Health Pluralism - A More Appropriate Alternative to Western Models of Therapy in the Context of the conflict and Natural Disaster in Sri Lanka?

Abstract

This paper considers some dilemmas relating to developing effective assistance with and to people who have lived through extreme events in a civil war and post-conflict context within Sri Lanka. The recent tsunami which has devastated many coastal areas of the island of Sri Lanka and left many people with no homes or livelihood has further affected the country. It is hoped that some of the issues raised in this paper will have wider applicability and relevance to other countries. A major issue is how far the concepts and methods of western psychology are appropriate to radically different cultures and contexts. In particular how post-conflict and post disaster psycho-social rehabilitation may depend in complex ways on local specifics and interact or not with biomedical notions of PTSD diagnosis and individual therapy. The relationship between a culture and its healing rituals is a complex one, and cultural, personal, socio-political, existential and personal meanings, expressions and responses to civil war or traumatic events and their aftermath may be mediated by context. The recent tsunami which devastated the many coastal areas of the island of Sri Lanka has compounded the losses and difficulties many people have to face after 22 years of civil war. This paper details our findings and offers some suggestions for future practice.

Introduction

Health pluralism is widely found in Sri Lanka, where the people identified as healers may not always be those to whom this role would be ascribed in the west (Lawrence,1997). Priests and indigenous healers, local rituals and traditions can have an important role in assisting people deal with the potential psychological effects of both the prolonged civil war, the return to peace (Somasundaram and Sivayokan, 2000) as well as the recent tsunami. By health pluralism, we refer, to a multi-layered or diverse range of explanatory health beliefs, and a concomitant wide range of coping strategies or help-seeking behaviours, as well as a varied range of designated healers. This paper will argue that working with these individuals and resources may be more appropriate in assisting communities than western models of individual trauma diagnosis and therapy in the context of civil war and post conflict context in Sri Lanka, particularly as this appears to be the preferred option for many people. This is not to say that traditional psychological notions do not have a place, but may provide one of a range of possible strategies.

The current research was prompted by a concern that an individualised model of diagnosis and therapy seemed somewhat culturally and resource in-appropriate, and was not widely taken up. The authors wished to consider how individuals and communities were surviving together, what had helped them cope and what they felt their own needs were, rather than merely offering something which might be inappropriate. We hoped the research might have pragmatic value, and contribute to the wider debate of these issues in Sri Lanka and beyond. We were also concerned that western

models have often been positioned as being “better” and imbued with a set of privileged values. See Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller, Nadirshaw, 2000; Patel, 2003 for a further discussion of this issue.

How each individual constructs the meaning of events within a civil war is likely to depend on a range of potentially interacting variables, including social, community, spiritual, socio-political and individual factors. How these relate to expressions of coping or distress, and how individuals construct individual or collective narratives may be complex (Tribe, 2004).

Socio-political Context

Sri Lanka had been involved in armed conflict/war for twenty two years, although a cease-fire was negotiated in February 2002. Recent factional splits among the militants has lead to uncertainty about the future as has the election of a new president in November 2005. The Tamil militants, known as the Liberation Tigers of Tamil Eelam (LTTE) or more colloquially the Tamil Tigers, fought the Sri Lankan army for control of the North and East of the country. The Tamil militants wished the North and East to become an independent Tamil state, while the Sri Lankan government aimed to maintain the status quo. There are also smaller populations of Moors, Malay, Vedda and Burghers (descendants of the European colonialists) in Sri Lanka. Approximately 8% of the population is Christian, represented by members of all ethnic groups, and 7% are Muslim (CIA World Factbook, July 2005). As a

result of military action and violence on both sides, approximately 65,000 men, women and children from all the ethnic groups have lost their lives (Refugee Council, 2005). 1.8 million people were uprooted by the civil war, 100,000 Tamils fled to India and 800,000 people representing all the ethnic groups have been displaced within Sri Lanka (UNHCR, 2003). 170,300 Sri Lankans applied for asylum in Europe and North America between 1990 and 1998 (Refugee Council, 2000).

Differences in religion, cultural practices, and personal names divide the two main groups, although there are also similarities. In parts of the north and east of the country, where the theatre of war was located, people lived in daily fear of the war and its repercussions. Elsewhere there have been a number of bomb attacks around the capital in the south of the country which led to considerable loss of life and injuries as well as damage to property.

Background

Ideas identified in this paper were generated through ten years of psycho-social work, and through training people to assist those with psychological distress caused by organised violence throughout the country. In conjunction with a participant observation methodology, texts and relevant materials were reviewed, on-going discussions held with colleagues and some semi-structured interviews were conducted. All the main ethnic groups in the civil conflict participated in the research, anybody who wished to participate in the research was welcomed to do so.

In line with the work of Strauss & Corbin (1990), we have related our findings to the literature in an attempt to maximise the pragmatic value of this piece of work. An interpretative phenomenological perspective was used, as it seemed most appropriate to the context and more sensitive to socially-constructed meanings and the needs of the population. The quotes given within the text are used to illustrate a theme which was raised by a number of participants.

Health pluralism in Sri Lanka

The psychiatric/psychological infrastructure in Sri Lanka is relatively young. There are approximately 33 psychiatrists and 4 psychologists for a population of 19.5 million. Psychiatrists and psychologists are mainly employed in government hospitals, private practice or universities. Many have trained overseas, although there are (about) five medical schools training psychiatrists, all in urban locations.

The question of the relevance of psychological models developed in the West and their relationship to an Eastern country is a vexing and complicated one. Ayurvedic medicine is practised widely, particularly in the rural areas, and many people may receive allopathic and ayurvedic medicine concurrently. (see below)

> *‘ I am receiving some treatment from the people at the government hospital, but it is not strong enough, so I am*

seeing an ayuverdic doctor also, I take all the medicines both of them give me.' Mr. S following a traumatic incident

Ayurvedic medicine is based on the view that disequilibrium causes illness. It has existed since several centuries BC (Bhugra, 1992). The word ayurveda means 'knowledge of long life', and is a system of healing based on a holistic inclusive and spiritual model. (For further details of the role of the Ayurvedic tradition within Sri Lanka, see Obeysekere, 1976). In addition, the use of cultural and religious rituals and traditions in dealing with emotional difficulties is widely practised, particularly in rural and war torn parts of the country. Writing about mental health in the Tamil community, Somasundaram & Sivayokan, (2000) p.26, say:

> 'If these rituals are not performed in the proper way (e.g. due to disturbed situations, disappearances, remains of the person is not found) there is a greater chance to develop psychosocial problems. Cultural and traditional rituals have a very important role in maintaining and promoting social, family and individual health as well as preventing psychosocial problems from developing.'

Siddha, Ayurvedic, traditional healers, mediums, astrologers and religious leaders within the community are also consulted for problems or difficulties encountered in life. Western medicine, traditional medicine, the use of rituals and the skills of healers are frequently interwoven in the Sri Lankan context. It

is important that any healing practices are conducted in a way that is predicated on cultural context, common health beliefs and locally-identified priorities (Tribe, 2002; Somasundaram & Sivayokan, 2000). The export of western models of emotional distress and treatment regimes to developing countries has been criticised, particularly in relation to traumatic reactions (Bracken & Petty, 1998, Summerfield 2000). The present authors propose that each model of health and recovery may offer some mutual illumination, and that health pluralism based on locally-identified needs may be the most useful way forward since it appears to be the preferred choice of survivors of the Sri Lankan conflict situation for dealing with psychological distress (Samarasinghe, 2002).

One of the research participants working in mental health for a Non-Governmental organisation (NGO) said:

> *'One traumatised person came for counselling, it did not help at all, but when he completed a ritual he was better. Is this because he believed in it and had no faith in counselling? If you believe in anything it will work.' (Participant C)*

Radley (1994) has stressed the difference between faith in the healer and faith in the treatment. Although religious and cultural practices might not commonly be associated with 'treatment', they can provide a healing function. It might be argued that the division is an arbitrary or semantic one anyway.

Helman (1985) has written that the very act of seeking help from a person viewed as a healer/helper may be construed as a ritual in itself.

Having mental health/emotional problems is seen, as in much of the world, as carrying a stigma, but in Sri Lanka the information that an individual has received professional psychological treatment may have wider implications than in the West. For example, the marriage prospects of individuals in the presenting client's family may be badly affected for several generations (Ranawake, 2003). (Owing to the notion of mental illness being due to "bad blood," this is viewed as the bodily component of bad karma.) In addition, consulting a mental health professional is frequently not part of people's help-seeking repertoire, particularly in rural areas.

Several of the research participants noted that many people in a community may be viewed as the healers or helpers other than a psychiatrist or psychologist.

> *'Traditional counselling had been done by the astrologer, the priests, at the various ceremonies, the thovil, (Hindu) ceremony, or where you get the thread tied, all these things.'* (Sivayogen, 1996).

(The latter is a common practice, where a thread is tied round the wrist, neck or hips by a Hindu Priest to imbue the wearer with good luck and religious protection).

Lawrence (1997), an anthropologist, writes,

> *'Local healers/oracles/seeresses in Sri Lanka; I believe that one way to initiate alternative programs which assist with forms of healing the injury of war is to educate those who are most popular in these local healing practices.'* (March 1997.) p.341

Landy (1977) claims that, where health pluralism is practiced, the cultural and social aspects of treatment may be equally weighted. The explanatory health model held by the patient may well determine where s/he seeks help for emotional or physical pain (Helman, 1984). Any health/illness model is likely to contain beliefs about aetiology, epidemiology and cure. Ideas and beliefs relating to heredity or causality may differ between models. Some may carry notions of spirituality or past "bad" behaviour. In Sri Lanka, the Buddhist and Hindu concept of 'karma' is very important. This envisages an external locus of control, with connotations of blame, the event/psychological state being viewed as an inevitable consequence of behaviour in a previous life, regardless of individual volition or politics, as though it were pre-ordained. This does not marry well with western ideas of therapy, internal locus of control and individual notions of choice and causality, as shown in the quote from a Sri Lankan mental health worker given below.

> *'If someone was disturbed they would say this is because of the karma if they are a Buddhist. A Christian might say this is because of the judgement by God or Satan- because they were*

close or not to Go. For example, after a bomb blast. There are things they will not understand, I have a very educated client. She will not come for psychological help, but will come for advice.'

Participant K

While Rubel (1977), writing about 'folk illnesses', noted that these are specific illnesses which people from a particular group appear to suffer, and for which their belief systems and practices provide an aetiology, diagnosis, prognosis, preventative factors and specific methods of treatment. Examples might be eating disorders in the west, amok in Malaysia, and brain fag in parts of Africa . The assumptions in the West tend to reflect the physical reality and psychological suppositions of the mental health practitioners that live there, and are frequently generalised to the whole world, where it may not always be appropriate. Arguments are also made by some authors for the universality of various syndromes.

Summerfield (2002: 248) writing specifically of mental health claims: "DSM and ICD are not, as some imagine, atheoretical and purely descriptive nosologies with universal validity. They are western cultural documents, carrying ontological notions of what constitutes a real disorder, epistemological ideas about what counts as scientific evidence, and methodological ideas as to how research should be conducted."

Post-traumatic Stress Disorder (PTSD) may be taken as one example with particular relevance to the issues discussed in this paper. There is a range of

views about its robustness as a diagnosis. Some theorists believe PTSD is an inappropriate diagnosis, reflecting a specific cultural context, and should not be exported wholesale, particularly in contexts of war (Summerfield, 1999; Bracken & Petty 1999), while Mezzich, Kirkmayer and Kleinman, (1999) argue that the Diagnostic Statistical Manual (DSM) does not consider the importance of cultural factors in relation to diagnosis adequately.

Although, de Silva (1999), writing on (PTSD), notes that there appear to be areas of commonality that are mediated by cultural and other factors while pointing to complex differences to be found within the whole category of PTSD, its relationship to the original traumatic event and other relevant variables. Further research is required to identify the generalisability of PTSD to other contexts and cultures, particularly in a civil war context. For example, in relation to PTSD the assumption that there has been single traumatic event is not usually true in the context of an on-going civil conflict, where there may be a range of traumatic events currently happening and constant fear of further ones. The literature on type 2 or complex PTSD has started to address this issue, and the reader is referred to van der Kolk, 1996 or Terr, 1994 for a more detailed discussion of this and related issues.

The explanatory model of health held by those offering help or treatment and those requesting it may require careful thought and consideration if misunderstandings are to be minimised. It might be assumed that living under civil war conditions for a period of nineteen years would have an effect on individuals and communities. While many survivors will have shown

resilience and adaptability, some individuals and families will have found their tremendous losses very difficult to bear.

"Since everyone in this society has been made to experience the terrifying situation and continue suffering, the total effect at the social level can be called collective trauma. For example most people have faced loss due to deaths, displacements, riots, starvation and hunger, destruction etc." Somasundaram & Siyayokan (2000) p.80

Issues of trust and loyalty may be fragmented or positioned differently in a situation of civil war. Tribe (1998) has written elsewhere about how it may be difficult to know whom to trust, and how suspicion and fear may become normal and functional responses. With long term peace looking a distinct possibility, the transition from 19 years of civil war raises a number of issues at individual and community levels.

One Tamil participant living in a largely Sinhalese area said,

> 'Every day we are getting traumatised, we can not dress our way, most of the people are controlling themselves to show they are not Tamils, even will turn the radio not to a Tamil station so that people will not know they are Tamils. We have to hide our real identity'. Partipipant T

While a health worker stated about the people she was working with,

> ‘They have no hope, they are always thinking that they have lost everything. Parents go off their heads, missing, raped, their children never seen again, what is it possible to do, what are any of us to do.’ Participant P,

The cultural milieu of Sri Lanka differs greatly from that of the West, where most psychological ideas have been based on liberal humanism. Although it has often been assumed that these ideas have universal generality, it is in fact an empirical question how far they retain validity in greatly different contexts of belief and culture. As a Sri Lankan Buddhist monk stated to a colleague, Ms Dissanayake (quoted with her permission):

> ‘*The location of the individual at the centre of western morality and cosmology makes it difficult for many to accept that this is, in fact, specific to western culture, and not simply a view of the world as it really is.’*

Ingleby, (1989) writes:

> *‘Yet the norms psychology incorporated were not just ethnocentric: even as a description of modern Western societies, they were highly idealistic. They were not statistical norms, but moral ones.’* (Ingleby, 1989,p.22).

Henriques, Holloway, Urwin, Venn and Walkerdine (1989) have written on this theme, and Kessen (1983) has discussed notions of childhood encapsulated and generalised within psychology as unalterable norms. MacLachlan & Carr (1997) write of the need for western psychology on occasions to be rejected, or at least not accepted uncritically, and of the need to develop indigenous psychologies, noting that psychologies developed in different parts of the world may have much to learn from each other.

Case example.

A Sri Lankan medical colleague considering the relevance of western psychological models stated to a colleague, as above (quoted with her permission):

> *'When you ask them the classical,…the whole thing, the PTSD criteria would be there, but these are all leading questions, this is the other problem. When you ask do you have intrusive memories? One thing is that it is easier to say 'intrusive memory' in English, but trying to put it into Sinhala or Tamil, you see, is very difficult and by the time you have explained all that, they know that they have to answer in the positive. So these are the shortcomings.'* Sivayogan, (1996).

This case example illustrates one potential difficulty in attempting to use an aspect of a western psychological model in a context where health pluralism

is prevalent and also in different cultural locations. The inter-relationship between language and meaning, explanatory health beliefs, culture and healing traditions is multi-layered and complex (Tribe & Raval, 2003). Fernando (1995) and Tribe (2002) have written about how the methods people use to maintain their psychological equilibrium and find help are in part developed and defined by the cultural, societal and health rules and meanings these are ascribed in their 'world'. A number of authors have also noted that different cultures define different behaviours/feelings as problematic (Torrey, 1972; MacLachlan, 1997). Examples of different idioms of distress and health behaviour might include agraphobia, type-A behaviour and eating disorders in the west, and inarun found among the Yoruba of Nigeria, quajihaillituq among the Inuit and tabacazo in Chile (MacLachlan, 1997). Western notions of mental health are frequently based on underlying positivistic philosophical tradition (by this is meant the philosophy of Auguste Comte, who claimed that recognising only positive facts and observable phenomena was important, while ignoring all inquiry into causes or ultimate origins). These notions may therefore be not only reductionist but may superimpose one set of constructions or a narrative devised in one part of the world onto another culture (Ager, 1997; Gibbs, 1994, Summerfield, 2002). Moreover, positivistic approaches have not much addressed cross-cultural variations, gender, religious and age-related variations. There are examples in a western context of political and folk ideologies changing or being replaced by medico-scientific labelling – witchcraft and mental disorder up to C18 or the re-categorising of the distress of army personnel in WW1 as 'shell shock' and traumatic stress, with the British armed forces describing ' a lack of moral fibre' in WW2.

The importance of locating emotional difficulties in their socio-political and cultural context has been argued by a number of authors, including Blackwell (1986), Tribe (1998), Kordon, Edelman,, Lagos, Nicoletti, Bozzolo (1988), Lago & Thompson, (1996). In a context of civil conflict, individual and collective identity, ethnicity and political loyalties may more often become intertwined than in other situations, resulting in the expression of traumatic experiences taking many forms.

Furthermore, the politics of war mean that psychological traumatisation may be constructed as a narrative of 'emotional weakness. Somasundaram (1998) in his work Scarred Minds -The Psychological Impact of War on Sri Lankan Tamils writes:

> *'For people to be pushed into war, to sacrifice their material, physical, psychological, social and spiritual well-being for a cause determined by others, basic psychological processes have to be activated and manipulated towards this end.'* Somasundaram (1998) p.91.

The research on the psychological effects of war on civilians is extremely small (Haugh, 1995; Karnow, 1984; Krystal, 1995; Waugh, 1997). In Britain during the Second World War, the government apparently went to enormous lengths to uphold a position of apparent positive spirit and morale by civilians. This was viewed as a part of the war effort, and resulted in negative

perceptions of traumatised individuals. (Calder, 1991; Freedman; 1994). Orner (1997) argues vociferously that the British Ministry of Defence (MOD) continues to deny or hide the potential psychological effects of war, in collusion with veterans' groups. He also writes that physical injuries are continually rated as more serious than psychological injuries, as reflected in compensation payments, acknowledgement, respect by the MOD, etc.

In Sri Lanka assumptions may be made that a particular political viewpoint will be held and that various sacrifices will be willingly undertaken based on ethnic background. In reality, this may not always be the case. Fear may prevent an individual expressing his/her real feelings. The Tamil Tigers have been accused of forcing Tamil people either to pay a significant financial levy to them, or to give one of their children as fighters. Stories of similar exhortations taking place in Sri Lanka continue to appear at intervals in the west (Reuters, Nov. 1996). Atrocities carried out by the Sinhalese army and other armed groups are contained in Amnesty International reports (1985, 1996b, 1999. As stated earlier, the socio-political context may affect the way that people react, how individual and collective loyalties may be linked, and how subsequent emotional feelings are expressed.

When the war finally ends, the process of "normalisation" or a return to peace time may take some time. One of the research participants noted that it is perhaps pertinent to consider what a truth commission, as established in South Africa, would uncover, and what role this might play. When such antagonism and loss has been suffered by some members of the two

communities, it is difficult to see how the potential long-term effects could easily be dealt with. This is increasingly important as the current cease-fire holds.

> *'At the end of the war…all will need counselling, at the grassroots level. There will be a legacy of hatred and fear, it will be necessary to work with the entire community to sort out the issues. Many arguments will arise otherwise, those who are abroad, they think that the well-to-do people should not have left the country, but should have stayed with us.'*
>
> *Participant L*

While the following case provides an example of the importance of attempting to locate emotional difficulties in their socio-political and cultural context it also illustrates that in a context of civil conflict and war, individual and collective loyalties may become intertwined and that people's choices may become severely limited in ways that may adversely affect their mental health.

Case example

J was a young man who was carrying out his trade of furniture maker at the edge of his village one-day. J and his friends had often shared tales of bravado about what they would do if anyone came to trouble them. When masked-armed men suddenly surrounded him, he did not know at first, which armed group they represented. He was terrified, he lost control of many of his

bodily functions. He begged them, to tell him what they required and he would do it. They teased him, and said," we know who you are, where your family live, naming various family members, if you don't help us we will 'see to them and to your shop.' We know you don't really support us." They required him to use his carpentry skills to make them something, he was forced to do this and told not to tell anyone. They told him they would be watching him, and might be back for more 'favours'. J was forced to live with the knowledge that he was providing for a political group he did not support, he did not dare stop but was ashamed that he did not. His previous self-image as a strong and brave independent man had been destroyed. He was also terrified that if one of the other political groupings discovered what he had done, they might extract their own revenge. He was also scared that someone in his village might have seen something and might denounce him. He felt he had no choice. His emotional state slowly deteriorated, he was unable to continue his trade and provide for his family. He eventually fled to Europe where he lived an extremely marginal existence wracked with guilt for leaving his elderly parents with no source of income, with very fragile emotional health and worried how his flight might be interpreted by others. He dreamt frequently of returning, but feared to do this.

Stigmatisation through Western Labelling?

Research from around the world shows that any group or government may want to keep hidden the negative psychological effects that the war or civil conflict is having on 'its' side as part of psychological warfare and the politics

of war (Levy, 1995; Tribe 1998). 'Group-think' and a range of behaviours relating to crowd and group behaviour may occur. A climate of fear and suspicion may develop. There is accumulating evidence on long-term individual and inter-generational consequences of severe war trauma (Davies, 1997; Waugh, 1997; Hunt, 1997). However, some authors argue that evidence of severe psychological effects might be distorted through being based on clinical samples (for example, Summerfield, 1999, while the powers of recovery of individuals and communities have been either underestimated or excluded from the dominant discourse because they do not readily fit a medical paradigm (Bracken, 1999; Richman, 1999; Summerfield, 2002).

As to setting up appropriate services, experience has shown that the 'pathologising' of certain individuals may lead to secondary stigmatisation through their first being seen as having emotional difficulties, and secondly as needing to see a mental health professional (Foster, 1989; Schwarzwald , 1993; Tribe & de Silva, 1999). If services are located in a city, travel is difficult for people from rural communities, particularly in a civil conflict situation, with regular road blocks and associated difficulties. An advantage is this allows people to retain anonymity, although distance may also prevent them getting adequate long-term care. If services go to the villages, this may provide psychological assistance to more people, although they may fear being identified as having difficulties with all the concomitant cultural negativities this may bring.

What appears to have been largely ignored are the longer term needs of survivors. Hassan (1994), working with holocaust survivors argues that many people ‘coped’ for many years, and refers to the ‘symptom free interval’. The needs of the survivors changed as they grew older. This is in line with work from psycho-geriatrics, which shows that as short-term memory diminishes, long-term memories may become more lucid and pressing (Hunt and Robbins, 1995; Davies, 1997; Waugh, 1997). In Sri Lanka resources, even in the short term,, are very limited, but long-term considerations, after 19 years of civil conflict must not be ignored. The on -going peace process may lead to many changes in the lives of people who have been displaced by the civil war. Although the final outcome is not yet certain, negotiations are continuing. Some people have started leaving the refugee camps and returning to their home areas, but many remain in refugee camps, waiting to ensure that the peace holds and many areas still contain unexploded landmines. War damage to property as well as lack of an established infrastructure has also prevented many displaced people returning home, while in some areas there are disputes over property and land ownership.

It has been claimed that war or civil conflict may have long-term effects on individuals (Brown and Fromm, 1986). This may lead to interpersonal friction and perhaps secondary victimisation where the individual’s family or work colleagues are further affected by the changes. For example, taking away responsibilities previously held by the survivor in an attempt to help him/her, may enhance feelings of helplessness and impotence. This may be

heightened when issues of causality and blame are entangled at the individual and community levels. The opposing view or discourse must also be considered; this relates to the power of survival and recovery of individuals and communities, particularly when wider socio-political issues form part of an over-arching narrative.

Cultural and Existential Meaning Within the Civil Conflict Situation

Cultural manifestations and meanings may be numerous, as McQuaide (1989) notes in connection with work conducted with South East Asian clients.

> *'An emotional problem may have a very different meaning- a meaning not immediately obvious to the Western mind. The emotionally troubled individual may feel that he or she is being punished, and that confiding to a psychotherapist is shaming or betraying the family and the ancestors. Consequently emotional problems may be converted to somatic complaints.'* McQuaide (1989) p.22.

A wide range of traumatic events and subsequent responses are to be found in Sri Lanka, as are beliefs about causality and agency in dealing with them. A Sri Lankan medical practitioner told a colleague, Ms Dissanayake (quoted with her permission):

'*If you ask 'Do you attribute that to the bad period, or do you think there is a good period coming up in your horoscope? 0r something, could have led you from here to there, they will not recognise that as a coping strategy, even if most of them would have used it.....People will visit soothsayers, or undertaken rituals but if you asked them if they had used a coping strategy they would have said no.'* Sivayogan (1996).

Situational Factors

All recorded histories of war document instances of 'normal' moral codes breaking down, and behaviour taking place that in peace time would lead to social censure (Butollo, 1996; Figley, 1987). In addition to these behaviours commonly associated with war, there may be more subtle examples of behaviour taking place in war time that can have very negative effects for individuals or communities, an example is given below.

Case example.

One of the authors was asked a while ago to see a young woman C, she was told C had an impressive and brave record in working for respect and human rights in her village located in a civil conflict area. She was widely respected by her community, but disliked by those with political power for her concern for her compatriots' human rights, which it appeared they saw as interfering with their work of war. C had stated that she would rather speak to someone who had no political or ethnic loyalties and who was going to remain in the country for only a short time. When she came into the room, she sat and

sobbed, and kept telling me 'it was all over'. Slowly we began to develop some trust and to talk about what was troubling her. It transpired that the local armed personnel, had picked her up. I could not understand initially what it was the armed personnel had done, and I continued to encourage her to talk. My formulation, based on a western premise, was that I suspected the armed men had sexually abused her and that she felt unable to mention this. She kept repeating, in distress and anger that the armed personnel had stolen her future. It eventually transpired that the army men had not touched her, they had instead sat her on a chair just inside the veranda of their base, but in full view of anyone walking past. They knew this would be interpreted by people walking past, as that she had been raped, which would mean, within this cultural frame that it would be virtually impossible for her family to find her a husband, and might affect the family's position (social and financial) for generations to come. The armed men knew this would destroy her and her family, and any threat they believed she posed would be removed. The family would have no grounds to complain, as the armed men could say she merely sat in a chair on the veranda all day. She decided to leave the country almost immediately, as this seemed a more comfortable option than remaining within.

This case study illustrates how cultural meanings and manifestations within a civil conflict may be misunderstood by outsiders and how a subgroup's social and moral codes may be broken by an opposing group as part of psychological warfare within a civil conflict situation. In this example the armed men knew that by making it appear that C had been raped they would

have silenced her as a locally powerful opposition figure, ruined her marriage prospects and brought great shame and embarrassment upon the family.

The view that people's psychological reactions to civil conflict/war situation become the norm, has been pointed out by McWhirter (1988,) who claims that in an ongoing war situation, abnormality becomes normality and habituation occurs. Cairns (1996) has similarly advocated this view. Two models most frequently found in the literature and proposed in a situation of a drawn out civil conflict are;

- firstly the distancing/denial model
- or secondly the habituation model.

The literature in this area is rather confused and the terms are often used interchangeably. Cairns, (1996).]

The Positioning of Traumatic Responses Within a Civil Conflict Situation

There is a long history relating to the emotional effects of war, as early as the American Civil War, when William Hammed, Surgeon General of the Union Army noted the psychological effects of war, he described them as 'nostalgia', while Shakespeare's Henry IV Part II gives a clear account of battle stress.

Governments involved in costly civil conflicts may be understandably reluctant to direct limited resources towards rehabilitation particularly when, as in the

case of the Sri Lankan government they until recently appeared to deny even the premise of psychological distress caused by traumatic events. The same pattern during and after the Second World War has been documented in Britain (Calder, 1969), where psychological breakdown was usually seen as inner weakness, rather than a normal reaction to abnormal events.)

In World War I, mental health professionals were very concerned not to be seen as soft professionals who would allow soldiers suffering from shell shock or other responses to the war to 'shirk' their duties, and in the process affect the military and the public's perception of psychology/psychiatry (Rivers, 1923).

Case example.

> *'Better for him perhaps, what about the hospital.....is going to say ,when he finds out we're sheltering conchies (conscientious objectors) as well as cowards, shirkers, scrimshankers and degenerates?' Barker (1994) in Regeneration. p.4.*

The above is a case example to illustrate that throughout history those suffering from the psychological effects of warfare may have been labelled as fraudsters or as not being sufficiently strong or courageous to withstand its concomitant difficulties. The wider politics of war meant that those in control wished to represent those people as individually weak rather than raise questions about the inherent risks to psychological health of warfare

It has been suggested that the military has concentrated largely on acute stress reactions as these stop a soldier working. After much work on Vietnam veterans and Holocaust survivors, definition of the traumatic experience and its effects has been linked in some way to compensation schemes. In other words, there has been a focus on linking emotional damage to a specific or series of events, which is particularly difficult even if it is desirable in a civil conflict situation of 19 years duration.

Unfortunately, much of the outcome research on psychological interventions in response to civil conflict or war situations could be criticised within the traditional scientific psychological paradigm for being methodologically weak and also contradictory This does not necessarily mean that any results are incorrect, but rather may reflect different settings and conditions where the 'contradictory' research has been done,

Conclusions should be more closely linked to the data reported and arguments made. his may be inevitable given the nature of the subject. Methodological weaknesses may include;

- lack of consistency of interventions,
- differing degrees of trauma,
- timing variance,
- sample size inadequacy for the analytic method selected,
- a selected group being studied

- various confounding variables including continued exposure to the traumatic event/s among others.

Combat Stress Reaction

If Combat Stress Reaction is accepted as a meaningful diagnosis then there are two opposing views regarding longer term prognosis:

- The stress evaporation hypothesis - which holds that there are likely to be only a small number of casualties after the threat /war has finished. Helzer et al. (1979).

- The residual stress hypothesis - which holds that exposure to stressful conditions does leave residual effects, i.e. a large number of casualties would be left with long-lasting effects (Steun and Solberg, 1972).

After 19 years of civil conflict and extremely limited resources being allocated to help those psychologically affected by the civil conflict in Sri Lanka, it is impossible to examine either hypothesis thoroughly.

Bleich., Shalev, .,Shoham, and Kotler, (1992) have written about the now famous Koach project, funded by the military in Israel to examine the treatment and care of chronic CSR (Combat Stress Reaction) four years after the designated date of injury. The participants were extremely positive about its value but the findings were contradicted by measures of functioning and

symptomatology. Keane et al. (1985) argue that in order to extinguish PTSD symptoms one needs to be totally immersed in the traumatic memories: this was systematically avoided by the Koach therapists.

Keane, et al. (1989) claimed that behavioural techniques such as imaginal flooding produced significant results in relation to depression, anxiety, startle responses, and re-experiencing of the trauma in a group of Vietnam veterans compared with a no-treatment control group. A difficulty encountered was that the therapist lacked detailed knowledge and understanding the patient had of the traumatic events.

Solomon, (1989), in a 3-year prospective study of post-traumatic stress disorder in Israeli combat veterans, found that combat stress reaction casualties had significantly higher rates of PTSD than a matched sample at 1, 2, and 3 years after the event, although this was at a decreasing rate.

Another dilemma has been enforced participation in such interventions. McFarlane (1989), working not in a civil conflict situation but with emergency fire-fighting personnel, has raised concerns that enthusiasm for such primary prevention by mental health professionals may mask appropriate diagnosis and subsequent treatments. Another problem is that follow-up measures have frequently been lacking, and the aetiology of possible symptomology ignored.

The traditional paradigm may not be the most appropriate given the individual nature of existential factors involved in traumatic responses. Ideographic data

may do much to increase our understanding. Also, ethical concerns would prevent many of the requirements of this paradigm being fulfilled, for example the use of a control group.

Most of the studies have concerned themselves with the traumatic effects felt by the military rather than the civilian population. Chalker (1996), speaking on behalf of the British Overseas Development Agency, noted that in October 1996 there were 300 million victims of 30 internal wars and violent conflicts. She also noted that 95% of war casualties are now civilian, whereas 90% were military at the start of the century. Summerfield (2000) claims that nearly one percent of the people in the world are refugees or internally displaced persons resulting from approximately 40 current violent conflicts.

Summary

Socio-political and cultural factors are at work in a number of ways in a civil conflict situation. While assumptions underlying psychological theories may in part reflect the western historical and social context of its development, they may not adequately reflect the situation of people living under nineteen years of civil conflict in Sri Lanka and the recent tragic tsunami. Cultural and socio-political factors require attention if interventions are to be helpful. Visiting a psychologist/psychiatrist is unlikely to be in the help-seeking repertoire of many people, as they are seen as dealing with mental illness, which is viewed as stigmatising. Religious beliefs drawing upon Hindu and Buddhist beliefs often explain that poor psychological well being and health depend on

behaviour in a previous life. This is at odds with western notions of choice, causality and models of psychological intervention.

Healers /helpers are more likely to be priests, astrologers or oracles. The relationship between a culture and its healing rituals is a complex one. Reification of mental health and positivist notions do little to assist this issue. Explanatory health beliefs may be different from those frequently taken as read by psychologists trained in the west.

In addition, existential meaning has been almost absent from the literature on psychological health and trauma. In a civil conflict, political and ethnic loyalties may become heightened and act to protect psychological health. Most of the literature on civil conflict and war and psychological interventions has concerned American military samples, and thus relates to a particular cultural context and a specific sub-population. This paper suggests that health pluralism in a situation of civil conflict in Sri Lanka may be one alternative, drawing as it does on traditional resources as well as western psychological health models.

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