A thesis submitted in partial fulfilment of
the requirements for the degree of
Doctor of Philosophy


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Alleviating psychosocial suffering: an analysis of approaches to coping with war-related distress in Angola.

Carola Eyber

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in the discipline of International Health Studies

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Abstract

This study investigates the role that the notions of trauma and culture play in relation to the alleviation of distress within a war-affected population. It analyses how local, cultural conceptions of distress and those held by psychological service providers relate to one another, and how they contribute to improving the well-being of the displaced. Fieldwork was conducted with urban and rural displaced populations in the south-eastern province of Huila in Angola. Ethnographic, psychometric and participatory methods were used to examine issues of health, illness and distress amongst the displaced. Local idioms of distress in the form of pensamentos, mutima, madness and high and low blood pressure are common ways of expressing suffering related to war. The different explanatory models held about these illnesses and the various resources available in the popular, folk and professionals sectors of the health care system were explored. The religious and spiritual domains were found to be influential in the treatment of distress-related illnesses. The psychological services available in the war-displaced communities were examined in terms of their common theoretical and practical elements. These were then analysed in relation to the conceptualisations held by local populations, and points of similarity and difference were noted. Specifically, the conceptualisation of suffering as trauma and the cultural misunderstandings that arise as a result of this, and the representation of the displaced as traumatised and therefore dependent and passive people, are discussed. A particular subgroup in the community, the adolescents, was identified and participatory methods were employed to investigate the strategies and resources this group uses for coping with war-related distress. The youths predominantly make use of distraction, conselho, religious and cultural resources. The application of a PTSD scale, the EARAT, suggests that 71% of the adolescents had symptoms of trauma consistent with a diagnosis of PTSD. It is argued that for the vast majority such a conceptualisation does not reflect the adolescents’ abilities to function on social, vocational, educational and physical levels. The implications of these findings for research and practice in the field of psychosocial work are discussed.
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Glossary of terms

activista de saúde (pl.: ativistas de saúde)

adivinhador (pl.: adivinhadores; female: adivinhadora)

administrador (pl.: administradores)

adulto (pl.: adultos)

assimilados

bairro (pl.: bairros)

bandidos

cabeça quente

capim

catecista (pl.: catecistas)

chefe da família

condições

confusão

conselho

coordenador (pl.: coordenadores)

curandeiro (pl.: curandeiros; female: curandeira)

Dona

dor de coração

embala

falta de condições

community health worker

diviner, someone with powers of divination

government-appointed official

adult

educated Angolans who assimilated into Portuguese culture during colonial times

neighbourhood

criminals, thieves

Lit: a hot head, indicating a sensation of heat and tingling in the head

grass

catecist

head of the household

basic conditions

confusion, chaos, disorder, trouble (also political)

advice, consolation

government-appointed official

traditional healer

form of address for a woman

heartache

traditional village consisting of several kinbus

lack of basic conditions
fazer confusão  
make trouble or cause disorder  
feiticeiro (pl.: feiticeiros)  
people who have the skill to bewitch someone  
funje  
porridge made from cassava or maize  
jango (pl.: jangos)  
communal hut where community members meet  
jovem (pl.: jovens)  
young person  
joventude  
youth (phase in life-cycle)  
juízo  
good sense, common sense  
justiça  
justice, used here to indicate traditional court  
kimbanda  
traditional healer  
kimbu (pl.: kimbus)  
household of an extended family  
Kwanza (Kw)  
Angolan currency  
 loucura  
madness, insanity  
mais velho (pl.: mais velhos; female: mais velha)  
term of respect for an older person  
mbindi  
pain in the heart  
mbungo kuvavale  
people of mixed ‘race’ origins  
 mestigo (pl.: mestigos)  
a type of tree  
mulemba  
disabled person, amputee  
mutilado (pl.: mutilados; female: mutilada)  
heart  
mutila  
business, informal trading  
mutima  
those conducting business or informal trading  
negócio  
nerves  
negociantes  
okuahia  
preventative treatment  
padre  
Catholic priest
pano (pl.: panos)

passear

pensador

pensamentos

pensativos

promotor (pl.: promotores)

promotor de saúde

quissange

religioso (pl.: religiosos)

santa (pl.: santas; male: santo)

saudades

serão

soba (pl.: sobas)

susto

tensão alta

tensão baixa

terra

cloth, traditional dress worn mostly by women
going for a walk, ‘hanging out’
‘Thinker’, national symbol of Angola

thoughts, memories, term
frequently used in relation to experiences of war

thoughtful, brooding

community worker

health workers

traditional drink made from maize meal

someone who is religious

Lit: saint, holy person who possesses skill of healing

homesickness, longing, nostalgia

staying up late at night

traditional head of a kimbu or embala

fright

high blood pressure

low blood pressure

home area, land
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACF</td>
<td>Ação Contra o Fome [Action Against Hunger]</td>
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<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>ATR</td>
<td>African traditional religion</td>
</tr>
<tr>
<td>CBS</td>
<td>culture-bound syndromes</td>
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<tr>
<td>CCF</td>
<td>Christian Children’s Fund</td>
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<tr>
<td>CCR</td>
<td>Centre for Conflict Resolution</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>EARAT</td>
<td>Escala de avaliação da resposta ao acontecimento traumático [Evaluation Scale of Post-traumatic Stress Disorder]</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye movement desensitisation and reprocessing</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>FNLA</td>
<td>Frente Nacional de Libertação de Angola [National Liberation Front of Angola]</td>
</tr>
<tr>
<td>HBP</td>
<td>high blood pressure</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross and Red Crescent</td>
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<td>IDP</td>
<td>internally displaced persons</td>
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<tr>
<td>IDS</td>
<td>Institute for Development Studies</td>
</tr>
<tr>
<td>IESA</td>
<td>Igreja Evangélica de Sudoeste de Angola [Evangelical Church of Southwest Angola]</td>
</tr>
<tr>
<td>Kw</td>
<td>Kwanza</td>
</tr>
<tr>
<td>LBP</td>
<td>low blood pressure</td>
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<tr>
<td>MINARS</td>
<td>Ministério de Assistência e Reintegração Social [Ministry of Assistance and Social Reintegration]</td>
</tr>
<tr>
<td>MPD</td>
<td>multiple personality disorder</td>
</tr>
<tr>
<td>MPLA</td>
<td>Movimento Popular de Libertação de Angola [Popular Liberation Movement of Angola]</td>
</tr>
<tr>
<td>MSF</td>
<td>Medicos Sem Fronteiras [Doctors Without Borders]</td>
</tr>
<tr>
<td>NRC</td>
<td>Norwegian Refugee Council</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
</tr>
<tr>
<td>NRM</td>
<td>new religious movements</td>
</tr>
<tr>
<td>NVVRS</td>
<td>National Vietnam Veterans Readjustment Study</td>
</tr>
<tr>
<td>OCHA</td>
<td>Office for the Co-ordination of Humanitarian Affairs</td>
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<tr>
<td>POW</td>
<td>prisoner of war</td>
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<td>PRA</td>
<td>participatory rapid appraisal</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<tr>
<td>RCC</td>
<td>Roman Catholic Church</td>
</tr>
<tr>
<td>TEP</td>
<td>Teacher Education Programme</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>UNITA</td>
<td>União Nacional para a Independência Total de Angol [National Union for the Total Independence of Angola]</td>
</tr>
<tr>
<td>UNSC</td>
<td>United Nations Security Council</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WWI</td>
<td>World War I</td>
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<tr>
<td>WWII</td>
<td>World War II</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

Over the last two decades humanitarian agencies providing assistance to war-affected populations have increasingly paid attention to the psychological and social impact of violent conflict and displacement on communities. The rise in interest in this area is linked to a general ‘psychologisation’ of the public discourse in the west\(^1\) (Rose, 1996), and the prominence that explanations of trauma are gaining in relation to a number of distressing experiences such as natural disasters, violence in inner city neighbourhoods, and accidental injury, amongst others (see, for example, the ESTSS 7\(^{th}\) European Conference on Traumatic Stress, 2001). The word ‘trauma’ has become part of everyday vocabulary in many western countries, “invading the social and cultural arena through television, commercial movies and even talk shows” (Nashat, 2001), popularising the notion that some adverse experiences have long-term psychological consequences (Bracken, \textit{et al.}, 1997).

The link between psychological well-being and experiences of war became increasingly explicit in countries in the west since the advent of World War II (Ager, 2001). As war-displaced people sought refuge in European and North American countries, attention initially focused on facilitating the assimilation of the arriving refugees into the host populations, as well as on their medical problems (Muecke, 1992). Some psychologists and psychiatrists provided specialised rehabilitation work with survivors of concentration camps and torture in various centres in the west (Krystal, 1995), but there were almost no mental health programmes specifically designed for refugee groups. The provision of such services arose as a response to two events. Firstly, the formal recognition of Post-Traumatic Stress Disorder

\(^1\) The term ‘west’ refers to the countries of western Europe and North America, and ‘western’ refers to ideologies and approaches to psychological knowledge that originate in these countries (Dawes and Cairns, 1998: 336).
(PTSD) as a psychiatric disorder in 1980 contributed to a growth in clinical and epidemiological studies focusing on the psychological effects of "abnormal situations" such as violent conflict (Parker, 1997). Secondly, medical centres working with refugees in western countries noted a number of seemingly intractable medical problems that they interpreted as long-term somatic expressions of emotional pain, indicating the necessity for medical practitioners to take the psychological well-being of their clients into account (Eisenbruch, 1992; Muecke, 1992).

The provision of forms of psychological assistance to large-scale refugee displacements started appearing on the agendas of non-governmental organisations (NGOs) and inter-governmental organisations from the mid 1980s onwards. Psychological professionals maintained that the focus on the priorities of human survival, such as safe water, food and shelter, should not relegate the mental health and well-being of refugees to a position of lesser importance and concern (Marsella et al., 1994). The international aid community, it was argued, has a responsibility to address the psychological and emotional dimensions of the refugee experience. This led to a proliferation of psychosocial projects in conflict zones in the early 1990s, particularly in response to the wars in the former Yugoslavia and the genocide in Rwanda in 1994. Summerfield (1996) notes, for instance, that 185 psychosocial projects were operating in areas of the former Yugoslavia in 1995. The implementation practices of such projects are diverse with some focusing predominantly on providing psychological services, for instance counselling for individuals or groups, while others place more emphasis on social assistance through community development (Strang and Ager, 2001).

The broad range of approaches to providing psychosocial assistance raises questions of definition: are there specific criteria that delineate the realm of psychosocial assistance? Is the term 'psychosocial' a substitute for 'psychological services' or for 'mental health care'? Or
should it encompass all attempts that improve the general well-being of war-affected populations? Ahearn (2000) notes that there is little agreement as to what constitutes the concept as different approaches emphasise various aspects of psychological and social assistance. He argues for linking the notion of ‘psychosocial’ with ‘well-being’ in order to stress that they form part of the general concept of health, defined by the World Health Organisation (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO,1996 in Ahearn, 2000: 4). Common to most definitions of the term ‘psychosocial’ is the idea that a combination of psychological and social factors are responsible for the well-being of people, and that these cannot necessarily be separated out from one another. The term directs attention towards the totality of people’s experience rather than focusing exclusively on the psychological aspects of health and well-being, and emphasises the need to view these issues within the interpersonal contexts of wider family and community networks in which they are located. Ager (2001), for example, describes psychosocial interventions as the integration of social and psychological approaches to the prevention of mental health problems and social difficulties.

The proliferation of psychosocial programmes within the context of international aid to war-affected populations has increasingly come under criticism from scholars and practitioners over recent years (Boyden and Gibbs, 1997; Bracken and Petty, 1998; Summerfield, 1996). They argue that political and historical issues and material conditions are at times neglected at the expense of the focus on psychological and biomedical issues, thereby reflecting a eurocentric modernist agenda instead of the expressed needs of war-affected populations themselves (Bracken et al., 1997). The imposition of a western trauma framework on the suffering and distress experienced by non-western populations has been the focus of much of this criticism as the trauma model is seen as inappropriate in cultural contexts that differ from the ones in which it originates.
The ‘psychosocial industry’, it is argued, has largely ignored the role that culture plays in issues of distress and mental health, instead focusing on interpreting the suffering of people by means of pre-determined psychiatric categories and PTSD symptom checklists (Parker, 1996). A consequence of this is that western treatment and intervention practices tend to use uniform programmes which are implemented regardless of the cultural context within which they work, thereby failing to acknowledge the diversity in expression, understanding and treatments available locally (Adjukovic, 1997). Where attempts have been made to implement culturally sensitive programmes, these have often been guided by the notion that cultural factors are potential barriers to overcome in the provision of psychological services rather than viewing them as resources:

Trauma projects which seek to objectify ‘suffering’ as an entity apart, converting it into a technical problem to which are applied technical solutions like Western talk therapies, are discounting indigenous knowledge, capacities and priorities (Bracken et al., 1997: 441).

Critics maintain that people make sense of their experiences in reference to cultural frameworks and local cosmologies, and their reactions are, to a great extent, influenced by their perceptions of the meaning of those events (Boyden and Gibbs, 1997). The distress and suffering caused by war cannot, therefore, be captured through universal concepts and is instead related to contexts and local cultures. In addition, communities have resources for coping with distress that they draw on in situations of adversity, a fact frequently ignored by psychological professionals who focus more on factors of vulnerability than on people’s resilience and abilities to cope. At times western models of trauma may be in direct opposition to local cultural understandings of distress, or fit poorly with local cosmologies, norms and values (Wessells, 1999). Psychosocial projects have been described by some scholars as ineffective at best, and as having a destructive influence at worst when indigenous efforts to cope with the social and material devastation are overridden and undermined by western “trauma experts” (Richters, 1998).
Some scholars continue to argue that the trauma model is the most appropriate way of conceptualising the effects of war and providing psychological assistance (Danieli et al., 1996), while others call for a complete disengagement of the international aid community from this area of work (Summerfield, 1996). The most commonly expressed position is, however, that psychosocial work needs to engage critically with the concept of culture and with local contexts in order to avoid inappropriate and ineffective programme implementation (Wessells, 1999). This view also suggests that recognition needs to be given to the important role of local healing practices and coping strategies as these are central to strengthening community reconstruction in post-conflict situations. Agencies implement psychosocial programmes in war-affected areas around the world as this continues to be an area of concern to humanitarian agendas. There is thus a need to advance knowledge in this field, specifically in relation to the conceptualisations of distress, suffering and trauma and how these guide implementation practices.

This study seeks to contribute to the current debates about the roles that the notions of trauma and culture play in relation to the alleviation of distress among war-affected populations. Fieldwork was conducted in communities in the south-east of Angola with the aim of examining local understandings of distress and relating these to psychological models used by service providers in the area. The overall objective of the study is to provide further insight into the compatibility between local and ‘outsider’ conceptualisations of war-related distress by investigating points of similarity and difference between them. Greater understanding of such issues will contribute to improving the relevance and appropriateness of psychosocial assistance to war-affected populations.
Overview of the thesis

The thesis begins with a review of the literature in which the theoretical underpinnings of the trauma model and the culture framework are discussed. Chapter 1 outlines the trauma model: its historical roots in the disciplines of psychology and psychiatry, the current issues in the diagnosis and assessment of trauma, and the dominant treatment approaches used in the field. In chapter 2 the cultural perspectives on distress are considered by drawing on medical anthropology and related fields, and by reviewing the literature on culture, distress and mental health. The different positions regarding the relationship between culture and psychiatry, as well as the role of the different sectors of the health care system in the alleviation of distress-related illnesses will be clarified.

Chapter 3 brings together the diverse literature on trauma and culture in order to present an overview of how these concepts have been applied in initiatives to provide psychosocial assistance to war-affected populations. First, the major theoretical positions that have developed in the field will be explained, followed by examples of the practical application of these positions in the form of case examples of actual psychosocial projects. The assumptions guiding the research of this study are then made explicit, and the chapter closes with a presentation of the research questions which the study addresses.

Chapter 4 provides the core background information on the political and socio-economic situation of the displaced in south-eastern Angola where the research was conducted. The chapter ends with a discussion of some aspects of the lived cultural tradition in Angolan communities that not only regulate communal life but are also used as resources in times of difficulty and disruption. Chapter 5 describes the research methodology used in this study, namely ethnography, participatory rapid appraisal (PRA) and a psychometric assessment tool
for assessing symptoms of trauma. In addition, access to the field, issues of language and translation and some of the practical dilemmas encountered during the research process are discussed.

The following four chapters present the findings of the study. Chapter 6 outlines some of the ways in which distress is expressed in the communities studied, and gives an overview of the health care system and the resources provided within its different sectors for coping with the suffering of war. Chapter 7 focuses in more detail on a particular aspect of the local context which was found to have an important influence on issues of health, illness and distress in the communities, namely the religious and spiritual domains. Some of the potential implications of engaging with these factors for psychosocial professionals are explored. Chapter 8 examines the different psychological services available in the war-displaced communities, drawing out common elements in theory and practice. The perspectives of the psychological models employed by service providers are compared to those held by the local populations, and points of similarity and difference are analysed.

The next chapter, chapter 9, investigates how the various paradigms, explanatory models and services that exist in the communities for coping with distress are drawn upon by a particular subgroup of the displaced population, in order to focus in more detail on the factors that influence their utilisation. Adolescents were chosen as a subgroup as they are, by virtue of their age and position in society, a group that is at the forefront of change and transition. The use they make of various resources and coping strategies in their lives is of interest to debates about the appropriateness of the different models.

The concluding chapter 10 draws out some recurrent themes of the findings, and relates these back to the debates raised in the literature review. The findings of the study and their potential
implications for practice as well as for contributing to the ongoing theoretical debate in the field of war-related distress, culture and mental health are discussed.
Chapter 1

Psychiatric and psychological paradigms: the trauma model

The aim of this chapter is to provide a general introduction to the theoretical background to current debates regarding traumatic stress in the disciplines of psychology and psychiatry. The focus of the first part of this chapter is the historical roots of the development of the concept of trauma and the origins of certain accepted core assumptions of the trauma model. This is followed by brief discussions of issues of diagnosis, assessment and treatment of traumatic stress as currently implemented by mental health professionals and researchers.

A note on terminology: the word ‘trauma’ was originally a medical term used to refer not to a physical injury inflicted, but to the blow that inflicted it (Erikson, 1995). In psychological terms trauma should thus refer not to the state of mind that ensues but to the event that provoked it, a distinction which has become blurred. For the purposes of this thesis the terms trauma and ‘traumatic event’ will be used to indicate the precipitating event, and traumatic stress, distress, symptoms or reactions to indicate the consequences which may ensue.

The development of the concept of traumatic stress in the fields of psychiatry and psychology has been influenced by two strands of thought which were current at the turn of the century: the first originated from attempts by medical practitioners to treat soldiers adversely affected by war experiences; and the second arose from the work of Charcot, Freud, Breuer and Janet on hysterical neurosis and traumatic hysteria.
1. Psychiatry: the history of war-related distress

The psychological consequences of trauma have held the attention of the medical profession intermittently over the last century. The history and development of the concept of traumatic stress is intricately linked to warfare: human beings seem to have been emotionally adversely affected by war, armed conflict and violence for as long as these have been in existence (Herman, 1992). The first medical account of ‘nervous shock’ did not come from warfare, however. In the 1830s a phenomenon called the “railway spine” emerged, following incidents of railway accidents where survivors were unable to return to work although it was not possible to detect any physical ailment (Hacking, 1996). According to Young (A., 1996), this marked the point in time when the concepts of shock and ‘trauma’ were extended for the first time to include invisible injuries inflicted on the mind, self and soul, as opposed to designating physical injury only.

The medical profession became interested in the effects of war on soldiers during the American Civil War, some of whom were said to be suffering from neurasthenia, an illness characterised by mental and physical fatigue, weakness and a failure to recover with normal periods of rest and relaxation (Trimble 1981). A second condition was identified during the same war by Jacob Mendes Da Costa, who reported a number of soldiers suffering from an irritable heart and chest pains without an obvious cardiac cause. This condition became known as the Da Costa syndrome (Healey, 1993), and similar conditions were also reported from the Franco-Prussian War of 1870 and the Boer War of 1890 (Healey, 1993).

It was the advent of World War I (WWI), however, that focused medical attention on the psychological consequences of combat. A quarter of a million British soldiers were affected by what came to be known as “shell shock”, a term used to describe a range of symptoms such
as aphasia, loss of sight or hearing, spasmodic convulsions, trembling of limbs, exhaustion, sleep disturbances, depression and nightmares (Leys, 1996). Mott coined the term “shell shock” in 1919 and suggested that the exploding shells caused changes in atmospheric pressure and levels of carbon monoxide which in turn led to a physical lesion of the brain (Trimble, 1981). Others believed that the impact of shells exploding in close vicinity to soldiers resulted in the dissociation and disequilibrium of the delicate mechanism of the nervous system (Marr, 1919).

However, the connection between exploding shells and the symptoms mentioned above was tenuous, and it seemed that the experiences of combat in general were the cause of the disturbances. Myers (1940, in Trimble, 1981), for instance, suggested that ‘psychical’ causes were involved and that these were related to the horrors and fright of war. Many terms used at the time of the two World Wars reflected this thinking, for example combat exhaustion, battle fatigue, acute combat stress reaction, and war neurosis. The system of classifying syndromes on the basis of the aetiology of the accident or event, such as the railway spine, shell shock, barbed wire disease\(^2\), fell into disuse after WWI. Instead, attempts were made to focus on the symptomology as a basis for classification and not the precipitating factors (Kardiner and Spiegel, 1941 in Trimble, 1981).

Reactions to events of World War II (WWII), such as the Nazi concentration camps (Krystal, 1995) and distress caused by combat, were officially given recognition in the first Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1952. Gross Stress Reactions were defined as reactions to severe combat or a civilian catastrophe that may progress to a

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\(^2\) This term was coined by Vischer (1919), a psychiatrist studying the psychological consequences of being a prisoner of war (POW) at the time of WWI. He described the symptoms of barbed wire disease as irritability, depression, moodiness, failure of memory, restlessness, difficulty in concentrating. Vischer refers to the effect of being a POW like “a barbed wire [which] winds like a thread through the mental processes of the prisoner (1919: 3).
neurotic reaction. The second edition of the DSM in 1968 had a fairly insignificant entry under this category and minimised the importance of reactions to distressing events by merely referring to them as "transient situational disturbances". More persistent reactions were presumed to indicate the presence of another disorder (Gerrity and Solomon, 1996). A new diagnosis was, however, included and was called "survivor's syndrome", describing the long-term effects of surviving concentration camps (DSM-II, 1968).

It was only in 1980 that the DSM-III included a diagnosis which accepted that trauma can cause mental illness, i.e. post-traumatic stress disorder (PTSD). This was the direct consequence of the Vietnam War which from the 1970s onwards resulted in relatively large numbers of returning soldiers reporting a range of psychological problems and symptoms (Young, A., 1996). These symptoms included flash-backs to situations which had caused extreme distress, emotional numbing, aggressive behaviour, exaggerated startle responses, sleep disturbances, difficulties with intimate relationships and relating to others, avoidance of situations which may trigger memories of distressing events and occasionally a loss of memory.

The Vietnam veterans attracted public attention through their political organisation, their opposition to the war and through their difficulties in adjusting to civilian life upon their return. Between 1964 and 1975 3.14 million U.S. service people served in Vietnam. A quarter of Vietnam veterans who saw heavy combat were subsequently charged with having committed a criminal offence in the U.S. (Adshead and Mezey, 1997), and problems with alcohol abuse or dependence were frequently reported (Herman, 1992). The National Vietnam Veterans Readjustment Study (NVVRS), conducted in 1987, was a comprehensive study investigating the psychological and social consequences of the Vietnam war for veterans. It used a sample of 3016 service men and women in order to determine the prevalence of PTSD.
in this population. The researchers found that 15.2% of men and 8.5% of women qualified for a diagnosis of PTSD, and an additional 11.1% of men and 7.8% of women are believed to be suffering from partial PTSD (Kulka et al., 1990). These figures were extrapolated to the Vietnam veterans in general and it is now widely accepted that an estimated 15.2% of the veterans suffer from life-long PTSD, meaning that they continue to experience symptoms of trauma consistent with a diagnosis of PTSD throughout their lives (De Girolamo and McFarlane, 1996).

Two important aspects of the development of the concept of trauma in psychiatry must be noted. Firstly, the establishment of PTSD as a diagnostic category in the wake of the Vietnam War was not purely motivated by medical or psychiatric considerations. It also played a substantial role in supporting the pacifist movement, destroying myths of the brave soldier, and highlighting the devastating impact that participating in warfare can have on human beings (Young, 1995). The Vietnam veterans argued, for example, that the phenomenon of PTSD was yet another reason for why the war was untenable and inhuman (Herman, 1992). The official recognition of responses to traumatic incidents thus involved political and social factors that contributed to a moral dimension to psychiatry’s engagement with responses to war, violence, and torture. This original impetus, critics of the trauma model claim, has been largely lost as the process of diagnosing PTSD often results in the depoliticisation of what is essentially a political problem by reconstituting it in the arena of medicine and science (Summerfield, 2001).

Secondly, the inclusion of PTSD in the DSM has to be situated within the broader context of the development of psychiatry as a credible biomedical endeavour. When the American Psychiatric Association (APA) officially adopted a new classification system of mental
disorders in 1980 through the development of the DSM-III, it marked the claim of the psychiatric profession to scientific principles and reliability:

The decision of the APA first to develop DSM-III and then to promulgate its use represents a significant reaffirmation on the part of American psychiatry to its medical identity and its commitment to scientific medicine (Klerman, 1984 in Kirk and Hutchins, 1992: 6).

Kirk and Hutchins (1992) point out that this occurred at a significant point in time because of the need of psychiatrists to reassert themselves as leaders in the mental health field. The growing trend in the mental health field from the 1960s onwards was towards multi-professionalism with widespread competition between psychologists, social workers, nurses, marriage counsellors etc., with the result that mental health issues had become less medical in orientation. In addition, psychiatry occupied a marginal status within the medical profession itself as the ‘non-scientific’ basis for psychotherapeutic theory and treatment was an issue of debate. The development of a new diagnostic system through the publication of DSM-III was thus seen as a way in which a more powerful base for psychiatry could be secured within the jurisdiction of both medicine and mental health (Kirk and Hutchins, 1992).

The publication of the DSM-III had a powerful effect on the mental health field: it rapidly shaped discussion of diagnosis not only in the U.S. but in many parts of the world; it had large sales and was widely used by other mental health professionals apart from psychiatrists. The DSM-III became part of the way in which the psychiatric profession developed an official language about mental disorders and most clinical discourse and psychiatric research started being conducted within its confines or with reference to it (Kirk and Hutchins, 1992). The popularity of the PTSD model of traumatic distress thus forms part of the general trend amongst mental health professionals to make use of the dominant classification approach to mental health, a development predicted, amongst others, by Foucault (1961) in his discussion of the history of madness.
The assumptions of psychiatry in relation to trauma are thus, firstly, that experiences of war lead not only to distress, but may also result in severe forms of psychological disturbances and mental illness. This, it has been claimed, has always been the case throughout the history of humanity but has not always been recognised (Tomb, 1994). Secondly, these illnesses are to be located within the arena of psychiatry and medicine where they can be captured and adequately described through the use of diagnostic manuals such as the DSM. Thirdly, the expertise and influence of medically trained professionals is important in the treatment of traumatic distress. These ‘facts’ continue to dominate discussions about trauma in the field of psychiatry.

The above discussion takes place within the broader context of the growing dominance of the bio-medical model in health-related disciplines (Good, 1994; Hahn, 1995). It is not only the discipline of psychiatry that seeks to justify its’ work by making reference to biomedicine: similar processes occur in almost all spheres of life where health-related problems are experienced and the medical model is used as a ‘gold standard’ by which other health systems are measured (Samson., 1999). The dominance of the biomedical model in understanding health care and treating illnesses has led to a general medicalisation of psychosocial problems, a process whereby an illness is striped of its social, political, religious and moral concerns and is transformed into a physical problem only (Fabrega, 1993). Medicalisation is related to western assumptions about the dualism of mind and body, affect and cognition, individual and society (Swartz, 1998) (see chapter 2).

The general trend towards interpreting psychological and social problems as physical illnesses within the biomedical paradigm is reflected in the popularity of the PTSD model in the west as it provides an explanation for the symptoms and expressions of distress of people who have undergone a traumatic experiences easily understood by the public. In this sense PTSD is a useful and relevant concept in western societies as it is an explanatory model (see chapter 2)
that is understood and broadly accepted by the majority of the population. Caution needs to be exercised, however, in not applying the concept simplistically to large numbers of people without taking into consideration their personal, political and cultural circumstances which vary greatly even amongst populations living in western countries.

2. The psychoanalytic tradition: hysteria and trauma

The second strand of thought that strongly influenced the development of the concept of trauma in the field of psychology is the psychoanalytic tradition based on the work of Charcot, Janet, Freud and Breuer with women suffering from hysteria at the turn of the century (Herman, 1992). The word ‘hysteria’ comes from ancient Greek and was believed to be an illness caused by a ‘wandering uterus’, characterised by symptoms that resembled neurological damage such as motor paralysis, sensory losses, convulsions and amnesia (Leys, 1996).

Charcot, working at the Salpetriere in Paris in the 1870s, demonstrated through the use of hypnosis that these symptoms were psychological in nature as they could be artificially induced, and relieved. His followers such as Pierre Janet and Sigmund Freud sought to demonstrate the cause of hysteria, conducting daily meetings with their patients and spending many hours trying to determine how, where and why the onset of symptoms had occurred. They both reached similar conclusions: hysteria was caused by psychological trauma (Herman, 1992). The somatic symptoms were disguised representations of the distressing events which had been banished from memory. Unbearable emotional reactions to traumatic events thus seemed to produce an altered state of consciousness which in turn induced hysterical
symptoms. Janet called this altered state ‘dissociation’ (Caruth, 1995) and Freud and his colleague, Breuer, (1955) called it ‘double consciousness’.

Freud and Breuer’s work (1955) laid some of the foundations for the psychoanalytic approach to treating survivors of trauma. The concept of repressing into the unconscious images, experiences, thoughts and feelings that are unwanted or overwhelming has informed the work of psychologists to the present day. Repression is often quoted as being evident in the notion that traumatic stress takes the form of a cycle of denial and intrusion (for instance van der Kolk *et al.*, 1996). This is interpreted as the result of defence mechanisms not ‘allowing’ the overwhelming traumatic memory to enter consciousness, but the traumatic images ‘breaking through’ periodically despite this. One explanation given for the typical cycles of intrusion and avoidance is that the event is not experienced fully at the time and cannot therefore be assimilated. The image or event thus repeatedly ‘possesses’ the survivor; as Caruth puts it: “to be traumatised is to be possessed by an image or event” (1995: 5). The original meaning of the word ‘trauma’ in Greek is to wound or to pierce: it is a blow to the tissues of the body that results in injury or disturbance. Freud used the word to imply a breaching of the protective shield which normally prevents overwhelming of the mind (or the ego) from internal and external stimuli (Raphael, 1997).

Another central tenet of Freud and Breuer’s discoveries was that the hysterical symptoms could be alleviated when the traumatic memories and the intense feelings that accompany them were recovered and put into words, i.e. when repression was no longer a necessary defence mechanism. This method is the basis of modern psychotherapy and was called abreaction,

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1 Freud who was initially reluctant to link hysteria with sexuality, came to the conclusion that the nature of the psychological trauma that his patients had experienced was sexual assault, abuse and incest (Freud, 1896 in Herman, 1992). Later he retracted his earlier conclusion and stated that his hysterical patients’ accounts of abuse were untrue and mere fabrications of fantasy.
catharsis or psycho-analysis. It was described by one of Breuer's most famous patients, Anna O., as "the talking cure" (Herman, 1992: 12), and implemented by physicians as early as the 1920s:

The facts seem to indicate that emotion has been pent up in these patients, under strain of attempted self-control, and that liberation of such pent-up emotion (known as abreaction) produces a resolution of the functional symptoms (Brown, 1920, in Leys, 1996: 108).

The significance of this to the area of psychosocial studies should not be underestimated as certain elements of this approach have been incorporated as fundamental assumptions into western discourses on distress and trauma. Of course, many modifications have been made over the last 100 years since Freud's and Breuer's work on hysteria, and other therapeutic traditions have been developed and included in work with survivors of trauma. Hysteria became a rare diagnosis after WWII (Healey, 1993), but new diagnoses such as PTSD, multiple personality disorder (MPD), and other dissociative disorders emerged which are all considered to arise as a result of traumatic stress (Mollon, 1996). The concept of the traumatic memory and the idea that distressing memories have to be recovered and verbalised have remained prevalent in psychological treatment of survivors of war. While few psychologists would now adopt a traditional psychoanalytic approach to therapy, therapeutic methods in many trauma clinics around the world reflect the influence of these ideas (see chapter 3).

The next section focuses on issues related to the diagnosis and assessment of PTSD, and explores two dominant treatment approaches to alleviating distress frequently adopted by mental health professionals in the west.

### 3. Diagnostic issues

According to the DSM-IV (1994), a diagnosis of PTSD can be made if six diagnostic criteria are met [see Appendix A for complete list of diagnostic criteria]. A person has to have been
exposed to a traumatic event where he or she experienced, witnessed or was confronted with actual or threatened death or serious injury of self or others. In addition, the person’s response has to have involved intense fear, helplessness or horror at the time of the event (Criterion A of the disorder). The critical features of PTSD are divided into three sections and are briefly summarised here:

1) persistent re-experiencing of the event through intrusive distressing recollections of the event, dreams, reliving of event through flashbacks, hallucinations etc., distress at internal or external cues that symbolise aspects of the event (Criterion B).

2) persistent avoidance of stimuli associated with the event and numbing of general responsiveness. This can be indicated through efforts to avoid thoughts, feelings and conversations, activities or places which are associated with the event. The inability to recall aspects of the trauma, diminished interest in significant activities, feelings of detachment, a restricted range of affect and a sense of a foreshortened future are other indications of this category of symptoms (Criterion C).

3) persistent symptoms of increased arousal such as difficulties falling asleep, irritability, difficulty concentrating, hypervigilence, or exaggerated startle response (Criterion D).

In order to be able to make a diagnosis one of the possible five symptoms need to be present in the category of Criterion B; three out of the possible seven symptoms in category of Criterion C; and two of the possible five in the category of Criterion D. If one or more of the above outlined categories of symptoms are present for longer than a month (Criterion E), and if the disturbances causes significant distress or impairment in social, occupational, or other areas of functioning (Criterion F), a diagnosis of PTSD should be made.

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4 Exposure to a potentially traumatic event is a risk factor for the development of numerous mental health problems, amongst which PTSD is just one possibility (Newman, et al., 1996). The DSM-IV also provides the option of making a diagnosis of Acute Distress Disorder which lasts from two days to four weeks with onset no more than four weeks after occurrence of the stressor. Other frequently diagnosed disorders are depression, anxiety, chronic dysthymia and dissociative disorders such as MPD, dissociative fugue and dissociative amnesia. Other DSM-IV disorders in which prior exposure to extreme physical or psychological stress appears to be
The second most commonly used diagnostic manual for psychiatric disorders is the International Classification of Diseases (ICD), the official publication of the World Health Organisation (WHO), which is periodically revised in consultation with health officials from many countries. The ICD-10 describes PTSD as a “delayed and / or protracted response to a stressful event or situation” and defines the traumatic event as one that is either short or long-lasting and is of “an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone” (WHO, 1992: 147). The ICD-10 requires intrusive symptomology for a diagnosis of PTSD but sees numbing or avoidance symptoms as frequently occurring symptoms that do not necessarily need to be present in order for a diagnosis to be made. Arousal and avoidance are given less prominence than in the DSM-IV, resulting in higher rates of diagnostic prevalence for PTSD in the ICD-10 than in the DSM-IV (Gerrity and Solomon, 1996).

The diagnostic criteria for PTSD raise a number of questions. Firstly, it is unusual in the DSM to have the aetiological factor (the traumatic event) present as part of the diagnostic category. Controversy surrounds the debate of where to draw the line between traumatic events and painful stressors that constitute the “common vicissitudes of life” such as divorce, failure, rejection, serious illness etc. (Friedman and Marsella, 1996). While one can argue that the first criterion of “threat to life” needs to be present, some scholars feel that the category of PTSD as described in the DSM-IV may still be too inclusive (Caruth, 1995).

instrumental include brief reactive psychosis, conversion disorder, depersonalisation disorder, dream anxiety disorder and antisocial personality disorder (Friedman and Marsella, 1996). Comorbidity may occur and depression, substance abuse, cognitive impairment and the deterioration of physical health (tiredness, gastrointestinal complaints, cardiovascular disorders, for example) may accompany a diagnosis of PTSD (Tomb, 1994).
Secondly, the emphasis placed on the subjective response to the extreme stress (i.e. the person’s response has to involve intense fear, helplessness or horror) has to be seen in relation to the fact that people have varying “trauma thresholds”, and that the subjective appraisal of an event may determine whether the event is perceived as traumatic or merely as difficult (Friedman and Marsella, 1996). Thirdly, no account is taken of situations of prolonged or continuing stress as, for instance, experienced by many war-displaced populations whose lives before, during, and after flight are marked by on-going violence (Parker, 1996). PTSD is based on prototypes of disaster, combat and rape which are viewed as time-limited and circumscribed traumatic events that do not reflect the realities of survivors of prolonged, repeated experiences of trauma (Herman, 1992). This has been one of the strongest criticisms of the application of PTSD to war-affected populations in developing countries as scholars point out that the identification of one or several events as traumatic is non-sensical and inappropriate in situations of continuing stress and extreme discomfort (Bolton, 2001, personal communication).

4. Assessment of PTSD

The basic task of assessing PTSD is establishing the presence of specific symptoms of the disorder. Four common purposes for which PTSD assessment techniques are frequently employed are, firstly, to assess whether or not a diagnosis of PTSD can be made for an individual; secondly, to determine the severity of symptoms; thirdly, to monitor progress made throughout therapy or other interventions; and, fourthly, to screen subjects most likely to be suffering from PTSD and make predictions about the prevalence of PTSD in a population. The level of required detail and confidence in the diagnoses will vary by assessment purpose as different measurements will be used, for instance, for epidemiological surveys as opposed to monitoring progress made throughout therapeutic interventions with a survivor. The assessment of PTSD has usually been undertaken in one of three ways: through the use of structured and
semi-structured diagnostic interviews; through self-report checklists; or by means of empirically derived psychometric measurements (Newman et al., 1996).

Each of these three assessment strategies have advantages and disadvantages, as reviewed in detail by Newman et al. (1996); van der Kolk et al. (1996); and Wilson and Keane (1997). Structured and semi-structured diagnostic interviews are the most common methods of assessing the presence or absence of the diagnostic criteria for PTSD, and may be administered by clinicians or researchers. Examples of these are the SCID (Structured Clinical Interview for the DSM-III-R), the DIS (Diagnostic Interview Schedule) and the PTSD Interview (see Wilson and Keane, 1997). Self-report checklists provide information about how the respondents view their symptoms in a context that is not influenced by direct interaction with the interviewer. Frequently used measures include the PTSD Checklist and the Penn Inventory for Posttraumatic Stress (see Newman et al., 1996). Empirically derived psychometric measures of PTSD are not formally based on the diagnostic criteria for PTSD but document some of the symptoms of trauma and provide thresholds above which the probability of being diagnosed with PTSD can be defined (De Girolamo and McFarlane, 1996). The Impact of Event Scale is one of the most widely used PTSD-related scales and has been applied across several different trauma samples (Horowitz et al., 1979).

Apart from these three forms of assessment for PTSD or PTSD-related symptoms, a number of psychometric instruments have been developed that aim to identify and quantify events as sufficient in nature and scope to satisfy Criterion A of the disorder (Newman et al., 1996). The intensity of exposure, the exposure to multiple stressors and the unique qualitative features of particular stressors have been investigated, and scales such as the Combat Exposure Scale and

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1 Other measures such as the Rorschach Inkblot Test, cognitive and neuropsychological measures have also been used (see Allen, 1994, for an overview of these).
the Harvard Trauma Questionnaire are used to detect and analyse trauma histories (Newman et al., 1996).

Debates about the diagnostic utility of these different techniques (Newman et al., 1996), and about issues of diagnostic sensitivity, validity and reliability (Ager, 2000; De Girolamo and McFarlane, 1996) abound, and will not be reviewed here. Suffice it to point to two contentious issues that have dominated the field in recent years: the first is the focus on vulnerability versus resilience, and the second is the extent to which cultural, social and political factors are taken into account when applying the PTSD model across different populations. In relation to the issue of vulnerability, mental health professionals have tried to examine the reasons for why some people suffer from severe traumatic distress while others cope better (Danieli et al., 1996). Different theories have been proposed, including how the characteristics of the survivor affect the reaction to the event (Danieli et al., 1996; Herman, 1992), how prior psychiatric problems are predictive of persisting symptoms of PTSD (Weisaeth, 1984); the relationship between vulnerability and childhood events (Leys, 1996); causal attributions that survivors make about the event (Janoff-Bulman, 1979; Joseph, 1999a; van der Kolk, 1987); and the theory of the predisposing (neurotic) personality (Williams, 1999).

The common factor in these theories is that they are based on a stressor-strain model of trauma (Ager, 2001) which frequently takes vulnerability rather than resiliency as its starting point. In recent years this has begun to change with more scholars focusing on the mediating factors that prevent survivors from developing psychosocial problems or mental disorder, for example the role of social support (Joseph, 1999b; Majodina, 1995); internal locus of control (Joseph, 1999a; van der Kolk, 1987), internal characteristics of stress-resistant individuals (Flannery, 1987), the role of religious and ideological commitment (Pargament, 1997); and the interaction between survivors and others around them (Williams, 1999). Scholars such as Cairns (1996)
and Boyden (2001) have argued that more attention needs to be paid to the social agency of survivors, be they children or adults, and that, while recognition needs to be given to the suffering and impairment that can result from experiences of violence, the enhancement of the adaptive power of people and their varied survival strategies should form a legitimate focus for psychological research.

The role that cultural factors play in the diagnosis of PTSD has received attention over recent years from psychologists and psychiatrists who seek to assess the applicability and appropriateness of the PTSD model and its assessment techniques to different ethnic groups (see for example Keane et al., 1996; Manson, 1997; Marsella et al., 1996). Attention has focused on the danger of ethnocentrism in applying PTSD models uncritically across different population groups (Eisenbruch, 1992); linguistic and conceptual equivalency in psychometric measurements (Marsella et al., 1996); the differentiation between universal and culture-specific aspects of PTSD, as well as issues of somatisation (Kirmayer, 1996), and culture-specific expressions of emotion (Jenkins, 1996). The purpose of the DSM-IV Outline for Cultural Formulation for diagnosis is discussed in detail by Manson (1997) who points to its potential as a guideline for taking into account the role of the cultural context in the expression and evaluation of symptoms and dysfunction. In addition, the effect that cultural differences may have on the relationship between the clinician and the patient is considered (see also Parson, 1990).

However, while some scholars have paid attention to such issues, these discussions have not substantially altered the way in which the PTSD model is being applied in psychological and psychiatric assessments and research in general. A statement made by a colleague of Manson’s probably adequately summarises the dominant attitude towards these endeavours: “These are interesting issues, but they slow things down” (1997: 261). The opinion expressed suggests that
attempts to make PTSD culturally relevant are regarded as peripheral 'refinements' to the concept but are not considered as relevant to essential core assumptions. Because these attempts are located firmly within the realm of the trauma model they do not pose a challenge to its fundamental premise, i.e. that PTSD is a universal phenomenon that can be identified in all populations.

5. Dominant treatment approaches in psychiatry and psychology

Different conceptual orientations within psychology and psychiatry have led to numerous approaches to treating the effects of traumatic experiences. Within psychiatry this has included psychopharmacological medication to control prolonged central nervous system hyper-reactivity and autonomic nervous system arousal, a treatment regime grounded in a biological model of trauma (Keane et al., 1992). Recently, eye movement desensitisation and reprocessing (EMDR) was developed as a treatment approach by Shapiro (1989, in Smith and Yule, 1999), based on the notion that accelerated processing of disturbing material can be directly facilitated at neurophysiological level by using a variety of dual attention tasks.

In psychology treatment approaches based on particular theories have evolved, each focusing on specific aspects or symptoms of trauma. Behavioural explanations, for example, understand trauma to be the result of conditioning that occurs at the time of the distressing event, linking certain neutral stimuli with negative emotions (van der Veer, 1998). Interventions focus on changing these associations through systematic exposure to feared situations, objects or memories, and through anxiety management techniques (Richards and Lovell, 1999). An approach to preventing the development of PTSD following a distressing event is debriefing,
developed by Mitchell (1983, in Canterbury and Yule 1999), which involves survivors discussing their experiences, thoughts and emotions about the event with a trained counsellor shortly after its occurrence.

Debate surrounds all of the different treatment methods, as scholars argue for and against the effectiveness, appropriateness and the potential for increasing distress rather than decreasing it (for example, in the case of debriefing, see Busuttil and Busuttil, 1997). In order to delineate some of the key elements that inform much of psychosocial practice with survivors of violence and war (see chapter 3), two of the more prominent treatment approaches in psychology, namely cognitive and psychodynamic interventions, will be briefly discussed.

5. 1. Cognitive approaches to treating traumatic distress

Common to all cognitive theories of PTSD is the idea that individuals have sets of pre-existing schemata which help the mind organise new sensory information into pre-existing patterns. The traumatic event cannot be interpreted by past meaning schemata because the intense autonomic activation at the time of the event leads to intense arousal which interferes with proper information processing (van der Kolk and van der Hart, 1995). This in turn causes memories to become fixed. Traumatic memories are thus unassimilated scraps of overwhelming experiences which need to be integrated with existing mental schemata (van der Kolk and van der Hart, 1995).

One of the leading proponents of the cognitive model in trauma therapy is Mardi Horowitz. His formulation of stress response syndromes is derived from classical psychodynamic psychology but is predominantly concerned with the cognitive processing of traumatic information (Horowitz, 1986). The main tenet of his theory is the completion tendency: the psychological
“need to match new information with inner models based on older information and the revision of both until they agree” (Horowitz, 1986: 92). The information overload which occurs at the time of the traumatic event means that thoughts, memories and images of the trauma cannot be reconciled with current meaning structures and there is therefore a failure ‘to complete’. A number of defence mechanism such as denial, numbing, amnesia and detachment come into play to keep the traumatic information in the unconscious. According to Horowitz, the trauma-related information is retained in active memory, however, as the completion tendency demands the merging of new information with pre-existing models. The information ‘breaks through’ the defences in the form of flash-backs, nightmares and unwanted thoughts. This two-phase model of intrusion-repetition and denial-numbing explains the core symptoms of PTSD (Raphael, 1997).

Another conceptualisation of trauma is Janoff-Bulman’s (1992) theory of cognitive appraisal which proposes that PTSD is the result of certain basic assumptions about the self and the world being “shattered”. These beliefs pertain to assumptions of personal invulnerability, the perception of the world as meaningful or comprehensible, and a positive view of the self. They provide structure and meaning in the individual’s life but cannot be maintained in light of the traumatic experience and thus result in confusion and cycles of avoidance and intrusion in a similar manner as described above.

Treatment within the cognitive model of trauma concerns itself with breaking the cycles of intrusion and avoidance through facilitating the assimilation of the unprocessed information about the traumatic event. This can occur by the means of verbalisation within a supportive therapeutic context where the survivor can slowly confront, order and transform the information about the event; or by adapting their world-view and self-image to such an extent that the traumatic experience can be accommodated. Cognitive therapy has been defined as
the application of the cognitive model [to] a particular disorder with the use of a variety of techniques designed to modify the dysfunctional beliefs and faulty information processing characteristics of each disorder (Beck, 1993 in Richards and Lovell, 1999: 244).

It aims to describe the trauma as it was, not as the client sees it (Scott and Stradling, 1992). This is done by educating the client to identify and monitor negative thoughts, beliefs and assumptions; identifying the logical errors contained in these beliefs and finding alternative ways of thinking. Cognitive therapy uses what Richards and Lovell (1999) refer to as “Socratic questioning techniques” and guided self-discovery to help clients investigate whether or not their assumptions can be validated.

5.2. Psychodynamic approaches to treating traumatic stress

The focus here is on the inner conflicts that have arisen as a result of the traumatic experiences and the intra-psychic processing necessary to resolve these. The nature of these inner conflicts varies with the personality structure of the individual, as well as with the characteristics of the traumatic episode, and different interpretations place varying emphasis on their significance. Anxiety, hatred, disgust, shame, helplessness, meaninglessness and despair are some of the emotions that survivors of violence and human rights abuses feel, and against which they employ a range of defence mechanisms as these emotions threaten to overwhelm the individual. Underlying disturbances in personality development, experiences of neglect in primary relationships or unconscious motivations may be seen as compounding factors in the experiences of trauma and may need to be addressed during the treatment intervention (van der Veer, 1998).

A conflict frequently referred to by psychodynamic therapists is that of survivor guilt where a person may feel that he or she did not deserve to live when others died or were injured, or where he or she were forced to participate in atrocities to save their own lives (Bettelheim,
Survivor guilt is sometimes understood in terms of ‘failed enactment’ which refers to an individual’s self-condemnation for having failed to respond because of extreme helplessness in a situation of overpowering threat (Lifton, 1993 in Eastmond, 2000). Levy (1999) describes this conflict as the struggle between the life and the death drive which must be acknowledged and resolved in order for the survivor to continue with his or her life and make peace with the fact of their own survival.

The inner conflicts have to be resolved by confronting the reality of the traumatic experience and expressing the emotions and fears evoked by this, usually verbally but also through the means of art or drama. The articulation and expression of emotions is seen as beneficial to the survivor who no longer employs psychological energy to defend against them and frees him- or herself up to engage with his or her current life situation. The client-therapist relationship is the crucial tool that facilitates this process where the therapist validates the client’s experiences and emotions and encourages him or her to gain insight into the dynamics of his or her responses. The therapeutic relationship typically involves transference and counter-transference processes (Krystal, 1968), which are especially important in the work with survivors of trauma and demand great therapeutic skill on behalf of the therapist (Herman, 1992). The client is provided with the opportunity to ‘renegotiate’ previous relationships with his or her torturers or persecutors, as well as to convey feelings of intense horror, rage, helplessness etc. through the process of projection. The therapist’s role is to facilitate this process and to constantly reflect on the emotional reactions evoked in him- or herself in order to gain greater understanding into the client’s psychological state, thereby improving his or her capacity to provide emotional containment (van der Veer, 1998).

Most therapists distinguish various phases that survivors pass through during the therapeutic process. The ‘outercy’ or opening phase involves the client expressing the traumatic experience
(Bustos, 1992). During this phase the traumatic memories are linked to the symptoms and the corresponding affective states. In the “working through” phase the traumatic episodes become an important part of the person’s experience and the person learns to live with them and integrate them into his or her life (Levy, 1999). By the time the termination phase is reached the client should have gained a satisfactory level of psychological, personal, and social functioning, where he or she will have given new meaning to the traumatic experiences and will start reconstructing new expectations of life. The aim is to “enable our patients to be masters of themselves and their emotions” (Amati, 1976, in Bustos, 1992).

The two approaches discussed here do not represent the full scope of treatment options available, and merely touch upon some aspects of commonly used interventions in the disciplines of psychology and psychiatry (see van der Kolk et al., 1996, and van der Veer, 1998 for more comprehensive overviews). They reflect, however, some of the elements of ‘trauma work’ that characterise interventions with victims of violence and torture both in the west and in developing countries, an issue that will be further explored in chapter 3. While the form that interventions take in situations of large-scale displacement usually differ from the one-to-one therapeutic sessions described here, the notion of ‘working through’ the trauma emotionally and cognitively remains constant.

This chapter has outlined some of the core elements of the trauma discourse: its theoretical foundations in psychiatry and psychology, the debates regarding the diagnosis and assessment of PTSD, as well as some popular treatment approaches. The next chapter presents the perspectives of another paradigm that has substantially influenced debates about war, distress and healing in the last few decades, namely that of medical anthropology, and the contributions it has made to the conceptualisation of war-related distress.

8 Despite these expressed goals of psychotherapy, the notion of psychological damage permeates many psychodynamic discussions of trauma, for example Perren-Klingler’s statement that “There is no healing from trauma. At best one can come to live with the scars” (1996: 26).
Chapter 2

The cultural framework: distress, healing and the health care system

This chapter focuses on the perspectives on distress and suffering from within the fields of medical anthropology and cultural psychology, disciplines which consider culture as central to their investigations. First, a definition of the concept of culture will be given, followed by a discussion of the main theoretical positions in relation to culture and mental health, i.e. universalism, relativism and the critical approaches. Next, the different sectors of health care systems will be briefly outlined, and some of the factors influencing health care seeking behaviour will be described. The final section focuses on issues pertaining specifically to how distress-related illnesses have been investigated within the cultural framework.

1. The concept of culture

The definition of the concept of culture has a significant impact on how the relationship between culture and mental health is understood, and has undergone many changes in the social sciences. Sometimes referred to as the “unknown factor” in mental health (Jablensky et al., 1992 in Swartz, 1998: 205), it was frequently thought to pertain only to the ‘other’, i.e. to non-western societies and communities whose ways of thinking and living were unfamiliar to western social scientists. Western anthropologists and psychologists initially focused on describing behaviours, customs and traditions as a means of identifying differences between

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7 Schwartz describes this as the attitude where “others have culture while we have human nature” (1992: 329).
cultures, thus investigating ‘exotic’ societies and practices in order to render an account of “odd happenings in distant places” (Chakraborty, 1991: 1205).

A shift in thinking occurred in the social sciences in more recent years where culture has not been merely understood as sets of habits and behaviours but as being intricately related to meanings, relationships, ways of feeling, thinking and being in the world (Jenkins, 1996). One of the early influential anthropologists in the discipline, Clifford Geertz, emphasises that culture is a context of dynamic symbols and meanings that people create and recreate for themselves in the process of social interaction (1973). A significant implication of this definition is that it encapsulates all human communities and populations as none are ‘culture-free’. In addition, it implies that culture is not static but dynamic and constantly evolving, a fact underscored by scholars who claim that anthropological myths of pure, contained and homogenous cultures existing in isolation from one another are fabrications (Appadurai, 1988). A second useful definition of culture is that given by Helman (1994) who defines culture as a

set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relations to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation - by the use of symbols, language, art and ritual (p. 2-3)

A central question in psychology and psychiatry has always been how much significance is attached to the issue of culture in studying and understanding the emotional and psychological well-being of people. Three positions have been used to categorise the dominant approaches to issues of culture and mental health.
2. Approaches to culture and mental health

2.1. Universalism

The universalist position assumes that psychic unity exists and that ‘deep down’ all human beings have the same central processing mechanisms which enable them to think, act and experience. Fundamentally, universalists conceive of culture as ‘the icing on the cake’ of human psychological experience and processes: culture is relatively shallow in determining the ways in which individuals respond, as core psychological processes exist and operate independently of culture (Bracken and Petty, 1998, Stigler et al., 1990).

Universalists also assume that mental illnesses are essentially the same across cultures. What differs is merely the way in which illnesses are expressed and how they are labelled (Leff, 1988). Cross-cultural psychiatry, for instance, seeks to demonstrate that the only differences in mental illnesses lie in the content of psychiatric symptoms but that their form is universal:

The division of psychological functioning into an organic substratum and a superimposed, culturally conditioned layer of response and behaviour enables us to understand why the form of psychiatric disorders remains essentially constant throughout the world, irrespective of the cultural context within which the disorders appear. The secondary features of psychiatric illness, such as the content of the delusions and hallucinations, are determined by the pathoplastic or compensatory effects of particular cultures; as such they are different from culture to culture (Kiev, 1972 in Bracken, 1993: 269).

The form / content debate has influenced thinking in psychology and psychiatry for many decades where members of the “old school” of cross-cultural psychiatry have maintained that anthropologists should concern themselves with the cultural content of mental illnesses whereas psychiatrists should focus on their form (Schwartz, 1992). The assumption is that psychiatry, although based on a western nosological model, is applicable the world over. Depression in Japan will thus be the same as depression in Chile with slight variation in the cultural expression of symptoms.
While the idea that one can diagnose and categorise mental illnesses according to one system only is an appealing one, there are fundamental problems with this notion. Criticisms of the universalist position on culture and mental health have focused on three assumptions: firstly, that psychiatry is a scientifically neutral and empiricist undertaking and therefore valid as a nosology; secondly, that the form and content distinction is valid and useful; and, thirdly, that culture is not essential in considerations of mental health. Byron Good suggests that it is difficult for westerners to avoid the strong conviction that their system of medical knowledge reflects the natural order as they believe “that it is a progressive system that has emerged through the cumulative results of experiential efforts, and that our biological categories are natural and descriptive rather than essentially cultural and classificatory” (1994: 3). Western biomedicine and psychiatry have been essentially positivistic and empiricist in their orientation, using the medical model as a ‘gold standard’ by which other health systems are measured (Hahn, 1995; Samson, 1999). The scientific rationality of the medical model is taken as fact devoid of cultural and social influences which results in biomedicine attaining a false sense of legitimacy (Lindenbaum and Lock, 1993).

Medical anthropologists have criticised the cultural naiveté of physicians who have failed to recognise that biomedicine is just one system among many and that its hegemonic claims to success and rationality have not been unequivocally validated. Especially in regard to mental health, scholars have long pointed out that what is viewed as psychologically normal and abnormal varies between societies (Benedict, 1934 in Good, 1994: 32). All forms of medical knowledge are to some extent socially constructed, and medical theories and medical texts are narratives which draw on a wide range of cultural signs and symbols for their effect (Vaughan, 1991). In addition, the imposition of the western psychiatric model ignores and delegitimises other ways of understanding and treating issues of mental health by assuming the superiority of one particular way of seeing these issues.
The validity of the content / form distinction has also been queried, as scholars point out that it is as a theoretical construct which primarily serves the function of delineating areas of research and interest for psychologists and anthropologists. It is not, however, useful for understanding how mental illnesses are experienced and understood by people who suffer from them. Schwartz (1992) points out that culture is never just ‘content’ but has a thoroughly constitutive role in issues of mental health. Cross-cultural psychology and cross-cultural psychiatry’s ambition to undertake ‘culture-free’, ‘culture-fair’ or ‘cross-culturally valid’ testing fails to acknowledge the constitutive role of culture in matters of health which affect the meaning attached to illness, the form of expression, the course of illness, diagnosis and treatment (Kleinman, 1980). Universalists have, of course, acknowledged that mental illnesses are expressed differently in different parts of the world but their emphasis has remained on establishing how these illnesses can be classified according to biomedical criteria.

2.2. Relativism

This is essentially a hermeneutic approach which takes culture as its central focus and tries to understand the illness experiences of people within their specific contexts. The role of the mental health practitioner is to gain as much understanding about the meaning of an illness to the sufferer, in the context of the sufferer’s family, community and spiritual background (Swartz, 1998). A relativist approach, as opposed to universalist one, assumes that health and mental illness cannot be adequately represented, diagnosed or explained within one universal nosology. Relativists often draw on the etic / emic distinction to explain how relativism differs from universalism: an etic approach is one which imposes a way of seeing the world, i.e. a western, biomedical way, on the data observed. Behaviour and illnesses are thus examined from a position outside of the particular social or cultural system studied, and the analyst
creates an analytical structure for making sense of the data. An etic approach allows many
different societies or cultures to be investigated. An emic approach, on the other hand,
emphasises the world-view of the people being observed and studies behaviour and illnesses
from within a cultural or social system. The analytical structure is not imposed by researchers
but a local structure is ‘discovered’ by them. Generally, within an emic approach the focus is
only on one society or culture (Berry et al., 1992).

Arthur Kleinman, a psychiatrist and anthropologist, has been a leading figure in promoting a
relativist understanding of health issues. He developed the concept of explanatory models to
draw attention to the fact that patients and healers may hold different conceptual
understandings of the nature of the illness, its cause, what course it will take and what
treatment would be most appropriate (Kleinman, 1978). Explanatory models are thus “notions
about sickness and its treatment that are employed by all engaged in the clinical process”
(Kleinman, 1980: 105). This relates to the difference between disease and illness:

Disease refers to a malfunctioning of biological and/or psychological processes, while the term illness
refers to the psychosocial experience and meaning of perceived disease... Illness involves processes of
attention, perception, affective response, cognition, and valuation directed at the disease and its
manifestations... also included in the idea of illness are communication and interpersonal interaction,
particularly within the context of family and social network... It is created by personal, social, and
cultural reactions to disease (p. 72).

One of the problems may be that professional healers concentrate on treating the disease
without understanding the patient’s concept of his or her illness which may lead to
misunderstandings and inappropriate and ineffective treatment. Kleinman (1978) points out
that explanatory models are not static entities in societies but undergo constant change; nor
are they necessarily coherent or unambiguous.

A related concept is that of a category fallacy: the ethnocentric imposition of one culture’s
diagnostic system and the tacit beliefs and values it contains on the illness experiences in
another culture, whose indigenous diagnostic categories and beliefs and values may be
The cultural framework

divergent (Kleinman, 1986). This may result in misdiagnosis because the role that culture plays in constituting an illness is ignored, and important information and meaning attached to an illness therefore remains unrecognised. The relativist approach has made a number of other contributions to the field of mental health and culture, for instance drawing attention to the fact that notions of self, emotion and cognition are understood differently in societies and cultures. This has profound implications for psychiatry and psychology’s understanding of self and agency and the emphasis they place on the individual (Kim and Berry, 1993; Nsamenang, 1994; Stigler et al., 1990; White, 1992).

Relativism as an approach to issues of culture and mental health has been criticised on a number of accounts. The biggest potential problem that relativism presents is that it produces insight into micro-issues of mental health but does not address macro-issues, i.e. a lot of information about different healing systems is produced but no overall frame exists into which this can be assimilated. It has been argued that this approach therefore may have limited practical value (see Dilley, 1999, for current debates in this area).

A further problem with a relativist position is the potential for ‘romanticising’ indigenous medical systems and ‘demonising’ biomedicine (Lindenbaum and Lock, 1993; Good, 1994). The juxtapositioning of western and non-western medical system is useful in order to challenge biomedicine’s hegemonic claims and to highlight those qualities of healing which may be absent from the western system. However, as will be seen in the discussion on critical approaches below, other medical systems are not devoid of authority hierarchies and power struggles, ideological and political interest, and they may also have the tendency to reify knowledge as natural and absolute. Nor is it particularly helpful to disengage from biomedicine entirely or to deny the potential benefit that it has. As Bracken (1998) points out:
the western discourse is not necessarily fallacious and mistaken, but it makes sense only within the context of a particular cultural and moral framework.

Another related danger involves relativists falling into a similar trap to that of universalists who look at the 'other' from a eurocentric point of view. Schwartz (1992), for example, takes issue with what Margaret Mead termed the "Yes, but the Eskimo..." approach to culture which focuses predominantly on significant cross-cultural variation and may therefore become another version of studying the 'exoticised other'. In psychology and psychiatry this has often taken the form of the fascination with culture-bound syndromes (CBS). A CBS has been defined as "episodic and dramatic reactions specific to a particular community ... locally identified... consistent over time and embedded for each generation in a continuing cultural tradition" (Littlewood and Lipsedge, 1985 in Chakraborty, 1991). More recently the concept has been the subject of much debate as researchers have attempted to move away from this conceptualisation to a more critical perspective on knowledge construction in psychology and psychiatry.

2.3. Critical approaches

Critical approaches to culture and mental health issues have drawn on the disciplines of medical anthropology, cultural studies and philosophy, amongst others (Swartz, 1998; Good, 1994). Some scholars have maintained that the crucial question in relation to health and medicine is not the cultural construction of disease but its social production, i.e. how political and economic forces are present on global and local levels in health conditions and in medical institutions (Good, 1994). Cultural constructions of illness can be misleading as they look to

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8 It has been argued that the concept of CBS should be discarded entirely as it is a product of western psychiatry which has consistently represented other cultures through a 'western psychiatric gaze' (Swartz, 1998). Littlewood (1996) argues that all psychiatric diagnostic systems are culturally constructed and therefore all mental disorders can be considered as CBS which would in essence render the concept meaningless (in Swartz, 1998).
"strange knowledge, attitudes and behaviours" in explaining issues which are, in fact, related to structural violence and poverty (Farmer, 1997). Issues of concern are the distribution and access to health services, the role of power in health care relationships and social institutions, and inequities responsible for distributions of morbidity and mortality.

Medical anthropologists who work within this perspective attempt to relate historical and macro-societal forces to their ethnographic research on health issues. From a neo-Marxist perspective illness representations are often seen as mystification of underlying relations of power and the hegemony of certain world-views (Scheper-Hughes, 1992). This applies equally to western and other societies as it is vital to investigate whose interests are served within medical processes, for example elites within a society, empowered men, the medical profession or colonial powers. Scheper-Hughes' (1992) study of the folk-diagnostic category of nervos in a Brazilian shantytown concluded, for instance, that rather than being an illness or an expression of distress, nervos is related to the pervasive hunger and poverty that inhabitants of the shantytown are subjected to. A political and social problem - hunger - is thus being treated by all parties involved as a condition of individual bodies ('nerves' or stress), thereby neutralising critical consciousness and overt forms of resistance.

The practice of psychiatry specifically has attracted critical attention for many decades (Fabrega, 1993). It has been argued that psychiatry often reflects social and political attitudes which disempowers those who do not conform (Crossley, 1998). The trend towards the medicalisation and psychologisation of political and social problems has been noted, a process whereby biomedicine and psychiatry have attempted to 'strip' illness of its social, political, religious and moral concerns and render disease as the impersonal essence of an object
(Fabrega, 1993). Both medicalisation and psychologisation are seen as related to western assumptions about dualism of mind and body, affect and cognition, individual and society (Swartz, 1998).

The work of Michel Foucault has been used to analyse power and knowledge relations within medical systems and psychiatry (1961; 1973; 1977). Foucauldian analysts make use of the concepts of ideology and discourse to understand how systems of knowledge are embedded within particular institutional hierarchies and production processes, and how they let these appear as natural and given (Young, 1993). In psychiatry where diagnostic categories are usually reified and accepted as given entities which have an independent existence in reality, it is important to question the dominant status quo which defines forms of suffering as pathologies, as disorders and as “dehistoricised objects in themselves” (Young, 1982 in Good, 1994: 57). Ideology also has the power to render certain forms of knowledge as commonsensical so that ways of understanding health and ill-health are perpetuated by the parties involved. Scholars within the critical tradition see it as their task to constantly question how knowledge becomes accepted as truth.

Critical anthropologists have not only concentrated on pointing out the effects of power, ideology and discourse but have also emphasised points of resistance and ‘fractures’ in the hegemonic order of medicine and psychiatry. One example of such a ‘point of resistance’ are the violent episodes of spirit possession of peasant women on the shop floors of multinational factories in Malaysia (Ong, 1988 in Good, 1994). These episodes which bring production to a halt have been interpreted by Ong as expressing the women’s reactions to demeaning work conditions and to changes in their identity. The critical perspective on illness and health thus promotes awareness of the ways in which illness can be a way of subverting, challenging and pronouncing as unacceptable conditions of life and living.
Critical perspectives have taken issues of culture and mental health beyond the debate of universalism versus relativism by exploring how structures, agendas and interests are relevant to the provision of health care. However, there are some problems with some of these approaches. The relevance of a Foucauldian perspectives on mental health and power/knowledge relations has been questioned, for example, for analysis in countries where power is directly and blatantly repressive (Vaughan, 1991). Nevertheless, these perspectives have raised awareness of the inter-relationship between ideology, discourse, knowledge production and power which are useful analytical tools wherever claims to ‘truths’ are made.

Neo-Marxist scholars have been criticised for their assumption that they can identify the ‘real’ problems of the people they are studying, for instance in Schepers-Hughes’ (1992) study on nervos and hunger in Brazil. This raises questions about the authority of ‘outsiders’ imposing their particular interpretations on situations which may not be shared by the participants, as well as the potential for undermining local perspectives on the realities of their situations. This is an issue that affects all research and draws attention to the need to be aware of relations of power between the people ‘being studied’ and those studying them (Davies, 1999).

Finally, some critical researchers, especially from the discipline of medical anthropology, have a tendency to view biomedical practice as ‘waging war on the poor’: duping the poor with scientific labels and placebo drugs, carrying out medical experiments disguised by lies or silence, serving the interests of the wealthy and powerful (Good, 1994). While all these things occur, are unacceptable and need to be exposed and challenged, biomedicine is not just about antagonism and power abuse:
Medicine is not all war or exploitation, strident claims notwithstanding. It is also a conversation, a dance, a search for significance, the application of simple techniques that save lives and alleviate pain, and a complex technological imagination of immortality. It is a commodity desperately desired and fought for, perhaps even a basic "human right", even as it is a fundamental form of human relating (Good, 1994: 60).

Just as the simplified juxtapositioning of universalist vs. relativist positions is of limited value, the one-sidedness of critical perspectives may be similarly problematic, for instance, if it leads to the making of assumptions on behalf of local populations.

3. Sectors of the health care system

Kleinman (1980) argues that health care activities are part of a system, and suggests that medicine is a cultural system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. He uses Geertz's (1973) definition of a cultural system as a map to illustrate that health care systems too provide 'maps' for understanding the causes of illness and disease and the norms governing the choices and evaluation of treatment. Health care systems are influenced not only by culture but also by historical and economic issues, as well as environmental factors (such as ecological disasters like famine or pollution), local epidemiological patterns of disease and political issues. It is essential to have knowledge of these factors in order to understand the context within which people make decisions regarding their well-being.

Three parts of the health care system have been identified, namely the professional sector, the folk sector and the popular sector (Kleinman, 1980). Although these three parts are often inter-related and not as separate as may be implied, this distinction is maintained here as it is helpful in an analysis of different practices and resources within a local health system. The professional sector refers to organised healing professions which includes practitioners who make use of biomedicine and those who make use of cultural healing practices. In most parts of the world this sector is mostly dominated by western biomedicine, however, and in relation
to mental health may include psychiatry, clinical psychology, occupational therapy, social work and psychiatric nursing (Helman, 2000). In developing countries it is usually primary health care workers and general practitioners who deal with most of the mental health issues in the professional sector, as they have the most contact with patients suffering from all kinds of illnesses and are often most likely to be the only professional medical practitioners in an area (Swartz, 1998).

In some countries indigenous medical systems have always existed as part of the professional sector, for example in Chinese and Indian societies where traditional Chinese medicine and Ayurvedic medicine, respectively, have been practised and have been professionalised along lines similar to those of the modern medical profession (Kleinman, 1980). There are also trends towards increased professionalisation of indigenous healing in some African countries (Last and Chavunduka, 1989). What practices are regarded as professional or not changes over time and is related to the extent to which certain practitioners lobby to have a professional system set up, as was the case with clinical psychology, for instance (Swartz, 1998). It is important to emphasise the flexibility and fluidity of the professional sector in order not to reify certain professions and regard them as ‘cast in stone’, forgetting that they too have evolved and are socially and culturally constructed.

The folk sector is described by Kleinman (1980) as specialist, non-professional and non-bureaucratic. This sector includes ritual healing, traditional surgical and manipulative treatment, herbalism and special exercise. Card reading, astrology, the use of crystals and homeopathy are other examples of this sector. In southern Africa the two major components of the folk sector are indigenous healing and faith healing performed by the African independent churches (Swartz, 1998). A wide variety of indigenous healing practices exist and the process of healing can involve herbal remedies and rituals and dream interpretations
(Pearce, 1993). In many parts of the world religious healing is practised, for example in Pentecostal churches and in Catholic Charismatic churches (see Csordas, 1994, for an ethnographic description of healing practices in Catholic churches in the U.S.). African independent churches often use a combination of Christian beliefs and indigenous practices, although varying status and importance may be accorded to the various religious aspects in the different churches (Mbiti, 1989).

Kleinman maintains that folk medicine serves a significant function in many parts of the world: new forms of "folk psychotherapies", alternative medicines in the west and an increase in folk healers in some developing countries, indicate this (1980: 60). This view is not shared by modernisation theorists who suggest that world-wide trends towards urbanisation, modernisation and secularisation may make traditional healing obsolete and irrelevant to their potential participants (Draguns, 1996). Practices of the folk sector are equated with 'belief systems' and these are unfavourably compared with the 'scientific knowledge' of biomedicine. Draguns' (1996) comments are thus typical of studies that are conducted according to the following pattern:

... traditional medical culture is routinely analysed as a set of beliefs, explicitly or implicitly juxtaposed to medical knowledge, and a central question for the research is how "traditional medical beliefs" (which are obviously false) can hold out in the face of biomedicine's efficacy and claims to rationality (Good, 1994: 40).

Good (1994) points out the problems with this approach: firstly, disease is taken to be a natural object separate from human consciousness which can only be correctly represented through the biosciences. Secondly, culture is perceived exclusively in utilitarian terms and each medical system is judged according to how successful it is in curing disease. This view is incompatible with the one outlined above which emphasises the cultural and social construction of all aspects of the different medical systems, recognising that utilitarianism is not the only motivating factor in people's understanding of illness. Kleinman (1978) suggests,
for example, that demonstrable empirical efficiency is not purely nor sometimes the most important factor in evaluating a medical system: social and cultural factors, the communicative models employed and the system of health values may be used as evaluation criteria. A third argument against the modernisation view of the health care system is that there is an implicit belief that indigenous healing is fundamentally irrational. Swartz (1998) points out that this is not so as many studies show that rationality plays an important part in decision-making and treatment in indigenous healing (see also Pedersen et al., 1984).

The modernist argument that folk medicine will disappear with time does not seem to holding true. Vaughan (1991) maintains that African healing systems, for example, have shown themselves remarkably resilient and adaptive and are not destroyed despite the “joint assault of colonialism and biomedicine” (p. 23) but instead sought to absorb and indigenise those elements of biomedical practice which seemed most effective and impressive. In this, Vaughan asserts, the continuities of African ideas about health and healing are more remarkable than the fractures which have occurred.

The third sector is the popular sector. This sector refers to the lay, non-professional, non-specialist popular culture arena where illnesses are first noted and health care activities initiated (Kleinman, 1980). It consists of informal and unpaid healing relationships, of variable duration, which occur within the sufferer’s social network of individuals, families, neighbours, and community members (Helman, 2000). Numerous studies have shown that when people become ill or distressed they usually turn first towards those around them for help (Nichter, 1992; Rubel and Hass, 1996; Williams and Popay, 1994). People may give advice on changes in diet or lifestyle, may suggest certain medicines or remedies, or may relate old ‘home truths’ about how to cure certain illnesses. Pearce (1993) points out that in Nigeria home remedies may also be developed on the basis of dreams, visions and knowledge
of others. Often there are contradictory opinions and approaches to any illness. Consider Herodotus’ account of how the Babylonians dealt with illness:

They have no physician, but when a man is ill, they lay him in the public square, and the passers-by go up to him, and if they had ever had this disease themselves or know anyone who has suffered from it, they give him advice, recommending him to do whatever they have found good in their own case, or in the case known to them, and no one is allowed to pass the sick man in silence without asking what his ailment is (Lewis, 1993: 215).

This example illustrates that medical systems have not always been present in their current form and that radically different ways of conceiving diagnosis and treatment have existed throughout history. It also points to the potential power of lay experience in dealing with illnesses, reflected on a daily basis in comments to people suffering from an illness others have experience of (“I had that and I used / did .... and it worked”). The example demonstrates the acceptance amongst the population that non-professional knowledge of health and illness is valid and useful. An important component of the popular sector in many countries are self-help groups where members’ experiences, rather than education or social status, qualify them to participate as they are able to provide an insider perspective on illness which an ‘outsider’ health professional may not have (Helman, 2000).

The popular sector constitutes the largest part of any health care system and is, according to Kleinman, the least studied and the most poorly understood. An estimated 70 to 90 percent of all illness episodes in the U.S. are dealt with within the popular sector, with a similar figure estimated in Taiwan (Kleinman, 1980). It is within the popular sector that lay people activate their health care by deciding when and whom to consult, whether or not to comply, when to switch to alternatives and whether the care is effective and they are satisfied with its quality. In many parts of the world family members are directly involved in medical activities, for example in the choice of health care provider, in the performance of rituals, the preparation of medications, assistance with paying, and visiting the patient (Pearce, 1993). The popular

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9 Women in particular may depend on others to make decisions about health care and may have limited say about the choices made (Lewis and Kieffer, 1994).
sector usually overlaps with other parts of the health system when decisions are made to seek help beyond the health care boundaries of the family.

3.1. Decision-making in health care

The three parts of a medical system are not as separate as implied here, nor are their ‘boundaries’ always clear and decisive. Mental health professionals often construct interdisciplinary boundaries that are meaningless to patients seeking solutions for problems which cannot be neatly divided into distinct categories (Swartz, 1998). Recent writing on decision-making in health care have pointed to the pragmatism and flexibility with which people draw on various sectors of health care available to them (Helman, 2000; Pedersen et al., 1984). Many different aspects of their environment and daily lives are used to construct medical truths, and often several treatment approaches are used simultaneously (Kleinman, 1980). Indeed, the use of multiple healing systems is the norm in most parts of the world, a fact which is not necessarily seen in terms of conflict, contradiction or confrontation, as sufferers may seek to ensure ‘multiple insurance’ for recovering their health from a variety of sources (Swartz, 1998).

Explanatory models held about certain illnesses are considered to be a primary motivating force in health care decision-making as the strengths and weaknesses of each sector are evaluated by the people making use of them. Peace (1993) gives an example of this in West Africa where people consider biomedicine to be effective for surgical problems, accidents, aches and pains; and indigenous medicine and faith healing for problems of the mind, sleeplessness, bad dreams and mental disorders. Other factors that play important roles in decision-making about health care are accessibility, availability of health care options and economic factors (Helman, 2000).
Studies suggest that people engage actively in choices of treatment systems even while they suffer the very real limitations that poverty, displacements, war and political oppression impose on populations (Eastmond, 2000). The relationships between health care provision and demands are reciprocal and populations can influence the development of each type of medicine by the demands they make on it (Pearce, 1993). It is also important to be aware that healing systems are not static but undergo constant change, develop, and incorporate new elements on an on-going basis.

It has increasingly been acknowledged that biomedicine has limitations and short-comings (Lewis, 1993). Some medical anthropologists juxtapose biomedicine and non-western medicine and conclude that biomedicine fares worse to the extent that other healing systems have qualities which are increasingly absent from biomedicine, such as the “caring, consoling and comforting” qualities of health care (Pearce, 1993). While an attitude of respect for other health systems is essential, it is equally important, however, to maintain a critical approach that interrogates the contributions as well as the short-comings of each approach (Farmer, 1997; Kleinman, 1980; Swartz, 1998). It cannot be assumed that indigenous healers are automatically more in touch with their clients than western-trained professionals, nor that because a practice is culturally acceptable to a client that the treatment is therefore always helpful for him or her. Just because a patient and a healer share the same cultural background, does not imply that they will necessarily agree on the cause and treatment of an illness (Ensink and Robertson, 1999).

Damage can be done by supporting diversity in health approaches for diversity’s sake or for ‘political correctness’ without assessing what is helpful for people (Farmer, 1997). The potential for conflict, power imbalances and struggles, and the reification of knowledge as
natural and as truth are all given in indigenous healing practices as well as in biomedical systems. It would be naïve to assume that any health care system is devoid of personal and political interests. Attention also needs to be paid to how competition for clients between and within the different sectors affects the provision of health care, as the relationships between different sectors can be conflictual.

4. Perspectives on distress and mental health

Issues of distress following events such as war, violent displacement and torture have usually not been conceptualised as trauma within a cultural framework. Instead, attention has focused on local expressions of distress and their explanatory models; the healing resources available for treating distress-related illnesses in the folk and popular sectors; and the role of indigenous healers in mental health provisions in general. The literature in this area is extensive, and scholars such as Helman (2000), MacLachlan (1997), Swartz (1998) and Pedersen et al. (1984) provide overviews of relevant studies.

Scholars and medical professionals have found that a common expression of distress in all parts of the world\(^\text{10}\) is somatisation, a concept which Helman (1994) defines as “the cultural patterning of psychological disorders into a ‘language of distress’ of mainly physical symptoms and signs” (p. 267). Debate surrounds such definitions which are rooted in western ideas of mind-body dualism: distress must be either physical (real) or psychological (imaginary) (Kirmayer, 1996). Practitioners who hold this view of somatisation may believe that the bodily experience of distress is characteristic of unsophisticated patients and that more ‘sophisticated’ patients will be able to distinguish more clearly, or have more insight, into what is physical and what is psychological about their illness (Swartz, 1998). Such a view

\(^{10}\) Kirmayer (1996) notes, for instance, that 25% of all patients in North America present with somatic symptoms.
is problematic not only because it is an imposition of westerns ideas about mind-body dualism on other cultures, but also because it may be influenced by beliefs about education, class, ‘race’\textsuperscript{11} and sophistication.

Common ‘symptoms’ of somatisation have been characterised as vague aches and pains, headaches, palpitations, dizziness and weight loss (Helman, 2000). Kleinman suggests that somatisation should not be used as a diagnostic category nor as a label: “it is not so much a substitution for something more basic as it is a basic way of being in the world” (1995, in Swartz, 1998). He argues that many other cultures do not make the same distinction between physical and emotional distress, and the notion that one has to find the ‘real’ cause of distress is inappropriate. Instead, somatisation may be a normative way of expressing distress within a culture where everybody understands the symptoms of the illness and where somatic symptoms may convey a wide range of personal and social concerns. Kleinman (1986) defines somatisation as the normative expression of personal and social distress in an idiom of bodily complaints and medical help-seeking. Somatic symptoms can thus be a “language of loss and mourning” (Jenkins, 1991: 153) as well as the embodied way in which distress is experienced.

The term “idioms of distress” (Nichter, 1981 in Good, 1994) has been used to refer to modes of explanation and metaphoric expression that are used in many different ways to explain, comment and adapt to a wide range of problems (Kirmayer, 1996). These idioms are not syndromes in the sense that they are fixed or highly correlated clusters of co-occurring symptoms but rather folk categories which are commonly understood within specific populations. People use somatic symptoms or talk of bodily symptoms as idioms of distress in order to draw attention to and allow others to metaphorically comment on the nature of their

\textsuperscript{11} The word ‘race’ is put into inverted commas to indicate that it is a construct which was created through the political interests of physical and social scientists rather than as an entity that exists ‘out there’ in reality (Eyber et
quandaries (Kirmayer, 1996). Idioms of distress are not to be equated with what previously
known as CBS and is now sometimes referred to as culture-specific symptoms: some culture-
specific symptoms may be idioms of distress (for example amok\textsuperscript{12}), but others may be
illnesses which explain a variety of symptoms (for instance dhat\textsuperscript{13}) (MacLachlan, 1997).

An example which illustrates both the terms somatisation and idioms of distress is that of
‘nerves’. This term is used in many parts of the world and is described in terms of bodily pain
and emotions: headaches, insomnia, fatigue, poor appetite, stomach cramps, restlessness,
lameness in the legs, as well as feelings of sadness, weepiness, tension, anxiety and feeling
hysterical (Jenkins, 1991; Lock, 1990; Schepers-Hughes, 1992). In South America nervios can
also be accompanied by bouts of uncontrollable shouting and crying (Kirmayer, 1996). Within
a biomedical or psychiatric framework nerves would be considered a form of somatisation in
the sense that the ‘real’ underlying problem is either organic (perhaps a stomach ulcer), or
psychological (perhaps depression). Such a diagnosis would ‘lose’ not only one half of the
symptoms (either the physical or the emotional), but also the meaning that this idiom of
distress conveys. In a study of nerves in a South African village respondents associated nerves
with poor economic conditions, worries, bad feelings and interpersonal conflict (Rogers, 1992
in Swartz, 1998). The illness has also been linked to political and domestic violence,
oppression and exploitation (Lock, 1990), indications that people make use of their bodies in
order to communicate their suffering in attempts to change and improve their lives. Jenkins
(1996) points out that nervios refers at once to matters of mind, body and spirit and that it
therefore does not make good cultural sense in relation to mind-body dualism. No one

\textsuperscript{12} Amok refers to violent and aggressive behaviour which may follow a severe disappointment. The person usually
acts in some state of dissociation and does not recall what has happened.

\textsuperscript{13} Dhat is related to the belief in Ayurvedic theory which holds that vital essence (dhatu) is highly concentrated in
the blood and semen. Symptoms such as fatigue and weakness are seen to be related to excessive semen loss.
explanation can ever adequately convey the multiple meanings and interpretations that an illness like nerves communicates (Swartz, 1998).

Within a cultural framework expressions of distress accompanying experiences of violent conflict have been predominantly studied from a relativist perspective rather than from within a universalist paradigm. The spiritual and supernatural dimensions of many mental illnesses and expressions of distress in different parts of the world, for example the involvement of witchcraft or disturbances caused by vengeful spirits, have often been highlighted in such studies (see for instance Reynolds, 1996). The relationship of psychiatry and psychology to local explanatory models has received attention, especially in regard to the potential for category fallacies to occur when western nosological models are applied uncritically to idioms of distress and forms of somatisation (Ben-Tovim, 1987; de Jong, 1987; Good, 1994; Littlewood and Dein, 2000).

Finally, countless anthropological studies of indigenous healing practices have been conducted (see for instance Clifford, 1984 on Tibetan Buddhist medicine; Englund, 1998, on Mozambican healing rituals; Greeenway, 1998, on healing amongst the Quechua in the Peruvian Andes; Manson et al., 1996, on the sweat lodge purification of the Navajo; etc.). Recognition has increasingly be given to the value of indigenous healing practices in relation to distress. The World Mental Health Report points out that studies have been consistent in their findings

... that folk and shamanic healers are generally effective in alleviating malaise spawned by psychological and social distress. Many healers are charismatic and draw on culturally sanctioned healing rituals that radiate power, inspire confidence, and attend to their clients’ experience. Many are successful in remoralising their clients, giving the sufferers and families a sense of control over their illness, and providing great benefit to certain classes of patients.... Data are available for some societies on the types of patients for which certain indigenous healers are most successful, and we know that healers often engender greater satisfaction than physicians or mental health workers or psychiatric facilities (Desjarlais et al., 1995: 54).
The positive significance and value that the healers have in societies severely disrupted by violent conflict have been studied by Honwana (1997), Nordstrom (1997), Reynolds (1996), and Wessells (1999), amongst others. They have pointed to the creative ways in which healers engage with the problems facing communities affected by war. Nordstrom, discussing healers in Mozambique, suggests that

Curandeiros helped people reconstitute their worlds in the most profound of ways. The success was in part due to the fact that traditional healing combines individual and collective resources - cultural wisdom applied by individuals to meet specific circumstances, flexible, fluid, enduring - a tradition dedicated to healing, protection, and re-creation at all levels of socio-cultural life (1997: 209).

Resources within the folk and popular sectors of the health care system are routinely mobilised for dealing with distress-related illnesses in societies marked by war and displacement.

This chapter has presented a brief overview of some of the dominant concerns within a cultural perspectives on issues of distress and healing. While both the trauma model and the cultural framework have as their main aim the alleviation of distress, their approaches differ substantially from one another on a number of dimensions. The following chapter aims to analyse the way in which these two paradigms, the trauma model outlined in the previous chapter and the perspectives in the present chapter, have been applied in theory and practice to the area of psychosocial assistance to war-affected populations.
Chapter 3

War, trauma and culture: Implications for theory and practice

In this chapter the diverse literature on traumatic stress (chapter 1) and on the role of culture in healing (chapter 2) will be drawn together in order to analyse the ways in which they have influenced psychosocial work with war-affected populations in developing countries. This will be done, firstly, by considering the various theoretical positions developed in this area and, secondly, by focusing on the way in which they have influenced practice in the field of psychosocial assistance. This will be followed by a clarification of the theoretical assumptions which guide the research conducted in this study, and will conclude with the research questions which the study addresses.

1. Five theoretical positions

Recent debates in the area of psychosocial work with war-affected populations have increasingly questioned the relevance and appropriateness of the trauma model to societies in the south and in eastern Europe (Bracken and Petty, 1998; Summerfield, 1996, 2001; Zarowsky, 2000). The assumption of universal psychological processes which can be found in all societies, the Cartesian division between mind and body and the relevance of ‘talk’ and other forms of therapy are some of the problematic issues that scholars have identified. Local strategies and healing systems which seek to assist people affected by the suffering and disruption of war have received attention (Honwana, 1997; Peddle et al., 1999; Nordstrom,
1997; Reynolds, 1996), and it has been argued that different societies and groups have their own ways of assisting those affected by war and violence based on their world-views, cultural and religious beliefs. Questions have thus arisen regarding the compatibility of ‘outsider’ and ‘insider’ approaches to alleviating distress.

While this debate has become polarised in certain sectors (Summerfield, 2001; Agger, 2001), the two approaches are not as diametrically opposed as it may appear. For example, the acknowledgement of the relevance and importance of culture in understanding the impact of war, violence and displacement on people has become standard (see for instance Peltzer, 1996; Perren-Klingler, 1996; van der Veer, 1998). There are virtually no practitioners nor theorists in the field who fail to make reference to the fact that trauma needs to be understood within the specific cultural context in which people live. Many authors also point to the need to incorporate forms of indigenous healing practices into psychosocial programmes for war-affected communities (Nader et al., 1999; Tolfree, 1996). However, the role that culture and indigenous healing play in the analysis of needs, ‘treatment’ approaches and perspectives varies greatly, as will be shown below.

In order to develop a critical position on these debates it is necessary to pay careful attention to the way in which people use and define notions of war, trauma, suffering and mental health. All of these concepts are used in different ways by theorists and practitioners and various positions and arguments may therefore be developed in regard to different entities. As outlined in chapter 1, the word trauma implies a history of psychological as well as psychiatric knowledge related to an understanding of the effects of violence and war as described, amongst other things, by symptoms of PTSD. The word suffering is sometimes used to emphasise that the effects of war are serious wounds to the body and spirit which occur and are experienced within the contexts of specific religious, political, economic and historical
situations (Kleinman and Kleinman, 1991). The different terms indicate various ways in which the impact of war is conceptualised by theorists, for example as medical or technical problems to be solved, or as human experience which spans many aspects of people’s lives. The term most frequently used in this study is distress, based on the definition given in the Oxford English Dictionary (1989) which defines distress as “the sore pressure or strain of adversity, trouble, sickness, pain or sorrow; anguish or affliction affecting the body, spirit, or community” [emphasis added].

The terms ‘war’ and ‘violence’ may also have varying meaning and significance to different people. For many groups war is part of social experience and is embedded in social life and may therefore not be an exceptional horror but a continuing and long-term hardship which may become part of daily living (Davis, 1992). Western mental health professionals may believe that war constitutes a more traumatic event than surviving poverty and fighting for daily survival, but this may not reflect the priorities of the people themselves. Summerfield points out that

we should not assume that the stresses of war are necessarily discontinuous with those arising from other sources of social destabilisation, including endemic poverty (1996:5).

In a similar vein, assumptions made by professionals about which events are traumatic and which are not, are to be questioned. This is illustrated by an example from a South African township where some women had been offered psychological support when their homes had been destroyed in violence during the anti-apartheid struggle (Swartz and Levett, 1989). The women who had been living in deprived circumstances for a long time, were highly sceptical and critical of this offer and asked why these services were being offered only now that they had no homes and whether these services would be withdrawn once they had rebuilt them. Within the context of these women’s lives it made little sense to isolate a specific incident (the loss of their houses) as requiring psychological support when most of their lives consisted
of struggle for survival and living through violence and poverty. Assumptions about the impact and significance of violent events cannot be made in absolutist terms, and attention needs to be paid to how terms and definitions are used when discussing war, trauma and distress. The main positions in regard to these issues will now be briefly outlined.

**Position 1: Traumatic distress and PTSD are universal**

This orientation argues that the effects of trauma are universal and are encapsulated within the diagnostic category of PTSD as described in the DSM. Advocates of this position base their reasoning on a number of claims:

1) All psychiatric illness can be found cross-culturally and the same applies to PTSD (Leff, 1988).

2) PTSD has always existed throughout history and evidence for this can be found in descriptions of people’s reactions to traumatic events in the past such as the Great Fire of London in 1666 (Young, 1995) and shell shock in World War I (Trimble, 1981). It is only recently, however, that PTSD has been formally recognised as a psychiatric illness, i.e. it has been re-discovered (Herman, 1992).

3) There are a number of universal biological responses to traumatic events that occur regardless of ethnic background, for example autonomic nervous system arousal (Keane et al., 1992).

4) Studies have proven that variations in symptoms exist between different ethnic groups but that these are negligible in light of the main categories of symptoms of PTSD (Danieli et al., 1996).

5) The existence of a traumatic memory (see chapter 1) is assumed to be fact and to affect all individuals irrespective of their cultural background (van der Kolk et al., 1996).
Proponents of the universal position usually base their claims on the validity of scientific research which indicates that these symptoms occur in all populations affected by distressing events (Danieli et al., 1996). They also refer to the practical need for epidemiological studies that are able to predict prevalence rates of PTSD in order to be able to provide treatment and assistance. This position has remained dominant in the area of research into the effects of war on populations, but less so in intervention approaches (see below).

The assumption that traumatic stress is a universal phenomenon has been criticised on a number of levels, some of which have been outlined in chapter 2 in relation to general psychiatric classifications in the mental health field. Specifically, the ‘translation’ of suffering into trauma by medical professionals, who are usually outsiders to a community, has been questioned as scholars point out that in this process the local meanings attached to the experiences and to the ‘symptoms’ are lost and transposed into something which is familiar to western-trained practitioners but not to local people (Boyden and Gibbs, 1997). The implications of the trauma model for practice have come under critique, as it of necessity positions medically trained staff as ‘experts’ and subjects who can treat and cure trauma, as opposed to the victims whose role is to receive the treatment provided (Bracken, 1998). The universalist position has also been criticised for its narrow focus on ‘symptoms’, thereby ignoring and being blinded to various other forms in which distress is expressed in populations, including forms of somatisation, spiritual and religious concerns and idioms of distress.

**Position 2: Culture as a ‘variable’**

Proponents of this view see culture as an ‘extraneous variable’ that needs to be acknowledged and worked with as local culture will affect some of the ways in which symptoms of trauma
are expressed (van der Veer, 1998). Cultural variation may occur in the content of symptoms but it does not affect their form, for example the symptom of nightmares following a traumatic event will be universal but the content of the dreams will be different. Form is judged to be of utmost importance and content is secondary. The western diagnostic system is thus seen as valid and applicable but “caution should be exercised in the application of [DSM] diagnostic criteria to assure that their use is culturally valid. It is important that the clinician not employ [DSM] in a mechanical fashion, insensitive to differences in language, values, behavioural norms, and idiomatic expressions of distress” (DSM-III-R, 1987).

There is some fluidity in this position depending on how much emphasis authors place on the universal vs. the culture-specific aspects. Most authors acknowledge that culture does have some effect on how people experience distress but that this generally remains on a relatively superficial level. Some scholars maintain that PTSD is a comprehensive and valid diagnostic category that applies across time, history and place and at the same time propose that culture is an important variant in the way in which PTSD is expressed Marsella et al (1996) fall into this category: they suggest that PTSD encompasses both universal and culture-specific responses but that PTSD is not the only transcultural conceptualisation of the psychosocial impact of war on all populations. Somatisation and dissociation are mentioned by them as two other frequent expressions in non-western cultures. Nevertheless, Marsella et al. (1996) assert that PTSD is a clinically meaningful diagnosis because there are universal responses to trauma, and that there is no “ethnocultural cohort” where this diagnosis has not been made.

In reality this position often means that culture is regarded as peripheral to understanding distress and suffering instead of as central to the experience, expression and meaning attached to distressing events by war-affected populations. The aim of its advocates is to improve the culture-sensitive application of PTSD rather than take into account the criticisms directed at
its fundamental assumptions. Criticism of this approach has focused on the fact that local practices and beliefs are understood not in their own terms but are interpreted through a western psychiatric / psychological lens, thereby failing to recognise, amongst other things, the possible incompatibility between various approaches and beliefs about dealing with distressing experiences and events.

**Position 3: Relativism**

The tenet of this position is that psychological concepts about trauma and responses to it are strongly influenced by social and cultural ideas which change over different historical time periods (Young, 1995). Scholars within this position suggest that PTSD and the concept of traumatic stress are historical constructs which are glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented by various interests, institutions, and moral arguments that mobilised these efforts and resources (Young, 1995: 5).

The trauma discourse and PTSD are thus a particular ‘western’ version which describes how people are affected by war - many other versions exist. PTSD makes sense only within a western psychiatric context for people who are part of that cultural orientation, as it originates from a specific ethnocentric understanding of health which prescribes how war-affected persons express their distress, how disorders should be classified and how distress should be ameliorated (Eisenbruch, 1992). Even the nature of physical symptoms cannot be assumed to be universal as they vary cross-culturally, evident in the existence of local idioms of distress and different forms of somatisation. The different systems and ways of understanding the effects of war, distress and mental health are fundamental to the meaning which people attach to what has happened to them. Dawes and Cairns (1998) make the point that proponents of the universalist position often ignore the existence of local knowledge and understandings of how to deal with distress:

... if Britain were to be involved in a war, it would be most unlikely for psychological aid for British children to be sought from Cambodian or African indigenous healers. Indeed if they
volunteered their services, there would probably not be too many takers among the British healers. But mental health aid in the reverse direction is taken for granted, as though locals in these countries do not have the knowledge to deal with victims of war on their own terms (p. 342).

There are two major implications of the relativist position: firstly, that local strategies of dealing with suffering exist and should be used and encouraged; and, secondly, that western psychological knowledge may be of no relevance to societies or groups in the south. The first notion implies that local understandings and cultural practices regarding the nature of emotional suffering, the causes and mediation of mental distress and community support given to people who are distressed need to be taken as a starting point for any assistance given to communities (Wessells, 1999). As pointed out in the previous chapter, the Cartesian division of mind and body as practised in biomedicine and psychology in the west is seen as inappropriate in most societies where social, spiritual, emotional and physical dimensions of life are seen as intricately connected (Honwana, 1997; Kleinman et al., 1997; Swartz, 1998;).

A second implication of the relativist position may be that western knowledge of trauma is seen as being of no relevance at all to non-western societies. The western discourse makes sense only within the context of that particular cultural and moral framework and should not be ‘exported’ to other societies. Bracken (1993), for example, maintains that one form of life cannot be explained in terms of another, i.e. PTSD and the western trauma discourse cannot express the experiences of people from other cultures. One of the reasons for this is that psychology tends to focus predominantly on individuals and intra-psychic processes which may be inappropriate in other cultures. Summerfield (1996) suggests that the ‘psycho’ part of ‘psychosocial’ should thus be removed as

the prefix ‘psycho-’ in psychosocial projects has fostered basic misconceptions and diverted us from the collective focus required. We must look to the pivotal role of the social world, invariably targeted in today’s ‘total’ war and yet still embodying the capacity of survivor populations to manage their suffering, endure and adapt (p. 14).
Issues of distress and suffering caused by war are seen as falling into the realm of social, material, economic, religious, political and spiritual concerns, as opposed to psychiatric and psychological spheres.

Position 4: Integration of ‘insider’ and ‘outsider’ approaches

A less absolutist position suggests that an engagement between western and local systems is inevitable and can be productive. The opinion has been expressed that “either/or” thinking which portrays western approaches as flawed, irrelevant and harmful is not helpful, as more flexibility and creativity is required in assessing which elements and aspects of different approaches can be used (Parson, 1996). Similarly, it cannot always be assumed that people belonging to a certain group or society will necessarily always believe in or choose to engage in the indigenous practices of their community (Swartz, 1998). It has thus been suggested that an integrated approach based on careful evaluation of the appropriateness and usefulness of various practices and approaches may be most helpful (Eisenbruch, 1992).

There are various ways in which people have attempted to integrate indigenous approaches to healing and western psychological knowledge. This ranges for example from facilitating purification rituals in a therapeutic context (for example Junior, 1996; Straker, 1994), combining African medicine, religious beliefs and biomedical approaches in various healing contexts (Ben-Tovim, 1987), and understanding and treating somatic complaints and mental illnesses as part of a primary health care system (de Jong, 1987). It may also be necessary to make use of different approaches at different times of providing assistance. Ager (1997) suggests a phased response where the first and second phases focus on keeping intact, or reinstituting protective influences within communities through maintaining and enhancing
community structures, meanings and networks. While this should be the overall long-term strategy on a community level, Ager asserts that this may be insufficient for some especially affected or vulnerable groups who may benefit from the provision of compensatory support. In a fourth suggested phase targeted therapeutic interventions may thus be deemed necessary where needs have remained unmet. The implication of this approach is that local, indigenous structures and approaches should be utilised first, and only when they cannot be reactivated (due to too much disruption) or do not meet the needs of the population, should other forms of assistance be used.

The main danger in this approach comes from the imbalance of power and resources between foreign experts and local recipients (Richters, 1998). This needs to be managed in such a way that local knowledge is not subsumed and sidelined by foreign knowledge (Dawes and Cairns, 1998). Efforts need to be made to equalise the power relations between local and foreign actors and systems so that “joint activity between local and outsider generates new emergent goals, action and technologies, which draw on both communities of practice ... and new local knowledge is created” (Gilbert, 1997 in Dawes and Cairns, 1998: 343). The approach has also been criticised for falling into similar traps as the universalist or ‘culture as a variable positions where it is assumed that western approaches are more able to address acute cases of distress than are local healing practices (Bracken and Petty, 1998).

Position 5: Critical perspectives

A number of issues have been raised by scholars who position themselves within a critic paradigm. Most argue that the crucial questions are not about how much of the trauma one adopts or how much ‘culture’ one integrates within psychosocial projects, and that such issues attract attention away from the more central concerns. These central concerns he
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been identified as issues of human rights and social justice (Jenkins, 1991; Summerfield, 1996, 1998), the negative and destructive effects that psychosocial projects can have on war-displaced populations (Giller, 1998; Stubbs and Soroya, 1996; Richters, 1998), and the conflicts of interest between aid agencies and the displaced (Daniel and Knudsen, 1995; Voutira and Harrell-Bond, 1995; Walkup, 1997). In addition, the relationship between individual and social suffering has received attention (Englund, 1998; Farmer, 1997; Kleinman, et al., 1997).

A common element in all of these perspectives is the focus on power, empowerment and disempowerment in the realm of psychosocial work. Wessells (1999) points to the potential for outside psychological consultants to bring into play “the tyranny of western expertise” (p. 275), based on tacit assumptions that western knowledge supersedes local knowledge. Some scholars point to the potential for recolonisation to occur through psychology and trauma discourses which can serve to undermine local coping practices (Bracken, 1998; Giller, 1998). The imposition of an ‘alien’ discourse on distress is often seen as being further destructive of existing community functioning and should be prevented (see Richters, 1998; Giller, 1998; Summerfield, 2001; Bracken 1993, 1998). Local knowledge and practices have to be recognised as central components of coping, and should not be regarded in a reductionist and deterministic manner (Kleinman and Kleinman, 1991).

In addition, a critical analysis of the relationships between the ‘helped’ and the ‘helpers’ (Gronemeyer, 1992) is seen as necessary in order to investigate implicit and explicit assumptions about who knows best what a populations’ needs are and how they should be alleviated. The involvement of outside agencies, be they psychosocial professionals or humanitarian aid workers, always entails political dimensions and effects, and ignoring these can be detrimental and harmful.
A further common suggestion of critical perspectives is that attention should be paid to the testimonies and voices of people affected by war without theorising or converting these testimonies into something else through medicalising, ‘psychologising’ or ‘anthropologising’ suffering (Kleinman and Kleinman, 1991; 1997). Processes whereby suffering and distress is ‘remade’ as disease, psychiatric disorders, undeciphered anthropological codes or class warfare simplify and reduce complex experiences by privileging the interpretation, analysis and theories of suffering over the voices of those who experience it (Kleinman and Kleinman, 1991). Instead, the unacceptable conditions of life and living of poor and war-affected people should be brought into the foreground, and advocacy with and on behalf of those affected by violence in order to affect equity is crucial.

2. Practice “in the field”: some examples of psychosocial projects

The five theoretical positions on trauma and culture outlined above do not translate directly or simplistically into practice in the sense that each position advocates the use of a particular approach to psychosocial work. Indeed, the relationship between theory and practice is complex (Tolman and Bryden-Miller, 1997), an aspect which has received little attention in the area of psychosocial work to date. It is, however, possible to draw some general conclusions about the way in which general theoretical orientations are linked to certain dominant implementation practices in the field.

Researchers and professionals who locate themselves within position 1 and 2 have generally advocated the use of psychometric measurement tools such as PTSD scales as reliable means to assess the extent and severity of the impact of war experiences on populations (Friedman
and Jaranson, 1994). Despite the growing criticism directed against this approach it has remained popular with many inter-governmental agencies such as UNHCR, UNICEF and WHO who use the information to plan project implementation (Agger et al., 1995; UNICEF, 1996). It is also reflected in many European and North American medical and scientific publications aimed at disseminating information to professionals in this area, such as the Journal of Traumatic Stress and the conference proceedings of the European Society for Traumatic Stress Studies (ESTSS, 2001).

The psychosocial projects implemented from within these positions have often assumed the relevance and appropriateness of western psychological knowledge and treatment approaches, with minor 'cultural' adaptations to suit the specific populations. A common factor has been the notion of helping survivors cope with trauma by 'working through' the traumatic experience and integrating it into world-view and self image in order to (re)gain a satisfactory level of psychological, personal, and social functioning. This has usually not been implemented through the means of individual therapeutic sessions as these are perceived to be impractical in situations of large-scale conflict (Petevi, 1996), but are instead conducted in the form of group sessions which may employ discussions, drama or art to achieve their aims. A typical example of this is a UNICEF project implemented in the province of Cuito in south-eastern Angola with child survivors of land mine incidents (Schepers, 1995 in Ventura, 1997). The children, aged between 6 and 18, were divided into groups and each group met four times for two-hour sessions with the UNICEF ex-patriate who ran the project. During these sessions the children were encouraged to talk about the land mine incidents and other traumatic events they experienced during the war. Drawings, games and songs that help the children express their feelings were also used (Schepers, 1995 in Ventura, 1997). Those children who were "unable to open up" during these sessions attended further individual meetings with the UNICEF representative in which they were again encouraged to talk about
their feelings (Ventura, 1997: 251). The rationale for this project was that these children, who had been permanently affected by the war through the loss of limbs, would carry the burden of traumatic memories with them for the rest of their lives, and needed to be confronted with their memories and express their suffering in order to initiate a process of healing.

This project is a classic example of how the suffering of survivors, in this case the children, is transformed into psychological trauma, a distinct entity ‘out there’ located within individuals and to be treated by psychological experts. There is no apparent recognition of the meanings that the children themselves attach to the event, nor about what they identify as the most pressing problems related to it. It is likely, for example, that the adolescents would be concerned about their vocational and economic possibilities, or about how the disability impacts their social relationships, perhaps more so than about the psychological problems resulting from memories of the traumatic event. In addition, there is no acknowledgement of local perspectives, practices and healing resources that people draw on, the project thus failing to take account of the cultural and spiritual context within which the communities experience their problems. The reluctance to talk about these experiences is interpreted as a inability on behalf of the survivors to engage with this process, and the children’s silence in not wanting to “open up” was not respected. There is a danger of distressing the children even more through insisting on confronting them with their suffering. The UNICEF project was also not integrated into on-going activities for children, nor did it form part of broader educational, health-related or other development-orientated activities. It was, instead, a separate, short and added-on initiative that is unlikely to have a long-term impact on the children’s lives. Of course, not all projects that arise out of universalist positions are conceptualised in the manner just described. However, the dangers involved in the imposition of ‘outsider’ frameworks on populations are clearly demonstrated in this example.
Practitioners who adopt a relativist position frequently advocate for a re-establishment of previously supportive cultural practices and routines which have been disrupted through conflict and displacement, in recognition that these are valuable healing resources in the communities. Activities such as the restoration of productive activities, schooling and religious practices are considered important (Ager, 1997; Dawes and Cairns, 1998; Wessells and Kostelny, 1998). A thoroughly integrated approach to rebuilding communities is called for as cultural practices are intricately related to structural and economic reconstruction (Wessells and Monteiro, 2000). In addition, the process of healing has to be redefined in local terms, as this example from Angola illustrates:

Western psychologists often think of healing occurring in therapeutic spaces constructed in individual and small counselling sessions. In contrast, healing in rural Angola is probably better conceptualised as a process of social integration involving the reestablishment of normal patterns of living and the recovery of traditions weakened by war (Wessells and Monteiro, 2000: 198).

Ager (1997) calls this the “reinstitution of protective influences” where, for example, community development initiatives or vocational training schemes can strengthen family structures, social networks of support, shared ideologies and understandings (p. 405). Examples of such an approach are described by Tolfree (1996) who advocates community-based interventions grounded in the traditional, local ways of coping as the most appropriate form of providing assistance. The activities of the National Children and Violence Trust (NCVT), an NGO based in Johannesburg, South Africa, for instance, are aimed at addressing the different forms of violence and their impact on children, families and communities through a programme which utilises and promotes existing structures and activities. The NCVT makes use of community-based networks where child care workers from the communities engage in a range of activities such as violence prevention programmes, awareness creation through advocacy, and the promotion of indigenous healing methods in order to enhance the abilities of the communities to deal with the psychosocial consequences of violence.
Proponents of the belief that western psychologists have nothing to contribute to war-affected populations propose that resources should be aimed at identifying local agendas and priorities, and enhancing local ways of dealing with distress (Bracken and Petty, 1998). Emphasis should be placed on issues of social justice, community restructuring, economic development and the rebuilding of social infrastructures, rather than on the emotional or psychological difficulties which the war-affected populations themselves usually do not identify as a problem they require outside assistance for (Summerfield, 2001). Summerfield asserts that

... there is no more evidence from westernized Bosnia than from Rwanda or Sri Lanka that the 'trauma' component of psychosocial programmes was brought to satisfy an expressed need for this kind of help. War-affected people have largely not given permission for their personal psychology to be objectified, nor offered a general case for mental health to be seen as an appropriate realm for humanitarian operation (p. 49).

Some scholars such as Summerfield (2001) accept that psychosocial practitioners and mental health workers may have a role to play in providing assistance to severely distressed individuals, while others such as Bracken and Petty (1998) disagree, stating that such individuals will be better served through feeling part of their community and not being 'singled out' in any way.

Projects that declare their objective to be the integration of 'outsider' and 'insider' perspectives, as described in the fourth position, abound as almost all projects lay claim to some form of integration of different approaches. Professions about taking local perspectives and practices as starting points need to be critically examined, however, as many such initiatives pay lip service to 'local culture' while pursuing their own pre-determined psychological agendas. An example of this are the projects described by Peltzer (1996) which he refers to as interventions working “in tandem with local values” (p. 11). A rehabilitation centre for torture survivors in Malawi and a project for Sudanese refugees in Uganda are both supposedly based on local perspectives on suffering and coping, but an examination of their
practices in Peltzer's account (1996) indicate that they are dominated by western psychological approaches to trauma counselling, including dream analysis, 'working through' the distressing experiences, and the use of psychometric measurements to determine the severity of PTSD symptomology. The problem with calling these projects 'integrated' is that the power relations between western-trained professionals and local people remain hidden, and that the projects therefore cannot become community-owned or -based:

...the key question is: which form of understanding exerts the dominant influence on programme goals, structure and reporting? Local understandings may be captured in the course of assessment or intervention, but if overall programme strategy is set prior to implementation with regard to a Western, psychological framework, the latter remains the dominant discourse (Ager, 1997: 403).

Claims to success by such projects, and indeed by all projects, need to be critically examined, as, all too often, evaluation of psychosocial interventions rely predominantly on the subjective appraisal of beneficiaries and anecdotal evidence of staff (Ager, 2000).

An example of a project located within the integration position that aimed to place local culture at its centre is the Christian Children's Fund's (CCF) project with demobilised underage soldiers in Angola, described by Wessells and Monteiro (2000). This project sought to validate local healing practices as resources in the process of assisting the children reintegrate into their communities, as well as developing new forms of psychosocial knowledge and practice through the interaction of western and local approaches. Most psychosocial projects lie somewhere in-between these two projects mentioned here, choosing to use local resources for some aspects of intervention and western psychological ones for others.

Advocates of the critical positions do not propose uniform approaches to practice and implementation. Most stress the need for testimony and advocacy (Nordstrom, 1997), as this is seen as an effective way in which it is possible to elucidate the connection between individual stories of suffering and their broader context. Farmer (1997), for example,
demonstrates how social forces such as poverty, violence and racism become embodied as individual experiences. He notes that "large-scale social forces crystallise into the sharp, hard surfaces of individual suffering" (1997: 263) but also that it is within "the context of these global forces that the suffering of individuals receives its appropriate context of interpretation" (p. 273). Displacement is primarily seen as a political and social issue, and the role of outsiders is to draw attention to this with the aim of influencing public opinion. The treatment of individuals or groups is thus not necessarily identified as a primary goal within this approach.

The need to empower those who have been disempowered not only through violent displacement but also through a combination of political, social and economic factors, is a central concern. One example of an organisation that aims to address some of these issues in its work is the KwaZulu-Natal Programme for Survivors of Violence (Higson-Smith, 1999). Civil violence is understood to result in the fragmentation and disempowerment at various levels of society, processes which need to be halted and reversed in order to prevent further damage. 'Linking' and empowering are thus the two strategies pursued by this organisation who focus on capacity-building of local leaders and service providers, supporting economic relief, facilitating the development of community structures, and rebuilding fragmented relationships within and between communities, amongst others (Higson-Smith, 1999).

The aim of this brief overview of practice in the psychosocial field is not to oversimplify the issues involved nor to characterise certain projects as 'belonging' to one or another theoretical position. It serves merely as a means of drawing out some common elements of work in this area which illustrate the current debates and dilemmas posed by theoretical and practical considerations in the field. Although the focus in this discussion has been predominantly on the trauma / culture dimension, this does not imply that this is the only dimension or issue
facing psychosocial work at present. Ager (1997), for instance, points to the conceptual
tensions about generalisability of knowledge in the field, the extent to which it is community-
orientated or targeted towards specific groups, as well as to the relative emphasis given to
technical versus indigenous knowledge. All of these issues impact on the debate outlined
above, and some of these themes recur throughout the thesis.

3. Assumptions guiding the research of this study

The assumptions guiding this study are based on a number of elements from the various
positions outlined above rather than originating from just one particular position. This is done
in order to avoid foreclosing the possibilities offered by various aspects of the debate. No
research is devoid of ideological and theoretical orientations (Davies, 1999), however, and
this section outlines some of the core suppositions of this study.

Firstly, the starting point of the study is the validity and importance of local perspectives and
knowledge. It is assumed that local belief systems and practices provide a coherent framework
for understanding and coping with distress, and that culture is central to the meaning attached
to suffering, the way in which it is expressed and treated. A second related assumptions is that
various coping strategies exist within the communities and their health care systems that serve
as resources for dealing with distress. What these coping resources are, how they are used, to
what extent they have been disrupted by the war, and how communities and their various sub-
groups make use of them, form part of the research questions of the study.

Secondly, while the above assumption resonates with a relativist approach to studying distress,
the simplified juxtapositioning of universalist versus relativist positions in the discussion of
trauma and distress is avoided in this study. Good (1994) suggests that the universalism versus
relativism debate is out-dated and that "the stark juxtaposition of rationalism and relativism no longer maps the important epistemological positions in anthropology, philosophy, or the sociology of science, though they continue to be evoked in arguments" (p. 36). The notions of power and empowerment, conflict and change, as delineated by critical scholars above, are considered central to an investigation of war-related distress, as well as questions about the relationships between local and 'outsider' perspectives on providing psychosocial assistance.

A third assumption is that the disciplines of psychology and psychiatry cannot be dismissed in their entirety as irrelevant to war-affected populations in non-western countries. While there is no doubt that the effects of 'importing' and imposing western biomedicine, psychiatry and psychology onto populations who have different systems of knowledge and practice has been detrimental in many parts of the world (see for example Butchart, 1998; Nsamang and Dawes, 1998; Vaughan, 1991), this study aims to examine the potential benefits and contributions made by these disciplines to the alleviation of distress in a particular community. One of the goals of the research is thus to investigate the points of similarity and difference between the different paradigms in order to analyse how they relate to one another and how they are utilised in the communities.

A fourth assumption is based on the knowledge that communities are not homogenous units but contain various groups and subgroups (Voutira and Harrell-Bond, 1995). It is therefore assumed that groups may differ from one another in aspects that may be relevant to the alleviation of distress, for example in age, gender or geographical location. It is further assumed that not all available coping strategies are used in the same manner nor to the same

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14 The situation of refugee women and children has been paid particular attention over the past two decades, for example, with some scholars arguing that their experiences indicate the need for specific policies and enquiries (Callamard, 1999; Diaz, 1997).
extent by all parts of the communities, and that this may be a relevant factor in attempts to alleviate distress.

4. Research questions

As noted in the introduction, current debates about the appropriateness and applicability of psychosocial programmes to war-affected populations in developing countries have frequently focused on the relationship between psychological and local models of alleviating distress. Questions have been raised about the role that culture and local resources play in relation to these issues within communities. This study, guided by the assumptions outlined above, thus aims to address the following questions pertaining to the debates about psychosocial work with war-affected populations:

- **War-related distress**: How is war-related distress expressed in these communities and what forms does it take? What are the explanatory models held about these forms of distress in the local context and culture(s)?

- **Coping resources**: What treatment options exist within the health care system and how do people draw on these? What other coping resources and skills are used by the displaced?

- **Psychological perspectives**: What psychological and psychiatric models are used by psychological service providers in the communities and what views on trauma, distress and culture do they hold? What are some of their underlying theoretical assumptions and practical implementation approaches?

- **Specific sub-group in the community**: What are the psychosocial issues affecting a particular sub-group within the community? How do members of this group make use of the various coping resources available to them? What implications for psychosocial practice does this have?
- **Relevance of different frameworks:** How do the various local, biomedical and psychological perspectives relate to one another in general? What points of similarity and divergence exist between them? What does an analysis of these factors contribute the trauma/culture debate in the area of psychosocial assistance?

The research for this study was carried out in a province of south-eastern Angola. Before the methodology used to answer the research questions is described, some background information on the political and socio-economic situation and some cultural aspects of ethnolinguistic groups in this area will be given.
Chapter 4

The situation of war-affected communities in Angola: political, socio-economic and cultural factors

we must return
To the houses, to our crops
to the beaches, to our fields
we must return

To our lands
red with coffee
white with cotton
green with maize fields
we must return

To our mines of diamonds
gold, copper, oil
we must return

To our rivers, our lakes
to the mountains, the forests
we must return

To the coolness of the mulemba 15
to our traditions
to the rhythms and bonfires
we must return

To the marimba and quissange 16
to our carnival
we must return

To our beautiful Angolan homeland
our land, our mother
we must return

We must return
to liberated Angola
independent Angola.

[Agostinho Neto, 1974]

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15 The mulemba is a type of tree.
16 Quissange is a traditional beverage made with maize meal.
This poem was written by the founder of the Movimento Popular de Libertação de Angola (MPLA), Agostinho Neto, in 1960 while he was imprisoned by the Portuguese colonial government for subversive political activity. The ‘return’ referred to in the poem is the liberation of Angola from its colonialists and the achievement of independence which would allow the exiled activists, the ordinary Angolans dispossessed of their lands and the freedom fighters to take repossession of their country. Now, forty years later, the applicability of this poem to the situation of the hundreds of thousands of internally war-displaced Angolans is ironic and poignant. In this chapter a summarised outline of the political background of the war in Angola will be given, followed by a description of the present social and economic situation in the country. The circumstances of the deslocados [internally war-displaced people] will be examined more closely, with particular attention to the province of Huila where the research for this thesis was conducted. Finally, three key aspects of the lived cultural tradition of the Nhaneka-Mhumbe, the MumHuila, the Nganguela and the Ovimbundu ethnolinguistic17 groups will be briefly discussed.

1. History and politics: the wars

The war in Angola has often been portrayed in the international media as an internal conflict between two antagonistic political movements, or more recently, as the illegitimate warfare of a rebel group, the União Nacional para a Independencia Total de Angola (UNITA), against the legitimate government of the MPLA (see for example, The Star, Johannesburg, 16/5/2001; Neue Züricher Zeitung, Zürich, 9/5/2001). Such a dichotomisation of opposing forces is the way in which traditional political science has approached issues of war, allowing for the identification of protagonist (in the west this was UNITA during the Cold War era, but has

17 An ethnolinguistic group is defined as a group of people who set themselves apart and are set apart from other groups with whom they interact or coexist in terms of a socially relevant cultural characteristics such as language (Seymour-Smith, 1986).
since changed to the MPLA), and an antagonist (originally seen as the MLPA government in the west, but is now UNITA). This, however, is not only an over-simplification of the historical situation that contributed to the development of the war in Angola, but also ignores the reality of the nature of war (Nordstrom, 1997). No war is ever an isolated event confined to a region or a country, a fact illustrated in Angola by the international interest in its resources of oil and diamonds (Centre for Conflict Resolution (CCR), 2000). Reductionist analyses of political situations that have led to violent conflict often disregard the particular historical and general cultural dynamics of wars. While it is not possible to present a comprehensive overview of these factors in the Angolan war here, a brief sketch of the historical and present context of the conflict will be given (see Birmingham, 1992; Bloomfield, 1988; Guimaraes, 1998; Tvedten, 1997 for more detailed analyses).

Angolans refer to specific periods of the almost forty years of continuous war in their country in terms of numbers. The First War was the War of Independence whose beginning was marked in 1961 by violent boycotts against the forced cultivation of agricultural fields and an attack on two prisons in Luanda, Angola’s capital city, to hinder the movement of political prisoners to Portugal (Tvedten, 1997). African national sentiments led to the formation of three political groups in the 1950s and 1960s which declared their goal of independence publicly, and who led military assaults on colonial targets in rural and semi-urban areas, mobilising support from amongst the peasant population. These three groups were the MPLA, formed by Agostinho Neto in 1956, which had its main support base in larger cities and amongst the Mbundu ethnolinguistic group; the Frente Nacional de Libertação de Angola

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18 The history of Angola does not, of course, start with these wars. Accounts of Angola’s precolonial history can be found in Vansina (1988), and the impact of more than 300 years of slave trade which “drained the country of human and material resources and left scars in the basic fabric of society that are still not healed” (Tvedten, 1997: 8) are presented by Henderson (1990).
(FNLA), established by Holden Roberto in 1962 with support mostly from the BaKongo in the northern provinces of Angola; and UNITA, founded by Jonas Savimbi in 1966 and consisting predominantly of Ovimbundu members from the south and east of the country. The costs of the war for independence were high for Portugal in both human and material terms, and following a coup in Portugal in 1974 which resulted in a change of the country’s policies towards its African colonies, a process of rapid decolonisation was initiated (Cravinho, 1998). An agreement was signed by the three independence movements to form a transitional government and hold elections before independence in November 197519.

Ideological differences and mutual suspicion among the MPLA, UNITA and FLNA resulted in outbreaks of fighting between the movements in July 1975 and led to a break-down of the transitional government. This initiated the Second War, also known as the Cold War, which was to last from 1975 till 1990. Various other countries who had ideological, political and material interests in Angola gave their support to the parties, with the Soviet Union and Cuba providing arms, combat troops, pilots, advisers, and engineers to the socialist-orientated MPLA, and South Africa and the U.S. aiding UNITA with military attacks and with covert financial assistance respectively. Angola became a cold war battleground for influence of the world powers in southern Africa, bound up with the liberation struggles of its neighbours such as Namibia, Zimbabwe and South Africa. The war was initially confined to the south-eastern part of the country, but UNITA tactics created insecurity in around 80 percent of the country, severely affecting the productive life and the socio-economic situation of the population. During these years UNITA increasingly depicted themselves as anti-Marxist and pro-western but also as ‘truly Angolan’, juxtapositioning the MPLA as a party of assimilados [urban, educated, Portuguese-orientated, non-white Angolans], mestiços [mixed race] and Marxists.

19 Independence was declared on 11th November 1975 by the MPLA who went on to form a single-party socialist government.
(CCR, 2000). The MPLA, on the other hand, portrayed UNITA as power-hungry tribalists who were not interested in the welfare of all Angolans but only in that of the Ovimbundu. Negotiations involving South Africa, Cuba, the U.S., Portugal and the warring factions finally culminated in the signing of the Bicesse Peace Accord in 1991.

The Bicesse Accord stipulated a timetable for demobilisation of both sides of the conflict and fixed a date for multiparty elections. However, the United Nations mission to Angola (UNAVEM II) which was to oversee the cease-fire and monitor the demobilisation was severely underfunded and inadequate (Anstee, 1996), failing to implement the agreements of the Accord. When UNITA lost the elections in September 1992, Savimbi rejected the results\(^{20}\) as biased and manipulated and returned to war with largely intact troops. This marked the beginning of the Third War or the Election War, which lasted from October 1992 till November 1994. This war proved to be more destructive and all-encompassing than the first two wars, and became known for its systematic violations of the laws of war by both the government and UNITA (Human Rights Watch, 1994). UNITA went on the offensive in provinces throughout the country, and indiscriminate bombings by the government, the laying of land mines and the entrapment of civilians in cities under prolonged siege resulted in extremely high losses of civilian lives (Tvedten, 1997). The UN estimated that 1 000 people were dying every day in Angola during 1993, more than in any other conflict in the world (Human Rights Watch, 1994). Tens of thousands of people were displaced from the countryside, fleeing to towns and cities where they lived in conditions of abject poverty, cut off from food supplies and from basic sanitary and hygienic provisions.

\(^{20}\) There was a turnout of 91% for the elections with President Dos Santos receiving 49,6% and Jonas Savimbi receiving 40,7% of the vote. In the election for the legislature the MPLA won 54% of the vote compared to UNITA’s 34% (CCR, 2000).
New peace talks began towards the end of 1993 and the signing of the Lusaka Protocol in November 1994 formally marked the end of the Third War. Almost from the start UNITA failed to comply with the obligations of the Protocol such as demilitarisation and demobilisation of soldiers, and small scale conflict continued to flare up in various parts of the country, increasing to incidents of serious violations of the cease-fire in 1997 (CCR, 2000). Throughout 1998 both the government and UNITA prepared for a new war which broke out in December of that year. This Fourth War continues till the present, and neither side seems to have the political will at present to bring the conflict to an end. UNITA, which has been financing its military exploits through its diamond revenues from its territories in the north and the east of the country, has found itself increasingly isolated internationally, experiencing the effect of the UN sanction packages imposed on it. The MPLA government uses the country’s oil resources to fund its war efforts, confident that their capacity to purchase military equipment surpasses that of UNITA.

2. Angolan civil society and the social and economic situation

Ninety percent of all war casualties in the world today are non-combatants (UNICEF, 1996), and Angola is no exception to this. The current population of Angola is estimated at 12.7 million with population density varying considerably between regions (Tvedten, 1997). The influx of war-displaced people from rural into urban areas has risen dramatically since the onset of the Second War: in 1995 it was estimated that 50 percent of the population now lives in urban areas (UNDP, 1995). Angola’s age distribution is typical of many developing countries, with an estimated 30 percent under the age of ten; 45 percent of the population under the age of 15 in 1993; and more than 50 percent under the age of 25 (OCHA, 2001). The sex distribution reflects regional differences with a large female surplus in most rural
areas and a large male surplus in urban areas. Overall there are 92 men to every 100 women in Angola, but with the largest discrepancy occurring in the 20 - 24 age group where there are only 70 men to every 100 women. This is due to the mortality rate of young men killed in the war, and has led to an increasing number of female-headed households in the country.

The largest ethnolinguistic group in Angola are the Ovimbundu (language Umbundu) which make up an estimated 37 percent of the population, living in the Central Highlands in the interior of the country (Tvedten, 1997). The Mbundu (language Kimbundu) make up approximately 25 percent of the population and live predominantly in the coastal regions around Luanda and the provinces of Malanje. The third largest ethnic group is the BaKongo (language Kikongo) who compose about 15 percent of the population, settled in the north-western provinces that form a border with the DRC (Democratic Republic of Congo) and Congo. Smaller ethnolinguistic groups are the Lunda-Chokwe (language Chokwe) who make up around 8 percent of the population and the Nganguela\(^\text{21}\) (language Nganguela) who compose 7 percent and are located in a belt through several of the central provinces, including Huila and Huambo (Broadhead, 1992). Angolans of mestizo and white (predominantly Portuguese) descent make up a small minority of the population, estimated at about 2-3 percent.

What impact have the wars had on the Angolan population? Angolan conditions fulfil most classical indicators of poverty and vulnerability, with a life expectancy at birth of only forty-five years, and 320 out of 1000 children dying before they reach the age of five (Norwegian Refugee Council (NRC), 2001). In 1999 UNICEF described Angola as “the country whose children are at greatest risk of death, malnutrition, abuse and development failure” (OCHA,

\(^{21}\) The term Nganguela was originally pejorative in connotation, applied by the Ovimbundu to peoples living east and south-east of them. Only some groups accepted the name Nganguela, others carried names such as Lwena (Miller, 1976).
2001), leading many organisations to conclude that Angola is “the worst place in the world in which to be a child” (NRC, 2001). Malnutrition rates amongst children are high: according to government statistics 35 percent of the country’s children are malnourished, with rates as high as 46 percent recorded amongst infants amongst the war-displaced in provinces such as Bié (OCHA, 2001).

No aspect of life has been left unaffected by the four decades of war. The country’s infrastructure has been severely damaged through the destruction of roads, buildings, airports, harbours, water supply systems, telecommunications and electricity systems (Cravinho, 1998). An estimated 80 percent of all schools have been destroyed or abandoned during the last three decades of war, and while school buildings are being rehabilitated by local and foreign organisations, the impact on the educational system has been severe (Tvedten, 1997). NRC (2001) estimates that 70 percent of first grade-aged children failed to enter school in the year 2000 due to a lack of resources and facilities. Of those who do enter the educational system, two thirds currently do not reach their fifth year of schooling. Illiteracy levels are high amongst children and adults, with approximately 54 percent of adult women and 46 percent of adult men being illiterate. Education received less than 2 percent of the government’s public expenditure during the year 2000 (NRC, 2001).

The public health system has seriously deteriorated since the outbreak of the Third War, with the destruction of clinics and hospitals, inadequate supplies of medicines and medical equipment, a lack of qualified personnel and the difficulty of providing basic sanitary conditions for the displaced being characteristic of most areas. Health indicators suggest that only 30 percent of the population have access to even the most basic health services, and that
a complete break-down of the health network has occurred in many war zones (Tvedten, 1997). Infectious and parasitic diseases such as measles, tuberculosis, sleeping sickness, malaria and tetanus are the most common causes of death (NRC, 2001). The government’s budget allocation to the health sector has been low, in 1994 being only 2.8 percent. The reliance on external aid for medical supplies, for meeting the health needs of large groups of deslocados, and for health programmes such as vaccinations is increasing with international organisations such as Medicos Sem Fronteiras (MSF), UNICEF and International Committee of the Red Cross and Red Crescent (ICRC) taking a lead.

Another consequence of the war are the injuries and deaths caused by land mines. Human Rights Watch (1994) estimates that about 10 million land mines have been planted throughout the country. While it is not possible to approximate the number of deaths they have caused, the number of amputees is said to be in the region of 70 000 - 100 000 (UNICEF, 1997). Only a small proportion of amputees have been fitted with wheelchairs, artificial limbs or given physiotherapy as there are only five centres in the country that provide such treatment, operated by foreign relief agencies (OCHA, 2001). Land mines also affect the economic survival abilities of communities as farmlands become inaccessible. Only an estimated 25 percent of the farmland cultivated in 1975 was being used in 1990; cattle-grazing areas are deserted; and many large farms have been abandoned (Tvedten, 1997). Many people continue to cultivate their fields despite the presence of land mines, however, out of desperation and the lack of alternative methods of survival.

The traditional micro- and macro-economic systems in Angola have been affected through the war as well. UNITA’s strategy of attacking during the harvesting season and stealing

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22 This number refers only to land mine-related injuries. The number of war-disabled civilians was thought to be at least an additional 100,000, and those of disabled soldiers another 50,000 (NRC, 2001).
harvested crops\textsuperscript{22} as well as animals from their owners have forced many people to abandon their agricultural lifestyles, or to visit their fields only at night-time. Creativity and desperation have led to many innovative survival strategies which include “green belt farming” in semi-urban neighbourhoods, chicken, pig and goat farming in small backyards, and \textit{negócio}: informal trading in anything from cool drinks and cigarettes to diamonds and weapons (Van der Winden, 1996). Blacksmiths, tinsmiths, tailors and shoemakers ply their trades in urban centres and less conventional economic activities such as money-changing, child-care and carrying water are common ways in which people try to make a living. Urban environments may offer more chances of access to work, education and medical facilities but the rising numbers of children living in the streets attest to the fact that life in the towns and cities can be extremely harsh and difficult, especially for the young and the elderly.

Socio-economic conditions vary greatly between regions and between social groups. A small minority of the wealthy elite live a life not dissimilar to European and North American lifestyles, while the vast majority of the population struggles with issues of daily survival. Such discrepancies between rich and poor are even more pronounced in Angola than in other developing countries by virtue of the fact that the significant wealth of the country’s natural resources remains in the hands of a minute minority and does not reach the general population in any form.

Angola’s civil society has been curtailed by various dominant political groups who use the war as a perpetual excuse (CCR, 2000). Mass organisations such as trade unions, women’s and youth organisations were all tied to the MPLA after 1975 and lacked independent status and the ability to press for claims on behalf of their members. In government areas local

\textsuperscript{22} The dominant crops are maize, sorghum and millet.
organisations were repressed for the first 15 years following independence but in 1990 the
MPLA announced its toleration of citizen action free from party and state supervision
(Tvedten, 1997). This lead to the formation of a number of small civic organisations that
included welfare and charity organisations, women’s organisations, sports clubs, professional
associations and environmental committees, amongst others (Hart & Lewis, 1995). However,
political constraints continue to hinder NGOs and the media from working freely.

3. Internal displacement

In 1996 UNICEF estimated that 1.2 million people in Angola were internally displaced, with
over 450 000 Angolan refugees in neighbouring countries and a total of over 3 million people
dependent upon humanitarian assistance for their survival (UNICEF, 1996). Since the
outbreak of the Fourth War the number of internally displaced persons (IDPs) have increased
dramatically and UNHCR now considers approximately 2 million people to be internally
displaced (NRC, 2001). IDPs usually follow one of two settlement patterns in Angola: they
may be settled in government-run centres of a transitory or permanent basis, or they may
become self-settled in nearby towns or cities. This section focuses specifically on the situation
of the deslocados in the province of Huila in the south-west of the country, as the research
was conducted amongst the government-settled deslocados in IDP centres in Matala and the
self-settled deslocados in Lubango.

In Huila there were several areas in which large government-administered IDP centres were to
be found during 1999-2000, the largest number of centres concentrated around Caluquembe in
the north-west of the province, and the second-largest number around Matala24 in the centre of
the province. Sixteen IDP camps were situated around Matala and nearby Quipungo, some

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24 Matala is a small town with a growing IDP population. Exact population statistics are not available.
Map of Angola with province of Huila demarcated
already having been established during the Third War in 1992 but peace never having lasted long enough to allow for the return of the deslocados to their home areas. The two largest and most recently established centres are Vissaka and Chipopia and, as my research was predominantly conducted in these, they will be described in more detail.

In the middle of August 1999 UNITA attacked the municipality of Ndongo in the north-east of Huila province during which they killed, maimed, looted, raped and chased away residents of that area.\(^25\) This resulted in a mass displacement of approximately 12,000 -13,000 people who fled towards Matala. Their condition upon arrival was extremely poor as the flight had been long and exhausting and many people succumbed to illness and malnutrition. People arrived with no or few possessions, being entirely reliant on external assistance for essential items such as blankets, kitchen utensils and clothing. Upon arrival they were first screened by the administrative and military authorities, and were thereafter received by the local MINARS [Ministry of Assistance and Social Reintegration] representatives. The deslocados were then sent to a centre named Vissaka, 37 km outside of Matala, where they were first housed in transit tents, and later allocated a plot and given some wood with which to construct a hut. When the numbers of the displaced from Ndongo exceeded 8,000, a second centre called Chipopia was established nearby, and the later arrivals were assigned plots there. Deslocados from other areas of Huila also started arriving en masse, namely from Chipindo, Cuvango and Chicomba, and they were all allocated to Chipopia. In March 2000 there were about 8,400 people in Vissaka and 9,200 in Chipopia, amongst whom women and children formed the majority.\(^26\) Conspicuously absent were young men, most of them having either joined one or

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\(^{25}\) The attack started at 3:00 am at night and the deslocados recounted the horror, brutality and viciousness with which this attack was carried out. Many people had already fled their own homes some months earlier and moved into the central village of Ndongo in order to avoid persistent attacks and were thus displaced for the second, third or fourth time over a period of two years.

\(^{26}\) Exact statistics are not available.
the other side of the conflict, been killed in the attacks or fled to larger urban centres on their own.

Ação Contra o Fome (ACF) ran a nutrition and water project for six months until the immediate emergency situation passed. MSF Espanha rehabilitated and set up clinics in both centres, employing nurses predominantly from nearby Matala. NRC built schools, a primary school in Chipopia and a primary and secondary school in Vissaka, which were handed over to the government on completion. The majority of teachers came from the displaced populations themselves and they taught classes consisting of a mixture of the displaced and local children and adults. In addition, TEP [Teacher Education Programmes] programmes were run by UNICEF-trained teachers with the aim of delivering a nine-months long literacy and numeracy programme to children who had been out of school for extended periods of time.

Living conditions in the centres are difficult. Vissaka is situated on a vast expanse of dusty land, described recently by an Angolan journalist as “a desolate landscape” (NRC, 2001), with no trees to break the monotony or provide relief from the harsh weather conditions. The huts constructed of wood and mud do not provide adequate shelter from the wind, cold nor the heavy downpours which can last for up to eight months of the year. Close proximity to neighbours results in infectious diseases being passed on quickly. A recent report from an Angolan NGO also highlights the difficult and slow adaptation to the new physical environment in which the deslocados find themselves: people who were accustomed to having their own houses and living in kimbus [household of an extended family, sometimes consisting of up to twenty huts] with their relatives find it strenuous to live in such close proximity to people who were strangers to them (Andrade, 2001). In Vissaka the fact that everybody comes from the same area, Ndongo, and therefore knew each other prior to
displacement, creates a sense of cohesion and communal support which is largely absent in Chipopio. In the latter centre, where the deslocados came from many different municipalities of Huila, people seem less willing to assist each other and more inclined to think primarily of the well-being of their own immediate families.

Economic survival is a constant concern and high priority in both centres. The deslocados do not have access to farming land around the centres, and are thus deprived of their previous methods of subsistence through agriculture and animal husbandry. They are largely dependent on the food provisions of the World Food Programme (WFP), consisting of 10 kg maize meal, 1.2 kg beans, 0.75 kg cooking oil and 0.15 kg salt per person per month, hardly enough to sustain a person for two weeks. Additional sources of income thus have to be sought and a combination of kinship exchange, petty-commodity production, collecting and selling firewood, food and beverage preparation are used. Women also perform farm labour on the fields of local residents in exchange for food, usually paid in the form of maize barely sufficient for the evening meal. Assets such emergency items and food provided by aid agencies are routinely exchanged or sold as part of the coping strategies of the population, and it is common to see WFP sacks of maize meal on the marketplaces of surrounding villages after food distribution had taken place in an area (NRC, 2001). Despite these initiatives, people live in a state of acute poverty, unable to cope with disruptions to their survival strategies through illness or other events. Especially households headed by elderly widows seem vulnerable and fragile with high rates of malnutrition and visible destitution common among them (OCHA, 2001).

An additional stressor in the lives of the deslocados in the centres are security issues. Relations with local residents in Matala and Quipungo are strained over matters such as the collection of firewood, residents claiming that the deslocados were stripping ‘their’
surrounding countryside of suitable firewood at a rapid rate which forces them to walk greater distances than before [Field notes, Chipopia]. Incidents of women deslocados being raped by locals while collecting firewood were increasing during the latter half of 2000. Local bandidos [criminals, thieves] also lie in wait for deslocados after food distribution has taken place in an area, ambushing them and stealing their goods (NRC, 2001). The constant threat of attacks from UNITA forces even in areas supposedly designated as ‘safe havens’ is a further concern for the deslocados, a concern that increased dramatically in April 2000 when the government embarked on a scheme of forcefully resettling deslocados to areas that were deemed unsafe both by local and foreign organisations (NRC, 2001). Ostensibly, the government justified these schemes by saying that the deslocados would gain access to farm land, but they were regarded by many as part of the government’s attempt to consolidate its presence and control in newly liberated areas (NRC, 2001). In Vissaka and Chipopia large segments of the population were forced to relocate to areas across the Cunene River where attacks from UNITA were frequent. This occurred during a time when the town of Matala itself, considered to be a highly secure area, was attacked by UNITA forces in July 2000, resulting in more than 30 deaths.

The lives of the free-settled deslocados in Lubango27 are stressful in different ways. In Lubango the number of displaced far outnumber that of the ‘original’ residents of the town, although scarcely anyone is ‘local’ (in the sense of having been born and lived there into their adult life) in a town which has received vast numbers of displaced people over the past 40 years. Great variation in the economic circumstances exists between different groups of deslocados, the single most important factor being whether or not the arriving deslocados have kinship networks in the town that they can draw on for initial support (Andrade, 2001).

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27 Lubango is the third largest city in Angola with a population of approximately 500,000. Exact population statistics are not available.
However, not even highly effective kinship networks can cope with the massive levels of displacement that have occurred since 1992, and host households quickly find themselves depleted if they are expected to cope with large numbers of additional people:

With the majority of the Angolan population living at, or below, the poverty line... resources in most households are limited and can be extended very little without creating further hardship. During the past eight years, agencies estimate that a majority of host households have become destitute as scarce assets are shared among larger numbers of people (UNSC, 2000: 16).

The same problem facing self-settled IDPs as those settled in centres, is the lack of access to farming land. In urban areas the peripheral areas around the towns are all owned and farmed by residents who rely on the produce for their livelihood. However, other opportunities and possibilities present themselves for making a living in urban areas, as outlined above. It has been suggested that those IDPs most likely to attempt life in the urban areas are those who are best educated and most resourceful, leaving behind the more vulnerable and less influential people in the centres (Tvedten, 1997). This seemed to be the case in Matala and Lubango where former community leaders and intellectuals migrated to the towns in order to make a living for themselves there. Despite this, however, many deslocados find it very difficult to survive in Lubango, the competition in the informal trading market already being strained to maximum capacity. Some work long hours in order to make enough for just one bread roll and a teabag at the end of the day, living constantly and precariously on the brink of destitution [Field notes, Lubango, February 2000]. Others who are not able to work live on the streets, surviving on begging and stealing what little they can get.

Opinions vary amongst the displaced as to how they are received by the local communities. Social integration into the host community is more easily achieved by those deslocados who share language and ethnic affiliation with local residents. Others reported hostility and aggression directed towards them as locals see them as competition for scarce resources in the urban areas. The deslocados expressed sympathy with the plight of the local residents,
recognising that the whole country is suffering from shortages and that “it is not possible to
give things you do not have” (Andrade, 2001: p.8). Others, however, felt that locals were still
far better off than they were and that the deslocados were sometimes exploited by locals who
used the situation to gain benefits for themselves [Field notes, Lubango]. A compounding
factor is that many deslocados come from UNITA territories and are thus often suspected of
being sympathisers of the rebel movement. Host communities sometimes do not want to
compromise themselves and their safety by being seen as ‘aiding and abetting’ supporters of
the enemy in fear of reprisals from the government.

4. Cultural lives and displacement

Many deslocados in Lubango and Matala originate from within the province of Huila, but also
came from surrounding provinces such as Huambo, Bié, Cuando Cubango and Benguela. The
four main ethnolinguistic groups with whom I worked were the MumHuila and the Nhaneka-
Mhumbe in Lubango, and the Ovimbundu and Nganguela in the centres of Matala. These
groups differ from one another in a variety of traditional practices and beliefs, for example in
customs related to circumcision, burial rites and ancestral veneration. However, the cultural
lives of these groups will not be described here in detail for two reasons. Firstly, in keeping
with the definition of culture presented in the literature review in chapter 2, the
essentialisation and reductionism involved in identifying specific ‘cultural traits’ of particular
groups will be avoided. The significance and meaning of cultural practices in the lives of the
deslocados cannot be understood by merely describing or listing them, as culture encompasses
much more than just customs or habits. Secondly, those aspects of traditional life that are
relevant to the topic of this thesis have been incorporated into the analysis chapters (6, 7 and
9), and do not, therefore, need to be presented separately here. Instead, I focus briefly on three
elements of lived tradition common to all four groups that are based in local culture and are
used as coping strategies in dealing with difficult situations: the system of chieftaincy in rural society, the structure of the jango and the judicial system.

4.1. The sobas

Traditional authority structures of rural Angolan society have been organised around a system of chieftaincy where several kimbus constitute an embala and each embala elects a soba (Milheiros, 1967). In areas with greater population density the sobas of the embala are referred to as sobetas who are in turn responsible to a soba grande who oversees the entire area. The chieftaincy is hereditary: when the soba dies a new one is selected from amongst his children, nephews or grandchildren by the elders of the extended family. Usually this follows a patriarchal lineage but occasionally daughters are elected to the position if the sons are deemed unfit and unable to hold such an important position. The practice of chieftainship has survived the double onslaught of slavery and colonialism and continues mainly in the rural areas of Angola. Major changes have taken place post-independence, however, where the MPLA government developed a second authority structure that was superimposed on but did not completely replace the traditional system of chieftaincy (Tvedten, 1997). This government structure ensured that party-loyal coordinadores and administradores maintained ultimate control over village and embala affairs, leaving the sobas mainly in charge of ‘traditional’ problems. In some instances, especially in the rural areas, administradores and sobas have respected each others’ domains of influence and developed a positive working relationship. In towns such as Lubango the authority of the sobas was undermined by the fact that they were no longer elected by families but were appointed into their positions by the administrador. The communities do not take them seriously and consider them to be puppets of the government. In the centres of Matala and in other rural areas, however, the sobas still wield considerable influence over the affairs of their communities.
What contributions do the sobas make to the lives of the destocados? Not only do they provide guidance, advice and direction in practical terms to the communities but they also delegate and organise communal activities, take initiatives around the building of communal structures and set up channels for service provision. They are indispensable in many of the traditional practices and ceremonies that have to be performed, for example in male circumcision, feasts for the ancestors, and cattle ceremonies where they make offerings to the spirits (Estermann, 1957). The soba is thus the visible representative of the ancestral laws that regulate the lives of the community (Milheiros, 1967). A good soba needs to have extensive knowledge of the history and culture of his people, be responsible, represent the views of his people to the government, be an example in his lifestyle, and, most importantly, needs to have juízo [good sense, common sense, can signify wisdom]. Nordstrom (1997) points out that elders and leaders may also act as creative visionaries who suggest new ways in which people can reconstruct their symbolic and social universes. They share their insights into possibilities for the future with their communities, based on the knowledge of past suffering and difficulties and the strategies that their ancestors used to overcome these.

4.2. The jangos

Another feature of traditional life in many rural communities in Huila is the jango (or onjango). This is a round structure usually built by communal labour from adobes and covered with a thatched roof. Traditionally it formed the most important social and communal centre of a kimbu and was used by the men and boys who gathered there in the evenings to converse, tell stories, talk about problems and eat. This was a place for informal education where the young could learn from the old and where oral traditions were passed on from one generation to the next. As one elder out it:
The elders need to tell the youngsters how to live, the story of our nation, we have to tell them the stories about their terra [home area] and villages. If one of the old ones die a whole library is lost (CCF, 2000: 2).

The jango was a place where all formal and informal meetings took place, for example such as the justiça (see below). Punishments were also sometimes meted out in the jango to serve as a public warning to others not to follow in the footsteps of those who had wronged. The spirits of the kimbu abided in the jango and daily libations were poured out to them there (Childs, 1949). The jango was a respected place that was kept clean and orderly, representing in many ways not only the power of the soba but also the centre of the community.

In most bairros [neighbourhoods] in Lubango there are presently no jangos. This issue has become incorporated into the community work of CCF who initiate the building of jangos so that community committees and organisations have a place to meet and can conduct classes of various kinds. In the IDP camps there is a severe shortage of wood or mud to construct jangos or any other communal structure but some zones nevertheless managed to erect them. Besides the purely practical functions that jangos provide, they also restored some dignity to the community and represented the re-establishment of the community in its new habitat. Visitors can be received there and the soba has a place to conduct his affairs in a dignified and appropriate manner. As one person informed me: “a soba cannot conduct his business out on the street” [Field notes, Chipopia]. The absence of a jango serves as a reminder of what is lost and its presence signifies the re-initiation of communal life.

4.3. The justiça

The third tradition that will be briefly discussed is that of the justiça [court]: the traditional council of the sobas and the elders which serves as a judicial system. Due to the dual authority

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28 Although the purpose of the jangos is no longer the same as it was historically, CCF reports indicate that the presence of a jango improves community cohesiveness.
structure imposed by the government, the *justiça* deals primarily with what are termed traditional problems whereas the *administrador* and the police deal with criminal and political matters. Traditional problems are defined as accusations of witchcraft, adultery, robbery, land disputes and issues of inheritance. The format of the *justiça* is the following: the council sits in the *jangó* or underneath trees and are joined by anyone from the community who wishes to observe the proceedings. The groups of people who wish to present their problems sit in their groups at a distance away and are called one after the other into the communal area. They are given a chance to present their case and everyone is allowed to speak uninterrupted, with the *soba*, the elders and occasionally members of the audience asking questions of clarification. In cases where information is lacking, for example in accusations of witchcraft where guilt has not been established yet, the concerned parties are sent away to gather this information and bring it back on the same day or at the next *justiça*. The *soba*, upon hearing all sides of the story, having gathered sufficient information and consulted with the elders, then pronounces a judgement and decides on punishment and compensation that the guilty party needs to pay.

The institution of the *justiça* has relevance on many levels of communal life. Firstly, it is a confirmation of the powers and wisdom of the *soba* and the elders as a resource on which people can draw in times of difficulties and conflict. Secondly, the *justiça* functions as a form of conflict resolution that prevents the escalation of friction and disharmony amongst sectors of the population. As one of the *soba* stated:

> My job is that of a diplomat and a politician. I have to be intelligent and find the truth. I also have to stop people from fighting with each other” [Soba João, Chipopia].

Thirdly, the *justiça* brings issues out into the open by being a public forum where everyone can attend, forestalling some of the negative and potentially destructive effects of rumour-mongering and secret accusations that seem to be a common feature of village life. Fourthly,

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29 At one *justiça* I attended the range of problems was much wider than that, however; there were three cases of witchcraft, one of assault, one of divorce, one of embezzlement of funds from a committee, and one concerning a marital problem [Field notes, Quipungo].
the council serves as a guidance to the people in terms of what is and is not acceptable and permissible in their tradition and communities. In times of upheaval and disruption this is of great relevance as the council ensures that no transgressions against the spirits occur and no severe harm will be incurred from the actions of community members.

These three cultural practices and structures are ‘living culture’ in the sense that they are being used in Huila currently. They have been used in times of difficulty for centuries, and although less frequently used in Lubango where different rules operate, sobas and elders in Matala use them to deal with the problems posed by the war as well. While they seldom address issues of war directly, these features of traditional life are perceived as being an important part of re-establishing and maintaining ways of life that are valued in the community. Often these customs have symbolic as well as practical importance in regulating life and restoring order and meaning to a world disrupted by violence and displacement.
Chapter 5
Methodology

The research questions, as outlined at the end of chapter 3, indicate the appropriateness of a broadly qualitative approach to the study. Ethnography was the primary method used in this research. Two other methods were used with groups of adolescents, namely participatory research methods based on PRA (Participatory Rapid Appraisal), and the use of a psychometric instrument to assess the presence of PTSD symptoms.

There were a number of reasons for using a qualitative approach. Firstly, the aim was to try to avoid as far as possible the imposition of western frameworks on local understandings and going ‘into the field’ with ready-made explanations so as to “find truths” to support my theories (Robben and Nordstrom, 1995). Instead, I wished primarily to engage in an inductive process characterised by an openness to new data, where insight into local perspectives and cosmologies would lead to the development of concepts and theoretical knowledge. This process was facilitated through taking the perspectives of the war-affected population as a starting point and building parts of my investigation on the results of these initial findings.

Secondly, the research questions concerned themselves with issues of understanding, beliefs, values, explanations, relationships and world-views, knowledge of which can be gained most effectively through qualitative methods such as interviews, observation, participation and discussions. The emphasis placed on understanding the meaning attached to suffering, distress and related illnesses necessarily implied a focus on local contexts, cultures and realities which can only be accessed by ‘going into the field’, listening, talking, watching and participating.
The complexity of the issues under investigation warranted a methodology that could provide flexibility and a time-frame that allows for long-term engagement and in-depth investigations of communities.

Thirdly, while a number of studies exist that investigate psychosocial distress in war-affected populations through the means of psychometric measurements and formal clinical interviews, few studies have attempted to use ethnographic methods to examine these issues in developing countries (Ahearn, 2000). This study aims to make contribution to the field by providing information that is not readily available through the use of quantitative measurements. Multiple sources of data collection were used in a process of triangulation which involved the confirmation or cross-checking of the accuracy of data obtained from one source with data collected from other sources (LeCompte and Schensul, 1999a).

The study was designed as an in-depth analysis of communities in one country as opposed to spending shorter time periods in several different countries. This decision was based on considerations of the research questions which required unhurried ethnographic research in order to gain insight into local cosmologies, data which could best be collected through an extended residency in one location. Possible research settings with various organisations in several different countries, including Angola, Uganda and Sudan, were explored. Given the need for initial logistical and administrative support for fieldwork through an organisation working in the research setting, an invitation from CCF Angola to base initial research in their field areas ultimately determined Angola as the focus of the investigation.

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30 The support given to me by staff members of CCF extended far beyond that, however, as people actively supported my research by facilitating access to community members, discussing findings with me, providing information and commentary about social, economic and political matters in Angolan society, and becoming friends and house mates.
1. Ethnographic methods

Ethnography is an approach to learning about the social and cultural life of communities that uses the researcher as a primary tool of data collection with the aim of presenting an accurate reflection of the participants’ perspectives and behaviours (LeCompte and Schensul, 1999a). It is carried out in a natural setting and involves intimate, face-to-face interaction with participants, taking into account and emphasising the constituting role of context and culture in the lives of the participants, as well as that of the ethnographer. The ethnographic methods used in this study are participant observation, interviews and focus group discussions. These methods were complemented by analysis of various NGO and government documents such as project proposals, evaluation and field reports, articles and memos.

I conducted eight months of fieldwork research in the province of Huila during the year 2000, of which approximately five months were spent in Lubango and approximately three months in Matala. Access to the communities in Lubango was predominantly facilitated by CCF who had established extensive working relationships and knowledge of these areas and introduced me to sobas, administradores and other influential community members. The research was mainly undertaken in the bairros of Lubango as well as in rural communities in the surrounding district.

Access to the centres in Matala was officially negotiated with MINARS and representatives of the vice-governor of the province of Huila who contacted the chief administrator in Matala. This formal process, which involved the sending of letters of introduction and authorisation between all relevant parties and a series of meetings with government officials, was due to the

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31 In traditional anthropological studies this is referred to as 'the field'. Atkinson notes that the field is produced (not discovered) through the social transactions engaged in by the ethnographer. The boundaries of the field are not 'given'. They are the outcome of what the ethnographer may encompass in his or her gaze; what he
fact that I was not officially affiliated with any NGO working in that part of the province. Research was conducted mostly in the two centres of Vissaka and Chipopía, as well as in the nearby town of Quipungo.

Upon entering an area for the first time I asked to be introduced to the administrador and the soba of the community in order to present myself and ask for permission to work in their areas. I then conducted transect observational walks (Barton et al., 1997) through the different zones of a bairro or a centre with a member of the community. At times these were spontaneous walks, for example with adolescents or a community worker; at other times they were pre-arranged with promotores (community workers) who would meet me at a specified time and place. Decisions about where to go were left up to my 'guides', based on assumptions that they would show me what they considered to be important features in their communities and/or what they thought I wanted to see. In this way I was usually introduced to the unofficially influential members of the community, people who possessed specific skills, and was shown the churches, clinics, the markets, the places where the youths 'hang out', the rivers, the places where the women and girls pound maize, the jangos, the water points, the houses of the sobas, amongst others.

During the research process I sought to ensure informed consent of my participants. I explained who I was, where I was from, what research I was doing and why, and what would happen to the information they provided to me. I assured people of confidentiality. In a society characterised by violent conflict, suspicion and fear are common reactions to outsiders, as well as the hope that foreigners such as myself may have access to resources which could provide valuable assistance to severely impoverished communities. I dealt with these

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or she may negotiate with hosts and informants; and what the ethnographer omits and overlooks as much as what the ethnographer writes (1992 in Emerson et al., 2001: 354).
responses through being honest and open about myself, my research and the limitations as well as the possible benefit that could be derived from it.

Language and translation

The population amongst whom I worked spoke a number of different national languages, mainly Nhaneka, Nganguela, Umbundu and Chokwe (see previous chapter). Fluency in Portuguese varied with people in Lubango more likely to be fluent in it than in Matala, and deslocados and old people less likely to communicate in it than local residents and young people. I arrived in Angola with limited knowledge of Portuguese and initially made use of a translator both for interviews conducted in Portuguese as well as in the other languages. After approximately four months I no longer required language assistance for Portuguese but continued to use a translator for all other languages in Lubango. In Matala I did not make use of a translator and interacted directly with people in Portuguese, receiving translations from Umbundu and Nganguela into Portuguese from other deslocados. This decision was based on two considerations. Firstly, I could not find a suitable local translator and would have had to hire someone in Lubango, a decision which would have further underscored tensions between local residents and the NGOs who ‘imported’ their staff from the town instead of employing residents of Matala. Secondly, I found that fieldwork was much more informal and therefore interactive when I was not accompanied by a translator.

Working in translation always has implications and limitations for research as some levels of meaning are lost, and the translator’s theoretical assumptions filter their informants’ talk (Davies, 1999). I worked with three different translators in Lubango: Manuel, Luis and Elias. Manuel was the translator I worked with most of the time and when he was not available Luis

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32 In order to preserve the anonymity of the participants, pseudonyms for translators and informants are used throughout.
or Elias filled in for him. The effect that the different personalities, interpersonal skills and intellectual orientation of the translators had on the research process was notable: Manuel was at ease with people of all backgrounds, made conversation readily with participants and effortlessly adjusted to the different research situations. He was interested in the topic of my research and sometimes pointed me in directions of further enquiry, or privately expressed scepticism of certain information gained during interviews. As the research progressed Manuel seemed to assume the position of research assistant rather than of translator as he became more familiar with the aims of the study. The other two translators did not display the same informality with participants, made less effort at conversation with them and appeared distant in dress and manner. The interviews with Manuel consistently yielded more relevant information than with the other two translators, a fact which underscores not only the important influence that a translator has in research settings, but also the central role that establishing relationships and gaining acceptance by participants has in qualitative research (Hammersley and Atkinson, 1995).

1.1. Participant observation

This method forms the core of ethnographic research and was developed primarily from the disciplines of cultural anthropology and sociology (Marshall and Rossman, 1999). It involves the long-term personal involvement of the researcher with those being studied, ideally including participation in their lives to such an extent that he or she comes to understand the culture as an insider (Davies, 1999). Observation entails the systematic noting and recording of events, behaviours and artefacts in the social setting of the study.

Differences exist in the emphasis placed by ethnographers on participating as opposed to (merely) observing, with traditional anthropologists often using their level of participation as
an indication of the quality of their research\textsuperscript{33}. The methods of participation and observation work in a dialectic relationship, however, influencing one another and gaining greater significance and appropriateness depending on specific situations. In this study both methods were frequently used simultaneously although there were many instances in which I assumed the role of observer without participating in the activities.

Participant observation also involves the constant and extensive use of unstructured interviewing in the form of conversations with participants about various topics of interest to the researcher. These may be solicited or unsolicited accounts which can provide both direct and indirect information about the setting, people’s perspectives, concerns and practices. Another commonly used aspect of participant observation is building relationships with key informants\textsuperscript{34}, individuals who are effective at relating cultural practices or are more willing than most to take the time to do so (Davies, 1999). Some of my key informants included a soba in Chipopipa who took it upon himself to teach me about cultural issues; an elderly woman in Vissaka who played this role in regard to issues of health; and a few adolescents who gave me insight into their lives which would have been difficult to obtain otherwise.

Initially my observations were wide-ranging and partially unfocused, including all aspects of the political, social, physical and cultural life in Angola. After the first few weeks, and as my Portuguese improved, I focused more closely on issues of war, health care and distress in my conversations with people. I used a variety of sampling techniques during the ethnographic research, such as purposive sampling (to select information-rich cases for in-depth study), opportunistic sampling (which allowed me to take advantage of unexpected situations),

\textsuperscript{33} See Hammersley and Atkinson (1995) for a discussion of ‘insider’ and ‘outsider’ myths.

\textsuperscript{34} The over-reliance on key informants may be hazardous to the validity of the data collected if the researcher does not cross-check the information received from them (Davies, 1999). A number of scholars advise caution in typifying behaviours or beliefs of groups based on the accounts of key informants (Rock, 2001).
criterion sampling (for instance where adolescents between certain ages were selected), and snowball sampling (Bernard, 1988, where one informant points to others who may be willing to participate and they in turn facilitate access to others).

Field notes were aimed to be detailed, non-judgemental, concrete descriptions of what was observed. The taking of field notes is inevitably a selective and descriptive process of interpretation and sense-making, embodying and reflecting particular purposes and commitments of the researcher (Emerson et al., 2001). However, by composing them day-by-day in an open-ended fashion, and by focusing on actual events and conversations, the notes served as reference points to which I could return at later stages of the research process. I always carried notebooks and pens with me when in the communities or centres, and during the initial few weeks I occasionally made notes while in the ‘field’. Increasingly I abandoned the use of writing in the presence of the deslocados, however, as I felt that this was inappropriate, at times raising suspicions about my motives and hampering the interaction between the participants and myself. From approximately the third month onwards I seldom made recordings in the field, writing up full field notes in the evenings. At times I made jotted notes of observations or quotes in the clinic waiting rooms or during trips so as not to forget important observations later on. In the evenings I word-processed the field notes as soon as I returned from the communities (when there was electricity), or otherwise wrote them out by hand into my notebooks. Extracts from field notes in the thesis are accompanied by information about the place where the interview was held, for example Chipopía or Lubango.

I also kept a separate personal journal in which I recorded a mixture of personal thoughts and emotions on the fieldwork, concerns, worries, high- and lowlights of my stay in Angola [see Appendix B for an extract of the journal]. The keeping of this journal facilitated some separation between my observations in the field which I attempted to record as objectively as
possible, and my subjective views and opinions about them. While such a separation is of course not always achievable and has in fact been contested in critical anthropology (see for example Davies, 1999), it aided reflexivity on the research process during later stages of the analysis, illustrating how my perspectives had undergone changes during the fieldwork residency.

1.2. Interviews

I conducted interviews with a large range of people in the communities and amongst NGO workers. Various types of interview format were used, such as semi-structured and unstructured interviews, and the taking of life histories. Individual as well as group interviews were conducted. Some interviews were planned where people were contacted in advance and asked if they were willing to participate, in which case appointments were made, and others arose spontaneously when opportunities presented themselves in the field. For planned interviews I prepared an interview guide consisting of the main areas which I hoped to address as well as more specific questions about aspects which I needed more detailed clarification on. A semi-structured interviewing approach allowed me to be flexible during my interactions with the participants, and to pursue particular lines of enquiry which yielded more information than others. Frequently I conducted an initial ‘introductory’ interview with someone and returned for follow-up interviews days, weeks or even months later. Subsequent interviews were usually more focused and more detailed, and were often combined with observing someone at work or participating in some activity such as a session of the justiça or attending a church service.

Most interviews conducted with people such as healers, diviners, church leaders, faith healers, nurses and the psychologist were tape recorded if permission was granted. The tapes were
transcribed into English with the help of my translator at a later stage, often on the weekend following the interview. Later on I transcribed interviews directly into Portuguese as this was easier for both my translator and myself. The few instances in which permission to tape record was not given I took notes during the interview or just listened and recalled what was said afterwards. Naturally occurring conversations were not tape recorded.

I also conducted separate life history interviews with three deslocados. Life histories are biographies or personal narratives, usually collected through a series of interviews over an extended time period, which provide insight into social, cultural and historical processes rather than just information about a single individual’s life (Davies, 1999). They help establish collective memories and tell of the concerns of their time and place, thus bridging cultural history with personal biography (Plummer, 2001). The three participants, two men and one woman, told me about their childhood, their families, their work and educational experiences and about the various experiences and encounters with political activity and violence. The interviews were largely undirected as I was interested in knowing what they chose to talk about and how they presented certain aspects of their lives to me. My focus was not the veracity of their accounts but the way in which oral history it used to make sense of the past, how it connects individual experience and its social context, and how people use it to interpret their lives and the world around them (Frisch, 1990 in Plummer, 2001).

1.3. Focus group discussions

Focus group discussions (FGD) are semi-structured discussions with small groups of people who share a common feature (Krueger, 1994). FGDs generate a considerable quantity of data in a relatively short period from a larger number of people than would be possible by

35 In all three cases the participants were faith healers (santos).
interviewing key informants. They also allow the researcher to record and analyse groups' reactions to ideas and to each other, thus producing data that would be less accessible without the interaction in a group (Schensul, 1999). FGDs can range from highly informal to highly formal depending on their purpose and context.

Most of the FGDs in this study were conducted in a semi-formal manner, arranged beforehand with one or two participants, asking them to bring along others who wished to participate. Usually the meetings took place in a confined space such as a jangó, consultation or classroom and all were tape-recorded. FGDs were held with women in rural areas outside of Lubango and in Chipopía and Vissaka; with church members; community health workers; adolescents; os mais velhos; teachers; and nurses. A short list of open-ended topics were posed as questions, these varying depending on the composition of the group and the data I aimed to obtain. Some of the FGDs consisted of two or three meetings with the same participants in order to gain more clarification on specific aspects of a discussion. It was difficult to ensure that the same participants were present in these follow-up FGDs, however, which meant that ground that had already been covered in the first FGD had to be repeated for new participants.

1.4. Analysis

1.4.1. Primary analysis

This is an iterative process conducted during the field work period where the researcher moves between data collection and analysis in what has sometimes been referred to as the “flip-flop” process (Pidgeon and Henwood, 1996). During the research period initial categories, themes, patterns and links were identified and data collection was orientated towards confirming or dismissing these emerging concepts. Depending on the subsequent
findings lines of enquiry were further pursued, adjusted or abandoned, leading to the progressive focusing during data collection characteristic of all qualitative research:

Ethnographic research has a characteristic ‘funnel’ structure, being progressively focused over its course. Progressive focusing has two analytically distinct components. First, over time the research problem is developed or transformed, and eventually its scope is clarified and delimited and its internal structure explored (Hammersley and Atkinson, 1995: 175).

Recurring themes in the data collection such as the need to avoid thoughts about the experiences of war, witchcraft, the conflict between healers and churches, were noted but their significance was not immediately clear nor were some of these themes identified as central to my investigation at this early stage. From an initial openness and relatively unspecified area of research more defined topics developed based on findings in the field. The implications of these incipient analytic categories were ‘checked back’ with participants and colleagues in order to ensure that I had correctly understood the meanings attached to the information provided.

At this initial “pattern level of analysis” (LeCompte and Schensul, 1999b: 98) the researcher’s developing conceptualisations are commonly based on similarities between occurrences, confirmation, co-occurrence, sequencing and frequency of findings. Through the constant engagement with the process of data collection ‘sensitising concepts’ rather than clear or definite categories were developed (Hammersley and Atkinson, 1995), some of which were retained and others discarded as the research progressed. This period also allowed for an identification of gaps in my understanding of the issues under investigation.

1.4.2. Coding and secondary analysis

This stage of the research process occurred once I had left Angola. The field notes and transcripts of interviews were printed out and read through repeatedly. General themes and corresponding codes were identified and passages of the notes and transcripts were analysed
and annotated accordingly. These themes were initially broad and did not remain constant but were refined as the analysis proceeded. An instance of an earlier code is that of Indigenous Coping Resources (ICR) which was later further differentiated into ICR (Churches), ICR (African Traditional Religions), ICR (Social), ICR (Medicinal), ICR (Advice) and ICR (Practical).

Once these codes had evolved and were applied to the material, they were developed further into categories, exploring links and relationships between them. Secondary analysis involved expanding regularities, patterns, explanations and causal flows that had emerged during the phase of primary analysis and fieldwork, and testing to what extent these initial concepts and categories 'withstood' the more rigorous analysis based on the data (Marshall and Rossman, 1999). For example, all findings concerned with 'spiritual' illnesses and problems were originally subsumed under the category of culture; as analysis progressed this was found to be inadequate and further subcategories were developed, which took into account the interrelationship between spiritual, cultural and religious aspects of the local health care system. The validity and relevance of the categories were tested by trying to 'saturate' these categories with many appropriate cases (see Silverman, 2000). Instances that remained 'uncategorised', such as negative case examples, were assessed to see how they could be accounted for in the scheme developed. For instance, early assertions in one of the IDP centres that there were no traditional healers available were found to be related to the particular composition of the population, and tensions between the churches and the healers in that community.
2. PRA-type\textsuperscript{36} exercises with the adolescents

The second methodological approach used in this study was PRA. This method was developed as a research tool for development workers and arose from a number of intellectual movements which shared an interest in increasing the participation\textsuperscript{37} and empowerment of local people, such as participatory action research inspired by the work of Paulo Freire, and rapid rural assessment which arose out of field research into farming systems in South American and African countries (Chambers, 1997; Nelson and Wright, 1995; Theis and Grady, 1991).

The basic principle of PRA is that outsiders do not dominate and impose their own theoretical models, and instead ‘hand over the stick’ to local people who become the analysts, planners, actors and facilitators themselves (Chambers, 1997). Fundamental to this process is the assumption of the richness and validity of local knowledge which forms the basis of the interaction between outsiders and local people. When the ‘experts’ have gained insight into local realities and perspectives, they share their own perspectives, models and practices with local people, ideally resulting in synthesis of both approaches based on decisions made by local people (see Nelson and Wright, 1995, for a discussion of the various levels at which this can be implemented).

There is a strong emphasis on visual rather than verbal or written research methods, as well as on working with groups in a public manner as opposed to gathering private information from individuals (Hinton, 1995). This means that often special attention needs to be given to

\textsuperscript{36} I use the prefix ‘type’ to indicate that I used exercises based on a PRA approach but did not always do PRA as such, as I was not able to adhere to all of the guiding principles of PRA (Chambers, 1997; Institute of Development Studies (IDS), 1996a), my research being at times more extractive than action-orientated, for example.

\textsuperscript{37} I use Eyben and Ladbury’s (1995) definition of participation as a process whereby those with legitimate interests in a project influence decisions which affect them.
marginalised groups such as ethnic minorities, poorer people, the disabled or the elderly as they may not be able to participate fully in public PRA exercises (Mukasa and Mugisha, 1999). The triangulation of data requires that PRA practitioners collate information from different groups and locations, using a variety of methods and 'back-checking' findings with participants. PRA has been described as a form of applied anthropology with reduced time for fieldwork, where rapid and progressive leaning on behalf of the researchers depends on establishing rapport and some measure of trust early on (Chambers, 1997). The attitude and behaviour of the researchers are vital, and PRA texts stress the need for relaxed participant observation in the field, marked by respect and transparent honesty, as well as an awareness of cultural differences between facilitators and local people (Gardner and Lewis, 1996; Leurs, 1998).

I trained a group of adolescents as facilitators in the use of PRA-types activities in Lubango so that they themselves would then constitute their own groups of approximately 4 - 7 adolescents and conduct the exercises with them. The reason for this was three-fold: firstly, I wanted to avoid purely extractive research methods where I was positioned as the researcher and the adolescents as the respondents; secondly, the findings generated by the adolescents and the subsequent discussions would provide different perspectives on the issues than if an outsider conducted the exercises (Johnson, 1996); and thirdly, the experience of learning some of the techniques and being facilitators could potentially benefit the adolescents through the enhancement of self-confidence, critical insight and leadership skills.
Fifteen displaced youths from two bairros in Lubango were trained in PRA exercises and consisted of four girls and eleven boys\textsuperscript{38}. In one bairro they were chosen by CCF community workers, who were familiar with the youths in the area, according to the following criteria: 1) they had an interest in participating in the research 2) they were displaced, preferably within the last six years 3) they were between the ages of fifteen and eighteen and 4) they were known to be reliable in participating in other youth activities. In the other bairro I had come to know a number of adolescents through my ethnographic research already and invited seven of them to participate.

I conducted a series of three meetings with the facilitators during which I explained the purpose of the study, trained them in the techniques and distributed materials to them. Each facilitator met with his or her group three times during which they conducted sets of exercises on specific topics (see below). After each round of exercises I met with the facilitators and they explained to me how the exercises had been done; what problems they had encountered, if any; what the adolescents had said about each exercise and what aspects they had enjoyed or not. I ‘interrogated’ the ‘results’, i.e. charts, maps and diagrams, as this forms a crucial part of the PRA process during which the researcher ensures that he or she has fully understood the meanings of the visual products and the particular cultural mode of representation employed (Wright and Nelson, 1995).

In Mataela I did not have sufficient time to undertake the training of facilitators and conducted the PRA-type exercises myself. Since there were no organisations working with adolescents in the camps at the time of the research I accessed adolescents through the schools in Chipopio and Vissaka, asking the principal if he could ask for volunteers to participate in the exercises

\textsuperscript{38} It proved difficult to involve equal numbers of girls and boys throughout the research, as girls had more work commitments than boys and therefore less time to participate in meetings, seminars and other activities.
with me. The adolescents came from classes at the third, fourth and fifth levels of schooling and were mostly literate. In Chipopia I conducted the exercises with two groups of students, each consisting approximately of 17 students, and in Vissaka I worked with one group comprised of 22 students. Because all adolescents in Matala were students there was less diversity amongst this group than there had been in Lubango, where youths of various occupations and educational and social background had participated.

In both settings a range of exercises were conducted with or by the adolescents, including mobility maps (Sapkota and Sharma, 1996), work activity lists, daily schedules (IDS, 1996b), household activity rankings, Venn diagrams on problems with education and training (Theis and Grady, 1991), H-forms on schooling (Inglis, 1999) and writing guidelines for adolescent new-comers into their communities. These exercises primarily served the purpose of familiarising myself with the lifestyles of the youths, and gaining insight into areas of their lives they felt were important. Since these exercises were not directly relevant to the topic of this study, however, they will not be described here. Instead, I focus on those PRA-type activities that were directly related to health, illness, distress and the war:

- **Issues Matrix**: this is a table which captures in summary form the issues of concern identified by participants, allowing for a differentiation between different sub-groups within a community (Mukasa and Mugisha, 1999). The adolescents first identified groups who differed from one another, for instance boys and girls, local and destocados, workers and students etc. These were then entered on the horizontal line across the top. The major preoccupations, worries and problems of adolescents were listed down the vertical side of the matrix and the adolescents then jointly decided how severely affected each of the groups were by a specific problem, indicated by means of different numbers of crosses in the matrix.
• Health Curative Matrix: the adolescents listed the most common illnesses that they suffer from in order of frequency in the first vertical column of the matrix, for instance malaria, diarrhoea, chest infections etc. Across the horizontal line they listed all the treatment options available in their communities, such as the clinic, the hospital, the curandeiro [traditional healer], the adivinhador [diviner], home remedies etc. Then they indicated by means of different numbers of crosses what options they generally pursue for the different illnesses. This provided insight into common perceptions about the effectiveness of health care options and raised issues about access, effectiveness and the differences between explanatory models (de Koning and Martin, 1996).

• Body Maps: the adolescents were asked to draw a person onto a piece of paper and to then mark on the drawing all the illnesses they have personally had over the last two years, as well as indicate where they went for treatment for each illness. At times the Body Maps were also used to discuss general effects of the war on people’s health where the adolescents marked all the illnesses that could result from violent conflict and displacement. The maps were then used as a basis for discussion of the adolescents’ explanatory models of illnesses, including aetiology and treatment (IDS, 1996c).

• Worry Lists about Health Issues: here the adolescents were asked to discuss and construct individual or group worry lists about health issues, i.e. what concerned them, what they were unclear about, what had happened to them or someone they knew in the past. These lists served as general information about the issues that adolescents regarded as important in relation to illness and health-care.

• Spider diagrams on the impact of war and displacement: in groups the adolescents discussed the various consequences of war and displacement for themselves and for their communities, filling in spider diagrams about issues related to health, survival, emotions, education etc.
• *Radio programmes* about their experiences of displacement: in groups the adolescents designed short radio programmes about how adolescents are affected by war and displacement. They used interviews, drama, songs and speeches to convey their experiences and thoughts which were tape-recorded.

• *Drawings on culture*: this exercise was left deliberately open-ended, the only instruction to the facilitators being that they should discuss with their group what they understand by culture and what aspects they like or dislike about it, representing this in some visual form on paper.

For an example of a PRA-type exercise completed by the adolescents see Appendix C.

Some of the activities implemented first with the Lubango adolescents were changed or replaced when conducted with the adolescents in Matala if they had not worked well or if the youths had not engaged actively with them. An example of this is the Venn diagram used for analysing problems in the school system which most of the participants found confusing and difficult. PRA allows practitioners to ‘fail forward’ by encouraging self-critical awareness of errors and non-success which in turn should lead to the adaptation and correction of activities and approaches while still in the field (Chambers, 1997).

A final meeting with all facilitators and adolescents who had participated was held, where some of the maps, charts and diagrams were shown and the radio programmes played to all participants and commented on. I met the facilitators separately afterwards and paid them a small amount of money for the facilitation work, based on the knowledge that a number of them worked full time as *negociantes* [informal traders] and had taken time out from their work in order to participate in the research activities\(^\text{39}\).

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\(^{39}\) This decision was made in conjunction with CCF staff members who were working with youths in these communities.
3. Psychometric measurement: the EARAT

In order to investigate the contributions made by psychometric measurements that seek to establish and explain the relationship between experiences of violent conflict and displacement on the one hand, and emotional and physical responses on the other, one such measure was employed with the same groups of adolescents in Lubango and Matala who had participated in the PRA-type exercises. An instrument that was available in Portuguese (see Manson, 1997; Marsella et al., 1996 on issues related to the translation of PTSD scales) and had been standardised in the Angolan context was selected, namely the EARAT (Escala de avaliação da resposta ao acontecimento traumático, versão adolescentes), developed by McIntyre and Ventura (1996) (see Appendix D for the original EARAT in Portuguese and its English translation). The selection of the EARAT was also partly based on it being representative of a range of instruments which seek to determine the frequency of symptoms associated with the diagnosis of PTSD. The results of the EARAT were analysed using the statistical programme SPSS for Windows Version 10.

The EARAT is based on the Children’s PTSD Inventory (Saigh, 1987) and consists of three sections. The first relates to the traumatic event (what happened?; when?; how did you feel? etc.); the second part comprises 17 questions covering the three categories of DSM-IV symptoms for PTSD (Reliving of the experience; Avoidance and Numbing; and Hyperarousal); and the third section contains 15 Likert-type questions testing the intensity of specific emotions or physical experiences (fear, nausea, sweating etc.)\(^{40}\). The EARAT is an example of a structured diagnostic interview based on the DSM-IV criteria for PTSD, utilising a dichotomous (yes-no) rating to determine presence of symptoms. It is not a clinical

\(^{40}\) See Appendix D for a copy of the complete EARAT.
assessment tool in that it was not designed nor used to make careful diagnoses of each and every individual interviewed within a clinical context, but is instead a means of estimating incidence and prevalence of possible symptoms of trauma and PTSD diagnoses for systematic empirical research (Ventura, 1997). The EARAT and its standardisation is further discussed in chapter 9.

The EARAT was administered to 50 displaced adolescents in Lubango and 52 adolescents in the IDP centres of Chipopha and Vissaka. The number of males and females within the sample is shown in Table 5.1. The youths were between the ages of 13 and 18 with only one participant being 19 years of age:

<table>
<thead>
<tr>
<th>Place</th>
<th>Lubango</th>
<th>Matala</th>
<th>Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>39</td>
<td>29</td>
<td>15.2</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>23</td>
<td>15.1</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>52</td>
<td>15.2</td>
</tr>
</tbody>
</table>

Table 5.1 Descriptive statistics of adolescents who completed the EARAT

Both groups of adolescents were not randomly selected and the sample was a convenience sample (see chapter 9). It cannot therefore be claimed that they were truly representative of displaced adolescents in Lubango and Matala. Nevertheless, the groups were diverse in terms of social background, educational levels, occupations and lifestyles, and conclusions can therefore be drawn from the data about the experiences and attitudes of ‘typical’ adolescents in Huila.

The EARAT was administered to all adolescents by myself and on a few occasions with the additional help of Manuel to whom I had explained the purpose of the scale and the required manner of administration. I explained to the adolescents how the scale should be completed (crosses in the ‘yes’ or ‘no’ boxes) and read the questions (items) out to the participants one at a
a time, clarifying the questions where necessary\textsuperscript{41}. Where youths were not sufficiently literate to complete the scale by themselves I helped them by pointing to the boxes they indicated verbally. Initially I attempted to complete all three sections with the adolescents but often ran out of time during the administration of the final, third part of the EARAT. This was due to the difficulty that many of the adolescents had with the concept of the Likert scale as well as with understanding the questions in relation to their war experiences as opposed to their general life experience. An example of this is the question about whether they feel cold or hot when remembering the traumatic event, a question which required lengthy discussion and clarification, as the adolescents frequently did not make connections between these sensations and their war experiences. After the first few interviews I therefore ceased administering the third section of the EARAT, completing only the first two sections.

With the Lubango adolescents administration took place in the small groups of six or seven in jangos, schools, or church halls where it was easier to clarify misunderstandings or questions regarding the items on the scale. In Chipopia and Vissaka the adolescents completed the EARAT in larger groups of about 17 in a school classroom. The administration of the scale took an average of 45 minutes - 1 hour with the groups. At the end of the session I discussed with the adolescents how they felt while answering the questions, why they thought people would want to ask about these issues, and how relevant these questions were to what they were experiencing. I also provided “normalising responses” about the adolescents’ reactions to the experiences of war by explaining that others have experienced similar reactions (see Manson, 1997).

\textsuperscript{41} I was very aware of the potential for influencing the responses by giving further clarification but this could not be avoided as the adolescents often did not understand the questions as they were phrased, mainly due to the fact that they had problems understanding the vocabulary used.
Extraneous factors that may have affected the results of the EARAT were, firstly, that the vast majority of adolescents in Lubango and all of the adolescents in Matala knew me prior to the administration of the scale and may have developed ideas about my expectations regarding their answers. I decided to run this risk of response bias in order to avoid the purely extractive situation under which most PTSD scales are administered where the researcher has only one direct contact with the respondents, i.e. when he or she implements the scale. Instead, I developed rapport with the adolescents and could monitor and contain possible emotional distress resulting from remembering and discussing their experiences of the war.

Secondly, the adolescents’ responses to the questions may have been influenced by the fact that the EARAT was administered to them in a group, as children and adolescents tend to answer in the way they think that their peers will answer (Nader, 1997). However, this was partially counter-balanced by explaining in detail to the children why I was gathering the information and what was to be done with it, as well as reminding the children several times during the assessment that each person responds differently to distressing experiences, and that there are not right or wrong answers. Thirdly, the assessment process was influenced by the setting in which the EARAT was administered, this ranging from enclosed settings such as a church meeting room to public spaces such as jangos where the adolescents could be easily distracted. The latter situations were far from ideal but were usually the only places available in communities in which to conduct the sessions.

A final comment regarding the methodologies employed in this study: over recent years scholars have argued for a reflexive approach to research, calling on researchers to become aware of how their characteristics and theoretical orientations impact on the interaction in the field and the production of ethnographic texts (Pidgeon, 1996). The need for reflexivity is especially relevant in relation to field work with war-affected populations as a number of
ethical questions arise in these contexts. Due to space restrictions these issues are discussed in Appendix E.

The following four chapters present the findings of the study, starting with a general introduction to the health care systems operating in the areas where the deslocados lived.
Chapter 6

Idioms of distress and resources in the local health care system

At the end of chapter 3 the central research questions of this thesis were identified. Some of the major themes which will be addressed in this chapter are firstly, the centrality of local contexts and realities within which the displaced find themselves and within which they attach meaning to their suffering; secondly, the various forms in which suffering and distress are experienced and expressed; and thirdly, the coping resources that people make use of in dealing with distress.

This chapter provides a general introduction to the local context within which the deslocados in Huila attempt to cope with the distress and suffering caused by war. It starts with a presentation of some of the commonly found idioms of distress and illnesses of somatisation amongst the deslocados. This is followed by an overview of the different sectors of the health-care system, focusing specifically on what resources the professional, folk and popular sectors provide in addressing illnesses related to distress. Factors that affect health-care seeking behaviour are discussed, and, in conclusion, issues and questions raised by the presentation of this material are summarised. Throughout this chapter an attempt is made to let the deslocados speak for themselves as much as possible, and to “privilege their voices and their experiences over our interpretation, analysis and theories” (Kleinman & Kleinman, 1991: 284). This is done in order to take the local context and perspectives of the deslocados
themselves as a starting point for subsequent analyses, and all ensuing chapters will refer back to the material presented here.

1. Local idioms of distress

Suffering requires a language. The language of a syndrome or illness makes its objects real and may be an appropriate and positive way in which people express their experiences (Antze, 1996). As has been pointed out in chapter 2, illnesses are expressed not only in physical but also in spiritual, emotional and psychological ways. Often these expressions may take the form of folk categories or illnesses that are commonly understood within specific populations. Such folk illnesses come into existence when general agreement exists within a society or community around a pattern of symptoms and signs, their origin, significance and treatment, i.e. when the language of suffering is communally understood (Helman, 2000). The illness becomes an entity with a recurring identity which has symbolic meaning in terms of the physical, social, moral and cultural issues related to health and ill-health. Folk illnesses thus blend together physical, emotional and social experiences into a single image that may be an effective means of communicating distress to others.

1.1. Os pensamentos

In Lubango and in the camps there were several ways in which people spoke about their experiences of war. The most common way is to refer to os pensamentos, meaning in direct translation “thoughts”. These are thoughts and memories of the destruction and violence that has occurred as well as about what has been lost: the brutal attacks, family members and neighbours who have been killed or injured, animals that have been taken by the armed forces, land that has been abandoned, crops that have been stolen, fields that remain unploughed and unsafe due to land mines, hunger and deprivation suffered during the flight and afterwards.
All deslocados have pensamentos about their experiences of war and displacement and it is considered normal to have these:

Q: What are pensamentos?
This happens in all of Africa. Some people leave their place and come a long way because they are refugees. And there where they came from they had fields. There they had lots of food and now they have no money. I had pigs, goats, cattle, chicken - at this time I have nothing and only make funje [cassava/maize porridge]. .... It is like this for the deslocados who are in Lubango, Benguela or Huambo. We think about what we had before and that we have nothing now [Santa Filomena, Lubango].

The majority of people accept periods in which they have pensamentos as inevitable, times during which they may feel sad, angry and lonely. Pensamentos are related to the current situation of the deslocados where their daily hardship is a constant reminder of their previous experiences: continued suffering in the form of hunger, the lack of an opportunity to make a livelihood, the absence of family members and the support they normally provide form part of the reality of the deslocados’ lives. In general, however, pensamentos do not prevent people from making ongoing efforts to improve their situation, to look after their families and carry on with their daily activities, in other words to engage in what Nordstrom (1997) calls “world-making”:

Q: Do the pensamentos prevent you from doing the things you need to do?
No, not here because you may have pensamentos but you will still work. Because if you don’t work, your children will die. People here in the camp always think ahead to the future [Isabel, Vissaka].

A problem arises, however, when some people “think too much” and subsequently become ill because of this. Constant and persistent pensamentos can lead to various illnesses and can start affecting the person’s ability to function in their daily life. In this context the term pensamentos no longer refers to the ‘normal’ process of remembering but to something that a person is suffering from:

Q: Sometimes things happen in life that are very bad and people get sick. What do you call this?
We call this os pensamentos. Sometimes someone goes to another world [dies] because of thinking too much [Curandeira Josefa, Lubango].

“Thinking too much” is an intensified form of having pensamentos where the person spends large parts of the day thinking about the past:
I spend the days sleeping. It is because my heart is aching. When I think about the cassava which I left behind, my house with a place to sleep, they burnt it; then a field with beans, they burnt it. When I think about this my heart pains and I don’t manage to do anything [Dona Paula, Chipioia].

This state was described by some of my informants in Lubango as “brooding”, being lost in thought, being melancholic. One of the catecistas in Vissaka, however, described it succinctly as a pain in the heart which never stops (“um dor no coração que nunca acaba”) [Catecista Manuel, Vissaka]. A person suffering from this is usually listless and uninterested in daily activities, will spend a lot of time on her own not doing anything, may lose weight, may have problems with sleeping, and may stop caring or providing for her family. One of the common signs that one is “thinking too much” is that one will develop a cabeça quente, [a hot head] which is described by people as an experience of heat and tingling in the head.

I met a woman the other day, just sitting there, thinking. I asked her what she is doing. She said that her head is aching, she is very thin. “My head is hot, here on top. I am thinking only about the things I left behind”. This is because of the pensamentos. This will bring lots of illnesses [Dona Emília, Chipioia].

A cabeça quente can in turn lead to madness if it is not treated:

People call this as having memoria quente [hot memory]. You need to calm down the memory. The behaviour of these people is that they can be almost mad, distracted, the veins in the head are pushing up and causing pressure. This causes the headache. The nerves are hot and the conscience as well. The person doesn’t sleep well, has lots of pain. This is caused by pensamentos which cause the head to heat up. This causes you to lose your sense and you may become mad [Catecista Manuel, Vissaka].

Pensamentos and “thinking too much” can lead to several other illnesses such as high or low blood pressure, madness and an illness called mutina (‘heart’ in Nhaneka) or mbunge kuavale (‘pain in the heart’ in Nganguela). Some of these illnesses will be briefly discussed below.

1.2. High and low blood pressure

Two of the most common illnesses that people described resulting from pensamentos are high blood pressure (HBP) [a tensão alta] and low blood pressure (LBP) [a tensão baixa]. These terms were used both by the deslocados and by the medical staff at the clinics and seemed to be a shared language used to communicate the fact that the person is worried, distressed or
upset. As such, it is an example of somatisation as normative expression of personal and social distress in the form of an idiom of bodily complaints and medical help-seeking (Kleinman, 1986). As described in chapter 2, somatisation is the embodied way in which distress is experienced in many societies and communities where people do not always make a distinction between physical and emotional distress. The cause of high blood pressure is “thinking too much” about what has happened:

The war brings a lot of illnesses... and also low blood pressure and high blood pressure. This is because of thinking too much and many times you can’t sleep. If you try to sleep and make a lot of effort to sleep and can’t, then the blood pressure rises [Dona Isabel, Chipopia].

I suffer from high blood pressure. I always have headaches, my head is hot. I always think about the things I left behind and that I have nothing to eat. And I have no place to live. And this provokes illness [Flavia, Chipopia].

A differentiation is made between HBP and LBP: those suffering from HBP tend to be more agitated and restless and may suffer from insomnia, whereas those with LBP are quiet, listless and may sleep a lot. With LBP the slowing down or a loss of heartbeat may occur:

Then there is low blood pressure - this is more dangerous because your heart can stop beating. The pulse can be as low as 0. This is also caused by pensamentos but the difference is that the person thinks but doesn’t talk to anyone, just stays thinking and keeping it all inside himself. Later he can fall down but he is not sick - it is because the heart doesn’t beat. People then come and say “the memory is not well, it is low”, or “the heart doesn’t beat well” [Community health workers, Vissaka].

Not all of the pensamentos that cause changes in blood pressure are necessarily related to the war. Distress caused by the death of a child from illness may for example also lead to these symptoms. HBP and LBP thus serve as general idioms of distress in society. The deslocados and the medical profession clearly recognise that the causes of high blood pressure are not physical but have social or emotional grounds. Unlike many other cases of somatisation where patients present only with their physical complaints and make no reference to their mental or emotional states (for e.g. Kleinman, 1995, on his work in Taiwan; Ots, 1990, on

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42 Categorising HBP and LBP as forms of somatisation does not imply that these illnesses are fictitious in the sense that people do not ‘really’ experience them as physical symptoms, but merely emphasises the fact that these illnesses serve as a means of expressing distress in bodily terms.

45 HBP in Angola cannot be equated with the similar symptom in high-income countries where its causes are often related to lifestyle issues, nutrition and alcohol consumption, issues which do not apply to the deslocados.
somatic illnesses in China), the deslocados explain the connection between their distressing experiences and their symptoms of HBP/LBP. Nevertheless, they actively seek assistance from the health clinic in the form of medication that will lower the blood pressure, believing that the causes may be mental or emotional but that the symptoms are physical and will thus be cured only through biomedical drugs. It was also for this reason that people preferred to consult the nurses at the clinic rather than a curandeiro for changes in blood pressure: it was predominantly seen as a “hospital sickness”, as opposed to a “traditional illness”, and therefore falls into the realm of biomedicine. This perspective was shared by the majority of the nurses who treated HBP and LBP as a physical illness with an emotional aetiology:

I have about five patients a week with this. This happens when they are very pensativos [think a lot], they have lost all their goods and members of their family. They present with headaches and high blood pressure, they don’t sleep or they have bad dreams, have a lot of confusão [confusion, chaos] in their head. I measure the blood pressure and it may be normal, high or low. If it is normal we inform the person that it is normal and we give them aspirin and tell them to come back after three days to check how things are. Those who have high blood pressure we monitor twice a day to see how it is and we give them medication to control the blood pressure. Normally this helps and the pressure comes down. Some cases people are very agitated and don’t calm down... In cases where there is low blood pressure this may be with the old people who think a lot. Pensamentos can cause high or low blood pressure... More common is high: there are very few cases of low in Chipopia [Nurse Joaquina, Chipopia].

1.3. Mutima

Another illness that can occur as a consequence of suffering is mutima or mbunge kuvavale. The word mutima means heart in Nhaneka and mbunge kuvavale means “pain in the heart” in Nganguela. This illness may occur when a person experiences distressing events, such as the death of a family member, and the heart leaves its ‘normal’ place in the chest and wanders to another part of the body. This is how mutima was described to me by two curandeiras who could treat this illness:

Mutima is a pain in the heart. The heart moves to any place in the body, maybe into the toe or the stomach or the back.... [You find out] where the heart is by feeling where the pulse is beating. There is no pulse in the place where the heart normally is. The person doesn’t feel pain when the heart moves to another place, just that the person doesn’t want to do anything, sleeps all day, doesn’t talk, has no energy [Curandeira Julia, Vissaka].
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The heart may go anywhere - to the feet, to the toes, at the head, wherever. If someone can’t walk this is a sign that the heart is in the feet. If someone is sad the heart is in the head... You don’t care about your family because you are sad. If you stay with this illness for a long time it will be difficult to treat [Curandeira Anna, Vissaka].

Mutima, like changes in blood pressure, is not specifically related to the suffering caused by war but may be brought on by other situations of acute distress as well. It is an illness associated primarily with death where those who think and talk too much about the deceased person are likely to develop it. The onset of the illness may be sudden or gradual. In the former case the person may experience a rapid attack of symptoms, losing consciousness and collapsing. This constitutes a situation of crisis where swift intervention is necessary:

This happened the other day with the mother whose son died a few days ago... When they were putting the coffin into the ground the same thing happenend with the mother: she looked at this and fell down, she was shaking and she had no life left and the other women went and started to massage her quickly, shouting: “Massage her here on the arms, no, here on the legs”. The heart fell down and she lost consciousness [Dona Marta, Chipopia].

The illness may also develop over a certain time period as a result of an accumulation of losses that culminate in the heart leaving its place. An example of this was the wife of the soba in a rural area outside of Lubango who had eleven children, five of whom died over a space of three or four years. After the fifth child died her heart wandered into her head and she had to seek treatment from a curandeira. The treatment was considered successful by her because she could now remember her dead children and think about them without feeling sad.

Some people who develop mutima experience it primarily as a loss of heartbeat where the heart ceases to beat. They may live with this condition for some time but will suffer from insomnia, a lack of interest in daily life, tiredness or restlessness:

She sometimes has her heart which beats and beats and then it stops beating. She goes to the clinic and they listen to her heartbeat and they can’t hear where her heart is beating. You can’t hear her heart. She also can’t sleep. She can pass the whole night without sleeping, sitting upright, or she sleeps but she is tired [Dona Isabel, talking about a woman suffering from mutima in Chipopia].

If untreated this illness may lead to death or to madness. The latter is especially likely if the heart has moved into the head. It can also be life-threatening because if one injures the part of
the body where the heart has moved to, one may die. The example given by a woman was that if the heart is in the toe and one hurts the toe one may accidentally ‘kill’ the heart and die [Field notes, Lubango].

*Mutima* cannot be cured at the clinic: it is understood to be a traditional illness that can only be treated by *curandeiros* or *santas*. People felt that the nurses misdiagnosed the illness as something else if they present with their symptoms at the clinic:

There is specific medication to prevent the person from thinking too much. The *kimbandas* [Umbundu word for traditional healers] have a lot of people with this problem. Sometimes people at the hospital think that this is a problem of high or low blood pressure in the hospital but it’s not - it’s a problem of thinking too much [Xavier, Lubango].

Occasionally, however, some overlap existed between the way in which *mutima* and LBP were described, for example:

War provokes many illnesses because sometimes you see a person and then you see him killed in the war. And the intestines are outside of the body, or the head is cut open but the person is still not dead. If you see these things a person is not well. The heart leaves its place. You get low blood pressure [Dona Emelia, Chipopia].

This was also noticeable in the way that LBP was sometimes described as being a loss of heartbeat, i.e. the heart stops beating, a symptom associated with *mutima*. To my question whether the two are in fact the same illness with different names, people replied that this was not so, pointing out that LBP is primarily an illness of the blood and *mutima* an illness of the heart. The former must be treated at the clinic with medication, the latter can only be treated by a *curandeiro*.

The treatment performed by the *curandeiro* involves locating the heart in the part of the body to which it has moved by finding its pulse. The heart is then massaged back into its proper place in the chest and tea made from *enyatí*, a root that has calming effects, is administered. A *curandeira* who specialised in the treatment of *mutima* demonstrated and explained the treatment with a female patient:
I listen to the heart, I look for the place where the heart is and after this I will give the information: the heart is in the head... I listen to how the heart is beating [high, fast, slow]. Now I massage [the client] to put the heart in the right place. I need to put it back into place by massaging [she starts to massage the woman, stroking her body and her arms all over in a rhythmic fashion with strength and consistency]. If the heart is in the feet I need to take it out from there by massaging. After this massaging you will feel yourself better but it is not yet right - it takes some more time. She goes home and she drinks some medicine and after some while she will feel that the heart is in the right place [Curandeira Fatima, Lubango].

Amongst the deslocados mutima was a relatively frequent illness. The curandeiros in Vissaka and Chipopia reported that when the deslocados first started arriving in the camp they treated a large number of people suffering from mutima, each treating four or five people per week. By July 2000 this number had dropped to about four people a month. In Lubango curandeiros confirmed similar trends amongst newly-arrived deslocados.

1.4. Loucura

The word loucura signifies madness or insanity. According to local opinion there are a number of causes of madness: the war, domestic violence, pensamentos, witchcraft or the wind ["sent by God", meaning ‘just like that’ without specific reason]. The symptoms are independent of the aetiology and usually follow the same patterns: running around wildly, talking incoherently, eating inappropriate things, and wandering around naked\(^4\). A differentiation is made between mad people who become aggressive and those who do not, the former being more common and presenting a danger to others by physically attacking or biting people:

When they arrive they are tied up and sometimes it is necessary to tie them to the tree... He has to be tied because he wants to fight all the time and is very aggressive. He doesn’t want to eat anything... He looks like a lion [Curandeiro Augusto, Lubango].

\(^4\) This finding is similar to a study conducted by Edgerton (1977, in Helman, 2000) amongst four East African communities in Kenya, Uganda and Tanzania where participants were in broad agreement that behaviours such as violent conduct, wandering around naked, ‘talking nonsense’ and ‘sleeping or hiding in the bush’ constitutes madness.
Ordinary people can become mad if they develop *pensamentos*, a *cabeça quente* or HBP and do not receive treatment for these early on. Madness as a result of *pensamentos* is seen as an escalation of symptoms:

If someone goes mad because of *pensamentos* he will first get a *cabeça quente* and it may seem like his head is on fire, and then he will get high blood pressure, and if he is not treated then he will go mad. He will behave in an uncontrolled way, talk at random, take off his clothes, walk around without aim or direction. [Selestino, Vissaka].

There were not many cases of *loucura* amongst the *deslocados* in Lubango and in the centres. In Vissaka there were two men who were being monitored by the *curandeiros* and whose madness was said to be related to bewitchment rather than *pensamentos*. In Chipopía two people were known to be suffering from *loucura*: one man was successfully treated by a local *curandeiro*; the other was a woman who reportedly became mad at full moon every month, a condition she had already suffered from before the displacement and for which no one could find a cure.

*Loucura* was reported to be common amongst soldiers who were directly involved in warfare. A number of factors could contribute to this, for example if the soldiers were very young and inexperienced and were exposed to a lot of blood during combat:

Some are crazy because of seeing blood. When they were in the army they saw a lot of blood. When they leave they stay troubled [Santa Maria, Lubango].

Another cause of *loucura* is the shock that results from the noise and impact of exploding bombs:

Q: Why do some soldiers go mad in the war?
   The explosions of the guns and bombs. People go to the war and when the bombs explode they get a fright and you get *ohwuhaluka* [get frightened]. This is the same as *susto* [fright].
Q: What do the people think or feel?
   They think that something is about to kill them and this is why they get mad [Curandeiro Augusto, Lubango].

A further cause of madness amongst soldiers is through a witchcraft deal known as *mbindi* which will be discussed in detail in the following chapter 7.
Most informants were of the opinion that loucura cannot be successfully treated at the clinic nor the hospital:

It’s impossible to treat madness at the hospital. If a mad man goes to the hospital they will inject him with calmants but afterwards he will wake up and fight. He will kill the nurses and everyone so it’s impossible to treat madness there. It is very difficult to treat. It is only the curandeiros who can do this [Eduardo, Lubango].

This is how a curandeiro who specialises in the treatment of madness described his treatment procedure:

The people come and they bring the mad here and they bring wine, a litre of wine and money. I use different kinds of medicine. [He shows us a brown powder made from the roots of a tree called omumumbili]. I put this medicine in the nose of the person and if he sneezes I will treat him, but if he doesn’t, I will never touch him because he is going to die and there is no hope for him. He cannot be treated. [It means] they left the illness too long and now it is too late for treatment. [He shows us another powder made from the bulb of a bush called etindi]. This medicine I use to check, I put the medicine on my tongue and I touch the head with my tongue. If the person has madness I will feel a kind of shock. If I don’t get a shock it means that he is not mad... This is a third medicine for putting it on the teeth to prevent him from biting other people... Here is another medicine: this is to make the person vomit. He has to vomit to become well. When the mad person first comes he wants to run away. I stop him from running away by putting my hand on the head of the person and hitting it with the other hand. [He demonstrates this on Manuel, the translator]. Just to keep him here. [Curandeiro Augusto, Lubango].

The success of the treatment depends on how soon after the onset of the symptoms the ill person is brought to the curandeiro: the sooner the person comes for treatment the better the chances of recovery. Nursing staff at the clinics were hesitantly supportive of curandeiros treating cases of loucura, many expressing the opinion that because the hospitals lacked appropriate medication they were unable to provide treatment for such patients who were thus better cared for by the traditional healers:

The person gets good food at the house curandeiro and this helps him improve. If the person gets better it depends on the kind of medication that the curandeiro gives - sometimes the medication is good. But if not it means that the medication didn’t work. At times the curandeiro doesn’t manage to cure and then the person comes to the clinic but there are already complications [Nurse Adriana, Lubango].
1.5. Social and cultural meanings of the idioms of distress and somatisation

Apart from loucura the idioms of distress and the forms that somatisation takes in the south of Angola relate to thought, the heart and blood. What is the cultural and social significance of people expressing their distress in these terms? In other words, why do people not talk about their nerves as, for instance, is the case in many parts of South America, or develop problems in the kidneys or liver as they do in Taiwan? Helman (2000) suggests that the organ(s) in which the illness manifests often have a symbolic or metaphorical significance for the group concerned. He terms this phenomenon cultural somatisation where core cultural themes of a society become embodied through the symptoms of the illness. One of these themes is personified in Angola’s national symbol, the pensador [thinker]: the figure of an emaciated man, sitting on his haunches and resting his head in his arms, giving the impression of being engaged in the contemplation of serious issues\textsuperscript{45}. The connection between pensamentos about war and suffering and this figure, visible in many areas of public life, is not difficult to propose.

An intimate connection seems to exist between the mind and the heart in the local expressions of distress: problems with the heart are a direct result of processes in the mind, i.e. a loss of heartbeat, pain in the heart or mutima are symptoms that occur as a consequence of pensamentos or “thinking too much”:

\begin{itemize}
  \item Q: Does this have anything to do with the heart or is it because a person thinks too much? This is a problem of thinking too much connected with the heart. Because sometimes if a woman loses one, two, three children even if she is walking alone she starts talking alone. Or thinking very much about the children and this causes heart pain [Curandeiro Paulo, Lubango].
  
  \item Q: Are pensamentos and heartache [dor de coração] the same thing? Yes, they are the same... If the illness originates from pensamentos or from the heart the head doesn’t work well. Because the heart always thinks better [than the head] [Santa Maria, Lubango].
\end{itemize}

\textsuperscript{45} The origins of this figure are traced to the ethnolinguistic group of the Chokwe in the east of Angola (Estermann, 1957).
The illness thus seems to originate from the mental activity of remembering the past or spending too much time thinking but the effect is felt in the heart. The heart is perceived as the most important organ that gives and maintains life - but not necessarily in western medical terms as is demonstrated by the belief that people can suffer a loss of heartbeat and continue living. Instead, the heart is seen as the source of emotion and the locus of distress. Ben-Tovim (1987) points to a similar view of the heart amongst the BaTswana in Botswana, and Peltzer (1996) reports that in Malawi thoughts are believed to come from the heart and not the head. Other studies from around the world confirm the central role that the heart can play in idioms of distress and the language of emotion, for example, ‘heart distress’ in Iran (Good, 1977) and ‘sinking heart’ amongst Punjabis in the UK (Krause, 1989).

Clearly, symptoms such as those of HBP and LBP cannot be reduced to being either emotional or physical in nature. Instead, they are a mixture of both (Swartz, 1998). The importance of such idioms of distress lies in meanings attached to them in the society or community in which they occur. One interpretation offered in relation to other forms of somatisation such as nervios in Latin America is that the body is used as a mode of expressing dissent by people in structurally powerless situations (Lock, 1990). A study of somatisation thus becomes the study of relationships of power in themselves and of the ‘weapons of the weak’ (Turner, 1968). Certainly, the deslocados in the rural areas in southern Angola are amongst the forgotten victims of a war in a country itself mostly forgotten by the rest of the world. As described in chapter 4, the deslocados do not feel secure in the government’s “safe havens” and many feel abandoned, unheard and unacknowledged by the people who make decisions about their fate. This leads to feelings of helplessness as expressed by one elderly man in an IDP centre in Lubango:

What can we do? This is my country and where can I go for help? I can’t go anywhere [Jamba., Tundavala].
Such feelings of helplessness may find expression through somatisation as a way of indicating protest and communicating anxiety about the future. When people in the centres near Matala, for example, heard that they were to be relocated to another area which they said was not safe from UNITA attacks (see chapter 4), people reported a rise in symptoms of distress, such as insomnia, more *pensamentos*, and more problems with HBP:

They don’t want to go when there is still war. They only want to go back when they can be in the same way there as they are here: sleep well, eat well, don’t carry anymore heavy loads, don’t run anymore, the body is well... Now we are okay here and now they say that we have to go back there. The people are not sleeping well nor eating well because they are thinking about having to return there where there is suffering [Emelia, Chipopia].

Somatisation and idioms of distress thus operate not only on physical and emotional levels but also on social and political ones.

A further issue to note is that when deslocados present at the clinics with problems of the heart they often seem to ‘translate’ their symptoms of distress into a medically acceptable language that they use in their interactions with the staff [Field notes, Vissaka]. Thus, instead of talking about the heart leaving its place or a loss of heartbeat, they are more likely to talk about HBP and LBP. If, however, patients do present with *mutima* at the clinics the health staff usually assert that the heart cannot leave its place

If people come with this illness we say that the heart has not really left its place: it may just be beating more hard or more soft than usual but that it will become better with time [Nurse Pedro, Chipopia].

It may thus be that patients ‘know’ or ‘learn’ the expected way in which they have to present their problem to the medical staff in order to be taken seriously and to access medication⁴⁶. In this way they may be adopting the explanatory model of the medical profession rather than using the traditional one (*mutima*) used when consulting a *curandeiro*.

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⁴⁶ Swartz (1998) discusses a similar phenomenon in the use of the term ‘nerves’ introduced into a community in South Africa by medical personnel who attempt to provide an explanation in easily comprehensible language to their patients.
When the deslocados discussed issues of health and illness related to the war, they described a range of physical ailments and injuries which people sustain as a consequence of the attacks, the lack of food and clean drinking water, the exhaustion of the flight, and the harsh living conditions. While the physical health problems of war-affected populations are beyond the scope of this thesis, it is important to point to the wider context in which issues of psychological and mental health are situated. This became particularly apparent during my research when people routinely mentioned illnesses such as cerebral malaria and bovine disease as being caused by the suffering of war. Within a biomedical explanatory model the aetiology of these illnesses is unrelated to the experience of war, as they are regarded as being caused by parasites transmitted by mosquitoes and cattle. The deslocados, however, saw these as a result of the excessive suffering of war:

Malaria can be caused by pensamentos about what you have left behind and about the people who have died. Malaria is when a person does not get better and becomes more or less mad. A person with malaria doesn’t talk, doesn’t move and cannot be cured in the clinic [Curandeiro José, Matala].

I also caught that illness which you get because of the war, that one where you get lots of black bubbles at the mouth. You start to bleed from the mouth and the nose. This is very dangerous. I got this and then my husband made a treatment and it passed [Dona Dominga, describing symptoms often associated with bovine disease. Chipopial].

One of the reasons for the association made between these illnesses and war is that the war dominates most aspects of people’s lives in Angola, but especially those of the deslocados. Many difficulties are attributed to the war and throughout the country one often hears the phrase “é por causa da guerra” [“it is because of the war”]. In a society embroiled in long-term violent conflict everything becomes subsumed under the war, and the causes and consequences of misfortune cannot be separated from the violent conflict that has fundamentally affected people’s lives (Nordstrom, 1997). War kills in many ways, not just through guns, machetes and bombs, and it brings illness and death in many different forms. The lack of social and communal stability and normality, the inaccessibility to health care and the physical and emotional hardships all contribute to this situation. Such illnesses are also sometimes attributed to the war because people hold explanatory models which do not
necessarily draw clear distinctions between the physical, emotional and mental causes of an illness.

I now turn to a discussion of the different sectors of the health care system and highlight some of the factors that influence decision-making for treatment.

2. Health care and treatment options

Societies have multiple healing traditions that are drawn on not only in order to ‘cure’ illnesses but also to make sense of them, categorise them, explain their causes and organise personal and community responses to them (Desjarlais et al., 1995). Knowledge of local health care systems is the starting point for understanding the resources populations draw on in order to deal with distress. This includes local systems of cultural knowledge, family structures and communities, systems of folk healing and local medical services. As discussed in chapter 2, choices about health care are influenced by the context within which they are made: the types of options available, payment required, accessibility and, perhaps most importantly, the explanatory model that the patient holds about the particular illness and health in general.

The sectors of health care that are available to deslocados suffering from pensamentos and related illnesses are, firstly, the professional sector which consists of medical staff at clinics and hospitals; secondly, the folk sector which includes of curandeiros, adivinhadores, faith healers and vendors who dispense medication at the markets; and, thirdly, the popular sector in which family members, neighbours, church leaders and religious groups provide ‘lay counselling’, home remedies and practical assistance. Often these sectors are used
simultaneously or consecutively for the same illness. The following was a typical response to my question about help-seeking:

Q: Where does a person go if he has this problem of *pensamentos*?  
You go to the *curandeiro* or the church. Here in Lubango some go to the hospital and some go to the church and talk to the priests. Depends on the person [Nino, Lubango].

2.1. The professional sector: medical staff at clinics and hospitals

In Lubango the self-settled *deslocados* made use of the clinics situated in the *bairros* around the town, sharing and utilising the existing, and usually inadequate, health resources of the local population. In Chipopia and Vissaka the clinics set up for the *deslocados* catered also for the local population of surrounding farm areas. The number of staff and their level of training varied greatly between clinics, with some clinics having only one qualified nurse on their staff and the rest consisting of *promotores de saúde* [health promoters] who have had short and limited training. The clinic worst affected by staff shortages was in Vissaka: only one person had been assigned to this clinic and when he was absent the clinic closed for the day. There was one district hospital in Lubango and a smaller hospital in Matala.

Most staff at the clinics work under very difficult and stressful circumstances with large numbers of patients, a shortage of essential medication, and little or no supervision. At times they were faced with complex medical problems for which no referrals could be made due to an absence of specialised medical care. Their pay at the time of research was the equivalent of about $5.00 a month with which they could not support a family. They, like many other state employees in Angola, thus had to find supplementary income through *negócio*. Working under such conditions, the morale amongst medical staff was generally low and interest in, and commitment to, their work limited. Of course, variation existed and depended on particular individuals and how they perceived their role in health care provision.
A typical consultation at a clinic lasts approximately four minutes in which the nurse asks the patient’s name and age, weighs them, enquires about the symptoms, makes a diagnosis and writes out a prescription [Field notes, Lubango and Matala]. Often no greetings are exchanged when a patient enters the consultation room and the nurse frequently does not inform the patient about his or her diagnosis, nor inform them how the medication should be taken. The interchange between staff and patients is thus generally limited in terms of the quality of communication and the exchange of information, especially as diagnoses are mostly made on the basis of the one or two sentences spoken by the patient. During these consultations there was a considerable absence of the customary politeness of Angolans in interactions with others and respect towards those who are older [Field notes, Matala]. A definite power differential exists between medical personnel and patients: the majority of the staff do not live in the areas where they work; they were literate and had received some form of training or education; they were used to urban or semi-urban lifestyles; and some did not speak the vernacular language of their patients. They were thus separated from their patients by educational background, economic position, social class and sometimes by cultural background. The perception of the staff by the communities varied and their efficiency and professional competence were frequently commented upon. In one of the centres some of the medical staff regularly arrived at work drunk, a fact that angered the deslocados who nevertheless felt they could do nothing about it.

When deslocados consulted staff at the clinics about illnesses related to pensamentos and distress they often presented with complaints of HBP, insomnia and headaches. If HBP was indeed confirmed, the medical staff diagnosed the constellation of symptoms as hypertension which they described as the correct medical term for the lay understanding of HBP [Nurse

47 In the centres the drugs were supplied free of charge; in Lubango the patients usually had to buy the medication.
Esperança, Chipopio]. If the symptoms could not be confirmed, staff usually concluded that the patient was suffering from *pensamentos*. For this they felt they could not provide any “real” help in the form of medication but would occasionally dispense paracetamol to those severely affected by insomnia. At times the medical personnel displayed irritation with people who complained of HBP but whose measurements were in fact normal, especially if the patient seemed not to accept that there was nothing physically wrong with his or her health:

And we say: “Your health is good, your blood pressure is good and your heart is in the right place”... But it is difficult for them to accept this. They will still believe that something is wrong [Nurse Adriana, Lubango].

The irritation in part also seemed to be due to feelings of helplessness of the staff when confronted with such patients for whose situations they often expressed great feelings of sympathy but felt powerless to assist [Field notes, Lubango].

Some staff were of the opinion that people suffering from *pensamentos* could be better assisted by a *curandeiro* and a few stated that they had already referred a few patients to healers in the past. However, ambivalence about the general benefit of traditional healing dominated these discussions with most staff attempting to reconcile some of the differences in treatment approaches between themselves and the healers:

Usually there is a conflict between the *curandeiro* and the modern nurses and we try to work out this conflict but sometimes it’s difficult. We try not to morally offend the *curandeiro* in order to avoid bad relationships. We try to show that we can work together: they do the same kind of work that we are doing. But we know the *curandeiros* are not always doing well [do not always treat the illnesses successfully] [Nurse Linda, Lubango].

The biggest complaints from the nurses was in relation to illnesses such as diarrhoea and malaria where people tended to consult *curandeiros* first before coming to the clinic, at which point the illness may have advanced to a serious stage already.
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What numbers of people consulted the clinic for problems related to H/LBP, insomnia, and *pensamentos*? An analysis of the registers in which each consultation and diagnosis was noted by the nurses suggested an average of about 10 - 12 people receiving this diagnosis on a monthly basis in Chipopia and Vissaka, out of an approximate 1200 patients in total per month.\(^\text{48}\) Men and women were split almost evenly in this group with women occasionally leading in the diagnosis. This contradicted the accounts of the medical staff who reported a substantially higher number of women patients with these complaints. The clinic registers were not reliable sources of information, however, for a number of reasons. Firstly, because medication was free at the clinics in the centres people sometimes faked illnesses in order to receive the drugs which they could then sell at the markets (MSF, Chipopia). Secondly, there were some problems with the way in which diagnoses were made. Staff members who were unsure about symptoms felt compelled to make a diagnosis anyway and at times used hypertension as a ‘filler’ diagnosis (MSF, Chipopia). Conversely, some staff were not familiar with the diagnoses of hypertension and insomnia and therefore never made use of these. The diagnoses made by the clinics are thus not a reliable source of information about illnesses and no other records existed in the communities.

2.2. The folk sector: *curandeiros*, *adivinhadores*, faith healers and vendors of medication

The vast majority of illnesses for which people in Huila decided to consult someone were treated by practitioners in the folk sector. This applied almost exclusively to illnesses considered to be “traditional illnesses” but also included “hospital” illnesses such as malaria, tuberculosis and cholera. Considerable differences exist between the main providers of services in this sector, i.e. between *curandeiros*, *adivinhadores* and faith healers. Decision-

\(^{48}\) The number of patients varied greatly during the year with periods of hot temperatures resulting in a substantial increases in malaria-related illnesses.
making about whom to consult depended predominantly on people’s religious and spiritual beliefs. These beliefs and how they relate to issues of distress, health and illness will be explored in greater detail in chapter 7 where the role of the adivinhadores and faith healers will be discussed in more depth. In this section I will instead concentrate on the treatment provided by curandeiros and make a brief reference to vendors of medication at the marketplaces.

2.2.1 The curandeiros

The defining characteristic of curandeiros is that they are people who have the skill to heal. This skill can be acquired in two ways: either through the help of a spirit who takes possession of the person and guides him or her in their treatment, or by undergoing an apprenticeship with an experienced healer who knows the plants and roots required for treatment. These two ways are not exclusive and many healers are first possessed by a spirit and then undergo an apprenticeship. Being chosen by a spirit to become a curandeiro is a process over which the healer-to-be has no control, the spirit will cause him or her to fall ill until the person acknowledges, honours and uses the spirit for healing. Here is a description of this process:

My spirit came to me when I was in the army. I went crazy and at first I thought this was witchcraft and I had been bewitched. But it wouldn’t go away. Then I was discharged [from the army] because of this. One day I was sitting with family and others and one old man said to me: “You have the spirit of your grand-grandmother”. This spirit has been in the family for a long time: first with my grand-grandmother, then with my grandmother, then with the uncle of my mother and then it came to me. I didn’t want to understand or accept this at first because I thought these things are for the elders and it has nothing to do with me. But the spirit wanted me and it stayed with me. If I had not obeyed the spirit I would have stayed mad and would have died. The person into whom the spirit enters has no choice in this. I made a feast for the spirit and since then I have worked with the spirit. In the beginning the spirit came every day and showed me what to do - now the spirit comes only sometimes. I also learnt with another old man for five years to learn to distinguish between the plants and roots [Curandeiro José, Matale].

Occasionally the spirit bestows the skill of divining as well as of healing, in which case the curandeiro is not only able to treat the illness, but also to determine its cause. Usually, however, the task of identifying the cause of an illness is left to the adivinhadores who consult their own spirits in order to answer questions regarding the reasons for why someone has
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fallen ill. In some areas the adivinhadores and curandeiros have a working relationship where they refer clients to one another: the diviner determines the cause of the illness but refers the sick person for treatment to the curandeiro, and similarly a curandeiro may refer the person to a diviner to ascertain the cause of the problem.

As mentioned above, curandeiros are consulted for all types of illnesses but especially those caused by witchcraft, those considered untreatable by the clinics and for specific illnesses that particular healers have developed a reputation for being able to treat, for example loucura, mutima or infertility. Not all curandeiros have the same abilities and a noticeable characteristic of most curandeiros is that they are very clear about their competencies as well as their limitations. Only a small minority claim to be able to cure every illness as, for instance, a curandreira in Lubango did:

There is no illness I cannot cure. I have even cured AIDS. There was a girl from Oshakati with this and I treated her and now she is better. She went to hospital a few times for an analysis and they couldn’t detect anything [in her blood] [Curandreira Dina, Lubango].

Most healers, however, distinguish between illnesses that they specialise in treating due to their spirits’ abilities, illnesses that almost all curandeiros can treat, and those that require exceptional powers which are beyond their capacities. An illness considered to be very difficult to treat is loucura and only few curandeiros stated that they were able to treat this illness.

Mutima and excessive pensamentos fell into the category of illnesses that almost all curandeiros considered easy to treat with some specialising in their treatment. The treatment procedure has already been described briefly above and involves the location of the heart, the massaging of the limbs and body until the heart returns to its place and the drinking of tea made from plants that have a calming effect. Some curandeiros are also able to prevent a
person from developing *mutima* or *pensamentos* if a family member brings the person for a consultation at an early stage:

The word used is *okuhahia*: to prevent someone from getting an illness. I can see a person who cries too much and I know this one will get *mutima* and I will give her medicine. I do this as soon as possible and it will avoid the heart from going to other places ([Curandeira Fatima, Lubango](#)).

Most *curandeiros*, when asked if they treat blood pressure related illnesses, affirmed that they do. The treatment procedure is similar to that of *mutima*, confirming the close association between the heart and the blood in local understandings of distress related illnesses.

*Curandeiros*, as well as *adivinhadores*, are frequently responsible for conducting healing rituals in the communities. One of these is a purification ritual performed for soldiers returning from war which involves ridding the soldier of possible contamination by angry or vengeful spirits (Honwana, 1998). The primary aim of this ritual is to appease these spirits and to ask for protection from the family’s ancestral spirits (see next chapter). These public rituals operate on a number of different levels, including personal, social and communal levels, and facilitate the return to civilian life and the reintegration into the community for the soldiers (see Honwana, 1998, 2001; Wessells and Kostelny, 1998 for detailed accounts of these rituals and their functions). *Curandeiros*, by virtue of the skills bestowed upon them by their spirits, are able to contribute to the well-being of their communities through the performance of such rituals, thus providing a significant resource for coping with problems of distress caused by the war.

### 2.2.2 Vendors of medication

In every marketplace in Huila there are vendors who sell herbal and chemical medication. This is one of the health care options that people utilise frequently in the folk sector, especially if they have to pay for consultations and medication at the clinics. People self-diagnose, approach the vendor and ask what medication they should buy and how much they
should take. At times clients explain their symptoms to the vendor and ask him\textsuperscript{49} to make a diagnosis and sell them the appropriate medicines. The vendors sell medication for all of the common illnesses for which people go to the clinic:

The illnesses which are most frequent and which I treat here are: malaria, stomach ache, headache, tese\textit{ do alta}, diarrhoea, allergy, bleeding [after a birth, or nose-bleeds], bronchitis, asthma, boils. For me the most difficult to treat and the most serious are bronchitis, asthma, boils, specifically in the nose [Vendor Fernando, Vissaka].

The advantages for people is that they have no waiting time as they do at the clinics, they do not have to pay for the consultation but only for the medicine, and they can sometimes pay in instalments or barter for the medicines, neither of which is possible at the clinics. Often the appropriate medicine is not available at the clinics and patients are referred to the markets to purchase it there. The vendors may also operate as a referral source for further treatment and may dispense health advice.

There are potential risks to making use of this service in the health care sector. The medication is exposed to heat and dust for unpredictable periods of time before it is sold to clients. Some vendors have a good knowledge of the medication they sell whereas others possess only scarce or at times incorrect knowledge of the drugs. Although vendors require an authorisation to sell medication this does not involve having to demonstrate a knowledge of drugs. Clients may also not have sufficient money to pay for a full course of the treatment, for example of antibiotics or treatment for malaria, and vendors usually sell the minimum amount of tablets necessary in order to bring about a change in the state of health without insisting that the person complete the course of antibiotics or quinine, thus precipitating a relapse. The vendors are at times compromised between their client’s poverty and what they believe to be the right course of treatment for an illness:

I sell one tablet at Kw 0.25 [Kwanza\textsuperscript{50}, local currency] but I think that this will increase to Kw 0.50 soon.
There is a problem if people come and are sick and they have little money and only want to buy a few

\textsuperscript{49} The vendors were almost exclusively male.
\textsuperscript{50} $1 was equivalent to Kw 6 at the time of the research.
tablets. People think that I just want to make money when I tell them that they need to buy 28 antibiotics. They come with Kw 1 and don’t complete the course. Many of the plastic bags I have now contain much less than 28 tablets because I sell them at individual levels [Vendor Toni, Chipapia].

For the majority of vendors their occupation is primarily a means of making a living but some displayed compassion and interest in their clients’ health concerns [Field notes, Vissaka]. People in the community formed opinions about the abilities and knowledge of specific vendors, frequenting those who they felt were better informed and most lenient in payment issues.

Of the distress-related illness discussed in this chapter, the vendors typically only dealt with problems of HBP, some reporting that they had about six or seven clients a week with this problem [Field notes, Chipapia]. The vendors sold paracetamol, diazepam and vitamins to these clients and would occasionally tell people to go to the clinic to have their blood pressure measured and monitored there.

2.3 The popular sector: conselho and home remedies

2.3.1. Conselho

The vast majority of people who experience distress, pain and illness first turn to others around them for advice or suggestions (Kleinman, 1978). This is no different for the deslocados: their family members, neighbours, church groups and elders are actively involved in giving conselho to those experiencing pensamentos and consequent illnesses. The word conselho is used in the sense of advice or consolation, rather than counselling, and refers to the general encouragement given to people to abandon the pensamentos. In chapter 7 the religious dimension of this conselho will be explored in detail. Here three common themes of the conselho are drawn out by means of some typical examples:

We give them advice and we say don’t think too much. As you see, our grandfathers are not here beside us, they are dead already. So there is no need to think about it [Daniel, Lubango].
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It is not only you, it is all people. Stay calm and don’t think anymore about it... Because tomorrow or the day after tomorrow she will also die and will accompany the child [who has died]. Because this doesn’t only happen with her but happens to everyone [Santa Filomena, Lubango].

So she [a widow] needs conselho first of all. This is not enough. This person needs a community of relatives or friends who will play the role of her husband. And then she will forget these kinds of thoughts. This is not an illness for which we can give medicines so that she can get better because she is destroying herself [Catecista Lucas, Lubango].

Conselho often refers to these three issues: firstly, death is natural and the inevitable goal of all human beings; secondly, everybody suffers and strength can be drawn from the fact that one is not alone in the suffering; and thirdly, practical help must be given to those who are distressed.

A common way in which people try to ease the pain of the bereaved is to communicate to the person that although death has come prematurely through the violence of war, it is the inescapable endpoint of all humans and must therefore be accepted. This is expressed in the sentence: “As you see, our grandfathers are not here beside us, they are dead already”. How people come to ‘accept’ death is, however, a complex matter related to the cultural and spiritual cosmologies of the communities. In Angola, as in many parts of Africa, death is seen as part of the rhythm of life but is considered natural only for the elderly who have completed the full and normal circle of adult life (Monteiro, 1996). Any other death is considered premature and therefore unnatural (Mbiti, 1989). The cause of such an unnatural death, for example of a young person, has to be identified and amends have to be made before the death can be accepted by family members. The two most common causes of unnatural deaths in times of peace are witchcraft and death brought about by vengeful spirits, each demanding specific recompense from the living and those responsible. The performance of funeral rites forms an important part of this process as it facilitates the transition which the spirit of the deceased has to undergo, during which he or she moves from the world of the living to that of the spirits (see next chapter). Death through the violence of war is always perceived as
unnatural and brutal. The conselho given to family members attempts to bring some element of normality to the violent deaths by referring to death’s inevitability. People find some consolation in this thought but did not lose sight of the fact that the normal cycle of life has been cruelly disrupted by the introduction of death at a point when it should not have occurred. The meaninglessness of death that cannot be explained in customary ways impacts profoundly on the survivors.

The second theme refers to the shared suffering of people who have experienced the effects of war, expressed in the sentence: “It is not only you, it is all people”. Time and again the deslocados would say “Yes, we are suffering here in Lubango/ Matala but in Huambo/ Mexico/ my village people are also suffering”. They never lost their sense of compassion upon hearing accounts of war in other areas or events such as attacks on communities and subsequent deaths. The deslocados were very interested in hearing that there were wars in other countries, places they had sometimes never heard of, symbols of a connection to a world beyond theirs where others too shared their experiences of loss and suffering. Nordstrom (1997) discusses the notion of the shared experience of victims of war in her account of the creative resistance that Mozambicans displayed and enacted during and after the civil war. In her opinion it is important to recognise people and cultures as resonating with the human condition in their experiences of and resistance to war, expressed through their feelings of empathy and connection with others who they may never have met but who have undergone similar experiences. Feeling part of this human condition was something from which the deslocados derived some hope and comfort. “You are not the only one suffering” were thoughts that the deslocados used to console those burdened by pensamentos, reminding themselves that if others manage to continue living and working despite their suffering, they must also be able to. Fate had not singled them out in a particularly cruel way as “it is happening to the whole country” [Dona Teresa, Chipopia].
The third issue relates to the recognition that *conselho* is good but not sufficient to help people overcome their *pensamentos*. It is also necessary to assist them with food, clothes and give them opportunities to make a living:

These people don’t have clothes, don’t have food - they need food. You only need to give them food, and they will soon forget where they come from. I think this helps because at this time without child or anyone else they will not eat anything. Some suffer from stomach-ache and the stomach needs something warm in the morning. If you sleep with hunger and then don’t eat anything what will you do? You will stay with the stomach-ache and then it will turn into an illness [Santa Regina, Lubango].

The minimum of consolation is just to eat and to sleep well. Peacefully. If there are more disturbances a person cannot become well. The consolation depends on eating, sleeping and having clothes to dress [Dona Emelie, Chipopio].

As the *catecista* Lucas above noted when he stated that a widow needs others around her to play the role of her husband, these comments point to the necessity to provide practical and material assistance to those who are susceptible to *pensamentos*. Orphans, widows, the elderly and those who were sole survivors of a family often reiterated their main worry: “Who will take care of me now?”:

A child dies and the person always thinks about it because a child is always a child. And even if it was a member of the family you will always think about this because the person always came to visit you and see you. “If she dies today who will take care of me and treat me? If I need food or other things who will give me more?” Family always needs family [Florença, Lubango].

Practical help from family, neighbours and others in the community thus forms an essential part of providing *conselho*. In addition, basic living conditions such as food, clothes and safety have to be met if recovery is to take place. The *deslocados* recognise that emotional distress is not separate from the physical and material reality within which people battle for survival on a daily basis.

The phrase used most often in *conselho* is “don’t think too much”. It implies, amongst other things, that the person has to focus on the present and the challenges that must be dealt with. One of the main reasons why *pensamentos* are discouraged and seen as destructive is because the survivors need to take responsibility for themselves and their family, especially the
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children. Having a job or being able to make a living through farming or trading are part of the process of leaving behind the past and therefore the *pensamentos*. This was equally the case for men and women. Widows and widowers were encouraged to marry again soon as people thought this was one of the best ways in which the bereaved can focus on the present. Women in child-bearing age who had lost children but were with their husbands were advised to become pregnant again.

In summary, *conselho* encourages survivors to see death as part of life’s cycle and to derive comfort from the knowledge that one is not the only person suffering. People also emphasise the need for safety, sufficient food, clothes, health and sleep as minimum requirements for recovery or for establishing a life post-flight. In addition, taking responsibility for the family, the opportunity to make a living, remarrying and having children were seen as things that would also aid the process of focusing on the present. However, as one woman expressed, real comfort and consolation lies in the advent of peace and a return to their homes and their lands:

> The *pensamentos* never stop. Only if the war will stop and a person can return to their land and can work there at peace. But up to now the war continues - how can a person stop to think? For me there is no way to stop the *pensamentos*. Only if the war will stop and we can go back to where we have fields
> [Dona Gina, Vissaka].

A final point needs to be made in regard to the *conselho* that the *deslocados* dispense to others. It is predominantly a response to the issues that people themselves talk about, i.e. the preoccupations they voice in regard to what they have lost and their situation at present. People often talk about the death of loved ones and the loss of property and lands, and very seldom about the physical atrocities that were perpetrated against them and others during the attacks. They talked about the indignity of having their animals and property taken from them, of having to sleep “like animals in the bush”, about the betrayal by neighbours or colleagues, about the hunger, the illnesses, the deprivation during the flight, about how they had managed to survive, and about how others had not. At times people would refer to the atrocities they
had seen committed such as pregnant women being sliced open, people burnt alive, torture by armed groups who wanted information, being forced to watch the murder of loved ones, being raped and other forms of cruelty and violation. These incidents usually form part of the narrative of their experiences and were not singled out or emphasised in a special way. Nordstrom (1997) makes a similar observation in her work in Mozambique:

Readers may have noticed that the songs, the stories, and the quotes so far presented in this book do not often deal solely, or even mainly, with actual physical acts of violence, but rather with a type of violence that is much deeper and enduring. This perspective stands in contrast to the more official accounts of violence in global culture... The stories that most violate notions of human decency tend to be the most circulated. Yet when I listen to average Mozambican civilians discuss the war, these barbarous accounts, while present, were not the focal point. The destruction of home and humanity, of hope and future, of valued traditions and the integrity of the community resonated throughout these conversations (p. 123).

There were exceptions to this, especially with some adolescents (discussed in chapter 9). In general, however, people talked about loss, the suffering, illnesses and the difficulties in which they find themselves presently. The conselho given responds to and addresses these issues.

2.3.2. Home remedies

A brief mention will be made of another resource that people drew upon in the popular sector, namely home remedies for ailments and illnesses. Many kimbus have a member of the family who has knowledge about basic, simple remedies that can be concocted and applied when someone falls ill. Often these are older women who were taught these skills in their youth by another family member. The difference between these women and the curandeiros is that the former do not work with spirits and also do not possess the depth of knowledge of medicinal roots, plants and herbs that curandeiros have. They usually only assist family members and do not receive payment for their services. In the rural areas home remedies are often the first recourse to healing and a large number of illnesses are dealt with by such means before anyone else is consulted. Pensamentos-related illnesses such as blood pressure changes are treated by a range of different teas made from plants with calming effects, and include advice
about keeping out of sunlight, not being surrounded by noise, or, on the contrary, making sure the sick person is surrounded by people and is kept distracted [Field notes, Lubango]. More serious illnesses like loucura or mutima cannot be treated by home remedies and will be referred to a curandeiro.

3. Factors influencing health care seeking behaviour for distress-related illnesses

The data presented above indicates that the majority of distress-related illnesses are dealt with in the folk and popular sectors of the local health care system. What are some of the factors that influence people’s decision-making in the treatment of these illnesses? One factor has already been emphasised: the fact that some of the common ways in which distress is expressed, for example mutima, are not recognised as ‘valid’ ways of presenting with an illness at the clinics. There is thus a conflict in terms of the different explanatory models held by the patient and the staff trained in biomedical approaches to health. A second factor was reiterated often by both healers and the deslocados, namely that the staff at the clinic do not possess the skills to treat the majority of these illnesses, even if they were to acknowledge their reality. Competence in alleviating certain forms of distress was generally perceived to lie with curandeiros and faith healers but they also had to prove their capabilities through the efficacy of their treatment. Healers, unlike medical staff, are not appointed into positions and have to derive their legitimacy from the success of their treatments. Curandeiros thus have to earn their reputation by being successful, and those considered to be incompetent lose their clientele quickly, as was the case with some of the healers in Vissaka [Field notes, Vissaka].

A third factor influencing decision-making relates to the interaction between the service provider and ill person. The deslocados and the healer often shared an understanding of the
nature of the illness, and, even if the *curandeiro* does not speak the vernacular language of the client, he or she would use familiar terminology. A number of studies point to the psychological and social effect that the warmth, informality and closeness of the interaction between healer and client can have on the sick person (Reynolds, 1996; Swartz, 1998). The *curandeiros* do not necessarily engage their clients directly in conversations about how they are feeling but many conversations take place around the worries and preoccupations of the ill person over the course of the treatment [Field notes, Lubango]. The fact that clients often move into the *kimbu* of the healer for the duration of their illness and receive good food, attention and special care, thus allowing them play a sick role recognised by family and other community members, is likely to also have a healing effect. In Huila it was common for a family member to stay with the patient in the *curandeiro’s kimbu* and take care of him or her if the person was unable to do so for him- or herself. This fulfils a useful monitoring function of the well-being of the client. Those who are well enough to look after themselves form part of the household of the *curandeiro* and are given tasks to perform as their health improves. This way of approaching the consultation and healing contrasts sharply with the nature of consultations that take place in the clinic.

The treatment provided in the folk sector operates on various levels. It includes social aspects where relatives are drawn into the treatment procedures through being assigned specific tasks, and spiritual aspects, for instance, in the treatment of *loucura* caused by vengeful spirits. It also contains cultural aspects through the performance of certain rituals, as well as addresses the physical complaints through the administration of plant-based remedies. The multifaceted treatment may be an important reason for why many distress-related illnesses are treated primarily in this domain of the health care system once the decision has been made to seek assistance outside of the immediate family circle. However, as with most other illnesses, the *deslocados* did not confine themselves to one or the other health care service and often
employed simultaneous consultations [Field notes, Lubango]. This operated as a form of ‘multiple insurance’ where people consult a curandeiro for excessive pensamentos but also attend the clinic for HBP. For distress-related illnesses the general tendency was first to consult someone within the folk sector and if this was not successful to consult the medical staff at the clinic. Availability of healers influenced these decisions: in Chipopia, for example, few healers were amongst the displaced population and the deslocados were at times reluctant to consult those of the resident population [Field notes, Chipopia]. In addition, fees charged by the healers or by the clinics was another factor affecting decision-making with many deslocados struggling to find the money for any form of consultation in a severely impoverished community. Healers charged less than the clinics in Lubango, but in the centres in Mataela the clinics provided free consultations and medication, and this influenced where people would go first in their quest for treatment. Despite these financial considerations, simultaneous health care seeking behaviour appeared to be the most common strategy in both areas.

Finally, as pointed out in chapter 2, assumptions should not be made about the unilateral benefits of all healing practices and treatment approaches in the folk and popular sectors. Reports of harmful or dangerous practices were occasionally recounted by deslocados who explained that the condition of the ill person further deteriorated when treated by a healer. The folk sector should therefore be viewed as critically as the professional sector, as Helman suggests:

Like all other health care providers - including doctors and nurses - [the] ranks [of traditional healers] may include those who are incompetent, ignorant, arrogant, or greedy, or have a very reductionist view of ill-health, and how it should be treated” (1990: 72).

Cases of wrong diagnoses or misadministration of medication in the clinics were also reported, indicating that no broad generalisations about the advantages of any one sector of health care should be made.
4. Conclusion

What are the important issues that arise out of the material presented here and how do they relate to the main themes of this study? Firstly, the importance of understanding the local context of war-affected populations is evident. Distress needs to be contextualised within the realities confronting the deslocados, for example the way in which daily hardship in the form of hunger, poverty and insecurity contribute significantly to the suffering of the displaced. Social and economic factors play a crucial role in the lives of the displaced not only in relation to issues of health and illness but also in how they are able to confront and cope with the losses they have experienced. In addition, the local context is also crucial for gaining insight into the conceptions, beliefs and practices as they pertain to health and illness in the communities. This issue will be pursued further in the next chapter where an important part of local cosmology and belief system is examined in detail in order to understand how it influences issues of health and illness as they relate to distress and war.

Secondly, the suffering caused by war is expressed in various ways and may take many different forms. Some of these expressions may be more ‘dramatic’ and overt, for example mutima which indicates an acute crisis and draws immediate attention to the sufferer; others manifest primarily through the medicalisation of physical complaints such as HBP; some express themselves in the form of spiritual problems. Distress, just as health, is not an “all or none dichotomy” (MacLachlan, 1997: 15) and attention has to be paid not only to the ways in which it reveals itself as illness, but also to the fact that pensamentos are ubiquitous amongst the displaced. In considering expressions of distress it is also important to avoid seeing idioms of distress as fixed entities “out there” which can be identified and counted - illnesses happen between people rather than to people (Swartz, 1998). The social and interpersonal dimensions
of war-related illnesses are thus vital to the meanings attached to them. A further notable factor is the emphasis the deslocados themselves place on certain aspects of their suffering, for example on the losses they have experienced, rather than on the barbaric acts of violence which are often identified by psychologists as significant traumatising incidents.

The latter point raises questions about the relationship between the local context, understandings and expressions of distress on the one hand, and psychological and psychiatric perspectives on the other. Some of the local idioms of distress seem to bear resemblance with established diagnostic psychiatric categories. Is HBP, for instance, a symptom of or the same as anxiety? Is mutima a form of depression and should it be treated as such? Can loucura be equated with psychosis? Are all forms of madness a symptom of psychosis, including those caused by witchcraft, or by disturbance of vengeful spirits? If not, what are the implications for providing assistance to those suffering from loucura? Are there distortions in the epidemiology of mental illness across Angola in that there are more mentally ill people in the country than can statistically be expected in a sub-Saharan region? Is it possible that some of those severely disturbed are suffering from PTSD? Or are attempts at equating these idioms of distress with psychiatric disorders forms of category fallacies?

The potential for misunderstanding and miscommunication between the deslocados and representatives of the mental health professions emerges from the material presented in this chapter. A good illustration of this is the case of “shell shock”, perceived by some deslocados to be a cause of madness in war, as was explained by curandeiro Augusto on page 131. This is an explanation that was current during WWI (see chapter 1) but which is no longer accepted by psychiatrists (Leys, 1996; Trimble, 1981). Is this merely an issue of different explanatory models or does it reflect more fundamental differences in paradigms and frameworks between local and professional perceptions? Such questions and the ones raised above are further
pursued in chapter 8 where the psychological services in Huila are presented and their interactions with the local population examined in more detail.

Thirdly, the fact that the deslocados are not passive and inactive victims in the face of violence and destruction cannot be overemphasised. People from the first are engaged in “world-making”: through the “mundane everyday activities” that are the day-to-day manifestations of the creative process (Rosaldo et al., 1993 in Nordstrom, 1997: 198), to the ways in which healers and diviners perform treatments, and elderly women provide home remedies for those suffering from excessive pensamentos. The deslocados have considerable and important coping resources with which they confront and attempt to cope with the suffering brought about by war. The majority of “psychosocial work” is being done in the popular sector on a daily basis by ordinary people giving conselho to those who are distressed. This is a well-recognised fact in most parts of the world (Kleinman, 1980) but one with which psychosocial professionals are only now beginning to engage. While the ability to be resourceful, resilient and to cope should not be unilaterally assumed, the starting point of all psychosocial practice should be the recognition of the strengths and initiatives of the populations themselves.

This chapter has presented a general overview and introduction to the local health context within which the deslocados attempt to cope with the suffering and distress caused by war. The next chapter will examine some of the aspects of this local context in more detail by focusing on a particular resource in the health care system which is routinely overlooked in psychosocial research and practice, namely the religious and spiritual sectors in the communities of war-affected populations. This is done in order to allow for the in-depth exploration of the relationship between local cosmologies, coping resources and the suffering caused by war. Chapter 7 will also introduce topics which have so far remained obscured in
the presentation given of the health care system but which form a central part of the argument of this thesis, namely issues of conflict, power and change and their relationships to distress, health and war.
Chapter 7

The religious and spiritual domain as a resource for coping with distress

The religious and spiritual aspects of the lives of war-affected populations are frequently ignored by psychosocial professionals. It has been suggested that perhaps no aspect of African refugee society and culture is as overlooked by researchers and most humanitarian relief agencies as their religious lives (Sommers, 2000: 83).

Yet this study found that churches of many denominations are prominent in the daily lives of people in Huila, and that constant and frequent references to good and evil spirits, witchcraft and issues of faith point to the prominence that these aspects are accorded by the deslocados. Explanations for various experiences are often sought in the religious and spiritual realm, and practices of worship are perceived as significant resources by the war-affected communities. This chapter focuses on the local religious and spiritual context, its perspectives on health, illness, distress and suffering caused by war, and on the various forms of assistance and healing provided in this domain which span both the folk as well as the popular sector of the health care system. The three main sectors that dominate the spiritual discourse in Huila will be examined. First, traditional African religions practised in the area will be investigated, followed by an overview of the perspectives of established Christian denominations, and finally the independent churches and their views on war and distress are explored. The chapter concludes with reflections on the inter-relationship between local contexts, expressions of distress and healing resources. Issues of conflict, power and change are raised and some possible implications for psychosocial work with war-affected communities are discussed.
1. African traditional religions

In this section the main tenets of African traditional religions (ATR) as practised in Huila are presented. In focusing on four of the over 3000 tribal groups in Africa (Mbiti, 1989), namely the Nhaneka-Mhumbe, the MumHuila, the Nganguela and the Umbundu, it is clear that no generalisations about the religious practices and belief systems of African peoples nor about ATR in other parts of Angola can be made. However, some commonalties between groups who adhere to ATR throughout different parts of Africa exist and will be noted.

1.1. General concepts

ATR are beliefs and practices based on a cosmology that explains the relationship between the spiritual world and the ‘actual’ world in which humans live. These beliefs and practices are not generally formulated into a set of dogmas which a person is expected to accept but are traditions that are assimilated by observing and participating in them in families and communities:

The children learn these things by sitting and listening when the elders talk. In the jango at night or when there is a feast or a ceremony. The elders don’t sit down with the children and teach them. But they learn all of it [Avelino, Chipopia].

The traditions are handed down by the forebears and are taken up by each generation with modifications suited to its own historical situation and needs (Mbiti, 1989). ATRs have been described as pragmatic and utilitarian systems, concentrated on earthly and practical rather than on purely spiritual or mystical matters (Booth, 1977; Parrinder, 1962).

A pivotal aspect of ATRs is the importance of maintaining relations between humans and the spirit world, and social relationships amongst humans. All difficulties and crises are caused by a break-down in one of those two spheres (Milheiros, 1967). The spirit world consists of
various types of spirits, one of which is the ancestral spirits\textsuperscript{51}. These are of primary importance in ATR as they are the ‘object’ of most practices and traditions. Ancestral spirits are the spirits of deceased adult family members who are remembered by those surviving him or her. It is crucial that there are surviving family members who remember the deceased by name, recall his or her personality, character and incidents in his or her life (Mbiti, 1989). As long as this is the case, and this may be the case for up to four or five generations, the person remains in the category of ancestral spirits as opposed to that of the general spirits. Only when the last person who knows the deceased by name dies does he or she become truly dead and move into the category of general spirits. Until that occurs the deceased is a “living-dead”: a person who is physically dead but alive in the memory of family members, as well as alive in the world of spirits (Mbiti, 1989). The living-dead are sometimes thought of as intermediaries between humans and the general spirits:

Sometimes when we are walking during the day our spirits of the ancestors have contact with us, the living, or in the night the spirits come to us. The spirit of the dead are wandering around at night. When we are sleeping the spirits of the living and the spirits of the dead talk to each other. They talk about the things that have happened and the things that are wrong [Camati, Lubango].

The relationship between the ancestral spirits and humans is reciprocal. The spirits are considered to be guardians of family traditions and affairs and take an interest in what happens in the family. They may warn of impending danger, an example of which was given by a woman who was warned by the spirits in her dreams about an imminent attack:

I was living in the countryside once when we were already destocados and I had a dream in which the spirits told me that this area will be attacked. I told my husband this at the time but he didn’t believe me. So I took my children and left the area and soon after that the area was attacked and my husband was killed [Lucia, Lubango].

The spirits may also express their dissatisfaction with the conduct of family members and others by bringing about illness or misfortune (Monteiro, 1996). Ancestral spirits can be demanding, friendly, unfriendly, peaceful, unobtrusive, good or bad, usually reflecting what

\textsuperscript{51} Other categories are the general spirits who do not ‘belong’ to a particular family or clan; spirits of deceased sober, heroes or leaders; and spirits that bring specific skills to individuals such as skills of divining, healing, or breeding cattle successfully (Milheiros, 1967).
the deceased was like while alive. In this sense ancestral spirits are like humans in that they possess various traits, and the living do not generally perceive them as evil (Parrinder, 1962). They may bless, punish or admonish the living by sending warnings to the descendants to return to the right way (Barbosa, 1990). Ancestral spirits may return to the family sometimes, share a meal and appear in visions or dreams to older members of the family:

> When you had a dream as soon as you get up you tell the others that you had a dream and that you were talking to the person [who is deceased]. You remember the name. After this dream you will not forget what happened because it is on your heart: you remember that you were with the spirit of that person and that you were doing things together [Camuti, Lubango].

Although the living strive to maintain links with them frequent appearances of the ancestral spirits are not perceived with great enthusiasm. If the appearances persist over a certain time period this may be resented by the living, and may require the intervention of a ‘spirit specialist’ such as a diviner (Redinha, 1974). Frequent appearances are usually a sign that some duty has been left unfulfilled or that a particular spirit seeks to communicate a specific message to a person:

The living need to fulfil their obligations to the ancestral spirits by remembering them, pouring out libation, offering food and occasionally sacrificing an animal. If the spirits feel neglected or slighted they may become sad or angry and will demand a sacrifice or a feast in their honour:

> Normally this happens when something happens to the things that belong to the spirit, like if someone has eaten the food which is put on the plates for the spirits [food offerings]. The spirit will become angry and ask for it. And the person who has taken it has to replace it [Rodina, Lubango].

> Yes, the spirits get angry but only when they want to eat and drink. Sometimes this happens and then you have to give a party for them [Selestino, Vissaka].

These actions are ways of keeping the departed in touch with their family, and need to be understood as tokens of fellowship, communion and respect (Estermann, 1957). In Huila it is usually the elders of the family and the head of the homestead [chefé da família] who are responsible for making offerings to the spirits and resolving their grievances through
performing the required rituals. The performance of certain rituals of integration into the community at specific points of an individual’s life cycle (birth, circumcision, wedding, death) are also perceived as a necessary part of the continuing responsibilities between humans and their ancestral spirits [Field notes, Lubango]. They form part of an active engagement of the living with the world of the spirits, based on the understanding that it is possible to exert some influence over the ancestral spirits and their effects on the living.

The notion of *ubuntu*, which means that human beings are not human beings on their own but gain significance and humanity only from and through their relationships with others, is also important in the cosmology of many ATRs (Nsamenang, 1994). It is, for example, impossible for an individual to perform religious rituals on his or her own: the participation of family and community members is a prerequisite. When giving a feast for ancestral spirits neighbours, friends and extended family have to be invited in order for it to be considered worthy of the spirits:

> Every year I kill an ox and I invite everyone, all the people from my family and the neighbours and elders. I give drink and food to the spirit and then he will be happy. Everybody has to be invited and everyone has to come so that it can be a big feast. This is a time for joy and celebration, drinking and dancing [Gabriel, Matala].

Equally, sacrifices that have to be performed by elders are attended by the whole community in order to be effective. A significant aspect of ATR is thus the concrete way in which it cements community structures and relations, highlighting the need that people within a community have for one another in times of crisis and celebration.

A practice of ATR which has particular relevance to the topic of this thesis is that of funeral and burial rites. In Huila the belief that there is a continuation of life after death where the spirit of the deceased moves on to another state of existence is common. All of the four ethnolinguistic groups in this study believe that this process needs to be facilitated through performing traditional funeral rites and by reciting prayers for them. A funeral ceremony
which involves the slaughtering of a chicken, goat or cow, the attendance of family members, and the performance of certain rituals is obligatory [Field notes, Lubango]. It is widely understood that those who do not receive proper burial rites may never reach the world of spirits and may, therefore, trouble the relatives until they perform the necessary rituals (see also Honwana, 1997 on Mozambique; Reynolds, 1996 on Zimbabwe). The deceased may appear to surviving relatives in dreams or visions until the person fulfils her or his obligations to the deceased[52]. Because of the nature of war and displacement it is often not possible for the deslocados to fulfil their obligations to those killed in the attacks, by land mines or in combat, nor to receive the emotional and practical support traditionally provided during the period of mourning. Surviving family members worry that they have not been able to facilitate the transition of the deceased from the world of the living into the spirit world, and further sorrow is caused by the fact that they have been prevented from showing their respect for the deceased.

The funerals thus do not only serve the spirit of the deceased but also play a role in providing support and preventing pensamentos from occurring amongst the immediate family of the deceased. This is demonstrated in customs surrounding children at funerals. While the Nganguela believe that children should not see dead bodies because only adults have the maturity to deal with such an experience [Field notes, Chipapia], the other ethnolinguistic groups ensure that children participate in the funeral. This is done because people believe that grieving should occur at the correct moment, i.e. the funeral, and if this does not happen the child may become sick later on. Amongst certain groups children who do not cry at funerals of their parents are beaten until they start crying in order to facilitate the grieving process.

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[52] My neighbour in Matala told me that her father had died two years previously but that she had remained troubled by recurrent dreams of him. Finally her mother informed her that this meant that my neighbour had to perform a ritual for him, but being Catholics, she should say a mass on her father's behalf. My neighbour promptly did as she was told and the dreams stopped [Field notes, Matala].
Various customs exist that help children whose parent has died to overcome the grief, forget the deceased and continue their lives without too many *pensamentos*. One such custom involves taking some earth from the grave, mixing it with water and giving it to the children to drink; another is to tie a piece of black cloth around the arm of the child during the funeral.

### 1.2. Health, illness and distress

Within the cosmology of ATR most illnesses are seen as misfortunes for which an explanation has to be found. Some illnesses are thought to be brought by God or the wind, implying that they have no specific reason or cause. However, the majority of illnesses do not occur by chance but are the result of either vengeful spirits or of witchcraft, brought upon the person him- or herself through wrong deeds\(^\text{53}\) or, more commonly, through bewitchment by someone else. This applies equally to illnesses such as malaria as to madness:

> ... even if it is explained to a patient that he has malaria because a mosquito carrying malaria parasites has stung him, he will still want to know why that mosquito stung him and not another person (Mbiti, 1989: 165).

ATRs are consequential in their understanding of illness: it is not enough to remove the symptoms, i.e. the malaria, but one also needs to remove its cause by addressing the bewitchment or appeasing the angry spirits. If not, it is like treating bilharzia but continuing to swim in an infested pool (Ngubane, 1977). The consultation of a diviner is thus a matter of course for many *deslocados* who may attend the clinic for medication and treatment but identify the cause of an illness through divination. As noted in the previous chapter, illnesses classified as “traditional” illnesses are generally seen as being exclusively the domain of spirit specialists, such as *curandeiros* and *adivinhadores*, as their causes are linked to problems located within the spiritual domain, *loucura* being an example of this. Excessive *pensamentos*, although clearly linked to the experiences of loss and death, may also be related directly to

\(^{53}\) Wrong deeds were often described by people as those actions which harm others [Field notes, Lubango].
such problems as will be illustrated below. Two central concepts that affect understandings of health and illness as they relate to the experiences of war will be examined in more detail, namely social pollution and witchcraft.

1.2.1. Social pollution

According to ATR, if people come into contact with death, violence or bloodshed they may be contaminated with spiritual impurity and may in turn contaminate others around them (Honwana, 1997, Reynolds, 1996). Pollution leaves misfortune and suffering in its wake and can cause madness and uncontrollable aggression (Ngubane, 1977). In Huila the deslocados stated that pollution can occur in cases of homicide and suicide, depending on the circumstances associated with the death. Usually the pollution is related to the anger of the spirit of a person wrongfully killed who did not receive a proper burial and therefore appropriate recognition of his or her death. Wrongful killing can occur through means of witchcraft or through physical aggression and results in the aggrieved spirit demanding compensation for having its human life ended prematurely. The exception to this is in situations of war where soldiers are fighting an enemy and killing is part of their duty; in this case they are not held accountable by the spirits of those whom they have killed in battle. Should the soldiers kill unjustly, however, for instance when looting a village and thereby killing innocent civilians, they will be contaminated\(^{54}\). This was explained by Jamba, an elder in a community of deslocados, talking about young soldiers who return from the war and are troubled by the spirits of those whom they have killed:

> These young people who come from the war and have done wrong things, they are guilty but when they come here in the community they say: “The problem is the war and that is why I am like this”. But if you go to the war and do what is expected from you will be okay. But if you go and do wrong things you will be a very bad person. There are people who are captured [prisoners of war] and you have to take care of them. But if the soldier is drugged he will kill them. You have already promised those people that you will not kill them and keep them safe because they are Angolan like us. But the young people say: “You

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\(^{54}\) Reynolds (1996) observes a similar ‘spiritual order’ in Zimbabwe’s war of liberation.
are UNITA” and kill them. If he kills them the problem is his. When he leaves the military the soul follows him saying “You killed me” [Tandavala].

The concepts of justice and accountability are of tantamount importance in establishing how and why pollution has occurred, and how it can be rectified. In ATR transgressions against fellow humans result in spiritual problems that can be a source of danger and harm to the individual and his or her family: the offended spirit(s) may “trouble” the person responsible with frequent appearances and may cause accidents and misfortunes to befall the entire household. Usually the skills of a spirit specialist are needed in order to resolve the grievances of the offended spirit. In cases of homicide the guilty person first has to confess in order for the treatment to be effective, and a proper burial for those killed may also be necessary:

[The spirits] don’t accept that someone is dead just like that and leave him. Their souls will ask: “Why did you kill us and not give us a proper burial?” This will make them sad. They have to give him a proper funeral. UNITA went to this place some years ago and they killed many people here. Because there were so many they had to use a tractor to open a mass grave to put all of them there. They needed a burial because their spirits will make a lot of confusão [chaos, disorder, confusion] afterwards so they need to be buried [Amalia, Luângano].

As illustrated in this example, people may be troubled for a number of years by pollution and this may be a cause of persistent pensamentos. The example also points to the fact that because of the ‘untypical’ situations brought about by war and displacement where, for instance, many people remain unburied, innovative ways of appeasing the angry spirits have to be found, in this case through making a mass grave (see also Wessells and Kostelny, 1998).

1.2.2. Witchcraft and magic

Other factors that play a central role in understandings of health, illness and distress in the ATR are those of witchcraft and magic. Witchcraft⁵⁵ refers to mystical power that is used with the intention of harming people. Mystical power in itself is not regarded as harmful or bad but its malicious use is experienced as evil (Mbiti, 1989). It is seen as a threat to vitality and the

⁵⁵ The term witchcraft is used here to refer to the inherited power of individuals that can be used for evil ends. Such individuals are referred to as feitiços [those who practice witchcraft].
life force of a community and is thus perceived as an anti-social force that sets out to destroy relationships and undermine the moral integrity of a community. Magic refers to the power to use, manipulate and change natural and supernatural events through the employment of magical knowledge and the performance of ritual, and is usually considered less harmful than witchcraft, employed predominantly for personal gain (Reynolds, 1996).

Witchcraft and magic are feared as they are considered to be a source of the uncanny and the weird (Reynolds, 1996). Feiticeiros are usually the most feared and hated members of their community: they can send spirits to attack someone, cause illness, death or other misfortunes and can place harmful potions where a person comes into contact with them. People who are able to practice magic can transform themselves into animals and enter into someone’s house at night in order to steal or to bewitch the inhabitants [Antonio, Lubango]. They may engender harm to people for no apparent reason and usually operate at night. Witchcraft and magic can also be purchased from a feiticeiro by ordinary people who are driven to this by envy, malice or revenge, or who wish to become wealthy and successful.

One particular type of magic in Huila directly relevant to discussions of war and distress is mbindi. This is the Nhaneka word for “protection” and may be used in two ways. It can be used purely as a protection against harm, bewitchment or misfortune and is then usually not perceived as witchcraft but as a helpful form of magic against the envy and evil intent of others. Mbindi can also be used by soldiers in war, however, when it takes on a less ‘innocent’ form, involving the killing of human beings, usually a family member, in order to make use of the dead person’s spirit. This spirit will then accompany the soldier constantly, providing protection from bullets, from injury in close combat, from stepping onto land mines, and may even ensure success in military feats. A soldier wishing to use mbindi seeks out a feiticeiro
who knows how to perform the necessary ‘deal’\textsuperscript{56} between him- or herself, the soldier and the spirit of the murdered person. Once the soldier enters into the contract it is binding and cannot be reversed, i.e. the \textit{feiticeiro} will reveal to the soldier which family member he or she has to kill, sometimes the first-born son or the person’s mother. Should the soldier fail to perform this act, he or she will become mad. The contract also requires that the soldier stays in battle and continues to kill people in order to satisfy the spirit working with him or her, and, again, failure to do so results in madness:

Some who cannot bear to be in civilian life are like this because they have bought magic or have made a deal with a \textit{feiticeiro}. The \textit{feiticeiro} may tell them to kill someone, usually one person in the family. The spirit of that person will then protect the soldier and help him to kill. But as soon as the soldier leaves the war the spirit will ask: “Why did you kill me if you are not fighting in the war? You killed me to fight in the war - now go and fight”. If the soldier doesn’t do this he will go mad. And this is also the reason why some soldiers stay in the war all the time and don’t want to return from war. If they do return the spirit will make trouble [Curandeiro José, Matala].

The soldier will also become mad if he or she enters into the contract but fails to complete a particular part of it, for instance forgets to pay the \textit{feiticeiro}, or refuses to kill the particular member of his family chosen by the \textit{feiticeiro}.

Lubango has a large army base where soldiers and commanders who have a recess from the war zones are stationed for some time. A few of these soldiers were rumoured to be very successful in battle, leading their troops victoriously and gaining promotion rapidly, but having great difficulty adapting to civilian life once they are removed from the front-line [Field notes, Lubango]. These soldiers were notorious in the town for being aggressive, getting drunk and frequently starting fights with other soldiers or civilians. General opinion held that these soldiers had performed \textit{mbindi}, something the soldiers would never admit to but which the local population considered to be an open secret\textsuperscript{57}. Because of the witchcraft deal the soldiers could not cope with being removed from combat because their spirits do not allow

\textsuperscript{56} It is a rare skill and there were reportedly only a few \textit{feiticeiros} who know how to perform it: in the whole of Quipungo and Matala there were only two [Field notes, Matala].

\textsuperscript{57} I made several attempts to meet such soldiers and interview them but none of them agreed to talk to me.
them to stop killing, and their aggression was a direct result of the spirits “troubling” them
[fazem confusão] [Manuel, Lubango]. Only a skilled adivinhador or curandeiro would be able
to undo the mbindi by chasing the spirit away and freeing the soldier from his or her
obligation to the witchcraft contract.

Stories of mbindi and its connection to the war and madness abound in Huila, and, indeed, as
Brinkman (2000) observes, amongst Angolan refugees generally. Jonas Savimbi is widely
believed to be participating in witchcraft practices in order to achieve military and personal
victory (Brinkman, 2000)\textsuperscript{58}. Witchcraft is intimately related to issues of power and control
where individuals try to gain authority by illegitimate means, a familiar occurrence in a
country steeped in war, violence and chaos. Witchcraft also speaks fundamentally to the
values that operate within a society and therefore forms part of the broader discourse on
spiritual and religious matters in the context of war (Reynolds, 1996).

1.3. Resources and assistance

The major resource within the domain of ATR upon whom the destocados draw when
confronted by illnesses and distress as described above are the adivinhadores. Adivinhadores
undergo similar initiation processes as described in the previous chapter with curandeiros,
where spirits take possession of a person whom they have chosen as their medium and pass on
the skill of divining to him or her. Usually these spirits are direct ancestral spirits of the living-
dead remembered by the family, but adivinhadores may also be possessed by unknown,
general spirits, as was recounted by one diviner:

One time I was coming from work and I was walking and I found a small bracelet on the ground. I took
it and put it on my arm. I went back to the place where I was working. One month later I was sick... I
was sick for 3 months and my parents were looking for doctors to treat me. They went to a curandeira

\textsuperscript{58} Savimbi is reported to have killed his own mother which is perceived to be an indication of the practice of
mbindi. An alternative explanation is that Savimbi’s mother once dared to criticised him in public and that this
action led to her demise.
and she was divining and looked at her mirror. She told me that I was walking somewhere and I found a small bracelet... This bracelet is a spirit and I have to become an adinvhador, and I will treat people. Since that day I became a good adinvhador... This spirit is not from my relatives. This is a spirit I just took. I received it in Malanje but the owner of this spirit was from Benguela, from Dombe-Grande, and it was him who left this there. This spirit is Ovimbundu and I am Chokwe. When the spirit comes he speaks Umbundu [Faustino, Lubango].

The adinvhador has to maintain a positive relationship with his or her spirit(s)\(^{59}\), expressing gratitude for the skills it brings by sacrificing an animal in its honour:

I have to treat this spirit as well as possible. If I don't I will become sick and will loose the skill... You keep the spirit happy by making a feast, killing an ox, preparing African beers, and the people will dance and sing. And afterwards you will become a good adinvhadora and have more than you have spent. You have to do [the feast] only once unless the spirit asks you again and then you have to do it again [Joana, Lubango].

Unlike most curandeiros, the majority of adinvhadores do not undergo an apprenticeship with an experienced diviner unless they also perform treatments for illnesses. The practice of divining relies entirely on the information obtained from the spirit who enters his or her medium and conveys messages or reveals hidden knowledge\(^{60}\). Several different ways of divining exist, for example by using a chicken, a goat, an ox, a mirror, a bowl of water, a special plate or money. If an animal is used the adinvhador is guided by several indicators for information about the nature of the problem, such as signs on specific parts of the body, the way in which a chicken dies when it's throat has been cut (the position of the wings and the neck for example), or the colour of the intestines (Estermann, 1957; Milheiros, 1967). Here is a description from a session I attended with an adinvhador:

The group that has come to consult the adinvhador consists of five men and four women and they have brought two chickens. They exchange greetings with Tito, the adinvhador, but do not state why they have come nor what their problem is. Tito seats himself in the middle of the group on a chair and starts plucking the feathers of one of the chicken's wings... He holds the chicken back to one of the persons, takes the second chicken and repeats the action. During this time there is little conversation. Then Tito starts talking and the spirit talks through him: although he does not enter a state of trance his tone changes and becomes fast and monotonous. He asks questions and the group shouts back "toma". This Nhaneke word serves to encourage the spirit to continue talking. They shout the word with great fervour and volume and when Tito says something that is true they shout louder. Sometimes they pick up dust

\(^{59}\) Some adinvhadores reported that they have up to four or five spirits whom they draw on for specific skills.

\(^{60}\) There are differences between spirit mediums and diviners: spirit mediums are ordinary people without specialised duties who only function in their roles as mediums when possessed by a spirit. Spirit mediums do not have the ability to interpret the messages of the spirits whereas diviners do, in addition to giving directions to people on how they should proceed to resolve their problems (Bowie, 2000). Adinvhadores are thus strictly speaking diviners and not spirit mediums.
and throw it at Tito. Then Tito takes the chickens and puts them on the floor and draws a circle around them. He gives a chicken to one person to hold and cuts the throat of the chicken but only in half. He does the same with the other chicken and places both of them in front of him with their heads towards the group. He pats them on the back and releases them. The chickens then perform their death dance... The chickens die more or less in front of an elderly man who is sitting in the middle of the circle. Tito takes each chicken and rips open the feathers to expose the thigh. The spirit continues to talk and make statements. When the statements are true it is confirmed by those present who seem to be getting more agitated. Tito rips open the breast and rips out the intestines of the chicken. He then cuts open the stomach and removes the interior. He then rips off the feathers around the leg as he continues to speak. He concludes and reverts to his normal voice, explaining to me that the guilty person is the elderly man in front of whom the chickens died. He murdered one of his grandchildren through witchcraft. There is high emotion in the group who have witnessed the divining ... The man admits to having done these things and Tito tells him that he must do a treatment in order to undo the contract he has made with the evil spirits [Field notes, Matala].

People consult an adivinhador in order to gain information and knowledge from the spirits that would otherwise be difficult or impossible to know. If someone remains troubled by pensamentos and suspects that this may be caused by a ‘spiritual’ problem, i.e. an unfulfilled obligation to a deceased or the vengeance of angry spirits, he or she seeks out the services of a diviner. The diviner will identify the cause of the illness and will give directions for how this problem can be resolved, either by referring to a curandeiro or by performing rituals which will appease or chase away the spirits. In more complex cases such as madness caused by mbindi, for instance, an expert adivinhador has to be located who possesses the ability to ‘undo’ the witchcraft contract, something which few adivinhadores in Matala and Lubango were willing to take on [Field notes, Matala].

The war has brought about many spiritual problems involving unsettled, vengeful and evil spirits and adivinhadores are considered to be the only people able to cope with these, thus serving as valuable resources for large sectors of the population in Huila. Diviners are also used for problems affecting whole communities as they mediate between the spirit world and humans, restoring harmony and order in their relations. They are

Their positive contributions to the well-being of the deslocados are manifold: they are used in cases of the justiça (chapter 4) where they resolve situations of conflict and accusations of witchcraft, and they form part of the treatment cycle. Adivinhadores are not always perceived positively by everyone in the communities, however. Because they possess access to spirits they may be viewed with ambivalence if they are suspected of using their powers for evil purposes. False accusations of witchcraft may also contribute to an escalation of conflict in a community, destroying people’s lives and disrupting family and communal relations (Parrinder, 1962). Differences in beliefs and practices between the ATR and Christianity are also significant causes of strife in the religious domain, as will be explained below.

2. The established Christian denominations

The second main domain of the spiritual and religious discourse is shaped by the established Christian denominations\(^{61}\). Other faiths such as Islam or Hinduism were not represented amongst the deslocados in Huila, the dominance of the Christian church being intricately linked to the history of colonialism in Angola (Henderson, 1990). The Roman Catholic Church (RCC) aligned itself with the colonial Portuguese government and became the largest and most powerful religious institutions in the country during the colonial era. It has maintained this status to the present day with an estimated 44.7 percent of the total population being adherents in 1995 (Cravinho, 1998). The Protestant churches were historically in a minority position in Angola socio-politically as well as membership-wise, and were not given official recognition during the era of Portuguese occupation of Angola (Tvedten, 1997). They were suspected of being “subversive organisations providing theological cover for nationalists

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\(^{61}\) The term ‘established Christian denominations’ is used here to refer to official churches recognised by the World Council of Churches and the Roman Catholic Church, in order to differentiate them from smaller, independent religious movements that may have originated in more recent times. These definitions are, however, in themselves problematic as they define newer, smaller religious movements in relation to the European-founded mission churches, thus perpetuating the dominant position of the latter (Sindima, 1999).
bent on liberation” (Birmingham, 1992: 90), as the leaders of the three main liberation movements, amongst others, were all educated at Protestant mission schools. Post-independence in 1975 the Angolan government instituted a process whereby churches had to seek official registration, with the aim of placing all churches under effective government control. This goal was not achieved as a large number of churches that were not accepted for registration continued to operate, with many new religious movements also being established.

2.1. General concepts

The doctrines of the established churches are founded on the central principles of Christianity, namely that Jesus Christ is the son of God and facilitates forgiveness and reconciliation of humans to God. The relationship between God and humans is seen as central to life on earth during which people have the responsibility to live according to the guidelines and rules set out in the Bible, repent their sins, ask for forgiveness from God, and prepare themselves for the hereafter, i.e. paradise:

> We, as Christians, we believe in the eternal life, we believe that we should do what the church tells us. When someone sins he has to stop and change, otherwise he will never live well [Catecista Manuel, Vissaka].

While some variation exists between the churches, for example regarding the day of worship or the practices of communion and baptism, most church leaders and members in Huila stressed the similarities in the core religious practices and doctrines of the various denominations.

The denominations in Angola have their strongholds amongst different sectors of the population. The RCC has remained the strongest church in the urban centres of Angola and its members tend to be more modern in their outlook and lifestyles. Smoking, drinking alcohol and dancing are usually accepted in the church if done in moderation. Members of the
Protestant churches\textsuperscript{62} tend to be strongest in the rural areas and are generally more traditional and conservative in their opinions. Alcohol, tobacco and sexual relations outside of marriage, for example, are strictly forbidden in all Protestant churches. At times members of the Protestant churches accused the RCC in the centres of Vissaka and Chipopia of allowing and encouraging drunkenness and immoral behaviour through their leniency in such matters, a claim disputed strongly by members of the RCC [Field notes, Chipopia].

The churches play an important role in the lives of the deslocados, a fact reflected in the physical presence of church structures or areas designated for worship in the centres. The building of such structures is almost always the first communal initiative undertaken by the communities after displacement, and at times churches consist of nothing more than a cross nailed to a tree and wooden logs for the congregation to sit on. In the centres where services were mostly held in the open, worshippers attended daily services irrespective of the weather conditions, braving the cold of the winter months as early as 5:00 o'clock in the morning, or the heat and rain during the summer. In the towns all churches are filled beyond capacity with no space for late-comers, who end up standing outside of the church doors because aisles and standing space are already occupied. In the centres the deslocados greatly lament the loss of Bibles and songbooks which they more often than could not carry with them when they were forced to flee [Catecista Ndala, Chipopia].

Most churches operate with hierarchical authority structures with priests, pastors and catecistas\textsuperscript{63} heading the churches, followed in importance by church elders. Church leaders are accorded great respect in the communities and are seen as having an important and vital

\textsuperscript{62} Prominent Protestant churches in Huila were IESA (Evangelical Church of Southwest Angola), the 7th Day Adventists, the Charismatic Assemblies of God, the United Methodist Church of Angola, the Evangelical Baptist Church of Angola, and the Jehovah's Witnesses.

\textsuperscript{63} In many rural areas there were not enough fully trained priests and pastors available to head the churches. Their places were filled by catechists who had received some form of religious training.
role to play not only in the running and organisation of the churches, but also as advisors in
times of personal or communal difficulty. In addition, the churches give structure and purpose
to the lives of the deslocados through a range of activities such as daily prayer meetings and
services, women’s groups and youth gatherings and provide people with the opportunities to
socialise.

2.2. Health, illness and distress

The approach to health care advocated by the established churches and practised in their
clinics and hospitals is essentially biomedical, a process initiated by the early missionaries
who brought with them knowledge of the then current treatment practices in Europe and
Northern America (Tvedten, 1997). Many of the large and successful hospitals that were
established by missionary doctors during the colonial period were situated near mission
stations in areas such as Humpata, Caluquembe and Caconda in the province of Huila
(Henderson, 1990). Of these, a number closed down due to the exodus of expatriate
missionaries after independence, cuts in financial support from overseas ‘mother’ churches
and the constraints brought about by the war.

The churches nevertheless continue to provide health care to populations, with many small
clinics staffed either by nuns trained as nurses, commonly the case with the RCC, or by
personnel with varying backgrounds in health promotion or nursing. The clinics run by large
churches such as the RCC, IESA, Baptist and Methodist churches usually receive medical
supplies from overseas churches and donors, whereas those run by smaller denominations
such as the 7th Day Adventists have to procure funding on their own and often struggle to
obtain medical supplies. Most of the church clinics charge their patients the same amount as
state-run clinics, although slightly higher or lower fees can sometimes be levied. If a patient is
unable to pay or is perceived to be more poverty-stricken than is usual they will usually be
treated for free. The deslocados generally perceive the health care given at most church-run
clinics, especially those of the RCC, to be better than the government clinics because of the
range of medication they have available and because of perceived superior competence and
training of the staff [Field notes, Lubango].

Although the established churches operate predominantly within a biomedical framework, they
are influenced by and participate in the local debates on the relationships between religion,
spirituality and health care. Nowhere is this more apparent than when the staff at the church-run
clinics talk about the services provided by adivinhadores and curandeiros in the folk sector.
The churches advise their members not to make use of the services of healers and diviners but
to rely exclusively on consultations at the clinics and the mercy of God for their recovery:

People who live in the village and don’t know anything about development they believe that the sickness
is sent by the spirits of the ancestors. So we have to tell them this is not so and to tell them to stop using
the curandeiros. It is only in the clinics that they can be healed [Feliciano, Lubango].

Some priests and nuns of the RCC expressed tolerance of people consulting curandeiros as
long as no spirits were involved in the treatment, i.e. as long as the healer relied solely on his or
her knowledge of plants and herbs. This was a stance not shared by Protestant churches, many
of whom threaten their members with expulsion if they are discovered to be consulting a
curandeiro. In the case of adivinhadores staff at all church clinics and the majority of church
leaders were adamant: no benefit or potential good could be derived from consulting them. On
the contrary, most were of the opinion that it could cause the patient harm in a spiritual, social
and physical way. The sick person could be drawn into occult matters through coming into
contact with evil spirits and may find it difficult to extract him- or herself from these. Social
relations may be negatively affected by false accusations of witchcraft and the
health of the sick person may deteriorate further if not treated with appropriate biomedical drugs.

Most of the practitioners at church-run clinics did not doubt the reality of witchcraft, spirits, demons and the power some people have to manipulate them. While the majority also acknowledged that illnesses such as loucura can be caused by witchcraft, spirit exorcism, traditional rituals and sacrifices to appease spirits were not considered acceptable nor effective forms of treatment. These opinions resonate with the general perception expressed in the communities that such practices are contrary to Christian beliefs. In the centres of Vissaka and Chipopia my questions about traditional healers were often first met with a denial that they were present in the communities, typically by saying “There aren’t any here. We don’t use them”, followed by explanations such as “We are religious people here. We go to church” [Field notes, Chipopia]. In none of the communities did it turn out to be the case that no healers and diviners were present nor that they were not used. People did make use of the healers, a fact confirmed by the curandeiros and advinhadores, and did perform sacrifices for the ancestral spirits but often in secret, in fear of being discovered by the church leaders. The established denominations recognised that their attempts at discouraging people from using the healers were frequently not successful. As one priest of the RCC explained:

If we had more health posts here the evangelisation would go much more quickly. We priests, we go to the villages and we talk there with someone. We talk a lot, look at the watch and come back here. The person may be sick because of the sun, there are no doctors, no medication - where will he go? To the curandeiro. The missionary goes with the Bible and comes back with the Bible. The person who is sick doesn’t have anything else and goes to the curandeiro. This is a vicious circle because we do evangelism only theoretically. There are no clinics, no alternatives. If we want them to stop going to the curandeiro we must give them alternatives. A person is not cured only with the Bible. Because after that he needs tablets. And he doesn’t have them he goes to the curandeiro. And the missionary says [to the sick person]: “You are stubborn and thick-headed”. But it is not because of that, just that there is no alternative [Padre Santos, Lubango].

A further factor influencing people’s decisions to consult healers is also that the established churches tend to ignore the spiritual and social aspects involved in illnesses, concentrating
only on its physical aspects, an issue discussed in more detail in the section on independent churches below.

2.3. Resources and assistance

The vast majority of church leaders and nuns in Huila had experienced the war first-hand, either when they had been working in the war zones or as deslocados themselves. The religious leaders mentioned three aspects of the suffering the war causes: material poverty, health-related problems and the spiritual and emotional aspects of suffering. All felt that the churches have a responsibility in alleviating poverty but that the churches themselves were in a difficult financial situation. As one of the deslocados explained:

The church could help when we were in our terra. If there was a widow or someone sick everyone gives something quickly to help that person. But here no one has anything. The church can only help when someone dies, with the coffin, or some panos [cloth]... No one has anything here and the church also doesn’t have anything. Because the church is a person [Dona Paula, Chipopia].

Despite these economic hardships the churches make an effort to assist those who find themselves in especially difficult situations such as illness or a death in the family. In the centres groups of women from churches in surrounding areas would sometimes come to visit the sick and bring food, an action which was greatly appreciated by the deslocados, not only for the material assistance but also for the solidarity and support displayed by the local population.

Churches saw their role predominantly in helping to alleviate the emotional and spiritual suffering of their congregations, as “the problems of war are not just material; they are also spiritual” [Catecista Manuel, Vissaka]. This was done in the form of conselho and giving spiritual advice to those suffering from pensamentos and other distress-related illnesses. Church groups and catecistas visit the homes of those whom they knew to be experiencing difficulty with coping with the losses and deaths that had occurred, an action which the
deslocados not only valued but also saw as a crucial part of helping the person overcome their pensamentos:

The first thing they [widows] need is to receive a spiritual consolation. They are consoled by the churches, they have some men and women who go there to console the woman. When you meet them they will say: “Don’t think a lot about that which you left behind. Because many people lost many things, and many people lost their land. Because if you spend all your life thinking about that what you left behind you will spoil your body. Pensamentos will destroy your body. You will not manage to do anything anymore, nor to take care of your children”. They will read from the Bible and pray. The women and men from the churches come always to console and say this [Dona Teresa, Chipopía].

Similar themes to those outlined in the previous chapter form part of the conselho, i.e. the notion of shared suffering and the need to focus on the present. In addition, some priests were of the opinion that more concrete advice needs to be given to the person in order to stop him or her from “thinking too much”, such as reading the Bible:

A person cannot not think. My way of seeing this is that it would be more solid to say: “You can think but let the thoughts go on this road and not on another”. If you lose someone of the family you will think about it: this is normal. But to prevent a person from having depressive thoughts and destructive thoughts it is necessary to help a person to go from one place to another. It is not enough to say: “Don’t think”. We also need to indicate ways in which people can change direction of thinking through action… Spiritually I can say to a person you will open the Bible and you will read this section. Then you will answer two questions. The person will do this work…. Then the person is doing something active. And I help by orientating the person’s thinking to something else [Padre Santos, Lubango].

The conselho given by the churches relates directly to Christian beliefs such as to the promise of after-life and the omnipotence and wisdom of God in handling affairs on earth. Here are two examples:

As we are Christians we give them the message of hope: death is for everyone. So if this happens it is because we are in the world of sin, in the world of death. So if it happens here, it can happen there or with someone else as it happens with everyone. So what we do is take the person to the Christian environment… He will believe in God and he will forget all these dead people [Catecista Lucas, Lubango].

This is what the Bible teaches: that we need hope. Because everyone who believes in Jesus believes in the resurrection, so they don’t have to worry about death. They just have to conform themselves to what life gives. This is the Christian teaching we give to them [Jacinto, Lubango].

While it may at first be difficult to understand that the “message of hope” is that “death is for everyone”, this is seen as part of human destiny in God’s plan, and emphasises the need to accept the suffering of life on earth while continuing to hope for paradise in the next life. This belief has been central in Christian (and Judaic) understandings of suffering over centuries,
and has given adherents of the religion a means of confronting, enduring and perhaps overcoming suffering (Pargament, 1997). The story of Job in the Old Testament was sometimes referred to by some deslocados when they talked of their own suffering: like Job they would bear what God had decided for them. Faith is, however, not only something to cling to in times of crises but forms part of everyday life for the deslocados. One of the Protestant catecistas expressed this succinctly when asked why he thought the churches were important in the centres:

Because we were already Christians before we came and we continue to be Christians here. The suffering will not make us leave God. Before the attack we used to go to church at home in our village, and now here in the centres we will go to church [Catecista Antonio, Matala].

Belief in God, His omnipotence and His ability to intervene was seen by many deslocados as a sustaining force in their lives. When telling their stories, people frequently referred to God as having saved them from the fate that befell others around them, such as death, injury, detection, capture and rape. References such as “It is God who helped me”, “God prevented them from seeing me”, “My child was saved because of God” and “God helps me now to survive” are frequent expressions of this belief [Field notes, Chipopia]. Faced with situations that at times seem impossible to surmount, many widows would use the phrase “Only God knows” when talking about the future and the difficulties it would bring. This was not done out of a sense of fatalism as the women actively engaged in trying to find means of survival, but seemed to be an expression of hope that a higher force, God, will assist them in practical and spiritual ways. One widow, Valeria, a woman of 55 whose husband was killed in an attack, had managed to flee with five grandchildren for whom she had sole responsibility. She did not know the whereabouts of three of her children. In the last eight months since the flight three of her grandchildren had died one after the other from various illnesses. Valeria suffered from mutina and insomnia, recounting that she spent many nights sitting upright in her hut, thinking about what she had lost. Her only hope for curing her illness and for surviving in the future, she said, was God:
I have no cure but only ask God to help me not to think about this anymore what happenend... only God can help me. So God should help me not to think anymore about this [Dona Valeria, Chipopia].

The deslocados derived comfort not only from their belief systems and the conselho of the religious leaders but also from being part of a congregation. Churches provide a sense of belonging in a society where the war has disrupted family unity and relations and where support is difficult to find. As one of the 7th Day Adventists told me:

The war destroys. Up to now we never lived where we were born. A person was born in that province but you can’t go there anymore because of the war. People live far from one another, the mother here, the grandmother there and the son in another place. Things here are complicated and the only thing that saves us is to join a church. In church you find friends with good sense and you become family, relatives [João, Lubango].

Members of a congregation often considered themselves as brothers and sisters to whom they extended trust and towards whom they felt a greater sense of responsibility than towards non-members, thus in some way replicating an extended family structure.

The churches also provided a symbol of hope to people directly affected by the war. People expressed admiration for the Catholic nuns who often went to war zones where no other organisation accepted to work because of security risks [Field notes, Lubango]. Deslocados recounted that the nuns are always the last ones to abandon an area, and do so only when the situation becomes so intolerable that their lives are directly at risk. They were hence used as ‘risk monitors’ to determine when a situation had become so serious that it was time for the population to flee [Field notes, Matala]. Many nuns and priests do not withdraw in time, however, and suffer attacks, rape and abduction. A number of nuns, priests and other religious leaders have been killed in Angola over the past 25 years (Richardson, 1999). It is thus not only through the spiritual support that religious workers give courage to populations affected by war, but also through their physical presence in war zones.
3. The independent churches

The third sector of the spiritual domain comprises independent churches that are not affiliated to any of the main governing international church bodies. The rise of new religious movements in many parts of the world, and in Africa specifically, has been well documented over the last two decades (Bowie, 2000; Geschie, 1997; Githieya, 1997; Henderson, 1990; Maxwell, 2001). Mbiti (1989) estimates that in 1984 there were more than 7000 independent churches in Africa, a number that will have greatly increased since then due to the growth in small separate religious movements in recent years. Different categories of independent churches exist in Huila, which can be broadly divided into the charismatic, ‘born-again’ churches on the one hand, and the prophetic and indigenous churches on the other.

3.1. General concepts

The most well-known charismatic churches in the towns are the Igreja de Mana [Church of Mana], the Igreja Universal de Reino de Deus [Universal Church of the Kingdom of God] and the Pentecostal Church of Angola, all of which have established themselves in Lubango and Matala over the last four or five years. The Church of Mana was founded by a Mozambican in 1984 and has branches in over 20 different countries; and the Universal Church was founded by a Brazilian and is represented in four Portuguese-speaking countries. Charismatic churches place special emphasis on the intervention and power of the Holy Spirit and practices such as speaking in tongues and being ‘born again’, a spiritual experience during which a person sheds his or her past life and becomes a new person through faith in Jesus Christ. Many churches also preach the “gospel of prosperity”: faith in Jesus Christ will bring blessings of health, wealth and success:

If a person accepts Jesus He takes all our problems away from us. A person accepts Jesus into his life and swops his life for that of Jesus. This person starts to become totally different at the moment, his life
Religious and spiritual domains

becomes different - no more illness, no more financial worries, no more hate. He leaves behind all that [Pastor Joaquim, Lubango].

Born-again Christians are called to be successful in all areas of their lives because it is God’s plan that humankind should prosper in all things. A central principle of faith is that God has met all the needs of human beings in the suffering and death of Jesus Christ, implying that every Christian now shares the victory over sin, illness and poverty (Gifford, 1998).

In relation to this latter doctrine, in order to participate in God’s prosperity Christians have to make an investment by giving “seed money”, a concept based on the New Testament verse which states: “A man reaps what he sows” (Gal., 6:7, Holy Bible). Members of the congregation ‘plant seeds’ by giving money to the church, considered to be an act of faith that will be richly rewarded by God:

We teach the will of God to the people in regard to financial matters. We ask for their contributions because God says we should do this. We have many examples here in the church of people who obey God and then God helps them to prosper. The law of God says for all people that they must bring a part of their earnings to the house of God to prosper and have good jobs [Pastor Joaquim, Lubango].

A series of special blessings are performed by the pastors in the churches of Mana and Universal during services, for example for those who want a car or who need extra help with their business undertakings. In the Universal Church specific days are set aside for certain spiritual activities, for example Monday is a day for faith-healing, Tuesday for spirit exorcism and Wednesday for receiving blessings for prosperity.

Prophetic movements and African indigenous churches are churches that have ‘indigenised’ Christianity by absorbing the Christian beliefs into traditional African religious and cultural forms thus creating new, Christian, African religious communities (Gifford, 1998; Sindima, 1999). They were often formed as religious and political protests against the missionary churches, based on the belief that adherence to Jesus Christ as Lord rather than adherence to western culture is a measure of Christian identity (Githieya, 1997). They are usually founded
by a strong, inspired prophet, who receives a message from God instructing him or her to break away from another church because of its unchristian practises. The founders have special spiritual powers that, in order to be practised and expressed, require the formation of a separate church organised around the prophet’s person. In Huila the most well-known of these are the churches of Simão Togo and Simon Kimbanigsta, as well as the Igreja Cheio da Palavra do Deus [Church Full of the Word of God]. In addition, countless numbers of small churches lead by santas and santos exist in almost every neighbourhood in Lubango. The word santo means ‘saint’ but is used in the sense of a holy person who possesses the power of faith-healing. They distinguish themselves from curandeiros and adivinhadores through the type of spirit they draw on during their healing activities: instead of using ancestral spirits santas use the Holy Spirit:

This is the church of the spirit of God. The spirit came to me when I was a child and I saw Jesus with my own eyes. I saw him several times and whenever he came I bowed down on my knees. Later the Virgin Mary appeared to me and Jesus talked to me and said that I should serve him. God gave me the power of healing and I can heal many things [Santa Filomena, Lubango].

In Huila santas are predominantly female and often build small church structures on their properties from which they conduct daily church services and healing activities. They may remain affiliated to established denominations but usually find themselves ostracised by other church members:

As time passed people saw that I have a different spirit. Many people found this strange and didn’t like it. People in the other churches didn’t allow me to perform this service of healing and so I decided to open my own church [Santa Regina, Lubango].

The independent churches expect their followers to abide by a number of rules and taboos. These usually involve a complete abstinence from sexual relations outside of marriage, alcohol, tobacco, secular forms of entertainment and any form of traditional healing or divining. Eating of pork, and sometimes all meat, may be forbidden. If someone has sinned against these prohibitions they may be put on probation, suspended from church or excommunicated, depending on the severity of the sin. In the prophetic, indigenous churches Old Testament texts and practices are often more prominent than those from the New
Testament. Bible verses may be interpreted literally and are taken as directives from God. A characteristic of the independent church sector is, however, the variation and innovation in beliefs and practices amongst the churches, with no two churches sharing exactly the same practices.

The churches attract different groups within communities, the charismatic movements appealing to urban youth and the prophetic churches to a cross section of ages and backgrounds. The charismatic churches are predominantly an urban phenomenon in Huila and are largely absent in the rural areas. As with the mainstream churches, the role that the churches play in the lives of their members needs to be understood primarily in religious and spiritual terms but also includes social, economic and political elements. The social life of members of the charismatic churches, for instance, often revolve around the church where there are continuous rounds of Bible studies, prayer meetings, choir practices, revivals and evangelistic activities, thus providing a "new spiritual family" within the religious group (Adogame, 2001). All over Africa charismatic churches, also known as new religious movements (NRM), are becoming increasingly popular with youth, a phenomenon that has been attributed to a number of factors such as their modern styles of worship and that they offer people a sense of hope, purpose and empowerment in a world where secular ideologies have failed (Maxwell, 2001). The appeal of both indigenous and charismatic churches has also been explained in terms of the freer expression of faith they allow in comparison to the established denominations through singing, dancing, weeping and shouting:

Beneath the umbrella of independent churches, African Christians can freely shed their tears, voice their sorrows, present their spiritual and physical needs, respond to the world in which they live and empty their selves before God (Mbiti, 1989: 228).
3.2. Health, illness and distress

The independent churches use spiritual explanations for understanding issues of health and illness, and the majority see biomedical factors as either irrelevant or as secondary to these. According to the “gospel of prosperity”, Christians should enjoy physical and mental health, and its absence indicates a spiritual problem. Illness, just as poverty, is attributed to a lack of faith, to sinful behaviour or to the invasion of the body or soul by satanic spirits. In the first two cases illness is the consequence of turning away from God and is thus the fault and responsibility of the ill person. In the case of demonic possession or witchcraft the person cannot be held responsible for his or her illness and is considered to be a blameless victim. Some of the charismatic churches believe that all illness is caused directly by the devil, as explained by the pastor of one of the large, popular churches in Lubango:

I can’t give what I don’t have. It’s the same with God: He can’t give what He doesn’t have. The illnesses don’t come from God - it is the devil who destroys, kills, robs. An illness destroys humans. If you have a house and it’s all good and then you start breaking a window, break the door. Would you do this? No, you would not. It’s the same with God: He created everything and the best thing He created is the human. He won’t destroy this [Pastor Roberto, Lubango].

The basic premise for being cured is faith in God and in the healing power of Jesus Christ and the Holy Spirit. Healing may occur instantaneously or gradually but can only occur if sufficient faith is present:

Yes, the cure comes to those people who believe in Jesus. When Jesus comes to a person, the person receives everything: salvation, liberation, healing. The person is liberated from this moment onwards. But this doesn’t mean that from this moment on the person will not feel sick… This depends on the right faith of the person. Because some people think like this: “Today I will go to the church but I will not be cured”. The attitude of the person is that it will not work or he will say: “Is it possible that God will heal me?” He has some doubt and then he will not be healed [Pastor Roberto, Lubango].

A number of further actions need to be undertaken depending on the cause of illness: if the ill person has sinned, he or she must confess the sins and make amends to the person wronged; if he or she is possessed the demons must be exorcised; and all ill people should participate in faith healing conducted by the church leaders or santas. Some independent churches, such as the Universal Church, for example, forbid their members to consult a doctor or visit a clinic as
medication is considered unbiblical on the basis that Jesus healed only with the power of the Holy Spirit (see Sundkler, 1961 on the Zionist churches in South Africa). Church members should rely entirely on God’s healing power which can be accessed through the church leaders, prayer and reading the Bible, and not through doctors:

Sometimes the problem is that the person hasn’t prepared the soul. At times God wants you to go to church to pray. You spend your life just with drinking and with adultery - you will not stay well. You are sick because of the result of your sins because God punishes you for these things... Many people are sick because of their sins or because their soul is dirty, a dirty body and a dirty soul [Simp Lena, Lubango].

Consultation of curandeiros and adivinhadores is strictly forbidden in charismatic churches and by the majority of santas and prophetic churches, as they are seen as working in cohort with the devil, drawing on demonic spirits in their practices.

Faith-healing forms a central part of each service and may take place during the worship or afterwards when people line up in front of the pastor to receive blessings, laying on of hands or prayers for their recovery. Often healing is done through the sprinkling of ashes, water or perfume that have been blessed by the pastor or santa. In the indigenous churches the healers are usually possessed by a spirit while they engage in healing and several other people may be possessed and healing at the same time. Faith-healing is an important way in which the prophet or the leaders of the church demonstrate their power and explicit closeness to God (Ben-Tovim, 1987). The healers do not take credit for the miracles performed, however, as their powers come directly from God and the Holy Spirit:

Who cures is God himself. God only cures when you follow him. If you don’t follow him you will be sick. The soul is like the body: the body needs to have breakfast, and then lunch and then dinner. There is a time when you need to pray because the soul works as the body [Simpeta Filomena, Lubango].

Some healers rely only on spiritual healing while others use herbal treatments as well, the latter being most common amongst santas who may undergo training periods similar to those of curandeiros in order to learn the healing properties of plants, roots and herbs. Successful faith-healers acquire reputations that spread from one area or town to another, attracting new converts to their churches. Many people who have tried several different health care options
and have not been cured, approach the independent churches in the hope of being healed. The charismatic churches do not ask for direct payment for healing while santas charge for individual consultations along similar lines as the curandeiros.

While the charismatic churches reject many of the traditional cultural practices of the local populations, they nevertheless use a supernaturalistic vision of reality and a discourse that includes God and the devil, miracles and an instrumental understanding of religion (Bowie, 2000). This accords well with aspects of traditional religious thinking, as well as with an understanding of illness as a spiritual, social and physical issue. Similarities exist between traditional religious practices and those of the prophetic, indigenous churches, for example in the healing practices of the santas which may closely resemble those of the curandeiros:

Q: How do you heal someone who is sick?
   The spirit tells me that a sick person is coming. And if the patient has luck the spirit will also tell me what sickness this is. At times the spirit doesn’t say what the illness is, I sit down and start to pray and then I discover what are the problems of this patient.

Q: Is this the spirit of God?
   I cannot say if this is an evil spirit or a spirit of God. But I think it is the spirit of God because he never tells me to do something else apart from prayer. It’s only prayer [Santa Maria, Lubango].

Cox (1998) and Sindima (1999) suggest that the ability to bridge traditional and Christian beliefs and practices explains some of the success and growth of independent churches in may parts of Africa, as they offer people a religious space where both can be accessed. Those who do not feel comfortable in established churches because they may not want to abandon certain aspects of their traditional culture may find a greater sense of belonging and freedom in indigenous churches.

Spirit exorcism forms part of most of the independent churches’ understanding of spiritual and holistic health, as a constant battle is being waged between witchcraft, evil ancestral spirits and demons on the one hand, and the churches on the other. The battleground of this contest is not only the body of the ill person but also in the communities where members of
the churches confront and challenge people suspected of practising witchcraft. Demon possession may express itself through illness but also through signs such as repeated miscarriages, an unhappy marriage or an addiction to alcohol. The practice of spirit exorcism is an important resource to local populations who are confronted with issues of witchcraft and spiritual forces in their daily lives and who find the existence of witchcraft not only affirmed in the independent churches, but are also provided with the means to combat it (Geschiere, 1997). This is in contrast to the mainstream churches who often do not acknowledge the existence of witchcraft and who may have dropped talk of the devil and demons from their discourses. Services where demon exorcism take place are emotionally charged events where the cathartic effects of the final resolution, i.e. the casting out of the demon, may have a powerful impact on participants. Here is an extract from my field notes on a spirit exorcism service at one of the churches:

Then during one of the prayers the possession starts and the assistants walk up and down the aisles, looking for those who are possessed. When they have identified someone they hold them with both hands behind their neck and pull them out to the front where they stay on their knees. There are five women, all of them seem to be between the ages of 30 - 50. Some seem somewhat reluctant to come to the front but already seem to be in a state of possession... The women remain kneeling in front of the church and seem to be in a kind of stupor. The pastor descends from his stage and starts talking about how these women are possessed by demons and the devil. He demonstrates this by 'interviewing' the women: he asks them questions about the intention of the demons. The women answer and say that their intention is to destroy life. The women make strange sounds and the pastor tells them to speak more clearly... The exorcising begins and the congregation stretch out their hands and pray, shouting loudly. The assistants take one woman each and exorcise the spirits by praying and making sweeping movements with their hands. The women return to their seats and the service continues [Field notes, Lubango].

3.3. Resources and assistance

The independent churches overtly emphasise the spiritual dimensions of war and suffering, with charismatic churches attributing the war and its consequences to the devil:

The Bible teaches us that our enemy is not the human being. Our enemy is the devil... The role of the devil is to injure the hearts of people.... These injuries of the heart cause the terrible things we see in life: there are many people who do barbaric things, have no hope in life, people who are traumatised and injured by the devil.... The devil puts one man against the other. The mission of the church is to convince the people of this reality and show people this [Pastor Joaquim, Lubango].
This perspective on the war frees people from direct responsibility for their actions during the war, perhaps making the act of forgiveness easier for those who have been harmed. It also places certain consequences of the war into a realm in which the churches and their leaders are the experts, for example in facilitating the healing power of Jesus. The santas and prophets often have more complex explanations of the war, attributing it to the greed of humans, witchcraft, the neglect of God and His ways by humans, and to sin.

As described above, in some churches all illnesses are seen as being due to spiritual forces including those caused by pensamentos and distress. Faith-healing, confession and spirit exorcism are thus provided by church leaders in order to assist those who are ill. Some of the santas and leaders of the charismatic churches, however, distinguished between illnesses that occur as a ‘normal’ consequence of the suffering of war and those caused by sin and witchcraft. For those suffering from distress-related illnesses prayer, having faith in God and reading the Bible were seen as imperative for overcoming the illness. “Pray until it passes” was the advice one santa gave to people with pensamentos, while a pastor of a charismatic church explained:

When such a person comes here we turn to the word of God... God’s word penetrates everything and into our very bones and into our thoughts. It cures all our illnesses and restores everything to us. The only medication we need is the word of God because there is nothing better than the word of God. It is not an empty word - it is a blessed word [Pastor Alfredo, Lubango].

One santa, talking about children who had witnessed a parent being killed, expressed the opinion that those who have suffered severely in the war need special attention and care in order to leave behind the pensamentos:

When children have lost a parent they can lose their minds. They will not do well at school and will get a spirit in them where they want to kill someone. This child needs to be treated with love, and must be taught to pray and have faith in God. We must teach the child to forgive and it must grow up with God. We pray for the child every morning and advise the parents: ‘Preach the word of God, read the Bible,

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64 This perspective is also an example of a theology that believes in personal salvation first and hopes that social salvation follows, a theology criticised in many parts of Latin America and Africa for its lack of insight into the workings of political realities (Nolan, 1984).
Relax and play with the child”. This is important because then slowly the child will forget and slowly the suffering will become less [Santa Maria, Lubango].

Some santas perform treatments for mutima which essentially resemble those performed by the curandeiros but with minor variations, for instance the additional use of blessed water or perfume and prayers to the Holy Spirit for health and recovery. Opinions about the cause and treatment of mutima were not uniform across the different churches, however.

The deslocados, both members and non-members, made use of the independent churches for problems of mutima and loucura. The fact that some independent churches prohibit their members from using biomedical treatment was, however, viewed with scepticism by non-members who doubted the wisdom of this, as well as the efficacy of the faith-healing practices. Church members expressed support and faith in the particular approach of their church and many claimed to adhere strictly and exclusively to their churches’ perspectives on health and healing. Because complete trust in God’s healing power is a requirement for a successful faith-healing process, members of the independent churches usually consider the use of health-care pluralism counter-productive. Nevertheless, some degree of medical pluralism does take place amongst congregations of independent churches. This became apparent in conversations with a few church members who noted that they have consulted the clinic or “another healer” for an illness, as well as from conversations with curandeiros who occasionally treat members of independent churches [Field notes, Lubango].

4. Concluding discussion

The three sectors in the religious and spiritual domain in Huila have been outlined, namely the ATR, the established Christian denominations and the independent churches. Their

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65 The burden of responsibility may be placed on the ill person if a lack of faith is perceived to be the reason for non-recovery. Members of the congregation may be criticised for not placing enough trust in God’s healing powers as exercised by the church leaders.
perspectives on health, illness and distress have been discussed as well as the resources and types of assistance they provide to the deslocados. The chapter has shown that suffering is not only frequently expressed in spiritual terms, but is also often understood as resulting from spiritual and religious problems, for example the pollution caused by vengeful spirits, or loucura ensuing from mbindi. Solutions are therefore regularly sought in the spiritual and religious domain. As mentioned in the introduction, psychosocial professionals have commonly neglected the fact that there is a religious and spiritual context to the experiences and concerns of many war-affected populations that dominates debates on distress, health and illness in these communities. Part of this context in Huila involves issues of spirit pollution, witchcraft, religious beliefs, practices of faith healing and an array of religious leaders, prophets and healers who influence and contribute to the debates.

4.1. Conflict, power and change

As demonstrated in this chapter, the perspectives within the religious sector are not homogenous and their presentation of the spiritual issues that are salient to understanding the distress and suffering caused by war do not necessarily concur with one another. In fact, in some communities in Huila considerable antagonism and conflict exist between representatives of the three sectors. The established churches often denounce the independent churches as heretics who have left the fold of Christianity, while independent churches are frequently hostile towards curandeiros and adivinhadores.\(^66\) A ‘competition’ for adherents may ensue between churches where insults are traded and practices derided. In one area of Lubango a small scale battle raged between a santa and a charismatic church, each one

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\(^66\) Practitioners of ATR were the most tolerant of the three sectors, being openly understanding and accepting of a pluralistic approach to health care but also stating decisively that only they could cure certain illnesses such as mutima [Field notes, Lubango].
denouncing the other for devil worship and practising witchcraft, drawing community members into the conflict:

The devil creates things that are intended to make people concentrate on other things and not on God... And so what does he do: he creates curandeiros, santas, the astrologers who read the stars. And when you go there you find a Bible there. But they do not speak in the name of God, they speak in the name of the devil... they are deceivers, liars [Pastor Roberto, Lubango].

The religious and spiritual domain is thus a contested area in the communities about which people have strong opinions and feelings and one in which conflicts of power and influence play themselves out. Religious and spiritual matters, just like matters of health care, can never be divorced from the social and political contexts in which they occur and need to be situated within a wider field of power relations in which various competing discourses and practices exist. In addition, authority is vested in religious leaders such as priests and pastors and in people with special spiritual abilities such as adivinhadores and santas. Those who dispense healing and who claim to be in touch with supernatural forces have some influence in the communities and may have the power to make decisions about the distribution of resources. Attention needs to be drawn to the fact that while these different actors play an important role in the lives of the destocados and provide resources to them, they may also have the potential to increase and contribute to a situation of destructiveness and stress in an already volatile society. What can serve as a coping strategy within a community can also lead to hostility and strife.

Outsiders wishing to understand the perspectives and resources provided in the religious sector have to familiarise themselves with the tensions and power dynamics that exist in the communities in order not to alienate, promote or disenfranchise specific groups, thereby further contributing to the already existing conflict. The presence of conflict also points to the fact that while people share the same explanatory models of an illness, for example spirit possession, they can nevertheless come to entirely different conclusions regarding the
appropriate treatment. Again, knowledge of the differences between various explanatory models in the folk and popular sectors is crucial.

Communities, cultures and contexts are not static but constantly undergo alterations. The religious sector in Huila powerfully demonstrates this phenomenon through the perpetually changing and newly emerging dynamics in the spiritual discourse, for example the rise of the NRM's, and the appearance of new types of spiritual practices and forms of witchcraft. An example of this was given by a feiticeiro who explained how he uses specific herbs to kill others⁶⁷, and then qualified this by saying:

But now we are in the church, we are catholic and we don’t do it like that anymore [with herbs]. Now if someone does a bad thing to us we just go to the market and buy candles. You light the candle and start saying things [curses] up to the end of the candle and the person who has done bad things to you he will die. This is another way to do this [Zé, Lubango].

Apart from being an interesting reflection on what it means to be catholic (!), Zé’s comments reflect how elements of the different religious influences interact with one another, creating different and innovative ways in which adaptation to new situations takes place. The tendency amongst some humanitarian aid workers to define ‘cultures’ as consisting of fixed, essentialised characteristics run the risk of overlooking new developments in local contexts. ATRs, for example, while they continue to play a central role in the way people understand and cope with illness and suffering, are no longer the final nor the only source of reference and identity in many communities in Huila. The inter-relationship between change, culture and coping will be further elaborated upon in chapter 9 which focuses on the views held by adolescents in the communities.

⁶⁷ This was an unusual interview as most curandeiros and adivinhadores who practise witchcraft do not reveal this to people, let alone to strangers.
4.2. Coping resources

This chapter has presented an analysis of how various resources in the religious sectors contribute to helping the deslocados cope with the suffering of war. It is difficult to gauge how comparatively significant and useful these resources are to different sectors in the communities. In times of crises people often revert to the practices of ATR such as remembering the ancestors and asking for their guidance and intervention. In Huila this was done by many deslocados who were members of churches but who continued to perform ancestral rituals when difficulties rose, mostly in secret for fear of reprisals from the churches:

People do mahamba [ritual to venerate the ancestral spirits] here in Vissaka but they don’t like to talk about it.
Q: Why not?
The churches don’t like it. The RCC and the 7th Day Adventists, they don’t like to see it if you do mahamba. But people do it, just quietly, inside their houses [Anna, Vissaka].

The numbers of ill people who ‘try out’ faith healing at the independent churches or the santas seem to be increasing from reports of local residents [Field notes, Lubango]. People seem to be utilising different ‘treatment’ options in the religious sectors in much the same way as they do across the health care system, making sure that they have double or triple ‘insurance’ in various domains. Coping strategies are thus clearly flexible and not “cast in stone”, with people utilising a number of different resources.

Spiritual beliefs and practices are a source of coping not only because they provide comfort and explanations for what has happened, but also because religion is a means through which people affected by hardship and suffering seek to exert control over their environment by influencing the supernatural (Pals, 1996). This in itself can be anxiety-reducing and can be beneficial in that it diminishes a feeling of helplessness, for example by following a prescribed set of rituals that gives the person ‘something to do’ (Pargament, 1997). Religion also helps people to derive comfort from knowing that a higher force (the ancestral spirits,
God) is involved in the affairs of mankind and that they, through prayers for example, may be able to influence the outcome in some way.

4.3. Implications for psychosocial practice

Over the last two decades psychosocial practitioners have been called upon to take the cultural context of the people they work with into account (Dawes and Honwana, 1996; Nader et al., 1999). While this call has been taken seriously and initiatives to incorporate culture into mental health work have burgeoned, there has been a marked absence of debates on religious and spiritual issues, despite the fact that many war-affected populations attach great importance to this aspect. One of the reasons for this is that religious issues are usually subsumed under the umbrella of culture instead of being addressed in their own right. As has been shown in this chapter, religious and spiritual dimensions of distress need to be studied not merely as aspects of cultural belief systems and practices but as significant healing resources in themselves. There is a certain amount of overlap between cultural and spiritual issues especially in the ART, of course, and the boundaries between them are at times blurred.

The deslocados often distinguished between culture and religion in complex ways, demonstrated in the following quote from one of the pastors of a charismatic churches in Lubango. To the question if the practise of venerating ancestors is not part of Angolan culture, he replied emphatically:

No, no, no. This is not the culture of Angola - it is the culture of the devil! I am Angolan: why do I not think like this? [Pastor Joaquim, Lubango].

Mental health professionals will be interested in the effectiveness of the various treatment described in this chapter, as indeed are the deslocados. This study cannot do justice to such a complex issue (see Csordas, 1994; Good, 1994; Kleinman, 1980 etc. for an overview of this issue) but merely raises some considerations. The effectiveness of the practices seems to be evaluated by the deslocados in terms of the “spiritual results” they bring and, if these are
deemed to have occurred, they are considered to have been successful. The deslocados also sometimes suggested that the success of a particular treatment depends primarily on one’s spiritual affiliation and the faith one has in the successful outcome of the treatment.

Clearly, the issue of effectiveness is intricately related to the explanatory models people hold and the paradigms within which they understand issues of health, illness and distress. These, as has been shown in this chapter, can be radically different from those held by many western-trained mental health professionals. I will use the example of mbindi to illustrate some of these differences. A psychologist, familiar with the phenomenon of the Vietnam veterans and their symptoms of distress, may assume that the disorderly soldiers who return from the frontline and have difficulties in readjusting to civilian life may be suffering from PTSD. However, such an explanation was rejected by my informants who saw mbindi and witchcraft as the cause of the problem. A treatment approach which is orientated towards helping the soldiers overcome their experiences of trauma would be considered unsuccessful in the eyes of the deslocados as it fails to deal with the origin of the affliction, i.e. it would not free the soldier from the demands of the spirit(s) he or she has enlisted for protection. According to local explanatory models both the aetiology and the treatment are spiritual rather than emotional or psychological in nature. Crucial to an assessment of appropriate treatment are the perspectives of the soldiers themselves, data unfortunately not available to this study. This example does throw doubt, however, on universalist notions regarding the compatibility of psychiatric diagnostic categories and local idioms of distress, as presented in the form of the closing questions of the last chapter: while some symptoms may be shared between loucura incurred through mbindi and PTSD, for example, or between mutima and depression, a superimposition of one on the other would run the risk of overlooking other vital characteristics of the illnesses, thus committing a category fallacy (Kleinman, 1986).
How do mental health professionals engage with cosmologies and local realities that are very different to those they may be accustomed to or to the training they have received? Many issues discussed in this chapter may be ‘alien’ to psychosocial practitioners in that they do not fall into the purely psychological, social or even cultural realm in which they are used to working. They may find themselves challenged by beliefs about the influence of ancestral spirits, the workings of witchcraft, faith healing, the prohibition of biomedical health care and other issues. They may choose to ignore issues that they feel they have no competence to deal with, instead leaving these to religious leaders to address. Mental health professionals may be ethnocentric in the way they neglect the spiritual dimensions of the lives of war-affected populations, perhaps because religious and spiritual issues do not feature prominently in the public discourse in parts of Europe or because they are perceived as quaint customs irrelevant to the modern world (Comaroff and Comaroff, 1993). This chapter has demonstrated that this risks missing important insights into local understandings of distress and may lead to potential misunderstandings.

The next chapter examines the existing psychological services in Huila during the time of the study with the aim of providing an overview of the theoretical and practical approaches to mental health and psychosocial work. Such an examination will stress some of the points of similarity and divergence between the material presented in the present and previous chapters, and these psychological perspectives.

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68 This is an issue that affects not only psychosocial professionals but all scholars who come from a different cultural or educational background than the people with whom they work. It has been suggested that witchcraft is a discourse that is real to those who use it (Geschiere, 1997). The distinction between what is real and imaginary is not always clear in the domain of spiritual affairs and Geschiere suggests that if one wants to understand the hold that such conceptions have on people's minds, one has to overcome the tendency to simply oppose reality and fantasy. Evans-Pritchard who pioneered the study of witchcraft in anthropology offers this explanation:

In my own culture, in the climate of thought I was born into and brought up in and have been conditioned by, I rejected, and reject, Zande notions of witchcraft. In their culture, in the set of ideas I then lived in, I accepted them; in a kind of way I believed them ... if one must act as though one believed, one ends in believing, or half-believing as one acts (1976: 244).
Chapter 8
Psychological perspectives

In chapter 6 an introduction to expressions of distress amongst the deslocados and the different health care sectors was given. The chapter emphasised the local resources available to war-affected populations in Huila. Chapter 7 then explored a specific, salient aspect of local reality and its influences on issues of health, illness and distress in more detail, namely the domain of religious and spiritual beliefs and practices. The present chapter focuses on the psychological discourse in Huila, i.e. the psychological services and initiatives provided by the health and NGO sectors in Huila. The aim of this chapter is firstly to give an overview of these initiatives, highlighting their perspectives, theories and practices in regard to the distress caused by war. Secondly, some common themes in their theoretical underpinnings are drawn out and analysed in more depth. These include, specifically, the notion of trauma and traumatisation, the emphasis placed on narrating distressing experiences, and the focus on the individual. Some of the shared elements in their practical approaches will be discussed, namely that of psychoeducation and the training of lay counsellors. Finally, an attempt will be made to critically analyse the ‘fit’ between local paradigms and the psychological frameworks by relating back to the data presented in earlier chapters.
1. Psychosocial services and initiatives in Huila

1.1. The psychiatric hospital in Lubango

In 2000 the mental health sector in Angola consisted of three psychiatric hospitals (Luanda, Huambo and Lubango) and two psychiatrists, both based in Luanda. Nurses receive basic training in psychiatric care but the other levels of nursing assistants such as technical assistants and promotores de saúde [health workers] do not. No primary mental health care programmes exist that provide referrals, medication or follow-up to the mentally ill. In the province of Huila a psychiatric hospital was founded in 1986 and is located upon the rocky slopes of a hill approximately fifteen kilometres outside of Lubango\textsuperscript{69}. The hospital has 30 beds but the numbers of patients varies greatly: in November 1999 there were over 60 patients but by March 2000 there were only 18\textsuperscript{70} [Field notes, Lubango]. The assessment and treatment of patients is overseen by a Cuban-trained clinical psychologist who will be referred to here as Carla.

According to Carla a large proportion of the patients at the hospital suffer from mental illnesses which are either caused directly by distressing experiences of war or are related indirectly to them. Mood disorders such as depression, psychotic disorders such as schizophrenia and anxiety disorders such as PTSD were listed by her as common diagnoses related to the consequences of war\textsuperscript{71}. Of these, PTSD was the least frequent diagnosis, only made occasionally for soldiers whose combat experiences, according to Carla, were

\textsuperscript{69} The location of the hospital is remote and access is difficult to negotiate during the rainy season. The remoteness of the hospital is underscored by the fact that many people working in the health sector in Lubango did not know of its existence and were surprised to hear that such facilities exist [Field notes, Lubango].

\textsuperscript{70} What had happened to the large numbers of patients in the five months? “Some recover, some die, some were taken to the curandeiro by their families” [Carla, Lubango].

\textsuperscript{71} Other diagnoses mentioned by the psychologist are organic disorders, brain injury, drug-induced psychosis and schizophrenia [Field notes, Lubango].
particularly distressing. At the time of the interview in March 2000 there were no such cases in the hospital but in January 2000 there had been two. One had been transferred to a military hospital and the other recovered and returned to duty in Luanda. The psychologist described these patients in the following way:

Most of them appear at the hospital totally disorientated. They don’t know their names. Afterwards when they get better ... they ask: “Doctor, how did I come here and who brought me here?” And then they will remember step by step... When they have hallucinations their hallucinations pertain to the world of war. For example: “Someone is coming over there, look there is a UNITA tank”. Traumatic things but those which refer to the experiences of war.... The dreams are about the war... Because many of them exteriorise in their behaviour. They don’t only talk about the war but also at the level of behaviour they exteriorise and manifest this. If alone, they can pick up a stick and start firing with it, fall down - it seems as if they are in a trench.

One of the reasons why only a few soldiers with PTSD arrive at the hospital is that most of them receive treatment elsewhere, in the military hospitals or in private clinics outside of the country. Asked why she thought some soldiers become traumatised by their combat experiences while others do not, Carla said:

It is difficult for me to say what are the real causes [of trauma]. But what I know is that the war itself brought these problems. It can be stress: some of them go to the army and never had any experience of war before or some don’t get training, or they were forced to go into the army. They are very very afraid. And then the situation of combat, what happens there, makes it worse.

The exact causes of PTSD are not assessed: “We can’t identify exactly what are the causes of the traumas” [Carla, Lubango]. In the vast majority of cases these soldiers were reported to recover over a short period of time when they overcome their disorientation.

The psychologist also described the war as a general and indirect destructive force that defines and influences every aspect of life, negatively affecting the mental well-being of people and contributing to distress by creating a difficult context of daily life.72

A mother who loses a child, one, no, sometimes two or three in the war, or sometimes all in the war will be distressed. Or one child dies because he fought the war in Mexico but there is another one who is in

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72 This perspective was shared by many Angolans who talked not only about the attacks, killings and displacement but about poverty and hunger, about bad health services and unfriendly shop owners, about the fact that the roads have not been repaired for years, and that the traffic police expect bribes at regular intervals [Field notes, Lubango]. War makes day-to-day living difficult in a multitude of ways all of which contribute to an extremely stressful situation.
the war in Cunene and she worries that this will happen to him too. And this disrupts. It's not just death that does this. It is also the day-to-day context.

Poverty and the absence of social and material support are further compounding factors in the development of mental illness and contribute to patients becoming chronically ill. Relatively 'mild' states of depression and distress may develop into serious mental illnesses because of the absence of material support:

A lot of those who come here it's because of the poverty. They arrive here because, for example, if one child is killed and he was the one who was supporting the family, he [the patient] will not have anyone to lean on. Even if he has the will to continue with his life it seems that he is lying to himself - he will continue to fall down because he doesn't have help.

Carla's analysis suggests that economic factors are intertwined with social issues: "mental problems are a mixture of various things; it's not just an isolated problem". Distress results not only from the direct impact of death and the absence of material support but also from the loss of emotionally sustaining relationships:

I am not only talking about those people who are dying from hunger, who don't have resources, who don't have jobs or nothing to wear. This also refers to the social problems which occur in our society. Because when someone has shared a life with a spouse or a brother and suddenly you lose this person this is traumatic... He feels lonely in the world. He has neighbours but still feels lonely. There is no other solution except stopping [Carla, Lubango].

The psychologist uses the metaphor of illness to describe the problems that war brings: the whole of Angolan society is sick. Those who are admitted as patients to the psychiatric hospital represent only a small percentage of the mentally ill as the majority of those suffering from psychiatric disorders and psychological problems are left to fend for themselves:

The Angolan society is the one who is sick.... This group which ends up in the hospital is not the only one that can't cope with life. They come here because the family is worried and decides to send them here. Those who remain and continue with their lives amongst them we can find some who are more sick but they continue because there is no one who worries about them. Because they have no help, they are exposed and alone [Carla, Lubango].

According to the psychologist's analysis it is surprising that not more Angolans are interred in psychiatric institutions as the war has raised the general level of distress in the society to such a degree that mental well-being is the exception rather than the rule. The relationship between

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73 Angolan friends would at times express similar sentiments: "No one here in Angola is normal: we are all somehow crazy" [Field notes, Lubango].
the war, distress and mental illness is thus presented here as a linear cause and effect model while acknowledging the role that social factors such as poverty and personal factors play.

Diagnoses of disorders in the psychiatric hospital are made with a standard diagnostic interview based on a psychiatric manual but no psychometric tests nor any other forms of assessment were available [Field notes, Lubango]. The only form of treatment used at the hospital is a drug regime consisting of neuroleptics which are administered to psychotic patients when available. Other patients receive sedative medication. There is no therapeutic intervention nor any other form of psychological, occupational or physical rehabilitation for the patients. This was attributed to "falta de condições" [lack of conditions], including a lack of assessment tools and materials, and the remote location of the hospital which made access difficult for the psychologist. Essentially, therefore, the theoretical approach to understanding the cause of mental illness at the hospital is psychological and the treatment of the patients biomedical.

In relation to the role that various indigenous healing resources play in treating illnesses of distress, the psychologist and her colleagues stated that they respect the treatments that the healers perform as these may be effective. The psychologist was of the opinion that no progress can be made with the patients without acknowledging and working within their traditional framework of belief as this is a powerful determinant of perceptions of illness. Collaboration is needed between the health staff and the curandeiros and occasionally patients are referred to indigenous healers when they feel the patient is better served with that:

Even if someone thinks that he is not treated in the hospital and goes to a curandeto and is treated there we thank him, because the most important thing is that the person is treated. Even though we think it is a psychological problem. The collaboration which has to exist is that each belief has its own explanation and we have our own explanation [Carla, Lubango].

The explanations offered by the traditional perspectives were rejected by the psychologist, for instance for an illness such as mutina: "We really believe that the treatment can have positive
results but the explanation they give for it we don’t believe because the heart doesn’t move” [Carla, Lubango].

1.2. The psychological programmes of three NGOs\textsuperscript{74}

1.2.1. The ABC Children’s Programme

One of the few organisations that seeks to implement a psychosocial programme in Huila is ABC, an international organisation that focuses on the relationship between child and caregiver. It is based on the assumption that the neglect and abuse of children is due to a blockage or underdevelopment of caring skills in care-givers and that these need to be developed in order to enhance a child’s ‘optimal’ emotional, psychological and cognitive development. The theoretical underpinnings of the ABC programme span the developmental theories of Winnicott, Bowlby and Stern, as well as Vygotsky’s concept of the zone of proximal development, and Feuerstein’s theory of mediated learning experiences\textsuperscript{75}.

The workshops and activities of ABC are geared towards care-givers who are sensitised about ways in which they can improve their relationships with children in their care. ABC points out that the programme does not seek to help care-givers acquire new skills but rather to help them overcome the obstacles that prevent them from applying the skills or competencies they already possess\textsuperscript{76}. The reasons for this are two-fold: firstly, so as not to imply that the care-givers are incapable of caring for the children, thereby undermining their self-confidence; and secondly, so as not to draw the care-givers away from their natural ways of child rearing, thereby alienating them from their local traditions and customs of care. High risk groups of caregivers, amongst which ABC count Angolans and other societies affected by war, display

\textsuperscript{74} Pseudonyms have been provided for all organisations working in Huila for reasons of confidentiality.
\textsuperscript{75} Information obtained from ABC’s training manual.
\textsuperscript{76} Information obtained from ABC’s training manual.
low self-confidence and negative conceptions of the child. The first objective of the
programmes is thus to raise their self-confidence as caregivers and to influence positive
conceptions of the child. Further objectives of the workshops are to promote sensitive
emotional expressive communication between the care-giver and the child and to promote
enriching mediational interaction between them.

ABC operates a “training of trainers” programme which consists of five components. The first
relates to the caregiver’s conception of the child and includes exercises for promoting
“participatory involvement” with the child’s experiences through empathic identification. The
concept of the zone of intimacy is used to illustrate the idea that caregivers feel empathic
identification only with those who are “insiders” to their personal zone. If a child is an
“outsider” to the care-giver’s zone of intimacy, empathy and communication with the child
will not be easy nor natural. The mechanisms for empathic identification thus need to be
released by bringing the child into the zone of intimacy and enabling the caregiver to relate
naturally to him or her as a person with human feelings and motives. The second component
gives eight guidelines for, firstly, emotional-expressive communication, for example
expressing positive and loving feelings and praising the child; and, secondly, for mediational
interaction between care-giver and child, such as giving guided assistance to the child and
setting limits for acceptable behaviour\(^7\).

The third component of the programme is directed towards the trainers and the role they play
in enabling caregivers to change their relationship with the children. Principles of sensitisation
form the basis of this section and some techniques for enacting these are described which
include the use of stories and giving personal examples from the trainer’s own childhood. A
positive redefinition of the child must also be achieved with the caregiver, as well as placing

\(^7\) Information obtained from ABC’s training manual.
emphasis on the positive features of the caregivers’ existing practice. The fourth part of the programme consists of the exercises and training which correspond to the skills the trainers need in order to implement the programme with caregivers, i.e. observation, personal enactment, instruction and verbalising personal experiences. The fifth component provides information about working with children in exceptionally difficult circumstances which includes homeless and war-displaced children.

ABC thus focuses on a particular aspect of the psychological impact of war, namely on the negative consequences which violence and displacement have on the relationship between children and their caregivers. They offer their “training of trainers” programme to interested participants amongst deslocados and residents in areas in Lubango, and issue certificates upon successful completion of the course. More recently, ABC has been awarded a contract to conduct training courses in the centres near Matala where they aim to present their programme as broadly as possible with the long-term goal of reducing the emotional suffering of war-affected children.

1.2.2. The DEF proposal for a psychosocial programme in the IDP centres

DEF is an international organisation which has been operating a water project for the deslocados in Matala and Quipungo since 1998. In 1999 DEF wrote a proposal for a psychosocial project in the IDP camps, arguing that the psychological consequences of war and displacement inhibit the full participation of the deslocados in daily activities, thus necessitating a psychosocial programme that would reduce the build-up of stress and prevent the development of further psychopathology amongst the displaced.
The project justification refers to the problematic presence of intrusive thoughts (which is how DEF translates the term pensamentos) amongst the population, which is seen as a symptom of trauma. Inactivity, withdrawal and disinterest are said to be wide-spread amongst the displaced, as well as reports of people who are suffering from madness because of the war, both regarded as further evidence of the traumatisation that has taken place. The experience of being displaced renders the deslocados dependent on external food support, a situation which may become fatal for the most vulnerable amongst them, for example widows and the disabled. They may not be able to cope with the double burden of being traumatised as well as physically unable to take care of themselves and their families. Large numbers of the deslocados in the centres are considered to be suffering from PTSD, and part of the proposed project is an assessment of exactly how many people are affected by this disorder.

According to DEF, traditional ways of coping with these effects of war are inadequate as the system of extended families has been disrupted and the lives of the deslocados have become "individualised" into nuclear families. One of the signs of inadequate coping mechanisms is that the deslocados do not want to talk about their experiences of war:

Many want to forget about the events of war. This does not imply a denial of the violence that has occurred, but refers to the incapacity to deal with these memories at this stage.... This way of coping makes it more difficult to address war-related trauma.78

Traditional healers are recognised as a local resource in treating mental illnesses including war-related trauma, but, according to DEF, they are not present in the centres. Local healers in the surrounding residential areas are also said to charge higher prices for treatment than the clinics. It is thus proposed that a contract be made with these curandeiros as part of the planned programme in order to integrate them into the project. The healers would receive referrals of particularly traumatised individuals from counsellors who would be working for DEF.

78 Information obtained from DEF’s project proposal.
DEF suggests that a two-pronged approach to providing assistance is necessary: a psychosocial programme, and a micro-credit scheme. The latter includes the establishment of a social fund for the most vulnerable groups such as widows, child-headed households and the disabled in order to improve their economically vulnerable positions. The psychosocial component would consist of three parts. The first of these is psychoeducation about the psychological consequences of war which would be implemented through sensitisation sessions with community leaders, the design of psychoeducational material such as newspapers and pamphlets and the subsequent distribution of these in the centres. Secondly, cases of severe trauma will be managed through psychological counselling skills and through traditional healing ceremonies. A group of counsellors would be trained in counselling skills who would then organise both individual and groups sessions with traumatised deslocados. This group would also act as a referral system to the traditional healers. The third component of the programme aims to reduce built-up stress amongst the deslocados through weekly activities such as games, sports and dances which will be organised by activity committees.

The DEF project is based on the assumption that PTSD is wide-spread amongst the deslocados but that traumatic symptoms can be alleviated through a programme such as it proposes. The poor physical conditions under which the deslocados live are seen as compounding factors in the trauma, as well as the situation of dependency where they are unable to provide for their own livelihood.

1.2.3. The GHI programme for children and youths

In 1998 GHI, an international organisation with a national branch staffed by Angolans, launched a three-year programme in five provinces of the country, including Huila, with the
aim of improving the psychosocial well-being of children aged 12-18. The programme does not focus specifically on displaced youth, based on the assumption that almost the entire country is affected by the war and that it does not make sense, therefore, to single out specific groups in the population. Instead, the project is community-based and aims to improve the situation of youths primarily via the training of adults who work with children in the communities or in schools. In addition, it aims to provide job and life skills training for youth, and to develop positive values and pro-social behaviour in children.

There are three main components of the GHI programme of which the first involves running week-long seminars with adults to reinforce their knowledge of children’s and adolescents’ psychosocial needs. The topics covered during these seminars include adults reflecting on their own experiences of violence both as children and as adults, and on the relationships between youth and adults. The latter is done in order to improve positive parenting skills amongst adults who are seen as having a strong influence on children’s well-being. Traditional healing, as a local and valuable resource for dealing with distress and death, is emphasised during the seminars. The second component involves the youths directly. Promotores are chosen from the communities and trained by GHI, and subsequently work with youths in their areas on a regular basis in order to facilitate the youths’ social integration into the communities. The promotores organise recreational activities such as sports, games and drama with the children, and also participate in the running of seminars for the youths. These seminars are similar in content to the ones run with adults but also include themes such as communication skills and conflict resolution. Income-generating activities such as a micro-credit scheme, vocational training and apprenticeships are also organised by GHI for the youths, in addition to running literacy and numeracy classes for youths who are out of school.
The third aspect of the GHI programme is to initiate community projects with leaders and community members such as the building of jangos, schools, and the installation of water pumps. This is done in order to encourage hope on a communal level and to enhance the capacities of local people to confront and change the realities with which they are faced. Building relationships with community members is an essential aspect of gaining credibility, and thus influencing the way in which youth is viewed in the community.

The GHI training seminars aim to increase self-esteem and resilience amongst the youths and the community in general by pointing to the constructive ways in which Angolans are coping with the difficulties they face. Positive aspects of Angolan culture are emphasised in these seminars as GHI believes that a loss of cultural values is occurring in the country because of the on-going war and the resulting displacement. This process needs to be reversed because cultural values and traditions constitute a valuable coping resource for people. The seminars focus, amongst other things, on the general impact of violence, but the experience of war is not directly discussed in these seminars since the emotional and spiritual wounds associated with the ongoing conflict are considered to be too close to the surface. Because all the staff are Angolan there is a sense that they understand both the devastation of war as well as the local perspectives on suffering and distress.

The organisation thus aims to alleviate the negative impact of war on the psychosocial well-being of children through a combination of approaches. It seeks to inform both adults and youths about the psychological consequences of violence through psychoeducation, which includes listing symptoms of trauma at the seminars, thereby alerting adults to the possibility of such reactions amongst themselves and amongst children. It also aims to build on existing local coping strategies in the population, reinforcing those cultural traditions that have served similar functions in the past. The approach taken by GHI is community-focused rather than
individual, and holistic in that it includes social, educational and vocational aspects of the youths’ well-being.

The three NGO programmes outlined here, as well as the perspectives offered by staff of the psychiatric hospital, all draw on psychological and psychiatric discourses and paradigms for understanding the suffering and distress caused by war. The programmes of ABC, DEF and GHI are arguably typical of a range of programmes currently implemented by international agencies and their strategies draw attention to some of the issues that are being debated in the field at the present time. Although their conceptualisation of distress as well as their practical approaches differ, some common themes emerge from the four service providers. These themes will be discussed from a theoretical perspective first, and then two prevalent elements of their implementation strategies will be analysed.

2. Common theoretical elements of the psychological discourse in Huila

2.1. Trauma and PTSD

As reviewed in chapters 1 and 3, the trauma discourse, although under increasing criticism, continues to dominate international discussions of the psychological impact of war. In Huila it is used by the psychologist at the psychiatric hospital to explain the development of PTSD in soldiers on the one hand, and as an underlying cause of most other psychiatric disorders on the other. DEF uses the notion of trauma to characterise entire populations of deslocados in the centres. These ideas will be examined in turn, and the perspectives of the deslocados on some of the issues raised will be presented alongside in order to initiate a process of comparative analysis.
2.1.1. Trauma and mental illness

The psychologist states that the entire Angolan society is sick, i.e. psychologically unwell, as a consequence of the war but that only a few of those particularly affected by mental illness 'end up' as patients in the psychiatric hospital. This notion, although expressed in psychological jargon, is comparable to that of the destocados when they talk about the fact that everyone suffers from pensamentos but that only a few become ill with it. The difference between these two ways of talking about the effects of war lies in the use of the concept of pathology that is applied by the psychologist: Angolans are not just suffering, they are sick. However, both ways of talking about the large-scale impact of war on society serve to underscore the abnormality of the situation of war in which ordinary Angolans find themselves. Their reactions to this abnormal situation are normal in that they become 'sick' or suffer from pensamentos, a natural and understandable response to their anomalous circumstances. This echoes the original psychiatric definition of a traumatic event as one that is outside of the range of usual human experience (DSM III, 1980; DSM-III-R, 1987), which characterises the symptoms of trauma as normal reactions to extra-ordinary events, up to the point where they become long-term and then indicate the presence of pathology (see chapter 1).

This conceptualisation helps to explain the mental illness of the psychiatric patients in hospital as the 'tip of the iceberg' of the general mental illness of Angolan society. As the psychologist states, it is surprising that there are not more of "us" (Angolans) in the psychiatric hospital. It raises questions, however, about why certain people go on to develop a mental illness and others do not, and whether or not there are specific groups amongst the population who are more vulnerable or prone to this than others (see chapter 1). One group
identified by the psychologist as particularly affected by trauma are soldiers who have been directly exposed to combat experience and who subsequently suffer from PTSD. A lack of experience, fear, an unwillingness to participate in combat and a lack of ideological commitment are mentioned by the psychologist as compounding factors. This perspective corresponds with psychiatric thinking on issues affecting soldiers from the WWI, WWII and the Vietnam War (Young, 1995). The psychologist does not share the emphasis placed on a particular traumatic event as a trigger or as the main precipitating cause of PTSD, however, stating that she does not seek to identify a specific traumatic event in her assessment of what has brought on the trauma. This, she feels, is not important and the staff often do not know what the causes of trauma are. The salient aspect of PTSD in soldiers, who are in fact the only patients at the psychiatric hospital diagnosed with this disorder, is that it is caused by exposure to direct combat experience.

The psychologist also discusses other groups of people who are particularly vulnerable to developing other forms of mental illness, namely those who find themselves without emotional and material support through the death of family members. The DEF project expresses a similar view by giving special assistance to vulnerable groups such as widows and orphans who are heads of households in order to prevent them from becoming increasingly dependent and therefore more traumatised. The view that those left alone to fend for themselves are more likely to develop pensamentos-related illness was also common amongst the deslocados:

Q: Who are the people here who have most suffering?
This woman here is young. She doesn’t have a husband. He stayed behind and she doesn’t know if he is alive or just died. And like this she doesn’t know where she will stay [Dona Marta].
The answer is this: the widows, the older ones, those who don’t have children. The suffering for them is almost the same [Dona Teresa, Chipopia].

According to the psychologist, ‘ending up’ in the psychiatric hospital was already an indication that most of the patients had no one to take care of them because otherwise their
relatives would try to secure another form of treatment. The financial resources of the mentally ill person are a vital aspect of how well someone can recover from the impact of a death of a spouse, children or parents. The psychologist reflected on the fact that if she herself were to become a widow she would be able to cope with this on a psychological level because she has the material means and the educational level to maintain her lifestyle. However, for her patients this was usually not the case, a fact precipitating the onset of mental illness.

DEF also includes the disabled in its definition of vulnerable groups, a view shared widely amongst the deslocados. The mutilados [victims of land mines or those who had lost limbs during attacks or combat] often find themselves unable to provide for themselves or their families due to the disability and thus move to the towns, surviving by begging and receiving hand-outs. One of the priests described some of the problems that mutilados experience:

I know people who used to be very calm but then step on a mine and when they come here the person becomes very problematic. The person is totally transformed. The person has a lot of pensamentos: “Nothing good will happen in my life. I will never have a wife” - these thoughts enter into the mind of a person. And because of this a mutilado is an aggressive person. The person believes he has no value and no one cares for him. This needs psychological work [Pastor Roberto, Lubango].

According to the psychologist, mutilados never reach the psychiatric hospital because there is no one who will bring them there, most of them living on their own on the streets with their mental illness.

The issue of gender was seen as being related to trauma in several ways. DEF, for example, is of the opinion that women were more likely to be affected severely by experiences of war than men, thus constituting a special group that requires attention. Amongst the deslocados opinion was split: some thought that men and women are equally affected by pensamentos-related illnesses as “the illness doesn’t choose” but some reported higher numbers of women consulting curandeiros for these illnesses than men [Field notes, Chipopia, Vissaka]. At the psychiatric hospital, however, male patients were definitely predominant with the
psychologist estimating a ratio of 8:2 male versus female patients. Asked for a possible explanation Carla said that she could not give a definite answer to this:

Personally I think that there are more men because they have more pressures in relation to the war. But when men are in the war the women are the ones who have to carry the load. They have a lot of responsibility. As I am saying this I have a lot of doubt: what is the reason that there are more men here? We have a lot of unanswered questions and we need to investigate more [Carla, Lubango].

Trauma is thus seen as leading to an increase of mental illness amongst the general population which is already considered to be ill as a result of the war. Vulnerable groups such as inexperienced, reluctant soldiers, those without family support, and the disabled are regarded as particularly prone to developing disorders as a consequence of their distressing experiences.

2.1.2. Traumatisation of entire populations

A second common theme in the psychological discourse on trauma is that entire populations or groups of Angolan IDPs are traumatised. An example of this is the work of Ventura (1997), an Angolan psychologist who investigated post-traumatic stress in adolescents who have been exposed to the war. Ventura developed her own version of a PTSD scale in Portuguese (McIntyre & Ventura, 1996), based on the Children's PTSD Inventory (Saigh, 1987), and called it the EARAT, described in chapter 5.

The EARAT was standardised on 150 adolescents between the ages of 13 and 16 in Lubango (McIntyre and Ventura, 1996). These adolescents had moderate exposure to war and were thus seen as appropriate subjects for establishing norms. Internal consistency of the scale was shown to be good with 16 questions in the main part of the scale having a correlation coefficient of at least .20 with the total scale. The exception to this was Question 9 ("I feel less like being with friends, playing or doing things I liked to do before") which produced a correlation of only .16 but was retained because of "the relevance of its content" and its
importance as a DSM-IV criteria for PTSD (McIntyre and Ventura, 1996: 6). The results of the validation in terms of symptom reportage are given in Table 8.1. According to McIntyre and Ventura’s (1996) data, the norm for Angolan adolescents with moderate war exposure is a diagnosis of PTSD.

<table>
<thead>
<tr>
<th>Number of symptoms on scale</th>
<th>Group B Reliving experience</th>
<th>Group C Avoidance/numbing</th>
<th>Group D Hyperarousal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threshold required for PTSD diagnosis</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Mean number of symptoms reported</td>
<td>3.81</td>
<td>3.92</td>
<td>3.11</td>
<td>10.88</td>
</tr>
</tbody>
</table>

Table 8.1 Symptom reportage across the three domains of the EARAT for the validation sample (after McIntyre and Ventura, 1996)

Ventura (1997) conducted her main study with three groups of Angolan adolescents aged between thirteen and sixteen: 41 Angolans living in Portugal for study-related purposes who had minimal war exposure; 150 adolescents resident in Lubango who had moderate war exposure, and 40 adolescents living in Lubango as deslocados who had high war exposure. The study also included a control group of 40 Portuguese adolescents who had no war exposure. The overall hypotheses of the study predicted an increase in symptoms and in PTSD diagnosis with increased war exposure, as well as a corresponding increase in clinical and developmental sequale. The hypotheses were confirmed by the results with the corresponding percentages of 22% of the Angolans living in Portugal, 82% of the adolescents resident in Lubango, and 90% of the deslocados qualifying for a diagnosis of PTSD respectively. 7% of the control group of Portuguese adolescents scored at a level consistent with a diagnosis of PTSD. In addition, Ventura (1997) also asserts that there is a positive correlation between war exposure and anxiety, depression, adjustment and behaviour.

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79 Ventura (1997) also used a range of other psychometric instruments to assess other psychological sequale of war, for example the self-perception amongst adolescents, and effects on intelligence.
problems, and a negative correlation between war exposure and intellectual functioning and self-concept, based on a range of five psychometric measures used with the adolescents. Girls were found to have a statistically significant higher rate of PTSD than boys, but age was not found to be a significant variable.

The high rates of 82% and 90% of war-affected adolescents qualifying for a diagnosis of PTSD on the basis of their presenting symptoms of trauma, is seen as proof that large-scale traumatisation has taken place in Angolan society. This argument differs slightly from the ‘war causes mental illness’ argument, above, by locating the impact of war within a specific psychiatric understanding of distress, namely that of trauma. As discussed in chapter 1, according to this discourse distress expresses itself as traumatisation, specifically in the form of the 17 symptoms which are caused by reliving of the traumatising experience, avoidance and numbing, and through hyperarousal. But the work of Ventura and other scholars who adopt this framework go further than merely noting the presence of these symptoms: the adolescents suffer from these symptoms to such a degree that they have a disorder, i.e. that “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Criteria F for PTSD, DSM-V, 1994).

A similar argument is made by DEF, although the organisation does not adopt psychiatric language nor use empirical means to test the assertion. They maintain, nevertheless, that experiences of war have resulted in wide-scale traumatisation which has rendered the majority of the deslocados disabled: they are inactive and apathetic, waiting “in their houses for WFP to pass by, meanwhile thinking about the time that they still had lands and animals”\(^{80}\). Both Ventura (1997) and DEF argue, firstly, that this is a serious problem that has remained unacknowledged so far; secondly, that the deslocados are unable to cope with this situation

\(^{80}\) Information obtained from DEF’s project proposal.
themselves for a number of reasons; and, thirdly, that the intervention of psychological professionals is necessary in order to rectify this situation.

2.2. Talk about it: curing through narration

The notion that talking about their distressing experiences is beneficial for the deslocados was common amongst psychological service providers. The project proposal of DEF, for instance, notes that talk about the war occurs only indirectly when the deslocados discuss the loss of goods and property. They interpret this as a reluctance to talk ‘directly’ about the war, for example about events such as killings, rape, torture and bombings. This, according to DEF, is due not to a denial of the violence that has occurred but to the incapacity to confront and deal with these memories. An intervention is thus necessary to facilitate the process of confrontation with these memories which would result in the verbalisation of the distressing incidents. GHI, while not making use of the concept of trauma for understanding the impact of war, share the notion that it is beneficial to remember and talk about distressing events. They make use of a technique during their seminars with the adolescents and adults which involves asking the participants to close their eyes, and remember a particularly distressing event (of the war, or of childhood) and then share it and their feelings about it with the group. The psychologist at the psychiatric hospital refers to the relief that can accompany the experience of talking and being listened to:

Some of the patients just start crying and one of them said: “Oh doctor, I feel better now. I never saw anyone like you in my life. You are the only one who has ever talked to me like this. You are the only one...” [Carla, Lubango].

A deep-seated assumption exists amongst western-trained mental health workers that talking about a distressing experience helps victims ‘work through’ and resolve their trauma (Summerfield, 2001), the origins of which were traced in chapter 1. In the west the belief that
talking in itself is beneficial and therefore of indisputable value is held with a conviction akin to religious faith, and is reinforced through the trend in the psychologisation of medical, social and political life (Rose, 1996). As discussed in chapter 3, many psychosocial initiatives around the world are based on therapeutic principles that advocate that resolution of psychological problems can be found in narration. This may take the form of one-to-one therapy, group sessions or self-help gatherings. What constitutes ‘talking about it’, however, is defined and practised in very different ways not only in various cultures and societies, but also within the professional, folk and popular sectors of health-care. In Huila, for example, Ventura (1997) and the psychologist at the psychiatric hospital would ideally like to institute individual and group therapy sessions with a professionally trained mental health worker. DEF advocates for a similar approach but aims to train lay counsellors who would lead these counselling sessions aimed at talking about the emotional difficulties. In contrast, amongst the deslocados the conselho which is frequently dispensed in the popular sector is not based on the idea that the ventilation of emotions is important, but is instead mostly practical and directive. In this case “talking” is conceptualised as lay advice that is grounded in communal experiences and interpretations of events, rather than as organised encounters between people where the distressing events are verbalised.

Talking and listening serve broader purposes than the alleviation of distressing symptoms or solving specific problems, for instance through bearing witness to the experience of atrocities so that the truth can be recorded and communicated. Veena Das discusses the importance of this in her anthropological work and quotes a statement from a riot victim in India who wanted her to publish the account of his experiences: “Our work to cry: your work to listen” (in Nordstrom, 1997: 79). In addition, Farmer’s (1997) use of the illness narrative demonstrates how the life-story of an individual can be used to analyse the interconnectedness of social, economic and political forces with the lives of ordinary people. Listening can also
be a means of showing solidarity with those affected by war, illustrated by a comment one of the women in Chipopio made during my research. I had conducted a focus group discussion with seven women the previous day in which the women had talked at length about their experiences of the war, and I asked the women how they were feeling and "how their hearts were" after having remembered all of these experiences:

As for me, last night I slept well. After this conversation we had yesterday I went home and I felt good. I didn't have so many pensamentos as I normally have. I thought: how is this, this person comes to visit us from far away, only to hear our stories? This is good. I feel consoled. Our conversation has given me consolation [Dona Paula, Chipopio].

People may find some relief in talking about their experience and being listened to as this can in itself be an empowering process in a context where people have been denied the opportunity to present their versions of "the story", having their experiences appropriated by various political, media or government forces. Nordstrom (1997) and other anthropologists of war zones suggest that listening is a creative act that goes beyond the mere collection of people's stories of hardship and tragedy:

Listening is a magnetic and strange thing, a creative force ... When we are listened to, it creates us, makes us unfold and expand (Ueland, 1992 in Nordstrom, 1997: 80).

Through this, Nordstrom suggests, listening becomes "an art of the impossible": the possibility of subverting the transgressions of war, of surviving, and of humanity, all of which are central to psychosocial work.

Do the deslocados talk to each other about what has happened? Neighbours know the facts of each household in their zone, for example who has been killed, how many family members are missing, how many sons are involved in the conflict, and what practical difficulties the household faces. Health problems are often discussed amongst one another and advice sought, funerals are communal affairs, and church and women's groups specifically make it their duty to provide conselho to those afflicted more than others. It was with surprise that I therefore
heard that most of the women had never told each other the stories of their experiences of war:

No, we don’t talk about this. No one talks to another one because the situation is the same for everyone: the area where we come from is the same, the situation here is the same. No one here who doesn’t know the situation, no one here who hasn’t lived through suffering. The suffering is the same [Dona Helena, Vissaka].

Only when we are on the way to fetch firewood do we have time to tell each other our stories. When we get back each one is tired and goes to her house to rest. We don’t talk a lot to each other, each one only thinks about their own problems [Dona Isabel, Chipopia].

In the focus groups discussions the women themselves decided that they wanted to take turns to tell me, and each other, their stories. The environment in which this talking and listening occurred was supportive and unhurried with the women spending between three to four hours listening to each other. Yet, such an exchange of stories normally does not take place. There appear to be a number of reasons for this.

Firstly, the deslocados do talk about their experiences and the events of the war, but not necessarily with their neighbours whom they sometimes did not know well. Talk about the war usually occurs within the family circle, especially between adults and adolescents, and between adolescents (see chapter 9). The focus of these conversations is less on specific events of the war and more on how life was before displacement, on the history of the family of clan, or on the life experiences of one particular person.

Secondly, an important reason for not talking about their experiences is the danger connected to revealing information about oneself, especially when the deslocados had escaped from UNITA areas and may be suspected of being sympathisers. The presentations of their stories thus need to be carefully thought through in order not to give rise to further mistrust. In Vissaka this danger was not present to a great extent as all of the deslocados had fled from the same area at the same time and knew each other from before, but in Chipopia people came from various areas of three different provinces and did not know each other well. Talking
about one's experiences involves trust: trust that one's story will not be used against one at some point.

Thirdly, these stories are "all the same suffering" to the women. Yes, some women were raped and others were not, some women lost their husbands and others did not, others were beaten, burnt, mutilated and others not - but all experienced suffering, death and the loss of their homes and land. In this sense, telling each other their experiences does not serve to convey new information to anyone and may seem non-sensical to the women. Everyone already knows about the suffering and to dwell on it just serves to increase *pensamentos*. The women judged it more important to focus on the present circumstances and current problems they face and to support each other through them. Nevertheless, comments about the emotional relief accompanying the verbalisation of experiences should not be disregarded, as is apparent in the comment made by the woman in Chipopia following our focus group discussion.

2.3. Focus on the individual

2.3.1. Individualisation

All psychological initiatives discussed in this chapter acknowledge the important role that the extended family structures and communal support systems play in assisting the displaced overcome their distressing experiences and rebuild their lives. However, a number of service providers suggest that war has disrupted these systems of support and that they are therefore no longer available as a resource. For this reason psychological interventions by people outside of the communities are necessary.

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81 It made sense, however, to tell me, an outsider, their stories as I was unfamiliar with the facts of their experiences.
This argument is partly based on the concept of individualisation which is said to be taking place throughout Africa and other developing societies. Mass displacement through armed conflict is a powerful factor in this process, resulting in situations where family members, often from rural areas, are separated and dispersed over large geographical areas, different countries and sometimes over continents (Harrell-Bond, 1986). Forty years of war in Angola have meant that no family has been left unaffected by the separation caused by the conflict. The splintering of the extended family has effects on various levels. On one level a reduction of a larger unit to a ‘nuclear’ family unit may occur, although in the case of the deslocados the smaller family unit may consist, for example, of a mother, two children, a grandchild, a niece, a cousin and an in-law, depending on who had survived and who had managed to find one another after the attacks.

On a another level a fragmentation of relationships occurs, and work roles remain unfilled by the absence of family members or are performed with difficulty by the remaining members. The hardships that result from this are not always alleviated by neighbours or other ‘community members’ who may be strangers to one another, as is the case in Chipopia. Some widows expressed this problem when asked who helped them build their huts upon arrival in the centre:

The house of the widows they just put up one stick here, one there, and the widows had to find the other wood to make the house complete. They had to finish their house off. Each woman had to build her own house [Dona Flavia].

Q: The neighbours don’t help?
When you arrive each person is only worried about constructing their own house [Dona Marta]. Almost all of the widows constructed their own houses. She [referring to another woman] says that till this day she feels pain in the side because of the construction of the house. She went to the hospital but she still has pain when she works... That’s another reason why they are worried about having to go to another place: to have to construct again from nothing there with no one to help [Dona Teresa].

Q: Why does no one help?
It is just like that [Dona Teresa, Chipopia].
Harrell-Bond (1986) observed a similar lack of mutual support in her work with Ugandan refugees in Sudan which she attributes to the undermining of social values by the demands of individual survival, as well as to the time period it takes for new supportive networks to develop. Of course, many examples given in previous chapters demonstrate that the fragmentation and individualisation which occurs does not mean that no collective help is given to those in need. Nevertheless, the lack of mutual support is a factor that needs to be taken into account if one is to avoid the trap of romanticising the way in which rural populations are able to ‘help each other out’, or as UNHCR calls it, provide “mutual assistance among neighbours” (Peltzer, 1996: 156).

The level of impact of individualisation which is of most interest to the psychological service providers discussed in this chapter is the lack of emotional support accorded to an individual which may lead to an exacerbation of his or her distress and subsequent psychological problems. The psychologist at the psychiatric hospital, for example, is of the opinion that a large number of patients who lack family support and who have no one to turn to go on to develop serious mental health problems. DEF also espouse the position that individualisation has contributed to vulnerable groups receiving less support, thereby becoming more prone to develop PTSD and less likely to overcome it on their own. GHI take a slightly different view on the effects of displacement, focusing on the way in which communal coping mechanisms based on ATR and tribal customs have fallen into disuse. Similarly, ABC suggests that the war has disrupted traditional child-caring behaviour with the result that relationships between children and their care-givers have become wanting and deficient. While the latter two do not refer to the process of individualisation directly, the negative impact of war is seen as resulting from the disruption of previously functioning relationships.
All service providers in Huila, irrespective of the importance they accord to the process of individualisation, argue for a need for compensatory interventions that replace the disrupted communal support systems (Ager, 1997). These interventions are not necessarily concentrated on individuals as GHI, for instance, advocate a community-based approach that allows people to remember coping strategies used before displacement and violence interrupted these. The psychologist is of the opinion that interventions need to be aimed both at the individual, at his or her family and at the community if they are to be successful, pointing out that social support is important in both the recovery and the prevention of mental illness. DEF share this perspective and suggest that both individual and group counselling sessions are necessary. ABC, with its particularly narrow focus on the emotional well-being of children, nevertheless aims its interventions at the interpersonal relationship between the child and care-giver rather than the child, thus also widening the scope of the assistance it provides. While individuals may remain the ultimate recipients of some of the interventions, the method employed by the service providers encompasses the social field around them in an attempt to reconstitute support mechanisms and communal coping strategies, thus attempting to compensate for the disruption of relationships. In addition, some organisations identify a need for working specifically with certain individuals who require extra support.

2.3.2. Counselling interventions with individuals

In psychology the individual has always played a special role as it has historically been regarded as the unit of theoretical analysis and the subject of this field of enquiry (Rose, 1989). As mentioned above, several of the service providers believe that individual therapeutic interventions of some form would be appropriate for severely distressed or mentally ill deslocados. The psychologist and DEF suggest that western psychology has
developed effective interventions for individuals who have been severely affected by their experiences, expressed in the following way by Punamaki (2000) who argues that

Traumatised people often suffer from nightmares, excessive fears, and concentration difficulties. If there is effective treatment available, it would be unethical to deprive survivors from it (p. 115).

Certainly, reports of therapeutic work all over the world with torture and war survivors that focuses on the survivors’ strengths and addresses practical and social aspects of his or her life as well as the symptoms mentioned above, seem to support Punamaki’s statement (Agger, 1994; Bustos, 1992). Notions exist about the ‘power’ and ability of mental health workers to provide “effective treatment” in situations of distress. DEF, for example, refers in the project proposal to trained advisors who “can successfully relieve immediate stress when needed”\(^{82}\), implying that these trained counsellors will possess special psychological insight that will instantaneously solve the problems of suffering. Swartz refers to this as the “widespread belief (some might call this a ‘myth’ …) that mental health workers know and understand emotional trauma, and are able to heal trauma” (1998: 171). The reality of the situation of people affected by violence is, however, complex as illustrated by the case example below.

Amongst the population of destocados there were a small number of people who suffered from a variety of symptoms from which they seemed unable to find relief. One such person was Susana, a woman who lived in Vissaka and came to the health clinic every few days, complaining of HBP, the inability to sleep and headaches. Susana was an emaciated woman whose husband and younger children had been killed in UNITA attacks. Her left arm had been cut off in one of the attacks and she kept the limb wrapped up in a cloth. She told her story:

I am 37 years old and I am from Cuvango. My arm was cut off by UNITA when they came to attack us. My husband was killed in front of me in that attack. This was 3 years ago. After that things have been very bad for me. Then 6 months ago UNITA attacked again and I fled with my child to this camp. I have been here for 3 months now. I have only this one child now, she is 10 and we live alone together. I have headaches. I have to come here for tablets every few days because I can’t stand the pain. I can’t sleep because I have high blood pressure. I am so tired but I can’t sleep at night because of the headaches and the pain. The pain is here in my head and in my heart. I also have this [shows me the scars on her breast

\(^{82}\) Information obtained from DEF’s project proposal.
and shoulders] from the attack. I can’t work and I can’t think. I want the nurse to help me with the blood pressure [Susana, Vissaka].

During this conversation Susana spoke slowly and quietly and was often close to tears. In further conversations it became clear that a lot of her anguish was connected to the loss of her arm which Susana felt prevented her from ever living a normal life again: how could she work the fields, take care of her daughter, and find another husband as a cripple? Susana was being supported with firewood, help with cleaning and cooking and advice by the women’s church group, and her daughter performed the majority of the household duties. Susana had not consulted a curandeiro nor a faith healer and did not wish to, stating that she belongs to a church which does not allow this. The nurse at the clinic who saw Susana every couple of days was very sympathetic towards her but felt that he could not continue to provide her with paracetamol because of his limited supplies. He also felt that the source of her problems was not physical but emotional in nature, and that she needed more support than the church groups could provide her with.

Susana is perhaps a ‘textbook’ example of a distressed individual whose trauma is not only visible in the form of her physical injuries but who is also clearly asking for some form of assistance for coping with the life she faces as a mutilada. In every community there seem to be a few individuals who ‘fall through the support net’ provided within communal structures and whose needs are not met in the popular and folk sectors of the health care system. Many NGOs who run psychosocial programmes assert that individual counselling sessions are the most appropriate way of assisting Susana and others faced with situations by which they felt overwhelmed, so that they can learn to cope with their experiences. Both the psychologist and DEF emphasise the importance of the provision of such services to the deslocados based on the belief that existing community resources are inadequate in addressing the special needs of people like Susana. Such a time- and resource-intensive strategy is often perceived by
western-trained psychologists to be the only effective way of helping distressed individuals come to terms with their traumatic experiences. Some brief comments on two commonly used intervention strategies amongst psychological service providers will now be made.

3. Practical intervention strategies

3.1. Training of counsellors

Many psychosocial initiatives for war-affected populations rely on the training of lay community counsellors who provide counselling specifically to severely affected individuals such as Susana, above, and advice to the general population. The training may take different forms depending on the aims of the project: identifying and referring mentally ill people to the clinic or to a curandeiro, setting up self-help groups, promoting stress-relieving activities or doing general psychoeducation. DEF suggests that community workers be trained in these techniques so that they can provide a form of primary mental health care which is absent from the Angolan health care system. Such initiatives already exist for general primary health care in some of the IDP centres, for example a network of aktivistas de saúde set up by NRC in Chipopia and Vissaka where five women from each bairro were trained in basic hygiene and health education messages regarding common illnesses. These aktivistas visit households, refer people to the clinic, and hold small meetings about issues such as diarrhoea, feeding practices, and water purification.

Within such a system of community health workers the aktivistas know the households in their areas well enough to discern who is suffering from pensamentos or mutima, and who may be facing particular difficulties or may be in need of support. DEF plans to provide such community workers with skills to counsel, disperse information and initiate “stress-releasing”
activities in order to address unmet psychological needs of individuals and the community. As mentioned above, the psychologist envisages a similar system which would provide more professional training for those working as counsellors and concentrate on conveying psychoeducational messages about mental illness to the community. GHI, while not expecting its promotores to provide counselling services, relies on a system of training youth workers in the basics of recognising symptoms of distress in order to be aware of children or adolescents who are not coping with their experiences. All of the service providers would thus ideally aim to institute a referral system based on the training of a few community members as counsellors and conveyors of information.

The training of lay counsellors implies that the communal systems of providing care are somehow inadequate, either because no one takes notice of people like Susana, or because people do not have the competence or skill to address their problems. It also assumes that in order to rectify this situation outsiders to the community need to organise or put in place an additional system such as described here, or to enhance structures and coping mechanisms already in place (for example, referrals to traditional healers in the DEF project).

3.2. Psychoeducation

All service providers advocate the use of psychoeducation as a means of addressing distress-related problems. Psychoeducation is described by van der Veer (1998) as a technique that involves explaining the cause of symptoms and placing the person’s experiences within a conceptual framework, which can lead to a reduction in feelings of helplessness and powerlessness. In Huila, the emphases placed on specific aspects of psychoeducation and ways of implementation varied, depending on what each programme regards as important to convey. The psychologist is of the opinion, for instance, that it is vital to provide information
to the public about mental health issues, based on the assumption that such knowledge leads to insight, earlier detection and possible prevention amongst the population. DEF and GHI place emphasis on informing people about reactions to distress and violence amongst adults and children, often with the aim of reassuring people that their reactions are normal. Psychoeducation may include guidelines on how to distinguish between normal and pathological reactions (Genefke, 1984). ABC includes information about developmental psychology as a form of psychoeducation in its training programmes, believing that care-givers will benefit from the insight gained from understanding the developmental processes their children undergo.

Staff members of GHI report that participants in their seminars and even their own staff found psychoeducation on common symptoms of distress useful, and were comforted by knowing that they were not “going crazy” but were experiencing emotions, thoughts and behaviours that were to be expected under conditions of war [Field notes, Lubango]. This seems to be a frequent reaction to information that ‘normalises’ reactions to distress, a comment also reiterated by the psychologist when talking about the family members of the mentally ill. The assumptions that guide the decision to use psychoeducation as an intervention strategy relate to the importance attached to a particular set of information, the potential recipients and the manner in which the information is conveyed. Differences between various psychoeducational programmes may be profound. For instance, the content of ABC’s psychoeducational programme is targeted at care-givers and consists, amongst other things, of information about children’s emotional development; whereas DEF aims to inform the general population of deslocados about types of mental illnesses that can occur as a result of distress caused by war. ABC uses seminar-type situations in which to train their participants, as opposed to DEF who plan to design pamphlets, posters and use theatre to convey the information they consider relevant. The term psychoeducation is thus used to encompass a range of activities intended to
communicate psychological knowledge, the content of which has frequently been decided upon *a priori* by service providers.

## 4. Discussion

This discussion aims to critically relate perspectives of the psychological model to the explanatory models of the *deslocados* presented in the previous chapters. This is done by investigating the applicability, appropriateness, and points of similarity and difference of the elements of the psychological discourse to the local realities of the *deslocados* in Huila.

### 4.1. Trauma and PTSD

The perspective of the psychologist on the issues of mental illness highlights an important aspect of the Angolan health system, namely the absence of mental health care except in the form of locked institutions for the severely mentally ill unable to be cared for by their family members. While the psychologist ‘pathologises’ the entire society by claiming that all Angolans are sick, she nevertheless draws attention to the fact that, like in other impoverished and under-resourced developing countries (Desjarlais *et al.*, 1995), Angola does not provide primary mental health care nor adequate treatment for the severely mentally ill. This, rather than the presence of trauma, seems to be the primary concern affecting the whole country at the broader level of mental health care. Certainly, the absence of psychiatric care is an important issue that affects not only those members of society directly affected by war but is relevant to all Angolans. Targeting only the *deslocados* for trauma-related illnesses is thus an approach with limited scope.

Amongst the severely mentally ill who are admitted at the hospital only a few soldiers are ever diagnosed with PTSD. Of course, this does not necessarily mean that PTSD does not occur
more frequently, as it could be that the ill are primarily treated by curandeiros, in the military hospitals, or outside of the country. It does, however, at the very least, raise the issue of allocation of resources. If only a minute proportion of the mentally ill are suffering from PTSD, it makes sense to concentrate resources of psychiatric care on those illnesses more prevalent which, according to the psychologist, are schizophrenia and mood disorders such as depression. An argument can be made for the necessity to investigate the epidemiology of mental illness in Angola as a whole in order to gain insight into the distributions and frequencies of different disorders. As Bolton and Ndogoni argue:

Without quantitative measurement of mental health indicators there is no basis for allocating resources, for determining whether an intervention has been successful, or for choosing between multiple competing interventions (Bolton and Ndogoni, 2000: 12).

How does this relate to the argument that the vast majority of the displaced populations are traumatised and suffer from a number of symptoms which would qualify them for a diagnosis of PTSD (Ventura, 1997)? Questions arise: firstly, what purpose is served when such assertions are made; and secondly, how accurate are such statements? Claims about large-scale traumatisation in war-affected countries can serve a number of purposes, for example to communicate to the ‘outside’ world the suffering that the displaced are experiencing in a language with which the western and northern world is familiar (Welsh, 1996). It can also justify to donors the need for psychosocial interventions with the displaced, as is the case with DEF. A crucial issue here is that of agendas: who determines them, who decides how and with whom they are to be implemented, and who is supposed to benefit from them? To take the example of communicating the suffering of Angolans to the ‘outside’ world: this is a valuable undertaking and one to which the majority of Angolans would readily assent. It is far from obvious, however, that the deslocados would wish such communication to focus on their emotional or psychological suffering (Summerfield, 2001). In the interviews conducted deslocados returned over and over again to the necessity for others to know about the destruction of their lives, loss of lands and livestock, and their need for economic, vocational
and agricultural means of survival. This is not to say that the deslocados did not deem the emotional and spiritual wounds of war to be important, but that they may not wish to make them the focus of external assistance. The voices of refugees are not heard when reports about them speak of their suffering in numbers and statistics, and they may, in fact, be excluded from the debate entirely as others, researchers and agency workers, speak on their behalf (Farmer, 1997).

A related issue is the conceptualisation of suffering as trauma. As has been shown in preceding chapters, the distress and suffering of the deslocados expresses itself in a variety of different physical, emotional and spiritual forms which encompass meanings and have implications that are not acknowledged nor captured by the concept of trauma, for instance the significance and meaning attached to the notion of pensamentos, and the symbolic loss of heartbeat. Trauma as a concept does not touch upon those aspects of their suffering that the deslocados highlight or describe as important and relevant. Recent work by scholars has focused on depression rather than traumatisation or PTSD as a consequence of the exposure to war, as this seems to correlate better with local understandings of experiences such as soul loss, nervios and other idioms of distress (see for example, Bolton and Ndogoni, 2000). Certainly, the symptoms described by someone like Susana seem to bear closer resemblance to depression than to PTSD.

Claims about the large-scale traumatisation of populations present a picture of the displaced as victims who are in need of outside assistance in order to overcome and resolve the destructive effects of trauma. This is done, for instance, in the DEF project proposal which speaks of the deslocados as passive, dependent, withdrawn people who do not have energy nor initiative to conduct their daily lives. This is an inaccurate depiction of the displaced, as will have become clear from the previous chapters, and contrasts sharply with the reality of life in
the centres where the deslocados develop creative ways to overcome the difficulties they face on economic, cultural, social and spiritual levels. Far from being ‘disabled’ and dysfunctional because of the “intrusive thoughts” of the war, they initiate and confront the issues of daily survival. Presentations of the deslocados as traumatised people thus commonly involve a lack of recognition of the effective and convincing ways in which they make use of resources and cope with their difficult situation, for example through giving conselho and participating in cultural and religious activities. In the trauma discourse objects and subjects are created: the powerless victims, i.e. the deslocados, waiting around for assistance are the ‘objects’ who depend on the subjects, i.e. the NGOs, who have the solutions to their problems (Foucault, 1961). This not only helps to further entrench myths and stereotypes of dependency and helplessness amongst forced migrants, but also sets up a problematic relationship between ‘the rescued’ and their ‘rescuers’ (Richters, 1998).

The assumption that experiences of war inevitably lead to traumatisation and psychological damage is problematic. ABC’s programme is based on this supposition which also assumes that children in war-affected areas are at risk from dysfunctional care-giving, a situation which needs to be corrected through external, i.e. non-local, psychological intervention. The idea that all children are ‘damaged’ through experiences of war and violence is contested by various scholars such as Dawes and Donald (1994) and Cairns (1996) who point out that little evidence exists to support the notion that political violence results in permanent or long-term harm. In addition, the notion that care-giving in some societies is inadequate rests on western models of children’s needs and optimal child development which may be inappropriate to other cultures and societies (Panter-Brick, 1998). These arguments do not deny that violence, poverty and repression have consequences for children’s and adults’ emotional, physical and spiritual experiences, but point out that these experiences cannot be universally defined as
psychological damage or traumatisation, nor be reduced to impaired interpersonal relationships.

It is assumed that a PTSD scale such as the EARAT is an empirical method of measuring the psychological and emotional suffering of the deslocados in the form of trauma symptoms. There are some methodological problems with the way in which this is done, however, originating in assumptions about the meanings attached to particular symptoms of trauma. One example from the EARAT which highlights the dangers of ‘translating’ symptoms from one culture to another without ensuring that they mean the same thing is item 6 (“I try not to have thoughts or feelings about this experience”). This was interpreted by my participants as referring to normative ways of coping with pensamentos (see chapter 9). As was explained in chapter 6, efforts to avoid thoughts, feelings and at times conversations associated with the experiences and losses of war are viewed as healthy and adaptive in Angolan society. People are actively discouraged from having pensamentos and their presence, rather than efforts to avoid them, are seen as indicators that something is wrong with the person. According to DSM-IV criteria for PTSD, the opposite is indicated: the efforts to avoid thoughts of the distressing experiences are a sign that the person is potentially traumatised. The validity of item 6 is thus questionable because of the different interpretations ascribed to this symptom.

Assertions about large scale traumatisation also lead to the PTSD scale losing its potential value as a diagnostic tool for those individuals who are severely affected by their experiences and are not coping adequately, such as Susana. She, along with others like her, become just one among 90% of the deslocados who are traumatised (Ventura, 1997), and she cannot be distinguished from the others through the use of this diagnostic instrument. Additional issues regarding the accuracy and the utility of PTSD scales will be raised in chapter 9 in which the results of the EARAT with displaced adolescents will be discussed.
Is there benefit to be gained from employing a trauma model to a situation such as Huila? Many agencies operating in war-affected areas are primarily concerned with providing much needed material and health assistance to the deslocados and do not consider psychosocial issues or mental health concerns to be of primary importance\textsuperscript{83}. Organisations and individuals not directly involved in service provision are often not convinced of the relevance and need for such initiatives, referring to discussions about these issues as “psycho-babble” that distracts from the ‘real problems’ (Richardson, 2001; personal communication). In such a context an effective strategy of persuading organisations to take the psychosocial effects of war seriously is through presenting empirical data that demonstrates the need for interventions. The PTSD model is seen to offer the quickest and most accessible way of doing this, both on a public level to raise awareness, and for funders who need to be persuaded that a problem exists. Presenting statistics that ‘show’ how many people are suffering from the traumatic after-effects of war can be a powerful tool of persuasion.

4.2. Intervention strategies

This chapter has outlined some of the practical approaches taken by psychological service providers, for instance providing assistance to individuals who seem particularly vulnerable and severely affected by their circumstances and experiences. The argument that such people could benefit from psychological support and from material assistance in order to prevent their inability to function in daily life from becoming a permanent condition may be convincing to psychological professionals. According to DEF and to the psychologist this would be achieved primarily through counselling services, either with individuals or within

\textsuperscript{83} Those agencies in Angola that were interested in the possibility of psychosocial work expressed the following sentiment: “Our head office tells us that we should be doing this but we don’t really know how to” [Field notes, Lubango].
groups. However, Bracken and Petty's (1998) argument that this would further isolate them and set them apart from their communities when they need, more than anything else, to be reintegrated into them, has to be considered. Other options for providing such individuals with support are available, for example through channelling resources through existing community structures or through providing training to medical staff at the clinic.

The emphasis placed on narration as a means of alleviating distress is not shared by the local perspectives. This is mainly due to the conceptualisation of *pensamentos* as a cause of further illnesses, and thus as something not to be dwelled on or talked about. *Conselho* reiterates that nothing good is to be gained from continuing to think about past experiences and losses, and that energy needs to be concentrated on facing the present situation. Healing methods in the folk sector frequently focus on resolving spiritual problems seen as being the 'real' cause of feeling disturbed, and physical symptoms are addressed through a *curandeiro* or a faith healer. The connection to a higher power, the ancestral spirits, God or the Holy Spirit, is seen as salient rather than the verbalisation of emotion. This is not to ignore that the *deslocados* expressed feelings of relief when talking about their experiences as was mentioned by the psychologist in her work and as I observed in my interactions with the women in Chipopia and Vissaka. Nor is it to suggest that everyday communication about events, experiences and emotions does not take place amongst the *deslocados*. It does mean, however, that the relief accompanying the narration of experiences is perceived as a by-product rather than a solution to the *pensamentos*. Solutions need to be found in the spiritual, physical and material realms rather than in the emotional or psychological ones. There are thus diverging perspectives on the cause of the suffering as well as on how it can be alleviated, an issue that will be pursued further in the next chapter.
Consensus does seem to exist around strategies that are aimed at the strengthening of communal structures, for example GHI’s practices of involving leaders and community members in addressing social issues, or involving adults in the vocational training of adolescents. To use the words of Higson-Smith (1999), interventions that seek to empower and link the different levels of society with one another are important strategies in coping with the adverse effects of war. What is less clear is whether strategies aimed at reinitiating or validating traditional practices that have fallen into disuse are effective across the communities, or whether these are applicable primarily to certain sectors of the population. This question will be investigated when an in-depth analysis of adolescents and their perspectives are presented.

The two practical strategies pursued by many organisations, namely that of training lay counsellors and of conducting psychoeducation among the communities, need to viewed critically. The idea that lay counsellors need to be trained by external agents does imply that current practices in the popular sector are inadequate, in other words, that the conselho given to people is not sufficient or could be improved. This may be a problematic notion if it implies that western psychology knows better than the deslocados themselves how people overcome their suffering. Psychoeducation, as conducted by GHI for example, seems to be received well by community members and found to be of value. However, Bracken et al. (1997) warn against an approach that aims to educate populations about the ‘real’ affects of violence, as this may undermine local expressions and ways of dealing with distress. The manner and intention with which psychoeducational messages are delivered thus seem to be important.

Finally, the degree to which the psychological service providers take account of or incorporate local coping resources varies and has implications for the relationship between external agents
and the communities they seek to assist (Ager, 1997). DEF, for example, acknowledges the important role played by traditional healers and aims to incorporate them into its programme. However, the way in which this is proposed is questionable: would a system of referral via a third person, i.e. the DEF-trained counsellors, be acceptable to the deslocados who are used to making their own decisions about health care? In addition, issues of accountability, effectiveness and power arise in regard to the validation of specific healers by external agents, as pointed out by Harrell-Bond (1986) who discusses the employment of healers by international agencies in the Ugandan refugee camps in Sudan. The use of traditional healers in the DEF project does not reflect the notion that local perspectives are core determining features of the programme but appear ‘added-on’, almost as an after-thought. ABC pays lip service to local realities by stating that it intends to reactivate indigenous child-care practices. Its very premise not only denies the relevance of different forms of child-care as culturally valid practices, however, but also seeks to promote the “right way” in which to relate to and care for children, based on eurocentric notions that there are appropriate and inappropriate ways of guiding a child’s learning experience and relating emotionally to him or her. This has the potential to undermine local strategies and cultural practices.

5. Conclusion

This chapter has presented the perspectives that dominate the psychological discourse and services in Huila. The discourse is not consistent and shows great variation in both theoretical and practical approaches, demonstrated for instance in the way in which the concepts of trauma and mental illness are used by various service providers. The intervention strategies of service providers in Huila are composed of a mixture of elements of the various positions outlined in chapter 3 of the literature review, and indicate that the simplistic categorisation of projects into ‘positions’ along a trauma/culture dimension is not always possible. Differences
exist in the way in which agents engage with specific aspects of the deslocados' lives and experiences, and to what degree they attempt to incorporate elements of their own paradigm into the local realities and vice versa. Integrationist strategies are, for instance, mentioned by all projects to some degree although these are clearly utilised to different degrees by the various service providers, with ABC, for example, making little use of local knowledge and GHI attempting to further the use of traditional healing resources in the folk sector.

The material presented here also indicates that while potential for misunderstanding exists because of the disparities between local and external, psychological discourses, there are points of convergence and similarity that allow for the possible incorporation and application of elements across frameworks, such as the use of psychoeducation or the inclusion of primary mental health care into existing health care systems.

The next chapter focuses on a specific sub-group of the displaced population that is particularly affected and influenced by the various paradigms which exist amongst the displaced populations of Angola, namely the adolescents. They are, by virtue of their age and position in society, a group that is at the forefront of change and transition and are therefore an interesting group to investigate in regard to the dilemmas presented in this chapter, as well as to the main themes of the study.
Chapter 9
The adolescents: war, distress and coping

Children and youth are often perceived to be the ‘silent’ victims of war, yet are seldom seen as agents who actively engage with their environment and the challenges it presents (Boyden, 2001). This study investigated the perspectives of adolescents on war and how they cope with their experiences of displacement. As “members of society’s younger generations always select from, elaborate upon, and transform the traditions they inherit” (Lavie, Narayan and Rosaldo, 1993:5), adolescents are of particular interest in investigating how available resources for coping with distress and related illnesses are made use of in the communities. This chapter briefly presents the contexts within which the lives of displaced adolescents’ take place in Huila by focusing on their concerns as well as some aspects of their lifestyles. The youths’ experiences of war and suffering are presented in more detail, followed by a presentation and discussion of the results of the EARAT PTSD scale which was implemented with the adolescents. The youths’ coping resources and strategies will then be discussed in relation to the cultural, spiritual and psychological discourses presented in the previous chapters. Finally, the chapter closes with short discussions of the issues of traditions and change, and of the youths’ perspectives on the future.

1. Adolescence: representations and perspectives

Issues of how children and adolescents are affected by situations of adversity have been debated over the past several decades. These debates have been closely mirrored by the images or notions of childhood that scholars and professionals implicitly hold, images that
have varied not only across historical periods but also across cultures (Burman, 1994; Dawes and Donald, 1994; Griffin, 1993; Hwang et al., 1996). Hwang et al. (1996) point out that notions of childhood seem to reflect the politically correct ideology of particular times and places at least as much as they represent the objective findings of scientific research.

In regard to adolescence, the notion of the universality of the adolescent experience dominates discussions of many psychologists who draw on theorists such as Anna Freud (Blos, 1967) and Eric Erikson (1968) to argue that all adolescents undergo similar experiences, irrespective of cultural, economic or social contexts (see for instance Offer et al., 1988; Noller and Callan, 1991). The American psychologist Stanley Hall is credited with the ‘discovery’ of adolescence in the 1880s when he maintained that the onset of puberty initiated a period of Sturm und Drang [storm and stress] characterised by alternating and opposing emotions. This has remained a recurrent theme in youth research for the past 100 years across disciplines, and is based on what Griffin (1993) refers to as the “raging hormone theory” (p. 22). The origin of adolescence is seen as being determined by physiological and hormonal processes, and some theorists argue that certain emotional, social and psychological issues are inevitably associated with the ‘transition’ from child to adult. According to Erikson (1950, 1968), for example, every adolescent has to successfully negotiate particular developmental milestones in order to achieve adulthood and healthy psychosocial functioning. These are defined as the establishment of a firm sense of ego identity which provides a crucial bridge between childhood and adulthood and allows the initiation of intimacy; the formation of stable relationships; the achievement of psychosexual differentiation; and the acquisition of skills necessary for economic independence (Noller and Callan, 1991). Psychic turmoil and rebellion against authority are seen as a natural consequence of the negotiation of these developmental tasks (Danesi, 1994).
From the perspectives of social constructivism and anthropology the assumption of the universality of the adolescent experience has been questioned, especially the notion that adolescence constitutes a distinct category of experience separate from that of the adult world. The earliest of these criticisms was a study by Margaret Mead in the early 1920s on adolescents in Samoa. She claimed that in Samoa "adolescence represented no period of crisis and stress but was instead an orderly developing of a set of slowly maturing interests and activities" (1968: 157). While Mead’s findings have been criticised in terms of accuracy and generalisations about Samoan culture (Harkness, 1996), her work challenged western cultural assumptions about the way in which puberty is perceived in different cultures and the significance attached to it. This critical tradition has continued in anthropological and cultural psychological work ever since (see for instance Segall et al., 1990) where the categories of adolescence, youth and adulthood are seen as social and cultural constructions of particular phases in the life course rather than as universal categories. All societies have ways of defining what constitutes adulthood and how one attains it, and these may be age-related or may be determined by physical, social and religious rites (La Fontaine, 1986). The concept of adolescence is not present in all societies and some scholars argue that it is a construction that does not apply in societies where childhood and adulthood are the only two defining phases of a human being’s life cycle. A central argument of this perspective holds that young people cannot be considered in isolation from other social groups within communities and societies, and that social, cultural and political issues should be foregrounded rather than biological or intrapsychic processes (Schepker-Hughes and Sargent, 1998).

The unifying factor in many discussions of youth in the west has been that they are perceived as a problem: they have left the ‘innocent’ and ‘passive’ world of childhood and entered into a phase of active and often oppositional engagement with the world of adults. This has varied
from representations of youths as a direct threat to the established order, for example in
Britain in the 1970s and 1980s when large numbers of jobless youths were seen both as a
source and as victims of social problems, to a focus on ‘crises’ that adolescents are faced with,
such as teenage pregnancy, drug use and delinquency (Griffin, 1993). Certain groups of youths
are perceived as being particularly deviant and ‘asocial’ and where social and economic
explanations for their behaviour are sought, they rest on the construction of the adolescents
and their families as somehow inadequate and deficient, displaying a victim-blaming
approach. Griffin (1993) points out that youths are often presented as a strange ‘Other’ who
need to be contained while they transit the stage of immaturity and reach ‘normal’ adulthood.

While aspects of such academic research generally reflect the preoccupations of western states
with social and economic control, youths in many African countries have also been the subject
of adult concern. The term ‘lost generation’ has been applied to youth who have been exposed
to political violence in various parts of the continent, as popular opinion holds that such
youths will develop a tendency to generalise an acceptance of violent means of conflict
resolution to other areas of social life (Dawes and Donald, 1994). It is believed that children
and young people who experience and witness aggression will become ‘uncivilised’ and
uncontrollable as their socio-moral reasoning and conduct is affected by the internalisation
and normalisation of aggression. Only weak empirical evidence exists, however, that
children’s moral attitudes and values may in fact be modified by exposure to political violence
(Cairns, 1996). Increasingly, evidence from countries such as South Africa (Straker, 1992) and
Northern Ireland (Cairns, 1987, 1996) suggests that the relationship between the effects of
violence and the ability of youths to integrate into post-conflict civilian societies is varied and
complex, depending on a number of important factors. The most salient factor in determining
the extent of integration of youths into society seems to be the degree of opportunity they have
to improve both their own economic situation and their role in the reconstruction of civil society (Sommers, 2000; Richards, 1996).

Even in societies that are not experiencing violent conflict, youths are often perceived as a threat, as was described by Robert Kaplan in an influential article on West African cities which was published in the Atlantic Monthly:

I saw young men everywhere - hordes of them... They are like loose molecules in a very unstable social fluid, a fluid that was clearly on the verge of igniting" (in Sommers, 2000: 68).

Kaplan, whom Richards (1996) describes as a proponent of the New Barbarism theory, warns of the anarchic, volatile and irrational nature of African youth who are “criminally inclined young migrants”. They have “spun off from a failing traditional society” and are dispirited, unskilled, undereducated and therefore potentially dangerous young men (Kaplan, 1993 in Richards, 1996: xv). The representation of African youths as barbarians has racist implications, but may also resonate with concerns and fear for economic and political control that the ruling elite within the countries have. The associations between jobless youths in cities and crime are often made in many parts of Africa, for instance in South Africa (Ramphele, 1997). Especially young displaced people who migrate to cities instead of remaining in designated camp areas, are often perceived as being a destabilising factor, despite emerging evidence to the contrary (Sommers, 2000). As discussed below, Angola is no exception to the phenomenon of young displaced migrants who crowd into urban areas where they are regarded as a danger and a major factor in crime.

1.1. Angolan perspectives on youth

Adolescence, as opposed to the vaguer concept of youth, is usually defined by psychologists and sociologists as starting at the onset of puberty at 12 or 13 years of age, and ends at age 19

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84 The article was considered so important that it was faxed to every U.S. embassy in Africa (Richards, 1996).
or 20 (Offer et al., 1988). In official charters, such as the UN Convention on the Rights of the Child (CRC) (1989) and the African Charter on the Rights and Welfare of the Child (1990), adolescence is subsumed under the general category of childhood, where a child is defined as “every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier” (CRC, 1989). Adolescence is thus generally understood to end at the age of 18, a definition also adopted in this study.

In many African societies the transition from childhood to adulthood are marked by initiation rites performed during puberty. In Angola this is the case for most of the ethnic groups, with some practising initiation both for males and females (Milheiros, 1967). These rites are of utmost importance in the communities as they are accompanied by a change of status for the youths: one cannot be considered a man (or amongst some ethnic groups a woman) if one has not performed them. The adolescents who participated in this study, both in Lubango and Matala, were adamant that the rites are an essential part of becoming an adult and something that the vast majority of youths participate in [Field notes, Lubango, Matala].

After initiation one will still be considered a jovem (youth) as opposed to an adulto (adult) for some time. The concepts of juventude (youth) and jovens (youths) are commonly held notions in Angola that are in some ways unrelated to definitions of adulthood. They include anyone who is no longer a child up to approximately 35 years of age, thus including young adults. As Adogame (2001:2) suggests, the “youth age range is usually wide and somewhat elastic” in African societies where the term youth can indicate a particular position in society, for instance unmarried status, certain political views or specific lifestyles. Angolans frequently talk of the jovens as a specific set of people with particular opinions, behaviours and life
The adolescents

circumstances [Field notes, Lubango]. Some African societies use an age grade system where age groups or age sets are used as a basis for locating a person on the continuum from infant to elder rather than a specific age defined in countable years (Bernardi, 1985). In Angola commonly held age grades include those of infant, child, boy/girl (for middle childhood), youth, adult and elder [o mais velho or a mais velha] [Field notes, Matala]. A clear distinction between a child and a youth, and between a youth and an adult are thus not necessarily easy to make in many social situations.\footnote{In this chapter the terms adolescents and youths are used interchangeably.}

In Angola elders will often refer to anyone younger than their age set as jovens, including people over the age of 50, to emphasise that they lack the wisdom, knowledge and experience of life and traditions that age brings with it. It is expected that youths will accord respect to their elders on the basis of the wisdom that the latter have acquired, and there is also an expectation of a natural order of authority and obedience based on age. For instance, an older child of age ten will expect a child of five to fetch things and to perform certain tasks for him or her. Obedience towards those who are older is considered a sign of responsibility and intelligence and the acquisition of this is considered to be an important goal of education and parenting.\footnote{Serpell (1996) observed similar goals of parenting amongst Zambians.} Youths are also judged according to how much juizo they have, a concept used to describe the inherent ability of an individual to display common sense, to make good judgements and be trustworthy.

In Angola, as elsewhere in Africa, the demographics indicate that the young constitute the majority of the population yet often receive the least resources and attention. In 1993 it was estimated that 45% of the Angolan population was under the age of 15, and that more than 50% were under the age of 25 (Ventura, 1997: 40). Increasingly, scholars (Hinton, 2000;
Nordstrom, 1997) draw attention to the need to understand the lifeworlds of these children and youths from their own perspectives as opposed to from adults’ constructions of them: what are their preoccupations, opinions, and to what do they attach significance and value? I turn to an examination of some of these issues with the particular groups of displaced adolescents in Lubango and Matala who participated in this study. As noted in chapter 5, these youths were between the ages of 13 and 18 (with a mean age of 15), and approximately two thirds of them were boys. The general problems and concerns of the youths as elicited through Issues Matrices, Worry Lists and in discussions will be briefly presented, as well as some of their pastimes.

2. Contexts: the adolescents’ concerns and lifestyles

Youth never form one homogenous group within a community but consist of various subgroups that may have different concerns and problems. The adolescents generally distinguished between girls and boys, deslocados and residents, workers, negociantes (traders) and students, and used these as a basis for their Issue Matrices (see chapter 5). Some of these subgroups were categorical, such as gender, and others were flexible as adolescents moved between the identities of negociantes, workers and students.

An issue of utmost importance to the adolescents was education and school-related problems. This was ranked as the most pressing issue. Firstly, many adolescents in Lubango could not attend school because they could not afford it financially. Students are required to buy their own materials as well as pay for the exam papers and for many this is unaffordable. Conflict between parents and adolescents existed when parents insist that their children work and bring home money rather than pursue an education. All groups of adolescents agreed that girls are more affected by a lack of money for schooling because girls need to help more in the
household and because boys are given priority as they are perceived to be more likely to obtain formal jobs than girls.

Secondly, the students experience problems directly related to the behaviour of teachers who often do not receive salaries for months on end and supplement their income, either through pursuing negócios during school hours outside of the school, or by demanding money and other goods from their students. Those students who are not able to pay do not pass the exams, even if they are intelligent and work hard. The teaching styles also presented problems to the students as some teachers arrive late or drunk for classes, teach badly, beat and ridicule students. As one student stated: “I have been in this school for three years and still don’t know how to write well and know nothing of mathematics” [Emanuel, Lubango].

As in many developing countries (Serpell, 1996), the adolescents were convinced that the best opportunity for their future development lies in obtaining as much formal education as possible. This perspective was shared by the displaced youths in Lubango and Matala; the former because they saw the lack of opportunities for making a livelihood in the town, and the latter because they did not anticipate being able to return to their home areas to farm. Formal education thus symbolises hope to the youths, an alternative to a lifestyle of poverty and hardship, and the possibility of personal achievement. Not being able to study, on the other hand, threatens future plans which include having a job, a family and a house. None of the adolescents who had dropped out of school had given up the desire and the hope of being able to return to education at some point in the future.

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88 Teachers have been reported to demand anything from beers and cool drinks (for their own private parties), to car tyres from their students [Field notes, Lubango].
A further pressing issue of concern for the displaced adolescents was the lack of clothing and shoes. In Lubango local adolescents make fun of the *deslocados* who are poor and wear old, torn clothing. Having appropriate clothing prevents one from being immediately identified as a *deslocado*, from being branded even more of an outsider and helps facilitate integration into friendship groups. The adolescents also often outgrew their clothes quickly and were embarrassed about having to wear clothes that were too small for them. They no longer identified themselves as children and part of representing this was by dressing in a way that they perceived reflected their new status, for instance boys wanted to wear long trousers. Wearing shoes is particularly relevant in this respect, as children often do not have shoes whereas many adults in the towns have at least one pair. Every adolescent thus strove to obtain a pair. The youths were also concerned about looking attractive in order to find a girl- or boyfriend. In Lubango this had much to do with fashion and what the trends from Luanda dictate. In the centres there was not much concern with issues of fashion, but looking good and wearing clean clothes was seen as an important factor in attracting the attention of a member of the opposite sex. The difficulty in obtaining soap to wash their clothes was a problem for the youths in the centres.

Also ranking high on some issues Matrices was the fact that there was not enough food, little variation in the diet and that certain things like meat, fruit, vegetables and potatoes were unavailable or unaffordable. Youths in Lubango mentioned a lack of shelter and blankets as a problem affecting both displaced girls and boys. Other issues that were seen by most adolescents as less important problems, were the facts that there were no soccer balls, no chance to listen to music, no watches, no videos and games (“We would like to play the same games that the others play in the towns” [Benguí, Vissaka]). The lack of soccer balls was

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89 In an interview with a child who had fled a UNITA attack and had experienced illness, hunger and extreme exposure to the elements, she was asked what the most terrible thing was that she had experienced. She replied that it was the loss of her only pair of shoes (Monteiro, 2000, personal communication).
present on every list of problems and the boys ranked this as fairly important. The lack of watches was mentioned by some of the boys, but this was disputed by the girls who thought this to be irrelevant.

Some issues pertained more to one sex than the other. Problems specifically affecting the girls were that they have to do a lot of household work and that their parents do not allow them to passear [see next page for explanation]. Boys were more affected by a lack of money to conduct negócio, and in Lubango by problems with drugs, violence and fighting in the bairros. Questions as to who is more affected by a particular problem led to some heated discussions and agreement was not always reached. One example is the lack of blankets: the girls felt that they were more affected by this problem than the boys, while the boys were convinced of the opposite. Clearly, their opinions were based on their own experiences in their homes as well as on information from their friends. While it is not possible to determine who was ‘right’, the issue itself gives valuable insight into gender dynamics in the household: are girls perceived as being physically more vulnerable and therefore receive more care and blankets (the boys’ argument); or are girls considered to be less important than boys, receive what is left over and are therefore less likely to have blankets (the girls’ argument)? A further interesting observation is that the deslocados represent themselves as disadvantaged but good people in comparison to local residents: the residents have less problems with money, shelter, food and clothing than the deslocados, but have more problems with violence and drugs.

In Lubango the adolescents sometimes talked about their relationship with their parents and with other adults in the bairro which were at times characterised by conflict. The generally authoritative parenting styles of Angolans includes physical castigation, especially towards boys, and were strongly resented by many adolescents. Some of the displaced youths lived with relatives because they were orphaned or because they had been sent to the towns by their
parents in order to try and secure education, and some of these youths felt that they were not wanted by the relatives and were made to feel a burden. Adolescents also disliked being called names such as bandidos by adults in the communities who stereotyped all youths as drug users and criminals and regarded them with contempt. The youths felt that they were being judged unfairly, misunderstood and unappreciated by adults, a common theme in relations between adults and adolescents in other parts of the world as well (Offer et al., 1988).

The lifestyles of the youths varied depending on their economic, educational and personal circumstances. A large proportion of the adolescents’ time was taken up with work-related activities. The type of work and household activities that the youths engage in differed between Lubango and Matala, and for the two sexes. Girls in both areas perform household work such as washing clothes and dishes, fetching water, pounding maize, taking care of the younger children, cooking, and cleaning. The girls in Matala also participate in activities such as fetching firewood, working on the fields in return for food, and selling at the market place. Boys in both areas are responsible for fetching grass, helping construct or repair houses, cutting wood and doing negócio. In Lubango boys are furthermore involved in hourly paid work such as carrying water and crates, and helping in the fields. On average girls spend about five to six hours daily engaged in work and household chores, while the time spent by the boys fluctuated greatly.

For both groups of adolescents friendships were of great importance. Leisure time was predominantly spent in the company of friends, usually engaged in going to passear or playing games. To passear involves the companionship of friends with whom one chats while passing away the time, strolling through the bairro or ‘hanging out’ at popular spots such as the

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90 According to the adolescents, certain activities were classified as ‘belonging’ to the domain of one sex, meaning that they are performed more frequently by either boys or girls, but usually both sexes participate in most of these activities to some extent.
marketplaces, the streets, the river or underneath trees where the adolescents meet. It also involves catching up on news and seeing if anything interesting has occurred in the bairro. The major point of this activity is to socialise. Friendship circles predominantly consisted of other deslocados and seldom involved local residents. Reasons given for this are that the deslocados can speak their own languages, that they have more in common with youths from their own home areas, and that the local residents are unfriendly and at times hostile towards deslocados. None of the adolescents could imagine a life without friends and a large part of their personal concerns revolved around friendships and relationships with the opposite sex.

The youths engaged in a number of other pastimes in their free time. The girls like to play games, sing songs, go to the river to wash clothes or bathe, and occasionally to play football. The boys’ main leisure activity is playing football, and in Lubango basketball was also popular. A number of the boys in the town attend training sessions at a soccer field or basketball area early in the morning at 5:30 am. Watching television and listening to music are also popular in Lubango, as well as playing cards for boys. In Matala night time activities involved meeting at a house or in an open area to sing songs and participate in dances. Listening to stories and legends recounted by parents, grandparents, aunts and uncles was also a popular pastime in the evenings. A fair amount of the adolescents’ time is spent visiting family members who live nearby or in another town, socialising or performing tasks for them.

Gaining insight into the daily activities of the adolescents provided information about their lifestyles and the values they attach to them. Unlike the stereotype of disenfranchised and angry young men hanging around the streets looking for trouble, the vast majority of male adolescents who participated in the study had relatively structured lives that involved ‘juggling’ many different daily commitments. Most boys and girls engaged in various activities such as educational, work and sports activities on regular bases and with a sense of
seriousness and responsibility for what they do. The data shows that the adolescents are actively making decisions about their lifestyles and their futures, exploring options, contributing to their families’ households, developing their own opinions and perspectives and living multi-faceted lives.

3. The suffering caused by war

_Quando penso ao Cuvango,
Passo o dia a chorar.
O Savimbi, não mata mais
Somos crianças, não queremos mais sofrer._

_When I think about Cuvango,
I spend the day crying.
Oh Savimbi, don’t kill anymore.
We are children, we don’t want to suffer more._

[Song of youths displaced from Cuvango, Matala].

When the adolescents talked about their worries they seldom mentioned the war directly as a problem or a concern, nor the distressing experiences such as the killings and attacks they have been subjected to. The war was, however, an ever-present feature of their lives much as it was for adults, and one which they saw as being not only the direct cause of their own displacement and misery but also of general problems in the health and educational sectors of society. Nordstrom (1997) notes that adults often treat children as if they have no philosophies nor feelings on the war themselves, whereas the children develop remarkable social commentaries on the situations in which they find themselves. This section explores some of the adolescents’ perspectives in more detail.

In Matala when the girls pound maize or when the youths go down to the river to collect firewood, they often sing songs. The children and adolescents make up the words and develop new ones over periods of time when walking and working together. The contents of these songs are frequently either of a religious nature or about the war and speak of the experiences of the adolescents and the shared suffering of their communities. The following song is an example of this:
Other songs specifically relate to the experiences of children in war, for instance the following song in which a child recounts his experiences of war to an enquiring adult:

Chê pioneiro  
O que é que tu fazes ali?  
Estou aqui abandonado  
Sem saber por onde vou  
A minha mãe morreu na guerra  
O meu pai morreu na guerra  
Só por causa destes bandidos  
Que robaram o nosso bem.

Hey, pioneer/young boy  
What are you doing here?  
I am abandoned here  
Without knowing where I'm going  
My mother died in the war  
My father died in the war  
All because of these bandits  
Who robbed our goods.

For many of the youths the war had been continuing in their home areas for numerous years before the latest displacement to Lubango and Matala. The experience of pre-flight life in a war zone was described vividly:

People don't sleep inside the houses. Sometimes, at night, when you are sleeping in the capim houses [huts made from grass and wood] you just hear other people screaming and you can't say or do anything. If they [UNITA soldiers attacking the village] hear your voice, they will take you and put you in the fire and kill you... At times the troops from MPLA and UNITA meet and they fight. The troops don't always die - it is the people who die. At times when UNITA leave, they leave mines in the countryside. At times they hide nearby in the countryside. They wait until you go to fetch your maize from your fields. And when you go there they catch you and cut your throat [Zacarias, Lubango].

In the villages we couldn't sleep well, because we had to think about the enemy, if they were coming or not. We always felt oppressed. They could have come during the day, in the morning or in the night. No one knows their hour. We only waited for them, the hour when they come. These are things that we thought about a lot: are they coming, today or could I die today? [Beatriz, Chipopia].

The youths recounted experiences which included sleeping in the bush before and after the attacks, seeing land mine accidents, bombings, rapes, people and houses being burnt, having possessions stolen, being beaten and witnessing people being maltreated and killed. Many adolescents talked of the hardship of flight during which they suffered severe hunger, illness,
and exhaustion. The *deslocados* from Ndongo who had fled *en masse* over a period of three
days, had been exposed to heavy rains during their flight. The flight usually involved moving
through insecure areas for many days and weeks:

> We passed through fields. We walked a lot. We met up with my father and we went together. My father
asked how we came and we told him how we escaped [from a UNITA base]. We explained the whole
situation to him, everything that happened, that we didn’t eat food, and how we walked a lot and how we
saw a river… So we walked and walked. We slept by the side of the road and found something to cover
our heads. We continued to walk. We ate only leaves from the plants and some river. We walked for two
weeks [Júnior, Tandavala].

Some of the youths had been captured by UNITA soldiers and taken to the camps where they
were forced to carry heavy loads, beaten, maltreated, and made to participate in or witness
cruelty and torture:

> When I was captured I only stayed for three days in the [UNITA] base. There it was very difficult for me:
hunger, a lot of suffering. Sometimes we had to work and we had to look after the cattle. The suffering
was too much. There were many other civilians with us. Some were killed. I saw this happening. They
[UNITA soldiers] tied them to the tree, they came with guns and fired at them. When they shot them the
pieces of flesh came off. We were forced to watch this, we had to watch this so that we became fearful of
fleeing. They kill all who want to flee [Venâncio, Tandavala].

Other events that had destroyed their families and led to death and displacement, for example
the imprisonment of a family member for political reasons, accusations and betrayal by
neighbours or friends in the war zones, were also mentioned by the youths. Although they
were now in relatively secure areas where they did not fear attacks on a daily basis anymore,
ongoing distress was caused by worrying about family members and friends who had been left
behind in the war zones, and receiving sporadic news of further attacks and deaths in their
home areas. Not being able to communicate with family and friends was a constant problem
for the adolescents and their families. A further disturbing issue frequently mentioned was the
inability to perform appropriate funeral rites for a deceased family member. When the youths
spoke about the killing and deaths of family members, more often than not they mentioned
whether or not the family had managed to perform the funeral for that person. A few youths
spoke about the need for their family to perform these rites at some point in the future in order
to pay respect to the dead person:
When my brother died from a mine we didn’t manage to do the funeral. We are not going to manage to do this because you need some money to do this. This is a problem [Baptista, Vissaka].

One issue consistently mentioned by the adolescents in connection with the war was the loss of their homes and possessions. This signified a number of things to the adolescents: for many in Lubango it meant that they had lost the protection of their families and parents and had to fend for themselves. A large number of the adolescents had lost either a father or a mother in the war or had been sent out of the war zones on their own, and lived with relatives in the town or on the streets. They lived lives of extreme hardship and sometimes of neglect and abuse. Ngongo, an orphan whose mother had been killed in front of him three years ago, was one of the youths whose malnourished appearance testified to a life of poverty:

I was only 12 years [when they killed my mother]. I was very sad and I was thinking how will I live. I am the oldest of the siblings and I need to take care of all of them... Here I live with the sister of my father. I feel very bad when I remember these things and I start to cry... If my mother had not died I would be living differently, I would be living well [Ngongo, Lubango].

The loss of home and possessions also meant a change in status for all deslocados, a fact that affected many adolescents strongly:

When I lived with my father, he didn’t let me do the kind of work I am doing here now. When I arrived here, I didn’t manage to live like I did before. I have to do other things now in order to get what I need [Sousa, Lubango].

According to the youths, war causes health problems, and they made clear links between their own state of health and the worries they had to contend with in their daily lives. One boy expressed this in the following way: “I have a lot of headache and stomach ache because of thinking too much about not having money and a job” [Rui, Lubango]. Apart from becoming frail and weak because of a lack of food, worrying and “thinking too much” can lead to a number of illnesses such as headaches, heart pain, and feeling tired:

My health is not good because I think a lot. I am a deslocado without any family in Lubango. When I stay at home not doing anything, I think too much. Sometimes the others get up early to go to school or to work, some go the market, and I stay behind thinking a lot with nothing to do. Because of that my health is not good, because if I had some money or some work I wouldn’t have these bad pensamentos. It’s these pensamentos that provoke one to steal or to look in the rubbish on the streets. With the rubbish you catch even more illnesses [Ornelio, Lubango].
The youths were very familiar with the term *pensamentos* and used it much in the same way as adults do, stating, as in the example above, that they too suffer from *pensamentos* about the past, their present circumstances and an uncertain, difficult future. The adolescents strongly disagreed with the opinion of some adults that they were too young to suffer from *pensamentos*, stating that they experienced illnesses such as a *cabeça quente* and *mutima*, and some youths suffer from *loucura*. Adolescents and children do not, however, get illnesses such as HBP or LBP, this being considered an illness mainly for adults. In addition, while young people become sick from *pensamentos* only *os velhos* [older people] can die from this, the reason being that young people have to think about their own futures whereas old people "think too much about the past" [Lubango, Field notes].

The two categories of youths who were considered to suffer more from *pensamentos* than others are those who had lost one or two parents and those who were living on the streets:

*Pensamentos* about the war are for those people who live without mother or father. When he thinks about this, he is very sad. He thinks about those he lost in the war. This happens to all people who have been through war, not just those who lost their parents. Generally, all people have *pensamentos* [Madalena, Vissaka].

In regard to younger children below the age of 12, the youths’ opinions were divided as to whether they experienced *pensamentos*. Most expressed the opinion that children forget past events more easily and do not worry so much about their present circumstances, but others disagreed, saying that they knew of children who were very sad about the things that had happened to them. They also talked about their own experiences as young children when they had experienced *pensamentos* about a deceased family member and had remembered them long afterwards. Another emotion identified by the adolescents was that of having *saudades* [homesickness, longing, nostalgia] for their home areas which included missing people, physical places and lifestyles.
4. Psychological perspectives: PTSD and trauma

In conversations with the youths, a number reported that they frequently remembered certain incidents of the war vividly. These were incidents that had been severely distressing to them at the time as well as when they remembered them, for instance Venâncio, above, who witnessed the execution of civilians by UNITA. Some youths also stated that they had bad dreams about the war, with the majority declaring that this had occurred mostly in the first few months after the attacks but had now receded\(^9\). Are these memories and dreams symptoms of trauma or PTSD, indicating, perhaps, that the adolescents were reliving their distressing experiences? Within the psychological paradigm explained in the previous chapter, the experiences of the displaced youths would certainly be classified as traumatic, and they would be considered vulnerable to PTSD. In order to investigate the suitability and applicability of the trauma framework the EARAT (McIntyre and Ventura, 1996) was implemented with 102 of the adolescents in Lubango and Matala.

4.1. Results of the EARAT

All of the participating adolescents had experienced at least one event that the DSM-IV classifies as traumatic, involving "actual or threatened death or serious injury, or a threat to the physical integrity of self and others" (DSM-IV, 1994). The most often cited events are attacks by armed forces, witnessing people being killed, seeing corpses, and experiencing bombings. According to Ventura’s (1997) way of distinguishing between minimal, moderate and high degree of war exposure, the adolescents in this study would fall into the category of high degree of exposure due to the fact that they have all been forcefully displaced by direct physical threat to their own or their families’ lives. The adolescents described their response

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\(^9\) For instance: "I used to have bad dreams about those people who were killed. But now not anymore" [Ernestina, Lubango].
to these events at the time as involving fear, anxiety, anger, feeling bad or troubled, sadness and *saúdades*. In all 102 cases these events had *taken place* more than six months previously, and for some in the Lubango group as long ago as eight years ago.

According to the DSM-IV criteria, 70.6% of the adolescents had scores suggestive of a diagnosis of PTSD. Of the Lubango group 66.0% qualified for a PTSD diagnosis and of the Matała group 75.0% meet the criteria for the diagnosis. Boys and girls recorded exactly the same frequency of PTSD diagnosis, namely 70.5%. Neither group nor sex differences were found to be statistically significant in relation to PTSD diagnosis (p>0.01) [see Appendix F for results of the analysis of the EARAT]. Overall, the number of traumatic symptoms averaged 11.4 per person, with the Lubango group scoring 10.4 and the Matała group 12.2. The mean for the entire sample for scoring symptoms in Category B (Reliving the experience) was 4.3, for Group C (Avoidance/numbing) was 3.2, and for Category D (Hyperarousal) it was 3.9.

<table>
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<tr>
<th>Mean number of symptoms reported</th>
<th>Group B Reliving experience</th>
<th>Group C Avoidance/numbing</th>
<th>Group D Hyperarousal</th>
<th>Total scale</th>
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<tr>
<td>4.3</td>
<td>3.2</td>
<td>3.9</td>
<td>11.4</td>
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Table 9.1 Symptom reportage across the three domains of the EARAT with the adolescents in Lubango and Matała

The frequencies for each symptom are listed in Appendix F. The highest frequencies were scored for item 5 ("I react with sweating, shaking or my heart beats faster when I have an experience similar to the traumatic event", 96.1%), and items 4 ("I feel nervous or troubled when I see or hear something similar to the traumatic event or that makes me remember it"), 11 ("At times I feel so sad and alone that I can’t speak nor cry") and 17 ("I feel nervous or get a fright when I hear loud, unexpected noises"), all of which were scored with a frequency of 92%. The lowest frequencies were scored for items 9 ("I feel less like being with friends,
playing or doing things which I liked to do before the traumatic event”, 6%), item 12 (“I am unable to think about the future”, 15%) and item 10 (“I have been feeling odd and different to my friends as if I don’t care about them”, 19%).

The results of this study suggest a high level of potential PTSD diagnosis (71%), findings shared with Ventura’s study (1997) who recorded that 90% of her participants in the high war exposure groups qualified for a PTSD diagnosis. The results of this study differed from Ventura’s in that no gender differences were found, i.e. in this study girls and boys did not record statistically significant differences in the frequency of PTSD diagnosis. How are the obtained results to be understood? From within a psychological framework these results indicate that these adolescents are not only traumatised but also at risk for emotional and psychological impairment, as well as possible failed adaptiveness in later life (see for instance Kinzie et al., 1986). However, there are a number of questions that arise with regard to the EARAT, and with the groups of adolescents who were participants in this study.

4.2. Discussion

Firstly, some methodological issues arose in the application of the EARAT where the conceptual validity, the complex wording and a lack of clarity in some items may have affected the scoring of the scale by the adolescents. To give just one example: item 13 (“I have problems falling asleep or staying asleep”) had a high prevalence rate of 86.3% among the adolescents, but resulted in some confusion amongst participants who stated that they often have problems falling asleep because it is cold at night and their huts do not accord them sufficient shelter from the elements. During the administration of the EARAT it was stressed

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92 Ventura (1997) does not give the results of an analysis of sex by PTSD diagnosis for the subgroup of adolescents with high exposure but only for all participants together. It is thus not possible to compare her results of sex differences in diagnosis with those obtained here.
that the question pertains to sleep problems related to the distressing experiences of war but the distinction between these two issues were blurred: how does a participant distinguish between lying awake at night because of the cold and then thinking about the losses he or she has experienced, and lying awake because of the *pensamentos* and then feeling cold or hungry? The limitations of the yes-no dichotomy in which the questions were framed do not allow for an exploration of such issues (Weiss, 1997). Such considerations cast some doubt upon the internal validity of the scale for the purpose of PTSD diagnosis.

More importantly, however, the question presents itself what such a diagnosis actually means in relation to the lives of those so categorised: how does ‘being traumatised’ affect their functioning in everyday life? Are the 90% of adolescents of Ventura’s (1997) study and the 71% of this study dysfunctional in social, educational, vocational or physical terms, as specified in Criterion F of the DSM-IV (1994) definition of PTSD? Ventura (1997) argues that the adolescents are traumatised, if not dysfunctional, and that the presence of trauma negatively affects intellectual functioning, adjustment, behaviour and self-concept, and leads to an increase in depression and anxiety. Throughout the eight months of this study many opportunities for conversations and observations arose during interactions with the adolescents. The vast majority of adolescents reported that they still felt sad when they remembered their experiences but that they now felt fine or ‘normal’ since some time had passed since the attacks. They stated that although they did experience *pensamentos* and nightmares sometimes, these did not prevent them from doing things nor were they worried about experiencing them [Field notes, Lubango]. In addition, the qualitative exercises in which the adolescents talked, drew and wrote at length about their perceptions, feelings,

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93 Ventura (1997) bases these assertions on the results of the five other psychometric measures in her study. Questions arise about the validity of these measures for the Angolan adolescents, for instance, intellectual functioning is assessed using arithmetic, vocabulary, comprehension and memory tests, all of which are more related to educational standards than to a child’s intellectual ability.

94 Perhaps this is one reason for why the adolescents did not mention their experiences of war as a major concern during exercises such as the Issues Matrix described earlier.
activities and hopes for the future, showed that far from being ‘disordered’, disabled or dysfunctional, the vast majority of the adolescents engaged actively on emotional, religious and intellectual levels with the situation in which they, their families and communities find themselves.

It is, of course, possible that the adolescents are traumatised but still able to meaningfully engage with their environment. The question of usefulness of the PTSD diagnosis and the concept of traumatisation arises, however, as the majority of adolescents seemed to be able to adapt themselves effectively to living with their symptoms of trauma, without it impacting their lives significantly. This notion was illustrated by the adolescents’ reactions to three items on the EARAT which they found strange, and at times funny: item 12 (“I am unable to think about the future”), and the two items that ask if the adolescent now has less interest or is less inclined to spend time with his or her friends (items 9 and 10). These items received the lowest scores on the scale as the adolescents found it odd to even consider that they would not be engaged in thinking about their future nor spending time with their friends.

According to the DSM-IV, in order to make a diagnosis of PTSD “impairment” of function or “clinically significant distress” needs to be present: “The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Criterion F for PTSD, DSM-V, 1994). Clearly, since impairment is not assessed, scholars using symptom checklists assume that “clinically significant distress” is present when the required number of symptoms in each of the three symptom categories are ‘found’. Criterion F thus effectively becomes redundant and issues of functioning are ignored. A strong argument can be made for retaining this criteria in order to avoid a situation where the
majority of the Angolan adolescents are deemed to be suffering from a psychiatric disorder but are able to function effectively in their daily lives. It seems commonsensical to use the criterion of functioning rather than the number of trauma symptoms as a marker of who is so severely affected that they need help.

A diagnosis of PTSD alone is poorly predictive of the capacity to pay the psychological costs of a war, to keep going despite hardship, nor a reliable indicator of a need for psychological treatment (Summerfield, 2001: 41).

This criteria would satisfy the need to have some means of distinguishing severely affected adolescents from the rest of the 71% of youths characterised as traumatised. A further problem with the trauma framework is that it does not allow for situations of chronic stress in which the Angolan deslocados find themselves and where a number of ‘symptoms’ may have become adaptive responses rather than signalling pathology, for example item 17 (“I fell nervous or get a fright when I hear loud, unexpected noises”).

In this study the minority of the adolescents whose functioning in daily life did seem affected comprised eleven participants. These youths displayed problems in a range of social situations and came to my attention through observation and through comments made by others in the communities. Two boys showed symptoms of what appeared to be mental illness such as incoherent speech, inability to concentrate and respond to questions. This could have been due to organic causes or disability, but, as I was unable to do in-depth assessments with the youths, it was not possible to determine the cause of these symptoms. Four adolescents said that they were thinking a lot about their situation and that they often did not want to participate in activities with their friends. They appeared withdrawn and depressed. Five of the adolescents seemed to have problems with maintaining relationships and functioning in a social

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95 I brought these eleven adolescents to the attention of community workers and teachers in the areas who were familiar with the adolescents and their families. Some of the youths were referred to clinics for a consultation by the community workers.
environment. These youths were described by others as being aggressive, not having \textit{juizo}, causing problems, having no or few friends and being very difficult to get on with.

How did others around them view the difficulties of these youths to cope? In the opinion of a local organisation and some of the adults in the community, the latter group of adolescents should receive traditional treatment through purification rituals which would help them to become calm and to resolve the spiritual causes of their problems (see chapter 7). Others in the community thought that the five youths who displayed aggression were just being unruly and were on the way to becoming \textit{bandidos} and therefore needed to be disciplined in some way. From a psychological perspective such as outlined in chapter 1, these adolescents would perhaps be seen as overtly manifesting the negative effects of not being able to assimilate their traumatic experiences, thus being locked in a cycle of intrusion and denial (Horowitz, 1986). According to this view, this may express itself in the form of depression or aggression, and counselling or therapeutic intervention would be necessary in order to help them come to terms with their experiences. Before treatment possibilities for this group are discussed further, however, a discussion of the general coping strategies of the adolescents will be presented.

\textbf{5. Coping with \textit{pensamentos} and loss}

Recently attention has been paid to the active way in which children and adolescents confront and attempt to cope with adversity, emphasising that rather than being helpless victims, children draw on a number of resources and interpret, adjust to and change the situations within which they find themselves (Hutchby and Moran-Ellis, 1998; James \textit{et al.}, 1998). This study investigated some of the ways in which the displaced adolescents cope with \textit{pensamentos} and the losses they had experienced.
5.1. Social and personal strategies

The most common way in which the adolescents dealt with *pensamentos* of the war and *saudades* for their home areas was to try and stop them by distracting themselves. These findings correlate with studies conducted on coping strategies amongst Malawian students which found evidence to suggest that distraction is a commonly used coping strategy in times of stress (Ager and MacLachlan, 1998). Various methods of distraction were used by the displaced adolescents in this study, most involving being in the company of friends, talking to them, playing games, and going to *passear*. All adolescents agreed that the worst thing that can happen when one is suffering from *pensamentos* is that one stays alone brooding, as this will make one more sad and will increase the *pensamentos*:

- When one is alone, doing nothing, you remember these things. But when someone comes with a game, a person forgets [Filipe, Matala].
- Yes, when you are alone in the house, doing nothing, then you think about this. It’s important that you don’t stay alone [Vici, Lubango].
- In my case, when someone comes to distract me I don’t think anymore. That is better [Jeronimo, Lubango].

It is thus crucial that one avoids being alone for long time periods. The adolescents recognised that sometimes when one has *pensamentos* one may not feel like being with other people because one is too sad. If this occurred, it is the task of good friends to observe this and make a point of persuading the person to come with them to do something. Friendship, the youths felt, brings with it the responsibility to know if someone is sad and to help them forget. It also implies that one should give *conselho* to the friend by saying things like:

- Listen, my friend, don’t think about this anymore. All of this will pass. Don’t cry anymore. Let’s go to the market so that you can stop thinking [Diogo, Lubango].
- This is all because of the war. The war destroys. Still the war has not stopped. So it is not good to carry on thinking about it [Filipe, Vissaka].
- Don’t think too much about this. If you think too much you will become sick. You have to have hope because things will get better [Ester, Chipopia].
- Stay calm and forget what has happened [Marcos, Lubango].
The *conselho* given by the youths to each other differed from that given by the adults in that it did not refer to the inevitability of death, the commonality of suffering nor to religious themes. However, it was, together with distraction, the first and most often used way in which *pensamentos* were dealt with by the youths. It confirms the importance of the popular sector and the fact that the adolescents provide support and comfort to each other.

In terms of their own personal strategies, there was some variation but most involved distracting oneself from the *pensamentos*. The strategies of the displaced adolescents included listening to music, watching television if possible, keeping busy, working and studying. Adolescents frequently mentioned listening and dancing to music as a way of making themselves feel better, and music seemed to have personal as well as social meaning to them. Schlegel (2000) observes that adolescents in most parts of the world listen to music to pass time, to relieve boredom, tension, loneliness and as a stimulus for fantasy and imagination.

From conversations with the adolescents this seems to be the case in Huila as well, in addition to the fun and enjoyment that they derived from dancing:

We like dancing so much. When I go home I play the music of Michael Jackson and we dance and we dance. You won’t believe how well I can dance [Bernardo, Lubango].

The adolescents described that they often feel as if they are in a different world when they are absorbed in the music, an experience that helped them forget the *pensamentos* and become more hopeful.

The adolescents were unequivocal and unanimous in their opinion that one should not dwell on *pensamentos*. This, they stated, was at times very difficult. One of the first things that needs to be done is to leave the war zone:

Q: What do people do when they feel hopeless?
You have to leave and forget the place where there was lot of war and move to another place. You need to find some people to talk to. First you need to remove the person from the place where there is war. You need to also arrange something to distract him [Ernestina, Lubango].
This is not enough, however, because one also needs to have condições [the right conditions] to establish a new life that will help one forget about the past difficulties. If life consists of a daily struggle to survive, it is a constant reminder of what one has lost:

For me to forget is very difficult. Because the work here is very heavy. When you remember the past, you think: “If it wasn’t for the war I wouldn’t be doing this heavy work”. I fetch firewood, sometimes many hours a day. I work from the sunrise to sunset for very little money. How can I forget what happened? [Jeremias, Lubango].

Another factor that makes it difficult to forget for the youths is if they feel excluded from activities that their friends engage in:

It is important that you don’t leave the things that others are doing. For example, a person has to be able to buy clothes, and so on and then things become easier [Diogo, Lubango].

This relates to the discussion above about the importance of being able to dress in a manner appropriate to age and peer standards, so as to not be identified as someone poor or ‘backward’. It is also important that one does not suffer more than others, i.e. if one is the only one amongst one’s friends who does not have shoes, one will feel bad and this will increase the suffering.

5.2. Religious and spiritual resources

Going to church, praying and reading the Bible were also used by the adolescents as a means of coping with pensamentos. The majority of the adolescents in Lubango and the vast majority in Matala attend church on a Sunday. Most of the adolescents considered this a regular and accepted weekly activity in which they participate with other family members and which they enjoy:

I like going to church and singing and praying [Mariana, Lubango].
It’s good to go to church because it lessens the sins [Eva, Lubango].
In church to pray and worship with other people you already feel differently. People behave honestly. You can ask God to help you and stop doing the bad things [Gonçalves, Chipopia].

Boys mostly restricted their church activities to attending mass or a church service once a week, although some attended mass every morning or every evening. Girls tended to
participate more regularly and more often in church activities and related groups and meetings. Not all of the adolescents attended church, however, and some maintained that church services were boring.

Many youths of all churches felt that attending church and praying was helpful when they suffered from pensamentos. There were three aspects to this: firstly, it was a way in which to distract oneself from one’s problems by thinking about something else; secondly, it involved asking God for assistance with problems one is facing now, and, thirdly, one can receive consolation from one’s faith which may lead to accepting one’s fate. One girl who often went to church to pray when she remembered the death of her father, expressed this by saying:

Every time I remember my father I cry. But no one knows when the Lord will call a person to Him. I have to accept this [Odeth, Lubango].

In both Matala and Lubango subgroups of youths existed that distinguished themselves from the rest by describing themselves as religiosos [religious]. These youths participated more actively than others in church events such as youth groups, and tried to live their lives according to the particular doctrine of the churches they belonged to. Usually this involved not practising “sinful” behaviour such as smoking, drinking alcohol, dancing, taking marihuana and having sex outside of marriage. All of the established denominations have groups of young religiosos, with the RCC and IESA having particularly strong and active youth movements. The independent charismatic churches in Lubango are increasingly attracting youths who are welcomed as valued members (chapter 7). They facilitate and encourage young people to take on responsibilities such as leading in prayer and conducting healing rituals, thus empowering youth who have little opportunity for participating in other spheres of civil society. In addition, the networks and connections established through the NRMs give the youths not only a sense of identity and community, but can also provide support and access to scarce resources (Sommers, 2000). While the latter issue was less salient for
Angolan youths, the peer network from which they derived legitimacy was important for the adolescents. The social life of the religiosos often revolves around the church where there are daily activities and meetings thus providing a structure and consistency in a society that usually offers neither of these.

The adolescents did not mention ATR directly as a source of spiritual comfort. However, elements of it were frequently referred to in conversations about what was troubling them or other members of their families, for instance not having been able to perform burial rites for a deceased relative. Great importance was attached to being able to show respect to the deceased as well as to preventing trouble with the spirits by fulfilling obligations to the dead. Most adolescents attend clan and family rituals for the ancestral spirits and expressed the sentiment that they considered it important to participate in and have knowledge of these.

The adolescents frequently discussed illnesses caused by witchcraft which were feared greatly by both groups in Matala and Lubango. The adolescents stated that they generally suffer less frequently from these type of illnesses than adults do, because their peers are not yet able to practice witchcraft against them. Young people were also the target of witchcraft, however, either through ‘picking up’ an illness by chance that had been left on the way for a passer-by, or because of jealous neighbours who would bewitch a child or adolescent of a household. The youths also discussed mbindi, recounting stories they had heard about other youths drafted into the army who had performed it, committing acts of murder, and had become mad or had turned into successful soldiers as a result.

The majority of the youths were of the opinion that once someone experienced problems such as witchcraft and mbindi, the only option is to seek help from a curandeiro and an adivinhador. The general conflicts between different sectors of the spiritual and religious
domains in the communities were, however, also reflected amongst the adolescents. In Lubango especially the *religiosos* of the NRM expressed strong opinions against any form of ATR practice and against the consultation of *adivinhadores*. Heated discussions took place amongst the adolescents on the effectiveness of traditional healers and whether they should be used, arguments that were seldom resolved. One boy in Lubango expressed the following opinion that resonated with many of the others around him:

> Some *curandeiros* you go to and they ask you to do things which you don't want to do or can't do. This depends a lot on the family in which you are. If you are in a family which does this kind of treatment you may become better from this. But if your family is connected to the church, even if you go there, you will not succeed [Kiala, Lubango].

Differences exist between the way in which adults make use of the ATRs and the way in which the adolescents do. Adolescents are exempt from performing certain rites for the ancestral spirits, for example pouring out libations, as this is considered to be the duty of the adults and elders who have sufficient knowledge of the clan and ancestral rites to maintain the relations. It is therefore not unexpected that adolescents are not actively engaging in ATRs at this point of their life-cycle, a fact which makes it difficult to gauge the extent of their engagement with this aspect of spiritual life. In addition, the adolescents may not have wished to discuss these issues openly with a researcher who is an outsider to their community.

### 5.3. *Curandeiros* and the use of healing rituals

Despite the debates about the effectiveness and the religious permissibility of consulting *adivinhadores*, there was less controversy around the use of *curandeiros*. These were mentioned by the adolescents as a resource to turn to when someone is so severely affected by *pensamentos* that help needs to be sought. According to the adolescents such a situation arose seldom with young people but could occur to those who could not stop thinking about the war despite their friends' efforts. They would become listless ("don’t feel like doing anything") and sleep a lot, a state described by one girl as:
Those who have no hope at all. He was in a situation with a lot of war and think that things will not get better. He doesn’t want to live anymore and he appears as if he is a person who is already dead [Toya, Vissaka].

Traditional healing practices as well as medical health care were both considered acceptable options in such cases, and were influenced by pragmatic considerations such as if there was a clinic or a well-known curandeiro nearby. In general, the views expressed by the adolescents reflected those of the adults in the communities (see chapter 6), although the adolescents had less knowledge of the types of treatments the curandeiros perform. According to the adolescents, the main reason for seeking help from a curandeiro is that “it helps to go to the curandeiro” [Ruben, Lubango]. None of the youths had undergone healing rituals such as those for returning soldiers themselves but several had attended some for relatives. Again, the youths could not explain how these rituals worked or how they had to be performed, saying that adults have greater knowledge of these rituals.

As with the adivinhadores, the youths in Lubango were less likely than their counterparts in Matala to say that they would consult a curandeiro if they fell sick from pensamentos. GHI, who was working in Lubango, interprets this as a result of general embarrassment in communities to admit that they make use of such methods so as not to appear ‘backward’ or uneducated. It was interesting to note that in the exercises of body mapping where the adolescents recorded what treatment they had used to recover from past illnesses (unrelated to pensamentos), curandeiros were often recorded, indicating that they are perhaps more frequently used than the adolescents claimed or admitted.

5.4. To talk or not to talk?

Some adolescents mentioned that when they were affected by pensamentos it helped them to talk to someone. Opinion on this was divided, however. All adolescents agreed that when one
is suffering from *pensamentos* it is good to talk with friends or family about other things, unconnected to the war. This is part of the distraction strategy described above. The youths talked about all the things they would normally talk about with each other, for instance about what had happened in the *bairro*, or what they had seen on television.

Some youths stated that when they had *saudades* about their *terra*, they went to talk to older family members, usually a mother, aunt, older brother or grandparents, who would tell them about what it had been like in their home areas in the old times or before the displacement. This was perceived to be an effective way of dealing with *pensamentos* and feelings of *saudades*, and they attached great value to hearing about their homes and knowing the history of their families and villages. One boy, Alves, who had been abducted by UNITA from his province of Cunene when he had been just five years old, and who lived in an orphanage in Lubango, had never had the opportunity to hear about his home area and family. He felt that this was a great loss in his life and something he missed out on in comparison to others who lived with their families. Many youths who lived with parents said that their parents talk about their home and the past to them as a matter of course:

> My mother at night when she is doing *serão* [staying up late at night], she tells us how it was when she was young, how she was. She talks about this almost always. My mother likes to talk about this [Isaac, Chipopia].

The adolescents enjoyed listening to these stories about the past but sometimes got bored with their grandparents who would talk about nothing else or who would become repetitive.

As far as talking directly about the events of war and displacement were concerned, conversations with parents and other family members, such as aunts, uncles, siblings and cousins took place sometimes:

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96 Alves had decided to take on the cultural identity of the Nhaneka amongst whom he lived, practising their traditions rather than those of his own ethnolinguistic group which he did not have much knowledge of. He was a strong advocate of the importance of maintaining traditional practices and cultural identities.
Q: Do you talk about how you feel with someone else, with your uncle or with friends?
Yes, sometimes we talk about the war. Or we talk about other things and we pretend that nothing has happened. But this doesn’t always work. It is difficult to forget the past [Madalena, Lubango].

The adolescents differed on whether it was good to do talk about the specific events of the war or not. Some adolescents stated that it was good to talk about this occasionally, in order to know exactly what had happened. Others felt very strongly that it was not a good idea at all: they never talked about the war and avoided conversations about it. Some of the youths spoke about the war not only to family members but also amongst each other, asking others what had happened in their provinces, or responding when they were asked about it by local residents. The majority felt, however, that such conversations were better reserved for family and close friends:

Q: Do you ever talk about what happened to you?
With friends? No, because they don’t accept what you say because they think that you are talking about things that never happened because they never saw this. Perhaps with a friend who is very close to you, who suffered with you together. He knows what happened and when these things happened [Jeremias, Lubango].

Local youths often dismissed stories about the experiences of the destocados, did not believe or understand them, thinking that the displaced youths invent stories of the hardships they had endured.

There is a difference, of course, in whether one talks about the events of war, i.e. what happened, or about how one felt or feels about these events. The majority of adolescents said that they talk about the events rather than about their feelings, and the few who did speak about their feelings about the war did so only to one special person with whom they had a particularly close relationship, often a mother or an older sibling: “I only tell my mother how I feel” [Aurelio, Lubango].

Those adolescents who stated that they never talk about the war, expressed the opinion that it does not benefit a person to talk about distressing events as this leads to further pensamentos:
I never talk about it. I don’t want to talk about it to anyone [Nilo, Lubango].

Talking to others who are also displaced was pointless, as they had the same experiences and therefore already knew everything that one could tell them. This opinion was similar to that expressed by the women (chapter 8) who saw little point in talking about the suffering of the past which was known to everyone, and instead preferred to focus on the present circumstances they were facing. One adolescent gave voice to this feeling in the following way:

What can be done? Nothing. This war has been going on for a long time and this happened a long time ago, it is not worth it to think about it. There is nothing to do about it [Sebastião, Lubango].

What implications do these different coping strategies have in light of the different perspectives outlined in the previous three chapters? Before this question is addressed, two further relevant issues will be briefly considered, namely the youths’ attitudes towards cultural practices in general and their perspectives on the future.

6. Culture, traditions and change

As noted in the introduction, youth are of particular interest in societies that are themselves in upheaval and transition as they are usually the group that is most affected by change and the influence of various social and cultural forces (Skelton and Valentine, 1998). Their perspectives on and affinity to traditional practices of their parents and grandparents is relevant to this study as this influences how and when the adolescents make use of these as coping strategies in dealing with distress and suffering.

The adolescents in Lubango and Matala expressed mixed views of traditional practices, attaching positive significance to activities such as traditional music and dances, festivities such as carnival, circumcision and to the stories told by the elders in the jango or in their houses. Farming and keeping livestock were sometimes seen as a traditional way of life which
was valuable, because it had allowed their grandparents and ancestors to develop and succeed in their lives. The majority of the youths felt that they would pass on these traditions to their own children as it was important for them to have knowledge of their ancestral origins and to continue the appropriate practices. Negative aspects of traditional practices were inevitably associated with the war, violence and with tribalism which some youths saw as the root cause of the continuing misery in their country. The adolescents were also critical of witchcraft and feiticeiros who cause illness, death and fear in the communities. Some youths saw the practice of divining as part of the same category of evil practices. Other less frequently mentioned aspects of tradition which the adolescents disapproved of or disliked were polygamy and traditional dress code.

The adolescents understood the concept of culture to refer not only to traditional practices of the rural areas, but also to issues of history, lifestyles, attitudes and behaviour. They displayed an ability to stand back from some of the ways of life of their communities and comment on them critically, for example on the issue of tribalism. The youths reflected on the ways in which traditions had changed for different generations, for instance expressing the opinion that girls do not need to marry so young anymore but can, instead, wait until they are older. Their perceptive analysis of the problems their communities confront and their ability to develop discerning views on these illustrate the adaptation of cultural practices to present-day situations, an on-going process observed in many societies in developing countries (Geschiere, 1997).

The youths attached great value to certain aspects of traditional Angolan culture especially those that related directly to their home areas. Because all the participants were deslocados it is possible that their positive associations with the rural life of their home areas symbolised what they had lost and what they yearned for, thus perhaps leading to a more positive
The adolescents

appraisal of traditions than may be usual amongst other local youths. In addition, expressing such opinions does not imply that they would choose to follow such a lifestyle nor voluntarily return to it, even if the war were not preventing them from this. Nevertheless, it does illustrate that the adolescents, while adapting to and coping with the challenges of displacement in towns, also attached value and significance to maintaining links of identity through traditional practices. This is not necessarily consistent across different groups of adolescents nor static, as some practices were considered essential, such as burial rites for instance, while others such as traditional clothing were fast becoming obsolete. It is thus difficult to gauge the relevance of cultural practices to the lives of displaced youth, particularly for urban youths living on their own or on the streets who may have lost connections to their families.

The majority of the displaced youths displayed great interest in music and clothing of other countries such as the U.S., Brazil and South Africa. Learning English was a desire which many youths expressed as well as gaining information about the lifestyles of other adolescents outside of Angola. This phenomenon has been noted by researchers in other parts of the world, some of whom suggest that this is an illustration of the notion that adolescents worldwide essentially share the same universal core, expressed in the shared collective consciousness and similar interests and concerns (Scott and Scott, 1998). The influence of U.S. on what has been called the emerging global culture of youth is obvious, as Massey (1998) notes, for example, in her discussion of Mexican youths, or Schlegel (2000) in her work on Moroccan adolescents. Gifford (1998) suggests that this process not only affects youth but all spheres of life in Africa, having a profound impact on the continent:

The status of the superpower signifies far more than the military might - it indicates a cultural appeal. Over much of Africa the young listen to Michael Jackson tapes, watch Rambo movies, smoke Marlboro, drink Coca-Cola, and wear Levis, NY Giants baseball caps and Nike trainers (or imitations thereof). Even where the baseball caps and T-shirts are made in China or Korea, they will be printed with NY Giants or Chicago Bulls logos - because that is a large part of their appeal - Deng Xiaoping or Kim II Sung T-shirts would not sell, while Michael Jordan or Magic Johnson shirts do. In Kisangani, in the wasteland of central Zaire, the only businesses still functioning were diamond trading houses with names like Captain Bob, American Ninja or Delta Force. In this very obvious sense President Bush was correct when he
claimed in his acceptance speech at the 1988 Republican convention: “We have whipped the world with our culture (p. 317).

However, while the marketable commodities of the U.S. exert a considerable attraction on Angolan youths, there is little evidence that suggests that the local youth culture is about to become a homogenised copy of American culture. Instead, these products become incorporated into the already existing cultural elements and lifestyles which are orientated towards the reality of the world in which the youths live, including local cosmologies, hardships brought by war, and family and community practices. Angolan youth culture is a product of interaction and hybridity as is the case with all cultures: cultural transmission is not an automatic process nor do the recipients of new ideas simply accept them unchanged (Hannerz, 1992 in Schlegel, 2000). Adaptation rather than adoption is occurring in Angola, as elsewhere on the continent.

7. Perspectives on the future

What attitudes and thoughts on the future did the displaced adolescents have? Gaining insight into this facilitates an understanding not only of their present concerns but also of their perspectives on the past and their anxieties about the challenges ahead. The overwhelming majority of the adolescents expressed the opinion that it is not currently a good time to be young in Angola. The main reason given for this is the continuation of the war and the suffering and poverty it causes. Many male adolescents were particularly concerned about being drafted into the army “where you will die; they will kill you like a dog” [Zacarias, Lubango]. The economic situation for young people in Angola was given as a second reason for pessimism about the future as the youths anticipated not having jobs, homes nor the opportunities to study. A third major concern for the adolescents is the prevalence of violence, drugs and crime amongst the youth which they considered to be a serious danger to their own safety and that of others. Only a small minority were confident that they would be able to
positively influence and shape their own destinies and the future of their communities and nation.

Despite the overwhelmingly pessimistic sentiments expressed by the adolescents, hope and courage were mentioned occasionally as two effects that emerge as a consequence of war. Living through such difficult circumstances as they had done required both of these qualities, and that the majority of youths felt that they had these:

We have hope that one day peace will come [Carlos, Chipopía].
Or that one day you will meet your family again [Julieta, Chipopía].
When we left our homes, we came here and we have some hope for the future [Veronica, Lubango].
When you are in the war, you need courage. Otherwise you can’t survive [Mauricio, Lubango].

Hope and courage, two qualities that are not normally associated with war, attest to the fact that the youths face adversity with an expectation of and a desire for a more positive future ahead.

A further relevant issue debated by the adolescents were feelings of hatred, anger and revenge. The overwhelming majority said that anger was a bad way to respond to war because it causes more destruction:

Sometimes with this anger you destroy even more. Because sometimes when someone comes and you see him you just want to hit him. At times with lots of thinking about what your parents had [and lost], you begin to hate and you want to destroy everything... And some of the children who have been in the war, when you play with them, they do the same things they have seen there... the gestures they make are to insult you [Filipe, Lubango].

Some youths felt that one should not hate the ‘other side’, because people sometimes had no choice in which side of the conflict they end up on. In Matala many youths said that although they and their families had suffered the consequences of UNITA attacks, they felt no anger of hatred towards UNITA. Many adolescents in Vissaka and Chipopía also had brothers who had joined UNITA voluntarily, a choice many said they accepted. It is not possible to say how widespread these sentiments were, but they resonated with attitudes of adults in the community who at times suggested that whether one ends up as part of the government or part
of UNITA depended on the area in which one is born, rather than on individual choice. This feeling was, of course, not shared by all. A few adolescents stated that they feel a lot of anger towards those who had caused their misery, and it seemed as if especially those who had witnessed a parent being killed expressed feelings of wanting to take revenge:

Those who killed my father - I have a lot of anger towards them. Sometimes I have thoughts of revenge: if I catch them I would do some things to them. But this will be very difficult [Sousa, Lubango].

In Angola youths have not been allowed to play an overtly political role in public life nor in civil society. Many adolescents below the age of 18 have been recruited, forcefully and voluntarily, by both sides of the conflict, and the mobilisation of youths for participation in the war is an ongoing concern (Queiroz, 2001). Adolescence is commonly held to be a time when the lure of ideology is particularly strong (Cohn and Goodwin-Gill, 1994; Machel Study, 1996) and where there is a strong receptivity to socio-political learning and attitude formation (Finchilescu and Dawes, 1998). The increasingly large numbers of displaced youths who migrate to the cities and who find themselves in desperate and vulnerable positions on the streets of Angolan cities are at risk of having to turn to crime for survival (Batalha, 1993 in Ventura, 1997). Adults frequently expressed concern that youths in Huila were increasingly disregarding the authority of the elders and becoming uncontrollable. This resonates with the age-old perception of youth as a problem, as outlined in the introduction of this chapter, but also represents a turning-away of youths from traditional ways of dealing with issues. One displaced elder from Huambo expressed this concern in the following way:

Our problem now is that we, os mais velhos here, are also fighting with life. We came here and invade the life of the locals and when we tell them this is not in our tradition, they don't take any notice of us. The young people say that our traditions are outdated. The reason why we don't manage to resolve our problems is because of the war (CCF, 2000).

There is nothing unique in this process which occurs in most societies to varying degrees. Adogame (2001) points out that in modern African societies youth has been a source of constant criticism and protest against institutions and the social, economic and political boundaries of states:
... societies have a tendency to stigmatise those who represent such a threat to their symbolic orders. Thus, youth represent various forms of threat: new ideas, new ways of life, and independence of judgement. To identify and isolate the threat, societies place a kind of stigma on the person(s) (Adogame, 2001: 3)

In Angola the traditional relationships between adults and youths which have partially been founded upon respect for the authority of the elders, are being seriously challenged by the radical shift resulting from the large-scale displacement and economic desperation of youths. In urban areas adolescents are often becoming the main income-generators in households through their involvement in the informal trading sector, and therefore become more powerful and influential in relation to the adult members of the households (Batalha, personal communication). In addition, youths who return from war where they have been expected to be strong and fearless, may experience difficulties in submitting to traditional forms of authority, making their integration potentially problematic.\(^\text{97}\)

The reactions and perspectives described in this section and in other parts of this chapter can be viewed as coping strategies on behalf of adolescents who not only engage with but also transform the environments around them. Not all of these strategies are viewed positively by adults and perhaps not all can be seen as being constructive in the long-term. Questions arise about the interrelation and application of the different paradigms described in earlier chapters to this subgroup of the displaced communities, which the concluding comments will begin to address.

8. Conclusion

It is beyond doubt that the war affects the youths’ lives in profound and disruptive ways, illustrated by the fact that the main reason given by the adolescents for their pessimistic

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\(^{97}\) As noted in chapter 7, many demobilised underage soldiers do not seem to experience problems reintegrating into civilian life. However, cases exist where this does occur (Wessells and Monteiro, 2000).
outlook on the future was the continuation of the war. Fear of being drafted into the army, poverty, homelessness, poor health service delivery, the lack of educational and vocational opportunities were just some of the concerns of the youths, issues they saw as being clearly linked to the on-going conflict. These concerns of daily life are not only survival issues for the youths but are also central to their psychosocial well-being. As Ornelio put it: “My health is not good because I think a lot... because if I had some money I would not have these bad pensamentos” (p. 258).

This perspective requires a critical rethinking of the trauma discourse as applied to adolescents. The youths had experienced incidents of violence and displacement which were severely disturbing to them, and they suffered pensamentos, nightmares, fear and sadness as a consequence of this. According to the EARAT results, 71% of the youths experienced these symptoms to such a degree that they were not only traumatised but had levels of symptomology associated with a mental disorder. The vast majority of the youths had not become disabled by these symptoms, however, and managed to live active, multi-dimensional lives that involved work, educational and leisure activities as well as maintaining relationships within and outside of their household circles. The experiences of war and their consequences were not mentioned as a problem by the youths in the qualitative exercises of this study. This indicates that the way in which the war affects the adolescents is dissimilar to the way in which mental health professionals think it affects them, in that the symptoms of trauma seem to be less important to the youths than the worry about the daily hardship they face as a consequence of the war. The findings also raise doubt about the centrality of the effects of the distressing experiences which are often presented in studies of the impact of war as if nothing else is happening in the child’s life (Dawes and Cairns, 1998). The question arises as to

98 A similar finding was presented by MacMullin and Loughry (2000) in their study of Palestinian children conducted in 1998.
whether mental health workers should focus on traumatic symptoms when other factors are clearly causing more distress, anxiety, worry and depression. It seems non-sensical to focus only on one aspect of the adolescents’ lives and address this when there are many other important issues that affect their psychosocial well-being.

There are some youths who are of particular concern, namely those whose mental state appears severely affected by their experiences, and those who are not living with family or are living with relatives who show little interest in their emotional and psychosocial well-being. If it is not possible to facilitate processes whereby these adolescents can receive attention through the already existing resources in the folk and popular sectors, other forms of assistance through outside agencies may be appropriate. However, within the context of a nearly absent mental health care system in the country this will clearly prove difficult.

This chapter has demonstrated that the youths draw on the spiritual and cultural resources of their communities in times of distress and suffering. In addition, the adolescents also have their own ways of coping with ‘normal’, i.e. not severe, pensamentos which involve activities such as going to passear and being in the company of friends. While these strategies are not always successful, they re-emphasise the fact that the majority of feelings of distress are dealt with in the popular sector by community members themselves. The influences of the churches and the NRMs on Angolan youth, their effectiveness in providing alternatives to violence and providing fulfilment on a number of levels, including psychological and social levels, have also been highlighted. This constitute one of the few areas in which youths seem to be organising and participating with enthusiasm and vigour. Psychological practitioners have tended to ignore both of these coping strategies.
What are the perspectives of adolescents on traditional healing strategies in dealing with the distress caused by war? The youths are exposed to diverse cultural influences that stem from a variety of sources, and are constantly engaged in selecting and adapting elements from these to their lives and a changing world. The two conclusions that can be drawn from the material presented in this chapter are, firstly, that traditional practices are utilised and seen as important resources by the adolescents, especially as pertaining to matters of healing, spiritually caused illnesses and burial rites. Secondly, it is clear that these are not the only resources that the adolescents draw on, as they are one of a number of different strategies. Care should be taken not to overemphasise traditional practices nor to romanticise them as a panacea for the youths' problems. Particularly for displaced youths in the urban areas who are not living with family or relatives, these traditional practices may seem remote or may be unknown to them\(^99\). For these youths other strategies of dealing with the psychosocial aspects of suffering may be more appropriate. Flexibility in regard to the role played by traditional practices is necessary as changing attitudes may emphasise and de-emphasise different coping strategies in varying social and cultural contexts at different times.

Finally, some preliminary reflections on possibilities for psychosocial projects with displaced youths in countries such as Angola are appropriate. The physical, material and social aspects of the youths’ lives are fundamentally intertwined with their emotional and psychological well-being, and this chapter has demonstrated that definite psychosocial benefit can be derived from improving the youths’ chances of making a livelihood, receiving education, being protected and accessing health care. Many opportunities present themselves which enable workers to incorporate elements of psychological knowledge in the delivery of such

\(^{99}\) The case of the approximately 10,000 ‘lost boys’ of Sudan who arrived in the refugee camps in northern Kenya a few years ago and grew up with little knowledge of their clans’ traditions (Refugees International, 2001), as well as the vast numbers of children who live on the streets of cities in many conflict-ridden societies are further examples of youths who may have little connection to traditional cultural practices of their societies.
projects. In addition, the (re-)establishment of communal mechanisms that serve as sources of support and coping are important (Ager, 1997; Summerfield, 1998), and these could include the facilitation of the building of jangos, church structures, football fields or areas of entertainment, amongst others.

The appropriateness of youth-to-youth programmes could be explored which would tap into and enhance the adolescents’ already existing networks of support amongst each other. A number of such programmes have been running successfully in different parts of the world (Hawes and Scotchmer, 1993) by drawing on and facilitating the special characteristics that young people bring with them, such as creativity, energy, and the potential for being agents of change. The adolescents in this study displayed varied and often mature problem-solving skills, suggesting the need to take seriously the critical capacity of the adolescents to engage with issues in potentially constructive ways. A vitally important issue is the area of peace building and conflict resolution which could be incorporated into a number of different initiatives with displaced youth, for instance in educational, health and recreational activities. The possibility of engaging youths in such activities seems to be great, as some already seem to be engaging in finding alternatives to situations of war and violence.

Consideration needs to be given to the different groups of adolescents and their varying coping strategies as well as their needs and concerns. Boys and girls were shown in this chapter to make use of different types of resources, for example girls were generally to be more involved in church-related activities and boys engaged more regularly in physical and sports activities. Attention needs to be paid to the differences between the sexes in order to devise programmes which reflect the realities, lifestyles and strategies of both girls and boys. In addition, some attention should be paid to the differences and similarities between displaced and local youths in the towns, in order to see if they identify themselves as distinct
groups with particular sets of problems, or whether they share the majority of concerns. From the data presented here it seems as if the displaced youths do consider themselves a distinct group. Careful thought must be given to how to assist different groups without singling them out for preferential treatment, an issue which could lead to further conflict as has been noted in other situations of forced migration (Bascom, 1993; Leach, 1992).

Programmes aimed at improving the situation of youth cannot only be orientated towards the adolescents themselves but needs to incorporate other groups from the community as well. Conflict between the generations is likely to increase as more and more displaced youths are forced to fend for themselves in urban areas. In addition, adult perceptions of adolescents as criminals and as a problem to society need to be addressed in various forms, for example through advocacy on behalf of organisations for the involvement of youth in the reconstruction of societies and communities in post-emergency situations. Sommers (2000) suggests that

understanding and addressing connections between perceptions of ... [youths] as criminals during and after wars and their role in the construction or obstruction of peace is a critical component of peace building (p. 86).

The standard response of the Angolan government to youths has been repressive and, while this is by no means unique to Angola, it illustrates the extent of their marginalisation in civil society. Prospects of enduring peace in post-war Angola will in part depend on whether or not the country continues to exclude over 50% of its population from participating in its civil society.
Chapter 10

Conclusion

We must never merely discourse on the present situation, must never provide the people with programs which have little or nothing to do with their own preoccupations, doubts, hopes, and fears... It is not our role to speak to the people about our own view of the world nor to attempt to impose that view on them, but rather to dialogue with the people about their views and ours (Paulo Freire, 1993:77).

The overall objective of this study was to investigate the role that the notions of trauma and culture play in relation to the alleviation of distress among war-affected populations. The thesis aimed to analyse how local conceptions of distress and psychosocial conceptualisations relate to one another, and how they in turn contribute to improving the well-being of the displaced. The research was guided by four assumptions: firstly, that local perspectives on and knowledge of distress are valid and important; secondly, that a simplified juxtapositioning of universalist vs. relativist positions no longer reflects the current debates in the field and that attention needs to be paid to issues of conflict, power and change; thirdly, that the blanket rejection of the applicability of psychological models and programmes is not tenable; and that, fourthly, no community or population is homogenous and that attention therefore needs to be paid to how these issues are played out within specific subgroups of communities (see chapter 3).

Specifically, the research questions which the thesis aimed to answer focused on war-related distress, how it is expressed in the communities and what explanatory models are held by the war-affected populations about it (chapter 6 and 7). The coping resources and treatment options that exist in the various sectors of the health care system were examined (chapter 6).
Specific attention was paid to the religious and spiritual domains that provide a number of divergent perspectives on suffering caused by war and how it can be alleviated (Chapter 7). The psychological perspectives presented by four different service providers, the psychiatric hospital and three NGOs, were investigated, and elements of their underlying theoretical assumptions and their practical implementation approaches were analysed (chapter 8). The study also investigated a specific subgroup in the communities, namely the adolescents, and explored how members of this group make use of the various coping resources available to them (chapter 9). The overall objective of the research was thus to analyse points of similarity and divergence between the different local, biomedical and psychological perspectives on war-related distress, thereby gaining insight into the relative contributions they make to the alleviation of suffering (chapters 6 - 9).

In this concluding chapter some themes of the material presented will be drawn out with the aim of relating these to possible implications for research and practice in the field of psychosocial work with war-affected populations.

1. War-related distress, local contexts and coping

This research was conducted in Angola, a country which has experienced more than four decades of war and therefore the longest ongoing conflict on the African continent. As described in chapter 4, the socio-economic conditions in the country are generally so desperate and health indicators so poor that the majority of the population struggles for survival on a daily basis, a situation affecting the internally displaced even more intensely as they frequently receive no or little support post-displacement. It is this context which must be taken into account when seeking to understand war-related distress amongst these populations. The data presented in this study suggests that suffering experienced by the
*deslocados* predominantly centred on the deaths of loved ones, the loss of lands and possessions, the present hardships of life after displacement, and on worries about the future. If there is to be any attempt at providing the war-displaced with assistance centred on “their own preoccupations, doubts, hopes, and fears” (Freire, 1993, above), the point of departure is understanding, firstly, the reality they are confronting and, secondly, what aspects of their experience they find distressing and why. As shown in chapter 6, distress was, amongst other things, frequently linked to concerns about economic survival.

The implication of this assertion is not that the alleviation of psychological distress is unimportant to the *deslocados*, nor that it is considered irrelevant in light of the great material and physical needs of these populations. On the contrary, as the findings presented in chapters 6 and 7 clearly show, local conceptions of *pensamentos* reflect not only an awareness of these issues but are also a means through which the *deslocados* understand their experiences and make sense of them. One aspect of the explanatory model of *pensamentos* is the notion that *pensamentos*, as well as feelings like *saudades*, are inevitable for all war-displaced people but that one needs to continue with life despite experiencing them. When they, however, become so severe that they result in illnesses, expressed in various forms such as *cabeça quente*, *mutima*, *loucura*, and high and low blood pressure problems, they were considered to be so serious as to require intervention and treatment. This indicates that the *deslocados* do not dismiss or ignore the effects of war-related distress on people’s lives.

However, the data also shows, firstly, that the causes of *pensamentos* and related illnesses were not always primarily or exclusively related to past events of war and violence but to present hardships that the *deslocados* were undergoing at the time of the study. The women in Chipopia and Vissaka were articulate and outspoken about the connections between the deaths of loved ones, the loss of lands and means of survival, and the occurrence of distress-
related illnesses (chapter 6), reinforcing the idea that the material and physical context in which the deslocados’ lives take place are central to psychosocial concerns. The decrease in numbers of people suffering from these illnesses following the first months after settling into the centres was interpreted by the women as the result of people establishing lives for themselves again and at least beginning to initiate some form of economic activity. The data of this study thus strongly supports assertions that the re-establishment of economic and social structures following displacement is a vital component of providing psychosocial support (Ager, 1997; Higson-Smith, 1999).

Secondly, the explanatory models held by the deslocados suggest that issues of distress are not easily classified according to categories that distinguish between psychological, mental, physical, or spiritual distress. In fact, such differentiation do not seem logical in light of the intricate interrelationships between these different aspects of health, and attempts to ‘disentangle’, for instance, mental health issues from overall health and well-being, or psychological distress from spiritual problems, would be as non-sensical as trying to separate pensameritos from economic hardship. Both the expression of distress in the form of somatic and idiomatic symptoms, as well as the use of multiple strategies in health care involving religious, spiritual, cultural and biomedical resources, testify to the idea that war-related distress is unlikely to be captured by means of a uni-dimensional concept. Instead, it is necessary to gain insight into the different elements of the explanatory models held by the deslocados in order to understand local views of health and illness. The information presented in chapters 6 and 7 also illustrates that there is not just one explanatory model about an illness in the communities but that several may exist which may be in conflict with one another. An example of this is loucura which may be caused by spiritual problems such as vengeful spirits, witchcraft, experiences of combat such as exploding bombs, or by witchcraft deals gone wrong (chapter 6).
As noted in the literature review (chapter 2 and 3), emphasis has increasingly been placed by psychosocial professionals on cultural healing practices amongst war-affected populations. These are seen as effective means of alleviating distress that draw on local explanatory models and utilise indigenous resources, and may therefore be more appropriate than ‘outside’ approaches introduced by western-trained professionals (Eisenbruch, 1992; Englund, 1998; Honwana, 1997; Reynolds, 1996; Wessells and Monteiro, 2000). The findings of this study confirm these views by pointing to the general fit between expressions of distress and their treatment in the folk and popular sectors. The underestimated value of local knowledge, a frequent topic in the development literature (see for example Hobart, 1993), and the contributions it makes to the alleviation of distress in people’s lives generally need to be given recognition in the area of psychosocial work as well. This applies not only to healing strategies but also to cultural traditions that impact indirectly on a community’s general ability to cope with the disruption of war, such as the sobas, the justiça and jangos which were discussed in chapter 4.

The results also suggest that closer attention has to be paid to what the terms ‘culture’ and ‘local healing resources’ encompass. The discussions in chapter 7 point to the common practice amongst NGOs to subsume religious and spiritual issues under the category of ‘local’ or ‘cultural’, with little reflection on the differentiation that exist between the various perspectives. As noted in that chapter, the boundaries between what is spiritual and cultural are not always clear, although the deslocados themselves were very concerned with exactly such debates, indicating that these issues were taken seriously in the communities, and should, therefore, be taken into account by psychosocial service providers as well. It seems that the term ‘culture’ is frequently used in the area of psychosocial work in much the same way as in development work: as encompassing everything that is not explained by the theoretical models
the professionals themselves bring to the situations (Gardner and Lewis, 1996). The result of this may be that all issues, concerns and beliefs that are unfamiliar to psychological professionals are relegated to the sphere of ‘culture’ without attempting to understand the different perspectives on distress that exist within communities. The term culture thus needs to be clarified in order not to become vague and random: while culture permeates everything, it does not include everything. In Huila a strong argument can be made for not subsuming religion under the umbrella of culture and engaging with local debates on these matters in order to comprehend the diverse types of resources offered by the various religious sectors.

In addition, the conceptualisation of culture as a static entity or as the preservation of tradition is clearly inappropriate in the communities investigated. Chapter 2 referred to the danger of a reductionist view that sees culture as something that can be found in places (Appadurai 1988), this leading inevitably to a process of ‘essentialising’ what is an inescapably dynamic and constantly evolving aspect of communal life. At times outsiders who adopt a relativist perspective or members of a community who attach value to cultural practices that are falling into disuse may campaign for the re-activation of such traditions, despite the fact that such traditions may no longer be relevant nor the preferred strategies of present-day communities. Instead, new approaches and strategies may be evolving which may be based on various elements of different cultural traditions or worldviews. In Huila this was evident in the popularity of the new religious movements (chapter 7), in the ‘medicalisation’ of distress in the form of HBP (chapter 6), in the hybridisation of practices of African traditional religions and Christianity (chapter 7), and amongst the adolescents who use pop music and dancing as distraction from distress (chapter 9). If psychosocial service providers are ‘out of

\footnote{Attempts to defend the integrity of indigenous or authentic cultures easily slip into a conservative defence of nostalgic visions of the past, referred to by Rushdie as “an absolutism of the pure” which may never have existed in such form as every culture has historically always ingested foreign elements (1982 in Morley and Robins, 1995: 234).}
touch’ with developments on these various levels they may well advocate a return to practices that are outdated, thereby missing out on changing dynamics in communities.

Another aspect to this debate is the notion that the ‘importation’ of western psychological knowledge will undermine local cosmologies and coping systems (Bracken, 1998), the implication being that non-western cultures need to be protected somehow from destructive western influences. One interpretation of this relativist position is that communities and cultures should be left as they are without outside ‘interference’ as they will otherwise fail to cope with the challenges facing them. This idea rests on the assumption that western influences are so strong that they will substitute local cultural practices, a notion which was not evident amongst the deslocados. On the contrary, Bantu culture is a lived and vibrant reality in Huila which has not fallen into disuse but has incorporated diverse aspects of other traditions such as Christianity and Portuguese culture. As Carr et al. (1998) state in regard to health and development work in developing countries:

Culture is not a fragile entity, and it would be naïve in the extreme to believe that one set of such values (for example that of a donor agency) will ever eclipse another (for example those belonging to a host) (p. 200).

While cultural practices undergo change, they are also related to people’s cosmologies and worldviews and, as such, are central to issues of identity and being-in-the-world (Jenkins, 1996).

This thesis has emphasised the deslocados’ abilities to cope with war-related distress, thereby focusing not only on their distress and suffering but also on the available resources and on the active engagement with the difficulties they confront. The different sectors of the local health care system provide a range of treatment options for dealing with distress and its related illnesses and problems. The deslocados participate in their own health care, and give assistance and advice to those severely affected by pensamentos, thereby providing, in effect,
psychosocial assistance to one another on a daily basis. They initiate processes of “world-making” where they “seek new sources of survival; they seek to understand what it is they need, and how they are to go about getting it” (Nordstrom, 1997: 189). As pointed out in chapter 8, the importance of acknowledging people’s strength and agency helps dispel myths of dependency and passivity that are common amongst those working with war-displaced populations (Harrell-Bond, 1999).

2. The trauma / culture debate

What contribution has this study made to the trauma / culture debate as outlined in chapters 1 to 3 of the literature review? Firstly, the study draws attention to the need for the contextualisation of this debate in the realities confronting mental health care in general. The fact that Angola does not have the resources to provide psychiatric care for its population (apart from locked institutions) affects all Angolâns, and not just those who are displaced by the war. This does not imply that the psychiatric model is necessarily the best nor the most appropriate way of providing mental health care in the country, and careful attention would have to be paid to what types of treatment and care would most effectively assist those severally mentally disturbed (see for example Desjarlais et al., 1995). It does, however, focus attention on the need for general strategies and assistance directed at this area of health rather than advocating a narrow approach to assisting only those directly affected by experiences of war. A primary mental health care approach which encompasses the most frequent mental health problems may be appropriate, rather than individual projects aimed at trauma-related illnesses.

Debates about the applicability of psychiatric diagnostic systems and treatment methods to other cultures and societies were discussed in chapter 2 as well as their application to war-
affected populations (chapter 3). The material presented in this study about illnesses such as mutima, loucura and HBP confirms the notion that no easy ‘fit’ between local and psychiatric diagnostic categories is possible, and that such attempts are likely to result in category fallacies (Kleinman, 1980). For instance, mutima shares some symptoms with depression such as listlessness, but also comprises symptoms related to the heart which are considered by the local population to be central defining features of the illness, i.e. the movement of the heart to another part of the body or a loss of heartbeat. A universalist attempt at reconciling these two diagnoses, mutima and depression, would lose the significance of these symptom as well as the opportunities this illness affords individuals for indicating the presence of an acute crisis. War-related illnesses thus need to be viewed in their context if the meanings attached to various symptoms are to be understood.

Data directly relevant to the PTSD model was discussed in chapter 9 where the majority of adolescents who had symptomology sufficient to meet criteria B - D of the DSM-IV (1994) definition of PTSD were not found to be dysfunctional in social, educational, vocational or physical terms. This raises doubt about whether such a diagnosis can meaningfully be applied to these adolescents. It was argued that dysfunction, as specified in Criterion F of the diagnostic criteria, should be maintained if a distinction is to be made between those so severely affected by their experiences of war that they are unable to cope with certain aspects of life, and others who may also be affected yet are able to continue functioning in various areas of life. A refocusing on function rather than on symptoms of trauma may thus be useful in attempts to assess the psychosocial impact of war on a population.

The interpretations attached by members of the community to certain forms of behaviour may differ from those of psychosocial professionals, and, indeed, from one another. An example of this was given in chapter 7 where loucura caused by mbindi was discussed. An instance of
differences of perspectives within communities is that adult *deslocados* were mostly of the opinion that children and adolescents do not suffer from *pensamentos* and were not profoundly affected by the experiences of war. The data in chapter 9 conclusively demonstrated, however, that adolescents do indeed experience *pensamentos* and that they share many ways of expressing and coping with their distress with adults. If the adolescents are not asked themselves about the suffering they experience and how it affects them, this may lead to their exclusion from potential project planning for psychosocial assistance. In order to gain insight into psychosocial issues it is vital to gather information from a variety of sources and different groups in communities on how the war has affected them as they may have varying problems, concerns, priorities and interests.

In relation to the different positions in the trauma/culture debate outlined in chapter 3, the analysis of the psychological services in Huila revealed a number of varying approaches to how culture is understood and the importance it is accorded. The findings of chapter 8 will not be repeated here; suffice it to draw attention to an approach which is common amongst many psychosocial projects currently. This view falls under the ‘culture as variable’ position which sees culture as an addendum to ‘what is really going on’, i.e. traumatisation. The DEF project exemplifies this approach which takes a western view of understanding distress as a starting point and views culture and context as external variables that affect the particular local expressions of distress but do not change its basic form. The interventions based on such an approach frequently ‘extract’ a few cultural practices and attempt to incorporate these into existing programmes rather than attempting to understand culture at a systems level (MacLachlan, 1997). Examples of this are the incorporation of purification rituals into programmatic interventions, the use of *curandeiros* as partners in projects, or the promotion of ‘cultural’ activities like dancing and singing. These activities are seen as supplementing psychological methods (counselling, psychoeducation etc.) but not as principal resources for
dealing with distress. Such an approach does not do justice to local ways of understanding and expressing distress, nor does it recognise that context and culture permeate every aspect of suffering and the range of treatment options available.

As has been demonstrated throughout the study, local perceptions have to be taken as central to war-related distress in order to understand the cultural, spiritual, religious, social and political dimensions of the different forms the distress takes. If local perceptions and local concerns are taken as the core elements for alleviating distress, the question presents itself whether psychological models can or should be incorporated at all, or whether a strategy of non-involvement on behalf of psychological practitioners is called for. I concur with scholars such as Bracken and Petty (1998) and Summerfield (2001) who maintain that psychosocial work with war-affected populations is politically and ethically problematic. However, the findings of this study suggest that there are various important ways in which psychological professionals can reorientate the dominant psychological models and discourses by focusing on local knowledge and local experience, thereby contributing to the alleviation of psychosocial suffering within frameworks acceptable to war-affected populations. The work of GHI, for instance, attempts to do this by emphasising the need for empowering the communities in which they work and by adopting a community-based approach to implementing programmes. In addition, possibilities exist for usefully incorporating specific elements of psychological knowledge which war-affected populations themselves have found useful into projects, for example psychoeducation, conflict resolution or life skills programmes (for adolescents). There is thus scope for introducing new practices and knowledge into the field which can help to reorientate psychological professionals away from earlier conceptions of trauma and PTSD as the only, or the correct way, of conceptualising suffering and distress.
3. Power, conflict and change

Throughout the thesis it has been noted that psychosocial work is not devoid of nor separate from issues of power, conflict and change. This applies both to dynamics within communities, for example in the form of competition for church members (chapter 7), as well as to relations between communities and external agents such as aid agencies and the government (see for instance chapter 4 and 6 on government attempts to resettle the deslocados in unsafe areas). One of the common problems of psychosocial work is that practitioners have tended to ignore these dynamics, choosing to interpret their work as providing technical solutions (psychosocial programmes) to neutral problems (distress) (Bracken et al., 1997). Such a narrow focus is naïve as it overlooks the political dimensions of programmes and the implications they have for connections between people and structures, as well as for the distribution of resources. The proposed incorporation of curandeiros from Matala into the DEF psychosocial project would, for instance, be likely to lead to conflict both within the communities and between community members and DEF, as the allocation of resources to the curandeiros would be contested by various sectors of the population.

Psychosocial interventions share some of the same issues that confront development and health work in general: conflicts about different understandings of the situation, opposing agendas and contrary approaches to interventions (Chambers, 1997; Gardner and Lewis, 1996; Sachs, 1992). The importance attached to local understandings and initiatives as opposed to those of the external donors is as relevant for psychosocial practice as it is for other areas of development work. Increasingly terms such as community participation, mobilisation and empowerment are used as part of the psychosocial jargon but, as Carr et al. (1998) point out in relation to health work, what happens on the ground does not always correspond with the rhetoric that is in vogue: “participation may dominate development discourse, but hierarchy
remains its dominant practice (Brett, 1996 in Carr et al., 1998: 57). Equally, in psychosocial work it is often external agents such as NGOs who decide on the form that assistance will take, the agenda of the organisation taking precedent over that of the community (Richters, 1998). ABC is an example of this approach, illustrated by the fact they implement similar programmes in many countries in the world without taking local concerns or priorities into account (chapter 8). Community participation thus remains at a token level instead of informing the planning of a project from the start, thereby restricting the role of the deslocados to being participants in a seminar. The basis for preventing such situations from arising is, in the words of Freire (1993:77), “dialogue with the people about their views and ours”, as communication and dialogue are essential requisites for any form of community participation.

How can psychosocial programmes play a role in the empowerment of war-affected populations? This issue is intimately related to the local political context within which forced migrants find themselves and which will vary from population to population. Displacement and events of violent conflict cause change on all levels of communal living. While change is a constant factor of life everywhere, and people exist in “a continual process of re-formation ... even in locales far removed from war [where] people undergo constant, if often imperceptible change” (Nordstrom, 1997:185), the characteristic of forced migration is that people have not chosen these changes for themselves but have had them forced upon them. Changes brought through violence pose severe challenges and difficulties for the displaced as they face the task of re-making or making their worlds anew. What existed before the war can never be the same again, even in the best of all possible scenarios where a rapid return home becomes possible: people have died or moved away, different buildings need to be constructed, settlement patterns will have changed, farmlands may have been refigured, ways of making a livelihood may no longer be viable. In Huila communal ways of resolving
Conflict, the political systems, ways of worship and health care systems were all affected by the war, and a simple reconstruction of the past seems unlikely.

The potential exists for disempowered or less empowered groups within the displaced communities to change previously existing power relations to their advantage, an issue that agencies have taken note of especially in relation to gender issues (Díaz, 2001)\textsuperscript{101}. As described in chapter 9, the social position of adolescents in Lubango was, for instance, undergoing change as some youths were increasingly becoming the most important income-generators of families through their trading skills. This gave them some financial power which was in conflict with traditional views requiring jovens to be deferential towards os mais velhos. The recognition given to young people in the NRM is a further example of how relations of power may change from previously established norms.

The tasks of external agents are, firstly, to be aware of how people’s multiple dimensions of difference are constructed and infused with hierarchies of power (Nelson and Wright, 1995), and, secondly, to be aware of how their own presence and involvement affect these relationships of power, for instance through maintaining or undermining the position of certain subgroups. Psychosocial professionals also have a responsibility to advocate for the rights of the displaced to social justice and for access to resources, an issue which may be overlooked by those who define their mandate in primarily technical or medical terms (Summerfield, 2001). In many societies that experience civil conflict advocacy for the rights of the war-displaced runs counter to the political aims of various interest groups, and is thus an undertaking that requires a strategy of diplomacy and tact.

\textsuperscript{101} Such changes can have unexpected and negative consequences as Turner (1999) notes in his article on ‘angry young men’ in refugee camps in Tanzania who felt undermined by UNHCR’s policies favouring women. The young men devised new ways of reasserting their masculinity which in turn disempowered older men who were unable to acquire the necessary skills for negotiating with the international agencies working in the camps.
4. Research and practice

A strength of this study was its use of three research methods which each contributed certain information about the situation of the deslocados in Huila. The EARAT and some of its potential problems were discussed in chapter 8 and 9, including the narrow focus of its dichotomous (yes-no) questions and the confusion the wording of some of the items created amongst the adolescents. The EARAT in itself would have been insufficient for understanding the meanings attached to certain concepts such as pensamentos, as well as for gaining insight into the explanatory models held about certain symptoms, for instance the spiritual aspects of illnesses. Some frequent ‘symptoms’ of distress were not addressed in the EARAT as they do not form part of the DSM-IV definition of PTSD, for example, somatic connections between feeling physically unwell and pensamentos. In addition, information about the role the symptoms of trauma play in the lives of adolescents could not be provided by the EARAT, for instance the fact that for most of the adolescents these symptoms did not result in dysfunction in various aspects of their lives. These findings indicate that the use of a psychometric measurement based on DSM-IV criteria is inadequate on its own for understanding issues of war-related distress as the a priori determined symptoms of trauma do not yield insight into what the displaced themselves consider to be important aspects of their distress.

The data obtained from the PRA-type exercises provided information about a variety of aspects of the adolescents’ lives, including their daily concerns and routines, health problems, resources in the health care system, coping strategies and their thoughts and feelings about the war. The exercises served as productive starting points for discussions and opened up a number of different channels of information which would have been more difficult to achieve through more conventional interviewing methods. An example of this was mentioned in
Conclusion

Chapter 9 where the youths felt reluctant to talk about consulting a *curandeiro* but indicated that they do indeed make use of them during the exercises involving the Body Maps, allowing for further discussions to take place about the role of the healers. The benefits of PRA are that they allow the establishment of rapport to occur quickly and easily, and that they provide time-efficient ways of gathering information. In addition, the adolescents enjoyed engaging with the tasks set for them, especially when they themselves were facilitating the exercises. The use of PRA exercises for issues of mental health and psychosocial concerns needs to be developed further, however, as no systematic investigations of the application and usefulness of these methods has yet been undertaken in this area.

The most information-rich data in the study was obtained by means of ethnographic methods in the form of interviews, observation, participation and focus group discussions. This suggests that some form of fieldwork is necessary if one aims to acquire more detailed knowledge about local perspectives and explanatory models. The question presents itself how much of the local context is relevant to providing appropriate psychosocial assistance, and how much knowledge of the local health care system is necessary before useful interventions can be designed. Given the time restrictions under which many organisations work, this is a challenge which usually requires accessing communities through people already familiar with local realities, and the use of guidelines of ‘best practice in the field’. The work of groups such as the Psychosocial Working Group, a joint academic-humanitarian agency initiative which seeks to develop a unifying framework with respect to which interventions can be developed and evaluated, are vital in this regard (Strang and Ager, 2001).

While some of the data presented in this study is specific to the situation of war-affected populations in the south of Angola and cannot therefore be generalised to other populations, the general observations and principles in regard to matters such as the importance of local
explanatory models, the relevance of religious and spiritual resources, and the active engagement of the local population with war-related distress can be extrapolated to other communities. Questions remain, however. It is important to investigate how local perspectives vary across different geographical locations and communities in order to contribute to existing knowledge in the field concerned with ensuring relevant assistance to war-affected populations. More in-depth information about the interface between western approaches to providing psychosocial assistance and local coping strategies is needed so as to provide insight into how war-affected people themselves perceive the benefit of various aspects of the assistance provided to them. The on-going development of evaluation tools could be incorporated into research strategies that seek to address such issues.

In addition, a number of aspects of psychosocial work with war-affected populations which could not be addressed in this study need to be explored further. One of these is the interconnectedness between different areas of coping on religious, economic, cultural and social levels in order to gain insight into how local strengths and resources are actively enhanced or undermined by various factors in these domains. Another important research area is the perceived effectiveness of different strategies in the professional, folk and popular sectors of the health care system, as little is known about how the war-displaced themselves perceive the usefulness and efficacy of the various resources (Kleinman, 1980; Swartz, 1998). As pointed out in chapter 2, the ‘fit’ of explanatory models between patient and healer does not automatically imply that treatment will be perceived as successful, and other criteria need to be developed in conjunction with the displaced in order to explore the effectiveness of various treatment options. Follow-ups of individual cases may yield valuable insight into the short-term and long-term alleviation of distress and related illnesses.
A weakness of this study was that access to certain types of information could not be negotiated, for example interviews with soldiers who displayed aggressive behaviour when stationed in the towns and civilian areas. Data obtained directly from research with these soldiers and their families is likely to enhance discussions about the different explanatory models used to understand their behaviour and experiences. Another area of research which was not sufficiently covered in this study was the in-depth investigation of issues affecting individuals, families and groups which the destocados identified as vulnerable to both severe economic destitution as well as to pensamentos-related illnesses. Information about this group of people could provide more insight into the connections between the different salient factors that contribute to resilience and vulnerability.

The situation of adolescents in Angola warrants further attention. As outlined in chapter 9, not only is their situation dire but there is little information about their perspectives on the social, economic and cultural issues that seem to have a profound influence on their psychosocial well-being. This study has shown that the adolescents responded well to participatory research methods, and an action research project that would lead to implementation of projects aimed at improving the situation of adolescents is indicated.

Finally, further and extensive research into the relationship between theory and practice in psychosocial projects is necessary. Chapter 8 noted that some organisations take psychological theories as their starting points for "how things are" and thereafter attempt to adjust these theories to the local realities they encounter. As pointed out in the discussion of that chapter, problems exist with such an approach that takes theories developed within 'other' cultural paradigms as starting point rather than local cosmologies. Of interest is the process whereby service providers reach decisions about the types of interventions they provide: how are theoretical understandings translated into practice and how does practice inform theory? This
is an area in which considerable research exists in the development and aid industry (Chambers, 1997) and within areas of community psychology (Bryden-Miller, 1997), and from which psychosocial professionals may benefit by subjecting their theoretical orientations, conceptualisation and implementation of psychological assistance to closer scrutiny.

In conclusion, I return to a basic premise that has guided this research: in order to provide any form of assistance to the war-displaced one first needs to listen to their perspectives and gain insight into their understandings of the suffering they are enduring. The deslocados in Huila reminded me frequently of the fact that the source of their suffering, the on-going war, had not come to an end yet, and that the alleviation of their distress depends to a large extent on how the political situation develops. As Dona Gina, quoted in chapter 6, stated:

The pensamentos never stop. Only if the war will stop and a person can return to their land and can work there at peace. But up to now the war continues - how can a person stop to think? For me there is no way to stop the pensamentos. Only if the war will stop and we can go back to where we have fields [Dona Gina, Vissaka].

Humanitarian attempts to contribute to the alleviation of distress thus need to be situated within this broader context that implies a responsibility to advocate for the rights of the war-displaced to the protection of life and livelihoods, and a voluntary return to their homes and land.
APPENDIX A:

Diagnostic criteria for post-traumatic stress disorder as specified in the DSM-IV
Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person’s response involved intense fear, helplessness, or horror. Note: In children this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) recurrent distressing dreams of event. Note: In children, there may be frightening dreams without recognizable content.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g. unable to have loving feelings)
   (7) sense of a fore-shortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilence
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more.

Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor
APPENDIX B:
Extract from Personal Journal kept
during field work in Angola in 2000
16 March

Can’t get rid off the feeling that my research won’t be of much practical relevance to the deslocados. There are two voices in my head, fighting with each other. One keeps saying: what on earth are you doing here, you are spending your time sitting around talking to people (that’s what my research must look like to the deslocados) instead of trying to organise resources for the people or trying to do something practical. The other voice says: hold on a minute, that’s not the only way in which to change things. “Rushing in to save lives” without knowing what’s going on is something I have always criticised in the past but now it seems I want to do just that.

The problem is that I could do something if I want to. X. mentioned the possibility of giving me money to start a project for the kids in the centres again the other day. I am tempted and I keep thinking about it. Could I do both - run a project and continue with the research? Perhaps do a 6 months project with the kids in the centres and then hand it over to one of the local organisations? I don’t know if that is realistic and I’ve heard lots of stories of people having their research derailed like that, by getting involved in a project. But then am I not prioritising my own agenda - the research - above doing something practical for the deslocados? Which is exactly what people always criticise about researchers who come into settings and ‘extract’ info and leave again.

I also don’t think that starting a project is the right way to go about things. H. told me a story the other day of a UN delegate who visited the camps and saw a severely disfigured child and decided that this child must have cosmetic surgery in Luanda for which she herself would pay. The woman wanted to take the child with her immediately and already put her into the car while the mother was standing around looking bewildered. The UN person didn’t speak any Portuguese and couldn’t explain to the mother why she wanted to take the child away with her. H. had to intervene and explain to the UN delegate that there are no such medical facilities in Luanda and besides which there are lots of other disfigured children in the centres and what about them? The money would be better spent on trying to get some crutches of wheelchairs for the disabled kids. H. was laughing a lot about the naïveté of this woman when he told me the story, and so was I. There was also a feeling of “who does this woman think she is?” I also thought: isn’t this what I would be doing if I decide to start some project that’s not sustainable? I feel a constant tension between all of these issues: the value of doing research in a setting like this, my own responses to the abject misery and wanting to do something about it, and knowing that “rushing in” does more bad than good. What are my responsibilities as a person in this situation? What are my responsibilities as a researcher?
APPENDIX C:

Example of a PRA exercise (Body Map) completed by an adolescent in Matala
APPENDIX D:

The EARAT [Original version by McIntyre and Ventura (1996) and translation into English by C. Eyber]
Evaluation Scale of Post-traumatic Stress Disorder -
Version for Adolescents* [translated by C. Eyber]

Teresa McIntyre, Ph.D. University of Minho
Margarida Ventura, Ph.D. University of Agostinho Neto
1996.

Instructions

People respond to traumatic events in various forms. This questionnaire contains questions and statements that aim to describe these responses to such an event. There are no right or wrong answers, only different ways of responding to traumatic events. Answer all questions accurately and truthfully.

Name:                                      Age:
Date of birth:                             Sex: Masc.  Fem.
Profession:

Date of evaluations:
Evaluation:
Administrator:

* Based on the DSM-IV
I - The traumatic event

A) 1 - Have you ever experienced a traumatic event? (For example, combat, assault, serious injuries, floods, fires or other experiences that seriously threatened your life or that of others?)

Yes____ No____

2 - Describe this experience:

__________________________________________________________________________________________

3 - When did this occur? Year_____ Month____
   a) Less than 6 months ago ________
   b) More than 6 months ago ________

4 - Did you feel that you changed after this event?

5 - How long after this event did you start to feel like this?
   a) Within 6 months ________
   b) After 6 months ________

6 - How do you feel now?

__________________________________________________________________________________________

7 - If you don’t feel like you that anymore when did you stop feeling like that?

8 - Do you feel bad because you didn’t have the power to stop what was happening?

Yes____ No____

B) 1 - Have you ever seen someone be seriously injured or die as a result of an accident or physical violence?

Yes____ No____

2 - Describe this experience:

__________________________________________________________________________________________
3 - When did this occur? Year_____ Month_____
   a) Less than 6 months ago ____________
   b) More than 6 months ago __________

4 - Did you feel that you changed after this event?

5 - How long after this event did you start to feel like this?
   a) Within 6 months ____________
   b) After 6 months ____________

6 - How do you feel now?

_________________________________________________________________________

7 - If you don’t feel like you anymore when did you stop feeling like that?

8 - Do you feel bad because you didn’t have the power to stop what was happening?
   Yes_______  No_______

II - Re-experiencing the event

Indicate with a cross if the statements below are true for you at the present moment:

1 - I have been having a lot of bad dreams or nightmares about this experience:
   Yes_______  No_______

2 - I have been having unpleasant thoughts about this experience although I don’t want to think about it (involuntarily):
   Yes_______  No_______

3 - At times I feel that this traumatic event will happen again:
   Yes_______  No_______

4 - I feel strange nervous or troubled when I see or hear something similar to the traumatic event or that makes me remember it.
   Yes_______  No_______
5 - I react with sweating, shaking or my hearts beats faster when I have an experience similar to the traumatic event.

    Yes_______    No_______

III - Avoidance/ Numbing

Indicate with a cross if the statements below are true for you at the present moment:

6 - I try not have thoughts or feelings about this experience:

    Yes_______    No_______

7 - I try not to do things that remind me of this experience:

    Yes_______    No_______

8 - I can’t remember some of the important things about this experience:

    Yes_______    No_______

9 - I feel less like being with friends, playing or doing things which I liked to do before the traumatic event.

    Yes_______    No_______

10 - I have been feeling odd and different to my friends as if I don’t care about them.

    Yes_______    No_______

11 - At times I feel so sad and alone that I can’t speak nor cry.

    Yes_______    No_______

12 - I am unable to think about the future.

    Yes_______    No_______

IV- Hyperarousal

13 - I have problems falling asleep or staying asleep.

    Yes_______    No_______
14 - I feel irritation or anger which I cannot control

Yes_______  No_______

15 - I am not able to pay attention, and get distracted easily:

Yes_______  No_______

16 - I am always alert because I fear that something bad is going to happen:

Yes_______  No_______

17 - I feel nervous or get a fright when I hear loud, unexpected noises

Yes_______  No_______

V - Intensity

Evaluate the intensity of your reactions when you remember, think or dream about the traumatic event by drawing a circle around the word which indicates how intensely you react:

a) fear

none  little  moderate  intense  very intense

b) short of breath

none  little  moderate  intense  very intense

c) feelings of suffocation

none  little  moderate  intense  very intense

d) palpitations or heart beats faster

none  little  moderate  intense  very intense

e) discomfort or pain in the chest

none  little  moderate  intense  very intense

f) sweating

none  little  moderate  intense  very intense
g) dizziness, loosing my balance or fainting

none   little   moderate   intense   very intense

h) nausea of stomach ache

none   little   moderate   intense   very intense

i) feel so confused it seems I don’t know where I am

none   little   moderate   intense   very intense

j) feel pins and needles in my hands or feet or I seem to be unable to move

none   little   moderate   intense   very intense

l) feel cold or hot

none   little   moderate   intense   very intense

m) shuddering or shaking

none   little   moderate   intense   very intense

n) fear of dying

none   little   moderate   intense   very intense

o) fear of going crazy and I don’t know what I am doing

none   little   moderate   intense   very intense

p) put myself at risk or am more adventurous than before

none   little   moderate   intense   very intense
APPENDIX E:

Reflexivity and ethical issues
Reflexivity and ethical issues: some brief comments

According to Spivak (1988) all research is irreducibly intertwined with politics and power. The authority of the ethnographer and the legitimacy of the ethnographic text have been questioned by postmodernist, feminist and critical scholars which has lead in recent times to a revision of the traditional notion of the anthropologist ‘in the field’ (Bazanger and Dodier, 1997). The constitutive role that interpretation and hermeneutics play in qualitative research requires of researchers to reflect critically and constantly on how their characteristics, their theoretical orientations, and those of the participants impact on the interaction in the field and the production of ethnographic texts (Pidgeon, 1996). This is in contrast to traditional accounts of scientific practice where the multiple layers of subjectivity and interpretation are over-written or obscured (Pidgeon, 1996: 85).

No research approach and no researcher can escape his or her cultural legacy (Robben and Nordstrom, 1995) and no research takes place within a vacuum. In this study, for example, the fact that I was a white woman affected how people responded to me and how they perceived me and interpreted my intentions. The participants were also influenced by their previous experiences of similar strangers:

Given that people among whom anthropologists do their research have usually never had an anthropologist working in their midst, it should be kept in mind that they are naturally going to try to figure out what you are doing there. Usually, at least at first, they will define the anthropologist with reference to preexisting categories derived from experience with other strangers who have appeared in the community (Sluka, 1995: 283).

People usually assumed that I worked for an NGO that was going to provide services to the deslocados and frequently asked about what type of services I would provide. I was also on occasion mistaken for a nurse or a missionary worker. The curandeiros and adivinhadores were often convinced that I was a healer myself and wanted to acquire their knowledge and skills in order to improve or set up my own practice. According to my translator, Manuel, this seemed to be the only possible reason for why a foreigner would display such interest in their healing practices. Although I was consistent in clarifying my position and the purpose of my work, and despite explaining that I myself did not have any ancestral spirits who could help me heal or divine, I suspect that some healers were not completely convinced by my assertions.

The various methodologies I used allowed me to establish different kinds of relationships with the deslocados. Casual conversations and interviews provided opportunities to engage with people, learn about their lives and to form friendships. The interview as a research tool has in the past sometimes portrayed respondents as ‘vessels-of-answers’: essentially passive subjects who are not engaged in the production of knowledge but merely supply information (Heyl, 2001). Reflexive perspectives emphasise that interviews are first and foremost interactions between the researcher and the interviewee, a give-and-take process during which the interviewer and the participants are constantly evolving. Holstein and Gubrium (1997) present the notion of the active interview which “transforms the subject behind the respondent from a
repository of opinions and reasons or a wellspring of emotions into a productive source of knowledge” (p. 119). It is not only the participants who are transformed during the interview process but also the interviewer. This was certainly the case for me as I got to know people, and their opinions and attitudes began to influence my own. I did at times experience tensions between a more traditional approach to interviewing which I adopted when I was interested in obtaining specific information, such as different treatment options for an illness, and the interviews that were exchanges of perspectives and transformative experiences for me. As Davies (1999) notes, these are tensions which cannot always be satisfactorily resolved.

Reflexivity implies a process of continuously moving from the intensely personal experience of one’s own social interactions in the field, to the more distanced analysis of that experience for an understanding of how identities are negotiated, and how social categories, boundaries, hierarchies and processes of domination are experienced and maintained (Wright and Nelson, 1995: 48). During the eight months in Huila I was acutely aware of how people reacted to me and aspects of my identity, and how I reacted to them in relation to a range of issues. To give two examples: the fact that I am a white South African and thus part of a nation that had waged war on Angola in the not so distant past, was an important issue for some informants who asked me about my personal experiences of this and my opinions about the attacks on their country. I met a number of deslocados who had fled from the provinces of Cuando Cubango and Cunene during the 1980s’ bombardment of the area by South African planes, giving me first-hand accounts of their suffering. This caused me to reflect on a political level on the larger context within which the present situation of the deslocados had developed, as well as on a personal level on my emotional responses to such accounts.

A second example arose in relation to the degree of my acceptance of local beliefs and cosmologies. My interest in cultural issues is great and I had always perceived myself to be tolerant, open and accepting of all local perspectives - until I was persistently interrogated by an Angolan friend about whether I truly believed that rain-makers are responsible for weather conditions in the province. I admitted that I did not, to the disappointment of my friend, and this incident alerted me to the need to pay closer attention to my own responses, thoughts and emotions about local belief systems in order not to fall into a relativist mode where “what they believe” and “what we believe” are catalogued as unrelated realities. As Wright and Nelson (1995) point out, reflexivity is the means through which the fieldworker’s double perspective of insider/outsider, stranger/friend, and participant/observer is kept in tension.

Reflexivity is especially important in regard to ethical issues that arise during the course of research. Ethnographers have been criticised for their unwitting location in power relationships and the unintended and unforeseen effects of their work (Spivak, 1988). In situations of armed conflict the primary responsibility of the researcher is to ensure that the informants are safe and not endangered in any way. While I tried to ensure this as much as possible there were two situations in which I felt that control of the research was taken out of my hands by government officials and I was faced with a choice between two risky options. These situations arose when high-ranking officials decided to afford me ‘protection’ in the communities, ostensibly from criminals in Lubango and from possible UNITA attacks in Mataja, delegating an armed soldier or member of a Self-Defense Unit (SDU, armed civilians under government control) to accompany me during my interviews with community members. The function of these soldiers
was probably to monitor the type of questions I was asking. My protestations that this 'protection' was unnecessary were ignored and a refusal on my behalf to conduct the interviews would have been interpreted as an insult by the officials. On the first occasion I was unable to avoid the situation as the SDU member only joined me once I was already on the doorstep of the informants' hut; I proceeded to conduct a shortened interview about an unrelated topic in the hope that this would not jeopardise the situation of my informant in any way. On the second occasion in one of the centres in Matala I said that I had changed my mind about the interview and no longer wished to conduct it; thereafter avoiding letting the particular officials know what my movements were. These incidents acutely brought home to me the unwanted negative effects that a researcher can have on the lives of his or her informants and the need to ensure that no harm comes to my informants after I leave the field (Sluka, 1995).

The topic of this study involved conducting many interviews about people's experiences of war¹. This not only had ethical implications but also required negotiating with participants the terrain of emotionally distressing events without leading to further distress while simultaneously maintaining the openness to hear accounts that were highly disturbing to me. I drew on my skills as a counselor and my previous experience of psychosocial work with refugees in letting the interviewee determine the course of the interview, and ensuring that emotional 'containment' had been achieved by the time the interview ended, i.e. that the interview was not terminated while the participant was still distressed. In these situations my priority lay with the emotional well-being of the participant rather than with the collection of information.

The process of reflexivity on the research itself and on the ethical issues involved in working with war-affected populations continues and did not stop on completion of my field work. As Nordstrom and Robben (1995) note, researchers, like those among whom they work, cannot remain removed from the impact of witnessing suffering and tragedy but must struggle with the implications of working in a context where questions about human nature are thrown into dramatic relief. Research in war zones reinforces the need for responsible and engaged work which aims to bear witness to the lives, struggles and victories of the war-affected people themselves.

¹ During the initial phase of research I was reluctant to discuss issues directly related to the war because I was worried that my then insufficient skills in Portuguese would result in me misunderstanding or having to ask people to repeat experiences of a distressing nature, which could lead to further distress. As my knowledge of Portuguese increased this ceased to be a problem.
APPENDIX F:

Statistical analysis of results of the EARAT with adolescents in Lubango and Matala
Frequencies with which each of the 17 symptoms of trauma (sections II - IV of the EARAT) were scored by the adolescents in Lubango and Matala

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<th>Percentage of positive responses</th>
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<td>Item 17</td>
<td>92.2</td>
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Results of the Chi-square test for statistically significant association between the variables of place (Lubango - Matala) and PTSD diagnosis

PLACE * PTSD Crosstabulation

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Chi-Square Tests

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<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>.995</td>
<td>1</td>
<td>.319</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction^a</td>
<td>.608</td>
<td>1</td>
<td>.435</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>.996</td>
<td>1</td>
<td>.318</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td>.387</td>
<td>.218</td>
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<tr>
<td>Linear-by-Linear Association</td>
<td>.985</td>
<td>1</td>
<td>.321</td>
<td></td>
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</tr>
<tr>
<td>N of Valid Cases</td>
<td>102</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Computed only for a 2x2 table
b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.71.

Symmetric Measures

<table>
<thead>
<tr>
<th></th>
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</tr>
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<tr>
<td>Nominal by Phi</td>
<td>-0.99</td>
<td>.319</td>
</tr>
<tr>
<td>Nominal</td>
<td>.099</td>
<td>.319</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>102</td>
<td></td>
</tr>
</tbody>
</table>

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.

There is no significant association between the variables place and PTSD:

\[ \chi^2 = 0.99; \ df = 1; \ p < 0.01 \]
Results of the Chi-square test for statistically significant association between the variables sex and PTSD diagnosis

**SEX * PTSD Crosstabulation**

<table>
<thead>
<tr>
<th></th>
<th>PTSD</th>
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</thead>
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<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td>MALE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>48</td>
<td>20</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
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<td>20.0</td>
<td>68.0</td>
</tr>
<tr>
<td>FEMALE</td>
<td>Count</td>
<td>24</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>24.0</td>
<td>10.0</td>
<td>34.0</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>72</td>
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<td>102</td>
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<tr>
<td></td>
<td>Expected Count</td>
<td>72.0</td>
<td>30.0</td>
<td>102.0</td>
</tr>
</tbody>
</table>

**Chi-Square Tests**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>.000b</td>
<td>1</td>
<td>1.000</td>
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<td></td>
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<tr>
<td>Continuity Correctiona</td>
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<td>1.000</td>
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<tr>
<td>Likelihood Ratio</td>
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<td>1</td>
<td>1.000</td>
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<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
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<td></td>
<td>1.000</td>
<td></td>
<td>.595</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>.000</td>
<td>1</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>102</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Computed only for a 2x2 table
b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.00.

**Symmetric Measures**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Phi</td>
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<td>.000</td>
</tr>
<tr>
<td>Nominal Cramer's V</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>102</td>
<td></td>
</tr>
</tbody>
</table>

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.

There is no significant association between the variables sex and PTSD:

\[ \chi^2 = 0; \text{ df } = 1; \ p < 0.01 \]
References


Ramphel, M. A. (1997). Adolescents and violence: “Adults are cruel, they just beat, beat, beat”. *Social Science and Medicine, 43* (8), 1189-1197.


