Effects of war: moral knowledge, revenge, reconciliation, and medicalised concepts of "recovery"

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Western health professionals and the public have a misguided image of war and its aftermath that is often far removed from the actual experience of non-westernised societies. A British psychiatrist looks at the effects of war and at the belief that the emotional reactions of victims of war should be modified

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Summary points

- Terms such as "traumatisation" or "brutalisation" may be simplistic and stigmatising
- Tension exists between medicotherapeutic viewpoints and sociomoral viewpoints
- "Recovery" from war is not a discrete psychological process or event
- Recovery centres around the person practically re-engaging with everyday life

In 1999, a survey of 600 households of Kosovo Albanians by the Centers for Disease Control and Prevention found that 86% of men and 89% of women had strong feelings of hatred towards the Serbs. Overall, 51% of men and 43% of women had a desire to seek revenge most or all of the time.[1] Similar findings are seen, for example, with people from both sides of the Israeli-Palestinian conflict.[2]

The idea that feelings of revenge are bad for you comes from the quietist Judaeo-Christian traditions of confessing, forgiving, and turning the other cheek. The report of the Kosovan survey cast feelings of revenge as indicators of poor mental health, and it concluded by making recommendations for mental health programmes. In Croatia—a part of former Yugoslavia—a foreign led project told Croatian children affected by the war that not hating and mistrusting Serbs would help them recover from the trauma.[3]

In a recent study of victims of the apartheid era in South Africa—some of whom testified to the Truth and Reconciliation Commission—post-traumatic stress disorder and depression were significantly more common in those who were unforgiving towards the perpetrators than in those with high "forgiveness" scores.[4] Such studies seek to give scientific weight to the notion that the mental health of victims is at risk if they do not forgive those who hurt them. The moral economy that operated during the hearings is indicated by the fact that commissioners were not uncomfortable if testifiers wept while giving evidence but that they did not like them to become angry.

Victims of war are often expected to be vengeful because of their "traumatisation" or "brutalisation" and to promote new "cycles of violence." The emotional reactions of people affected by war are perceived as harmful to themselves and dangerous to others; this leads to a belief that the reactions of victims should be modified. In Rwanda and former Yugoslavia, in particular, such a belief provided the basis for counselling interventions used—often on a large scale—by humanitarian organisations.[5]

But one man's revenge is another's social justice. The question is whether anger, hatred, and a felt need for revenge in people who have been grievously wronged are necessarily bad things. Such feelings carry a moral interrogative that points to social and individual wounds and to shared ideas about justice, accountability, and punishment that hold a social fabric together. They demand answers. Should Jewish survivors of the Nazi genocide have been counselled in 1945 not to hate Germans? Were the Nuremberg trials of Nazi war leaders, which handed down capital punishment after the second world war, the result of the brutalisation of victims of Nazism and their unhealthy feelings of hatred and revenge? Or did the trials show justice in action and help victims to make sense of a man made catastrophe?

Children affected by war are often reported as being "brutalised": the implication is of damaged psychologies and moral norms and of diminished humanity. The United Nations Children's Fund has stated that "time does not heal trauma" for millions of such children, who are often described as a "lost generation."[6] Did this turn out to be true for the children caught up in the second world war in Europe? The medical literature is replete with similarly sweeping statements that lack validity and are pathologising and stigmatising. Moreover, the people being studied have not given consent for their mental health to be objectified and characterised as unhealthy (typically by an observer far away), which raises ethical questions.

War as illness or as moral problem

The task that faces victims of war and atrocity is often spoken of as a "healing" or "recovery" through "processing" (of traumatic experience), "acceptance," and "coming to terms with the past." This posits an unduly mechanistic and medicalised view of human experience that suggests that the pathological effects of war are found inside a person and that the person recovers as if from an illness.

Thirty years of civil war in Northern Ireland has had no significant impact on referral rates to mental health services.[7] Elsewhere too, data that suggest that psychiatric morbidity is higher in populations exposed to war than in those not exposed are lacking. Nonetheless, as an effect of war, "trauma" seems to be displacing hunger as the issue of concern among the public; and Western approaches to mental health are seen as an automatic part of the humanitarian response, even for victims of war in non-Western countries.[8] Yet "talk therapy" implicitly aims to change not just a person's behaviour but their mind—the way a person construes. Such therapy trades on an ethos of acceptance: it is the person, not the society, that is meant to change; a truism is that "successful" therapy moves the world view of the client closer to that of the therapist.[9] The traditions of the clinic are for political and moral neutrality. Whose interpretations of the world will count at this critical moment?

"We are not mad, we are betrayed," was the response of one refugee approached by researchers for the pilot of a mental health project intended for Bosnians in Britain.[10] This statement aimed to reassert the problem as moral and collective rather than medicopsychological and individual. At issue here are the limitations of a discourse in which the effects of war and atrocity come to be represented as a person's illness and vulnerability. Like other kinds of crisis—a serious accident or a diagnosis of cancer—war generates moral knowledge that may throw into question a person's assumptions about the world and their values and priorities. War victims—who carry the bitter knowledge that no limits exist for what can be done to people without power—beg resonant "why?" or "why me?" questions that address a moral domain. Medical science is good at answering "how?" questions—technical questions—but it only deals with "why?" questions through impersonal statistics and epidemiological studies.[11] Patients may be alone in their need to find a social and moral meaning for what they have experienced.

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Victims of war may have to struggle with whether "recovery" and "acceptance" are merely markers of their own impotence and humiliation or whether, worse still, they are an acquiescence in injustice by themselves, by people they know, and, frequently, by the Western led world order that, behind the rhetorical screen of "human rights," retains the realpolitik of "business as usual." Trauma programmes certainly can be seen cynically by those for whom they are intended, they can be experienced as patronising or indeed as a form of pacification. In Bosnia, people derisively referred to the aid delivered to them through a model that did not offer physical protection, restitution, or justice as "bread and counselling."[12]

Truth commissions, catharsis, and reconciliation

The 21 official truth commissions established around the world since 1974 to document state terror and atrocity have grappled with concepts of reparation and reconciliation. Although the commissions seek to create a public narrative of acknowledgment, they have also traded on the idea that victims given a chance to speak would have a cathartic experience that would help their recovery. Here too, "recovery" is defined within a medicalised idiom, and it is presumed to be an individual centred process that is independent of, for example, justice (very few trials of perpetrators have been held) or broader factors such as economic improvement.[13] In the South African study, the act of testifying was not found to alter victims' psychiatric status or attitudes to forgiveness.[4]

No generalisations can be made about issues of accountability and the purifying power of "truth" in relation to social reconciliation. For example, South Africa's neighbour Mozambique has not had a truth commission. In this country, in which one million civilians have been tortured, maimed, or murdered, virtually no calls for accountability and punishment have been made. Traditional healing mechanisms (which do not include talking about traumatic experiences) have been deployed extensively at the grass roots.[14] Here, as in most countries of the non-Western world, "health" is defined as much in terms of social relations as in terms of biomedicine. The people believe that ill health can be caused by the socially polluting effects of the angry spirits of people wrongfully killed and not properly buried. If these spirits are appeased, health and peace can return.[15]

Recovery as a social process

Notions of healing, reparation, and justice to address the sociomoral aftermath of war vary between cultures and over time. Social memory—the domain of cenotaph ceremonies, truth commissions, etc—plays a role, but so too does silence about the past, as the Mozambique case shows. This silence does not mean that the events are forgotten—it shows reticence and a conservation of energy for the urgent task of rebuilding.[16] With 90% of recent wars being civil, negotiations between ordinary people about their feelings of mistrust or revenge and

about issues of responsibility, culpability, and restitution must typically be pragmatic.

Health professionals should beware of looking at responses to war through a Western medicotherapeutic prism. The question of how people recover from the catastrophe of war is profound, but the lesson of history is straightforward. "Recovery" is not a discrete process: it happens in people's lives rather than in their psychologies. It is practical and unspectacular, and it is grounded in the resumption of the ordinary rhythms of everyday life—the familial, sociocultural, religious, and economic activities that make the world intelligible.[17]

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WHO in 2002

Have the latest reforms reversed WHO's decline?

Gavin Yamey

In the mid-1990s the *BMJ* published a series on the World Health Organization by Fiona Godlee, an assistant editor at the journal. Godlee argued that WHO was in crisis—lacking effective leadership, direction, and priorities. Seven years later, has the organisation successfully reinvented itself?

This is the first of five articles

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In her book *Betrayal of Trust*, health writer Laurie Garrett described WHO's decade of decline: "The World Health Organization, once the conscience of global health, lost its way in the 1990s. Demoralized, rife with rumors of corruption, and lacking in leadership, WHO floundered."[1]

Fiona Godlee, in her series in the *BMJ* (box 1), came to a similar conclusion. She argued that Hiroshi Nakajima, then director general, had failed to communicate a coherent strategic direction for WHO. Its six regional offices were bureaucratic, rife with cronyism, and operating autonomously from headquarters and it had little impact at country level. Donors questioned WHO's effectiveness, seeing better "value for money" from channelling their funds into other agencies, especially the World Bank. Though WHO still carried out important work setting standards and giving technical support to countries, the bank took its place as the most influential global health agency. At the end of the series, Richard Smith wrote an editorial in which he challenged WHO to "change or die."[2]

Summary points

- In the 1990s WHO came under fire for poor leadership and lack of direction
- Gro Brundtland took office as director general in July 1998 and attempted sweeping reforms
- Brundtland prioritised WHO's activities and launched important global health campaigns
- She restored WHO'S credibility with donors and helped to place health on the international development agenda
- But her management changes have been unpopular, and critics argue that WHO is still too influenced by its donors
- Brundtland's reforms have not been felt where they matter most—at country level

A new leader

One woman was charged with saving the organisation. Gro Harlem Brundtland, a former prime minister of Norway, took office as director general on 21 July 1998 and promised radical reform for WHO. She restructured it, prioritised its activities, and launched new health campaigns. WHO made a comeback to the global political stage.

But in a few important ways, WHO is still struggling. Its new structure has created a different set of problems for the organisation. There are serious questions about whether Brundtland's reforms have