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Treatment of massive trauma due to war

Daya Somasundaram

Treatment of trauma has been already covered in this journal (Adshead, 1995) and elsewhere (Davidson, 1992; Kleber & Brom, 1992; Wilson & Raphael, 1993). However, there are situations where the trauma can become extensive and chronic, sometimes called Type II trauma (Terr, 1991), necessitating additional therapeutic considerations. Such situations are not uncommon in the world today, frequently occurring during wars that are typically 'low-intensity' conflicts involving poor, Third World countries. It has been estimated that there have been over 150 such wars since 1945, in which 90% of all casualties are civilians. According to Summerfield (1996), what predominates is the use of terror to exert social control, if necessary by disrupting the social, economic and cultural structures. The target is often population rather than territory and psychological warfare is the central element. Atrocities, including civilian massacres, reprisals, bombing, shelling, mass displacements, disappearances and torture are the norm. The consequences for mental health, not to mention the social, economic, cultural and other costs, can be substantial.

Unfortunately, in such circumstances the resources to help those affected are extremely limited. In particular, the infrastructure of the health services can be destroyed and the availability of health staff, equipment and drugs depleted. There may be no mental health services at all, or they may be functioning at a very basic level. Increasingly, consultant psychiatrists visit such despondent places on a short-term basis to offer their expertise and help. This paper is written with them in mind, using the experience of working in war-torn northern Sri Lanka and Cambodia. Nevertheless, it is hoped that the lessons learned will have wider applications for work with trauma, disasters, and general psychiatry as well.

In such situations a psychiatrist may be called upon not only to do routine clinical work, treating individuals with post-traumatic disorders and other common psychiatric illnesses, but also to take a lead in organising a general community response, educating, training personnel, starting services and setting up appropriate social structures.

Clinical work

Usually, clinical work will be done from out-patient departments in district or provincial hospitals. There may be considerable resistance from the authorities and even from other health staff to establishing or running mental health services. It will not be considered a priority, when other 'essential' medical services are already compromised and even basic needs (security, food, shelter, etc.) are in question.

General

Treatment of major mental illness, that is psychotic illnesses, can take up most of the consultant's time and energy, particularly if no other psychiatrist is available. Although everyone would have been affected by the ongoing trauma in one way or another, and in some cases trauma may have precipitated a psychotic illness or caused a relapse, straightforward treatment of psychotic illness would be sufficient in most cases. The ongoing

Daya Somasundaram (PO Box 1124, Phnom Penh, Cambodia) is Professor of Psychiatry at the Faculty of Medicine, University of Jaffna, and Consultant Psychiatrist at the Teaching Hospital, Jaffna, Sri Lanka. He is interested in traumatology and is currently working on a community mental health programme in Cambodia for the Transcultural Psychosocial Organization (formerly IPSER).

situation can cause relapses due to discontinuation of drugs. Clinics may not function regularly, psychotropic drugs may not always be available or may be in short supply, and travel to the clinic to collect maintenance drugs might be difficult and risky.

Under the circumstances of shortages and difficulties in regular supply, it is advisable to use cheap, easily available drugs – chlorpromazine, haloperidol, benzhexol, imipramine, amitriptyline and diazepam, and the anti-epileptic drugs phenobarbitone and phenytoin. If psychotropic drugs are not routinely supplied by the Ministry of Health or other responsible authority, efforts will have to be made to secure a regular supply. Basic training of local medical staff in diagnosis and treatment of mental illness will enable them to manage a psychiatric clinic (WHO, 1990,1992; de Jong, 1987). A rebound increase in patients should be expected during any temporary cease-fire, truce, cessation of hostilities or peace.

Part of the general psychiatric responsibilities will be of a forensic nature. Although courts and other judicial services may not be functioning, medical reports to certify mental illness in a patient can go a long way in alleviating unnecessary suffering. Patients with psychotic symptoms are often arrested, detained and sometimes tortured or executed because of misunderstandings by the armed forces or militants about their behaviour. Because of their illness, patients may become restless, wandering near camps or unauthorised areas at the wrong times (curfew), or they may say the wrong things. Initially, they will be suspected of being spies or enemy agents. Proper information about their condition will eventually persuade the authorities to hand them over. They will find that this will save them considerable time and effort. If a working relationship can be built up, considerable useful work can be done. Relations often request a simple letter stating that a particular patient attends the clinic.

Presentation after trauma

Few post-traumatic disorders, post-traumatic stress disorder (PTSD) in particular, first present at the psychiatric clinic, amounting to no more than 10% of the total cases. This minority invariably complains of depression and/or anxiety. It is only on further questioning that the underlying traumatisation will be discovered. More often, post-traumatic states will be referred from the regular out-patient departments, medical or surgical departments or wards where they have presented with somatic complaints. The comorbidity of PTSD with anxiety and depression is well established (American Psychiatric Association, 1994). However, it is less well known that PTSD often presents through somatisation, particularly in developing countries (Somasundaram, 1996).

PTSD

The reasons for the low attendance of people with post-traumatic disorders, particularly PTSD, at the psychiatric clinic are many. As PTSD usually does not produce severe, incapacitating dysfunction in quite the same way as a psychotic illness does, a mental health clinic would not be seen as an appropriate place to seek help, particularly considering the social stigma attached to mental illness. Instead, most seek help in the traditional sector, or in Western-style health services, with various somatic complaints.

Increasing awareness among colleagues through lectures and seminars will ensure that somatisation and PTSD will be identified at the out-patients department and other clinics. However, the psychiatric clinic will be ill-equipped to handle the large number of such cases if they begin to be identified correctly. One answer would be to train the staff at the point of identification to manage the less seriously affected individuals. Not all cases of diagnosed PTSD will need sophisticated psychiatric treatment. Fortunately, many will recover on their own or with minimal support, counselling or relaxation exercises. In this connection it is worth mentioning that although the ICD–10 diagnostic guidelines (World Health Organization, 1992) are quite sensitive in detecting most of those with PTSD, the DSM–IV criteria (American Psychiatric Association, 1994) are more specific in singling out those more serious cases needing special therapy. In particular, the requirement for one month duration of symptoms and impairment in social function is discriminatory in this regard.

There is considerable controversy regarding the cross-cultural validity of PTSD (Bracken *et al*, 1995). In my experience it is a universal phenomenon, appearing in a variety of post-traumatic situations including torture (Somasundaram, 1997), although there can be differences in the significance of the various criteria. For example survivor guilt may not be as important or prevalent as in Judeo-Christian cultures. The emotions of shame, blame (outward) and mistrust may be more relevant. These observations have clinical implications for assessment and psychotherapy. With regard to the danger of medicalising what is

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essentially a politico-social problem (Young, 1980), the diagnosis of PTSD helps to identify those who will benefit from special care and treatment to alleviate their individual suffering. Recognition of their suffering in itself goes a long way towards reassuring and supporting them. Furthermore, the diagnosis of PTSD is an internationally recognised way of describing the psychological cost of war and thus contributes towards influencing the political and economic causes of war.

Management of post-traumatic conditions should start with a complete assessment sensitive to the socio-cultural context, the meaning of the trauma and local idioms of distress. The first interview is crucial for establishing trust and the therapeutic alliance. The history should sensitively elicit the details of the trauma. Very often, the trauma will remain hidden behind the initial presentation of somatisation, anxiety or depression. There may be marked denial of mental problems or amnesia for parts or the whole of the traumatic event. A high degree of suspicion, particularly when one gives a history of having been detained or being a combatant, should lead to exploration of the possibility of having experienced trauma. It takes considerable skill to first recognise that traumatisation has taken place and then to probe for details. The opportunity for an individual to tell their story and express their emotions can be therapeutic in itself. The treatment plan for each individual will have to take into account the degree of traumatisation, the symptom profile, personality of the patient and the resources available. As a general rule, the following methods (Box 1) will be found to be useful in most cases of traumatisation.

Therapeutic interventions for post-traumatic disorders

Psychoeducation

Basic information about trauma and normal responses to stress can be very reassuring. Suggestions regarding what to do and coping techniques can be helpful.

Psychotherapy

Some form of psychotherapy remains the treatment of choice for most cases of traumatisation. For ultimately, traumatisation shatters the cognitive self-schemas and world view of the victim. These will have to be painfully reconstructed if recovery or healing is to take place. Various degrees of psychotherapeutic techniques ranging from listening, through counselling to brief dynamic psychotherapy can be effective. The basic principles include building a trusting relationship, listening to the story, helping to ventilate emotions and come to terms with what happened. The aim is to aid the working through process so that the traumatic event can be integrated into the self-system.

The more formal brief dynamic psychotherapy described by Horowitz (1986) can be undertaken if there is a skilled therapist. The therapy can be complicated as different aspects of the trauma can be at different levels of processing. In cases of multiple or chronic trauma the therapy becomes much more difficult. Furthermore, not all clients will benefit from psychotherapy. The 'talking cure' will be new to the culture and many may resist verbal communication or 'psychologising'.

Using supportive techniques and symptomatic relief within the psychotherapy as described by van de Veer (1993) can be effective. Grappling with issues such as guilt, loss of control and powerlessness, so important in the West, may not be that fruitful. However, shame, loss of face, trust, fate and blame can be more important in Third World settings. For example, the loss of control described as a fundamental sequela to traumatisation in the West, may be based on the cultural belief in control the individual is said to possess. The emphasis on individual responsibility, and thus guilt, flows from these beliefs. In contrast, in the East, beliefs in karma, fate and the links to family and ancestors make the world view very different. As such, a Western-trained psychotherapist will find it difficult to understand the socio-cultural context and belief systems, making it that much more difficult to handle these issues with their client.

Box 1. Therapeutic interventions for post-traumatic disorders

- Psychoeducation
- Crisis intervention
- Psychotherapy
- Cognitive–behavioural methods
- Relaxation techniques
- Pharmacotherapy
- Group therapy
- Family therapy
- Expressive methods
- Rehabilitation
- Community approaches

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Indeed, misunderstandings and pursual of Western preoccupations with guilt can make psychotherapy a perilous journey. It may be more prudent to leave these issues to the local priest, or traditional healer who will have a better understanding of the belief systems of the local population and thus may be in a better position to remedy the situation.

A much more ambitious aim, termed 'logotherapy' (Frankl, 1959) is to find meaning in what happened. For once meaning is found most clients appear to recover quickly. Again, the cultural and religious beliefs, for example the doctrines concerning karma and suffering, central to both Buddhist and Hindu systems, will be important. Attempts should be made to co-opt sympathetic traditional resources such as priests, monks and healers as co-therapists or, in the traditional nosology, as allies, in the therapeutic endeavor.

Cognitive–behavioural methods

Essentially, this amounts to systematic trauma desensitisation through exposure, by having the client confront the traumatic event using imagery (Foa & Rothbaum, 1989).

Relaxation techniques

Based on progressive muscular relaxation, culturally acceptable methods can be therapeutic for several of the consequences of traumatisation, namely states of arousal, anxiety and somatisation. Four basic methods adapted to the culture and religion of the client have been developed to be practiced twice daily:

Breathing exercises – Breathing, usually an unconscious or involuntary process, has been found to be closely linked to the emotional state, tending to become shallow, rapid and irregular when disturbed, progressing to hyperventilation in extreme reactions. The goal in therapy is to bring breathing under conscious control and make it deep, smooth and regular. This usually entails learning abdominal, diaphragmatic breathing in contrast to the usual thoracic type of breathing. In Hindu settings, the yogic method of *Pranayama* and for Buddhist clients, 'mindful breathing' or *Ana Pana Sati* can be taught. A mantra (*OM, Puthoo)* or word can be said in parts (e.g. *O – M* or *Puth – thoo*) while breathing in and out. For others, regular abdominal breathing is explained.

Progressive muscular relaxation – For most clients, Jaccobson's technique can be taught. Hindu clients can be taught the technically similar Yogic exercise, *Shanti* or *Sava Asana*. Buddhists can practice 'mindful body awareness'. Other physical exercises, especially *Yoga* and *Tai-chi*, are well known ways to produce relaxation and a sense of physical and mental well-being.

Repetition of words – In this method of *Jappa*, a meaningful word, phrase or verse is repeated over and over to oneself. First, this is done vocally, then after some weeks of practice, as a whisper, then sub-vocally and then finally, just the thought. For Hindus the mantra given to them during initiation or the *Pranava mantra*, 'OM', can be selected. For Buddhists it could be *Buddhang Saranang Gachchami*, in Islam it can be *Subhanallah* and for Catholic Christians, the Jesus prayer ('Jesus Christ have mercy on me') or prayer beads. In Cambodia, repetition of *Keatha*, Words (*Angkam*) or God's name (*Puthoo*) are well known. Transcendental meditation and Benson's relaxation response (1975) use a similar technique.

Meditation – Various meditation practices are in use. For Buddhists, *Vipassana* meditation and for Christians, contemplation can be chosen, the only contraindication being schizophrenia or other psychotic illness (for meditation may precipitate a psychotic illness in a predisposed individual, or exacerbate a pre-existing illness).

Using traditional methods of massage can also produce profound relaxation. *Aurvedic* or *Siddha* oil massage and the Cambodian *Thveu Saasay* are both culturally familiar and effective. It is wise to involve traditional practitioners and others in therapeutic programmes, for, in addition to mobilising available resources, it will help to spread awareness and knowledge about trauma in the community. In torture survivors with musculoskeletal pains and distorted body image due to the systematic infliction of excruciating pain and injury to various parts of the body, relaxation methods, massage and yoga have been found to be useful.

Labelling these cultural techniques as relaxation exercises may be a misnomer, leading to an underestimation of their value. When methods are culturally familiar, they tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in therapy and the healing process. Also, mindfulness and meditation draw upon hidden resources within the individual and open into dimensions that can create spiritual well-being and give meaning to what has happened. Although these techniques are not formal psychotherapy, they may accomplish what psychotherapy attempts to do by releasing cultural and spiritual processes. Monks, gurus or adepts can be asked to help in teaching these techniques.

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Pharmacotherapy

When there is coexisting depression, as there invariably is in more severe post-traumatic states, the response to antidepressants is good. In PTSD also, there is positive improvement with antidepressants, particularly regarding intrusive phenomena and nightmares. Low doses of imipramine work in the majority of cases. The dose can be increased gradually, depending on both response and side-effects.

Group therapy, family therapy, emotive methods (release of repressed emotions through artistic or other indirect means) and rehabilitation are important and effective in individual patients, particularly in those unable to communicate in psychotherapy. These methods are also very useful in working with large numbers of individuals and will be described below (see 'Community interventions'). These interventions can be advantageous in combination, as the following case shows.

Case example

O.Y. is a 45-year-old widow who lost her husband in 1987 when a shell landed on their house during fighting between the military and Khmer Rouge forces. There was a fire that burnt their house. Her husband was injured and burnt by the fire. She saw her husband suffer and die in front of her. Her three children were also injured and had severe burns. One had a head injury and amputation of his leg. Another child was chronically disabled and unable to attend school. O.Y. had to start working, selling fish, to support her family as there was no one else to help. She suffered from frequent headaches, dizziness and feeling hot in the head. Her sleep was poor with nightmares of what happened, during which she sometimes saw people trying to burn a corpse as had happened to her husband. During the day she often remembered the fateful event, as if it was happening again. Whenever there was a problem or trouble and she became aware of her poverty and her inability to provide for her children's schooling and food, the re-experiencing of what happened was intense. When she was reminded of what had happened and of the family's situation, she became very irritable, scolding her children and sometimes beating them. Even her capacity to work deteriorated and she was finding it difficult to cope. At the mental health clinic where she had been referred by another patient, she said that she thought too much, was worried about her children and felt there was no one to help her family. They didn't have enough money and she was afraid of what would happen to her children She was depressed and anxious. She was started on counselling, trauma desensitisation, relaxation exercises and imipramine (25 mg) and it was planned to introduce her to a women's group. An appropriate non-governmental organisation (NGO) was sought for socio-economic assistance for the family and, perhaps, occupational training for the patient in a profitable enterprise.

Children

Traumatised children are a particularly vulnerable group and will need special consideration. They may not be able to communicate their problems verbally, so play and art can be used diagnostically and therapeutically. As a general rule, efforts should be directed at keeping the family together and improve its functioning. However, problems in children can be a reflection of pathology in the family where the parents may themselves be traumatised and the family dynamics bring out the problem through a child, as the following example shows.

Case example

An 11-year-old girl was referred to the psychiatric clinic because of episodic fainting attacks during the previous month. The paediatrician had not been able to detect any organic abnormality. Her class teacher had observed that just before attacks, she said " why did they kill my sister?" and then complained of numbness of the head before 'fainting'. The history revealed that her sister had been killed by a shell piece five years before. At the time, the whole family had taken refuge in the front of the house because of intense shelling in the area. The father was carrying the youngest sister on his shoulder, while the elder one was in his lap. The latter was struck and the gruesome death in a pool of blood had taken place in the presence of the whole family. Following this the family faced several problems such as displacement to a refugee camp, grandfather and grand uncle killed and father detained and later released.

The father developed PTSD with re-experiencing and neurotic symptoms, particularly somatisation (11 somatic complaints). The mother also developed PTSD with severe depression and anxiety. She lost interest in all activities, developed crying spells and was withdrawn from all social activity. She dragged on for the sake of the other children and often repeated "the same thing should not happen to them". She became very anxious at any noise particularly the sound of a helicopter or aeroplane, when she would gather the family and run to a bunker; if they were not at home she would become very frightened. At other times, if they were late in returning, she would anxiously wait for them at the doorstep.

Treatment had to involve the whole family. The individual problems of the parents had to be addressed and then the family dynamics that avoided dealing with what had happened had to be brought out into the open. Slowly the family came to accept the death and the child recovered.

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Another common situation is where the father has been detained or killed but the family members are not sure of his fate. They are caught in a 'conspiracy of silence' where further inquiries may lead to more problems for the father were he still alive, and the mother may not be able to share the truth with the child. The child then presents with behavioural problems. Having the mother share her fears with the child can be helpful.

Malignant PTSD

In wartime combatants can present with a wide spectrum of psychiatric disorders. The more common, seen often in fresh teenage recruits, is hysterical conversion reactions. They are often admitted to medical wards with physical complaints, when they find the training or camp life too tough. The difficult issue, not welcome by the militants, is their return to their homes.

Another reaction is in experienced combatants who have seen many battles. They are often adolescents who had joined the movement very young and been exposed to massive trauma, having witnessed gruesome deaths and mutilating injuries to many of their comrades or had themselves been badly injured. They had frequently been involved in atrocities, having been responsible for many cruel deaths through torture. They show very disturbed aggressive outbursts when they re-experience traumatic events. Death scenes and battles repeatedly overwhelm them in the form of flashbacks and vivid hallucinations. During these periods they completely lose control over themselves, becoming very violent and destructive. We have called this 'malignant PTSD' (Somasundaram, 1994), referred to in the literature as 'complex PTSD', 'disorders of extreme stress not otherwise specified' (DESNOS) and found in DSM–IV under 'PTSD associated features and disorders' and ICD–10 (F62.0) 'Enduring personality changes after catastrophic experiences'. It is a condition that is very difficult to treat, as the following example shows:

Case example

R., a 17-year-old boy, came with complaints of insomnia, restless behaviour and aggressive outbursts. He had a normal childhood and had joined the militants two years previously. After training he had taken part in many battles. In the last major battle most of his colleagues had been killed in gruesome ways in front of his eyes and he had himself been injured. After recovering from his injury he had developed the above symptoms. He said he sometimes heard and saw his comrades shouting in pain and suffering agonising deaths. He usually lost control at these times.

Treatment of this disturbed adolescent was extremely difficult. He did not respond to high doses of any of the drugs available. The major tranquillisers, antidepressants, minor tranquillisers and the anti-epileptic carbamazepine were all tried. Psychotherapy proved impossible as he was not accessible and sometimes became violent during therapy. Other forms of behaviour, occupational, relaxation and emotive therapies also showed poor responses. In the ward he had broken most of the furniture, equipment, and the glass panes (once cutting his hand badly) and had assaulted the staff during his violent outbursts. When the severity of re-experiencing subsided with time, a period of rest at home caused re-emergence of the disturbance, with difficulties in relating and adapting to the home situation. At home, he frequently had violent outbursts, breaking things in the house, assaulting the family and sometimes running out on the road and beating innocent bystanders. He tried to commit suicide by jumping into the well or injuring himself. The family was constantly anxious about him and someone was always watching him to prevent any harm. When the behaviour became uncontrollable the family brought him to the psychiatric ward where he was kept for a few weeks. His behaviour in the ward and response to treatment was not improved. Once, he was admitted to the surgical ward after injuring himself during a suicidal attempt. There he had gone berserk, destroying everything in his path and assaulting many of the staff. He fractured his wrist in the process. He was admitted and discharged several times from the psychiatric ward with no long-term improvement.

As there would appear to be a fundamental personality change, a therapeutic community environment with facilities for education, vocational training, rehabilitation and leisure activities will be of benefit. During demobilisation, similar programmes would have to be set up.

Community

Given the widespread nature of traumatisation due to war, the reactions have come to be accepted as a normal part of life. This normalisation can be seen in the prevailing cultural idioms of distress which Eisenbruch (1994) and Mollica *et al* (1993) noted in apparently otherwise functional Cambodians. Indeed, it would be more appropriate to talk of collective trauma (Somasundaram & Sivayokan, 1994) or cultural bereavement (Eisenbruch, 1991) and look at how the community as a whole has responded, how the community coped, and what we can do at the collective level

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(Somasundaram, 1996). For example, it would be more beneficial to strengthen and rebuild the family and village structures and networks as well as to encourage rural development. A psychiatrist can play an important leadership role by increasing awareness and working for consideration of mental health principles in the context of national or regional planning. Also, a community psychiatry approach will enable one to reach a larger target population and to undertake preventive and promotional public mental health activities as well (see Box 2).

General awareness

Psychoeducation about trauma for the general public can be done through the media, pamphlets and popular lectures. The nature of stress, extreme events in war, normal and common reactions, what to do and not to do and useful coping strategies can be topics covered. A pamphlet issued by the Children's Royal Hospital and Prince Henry Hospital after the Ash Wednesday fires in Australia was subsequently modified and used in Britain and other parts of the world, including northern Sri Lanka. Increasing awareness of the psychological costs of war can at times bring into question the enthusiasm for war and thereby create a yearning for peace.

Training

Training community-level workers in basic mental health knowledge and skills is the easiest way of reaching a large population. They, in turn, increase general awareness and disseminate knowledge, as well as doing preventive and promotional work. Most minor mental health problems could be managed by them, with the remainder being referred to the appropriate level. Primary health workers, including doctors, medical assistants, nurses, family health workers (in Sri Lanka), village health volunteers (in Cambodia); school teachers; village resources such as the village headman, elder, traditional healer, priests, monks and nuns; governmental agencies, NGOs, volunteer relief and refugee camp workers are all ideal community-level workers suitable for such training. Trauma and mental health should become part of the normal curricula of health staff and teachers. Important topics would include psychological first aid (Raphael, 1986), crisis intervention, supportive therapy (van der Veer, 1993), and identification and treatment of minor mental health and psychosocial problems among others. A training manual in basic mental health (World Health Organization, 1996), particularly written for the local situation (Somasundaram, 1993; Somasundaram *et al*, 1997) will be handy. Teaching of the culturally appropriate relaxation exercises to large groups in the community and as part of the curriculum in schools can be both preventive and promotive of mental health. Similarly, structured play activity for children in refugee camps and community settings can promote mental health.

Indigenous coping strategies that have helped the local population to survive should be encouraged. However, what has survival value during war, such as keeping silent, mistrust and not organising, may be counterproductive, even maladaptive, during peace and national reconstruction. Culturally mediated protective factors such as rituals and ceremonies (e.g. funerals and anniversaries) should be strengthened and can be very powerful ways to help in grieving and finding comfort. They can be a source of strength, support and meaning.

Community interventions

Family

One important dimension is the family. In developing countries the family plays an important if not an overriding role. Thus, the family tends to think, feel, experience and respond together. When an event happens, the family faces it as a unit. They share the experience, perceive the event in a particular way and respond as a functioning whole.

Thus, efforts should be taken to keep the family together and united. Family cohesion should be strengthened. Family dynamics can be improved towards trusting one another, and interdependence

Box 2. Community approaches

- Awareness
- Training of community workers
- Public mental health promotion activities
- Encourage indigenous coping strategies
- Cultural rituals and ceremonies
- Community interventions:
  - family
  - groups
  - expressive methods
  - rehabilitation
- Prevention

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of its members encouraged. Traditional roles may have to be re-established. These considerations can hold true for the extended family as well.

Groups

Often in Third World countries, individuals who find it difficult to communicate with counsellors may find this easier in a group setting. A group of people who have similar problems can come together to share and find support from each other. Coping strategies that were helpful to one can be tried by others. Examples of self-help groups that have been successful are groups of torture survivors, widows, and mothers/wives of those who have disappeared.

Emotive methods

Creative expression of emotions and trauma can be cathartic for individuals and for the community as a whole. Art, drama, story-telling, writing poetry or novels (testimony), singing, dancing, clay modelling, sculpturing etc., are very useful emotive methods in trauma therapy, particularly for children. Drama is a powerful social method to create awareness and express collective emotions. Leisure activities such as sports, games, folk singing and dancing and religious festivals can be ways of meeting, finding mutual support and expressing emotions.

Rehabilitation

Rehabilitation is an important part of a holistic approach to therapy. Traumatised individuals, especially refugees, widows, and torture or rape victims, will need well-planned rehabilitation opportunities. Food, shelter, land, loans, income-generating projects, occupational training, resettlement and re-employment are examples of needs that will have to addressed. A governmental and NGO network, with integrated assistance and cross-referral possibilities, should be established. When the needs of the traumatised individual or community is met, they gain self-esteem, confidence, hope, faith in the future, motivation and self-respect. Those affected should be allowed to take leadership roles and participate in the decision-making process in these programmes so that they do not develop dependency and passivity to external aid.

Ethical issues

Despite every well-meant effort, it is very difficult to heal a traumatised patient in a war milieu. Furthermore, the ongoing war will continue to produce more and more traumatised individuals. After working in a war-devastated area and seeing the untold misery it causes, one begins to realise the enormous physical, psychological, socio-economic and spiritual cost. There can truly be no neutral position in war. As members of the medical profession we have a responsibility towards our community as well as humanity at large. Our calling is to a healing profession, trying to give solace and comfort to those afflicted. It is obvious that one way to prevent the trauma is to stop the war. Internationally, many members of the medical profession, individually and as a group, have taken a public stance against war. Medical organisations such as the World Medical Association (WMA), the Danish, Chilean and British Medical Associations, US Physicians for Human Rights, the American Public Health Association and the South African National Medical and Dental Association have voiced their concern regarding the effects of organised violence and war. There are several issues towards which one can make a cautious contribution. One concerns arbitrary arrest, detention and torture. The other is involvement of children in war. However, it may not be enough to condemn the recruitment of children; one may have to address the wider socio-political and economic oppression that forces children to fight.

We may feel rather weak and helpless when considering the real risks involved and regarding decision-making or finding a solution. Health workers in areas of conflict have started emphasising that as health professionals we cannot remain silent, we need to consider the ethics involved and take a principled stand for victims and society (Armenian, 1989; Zwi & Ugalde, 1989). The medical profession has a powerful and persuasive voice, particularly, if we can raise one consistent voice for peace. Reports, documentation, advocacy and publications are ways in which the medical profession can bring pressure; equally, in our day-to-day dealings and contacts we can take a

Box 3. Controversial issues

Cross-cultural validity of PTSD
Medicalising a socio-political problem
Relevance of guilt
Importance of somatisation
Use of traditional resources
Ethical stand towards war
Collective trauma

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principled stand on war issues and express our concerns.

Conclusion

Working in a war-affected area will appear daunting and hopeless. However, some of the aforementioned interventions can go a long way in not only alleviating the suffering in individuals and the community, but also reassuring them that they have not been forsaken. If one holds on to the basic principles of psychiatry, uses a flexible and eclectic humanitarian approach, and adopts culturally appropriate techniques according to the available resources, a great deal can be achieved.

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Multiple choice questions

1. Massive trauma:
   a does not give rise to PTSD
   b refers to situations of extreme and chronic stress
   c is best addressed by a combination of methods
   d is theoretically preventable in many cases
   e causes changes in the family and community.

2. Psychotherapy for trauma in Third World countries:
   a is the same as in Western countries
   b will not work
   c has to deal with the central issue of guilt
   d may be better done by monks or priests
   e would need to include Freudian psychoanalysis.

3. Community approaches to massive trauma:
   a will not be beneficial without concurrent medication
   b can begin only after the war is over
   c includes training as an important step
   d should discourage local superstitions
   e is best served by avoiding political issues.

4. Relaxation techniques:
   a are effective treatment for trauma
   b when culturally appropriate, can achieve the same results as psychotherapy

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c can be used at the community level for mental health promotion and prevention
d have almost no side-effects
e should be avoided in schizophrenia.

5. Traumatised children:
a often reflect traumatisation in adults
b should be separated from their parents initially for treatment
c benefit markedly from pharmacotherapy
d are helped though emotive forms of therapy
e are best managed through individual psychotherapy.

MCQ answers

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

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