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MENTAL WELL-BEING IN SETTINGS OF 'COMPLEX EMERGENCY': AN OVERVIEW

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The mental state of people affected by war and other disasters has been a subject of special interest to academic researchers and practitioners in humanitarian assistance and public health for over two decades. The last decade in particular has seen a rise in the number of papers published in scholarly journals around the Post-Traumatic Stress Disorder (PTSD) debate. Anthropologists have rarely engaged in this debate. Nevertheless, some of the most illuminating contributions have come from socio-medical anthropology (Last, 2000).

This volume brings together a wide range of disciplines in the human sciences to address some of the key questions that bear upon the mental health and well-being of populations affected by war and displacement, with contributions from applied biosocial and medical anthropology (Almedom; Lewando-Hundt *et al.*); applied psychology/public health and social psychiatry (Carballo *et al.*; Snider *et al.*; Fullilove *et al.*); social work (Ahearn & Noble); and political sciences (Pupavac). The four themes that run through this set of papers (outlined below) remain topical areas of contention in contemporary humanitarianism. Scholars and practitioners in the biosocial sciences may wish to engage in the empirical study of human (if not humanitarian) responses to disaster focusing on questions as yet unanswered.

Background context and the dynamics of humanitarian action

It has been argued that war is not as unique or unusual an occurrence as it is made out to be (Rieff, 2002) and humanitarian action is the selective response to the category of 'emergency' of donor countries' and/or the media and humanitarian agencies' choosing (Vaux, 2001). So when is a 'complex emergency' a thing apart? Can it be assumed that the effects of, say, a war, can be isolated from those arising from other sorts of destabilization and deprivation prevalent in a particular society? Up to 150 million children under five years of age in the world suffer from chronic protein–calorie malnutrition. Their suffering is not necessarily less 'traumatic' than that occasioned by bombs and bullets, yet it is the trauma of war that is talked about

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and not the trauma of poverty and powerlessness (Scheper-Hughes, 1992). The nation state itself is under pressure, the poorest 20% of the world being up to 80 times poorer than the top 20% (more than twice the difference of a generation ago); there are huge numbers of displaced peoples and a global rise in food insecurity. One-fifth of the nearly 6 billion people on earth live in extreme poverty, one-third of the world's children are undernourished, half the global population does not have access to essential drugs, and the vast majority of HIV-positive people are in some of the poorest countries in the world – in particular in sub-Saharan Africa.

It had been argued that in many parts of the world war is not an extraordinary and short-lived event to be seen as extrinsic to the way a society functions in 'normal' times. It had become a given, something constant and internal that colours the whole web of political, socioeconomic and cultural relations across the society, and the daily calculations and activities of citizens (Duffield, 1994). There are losers in war, but also winners, who may be an entire social sector or ethnic group who benefit (Keen, 1992). For these people war is far from 'irrational', as it is sometimes termed, and indeed might be the only way they can achieve their desired ends (Keen, 1997). The nature of humanitarian intervention is itself part of, and a contribution to, the complexity of modern emergencies. It is subject to influence, and indeed distortion by donor priorities and fashions, as well as by wider political forces, which can include governments themselves.

The medicalization of experience and the rise of 'trauma'

World religions have struggled with the question of pain and suffering for centuries, but over the last century it is medicine and psychology that have come to dominate this domain in the Western world, and the questions of responsibility and morality attached to it. These new understandings have become part of the shared beliefs of contemporary Western culture (the one globalizing culture) and thus come to be experienced as natural and self-evident. Terms like stress, trauma and emotional scarring have come into commonplace usage by the general public, used both metaphorically and as an indication for professional help. The medicalization of experience refers to the way that ideas about disease and illness are used to make sense of conditions with social and cultural roots. As Pupavac argues in this volume, contemporary culture is preoccupied with emotion and its problematization, and – a momentous shift – tends to now accentuate vulnerability rather than resilience among war-affected populations and aid workers alike. These shifts underpin the very nature of a query about 'mental well-being' in whatever context.

The medicalization of the perceived impact of a complex emergency like war upon victims has brought new influences to bear upon the repertoire of humanitarian provision in the last 15 or so years. For example, manuals on refugee health published up to the early 1980s made no mention of 'trauma', but since then Western mental health professionals have figured prominently in a burgeoning area of operations premised on the assumption that there was a distinct psychological fall-out of war for whole populations, and that this needed to be addressed in its own right. Expansive

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claims promoted the idea of war as a sort of mental health emergency, and of 'post-traumatic stress' as a 'hidden epidemic', trading on 'traditional Anglo-Saxon medical conceptions of illness, where selective symptoms and behavioural indices provide evidence of PTSD or other diseases' (Lykes, 1996). The assumptions underpinning the globalization of 'trauma' as a supposedly valid and relevant framework for capturing and addressing human response to extreme events have been evaluated elsewhere (Summerfield, 1999). In this new language, war-affected people have been routinely described as 'traumatized', but sometimes also as 'brutalized' and liable to be vengeful enough to go on to promote new 'cycles of violence'. Thus the emotional reactions of people affected by war have been perceived as harmful to themselves and potentially dangerous to others. Examinations of the origin and usefulness of the medical diagnosis of PTSD in relation to war veterans have demonstrated the social constructions of mental disease categories (Young, 1995; Shepard, 2000), and yet assumptions of mass trauma of combatants and non-combatants alike continue to dictate humanitarian operations. The implications of describing children as 'brutalized' by war have included damaged psychologies and moral norms, and diminished humanity. The assertion that 'time does not heal trauma' for millions of such children, often described as a 'lost generation' (UNICEF, 1996), is unsupported by empirical evidence. The medical literature is still replete with similarly sweeping statements that are questionable, pathologizing and stigmatizing. Moreover, the people being characterized in these ways have not given consent for their mental health to be objectified and labelled as unhealthy (typically by an observer from afar), which raises ethical questions. Contributions to this volume from Palestine and South Africa (Lewando Hundt *et al.*), Eritrea (Almedom), Nicaragua (Ahearn & Noble) and Peru (Snider *et al*.) all grapple with questions of context, ethics and the limitations of psychometric scales and standardized checklists in the search for understanding how human beings maintain their mental well-being in conflict and/or post-conflict settings of destitution, poverty and displacement. Almedom's model of *psychosocial transition*, which postulates that positive and negative aftermath may be dependent on the type(s), timing and level(s) of social support available to victim-survivors of crises, finds resonance in Carballo *et al*.'s report of non-depressed and non-mentally burdened people in Bosnia and Herzegovina, with marked differences between the displaced and non-displaced. More research is needed to give empirical (qualitative and quantitative) support to the notion of 'remaining unscathed', as indeed many would be expected to be, particularly if they are in some way associated with generating the crisis in the first place (for their own gain) or if they happen to just be spared for other reasons.

Medicalized constructions of the experience of war posit an unduly mechanistic view of human experience, one that suggests that the pathological effects of war are to be found inside a person (between the ears), and that a person recovers as if from an illness. In fact there is a singular dearth of data suggesting that mental health morbidity is higher in populations exposed to war or other complex emergencies than in those not exposed. One interesting example is Northern Ireland, since it is one war zone where comprehensive health records are available over the last 30 years of civil conflict. During this period there has been no evidence of significant impact on referral rates to mental health services (Loughrey, 1997). Ahearn and Noble in

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this volume come to more or less the same conclusion in their analysis of data from Nicaragua.

However, this is not to ignore the plight of those who suffer severe mental illness in whatever setting. It has indeed been argued, in human rights terms, that the plight of the severely mentally ill should not be neglected while the trauma debate rages on (Silove *et al.*, 2000). More generally, the World Health Organization Report (2001) was dedicated to mental health, a global burden of disease in the 21st century. Moreover, insightful contributions to the literature have included discussions of stigma and social inclusion from the perspectives of social policy and practice (Sayce, 2000). Contributors to this volume, including Carballo *et al.*, argue for the need to rebuild destroyed mental health services in Bosnia and Herzegovina; and Sinder *et al.* have explored the need for these services in the Peruvian Andes while recognizing the pitfalls of blanket assumptions and imported 'solutions'.

The medicalization of distress entails a missed identification between the individual and the social world, and a tendency to transform the social into the biological. The objectification of understandable distress or misery as a pathological entity apart ('trauma') – a technical problem to which short-term technical solutions like counselling apply – is a serious distortion. There is little or no evidence that survivors of war, even in Western cultural contexts, do better if they undergo individual counselling to emotionally vent their experiences, at least not through 'debriefing' with medical practitioners (Wessely *et al.*, 1998; Shepard, 2000; Shay, 2002). To those from non-Western cultures, individual or even group debriefing, at a point in time when their time and energy is taken up by the daily demands of survival and rebuilding, this would be an alien and irrelevant activity anyway. A particular feature of a medicotherapeutic approach is assumed moral and political neutrality. This is in tension with the political and sociomoral understandings which affected victim-survivors apply to what they have passed through, and humanitarian action has increasingly compromised itself on account of military humanitarianism, a contradiction in terms (Terry, 2002). There is still little evidence that those affected anywhere have seen their mental health as an issue apart, and wanted treatment specifically for this, *en masse*. Almedom's paper in this volume makes a deliberate choice to investigate the social history of war and the context of resilience, taking the focus of attention to the third main theme that runs through this volume.

Society, culture and the role of meaning

Orthodox psychological science conceptualizes human nature as ultimately residing in the way the brain is wired and memories stored, and sees the meaningful nature of reality as something arising from programmes or schemas running in individual minds. It is questionable how much such systems can capture universal truths about distress and madness when they largely ignore the active appraisal a particular subject brings to bear on what has happened (Bracken, 2002).

What constitutes psychological knowledge is the product of a particular culture at a particular point in time, and there is more than one true description of the world. Many ethnomedical systems have taxonomies that range across the physical,

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supernatural and moral realms, and do not conceive of illness as situated in body or mind alone. The body is seen to be susceptible to the actions and wishes of ancestors, and to spirits. Distress is commonly understood and expressed in terms of disruptions to the social and moral order and internal emotional factors are not seen as able to cause illness. Moreover, in some cultures 'depression' and social withdrawal may be seen as signs of wisdom and not as symptoms of mental disease (Kirmayer, 1989) and there is evidence that in settings of complex emergency, affected individuals may be demoralized by socio-political stressors, clearly outside the domain of biological determinants of health and well-being (Almedom, 1995).

Western psychological concepts, embodying ideas about how a disastrous event impacts on a human being and what he or she should say and do about it, are the product of a globalizing culture and increasingly present as definitive knowledge. The possibility that the Western medicotherapeutic approaches centred on 'trauma', imported into communities socioculturally devitalized by war might impair their struggle to reconstitute a shared sense of reality, morality and dignity merits serious consideration (Argenti-Pillen, 2003). For example, notions that what someone has had to endure may have caused psychological disruption may not be valid or helpful in cultures that place a premium on fate, determinism and spiritual influences. After all, what is being imported is not merely surface phenomena but core components of Western culture: a secular source of moral authority, a sense of time and identity, and a theory of memory.

What is surely fundamental is that the impact of a war or other major emergency is a function of the social meanings and understandings that people attach to it. This includes issues of accountability and responsibility, often doubly difficult to manage because most contemporary war is internal. Of course such meanings do not stand still; they may evolve in response to subsequent events and to public discourse. The past is subject to reworking for good or ill. On the one hand, a later successful outcome in the cause for which a person has suffered, or other political or judicial events offering vindication or reparation, will help to make sense of things. On the other hand, to take the case of Nicaragua, war-maimed young men were initially fortified by the belief that they had made a worthwhile sacrifice for the social values at stake in the Contra war waged by US proxies against the Sandinista revolutionary government. However, following the electoral defeat of the Sandinistas in 1990, some of these men had to struggle with the sense that the good cause for which they had fought was gone, and that perhaps their sacrifices had been in vain after all. Thus they were having to come to terms, different terms, with their physical disabilities and other losses (Hume & Summerfield, 1994).

Society and culture are impacted on by war, but also engage with it at many levels. There may be changes in the worldview and identity of particular populations, and in the social, political or religious institutions that represent these. Lewando Hudnt *et al.*'s paper from South Africa in this volume points to the considerable plasticity and dynamism which people bring to bear on their situations, shifting pragmatically between belief systems as seems useful at the time. This has been evident, for example in Uganda, in relation to the social crisis of AIDS (accelerated by war). AIDS was variably and interchangeably viewed as a 'poison' encompassable by beliefs drawn from witchcraft, Christianity and Western biomedicine (Allen, 1996).

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The rebuilding of social worlds

Pleas for humanitarian agencies to go where the concerns of survivor groups direct them, towards their devastated communities and ways of life, and towards urgent questions of rights and justice (Summerfield & Hume, 1993) remain unheeded in the face of media-influenced definitions of 'concern' and 'need'. For example, had the international (humanitarian) community been shown the MIG war fighter jet planes that were heading for the North while Michael Burke filmed the starving Ethiopians in Korem in 1985, solutions to both the famine and the war may have been found sooner (Vaux, 2001). The media in donor countries continue to influence the choice of what is newsworthy and deserving of humanitarian action, while researchers and practitioners remain behind, learning from past experiences, seldom in the lead or at one with the affected groups and their expressed needs and concerns (Mitchell, 2003).

How people recover from catastrophe is a profound question, but the lessons of history are straightforward: 'recovery' is not a discrete process. It happens in people's lives rather than their psychologies. It is practical and unspectacular, grounded in the resumption of the ordinary rhythms of everyday life – familial, sociocultural, religious and economic activities that make the world intelligible. Fullilove *et al*.'s account of recovery in New York city (this volume) bears this out. Most appropriately, even for the most Western of settings, 'NYC Recovers' is less about individual trauma counselling than about collective social, economic and (multi) cultural restoration of a devastated place and peoples. For those denied the opportunity to rebuild, the legacy of a war might well be enduring or even lifelong, but this is not 'trauma' as Western psychologists, psychiatrists, lawyers and other proponents of humanitarian 'trauma projects' would have it.

As some of the contributors to this volume (Abuateya, Ahearn, Almedom, Snider, Summerfield) were travelling west to Portland, Oregon, for a panel discussion of 'Mental Well-being in Settings of Complex Emergency', held at the Society of Applied Anthropology Annual Meeting on the 20th of March 2003, a profoundly complex emergency was unfolding in Iraq. The BBC news report on 19th March included a commentary on the proportion of Iraqi people expected to be 'traumatized' by the bombing. To many in the panel discussion, this speculation was objectionable. So too anecdotal accounts later in the year that 'shock and awe' was to be followed by international funding for psychosocial trauma programming. What is mental well-being in a world where the lives of Iraqis, Afghans and others, even in their thousands, can weigh so little on the scales of our times – as mere collateral damage? As this edition goes to press the world's newspapers are full of graphic accounts and pictures of what appears to have been systematic abuse of Iraqi detainees, amounting to torture, echoing reports from Bagram and other bases in Afghanistan, and from Guantanamo Bay (Summerfield, 2003). What is mental well-being in another part of the Middle East, where the life of Palestinian society is so relentlessly being squeezed out, that a Special Rapporteur to the 60th Session of the UN Commission on Human Rights (2003) could start his summary with the sentence: 'The Occupied Palestinian Territories are on the verge of a humanitarian catastrophe'? International humanitarian agencies have been keen to fund counselling programmes here, but the

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well-being of this population will depend on what happens not in individuals' mental space, but in their social, economic and political lives.

So where does this leave psychologists, psychiatrists, anthropologists and others? Should all humanitarian psychosocial project workers pack up and leave the people alone? Who should pick up the pieces after trauma counselling (opening of wounds for which talk therapy offers little or no dressing) and the side-effects of psychotropic drugs such those Fullilove *et al*. (this volume) mention? Psychologists can, in the words of Comas-Díaz *et al*. (1998) 'accompany and respond to a people rather than treat individuals' (p. 783); but this requires 'a deep confidence in the local community's capacity to draw on its traditional resources and forge responses to trauma collaboratively, in conjunction with European American and Ladino community psychologists and cultural workers' (p. 782). Comas-Díaz and her colleagues do not mean just paying lip service to community capacities for problem solving. For a start, humanitarian agencies would have to rethink current *modus operandi* and start conducting needs assessment studies that take account of change (Hawe, 1996). Disasters always bring about change in all dimensions including the biosocial, making dynamic models of needs assessment absolutely necessary. Any recognition of local capacity would imply a shift of attention away from pathology to resilience, but this is not new to social psychology and sociocultural psychiatry (Rutter, 1985; Littlewood, 1991). It is for our students, a new generation of scholars, to take on the challenges of effecting interdisciplinary empirical studies of mental well-being, in any setting – bearing in mind that the phrase 'complex emergency' amounts to a tautology as settings of 'simple emergency' are virtually non-existent.

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