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1 Department of Health. *Health secretary announces membership of modernisation action teams to draw up national plan for health.* London: Department of Health, 2000. (Press release 2000/02081.)
2 Viner RM, Keane M. *Youth matters: evidence-based best practice for the care of young people in hospital.* London: Caring for Children in the Health Services, 1998.
3 *Improving children's health. A survey of 1999-2000 health improvement programmes.* London: NSPCC, Children's Society, National Children's Bureau, 2000.
4 House of Commons Health Committee. *Second, third, fourth, and fifth reports of session 1996-7.* London: House of Commons Health Committee, 1997.
5 *Improving the health of mothers and children: NHS priorities for research and development.* London: Department of Health, 1996.
6 *Growing up in Britain.* London: British Medical Association, 1999.
7 Audit Commission. *Children first: a study of hospital services.* London: Audit Commission, 1993.
8 Berman S. Training pediatricians to become child advocates. *Pediatrics* 1998;102:632-6.

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Conflict and health

War and mental health: a brief overview

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About 40 violent conflicts are currently active and nearly 1% of the people in the world are refugees or displaced persons. Over 80% of all refugees are in developing countries, although 4 million have claimed asylum in western Europe in the past decade. Many wars are being played out on the terrain of subsistence economies; most conflict involves regimes at war with sectors of their own society—generally the poor and particular ethnic groups, such as the ethnic Albanians in Kosovo. Atrocity—extrajudicial execution, torture, disappearances, and sexual violation—generates terror, which maximises control over whole populations, as does the intentional destruction of the fabric of social, economic, and cultural life. Community leaders, health workers and facilities, schools, academics, places of worship, and anyone who speaks out for human rights and justice are often targets. In many regions such war is a factor in the daily lives and decision making of a whole society.

Summary points

- The reframing of normal distress as psychological disturbance is a serious distortion
- Personal recovery is grounded in social recovery
- Rights and social justice shape collective healing
- Researchers must attend to resilience factors and beware of extrapolating from clinic based samples

Individual effects

There is no such thing as a universal response to highly stressful events. However, somatic presentations such as headaches, non-specific pains or discomfort in torso and limbs, dizziness, weakness, and fatigue are central to the subjective experience and communication of distress wrought by war and its upheavals worldwide. This does not mean that these people do not have psychological insights but that somatic complaints reflect traditional modes of help seeking and also their view of what is relevant to bring to a medical setting.[1] Some researchers see somatic symptoms as physiological responses driven by stress; others emphasise their communicational element—these may be the only available expressions of the collective distress of powerless and persecuted people denied societal acknowledgment and reparation.[2]

Though the impact of combat on soldiers has been studied since the American civil war, the medical literature on civilians has burgeoned only in the past two decades. It is still based mainly on clinic populations of war refugees who have reached the West. One exception is Northern Ireland, one of the few conflicts from which comprehensive medical records are available. Over the past 30 years there has been no evidence of a significant impact on referral rates to mental health services.[3] The current literature is dominated by post-traumatic stress disorder, the successor to formulations such as "concentration camp syndrome," "survivor syndrome," and "war neurosis." Although post-traumatic stress disorder is reported to be prevalent worldwide in populations affected by war, the assumption that a Western diagnostic entity captures the essence of human response to such events anywhere, regardless of personal, social, and cultural variables, is problematic.[4] Features of post-traumatic stress disorder are often epiphenomenal and not what survivors are attending to or consider important: most of them remain active and effective in the face of continuing hardship and threat.[5] Thus uncritical application of diagnostic checklists for post-traumatic stress disorder may generate large overestimates of the numbers needing treatment.

Although some victims do develop significant psychiatric and social dysfunction, the relation between traumatic experiences and outcomes is not clearcut. A prewar history of psychological vulnerability is a risk factor.[6] Recent research shows that secondary consequences of war—on family, social, and economic life—are important predictors of psychological outcomes.[7] In Iraqi asylum seekers in London, poor social

support was more closely related to depression than was a history of torture.[8] Unquestionably, the major protective factor is the presence of a community able to provide mutual support and nurture problem-solving strategies.

Onwards from the classic study of Freud and Burlingham in 1943, the literature shows the positive effects of family attachment and other supports in buffering the impact of war on children.[9] Their emotional wellbeing remains reasonably intact for as long as parents or other caregivers can cope with the pressures of their situation.[10]

Physical ill health or disability has been cited as a risk factor for psychological dysfunction, but generalisations are difficult. For instance, a study of 72 war wounded combatants in Nicaragua did not indicate that a severe disability, such as paraplegia or amputation, made subsequent psychological dysfunction more likely.[11] More studies are needed, not least because of uncleared mines (over 20 million in Angola, Afghanistan, and Cambodia alone) which will continue to maim for decades.[12]

The question of long term effects of war on mental health is beyond the scope of this overview but has been discussed elsewhere.[13]

War as collective experience

Current concepts of trauma are in line with the tradition in Western biomedicine and psychology to regard the singular human being as the basic unit of study and to prescribe technical solutions.[5] But war is not a private experience, and the suffering it engenders is resolved in a social context. Fundamental to processing atrocious experience is the social meaning assigned to it, including attributions of supernatural, religious, and political causation. Thus members of a terrorised social group who find that what has happened to them is incomprehensible, and that their traditional recipes for handling crises are useless, are particularly likely to feel helpless and uncertain what to do. When war so routinely targets the social fabric, community structures may not be able to fill their customary role as a source of support and adaptation. Terror causes mistrust, which, as intended, further weakens communities. In situations of social crisis or breakdown there may be other consequences with deleterious effects: violation of unprotected women, alcohol abuse, prostitution for survival's sake.

Perhaps the primary impact of war on victims is through their witnessing the destruction of a social world embodying their history, identity, and living values. One example is the Guatemalan Mayans, who during the 1980s alone had 70 000 civilians slaughtered and 440 villages eradicated. Mayan myths and identity are linked to land and maize. Survivors feel that their collective body has been wounded, one which includes the ants, trees, domestic animals, and ancestors gathered across generations. To them the burning of crops by the army was an attack not just on their food sources but on the symbol which most fully represented them as the people of maize—it was genocide.[14] In Africa and Asia too there are subsistence peoples who may not be able to imagine personal survival if their way of life does not survive. Indeed there are no socially defined ways of mourning a lost way of life. Eisenbruch uses the term "cultural bereavement" to describe Cambodian refugees in the United States who continue to feel guilty about abandoning their homeland and unfulfilled obligations to the dead; many have found it hard to attend to the tasks facing them in an alien society.[15]

GIOVANNI DIFFIDENTI/AP PHOTOS

A young double amputee training at the orthopaedic centre in Huambo, one of the most densely mined areas of Angola

It is simplistic to see people who are exposed to political violence merely as hapless victims unable to act on their environment. Children too are not just passive bystanders but often active citizens with values and causes. In the 1990s children had activist roles, including bearing arms, in over 30 wars. Studies from Gaza and Soweto show that identification with a national struggle for freedom offered psychological protection to children facing high levels of violence from the Israeli and South African forces.[16 17] Conversely, some ex-activists or soldiers come to feel that their personal sacrifices were in vain (as many US Vietnam veterans did), and this may complicate postwar adjustment.[18]

Basic issues in interventions with victims

Most groups affected by war nominate restoration of the health services destroyed by the war as one of their priorities. Beyond the few people with clearcut psychiatric problems who need treatment, the question is whether the suffering of war itself should be framed as a mental health issue, and if so, in whose terms. The WHO emphasises that in developing countries mental health should be viewed as an integral part of public health and social welfare programmes, and not as a specialist activity set apart. The WHO has also begun to recognise the role of traditional healers who—in Zimbabwe and Cambodia, for example—have helped survivors to lay the war and its dead to rest.[19] Every culture has its own beliefs

and traditions which determine psychological norms and frameworks for mental health. Yet Western psychological concepts and techniques have accompanied the global expansion of Western culture and increasingly claim to be definitive knowledge, displacing local understandings.[20] Issues of power and ideology are especially relevant for people affected by war, who have so often lost much of their own worlds.

The recent rise of trauma programmes in war zones shows the danger of looking at war with a gaze borrowed from a psychiatric clinic and of applying a paradigm that transforms the social into the biopsychomedical. Even consultants to the WHO and Unicef have made expansive claims about epidemics of "post-traumatic stress" and said that early intervention with Western mental health technologies—a short term technical fix—would avert the later onset of mental disorders and new cycles of violence in exposed populations.[21] An empirical basis for these assumptions is lacking, as is evidence that those affected are calling for such programmes. For the vast majority "post-traumatic" stress is a pseudocondition. As noted earlier, the reframing of normal distress as psychological disturbance is a serious distortion which may increase people's sense of themselves as passive victims rather than active survivors and ignores their own strengths and priorities. Such projects have little or no claim for inclusion in the emergency relief delivered to war zones.

Psychiatric models too give little acknowledgment to the role of social action and empowerment in promoting mental health. The major thrust of humanitarian interventions must be towards the war-weakened social fabric of survivor populations, for herein lie the sources of psychological resilience and capacity for recovery for all. Survivors first seek to regain a measure of dignity and control over their environment and then to reconstitute the cultural, social, and economic institutions and activities that make sense to them. They are determined to preserve what they can of their culture and way of life, as these things define what it means to be human and civilised. In Guatemala, restitution of Mayan identity is central to both personal and social recovery after cultural assault. In Mozambique, the actual physical work of reconstruction—building houses and planting fields—is considered by ex-refugees to be particularly crucial. Nevertheless, people do not necessarily aim to restore everything to its prewar state; many recognise that some things have changed and they must adjust. Ultimately a population recovers from war not as recipients of aid or as patients but as active citizens. Structural poverty, landlessness, and lack of viable jobs too often retard this rebuilding of lives.

Anything that is pro-family (including employment opportunities) and pro-community will help children recover a more positive social reality. In some wars, family reunion is an urgent priority: through the use of tracing schemes the mass orphanhood in Mozambique has been largely absorbed by extended families and members of former communities or tribal groups. War related themes figure prominently in the talk and play of children: for the majority this is part of the way they make sense of events around them and is not a "post-traumatic" problem. None the less, liaison with teachers, primary health workers, or other community figures may assist in the recognition and handling of the minority who may remain distressed and dysfunctional. Projects directed to "child soldiers" (or elsewhere to "rape") have found that such definitions can be a dubious basis for psychological targeting.[22]

> Psychological trauma is not like physical trauma: people do not passively register the impact of external forces (unlike, say, a leg hit by a bullet) but engage with them in an active and social way.

In Western countries health services represent a place for refugees to turn to at a time when few other support structures are present, but their presentations may be driven by deeper dilemmas—disrupted life trajectories, loss of status, alienation in a strange culture—for which there are no medical answers. Some refugees face the risk of inappropriate psychiatric diagnoses because of ignorance of cross cultural factors and lack of interpreters. Though antidepressants seem to have a modest role, there has been little controlled evaluation of pharmacotherapy and the psychotherapies.[23] Even in Western populations there is no empirical evidence that survivors of traumatic events do better if they have psychological debriefing; for many non-Western peoples this would be an alien activity.[24]

Wellbeing, rights, and justice

History has shown that social reform is the best medicine; for victims of war and atrocity this means public recognition and justice. Health and illness have social and political roots: post-traumatic reactions are not just a private problem, with the onus on the individual to recover, but an indictment of the sociopolitical forces that produced them. Some patients will need to know how health professionals stand politically before they can trust them. It seems appropriate to go beyond the "binding of wounds" and the tradition for mental health work to be morally and politicaly neutral and to promote the wider rights of those seeking help or treatment. All over the world, military and economic elites defend rooted social inequities with arms purchased from the West for "national defence." Average expenditure per capita on arms in developing countries is $38—compared with $12 on health.[25] The world's major arms exporters all sit in the United Nations Security Council. Analysis of the causes of violent conflict thus highlights the values of the Western-led world order, in which geopolitical and business considerations far outweigh issues of human rights and justice for millions of the least protected people on earth.[26]

Western professionals can support health and human rights workers pressing for unfettered investigation into human rights abuses in oppressive societies abroad and help to publish and publicise their work. Such links may also afford these workers a measure of protection against elimination. We must pressurise medical bodies which collude, actively or passively, with torture in their societies, a not uncommon situation.[27]

Research challenges

There is only sketchy knowledge of the baseline prevalence of mental disorders in developing countries, let alone during violent turmoil that has cost the lives of

22 million people since 1945. We need longitudinal studies of victims of war, whether displaced (internally within their own countries or externally as refugees) or not, which take into account differing economic and social factors, including the extent to which the host culture is accepting or discriminatory. It may not be easy to separate out the effects of war from those of coexisting social stressors—for example, is the suffering of chronic poverty less of a "trauma" than that caused by bombs and bullets? We need to know more about the possible links between chronic ill health or illness behaviour and background unresolved grief or cultural alienation. We still know little about the degree of "fit" between mental health services and presentations by refugees from cultures in which Western psychiatry and the detached introspection of talk therapies have little purchase. Studies of subjects who do not seek help are also important: arguably the core question is not how or why some individuals become psychological casualties, but how or why the vast majority do not. Is it possible to show that justice—including truth commissions and war crimes tribunals—make a difference to outcomes? The relation between mental health and culture may, however, limit the extrapolation of findings from one population to another.

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1 Lin E, Carter W, Kleinman A. An exploration of somatization among Asian refugees and immigrants in primary care. *Am J Public Health* 1985;75:1080-4.
2 Farias P. Emotional distress and its socio-political correlates in Salvadoran refugees: analysis of a clinical sample. *Culture, Medicine and Psychiatry* 1991;15:167-92.
3 Loughrey G. Civil violence. In: Black D, Newman M, Harris-Hendriks J, Mezey G, eds. *Psychological trauma: a developmental approach*. London: Gaskell, 1997:156-60.
4 Mollica R, Caspi-Yavin Y. Overview: the assessment and diagnosis of torture events and symptoms. In: Basoglu M, ed. *Torture and its consequences* Cambridge: Cambridge University Press, 1992:253-74.
5 Bracken P, Giller J, Summerfield D. Psychological responses to war and atrocity: the limitations of current concepts. *Soc Sci Med* 1995;40:1073-82.
6 McFarlane A. The severity of the trauma: issues about its role in post-traumatic stress disorder. In: Kleber R, Figley C, Gersons B, eds. *Beyond trauma. Cultural and societal dynamics*. New York: Plenum, 1995: 31-54.
7 Basoglu M, Paker M, Ozmen E, Tasdemir O, Sahin D. Factors related to long-term traumatic stress in survivors of torture in Turkey. *JAMA* 1994;272:357-63.
8 Gorst-Unsworth C, Goldenberg E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared to social factors in exile. *Br J Psychiatry* 1998;172:90-4.
9 Freud A, Burlingham D. *War and children*. New York: Ernst Willard, 1943.
10 Richman N. Annotation: children in situations of political violence. *J Child Psychol Psychiatry* 1993;34:1286-302.
11 Hume F, Summerfield D. After the war in Nicaragua: a psychosocial study of war wounded ex-combatants. *Med War* 1994;10:4-25.
12 Arms Project of Human Rights Watch and Physicians for Human Rights. *Landmines. A deadly legacy*. New York: Human Rights Watch, 1993.
13 Summerfield D. The psychological legacy of war and atrocity: the question of longterm and transgenerational effects and the need for a broad view. *J Nervous Mental Dis* 1996;184:375-7.
14 Lykes B. Terror, silencing and children: international multidisciplinary collaboration with Guatemalan Mayan communities. *Soc Sci Med* 1994;38:543-52.
15 Eisenbruch M. From post-traumatic stress disorder to cultural bereavement: diagnosis of southeast Asian refugees. *Soc Sci Med* 1991;33:673-80.
16 Punamaki R, Suleiman R. Predictors and effectiveness of coping with political violence among Palestinian children. *Br J Social Psychol* 1990;29:67-77.
17 Dawes A. The effects of political violence on children: a consideration of South African and related studies. *Int J Psychol* 1990;25:13-31.
18 Summerfield D, Hume F. War and post-traumatic stress disorder: the question of social context. *J Nervous Mental Dis* 1993;181:522.
19 Reynolds P. Children of tribulation: the need to heal and the means to heal war trauma. *Africa* 1990;60:1-38.
20 Berry J, Poortinga Y, Segall M, Dasen P. Psychology and the developing world. In: *Cross cultural psychology, research and applications*. New York: Cambridge University Press, 1992:378-91.
21 Summerfield D. A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Soc Sci Med* 1999;48:1449-62
22 Peters K, Richards P. Fighting with open eyes: youth combatants talking about war in Sierra Leone. In: Bracken P, Petty C, eds. *Rethinking the trauma of war*. London: Free Association Books, 1998.
23 McIvor R, Turner S. Assessment and treatment approaches for survivors of torture. *Br J Psychiatry* 1995;166:705-11.
24 Raphael B, Meldrum L, McFarlane A. Does debriefing after psychological trauma work? *BMJ* 1995;310:1479-80.
25 Sivard RL. World military and social expenditures. Washington, DC: World Priorities, 1989.
26 Summerfield D. Raising the dead: war, reparation and the politics of memory. *BMJ* 1995;311:495-7.
27 British Medical Association. *Medicine betrayed: The participation of doctors in human rights abuses*. London: Zed Books, 1992.

A patient who changed my life twice

What medicine's all about

It may have been obvious to her at the time, but somehow I did not quite like to admit to Sylvia that she was my very first—patient, that is. I had just finished my preclinical training at Cambridge and had come down to London to walk the wards at Bart's.

Sylvia, on the other hand, was much more experienced. She had myasthenia gravis and was barely older than me but was already a veteran of the intensive care unit, and by now a pale, frail, frightened shadow of her former self, with a tracheostomy. Weighing less than 40 kg, just about coping without constant oxygen, she was more of a challenge than a fresh faced young nobody in a short white coat had bargained for. My heart fell as I realised how little I had to offer.

At least I could talk to her: the trouble was she couldn't talk back. She'd spend ages writing her replies in a note book with her curious backward sloping handwriting, tired out by the end of her written message while somewhat crassly I would ask yet another daft question. I soon realised that this couldn't go on and the obvious answer was to abandon my own speech and learn to use the same language as the patient.

We got on fine with me writing out my side of things, learning quickly how much it takes out of you, giving her a bit of time and space. Towards the end of my clinical studentship I realised that almost everything I'd learnt about patient communication, I'd learnt from her. I also recognised—a curiously life altering event—that despite all the hi-tech razzmatazz, doctor and patient rapport is the most fundamental of all medical skills. As Sylvia had been so ill—making no real progress while I had known her—I assumed the worst.

Thirty two years later, last week in fact, I got a letter written in oddly familiar handwriting. She'd seen me on television—not a grand event, just the opening of our new children's cancer unit, which had been broadcast on the local stations. I had said a few words, and for the first time in all those years she'd known where to find me and send a letter of greeting and thanks for coming to see her every day, etc, etc.

She has made a splendid recovery and the myasthenia gravis seems to have burnt itself out. Rereading the letter for the umpteenth time, I realised she'd done it again—changed my life, I mean. In these black days, after the cases of Harold Shipman and the Bristol heart surgeons, surgeons taking out the wrong kidney, angry parents confronting pathologists who'd removed their childrens' organs without consent, over £2bn worth of litigation because of mistakes waiting in the wings, when you almost feel embarrassed to admit to being a doctor, Sylvia had reminded me what medicine's really all about. Even as a medical student you can do something useful, perhaps even change a patient's life. She certainly changed mine.

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