomes.

Mental Health and Psychosocial Approaches

There is a perceived split between advocates of trauma-focused and psychosocial understandings related to the assessment of mental health needs in conflict

and post-conflict settings (Miller and Rasmussen 2010). Trauma-focused approaches attempt to establish a direct connection between exposures to violence (e.g., physical assault, demolition of one's home, disappearance and killing of loved ones, killing of livestock) and mental health. Research has revealed that cumulative trauma has the capacity to cause higher psychiatric symptom levels assuming that "each individual who has experienced or is experiencing traumatic events will develop PTSD after reaching a certain threshold of traumatic exposure" (Neuner et al. 2004, p. 2).

To assess the needs of survivors of trauma, culturally and linguistically validated screening tools have been developed based on symptom lists derived from different editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and International Classifications of Diseases (ICD). The intention is to aid clinicians and policymakers to distinguish between different syndromes like acute stress disorder and identity disorder, and chronic PTSD (Hinton and Lewis-Fernández 2010; Pedersen and Kienzler forthcoming). Studies have largely focused on symptoms of PTSD, which, according to the DSM-5 (APA 2013), include four symptom clusters in addition to the history of exposure to traumatic events (criterion A): intrusion symptoms (criterion B), avoidance (criterion C), negative alterations in cognitions and mood (criterion D), and alterations in arousal and reactivity (criterion E). Further criteria include the duration of symptoms (criterion F), functional significance (criterion G), and exclusion of substance use or co-occurring medical conditions as causes (criterion H) (APA 2013).

Research that focuses on individual vulnerability following the exposure to trauma includes studies on war-affected people from all over the world. A recently conducted systematic review indicates an average prevalence of 15.4% (30 studies) for PTSD and 17.3% (26 studies) for depression in conflict-affected populations (Tol et al. 2011). Similarly, Joop de Jong's (2003) findings indicate that the prevalence of PTSD ranges from 15.8% to 37.4% in Algeria, Cambodia, Ethiopia, and Palestine. These rates are considerably higher than the average of 7.6% for any anxiety disorder and 5.3% for any mood disorder, which have been reported in 17 general populations participating in the World Mental Health Survey (Demyttenaere et al. 2004). However, researchers have cautioned that data related to trauma and associated health problems are often conflicting and challenging to interpret as various methods and instruments are employed for their collection, analysis, and reporting (Hollifield et al. 2002).

Overall, studies conducted among war-affected populations recognize that while trauma-related mental illness seems to decline steadily over time, a small subgroup of people with a high degree of exposure to trauma shows long-term

psychiatric morbidity. In fact, a wide range of studies of populations including survivors of war, survivors of terrorist attacks, hospitalized survivors of motor vehicle accidents, and Gulf War veterans has highlighted that most survivors do not develop mental disorders (Paton and Violanti 2006; Lyons 1991). Research that emphasizes coping and resilience in survivors of war includes, for instance, investigations that document the psychosocial adjustment of young Cambodian refugees in Canada. Rousseau et al. (2003) argue that the trauma a family suffered before leaving their homeland and prior to the teenagers' birth seems to play a protective role at various times in adolescence with regard to externalized symptoms, risk behavior, school failure in boys, and social adjustment in girls. It is concluded that these reactions may be understood as overcompensation by the children of the survivors of a massacre, to whom the implicit duty to succeed has been passed on. Similar findings are reported by Ungar (2011) in a systematic review focusing on resilience among families exposed to human-made and natural disasters; Beiser et al. (1989) and Tousignant et al. (1999), who studied Vietnamese and Laotian refugees in Canada, respectively; as well as Eggerman and Panter-Brick (2010) among Afghan families and Barber (2008) among Palestinian youth.

Based on these and similar findings, guidelines and treatment protocols have been developed that focus on providing first aid in the aftermath of a disaster and more specialized interventions geared toward those with a high degree of exposure to trauma and with long-term psychiatric morbidity. Treatments for trauma-related health problems are various and include different forms of psychosocial, pharmacological, and cognitive-behavioral interventions (Kienzler and Pedersen 2012). As a consequence, a wide range of therapies is offered to individuals and communities suffering from psychological trauma, which has been shown to lead to competition between interventionists and sometimes confusion among service users (WHO 2003).

While the trauma-focused approach seems seductive in its simplicity, a growing number of researchers and interventionists consider it to be too one-dimensional and, thus, removed from what is actually happening in people's lives (Atlani and Rousseau 2000). It is argued that it is important to pay particular attention to the role of contextual factors in "shaping the mental health and psychosocial consequences of violence (…) rather than assuming a direct connection between traumatic events in creating symptomatology" (Tol et al. 2010, p. 35). Scholars also point out that evidence suggests that "organized violence (…) generates or exacerbates a host of highly stressful conditions or daily stressors, such as poverty, social marginalization, isolation, inadequate housing, and changes in family structure and functioning" (Miller and Rasmussen 2010, p. 8). Mental health is powerfully affected by social

position and by the scale of social and economic differences within the population (Wilkinson 1996). In other words, both in contexts of war and peace, health and illness follow a social gradient: the lower the social and economic position, the worse the health status of a population (Commission on Social Determinants of Health 2008).

A number of psychiatrists and anthropologists argue that the quality of social life is one of the most powerful determinants of mental health and suggest a more integrated approach to mental health to examine the different pathways through which political and structural violence affect psychological well-being. For example, in the context of the Lebanese civil war, Farhood and his team (1993) showed that distress led to multifaceted health effects. While the war flared up periodically, daily hassles resulting from the breakdown in community services prevailed more uniformly and continuously. As a consequence, families reported that their mental health and physical health were strongly impacted by the economic consequences of a process of rapid inflation, not being able to ensure the basic needs of decent living, and the reduced possibility of encounter with relatives and friends. In Sri Lanka, on the other hand, people recalled distress connected to the "immediacy" with which violence hit, including sudden disruptions of life routines and the unexpected dissolution and disappearance of families after a seemingly ordinary workday. Feeling incapable of providing and protecting family members was experienced as devastating (Henry 2006). Again in a different context, Locke (2012) highlights that the emotional pain suffered by war veterans in Bosnia and Herzegovina could not be interpreted through the PTSD model alone, as it would lead to the illusion that their distress stemmed exclusively from war experiences. Rather, their suffering was powerfully linked to *post*-war hardships including "the way in which (…) they had come to feel abandoned, neglected and misunderstood by their communities and public institutions" (p. 5).

In order to capture these interlinked stressors and related health problems, interventionists following a psychosocial approach propose to transform short-term mental health interventions into extended mental health and psychosocial support programs and, related to this, institutional development (Abramowitz 2010). In this approach, emphasis is placed on the enhancement of government-driven policies, human resources and training, programming and services, research and program monitoring, and finances (Ventevogel et al. 2013). According to a recent review, advocated mental health and psychosocial support practices include counseling, providing and facilitating community-based social supports, structured social activities, provision of information, psychoeducation, and raising awareness (Tol et al. 2011). In some contexts of conflict, myriad forms of psychosocial support are delivered

to people that are not always compatible. For example, Summerfield (1999) highlighted that a European Community Task Force (ECTF) review found that 185 of such psychosocial projects were carried out by 117 different organizations in the former Yugoslavia in 1995 (see also Locke 2012). Much of this work seems to have had limited long-term impact on the availability and quality of mental health care, due primarily to inadequate attention to and investment in local primary care and welfare infrastructures.

Despite debates surrounding the multiple treatment practices offered in the wake of conflicts, interventionists have largely come to an agreement to focus on population-based mental health approaches rather than individualistic ones (Patel et al. 2011). Population-based mental health interventions are described as "affordable, effective, acceptable, and culturally valid interventions at the community level" (Banatvala and Zwi 2000, p. 103). While allowing for more attention to sociocultural complexity than a trauma-focused approach, it is important to caution that in these particular biosocial environments, not only material resources but also rights, services (e.g., educational support, legal advice, health care) and opportunities to participate in the wider community are unevenly spread. In other words, people are not simply passive recipients of violence and culture but negotiate their life worlds actively depending on their particular social class, economic situation, and gender (Boehnlein 2001; Lopez and Guarnaccia 2000). These dynamics may not be fully captured or addressed by the tools available to population-level approaches, and call for forms of research and intervention that can help adapt standardized, "evidence-based" practices to local realities. Even more important would be to move beyond "adaptation" to the generation of locally relevant evidence to inform best practices and intervention strategies.

Social Suffering and Local Expression of Distress

Particularly anthropologists, but also increasingly psychiatrists and psychologists, criticize the usefulness of diagnostic categories such as PTSD as they fail to capture not only structural conditions and inequalities (along the lines of, e.g., poverty, ethnicity, gender, and education) but also cultural expressions of distress and the ways in which they both compromise and enhance well-being and mental health (Tol et al. 2010). Moreover, critics argue that clinical labels can obliterate the rich and urgent personal, social, and political meanings of suffering.

Byron Good (1977) was among the first to argue that it is crucial for clinical medicine to gain a better understanding of the way in which psychosocial

and cultural factors affect the incidence, course, experience, and outcome of disease. According to him, disease cannot be simply considered a natural entity but is a social and historical reality, in that it becomes a medium for negotiating transformations in life context. Ware and Kleinman (1992) note that over time, these "passively received and actively negotiated changes become interspersed to form a chain of illness-related interpersonal events and processes that is also an integral part of illness's 'social course'" (p. 548). Thus, the anthropological perception of the "social course" of illness encompasses two meanings: (1) aspects of the social environment influence the severity of symptomatology (a "sociosomatic" approach), and (2) symptoms themselves shape and structure the social world. Accordingly, there exists an ever-changing dialectic relationship between the experiences of individuals and the society they live in.

Social Suffering

This insight led medical anthropologists to introduce the concept of "social suffering" to anthropological and medical discourses. Kleinman et al. (1997) define social suffering as "human problems that have their origins and consequences in the devastating injuries that social force inflicts on human experience." That is, "social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence the responses to social problems" (p. xi). Suffering as a social experience takes place in three interconnected spheres as it is, at the same time, an interpersonal engagement with pain and hardship in social relationships, a societal construction that serves as a cultural model and moral guide of and for experience, and a professional discourse that organizes forms of suffering as bureaucratic categories and objects of technical intervention (Kleinman 1997).

The story of one of Locke's Bosnian interlocutors, encountered in 2008 in the offices of a small Sarajevo psychosocial support NGO called Horizons of Hope (a pseudonym), captures these intersecting social dimensions of suffering in a post-war context. Emir, a thin, graying man in his sixties, regularly brings his adolescent daughter Džana to lessons and creative workshops at the NGO's offices and waits there quietly with coffee and cigarettes. Emir has three children altogether with his wife: Džana, a 20-year-old son, and a 22-year-old daughter studying economics at the university (with the help of a small scholarship from a war veterans' association). Aside from the scholarship, the family's only income is the veteran's pension—300 marks per month—that Emir receives from the state.

Emir and his family are originally from Zvornik, a town on the Bosnian side of the Drina River, which forms Bosnia's eastern border with Serbia. Zvornik was brutally "cleansed" of its non-Serb population by Serb forces very early in the war. Emir and his family managed to leave in the nick of time; they lived for a while in Croatia before his wife and children were received as refugees in Pakistan. Emir fought with the Army of the Republic of Bosnia-Herzegovina throughout the conflict. He lost hearing in one of his ears when a shell landed next to him in a trench.

After the Dayton Accords ended the war in Bosnia in 1995, Emir's family returned from Pakistan and they lived for seven years in a tiny basement apartment in a Sarajevo suburb. He got a job working as a locksmith—his trade before the war—for a Slovenian-owned grocery store chain. He was paid around 350 Bosnian marks a month, which barely provided enough to pay basic bills and provide necessities for his family. For Emir, the day-to-day "struggle for subsistence" (a phrase he used often) and to provide for his family on a meager income would have been much more bearable were it not compounded by a persistent sense of alienation and disconnection from his adopted community, neighbors, and co-workers. Faced with urban resentment of rural refugees, Emir "felt like a stranger" in his own country. The impossibility of finding support and empathy—both in bureaucratic institutions and in social relations—was a constant theme in the stories he told about post-war life in Sarajevo. Emir felt this callousness as a grave injustice, a wound more painful, even, than his wartime experiences or the hard facts and choices of poverty:

> In the war I only had one goal: to keep my head, to survive. Just that. But now it's a fight with bureaucracy. A fight for my family and for financial subsistence. Back then we lived off humanitarian aid, this and that. You know how it was, would you or wouldn't you have food.

Emir said directly that life is harder since the war than it was during it:

> OK, during the war I didn't have my family, now I have to worry about them.

For Emir, this meant constant wrestling with cold and recalcitrant state institutions simply to sustain the basic conditions of day-to-day existence. Necessities keep getting more and more costly: heat, gas, electricity, food staples:

> I simply think that politicians only worry about themselves, about their own position, their own personal interests. The people don't interest them.

He follows war crimes trials taking place locally as well as proceedings at the International Criminal Tribunal for the former Yugoslavia (ICTY) in *The Hague*, in part because one of his brothers is among the thousands of missing people presumed murdered in concentration camps or mass killings. Another brother was severely wounded when a shell fired by Serb forces landed in his apartment, and later died undergoing surgery. Emir's niece, the granddaughter of his sister, was captured and held in a rape camp at the age of 15.

> "I can respect Serbs, Croats, Muslims, it doesn't matter to me," Emir said.
>
> "I respect all good people. But I do not respect nationalists."

Asked how he wished life and the way things work in post-war society would change, Emir responded:

> I'll tell you that I was a big optimist during the war. I was so optimistic that many things would be resolved, that things would be better, that everything would be fair for the people, and so on. But after the war I was so disappointed because of this bureaucracy. So disappointed, I went to the mental health clinic. They told me to contact a psychologist. That psychologist sent me to the psychiatrists at [the local psychiatric hospital]. So I go there once every month or two to talk.

But not just to talk: Emir visits psychiatrists for prescriptions:

> I must take some pills to calm down, really because of all that, the bureaucracy, the struggle for subsistence.

Emir's use of psychopharmaceuticals, it seems, is more about making the anxiety and frustration of his post-war life more endurable than about coping with strictly *posttraumatic* stress. Emir's story illustrates core aspects of the intricate interrelations of social and subjective experience that the notion of "social suffering" is intended to capture. We see the ways in which the near- and long-term mental health sequelae of experiences of societal violence are complexly conditioned by and reflective of deeply felt socioeconomic, cultural, and political dimensions of the post-war context, from war crimes trials in The Hague and the corruption of nationalist politicians to the indifference of neighbors and the presence of nongovernmental organizations offering services unavailable through a dysfunctional state. Psychosocial organizations like Horizons of Hope often find that to best serve families like Emir's, they

must expand their services beyond psychiatric consultation and counseling to include broader and more ad hoc forms of social support (Locke 2009).

Idioms of Distress

In addition to "social suffering," the "idioms of distress" approach offers a complementary tool for discussing the ways in which social and political determinants affect individuals' and communities' well-being. The concept has been in circulation for over 30 years and was first introduced by the anthropologist Mark Nichter (1981). In a more recent article, Nichter (2010) defines the idea as follows:

> Idioms of distress are socially and culturally resonant means of experiencing and expressing distress in local worlds. They are evocative and index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst. (p. 405)

He goes on to explain that when idioms of distress are experienced along with significant pathology, they express personal and interpersonal distress beyond that associated with universal disease processes.

Local idioms of distress are polysemic and idiosyncratic phenomena that bridge and transcend somatic, psychic, and social phenomena (Davis and Joakimsen 1997; Lock 1993; Sapkota et al. 2014). Since its first introduction into academic discourse, the concept of idioms of distress has become a self-explanatory term that is used to make sense of cultural categories as diverse as *nervios*, *susto*, *llaki, ñakary*, *ihahamuka*, *open mole, khyâl attacks* and so on (Abramowitz 2010; Hinton et al. 2010; Pedersen et al. 2010). For example, Hagengimana and Hinton (2009) describe the Rwandan idiom *ihahamuka*, which literally translates into "without lungs" and has been the most common presentation of traumatic distress since the genocide in 1994. Its main symptoms are shortness of breath, pain, and heat in the head. Catastrophic cognitions about this shortness of breath, which carries iconic resonances, are a key feature. *Ihahamuka* is thus connected simultaneously to traumatic personal experience, bodily experience and somatic symptoms, and social processes including ritual action, metaphor, ethnophysiology, and symbol.

In a different context, Kienzler (2010, 2012) investigated the lived experience of social inequalities and cultural idioms among Kosovar Albanian women in post-war Kosovo. She found that women often expressed their

distressing memories and thoughts through folk diagnostic categories such as *nervoz* (nervousness) and *mërzitna* (worried, sad), which could not be distinguished based on the symptomatology but rather in relation to particular emotions and the context in which they were expressed. Women often said that they only become *nervoz* about matters that are important to them such as memories of the war and the related grief, the burden of widowhood and the overwhelming responsibilities that go along with it, economic problems and the fears of not being able to provide for their children and anger due to interpersonal conflicts. Widows explained that *nervoz* resulted from the enormous responsibility of being "the man and the woman of the house" at the same time, having to provide an income for their family, entering into competition for the humanitarian aid delivered to their village and dealing with the gossip that usually resulted from this. *Mërzitna*, on the other hand, is the popular version of the word *mërzitem* and translates into to be sad or worried. The idiom is associated with compassion and helplessness. While both emotions are interrelated and tend to occur at the same time, they differ in their intensity depending on the context and, in many cases, whether a person is sad or worried.

Discourses on sadness often referred to a sense of loss and loneliness in the context of war, the death of a family member or friend, or husbands and children moving away from home to work abroad or to study in the city. This is illustrated by the story of an occasion when Kienzler met Fitore on her compound to buy detergent that she had bought in bulk to resell in order to make some money on the side. She looked tired and worn out. Leaning against the anthropologist's car, she said that she could hardly sleep last night and that her entire body was hurting. She sighed:

> I am *mërzitna,* that's why every bone in my body hurts.

When asked why she felt *mërzitna*, she explained that she had given an interview to Polish humanitarian aid workers the day before that had reminded her of past hardships:

> The Polish women are in Kosova for only four days and try to talk to as many women as possible. The interview lasted for two hours and was all about the war and the way I coped without my husband. I wasn't prepared for it and, before I knew it, war memories awoke inside me.

Discourses on the notion of feeling worried were usually very compassionate in that worrying about someone else's health and well-being brought on

feelings of sickness. This, in turn, accentuated a positive image of the women as they talked about their psychic and somatic symptoms within the context of their deeper concern for family members.

In sum, idioms of distress, expressed through a wide range of illness symptoms, served as mostly somatic references to multiple causal connections, including memories of war and post-war hardship, poverty, widowhood, sanctions against remarriage and divorce, restrictions on leaving the in-law's compound, and interpersonal conflict, gossip, and jealousy. To reduce them to "mental disorders" would be too simplistic as they also involve elements of societal critique, which particularly village women often cannot voice in the public arena due to their position in a strongly patriarchal society. Thus, a greater focus on idioms of distress could emphasize the agency of individuals in establishing social networks and drawing attention to the lack of support and other societal ills.

Concluding Remarks

Violence in its many forms is pervasive, ancient, infinitely various, and a central fact of human life, but also poorly understood in general (Whitehead 2004). In this chapter, we have introduced different approaches that aim to provide a better understanding of the consequences of violence from various angles, focusing on its communicative role, symbolic use, performative quality, and lived experience. We have shown that violence in contexts of war has been linked to physical and, particularly, mental health problems. A strong focus on PTSD and depression based on Western diagnostic practices has largely shaped the response to trauma-related health problems leading to the development of different kinds of trauma-focused responses ranging from psychotherapies to various pharmaceutical interventions. However, critical scholars have shown that such approaches lack evidence on their long-term effects and demonstrate that mental health problems are intricately connected to social, economic and cultural dimensions of life. Such recognition has complicated our understanding of the causation, development, and treatment of violence-related distress.

Having a better understanding of the ways in which individuals and communities express their suffering and distress and the influence this has on their lives could help health providers to tailor therapeutic interventions more effectively to the needs and expectations of their patients. There is a great danger of over-medicalizing or over-psychologizing forms of post-violence distress, which are complexly overdetermined by the socioeconomic,

political, and cultural dimensions of post-conflict societies. Anthropologists have shown that interventions that attempt to address health—and especially mental health—without engaging with these social determinants often fail to deliver aid that is meaningful to the intended beneficiaries, and can even cause unintended consequences insofar as they pathologize victimized populations and distract from substantive issues of restorative justice and political reform (Biehl and Locke 2010). While one-size-fits-all technoscientific or medical solutions to the social and personal consequences of societal violence may be elusive, the subjects of interventions reveal that we may have much to learn about the determinants of their suffering—and their resilience—before we can begin to deliver forms of care and support that are truly multidimensional and thoughtfully adapted to cultural difference. Ethnographic methods, with their commitment to cultural humility and deep forms of listening, surely have a central role to play in this process.

We do not deny that trauma-focused approaches have their place in the complex process of healing the psychological wounds of war and violence, but suggest that alone they are not sufficient and may lead to important unintended consequences. It is important to be attuned to the fact that suffering as well as recovery are resolved in a social context as "familial, sociocultural, religious and economic activities (…) make the world intelligible" (Almedom and Summerfield 2004, p. 386). With this understanding, trauma-focused approaches could possibly be reserved for very severe cases of mental illness while other forms of distress could be addressed meaningfully through locally developed (bottom-up) and socially integrated approaches addressing the often difficult to grasp combinations of social, emotional, physical, and cultural dimensions. This, in turn, can only be achieved through interdisciplinary approaches in which clinicians and other interventionists work closely with researchers from the health and social sciences. In the decades to come, it will be crucial to build connections across health, social welfare, education, and economic sectors while paying close attention to cultural and religious beliefs and practices in order to address the effects of societal violence on bodies, minds, and societies more effectively.

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