

Introduction¹

Over the last few years increasing attention has been given to documenting the mental health and well-being of populations throughout the world (Desjarlais *et al.* 1995; IBRD 1993). One of the consequences of this interest has been for governments and international aid agencies to express concern about the psychological health and well-being of adults and children that have witnessed, experienced or perpetrated violent and murderous acts at times of war. Indeed, it is increasingly common for aid agencies to send out counsellors and other types of therapists to both Western and non-Western parts of the world in their endeavour to alleviate some of the psychological traumas associated with war and upheaval. This article questions the wisdom of this new form of humanitarian intervention.

It argues that we know very little about the nature and extent of the psychological consequences of war and upheaval in the non-Western world. The small amount we know suggests that while suffering is intense, the therapeutic responses on offer (however well intentioned) are inappropriate and inadequate. Aid agency personnel should be wary of allowing key findings emerging from research and therapeutic practice undertaken in the Western world to inform policy and practice in other parts of the world. A great deal of what people do and think during and after war is locally specific. Behaviour is profoundly influenced by conceptions of causality, pain, accountability, spirituality and morality which may be quite different from those in Europe and North America. This is not to suggest that human beings never respond to certain kinds of stress in similar ways but rather that it is not at all clear which responses are widespread throughout the world.²

The study of war trauma

Until recently, the study of war trauma has been dominated by psychiatrists and psychoanalysts. Much of this work has taken place in clinical

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² The issues addressed in this article have been presented in more detail by Parker (1996) and Parker (forthcoming).

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settings in North America and Western Europe. It has focused on the repercussions of the Second World War and, more recently, American involvement in Vietnam. It has repeatedly shown that patients presenting themselves for psychiatric or psychoanalytic treatment suffer long-term impairment to their mental health and well-being as a consequence of the traumatic events they have witnessed, experienced or perpetrated.

There is, too, a burgeoning psychoanalytic literature documenting the effects of the Second World War on the second and even the third generations. In other words, the psychological effects of war continue to be lived and experienced by those who do not have first hand experiences of war. While there is very little epidemiological or social research documenting the proportion of people who suffer mental ill-health after the cessation of war - there are some indications that a substantial number of people are affected. For instance, American soldiers returning from Vietnam have found it difficult to resume their pre-war roles as husbands, fathers and stable employers. Self-destructive behaviour is common and the number of veterans who have subsequently died from suicide, drug and alcohol abuse and shoot-outs with the police now exceeds the 50,000 who died at war.

Far less is known about the repercussions of traumatic war-time events for individuals in the non-Western world. But it seems reasonable to suppose that the events described by journalists - not to mention anthropologists - in countries as diverse from each other as Cambodia, Rwanda, Guatemala, Uganda and Angola (to name but a few) will also exert a detrimental impact on health and well-being for many decades to come. The question is how are we to describe and understand the impact of war-related traumas on individual and collective well-being. Are there universal responses to extremely traumatic situations and, if so, is it appropriate to rely upon psychiatric diagnoses such as post-traumatic stress disorder to describe the longer term consequences of war and upheaval? Similarly, is it helpful to extrapolate ideas emerging from psychoanalytic work in the Western world (such as identification with the aggressor) to help us understand individual behaviour at times of war? The psychiatric and psychoanalytic literature are discussed in turn to address this question.

Psychiatric understandings

Psychiatrists practising in North America, Europe and many other parts of the world increasingly rely on the American Psychiatric Association's **Diagnostic and Statistical Manual of Mental Disorders** to make their diagnoses (APA 1987). This manual is currently known as DSM-111-R; and indicates that individuals respond to severely traumatic events in a multitude of ways. These include the development of depression and a variety of anxiety disorders. Post-traumatic stress disorder (otherwise known as PTSD) is one of the most commonly cited anxiety disorders and this section focuses on PTSD to address the question of whether this type of disorder can describe intense distress and trauma across cultures.

PTSD was first classified in 1980. It is premised on the idea that severely traumatic events occurring in adulthood might have psychological consequences which are prolonged - irrespective of an individual's pre-existing character vulnerability. It is usually diagnosed if the individual has experienced an event that is outside the range of 'usual' human experience and the traumatic event is persistently re-experienced by recurrent and intrusive recollections of the events (in dreams, nightmares or daytime 'flashbacks'). These occurrences may be so intense that the individual feels as if s/he is re-living the event. It is also characterized by reduced involvement with the external world (diminished interest, detachment or estrangement, or constricted affect); and at least two of the following symptoms: sleep disturbances, hypervigilance (often manifested by a tendency to startle easily); inability to concentrate; survivor guilt; avoidance of activities that arouse recollection of the trauma; and intensification of symptoms by exposure to events that symbolize or resemble the traumatic event. Secondary symptoms often associated with PTSD include depression, 'death anxiety', impulsive behaviour, substance abuse and somatization.

Psychiatrists working with those who have been caught up in wars and upheaval increasingly refer to the widespread occurrence of PTSD. Research undertaken by Kinzie *et al.* (1986) with Cambodian school children attending clinics in North America found that 50 per cent had developed PTSD; Summerfield's pilot study (1990) in Nicaragua suggested that up to 50 per cent of the adult

population experienced PTSD; and Richman's (1991) work with children in Mozambique also noted symptoms associated with PTSD.

Superficially, it may appear that PTSD occurs across cultures and is, indeed, a useful diagnostic category to describe intense distress in a variety of countries and cultures. But many of these psychiatrists would be the first to acknowledge the hazards of relying upon psychiatric diagnoses such as PTSD to describe individual responses to war and upheaval in the non-Western world. Indeed, their voices are increasingly heard among a growing number of disaffected psychiatrists who, after studying anthropology, have helped to draw attention to the different ways in which culture has influenced the way in which psychiatric diagnoses have been conceptualized; and the extent to which they are not, therefore, able to capture the experience and expression of distress (which itself varies across cultures).

The following three examples illustrate some of the hazards and difficulties of relying upon a psychiatric diagnosis such as PTSD. First, it can be very difficult to make appropriate diagnoses as the 'disorder' is imbued with culturally-specific conceptions of normality and deviance. For example, a feature of PTSD is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. Common experiences such as simple bereavement, chronic illness, business losses, and marital conflict are thus excluded. But while this may be appropriate for middle class Europeans and north Americans, it is not clear how to interpret distressing events that are outside the range of usual human experience among populations where it is usual to witness a great deal of murder and torture (Jenkins 1991; Littlewood 1992).

Second, the name 'post traumatic stress disorder' implies that the traumas are finite events which gradually recede into the past and the diagnostic criteria discount the fact that many people actually live with prolonged warfare, economic insecurity and sustained states of terror and fear. It is clearly difficult to diagnose PTSD against this background - especially as some of the primary symptoms of PTSD may be adaptive responses to particularly awful circumstances. To quote Summerfield: 'it is hard for a mother to mourn a murdered child

whilst her other children continue to be at risk of the same fate. And while threat continues, hypervigilance [often manifested by an ability to startle easily], and a core element of PTSD, is adaptive' (1990: 5).

Third, there are the more inherent limitations of relying upon epidemiological and clinical data. For instance, psychiatric epidemiological data monitoring variations in the prevalence of PTSD within and between regions and countries conveys little about how daily life is affected and altered by the manifestation of a variety of signs and symptoms. The impact on, say, a mother's ability to care for her children or a man's motivation to sow seeds for the coming year is not conveyed by these types of figures. Similarly, clinical data presented by psychiatrists does not help us understand why certain experiences are so devastating and distressing.

In addition to these difficulties many of the more general anthropological critiques of psychiatric approaches to mental ill-health apply to the work on trauma. For instance, psychiatric diagnoses such as PTSD are imbued with a notion of autonomy and individuality which has its origins in Western culture and is by no means universal. The notion of the self, and its relationships to others and to the outside world, is different in many non-Western cultures. Moreover, the experience and explanation of illness is also frequently and fundamentally different. Thus it is often the case that much more attention is given to supernatural forces and social relationships as causal agents.

In sum, it is likely that psychiatric diagnoses such as PTSD capture at least some aspects of intense distress in the Western world. But while there are some indications that suffering is great in the aftermath of war - it is difficult to say what proportion of people have been affected because psychiatric epidemiological research is non-existent. By contrast, there is considerable uncertainty as to whether diagnosing 'disorders' such as PTSD in the non-Western world tells us anything very helpful about the nature of intense distress and suffering in the non-Western world. At best, its application is limited and, at worst, damaging. Is the same true for insights emerging from psychoanalysis?

Psychoanalytic understandings

The vast majority of psychoanalytic writing on war trauma has been concerned with the aftermath of the Holocaust. With the notable exception of a few writers who had a psychoanalytic background prior to their internment in concentration camps (eg: Bettelheim 1960), information and insights are based upon work with a small number of self-selected patients in Europe, North America, Canada, and Israel. Not surprisingly, there has been no serious attempt to assess the generalizability of psychoanalytic findings as there is no psychoanalytic epidemiology. Moreover, the tendency among anthropologists to dismiss the whole discipline of psychoanalysis on the basis that is unscientific and reductionist (Heald 1994) has also meant that no serious attempt has been made to consider how, if at all, insights from psychoanalysis could usefully inform anthropological investigations of war trauma. This is a pity as the psychoanalytic literature is far richer than the psychiatric literature and many of the issues and themes in the psychoanalytic literature raise questions worthy of investigation by others working in a non-therapeutic capacity.

Some of the more interesting findings and themes include the following: first, in common with the psychiatric literature, there is a consensus that social catastrophe can have a devastating and permanent impact on individuals - and that previous personality might play a less than major role in the symptoms of the survivor. Indeed, Grubrich-Simitis (1982), a German psychoanalyst, argues that one of the most traumatizing factors in the Holocaust was experienced by adults whose children were taken away from them and murdered (thereby violently reversing the natural order of dying); and she posits that experiences such as these will break any psychic structure.

³ However, in addition to the so-called 'survivor syndrome' attempts have been made to understand the great variety of clinical pictures which have been identified among survivors as well as the second and third generation. These range from psychosis to neurosis and there is a considerable amount of writing exploring the extent to which individual responses to similarly awful events varies by age, gender, family circumstances etc. Psychiatrists are also interested in documenting and responding to this variability but the discipline is far less able to shed light on how people respond and live with trauma and why it is that some experiences are so devastating.

There is, too, widespread agreement that a clear-cut 'survivor syndrome' can be identified. This syndrome was first described by Niederland in 1968. It is composed of the following symptoms and signs: 'anxiety, chronic depression states; some disturbances of cognition and memory; a tendency to isolation and withdrawal; many psychosomatic complaints and, in some cases, an appearance that suggested a similarity to the 'living corpse' stage of concentration camp prisoners - who had regressed to such apathy and hopelessness that death was imminent' (Bergmann and Jucovy 1982).

This syndrome is similar to PTSD in a number of important respects. In view of the fact that psychoanalytic and psychiatric theories and practices are so different from each other it raises an interesting question: do human beings have a limited repertoire of responses to major trauma? Perceptions of major trauma may vary across cultures but is it possible that the physiological and psychological response to perceived trauma is the same?

Alongside the acknowledgement and understanding of the devastating, and possibly permanent, damage that some events can have for an individual's health and well-being is an awareness that not all survivors became ill after liberation. Similarly, the children of survivors' did not necessarily suffer from their parents violent experiences. Yet, in common with the psychiatric literature, there is no writing which sheds light on this phenomenon.³

However, unlike the psychiatric literature, there has been an attempt to address the question of whether the type of catastrophe presents different difficulties to the survivor. For instance, is it helpful to differentiate between the shades of horror that existed within a concentration camp? Did it make a difference to have existed in the 'death area' rather

In relation to age, for instance, it has been suggested that 'the younger the traumatised child, the greater the trauma; the more it is relived in the form of physical sensations. Pain condenses memories of hunger, cold, toxic states and the feeling of loss that no-one came to take away the pain' (Kestenberg and Brenner 1986:312). This type of reasoning has emerged out of complex and elaborate observations of infant and child development in the Western world. Understanding is far from complete - not least because we know little about the extent to which an infant's understanding and experience of physical and emotional deprivation varies with culture.

than one of the 'workman's barracks' for an individual's well-being? These are brutal and currently inanswerable questions - not least because there are no comparable psychoanalytic data - but it makes one wonder what type of ramifications there will be for, let us say, a three year old child who has witnessed and survived one of the recent massacres in Rwanda in comparison to a similar aged child who has lived through a period of protracted, low-intensity warfare in another part of Africa.

For all the difficulties of assessing the longer term effects of witnessing and experiencing appalling and traumatic events, it is possible that research in the non-Western world could benefit most by a sensitivity to those psychic mechanisms which - in psychoanalytic terms - are considered to be essential parts of mental functioning (ie: denial, splitting, projection, projective identification, introjection). Bettelheim, for instance, has convincingly described the different ways in which defence mechanisms such as 'denial' and 'identification with the aggressor' enabled people to survive imprisonment in extreme conditions.

There are many illustrations of this in his work. One of the most powerful includes an analysis of the different responses of 'old' and 'new' prisoners. To quote: 'the main concern of the new prisoners seemed to be to remain intact as a personality and to return to the outer world the same persons who had left it; all their emotional efforts were directed towards this goal. Old prisoners seemed mainly concerned with the problem of how to live as well as possible within the camp ... no longer was there a split between one to whom things happened and the one who observed them.'

He then goes on to describe how many of the 'old' prisoners took over the Gestapo's attitude in various ways. For instance, they were sometimes instrumental in getting rid of new prisoners who were considered unfit, thereby making a feature of Gestapo ideology a feature of their own behaviour. They also expressed a desire to conform and to identify with the Gestapo. Thus Bettelheim writes:

they would try to arrogate themselves old pieces of Gestapo uniforms. If that was not possible, they tried to sew and mend their uniforms so that they would resemble those of the guards.

The lengths to which prisoners would go in these efforts seemed unbelievable, particularly since the Gestapo punished them for their efforts to copy Gestapo uniforms. When asked why they did it they admitted that they loved to look like one of the guards.

(Bettelheim 1991: 448)

Examples such as these demonstrate that psychoanalytic understandings of the mind have much to contribute in terms of helping us understand behaviour at times of war and in the aftermath of war - at least in the Western world. That said, it is also the case that there are substantial biases in the literature. Most current psychoanalytic writing, for instance, focuses on the consequences for individuals of having witnessed and experienced traumatic events rather than the longer term psychological consequences for those that perpetrated violent and murderous acts. This is quite simply because Nazis have not been willing to present themselves for analysis. As a result, psychoanalysts would have little to say about why certain patterns of behaviour, such as the gang raping of women, recur at times of war.

So, to recap: psychoanalytic investigations have contributed towards furthering understanding of the nature, causes and consequences of war-related trauma. Much of this understanding is based upon self-selected patients in the Western world and, in common with the psychiatric literature, the generalizability of the findings are open to question.

Anthropologists have much to contribute in this arena. For example, research undertaken by Brett (1996) in Uganda suggests that while it is common for people to display symptoms of trauma, sometimes in locally specific ways, it is rare for anyone to express feelings which might be rendered in English as 'guilt'. This observation raises the question of whether we should assume that 'survivor guilt' - a feature of PTSD and the survivor syndrome - is always going to be present among the traumatized.

It is a difficult question to address. On the one hand it has been documented that in African communities guilt-type feelings can be interpreted as a motive for witchcraft. It follows, therefore, that there are good reasons to deny guilt and to avoid mentioning anything that could be construed as

guilt to a researcher. On the other hand, it is just as likely that guilt is absent rather than repressed as local conceptions of individuality and ideas about being a person throw up a different range of emotions and behaviours to those noted by psychiatrists and psychoanalysts in the West. There is a growing anthropological literature related to such issues but analysis remains largely speculative (Heald and Deluz 1994; Heelas and Lock 1981; Kareem and Littlewood 1992; Marcella and White 1982; Schwartz, White and Lutz 1992).

In addition to drawing attention to the questionable assumptions which underlie psychiatric approaches to war and trauma, anthropologists have also highlighted the different ways in which distress and suffering is manifest in the aftermath of war. There is a growing body of anthropological work from Africa, for instance, which suggests that poisoning, millenarian cults, accusations of witchcraft and sorcery often play a central role among populations attempting to establish a sense of order and cohesion during and after periods of prolonged warfare and upheaval. In some cases the outcome is fatal. Allen's work among the Madi of northern Uganda, for instance, describes a number of instances in which women, accused of poisoning, would be publicly tortured and killed (Allen forthcoming).

Research undertaken in Central America (Zur 1993) and South America (Suarez-Orozco 1987) also documents the devastating effects that war can have for individuals and social life. Zur's work with Indian war widows in highland Guatemala, for example, shows that a sense of trust and solidarity had been broken down within the immediate family - with one member of the family joining the left wing guerilla forces and another the right wing military government. The psychological impact of witnessing and experiencing violence and destruction in an atmosphere of terror has made it impossible for many people to even speak about what has happened. As a result she argues that much psychic pain is manifested through a variety of somatic complaints. Some people even told her that people had died of anger and sadness.

While it is undoubtedly helpful to describe local responses to disturbing and violent events (and the variety of ways in which distress may become manifest) it would be fair to say that there is a need

to go beyond this. It would be helpful to develop ways to document the scale and depth of distress and trauma; the different ways in which daily life is impaired as it is difficult to know what, if anything, governments and international agencies can do to help heal the social wounds of war.

One thing is clear. The so-called 'talking cure' or 'talk therapies' (such as psychotherapy and psychoanalysis) probably have little to offer in the non-Western world. The 'use of 'talk therapy' is, after all, based on the idea of altering individual behaviour through the individual's 'insight' into his or her own personality. It is firmly rooted in a conception of the person as a distinct and independent individual, capable of self-transformation in relative isolation from particular social contexts' (White and Marsella 1982:28).

In Africa and many other parts of the non-Western world, most therapy directly involves other family members and sometimes the wider community. It is probably not very helpful to 'individualize' the suffering of the person when their recovery is bound up with the recovery of the wider community. In other words, effective healing in the aftermath of war is greatly influenced by the local context. It entails reconstruction of exchange and trade relationships, networks of trust and accountability, cultural institutions and respect for human rights.

Social anthropological approaches

Many of the above criticisms of psychiatric and psychoanalytic approaches to war trauma among non-Western populations have drawn on the work of social anthropologists (eg. Allen 1992, 1996; Last forthcoming; Littlewood 1992; Reynolds 1990; Zur 1993 etc). However, most social anthropologists working in war zones have not consciously set out to investigate war trauma. More often they have witnessed behaviour which seems strange from a Western or 'scientific' perspective, and have then sought to understand it. They have usually avoided universal conceptions of what is normal, and their interpretations have a marked tendency towards cultural relativism. Indeed, many anthropologists have suspended or set aside their own moral views or own conceptions of suffering and therapy, and have focused almost exclusively on

what they have found to be the views of their informants (for a discussion of this characteristic of anthropological writing see James 1988: 143-156; Parker 1995).

A consequence of this relativism is that, while the social anthropological literature is helpful in identifying implicit assumptions in psychiatric and psychoanalytic analysis, it is often not clear how it actually improves the identification of trauma. In making the exotic comprehensible, anthropologists have sometimes 'culturalized' violence.

This is the case, for example, with much of Allen's work on spirit possession and witch-cleansing cults among the Madi and Acholi of northern Uganda (Allen 1991, 1992, 1996). He accepts that many people in the region had been severely traumatized, but he shows that conceptions of suffering and choice of therapy are bound up with interpersonal relationships, and perceptions of the spirit world. Sleeping in trees, running wildly into the forest, and speaking in strange voices are all made to seem quite comprehensible, even reasonable. Alice Lakwena's Holy Spirit movement, which appeared so bizarre to outsiders, is revealed as a cult of healing. Alice cleansed her followers, anointed them in oil and loaded them with angels. Hundreds followed her to their deaths in 1986 and 1987. From the perspective of institutions wanting to provide humanitarian assistance to war damaged people, it is not obvious what to do with this kind of material. Clearly such local understandings cannot be ignored. Is the whole society to be pathologized?

Several anthropologists have themselves tried to grapple with this problem, often thereby moving outside of their own discipline. Wendy James (1988), for example, draws upon philosophical ideas in her complex analysis of Uduk moral knowledge; and Barbara Harrel-Bond (1986) has made recourse to social psychology. But such cross disciplinary discussion is still at an early stage and there is much that is not understood.

Nevertheless one insight that is beginning to emerge from the anthropological literature on war damaged groups is that violence is not necessarily destructive of healing. This point has been discussed by Allen (Allen forthcoming). With reference

to the Holy Spirit Movement and witch hunts in northern Uganda he argues that there are circumstances in which collective violence may be therapeutic. The dynamics by which certain types of violence might play a role in healing communities and some individuals within them require further research. But, as Allen suggests, it is not at all surprising that violence plays a part in the fraught process of building and maintaining viable communities during and following war and upheaval. It is a locally 'rational' attempt to come to terms with the extremities of the present.

The Madi are not unique in this respect. In many societies there is an intimate connection between violence and healing. In the Western world, for example, it is enough to think of the Eucharist, the Crucifixion and the considerable violence that attends much biomedicine and surgery. Governments and aid agencies need to bear the universality of these connections in mind, if they are to advance their understanding and responses to violence and thereby improve their own contribution to healing the social wounds of war.

Conclusion

It is hard to overestimate our ignorance about the immediate and longer term psychological consequences of witnessing, experiencing or perpetrating violent and murderous acts at times of war and upheaval. While it is possible that there are universal human responses to extreme trauma, it is not yet clear exactly what these are, and it certainly does not follow that the best way to alleviate distress and suffering is to intervene with therapies that have been used in the West. Academics are often criticized for concluding their research with the statement that there is a need for more research, but in the field of comparative mental health this is surely the case.

See following page for references.

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