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6. "MY WHOLE BODY IS SICK … MY LIFE IS NOT GOOD" A Rwandan asylum seeker attends a psychiatric clinic in London

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Sara was a 32-year-old Rwandan woman who arrived alone in Britain in April 1997. In October 1997, she was referred by her general practitioner (GP) to my psychiatry clinic at the Medical Foundation for the Care of Victims of Torture, a charity offering services to asylum seekers and refugees. The referral letter stated that Sara was evoking considerable concern in her social workers and others, was increasingly depressed, sleepless and had intrusive thoughts. The letter also noted that Sara was a frequent attender at the GP surgery with somatic complaints. An urgent appointment was being sought.

1. BACKGROUND

Before seeing Sara I read the account she had given to her lawyer as the basis for her asylum claim. Born of a Hutu Rwandan father and Ugandan mother in Rwanda, she had completed primary schooling. At the time of the catastrophic events in Rwanda in 1994 (14% of the population – mainly Tutsis but also moderate Hutus – slaughtered in 3 months) she was married to a Hutu Rwandan, with five children aged 5-13 years. In the aftermath, when the largely Tutsi Rwandan Popular Front took over government, her husband left his post as an army sergeant and they devoted themselves to farming their small piece of land.

One day in December 1995, during a meeting in their home in which they and other Hutus were discussing the situation, the door was broken down and soldiers entered. Her husband and the other men scattered. The soldiers beat Sara and her mother to obtain information and then killed both her parents with machetes in front of her. She was taken to an army barracks and acid was poured on parts of her body. She was kept for a month in a mud hut and regularly raped. Then a soldier who had taken pity on her helped her to escape with the help of a Catholic priest. Arrangements were made for her to leave the country and she traveled via

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Nigeria, eventually flying to Britain. Since that day she had had no news of any kind about her husband or children.

This was not the first time that Sara had been referred to the Medical Foundation. In May 1997, a few weeks after her arrival, her social worker made a referral because she was worried by Sara's mental state. The manager of the hostel where she was living saw her as anxious and suspicious, and recorded that Sara said she wanted to walk back to Rwanda. There were concerns about suicide risk. Sara was allocated to a clinical psychologist at the Medical Foundation who found her very distressed but unwilling or unable to talk very much. She was offered a regular appointment but after attending on three occasions Sara dropped out and did not respond to a letter inviting her to resume.

2. THE INTERVIEW

I saw her with an interpreter. She looked subdued or unhappy but composed. From my verbatim notes, the first thing she said to me was: "I'm not depressed, I'm ill". She said her whole body was ill, but particularly her head which could become 'big'. She said she had terrible headaches, could not sleep and could not do anything.

When I asked her what she saw as her number one current problem, she told me it was the hostel: "the place makes me sick". She said she had to share a small room; the building was overheated and there was thieving. When asked about other major current problems, she mentioned her scars. She said she had been ill since 1995. When I asked what she saw as the cause of her illness, she replied that it was all her problems, mumbling something about her children and then tailing off into silence. A moment later she asked if she could be excused for a few minutes and left the room.

When she had not returned after five minutes I went out and found her standing in the corridor. Her demeanor had changed and she was obviously angry. She said she refused to talk any further in front of the interpreter, whom she had decided was a Tutsi. She said she was prepared to continue the interview with the English she had learned since being in Britain. I passed this on to the interpreter and Sara and I continued without her. Sara's command of English was better than I had expected.

Her anger disappeared when the interview resumed. She said to me spontaneously that she was not 'depressed' even though her general practitioner was saying that she was because of the loss of her children. Then she went on to make another allusion to her scars, saying that she had been given some massage the day before; this had felt good and had helped her sleep. She told me she was attending a woman's group and was also going to college to improve her English, though sometimes she did not understand the teacher.

She then made a reference to the antidepressant (Amitriptyline) she had been prescribed by her GP for some months, saying: "I am tired of medicine… they are no good". She went on to refer to the three sessions she had attended with a clinical psychologist several months earlier. She said "talk makes me feel tired" and "the doctor says talk is good but I don't think so" and "talk is not bad if you

are well …". Again she switched back to her scars, telling me of the throbbing pain in them. At this point she briefly mentioned that the Red Cross had been attempting to trace her children, but without success. Then she went on to say "people say I am mad", referring to the hostel staff and commenting that this was because of her allegations about thieving.

The next entry in my notes indicates that at this point she spontaneously mentioned her mother being killed in front of her, and that her mother made eye contact with her as she was being cut up. She said that this memory or image could 'shoot' at her at times: "the way she comes makes me feel bad".

Then she reverted to her current problems, telling me that her very helpful social worker was leaving her job: "who will help me now?" to change to a better hostel. Her last remark in the interview was: "my whole body is sick …my life is not good".

I did not ask for a systematic account of her experiences, including the rapes and torture (which she did not bring up). As far as mental state was concerned, my conclusions were tempered by my awareness of my limitations. What might a Western psychiatrist authoritatively conclude here? How far did his or her expert writ run? Nonetheless, I did not think she was suicidal, nor that it was useful – or wanted by her – to offer follow-up in a psychiatric clinic. I did not see her again. I heard subsequently that a referral her GP had also made to physiotherapy had been helpful, and that she continued to attend the woman's group regularly.

3. DISCUSSION

3.1. Western psychiatry and non-western distress: common ground, worlds apart or something in between?

In relation to prevailing medical practice in Britain this was not an inappropriate psychiatric referral. Sara brought herself frequently to the GP surgery, could be seen as a case of depression for whom a course of anti-depressants was indicated, and appeared not to be improving. The GP would have known that the social worker and hostel manager were also worried about her. Though the GP's letter did not specifically link the referral to her appalling story, its tone suggested that this was the key factor. This would have as much to do with contemporary social values and assumptions as with medical assessment *per se*. This century has witnessed a spectacular rise in the power of medicine and psychology, displacing religion as the source of explanations and antidotes for the vicissitudes of life. Many experiences far less objectively extreme than those in Sara's story are now expressed in the language of trauma, and viewed as capable of having long-lasting psychological effects (Summerfield, 2001). To many it would seem obvious that Sara needed psychiatric or psychotherapeutic help on this account alone, even if she didn't agree.

For her part Sara did not see herself as an appropriate case for a psychiatrist and indeed her opening statement – "I'm not depressed, I'm ill"- was an explicit reframing from a psychological paradigm to a bodily one. She immediately went on to cite bodily weariness, the sensation that her head and neck had swollen, headaches and poor sleep.

Somatic symptoms, which the GP noted Sara had been bringing to the surgery, are the most common clinical expression of distress worldwide. Somatic presentations represent that part of the whole predicament facing a person which he or she thinks is appropriate or expected to bring to a medical setting (Lin et al., 1985).

These are typically deemed 'psychosomatic' in Western medical terminology but this is simplistic. Somatic symptoms are located in multiple systems of meaning serving diverse functions (Kirmayer & Young, 1998). Depending on circumstances they can be seen as:

- an index of disease or disorder (the medical view in Sara's case);
- an indication of particular personality traits;
- a symbolic condensation of intrapsychic conflict;
- a culturally coded expression of distress (likely to apply here, given Sara's background as a Rwandan);
- a medium for expressing social discontent or for a repositioning in a social situation (also likely to apply, given that medicalized presentations may confer advantages for asylum seekers if the doctor is prepared to underwrite their claims for scarce resources like housing).

We can further note that her parting statement – "my whole body is sick..... my life is not good" – is a kind of metaphor for the totality of her experience since 1994. The sick or wounded body she presents stands for her sick or wounded social world, one in which a mother can lose her children and years later still not know if they are alive or dead, in which she and others could be murdered or mutilated with impunity, could lose her role, her place and nation, be cast as a marginal in a distant, strange land.

The additional factor underlying a physical presentation in Sara's case lay in the scar tissue left by the acid burns, associated by her with throbbing pain. Her GP had prescribed painkillers on this account, though Sara saw massage as offering more. The other physical treatment had been the anti-depressants, which both Sara and by implication the GP had seen as ineffective (though it was not unreasonable to have tried them).

The development of psychiatry as a scientific endeavor has its roots in the Enlightenment and in Cartesian assumptions that the inner world of the mind occupies a realm separable from the outer world of the body, and is available for study in a comparable way. With this came an assertion of the causal nature of psychological events and a reliance on positivism to guide theory and research on the singular human being as basic unit of study. All this constitutes an achievement, an ineffably Western one, but not a discovery. There are many true descriptions of the world and what might be called psychological knowledge is the product of a particular culture at a particular point in its history. Western psychiatry is one among many ethnomedical systems, yet it has tended to naturalize its own cultural distinctions, objectify them through empirical data and then reify them as universal natural science categories (Littlewood, 1990). Elsewhere, not least in Rwanda, illness is not conceived of as situated in body or mind alone and taxonomies may draw on physical, supernatural and moral realms in ways totally alien to a Western citizen. Distress or disease is commonly

understood in terms of disruptions to the social and moral order, which includes the influences of ancestors and spirits, and internal emotional factors per se are not viewed as capable of being pathogenic. This is not of course to say that 'culture' is homogenous, and that all Rwandans have the same constructions of distress and disorder because they are Rwandans: diversity also arises in relation to education, social class, urban versus rural location, for example.

The lack of fit between Western mental health services and those of non-Western asylum seekers, so evident to both Sara and myself during our interview, is exemplified by the assumptions of the Western trauma discourse. Its flagship is post-traumatic stress disorder (PTSD), an official psychiatry category since 1980. It is perhaps unusual that Sara's referral letter did not mention PTSD, since this has come to be used as a catch-all diagnosis and signifier of the mental state and well-being of survivors of extreme events anywhere. It has become the organizing concept for a fashionable plethora of assistance programs for war-affected peoples, including asylum seekers and refugees in Western Europe. I and others have critiqued and criticized these developments at length elsewhere (Summerfield, 1999a; Bracken, 1998). PTSD may be seen as a Western culture-bound syndrome.

The assumption underpinning such work, one which Sara was in effect holding out against, is that the biopsychomedical paradigm on which Western psychiatry and psychotherapy is based is universally applicable, whether or not recipients see it like this. There is little evidence that war-affected peoples have asked for such interventions, but Western experts are implicitly saying that they know better what war has done to them and what they need. Psychiatric universalism risks being imperialistic, reminding us of the colonial era when what was presented to indigenous peoples was that there were different types of knowledge, and that theirs were second-rate. The notion that 'traumatic stress' causes psychological disruption may be invalid in cultures that emphasize fate, determinism and spiritual influences. There is a serious possibility that the Western trauma discourse imported into the lives of people whose meaning systems have been devitalized by war and forced displacement might impair their struggle to reconstitute a sense of reality, morality and dignity. After all, the trauma discourse introduces elements that are not mere surface phenomena but core components of Western culture: a theory of human development and identity, a secular source of moral authority, a sense of time and a theory of memory (Argenti-Pillen, 2000).

Taussig (1980), while applauding the emphasis which the new cross-cultural psychiatry gave to elucidating the patient's model of illness, nonetheless cautioned that the knowledge so obtained could allow the management of the patient to be all the more persuasive or coercive. Said (1993) notes that a salient trait of modern imperialism is that it claims to be an education movement, setting out consciously to modernize, develop, instruct and civilize, echoing the earlier writings of such as Cesaire and Fanon on the surreptitious incorporation of the ideologies of colonial dependence and racial inferiority into modern psychological discourse.

It is a category fallacy to assume that because PTSD features can apparently be identified worldwide, they mean the same thing everywhere (Kleinman, 1987). In practice, since PTSD criteria distinguish poorly between the physiology of

normal distress and the physiology of pathological distress, over-recruitment of cases is typical. The most graphic, recent example of this was a community survey of 245 randomly selected, non-helpseeking adults in war-torn Freetown, Sierra Leone, in which PTSD was ascribed to 99% (de Jong et al., 2000). In these circumstances PTSD is a pseudocondition.

There is little doubt that Sara was diagnosable as a case of PTSD, though I did not choose to do this. In particular, proponents of trauma work would light on the image she carried of her mother's murder, able to distressingly 'shoot' at her, as evidence of the 'traumatic' memory often conceptualized as the core of the disorder. The backdrop to this, as Hacking (1995) argues, is that as scientific understandings of ourselves have come to replace religious ones, the notion of 'soul' has been supplanted by a focus on memory – to be seen as a thing open to scientific enquiry. The problem is that memory is fluid, variegated, untidy, inconsistent and indeed contradictory. There is no unearthing of the past in pristine condition, no one definitive narrative. A search for the meaning of something, whether a specific calamity or, say, the realization that one's life is generally unhappy, may drive a different scanning of the past than if one was not impelled to such a search: the act of remembering is interpretative. Memory is in interplay between private and public realms, addresses social as much as personal identity, and is thus shaped by the context in which the telling takes place and the purpose to which it is to be put. It may have as much to do with the future, via the wish to give this a particular shape, as the past. This understanding of memory is familiar to anthropology, though regrettably not to psychiatry, and is a principal point of departure between the two disciplines (Foxen, 2000; Summerfield, 2000; Skultans, 1998). It might be asked why psychiatric science and practice has been so impervious to insights from anthropology.

When Gulf War ex-soldiers were asked a standard set of questions tapping their combat experiences one month after the war, and again two years later, significant discrepancies emerged: the second account tended to report more traumatic exposure than the first (Southwick et al., 1997). (This shift may well be pertinent to the construction of so-called Gulf War Syndrome, which is still seeking the disease status accorded PTSD). Civilian accounts of war will have victim, protagonist (and sometimes perpetrator) themes intertwined. Sara would not tell quite the same story in quite the same way to an aid worker in Rwanda, to a doctor in London, a British immigration official, a human rights tribunal, or fellow asylum seekers. If I had been a Rwandan language speaker, her presentation to me that day in my clinic could not have been exactly the same.

Traumatic memory is a psychiatric construct rather than natural entity (Young, 1995). There have always been painful and disturbing recollections, and it would be strange if Sara did not still have these. However, the reification of traumatic memory - a private, static, circumscribed, universal and pathological entity which reveals itself in flashbacks and re-experiencing and requires processing – is in general a caricature of reality.

In her very first remark in the interview Sara, referred to depression. The following problems bedevil any claim that depression might have to be a universally valid construct: the cross-cultural variations in the definition of selfhood (and of human nature); differing local categories of emotions; the

difficulty of translating emotion- related vocabulary because of cultural variations in language use; the absence of a biological marker (Marsella & White, 1982; Littlewood, 1990). Even in the West the term is used very variably, and often figuratively. Even if Sara had agreed with her GP that she had depression, it would not be because the term had a precise equivalent in Rwandan culture. Rather, it would be because she realized that this was part of the lexicon of distress in the new society, and one legitimated by doctors. At a time when they have few allies of their own, asylum seekers see it as in their interests to present in ways that are intelligible, and if possible compelling, to the medical gaze. Indeed asylum seekers may pick up that terms like nightmares or flashbacks have a certain currency in relation to the traumatic account on which their asylum application depends, and use them accordingly. Thus the imperatives of asylum-seeking independently influence what is brought to medical settings, the way a story is told and the words chosen to illuminate it.

It is because medicalized and psychologized thinking is now so embedded in popular constructions of common sense, and in the aesthetics of expression, that not to automatically use the language of trauma can make it seem that the horrific nature of Sara's experiences is being played down. There is little doubt that Sara is an unhappy, haunted woman, and in part she does see herself as dysfunctional. The question is what grip Western psychiatry and its methods can have on her predicament. As far as treatment is concerned, it is mainstream mental health services that will be on offer in Western countries of asylum, for better or worse, though I suggest that their grip can only be a limited one. As far as documentation is concerned, the medicopsychiatric consequences of extreme experiences may be part of a counting of costs (and generate a report for asylum-seeking purposes), yet it is only a narrowly instrumental style of reasoning that suggests that torture and atrocity are a bad thing because PTSD is diagnosable in victims. Indeed the diagnosis cannot distinguish between past torture or a bicycle accident, nor exclude pre-existing psychiatric problems, nor the impact of current social difficulties.

For the record, during the 1990s I personally assessed over 800 asylum seeker or refugee survivors of organized violence and persecution selectively referred because of concerns (sometimes their own) held to warrant a psychiatric opinion. I saw plenty of unhappiness, frustration, anger and humiliation but the overwhelming majority of these people were not ill, by which I mean they had no significant breakdown in their capacity to function adaptively and to manage their lives. We must realize the limitations of a discourse in which the effects of state violence and atrocity are represented as individual illness and vulnerability. As Zarowsky (2000) puts it, this discourse may erase the very experience of coercion, powerlessness and threat - and the variety of human responses to these - that attention to the human costs of war promises. We need a greater responsibility to acknowledge Otherness.

3.2. Meaning, morality, talk therapy and healing

Collectively held beliefs about the consequences of highly negative experiences carry an element of self-fulfilling prophecy in their capacity to influence individual victims, shaping what they feel has been done to them, whether or how they seek help, and their expectations of recovery. In the clinical setting the mental health professional is part of this process, shaping the very words victims come to use to describe themselves and the legacy of their histories. The rise of talk therapies and counseling to address ever greater areas of life has been a significant trend in Western societies in the past two generations. It rests on a particular view of a person, a moral view, as an autonomous individual, a mini-universe of emotions, aspirations, conflicts etc., who is capable of changing him or herself in isolation from social context. The best candidates for talk therapy are often said to be psychologically minded, having a Western viewpoint and indeed a middle-class Western viewpoint. A core assertion, and this runs through the whole trauma field, is that distress or suffering is detachable from those carrying it and is a circumscribed technical problem amenable to mental health technologies.

In practice, talk therapy represents a kind of social movement, and in many respects an industry, and has not relied on rigorous theorizing and evidence-based practice. Little valid research has been done, though two recent studies of one-off trauma counseling have cast doubt on its efficacy and suggested that harm can be done if clients pick up the idea that they should ruminate on what happened and not put it aside (Wessely et al., 1998; Mayou et al., 2000; Kenardy, 2000).

Nonetheless, the assumption that professionally guided emotional catharsis or working through is universally valid and necessary for war victims has gained considerable currency. In USA and Europe a number of specialist centers have been operating for victims of torture, in particular, and this interview took place in one. The tendency has been to pitch the psychological impact of experiences like Sara's as having a special nature and demanding special expertise, not just in treatment but also in documentation for asylum-seeking purposes. But the testimony of experts is powerful only to the extent that their expertise is real. If asylum seekers like Sara are not understood to have a characteristic and distinct form of mental state (and they don't have), then the testimony of sympathetic professionals is simply that: sympathetic. Further, the claim – to be seen in the publicity literature of such centers – that people like Sara are likely to have a deep, potentially long term psychological wound requiring expert intervention (though a few may see themselves like this), casts them as a damaged and diminished group for whom others (the center staff) should speak. To effectively equate human pain with impairment can do war victims a far-reaching disservice, since it may muffle what they themselves want to say (not least politically), distort assistance priorities, and color how society comes to think of them, and they of themselves.

A recent example was the confidential recommendation made by the British Home Office strategy group handling the reception of 4,000 Kosovan refugees being airlifted to Britain in mid-1999. Writing at a point when most had not even landed, they nonetheless stated that the Kosovans were "in a serious state of trauma and chronic illness with a need for long term counseling and support" (Guardian, 1999). But a subsequent study of a large number of these refugees painted a very different picture. Very few saw themselves as having a mental

health problem at all, let alone a long-term one, bearing out observations by refugee workers that there had been no demand for counseling (N. Savage, personal communication). So who knew best?

The intention is not to cast Western and non-Western cultures as two monolithic blocs and the Kosovans are after all white Europeans. But for non-Western asylum seekers in particular, the very idea of the detached introspection of emotions, professionally guided, is alien. Indeed, one problem is that the cultural worlds in which people are immersed can differ so dramatically that translation of emotional terms needs more than merely finding semantic equivalents. Describing how it feels to be grieving or melancholy in another society draws one into an analysis of radically different ways of being a person (Kleinman and Good, 1985). In her study of Somali refugees in Ethiopia, Zarowsky (2000) noted that emotional experience and expression were interpreted primarily with respect to what they indicated about sociopolitical, not intrapsychic, processes. It was not that Somalis could not psychologize, but that the organizing framework reflected a context in which survival was the overriding concern.

In many cultures the harmony of the family or group matters more than the autonomy of the individual, who is not conceived of as a freestanding unit. Thus, containment of emotion and adaptation to social circumstances are viewed as signs of maturity. Fostering individualism through talk therapy may put people at odds with their families or local worlds (Kirmayer & Young, 1998).

Sara was referred twice to the Medical Foundation by a caring GP who had concerns about her current mental state, but was doubtless also horrified by her story. It is the caring Western citizen as much as the caring doctor who would feel that surely a woman who had lost 5 children, been multiply raped and witnessed grotesque atrocities directed at her parents, needed be assessed by a mental health professional, and to talk it through. The first referral led to sessions with a psychologist, which Sara broke off prematurely. The GP had acted in good faith but clearly Sara had felt coerced: "The doctor says talk is good but I don't think so". The three sessions with the psychologist had not persuaded her that this was a relevant activity – "talk makes me feel tired" – though she added (perhaps a conciliatory gesture to those she knew were trying to help), "talk is not bad if you are well..." The question also begged here is what constitutes informed consent when asylum seekers have so little social clout.

This insistence on a need for counseling, however it might strike recipients, has a wider Rwandan perspective: the establishment of the National Trauma Program and Center in Kigali, sponsored by UNICEF, after the events of 1994. By 1996 over 6,000 trauma advisors were reported to have received training (from outsiders), and 144,000 children had been contacted. Did ordinary Rwandans ask for this, given their pressing post-war problems, and given that trauma and counseling were entirely foreign concepts? It is instructive to transpose this situation to the Jewish Holocaust. A project, planned from afar and using a foreign psychology and its practices, is mobilized in 1945 to address concentration camp survivors. The project leaders have not worked in the area before and know little of its history and culture. The project is funded, say, for one year, the objective

being to purge subjects of the trauma of the Holocaust. Such an endeavor would surely be self-evidently presumptuous and unethical.

Some asylum seekers and refugees do make creative attempts to engage with this kind of work and, at a time when they have few other influential allies, may become attached to their therapists. One exception to the general paucity of research was an evaluation of therapeutic work given to asylum seekers in the Netherlands by local therapists. Though both therapists and patients gave an optimistic account of the sessions, marked differences in culturally and situationally determined expectations were evident. Therapists placed primary emphasis on the subjective psychological world of their clients, and on PTSD, and saw culture and the social problems all asylum seekers face, as issues outside the room. The patients spoke positively of the therapists, albeit sometimes seeing them as rather detached. They expressed surprise that therapists had paid so much attention to their childhood and said they had hoped for more practical help (Boomstra & Kramer, 1997; see also Chapter 8). In a recent survey of asylum seekers in London, 76% of those offered counseling or psychotherapy rated it as poor or very poor (Baluchi, 1999). In the mental health clinic refugees may naturally appreciate an empathic, non-judgmental listener but this is a non-specific benefit. (Indeed it might be argued that the mental health sciences have co-opted these and other facets of ordinary human solidarity and fraternity, mystifying them into technical procedures which require experts). The question here, and not just with asylum seekers and refugees, is whether benefits may accrue from talk therapy which are specific to a particular methodology and underlying theory.

Talk therapy has historical roots in Stoic ideas and, later, in Judeo-Christian traditions of confession, forgiveness and of turning the other cheek. It aims to change not just behavior but mind, the way a person construes. It trades on an ethos of acceptance: it is the person, not society that is meant to change (Ingleby, 1989). One reflection of this may be how uncomfortable the clinic or clinician can be when the client or patient forcefully expresses anger, that most moral of emotions. Expressions of grief or sadness are seen as the stuff of clinic work, but anger is difficult. It has been noted that in successful therapy the worldview of the client moves closer to that of the therapist. What does it mean to people like Sara that in one sense therapy is a form of persuasion? What does it mean that she sits opposite a professional who has not in fact experienced atrocity or grotesque loss, but who may have the power to define what it has done to her and what she needs to do to recover? Whose words will count at this critical moment in her life?

Mental health work, and the settings in which this is delivered, are traditionally regarded as politically and morally neutral. Yet the distress which war victims bring into the room points outwards at the political environment which evoked it. An apolitical humanitarianism cannot make full sense to them, even if there are gains in the short term. They are in no doubt that political questions are at the heart of what has happened to them, and what needs to be done. For her part Sara gave me a sharp reminder that she did not regard herself as in a neutral space when she interrupted the interview and left the room angrily. She objected to a Tutsi Rwandan interpreter because the soldiers who had attacked her and her family were, I presumed, Tutsi – but perhaps there was a more general

political reason too. Rwandan society and politics was right there with us in the clinic.

For the therapist, acceptance, coming to terms with the past, or processing may be synonyms for healing – the purpose of therapy. But victims may have to struggle with whether acceptance is merely a marker of their impotence and humiliation or, worse still, an acquiescence in injustice – on their part, by those they know and by the Western -led world order which behind the rhetorical screen of human rights retains the *realpolitik* of business as usual. The rise of programs offering talk therapy is certainly sometimes seen cynically by those for whom they are intended, experienced as patronizing or indeed a kind of pacification. In Bosnia, people derisively referred to the model of aid delivered to them as 'bread and counseling', a model which did not offer physical protection, restitution or justice.

A number of these programs has sought to address brutalization, by which an unforgiving (traumatized) victim is held to turn into a potential perpetrator (as a form of mental ill-health) and perpetuate what is called the cycle of violence. Rwanda and former Yugoslavia have particularly attracted facile analyses of this kind and, for example, a foreign-funded project sought to counsel war-affected Croatian children not to hate and mistrust Serbs. Should Sara be counseled not to hate Tutsis, for the sake of her own health and that of her nation, particularly after the anger she revealed for the Tutsi interpreter? Indeed, should Jewish survivors of Nazi genocide have been counseled in the 1940's not to hate Germans? The framing of some current research is illustrative of this medicalization of what was previously a religious piety, the quietist Christian values mentioned already – particularly forgiveness and turning the other cheek. (It is what Bacon in the seventeenth century expressed as: 'he who planneth revenge keeps his own wounds green, which otherwise would heal and do well'). In a recently published study of survivors of apartheid era human rights abuses in South Africa, some of whom testified to the Truth and Reconciliation Commission, PTSD and depression were said to be significantly higher in those who were unforgiving towards the perpetrators, compared to those with high forgiveness scores (Kaminer et al., 2001). The authors did not claim that the lack of forgiveness was necessarily causal rather than correlative, but such studies are seeking to consolidate the notion that it is bad for the mental health of victims if they do not forgive.[2]

Similarly, a survey of 600 Kosovo Albanian households by the Centers for Disease Control and Prevention (1999) found that 86% of men and 89% of women had strong feelings of hatred towards their Serbian oppressors. 51% of men and 43% of women said they had a desire to seek revenge most or all of the time. The title of the survey, as well as methodology and use of psychological instruments, made it explicit that these sentiments were to be cast as mental (ill)-health

[2] Their other finding was that giving testimony to the Truth and Reconciliation Commission did not alter psychiatric status or attitudes to forgiveness (though, from other sources, many of those who did testify were reportedly pleased that they had had the opportunity to do so). It is also indicative of the implicit moral framework that the Commission was not uncomfortable if testifiers wept while giving evidence, but did not like them to become angry. In this study 'recovery' was defined mechanistically and medically, and the psychiatric instruments and categories used were of questionable validity for this population.

phenomena. But one man's revenge is another's social justice. The question is whether anger, hatred and a felt need for revenge in those grievously wronged are a bad thing. Don't they carry a moral interrogative (again, the Why), pointing to a social wound as well as to an individual one, and to shared ideas about justice, accountability and punishment which hold a social fabric together? Don't they demand answers? Were the Nuremburg trials of Nazi war leaders after World War 2, which handed down capital punishment in many cases, the result of brutalization, of unhealthy feelings of hatred and revenge in traumatized victims of Nazism? Or did the trial provide a demonstration of justice in action, thus assisting a sense of closure after man-made catastrophe?

Refugee stories are moral tales. "We are not mad, we are betrayed" was the response of one refugee approached by a pilot Bosnian mental health project in Britain (McAfee, 1998). This response is witness to the collectivity (We) of the experience of war and refugeedom, and poses a fundamental question: 'are we impaired or wronged?' If both, how does the mental health profession frame the relationship between the two? How does the psychiatrist or psychotherapist trained to deliver technical outputs see the question of moral knowledge. This is the kind of knowledge that springs from a crisis (a serious accident, a diagnosis of cancer, a social upheaval) which shakes up an individual's assumptions about the world, his or her personal values and priorities. For the war victim, this invokes some of the most urgent questions of the day: the man made demolition of worlds, the impunity of the perpetrators, the indifference of the world order, the near possibility of restoring what was there before. These are Why? or Why me? questions, addressing a moral domain. Medical science is good at How? questions, which are technical ones, but only addresses the Why? by reference to impersonal statistics and epidemiology. The patient may be alone with his anxiety to locate the social and moral meaning of the crisis (Taussig, 1980).

The professional is not of course personally immune to a sense of moral outrage. An especially horrific or poignant story often induces in workers a particular identification with the person concerned, with extra energy devoted to treatment and advocacy. Part of this is the impulse to charity, in the Christian tradition springing from a sense of pity (and Sara may well see herself as pitiable). This works best when its object can be viewed as worthy victim pure and simple, shorn of complexity and context. Understandably, asylum seekers stories seek to deliver up their central character or characters in this form, sometimes with exaggeration or fabrication. The story is in many respects an artefact, constructed for a particular climate of asylum-seeking and help-seeking, and it is no surprise that it can sometimes seem rather formulaic. But it begs to be believed and indeed must be, more or less unreservedly, if the moral impulse to help is not to be diluted. But once some apparently implausible element is noticed and can't be rationalized, a taint may be cast on the integrity of the whole. The story is the strongest thing an asylum seeker as claimant possesses. When it loses its power, the asylum seeker may in effect be recategorized from deserving to undeserving poor – to recall the way the Victorians approached charity. This can even contaminate the way health-related concerns are appraised, a reminder that mental health practice is impressionistic and loses its bearings if what the patient says

(often all there is to go on) is not automatically believed. The clinician may be possessed by a sense of moral and clinical immobilization.[3]

The thrall in which Sara's story might be said to hold me, as with her GP and social worker, began before I even met her, when I was reading it through before the interview. Then I ushered her into my office and as I sat down opposite her, torture, rape and lost children lay in the space between us. The fantasies that possessed me at this moment, before Sara had even opened her mouth, were wholly my own, built on the imagined insertion of myself and people close to me, notably my own child, into such scenes (for this is what the hearer or reader does). The language of my thoughts could only draw on the words, and the hinterlands the words brought with them, familiar to me as a Western culture-carrier, and also as a health professional. Were I to feel that I couldn't be in my right mind after such experiences, or at least a deeply changed person, I would be likely to impute this to Sara – and unavoidably on my terms and in my language. As the interview began, did I unwittingly scan her face for signs of what she had passed through? If signs were there I was not in a position to read them, for the face she maintained (except in her brief reaction to the interpreter) was one of composure and dignity. What might this absence of overt distress denote? In some quarters it might be taken to cast doubt on her credibility: I've certainly heard refugee workers say that they find tears a more authentic expression of what someone has been through than their absence, and tearful clients may be prioritized for assistance. This seems to reflect the emotional expressiveness now taken to be the norm in the West: it is not only what an individual can do, but what he or she should do after a tragedy – partly a matter of aesthetics and partly the belief that to hold one's emotions in is bad for you. In fact Sara's demeanor may reflect the face she deems to be appropriate to bring to interviews with officialdom, including doctors, whether by virtue of background norms or simply her personal style.

I have no reason to doubt the veracity of Sara's story as she has told it, but it cannot be the full story: what it explains, what it might foretell of her future life, is not clear (nor definitively to Sara at this point). Firstly, how much can I know of what her experiences really mean to her (and it is meaning that matters)? As a Hutu woman and mother what did she think and do during the 3 months of slaughter in 1994, with Hutus massacring Tutsi men, women and children, and also moderate Hutus who opposed the persecution. What role did Sara's husband play, a Hutu soldier? Though Hutu men did most of the actual killing, Hutu women and children were also active participants, joining machete-wielding mobs

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[3] Another source of this immobilization is when the health professional is not politically neutral, and has a different view of the conflict than that conveyed explicitly or implicitly by the asylum seeker's story. For instance, a case was referred to me of a (white) South African wanted for trial on charges involving terrorism and politically inspired murder during the apartheid era. He was seeking a medically attested defense against extradition on the grounds that he had PTSD. I refused to see him, and felt he should be extradited. It might also apply, more subtly, to a Bosnian Serb asylum seeker whose version of events seemed at odds with the generally held conclusion that far fewer Serbs were victims, and far more were aggressors, than were Bosnian Muslims. Of course it might similarly be said that few Hutus were victims by comparison with Tutsis, but for me this did not intrude on Sara's case. Lastly, there is the situation faced by a college student counselor in London who opened the newspaper to discover that the nice young Rwandan in whose welfare she was taking considerable interest had just been indicted as a local organizer of the mass killings in 1994.

besieging places of refuge like churches, hostels and hospitals, denouncing their Tutsi neighbors, and stripping clothing and jewelry from the bodies of the just slain and barely living (African Rights, 1995). Others would have been bystanders, not joining in but not protesting or offering hiding places to Tutsi neighbors either. Some Hutus did hide Tutsis they knew.

But the story would need to go back further than 1994. What version of Hutu identity, and its relation to wider Rwandan citizenship, might Sara have inherited from her parents and immediate community? What version of the social memory of the inter-ethnic massacres of recent decades (1994 was not unprecedented, as the international community tended to assume) was she carrying? What was her understanding of the way that people had made sense of their losses after those disasters, negotiated issues of responsibility, culpability and restitution, repaired family, community and wider societal fabric? A public process of this kind is typically pragmatic, for the past must be squared with the urgent demands of the present. After civil war the supposedly stark categories of victim and perpetrator (in the lexicon of international human rights) are often insufficiently nuanced to be straightforwardly useful to those at the grassroots. As far as 1994 and its still evolving legacy is concerned, even in London, Sara would have a sense of the conversations flowing between ordinary people back home, going on around the tasks of everyday life, a kind of national stocktaking distilling through the micro-worlds of individual understanding and experience. This is how people adjust and re-group.

How does Sara connect the 1994 catastrophe to her own horrors of the following year at the hands of soldiers I presume to have been Tutsi? What is her attribution for these horrors, and does any part of their moral charge point inwards as well as outwards? Does she perhaps see what happened to her as a form of punishment at the hands of the wronged? If so, might she feel that she has paid enough, and the debt thus cleared, or is this kind of closure a ridiculous idea to her? What does her reaction to my Tutsi interpreter denote as to her mind set, and how much is she handicapped by being unable to be party to the whole process back home? What has stopped her from returning to Rwanda to search personally for her children?

In the light of all this, what explanatory power should be imputed to a cognitivist model which sees the human mind as the locus of the trauma, and of recovery or healing? This is a mechanistic view of man. Meaning and understanding are seen as stored in the brain in the form of schemata, with questions of morality and responsibility formulated in terms of the sciences of individual psychology and memory. It would carry us rather further into Sara's reality to see meaning as something generated through practical engagement with the world, through a lived life with all its complexity and capacity for multiple interpretations. These are not mere secondary influences, as a trauma model asserts, but the very stuff of a background intelligibility against which her experiences of war and refugeedom are set (Bracken, 2000). It would be a wiser and truer use of the term psychology to define this as an expression of this background intelligibility: a system of thought and practice based on the day-to-day behavior and points of view of the members of a particular group or people. Human misery is a slippery thing, sitting in socio-moral and philosophical

domains which themselves are variable and slippery. Nowhere is it straightforwardly subject to processing via a technical intervention in isolation from other aspects of life.

One of the lessons of history may be that the victims of terrible events have largely had to put aside what has happened to them, seek creative accommodation with their altered circumstances and get on with life. It might be said that the imperatives of survival left little choice. Notions of healing, reparation and justice after war have a long history, varying between cultures and over time, though the contemporary discourse of human rights, legalistic and individualistic, is of recent origin. People have always mourned and honored the dead by those means available and familiar to them, with religious or supernatural beliefs and practices typically central. The wider socialization and commemoration of grief and loss may be complicated when, as in Rwanda and in 90% of all modern war, the conflict is internal rather than transnational: a winner social group may take over the assets of the losers. Moreover the effects of war cannot be neatly separated off from those of other forces: poverty, landlessness and other forms of structural marginalization, and forced exile. Is the suffering of the world's hungry and undernourished children less of a trauma than that occasioned by bombs and bullets? Recent developments – Truth commissions, international human rights legislation, war crimes tribunals in extended sitting (notably in Bosnia and Rwanda) – do seem promising and are welcomed by some (though not all) victim groups, though their longer term impact remains to be traced (Summerfield, 1997).

Memory is a contemporary Western cultural preoccupation but there is also a need for silence about the past, a line drawn under humiliation. This is not forgetting, but reticence and a conserving of energies (Last, 2000). This kind of silence is not the same as the silence which is a survival strategy in societies where state oppression is pitiless and pervasive. People resume, largely out of sight of helping agencies, the rhythms of everyday life and through banal and unspectacular activities may move towards a sense of normality (albeit not the same normality as before): doing the washing up, taking children to school, helping a neighbor, supporting a football team. They seek to re-establish security and identity, and for asylum seekers in Europe a point of reference is naturally wage earning (see below). People endure, if only because they must. What personal costs they pay along the way are, with few exceptions, played out in their private lives and not in a mental health clinic. The work of historians, journalists, novelists, poets suggests that there are many who carry the fruits of bitter experience to the grave, and many more- if not most- who could aver to some sense of change in themselves or their attitudes. Not all of this change is negative. Lastly, if a trauma-based view seems to emphasize victims rather than survivors, we should also remember Levi (1988) in *The Drowned and the Saved*, reminding us that the public record is denuded of the accounts of the Drowned.

The observations in the paragraph above are not expert, do not constitute psychiatric insights, are merely the assessment of an ordinary citizen (and one who has not gone through these things). It is for the actors and their historians to say when getting over it or recovery or healing might represent something material,

and when merely an abstraction that does little justice to the complexity of what they have passed through.

3. ASYLUM SEEKER REALITIES: REPAIRING A BROKEN SOCIAL WORLD

Two adversarially opposed constructions have predominated in relation to the 4.2 million who have sought asylum in Western Europe in the past decade. Governments, and the conservative social sectors, stress the prevalence of bogus applications by people who are essentially economic migrants. They paint asylum seekers as resilient and wily (rather as they did in the colonial era). Overall this portrayal is too bad to be true. On the other side are the agencies and interests who support asylum seekers, and the liberal and radical social sectors. They pitch asylum seekers as people who had no choice but to run from their countries, innocent of any thought other than to escape further persecution, torture and the risk of death. They do not conjure up resilience, but vulnerability, weakness and damage. This portrayal is too good to be true. The reality, I suggest, is the muddied, uneven, contested ground that lies between the two entrenched positions.

Helping agencies may propagate the second of the images above (often as the traumatized), but their institutional interests sometimes push them to play also to stereotypes like dependent or even manipulative. These can be a self-fulfilling prophecy: agencies see what they expect to see (or what funders want to see), not least because their clients will organize their presentations to fit in with what is on offer at a time of limited options (Harrell Bond, 1999).

A central concern of this paper has been to review the consequences of a medicalized idiom applied too indiscriminately to this population, even as we acknowledge that the medicalization of life has been a major cultural trend across Western societies in this century. This may reduce still evolving experiences, meanings and priorities of asylum seekers from war zones to a single category – trauma – so that refugee suffering is too routinely attributed to pre-flight events, neglecting current factors. There may be risks that the host society offers refugees a sick role rather than what is really sought: opportunities for meaningful citizenship as part of rebuilding a way of life. Sara felt that her body was ill or sick, but she was not seeking the legitimated inactivity and convalescence of a sick role. She was actively seeking more suitable housing, which included her anticipating what else would need to be done once her social worker left her post. She was regularly convening with other women in her situation, an opportunity to acquire useful knowledge and tips on coping in London. She was learning English in college, successfully it seemed to me, a crucial skill in her new setting. Arguably psychiatric models have never sufficiently acknowledged the role of social agency and engagement in promoting mental health.

A Somali asylum seeker, referred for a psychiatric opinion, once said to me with exquisite politeness: “Your words are very fine, doctor, but when are you going to start to help me”. Helping agencies have a duty to recognize distress, but then to attend to what the people carrying the distress want to signal by it. Whilst

asylum seekers and refugees no doubt bring all that they have been through into the room, as experience embodied, Sara was entirely typical in her focus on practical assistance and advocacy to help bolster her immediate social situation. Housing issues are always a prominent concern. One study of Somali asylum seekers in London showed that insecure housing, not war experiences, torture or death of relatives, was the most significant variable predicting those who would report mental health problems (Dahoud & Pelosi, 1989). So too the question of family reunion, and Sara had sought out the Red Cross because they can help trace missing family members. She may have mentioned it in the interview with me because she thought that my presumed influence as a doctor could add weight to this search.

A service labeled counseling might thus be most acceptable to the majority when it centers on practical problems and directs attention to function-focused and problem-focused coping styles (How are you doing? and What do you need to do?) rather than the emotion-focus (How are you feeling?) more typically associated with counseling and with a Western (but not generally a non-Western) cultural idiom.

Socio-economic and socio-cultural factors are surely key determinants of longer term outcomes. The refugee literature highlights the pivotal role of family and social networks in exile. In Iraqi asylum seekers in London, poor social support was more closely related to low mood or depression than was a history of torture (Gorst-Unsworth & Goldenberg, 1998). In the survey of Kosovan refugees mentioned above, almost everyone nominated work, schooling and family reunion as their major priorities. Work has always been central to the way that newcomers – whether asylum seekers or other category of migrant –established a viable place in the new society, and unemployment levels in Western European countries since the early 1980's have made this a more fraught route than it once was. In the native British population at any rate, unemployment is associated with early death, divorce, family violence, accidents, suicide, higher mortality rates in spouse and children, anxiety and depression, disturbed sleep patterns and low self-esteem (Smith, 1992). There may also be analogies in research in Britain and USA which indicates that those with poor social capital, the poor and socially underconnected, live less long (Wilkinson, 1996; Kawachi & Kennedy, 1997). Women with young children in the lowest fifth of distribution of household income (where asylum seeker families congregate) were at substantially higher risk of poor health and depression. The risk increased further in US states with the biggest differences in incomes between those at the top and those at the bottom (Kahn et al., 2000). The macro- and microfactors mediating such outcomes are complex and still poorly elucidated.

Will some of these trends turn out to be extrapolatable to refugees? Steen's (1993) study of Sri Lankan Tamils compared outcomes in Denmark and Britain. She found that Tamils in Denmark had been effectively deskilled by the extended orientation program provided; even those who had arrived with employable skills had been discouraged by social workers from seeking work until they learnt Danish. In Britain, in contrast, with its *laisser faire* welfare approach, Tamil asylum seekers had an incentive to be independent and economically active as quickly as possible, and were doing much better in coming to terms with their new

reality. A recent study in Sweden compared two cohorts of families of survivors of a particular Bosnian concentration camp. The families were originally from the same town in Bosnia and had similar socioeconomic backgrounds. By chance half the families had been sent to a place where there was temporary employment but no psychological services, the other half to a place where no employment was available but there was a full range of psychological services. At follow-up at one year a clear difference had already emerged. The group given work seemed to be doing better, and the majority of adults in the second group were on indefinite sick leave (Eastmond, 1998).

What hold Sara's experiences will continue to exercise on her imagination remains to be seen, and to be influenced by what is to come – whether she will discover the fate of her children, or the children themselves, and much besides. All this will be played out in social space, at present one in which as an asylum seeker she still carries little weight (as she knows only too well); one day she might well be back in Rwanda and with a different set of constraints and possibilities. The core dimension of most modern warfare is that it is total; it aims for the destruction of worlds (Summerfield, 1999b). This renders life incoherent. What Sara faces in the longer term may perhaps fairly be seen as a struggle to recover a sense of coherence, the absence of which is bad for anyone. But this is not a struggle apart: it is subsumed within, and represented by, the practical struggle to recover agency and to rebuild a life that endures, and even be worth enduring.

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