



TRAUMA AND MENTAL HEALTH IN ZIMBABWE

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Preamble

The following document represents the thinking of many people over many years, and the writing of a few. Inevitably it is something of a patchwork: a composite that does not always sit together well or comprehensibly. Nonetheless we believe it can make a substantial contribution to the urgent needs of addressing trauma and beginning healing in our suffering nation. We urge our readers to see it as a starting point for conversations, thinking and action.

The paper was originally put together to stimulate and deepen discussion at the workshop on healing held at Mandel Centre, Harare in July 2011 and should be read in conjunction with the workshop report where the experience and ideas of participants are recorded.

Executive Summary

This paper falls into three sections.

The first section provides a brief overview of organised violence and torture in Zimbabwe, mainly drawing on statistics from the 2001-2009 period, but in some cases going back further, Figures showing the kinds of abuse inflicted and its frequency provide evidence of the extent to which Zimbabweans have suffered during this period of complex emergency, when the infrastructure of the country has collapsed around them. Further surveys are presented to support the argument that damage to the psychological well-being of the population is likely to be one of the most serious and long-lasting effects of the ongoing crisis. Information gathered from war veterans underlines the persistent impact of unresolved trauma after the liberation war and figures relating to the gukurahundi, to elections and to Operation Murambatsvina show how specific events have increased the level of mental suffering. Furthermore, the effects of organized violence and torture in Zimbabwe must be contextualized within the global HIV epidemic (of which Zimbabwe is an epicentre) and the social effects of economic decline and mass impoverishment.

It is also argued that attention must be paid to the psychological well-being of those who have suffered indirectly, particularly women and children, as research suggests that the impact of violence and torture extends beyond those directly victimised. A second category of 'indirect' sufferers includes the impact of these forms of suffering on mental health professionals and human rights workers.

The effect of organised violence and torture on the social fabric of communities and the disempowerment which results both from individual suffering and from the fragmentation of relationships and systems which might have provided support or offered resistance is acknowledged as another important area for attention.

The second section "Developing a response: learning from experience elsewhere" presents in brief the shifts in thinking in this field which have occurred over the last two decades as a result of experience in post-conflict situations round the world. The arguments of practitioners who realised that a narrow focus on PTSD and trauma, as defined in western psychology, was inadequate in the contexts in which they found themselves working, are summarised, and the case made for a wider psychosocial approach, which focuses on communities and the social fabric. Following from this, the need to make close links between development, peace-building and healing work is identified.

The IASC guidelines, which provide a very useful framework for considering the mental health needs of different sections of the population in a situation of complex emergency, and helpful criteria for intervention, are introduced.

Some general suggestions as to the way forward are included but reference should be made to the report of the Dialogue and Exchange Programme held at the Mandel Centre from July 27th to 29th, 2011 where the ideas and action plans of participants are recorded and explained.

Trauma and Complex Emergencies

The term "complex emergency" is increasingly being used to describe situations of disaster, frequently political in origin and process, which result in the massive destabilization of a state's capacity to care for its citizensⁱ. As Richard Mollica and his associates have put this, "*A complex emergency is a social catastrophe marked by the destruction of the affected population's political, economic, socio-cultural, and health care infrastructures*"ⁱⁱ: no better description could characterize Zimbabwe today.

Now complex emergencies can quite clearly occur as a consequence of natural events, as in the recent tsunami in Japan or the effects of Hurricane Katrina on New Orleans, but they can also occur as a consequence of human intervention, what may be termed "*organized violence and torture*". A distinction should therefore be made between accidental harm causing trauma, as in natural disasters, and deliberate infliction of harm as is seen in wars, civil wars, low intensity conflict, genocide, and widespread political repression. However the distinction is a conceptual one. In the case of Zimbabwe, human intervention, in the form of organized violence and torture, occurs alongside the natural complex emergency, in the form of the HIV epidemic and its associated mass deaths and cumulative, complex grief.

It is now evident that organised violence and torture [OVT] is a very significant cause of morbidity, with one study arguing that OVT may have affected as much as one billion people in recent decadesⁱⁱⁱ. In the case of Zimbabwe, we do not have clear figures for the numbers of people affected, directly or indirectly, by violence and torture. The true scale of the problem will not be known until an enabling political and legal infrastructure is in place to facilitate the research needed to generate accurate figures. The most obvious effects are physical, seen in illnesses and injuries, which may be short-lived, but also may lead to long-term disability. However, the most persistent consequences will be psychological, and especially if the trauma was deliberately inflicted, as in torture, for example^{iv}. The most probable long-term consequence of experiencing organized violence and torture is development of a psychological disorder. It should also be clear that this is not a necessary connection (exposure to violence does not always equal psychological disorder), and people affected by complex emergencies involving mass violence are also frequently more resilient than is conventionally assumed. We should also note that cross cultural research has long known that psychological injury and distress is most likely to manifest in somatic symptoms.^v

, The probability of psychological disorder increases with the number of exposures to trauma such as organized violence and torture. Whilst men are probably the most common primary victims of OVT, women and children are disproportionately the most common secondary victims, and certainly secondary victims are much more common than primary victims.

The comment should also be made that it is well-established that psychological disorder due to violence can be caused by physical injury or torture, but equally that mere psychological exposure, as in witnessing violence, or even living in situations of very common physical violence, such as a war can also cause psychological disorder. It is now clear that exposure to Potentially Traumatic Events [PTE's] results in increased probability of depression^{vi}, so we would do well not to focus exclusively on the physical consequences of OVT, and the primary victims, but pay careful attention to the secondary victims, and especially women and children.

It should also be pointed out that the clinical/medical language used in the reporting of research evidence included in the first section of this report which indicates high levels of "common mental disorders" and "psychological distress" should not mislead us into thinking that the responses needed are all, or even primarily, in the realm of psychology or therapy. Seen through a different lense, the responses to questionnaires used demonstrate a high level of distress, which could be described as normal given the abnormality of the ongoing situation in Zimbabwe. There clearly are people who need individual treatment and provision has to be made for this through development of mental health services within the existing health system. At the same time, it is argued here that healing interventions of quite a different kind, focusing on communities and the social/political context, will constitute the majority of the work that needs to be done. Furthermore it is also well established

that, outside of the global north, both individuals and communities appear to favour spiritual, religious and ritual interventions for healing.

Organised violence and torture in Zimbabwe: a brief overview

Organised violence and torture has been documented in all the last three decades of Zimbabwe's history, as was indicated earlier.^{vii} One study showed that 1 adult in 10 over the age of 30 years reported torture and was suffering from a clinically significant psychological disorder as a consequence,^{viii} and high rates of torture and consequent psychological disorder were found in a study of former guerrilla soldiers from the Liberation War of the 1970s.^{ix}

Even higher rates of torture and its sequelae were found in studies of the Gukurahundi period of the 1980s in Matabeleland.^x Here it was found that more than 80% of the sample reported torture, and the prevalence rate for consequent psychological disorder was 50% of all adults over 18 years.

Subsequently, there was a long period – from 1987 to 1998 – where there were little or no gross human rights violations reported. However, organized violence, torture, and intimidation were seen during the periods leading up to important political events such as elections. There is a strong correlation between reports on the patterns of violence in Zimbabwe and the lead up to elections. In June 2000, parliamentary elections were held and the period leading to the elections was marred by physical violence, political intimidation by the government sponsored war veterans against anyone who was perceived to be the opposition; despite these drawbacks the MDC won nearly half the seats in parliament.^{xi} Since the 2002 Presidential election, there has been no appreciable improvement in the human rights climate, and therefore no possibilities for either research or healing in regard to psychological trauma generated by Zimbabwe's recurrent bouts of severe and widespread violence and torture. During the period from July 2001 to April 2008, the Human Rights Forum reported 4,662 allegations of torture. The Human Rights Forum, during this period, recorded 35,574 violations. There has been a steady increase in violations during 2006 and 2007, with it being apparent that 2008 may well be the worst year for human rights violations, and possibly torture too, since 2000 [see Table 1 below].

Table 1

Consolidated statistics [numbers of violations reported] per year: July 2001 to June 2009

[Source: Monthly Political Violence Reports of the Human Rights Forum]

	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total:
Abduction	116	223	52	62	18	11	19	137	16	654
Arrest	670	274	627	389	1286	2611	2766	922	480	10025
Assault	0	86	388	401	530	486	865	1914	60	4730
Attempted murder	0	2	10	8	1	3	0	8	5	37
Death threats	0	12	80	35	9	7	7	51	2	203
Disappearance	0	28	4	0	0	0	0	19	0	51
Displacement	0	11	208	189	609	55	6	629	2	1709
Freedom of expression, etc	12	39	809	760	1036	1866	3500	2532	203	10757
Murder	34	61	10	3	4	2	3	107	1	225
Political intimidation	194	388	450	514	476	288	980	2787	282	6359
Property violation	356	807	153	132	61	55	16	396	35	2011
Rape	0	7	6	3	4	1	0	6	0	27
Torture	903	1172	497	160	136	366	603	723	6	4566
School closure	0	45	1	0	0	0	0	26	2	74
Total:	2285	3155	3295	2656	4170	5751	8765	10257	1094	41428

These figures are an under-estimate by an unknown order of magnitude, and an accurate assessment of the likely need can only come from a community-based study (which is not possible under current political and legal conditions), but some inferences can be drawn, and what seems evident is that

there are likely to be very large numbers of survivors requiring medical and psychological assistance, and particularly psychological assistance¹.

What is also evident from the data collected by the Human Rights Forum (and amply supported by other reports and studies) is that all violations since 2000 increase dramatically during election periods. For example, if the data from the Human Rights Forum monthly reports is separated according to whether the month in question occurred during the three months of an election, then there is a very strong statistically significant difference between election and non-election months [see Table 2 below].

Table 2: Differences in the average monthly frequency of violations, July 2001 to June 2009.

Source: Monthly Political Violence Reports of the Human rights Forum

	No election [n=71]	Election month [n=25]
Abduction	5.1	36.3**
Arrest & detention	214.4	177.5
Assault	61.7	192.9**
Attempted murder	0.5	1.4*
Death threat	1.9	10.5**
Disappearance	0.6	2.4
Displacement	23.9	65.2
Freedoms	219.4	220.2
Murder	1.8	12.5**
Political discrimination	92.2	248.0**
Property related	25.1	86.2**
Rape	0.3	1.4*
Torture	47.6	219.5**
School closure	0.2	5.2**

**p=0.01; **p=0.001*

Now, as pointed out above, torture and Potentially Traumatic Events [PTE's] have different, but not trivial, long-term psychological consequences, and it is to these consequences, as they have been studied in Zimbabwe, that we next turn.

The Prevalence of trauma disorders in Zimbabwe

Whilst there are very few good epidemiological studies of the incidence or prevalence of disorders due to trauma in Zimbabwe, there are a number of studies that are helpful in understanding the likely picture. These studies suggest that there are a number of periods in which trauma has occurred as a

¹ The very low rate of rape deserves some comment. Since rape victims are notoriously reluctant to report, and victims of political rape even more so, the figure from the Forum is clearly a gross underestimate. For a more nuanced understanding of political rape, see RAU (2010), *No Hiding Place. Politically Motivated Rape of Women in Zimbabwe*. Report prepared by the Research and Advocacy Unit (RAU) and the Zimbabwe Association of Doctors for Human Rights (ZADHR). December 2010. HARARE: RESEARCH & ADVOCACY UNIT; RAU (2011), *Politically Motivated Rape in Zimbabwe*. Report produced for the Women's Programme of the Research and Advocacy Unit. May 2011. HARARE:RESEARCH & ADVOCACY UNIT.

result of mass violence. This has occurred against the background of already existing mental health problems, most usually termed "common mental disorders" [CMD]. It is important to see the potential burden of disorders due to OVT within the context of the general psychological morbidity, for estimates of general morbidity will generally include disorders due to trauma. It is also important when it is realised that Unipolar Depressive Disorders are now one of the most common causes of non-communicable morbidity in Africa [Table 3 over].

Table 3: Rank order frequency of non-communicable causes of psychiatric morbidity, Africa compared to the World.

Source: WHO. The Global Burden of Disease.2008

Cause	WORLD	AFRICA
Alcohol use disorders	6	12
Migraine	15	4
Insomnia (primary)	14	16
Alzheimer and other dementias	7	25
Unipolar depressive disorders	2	3
Post-traumatic stress disorder	11	17
Bipolar affective disorder	3	15
Schizophrenia	4	19
Obsessive-compulsive disorder	12	10
Panic disorder	13	14
Drug use disorders	9	26

There is one comment to be made about these statistics in the light of what is known about social contexts of mass violence, particularly in certain parts of Africa, and this is the contrast between the frequency of Unipolar Depressive Disorders and Post-traumatic Stress Disorders [PTSD]: given the frequency of war and low-intensity conflict in parts of Africa in recent decades, it seems improbable that PTSD would be so less common than Unipolar Depressive Disorders, but, once the notion of Depression being a consequence of PTE's is accepted, then this difference is more readily understood. And, furthermore, outside of psychiatric clinics and care by mental health care professionals, it is probable that both Unipolar Depressive Disorders and PTSD would be more generally covered under the rubric of Common Mental Disorders [CMD]. And it should be remembered here that the rates for co-morbidity between depression and PTSD are very high, with the caveat noted from the research mentioned earlier that torture and PTEs can co-exist as well.

The general mental health picture that obtains in Zimbabwe indicates that CMD have been increasing in Zimbabwe over the past three decades. These are summarised in Table 4 [over].

The first epidemiological studies indicated a picture that is largely similar to that obtaining in western countries as well as in African countries, with prevalence rates of roughly between 20 to 30%. Some rates were higher, but generally the pattern was similar to that seen in many parts of Africa.^{xii} However, it appears that the rates have shifted upwards in a dramatic fashion in recent years, as seen in a recent unpublished community survey in Harare, which showed a prevalence rate of nearly 40%. There was also a marked shift in the risk factors associated with CMD, with experience of violence increasing risk significantly, and most startling the association with having goods confiscated, which increased the risk by 14 times. Thus, it would appear that not only has the deteriorating socio-economic environment had a deleterious effect on the mental health of Zimbabweans, but also that the increased levels of violence have been having an effect. More than a decade of HIV related illness and mortality is also highly likely to have had a major impact on levels of psychological morbidity, in the form of multiple, cumulative bereavements. Here we refer to unpublished and therefore non peer reviewed studies which may weaken the strength of the evidence. However such studies still provide useful approximations of Zimbabwean realities. It is unlikely that formal studies that are published and peer reviewed will become available until

Zimbabwe has the legal, political and social structures that would allow such work without endangering victims (individuals or communities) or researchers.

There is good understanding of the health consequences of organized violence in Zimbabwe. The morbidity due to the Liberation War has been best documented to date, and the most reliable study indicated a likely prevalence of trauma sufferers of approximately 1 adult in 10 over the age of 30 years in 1997. The Government has not provided any national programme of specialized medical or psychological assistance for these victims, although war veterans have been beneficiaries on a number of occasions of financial compensation. Morbidity due to the Gukurahundi has also received some attention, although remarkably little given the genocidal nature of the events associated with Gukurahundi. This lack of attention has itself resulted in a widespread belief in south western Zimbabwe (among both populations and professionals) of systematic denial. One small study, in Gwanda district, indicated that 5 adults in 10 over the age of 18 years were suffering from significant psychological disorders, with over 90% of the sample reporting an experience with organized violence and torture^{xiii}. The majority of these experiences dated from the 1980s rather than the Liberation War. In general, the events of Gukurahundi and their social and psychological sequelae are a very clear example of social denial and the silencing of suffering despite at least one group's remarkable and innovative attempts at community level healing.^{xiv}

There is no good estimate of the morbidity due to the violence occasioned by the Food Riots in 1998. At the time the Zimbabwe Republic Police estimated that over 3,000 persons had been arrested, and the Human Rights Forum was able to obtain data on 1,431 cases of persons that had been arrested. Only 44 persons eventually elected to report to the Human Rights Forum, but 36% were diagnosed as having clinically significant psychological disorders. It is clearly inappropriate to extrapolate from such a small sample, but it is probable that the numbers affected were significant^{xv}. The very low number of victims who chose to report to the Human Rights Forum speaks directly to widespread public suspicion of the impartiality of the police and other legal bodies.

Finally, there has been a virtual epidemic of organized violence and torture since February 2000, as seen in Table 1 above, and this is attested to by the vast outpouring of reports since that time. Very few studies have been done on the effects on victims, and certainly no reliable epidemiological studies. There are two indicative studies, however. The first, examining internally-displaced workers from the commercial farms demonstrated that 85% of the sample was suffering clinically significant psychological disorders^{xvi}, whilst the second, a "snap survey" of Zimbabwean refugees in Johannesburg, Gauteng, indicated a point prevalence rate of 14% in the sample^{xvii}.

These latter two studies are important for the purposes of understanding the effects of *Operation Murambatsvina* since they examine populations of displaced persons. Estimates of psychological disorders due to trauma are much higher amongst refugees or internally displaced persons than they are in the general population, as they are in specific populations such as those living in complex emergencies such as civil wars, or low intensity conflicts. In 2005, in the aftermath of Operation Murambatsvina, ActionAid International conducted a community survey,^{xviii} and this indicated the following:

The major finding was an extremely high rate of clinically significant psychological disorder in the sample. 69% of the sample had scores in the clinically significant range, which indicates a probable population needing psychological assistance of about 820,000 persons. The prevalence was higher in the HIV/AIDS group [75%].

It was also evident in the ActionAid study that women were considerably more vulnerable than men, with older women-headed households and single women-headed households the most vulnerable. Clearly, unaccompanied children and child-headed households are likely to be the most vulnerable. Additionally, there is considerable evidence that children are very common witnesses to the OVT that has taken place since 2000, and the many reports of violence within rural communities indicate this.

Table 3
Zimbabwean studies of the prevalence of CMD and Trauma

Source: Reeler, 2009

Study	Sample	Instrument	% prevalence
Community mental health:			
Williams & Hall [1987] ^{xxix}	District Hospitals	SRQ-20	11%-37%
Reeler, Williams & Todd [1991] ^{xxx}	Primary care clinics	SRQ-20	24%-28%
Community survey [2006. unpublished] ^{xxxi}	Primary care clinics	SSQ	39%
Trauma samples:			
Amani Trust [1996] ^{xxxi}	War veterans	SRQ-20	73%
Amani Trust [1997] ^{xxxii}	Community survivors	SRQ-20	13%
Reeler et al [1998] ^{xxxiii}	Primary care clinics	SRQ-20	51%
Human Rights Forum [1998] ^{xxxiv}	Food riots victims	SRQ-8	36%
Amani Trust [2002] ^{xxxv}	Commercial farm workers	SRQ-8	81%
Action Aid International [2005] ^{xxxvi}	Victims of Operation Murambatsvina	SRQ-8	69%
Idasa [2006] ^{xxxvii}	Zimbabwe refugees in South Africa [street survey]	SRQ-8	47%
ZTVP [2007] ^{xxxviii}	Women refugees in South Africa [clinic attendees]	SRQ-8	71%
SACST [2008] ^{xxxix}	Zimbabwe refugees in South Africa [multiple sites]	SRQ-8	49.5%
WOZA women [2007] ^{xxxix}	WOZA members	HTQ	53%

Finally, the unpublished study on the prevalence of Common Mental Disorders [CMD] in Harare demonstrated that the risks for developing a CMD increased significantly with the number of occasions a person experienced violence, with the startling finding that the risk increased 14 times with having one's property confiscated. This last would seem to reflect one of the consequences of Operation Murambatsvina.

There is a methodological point here. Whilst the Self-Reporting Questionnaires (SRQ-20m and SRQ-8) and the Shona Symptom Questionnaire (SSQ) have been widely used in Zimbabwe in trauma studies these are instruments developed for screening for psychological disorder, and are not instruments developed specifically for the study of trauma disorders, or for complex grief reactions. There is a clear need for a new generation of locally validated instruments capable of both detecting disorders due to trauma, as well as providing information about functionality, resilience, and protective factors. But, problems of method aside, it seems evident that there are significant numbers of Zimbabweans affected by the violence and Potentially Traumatic Events [PTEs] that have afflicted Zimbabwe over the past century, and this requires that we pay more attention to the effects of the complex emergencies than we have done to date. When considering responses to these statistics, it is also important to remember, as indicated earlier, that they are as much a measure of increasing social and political disorder as they are of individual pathology; arguably the increasing levels of distress recorded by Action Aid, for example, are a very normal reaction to a worsening context.

Furthermore, in addition to the urgent need for rigorous methodological, quantitative studies of psychological suffering as a consequence both of organized violence and HIV related mass death, there is an equal need for those forms of treatment and/or healing most favoured within a range of different sections of Zimbabwe's multicultural society. This raises a second, crucial methodological point: namely the need for rigorous qualitative studies that, through close attention to language and narration, can clarify the individual, social and cultural constructs through which victims ascribe specific meanings to their experiences of organized violence and torture, as well as their experiences of the symptoms they suffer as a consequence.^{xxxii} There has been regrettably little research work in such modes in Zimbabwe.^{xxxiii}

Nature of trauma disorders in Zimbabwe

Whilst the extent of trauma due to OVT and PTE's may not be clearly understood, there is some evidence about the nature of such disorders. The most detailed work has been done on the survivors of the Liberation War, but it has been possible to contrast this group – of chronic survivors – with the survivors of the more recent violence. The rationale here is that there has been little direct assistance to any of the groups of trauma survivors from any of the conflicts that have afflicted Zimbabwe, and hence there must a large population of untreated survivors with chronic disorders.

An unpublished report contrasted survivors from the survivors from the 1970s with those from the period 2000 to 2002^{xxxiv}. This was a sample of 998 in total, with 402 from the 1970s and 586 from the period 2000 to 2002, and 70% were male.

The survivors overall report many symptoms, both physical and psychological. They report more physical than psychological symptoms (as we would expect from recent work in cross cultural psychology and psychiatry), and some will have so many symptoms than they could be classified as somatoform disorders, Which contemporary cross cultural psychology would predict.^{xxxv} 46% reported one kind of problem with sleep or the other. A little more than a third of the sample [34.9%] reported scores on the SRQ-8 that were in the clinically significant range.

When the data was classified according to time period, then a number of differences emerged between the 1970s and post-2000. The 1970s group reported significantly higher rates of Impact torture, as well as many more types of torture overall, as well as there being a much greater probability of a survivor's abuse being witnessed in the 1970s. However, there are much higher rates of detention taking place in the current time period. The SRQ-8 was significantly higher in the 1970s group, which suggests that chronicity may be operating here. Reported sleep problems were more common in the 2000-2002 group.

Detention was again, as in other studies, significantly related to a number of factors. Only 107 [11.1%] reported being detained, but the detained group reported high rates of most types of torture, with Impact torture and the overall number of different torture types strongly significant. Once again, detention was significantly associated with worse torture, and there were some unexpected differences in the health consequences for the two groups: those not detained were more likely to score high on the SRQ-8, as well as more frequently reporting sleep disorder.

The one strong finding from this study was that the 1970s group were more likely to have both higher SRQ-8 scores and report more serious torture. However, when torture was used as the independent variable, this did not distinguish the groups in terms of the SRQ-8 score. Thus, it seems safe to conclude that the probability of acquiring a clinically significant psychological disorder increases as a function of the time between the original ill-treatment and the time of assistance rather than being a function of ill-treatment itself. It is also significant that there were a significantly larger number of cases of psychological disorder in the 1970s group. Thus, the long-term prognosis for survivors of torture is generally not good, and this replicates the general findings elsewhere. It should also be noted that trauma is rarely a single event, but can be ongoing in various ways, as has been noted previously^{xxxvi}. In particular, such forms of complex trauma reactions are likely to be very closely imbricated with the consequences of complex and cumulative HIV related bereavement.

Physical disability

One of the obvious consequences of physical, or Impact torture, is the possibility of physical injury and consequent disability, especially where the physical injury is not treated or treatment is significantly delayed.

Psychological impairment

The conventional finding is that OVT causes PTSD, crudely expressed, and this is supported by a very large literature, but has not been extensively researched in Zimbabwe. It is clear, as was shown in Table 3 that most studies show psychological disorder, with varying rates. We are not, however,

looking at a simple causal relationship between conflict, violence and mental health, as many practitioners in Africa have observed.^{xxxvii} Where mental health records are available for consultation, as in Northern Ireland for example, the psychological effect of prolonged conflict is not clear. Reactions to violence and torture are deeply intertwined with the meaning which people give to what has happened, with cultural and spiritual beliefs and with the ongoing context.

An early series of studies gives some understanding of the morbid profile. In a study of former freedom fighters, it was found that the diagnostic breakdown did not strongly support the view that PTSD was the common form of psychological morbidity. There were strong similarities between the pattern observed in combatant and non-combatant survivors.

Table 4: Diagnoses given to Mount Darwin Community survivors: Comparison with Zimbabwe War Veterans.

	PTSD	Anxiety	Depression	Mixed Emotional Disorder	Somatoform Disorder
Mashonaland Central [n=179]	24%	1%	21%	32%	21%
War Veterans [n=53]	28%	4%	12%	33%	24%

It is worth pointing out, in the light of the more recent research cited above, that both Depression and PTSD were frequent diagnoses, but also it is important to understand that the equally high rates of Mixed Emotional Disorder (or what would be termed Common Mental Disorder in more recent terminology) and Somatoform Disorder. It is probable that a more carefully designed study would provide a different typology, but it also the case that Common Mental Disorders [CMD] have been found to be a substantial category of psychological disorder in primary care settings, and also that multiple symptoms are a very common presenting profile of persons with psychological disorder Zimbabwe. It is also worth pointing out that previous work on torture survivors in Zimbabwe suggested that the multiple symptom presentation seemed to cover both physical symptoms from pain due to chronic injury – back ache, for example - as well as the more common symptoms associated with psychological disorder – headache, stomach pains, etc.^{xxxviii}

There have been few clinical studies of character of psychological disorders due to OVT or PTE's. One qualitative study outlined the interactions between the psychological distress and the social disempowerment suffered by the survivors attending for psychotherapy.^{xxxix} Amongst the men there was significant guilt at failing to protect themselves and their families, exacerbated by the impoverishment due to displacement that frequently accompanied the violence. And, furthermore, it was evident that the suffering was not merely individual or familial, but had profound consequences for the communities in which the violence had taken place, and for the forms of healing deemed most helpful by sufferers (typically spiritual). This is the destruction of "social capital" indicated by Mollica and others that is a common feature of complex emergencies.

Thus, there is a pressing need for good research into the nature of disorders due to trauma in Zimbabwe, of individuals, families, and communities, And there is equally a pressing need to examine critically the varied approaches to treatment that have been and are currently in use. This needs to include, as already indicated, both a broader assessment to include functionality, resilience and protective factors, a locally validated PTSD assessment tool, and indicators to help identify how villages and communities have been affected by events. With more focused assessment tools and a deeper understanding of the nature of trauma in Zimbabwe, it should be possible to build constructively on the extensive work done by the Amani Trust to research the effects of individual clinical work in primary care. As rising levels of distress can often be clearly linked to the deteriorating context, research is also needed to develop understanding of the kinds of social and community initiatives, and ways of working, including use of existing traditions and beliefs, which can be shown to result in improved psychological well-being.

Community consequences

Gross human rights violations, especially when they are part of a discriminatory political system such as apartheid, have profound and widespread effects beyond the narrow effects of torture. This was clearly part of the aim of the Truth and Reconciliation Commission: to describe the broad effects of apartheid. In studies in Zimbabwe, work with survivors of gross human rights violations such as torture clearly indicated that the survivors were suffering from a wider range of handicaps than merely the medical or psychological, and a number of studies were carried out to examine these additional areas of suffering. The findings from the most reliable of these studies are briefly reported below^{xi}. Survivors and their families were compared with their nearest neighbours in a detailed interview study.

Firstly, there were a number of differences in social and economic factors between the survivors and their neighbours, such as greater illiteracy, higher unemployment, spending more money on health care, greater potential indebtedness, poorer housing, and many other factors indicative of chronic poverty.

Secondly, the survivors showed many signs of having less self-esteem and greater apathy than their neighbours:

More likely to see war as a reason for poverty;

Less optimistic that the situation can be changed;

In need of humanitarian assistance. There is a substantial anthropological literature on the engagement between victimized individuals and communities and sources of material aid. It has been pointed out in more than a few well studied cases that the demand for practical help (and the eager and acquisitive engagement with sources of financial aid) is itself a sign of trauma, healing and empowerment in local communities.^{xli}

The first group of differences represents real and substantial differences in the social and economic well-being of the two groups. The survivors were markedly less well-off than their neighbours in many areas, and it seems fair to conclude that survivors had greater social adversity than other groups in the same community. This is probably not surprising, and would be found for other disabled populations. However, it does mean that survivors are more vulnerable to ongoing stresses, which will in turn exacerbate their medical and psychological problems. It is noteworthy that this was exactly the interpretation that was given by the survivors themselves, and it was indeed their preoccupation with the practical problems of their lives that originally alerted workers to the significance of social adversity. This is likely to have even greater effects for the current population of survivors, where the overall socio-economic climate is considerably worse than it was in the mid-1990s. It should be noted here that there are many critics of an overly medical approach to dealing with torture and PTEs, viewing the problem in more holistic terms.^{xlii} Even within medical paradigms the concept of trauma as pathology has come under serious criticism, particularly from medical history and anthropology.^{xliii}

The second group of findings speaks to the psychological consequences of OVT and the social adversity. The survivors had low self-efficacy, and this seemed due in part to the original violence and in part to the failure to overcome the social adversity. It is endlessly demonstrated by studies on individuals that OVT creates powerlessness and a lack of self-efficacy, and many commentators point out that this is replicated in the social and political arena. These findings speak to the heart of this problem: survivor's trauma results in feelings and beliefs of powerlessness, which can make them perform less well in the many tasks of life, and the failure compounds and reinforces the lack of self-efficacy. It takes little imagination to see how this then translates into community, social and political apathy, and provides severe problems for the development of rural areas and also of poor urban communities.

Developing a Response: learning from experience elsewhere.

Each country and community which has experienced prolonged and serious conflict, political violence and torture has its own needs, cultural factors and particular contextual features which need to be considered when healing and re-building are discussed and planned^{xliv}, and Zimbabwe is no different. At national, community, family and individual levels, people will need to work out the ways forward which are appropriate to them and to draw on their own traditions and ways of doing things. There is also, useful experience and learning from elsewhere: Zimbabwe does not need to re-invent the wheel when it comes to work for healing and re-building communities but can work towards its own processes for dealing with what has happened, drawing on a wealth of experience from other post-conflict societies.

During the last decades of the 20th century and the first decade of the 21st, peace-builders, development workers, psychologists, psychiatrists and mental health practitioners have been involved with communities and organisations in countries across the world, working with them to support their efforts to heal the wounds of violent conflict and torture, and to move forward to transform their lives. International work on healing and regeneration in post conflict societies is a prime example of a movement away from narrow disciplinary modes of study and models of healing. The interdisciplinary work of social scientists (particularly in anthropology and psychology) is exemplified in recent work.^{xlv} Zimbabwe also needs such approaches and the structures required to help initiate and sustain interdisciplinary work in these areas.

In the field of mental health, inevitably many international staff involved in such work brought with them frameworks and ideas based in their own training and cultures and sought to use these in planning interventions in post-conflict societies in Africa, Asia and South America, and after the Balkans conflict. This led early on to the use of the trauma "lense" by psychologists and psychiatrists trying to understand how people had been affected by what had happened, with a resulting focus on individual trauma, on the diagnosis of post-traumatic stress disorder (PTSD) and an interpretation of symptoms and reactions based in Western mental health practice and thinking. There is no doubt that the use of PTSD screening tools will reveal high levels of people in post-conflict situations suffering from its specific symptoms^{xlvi}, as well as high levels of depression and anxiety. As many practitioners began to realise, however, symptoms do not have universal meaning^{xlvii} and may well not have the same significance and priority in people's lives as they would in more affluent societies. The focus on PTSD and trauma led, in many cases, to the direction of efforts towards one-to-one counselling and individual support, within a medical framework, as use of the trauma discourse somehow carries with it the implication that there will be a medical/psychological cure which can be made available. The focus on psychological treatment for people's distress can deflect attention away from the social/political factors which are also likely to contribute to how people are feeling about their lives and experiencing events.

This is not to say, however, that PTSD is a diagnosis which cannot usefully be used, when appropriate, in non-western cultures; there is increasing neurological and clinical evidence for the universal effect of serious and life-threatening events on the human brain and body, and understanding of how PTSD symptoms are caused and can be treated. It would be a mistake to deny treatment to those whose lives are likely to be seriously disrupted by PTSD type symptoms, or other mental health problems, just as it is a mistake to foreground psychiatric diagnosis too much. Although every culture has its own frameworks and understanding of mental health^{xlviii}, these are not static; the exchange and mutual learning which is taking place across countries and cultures has blurred boundaries and opened the door to creative new thinking which blends "traditional" and western approaches. In addition, the use of PTSD diagnoses in conflict societies clearly has the power to generate western sympathies and sources of financial and political aid.^{xlix}

The word "trauma" itself has acquired such wide usage as to make it almost meaningless, as it is now used to cover the whole range of human suffering from bereavement, sadness, and distress through to the experience of extreme violence, unexpected disaster and loss inflicted by others. Its generalised usage masks the need for a wide range of different responses: the woman who has been raped by a gang of youths from her own community has different needs to the young male activist who was abducted and tortured by strangers; those who have suffered from ongoing divisions and

insecurity within their own community ,in a context of deeply entrenched structural violence, have a very different experience to those who have been attacked suddenly and violently by another community or grouping. An approach which emphasises individual responses possibly turns attention away from the way in which the social fabric of whole communities is torn apart by conflict and vital relationships and support networks are damaged, and, in some cases, may try to maintain a neutrality which does not fit with deeply divided political contexts where human rights are still being abused. If guided by the identification of PTSD associated symptoms, such an approach also risks overlooking resilience and the ways people are in fact coping and possibly developing as they overcome the effects of what has happenedⁱ, as well as diminishing both their innate capacity for self-healingⁱⁱ and the importance of different ways in which they continue to carry the painful burden of what has happened (for example, feelings of bitterness and desire for revenge because of continued injustice, on-going poverty, and dislocation because of displacement or persecution, intergenerational trauma, etc).ⁱⁱⁱ

In cultures where individual well-being is profoundly linked to being in good relationship with others, and to their well-being, the importance of interpersonal work within families and communities and of bringing people together to share experiences and draw on their spiritual and cultural traditions to help them face what has happened, is easily overlooked. For an influential account of such a society (in Sri Lanka) see Daniel's 1996 contributions to our understanding of 'the work of culture' in response to chronic social conflict and widespread psychological trauma. Crucially, in the face of huge numbers of people affected by political violence, frequently in the poorest parts of the world, a response based on an individualised approach is unsustainable and the expertise needed to deal with severe PTSD symptomology (or other psychiatric disorders) in very scarce supply. There is no quick fix for the suffering resulting from violent conflict and torture, and the effect of importing counsellors/psychologists/mental health practitioners into affected areas for the duration of a project, only for them to leave after a year or two, is potentially extremely destructiveⁱⁱⁱⁱ. A key learning from the last decades of experience across the world is the strong link between psychological well-being and social agency^{iv}; while outside input and help may be needed during a transition period, it is likely to be counter-productive if local control and initiatives sustainable within communities are not supported and developed. It is also highly questionable whether effective (individual, family and community) approaches to healing can be initiated and sustained in the absence of the end of conflict and new legal and political dispensations.

As practitioners identified the problems associated with focusing on PTSD and its diagnosis, new initiatives began to widen their emphasis to include a social dimension with work aimed at healing and reconciliation. A wider array of interventions in post-conflict situations have come under the umbrella of "psycho-social intervention"², some of them still principally trauma-focused, but using group work instead of individual therapy, while others have been almost entirely focused on social initiatives. Critically, the concept of 'psychosocial intervention' is in grave need of theoretical clarification and research evidence. The "psycho-social" umbrella would include, for example, work done in Rwanda and Burundi to help people to come to terms with the genocide and to start the re-building of relationships between the different ethnic groups, group work with survivors of violence in South Africa, work on the re-integration into the community of child soldiers in Northern Uganda, and work with survivors of rape in DRC. These programmes are enormously varied in their purpose and scope, often run by small organisations acting on their own and, for a variety of reasons, they have rarely been subject to rigorous evaluation.

Writers/practitioners such as Hamber and Wessells have categorised programmes in different ways in order to analyse what they can hope to achieve, and it will be important to draw on these analyses when considering the development and expansion of similar community based initiatives in Zimbabwe. At its best, psychosocial work at community level can promote healing and empowerment through holistic work with individuals, and help to transform communities through recreation of relationships, traditions and networks which hold together the social fabric; empowering and transformative psychosocial work will link naturally with development and peace-building programmes because a holistic approach recognises, for example, the importance to psychological well-being of livelihood and a sense of physical safety.

² An umbrella term with widely varying meanings and therefore needing rigorous clarification for the Zimbabwean situation.

Some programmes have been criticised for providing a welcome “band-aid” for victims, but ignoring the wider issues affecting people’s well-being, sometimes promoting a “premature reconciliation” between victim and perpetrator^{iv}, or turning a blind eye to ongoing human rights abuses. Using the TRC in South Africa as an example, Hamber also draws attention to the way in which interventions can inadvertently favour particular ways of dealing with issues (sadness, grief, forgiveness, for example,) while other expressions of emotion (anger, desire for revenge) are less acceptable and therefore pathologised, suppressed, or acted out in other contexts. The consequences of this for peace-building and for mental health are important; it could be argued that Zimbabwe has suffered over a long period from the lack of opportunities for these kinds of emotions to be expressed and dealt with in an appropriate way. Thus, trauma and mental health become political programmes as much as mental health initiatives. In a context such as the Zimbabwean one, with repeated waves of widespread violence and a sustained culture of impunity (and immunity) distinctions between victims and perpetrators themselves may become very blurred. While in the midst of continuing conflict, and in the absence of legal and political structures of acknowledgement and protection (as in the case of Zimbabwe), one primary function of mental health professionals and human rights workers will be the essential role of ‘witness’.^{vi} Bearing witness to suffering and violence is itself a mode of social and psychological healing.

There is a powerful discourse in Zimbabwe around trauma; people feel they are part of a traumatised nation and want their suffering to be acknowledged, with the damage to relationships and the social fabric to be made good. Any initiative will have to allow opportunity for stories to be told and to be inclusive of all those who have suffered and wish to participate, whether or not they have identifiable physical or mental health problems.

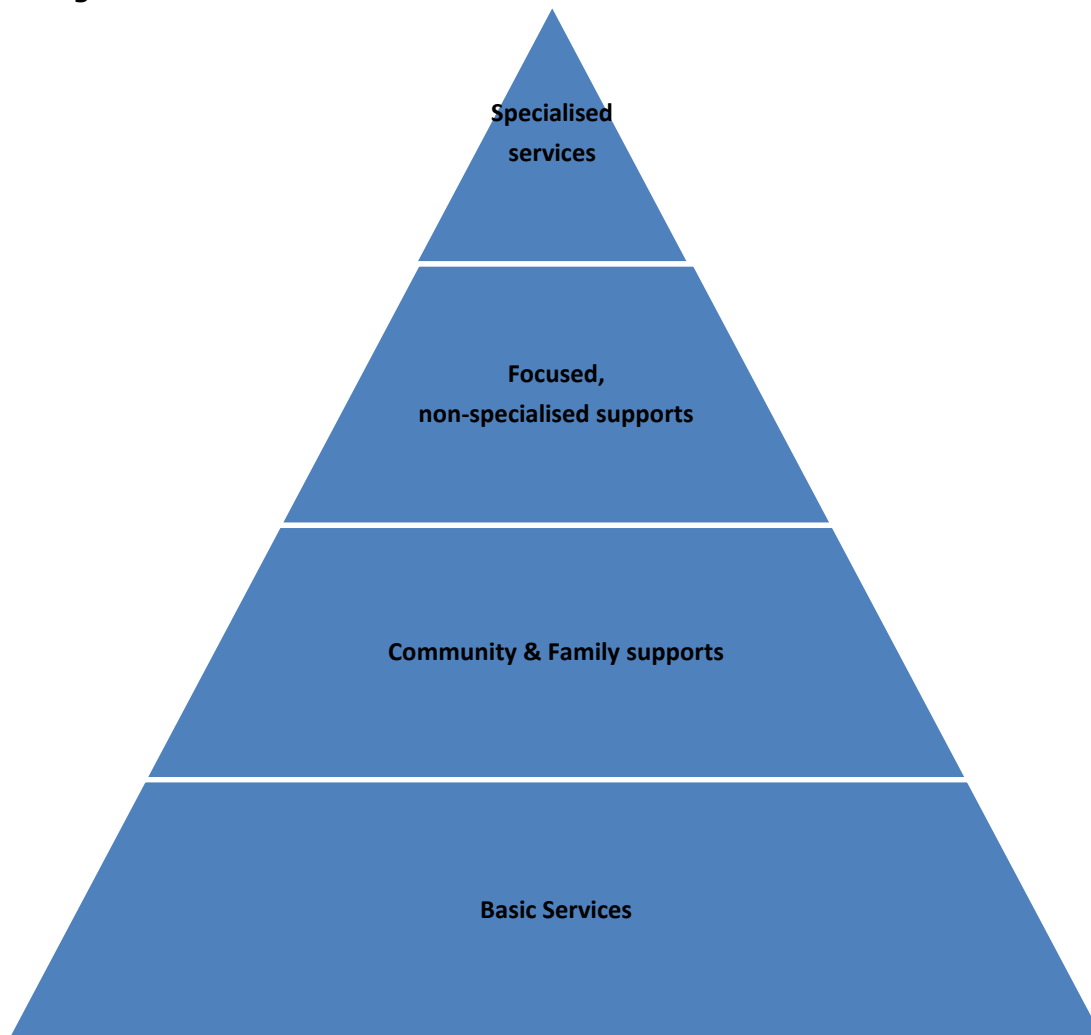
Drawing on wide experience elsewhere in Africa, Wessells argues that a shift of emphasis is needed at community level towards a focus on well-being, bringing trauma work into line with development and peace-building, which both have a positive orientation, and highlighting the overlap and mutual interdependence of these spheres of work. Well-being is related to a range of factors including the long-term stability of the community and the ability of families and individuals to earn a livelihood. Peace will be short-lived if long standing differences are not addressed and ways found of interrupting the cycle of violence within communities and the transfer of issues and beliefs from one generation to the next. Development workers will find that they cannot make progress when people are still pre-occupied and distressed by what has happened to them and divisions within the community are not resolved.

So it becomes very clear that, in post-conflict situations, organisations and workers who often regard themselves as working in distinct domains need in fact to work in close cooperation with each other, understanding each other’s approaches and incorporating thinking from each other’s disciplines into their work so that a holistic way of working develops. However, it will also be important for mental health practitioners to be highly aware that ‘positive’ approaches, while obviously valuable, can easily be unwittingly used to disenfranchise grief, loss and suffering: a process that could have negative mental health consequences itself.

This does not mean that the mental health needs of communities which have suffered from conflict or violence will be entirely met through development and peace-building programmes. It is crucial to identify different needs, to recognise that a wide variety of approaches will be needed, and to work towards the integration of work at different levels.

The guidelines produced by the Inter Agency Standing Committee in 2007 reflect the need to bring together mental health and more general work for psycho-social well-being, which Wessells highlights. Though there has been some criticism of them for under-rating the importance of prompt mental health intervention,^{xvii} they provide an extremely useful framework for planning and organising, including vital “Do No Harm” principles (p.3) and a do and don’t check-list (p.15). Designed for emergencies (situations where services have broken down, people have been displaced and lost their livelihoods either through natural disaster or conflict and war....)- and in some respects the highly politicised and ongoing conflict situation prevailing in Zimbabwe does not completely fit with their designation- they are nevertheless extremely relevant to the ongoing situation found within the country.

Diagram One: IASC Intervention pyramid for mental health and psychosocial support in emergencies.



Using this pyramid to illustrate different levels of need, IASC emphasise that the majority of people, forming the broad base of the pyramid, will move on after conflict and life-threatening events without the need for external help, particularly when some aspects of their lives return to relative normality. This includes the restoration of services, returning to school for children, being able to earn a living again and the resuming of community meetings and church gatherings. Papadopolous, Mollica and others emphasise that we tend to under-estimate people's resilience and capacity to self-heal in the face of events which horrify us and therefore create an expectation of long term psychological damage and trauma. It is also important to note, however, that in Zimbabwe it has often been the case that dislocation of services, displacement and loss of livelihood have been ongoing, because of the economic collapse and continued conflict; many of the victimised have not been able to pick up the threads of their lives, particularly the crucial economic ones. It also seems to be the case that there is an need, at every level, for stories to be told and acknowledged, for relationships to be re-established, and for local systems of justice, where possible, to attempt to right some of the wrongs that have as yet gone unpunished. In Zimbabwe, the role of religious groups and their spiritual rituals and practises can hardly be over emphasized.

At the next level of their pyramid, IASC identify those who will recover with support from their families and communities, and above them, more vulnerable community members (such as elderly people on their own, child headed households, women subjected to sexual assault) who may need additional support, either of a practical or therapeutic nature, or both. It is at this level, as well as on

the levels below in some cases, that counselling and therapeutic group work may well be needed, though practical needs cannot be ignored as well.

The top apex of the pyramid –a very small segment of the whole- is for those who need specialist psychiatric and/or psychological help. This will include those with serious mental health problems which preceded the crisis, who are likely to have suffered severe neglect because of the lack of services, those who have developed chronic mental health problems during the crisis and those who are affected by PTSD or PTSD type symptoms which persist long after the event, and may well relate to on-going stresses rather than to one particular event. While counselling may help with some of the issues surrounding those who are suffering in this way, there is little research evidence for its efficacy in directly addressing conditions such as PTSD.^{xlix} Specialist help (based as far as possible on research evidence) is needed at this level to alleviate symptoms which will be likely to seriously disrupt the ability of sufferers to lead a normal life. It is also important to note that, in Zimbabwe, research indicates that a large number of people may in fact fall within this top segment of the pyramid (see Table 3), though further research is needed to clarify their needs and look at the responses that may be helpful. Relatedly, Zimbabwean mental health professionals need to begin collaborative work to clarify what forms of intervention (specialised psychotherapy, pharmacology, etc) could be most effective and how such skills can be made available to sufferers in this category.

As Wessells emphasises, the challenge in work for transformation after conflict and violence is to identify needs and then to connect and link work done at different levels to achieve an integrated approach. Too often, excellent work is done at one level while the different needs of those who fall into another category are not identified and met. Strong work at village level will be undermined if structural violence at other levels of the system remains unchallenged, for example, or the need for specialist treatment goes unrecognised.

Another learning point over the last decades of experience, has been the sense of powerless amongst those who have been victimised, something which is clearly observable in Zimbabwe. A sense of agency and empowerment is clearly linked to psychological well-being; while NGOs and mental health practitioners may offer ideas and their own understanding of mental health and the wider healing agenda, each individual, community or local group needs to look at their own situation and debate what is needed, whether this be a transitional justice process based in existing local structures, traditional rituals to cleanse and re-integrate offenders or creation of a safe space for the sharing of stories and suffering. This is very clearly emphasised in the IASC guidelines. The process of discussing and deciding in itself can constitute part of the healing process and begin to restore some sense of agency to those involved.

It seems unlikely that, as mental health practitioners, much can be achieved with the victims of violence and trauma until a new political and legal dispensation is established. However, we can begin the work needed (as expressed in this document) and as many agencies have already begun to react over the past decade. In this regard the establishment of a group of practitioners and researchers would be a very valuable contribution in the clarification of the effects of violence and trauma in the specifics of various Zimbabwean contexts, and in the detailed description and evaluation of competing modes of intervention. One of the main lessons we can already draw from the past decade is the effects of violence and constant threat on practitioners and researchers who have often had (and continue to have) highly conflictual and fractured relationships with one another, thus undermining cohesion and progress in these crucial areas.

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