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Psychosocial costs of war in Rwanda

Ian Palmer

This paper is the third in a series on the implications for psychiatric services of chronic civilian strife or war. The two earlier papers are Curran & Miller (2001) and Schreuder et al (2001). Ideas for further papers are welcome: please write to Dr Gwen Adshead or Gillian Blease at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.

The extraordinary events of 1994 in Rwanda touched the world, and the extent and brutality of the atrocities committed scarred it (Anderson, 1998). There are no simple explanations or solutions for such human tragedy. Societies are shattered by war, and societal interventions are required to heal the physical and psychological wounds. The final outcome of such interventions is, however, difficult to predict. Psychiatric involvement in Rwanda's suffering has been small and examination of the literature reveals a paucity of data. Most of the data that are available are qualitative, as that is the only way of understanding what happened. Everyone involved in Rwanda in 1994 was changed by their experiences. Rwanda was a catastrophe.

Background

Rwanda was, and remains, one of the poorest nations on the planet. Land-locked, deforested and underfunded, the land has known mass slaughter before. Any attempt to understand what happened in 1994 requires knowledge of the country's history (Box 1, Rwanda website).

The population of Rwanda falls into three groups: Hutu, Watutsi (Tutsi) and Twa pigmies. Hutu and Watutsi are, however, not really single unified groups. Inter-ethnic antagonisms are the pernicious legacy of colonialisation. The Belgians created a Tutsi élite, which eventually led to revolt by Hutu and the first diasporas of Tutsi to Uganda, Burundi and Tanzania. The Rwandan Patriotic Front (RPF) recruited from the Tutsi diaspora in Uganda and invaded Rwanda in 1990 and 1992, resulting in the 1993 Arusha power-sharing accord. This was, in effect, the death warrant for President Habyarimana, who was assassinated by extremist Hutu in 1994, the event that signalled the start of the genocide.

A cabal (the Akazu) was created by President Habyarimana's wife. Its aims were to gain control by decimation of their 'enemies', primarily Hutu dissidents and, subsequently, Tutsi. The Azaku hoped that mass killing would bind the perpetrators to their leadership and instil fear and submission

Box 1 Websites

Rwanda
http://www.rwanda.net

Belgian Senate Inquiry into Rwandan Genocide
http://www.senate.be/english/rwanda.html

Oxfam
http://www.caa.org.au/oxfam/advocacy/debt/rwanda/summary.html

Amnesty International
http://www.amnesty-usa.org/ainews/congo_rwanda/trialgen.html
http://www.amnesty.org

International Criminal Tribunal for Rwanda
http://www.un.org/ictr

Ian Palmer is the Tri-Service Professor of Defence Psychiatry at the Royal Defence Medical College (Fort Blockhouse, Gosport PO1 2AB, UK; e-mail: psych@milmed.demon.co.uk). He has served operationally in many parts of the world, including the Balkans, and was the psychiatrist to the United Nations military mission to Rwanda in 1994, where he worked with local community and religious groups, NGOs, the media and the UN High Commission for Refugees and travelled extensively. His main interests are the history of military psychiatry, post-traumatic reactions and medically unexplained symptoms following conflict.

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into the population. The events of 1994 were not a simple flare-up of inter-ethnic tension: the killings were planned years in advance. Between 10 000 and 150 000 Rwandans became involved in the slaughter, either by coercion or choice (Smith, 1998; see also the Belgian Senate Inquiry into Rwandan Genocide website (Box 1)).

Of the survivors, 70% were women. Many had been raped and left with unwanted children. Many had lost children. Many had been widowed, with minimal or no property rights. By the end of 1994 over 100 000 children had been orphaned. The Hutu diaspora went to Zaire (1 million people), Tanzania (500 000) and Burundi (170 000) . The morbidity and mortality in these groups was extremely high (Anonymous, 1996*a*).

Rehabilitation of civil society

War damages the very fabric of society. This damage relates to its physical structure (buildings, homes, sanitation), its institutions (judicial, educational, medical, religious), its social fabric (families, communities), its environment (mines, defoliation, pollution, corpses, disease), its communications (roads, railways, postal and telecommunication services, radio and television) and the normal structure (routine) of life.

Ideally, any psychosocial intervention should follow a thorough sociocultural analysis of the country's culture, traditions and institutions (including any regional variations), in order to identify social differentiations and who will benefit from what and how (Box 2). In 1994, many such interventions were insensitive to Rwandan culture, economy and politics. In addition, they lacked coherence and coordination between, and within, humanitarian, military and political endeavour (Pottier, 1996; Gracia Antiquera & Morales Suarez-Varela, 1999; Banatvala & Zwi, 2000).

Box 2 Appropriateness of psychosocial intervention

Any intervention should:

Identify problems in consultation with those enduring them

Help in a culturally acceptable way

Avoid importing and imposing Western views – even subconsciously

Recognise when it is time to leave, i.e. when continuity has been established and self-sufficiency has been achieved

Social and economic planning go hand in hand. Local needs must be assessed in partnership with the intended recipients of aid. Priority should be given to medium- and long-term rehabilitation programmes that foster social cohesion. Solidarity of communities should be fostered and toleration of cultural, ethnic and religious diversity encouraged.

Economics

The post-conflict government in Rwanda had serious credibility difficulties both within and outwith their borders. Following war, the costs of restructuring and rehabilitation are astronomical, yet in Rwanda severe financial constraints were put on the new government and reconstruction was hampered by the significant reduction in population resulting from the diaspora, the decimated infrastructure and inadequate statistics from which to work.

Rwanda's debt situation remains unsustainable, being five times the value of its export revenue. Repayments absorb 30% of foreign exchange earnings and 25% of government revenues. The health ramifications are enormous and prioritisation of resources is inevitable. Poverty levels have increased (70% of Rwandan households live below the poverty line and more are living in poverty now than 10 years ago). Health care and education systems have collapsed: more is spent on debt repayment than on basic services. Worst of all, Rwanda continues to face serious security concerns and violent clashes continue (Box 1, Oxfam website).

Failure of reconstruction exacerbates social tensions, increases poverty and insecurity and raises the likelihood of intensified conflict, with all its attendant miseries. Sustainability is problematic and, following war, the capacity of a population to sustain itself, let alone develop, is severely limited.

Justice and human rights

The key to rebuilding a society is that justice exists and is seen to work. Human rights almost invariably require advocacy and strengthening. Appropriate United Nations (UN) human rights activities should be selected and advanced (e.g. training the police and military in their roles and responsibilities, educating survivors through schools and the media and tracing displaced persons). Rebuilding the fabric of Rwanadan society will be difficult, given the level of complicity by priests and nuns, government officials and medical staff. Some of those involved in the killings live in the same locations

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and are known to survivors, whom they may intimidate or who may kill them in revenge. Apportioning blame to 'collaborators' is an area fraught with difficulties.

The war in Rwanda effectively destroyed the criminal justice system. Is is said that 125 000 individuals are in prisons and detention centres, many held without charge, and of the 1420 tried, at least 180 have been sentenced to death. Amnesty International has raised concerns about the 'fairness' of the trials in Rwanda, stating that there is hostility towards defendants, who seldom have access to defence counsel (Box 1, Amnesty websites). Although it is to be deprecated, it is hardly surprising that those within Rwanda are hostile to defendants and perceive unfairness when those charged with war crimes are tried outside Rwanda. Amnesty International believes that some individuals are being forcibly repatriated and a number are 'disappearing'. Rwanda's prisons are grossly overcrowded and unsanitary. Many men, women (with their infants) and adolescents are said to die while awaiting trial.

The International Criminal Tribunal (ICT) for Rwanda (Box 1, website) sits in Arusha in Tanzania and a steady trickle of individuals indicted for genocide end up there.

Women

Women suffer greatly during and after conflicts, yet they are the key to the survival of families and communities. When their partners and children go off to war women's roles change. They may become the head of the household or the breadwinner, some turning to prostitution to earn a living. War disrupts family and community networks and loss of family members is likely. Women are often the target of rape and other violence, putting them at risk of sexually transmitted diseases (STDs). Their impregnation may be encouraged by some combatant groups as a deliberate attack or defilement of their cultural or religious status. Indeed, rape has now been made one of the indictable offences of genocide. Such enforced pregnancies are likely to be unwanted. Women may lose property and possessions, and in many countries widow's rights are not strong. Some will have collaborated to save themselves or their families and their reception back into their communities may be problematic.

They should be encouraged, supported and intimately involved in reintegration at all levels of public life (Box 3; Omorodion, 1993; Van der Straten *et al*, 1995; UN Department for Economic and Social Information and Policy Analysis, 1996; Richters, 1998).

Children

The war's effects on Rwanda's children were appalling (Table 1). One hundred thousand were orphaned or separated from their families (Gupta, 1996): using photographs and radio (there is virtually no TV in Rwanda) the International Committee of the Red Cross undertook their largest tracking of displaced individuals (90 000–115 000) since the Second World War. Of the 125 000 individuals detained, there were 1800 children (mostly boys aged 14–18) held on charges of genocide. Other children, many under 3 years old, were there simply because their mothers were awaiting trial (Gupta, 1996). The Intrahamwe (Hutu 'death squads') targeted children, maiming males and raping females. Some children were forced to kill relatives or other children.

The majority of surviving children live in the districts in which atrocities took place. Damaged landscapes, sites of execution (often churches), maimed and disabled civilians and veterans, the continued presence of armed soldiers all act as potent reminders of the genocide. The children's losses include loss of faith, of normal parenting, of trust (seeing parents killed or seeing them kill others) and of boundaries (killing others themselves). Interventions to provide safety, routines and normality offer the best hope of rehabilitation. Unemployment, poverty, and continuing political and military uncertainty will all undermine any such work.

Although delayed psychological problems are possible, they are not inevitable, as children's reactions are complex and interpretive. They may have been victims or pupils of war and may understand clearly what they were caught up in. They will require education (at an appropriate time) to aid their understanding and contextualisation of

Box 3 The role of women in post-war society

Women's involvement at all levels is vital in:

Planning, coordination and execution of reintegration at government level
Obstetric and women's STD services
Psychosocial support for abused and traumatised women and children
Initiatives to help women avoid prostitution
Day care facilities to enable women to undertake educational initiatives
Rehabilitation of child soldiers
Vocational programmes for street children

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Table 1 Percentage of 3030 children interviewed who had direct experiences of the war (data from Gupta, 1996)

Experience	Percentage
Witnessed massacres	96
Lost at least one family member	80
Witnessed other children killing	>30
Witnessed rape or sexual assault	>30
Had hidden under dead bodies	>16
Were personally threatened with death	60

what happened to them and their families. Workers in Uganda and Mozambique report little clear evidence that violence breeds violence in these circumstances, and this gives hope for the future. Violence has been described as a drug that assuages hopelessness and the grief of loss. Those pupils of war who have been socialised into an aggression that has provided them with a *raison d'être* may now be more susceptible to dropping out of society and falling into (or continuing) substance misuse and gang and criminal behaviour. Child soldiers require a step-by-step 'detuning' of aggression and violent behaviour through specific programmes. The importance of women in the reintegration process cannot be overstated.

Children affected by war require general psychosocial support (United Nations Children's Fund, 1986). But children should not be seen merely as passive victims: their active participation is required to help communities heal the wounds of war.

Child care in Rwanda

There is a Rwandan tradition of caring for children other than one's own. In 1992, apparently, one in two families included a child from an unrelated family (Smith, 1998), so surrogate mothers or families may fill a void. Orphanages are common but of variable quality, understaffed and often overcrowded. If not competently staffed and administered with enough (basic) equipment to undertake educative tasks and evaluate their outcomes (social and educational), they have the potential for worsening children's problems. Cultural and local beliefs, attributions and understandings about death, community, family, spirituality, disability, memory and illness should all be used to aid assimilation and accommodation to the new realities.

Children should be provided with the means to express their emotions if they wish to. Play is important and includes art, drama, storytelling, fairy tales and myths, dance and holding and touching games. No fixed time-scales should govern whatever is offered, as individuals deal with bereavement and its attendant rituals at their own pace.

Refugees

In addition to obvious material and cultural losses ('cultural bereavement'; Eisenbruch, 1991), involuntary refugees suffer loss of dignity and of occupation. Their problems are legion and stem from the damage war inflicts on the social fabric of their country as much as on them individually.

There may be no real safety in refugee camps. Individual refugees have different vulnerabilities and resources, and are exposed to different risks. However, the capacity to draw on social customs and religious beliefs, and a cooperative effort and solidarity, can bolster physical and psychological defences in even the most extreme situations. Passive waiting can lower self-esteem and lead to apathy, anonymity and exposure to abuse and exploitation.

In Goma, refugees found themselves not only in unsanitary and overcrowded camps, facing infectious diseases and inadequate feeding; they were also subjected to intimidation and extortion by the Intrahamwe in their midst. Furthermore, aid efforts were inefficient, poorly coordinated and occurred in the context of chronic and constant structural deficiencies. The mass movement of people that created this acute situation made the planning for long-term needs difficult, but all interventions must nevertheless consider the impact of short-termism and plan for the medium- and long-term from the outset.

Demobilisation

Veterans have special needs that require close attention. Ex-combatants may be local (adults, adolescents and children) or expatriate. Most cope adequately. They do, however, raise particular issues for politicians, funding agencies, receiving communities and the police. Any problems with ex-combatants will be compounded if inadequate effort is put into demobilisation, as so often happens.

Social reconstruction is slow, especially for men (and women) of action. Promises are frequently broken and a sense of disappointment, even of bitterness, resentment and anger, can pervade the minds of veterans and increase the likelihood of peacetime lawlessness. Disgruntled veterans are a potential source of disruption, especially in the hands of

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unscrupulous politicians. But those communities ravaged by soldiers may resent resources and money being given to them to aid their demobilisation.

Reconstruction of pre-war economic, social and cultural life is central to successful demobilisation of soldiers. It is vital in areas of the world that remain politically very volatile. Reintegration involves adjustment to new realities – not a return to 'normality'. Ex-soldiers, returning refugees, the internally displaced and residents of areas most severely affected during the crisis are part of a complex, expensive and problematic endeavour for a stagnant war-ravaged economy. Funding is the key to success and a coordinated approach is essential. No start should be made until a reintegration programme has been prepared, funded and is ready to go (UN Department for Economic and Social Information and Policy Analysis, 1996). Box 4 lists the principal requirements of a demobilisation programme.

Box 4 The requirements of demobilisation programmes

Funding
Careful planning
Skilful implementation
Training, including:
- literacy, mine-awareness, psychosocial understanding and life skills

Economic reactivation in:
- agriculture, small enterprises and businesses, public- and private (NGO)-sector reconstruction, commercial work

Support from:
- religious organisations, NGOs, employment organisations, veterans' associations, government agencies

Disability

Research has shown that 80% of people with disabilities live in rural areas and 98% get no treatment (Helander, 1993). People disabled during conflict have immense difficulties in reintegrating into war-ravaged countries. The poor living in rural communities are much less likely to get help for their physical needs or to live in an environment that can adapt to accommodate them. The estimated cost of one adequate rehabilitation of one person disabled by war in Cambodia is US$5000 (Somasundaram & Renol, 1998). Some ex-combatants may wear their disabilities (war wounds) with pride, others with shame. It is important to understand the cultural views of disability in the communities one is helping. Even after conflict has ended, land-mines continue to disable, destroying livestock and livelihoods and terrorising communities. Although 50% of the land-mines in Rwanda have been cleared, 20 000 remain in the fields and woods.

Veterans with head injuries have special handicaps, and facilities for dealing with subsequent personality and behavioural problems are unlikely to be available. Most will go unrecognised and untreated. In a study of lower-leg amputees in Sri Lanka, Manoharan (1998) found that 40% were severely depressed, 30% moderately depressed and 15% happy to have escaped death. Individuals suffer both personally and socially (Box 5).

Interventions with those disabled by war require respect, empathy, listening, trust-building, in addition to befriending and comfort-giving. Cultural understanding and diplomacy are essential, and community helpers and traditional healers should be involved wherever possible. Individuals also need practical help in terms of: financial support for themselves and their families; counsel and advocacy; low-cost technical aids such as prostheses and wheelchairs; accommodation; community-based rehabilitation, to facilitate independence and improve self-esteem; and respect for human rights.

Disease and illness

Disease is the malfunction or maladaption of biological systems, whereas illness is a personal reaction to discomfort, distress or disease and it is shaped by sociocultural factors such as valuation

Box 5 Individual suffering caused by war wounding

Personal
Psychological sequelae of the incident; effects of deformity and loss of function; embarrassment; shame; loss of self-esteem and confidence; feeling useless, 'impotent'; irritation at receiving pity, leading to social withdrawal

Social
Stigmatisation, rejection; unemployment; dependency on spouse and children; loss of productivity and ability to support extended family; loss of family support (divorce, abandonment); inability to marry; loss of respect; loss of social position; ridicule; ostracism

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of distress. Illness is culturally constructed, embedded within a complex nexus involving family, community and culture. Psychiatrists must be able (and willing) both to treat illness and to diagnose disease (Kleinman, 1987). In doing so, they must take into account both psychosocial and cultural aspects: ignoring these may lead to frustration for all concerned. Psychiatrists should also be prepared to use their medical, non-psychiatric training at times.

Traumatic experiences

Non-disclosure

When working with war victims from other cultures, it is important to attempt to understand non-Western views and methods of dealing with the after-effects of traumatic experiences. In Mozambique, for example, nightmares are seen as an essential part of the healing process. Natural wishes for privacy, cultural beliefs about mental illness and feelings of shame and stigma at being identified publicly as needing assistance (especially after rape) can all be misinterpreted within the Western model as denial or avoidance of dealing with problems. Care must be taken if contextual and historical variation are not to be undermined by Western psychology. For example the Western assumption that social processes cannot heal individual psychological distress is at direct odds with the situation in African society. There, sociality is a prerequisite for the expression of the self and the emphasis is on dependency and interdependency between families and communities rather than on independence and autonomy (Kenny, 1996; Summerfield, 1997).

Language is a model of culture, and non-disclosure may extend to emotions and senses. Important aspects of social life may reveal themselves through the use of the human body as the medium of expression. The body can enable individuals to undergo salient experiences. Rituals such as mortuary ceremonies, spirit exorcism and communication with the spirit world or the deceased may be transformative, permitting important changes and accommodations to occur. Any Western intervention may be facultative, to create the conditions in which local practices can develop, but must never be pre- or proscriptive.

Management

In the West, science, medicine and psychiatry have largely displaced spirituality and religion in describing and explaining human experience, but this is not the case in many developing countries.

Distress and suffering are normal following war and conflict and they relate primarily to the devastation of social worlds rather than intrapsychic problems. In the eyes of some, however, they are pathological entities requiring (medical) treatment. It is debatable whether such interventions are of benefit when such basic things such as safety, shelter and clean water have yet to be secured. Local populations must be involved in all post-war interventions, as they are uniquely able to define the problems, set norms, reveal social and cultural knowledge and set priorities (Kleinman *et al*, 1978; Mechanic, 1978; Skultans, 1991).

Mental health interventions must be realistic, concrete, affordable, flexible, unstigmatising, acceptable, culturally sensitive and non-medicalised (UN High Commission for Refugees, 1993).

After war, psychiatry is not high on any list of priorities, and will not be so while there is no safe drinking water, killings continue and security cannot be assured (Meddings, 2001). In war-torn countries the mental health worker is faced with a nation, community, group, individual or even culture in gross disorder. In the First World War 5% of the casualties were civilian, in the Second World War 50% and in Rwanda 90% (Lee, 1991). Most current conflicts are intercultural and it is well recognised that civil wars are among the bloodiest of all.

The aim of any intervention, be it physical, administrative or psychological, must be to repair and maintain the social world of those individuals and communities threatened by disease, malnutrition, overcrowding, lack of shelter and continuing physical threat, endeavouring to return routine and normality to daily life.

The individual's economic survival

How do individuals cope in the aftermath of disaster? Initially, they will probably use their savings (if they still have them, or if they have any worth). They may work at casual labour or on the black market, seek help from relatives or turn to prostitution. All of these may be tried before they come to rely on external aid, which is often viewed as a temporary, inadequate and unreliable windfall. It should also be remembered that corruption is rampant when civil order and structure break down and some funds will inevitably be misappropriated. Aid supplies are often manipulated by the politically powerful and those who define the population in 'need' of aid are often those who control its provision.

There may be hidden ethical dimensions to monetary and material interventions in such circumstances: it is estimated that the relief given in Goma

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allowed 40 000 militiamen to regroup and re-arm, control the camps, terrorise refugees, indoctrinate youngsters and mount raids back into Rwanda (Pottier, 1996). Many refugees are innocent victims of the Rwandan tragedy but others have blood on their hands and may even be war criminals. One of the unfortunate consequences of the events of 1994 has been the commonly held belief that all Hutu were involved in the killings. Some religious non-governmental organisations (NGOs) were even found to have videotaped atrocity sites to boost contributions in their home countries.

Psychiatric hospitals

This is an area in which psychiatrists can become usefully involved. All of Rwanda's psychiatrists left the country during the war. Before 1994 there were two psychiatric hospitals, in Butare and Kigali, but both were the scenes of subsequent massacres, some perpetrated by inmates on each other during psychotic episodes.

There are many problems in working with such a facility in the aftermath of mass killings. It is important to address the physical needs of the inmates and staff (food, shelter, safety, clean water and sanitation, medication, mine-clearing, structural repairs, disposal of dead and, if possible, physical examination and treatment of patients). It is also important to act as their advocates with NGOs, the UN and the military. A psychiatric hopsital can act as a focus for the education and recruitment of mental health workers. Resourcefulness, enthusiasm, determination and mental robustness are required for such work, as psychiatry is afforded low priority.

A local example

In October 1994 I made my first visit to one of Rwanda's major psychiatric hospitals. Before the war it was considered to be a good facility; it had over 300 inmates and was run by the Brothers of Charity. When I started to visit, there were 37 in-patients, cared for by a single pharmacy assistant, who was the only mental health worker in the hospital and had been on duty (unpaid) constantly for 6 months. I have seldom met a more kind and compassionate man.

Of the 37 cases, 21 were acute (14 women and 7 men) and 16 chronic (11 women and 5 men). Diagnosis was complicated by the fact that all 37 were prescribed a mixture of neuroleptics and at least two antidepressants, with attendant side-effects. Sixteen of the inmates had psychotic illnesses and exhibited agitated behaviour and aggression towards other inmates, and this was the primary indication for the use of a neuroleptic; 13 cases (12 women) appeared to be affective in nature; the remainder were difficult to diagnose and some probably had learning disabilities.

Many of the newer inmates were women who could speak French and were therefore likely to have come from the upper 5–10% of Rwandan society. It appeared that an increasingly large number of women with behavioural disturbances were being 'dumped' there. Alcohol (banana beer) played a large part in the genesis of some cases.

How can the international psychiatric community help?

Doctors are powerful both medically and politically and they can use that power to help war-torn nations both at the site of conflict and from their own countries.

Working abroad

I suspect that most psychiatrists would be happier engaged in 'hands-on' work in post-war countries. But they must take care that their interventions do not to become a double-edged sword for all parties. They must therefore have a practical, pragmatic and robust nature and the humility to act in support of local mental health workers in practical as well as medical (psychiatric and general), social and political ways. 'Pyramid empowerment' is needed. This requires good communication, interpersonal, negotiating, diplomatic, political and empathic skills, underpinned by a clear understanding of the in-country organisations, key players and the socio-political and cultural background. An ability to compromise also helps.

There will always be a need for in-patient provision and I suspect that many Western psychiatrists would be comfortable with this form of help. The ability of a psychiatric hospital to serve communities with shattered communications will be limited but it can act as a focus for recruitment and training of mental health workers and as a base for the development of strategy and community planning. It should not be forgotten that such institutions may also offer much-needed asylum for society's most vulnerable.

Work in communities perhaps requires even greater maturity, humility and resilience. It is vital to remember that any work initiated continues after you leave, and any omnipotent fantasies, be they conscious or unconscious, should be recognised and

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curbed. You must try to understand how the culture is attempting to heal itself and then to see what you, as an outsider, have to offer that is in synergy with this.

Credibility and acceptance are enhanced if you are prepared to use your medical skills when necessary. Your very presence should be therapeutic, offering solidarity and hope for those in great need: your presence is evidence that they have not been forgotten by the outside world.

On a strategic level, what do psychiatrists working locally have to offer? They should be prepared to become involved, in conjunction with national and international social agencies, in the planning, funding and implementation of multi-disciplinary interventions in many areas, including: education; mental health; social structure; work initiatives; government planning; forensic and human rights issues; care of mothers and children; orphanages; rehabilitation after disability; and demobilisation of soldiers (including child soldiers).

This work obviously requires a number of abilities and skills, such as: experience working in cultures other than one's own; political and diplomatic awareness; an ability to take a strategic view of problems; moral authority, honesty and willingness to make difficult decisions; and advocacy with the media, both medical and lay.

Working at home

Mental health professionals in their own countries have a role to play in the assessment and treatment of mental illness in refugees, asylum seekers and survivors of torture; they may also act as their advocates. Any psychosocial interventions and initiatives offered should be culturally acceptable.

Psychiatrists can be involved in non-medical ways. For example, by lobbying politicians (medical and non-medical); supporting Amnesty International and NGO work; and taking part in fact-finding missions for government agencies and NGOs. Another task is to set up academic and vocational links with the post-war country, with rotational posts for juniors – vital, if we are to have senior psychiatrists with the experience to influence politicians.

Does the College have a role?

The Royal College of Psychiatrists may lobby governments on behalf of its members, but to offer practical assistance to countries in need it could take a less parochial view of psychiatric training, which I believe is too narrowly focused. By training within and for NHS psychiatry, specialist registrars (SpRs) (and indeed registrars) may be missing much of both professional and personal value that they might gain on placement in developing or war-torn countries. Unfortunately, however, such a placement may not fulfil the College's requirements for SpR training.

Have psychiatrists forgotten the importance of society and culture in healing (rather than curing)? Let us learn from other cultures how to use our strengths and power for their benefit.

Conclusion

Wars differ in their effects on the societies and individuals involved. Intervention is not for amateurs (Anonymous, 1996*b*). Any intervention is complex to organise and run. Lessons learnt in one conflict may not easily transfer to others, but all require social intervention and investment in the fabric of the nation (Summerfield, 2000). Intervention should respect and be guided by the desires and priorities expressed by the communities in receipt of help. Psychological interventions must recognise the dignity of these communities and be synergistic with local customs and practice. Psychiatrists and their professional bodies clearly have a role to play, a role that should be encouraged.

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Multiple choice questions

1. Psychiatric disorders:
   a are the malfunction or maladaption of biological systems
   b are the same as illnesses
   c are not seen in developing countries
   d may be found in ex-combatants
   e do not require sociocultural assessment.

2. Failure of economic and social reconstruction:
   a diminishes social tensions
   b increases insecurity
   c increases infant mortality
   d destabilises a country
   e is inevitable.

3. The 1994 UNICEF survey of children revealed that:
   a <20% had witnessed massacres
   b >16% had hidden under dead bodies
   c 10% had been threatened with death
   d 1800 were in prison
   e 10 000 were orphaned.

4. Soldiers demobilised without adequate planning:
   a may become social outcasts
   b return seamlessly to their previous communities
   c are at risk of criminality, lawlessness and substance misuse
   d are always glad to stop fighting
   e may disrupt social stability and reconstruction.

5. As regards people with disabilities:
   a 80% live in cities
   b >98% get no psychiatric assessment or treatment
   c the estimated cost of an adequate rehabilitation is US$5000
   d depression is a common in amputees
   e shame is not associated with disability.

MCQ answers

1	2	3	4	5
a T	a F	a F	a T	a F
b F	b T	b T	b F	b T
c F	c T	c F	c T	c T
d T	d T	d T	d F	d T
e F	e F	e F	e T	e F

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