

Mending the Levee: How Supernaturally Anchored Conceptions of the Person Impact on Trauma Perception and Healing among Children (Cases from Madagascar and Nepal)

Sandra Evers*, Mienke van der Brug*, Floryt van Wesel[†] and Lydia Krabbendam[‡]

*Department of Social and Cultural Anthropology, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands

[†]Department of Methodology & Statistics, Utrecht University, Utrecht, The Netherlands

[‡]Department of Family and Education Studies, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands

When dealing with children and youth who experience distressing events, psychosocial diagnostics and healing programmes principally resort to biomedical models. Children are often viewed as individualised 'victims' suffering from trauma and 'in need' of outside help. Highlighting case studies from Madagascar and Nepal, this article argues that the biomedical approach to trauma would be strengthened by a concomitant analysis of social networks, including the perceived relations with the supernatural. The various tandems of family and kin relationships, the living and the dead, constitute not only a social 'levee' breached by distressing events, but also the locus around which social relations are rebuilt. © 2016 John Wiley & Sons Ltd and National Children's Bureau

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Introduction

This article is the fruit of a collaboration between neuropsychologists and anthropologists. With our interdisciplinary approach we wish to contribute to the plea of Kirmayer (2006, 2010) and Panter-Brick (2010) for conceptual models that transcend narrow disciplinary-based views, such as longitudinal and mixed-method approaches that include cultural assessments. Although the awareness of cultural differences amongst traumatic stress reactions has grown (see for example the 'outline for cultural formulation in DSM-IV the Diagnostic and Statistic Manual of mental disorders, 4th edition, American Psychiatric Association, 1994', 'Cultural Formulation Interview and related material in American Psychiatric Association, 2013 DSM-V'), there is still a gap to bridge between understandings of the phenomenon by (etic) mental health specialists and (emic) anthropologists (Rasmussen and others, 2014). De Jong (2005) advocates a phenomenological approach employing a combination of qualitative and quantitative research methods (De Jong and Van Ommeren, 2002). As he states: 'Such collaboration would be an important step toward furthering the discourse and deepening our insight into the cultural expressions of traumatic stress in particular, and possibly of psychiatry in general' (De Jong, 2005: 368). See also Breslau (2004) who makes a similar plea for interdisciplinary collaboration.

Trauma intervention is anchored in western biomedical protocols designed to apply curative remedies to a targeted group of diagnosed (making use of quantitative measuring tools) individuals in need of *outside* help (Kinghorn, 2015; Kriegler, 2014). Anthropologists generally qualify the biomedical approach as one form of western knowledge which also is subject to qualification (Yarrow and Venkatesan, 2012: 1; cf. also Asad, 2003; Clark, 2007; Mosse, 2005). Such qualitative studies look at cultural constructs of hardship. Social networks of people having experienced distressing events are front and centre of these analyses. Children are viewed as active participants in the construction of meaning and the development of coping mechanisms.

The argument in favour of broadening the knowledge base for trauma analysis presumes the existence of resources *inside* a given society of both children and adults that can be mobilised. Children are constructors of social environments and makers and interpreters of culture (Evers and others, 2011). They are also adept at innovating solutions for relief within their environment. Children may be thrust to the forefront as actors in new and mutating 'adult-child' and 'child-child' relations and have to find solutions to situations under conditions of extreme duress and deprivation. Rabaia and others (2014: 179) observed this phenomenon while working with Palestinian children living under conditions of chronic political violence. They observed no shortage of trauma intervention programmes addressing children's needs, but warned that 'Psychosocial project assessment frameworks are generally derived from biomedical and individualistic models utilising "objective" indicators of psychosocial health — often developed elsewhere — which may or may not be relevant and appropriate for culture and context. The assessment is based on the assumption of the temporality of a "traumatic event", while structural factors related to the historical, sociopolitical and economic context are often neglected'. Furthermore, tectonic shifts in the existing environment in turn alter the contours of definition of children, youth and adults, both in relational terms and culturally (Evers and others, 2014; Huijsmans and others, 2014). Age indeed is a factor where an anthropology-based examination of childhood clearly differs from biomedical models, that view age as an indicator of a particular developmental stage in relation to brain maturation (even though such assessments are far from obvious, see below). The definition of a 'child' or an 'adult' is constructed in varied ways against the political economy of poverty, marginalisation and struggles of nation-building prevalent in many developing countries (see also Gabrielli and others, 2014). Such factors should be taken into account when assessing trauma. Kriegler (2014: 604) in her analysis of the implementation of trauma intervention in South Africa even notes that:

When the American Psychiatric Association (APA) published the updated diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), critics of the DSM-V spotlighted the lowering of diagnostic thresholds for existing disorders and the introduction of disorders that may lead to inappropriate medical treatment of vulnerable populations.

Post-traumatic stress disorder (PTSD) has become a key concept within the biomedical model of mental disorders over recent decades. Terr (1979, 1983) stated that children may also suffer from symptoms characteristic of PTSD following a traumatic event, leading to the formal recognition of this hypothesis in DSM-III-R (American Psychiatric Association, 1987). The earlier prevailing view was that psychological reactions to trauma in children were mostly transient. Its manifestation may differ from adult reactions and include trauma-specific re-enactment or repetitive play in which trauma aspects are expressed (Udwin, 1993), leading to a PTSD preschool subtype in DSM-V American Psychiatric Association, 2013. Alisic and others (2014) conducted a meta-analysis of 72 studies investigating the prevalence of PTSD in children and adolescents exposed to trauma. In this meta-analysis, interpersonal trauma (such as war, terrorism, injury due to violence) was distinguished from non-interpersonal trauma (such as disaster, life-threatening disease, sudden death of a loved one) yielding findings that approximately one

in four children developed PTSD after interpersonal trauma. It should be noted, however, that most of the research included in this meta-analysis took place in western settings.

DSM was developed as a diagnostic tool for individual mental disorders. This emphasis on intra-psychic aspects has greatly facilitated the development of psychological and pharmaceutical intervention to reduce symptoms. As DSM is governed by a heuristic, schematic guideline, it indeed encounters difficulties in cross-cultural applications. As Kirmayer (2006, 136) states:

Efforts to develop an international nosology and standardised approaches to diagnosis and treatment remain highly biased toward the Euro-American constructs developed over the preceding century. While the World Health Organization and World Psychiatric Association have tried to broker international consensus on diagnostic nosology and 'best practices' in clinical intervention and prevention, the non-western database remains very limited.

This critique is also applicable to PTSD, where related issues were posed from its early existence. For instance, PTSD rates are higher for interpersonal violence in western settings compared to PTSD rates for interpersonal violence in non-western settings (i.e. Kessler and others, 1995), whereas for PTSD rates associated with disasters the reverse is true (i.e. Norris and others, 2002). At the same time, high rates of PTSD have been observed in every region of the globe as a result of war and internal conflict (Green and others, 2003).

According to Bracken and Petty (1998), it became generally assumed that PTSD captured the fundamental psychological disturbance after any particular type of trauma and extreme events. Here also, the superimposition of this biomedical perspective upon a range of contexts has been criticised, ignoring the broader social, emotional, political and economic circumstances of children and their families in war-affected areas (Bracken and Petty, 1998; Eyber and Ager, 2004; Summerfield, 1998).

In this article, we argue that aid programmes exclusively designed on the biomedical paradigm should pay more attention to local coping mechanisms, resilience and available social resources. Marsella (2010: 17), in his overview discussion on ethnocultural components of PTSD, emphasises the importance of conceptual issues (which in non-western settings often divert from biomedical definitions) when determining psychological illnesses in non-western settings as 'ethnocultural variables exercise major influence on perceived causes, symptom manifestations, clinical parameters (i.e., onset, course, and outcome), interventions, and societal responses'. Accordingly, coping and healing processes should be anchored in the view that the 'person' suffering is socially embedded, as Rousseau and others (2003: 1288) state, because: '...of the central but very delicate interrelationships between the subject in a community and culture, genealogy and history may become the key to a more comprehensive understanding of the phenomenon of resiliency'. Green (2009: 397) adds to this observation: 'This is not because of the epistemological *content* of different kinds of knowledge or a consequence of different *kinds* of practice, but the consequence of where what is counted as knowledge is situated within systems of organization'. Thus, we must consider as scientists that what is 'counted as knowledge' necessarily includes the supernatural, and generally holistic cosmologies in which the living and the dead are intrinsically interwoven. At the present time, intervention policies take insufficient notice of children's social networks or perceptions of a child as being part of a social configuration of the living and the dead (including interconnected energy streams regenerating life) and could gain by assessing children's capabilities as agents in the improvement of their own condition.

Below we discuss two case studies which point to the importance of perceptions of the 'person' in settings in Madagascar and Nepal when analysing children's and youth's reactions to distressing events and remedial perspectives. Notwithstanding the differences in geographical, cultural and social settings, we observe in these case studies two common variables

central to the assessment of 'trauma': (i) the concept of a person as intrinsic part of living and non-living collectivities and (ii) the concept of a person as embedded in social networks.

An existential overlap between the living and the dead in Madagascar

Madagascar is one of the poorest countries of the world. A combination of civil unrest, disease and chronic poverty erodes the vitality of communities (International Crisis Group 2014). Over a period of several years of research among the Betsileo living in the extreme Southern Highlands, the researcher attended funerals on a regular basis. This case discusses how life and death are closely interwoven in Madagascar and an individual is always assessed in terms of status in relation to the dead. This is not particular to the Betsileo (who comprise approximately 12 per cent of the Malagasy population) and constitutes a social touchstone for the Malagasy generally. Life is defined in connection with the ancestors. Disease, suffering and death constitute the fabric of wider social relations and the harmony between the living and the dead. This case study illustrates how the construct of 'trauma' is intrinsically linked to the world of the ancestors.

The following data are based on a qualitative study spanning a period of almost 20 years, principally with the Betsileo living in the extreme Southern Highlands of Madagascar (see Evers, 2002, 2006). Methods ranged from archival research (in Aix-en-Provence, France) to surveys, participant observation, focus groups and individual interviewing. Research permission was granted by village leaders who took pride in having 'raised' the researcher to become a person and to behave like a Betsileo (*mitondra tena Betsileo*). Gaining a better understanding of the bonds with the ancestors and their role in the regeneration of life allowed the researcher to be deemed a 'real' person by the Betsileo. The following case formed an important informative part of the puzzle.

A central concept connecting the living and the dead is *hasina* (an ancestral energy 'which makes people breathe'). *Hasina* infuses life and life is revitalised by the ancestors. If people work the land and renew their link with the ancestors, the ancestors in turn regenerate both people and land. This vital relation with the ancestors is also reflected in the description of *hasina* by Delivré (1975: 167–184) as a form of energy innate to existence. References to *hasina* have been encountered by many scholars conducting research in Madagascar (cf. Bloch, 1989: 46–88; Delivré, 1975; Dubois, 1938; Edholm, 1971). Southall (1986: 414) translates *hasina* as 'sacred ritual potency', and considers it to be a central concept for all Malagasy: 'Here is one of those pervasive themes which justify emphasis on the essential unity of all Malagasy culture, despite its apparent regional contrasts'. Bloch (1989: 65) also writes that the notion of *hasina* is the 'kernel of Malagasy thought'. Fertility, successful harvests and good health are all ascribed to *hasina*. The belief that ancestors can activate destructive aspects (also referred to as *hery*) of *hasina* causing, for example, infertility, illness and death, when people do not meet ancestral expectations (see Cole, 2001) is widespread in Madagascar.

In the extreme Southern Highlands of Madagascar, the principal occupations of zebu-breeding and farming (particularly manioc) are barely sustainable. Chronic hunger remains the rule for most Betsileo in the region. Poverty is often blamed on displeasure of the ancestors brought on by neglect in the upkeep of the family tombs and failure to comply with the strict rituals governing the reintegration of the recently deceased into the world of the ancestors. Manipulation or disruption of this ancestral energy flow is believed to have disastrous consequences, as witnessed by the following case recounting the fate of Lova (Lova is a fictitious name to protect her privacy; she gave her consent for the publication of this case).

Lova is a girl of 15 whose father died in 1996 (poisoned by a villager seeking revenge after he had committed adultery with the man's wife). As her husband met with a cruel end, Lova's

mother was convinced her husband and the other ancestors would be upset (also because the funeral had not been executed properly according to her). She fell ill and blamed it on lack of *hasina* which even had turned to *hery* (destructive supernatural energy). She said that she would die because of this and in fact did shortly thereafter. Her daughter Lova fell to the ground a few days after the death of her mother, claiming that she also had been possessed by *hery*. Lova was paralysed and could not walk for over a year. As potential remedy to her ailments, Lova's family consulted a French physician on a six-month tenure in the closest hospital 50 km from the village. The visiting doctor could detect no physical explanation for Lova's condition and entered a diagnostic of Post-traumatic Stress Disorder (PTSD). Unfamiliar with the concept, Lova's family consulted a number of *ombiasy* ('traditional healers'). The family spent substantial amounts of money on this as they believed that Lova had problems with *hery* that would sooner or later also affect them. The *hery* energy could potentially subsume the whole kinship group. None of the *ombiasy* succeeded in curing Lova. This they attributed to the discontent of the ancestors. Matters only improved when a healer from the town of Ambalavao was recruited. The whole village professed unhesitating faith that Lova would be cured with his skills. Only this *ombiasy*, it was explained to the researcher, could connect with the ancestors, force *hery* to retreat and make way for *hasina* again, bringing health and fertility.

After a ritual performed by the *ombiasy*, Lova incredibly rose from her mat and walked. A few years later she married, and gave birth to three healthy children. Her long-term reversal of fortune was explained by *hasina* and her renewed harmony with the ancestors, the benefits of which were felt by her entire family.

Lova's story illustrates how her ailments were seen as a disconnection between the living and the ancestors. Lova's problems were not viewed as an individual issue but as one that affected the whole family and accordingly treatment was found within the kinship networks in order to be able to regain the harmony with the ancestors. This case highlights not so much any flaw in the PTSD model *per se*, but rather that a diagnosis should not be exclusively biomedical, when the inclusion of other variables allows for a more comprehensive analysis. The following case on Nepal also describes a supernatural characterisation of distress exhibiting symptoms of PTSD.

Loss of soul during the Nepalese civil war

From 1996 until 2006, a Maoist rebellion triggered a civil war in Nepal that would eventually cost 13 000 lives (OHCHR, 2012). This case study — preliminary to an evaluation study on trauma intervention (Jordans and others, 2010) conducted for Healthnet-TPO in August 2006 — examines perceptions of children's responses to war-induced trauma, including abductions and attacks on schools (UNICEF, 2009), which became commonplace during the conflict. Research was conducted during 2006 in a Tharu (the Tharu comprise 6.6 per cent of the total population) farming village at the edge of a jungle located in south-west Nepal. During the conflict, the village was frequently searched by police and army sweeping for Maoists on the run. Six village men were summarily executed within the proximity of their homes after arrests within the family home. Several village children witnessed these incidents. Five focus groups were conducted with children aged 7–10 years, and three focus groups with their parents. An inventory of children's daily activities and walkabouts was compiled. Individual interviews took place with relatives of the victims, the village health worker, traditional healer and primary school teacher.

Common children's reactions to war time stressors were recorded, as described by the participants, including classic traumatic stress symptoms — fear, nightmares and concentration problems, avoidance of trauma-related external reminders, anger, irritable behaviour, and social apathy, a sampling of which follows.

All children experienced fear at the sight of the police or the army, or upon hearing the sounds of gunfire or explosions, particularly when Maoists were sheltering in their homes. Children feared harassment by armed forces when crossing the forest, going outdoors for toilet use after dark and expressed chronic, extreme fear, anguish and anxiety at the prospect of losing their parents. Eating and sleeping disorders were common. Children slept together with their mother, or in front of the statue of their god. During the ceasefire, children were less afraid, while others still felt 'uneasy'. Nightmares about the war were frequent; children were nervous when going to bed, and were screaming at night. Children experienced difficulties concentrating at school and while doing their homework. Parents and caregivers similarly reported a lack of concentration on schoolwork and general social apathy following the death of a father. Many children experienced anxiety at the prospect of entering their house alone, or remaining alone at home. A caregiver explained this anxiety: 'The children wonder why our elders are not eating, why they are not chatting. This makes the house empty, although there are many persons there. That is why they are afraid'. Increased anger in children was observed by the school teacher. Several children expressed deep hostility towards the army and police. One mother related the anger and behavioural issues of her own sons following the death of the father: 'My eldest son is often very cross with me. Whenever I try to guide my sons, they run away. I suspect they will not care about me anymore when I become old. With the father gone, they are ruined'. Eating disorders and social apathy were observed in children, especially in children of whom a relative was killed. One mother related how her own children refused to attend school for a full year following the loss of their father, despite having been good students earlier.

Several children declared they had lost their *sattoo*, or soul spirit, during wartime. *Sattoo* loss was described by participants as a state of shock, losing control, heightened fear and losing mental balance. A boy explained this condition: 'Because of fear there was a problem with me; I got headaches, fever and I lost my *sattoo*'. Adults can also suffer from soul loss. A woman lost her soul when her husband was killed: 'my husband was arrested by the army. When I protested, they put a pistol on my chest and then I lost my *sattoo*. When I found out what had happened to my husband, I became unconscious'.

In other regions of Nepal soul loss is recorded as well, such as in north-west Nepal and the Kathmandu area (Kohrt and Harper, 2008), and among the Yolmo people in the Helambu area (Desjarlais, 1992). Traditional healers describe that fear can drive out individual's souls, and that children are especially vulnerable to soul loss (Desjarlais, 1992). Because souls are less anchored in children, behavioural changes and nightmares are explained as an untethering of the soul (Kohrt and Hruschka, 2010).

To heal soul loss, children are brought to the traditional healer, the *bharra*. The village health worker explained: 'when children are frightened, we — the Tharu cast — take the children to the *bharra*. Doctors cannot make frightened children well'. During the healing sessions, the *bharra* sits in *pati* (a special sitting position) and 'looks rice' (*akashata*) to identify the problem. When treating soul loss, the healer uses secret mantras to retrieve the soul, and communicates with the gods, who are in turn in contact with the ghost. Most patients who suffer soul loss are believed to recover after this healing session. Children also testified that they were healed: 'the *bharra* made me well, he recalled my *sattoo*'.

Desjarlais (1992) describes similar healing sessions among the Yolmo people, whereby a shamanic ceremony is performed in order to recollect the patient's lost 'life' and reincorporate it within the body. The *bharra* is also approached for healing other wartime-related problems in children such as nightmares and headaches caused by fear. Children's fear of re-entering their home due to the death of a family member was successfully treated by the healer. Although treated, wartime-related problems remained, having consequences for the children's well-being. This impact was described by children as the loss of the feeling of *chainar* — a feeling of joy, peace and happiness.

The above case study testifies to supernaturally anchored perceptions and explanations of hardship and shows how children navigate their social and cultural settings when recovering from distressing events. It also underlines how perceptions of the person as part of a wider social and supernatural world impact on views on the source of suffering, the experience of pathology, treatment of the person affected and healing processes.

Discussion and recommendations

Whereas in Nepal misfortune was blamed on the loss of the soul, the Malagasy ascribe ill-fortune to the conversion of *hasina* into *hery*. What both settings share is a conceptualisation of the person as part of wider social and supernatural networks. In their article on idioms of distress among trauma survivors, Hinton and Fernández (2010: 217) draw attention to how individual embodied expressions are testimony to disentanglements on an interpersonal and societal level: 'Trauma does not occur in a vacuum: it develops and is understood in a particular cultural matrix, a key component of which are the idioms of distress. These constitute an essential component of the reticulum that connects the trauma event to the sufferer's body and to his or her social context'. Lambek (2013: 837-838) also observes that in many societies a person is not viewed as a biological individual or as psychological subject, but is rather anchored in public, sociocultural criteria. It could be said that the social is an extension of the interpersonal: 'persons are only persons in the context of and in relation to other persons'. This applies to personal suffering, which is viewed as a sign of ailment of a whole social grouping. The source of these troubles is often traced back to declining relations within social groups and even between the living and the dead as we saw in the cases above. Nor should the supernatural component of suffering be ignored in the assessment of personal views on the origins of such hardship.

The connection of suffering with the supernatural also explains why people resort to traditional healers to remedy hardship which is rooted in historical and social-interactive processes. In *Cultural Adaptation of Treatments*, Bernal and others (2009) investigate the modification of evidence-based treatments for mental disorders such as PTSD to fit local contexts. Bernal and others suggest that intervention protocols can be adapted to the client's 'cultural patterns, meanings and values' (362); observing that: '...Cultural adaptations may make it possible to go beyond the one-size-fits-all approach and move closer to the ideal of providing effective psychotherapies for all individuals, contextualized in terms of cultural values, language, socioeconomic status, gender, and preference' (366). This view would imply a critical reflection of diagnostics that are embedded in the predominance of biomedical knowledge regimes, discourses and power relations, and the integration of knowledge that challenges and diverts from what is deemed a 'given' in certain disciplinary fields. As Gone and Kirmayer (2010: 90) argue: 'In this view, the diagnostic entities found in psychiatric nosologies may not reflect natural kinds (occurring in nature dependently of our cognitive and cultural construals), but are the outcomes of social-interactive and historical processes that include our culturally mediated ways of understanding and interpreting suffering'. Kriegler (2014) has noted the significant numbers of psychiatric disorders in South Africa. She argues that 'Responding to psychological distress through a psychiatric discourse where the child is the locus for change fails to address how suffering can arise through exposure to pernicious political and economic ideologies. Promoting psychiatric or pharmacological interventions devalues Indigenous knowledge systems, ignores cultural specificity and contributes to new forms of colonialism through a globalisation discourse' (610).

Thus, where the 'biomedical' approach looks at the person as an individual, the supernaturally anchored assessments only make sense in reference to the wider social environment. Such an approach accordingly demands an analytical integration of individuals' and

communities' own structural means to deal with hardship and healing with their own social and cultural resources. This approach can also buttress resilience processes within communities, as Gabrielli and others (2014) point out in their study of trauma in children in the aftermath of the 2010 Haiti earthquake. Building on Betancourt and others (2010), they caution 'that cultures generate different resilience or vulnerability factors, leading to culturally specific post-trauma outcomes that cannot be foreseen from perspectives outside the culture' (441). Furthermore, it needs to be acknowledged that children and youth are central to such processes. The Nepal case confirms that children play active roles in the assessment and dealing with hardship within their social environment — due to the war, children were obliged to take on 'adult-like' roles that transformed adult-child and child-child tandems and had to find solutions to situations under conditions of extreme duress and deprivation. In other words, the community as a whole had to readjust to new social relations and come to terms with the distressing events it had endured. We therefore would argue in support of the social constructivist approach which points to the conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition) (Conrad and Barker, 2010; Kriegler, 2014). In the analysis of the social meaning component we would recommend the integration of the expanding definition of the 'social domain'. The conventional definition of the 'social' usually defines living people as the exclusive constituent of this category without taking into account the significance of 'dead' people and accompanied cosmologies. In the cases of Madagascar and Nepal, it becomes clear that assessments of disease and illness cannot be understood without taking such components into consideration.

Conclusion

In this article, we have discussed the nature of bio-medically anchored assessments of trauma which stem from an individualistic interpretation of the 'person-centred' approach to diagnosis as opposed to an integrative socially embedded notion of the 'person' including both the living and the dead. The latter might assist in the development of diagnostic and curative trajectories that are better adapted to perceptions of the sources of suffering, the experience of pathology, the suffering 'object' and healing. The case studies of Madagascar and Nepal show that children's dealings with distressing events cannot be assessed comprehensively without the integration of sociocultural factors, such as relational positionings of children within family and neighbourhood networks and the intimate relations between the world of the living and the dead. Questions of diagnostics and treatment can be enriched by the inclusion of assessments of what it means to be a human and how perceptions of illness and health are constructed. We therefore argue for the integration of the biomedical and interpersonal-contextualised approaches. An integrated model would serve to complement and contextualise analysis and assist in fine-tuning remedial solutions designed for children in environments stricken by war and other hardship.

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Correspondence to: Sandra Evers, Department of Social and Cultural Anthropology, Vrije Universiteit Amsterdam, 1081 HV, Boelelaan 1081, Amsterdam 1081 HV, The Netherlands. E-mail: s.j.t.m.evers@vu.nl

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