Ibrahim, Baher (2021) *Uprooting, trauma, and confinement: psychiatry in refugee camps, 1945 -1993*. PhD thesis.

https://theses.gla.ac.uk/82516/

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten: Theses
https://theses.gla.ac.uk/
research-enlighten@glasgow.ac.uk

Uprooting, Trauma, and Confinement: Psychiatry in Refugee Camps, 1945 -1993

Baher Ibrahim
MBBCh, MA, MSc

Submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy
January 2021

School of Humanities
College of Arts
University of Glasgow

© Baher Ibrahim, 04 January 2021.

Abstract

This thesis is a history of psychiatry through the lens of refugees, and a history of refugees through the lens of psychiatry. It explores the history of psychiatry in medical humanitarianism and refugee relief from the end of the Second World War to the end of the Cold War. My research shows that throughout the period under study, psychiatrists have approached refugees through three perspectives: as uprooted and homeless people, as people confined in a camp and dependent on humanitarian assistance, and as traumatized victims who have been through horrific experiences.

I trace how the notion of 'trauma' came to occupy a central place in discourses on refugee mental health. The centrality of the trauma of the Holocaust to the psychological legacy of World War II did not figure prominently in the minds of humanitarians, doctors, and policy makers in the immediate aftermath of the war. Europe's refugee problem was seen in terms of population displacement and not the aftermath of genocide. At the time psychiatrists pointed not to the horrors of Nazi persecution, but to the event of 'uprooting' from the homeland as the major cause of psychic suffering in refugees.

Despite a flurry of activity on the mental health aspects of camp containment, repatriation, and resettlement in the 1940s and 1950s, much of this work was forgotten by the 1960s when refugees became a Third World phenomenon. Throughout the 1960s and 1970s, very little attention was paid to mental health in humanitarian crises. The limited engagement with mental health issues in refugees in postcolonial independent African states happened in the context of modernisation and nation building rather than humanitarian relief.

This trend was reversed in the 1980s, when a new generation of Western humanitarians brought their own historical baggage emanating from the legacy of the Holocaust to refugee camps on the Thai-Cambodian border. The notion that Cambodians were uniquely traumatized was a popular one, and it was here that the idea of trauma and the now ubiquitous diagnosis of post-traumatic stress disorder were first applied in a humanitarian crisis. In this PhD, an interdisciplinary project encompassing history of medicine and refugee studies, I seek to historicize what Liisa Malkki has called the 'psychologizing modes of knowledge and therapeutic forms of relationship' that refugees are often subjected to by those who study them.

Dedication

To my father, who gave me my love of knowledge; my mother, who shares my existential predicament; and my brothers, who give continuity to my nostalgia.

Acknowledgements

A University of Glasgow Lord Kelvin Adam Smith scholarship generously funded this research over the past four years. I am grateful to Christelle Le Riguer and Rebekah Derrett at the University for their invaluable administrative assistance. It has been a pleasure to do this PhD with my supervisors, Dr. Benjamin Thomas White and Professor Malcolm Nicolson, and I am grateful for their guidance and mentorship. Ben was not only my primary supervisor, but the first human being I met in Scotland. This thesis has benefitted greatly from Malcolm's thoughtful comments, insights, and attention to detail, which I hope to replicate in my future work.

I extend my thanks to a number of funded fellowships from which this research has benefitted: an intensive two week placement at the Watson Institute of Brown University on forced population displacement, a month long research residency at the Brocher Foundation in Geneva, a two week Global Humanitarianism Research Academy at the Institute of European History, Mainz and the International Committee of the Red Cross in Geneva, and a history of psychiatry winter school at the University of Sydney.

I have been helped by the numerous archivists and librarians. I extend my thanks to the staff at University of Melbourne Library, UN High Commissioner for Refugees and World Health Organisation archives in Geneva, the UN Library in Geneva, the UN archives in New York City, the British Library and Wellcome Library in London, the Schlesinger Library at Harvard University in Boston, and the Oskar Diethlem History of Psychiatry Library at Cornell University in New York City. I also thank Dr. Richard Mollica, director of the Harvard Program in Refugee Trauma, for the opportunity to interview him.

A special thank you to George Ezzat, Mark Makar, and Karim Pourhamzavi for hosting me in Boston, New York, and Sydney, respectively, during my research trips.

This research has also benefitted from conversations with fellow scholars, all of whom have become good friends: Jennifer Carr, Rebecca Whiting, Michael Wolven, Karim Pourhamzavi, Alessio Albanese, and Helene Grøn.

I also thank my friends who have sustained me during this journey and witnessed it from inception to submission: Mark Makar, Michel Assaad, Ahmed Makky, Sarah Oeffler, Germeen Riad, David Gregory, Mohamed Maged, Torge Luckfiel, Hussein Seif El Nasr, and Habiba Makhlouf. 'I get by with a little help from my friends.'

Finally, a heartfelt thank you to Manar Eltahan, without whom I could not have done all the other things I wanted to do with my life other than the PhD.

Table of Contents

Abstract……………………………………………………………………..2

Dedication……………………………….………………………………....3

Acknowledgements……………………………….……………………….4

Declaration……………………………….………………………………...8

Epigraph..…………………………….……………………………………… 10

Introduction…………………………………………………………………11

Uprooting, nostalgia, and their underlying assumptions………………13

Psychological trauma and the condition of victimhood…………………19

Refugee camp confinement and humanitarian 'care and control'…….25

Thesis structure, sources, and progression…………………………….30

Chapter 1: Displacement……………………………………………………37

Introduction…………………………………………………………………37

Initial forays into refugee mental health…………………………………42

Uprooting on the couch……………………………………………………44

Uprooting in the outpatient department and hospital…………………..50

Uprootedness and loss of homeland as pathology……………………54

The unique trauma of concentration camps…………………………….65

Before the Holocaust became a paradigm for trauma………………...69

Conclusion…………………………………………………………………70

Chapter 2: Containment……………………………………………………75

Introduction………………………………………………………………...77

Liberation…………………………………………………………………82

The DP camps……………………………………………………………..85

The military antecedents of UNRRA's mental health model………….93

'Welfare' and 'Rehabilitation'…………………………………………….99

DP apathy: A failure of rehabilitation……………………………………..107

DPs as political pawns……………………………………………………111

Conclusion………………………………………………………………...114

Chapter 3: Durable Solutions……………………………………………………………116
Introduction: new directions in psychiatry…………………………………..116
The changing nature of the European refugee problem……………….120
From uprooting to striking new roots: DPs as cheap labour…………...128
From uprooting to striking new roots: DPs as fulfilment of ideology….132
The end of IRO…………………………………………………………………...137
When the refugee is a 'freedom fighter'……………………………………..138
Deserving and undeserving refugees: the reception of Hungarian refugees in Britain……………………………………………………………………………146
Adaptational difficulties and host expectations in Canada………………153
The clearance of the DP camp 'hardcore' (1959-60) …………………….156
Conclusion…………………………………………………………………………163

Chapter 4: Decolonisation and Development………………………………………166
Introduction………………………………………………………………………...166
The changing nature of the refugee problem globally…………………….168
The development turn in humanitarianism…………………………………..172
Rwanda's first refugees…………………………………………………………176
International mental health, transcultural psychiatry, and the search for a global psyche……………………………………………………………………...180
Development, migration, and social change in Uganda…………………..186
'Africans do not suffer like us' and other convenient stereotypes………196
Apathy and dependency revisited……………………………………………...199
The arrival of humanitarian psychiatry in Africa……………………………..206
Conclusion………………………………………………………………………….211

Chapter 5: Culture, Trauma, and Confinement………………………………………213
Introduction………………………………………………………………………….213
The 'new' refugees……………………………………………………………….....216
Psychiatry resumes an interest in refugees…………………………………..218
Improvisational mental health relief efforts in Southeast Asian camps…224
Transcultural psychiatry and the Traditional Medicine Centres…………..230
The birth of 'refugee trauma'……………………………………………………..246
Refugee trauma in the border camps: the 'mental health crisis' in Site 2….……………………………………………………………………………………..254

The globalisation of refugee trauma……………………………………………….259
Local Cambodian solutions………………………………………………………….263
PTSD: A 'universalist solution to a relativist problem'……………………..…268
Conclusion……………………………………………………………………….....273

Conclusion……………………………………………………………………………..275
Bibliography……………………………………………………………………………282

Declaration of Originality Form – Research Degrees

This form **must** be completed and signed and submitted with your thesis.
Please complete the information below (using BLOCK CAPITALS).

Name	**BAHER IBRAHIM**
Student Number.	
Title of degree.	**DOCTOR OF PHILOSOPHY (HISTORY)**
Title of thesis.	**UPROOTING, TRAUMA, AND CONFINEMENT: PSYCHIATRY IN REFUGEE CAMPS, 1945-1993**

The University's degrees and other academic awards are given in recognition of a student's personal achievement. All work submitted for assessment is accepted on the understanding that it is the student's own effort. **Plagiarism** is defined as the submission or presentation of work, in any form, which is not one's own, without **acknowledgement of the sources.** For further information on what may be considered 'plagiarism', please read carefully the University's Statement on Plagiarism as contained in the University Calendar**.**

I confirm that this thesis is my own work and that I have:	
Read and understood the University of Glasgow Statement on Plagiarism	✕
Clearly referenced, in both the text and the bibliography or references, **all sources** used in the work	✕
Fully referenced (including page numbers) and used inverted commas for **all text quoted** from books, journals, web etc.	✕
Provided the sources for all tables, figures, data etc. that are not my own work	✕
Not made use of the work of any other student(s) past or present without acknowledgement. This includes any of my own work, that has been previously, or concurrently, submitted for assessment, either at this or any other educational institution.	✕
Not sought or used the services of any professional agencies to produce this work	✕
In addition, I understand that any false claim in respect of this work will result in disciplinary action in accordance with University regulations	✕

DECLARATION:
I am aware of and understand the University's policy on plagiarism and I certify that this thesis is my own work**,** except where indicated by referencing, and that I have followed the good academic practices noted above

Signed

‘He was still too young to know that the heart’s memory eliminates the bad and magnifies the good, and that thanks to this artifice we manage to endure the burden of the past. But when he stood at the railing of the ship and saw the white promontory of the colonial district again, the motionless buzzards on the roofs, the washing of the poor hung out to dry on the balconies, only then did he understand to what extent he had been an easy victim to the charitable deceptions of nostalgia.’

- Gabriel García Márquez, *Love in the Time of Cholera*

‘It is usually regarded as useful or necessary that refugees, as rootless and aggrieved people, should be kept under a centralised and mobile control, and should not be allowed to forget their special status until those in control decide that this is advisable.’

– H.B.M. Murphy, Scottish psychiatrist, 1955

‘The emotionally unstable, the perpetual drifters, the chronic failures – in whose catastrophic lives revolution and escape were but passing episodes – reacted violently to the growing stresses of refugee life: friends of nobody and their own worst enemies, it was … hard to visualise them settling down to normal life.’

– Thomas Dormandy, British-Hungarian Royal Army Medical Corps physician, 1957

‘If the impoverished cannot organise themselves to better their conditions, then other groups must assume this responsibility, including medical personnel who are particularly well placed to be aware of the dangers and evils of social disintegration.’

– G. Allen German and Marcel Assael, psychiatrists at Makerere Medical School, Uganda, 1970

‘Although hardly mentioned and reported in the refugee literature, there can be no doubt that relief personnel working with refugees whose conditions are nothing other than disturbing, do experience psychological problems, and this may reflect on their relationship with refugees.’

– Allison Umar, Ugandan doctor and former refugee, 1986

‘The Indochinese refugee serves as a unique model for understanding other highly traumatised groups, such as Vietnam veterans and victims of rape trauma and child abuse.’

– Richard Mollica, psychiatrist and co-founder of Harvard Program in Refugee Trauma, late 1980s

‘If we name the aftermath of grief, trauma, rape and violence as mental illness and then say that mental illness is widespread, yet another misleading and unfortunate image of the Khmer people is created.’

– Joan Healy, Australian nun and social worker in Cambodian border camps, 1990

‘Your people suffer in paradise, our people suffer in hell.’

– Cambodian mental health worker and camp refugee speaking to a resettled Cambodian-American mental health worker, 1990

Introduction

This thesis explores the perspectives through which psychiatry has historically conceptualized mental illness and psychological distress in refugees. The three perspectives can be summed up as uprooting, trauma, and confinement. Refugees have been approached conceptually by psychiatrists as either homeless people who have been uprooted from their country, as people confined in a refugee camp and forced to depend on humanitarian assistance, and/or as traumatized victims who have been through horrific experiences. Since psychiatry first assumed an interest in the mental health problems of refugees as a distinct patient population in the aftermath of the Second World War, psychiatrists have employed these perspectives to make sense of their clinical observations in refugees. Which of these perspectives has been the most salient at any one particular moment in history has depended on sociopolitical context and the location of the refugees being studied.

This thesis seeks to answer the questions: How did psychiatry come to develop an interest in the mental health problems of refugees and migrants? What were the sociopolitical, institutional, and scientific contexts in which psychiatrists explored questions about refugees' mental states? How did these contexts influence the directions psychiatry took? Has the field of 'refugee mental health' or 'refugee psychiatry' taken different shapes based on the particular refugee 'problem' in question? And how did 'trauma' become the major paradigm through which to understand and respond to the mental suffering of displaced persons?

Accordingly, this thesis is an exploration of the history of psychiatry and the history of refugees and humanitarianism. I explore these by examining the evolution of psychiatric thinking and practice about refugees in relation to three factors: the dominant theoretical clinical orientations and diagnostic paradigms in psychiatry; the particular geographic and institutional context in which refugees' mental health needs were responded to, and the particular circumstances of medical practice in refugee camps. This thesis is not a history of refugee camp psychiatric practice *per se*, but utilizes particular case studies to illustrate the evolution of psychiatric thought and practice. In other words, I use psychiatric practice with refugees to illustrate wider developments in psychiatry, medical humanitarianism, and refugee regimes rather than providing a detailed chronology of psychiatric practice in refugee camps. In some respects, this thesis is a history of ideas,

though not in the narrow sense in which ideas are considered to be historical agents in themselves, stripped of context or of the motivations and positionality of the individuals and groups fashioning and mobilizing them. Rather, it is a history of ideas in context and practice. I examine how the ideas of uprooting and nostalgia, camp confinement, and psychological trauma that practitioners brought to their work were shaped by broader developments in psychiatry as a whole, while remaining attuned to the potential for refugee camps to function as sites for the creation and elaboration of psychiatric knowledge. I explore how this knowledge production was influenced by the context practitioners were working in, from Allied military humanitarian planning to United Nations bodies to international humanitarian non-governmental organisations (NGOs), over a half century period that roughly spans from the end of the Second World War to the end of the Cold War.

Refugee mental health practices have often been studied from anthropological perspectives, such as the work of Liisa Malkki, Didier Fassin and Richard Rechtman, Aihwa Ong, and Barbara Harrell-Bond; or from a political science and international relations perspective, such as the work of Vanessa Pupavac.[1] These are fieldwork-oriented disciplines that often focus a critical lens on the present. This thesis expands the focus by examining the history of psychological interpretations of displacement. As far as histories of psychiatry's involvement with refugees go, there is a gap in the historiography. The few historical examinations of the field's origins have been written by clinicians, such as David Ingleby's introduction to the edited volume *Forced Migration and Mental Health,* and more recently Silove, Ventevogel, and Rees's paper in *World Psychiatry.*[2] In both cases the history of the field is traced to the 1980s, when the psychiatric diagnosis of post-traumatic stress disorder (PTSD) was introduced and a science of 'refugee trauma' began to take shape. The website of the Harvard Program in Refugee Trauma (HPRT) claims that a 1989 study conducted by the program in a camp called Site 2 on the Thai-Cambodian

---

[1] Malkki, 'Refugees and Exile'; Didier Fassin and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood,* (Princeton University Press: 2009); Aihwa Ong, *Buddha is Hiding: Refugees, Citizenship, the New America* (University of California Press: 2003); Barbara Harrell-Bond, *Imposing Aid: Emergency Assistance to Refugees* (Oxford University Press:1986), Vanessa Pupavac, 'Therapeutic governance: psychosocial intervention and trauma risk management', *Disasters,* 25(4)(2001), 358-372; Vanessa Pupavac, 'Psychosocial interventions and the demoralization of humanitarianism', *Journal of Biosocial Science,* 36(4)(2004), 491-504.

[2] David Ingleby, 'Editor's Introduction', in David Ingleby (ed.), *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons* (Springer: 2005), pp.1-28; Derrick Silove, Peter Ventevogel, and Susan Rees, 'The contemporary refugee crisis: an overview of mental health challenges', *World Psychiatry,* 16(2)(2017).

border was the ‘first mental health survey of a refugee camp’.[3] All these chronologies share the same misconception, assuming the field of refugee trauma to be synonymous with refugee mental health, whereas in fact psychiatry’s involvement with refugees goes back at least 45 years prior to the Site 2 study and well before the advent of the field of ‘refugee trauma’. Where medicine and psychiatry in refugee camps have been examined historically, it has been in the form of specific case studies and lacking a comparative dimension, such as Paul Weindling’s study of medical humanitarian relief in Belsen Displaced Persons camp, or Rakefet Zalashik and Nadav Davidovitch’s examination of the work of medical delegations to internment camps for Jewish Displaced Persons in Cyprus.[4] By comparing several geographically and chronologically diverse case studies, this thesis allows a comparative examination of psychiatric practice in refugee camps in different contexts.

Uprooting, nostalgia, and their underlying assumptions

Each of these perspectives has been articulated according to the dominant clinical and theoretical paradigms of the time. For example, the understanding of ‘uprooting’ as a pathological event was often expressed in psychoanalytic terms in the 1940s and 1950s. Émigré Austrian and Jewish psychoanalyst Editha Sterba, who fled Austria in 1938, described the trauma of uprooting as a re-enactment of the trauma of weaning from the mother’s breast.[5] The Dutch Jewish physician Sal Prins compared his flight from the occupied Netherlands during World War II to the severing of the umbilical cord in childbirth.[6] This idea of uprooting would be expressed four decades later in transcultural psychiatric terms – like the ‘cultural bereavement’ Australian psychiatrist Maurice Eisenbruch described in resettled Cambodian refugee patients.[7]

---

[3] Methodology – More’, *Harvard Program in Refugee Trauma* <http://hprt-cambridge.org/about/methodology/methodology-more/> [Accessed November 2020].

[4] Paul Weindling, ‘“Belsenitis”: Liberating Belsen, Its Hospitals, UNRRA, and Selection for Re-emigration, 1945–1948’ *Science in Context,* 19(3)(2006), 401-418; Rakefet Zalashik and Nadav Davidovitch, ‘Measuring Adaptability: Psychological Examinations of Jewish Detainees in Cyprus Internment Camps’, *Science in Context,* 19(3)(2006), 419-41.

[5] Editha Sterba, ‘Homesickness and the mother's breast’, *Psychiatric Quarterly,* 14(4)(1940), 701-707.

[6] Sal A Prins, ‘The individual in flight’, in H.B.M. Murphy (ed.), *Flight and Resettlement* (UNESCO: 1955), pp.25-32.

[7] Maurice Eisenbruch, ‘Toward a culturally sensitive DSM: Cultural bereavement in Cambodian refugees and the traditional healer as taxonomist’, *Journal of Nervous and Mental Disease*, 180(1)(1992).

The idea of uprooting as conducive to mental illness has not been restricted to psychiatry. It is manifest in refugee studies as a tendency toward psychological interpretations of displacement. In refugee studies, it has been assumed that there is a ‘refugee experience’ common to all refugees, and that this experience consists of identifiable stages that begin with uprooting and flight from the homeland, through encampment, and ends in one of three ‘durable solutions’: resettlement in a third country, local settlement in the country of asylum, or repatriation.[8] The state of being a refugee is conceptualized as a unique pathology that is, ideally, time limited. In the words of Barry Stein, the basic premise of refugee research is ‘that there is a refugee experience and that this experience produces what we can call refugee behaviour. Refugees should be seen as a social psychological type whose behaviour is socially patterned.’[9] Stephen Keller, in his work on Partition refugees in Punjab, calls this pathology ‘refugeeism’, which he divides into three phases: ‘warning and impact, flight, and resettlement and return to normal life’, after which two enduring psychological and personality changes take place. The first of these is a ‘sense of invulnerability that grows as the refugee realizes that he has come through it all safely’ and which can lead to increased risk-taking behavior. The second is a sense of guilt at having survived, which predisposes to aggression, either directed inwardly or towards others as aggressive behavior.[10] EF Kunz writes of the refugee who, after spending a period of time in the country of asylum, begins to realize that there is little hope of improvement of the conditions that led to flight and even less hope of return. ‘He is taking the first step that will change him from a temporary refugee into an exile. He has arrived at the spiritual, spatial, temporal and emotional equidistant no man’s land of midway-to-nowhere, and the longer he remains there the longer he becomes subject to its demoralising effects.’[11]

---

[8] Katy Long, ‘Rethinking “durable” solutions’, in Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona (eds.), *Oxford Handbook of Refugee and Forced Migration Studies* (Oxford University Press: 2014), pp.475-85.

[9] Barry Stein ‘The experience of being a refugee: Insights from the research literature’, in C Williams and J Westermeyer (eds.), *Refugee Mental Health in Resettlement Countries* (Hemisphere Publishing Corp: 1986), pp.5-23.

[10] Stephen Keller *Uprooting and Social Change: The Role of Refugees in Development* (Manohar Book Service: 1975), pp.97-98.

[11] Egon F Kunz, ‘The refugee in flight: Kinetic models and forms of displacement’, *International Migration Review,* 7(2)(1973), p.133.

The assumptions and biases that facilitate these psychological interpretations of displacement were analysed by anthropologist Liisa Malkki almost thirty years ago. Despite being written a generation ago, her articles 'National Geographic' and 'Refugees and Exile' remain relevant and have been formative to my thinking about the subject matter because she has interrogated and made explicit the unacknowledged assumptions that structure our thinking about refugees. I analyse how these assumptions are manifested in medical and psychiatric discourse. Among them is the assumption 'that the world should be composed of sovereign, spatially discontinuous units', which is a 'premise in much of the literature on nations and nationalism', as well as in our thinking about identity, belonging, and territory. Accordingly, 'violated, broken roots signal an ailing cultural identity and a damaged nationality'.[12] Liisa Malkki's 1990s work remains relevant because of her anthropological insights into how space and borders can influence identity construction in displaced populations. In Peter Gatrell's words, Malkki's work has shown 'how population displacement might be understood as a cultural phenomenon and as a means of constituting new kinds of identity, and not just something that is inflicted on refugees'.[13]

Though uprooting from one's homeland happens as a result of events in the sociopolitical context, it is in the refugee's psyche rather than political context that the pathology of uprooting is located by those who study refugees. Psychiatrists have engaged in the medical and, more often, moral problematisation of uprooting. For example, Swiss psychiatrist Maria Pfister-Ammende, who worked with refugees after the Second World War, described the psychological distress she observed in refugees as an 'uprooting neurosis'. This neurosis had moral consequences: during a refugee's flight to safety, their will to survive led to a 'hypertrophy of the instinct of self-preservation with deterioration of moral values'.[14] Pfister-Ammende was not alone in seeing refugees' uprootedness as problematic. The Scottish psychiatry H.B.M. Murphy, who worked in Displaced Persons camps in Germany after the Second World War, wrote that it was usually 'necessary that refugees, as rootless and aggrieved people … be kept under a centralised and mobile

---

[12] Liisa Malkki, 'National geographic: The rooting of peoples and the territorialization of national identity among scholars and refugees', *Cultural anthropology,* 7(1)(1992), pp.26, 34.

[13] Peter Gatrell, 'Introduction: World wars and population displacement in Europe in the twentieth century', *Contemporary European History,* 16(4)(2007), pp.416-7.

[14] Maria Pfister-Ammende, 'The problem of uprooting' in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After ...* (Springer: 1973), p.7.

control and … not be allowed to forget their special status until those in control decide that this is advisable'.[15]

Another closely related assumption is that the place of one's birth is the ideal habitat for someone to reside. It is where 'one fits in, lives in peace, and has an unproblematic culture and identity'.[16] This assumption leads to a pathologisation of rootlessness and mobility. Just how implicitly territorial and sedentarist this assumption is, Malkki writes, is apparent in the suffix '-land' that is attached to the word homeland, as well as many countries' names, for example 'England' or 'Switzerland'.[17] The corollary of this assumption is that one's culture becomes problematic in a foreign land. Psychiatry has adopted this assumption. After the Second World War, refugee mental health work in resettlement aimed to expedite the process by which a refugee adapted and assimilated to their new country. If they could not, their own mind was implicated as the problem. Ideas about satisfactory refugee adaptation were influenced by contemporary cultural representations of the deserving and undeserving poor in the context of the postwar welfare state. When some Cold War Hungarian refugees failed to adapt to their new lives in Canada - which usually meant learning English, finding employment, and not receiving assistance - psychiatrists suggested that these refugees had already been maladapted in Hungary and brought their problems with them.[18] In the medical literature on resettlement in the 1950s, there is an unstated assumption that refugees will be able to blend in with the host population and become indistinguishable from them because there are no obvious racial differences. As Laura Madokoro has written, the manner in which some countries of resettlement, like Canada, Australia, and New Zealand, dealt with refugees was 'deeply informed by a settler mentality that privileged certain people for full membership in the nation'.[19] In the 1970s Western countries began to admit, for the first time, substantial numbers of non-white refugees, especially from Vietnam, Laos, and Cambodia. Those who could not adapt were problematised and medicalised. Their culture was problematised

---

[15] H.B.M. Murphy, 'The camps', in H.B.M. Murphy (ed.), *Flight and resettlement* (UNESCO: 1955), p.58.

[16] Malkki, 'Refugees and Exile', p.509

[17] Malkki, 'National geographic', p.26

[18] EK Koranyi, AB Kerenyi, and GJ Sarwer-Foner, 'Adaptive difficulties of some Hungarian immigrants—IV. The process of adaptation and acculturation', *Comprehensive psychiatry*, 4(1)(1963), 47-57.

[19] Laura Madokoro, 'Unwanted Refugees: Chinese Migration and the Making of a Global Humanitarian Agenda', PhD thesis, University of British Columbia, Vancouver, 2012. [Retrieved from https://www.collectionscanada.gc.ca/obj/thesescanada/vol2/BVAU/TC-BVAU-43061.pdf, accessed December 2020], p.13.

along racial lines. When Indochinese refugees could not adapt to their new lives in the West, suffered psychological distress, and were unresponsive to the methods of Western psychiatry, their minority culture was implicated as the reason.

Doctors examined the relationship between migration and mental illness long before the twentieth century, in the transatlantic migrations of Europeans to the New World and in the colonies of the British Empire.[20] And as far back as 1688, the Swiss doctor Johannes Hofer coined the diagnosis of 'nostalgia'. Nostalgia, coined from the Greek words *nostos*, meaning homecoming, and *algia*, meaning pain, was essentially a medicalization of homesickness. It was a potentially fatal disease seen in those far away from home, with the only definitive treatment being a return home, or the promise of return.[21] In the original formulation of nostalgia, it was a disease of spatial and geographical rather than temporal dimensions. Nostalgia was a condition that happened in those who were literally far away from home and not, as we think of it today, a benign wistful longing for the past.[22] It lost its status as a disease in the late nineteenth century, at around the same time that the concept of psychological 'trauma' was in ascendancy. Medical historians George Rosen and Jean Starobinski have noted that the psychiatric concern with 'uprooting' after the Second World War was reminiscent of nostalgia.[23] I argue that there are both continuities and ruptures between the uprooting of the twentieth-century refugee and the nostalgia formulated by Hofer. Like refugees, which are often understood as a problem with spatial dimensions, 'uprooting' was also understood as a pathology of spatial and geographic dimensions. This makes the uprooting described by twentieth-century psychiatrists structurally similar to Hofer's nostalgia. This is the limit of the analogy, however. Unlike Hofer's patients, or conscripts in the Napoleonic armies, the

---

[20] Angela McCarthy and Catharine Coleborne (eds.), *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010* (Routledge: 2012); Marjory Harper (ed.), *Migration and mental health: past and present* (Palgrave Macmillan: 2016); Letizia Gramaglia, 'Migration and Mental Illness in the British West Indies 1838–1900: The Cases of Trinidad and British Guiana Letizia Gramaglia' in Catherine Cox and Hilary Marland (eds.) *Migration, Health and Ethnicity in the Modern World* (Palgrave Macmillan: 2013), pp.61-82; Jennifer S Kain, *Insanity and Immigration Control in New Zealand and Australia, 1860–1930* (Palgrave Macmillan: 2019).

[21] Anspach, C.K., 'Medical dissertation on nostalgia by Johannes Hofer, 1688', *Bulletin of the Institute of the History of Medicine,* 2(6)(1934), 376-391.

[22] Thomas Dodman, *What Nostalgia Was: War, Empire and the Time of A Deadly Emotion* (University of Chicago Press: 2018).

[23] George Rosen, 'Nostalgia: a ''forgotten'' psychological disorder', *Psychological Medicine,* 5(4)(1975), 29-51; Jean Starobinski and William S. Kemp (trans.), 'The idea of nostalgia', *Diogenes,*14(54)(1966), 81-103.

plight of twentieth-century of refugees could not be cured by a return home or the promise of one, precisely because there was often no home to return to.

For this reason, the status of nostalgia as diagnosis and disease could not be resurrected for the purposes of twentieth-century refugees. Psychiatrists were nevertheless influenced by what Starobinski calls 'the idea of nostalgia', and continued to draw on these older frameworks.[24] But the refugee of the twentieth century was conceptually distinct from the exiles, émigrés, seasonal laborers, and conscripts of earlier centuries. In the words of H.B.M. Murphy, 'The present time is thus almost the first occasion on which it has been possible for the personal effects of flight and forced migration to be investigated.'[25] Because the displacements of earlier centuries occurred in vastly different geopolitical contexts, there is no 'proto-refugee' from which the refugee of the twentieth century is descended.[26] Because of this distinction, and because psychiatrists working with refugees in the twentieth century saw the challenges and opportunities presented by refugees as unprecedented in the history of migration, I have chosen to focus on the twentieth-century refugee. My historical inquiry thus contributes to, but is conceptually distinct from, histories of migration and mental illness in earlier centuries.

As Peter Gatrell has shown, it was the collapse of multi-ethnic European empires in the aftermath of the First World War, and the subsequent delineation of nation-state borders to contain within them homogeneous populations, that produced the legal category of the refugee of the twentieth century.[27] There is a world of difference between twentieth-century displacement and, say, the flight of one million Huguenots from France following the Revocation of the Edict of Nantes in 1685. As Gatrell writes, such earlier events 'point to persecution and discrimination, but they belong to a more remote geopolitical universe and generated nothing like the institutional response that became familiar in the modern era'.[28] There is a strong contingent relationship between the formation of state borders and

---

[24] Starobinski and Kemp (trans.), 'The idea of nostalgia'.

[25] H.B.M. Murphy, 'The extent of the problem', in H.B.M. Murphy (ed.), *Flight and Resettlement* (UNESCO: 1955), p.11.

[26] Malkki, 'Refugees and Exile', p.497.

[27] Peter Gatrell, *The Making of the Modern Refugee* (Oxford University Press: 2013).

[28] Gatrell, *The Making of the Modern Refugee,* p.2.

the creation of refugees.[29] This is not limited to refugees; state borders have also served to create other new categories of human beings such as religious 'minorities', as Benjamin Thomas White has shown in his work on French mandate Syria.[30] Nor is this a one way process; refugees also contribute to state formation and border delineation. Refugees call on history to make sense of their displacement and navigate a way out of their predicament. Through engaging with the past, they give meaning to their present situation and make political claims.[31]

Psychological trauma and the condition of victimhood

I examine how the notion of trauma came to be first applied in refugee contexts and humanitarian crises. When I embarked on this research, I was well aware of the association of refugees with psychological trauma in clinical practice, medical literature, and popular parlance. I was not, however, aware of the uprooting/nostalgia paradigms in place after the Second World War. One guiding question for me throughout this research that I have attempted to answer is why the language of trauma was not the paradigmatic method of discussing refugee mental health in post-war Europe, despite the availability and prominence of this paradigm in military psychiatry. While psychiatrists did note that European refugees had been through events that were experienced as traumatic, by and large they did not designate refugees as 'traumatised'. The fusion of refugee mental health and trauma, and the taken for granted link between them, would not be actualized for another three decades. The reason for this, I argue, is that the rise of psychological trauma in Western medical and societal discourse was closely related to a renewed consciousness of the Holocaust and its legacy; a legacy that did not exist when hostilities ended in 1945.

A key point I emphasise is that despite the industrial scale of German persecution and genocide in the Second World War, the plight of refugees and survivors was conceptualised by psychiatrists at the time in terms of uprooting and loss of homeland, not as 'Holocaust trauma'. It was only in the 1950s that some psychiatrists began to

---

[29] Randall Hansen, 'State controls: borders, refugees, and citizenship', in Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona (eds.), *Oxford Handbook of Refugee and Forced Migration Studies* (Oxford University Press: 2014), pp.253-264.

[30] Benjamin Thomas White, *The Emergence of Minorities in the Modern Middle East: The Politics of Community in French Mandate Syria* (Edinburgh University Press: 2011)

[31] Gatrell, *The Making of the Modern Refugee*, preface.

systematically investigate the effects of Nazi persecution and internment on survivors, and only in the 1960s that the issue gained traction. Therefore, even though the notion of psychological trauma had been around since the late nineteenth century, and was commonplace in military psychiatry, by and large European displaced persons were not looked at through the trauma perspective as 'Holocaust survivors'. Even the Norwegian psychiatrist Leo Eitinger, himself a concentration camp survivor and whose name would become most closely associated with the study of survivors, only really began this line of research in the 1960s. In the 1950s, he was interested in the plight of refugees as uprooted people, and wrote his thesis on resettled refugees in Norway in 1958.[32]

It was only in the 1970s and 1980s that a specific association was formed between psychological trauma and refugees. One of the earliest applications of the concept in a refugee camp and humanitarian crisis was in camps on the Thai-Cambodian border, in the late 1980s. At the border, a civil war was being waged between a Vietnamese-backed regime in Cambodia and various military factions in the border camps, including the recently deposed genocidal Khmer Rouge. Camps were in the line of fire and subjected to repeated shelling, and refugees were conscripted by the various factions into the war effort. They were also subjected to violence from the military leaders who controlled some camps and the Thai police. The ongoing violence in the camps led some psychiatrists to employ the idea of 'trauma' to make sense of what was happening to the refugees and advocate on their behalf. The new field of 'refugee trauma', elaborated in the United States with resettled Indochinese refugees, was mobilised on behalf of refugees in Site 2, the largest camp on the border, where a 'mental health crisis' was declared.[33] Site 2 was, in the words of Dr Richard Mollica, who led the study in 1988, 'basically a concentration camp'.[34] That trauma became a thinkable and practicable concept for psychiatrists working with refugees in the 1980s was in no small measure thanks to Western society's reckoning with the Holocaust and a rise in Holocaust consciousness.[35]

---

[32] Ralf Futselaar, 'From camp to claim' in (eds.) Jolande Withuis and Annet Mooij, *The Politics of War Trauma: The Aftermath of World War II in Eleven European Countries* (Aksant: 2010).

[33] Richard Mollica and Russell Jalbert, *Community of Confinement: The Mental Health Crisis in Site Two (Displaced Persons Camps on the Thai-Kampuchean Border)*.

[34] Oral history interview with Dr Richard Mollica, Boston, October 2017.

[35] Dagmar Herzog, *Cold War Freud: Psychoanalysis in an Age of Catastrophe* (Cambridge University Press: 2017).

There is an extensive literature on the history of trauma and its associated diagnosis of PTSD. Notable among these is Mark Micale and Paul Lerner's edited volume *Traumatic Pasts,* which examines the social and cultural history of trauma from 1870-1930.[36] More recently, Jason Crouthamel and Peter Leese have made a contribution to our understanding of the social and cultural history of the traumatic legacies of the two World Wars.[37] Ruth Leys' *Trauma: A Genealogy* provides an intellectual history of the concept.[38] Ben Shephard's *A War of Nerves* examines the history of trauma in military psychiatry in the twentieth century.[39] Thus far histories of trauma have not incorporated the story of refugee trauma. Refugee trauma and trauma in humanitarian crises have been examined from an anthropological perspective, as in Fassin and Rechtman's *Empire of Trauma,* and in Joshua Breslau's work.[40] This thesis contributes to historical trauma studies by incorporating a hitherto unexamined chapter.

The idea of psychological trauma first appeared in the third quarter of the nineteenth century. While early proponents of the concept sought to implicate physiological mechanisms, such as John Eric Erichsen's 'railway spine', it was psychoanalysis that cemented trauma's position in psychiatry and implicated the mind in its causation.[41] In the psychoanalytic understanding, trauma is not defined in terms of an external event, but through the effects of the event on the patient. A psychoanalytic definition of trauma thus involves not only the event, but the person's response to that event. Events are only judged as traumatising in relation to 'a person's internal capacities to deal with the event, the personal history that gives the event meaning, the availability of social support to deal with the event, and areas of current anxiety that overlap with the

---

[36] Mark Micale and Paul Lerner (eds.), *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge University Press: 2001).

[37] Jason Crouthamel and Peter Leese (eds.), *Psychological Trauma and the Legacies of the First World War* (Palgrave Macmillan: 2017); Peter Leese and Jason Crouthamel (eds.), *Traumatic Memories of the Second World War and After* (Palgrave Macmillan: 2016).

[38] Ruth Leys, *Trauma: A Genealogy* (University of Chicago Press: 2010)

[39] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Harvard University Press, 2003).

[40] Joshua Breslau, 'Cultures of Trauma: Anthropological Views of Post-traumatic Stress Disorder in International Health', *Culture, Medicine and Psychiatry,* 28(2)(2004), pp.113-126.

[41] Bill Bynum, 'Railway Spine', *the Lancet,* 358(9278)(2001), p.339

event.' Thus, no event is inherently traumatic.[42] In psychoanalysis, 'to be caught up in a severely traumatic event stirs up without fail the unresolved pains and conflicts of childhood.'[43]

Psychoanalysis initially began as a theory and therapy for the mysterious multiform symptoms of hysteria for which no organic basis could be found. Sigmund Freud, in his early work with Josef Breuer, saw hysteria as resulting from the repression into the unconscious of traumatic recollections.[44] To Freud, trauma resulted from an event that overwhelmed psychological defenses against anxiety in a way that also provided confirmation of a patient's deepest universal anxieties. As early as 1893 he had been clear that trauma was produced by the event's effect on one's mind: 'Any experience which calls up distressing affects - such as those of fright, anxiety, shame or physical pain - may operate as a trauma of this kind.'[45] Freud had initially believed that trauma in his female patients could be traced to actual early life sexual experiences - what he called the seduction theory. He later famously abandoned this theory and its 'practical reality' concerned with the pathogenic nature of the event experienced, choosing instead to focus on the 'psychical reality' and a detailed exploration and elaboration of the unconscious - a 'shift of emphasis from fact to phantasy'.[46]

Though the traumatic neurosis of the first half of the twentieth century can easily be identified with today's post-traumatic stress disorder (PTSD), particularly from a clinical point of view that sees PTSD as a timeless disease entity that was waiting to be discovered as medicine progressed and advanced, there are important differences between the meanings implied by the two diagnoses. A major difference between the understanding of trauma that emerged in 1980 with PTSD and that which had existed since the end of the 19th century was the role of the event, deemed 'traumatic', in bringing about the symptoms. It was only with the entry of PTSD into psychiatric nosology that it became

---

[42] Robert M. Galatzer-Levy, 'Psychoanalysis, Memory and Trauma', in (eds.) Paul Appelbaum, Lisa Uyehara and Mark, *Trauma and Memory: Clinical and Legal Controversies* (Oxford University Press: 1997), pp. 142-143.

[43] Caroline Garland, 'Why psychoanalysis', in (ed.) Caroline Garland, *Understanding Trauma: A Psychoanalytic Approach* (Karnac: 2002), p.4.

[44] Paul Lerner and Mark Micale, 'Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction', in (eds.) Micale and Lerner, *Traumatic Pasts,* p.14.

[45] Sigmund Freud and Josef Breuer, *Studies in Hysteria* (1893), cited in (ed.) Caroline Garland, *Understanding Trauma,* p.15.

[46] Caroline Garland, 'Thinking about Trauma', in *Understanding Trauma,* p.15.

officially and institutionally accepted that exposure to an event, in and of itself, could produce the symptoms of trauma, rather than requiring a preexisting disposition in the patient's character.[47] All that was required was exposure to 'an event that is outside the range of usual human experience' and that 'would evoke significant symptoms of distress in most people', as the diagnostic criteria of PTSD in the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) of the American Psychiatric Association said.[48] This marked a break in a century old legacy of suspicion. The causality of the event as opposed to intrapsychic factors had been a matter of debate for a hundred years, especially when it came to symptoms in victims of railway or industrial accidents who were demanding compensation or pensions, or in military psychiatry, where psychiatrists were institutionally disinclined to attribute the symptoms of the war neuroses to combat.[49]

The same debate would take place again as survivors of concentration camps took to the courts in the 1950s and 1960s to demand compensation for the suffering they had endured as a result of their persecution. There were both psychiatrists sympathetic to survivors who believed symptoms to be the consequence of persecution, as well as psychiatrists that sought to deny any causal link. This issue was only settled in favour of the survivors with the political struggle of Vietnam veterans in the US to get PTSD recognised.[50] Contrary to this linear story of progress and triumph, historians of trauma have shown how the great range of possible events and responses to them serve to 'problematize and relativize the very notion of trauma', which is impossible to define by external objective criteria. Paul Lerner and Mark Micale conclude that 'trauma turns out not to be an event per se but rather the *experiencing* or *remembering* of an event in the mind of an individual or the life of a community'. Emphasizing the recollective reconstruction of an event over its occurrence is not about minimising or trivialising the event and its associated suffering, but rather about acknowledging 'the central subjectivity of perceiving and remembering in the psychology *and history* of trauma.'[51]

---

[47] Patrick Bracken, *Trauma: Culture, Meaning and Philosophy* (London, Philadelphia: Whurr Publishers, 2002), p.64.

[48] American Psychiatric Association, *Anxiety Disorders,* in 'Diagnostic and Statistical Manual of Mental Disorders', 3rd editon (American Psychiatric Association: 1980), p.236.

[49] Lerner and Micale, 'Trauma, Psychiatry, and History', in *Traumatic Pasts*.

[50] Dagmar Herzog, *Cold War Freud: Psychoanalysis in an age of catastrophe* (Cambridge University Press: 2017)

[51] Lerner and Micale, 'Trauma, Psychiatry, and History', in *Traumatic Pasts,* p.20.

Trauma, then, is a particular way of remembering that psychiatrists working with refugees have drawn on; a way of remembering rooted in a particular social and political context and informed by practitioners' sense of their own place in history. Critics of trauma have argued that these particular contexts in which trauma originated make it unsuitable and potentially harmful when applied to non-Western populations.[52] This criticism is pertinent to refugee mental health, as the majority of refugees often hail from non-Western countries in the Global South, both currently and since the 1960s.

My intended contribution is to add another dimension to this debate by engaging in historical comparison. If trauma is a Western-centric way of remembering that is unsuitably applied to non-Western populations, what does the therapeutic landscape look like if a way of remembering that originated in Western countries is applied to refugees from these Western countries? This, I argue, was the case in postwar Europe, where a way of remembering that predates trauma – nostalgia, usually in the guise of 'uprooting' – was applied by European practitioners to European refugees. Does the fact that Europeans were aiding Europeans in the aftermath of World War II mean that there were no cultural differences to problematize interactions between the two? No, I argue. As I show in the first three chapters, there was no uniform 'Western culture' among European practitioners and refugees that facilitated interactions between the two. In fact, cultural differences were often alluded to and for some practitioners, like H.B.M. Murphy, heralded a lifetime career in transcultural psychiatry. What seemed to matter more than national origin in bridging the gulf between practitioner and refugee was the experience of war and displacement. While European practitioners working in refugee relief after World War II would have had some similar experience of these to bridge the gap between themselves and those they assisted, the same cannot be said for the European and American humanitarians who worked in refugee camps on the Thai-Cambodian border.

Comparing refugee mental health discourses, ideas, and practices of the 1940s/50s and the 1970s/80s helps to 'control' for the influence of cultural difference as a determining factor in therapeutic interactions and outcomes. By circumscribing and isolating the influence of cultural difference, other structural and institutional influences on refugee mental health practice become apparent: the hierarchical and bureaucratic nature of humanitarian and intergovernmental organisations, the power differentials between

[52] Bracken, *Trauma: Culture, Meaning and Philosophy*

practitioners and refugees, and the disempowering and dependency-inducing manner of international aid. That Baltic refugees have been described as 'dependent' and 'apathetic' in the 1940s, and Southeast Asian and African refugees were similarly described in the 1980s suggests that there is something other than simply cultural difference at play. Interactions between practitioners and refugees should not be reduced to a matter of cultural difference and cultural 'sensitivity', I argue, for this obscures the scale of similarities and continuities in humanitarian NGOs across time.

It is here that, I hope, the contribution of my particular focus on refugees is apparent. More than any other group, a focus on psychiatric interventions with refugees allows an elucidation of the influence of sociopolitical context and notions of cultural and national difference on psychiatric ideas and practice. Refugees are especially apposite for this scholarly inquiry because of their status as a marginalized group existing as an exception outside the 'national order of things'. Another merit of focusing on refugees is that it highlights the linkages between various areas of psychiatry and history of psychiatry, for example by uncovering the military psychiatric roots of refugee mental health, the contribution of refugee mental health to transcultural psychiatry, and the contribution of refugees to trauma and humanitarian psychiatry.

Refugee camp confinement and humanitarian 'care and control'[53]

The refugee camp is also a feature of the twentieth century. It has often been one of the first solutions applied to problems of population displacement. Though refugee camps have been in use since the early twentieth century, it was during World War II that 'the consistent, large-scale use of refugee camps as a response to forced migration' began. At the 'very height of camps as spaces of cruelty [concentration camps], they were adopted as spaces of compassionate humanitarianism'.[54] The effects of camp confinement have received major attention from psychiatrists. The Displaced Persons camps in Europe after the Second World War were not sites of forced labour and extermination like the German network of concentration and extermination camps, but they were far from benign. In different times and places, psychiatrists and relief workers have expressed concern about the demoralisation and apathy they have observed in encamped refugees receiving

---

[53] Malkki, 'Refugees and Exile', p.498.

[54] Kirsten McConnachie, 'Camps of containment: A genealogy of the refugee camp', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development,* 7(3)(2016), p.405.

assistance. In the DP camps, apathy was described in psychoanalytic terms by Allied psychiatrists: refugees had regressed to a child-like state and previously repressed 'primitive' behaviours had become dominant. Psychological rehabilitation was supposed to rebuild their personalities and wean them off dependency so that they could join a civilised society once again. In refugee camps in the Third World, refugees were described in terms similar to the ones used to stigmatise recipients of state welfare benefits in the West, in the language of morality and deservedness. It was only in the 1980s that an anthropologist, Barbara Harrell-Bond, seriously investigated the question of refugee dependency and suggested that it was the paternalistic international aid system that stripped refugees of their autonomy and forced them into a dependent position. This is closely related to the paternalistic and patronising attitudes Western relief workers have often had about the Global South, and their own reactions and frustrations to the situations they find themselves in. In the words of Allison Umar, a Ugandan doctor, public health student, and former refugee in southern Sudan, 'there can be no doubt that relief personnel working with refugees whose conditions are nothing other than disturbing, do experience psychological problems, and this may reflect on their relationship with refugees'.[55]

This thesis is about psychiatry and refugees, but it is also about the institutional response and international frameworks in which psychiatrists work with refugees: international humanitarian organisations, United Nations bodies with a mandate to assist and protect refugees, nation-states and their political priorities, and the sociopolitical contexts that lead to population displacement and encampment. It is also about how refugees have come to be constituted as a problem amenable to a solution, an exception to the 'national order of things' that is often taken to be the natural order of things.[56] I explore the coordinated international action that took place in the field of refugee mental health. The history of population displacement is 'closely linked to the creation and operation of an international refugee regime, meaning in the first instance a set of legal rules, norms and agreements between sovereign states about refugees and states' responsibilities towards them'.[57] Programs of international assistance and frameworks of international law have made refugees into objects of concern. These programs are

[55] UN Library Geneva, UNHCR collection (CDR HEA/MEN/62 D), Allison Umar, 'Refugee mental health: a comprehensive literature review and case study', MSc thesis, London School of Hygiene and Tropical Medicine, 1986, p.22.

[56] Malkki, 'Refugees and Exile'.

[57] Gatrell, *The Making of the Modern Refugee*, p. 5.

informed by cultural representation.[58] Peter Gatrell has written that 'refugee history cannot just be about refugees' since it is bound up with the matrices of administrative and legal practices that characterise refugeedom. He defines refugeedom as 'a matrix involving administrative practices, legal norms, social relations, and refugees' experiences, and how these have been represented in cultural terms', and argues that history is necessary to make sense of and conceptualise this matrix.[59] I explore how psychiatry has shaped, and been shaped by, different understandings of refugeedom.

A key theme in this thesis is the medicalization and problematization of refugee behaviours and attitudes that may have their root not in individual psychopathology, but in the structures of 'humanitarian governance' that serve to simultaneously care for and control refugees.[60] Humanitarian governance is defined by Michael Barnett as 'the increasingly organized and internationalized attempt to save the lives, enhance the welfare, and reduce the suffering of the world's most vulnerable populations'.[61] Psychiatrists working for humanitarian or UN organisations have adopted the view of refugees as a problem to be solved. The consequence for psychiatric research and practice is that they have functioned as an implementer of the views and interests of the states and organisations concerned. This is not to say that psychiatrists politicized their work with refugees – though some did – but that they have had to work in political and politicized contexts. Often they have given medical legitimacy to political concerns and stereotypes in the humanitarian sector about refugees as lazy, idle, and dependent, as the 1940s diagnosis of 'Displaced Person Apathy' shows. Even when psychiatrists have not been involved, the language of mental health has been used by doctors and relief workers to medicalize and stigmatise undesirable behavior in refugees, such as in the 'refugee dependency syndrome' of the 1980s. I examine the role of psychiatry and its attribution of diagnoses to refugees in this process. This is not to suggest that psychiatry has been the main tool of 'care and control' in refugee camps, or that psychiatrists had nefarious motives; it is only to acknowledge that they have been political actors, explicitly or implicitly, who have been aware of the political implications of their work.[62] Even ignoring the sociopolitical

---

[58] Gatrell, *The Making of the Modern Refugee*, preface.

[59] Peter Gatrell, 'Refugees - What's wrong with history?', *Journal of Refugee Studies*, 30(2)(2017), p.170.

[60] Michael Barnett, 'Humanitarian governance', *Annual Review of Political Science,* 16(1)(2013), 379-398.

[61] Michael Barnett, 'Humanitarian governance', p.379.

[62] Malkki, 'Refugees and Exile', p.498.

contexts responsible for refugees' plight, because both relief worker and refugee are powerless to change them, may be seen as a political choice.

I explore the potential of population displacement and refugee camps (and minds) for the generation of scientific knowledge. Psychiatrists working with refugees after the Second World War saw the potential of their refugee work to newly emerging areas of psychiatry. H.B.M. Murphy first became interested in differences in the manifestation of mental disorders across cultures when working in Europe's Displaced Persons camps, going on to become a psychiatric epidemiologist and transcultural psychiatrist. The Swiss psychiatrist and psychoanalyst Maria Pfister-Ammende, coming to terms with the immense differences in practice between analyzing an individual patient on a couch and creating favorable psychological conditions for thousands of encamped refugees, developed an interest in public and community mental health, and in the application of prevention models of public health to mental health. She pursued this interest by joining the World Health Organisation's mental health section. In the 1980s, American psychiatrists saw the potential that studying trauma in Indochinese refugees offered to the emerging science of trauma which was on the rise in the West, partly as a consequence of activism by doctors on behalf of Vietnam War veterans, Holocaust survivors, and victims of rape and incest. Refugee camps and clinics allowed both the generation and accumulation of new knowledge about refugees as well as other groups that psychiatrists saw as sharing similarities with refugees.

A key point here is the political contingency of knowledge creation in refugee contexts. The processes I examine by which doctors have defined certain refugee behaviours or states as pathological, and called into being solutions and treatments for them, is an example of what Michel Foucault has termed 'problematisation'. This term refers to 'the ensemble of discursive and nondiscursive practices that makes something enter into the play of the true and the false and constitutes it an object of thought (whether in the form of moral reflection, scientific knowledge, political analysis or the like)'.[63] Psychiatric knowledge making among refugees was a political process. This does not mean that psychiatry was instrumentalised exclusively or even primarily as a tool of political control; but that the questions asked by researchers and clinicians in refugee and

---

[63] Michel Foucault, Interview with Francois Ewald, "Le Souci de la verité", *Magazine litteraire* 207 (May 1984): 18, quoted in Gary Gutting (ed.), *The Cambridge Companion to Foucault* (Cambridge University Press: 2005), p.38.

humanitarian contexts were influenced to a great deal by the sociopolitical context. The medical and psychiatric problematization of refugees is a case study in the application of technical solutions to a sociopolitical and diplomatic problem, a theme I explore throughout this thesis. Such applications have not gone unchallenged, and the wisdom of applying psychiatric diagnoses to sociopolitical problems of human evil and misery has been questioned. For example, when psychiatrists from the Harvard Program in Refugee Trauma declared a 'mental health crisis' in refugee camps on the Thai-Cambodian border, Australian nun and camp relief worker Joan Healy strongly objected. 'If we name the aftermath of grief, trauma, rape and violence as mental illness and then say that mental illness is widespread, yet another misleading and unfortunate image of the Khmer people is created'.[64]

The refugee camp has received much scholarly attention, which I build on. Refugee camps are made distinctive by their combination of 'care and control'.[65] They are sites of accumulation of documentary evidence and of surveillance. A focus on the refugee camp allows an interrogation of the camp as a space of possibility in addition to aid and confinement. Some authors, such as Thomas Balkelis, have placed refugee camps alongside Erving Goffman's 'total institutions'.[66] Scholars have examined the role of refugee camps as 'laboratories' where social and scientific knowledge whose object is the refugee is generated. Silvia Salvatici has written on how postwar Europe's DP camps constituted a 'a testing ground on which to create an international corps for humanitarianism'.[67] Gerard Daniel Cohen has written about how, in the DP camps, refugees became a became an 'object of precise social-scientific knowledge'.[68] Bertrand

---

64 Cambodian American Women and Youth Oral History Program papers, Schlesinger Library, Harvard University, Cambridge, MA, MC 814 # 1.14, Richard Mollica and Russell Jalbert, *Community of Confinement: The Mental health Crisis in Site Two (Displaced Persons Camps on the Thai-Kampuchean Border),* (World Federation for Mental Health, Committee on Refugees and Migrants, 1989); Refugee Studies Centre, Forced Migration Online, RSC/EK-61 HEA, Joan Healy, 'A Dialogue on Khmer Mental Health from Site 2/Thai-Cambodian Border (January 18th, 1990)', p.2. <http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:563>, [Accessed 14 Aug 2019].

65 Malkki, 'Refugees and Exile', p.498.

66 Tomas Balkelis, 'Living in the Displaced Persons Camp: Lithuanian War Refugees in the West, 1944–54' in Peter Gatrell and Nick Baron (eds.), *Warlands: Population Resettlement and State Reconstruction in the Soviet-East European Borderlands, 1945-50*, (Palgrave Macmillan: 2009); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books: 1961).

67 Silvia Salvatici, '"Help the people to help themselves": UNRRA Relief Workers and European Displaced Persons', *Journal of Refugee Studies,* 25(3)(2012), p.429.

68 Gerard Daniel Cohen, *In War's Wake: Europe's Displaced Persons in the Postwar Order* (Oxford University Press: 2012), p.74.

Taithe has examined how refugee camps on the Thai-Cambodian border in the 1980s constituted an 'environment where knowledge was co-produced by European and American academics and humanitarians'.[69] I build on the work of these authors by examining how psychiatric knowledge was gathered, produced, and applied in these sites of humanitarian relief and containment. The refugee camp, a spatial solution to what is conceptualised as a spatial problem, is a site of exchanges and interactions that structures how refugees and doctors think of each other and of themselves. Focusing on it allows an examination of the ways in which psychiatrists have implicitly adopted states' and international organisations' conceptualisation of refugees as a problem to be solved.

Thesis structure, sources, and progression

I analyse the inception and evolution of refugee mental health in a chronology that extends from 1945, the end of the Second World War, to 1993, when the last refugee camp on the Thai-Cambodian border closed. The material is explored across five chapters. In chapter 1, which covers the 1940s and early 1950s, I explore the 'uprooting' paradigm that guided psychiatric and humanitarian, as well as popular, thinking about European refugees, through the work of Allied psychiatrists in Germany's Displaced Persons camps and the work of Maria Pfister-Ammende in refugee camps in Switzerland. In this chapter, I introduce the first UN organisation, founded in 1943, the United Nations Relief and Rehabilitation Administration (UNRRA). In chapter 2, covering the same time period, I direct my attention to the mental health effects of refugee camp living in postwar Europe. In chapter 3, I introduce the International Refugee Organisation (IRO), the successor to UNRRA, and the United Nations High Commissioner for Refugees (UNHCR), the successor to IRO. I follow the resettlement of European Displaced Persons overseas in Canada, Australia, and Israel. Moving further in the 1950s, I introduce the first Cold War European refugee crisis, when Hungarians fled the Soviet suppression of the Hungarian Revolution in 1956. I also explore the efforts of UNHCR to clear the remaining DP camps in 1959-60, which housed a 'hardcore' of refugees who had not secured offers of resettlement and had been in the camps for over a decade. In chapter 4, I move into the 1960s, questioning and analysing the disappearance of mental health relief efforts from humanitarianism when refugees become a problem of the Third World and humanitarian organisations packed up in Europe and moved south. Throughout the 1960s and 1970s, few

---

[69] Bertrand Taithe, 'The Cradle of the New Humanitarian System? International Work and European Volunteers at the Cambodian Border Camps, 1979–1993', *Contemporary European History*, 25(2)(2016), p.338.

refugees from the Global South were resettled in the West, meaning that far fewer psychiatrists had contact with refugees in this period. I examine the case of Uganda as a refugee receiving country in the 1960s and as a refugee producing country in the 1980s. Chapter 5 spans the late 1970s to the early 1990s, and explores the emergence of the refugee trauma field, from the arrival of Indochinese refugees in the West in 1975 to the declaration of a 'mental health crisis' in Site 2 refugee camp in 1989. It analyses the use of the language of mental health, trauma, and human rights to advocate for a political solution that would allow encamped, traumatised Cambodians to return to their country.

These case studies have been chosen to illustrate the narrative and chronological arc of refugee mental health theory and practice, showing enough continuities to indicate the development of knowledge and ideas while also being different enough to offer comparative value. The case of the post-Second World War European refugee crisis, covered in chapters one and two, seemed a good place to start for two reasons. First, it was in the aftermath of World War II that a new, professionalised medical humanitarianism began to take shape in the ground zero of an occupied Germany. Second, it seems to be, as far as I can tell, the earliest instance of a body of psychiatrists developing an interest in refugee mental health, considered a new frontier by practitioners of the time. The cases of Hungarian refugees in 1956 and the clearance of the remnant 'hardcore' refugee camps of WW2 illustrate how the psychiatric ideas about refugees elaborated in the 1940s and early 1950s took on new meanings in the bipolar political climate of the early Cold War: these are discussed in chapter three.

My choice to examine Uganda as a refugee receiving and producing country in chapter four is informed by my intention to explore the continuities and evolutions in medical humanitarianism going into the 1960s and 1970s, especially as wars of independence in the Third World made countries of the Global South the main site of humanitarian and refugee crises. I chose an African country to illustrate interactions and relationships between refugees in newly independent countries and humanitarians from former colonial powers. The African continent became, by the 1960s, where the major portion of UNHCR resources were invested. As humanitarianism evolved to incorporate World Bank-influenced ideas of 'development', modernisation, and industrialisation of developing economies, African countries became a major site of Western led and oriented development interventions, making an African country ideal for illustrating such developments and their relation (or lack thereof) to mental health. I chose Uganda in particular because of the availability of historical scholarship specifically on refugee

mental health there, namely Yolana Pringle's work on psychiatry and decolonisation in that country. This particular case study could have been strengthened by conducting archival research in Uganda, but the travel restrictions imposed by the COVID-19 pandemic of 2020 made this impossible.

The choice of the other major case study of this thesis, that of Cambodian refugees – and Southeast Asian refugees more broadly – which comprises the final chapter, was relatively straightforward: it was psychiatric work with refugees from the Indochinese peninsula, whether in camps in Southeast Asia or in resettlement in Western countries, that was formative for the refugee mental health field and 'refugee trauma' as we recognise it today. This stems from several contextual factors: the American involvement in Southeast Asia, the state-sponsored resettlement of hundreds of thousands of Indochinese refugees in the West with the United States taking the lion's share, and the availability of federal funds for mental health research and service provision for this group. The same cannot be said of other groups of refugees that arrived in the US in the 1970s and 1980s, such as those arriving from Nicaragua or other Central American countries. Being undocumented and coming from countries ruled by US-supported regimes, refugees from Central America attracted nothing like the federal funding and human rights advocacy that Indochinese refugees did.

Why stop in the early 1990s, precisely when the upsurge of interest in refugee trauma is just beginning, aided by the genocides in the former Yugoslavia and in Rwanda? I found it more worthwhile to begin with post-war Europe and end with the late Cold War, rather than, say, to start with Cambodia and continue into the 21st century for two reasons. First, my chosen case studies allow me to explore a greater diversity of clinical and theoretical psychiatric orientations. Focusing on the 1990s onwards would have led me to focus almost exclusively on the idea of trauma, this being the main diagnostic paradigm and driving force in refugee mental health for over three decades. I wanted to explore what was there before 'trauma' came along – nostalgia, I argue - in the process relativizing trauma as a category and complicating critiques of it as Western-centric and directed. Second, much work has been conducted on the use of the concept of trauma in the Balkans, Rwanda, and elsewhere, usually criticizing it as culturally inappropriate and reflecting Western interests. In my view, many of these critiques seem to be politically or ideologically motivated. I sought to inform this debate by examining how psychiatry arrived at trauma in general, and refugee trauma in particular, in the first place.

My sources include a mix of archival and published primary sources. In the first three chapters, I rely mainly on published primary sources; what has been written by doctors and relief workers, with selected archival material from the United Nations, World Health Organisation, and World Federation for Mental Health. Chapter 4 is to a large degree a case study of an absence; there was nothing in Africa like the institutional mental health response to European displacement. In this chapter I have relied on the published primary sources by the few psychiatrists in Africa who studied refugees and the work of historians who have examined these sources, especially Yolana Pringle's work on Uganda.[70] In chapter 5, the balance shifts towards archival sources, and I rely heavily on medical team reports of the Australian Red Cross Society, World Federation of Mental Health material at the World Health Organisation, and the archives of the Harvard Program in Refugee Trauma's Cambodian American Women and Youth Oral History Project.

My main reason for focusing on these sources, particularly the published primary sources that inform the first three chapters, is that they seem to have been entirely neglected, both in psychiatric practice and in historical scholarship. Integrating them and putting them in dialogue with other sources and the wider historiography allows for a more textured and nuanced understanding of how psychiatric concepts have been fashioned and applied in practice. What these sources allow me to do, and, by extension, what this thesis does, is as follows: they allow me to illustrate the thinking and planning of psychiatrists working with refugees and the decisions taken by them in the various humanitarian, state, academic, and health service organisations they were a part of; to examine the political influences shaping the work of psychiatrists working with refugees; to show how psychiatric concepts were articulated in practice with refugees, and to relate and contextualise the developments in the refugee mental health field to both broader developments in psychiatry and socio-political context.

The nature of these sources does not allow me to examine doctor-patient interactions or the nature of the therapeutic encounter, nor does it allow an exploration of how mental health interventions or medical consultations have been experienced by refugees. Accordingly, this thesis is not a history of therapeutic encounters, nor a 'medical history from below' in the sense articulated by historian Roy Porter.[71] To explore these

---

[70] Yolana Pringle, *Psychiatry and Decolonisation in Uganda* (Palgrave Macmillan: 2019).

[71] Roy Porter, 'The patient's view: Doing medical history from below', *Theory and Society,* 14(2)(1985), pp.175-198.

themes, additional source material would have had to be incorporated. Where hospital files, case notes, and clinic records are in existence, access to them is restricted, such as the files of the International Refugee Organisation at the National Archives in Paris. I made a considered choice not to conduct oral history interviews with refugees, in light of the ethical implications of interviewing potentially vulnerable populations. A previous experience of interviewing refugees during my MA had left a bitter taste and sensitized me to the parasitism that can characterize such research, despite the best intentions of researchers.

The voices of refugees appear in this thesis only insofar as they are quoted by doctors and relief workers, or when the refugees were themselves medical professionals. A methodological challenge in refugee history is the imbalance in the archival material, with the main voices preserved being those of international organisations and NGOs rather than the refugees. As Schwartz and Cook have written, 'Archives – as records – wield power over the shape and direction of historical scholarship, collective memory, and national identity, over how we know ourselves as individuals, groups, and societies.'[72] This has implications for refugee history. In the words of Philip Marfleet, 'Displaced people … are often unable to articulate publicly their experiences and needs and it may be years before their voices are heard.'[73] There is often an 'archival silence' where the voices of refugees and migrants are concerned and we must be aware of the 'power dynamics of the archive in relation to both individual identity and community memory'.[74] Accordingly, this thesis is more about how psychiatrists understood the mental states of their refugee patients than about how refugees articulated them. This is not to say that the voices of refugees are unimportant or tangential to this research. They are heard through the voices of doctors, or directly from them when they themselves have been doctors.

Refugee mental health lies at the intersection of several areas of psychiatry. This thesis is a contribution to histories of trauma, global mental health, and military, colonial, transcultural, and humanitarian psychiatry. It is also a contribution to our understanding of the relationship between humanitarianism and the military in developing mental health

---

[72] J.M. Schwartz and T. Cook, 'Archives, records, and power: The making of modern memory', *Archival Science*, 2(1–2)(2002), p.2.

[73] Philip Marfleet, 'Refugees and history: why we must address the past', *Refugee Survey Quarterly,* 26(3)(2007), p.145.

[74] Paul Dudman, 'Oral History and Collective Memory: Documenting Refugee Voices and the Challenges of Archival Representation', *Atlanti,* 29(2)(2019), p.38.

interventions in situations of crisis and conflict, a theme which has been explored by Hanna Kienzler and Duncan Pedersen.[75] The institutionalization and globalisation of PTSD has been heralded as ushering the 'modern' phase of research in the refugee mental health field, with the 'formative period' of the field identified as the 1970s to the 2000s.[76] The Cambodian border humanitarian crisis was the first refugee crisis in which the concepts of trauma and PTSD were deployed, and it set the stage for an exponential growth in trauma focused mental health programs in humanitarianism in the 1990s, in places like the Balkans and Rwanda. My thesis examines how psychiatry arrived at the 'modern' phase.

To summarize, this thesis examines how psychiatrists have understood and practiced psychiatry with refugees and in refugee camps, and how psychiatric theory has been articulated in refugee contexts. It questions and explores the prominence of psychological interpretations of displacement in scholarship on refugees and interrogates the 'psychologising modes of knowledge and therapeutic forms of relationship' that refugees are often subjected to by those who study or work with them.[77] It contributes to, and creates links among, a wide range of scholarship on the history of psychiatry. It also contributes to refugee studies and refugee history, which thus far have lacked a sustained examination of the history and development of psychological interpretations of displacement and how they have been applied. This thesis is a history of psychiatry through the lens of refugees, and a history of refugees through the lens of psychiatry.

---

[75] Hanna Kienzler and Duncan Pedersen, 'Strange but common bedfellows: The relationship between humanitarians and the military in developing psychosocial interventions for civilian populations affected by armed conflict', *Transcultural Psychiatry,* 49(3-4)(2012), 492-518.

[76] Derrick Silove, Peter Ventevogel, and Susan Rees, 'The contemporary refugee crisis: an overview of mental health challenges', pp.131,133.

[77] Liisa Malkki, 'Refugees and Exile: From "Refugee Studies" to the National Order of Things', *Annual Review of Anthropology*, 24(1)(1995), p.510.

Chapter 1
Displacement

Introduction

In this chapter and the next I seek to answer three questions. What led mid-century psychiatrists to view Europe's refugee problem as an unprecedented problem for psychiatry? What did psychiatrists working for humanitarian and international organisations see as the aim of their refugee relief work? What do the neglected sources I examine tell us about practitioners' work in refugee mental health in the aftermath of World War II? Briefly put, the unprecedented numbers of forcibly displaced people following the war and the sheer impossibility of repatriating millions of them led psychiatrists to view postwar displacement as something distinct from voluntary migration and meriting investigation and study. For those working in the new postwar humanitarian organisations, a major aim of psychiatric work with refugees was to rehabilitate them and prepare them for a return to society, with a view towards maintaining harmonious relations between societies, communities, and nations, and ultimately the prevention of another war.

My answers to these questions come mainly from the published material left by practitioners who worked with refugees or advised organisations with a mandate to provide them with relief, along with selected archival material where relevant. Placing these sources side by side and putting them in dialogue with one another, certain patterns and themes become apparent in the psychiatric and popular discourse around refugees and their mental health. The practitioners whose work I discuss here and in chapter two were aware of each other's work, crossed paths in various organisations, and occasionally corresponded. Put together, their writings indicate a coherent body of scholarly work and practice that constitutes one of the earliest attempts to understand the mental health effects of forced displacement.

This chapter sheds light on an unacknowledged episode in the history of psychiatry when practitioners, humanitarian and intergovernmental organisations, and state governments were intensely interested in the mental health of refugees. Until the European refugee problem receded from view at the end of the 1950s, psychiatrists, psychoanalysts, psychologists, and social workers conducted much conceptual and theoretical work on the

relationship between forced migration and mental illness, and in particular on what it was about becoming a refugee that was conducive to mental ill-health. The concepts they came up with arose out of interactions with and observations of refugees, either individually in the consulting room or hospital (if in resettlement) or as groups in refugee camps. Responses to problems of refugee mental ill-health were fashioned in light of these interactions and the knowledge that arose from them, often in the context of state institutions like the Hostels Administration in Switzerland, or new intergovernmental organisations like the UN Relief and Rehabilitation Administration (UNRRA) and its successor, the International Refugee Organisation (IRO). I explore the state of mind of refugees and displaced persons in postwar Europe, in light of their experiences of displacement and loss of homeland, or what was commonly referred to as 'uprooting'. I also explore the professional medical and psychological efforts to describe and categorise abnormal behaviour and mental states in refugees as a result of uprooting. These histories are intertwined, since many of those professionals had themselves experienced displacement, and their own experiences of persecution and dislocation, though not always comparable to their refugee patients, undoubtedly influenced their approach to studying such experiences.

I challenge the received wisdom about the origins of the field of refugee mental health. A 2013 report on mental health and psychosocial support (MHPSS) for refugees by the Policy Development and Evaluation Service of the UN High Commissioner for Refugees (UNHCR) states that in the postwar period 'there was practically a non-existent recognition of and response to the mental health and psychosocial needs (MHPSS) of refugees in humanitarian contexts', and that the only studies on refugee mental health were those conducted with resettled refugees with a focus on 'traumatic events, torture and conflict'.[1] Although UNHCR had itself appointed psychiatrists as mental health advisers as far back as the 1950s, the report tells us that the mental health needs of refugees in humanitarian contexts only began to be recognised with the emergence of reports on the mental health problems of Cambodian and Vietnamese refugees in Thailand in the 1980s.[2]

---

[1] Sarah Meyer, 'UNHCR's Mental Health and Psychosocial Support for Persons of Concern', *United Nations High Commissioner for Refugees* <https://www.unhcr.org/51bec3359.pdf> [Accessed September 2019], p.21.

[2] Meyer, 'UNHCR's Mental Health', p.21.

The scholarly literature shares this misconception: David Ingleby, for example, introduces a wide-ranging edited volume on forced migration and mental health by stating that prior to the 1980s, 'the concept of humanitarian aid was restricted to the provision of the most basic necessities: food, water, shelter and basic medical care'. Mental health services for refugees, he says, existed only in countries of resettlement, where they were 'viewed primarily as victims of organised violence' rather than displaced people.[3] Ingleby also traces the start of the field to the 1980s, especially as the introduction of the PTSD diagnosis enabled a science of 'refugee trauma' to take root.[4] Similarly, a widely-cited recent article in *World Psychiatry*, whose authors include a senior mental health officer at UNHCR, tells us that it was the diagnosis of PTSD that ushered in the modern era of research in the refugee mental health field, while 'prior to the 1970s, the field lacked robust scientific data detailing the nature, prevalence and determinants of mental health problems amongst refugees'.[5] As I show in this thesis, the 1970s and 1980s were only the beginning of a 'refugee trauma' approach but by no means the first time that psychiatrists took an interest in refugees as a special population worthy of attention. The assumption that the field originated in the late 1970s and 1980s and in close relation with PTSD is itself also an outcome of the legacy of the Holocaust, as later chapters will show.

Although I will discuss concentration camps and their effects on the mental state of those who survived them as understood by contemporary observers, this chapter is not an exploration of the state of mind of 'Holocaust survivors' as we would understand the term today. There was no 'Holocaust' with a capital H in 1945 when the Allies liberated the Nazi camps. When newspapers, magazines and radio reported the discoveries of American soldiers in the liberated camps, they were characterised as 'atrocities'. As Jeffrey Alexander has written, typifying them as 'atrocities' meant that these discoveries were placed side by side 'with a whole series of other brutalities that were considered to be the natural results of the ill wind of this second, very unnatural, and most inhuman world war'.[6] Historian Peter Novick has written that the Holocaust as we understand it today is a retrospective construction that would not have been recognisable to people at the time, and

---

[3] David Ingleby, 'Editor's Introduction', in David Ingleby (ed.), *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons* (Springer: 2005), p.5.

[4] Ingleby, 'Editor's Introduction', pp.6-7.

[5] Derrick Silove, Peter Ventevogel, and Susan Rees, 'The contemporary refugee crisis: an overview of mental health challenges', *World Psychiatry* ,16(2)(2017), p.131.

[6] Jeffrey C Alexander, *Trauma: A Social Theory* (Polity Press: 2012), p.31.

to speak of the Holocaust when talking about Europe in 1945 is to introduce an anachronism which stands in the way of understanding contemporary responses.[7]

Ben Shephard has argued that the Allied planning for the postwar period, in the time leading up to the invasion of Germany in 1945, was counterproductive, relying on past experiences that turned out to be irrelevant and 'which put into place, well before the end of the war, men and mechanisms unsuited to the task'.[8] One particularly important aspect was that the institutions established to help Europe in the aftermath of the war, such as UNRRA, were established in 1942 and 1943, before the Allies were fully aware of what was happening to Europe's Jews. What the Allies were aware of, and effectively monitoring, was the use of more than ten million slave labourers, mainly from Eastern Europe, that had been deported to Germany to feed the Nazi war economy. As a consequence, 'the planners' model was based not on genocide but on the displacement of populations', and 'Displaced Persons', or DPs, was the shorthand term used for all of Hitler's victims. Displaced Persons also became the 'defining mental construct for the rest of the decade'.[9] At the time, the most important legacy of the war was a refugee crisis, for there were one million people who remained in Germany, Austria and Italy who were disinclined to return to their own countries - 'Jews, Poles, Ukrainians, Latvians, Lithuanians, Estonians and Yugoslavs'.[10]

Mental health work followed this understanding of relief: refugees were not seen primarily as people 'traumatised' by years of violence and persecution, but as displaced masses that needed a solution to their homelessness and help in readjusting to life after the turbulent wartime years. Consequently, psychological advisors to UNRRA saw the purpose of psychological work to be the rehabilitation of refugees prior to their repatriation. When UNRRA closed down in 1947 and was replaced by the resettlement minded IRO, psychiatrists saw their task as the preparation for and facilitation of rapid adjustment of refugees in their new societies. This is not to say that the practitioners whose work I will discuss were oblivious to the horrific experiences of violence that their patients had been through. In fact, these experiences often came out in individual interactions between

---

[7] Peter Novick, *The Holocaust in American Life* (Houghton Mifflin:1999), p.20.

[8] Ben Shephard, *The Long Road Home: The Aftermath of the Second World War* (Bodley Head: 2011), p. 2.

[9] Shephard, *The Long Road Home,* p. 2.

[10] Shephard, *The Long Road Home*, p. 2.

practitioner and patient. But the overall framework, influenced by postwar Allied relief models of displacement and the use of refugee camps, was one of 'loss of homeland', 'uprooting', and adaptation. In the 1940s and 1950s, the term 'trauma', when used in connection with the Second World War and refugees, was used to describe the psychological reaction to a wide variety of events. Foremost among these was not violence and genocide, but loss of homeland. For example, to Scottish psychiatrist H.B.M. Murphy, who worked with UNRRA and IRO, the most traumatic experience someone could go through was the 'loss of homeland' - what was widely referred to as 'uprooting'.[11] Editha Sterba, an Austrian and Jewish psychoanalyst who fled for the United States after the Anschluss, wrote in 1940 that the trauma of uprooting was a reenactment of the trauma of weaning from the mother's breast.[12] Similarly, the Dutch Jewish doctor Sal A. Prins, describing his escape from the occupied Netherlands in 1941, called the act of escaping from one's country 'a severe emotional trauma, which I would like to compare with the severing of the umbilical cord in the well known real birth trauma'.[13] It was only in the 1960s that the psychological effects of the Second World War began to be seen in terms of Holocaust trauma, partly as a consequence of battles in German courts and medical journals to obtain compensation for and recognition of the ongoing psychological sequelae that survivors of concentration camps were still experiencing.[14]

The contribution of this chapter is thus a study of practices and understandings of mental health care in refugee relief and humanitarianism in the aftermath of the Second World War, but before the legacy of the Holocaust. I draw on archival and published primary sources detailing the experiences of relief workers, the published medical literature on refugees and mental health, the stories of psychiatrists who were themselves displaced, and the experiences of refugees either in their own words or through the words of doctors and relief personnel working with them.

Initial forays into refugee mental health

---

[11] H.B.M. Murphy, 'The extent of the problem', in H.B.M. Murphy (ed.), *Flight and Resettlement* (UNESCO: 1955), p. 22.

[12] Editha Sterba, 'Homesickness and the mother's breast', *Psychiatric Quarterly,* 14(4)(1940).

[13] SA Prins, 'The individual in flight', in *Flight and resettlement*, pp.26-7.

[14] Dagmar Herzog, *Cold War Freud: Psychoanalysis in An Age of Catastrophe* (Cambridge University Press: 2017).

In the mid-1940s, Swiss psychiatrist and psychoanalyst Maria Pfister-Ammende, director of a mental health service in refugee camps in Switzerland, received an emergency call from the governor of a rural canton. She was told that some refugees, upset with the monotony of the food they were provided, had smashed the windows of their dwelling by throwing potatoes through them. This provoked the ire of a group of Swiss villagers living nearby, who saw this as vandalism and a waste of perfectly good food. The provoked villagers were on their way to the refugee camp, armed with pitchforks. Nothing in Pfister-Ammende's training had prepared her for this. Recalling the incident in 1971, she wrote

> I was a well-intentioned psychoanalyst, fresh from the hot oven of control analysis with no preparation at all for advising on such a conflict … My patient had always been on the couch and I behind him, and I waited for his reaction, helping him to find his way. In this sense the responsibility in the therapeutic process was as much his as it was mine. In the present group situation I found myself more in the position of a psychiatrist a la King Solomon, not as a Freudian psychoanalyst. And, there was no time to wait![15]

In this particular situation, her reaction was to advise 'send up the best woman camp leader you have!' to help defuse the situation.[16] In working with refugees, she could not expect to rely on advice from her mentors. On one occasion, she asked the famous Swiss psychiatrist Carl Jung, then President of the Board of the Psychotherapeutic Institute of the University of Zurich, where she was based, for advice. He 'shied away' and responded 'You have to find the answer yourself, this is another world.'[17] Psychiatrists working with refugees would often find themselves in situations that their training had not prepared them for. This thesis tells their story.

In 1944, with Europe still engulfed in war, Maria Pfister-Ammende sent a petition to the Swiss authorities in which she explained that the psychological situation in refugee camps in Switzerland demanded immediate attention and action. There were 'severely harmed and exhausted persons to care for', and the work of refugee care and relief 'placed heavy demands upon tact, human understanding, and the ability to comprehend the

---

[15] Maria Pfister-Ammende, 'The Doctor as a Community Agent', *Bulletin of the Menninger Clinic*, 35(5)(1971), p.354

[16] Pfister-Ammende, 'The Doctor as a Community Agent', p.354.

[17] Pfister-Ammende, 'The Doctor as a Community Agent', p.359.

particular inner situation of the refugee'.[18] For this reason, she suggested the establishment of a camp mental health service, whose work would be the provision of advice to personnel on difficult camp situations and individual refugees, the treatment and referral of psychiatric cases, and the training of camp personnel in principles of social psychology and 'refugee psychology'.[19] The petition was accompanied by a letter from a group of Swiss psychiatrists from the Board of Supervisors of the Psychotherapeutic Training Institute, including Carl Jung, declaring their agreement with Pfister-Ammende's recommendations. A mental health service would not only be helpful to the Hostels Administration's running of the camps, they said, but it could also, by bringing 'about in the refugees a more positive attitude to the measures taken by the authorities, contribute favourably to the general psychological situation in Switzerland'.[20] Pfister-Ammende was chosen to head the service. She closed her private practice for four and a half years beginning in 1944 to pursue a different kind of psychiatric work, in a setting far removed from the individual and intimate world of psychoanalysis. She became, in her words, 'a member of a police department', the Swiss Federal Department of Justice and Police, which was the state authority that oversaw the administration and functioning of the 300 refugee camps in Switzerland.[21] Her role was the organisation and delivery of a Refugee Psychotherapeutic Service. Pfister-Ammende's main theoretical interest was the psychological sequelae of 'uprooting', which she sought to describe, categorise, and explain. We will return to her work below, but first, a survery of 'uprooting' as understood in the mid-twentieth century is in order.

Uprooting on the couch

---

[18] Maria Pfister-Ammende, 'Mental hygiene in refugee camps', in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After ...* (Springer: 1973), p.241.

[19] Pfister-Ammende, 'Mental hygiene', p.242.

[20] Pfister-Ammende, 'Mental hygiene', p.242. The full name of the Hostels Administration was Federal Camps and Hostels Administration, or *Eidgenössische Zentralleitung der Heime und Lager.*

[21] Maria Pfister-Ammende, 'The Doctor as a Community Agent', *Bulletin of the Menninger Clinic*, 35(5)(1971), p. 353.

Swedish psychoanalyst Stefi Pedersen saw uprooting, or 'sudden severance from the mother country', as the major cause of psychopathology in refugees. Pedersen was born in Berlin into a culturally assimilated Jewish family, though she had been baptised and converted to Catholicism. Following Hitler's ascendancy in 1933, she fled to Prague and then to Norway. After the Nazi invasion of Norway in 1940, she fled across the mountainous border with Sweden, helping a group of Austrian Jewish children that had recently arrived in Norway to flee again. She settled in Stockholm, where she remained until her death in 1980.[22] She would see many refugees in her private practice in Stockholm, both those who fled before being captured by the Nazis and those who had been through concentration camps. Unlike in refugee camps, individual psychoanalytic therapy was a possibility for refugees in resettlement. Pedersen first published on her refugee work in 1949, and later contributed to a 1955 UNESCO sponsored volume on refugee and immigrant mental health.

For Pedersen, it was the process of flight and reaching safety that deeply interested her. There were two aspects of one's flight to safety that she saw could be experienced as traumatic. The first was uprooting from one's homeland which produced a 'psychopathological reaction to extreme social displacement' that she called 'refugee neuroses' or, alternatively, 'displacement trauma'.[23] Displacement traumata often manifested as paranoid states and reactions borne out of being in a new and unfamiliar environment. The second was the experience of wartime persecution, violence and internment (or the threat of them), possibly during the flight to safety. These were reminiscent of the war neuroses seen in soldiers exposed to situations of extreme stress in combat.[24] In 1949, she wrote 'The recent world war has given us so much meaningless, shock-like social displacement, that it seems only reasonable that people have broken down.'[25] The sudden severance and flight from the mother country appeared to 'arouse so much anxiety that the sense of reality is temporarily set out of function', producing 'false evaluations and lack of orientation in the new surroundings' and paranoid behaviour. It was, therefore, 'no mere coincidence that in the treatment of refugees one is almost

---

[22] Elisabeth Punzi, 'Ellen Stephanie (Stefi) Pedersen', *Svenskt kvinnobiografiskt lexikon,* <https://skbl.se/en/article/StefiPedersen> [Accessed September 2019].

[23] Stefi Pedersen, 'Psychopathological reactions to extreme social displacements (refugee neuroses)', *The Psychoanalytic Review (1913-1957),* 36(4)(1949), p. 353.

[24] Stefi Pedersen, Reaching safety, in *Flight and Resettlement*, pp.33-43.

[25] Pedersen, 'Psychopathological reactions', p. 353.

everywhere dealing with paranoid reactions', even if personality structures differed widely.[26]

The earlier transatlantic migrations of Europeans to the New World provided a historical reference point for practitioners working with refugees. Pedersen saw in the paranoid reactions a more extreme manifestation of a tendency common in voluntary emigrants to new lands who were forced to adjust to and make contacts in a new society, making refugee problems similar to 'the mental-hygienic difficulties met by emigrants of earlier times in the new countries to which they came'.[27] The ubiquity of paranoid reactions in refugee patients apparently indicated that 'severe social trauma - in and of itself - has a tendency to release paranoid reactions, regardless of the character structure involved'.[28] The development of paranoid reactions needed to be stopped as soon as possible because they had a tendency to spread, as shown by the case of a thirty year old woman who had been in Sweden for a few months when she visited Pedersen's practice. This woman showed 'a sightly paranoid reaction' but otherwise quite normal behaviour. She complained that she 'never got the right change back when she went shopping', and had recently been indignantly ignored by a department store clerk when she asked for assistance. She felt that the general attitude towards refugees in Sweden was 'just as she had judged the conduct towards herself to have been - unjust, degrading, and ostracizing'.[29] Her daughter had adopted this paranoid attitude from her and felt she was being bullied by school pupils and teachers. Evidently Pedersen, herself a refugee, did not agree with her patient's assessment of Swedish attitudes to refugees, and she helped her patient to see that she was mistaken through analysis.

> When she looked more closely into her way of conducting herself she discovered of her own accord that it had really been her own behaviour which had produced the treatment she had experienced. She would stand uncertain and embarrassed in the background and let other people go ahead of her. When she went to ask for what she wanted, her voice

[26] Pedersen, 'Psychopathological reactions', pp.344-345.
[27] Pedersen, 'Psychopathological reactions', p. 344.
[28] Pedersen, 'Psychopathological reactions', p. 345.
[29] Pedersen, Reaching safety, p. 34.

> became so uncertain and indistinct that it was probable that the very busy department store clerk had not understood that she was saying anything at all.[30]

When the woman, who 'completely lacked insight into her difficulties' first visited Pedersen, she had come because her daughter was having problems in school. But, when she 'clearly understood her false evaluation of the real situation not only did her own paranoid attitude disappear, but the child's as well, without the need for further treatment'.[31] In this particular case, the patient's personality structure was not impaired as a whole because she had 'a stable character structure and more solid roots in reality'.[32] Pedersen's assessment of this woman's condition is open to interpretation. For example, Douglas Robinson has suggested that Pedersen's own successful integration into Swedish society worked to obscure her awareness of how she was inculcating her client with Swedish norms and expectations under the guise of psychoanalysis, making Pedersen an agent and representative of the Swedish state.[33]

More severe cases of paranoia could appear in the young, as in the case of a 19 year old refugee in Sweden. His first attempt to get to Sweden failed and he was captured by the Gestapo. After several months, he managed to get to Sweden. During that time he had been an indirect cause of another man's going to prison. Suspected of being a collaborator, he was not granted official refugee status in Sweden. He reacted to this denial with 'fits of ill temper and subsequent deep depressions'.[34] Six weeks after arrival in Sweden, he tried to kill himself by lying on train tracks, but because his watch was fifteen minutes ahead, he was discovered and moved before the train came. His attempt was not seen as genuine by other refugees, but as a stunt or 'pre-arranged demonstration', and he came to be regarded

---

[30] Pedersen, Reaching safety, p. 34.

[31] Pedersen, Reaching safety, p. 34.

[32] Pedersen, 'Psychopathological reactions', p.348.

[33] Douglas Robinson, *Displacement and the Somatics of Postcolonial Culture* (Ohio State University Press: 2013), p. 6. Robinson suggests that Pedersen's 'own successful assimilation to Swedish society works…to repress awareness of the guidance she gives this client. Pedersen, the professional or institutional representative of Swedish mental health, the client's exemplar of (refugee adaptation to) Swedish calm, fair, tolerant rationality, is her ideal guide to "true" perception, which is to say, to *Swedish* perception, to the proprioception of the Swedish body politic, or the group norms governing ordinary life in Sweden; and Pedersen's inclination to report the normative therapeutic guidance she has been giving her client as the client's own self-discovery is itself part of this guidance.'

[34] Pedersen, 'Psychopathological reactions', p.348.

with even more suspicion.[35] A few weeks later he was sent to work on a farm in the north of Sweden, isolated from the nearest village. Coming from an upper class background, he shunned the hard and poorly paid work and looked with disdain upon other workers. One day he did not go out to the fields and stayed in bed to rest, but he suddenly awoke with the impression that there was someone standing nearby preparing to attack him. He screamed and ran down the stairs, feeling that he had been stabbed in his side. He told others on the farm that he was being pursued, but their search did not find anyone. He was not stabbed either, but had been gashed by a rusty nail on the staircase on his way down.

A doctor was summoned to examine him, and recommended rest in a convalescent home, after which the young man moved to Stockholm where he found work in a large machine shop. He put in all his efforts into getting legal refugee status, which was no easy task, all the while 'filled with insecurity and depression'. When he returned home every night from his strenuous work, he would sink into a state of clouded consciousness where he would sit motionless in a chair and stare at the wall. One time he was awakened with a cigarette burning his fingers. In times like these, he was tormented by one thought: 'Are the others right, or am I right? Am I a Nazi or am I not a Nazi?' Amazingly, his condition vanished entirely in a single day, the day he was granted legal refugee status. Suddenly his 'exaggerated self-consciousness' and his 'very demanding and provocative nature' vanished. Instead, he was 'relieved, youthful, almost happy'. Now, he dismissed this entire period with a wave of the hand, saying with a smile 'That was a hideous time.'[36]

Another patient of Pedersen's, a 25 year old male who had been through concentration camps, exemplified the similarities she saw between traumatic reactions in soldiers and those in victims of violence and persecution. A Polish Jew, he had come to Sweden as part of the Bernadotte expedition, a Swedish Red Cross rescue operation to German concentration camps in March and April 1945. Though it was formally a Red Cross mission led by the Vice-President of the Swedish Red Cross Count Folke Bernadotte, it was actually a Swedish Army detachment funded by the Swedish government. About 17,000 prisoners were transported to Sweden via Denmark up to May 4th, 1945.[37] This patient's family had always looked down on the Poles and respected

---

[35] Pedersen, 'Psychopathological reactions', p.348.

[36] Pedersen, 'Psychopathological reactions', p.348.

[37] Sune Persson, 'Folke Bernadotte and the White Buses', *The Journal of Holocaust Education,* 9(2)(2009).

everything German: ‘You may say what you like, but until Hitler came to power the Germans were a cultural nation.’[38] His whole family was sent to Auschwitz, where he lost contact with his mother and sister, whom he later learned were dead. He saw his father die in what may as well be described as a suicide, for the old man would not eat anything incompatible with Jewish ritual, soon starving to death. In Auschwitz the young man was sent to the gas chambers three times in the space of a few weeks, but never gassed. A member of the SS treated him ‘as a kind of lapdog, which had to obey when he whistled but which he in return protected against the other masters’. Every time, at the last minute when he was about to reach the gas chambers, his SS master would come cycling after him and take him back to the camp.

He was later shipped to Belsen. Two days before the liberation, he had already fallen so weak his fellow inmates thought he was dead and placed him on a pile of corpses. Lying on the pile he thought to himself ‘As I am lying among the corpses, I must be dead’, and he was not able to move. After two days the British came and cleared the pile, and a soldier shouted ‘But he is alive!’ The young man thought in response ‘If he says I am alive, then I am not dead.’[39] Pedersen saw in this patient a ‘severe passivity and lack of willpower’[40] and an ‘extensive reduction in the personality’.[41] The everyday experiences of death and destruction had driven him into a feeling of complete powerlessness and impotence. When he arrived in Sweden, he had spent a year in Auschwitz and six months in Belsen. He did not want to return to Poland, and was housed first in a camp in southern Sweden and then one closer to Stockholm. Clothes, money, and a place to stay were offered by the Swedish Jewish community, he learned a trade, and it seemed likely that he was going to find work. But then he began to suffer feelings of worry and abandonment and slept poorly, and sought Pedersen’s help.

In the consulting room he was ‘like a small child’, unconsciously ‘hoping that the analysis would save him from working and that he would be helped to live on relief’.[42] Unsurprisingly for a psychoanalyst, Pedersen found her patient’s passivity and wish to be

---

[38] Pedersen, ‘Reaching safety’, p. 40.

[39] Pedersen, Reaching safety, p. 41.

[40] Pedersen, Reaching safety, p. 41.

[41] Pedersen, Reaching safety, p. 39.

[42] Pedersen, Reaching safety, p. 40.

taken care of had its roots in his childhood. But then these traits were reinforced through the time in concentration camps. He reported his camp experiences as if they were objective news reports, showing no emotion. He only got excited when talking about how Germans tormented his fellow prisoners, and 'it was obvious that his scorn was aimed not at the oppressor but at the oppressed'.[43] Witnessing his father starve had produced in him an unconscious wish to eat as much food as he could get his hands on. He had big dinners and breakfasts every day and consumed large quantities of sweets, pastries and chocolate. The world around him vanished when he had something sweet tasting in his mouth, and he would stand for hours in front of Stockholm central station, eating sweets and 'waiting'. When asked what he was waiting for he replied 'I don't know. Perhaps I am waiting for some of my former friends. Perhaps some of them will come to Stockholm.'[44] Nothing came of his waiting, and he would stand there in a trance waiting not for the living but for the dead, as if he had not quite realised yet that they were dead.

He put on weight and had to seek medical attention. This state of 'reckless eating' culminated in a severe anxiety attack as he was having breakfast one morning in a restaurant. The cause of the anxiety attack was only revealed to Pedersen when she asked him what he had been eating. Responding angrily and defiantly, he said 'A ham sandwich. Why shouldn't I eat a ham sandwich!' After a long silence he spoke again with some agitation: 'If father had seen that, he would have beaten me to death.'[45] This did not correspond to the history he had given of his father as a gentle, kind-hearted man, but to Pedersen this showed that 'the image of the father had merged with that of the enemy', facilitated by the father's respect for everything German.[46] The patient interpreted his father's preference of starving over eating non-kosher food as an unconscious command: 'Do as I do. You must not eat, that is to say, you shall not live, you shall die.' The Nazi enemy was 'the regressively distorted expression of a very early archaic image of the father'.[47] When he was able, through psychoanalysis, to work through his fear of submitting to the enemy and his feelings of excessive guilt towards his father, his destructive eating tendencies subsided and his mental state gradually improved. Shortly

[43] Pedersen, Reaching safety, p. 41.
[44] Pedersen, Reaching safety, p. 42.
[45] Pedersen, Reaching safety, p. 42.
[46] Pedersen, Reaching safety, p. 42.
[47] Pedersen, Reaching safety, p. 42.

afterward he decided to end his analysis, having fallen in love with a woman and decided to save the money spent on therapy sessions for the wedding. A year later he emigrated overseas with his wife and had largely overcome his attitude of passivity and dependency. ‘For the first time in his life he was in love. He did not live only for the present moment, he could plan for the time to come. He could look forward to a future that might bring happiness’.[48]

Uprooting in the outpatient department and hospital

Stefi Pedersen was able to escape before she could be put in a concentration camp by the Nazis. Leo Eitinger was not so lucky. Eitinger was born in 1912 in the town of Brno, in Moravia in the Austro-Hungarian Empire (present day Czech Republic). He obtained his medical degree in 1937, and fled Czechoslovakia for Norway in 1939 after the Nazi occupation. When the Nazis occupied Norway in 1940, he stayed underground till his arrest in 1942, when he was deported to Auschwitz, where he was a camp doctor,[49] and later moved to Buchenwald. Of 762 Norwegian Jews deported to concentration camps, only 23 survived, Eitinger among them. After the war he returned to Norway to specialise in psychiatry. Eitinger spent much of his career studying the effects of Nazi persecution on survivors.[50] But he also worked with many non-Jews who came to Norway as refugees. In his investigations of refugees, Eitinger reported that ‘in all patients one met an initial suspicion, which in most cases did not disappear until the author had disclosed his own background as a former refugee and concentration camp survivor’.[51] When, in the 1950s, he spent a week in a transit camp in Norway among newly arrived refugees to conduct research, he found that they had an enormous need for communication, which was facilitated by his personal background. The fact that he was a former concentration camp survivor and refugee in Norway became rapidly known in the camp and contributed to the establishment of rapport and good contact between Eitinger and the refugees.[52]

---

[48] Pedersen, Reaching safety, p. 43.

[49] Leo Eitinger, ‘The symptomatology of mental disease among refugees in Norway, *Journal of Mental Science*, 106(444)(1960), p. 960.

[50] ‘About Leo Eitinger’, *University of Oslo,* <https://www.uio.no/english/about/facts/awards/human-rights/leo-eitinger/> [Accessed September 2019].

[51] Leo Eitinger, ‘Mental diseases among refugees in Norway after World War II’, in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After* ... (Springer: 1973).

[52] Leo Eitinger, ‘A Clinical and Social Psychiatric Investigation of a ‘Hard-Core’ Refugee Transport in Norway’, *International Journal of Social Psychiatry,* 5(4)(1960).

Eitinger conducted an investigation of all 95 refugees who were treated in psychiatric departments (hospital or outpatient) in Norway between the start of 1946 and the end of 1955.[53] He also found paranoid thinking to be common among refugees. The isolation of a refugee in a new national, social and linguistic environment provided fertile ground for the development of paranoid ideation and behaviour.[54] The recently arrived refugee was exposed to an 'overflowing' of novel stimuli, 'which appeal to every sense and degree of experience', and which demanded 'such great adaptability that individuals less well equipped intellectually or affectively' would react pathologically. Isolation would breed insecurity, and the refugee would in turn project his own insecurities on the surrounding environment which was the source of 'overwhelming impressions [that] cannot be absorbed and "digested"', leading to a 'breakdown of the total personality'. No feeling of solidarity was available to the isolated refugee, nor did they possess any 'understanding of the situation or of the inner meaning of the impressions' they were exposed to, or of their 'position in the whole of this unknown and overwhelming system'.[55] The overflowing of new stimuli in complete isolation, combined with the refugee's feelings of insecurity, resulted clinically in confusional and persecutory paranoid psychotic pictures. Important external factors augmenting the refugee's insecurity and contributing to psychotic paranoid reactions were the 'economic dependency and restrictive laws concerning all foreigners' in Norway.[56] Eitinger concluded that 'difficulties during the first three years of "root-taking" are experienced as especially severe and traumatising', which necessitated 'social and mental-hygienic arrangements for refugees in this space of time'.[57]

For every refugee, circumstances in Norway conspired with their prior experiences to determine if, when, how, and to what degree they would break down mentally. There was, for example, the unmarried Polish man who came to Norway after the war and found regular employment. He did not seek to make any contacts and lived an introverted, isolated lifestyle. When he received a letter from the International Refugee Organisation

---

[53] Eitinger, 'The symptomatology'.
[54] Eitinger, 'Mental diseases among refugees'.
[55] Eitinger, 'Mental diseases among refugees', p. 197.
[56] Eitinger, 'Mental diseases among refugees', p. 198.
[57] Eitinger, 'Mental diseases among refugees', p. 199.

inquiring about somebody from his hometown he became paranoid, anxious, and depressed. He saw Jesus in his dreams and thought he was going to be deported to Siberia to die. Fearful of being spied upon, he went to the police, who sent him to a doctor. He thought the doctor's medicine was poison and refused to take it. He was diagnosed with paranoid schizophrenia and admitted to a mental hospital, where he had further persecutory delusions and both auditory and visual hallucinations. Electroconvulsive therapy (ECT) and insulin coma (a now entirely discredited form of treatment) produced no improvement. He deteriorated steadily and became more insecure and aggressive, necessitating treatment on a maximum security ward. An attempted follow up could not take place because he could not be reached.[58]

Sometimes prejudice from the local population played a part in a refugee's paranoia, such as in the case of a Yugoslav national who developed a reactive psychosis in Norway. He was in the Yugoslavian Navy when he was taken prisoner by the Germans and put to forced labour. The Gestapo imprisoned him when he tried to escape. In prison, he attempted suicide by stabbing himself in the chest, which led to empyema (accumulation of pus in the tissues lining the lungs) and a purulent pericarditis (inflammation of the lining of the heart). He got to Norway just before the end of the war and married a local, which did no good for him as the marriage became a site of conflict, accusations, and insults, largely because his national origins were a favourite 'topic of conversation' - as Eitinger put it, 'Balkan bandit and the like'. His health deteriorated and he developed hysterical conversion symptoms (loss of function of a part of the body in the absence of any organic lesion) necessitating hospitalisation. He developed persecutory delusions, asked for police protection, and then begged them not to shoot him. These symptoms cleared up gradually with ECT, but at follow up he was still preoccupied with his conversion symptoms and the marriage situation was no better.[59]

There was a Polish Jew who was only 13 when the war started. He lost his parents and all his siblings in concentration camps. After liberation and until 1952 he spent several years in multiple sanatoria for tuberculosis, with his 'healthy' intervals in displaced persons camps. In 1950 he married a Sudeten woman, and in 1952 he came to Norway as part of a 'hardcore' transport of refugees - those who, due to physical or mental

[58] Eitinger, 'The symptomatology', p. 954

[59] Eitinger, 'The symptomatology', p. 955

disabilities, found difficulty securing offers of immigration because they didn't fit the profile of the healthy, able-bodied worker Western countries were looking for (and their families, if they didn't want to be separated). Soon after arrival in Norway, his wife became pregnant. 'Well meaning' neighbours suggested that he should have the expected child christened so as to be a 'proper Norwegian'. After this he became suspicious and gradually developed 'massive paranoid delusions', thought he was being poisoned, and feared being gassed. On hospital admission he appeared 'afraid, unhappy, perplexed, unclear, confused, and hallucinated'. He received ECT and was discharged but required readmission later. Later follow up found him free of symptoms, well adjusted to his employment, and 'matrimonial conditions were good'.[60]

One feature of mental health responses by people like Pedersen and Eitinger that was unique to the postwar era was the common European background of both psychiatrists/relief workers and refugees. They may have had a language in common, known something about each others' countries or even hailed from the same country, and both had witnessed or experienced war and displacement. Perhaps this made them more able to understand or empathise with the people they were helping. For example, military psychiatrists advised UNRRA that a considerable number of the personnel in direct contact with the DPs should be 'those who have personal experience of the problem concerned and who have, in fact, *passed through the phases of difficulty and readjustment'* [emphasis added]. This would have the beneficial effect of letting DPs 'feel that the controlling authority [of the camps] contains effective representatives of their point of view' as opposed to feeling 'that they are being handled by people who have no personal experience of their problem'.[61] Hence it was not enough for relief workers to have had similar experiences; they needed to have successfully left behind that period in their lives and readjusted to a new life, making the relief workers a sort of role model for the refugee. It is not unreasonable to conjecture that former refugees like Pedersen and Eitinger may have seen themselves as examples of well adjusted and successful people to be emulated by their patients, reinforcing the idea that uprooting was to be treated by successfully growing new roots.

---

[60] Eitinger, 'The symptomatology', p. 956.

[61] United Nations Archives (hereafter UNA), New York City, S-1304-0000-0257, 'Psychological problems of displaced persons; a report prepared for the Welfare Division of the European Regional Office of UNRRA by an Inter-Allied Psychological Study Group', June 1945, pp.30-31.

Uprootedness and loss of homeland as pathology

According to Gerard Daniel Cohen, ‘more than any other feature, “uprootedness” encapsulated the displaced condition’. It constituted a trope on its own, one that was very popular in migration studies. Immigration historian Oscar Handlin, in his 1951 history of nineteenth-century transatlantic migration of European peasants to the United States, *The Uprooted*, described their migration in terms that Cohen says were ‘strikingly applicable to the DP experience’. Cohen sees Handlin, writing in the midst of the refugee crisis in postwar Europe, as conceiving of ‘mass migration to the United States as a process of absolute dislocation’. The resettlement of DPs in the New World ‘appeared indeed just as “uprooting” as previous waves of transoceanic crossings’.[62] The erection of the Iron Curtain after the war cemented this idea of uprooting, since it made the exile of many refugees ‘permanent and definitive’. With the onset of the Cold War, uprootedness became a ‘distinctive refugee pathology and a metaphor widely embraced by humanitarian actors’ - much like ‘traumatized’ at the end of the Cold War. The official emblem used by UNHCR in World Refugee Year in 1959-60 was that of an uprooted oak tree, symbolising the violent wrenching of human beings from their original surroundings.[63] In 1957, former US First Lady and refugee advocate Eleanor Roosevelt referred to ‘the age of the uprooted man’,[64] and European DPs exemplified, in the words of Elfan Rees of the World Council of Churches (WCC), ‘the age of the uprooted and the century of the homeless man’.[65] In this context, it is little wonder that psychiatry also adopted the idea of uprootedness when working with refugees.

The psychological sequelae of forced migration were a new concern of psychiatry’s. While insights could be obtained from studies on the mental health of immigrants and the effect of voluntary migration on the immigrant’s health, much less was known about forced migration. Though information existed on some groups like the nineteenth-century Irish immigrants to America, psychiatrist H.B.M. Murphy wrote in 1955, it was ‘difficult to say whether that migration should be called mainly voluntary or

---

[62] Gerard Daniel Cohen, *In War’s Wake: Europe’s Displaced Persons in the Postwar Order* (Oxford University Press: 2012), p.157.

[63] Cohen, *In War’s Wake,* p.157.

[64] Quoted in Carl J. Bon Tempo, *Americans at the Gate: The United States and Refugees during the Cold War* (Princeton University Press: 2008), p.11.

[65] Cohen, *In War’s Wake,* p.157.

forced. The present time is thus almost the first occasion on which it has been possible for the personal effects of flight and forced migration to be investigated.'[66] Murphy drew distinctions between different groups of people that could be called refugees, based on whether or not they had experienced a 'loss of homeland'. Those who had fled Europe before the war and those in Displaced Persons (DP) camps in Germany, as well as the anti-Communist East Europeans who started arriving in Germany from 1948, had experienced a loss of homeland; but repatriates and those caught up in population transfers had not. One reason Murphy devoted most of his attention to the 'D.P. type of refugee who has lost his homeland and who must seek resettlement among people of a different culture' was practical: there was readily available and elaborate data on them from IRO. But there was a personal reason too: what he described as his 'belief that loss of homeland was the most "traumatic" of the experiences which refugees undergo'.[67] Thus it was the loss of homeland that was considered the defining feature of a refugee or displaced person.

One of the first psychiatrists to systematically study the condition of the postwar uprooted, was the Swiss psychiatrist and Freudian psychoanalyst Maria Pfister-Ammende, whom we encountered at the beginning of this chapter. Pfister-Ammende was born in Bamberg, Germany, and obtained her medical degree from the University of Zurich in Switzerland in 1937. She did her postgraduate training in psychiatry and psychoanalysis in Germany and Switzerland. Though Switzerland remained neutral as the rest of Europe was engulfed in war, the war would influence Maria Pfister-Ammende's medical skills in ways that she would recall as helpful in the transition from private practice and psychoanalysis to her work in refugee camps. In a rural area in the Canton Appenzell, she was called to take take over the task of general practitioners who had been conscripted to the military. It was during this time in rural Switzerland that she first became cognisant of 'an environment different from my own in values, customs and social patterns', a 'world of poverty, of isolation, and of ignorance'. Later she would come to see commonalities between the 'extreme situations' of persecution and flight from one's homeland and similarly extreme situations of 'permanent social stress such as poverty, social and cultural isolation, and educational deprivation', both of which led to mental suffering and distress at the individual and group level. These groups, 'as long as they are forced to struggle for survival', did not need and would not benefit from individual, one-to-one treatments like

---

[66] Murphy, 'The extent of the problem', in *Flight and Resettlement*, p.11.

[67] Murphy, 'The extent of the problem', p.22.

psychoanalysis. What she advocated instead was an early example of public mental health work. Different 'sociotherapeutic' approaches were needed as well as a different attitude from the mental health worker; a 'social intervention combined with psychological understanding, advice and occasional psychotherapy' that, whenever possible, should 'be initiated by people from the particular setting and should if possible be carried out together with them'.[68] A decade later she would be in a position to apply public health methods to mental health on a global scale, as a Medical Officer in the mental health division of the World Health Organization.

From 1933 to 1939, responsibility for the care of refugees arriving in Switzerland was placed with the cantonal authorities. With the onset of hostilities and the swelling of refugee numbers, the Swiss Federal Department of Justice and Police and the Swiss Army took over. A specially constituted service was established, the Federal Camps and Hostels Administration (*Eidgenössische Zentralleitung der Heime und Lager*). The refugees included civilians as well as military formations that crossed the Swiss border *en bloc,* including a Polish division and the French 45th Army Corps. Military formations were placed under special control. Some civilians returned home as soon as they could, such as the border populations of Alsace and Italy. There remained, however, 55000 who had no prospect of returning home anytime soon. Of these, 20000 were placed in private lodging, and the remaining 35000 were placed in camps and homes under the auspices of the Hostels Administration.[69] A fifth of the refugees were from Germany, and a further quarter from Poland, with the remainder from Eastern Europe and 16% stateless.[70] In 1944, the Swiss Academy of Medical Sciences entrusted Pfister-Ammende with an investigation of 'the serious psychological difficulties which refugee aid was encountering'.[71] This was followed by a petition Maria Pfister-Ammende sent to the authorities urging the establishment of a mental health service for refugees, as previously mentioned above. The newly constituted 'Refugee Psychotherapeutic Service' would be headed by her, under the Federal Department of Justice and Police. She may have had some scruples about working for a police department, for in a 1955 essay she pointed out in that she was not the first

---

[68] Pfister-Ammende, 'The Doctor as a Community Agent', p.356.

[69] Maria Pfister-Ammende, 'The symptomatology, treatment, and prognosis in mentally ill refugees and repatriates in Switzerland, in *Flight and Resettlement* (1955), p. 148.

[70] Pfister-Ammende, 'The symptomatology', p. 150.

[71] Pfister-Ammende, 'The symptomatology', p. 149

psychiatrist to do this; Lucien Bovet had headed a *Service Médico-Pédagogique* under the Police Department of the Canton of Vaud.[72]

Pfister-Ammende conducted what may be the first mental health survey in a refugee camp in 1944; it consisted of psychological interviews with 300 mentally healthy refugees, a survey of 700 case histories of mentally disturbed refugees and Swiss repatriates, and socio-psychological observations of 2000 Soviet Russian refugees.[73] While most of the refugees 'possessed and maintained a measure of inner stability and security and some of them even found new roots',[74] there were many whose

> sole purpose in their life was the reality of their home country - although there was hardly a chance that they would ever return to it. Their roots were there and their country remained a living reality in their memories. Consumed by great nostalgia, they were in danger of fixation [obsession] like all those suffering from homesickness, a tragedy befalling those who, while clinging to the illusion of return, block their way to a new life in a new country.[75]

Rootedness in one's home country, Pfister-Ammende saw, had both individual and social dimensions. Individually, psychological rootedness was dependent on one's mental and emotional development. Socially, the crucial factor determining rootedness was one's relationship with a social environment.[76] In uprooting, those who were 'dependent on their immediate environment' suffered 'the loss of possibility of building [their] life and of human relationships by the individuated, sensitive person'.[77] Uprooting caused its effects in various ways, even in those who were not so embedded in their social environment. For example, it wrenched those who had long identified with their social class and profession out of that class and profession. These individuals, however, had only been 'pseudorooted' to begin with, because 'identification with and adherence to a social level have nothing in

---

[72] Pfister-Ammende, 'The symptomatology', p. 149.

[73] Pfister-Ammende, 'The problem of uprooting', in *Uprooting and After…,* p.7; I am not aware of an archival record of this survey.

[74] Pfister-Ammende, 'The problem of uprooting', p.10.

[75] Pfister-Ammende, 'The problem of uprooting', p.9.

[76] Pfister-Ammende, 'The problem of uprooting', p.14.

[77] Pfister-Ammende, 'The problem of uprooting', p.13.

common with the real security springing from a maternal soil'.[78] The importance of place is a recurrent theme in Pfister-Ammende's work. One of her patients, a young woman from Poland, complained that Switzerland was a country with a 'strange language and high mountains to be afraid of'.[79] Whereas a German who crossed the border from Würtemberg into Switzerland would be familiar with the Swiss climate and mountains, the same could not be said of all refugees.[80] Many refugees, Pfister-Ammende reported, particularly Soviet citizens from Ukraine, had a feeling of 'being oppressed by the mountains', 'a deeply rooted shyness and fear felt by people from the plains'.[81] What all uprooted people had in common was that external events had deprived them of a 'feeling of belonging (*Geborgenheit*) to the real, concrete world', a feeling they needed because they could not 'live without a relatedness to and feeling of "home" derived from their immediate environment'.[82]

While uprooting deprived people of their sense of rootedness and belonging, not all refugees reacted and coped in the same way. Uprootedness was not only the physical dislocation from one's homeland, but also 'an inner psychic process by which an individual loses his ties with his familiar surroundings, human or environmental', a 'drifting in the void'.[83] Merely personal ties to other people, even if strong, were usually not sufficient to give the refugee the support needed to 'feel at home', for these personal bonds would likely suffer in the conditions of camp life and uncertainty about the future.[84] What was needed was a sense of belonging to something that transcended oneself. For example, those who retained some tie to the home country fared better than those who had no ties left. Membership in a community, such as a national one of fellow exiles, also helped, as Pfister-Ammende observed among groups of Italian and Russian women who

---

[78] Pfister-Ammende, 'The problem of uprooting', p.11.

[79] Maria Pfister-Ammende, 'The Long Term Sequelae of Uprooting: Conceptual and Practical Issues', in (eds.) George V. Coelho and Paul I. Ahmed, *Uprooting and Development: Dilemmas of Coping With Modernization* (Plenum Press: 1980), p. 155.

[80] Maria Pfister-Ammende, 'Uprooting and Resettlement as a Sociological Problem', in *Uprooting and Resettlement* (World Federation for Mental Health: 1960), p.23.

[81] Pfister-Ammende, 'The Long Term Sequelae of Uprooting: Conceptual and Practical Issues', p.155.

[82] Pfister-Ammende, 'The problem of uprooting', p.12.

[83] Pfister-Ammende, 'The Long Term Sequelae of Uprooting', p.165.

[84] Pfister-Ammende, 'The Long Term Sequelae of Uprooting', p.170.

'gained strength from a vital comradeship which left no room for loneliness or isolation'.[85] The community membership that came with a 'deep commitment to an idea of religious, political or humanitarian nature' also helped, as it enabled refugees 'to find a deep meaning even in their present transitory existence', so that even camp life had meaning for them.[86] The age at which one was uprooted was an important factor, and in old age 'the capacity for responding to new impressions [was] restricted'. Losing one's social milieu at an old age deprived a refugee of their ability to establish contact with a new environment: 'if abruptly bereft of his homeland, his place in the family and of his world rich in memories of the past, he often creates the impression of having suffered an organic brain lesion as a consequence of the mental shock of the trauma of uprooting'. This could lead to 'stuporous depressions characterised by a peculiar void, a mental metamorphosis which has led to the emptying of the entire psychic apparatus'.[87]

More than any other group, it was Russian refugees who impressed upon Pfister-Ammende the attachment of person to place. This group largely comprised prisoners of war, forced labourers, and deportees to Germany who had managed to escape to Switzerland. Unlike many 'homeless' refugees who saw little chance of returning to their homeland, the Russians came 'as citizens of a powerful nation, still apprehensive in 1943 but then with continually growing confidence of victory. Their homeland and their country was their greatest pride.'[88] This distinction was felt acutely by other refugees. Once during a camp meeting with different nationalities, some Russians accused the other refugees of being cowards because they did not raise their voices in criticism. A stateless refugee replied 'For three years we have been refugees without rights. We are happy to be here at all. You have a red fist backing you up; we have nothing.'[89] On his or her own, or amongst persons of another nationality, the lone Russian refugee felt strange, forsaken, insecure and persecuted, a problem all the more exacerbated because the other refugees and the camp staff often did not speak Russian. When, however, he was 'among persons of his kind', he revived and flourished as an individual. Though other nationalities also tended to group among their own compatriots, particularly Poles, Yugoslavs and Italians, the Russians

---

[85] Pfister-Ammende, 'The problem of uprooting', p.10.

[86] Pfister-Ammende, 'The problem of uprooting', p.9.

[87] Pfister-Ammende, 'The problem of uprooting', p.15.

[88] Maria Pfister-Ammende, 'Displaced Soviet Russians in Switzerland', in *Uprooting and After…*, p.75.

[89] Pfister-Ammende, 'Displaced Soviet Russians', p.80.

demonstrated this phenomenon most clearly, telling Pfister-Ammende that they were 'only able to breathe in the air of the homeland'.[90] One refugee said of Switzerland that it was 'so hard, so many stones, so little earth, the land is so small. Russia is large, a great plain, much earth, many forests and large industries.' General observations notwithstanding, Pfister-Ammende found that she could not carry out thorough psychological examinations and interviews like she did with other refugees because Russians, in her view, were a collectivist people too 'inwardly bound to the Soviet system' to whom the individualism of Europe was strange and foreign.[91]

Refugees who had experienced severe persecution and violence on top of their uprooting were 'deeply traumatised individuals' whose 'suffering has been so great that they cannot go on despite good will and great effort', such as a Jewish woman who had lost all her children in a concentration camp. Pfister-Ammede encountered Jews 'who wanted very much to embark upon voluntary social work in order to be useful and to get over the past they had been through, but they were unable to elicit a response in those whom they wanted to help'. Such individuals had great difficulty coping with the 'makeshift existence of typical camp life' in all its uncertainty and protracted isolation, even more so if they felt their environment to be hostile or the camp had incompetent leadership. These people frequently did 'not react at all and continued to exist in a state of living death'; 'not in a state of inner upset but rather one of silent hopeless surrender'.[92] On the whole, however, Pfister-Ammende observed that neuroses and personality disorders were less common among Jewish refugees than their numbers would suggest. She offered two explanations for this. The first was that most Jews who sought refuge in Switzerland were those who 'voluntarily' fled persecution before they could be deported or interned, and so did not suffer the disorders like those seen in concentration camp survivors. The other reason is that those who had in fact survived concentration camps and made it to Switzerland had strong moral leadership in their camp. The camp for Orthodox Jews was staffed by refugee Orthodox Jewish doctors 'who had been through the hell of persecution and internment with their fellow believers. Thus doctor and patient were linked by a strong bond … As we saw time and again, these doctors could guide the mental reaction of their flock with great skill.' That the Jewish people had endured a thousand years of exile did

---

[90] Pfister-Ammende, 'Displaced Soviet Russians', p.79.

[91] Pfister-Ammende, 'Displaced Soviet Russians', p.74.

[92] Pfister-Ammende, 'The problem of uprooting', p.11.

not seem to have any bearing on the incidence of mental disorder among them, for it was 'only the most recent history of displacement' that was responsible.[93] Jewish refugees could also be sustained by the promise of a new home they had not yet seen, such as the Zionists for whom 'Israel was a reality, not merely a vague hope. They were secure in the knowledge that they were wanted there by the entire people and by relatives.' This was in marked contrast to Swiss repatriates, who 'had literally come home, but their expectations were often disappointed because they were lacking close relationships'.[94] Rootedness was thus not only a function of a particular geographic location, but depended on some sense of belonging that could be derived from that location.

Swiss 'repatriates' were Swiss in citizenship only. They were the children, grandchildren, or further descendants of Swiss citizens who had emigrated to neighbouring countries and established themselves there. Through provisions of Swiss law, they were allowed to retain and pass on Swiss citizenship. Many of the repatriates had remained in Nazi Germany despite their objections to the regime and had only been spurred to leave when the war resulted in a 'total destruction of their livelihoods'.[95] These 'repatriates' allowed Pfister-Ammende to compare between those refugees who had no home to go to and those who, though they had been displaced and sought refuge in the country of their parents or grandparents, were actually in their country of citizenship and not refugees in the legal sense. 90% of these 75000 *Rückwanderer* came over from Germany, 8% from the Baltic countries, and 2% from Poland.[96] Those who arrived in Switzerland before 1944 often established themselves and found work with the help of relatives, but the thousands who came after 1944 had no means to sustain themselves or any remaining links with the land their forefathers had left.[97] Ten thousand of these 'rootless repatriates' were placed in camps alongside the refugees to be looked after by the Hostels Administration, bringing the total number of refugees under its administration to 45000.[98] Though the repatriates did not suffer the legal obstacles that refugees faced, they remained 'quite foreign, both in language and mentality, to the people of their original motherland', and needed help and

---

[93] Pfister-Ammende, 'The symptomatology', p. 161.

[94] Pfister-Ammende, 'The problem of uprooting', p.9.

[95] Pfister-Ammende, 'The symptomatology', p. 170.

[96] Pfister-Ammende, 'The symptomatology', p. 150

[97] Pfister-Ammende, 'The symptomatology', p. 148.

[98] Pfister-Ammende, 'The symptomatology', p. 149.

time to adjust.[99] Despite being able to start looking for work immediately in Switzerland, many suffered a decline in their social status, such as ‘the milking foremen who formed the majority of the working males [who] scarcely found any possibility of resuming their occupation’ as methods in Switzerland were very different from those they were accustomed to in East Prussia.[100]

Comparing the patterns of mental disorder of Swiss repatriates to the refugees - both of whom had been ‘uprooted’ but only one of them facing legal obstacles in Switzerland - showed just how much a refugee’s stress from uprooting could be compounded by their legal status in the country of asylum. While the repatriates showed a four-fold greater incidence of psychiatric morbidity than the settled Swiss population, for the refugees this was five times greater than the local Swiss. Higher rates of psychosis and personality disorders were found among the refugees, except for the ‘organic psychoses’ that were more common in repatriates - due to the preponderance of older age groups among the returning repatriates.[101] The difference was most obvious in suicide rates and patterns of hospitalisation. During the four years of investigation, eight refugees committed suicide, only one of whom had been brought to the attention of psychiatrists previously for schizophrenia. This was an ‘enormous rate’ of 13 per 10000 compared to the local Swiss rate of 2.4 per 10000. Not one case of suicide was recorded among the repatriates, ‘a clear illustration of the very different social psychological situations in which the two groups found themselves’. Combining the cases of suicide with those who had been hospitalised allowed rates of ‘mental breakdown’ to be compared. The refugees showed a rate of 6.7 per 1000, compared to 1.6 for the repatriates.[102]

Maria Pfister-Ammende’s interests in the effects of violence, persecution and uprooting on a refugee’s mind can be seen coming together in the case of Anna Maurer, a Polish woman who came to Switzerland after marrying a Swiss national. Pfister-Ammende met Anna not as a refugee but as a patient in private practice a few years after she had come to Switzerland. While Anna did not have legal obstacles to staying and working in Switzerland, her separation from her home and family caused her great suffering. Anna

---

[99] Pfister-Ammende, ‘The symptomatology’, p. 148.
[100] Pfister-Ammende, ‘The symptomatology’, p. 151.
[101] Pfister-Ammende, ‘The symptomatology’, p. 168.
[102] Pfister-Ammende, ‘The symptomatology’, p. 155.

was born in 1923 in eastern Poland in a middle class Catholic family. The German invasion brought ‘an abrupt end to Anna’s peace, her family security, her job, and her mental development’. For two years she witnessed the massacres of thousands of Jews as well as raids and indiscriminate deportations. During this time she developed a fear of police officers in uniform. She became a victim of one such indiscriminate act, and was driven with others to a field where they were instructed to dig potatoes in the frozen ground with their bare hands. They also had to spend the night there. Those who could not work were beaten to death. On the second day, a man risked his life to save hers. On this ‘field of murder’, Anna was stricken ‘psychically with a severe shock trauma’ which deepened her fear of police uniforms. She hid with her family, but death caught up with her uncle and his family, which whom she saw die before her eyes. Anna was arrested alone and interned in a camp, where she was reunited with her family except for her sister Maria. The camp commander allowed her 33 hours, a ‘race against death’, to fetch Maria from another camp. Pfister-Ammende observed that ‘it was probably their unshakeable family bond which kept them all alive in the following years of deportation and forced labor; but just this very trait was to become fatal to Anna in the future’. It was not literally fatal to her, but the withdrawal of the support system that had allowed her to endure and survive the war deeply disturbed Anna and impeded her ability to build a new life in Switzerland after the war.

Anna was deported in a railroad cattle car with her family to eastern Germany, and three years of forced labor on a farm yard followed. During this time she met a Swiss man, who was a head milker on the same East Prussian farm. In 1945, she married him and moved with him to his country, and this was, paradoxically, ‘probably the hardest moment in the life of the young woman’. That moving to a neutral country untouched by the war was harder than years of forced labour, deportation, and fear for her life seems counterintuitive, but Anna’s separation from her family seemed to put her entire life on hold as she became increasingly isolated and alienated. With her marriage, Anna ‘lost the physical proximity of her family, her mother tongue, her church’, all of which rendered it difficult to take root in Switzerland. She soon had her first child. Her marriage was an unhappy one fraught with difficulties, and she found herself ‘tortured by homesickness for her family’: ‘I was so terribly homesick for my parents, who had moved to Belgium. At that time it was very difficult to have contact with displaced people across the border. I

would have taken the child and gone on foot to meet them.'[103] Pfister-Ammende called this state 'uprooting neurosis'.[104] During a subsequent pregnancy, Anna started to have headaches, developed kleptomaniac impulses, and would steal small items from shops, even if she did not know what they were for, like 'crockery for dogs, brushes for cows…medicaments with Latin names'. These items she 'collected' satisfied an 'inner impulse to "have something in her hand"'. The moment came when she was 'cornered' and caught by police, 'spoken to from behind', just 'like those times with the Germans'. She said 'yes' and 'no' to everything asked, concealing what she could, for 'this had been the rule with the Germans'. She could not explain why she had taken these items, saying 'I do not know' over and over, stupefying those questioning her. She was sentenced conditionally to ten days imprisonment for the theft of items worth 84 Swiss francs. Three days later she suffered a miscarriage. The responsible court, Pfister-Ammende said, unfortunately 'did not know of psychopathologic mechanisms such as uprooting neurosis and instinctual needs which cannot be controlled or stopped by willpower or by a later understanding'.[105] Scorned as a thief in the Swiss village she was living in, she moved with her husband to a city to work with him in the same factory, and gave their child to foster parents.

The uprooting neurosis subsequently manifested in a new way: Anna went on to have an affair with a married man. Like the items she would steal, Pfister-Ammende noted, this man fulfilled the same function; he was like 'the things one can hold in one's hand'. He became a sort of *'Ersatzheimat'* for her, a substitute or replacement 'home' that gave her 'psychologically a feeling of home (*Heimatgefühl*)'.[106] She got pregnant from this affair and the man procured a 'criminal abortion' for her. Eventually Anna's husband became aware of the affair and called the police, and a judicial inquest was opened by the public prosecutor against Anna and her extramarital lover. It was during this time, in 1954, that Anna came to the attention of Maria Pfister-Ammende, who was asked to give her psychiatric opinion to the court. Pfister-Ammende continued to see Anna in private practice and offer her psychotherapy. A few weeks into therapy, Anna came into the clinic 'overjoyed'. The court had decided to drop charges against her and not prosecute.

---

[103] Pfister-Ammende, 'The Long Term Sequelae of Uprooting, pp.155-156.

[104] Pfister-Ammende, 'The Long Term Sequelae of Uprooting, p. 160.

[105] Pfister-Ammende, 'The Long Term Sequelae of Uprooting, pp.156-157.

[106] Pfister-Ammende, 'The Long Term Sequelae of Uprooting, p.161.

Describing her joy, Anna said 'For me the war has ended today, ten years later than for the others'.[107]

The unique trauma of concentration camps

Among the practitioners who worked with and studied refugee mental health and whose work I have examined, at a time when the Holocaust was not yet central to understandings of the psychological legacy of World War II, it was Leo Eitinger that came closest to articulating a more specific trauma of Nazi persecution that went beyond the effects of loss of homeland, undoubtedly influenced by his own experience as a survivor of concentration camps. Unlike other medical professionals who survived the camps, like the Danish Paul Thygesen, the effects of German persecution and internment were not his first concern after the war. Unlike Thygesen, when Eitinger returned to Norway he was not surrounded by a sizeable group of people who had had the same experience. He was not a member of a victims' organization or group and retained a degree of professional detachment from such groups throughout his career. Throughout the 1950s, Eitinger was interested in the experiences of refugees as uprooted people, and wrote his thesis on this topic at the University of Oslo in 1958.[108]

From the 1960s, Eitinger's name became increasingly associated with the study of concentration camp survivors. To Eitinger, concentration camp survivors were a unique kind of psychiatric patient that 'cannot be compared with any other patients hitherto described in psychiatric literature'. While war and slavery were as old as humanity, victors had always annihilated the conquered, and slave camps had always been used to break down the will of the enemy, 'Hitler's regime was the first to apply the finesses of modern technique to carefully planned destruction of both the individual and the group, while well-planned propaganda techniques were used to hide the murderers'.[109] In Eitinger's view, two factors made survivors unique: firstly, this was the 'first opportunity to examine on a large scale, people sentenced to death, in whom the slow but efficacious execution of these sentences was in progress, but was interrupted by the cessation of the war'. This

---

[107] Pfister-Ammende, 'The Long Term Sequelae of Uprooting, p.163.

[108] Ralf Futselaar, 'From camp to claim' in (eds.) Jolande Withuis and Annet Mooij, *The Politics of War Trauma: The Aftermath of World War II in Eleven European Countries* (Aksant: 2010).

[109] Eitinger, 'Concentation camp survivors in Norway and Israel', in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After...* (Springer: 1973), p.190.

distinguished camp survivors from any other group that may have been exposed to extreme situations. Second, while this slow execution was taking place, the survivor's family and background environment were destroyed. Thus the survivors were not only subjected to 'severe immediate psychophysical traumata', but later, they were 'absolutely without any form of anchorage in the world'. Unless this 'existential and essential factor of isolation' was taken into account, it was impossible to compare Jewish concentration camp survivors with any other group.[110] Concentration camp internment produced 'prolonged and deep mental traumata' which 'caused irreversible personality changes' in the form of 'a mental disability which affects every side of the psychic life, the intellectual functions and, especially, emotional life and the life of the will, involving difficulties of adjustment and consequent complications'. Characteristic symptoms were chronic anxiety, nightmares, insomnia, disturbing thoughts and memories and chronic depression. Survivors suffered an 'inability to enjoy anything, to laugh with others, to establish adequate interpersonal contacts, to work with pleasure, to fill a position - in short, inability to live in a normal way'.[111]

Illustrative of this is the case of a Polish concentration camp survivor in Israel who was only 11 when the war started. When the Germans invaded he was put with his mother and grandfather in a ghetto. In the ghetto, he saw his grandfather have his beard scorched off, and then killed, by the Nazis. He quickly developed an uncanny talent for hiding during raids and managed to stay alive even four months after the ghetto was liquidated. In his words, he 'lived like a rat', coming out in the ruins of night to find whatever food he could. He was eventually captured and sent to Auschwitz. Once there, he became, in his admission, reckless and without any scruples. To obtain some extra soup, he got a 'very good' job sorting out the belongings of the exterminated. Immediately after the war, like many European Jews, he tried to emigrate illegally to British Mandate Palestine, was intercepted by the British, and interned in Cyprus. In 1948 he landed in the new state of Israel and immediately volunteered for the armed forces. Despite characterising himself as a 'good soldier', he was reckless and regarded as badly disciplined. He suffered a concussion in 1949 and two more in 1955. After demobilisation, he failed to adjust at all to civilian life, resorting to stealing to satisfy his immediate needs. He had no training in any skill, and lacked the discipline to gain any. In 1962 he was finally hospitalised in a

---

[110] Eitinger, 'Concentation camp survivors', p.190.

[111] Eitinger, 'Concentation camp survivors', p.191.

psychiatric ward, and at the time of interview was 'cynical and reserved', seeing the whole world as a concentration camp.

> They all behave exactly as they did in the camp, everyone thinks only about himself, they just grab all they can lay their hands on. The only difference is the way they speak and their clothes. Apart from this there is no difference.[112]

When asked if there was anyone he trusted, he only laughed. When asked who he hated 'here' in Israel, 'the answer came like a whiplash': 'Everyone'.[113] The question of how many such personality disorders could be attributed to concentration camp internment was in Eitinger's opinion

> a moot question. The different incidents are so entangled and so deeply tragic that I am inclined to look upon this young human wreck more as a concrete symbol of the total lack of meaning of war and persecution than as a "psychiatric compensation problem".[114]

The reference to compensation is indicative of the rising importance of the Holocaust in public discourse at the time of writing, 1965. Compensation and reparations for camp survivors became an explosive issue in the 1960s, as some psychiatrists contended that survivors' ongoing problems were due to issues that had their roots in childhood and character, while others traced these problems to the camps.[115] Eitinger took issue with those writers who attributed symptoms in concentration camp survivors, particularly the chronic hopelessness, to *Entwurzlungsdepression,* meaning 'depression of uprooting', and *Entfremdungsreaktionen,* meaning 'aleniation reactions'. According to this view, it was the fact that the outside world had become a strange and alien place for survivors that caused mental illness in them. Among the proponents of this view was the German Munich-based psychiatrist Kurt Kolle. In 1965, Eitinger responded to Kolle's argument, writing

---

[112] Eitinger, 'Concentation camp survivors', p.188.

[113] Eitinger, 'Concentation camp survivors', p.188.

[114] Eitinger, 'Concentation camp survivors', p.188.

[115] Dagmar Herzog, *Cold War Freud: Psychoanalysis in an age of catastrophe* (Cambridge University Press: 2017), pp.89-122.

> it is difficult to shake off the impression that Kolle was not in a position to comprehend fully the depth of the sufferings and hopelessness which concentration camp prisoners experienced through the exposure to constant and extremely concrete danger of death, and through the knowledge that, often, they were the only survivors of their families.[116]

Such views, Eitinger saw, wrongly 'suggest[ed] that the central pathogenesis is the absolute break, the patient being deprived of contact with the family, environment, and homeland'. While this was indeed a central pathogenic factor in displaced people, the issue was more complex for concentration camp survivors. If these writers were correct, Eitinger wrote, 'the same disorders should be presented by other refugees from Europe', and they were not. He pointed out that there were many Jews in Israel and the USA who had come from the same environment as the survivors, but had escaped before the war. These people too had had their families murdered and homes ruined. In consulting psychiatrists in Israel, Eitinger found that none of these people exhibited the same symptoms as those who had been through the concentration camps: 'Indeed they reacted with depression, moodiness, and sorrow, when they realised in 1945, the full extent of the disaster, and that their families were exterminated. These natural reactions disappeared as was expected after a relatively short time.'[117]

Before the Holocaust became a paradigm for trauma

In attempting to disentangle the memory of the Holocaust from mid-century perceptions of concentration camp survivors, my aim is emphatically not to minimize the importance or influence of the Holocaust to the psychological legacy of World War II. Rather, I hope arrive at a more accurate understanding of what psychiatric perceptions of survivors of Nazi persecution were like in the 1940s and 1950s. Though today the memory of the Holocaust is a 'paradigm for trauma' representing 'the most extreme reach of violence' and providing an 'unavoidable reference point for any experience of pain', Fassin and Rechtman remind us that the 'emergence and unfurling of this memory did not

---

[116] Leo Eitinger, *Concentration Camp Survivors in Norway and Israel* (Universitetsforlaget, Allen and Unwin: 1965), p.28.

[117] Eitinger, 'Concentation camp survivors', pp.188-189.

follow immediately after World War II and the discovery of the extermination camps'.[118] At the time, even Jewish philanthropic and humanitarian organisations whose staff were acutely aware of the sufferings of European Jewry seem to have been reluctant to fully explore the implications of Nazi persecution. Priorities of such organisations, like the Joint Distribution Committee (JDC), were geared more towards physical needs. When engaging with survivor narratives, they preferred ones that reflected such needs and celebrated Jewish resistance, redemption, and survival in spite of the horrors of war, mirroring stories that American Jews told about themselves and which celebrated freedom and spiritual strength.[119]

Such stories did not come straight from the mouths of survivors, but via secondary witnesses that could better communicate the current and immediate needs of survivors to Americans through fundraising networks of Jewish communal organisations. These mediators conveyed 'the urgency and precariousness of the postwar period' and converted survivor narratives into 'fundraising appeals, political justifications for the state of Israel and American immigration reform, and universal parables about freedom and democracy.'[120] Dr Paul Friedman, a Polish-born American Jewish psychiatrist who visited DP camps in September 1946 under the auspices of the JDC, wrote 'the indifference and often downright opposition to psychiatric aid' for survivors after liberation was because

> all of us – I do not by any means exclude myself – were filled with a sharp and pervasive feeling of guilt towards those very victims we were trying to help. As a defence against this omnipresent emotion, leaders in relief work tended to credit the optimistic stories about the survivors, while at the same time they discounted those describing psychological misery and disorder.[121]

Conclusion

In this chapter I have oscillated between the diagnostic paradigms of nostalgia and trauma. I have attempted to shed a light on, and make sense of, mid-century psychiatric

---

[118] Didier Fassin, and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood,* (Princeton University Press: 2009), pp.17-18.
[119] Rachel B. Deblinger, *'In a world still trembling': American Jewish philanthropy and the shaping of Holocaust survivor narratives in postwar America (1945-1953)*, Doctoral dissertation, UCLA, 2014, pp.68-70.
[120] Deblinger, *'In a world still trembling',* p.22
[121] Paul Friedman, 'The road back for the DPs: healing the psychological scars of Nazism', *Commentary,* December 1948 [https://www.commentarymagazine.com/articles/paul-friedman/the-road-back-for-the-dpshealing-the-psychological-scars-of-nazism/, accessed March 2020].

work with European refugees. I have argued that the mere presence of the vocabulary of trauma and its frequent use in military psychiatry was not sufficient for this diagnosis to be taken up by those working with refugees as would happen in the 1970s. In the particular historical moment and moral climate of Europe in 1945, there was no 'Holocaust' as we understand the term today to speak of. It took several decades for Western society's reckoning with the legacy of the Holocaust decades later that would make trauma a thinkable and practicable 'way of remembering' for communities, societies, and cultures. The 'collective belief in the existence of wounds stemming from the history of peoples and individuals' which would enable trauma to become a catch-all category for survivors of combat, genocide, natural disasters and rape had not yet come into being. In 1945, I argue, uprooting, with its lineage in nostalgia, was the more practicable 'way of remembering' that was employed to reckon with the aftermath of world war.[122]

Some medical historians have located in the clinical descriptions of uprooting by mid-twentieth century psychiatrists a resurgence of a diagnosis that had lost its medical status as a disease in the late 19th century: nostalgia. Nostalgia, in its original formulation and in how it was understood during the 18th and early 19th centuries, was not a temporal condition characterised by a longing for the past as we understand it today, but a spatial one that was, in essence, a medicalisation of homesickness.[123] Literary critic and medical historian Jean Starobinski observed in 1966 that nostalgia 'reappeared, sporadically, in the psychiatric literature which, after 1945, was consecrated to the mental disturbances caused by life in prison- and refugee-camps'.[124] In 1975, medical historian George Rosen wrote that nostalgia had reappeared in the twentieth century following attention to

> the psychological disabilities manifested by refugees, displaced persons, prisoners of war and survivors of concentration camps. In dealing with these uprooted people, a number of investigators recognized that their psychological problems were in fact very similar to those which physicians in the 18th and 19th centuries had categorized as nostalgia.[125]

---

[122] Fassin and Rechtman, *Empire of Trauma,*p.21.

[123] Filiberto Fuentenebro de Diego and Carmen Valiente Ots, 'Nostalgia: a conceptual history', *History of psychiatry,* 25(4), (2014).

[124] Jean Starobinski and William S. Kemp (trans.), 'The idea of nostalgia', *Diogenes,* 14(54)(1966) p.101.

[125] George Rosen, 'Nostalgia: a ''forgotten'' psychological disorder', *Psychological Medicine,* 5(4)(1975), p.340.

A few psychiatrists even suggested a revival of nostalgia. A 1976 *British Medical Journal* editorial titled 'Nostalgia: a vanished disease' outlined the guises in which nostalgia manifested itself in the 20th century, all related to migration: 'as a near-universal experience in migrants whether forced (refugees) or voluntary (immigrants, migrant workers); it is one of the factors responsible for the higher incidence of neurosis in migrants than in native populations; and it is possibly a factor causing psychotic illness to be commoner in them too'.[126] It lamented the disappearance of nostalgia as a diagnosis 'in spite of two great wars and their aftermath' in the twentieth century: 'to demote nostalgia from a disease to a doubtful cause of psychosis…even to a rather low ranking precipitating factor in neurosis' was 'flying in the face of all human experience'.[127] The *BMJ* editorial noted that nostalgia had disappeared 'in particular from the titles of military medicine of the last six years', as well as the general medical literature.[128] According to Fuentenebro de Diego and Valiente Ots, 'the last important publication on nostalgia in the twentieth century' was in 1946, on a case of psychosis associated with captivity.[129] De Diego and Valiente Ots, in their conceptual history of nostalgia, have observed that 'consecutive clinical descriptions [of nostalgia] from the seventeenth century up to the present day have been subjected to the aetiopathogenic and clinical paradigms of each period'. The 'nosological relay' of nostalgia into the twentieth century was visible in the clinical pictures of 'pathology associated with exile, forced displacements and psychosis of captivity'.[130]

But is it really possible to characterise the diagnostic terms and clinical pictures used by postwar psychiatrists to describe uprooting as 'nostalgia'? The answer, I believe, would have to be no. The discourse of uprooting does indeed bear a striking structural similarity to the nostalgia first named and described by the Swiss Johannes Hofer in 1688, especially in the writing of Maria Pfister-Ammende. What this means is that, like Hofer, who considered nostalgia to be a disease of spatial and not temporal dislocation, those who conceptualized refugee psychopathology in terms of 'uprooting' implicated the forced spatial and geographical movement of people as pathogenic. But to characterise the

---

[126] Editorial, 'Nostalgia: a vanished disease', *British Medical Journal,* 1(6024)(1976), p.857.

[127] Editorial, 'Nostalgia: a vanished disease', p.857-8.

[128] Editorial, 'Nostalgia: a vanished disease', *British Medical Journal* (1976), p. 857.

[129] Fuentenebro de Diego and Valiente Ots, 'Nostalgia: a conceptual history', p.409.

[130] Fuentenebro de Diego and Valiente Ots, 'Nostalgia: a conceptual history', p.404.

psychopathology of uprooting as a belated nostalgia is a step too far, for mid-twentieth century psychiatrists also frequently employed the language of trauma in describing the effects of uprooting. 'Trauma' was not in existence as an operative or diagnostic concept throughout the two centuries of nostalgia's status as disease. Nostalgia provided doctors with the first framework to approach the emotional state of soldiers (and, to a lesser extent, civilians) away from home. But, as Thomas Dodman has shown, nostalgia's status as disease declined in the third quarter of the nineteenth century, precisely as the idea of psychological trauma was beginning to take root in medicine.[131] Nostalgia would also have been a useless diagnosis. During its time as disease, nostalgia was seen as a deadly condition for which the definitive cure was a return home, with patients sometimes getting better at the mere promise of being allowed to go home. The picture was now different. While looking back towards a lost home was a torment, many refugees did not have a 'home' and social environment anymore to go to even if they wanted to, and in any case their countries would have been rendered unrecognisable by the destruction of war and the redrawing of borders in central and eastern Europe. The emphasis had to be on adjusting to a new country and society. As Starobinski wrote, the very idea of the disease of nostalgia was 'radically modified': 'we no longer speak of the desire to return but on the contrary, the failure of adaptation'. New names applied to the phenomenon of nostalgia, such as 'depressive reactions of social maladjustment' emphasised 'the lack of adaptation to the new society which the individual lives in', shifting the focus from the loss of the patient's original environment to the necessity of finding a sense of home in the new one. As opposed to the desire to return home, which had become a 'useless yearning for a world or way of life from which one has been irrevocably severed', psychiatrists accentuated 'the paramount importance of reintegration in an existing milieu'.[132]

What made it possible and practicable for psychiatrists to frame refugee mental health in terms of uprooting and displacement? The answer lies in the condition that enables both mass refugee movements and assumptions that one must be rooted to a particular geographical location: the nation state. It is in making states and delineating borders to contain within them homogeneous populations that refugees are made. Forced migration and refugees are intertwined with the nation state and its borders, and there is a strong contingent relationship between the emergence of the nation state and the generation

---

[131] Thomas Dodman, *What Nostalgia Was; War, Empire and the Time of A Deadly Emotion* (The University of Chicago Press: 2018).

[132] Starobinski and Kemp (trans.), 'The idea of nostalgia', p.101.

of violent large scale refugee movements.[133] Displacement 'is usually defined by those who study refugees as a subversion of (national) categories, as an international problem'.[134] The 'category of the refugee', the anthropologist Liisa Malkki contends, 'is a particularly informative one in the study of the sociopolitical construction of space and place'.[135]

In examining psychiatry's response to refugees in postwar Europe, we see that sociopolitical constructions of space and place did not only influence psychiatrists' understanding of their refugee patients' problems but also provided the very frame and blueprint which would determine the shape and form that that understanding took. Psychiatric and psychoanalytic understanding of and practice with European refugees after the Second World War differed substantially depending on the context in which the refugee was seen. In the hospital or clinic, the refugee was an individual patient with a story and medical history. In the DP camps, as I will show in the next chapter, psychiatrists adopted the Allies' conception of refugees as an international problem, what Liisa Malkki's calls 'a subversion of national categories'.[136] They approached displacement 'not as a fact about sociopolitical context, but rather as an inner, pathological condition of the displaced', a condition characterised by infantile regression, morally problematic behaviour, and apathy.[137]

Malkki has analysed how certain 'ways of thinking about identity and territory' that are taken for granted are 'reflected in ordinary language, in nationalist discourses, and in scholarly studies of nations, nationalism, and refugees'.[138] An example of such a way of thinking is the premise 'that the world should be composed of sovereign, spatially

---

[133] Randall Hansen, 'State controls: borders, refugees, and citizenship', in Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona (eds.), *Oxford Handbook of Refugee and Forced Migration Studies* (Oxford University Press: 2014).

[134] Liisa Malkki, 'National geographic: The rooting of peoples and the territorialization of national identity among scholars and refugees', *Cultural Anthropology,* 7(1)(1992), p.35.

[135] Malkki, 'National geographic', p.25.

[136] Malkki, 'National geographic', p. 35.

[137] Malkki, 'National geographic', p. 33.

[138] Malkki, 'National geographic', p.25.

discontinuous units',[139] what she calls the 'national order of things',[140] and which is often taken to be the natural order of things. Just how taken for granted these ideas are is crystal clear in postwar psychiatrists' discourses of uprooting and their references to the motherland, the loss of homeland, or the security springing from a maternal soil. How implicitly territorial these concepts are is apparent in the suffix -land in 'motherland' and 'homeland'. Malkki contends that such 'widely held common sense assumptions linking people to place, nation to territory, are not simply territorializing, but deeply metaphysical'. The link between people and place is naturalized, and is conceived in botanical metaphors: 'That is, people are often thought of, and think of themselves, as being rooted in place and as deriving their identity from that rootedness. The roots in question here are not just any kind of roots; very often they are specifically arborescent in form.'[141] Malkki has observed how scholars and disciplines that locate the refugee as their object of study tend to assume that to be 'uprooted and removed from a national community is automatically to lose one's identity, traditions and culture'.[142] I have shown how such assumptions operated in the work of psychiatrists working with refugees in postwar Europe. Not only did uprooted people lose their identity and culture, but the attempt to hold on to lost values from the old culture became a sign of psychopathology, and, in impeding attempts at adaptation to the new country, a cause of psychopathology in itself.

Malkki has theorised the 'analytical consequences of such deeply territorializing concepts of identity' for those who become displaced.[143] Among these are powerful sedentarist assumptions about the connection between people and place that 'directly enable a vision of territorial displacement as pathological'.[144] It is in 'confronting displacement that the sedentarist metaphysic embedded in the national order of things is at its most visible'.[145] These assumptions 'about attachment to place lead us to define

[139] Malkki, 'National geographic', p.26.

[140] Liisa Malkki, 'Refugees and Exile; From "Refugee Studies" to the National Order of Things', *Annual Review of Anthropology*, 24(1)(1995), pp.495-523.

[141] Malkki, 'National geographic', p.27.

[142] Malkki, 'Refugees and Exile', p.508.

[143] Malkki, 'National geographic', p.25.

[144] Malkki, 'National geographic', p.31.

[145] Malkki, 'National geographic', p.29.

displacement not as a fact about sociopolitical context, but rather as an inner, pathological condition of the displaced'. Refugees 'are not ordinary people, but represent, rather, an anomaly requiring specialised correctives and therapeutic interventions'.[146] In studying how refugees become objects of knowledge and management, Malkki argues, it becomes apparent how 'the displacement of refugees is constituted differently from other kinds of deterritorialisation by those states, organisations, and scholars who are concerned with refugees'.[147] To have 'violated, broken roots' is a sign of 'an ailing cultural identity and a damaged nationality'. As both cultural and national identities are conceived in territorial terms, uprootedness 'threatens to denature and spoil these', for to be rooted is 'not only normal; it is also perceived as a moral and spiritual need'.[148] This view finds support in the moral problematisation of refugees in, among others, Pfister-Ammende's writings. Though she insisted that uprootedness did not imply a value judgment, it is clear that uprootedness as a medical problem had moral consequences: during the flight to safety, a refugee's will to survive led to a 'hypertrophy of the instinct of self-preservation with deterioration of moral values', with the main sphere affected appearing to be 'that of moral behaviour based on super-ego control of the drives'.[149]

The emergence of the nation-state was not coterminous with post-WW2 refugee mental health work, but predates it by several decades. Since the mid-nineteenth century and even more so after the collapse of Europe's multiethnic empires after the First World War, European states had been engaged in a process of ethnic homogenisation of populations within their new borders, making refugees of those who did not fit in. But there was little psychiatric attention to the problems of refugees in these decades. The field of psychoanalysis, which emerged out of Sigmund Freud's attempts to treat hysteria starting in 1895, was still coalescing. During and after the First World War, military psychiatrists were preoccupied with shell shock and the war neuroses, and the ensuing debates over who was entitled to a war pension. The Health Organisation of the interwar League of Nations did not have a mental health section. It would take another world war for refugees to become an object of psychiatric attention in their own right and for mental

---

[146] Malkki, 'National geographic', p.33.

[147] Malkki, 'National geographic', p.25.

[148] Malkki, 'National geographic', p.34.

[149] Pfister-Ammende, 'The problem of uprooting', p.7; In psychoanalysis, the superego is the highest level of the psychic structure mapped by Freud, which forms the ethical and moral standards of the personality.

health to assume a place in humanitarianism, only to largely disappear again by the 1960s when the European WW2 refugee problem receded from view. In the next chapter, I will explore how humanitarian agencies and actors in postwar Europe approached the psychological problems of refugees within the setting of the most prevalent solution to population displacement: encampment.

Chapter 2
Containment

Introduction

In the previous chapter I explored the body of theoretical knowledge built by European psychiatrists and psychoanalysts on 'uprooting' that arose out of their experiences with refugees. Uprooting provided a psychological interpretation with which to make sense of the massive and senseless population displacements in Europe following the end of hostilities. The idea of uprooting was structurally very similar to the defunct diagnosis of nostalgia, and was inspired in part by the earlier transatlantic migrations of millions of Europeans to the New World. Diagnoses spawned by the concept of uprooting like 'uprooting neurosis' helped to make sense of refugees' psychological reactions to displacement. But while they offered some insight into the mental state of the displaced, they provided little guidance on how to deal with the psychological problems of Displaced Persons who would spend months or years in DP camps as they planned their future or awaited their fate. Having explored the efforts of individual practitioners in the clinic or hospital in the preceding chapter, in this chapter I analyse the place of psychiatry and mental health in humanitarian relief efforts of the first UN organisation, the United Nations Relief and Rehabilitation Administration (UNRRA). This chapter is an attempt to historicise the device of the refugee camp, through the stories of refugees living in them and of institutional and humanitarian attempts to provide mental health services or apply psychological principles to the camp context.

UNRRA became, as Ben Shephard has written, the 'vessel through which wartime idealism flowed - not simply as an instrument for repairing the horrors of war but as the first of the UN agencies taking international action to tackle the problems of the world'.[1] UNRRA ushered in a new kind of professionalised humanitarianism and relief work, one that would work through governments rather than simply soliciting private charitable donations as in the relief work of the interwar years.[2] The majority of its personnel were

---

[1] Ben Shephard, *The Long Road Home: The Aftermath of the Second World War* (Bodley Head: 2011), p. 50.

[2] Gerard Daniel Cohen, *In War's Wake: Europe's Displaced Persons in the Postwar Order* (Oxford University Press: 2012), p.60.

Anglo-American and French.[3] The major funder was the United States.[4] With UNRRA, humanitarianism finally became, in the words of one relief worker, 'planning minded'.[5] Both its supporters and detractors saw UNRRA as a new experiment in international collaboration – whether it was successful or not. The standard narrative surrounding UNRRA in the historiography has been, as Jessica Reinisch puts it, 'the rise of internationalism after the First World War, followed by its spectacular failure in the 1930s climate of fierce nationalism and protectionism, followed by its eventual triumph in the early 1940s and the second post-war era.'[6] This certainly corresponds to the views of Allied military psychiatrists advising UNRRA on psychological problems of DPs, as I will show below.

In the DP relief effort, a new and professionalized humanitarian industry emerged, and traditional charity groups were transformed into modern NGOs.[7] A new professionalized corps of humanitarian personnel also took shape, and it was at this time that the refugee camp became standardised as a tool for the management of displacement.[8] According to Gerard Cohen, the DP camps became a unique space for the deployment of new techniques of social work, welfare, and management for a generation of American social workers who had forged their skills under the New Deal. American personnel had qualifications in social work and experience in welfare techniques and administration, but had not worked with displaced populations. Europeans had plenty of experience with displacement. The UNRRA-IRO (International Refugee Organisation) experiment had several long lasting international consequences for humanitarianism and soon to be founded UN refugee organisations, such as the UN High Commissioner for Refugees (UNHCR) and the UN Relief and Works Administration for Palestine refugees (UNRWA).[9]

---

[3] Cohen, *In War's Wake,* p.62.

[4] Shephard, *The Long Road Home,* p. 49.

[5] Cohen, *In War's Wake,* p.59.

[6] Jessica Reinisch, 'Internationalism in Relief: The Birth (and Death) of UNRRA, *Past and Present,* 210(suppl_6)(2011), p259.

[7] Cohen, *In War's Wake,* p.64.

[8] Cohen, *In War's Wake,* p.61.

[9] Cohen, *In War's Wake,* p.61.

'Displaced Persons' was the name given by the Allies to those citizens nations that had suffered under the Germans and who would be eligible for UNRRA aid. As the name given to them implied, the problem of DPs was a spatial one, that would be solved by a spatial solution, a mere replacement and repatriation of the displaced back to their countries. In the meantime, the temporary solution pending repatriation was also a spatial one, containment in camps. Each DP was a mere number among thousands of other DPs rather than an individual with their own history and story. Collapsed into a single humanitarian category, Gerard Cohen writes, 'refugee experiences lost their historical specificity', and DPs became an 'abstract group of dispossessed people united by a need for special care'. Silvia Salvatici identifies an early instance of 'refugee depersonalisation' in the DP camps and UNRRA's relief work, an enduring feature of humanitarianism 'which underwent a significant laboratory test in the administration of DPs in the camps after the war'.[10] European Displaced Persons were the first postwar refugees to experience this disempowerment.[11]

The DP camps constituted 'a testing ground on which to create an international corps for humanitarianism', providing for the first time a fertile environment for military psychiatrists to apply the knowledge gained in the war to civilian masses in the postwar era.[12] The DP became an 'object of precise social-scientific knowledge' and the figure of the refugee was transformed from a war displaced civilian to an object of humanitarianism.[13] The containment of DPs under the central authority of UNRRA enabled close and continuous observation of masses of refugees to take place, and observation of the results of relief provision and welfare techniques on them. According to psychiatrists advising UNRRA, even if the results of social welfare work in the camps were disheartening, 'we shall at least learn something about the practical handling of human problems'. The camps provided them with a test case for 'the application to human affairs of the determined if only relative objectivity of modern psychology and sociology',

---

[10] Silvia Salvatici, '"Help the people to help themselves": UNRRA Relief Workers and European Displaced Persons', *Journal of Refugee Studies,* 25(3)(2012), p.432.

[11] Cohen, *In War's Wake,* p.77.

[12] Salvatici, 'UNRRA Relief Workers and European DPs', p.429.

[13] Cohen, *In War's Wake,* pp.74, 77.

with the possibility of 'improving the quality of human relationships, between individuals and groups'.[14]

For the millions of deportees, forced labourers, and concentration camp prisoners who were in Nazi Germany at the time of liberation in 1945 and were subsequently housed in Displaced Persons camps, there was neither the time nor the personnel to undertake the kind of long follow-up studies that would later be conducted by Eitinger or the psychoanalytic therapy of Pedersen. Insights into the mental state of the uprooted helped to understand some of what Displaced Persons were feeling and experiencing, but it did nothing to solve the logistical problem of millions of displaced persons that needed to be organised, clothed, fed, rehabilitated, and repatriated. The spatial containment of thousands of refugees in camps pending repatriation demanded the application of psychological principles on a mass level. Among the intellectual currents that influenced the humanitarian response to the war was the growth of psychology, and particularly Freudian psychoanalysis. In Western societies, the interwar period had seen the proliferation and popularisation of psychology and its application to areas of everyday life like education, advertising, industry, and juvenile delinquency. As the role of religion declined, psychology effectively established itself in the field of child rearing and development. The war also came to be seen in psychological terms. 'And so, for the first time in history, those who planned postwar relief in the 1940s factored in psychology; they had a vision of ameliorating the psychological aftermath of the conflict.'[15] In late 1944, an Inter-Allied Psychological Study Group (IAPSG) was formed as part of the Welfare division of UNRRA in Europe. Its members were largely Allied military psychiatrists, and in June 1945 they authored a report for UNRRA titled 'Psychological problems of displaced persons' in which they outlined an ambitious plan for the psychological rehabilitation of DPs in preparation for their repatriation. In the view of its authors, rehabilitation, the second R in UNRRA, had to go beyond beyond the simple provision of material aid and draw on the objective methods of psychology and sociology, 'for man does not live by bread alone'.[16] Though military psychiatrists did contribute to higher level UNRRA planning, it is doubtful whether they had much influence on day to day relief operations. In

---

[14] United Nations Archives (hereafter UNA), New York City, S-1304-0000-0257, 'Psychological problems of displaced persons; a report prepared for the Welfare Division of the European Regional Office of UNRRA by an Inter-Allied Psychological Study Group', June 1945, p.40.

[15] Shephard, *The Long Road Home,* p. 303.

[16] UNA, 'Psychological problems of DPs', p.1.

the French zone of occupation, for example, most French recruits had not even heard of Freud, writes Laure Humbert. And although many American recruits had relevant educational qualifications, and their work was somewhat informed by psychoanalytic theory, few were actually trained psychologists or psychoanalysts. Nevertheless, they understood their role as not only preventing disease and famine, but also the alleviation of psychological suffering.[17]

Allied military psychiatrists, having just emerged victorious from the war, saw DP camp work as only the first step in a new postwar era of international cooperation in the field of mental health. Indicative of the global role they envisioned for themselves after the war, they declared 'Perhaps we may thus find some hope of minimising these human discontents which led to the massive tragedy of modern war.'[18] The DPs were the symptom, and most tangible legacy, of the war, both reminiscent of the 1930s and an opportunity for the present and future: 'The strikes after the last [first world] war, the industrial unrest, the brittle international relationships, the pacifism, the pleasure seeking, and even the despairing cynicism from which fascism grew, were not unrelated to the emotional regression society suffered from, after its years of anguish.'[19] For these psychiatrists, the DP episode was a trial run for a new era of 'international mental health', and soon the mental health of refugees would merge with other postwar concerns on the agenda of newly founded organisations like the World Health Organisation (WHO) and the first international mental health NGO, the World Federation for Mental Health (WFMH), both founded in 1948. Military psychiatrists were also at the highest levels of these new organizations. They saw the mental health of DPs as crucial to the mental health of the communities and nations they would end up living in, and in turn the mental health of these communities and nations was key to the preservation of peace and avoiding another world war.

> Today we are better armed, for we have that example before us, and we know that the health of international relationships grows out of the mental health of nations. The mental health of any large section of humanity is therefore of consequence to the remainder. The

---

[17] Laure Humbert, '"When Most Relief Workers Had Never Heard of Freud": UNRRA in the French Zone of Occupation in Germany, 1945-47', in (eds.) Sandra Barkhof and Angela K Smith, *War and Displacement in the Twentieth Century: Global Conflicts* (Routlegde:2014), pp.199-223.

[18] UNA, 'Psychological problems of DPs', p.40.

[19] 'Pacifism' with a negative connotation as in this context most likely refers to the policy of appeasement and the desire to avoid a war in the 1930s.

> displaced people are a force of opinion and emotion and of great importance, and the state of mental health they can achieve will influence political, economic, and social health in several nations. The recapture of their self-respect, their recovery from mistrust of authority, the social resolution of their personal aims, in fact their psychological as well as their physical return to society is more than an individual matter; it is an attempt to heal a large wound in world society.[20]

Liberation

Though the Red Army had liberated Auschwitz in January of 1945, Moscow had given the event no publicity. The Allied militaries were wholly unprepared for what they found when they liberated Dachau, Buchenwald, and Bergen-Belsen.[21] Seen as another wartime atrocity among many, contemporary reports did not emphasise that most of the camp victims were Jewish, let alone that the extensive network of death camps uncovered was the final act of the Nazi 'Final Solution'.[22] Allied soldiers expected the liberated prisoners to be 'tractable, grateful and powerless', and this was the implicit assumption in their plans for the care and control of displaced persons. Instead, their behaviour earned the name 'Liberation Complex' - a triad of revenge, hunger, and exultation that made DPs' behaviour and conduct problematic for the liberators, and complicated plans for their care, feeding, disinfection, registration and repatriation.[23] Marta Korwin, a Polish social worker attached to the British Military Government, was one of the first persons to try to understand the state of mind of DPs. She was already in a DP camp in Bocholt in early April 1945.[24] Korwin was born Magdalena Maria Lipkowska in 1907 in Vilnius in the Russian Empire (present day Lithuania) to a wealthy family. Her family was captured and sentenced to death during the Russian Revolution but were released and escaped to Poland. Her international career as a pianist ended with the German invasion of Poland. After the German invasion she volunteered at a hospital in Warsaw founded by the Maltese order of Poland in cooperation with the Red Cross. During the bombing of Warsaw her right hand

---

[20] UNA, 'Psychological problems of DPs', p.49.

[21] Shephard, *The Long Road Home,* p. 70.

[22] Shephard, *The Long Road Home,* p. 418, footnote 12.

[23] Harry Cotes and Albert Weinberg, United States Army in World War II Special Studies, Civil Affairs: soldiers become governors, (Center of Military History United States Army: 1986), p. 858 [https://history.army.mil/html/books/011/11-3/CMH_Pub_11-3.pdf, Accessed March 2020].

[24] Shephard, *The Long Road Home,* p.67.

was severely injured and she would never play the piano again. While working at the hospital she secretly joined the Polish resistance and took up the name Marta Korwin. She was captured by the Gestapo, escaped, and in 1940 managed to flee to the UK. In October 1944 she joined UNRRA as a Welfare Officer. She became a British citizen in 1948.[25] In the early 1950s she emigrated to the US, becoming a professor of social work at Florida State University.[26] Korwin saw that the reasons behind the unbalanced behaviour of DPs were 'fear of the future and revenge unrealised'.[27] They all seemed to share a certain fragile state of mind. During the wartime years and in captivity in Germany they had been

> counterbalancing the reality that was always extremely hard, and often sordid and horrible, by calling up daydreams of their past life, until they were almost certain that, the moment they were liberated, they would find themselves in the same happy, beautiful world they knew before the war. All their past difficulties would be forgotten, freedom would take them back to a world where nothing had ever gone wrong … a paradise in which all people were good, all wives loving, all mothers-in-law charming, all husbands faithful and all homes beautiful. There was no unemployment, poverty and unhappiness.[28]

The post-liberation reality could not have been further from this idealized expectation. They were herded into crowded DP camps where they felt, psychologically, to be 'in worse conditions than before their liberation'. Confronted by their new reality and 'the ruin which had overtaken the world during the war years, seeing their hopes for a better future destroyed, and with time to reflect on it', they sought an escape in alcohol and sex.[29]

When the British entered Belsen in April 1945, their immediate priority was to rescue the thousands of inmates from starvation and an epidemic of typhus. This task consumed all of their energies, and thousands of inmates died *after* liberation. By May, Lieutenant Derrick Sington wrote, much of this work was well under way but there still remained

---

[25] Alexander Johnson and Daša Pahor, 'Magdalena Lipkowska a.k.a. Marta Korwin', Antiquariat Daša Pahor, 2019 [http://antiquariat-pahor.de/korwinny2.pdf, accessed March 2020] .

[26] Marta Korwin, 'Mr. Matthew in Foster Home: A Study in Cultural Factors', *Social Work,* 4(3)(1959), p.104.

[27] Quoted in Shephard, *The Long Road Home,* p.69.

[28] Quoted in Shephard, *The Long Road Home,* p.68.

[29] Quoted in Shephard, *The Long Road Home,* p.68.

> the tasks of psychological restoration, of rebuilding confidence, of making up for years of education lost, of re-accustoming 15000 people to enjoyment of work, of teaching many of them to respect authority rather than defy and outwit it, of persuading them to regard regulations and rules as benevolent and not diabolical. Obviously nothing more than a beginning could be made with this difficult work.[30]

No one at Belsen doubted that the survivors would have mental problems. Isaac Levy, the Jewish chaplain to the British Second Army, was 'certain that 90% of those who survive will never be normal. They have suffered too much.'[31] In Sington's words, 'three thousand British troops were faced with a problem of mental and moral reconditioning which might have defeated an equal number of psychiatric experts'.[32] In theory, Ben Shephard writes, some of the techniques developed by the British to treat shell shocked soldiers and civilian casualties in both world wars could have been used with the liberated prisoners, now DPs in Belsen Displaced Persons camp. However, nothing of the sort happened. None of the well known psychiatric and psychoanalytic experts in Britain at the time, like Anna Freud, Melanie Klein, or John Bowlby, ever entered Belsen.
British military psychiatrists were preoccupied with their own prisoners of war, and the language barrier limited what could be done. Only an extremely basic psychiatric program existed at Belsen. A mental ward was set up in the camp hospital for cases of schizophrenia and post-typhus psychosis. A volunteer who was a former Chelsea art student ran art classes as a form of psychotherapy. Successes were inadvertent, such as when a volunteer Red Cross worker managed to engage a group of seemingly apathetic Jewish women by distributing sewing materials among them - they had been seamstresses, tailors and designers in Hungary, Poland and Romania before the war.[33] Major RJ Phillips, psychiatrist to the British Second Army, after six weeks in the camp, estimated that 'a large proportion would again become reasonable citizens - but how long for and how deep will remain their painful memories is impossible to say'.[34] When the threat of psychosis lifted (most cases of post-typhus psychosis recovered) doctors reported continuing fear,

---

[30] Quoted in Ben Shephard, *After Daybreak: The Liberation of Belsen, 1945* (Schocken Books; 2005), pp.133-4.
[31] Quoted in Shephard, *After Daybreak*, p.135.
[32] Quoted in Shephard, *After Daybreak*, p.135.
[33] Shephard, *After Daybreak,* pp.135-6.
[34] Quoted in Shephard, *After Daybreak*, p.136.

apathy, social anxiety and emotional deadness. Captain Maurice Niremberski of the Royal Army Medical Corps wrote that feelings like joy and happiness, when expressed, 'were seldom the true expressions of the feelings of these people. They were only a pose, a means to express their gratefulness to their liberators.'[35]

The DP camps

Though refugee camps had been in use since the early 20th century, it was during World War II that 'the consistent, large-scale use of refugee camps as a response to forced migration' began. At the 'very height of camps as spaces of cruelty [concentration camps], they were adopted as spaces of compassionate humanitarianism'.[36] For some, like Hannah Arendt, refugee camps were strikingly reminiscent of the 1930s, and she lamented that 'the internment camp is the only thing that again and again comes out of all suggestions, plans and memoranda'.[37] 'The world has created a new type of human beings', she declared, 'the kind that are put in concentration camps by their foes and in internment camps by their friends'.[38] 'Contrary to her belief', Gerard Cohen writes, 'the vast camp system put into place by Allied armies and UNRRA was mainly the product of logistical preparations designed to facilitate a speedy transition from war to peace.'[39] From a psychiatric point of view, DP camps were nothing like concentration camps, but they were still far from benign. In the words of Leo Eitinger, after Hitler's victims had lost their 'physical and psychic power of resistance in the concentration camps', they suffered 'demoralization and resignation in the DP camps'.[40] Canadian psychiatrist Libuse Tyhurst noted in 1951 that although her refugee patients in Montreal did not want to talk about their time in forced labor or concentration camps, which they preferred not to recall, 'the time spent in the DP

---

[35] M. Niremberski, 'Psychological investigation of a group of internees at Belsen camp', *Journal of Mental Science,* 92(386)(1946), p.62.

[36] Kirsten McConnachie, 'Camps of containment: A genealogy of the refugee camp', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development,* 7(3)(2016), p.405.

[37] Hannah Arendt, 'The Stateless People', *Contemporary Jewish Record,* 8(2)(1945), p.149.

[38] Hannah Arendt, "We Refugees," in *Altogether Elsewhere: Writers on Exile*, ed. Marc Robinson (Faber and Faber: 1994), p.110.

[39] Cohen, *In War's Wake*, p.70.

[40] Leo Eitinger, 'Mental diseases among refugees in Norway after World War II', in (eds.) Charles Zwingmann and Maria Pfister-Ammende, *Uprooting and After...* (Springer: 1973), p.198.

camps [was] felt to be the most difficult, and in these situations, hunger and idleness are stressed'.[41]

Gerard Cohen argues that DP camps were different in purpose and spirit from prewar installations, as they were not built with the detention of refugees in mind. American and British planners had envisioned the use of temporary camps as a way to manage uncontrolled flows of civilian displacement and the potentially disruptive consequences. The major aim of UNRRA and Allied refugee policies was the repatriation of DPs to their countries; in the meantime the establishment of camps was seen as essential so that the work of relief and rehabilitation could begin while DPs awaited repatriation.[42] Between the spring and fall of 1945, UNRRA officials succeeded in getting some six to seven million DPs repatriated. By 1946, however, the flow of repatriation had turned to a trickle and it was clear that there were many who would not go home, about 1.2 million. It was at this point, with a remaining 'last million', that the second and much longer episode of the DP saga began, which was to last until the last camp closed in 1959.[43] The 'problem of "non-repatriable" DPs', Laure Humbert writes, 'was much more than a humanitarian problem and was bound up with issues of domestic reconstruction, policies of occupation, culture and identity as much as the provision of medical aid and relief'.[44] By the time UNRRA ceased to exist in 1947, it was running 688 camps in the American and British zones of Germany, 21 in Austria, and 8 in Italy. The successor organization, the International Refugee Organisation (IRO), was established to care for the last million. It took over the administration of about 700 camps, three quarters of them in western Germany.[45] When IRO closed down in 1951, UNHCR inherited responsibility for the DP camps.

---

[41] Libuse Tyhurst, 'Displacement and migration: a study in social psychiatry', *American Journal of Psychiatry,* 107(8)(1951), p. 566.

[42] Cohen, *In War's Wake*, p.69.

[43] Cohen, *In War's Wake*, p.5.

[44] Laure Humbert, 'French politics of relief and international aid France, UNRRA and the rescue of European displaced persons in postwar Germany, 1945-47', *Journal of Contemporary History,* 51(3)(2016), p.606.

[45] Cohen, *In War's Wake*, p.67.

Tomas Balkelis has placed the DP camp among sociologist Erving Goffman's 'total institutions'.[46] According to Goffman, what makes an institution 'total' is 'symbolised by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests or moors'. Goffman identified five types of total institution: those established for persons deemed by society to be incapable of caring for themselves and simultaneously harmless, like care homes for the blind, destitute or elderly; those for people deemed to need care and posing an unintentional threat to society, such as mental hospitals and tuberculosis sanatoria; those for people seen as an intentional threat to the community, such as prisons, prisoner of war camps, and concentration camps; those established for some work purpose and justified on instrumental grounds, like boarding schools and army barracks; and finally, those that function simultaneously as training sites for the religious and as retreats from the world, like monasteries and convents.[47] Goffman outlined the characteristics of total institutions, none of which are especially particular to total institutions except in terms of the intense degree to which they are exhibited. The central feature is that there is a breakdown of separation between the spheres of work, play, and sleep in the individual's life. 'All aspects of life are conducted in the same place and under the same single authority.' Each member's daily activities are carried out in close proximity to other members, often at the same time, since they are required to do the same task together. Daily activities are tightly scheduled, with the whole sequence being imposed from above. All these activities are rationalised into a single plan 'purportedly designed to fulfil the official aims of the institution'.[48]

Though Goffman analysed mental asylums, hospitals, prisons and convents, Balkelis sees that key conceptual features of total institutions were present in DP camps. By moving into a DP camp, refugees 'forfeited most of their liberties and rights as citizens of their former states. They became stateless persons in need of help and protection' under the centralised authority of UNRRA and later IRO.[49] Though refugees were housed in

---

[46] Tomas Balkelis, 'Living in the Displaced Persons Camp: Lithuanian War Refugees in the West, 1944–54' in Peter Gatrell and Nick Baron (eds.), *Warlands: Population Resettlement and State Reconstruction in the Soviet-East European Borderlands, 1945-50* (Palgrave Macmillan, 2009), p.26.

[47] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books: 1961), pp.4-5.

[48] Goffman, *Asylums*, pp.5-6.

[49] Balkelis, 'Living in the Displaced Persons camp', p.26.

camps for logistical reasons, such as facilitation of refugee registration and the distribution of relief and medical aid, there is no doubt that the DP camps also served the Allies' political purposes. DP camps isolated refugees from the rest of the world, and allowed Western officials to sift through refugees and verify their personal histories and political backgrounds. Balkelis argues that the DP camp served as a site for multiple 'interventions', which he defines as 'intrusive and cross-cutting policies that sought to control the refugees or competed for their loyalties'. Among these were political interventions such as screenings, propaganda campaigns, and attempts at forced repatriation. It was also a site of administrative interventions by 'UNRRA, IRO, and camp officials who regulated the everyday lives of the inmates by controlling resources and operating a system of rewards and penalties'. Finally, the DP camp was a 'site of intervention from within', since the isolation of the camps and regimentation of life inside them made them 'almost an ideal setting for political indoctrination'.[50]

Of the examples given by Goffman, it is probably the prisoner-of-war (POW) camp that refugee camps resemble most. Kirsten McConnachie has located refugee camps alongside POW camps and internment camps within a longer genealogy of 'camps of containment', seeing that they share certain characteristics that stem from their common function of containment. Containment is 'a particular type of encampment' that makes the refugee camp 'fundamentally unlike other spaces of marginalisation and exception'. While prisons exemplify disciplinary power and detain individuals based on their deeds and actions, refugee camps are 'created and managed for categories of population: they are biopolitical'. Like the POW camp, the refugee camp has a 'temporary, politically conditional existence', no longer serving a function or having a reason to exist when political conditions change or an alternative solution is found.[51]

It is important, McConnachie writes, to define the refugee camp with an eye towards its function because failure to do so 'has had consequences, not least of which has been to obscure the fact that such spaces are a distinct policy choice … not an inevitable response to forced migration'.[52] A broad historical comparison across camps of containment, she argues, has analytic value in 'potentially highlighting resonances between

---

[50] Balkelis, 'Living in the Displaced Persons camp', p.26.

[51] McConnachie, 'Camps of containment', p.398.

[52] McConnachie, 'Camps of containment', p.397.

camps…thus affording new insight into camps as a unique disciplining mechanism'.[53] Following McConnachie, I suggest that an exploration of psychiatric and psychological methods and technologies in the context of the refugee camp requires an awareness of the military antecedents of some of these techniques. Military psychiatrists advising UNRRA had the POW camp and the experiences of repatriated POWs in mind as they pondered how best to understand the experience and mental state of DPs in camps. If comparing the situation of forced migrants with earlier generations of voluntary transatlantic migrants offered some insight into the condition of the uprooted, military comparisons helped psychiatrists make sense of their observations in refugee camps.

H.B.M. Murphy, whom we encountered above, worked in refugee camps under both UNRRA and IRO. Murphy, known to his family as Brian, was born and raised in Edinburgh. He received his medical degree in 1938, and joined the Royal Army Medical Corps (RAMC) in the early 1940s. Most of his active service was in the Mediterranean. In 1944, he volunteered as a Special Operations parachute medical officer and organised medical services behind German lines in northern Italy. Upon discharge from the army in 1945, he joined UNRRA. After UNRRA, he joined IRO, where he was in charge of medical examinations of refugees in camps in Germany and Italy prior to their resettlement.[54] Murphy's assessment of life in DP camps lends support to McConnachie's analysis of the refugee camp. To Murphy, the continued use of refugee camps was 'as much a political as a residential expedient'. Writing in 1955, he contended that refugee camps, whether Spanish Republican camps in the south of France in 1939 or Palestinian camps in the Near East ten years later, 'could all have been reduced and their special hardships largely abolished if the powers concerned had permitted their inhabitants to spread throughout the countryside; and no native populations need have been displaced'. Whereas 'in postwar Germany the optimum use of all accommodation was a necessity…that was no justification for UNRRA to press alien refugees out of privately rented lodgings into assembly centres, on pain of loss of emigration rights' - something which would certainly have been a source of mental distress.[55]

---

[53] McConnachie, 'Camps of containment', p.399.

[54] Raymond Prince, 'In Memoriam: Henry BM Murphy 1915-1987, *Transcultural Psychiatric Research Review,* 24(3)(1987).

[55] H.B.M. Murphy, 'The camps', in *Flight and resettlement*, ed. H.B.M. Murphy (Paris: UNESCO, 1955), p.58; There was a severe housing crisis in postwar Germany. A quarter of German housing units were destroyed during the war. In the British Zone alone, the housing shortage stood at 6.5 million units.

Murphy observed that there were particular features of a refugee camp that made for certain unique characteristics of camp life which had consequences for the mental health of their inhabitants. Many of the special features of camp life, he observed, were a result of the conscious or automatic principle of regarding 'refugees as a political mass rather than as a conflux of individuals', especially when this principle was applied 'at lower echelons' of camp administration.[56] Another principle was the 'assumed transience of refugee administration'. Because of this, and the fact that that camps were usually hastily built as an emergency response, refugee camp work 'rarely attract[ed] a high quality of individual', with the consequence that UNRRA only had a 'tiny percentage of expert or competent staff'. The 'efficient and psychologically correct handling of newly arrived refugees' was a difficult task that could strain or defeat many workers, and in fact certain notable features of camp life, 'especially the regimentation, [could] be explained as honest attempts by second-rate administrators to cope with an exceptionally difficult psychological situation'. It was, Murphy said 'usually regarded as useful or necessary that refugees, as rootless and aggrieved people, should be kept under a centralised and mobile control, and should not be allowed to forget their special status until those in control decide that this is advisable'.[57] Though Murphy recognized that refugee camps were a political choice, this statement is a clear example of psychiatry giving legitimacy to that political choice, and contributing to the refugee camp apparatus of 'care and control'.[58]

Murphy identified four factors of camp life that were conducive to a characteristic 'DP camp mentality' of idleness and apathy: 'segregation from non-refugees, a sharing of certain facilities, a lack of privacy, and a sense of dependency'. Where these four factors were absent, 'no matter how poor or how improvised the accommodation may be, that characteristic mentality is rarely found'.[59] Of the four factors, Murphy saw the lack of privacy as the most important. The words of a Lithuanian DP, quoted by Tomas Balkelis, lend support to his conclusion.

Margarete Myers Feinstein, 'All Under One Roof: Persecutees, DPs, Expellees, and the Housing Shortage in Occupied Germany', *Holocaust and Genocide Studies,* 32(1)(2018), p.29.

[56] Murphy, 'The camps', p.58.

[57] Murphy, 'The camps', p.58.

[58] Liisa Malkki, 'Refugees and Exile: From "Refugee Studies" to the National Order of Things', *Annual Review of Anthropology*, 24(1)(1995), p. 498.

[59] Murphy, 'The camps', p.59.

> If earlier, while living in our homeland, we knew about each other only from our personal encounters, today one can hear every single conversation, even our breathing at night behind thin walls, and everything becomes public knowledge. Collective life exposes everything. Not only have we become tired of one another's company, we have also lost mutual respect. . . . This *kolkhoz* [collective] life has turned us into dull and banal people.[60]

Prolonged periods of camp living led refugees to 'develop a very high degree of social sense and social interdependency'. But these social skills were sterile because they occurred 'at the expense of the individual ego' and were unaccompanied by any exercise in personal responsibility, which the camps were very poor at providing because of their environment of 'autocratic paternalism'. Murphy thought that some paternalism was justified and probably even beneficial in the early stages of camp living, for 'the collective support which even the unwilling sharing of adversity produces gives the camps their psychological *raison d'être*'. This paternalism, however, was also the greatest fault of the camps, for it was 'persisted with long after its value is exhausted after it has become a barrier to further recovery'.[61]

The Inter-Allied Psychological Study Group advising UNRRA also had a list of characteristics of refugee camp living that contributed to the mental ill-health of DPs. The first of these we have already encountered: the uprooting from family, community, and country. DPs experienced a 'compulsive desire to return home' and would idealise the past and indulge in fantasies about it. The duration of absence from the home country was important, and an absence of three years was more than simply three times worse than an absence of one year, for after three years the refugee would suffer moral deterioration and apathy.[62] This anticipated Eitinger's crucial 'root taking period' after emigration, which was also three years. The desire was not so much to return to a geographical location, but for the emotional satisfaction and human relationships a refugee had known before being displaced.[63] The second factor was the state of uncertainty they lived in, particularly a lack of knowledge about what had happened to family and friends, but also about 'what form

---

[60] Cited in Thomas Balkelis, 'Living in the Displaced Persons Camp', p.34.

[61] Murphy, 'The camps', p.59.

[62] UNA, 'Psychological problems of DPs', p.34.

[63] UNA, 'Psychological problems of DPs', p.34.

the bullying might take tomorrow'.[64] This uncertainty had the potential to become so severe that the 'security of death' could become preferable to the uncertainty and colourlessness of the future.[65] Like Murphy, they also implicated loss of privacy as a factor, which repressed DPs' 'need of individuality and distinction'. The final factor was the 'loss of contact with all real information about what was happening in the world'.[66] Allied psychiatrists observed in the DPs 'generalized and embittered withdrawal from social relationships', despair, depression and melancholia, feelings of guilt and unworthiness, and damaged self-respect. Cliques, gangs, and a 'pecking order' soon appeared among DPs in an attempt to acquire lost self-respect and social status.[67] Hatred, boredom, monotony, sterility and dullness of life 'all play[ed] a degenerating part'.[68] The 'feelings of being unloved and isolated in strange communities create[d] moods of embittered and resentful gloom'. The refugees' sense of being unloved could cause 'even deeper wounds, and give rise to despairing beliefs in an individual…that attempts to form effective and trustful relationships with others [were] always futile'.[69] In this state, rigid, extreme, and inflexible political views were common, and some DPs found an outlet in the 'psychological safety valve of disruptive politics'.[70]

The military antecedents of UNRRA's mental health model

The commonalities between POWs and refugees, and their respective camps, were not lost on those psychiatrists working in refugee camps after the war. J.R. Rees, psychiatrist with the British Royal Army Medical Corps (RAMC) during the war, wrote that POWs were the main population on which studies had been conducted that would be of relevance to those concerned with 'the mental health of those who, for various reasons, as individuals or in groups, are dislocated from their normal background and are compelled

---

64 UNA, 'Psychological problems of DPs', p.17.
65 UNA, 'Psychological problems of DPs', p.22.
66 UNA, 'Psychological problems of DPs', p.17.
67 UNA, 'Psychological problems of DPs', p.29.
68 UNA, 'Psychological problems of DPs', p.17.
69 UNA, 'Psychological problems of DPs', p.41.
70 UNA, 'Psychological problems of DPs', p.47.

to face major readjustment of their lives'.[71] But beyond apparent commonalities between POW and refugee camps, postwar refugee mental health in the DP camps was a military affair because of the background of the personnel who were overseeing it. Most of them were military psychiatrists drawing on their wartime experiences. Though UNRRA was in charge of relief provision, the Allied armies occupying Germany were ultimately running the show and in control. In addition to being a humanitarian problem, refugees were a logistical problem for the Allies.[72] There was a crossover of personnel, too. Many UNRRA welfare officers were themselves discharged soldiers and officers from disbanded Allied armies looking for a job. In the 'ground zero of the humanitarian crisis' was a potential source of employment, attracting 'people who had neither commitment nor qualifications' for the job. UNRRA Team Directors blamed these former military men 'for their intolerance and fanatic insistence on military discipline'. At least part of UNRRA's personnel spoke the same kind of language as military forces. The prominence of former military personnel in organisations like UNRRA, Silvia Salvatici says, is 'a good reason to delve deeper into the connections between relief viewed as a military problem, and humanitarianism'.[73] Salvatici has highlighted how 'the co-construction of the aid operations between military and civilian personnel … followed a series of complex, non-linear paths that conditions the development of the humanitarian regime from within.'[74]

The Inter-Allied Psychological Study Group was established because the Welfare Division of the European Offices of UNRRA, in 'planning the handling of displaced persons realised it was of primary importance to consider certain characteristics of the people concerned, their background, what they had been through and the psychological problems confronting them on repatriation'. All the members of the IAPSG 'had experience of various aspects of repatriation'.[75] The IAPSG was thus guided, and its efforts shaped by, the political aim of UNRRA: the repatriation of displaced persons to their countries. This also closely followed the understanding of refugees' mental health as

---

[71] J.R. Rees, 'Foreword', in H.B.M. Murphy (ed.), *Flight and Resettlement* (Paris: UNESCO, 1955), p.5.

[72] Shephard, *The Long Road Home.*

[73] Salvatici, 'UNRRA Relief Workers and European DPs', p.435.

[74] Silvia Salvatici, '"Fighters without guns": humanitarianism and military action in the aftermath of the Second World War', *European Review of History,* 25(6)(2018), p.957.

[75] UNA, 'Psychological problems of DPs', 'History of the report', second page.

a matter of 'uprooting'. In 1945, the ideal solution to uprooting, in the Allied psychiatrists' and UNRRA's view, was to return - a simple replacement of the displaced persons.

The report of the IAPSG was written by six men and two women. Five of the men were military psychiatrists. Three of these, Lt. Col. Ronald Hargreaves, Lt. Col. Henry V. Dicks, and Lt. Col. ATM 'Tommy' Wilson, were all with the Royal Army Medical Corps (RAMC), and on loan from the British War Office.[76] Hargreaves would go on to become the first head of the World Health Organization's (WHO) Mental Health Section.[77] All three men were associated with the Tavistock Clinic. The Tavistock was established in 1920 as one of the first outpatient clinics in Britain to provide psychotherapy to those suffering from psychoneuroses and unable to afford private treatment. Its founder, Dr. Hugh Crichton-Miller, had worked on shellshock during the First World War and hoped to carry the military experience of treating the war neuroses into the civilian sphere.[78] Another key British military psychiatrist, though not among the report's authors, was Tavistock Director J.R. Rees, who in1948 would become the first president of the World Federation for Mental Health (WFMH).[79] During the Second World War much of the clinic's staff joined the Army as psychiatric specialists, and Rees became director of the Army's psychiatric services.[80] In 1941, Tavistock psychiatrists like Rees and Hargreaves had become 'in effect, psychological consultants to the Army'. They established their own medical division at Whitehall, 'advising on a range of issues that went well beyond usual definitions of psychiatry'. 'From this secure power base', Ben Shephard writes, 'they were able to make numerous bold policy initiatives - and enemies.' Army psychiatrists advised on issues such as the recruitment of soldiers and the selection of officers. These 'modern-minded, leftward-leaning psychiatrists took a certain pleasure in getting the Army to alter its old class-ridden ways' when they were able to identify through intelligence testing those innately intelligent candidates whose gifts and abilities had gone unnoticed because

---

[76] UNA, S-1449-0000-0100, Assembly Centres Vol 1, Letter from Chairman of Welfare Committee of UNRRA to the British Undersecretary of State for War, September 1944.

[77] J.R. Rees, 'George Ronald Hargreaves, OBE, M.Sc.(Leeds), FRCP (Edin.) (1908-1962)', *American Journal of Psychiatry*, 119(11)(1963).

[78] Henry V Dicks, *Fifty years of the Tavistock Clinic,* (London: Routledge & Kegan Paul, 1970), p.1.

[79] Eugene B. Brody, 'The World Federation for Mental Health: its origins and contemporary relevance to WHO and WPA policies', *World Psychiatry*, 3(1) (2004).

[80] Dicks, *Fifty years of the Tavistock Clinic,* p.5.

of lack of access to educational opportunities.[81] They also advised on the treatment of the war neuroses and how to get men back into combat, as well as the rehabilitation of returning prisoners of war. The last of these was Tommy Wilson's most notable wartime contribution. He pioneered the establishment of Civil Resettlement Units (CRUs) in Britain for returning POWs, which were reported to be successful at easing the transition of returning POWs back into civilian life and ridding them of their 'prisoner-of-war mentality'.[82] Meanwhile, Henry V. Dicks was born in Estonia (then part of the Russian Empire) to an English father and Baltic German mother. His family returned to the UK after the upheavals of WW1 and the Russian Revolution. Dicks spoke fluent Russian and German, and during the Second World War he was entrusted with the medical care of a very important prisoner, Rudolf Hess, on whom he would later write a book. He was also adviser to the Army on German morale, and to the Supreme Headquarters Allied Expeditionary Force (SHAEF) on psychological warfare.[83]

The two non-British psychiatrists on the IAPSG who contributed to the report were the Dutch Lt. Col. Joost Abraham Meerloo, with the Medical Corps of the Royal Netherlands Army and chief of its Psychological Department, and Erwin Popper, psychiatric consultant to the Czechoslovak forces in Great Britain.[84] Meerloo narrowly escaped the Germans in 1942, and fled to the UK. From 1944-6, he was an advisor to SHAEF and UNRRA, as well as High Commissioner for Welfare for the Netherlands Government. Meerloo observed first hand the techniques of mental torture and forced interrogation of the Nazis. He would later coin the term 'menticide' and become an expert on brainwashing and thought control, authoring a 1956 book called *The Rape of the Mind.*[85] The only man in the Group who was not a psychiatrist was the distinguished American sociologist from Chicago, Edward A. Shils. Shils had served with the US Office of Strategic Services in Europe during the war, and wrote a paper in 1946 on the psychological aspects of displacement and repatriation. Finally, among the group were two women: the Canadian Marjorie Bradford, UNRRA Welfare Officer and one of Canada's

---

[81] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Harvard University Press, 2003), p.190.

[82] Shephard, *A War of Nerves,* p.314.

[83] JD Sutherland, 'Henry Dicks', *Bulletin of the Royal College of Psychiatrists,* 1(4)(1977).

[84] UNA, 'Psychological problems of DPs', 'History of the report', second page.

[85] Joost AM Meerloo, *The Rape of the Mind: The Psychology of Thought Control, Menticide and Brainwashing* (Grosset & Dunlap: 1956), pp.662-663.

most respected social workers, and Gwen Chesters from the Tavistock Clinic, a child welfare expert and advisor to UNRRA on child psychology.[86] Chesters would later join the Children's Department of the Home Office in London, producing a report for it on the needs of displaced children. She would also serve as consultant to the United Nations Children's Fund (UNICEF), travelling widely across the developing world.[87] That child welfare and social work, stereotypically and traditionally 'female' domains, were the responsibilities of the two women in the Group, while the psychiatric and medical work was the domain of men with military experience, is not surprising. Bradford and Chesters do not seem to have had any military experience. It is notable that in the report prepared by the group for UNRRA, refugees are almost always referred to as 'he', unless discussing issues specific to women, like motherhood, or rehabilitation from forced sex work during the war. It is all the more surprising because most UNRRA relief workers, unlike the Allied military commanders running the show, were women.[88]

In addition, rehabilitation was seen in gendered terms: women's wartime experiences were seen to be not only dehumanizing, but defeminizing. Relief workers were concerned about the moral and sexual virtue of women refugees, and with reviving what they saw as a dead maternal instinct.[89] That the report often referred to refugees as 'he' may be a reflection of its dominance by military psychiatrists, who were used to working with combatants and POWs.

In the context of military psychiatry, the recent world war and the deployment of camps as a response to DPs, it was the repatriation experiences of (British) POWs that the IAPSG used to guide efforts in DP rehabilitation and repatriation. For example, its report on the psychological problems of DPs listed eight practical hints that had been given, with some success, to the family members and friends of POWs, such as 'Take care not to overdo the welcome', 'Let him take things slowly. Try not to hurry him or to worry yourself', 'Try to think of him as someone who has been away and not someone who has changed', and 'Remember you've changed about as much as he has, although you may feel

---

[86] Susan Armstrong-Reid and David R. Murray, *Armies of peace: Canada and the UNRRA years* (University of Toronto Press: 2008), p.163.; Henry V. Dicks, *Fifty Years of the Tavistock Clinic* (Routledge & Kegan Paul: 1970), p.118.

[87] Gwen Chesters, 'Social Services for Children and Their Families', *International Social Work* 5(3)(1962).

[88] Cohen, *In War's Wake*, p.66.

[89] Tara Zahra, '"The Psychological Marshall Plan": Displacement, gender, and human rights after World War II', *Central European History,* 44(1)(2011), 37-62.

it less.'[90] The report mentioned that the DPs' psychological problems on repatriation would be similar to those of expatriates returning to their native country in peacetime, or soldiers returning home from colonial service overseas. The DP was expected to experience problems in resocialization just like the expatriate and soldier, and the difficulties of returning POWs were an example of an 'exaggerated and complicated' form of this resocialization.[91] The report struck a parallel between the returning POW and the returning woman refugee who had been forced to engage in prostitution during the war to survive, explaining that both of them were returning with guilt issues, albeit from different sources. Both 'desperately want to get home but in some instances find it extremely difficult to tolerate the emotional tensions generated by a return to their own family and their own community'. The report advised that such women who could not face their families but wanted to return to their countries should return 'so to speak, incognito', and stay away from their family homes and 'take up work which will enable a self-respecting frame of mind to be achieved before facing the inevitable tensions of meeting their own families',[92]

The Civil Resettlement Units (CRUs), established by the British Army to serve as a halfway house for returning POWs to prepare them for civilian life offered inspiration for those working with DPs. Writing in 1955, J.R. Rees believed that the CRUs and the very thorough follow up studies that had been conducted with those who had passed through them years later 'demonstrated how problems which are in some ways similar to those of the refugees may be handled effectively'.[93] The CRUs had offered those who passed through them freedom within the units, individual concern for the men, and reorientation to civilian life and industry, all of which facilitated the returning prisoners' reintegration into society.[94]

Despite superficial similarities, there was a world of difference between DP camps and CRUs, and likewise between POWs and DPs. As Edward Shils found, there was no supranational 'DP identity' to create a sense of shared purpose and morale among DPs the

---

[90] UNA, 'Psychological problems of DPs', p.37.

[91] UNA, 'Psychological problems of DPs', p.26.

[92] UNA, 'Psychological problems of DPs', p.20.

[93] J.R. Rees, 'Foreword', p.5.

[94] Shephard, *A War of Nerves.*

way there was among POWs in their camps, who were often cared for by a senior officer. DPs would guard their meagre belongings with jealousy and a sense of distrust permeated interactions between them. DPs also did not receive any of the psychologically and physically restorative offerings POWs often got, like Red Cross parcels.[95] Nor were they treated the same. For example, in contrast to the recommendation by Tommy Wilson that returning POWs in CRUs be waited on at tables to avoid the anxiety that was often aroused in them by queuing for food,[96] British Army officer and UNRRA welfare officer Major Peter Rodd recommended that food be given to refugees in a raw or unfinished state, to force them to prepare their meals and develop a 'mildly predatory competitive temper'.[97] Even though many of the factors Murphy identified in refugee camps like lack of privacy and a sharing of facilities were present in POW camps, DPs could not govern themselves the way POWs could, something which had to do with the countries that they hailed from, according to Murphy. Writing in 1955, Murphy said

> With the exception of Czechoslovakia, all the countries from which the refugees have recently come had voluntarily relinquished democracy for dictatorship between the wars, or - in the cases of British India and Palestine - had never hitherto attained that form of rule. Hence to expect people with so little civic training and in a state of mental convalescence to fall naturally into democratic ways, is optimistic.[98]

While this statement can be read as prejudicial towards Eastern Europeans and non-Europeans, it can also be read as an early example of Murphy's interest in cross-cultural comparisons in mental health, with the lack of 'civic training' in Eastern European DPs a manifestation of cultural differences vis-à-vis Western Europeans. Of course, it could be both prejudice *and* an interest in cross-cultural comparisons, a common phenomenon, as I will show with the views of Western relief workers towards African and Southeast Asian refugees in chapters 4 and 5.

But perhaps the major difference between the treatment of POWs and DPs was the moral problematisation of DPs. Though returning POWs also behaved like 'hurt and lost

---

[95] Edward A Shils, 'Social and psychological aspects of displacement and repatriation', *Journal of Social Issues,* 2(3)(1946).

[96] Shephard, *A War of Nerves,* p.317.

[97] Peter Rodd, 'The psychology of refugees', *Horizon*, 10(59)(1944), p.315.

[98] Murphy, 'The camps', p.61.

children' and regressed to the 'dependent attitudes and primitive reactions of childhood', they do not seem to have descended into the perceived state of moral degeneration described in the DP camps.[99] Quite the contrary, those who entered the CRUs full of suspicion, insecurity, irritability, guilt and resentment left 'a month later their confidence, self-respect, and maturity regained'.[100] The task facing DPs was of greater magnitude. Indeed, it seems that DPs were problematised morally at least as much as medically, if not more. In the DP camps, the IAPSG report described, decency was swept away and customs of civilisation eroded. Standards of cleanliness and hygiene declined. Refugees lost their sense of shame and behaviour became rougher. Spoken language would assume 'primitive forms', and actions were devoid of any intellectual activity. DPs, observers noted, lacked any sense of responsibility to a community, had no respect for discipline or authority, and were crude and unreliable and hateful. They displayed a loss of initiative and aggression toward social workers. They had lost all morale and lived a lifestyle of 'compulsive hedonism', rife with alcoholism, delinquency, 'unaffectionate sexual promiscuity' and 'forced pleasure seeking'.[101] Thus, to the military psychiatrists who had experience with both POWs and DPs, the moral and psychological rehabilitation of DPs was an uphill battle of much greater magnitude.

'Welfare' and 'Rehabilitation'

In February 1945, Phillip Weintraub wrote in an article titled 'UNRRA: An Experiment in International Welfare Planning'

> The psychological effects UNRRA may have on the peoples of Europe are intangible but nonetheless real…It is quite possible that some will be so broken that they will turn to the resignation of cynicism and apathy. These people will be the last casualties of the war. The great majority, however, will insist on, and reach out after, every counsel and support. They offer UNRRA its supreme chance.[102]

---

[99] Margaret Bavin, 'A contribution towards the understanding of the repatriated prisoner of war', *British Journal of Psychiatric Social Work*, 1(1)(1947), p.30.

[100] Shephard, *War of Nerves,* p.317.

[101] UNA, 'Psychological problems of DPs', pp.6,18.

[102] Phillip Weintraub, 'UNRRA: An Experiment in International Welfare Planning', *The Journal of Politics*, 7(1)(1945), pp.18-19.

According to Silvia Salvatici, the notion of UNRRA and the DP camps constituting a crucible of a new professionalized humanitarianism is rendered problematic by the confusion and lack of consensus over UNRRA's aims at the time.[103] It was by no means clear, beyond repatriation, what the aims of UNRRA were and how they were to be realized. 'Relief' seemed to be simple enough: early planners envisioned it as the provision of material assistance to those who could not provide for themselves. For these planners, 'welfare' was synonymous with relief. Planners envisioned 'relief' as a technical, logistical issue of transporting sufficient quantities of needed items into essential areas, while objectively tabulating and assessing needs and determining resource allocations.[104] For the Americans inspired by New Deal planning, welfare took on a different meaning: the provision of services of rehabilitation for individuals requiring special assistance. The British relief worker Audrey Duchesne-Cripps wrote in a self-published 1955 essay that 'welfare' had to be more than 'a service of distribution of welfare supplies, with the addition of some handwork projects'.[105] Unfortunately, many relief workers, including some of her UNRRA colleagues, understood camp welfare to 'mean only the distribution of clothing or cigarettes, and the provision of a certain amount of entertainment'.[106] To Duchesne-Cripps, 'it was an obvious fundamental aim of welfare work to seek to provide conditions for the taking up of a normal life, with its accompanying psychological improvement'.[107] In addition to obtaining material necessities 'from toothbrushes to perambulators' and working to improve housing conditions and living quarters for DPs, she sought to promote 'welfare development in all its aspects, especially watching to fill in the gaps where national initiative was lacking'. This meant getting into close contact with DPs to understand their 'fears, needs, and beliefs'.[108] Duchesne-Cripps wrote the first draft of her essay, *The Mental Outlook of Displaced Persons as Seen Through Welfare work in Displaced Persons Camps,* in 1947 while awaiting approval for a visa to visit Poland to undertake relief work with the Save the Children Fund. The visa was refused.[109]

---

[103] Salvatici, 'UNRRA Relief Workers and European DPs'.

[104] Jessica Reinisch, '"Auntie UNRRA" at the Crossroads', *Past and Present,* 218(suppl_8)(2013), p. 73.

[105] Audrey Duchesne-Cripps, *The Mental Outlook of Displaced Persons as Seen Through Welfare Work in Displaced Persons Camps* (Self-published: 1955), p. 21. Copy consulted in the Library of Congress, Washington, DC.

[106] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 28.

[107] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 33.

[108] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 21.

[109] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 21

Though some Welfare Officers and Team Directors 'stated clearly that welfare followed immediate relief and that it implied a shift away from aid to rehabilitation, others were hard put to figure out what the first steps should be along the DP's path to rehabilitation'. Beyond the organisation's famous motto of 'help the people to help themselves', which was supposed to summarise UNRRA's rehabilitative aims, vagueness and ambiguity reigned.[110] The British and US governments saw 'rehabilitation' as the more innocuous term for 'reconstruction'. It would be, like relief, time-limited, because although the aftermath of the First World War had shown that relief without a means of getting the European economy running again would be useless, it was not practical to ask the US taxpayer to fund the recovery of businesses that would compete with American ones. [111] US Secretary of State Dean Acheson later wrote 'the word had no definition; rather it was propitiation by ignorance of the unknown. UNRRA would have done its work and passed away before we were to know what rehabilitation really required from us'. To Acheson, rehabilitation only really became politically feasible in 1949 with the Marshall Plan.[112]

The Inter-Allied Psychological Study Group was quite sure of what rehabilitation meant and what exactly it would address. The 'moral and psychological disturbance' caused by the Germans, they wrote, was probably greater than any physical devastation, for it had 'created in young people a wall of cynicism and brutishness which will require years of both mass and individual psychotherapeutic or social treatment to put right'.[113] The fifty page report by the Group paints a picture of the DP camps as places of demoralisation and moral degeneration, primitive child-like regressive behavior, and as places rife with promiscuity and alcoholism where all norms of civilized behaviour have eroded. The aim of rehabilitation, through work and entertainment and political education as well as the provision of an atmosphere conducive to psychological safety and security, was to turn the DPs into responsible, active, mature, working, politically conscious, tolerant, rights-bearing individuals and eventually citizens.

---

[110] Salvatici, 'UNRRA Relief Workers and European DPs', pp.435-6.

[111] Shephard, *The Land Road Home,* p.49.

[112] Quoted in Shephard, *The Land Road Home,* p. 416, footnote 17.

[113] UNA, 'Psychological problems of DPs', p.17.

They encouraged relief workers to ‘put oneself in the place of any new arrivals’. The DPs had had little or no ‘experience of benevolent authority’, and to them even neutrality would be interpreted as hostility. A relief worker had to be prepared for the ‘inevitable demands for repeated reassurance and information’ that would come, and which it would be ‘dangerous’ to evade. An understanding of ‘the relief worker through refugee eyes’ was therefore necessary. In working with such people, patience, tact and humility were needed; though not sympathy, for sympathy would ‘invite open or concealed resentment’.[114] These virtues were needed in a relief worker because ‘primitive and selfish behaviour among those who have felt themselves to be rejected by a hostile environment will invariably be upsetting, but the repair of wounds becomes a more appropriate and skilled matter if their causes are understood’. This understanding would also help avoid, on the part of the relief workers, ‘extreme reactions of irritation and condemnation at delinquency and fecklessness’ of refugees.[115]

The report did not detail how refugees actually saw relief workers, but it offered plenty of insight into how relief workers saw refugees. The ‘most characteristic personality change’ of people under severe emotional strain such as DPs was regression, ‘a falling back to earlier more primitive and for example infantile habits’.[116] As Murphy would write later, ‘Whether it is apathy, or helplessness, or maniac excitement, or aimless aggression, the underlying phenomenon is a regression to a more or less infantile stage in which ability to plan has disappeared and concerted effort can only be rudimentary’.[117] In a nod to Freud, the IAPSG authors explained the psychological defence mechanism of repression, whereby ‘painful emotional conflicts are banished from the mind’ into the unconscious automatically without the individual knowing it, comparable to ‘the closing of a lid over a set of ideas or feelings’. The unconscious process of repression was at work in the building of civilisation. Repressed forces were always seeking outlets, and ‘in civilised life, their direct expression or experience is constantly barred’. This process put in motion the ‘restless dynamic which has built our civilisation, our culture, and our art’. Civilization was the result of ‘instinctual forces seeking expression through new paths because of heavy internal resistances’. Below the civilised facade, the ‘original unmodified primitive

---

[114] UNA, ‘Psychological problems of DPs’, pp.27-8.
[115] UNA, ‘Psychological problems of DPs’, p.41.
[116] UNA, ‘Psychological problems of DPs’, p.21.
[117] Murphy, ‘The camps’, p.59.

urges' smouldered, and, if given the occasion, they would 'sweep away the barriers that have been raised by external authority and the development of conscience'.[118]

The war had provided ample opportunity for this to happen, and the primitive and infantile behaviour that DPs were seen to have regressed to would be 'painfully obvious' to those working in the camps. DPs were like 'hurt children', their demands like those of a 'greedy baby'.[119] Audrey Duchesne-Cripps echoed this sentiment writing that the DPs often did behave as children, 'and deserved treating as such'.[120] The report warned that DPs would erupt in outbursts of fear, engage in 'stealing safety' behaviour such as looting and black marketeering, and display heightened aggressiveness and an 'impulse to personal power'. Their hostility and suspicion would be surprising to the relief worker unless one understood that 'we are dealing with "hurt children" whose world has let them down, adults whose sense of security and confidence has been shattered, who regard all authority as tainted with ill-will and who may try to restore themselves by excessive egotism'.[121] Their feeling of being unwanted was comparable to the feelings of rejection felt by children who had been evacuated from London and separated from their parents during the Blitz.[122] Without a respect for authority, which could only be earned and not commanded, DPs would not be able to develop 'that self control essential for return to a civilized community'.[123] It is not unreasonable to conjecture that at least part of this assessment was a projection on the part of the report authors. Indeed, they alluded to this when they imagined how the DPs saw them, the relief workers: the DPs could 'hardly be other than envious of the status of relief workers whom they are likely to put in the category of "plump returning emigres" who evaded the war, but nevertheless have successfully acquired a place among the victors'.[124]

Rehabilitation was therefore a psychological process. Camp administrators were cautioned 'not to let the pressure of relieving material needs obscure the fact that

---

[118] UNA, 'Psychological problems of DPs', pp.4-5.
[119] UNA, Psychological problems of DPs, p.5.
[120] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 44.
[121] UNA, 'Psychological problems of DPs', p.5.
[122] UNA, 'Psychological problems of DPs', p.4.
[123] UNA, 'Psychological problems of DPs', p.3.
[124] UNA, 'Psychological problems of DPs', pp.26-7.

psychological understanding is not only a humanitarian theory but also a practical necessity'. Without an understanding of the 'specifically human problems' of the people concerned, any results of social planning would be temporary and unsustainable.[125] The Group put forth a lengthy definition of rehabilitation that emphasised the centrality of psychological methods. The main processes of rehabilitation were a recovery from losses - skills, personal relationships, social connections, and health. In practice, as a planned process, it meant

> the provision of an atmosphere and opportunities where the careful and graduated use of incentives leads to graded satisfactions over efforts. These satisfactions arise from the redevelopment of initiative and the realisation that satisfaction, contentment or even happiness are in fact inevitably bound up with the use of initiative and with the acceptance of responsibility. As a last phase in rehabilitation the individual, having accepted or returned to this mature point of view is able to leave behind the necessarily protected atmosphere of early psychological and social recovery and can step forward on his feet to a new social and psychological adaptation.[126]

The first step in rehabilitation was to restore a sense of material and emotional security for the refugees. Food was 'the primal token of security', around which feeling was 'likely to run high and to reflect many disturbed social attitudes'. Everything from 'sullen greed for affection' to 'desires for revenge and privilege' would colour attitudes to the source of food, manifesting in 'insistent demands for better food, in anger, and complaints about distribution methods, in grumbling, in thieving, in selfishness and even in violence'. For the 'full, reassuring effect' of food to be gained, supplies had to be '*felt to be* distributed generously' [emphasis in original]. Otherwise, refugees would be 'tempted to steal more than their share' and to 'fill their pockets with food even after a good meal', examples of 'illogical endeavours to ensure concrete rewards' from a hostile world. This was just like the case of a well fed child who would steal food from its parents anyway because it felt robbed and cheated of love.[127] The food also had to be familiar, for work with returning POWs had shown that hunger was not simply a search for calories, but a great longing for the familiar food and drink of the homeland. Unfamiliar food, to those cut

---

125 UNA, 'Psychological problems of DPs', p.40.

126 UNA, 'Psychological problems of DPs', p.26.

127 UNA, 'Psychological problems of DPs', p.42.

off from home and experiencing loneliness or homesickness, would be 'tasteless and irritating'.[128]

Once a basic sense of material and emotional security had been achieved, the DP could begin to regain a sense of dignity and independence through delegation of responsibilities to the refugees themselves, to 'help the growth of the belief that authority can be tolerant and freeing and not necessarily restrictive or retentive'. Since food was the site of much activity in camp life and relief work, the first delegation of welfare responsibilities to refugees had to be in this domain. It was recommended that refugees become involved in the distribution, cooking, preparation and catering of food alongside relief workers. This would provide the first opportunity to resume a sense of responsibility and initiative.[129]

The avoidance of boredom was an important objective, lest the refugees stagnate and degenerate into the dreaded state of apathy, and availability of entertainment was thus crucial. Initially, 'entertainments which make no active demands on audiences [were] the most acceptable', such as films, concerts, games and leisure. As initiative developed and refugees began to make demands for greater control, more active 'spontaneous activities' could be fostered which would be felt to be owned by the groups from which they sprang. The purpose of entertainment activities was not so much to direct refugees toward a particular activity, but 'the removal of immediate emotional and material barriers to activity, and the provision of facilities and opportunities to cater for latent needs'. Ideally, recreation and entertainment would eventually be handed over to committees of DPs, and the relief worker would simply cater for activities chosen by them rather than direct them.[130] The other obvious way to avoid boredom besides entertainment and recreation, and which was necessary for recovering a sense of purpose and self-respect, was work. Difficulties could arise however, since 'forced work has a familiar and unpleasant flavour for displaced people'. To ensure success, the psychiatrists recommended that 'the best results are to be gained from the management, by displaced people themselves, of work projects relevant to the welfare of their own community'. These projects were to be 'used deliberately, not as endpoints in themselves' but as methods to increase DPs' capacity to

---

[128] UNA, 'Psychological problems of DPs', p.41.

[129] UNA, 'Psychological problems of DPs', p.42.

[130] UNA, 'Psychological problems of DPs', pp.43-44.

form effective working relationships, shoulder and share responsibility, and acquire a sense of purpose and worth.[131] DP employment was seen as crucial to prevent the dreaded DP apathy, which we will encounter below.[132]

The IAPSG members also recommended a system of education that would address DPs' feelings of lack of belonging and help them understand and develop a sympathy for the 'modern society' they had been cut off from and their place in it. Such an education system would 'fill the gaps in their understanding' and 'help them participate in everyday emotional currents', allowing them to feel 'at one with' society's purpose and motive. Until this happened, they would remain 'psychologically displaced'.[133] Education about current affairs and the significant news events of the previous five years was needed too. Newspapers and radio reports from the outside world were essential for the reintegration of DPs into society: 'without news of society, they cannot know themselves as members of it or find any point in facing the painful business of resocialization'.[134]

Ultimately, successful rehabilitation aimed to reintegrate DPs into a political community. The formation of group meetings - similar to those in the CRUs - where discussions about matters of common interest such as problems with food and supplies, current events, and the exchange of information could take place was strongly recommended. These groups would offer DPs a place to ventilate anxieties and concerns, and help to stimulate feelings of communality that could eventually 'produce early feelings of responsibility for each other'. If well run, they could produce mutual understanding and tolerance between refugees, and the recognition of each other's needs would 'make possible the give-and-take of mature social life'. In these groups 'freedom of expression…should be firmly upheld even when the views expressed are destructive and hostile, for it is the touchstone of the sincerity of a liberating authority'. Inevitably, the social pressures within a group would compel individuals to listen to one another and 'lessen the tendency to hold immoderate views'. This was a more effective and acceptable disciplinary force than an authority imposed from above.[135]

---

131 UNA, 'Psychological problems of DPs', p.45.

132 Humbert, '"When Most Relief Workers Had Never Heard of Freud", p.212.

133 UNA, 'Psychological problems of DPs', p.43.

134 UNA, 'Psychological problems of DPs', p.44.

135 UNA, 'Psychological problems of DPs', pp.44-45.

The final, essential, step for producing social responsibility and integration was ‘the re-establishment of human rights’, that ‘basic evidence of being valued and wanted by society’. The ‘fundamental humiliation of displacement’ was that refugees had no rights at all. The restoration of human dignity could not happen until rights like freedom of speech, worship, assembly, and choice of work had been restored. This was an urgent matter, and the delay in restoration of rights could lead to ‘anxious protests and turbulent attempts at assertion, in much the same way as the pre-war unemployed fought against despairing feelings that society had no use for them’. It was only after the recognition of personal rights that responsibility would become acceptable and cooperation possible. Any refugees’ demands for privileges as compensation for years of suffering, or demands for special rights, would be stilled ‘by the practice of the common rights of mankind’. Thereafter, it was hoped, attainment of a ‘full social life’ was just a matter of adjustment and learning.[136]

DP apathy: A failure of rehabilitation

We can conjecture that the ambitious plans of the IAPSG were not much of a success. Reports of psychologists and experiences of DPs show that many of them succumbed to what was seen as the most dangerous consequence of camp life: a state of resignation and ‘complete apathy’, where there was a loss of interest in everything and a paralysis of all psychological defences.[137] To Murphy, this was the result of a complete loss of willpower.[138] The phenomenon of refugee apathy assumed such prominence that both DPs and relief workers referred to a condition they called ‘DP Apathy’. Peter Gatrell has noted that this is a strange term to employ, given what was known about the vibrancy of cultural life in the camps.[139] Eduard Bakis, an Estonian psychologist and for some years a DP before emigrating to the United States, studied and wrote about this ‘so called DP

---

[136] UNA, ‘Psychological problems of DPs’, p.48.

[137] UNA, ‘Psychological problems of DPs’, p.22.

[138] Murphy, ‘The camps’, p.58.

[139] Peter Gatrell, ‘Population displacement in the Baltic region in the twentieth century: from “refugee studies” to refugee history’, *Journal of Baltic Studies,* 38(1)(2007), 43-60.

apathy' among DPs from the Baltic nations of Latvia, Lithuania and Estonia.[140] Writing in 1952, Bakis said

> During the first winter in the DP camps in Germany, 1945-46, it was assumed that the main task of a psychologist would be to find out why wartime experiences, culminating in the loss of homeland, had not done very much harm to these people…However, time passed but no end of camp life was in sight. Christmas of 1945 was believed to be the last in the camps, yet Christmas 1946 found the refugees still there and with no outlooks for either returning to a liberated homeland or for emigration.[141] No wonder that since the summer of 1947, after two years in the camps, more serious symptoms became conspicuous.[142]

The symptoms included frequent absenteeism from work, a lack of interest in camp affairs such as elections, a drop in participation in any cultural activities, and the committing of serious crimes. 'Things were left undone for a considerable time, the style of life reminding one of a slow-motion picture. Sometimes it resembled a nightmare where connections between the will and executive organs are switched off'.[143] There was a feeling that one's 'personality was going to be dismantled'.[144] The major impression was one of procrastination and apathy. Eventually the displaced person 'ceased to be a normal, respectable personality, had become molded to the pattern of DP life, and begun to display traits of a "genuine" DP'.[145] The process of 'becoming a DP', where one lost all 'habits and social code of a normal life' was called 'Dipiistumine' by Estonians.[146]

For Bakis, the observed symptoms and causes of DP apathy could be subdivided into two groups, based on the function that apathy played in each individual. DP apathy was either a sensible adjustment to an extraordinary situation, or a genuine maladjustment. In the former, it could be explained as a function of the conservation of all available energy

---

[140] Eduard Bakis, 'The so-called DP-apathy in Germany's DP camps', *Transactions of the Kansas Academy of Science (1903-)*, 55(1)(1952).

[141] After a brief period of independence following the end of the First World War, the Baltic states were annexed by the Soviet Union after the Second World War.

[142] Bakis, 'DP apathy', p.62.

[143] Bakis, 'DP apathy', p.62.

[144] Bakis, 'DP apathy', p.63.

[145] Bakis, 'DP apathy', p.69.

[146] Bakis, 'DP apathy', p.72.

for the concentration on the single goal of emigration, and living on a limited supply of energy for many years as a result of physical and caloric deprivation. As a genuine maladjustment, DP apathy was the result of existence in a transitory, uncertain state of limbo. Cut off from their former lives and uncertain of the future, DPs became without a past and without a future, suffering 'a crisis in the philosophy of living' as they lived in an 'unbelievable, dreamlike world'.[147] The DP 'had no name, no duties or social position that would distinguish one from another consumer of goods donated by free world; just another user of a four-square-yard living space, a burden for already overcrowded Germany'.[148]

While not every DP camp had a psychologist eager to undertake a study of apathy and resignation of fellow DPs, this picture was not confined to Baltic camps. For example, a Ukrainian DP who recorded his day at a DP camp for researchers from Harvard University said

> Speaking of myself, I get up no earlier than 10 o'clock. There is no sense in getting up earlier - it's cold in the barracks and there is absolutely no comfort. After getting up I calmly proceed to do my morning toilet. When I am washed and shaved it's already time for lunch. What [do] we have for lunch? The first course some soup from pea powder or pearl-barley; the second - four potatoes boiled without being peeled, some sauerkraut on a little piece of blood sausage. After my lunch I lie down on my bed for half an hour. After that I get up and go to the other barrack where the other families are living, to listen to the radio. There I stay until supper, that is, until 6 o'clock. For supper, we have 200 grams of bread with pork fat or butter, a small piece of cheese or sausage, and black coffee. After having eaten I play chess or cards, and when I get a newspaper or a book no matter in which language it is: Russian, Polish or even German, I read until 9 or 10 o'clock in the evening. After that I go once more to listen to the Voice of America program and at 11 or 11.30 go to bed. And so goes my daily life. There is no place to go. Four kilometres from us is a little town, Scheinfeld, where a movie may be seen. But I can afford it seldom for lack of money. Nine marks of so-called Taschengeld [pocket money] should be spared very accurately for purchases of tobacco and stamps. There is no possibility of earning some money. The life is dull and aimless.[149]

---

[147] Bakis, 'DP apathy', pp.74,78.

[148] Bakis, 'DP apathy', p.82.

[149] Shephard, *The Long Road Home,* pp.274-5.

The observations of apathy in refugee camps in the 1940s became a stereotype in their own right, attaining the status of fact and stated in well-known texts on refugees. In 1953, sociologist Jacques Vernant wrote in *The Refugee in the Postwar World*

> the refugee often shows a typical lack of 'drive'. He no longer has the elasticity which enables a man when fortune has dealt him a hard blow to recover his poise and carry on; he is unable to adapt himself or to find ways to make himself acceptable in a social environment which is strange to him. This failure, partly psychological and partly physical, is most often due to the enforced idleness to which the refugee is condemned, or to the too sudden and too brutal rupture with his home and natural background.[150]

It is important to note that this stereotype of the apathetic refugee was not the result of psychologists' and psychiatrists' attribution of a diagnoses to the DPs. It was in fact well established during the First World War. As one relief worker in Britain said of Belgian refugees in Britain back then, 'They won't do a stroke of work and grumble at everything and their morals! It may be true enough that Belgum saved Europe, but save us from the Belgians!'[151] This suggests that designations of apathy by mental health professionals had their roots not entirely in clinical observation, and were often externally driven by the concerns of relief agencies, which played a part in directing and shaping such designations. As I will show in subsequent chapters, the characterisation of refugees as apathetic, idle, and dependent was remarkably durable across continents, cultures, and time spans. This tells us at least as much about how relief workers constructed their own sense of identity vis-à-vis the people that they cared for and controlled, as it tells us about the unhealthy atmosphere of a refugee camp.

DPs as political pawns

More than a clinical syndrome, 'DP apathy' was an individualisation and psychologisation of the political deadlocks that left many DPs unable to return to their countries, especially those from Eastern Europe. Military psychiatrists did not - indeed, could not - take into account how political settlements between the Allies and the Soviets, and changes in DPs' home countries, had the potential to thwart the process of postwar rehabilitation. Despite the assistance provided, Audrey Duchesne-Cripps wrote, it was to

---

[150] Jacques Vernant, *The Refugee in the Post-war World* (Yale University Press: 1953), p.17.

[151] Quoted in Gatrell, p.33

her ‘fundamentally true that all efforts at mitigating the difficulties of camp life remained in themselves no more than palliatives’.[152] As time passed, it became increasingly difficult for DPs to achieve the prerequisites for happiness, namely ‘a confident mind, and this could only be given through a feeling of security and the ability to view the future with hope’.[153] Here there was a marked contrast between ‘Westbound’ and ‘Eastbound’ DPs. By early June of 1945, the repatriation of Western European DPs from countries like France, the Netherlands, Belgium, and Luxembourg had been completed.[154] The Eastbound DPs, with their countries now within the Soviet sphere of influence, would have a very different post-war experience. For example, because of changing political conditions back home in Poland, pre-liberation hopes of Polish DPs for a speedy return home were dashed, and a sense of disillusionment and frustration set in.[155] Their ‘return to normal’ that welfare work was supposed to support was thwarted by the abnormal conditions of prolonged camp life, which made wartime experiences more difficult to overcome.[156] In frustration, some DPs complained that their lives had been better under the Germans. Disillusionment and consequent mental distress were down to two factors: the disappearance of the pre-war political regime in Poland they had been familiar with as their country’s national boundaries were redrawn after the war to reflect the Soviet annexation of its eastern territories; and the lack of any news or information from home about relatives and property left behind. For the DPs Audrey Duchesne-Cripps worked with, this uncertainty meant that none of them had the prospect of immediate repatriation on the horizon.[157] Many DPs believed that a war between the Soviet Union and the US and Britain was imminent, with some even hoping for such as war ‘as the only way to enable them, through the defeat of Soviet Russia, to return to their homelands under the conditions they desired’.[158]

The words of many DPs indicate that they were far from being helped to recover the dignity they had lost during the war. In August of 1946, Marta Korwin was running an

---

[152] Audrey Duchesne-Cripps, *The The Mental Outlook,* pp.21-22.

[153] Audrey Duchesne-Cripps, *The The Mental Outlook,* p. 22.

[154] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 10.

[155] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 17.

[156] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 33.

[157] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 16.

[158] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 32.

arts college for DPs in Kassel. She asked her students to write an essay on their personal experiences, translating and collating some of them the next month. They provide a striking comparator to the ambitious plans Allied psychiatrists had laid out the year before.[159] One former officer in the Polish Home Army said that during the war

> England was a vision for which we were all longing, waiting, trusting she will come, our Polish army with her, and the Germans will go and then - then the law of force and violence will cease to exist - and Freedom and Justice will reign.[160]

In the DP camp, he was bitter and resentful.

> I risked my life. For what? For those promises that England gave us? How stupid I was! They had the unlimited capital of our trust and enthusiasm, if they had only treated us like human beings. Under the Germans whatever we endured, we remained Poles. Today we are described by two letters only, DP. The destiny of the people reduced to two letters is decided by one stroke of the pencil at a bureaucratic desk.[161]

Another Pole who had been kidnapped at the age of 16 and sent to work as a bartender in Munster said

> Is there really much difference between 'now' and 'before'? I was a number. I am a number. I was called 'Polish Dog.' [Now] I am called 'Wretched Pole.' Food - the same. Despised by the Master Race Germans - rejected by the Master Race English. I hated the Germans before - I hate the English now.[162]

Yet another Polish DP, who had worked in two synthetic oil factories in Germany, said

> When we were drunk, our greatest pleasure was to picture the day when we in turn would see our 'Allies' as DPs in Siberia, and 'they' who treat us like dirt in camps themselves, and we pictured to ourselves how 'they' would feel when they could get the same

---

[159] Shephard, *The Long Road Home,* p.267.

[160] Quoted in Shephard, *The Long Road Home,* p.268.

[161] Quoted in Shephard, *The Long Road Home,* pp.268-9.

[162] Quoted in Shephard, *The Long Road Home,* p.269.

> treatment of humiliation as the military and so many UNRRA officers do not spare to give us.[163]

A major factor affecting DP morale and psychological state, Duchesne-Cripps observed, was the 'inability of the countries comprising UNRRA, which included USSR, to agree in many important matters, bearing sometimes only indirectly on Displaced Persons' but which DPs were powerless to influence. This had repercussions for the DPs.[164] It gradually became clear to them that despite their liberation - 'one of the few immediately obvious results of the Allied victory' - their return to a 'normal private life' was not a matter of prime importance to the Allies.[165] DPs 'had more personally to remember' about German aggression and domination than the British, and did not forget as easily as the British military forces whose contact with the enemy had not even been personal.[166] The 'bitterest blow to morale' in Polish DP camps was to feel slighted by their Allies after having suffered degradation and a loss of national dignity under the Germans.[167] Duchesne-Cripp's DPs 'could never understand nor condone the speed with which the Occupying Forces forgot that the Germans had been enemies'.[168] The British not only seemed to regard the DPs as inferior, but 'they seemed actively to be preferring Germans to them'.[169] She believed that the situation would have been different if the British had been unfortunate enough to endure occupation and concentration camps, citing the French 'policy and practice of dignity and equality' towards DPs in the their occupation zone.[170] It seemed to her that the British military forces 'had no clear conception of what Displaced Person status was, what achievement of that status might have meant in terms of human experience, or what it required as of right'.[171] These field observations of a relief worker in daily contact with DPs reveal nuances that were perhaps

---

[163] Quoted in Shephard, *The Long Road Home,* p.269.
[164] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 31.
[165] Audrey Duchesne-Cripps, *The Mental Outlook,* pp.31-2.
[166] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 45.
[167] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 44.
[168] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 45.
[169] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 43.
[170] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 44.
[171] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 40.

less apparent to British military psychiatrists writing up a general rehabilitation plan at the top levels of UNRRA's welfare division.

Conclusion

DPs who did not want to repatriate made that choice based on their understanding of sociopolitical context, but the psychological consequence of that choice was perceived as a problem in them - DP apathy. It is because rehabilitation planners treated displacement as an inner condition that all the welfare efforts amounted to 'no more than palliatives' in Audrey Duchesne-Cripps' words.[172] Though military psychiatrists compared the problems of returning POWs to those of repatriated refugees, we have seen how these two groups were constituted differently by the same psychiatrists. Returning POWs had *a* problem of resocialization back home. The mere presence of DPs (and that a million of them did not want to go home) was *the* problem. This is an example of Liisa Malkki's argument that 'the displacement of refugees is constituted differently from other kinds of deterritorialisation by those states, organisations, and scholars who are concerned with refugees'.[173]

When H.B.M. Murphy published *Flight and Resettlement,* an edited collection of essays from the late 1940s and early 1950s and one of my primary sources for this chapter, Europe's DP problems were not an issue of the past but an ongoing concern. But by then, Murphy was no longer working with refugees in Europe, but was based at the University of Malaya, where he was pursuing his interests in cross-cultural comparisons of mental health that were first kindled in the DP camps. Though the prolonged existence of the camps would have enabled long term psychological programs and studies to take place, I have not found a follow up report by the IAPSG. The efforts to explore and address the mental health of DPs arose largely out of personal initiatives, like those of Maria Korwin, Audrey Duchesne-Cripps, and Eduard Bakis. As the next chapter will show, psychiatrists' attention soon shifted to the problems of adaptation of DPs in their countries of resettlement in the West. There was little mention of the adaptation of those repatriated to Eastern Europe, who were behind the Iron Curtain. The psychiatrists responding to Europe's refugee crisis did not continue to work with refugees or develop careers in humanitarianism. Ronald

---

[172] Audrey Duchesne-Cripps, *The Mental Outlook,* p. 22.

[173] Malkki, 'National geographic', p.25.

Hargreaves of the IAPSG briefly joined Unilever as its chief industrial medical officer[174] but soon became the first head of the mental health section of the new World Health Organisation. Maria Pfister-Ammende, inspired by what she had learned from running a mental health service for thousands of refugees, joined WHO in 1955. Both Hargreaves and Pfister-Ammende promoted an expansion of psychiatry into communities and on the world stage through public health methods. Murphy became a pioneer in transcultural psychiatry.

Though UNRRA and the DP camps may have constituted a crucible for a new humanitarianism, this was not uniform across different types of relief, and did not hold true for psychiatry and mental health. No professionalised humanitarian psychiatry emerged from the mental health work in the DP camps. The careers of these men and women show that they were not interested in humanitarian work per se, but were working with refugees as the first step in a process of healing the wounds of the world through psychiatry. When theatres of humanitarianism shifted from Europe to the Third World, mental health did not follow for another forty years. For psychiatry, then, the DP camps were not a crucible of a new humanitarianism, but a springboard to a postwar globalised psychiatry.

---

[174] Shephard, *A War of Nerves,* p. 335.

Chapter 3
Durable Solutions

Introduction: new directions in psychiatry

This chapter follows psychiatrists and displaced persons after their departure from the DP camps, and introduces the first Cold War refugee crisis. The European refugee problem came to be seen in a new light from 1947, as the UN Relief and Rehabilitation Administration (UNRRA) expired and was superseded by the International Refugee Organization (IRO). Official thinking about the solution to the refugee problem changed from repatriation to resettlement in third countries, and DPs came to be seen in a new light: as a pool of labour to recruit from rather than idle, dependent charges to be maintained – except for the residual 'hardcore' who did not fit this profile. The setting of interactions between mental health workers and DPs also changed. The camp was no longer the main setting where DPs were observed and their mental health made sense of, as in the three years of UNRRA's existence and during Maria Pfister-Ammende's refugee camp work. As DPs moved overseas, mental health workers concerned with them were less likely to be employed under the centralised authority of a single international organisation, and more likely to be in the health and social services and universities of countries of resettlement. The metaphor of 'roots' as a way of understanding the DP experience persisted but its focus changed. Rather than study the effects of 'uprooting' on a refugee's mind, more effort was spent examining how refugees could 'take root' in resettlement. Rehabilitation no longer simply meant retraining and reeducating the homeless victims of war in the refugee camp, but helping them to adapt successfully to their lives in resettlement among their new societies. With the onset of the Cold War, the conception of a refugee shifted from that of war displaced ethnic or national groups to an individual fleeing Communist persecution. This raised new questions for psychiatrists working with Hungarian refugees during the first postwar refugee crisis in Europe. The implication of this changed political context for psychiatric research and practice was that it led to the formulation of different scientific and research questions than had been asked in the DP camps, moving beyond 'uprooting' to a focus on establishing new roots. This is an example of the political contingency of knowledge making in refugee contexts.

I examine the changing nature of the refugee problem through the lens of psychiatry during the 'Golden Age' of European refugees (1945-60).[1] This period extends from the end of the Second World War to the clearance of the last DP camps where 'hardcore' refugees were still to be found fifteen years later. It is also a study of how psychiatric practice with refugees evolved to reflect the transformations going on in psychiatry and refugee relief. Finally, it is a study of the influence of political context on the directions psychiatrists took in their theorisations and practice with refugees. In particular, I will draw on the career of Scottish psychiatrist H.B.M. Murphy, the most prolific in matters of refugee mental health. His intellectual trajectory in the aftermath of the war is illustrative of the generative potentialities of refugee work for psychiatry.

I argue that during the 'Golden Age', psychiatry functioned largely as an implementer of the agendas of national governments. The directions psychiatrists took in their refugee work reflected and were shaped by the political context they operated in, and they often adopted the prevailing values and attitudes of receiving countries – though not blindly. And while psychiatrists negotiated the parameters and limits set for them by the sociopolitical context, it nevertheless exercised a formative influence on their work. Politics influenced what questions psychiatrists asked of refugees, their treatment goals, and indeed which refugees received attention and which were ignored. Overall, psychiatry adopted the views of states and international organisations that refugees were a 'problem' to be solved, an aberration to be corrected. The ultimate aim of mental health work in resettlement was completely curing the refugee of their refugee condition, and making them well adjusted citizens of their new society.

From the mid-twentieth century, ideas and practices within psychiatry began to become increasingly similar across varied geographical and cultural contexts, the result of changes in 'patterns of transnational communication and exchange…in a process that was inextricably linked with modernity', as Yolana Pringle puts it.[2] With the foundation of new international health organisations like the World Health Organisation (WHO) and the World Federation for Mental Health (WFMH) which fostered global scientific networks, psychiatry underwent a transformation and globalisation, and expanded in new directions. Chief among these was a shift beyond the individual patient and the hospital to the

[1] Gerard Daniel Cohen, *In War's Wake: Europe's Displaced Persons in the Postwar Order* (Oxford University Press: 2012), p. 150.

[2] Yolana Pringle, *Psychiatry and Decolonisation in Uganda* (Palgrave Macmillan: 2019), p.11.

community and public at large, and 'international mental health' was born. In the public sphere, psychiatrists aimed to prevent mental health problems rather than simply cure them once they occurred. This had begun with the mental hygiene movement decades earlier, but it received a new impetus and relevance in the postwar era.[3] The nascent field of social psychiatry examined the effects of social and interpersonal relations on the mental health of groups and communities and sought ways to improve them. Many of the actors in international mental health were psychiatrists who had worked during the war with the military, refugees, or both. Ideas about applying psychological concepts to groups and communities, tried out in the DP camps of Germany and the refugee camps in Switzerland, assumed a world stage. I argue that psychiatric work with refugees was generative, giving psychiatrists the opportunity to try out ideas while also spurring them in new directions like public mental health, social psychiatry, community psychiatry, and transcultural psychiatry.

In June of 1945, the members of the Inter-Allied Psychological Study Group (IAPSG) who authored the report for UNRRA on the psychological problems of DPs hinted at the global role they saw for psychiatry - and themselves - in the postwar order. The mental health of DPs was seen by them as important not only to the individual DPs, but also to all the communities and nations in which they would end up living, and the relations between these nations. Psychiatry thus had a role to play in the preservation of peace and the prevention of another world conflict. Right after the war, military psychiatrists began working to make this vision a reality. A key figure was the Canadian psychiatrist and wartime head of the Canadian Army medical service, George Brock Chisholm. After the war, Chisholm became the Executive Secretary of the new Interim Commission for WHO, and in 1948 when WHO was founded, its first Director-General.[4] Chisholm coined the term 'world citizenship', the idea that human institutions should be adapted so that 'men can live together as world citizens in a world community, in which local loyalties are rendered compatible with a wider allegiance to mankind as a whole'. The idea of the 'world citizen' was not meant in a political sense, but in the sense of a common humanity. Those espousing it 'were concerned with the attitudes and ideals of groups of men in relation to one another, and with the principles and practices of mental

---

[3] David Freis, *Psycho-politics between the World Wars: Psychiatry and Society in Germany, Austria, and Switzerland* (Palgrave Macmillan: 2019).

[4] Eugene B. Brody, 'Harry Stack Sullivan, Brock Chisholm, Psychiatry, and the World Federation for Mental Health', *Psychiatry: Interpersonal and Biological Processes,* 67(1)(2004), 38-42.

health in relation to a world community'.[5] According to historian Harry Wu, 'The concept of world citizenship provided the core philosophy for all health initiatives' in WHO's early years. It 'hoped to achieve a universality of human minds and the hidden aspiration of promoting peace' and 'helped to shape scientific practices associated with WHO' during its first decade.[6]

A new set of organisations imbued with the 'world citizenship' ideal was founded. An International Congress on Mental Health, held in London in August of 1948 on the theme of 'mental health and world citizenship', functioned as something of a launching pad for psychiatry's postwar idealism.[7] Originally planned to be held in Brazil in 1942 and delayed by the war, the venue was changed to London to make it easier for Europeans to attend. It brought together professionals from a wide variety of backgrounds who pondered how to respond to the challenges of European recovery in the aftermath of the war's devastation, 'develop greater toleration', and build the foundations for peace.[8] At this conference, a new organisation called the World Federation for Mental Health was founded. British military psychiatrist J.R. Rees, who had been asked to organise the Congress, became its first president. WFMH was the first international mental health NGO and was granted official consultative status by the UN.[9] Also at the Congress, the WHO Expert Committee on Mental Disorders was also founded, whose purpose would be to develop forthcoming large scale surveys and measurement instruments.[10] The first head of WHO's mental health section was the British military psychiatrist Ronald Hargreaves, one of the authors of the IAPSG report on displaced persons' mental health.[11]

In the 'international mental health' vision articulated by WHO, psychiatry was to move beyond the walls of the asylum and mental hospital (and DP camp) and into the

---

[5] JC Flugel ed, *International Congress on Mental Health London 1948 Vol IV* (HK Lewis: 1948), p.299

[6] Harry Wu, 'World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948–c. 1965', *History of Psychiatry*, *26*(2)(2015), p. 166.

[7] Wu, 'World Citizenship'.

[8] Flugel ed, *International Congress on Mental Health London 1948 Vol I,* pp.34-5.

[9] EB Brody, 'The World Federation for Mental Health: its origins and contemporary relevance to WHO and WPA policies' *World Psychiatry*, 3(1)(2004).

[10] Wu, 'World Citizenship'.

[11] J.R. Rees, 'George Ronald Hargreaves, OBE, M. Sc.(Leeds), FRCP (Edin.) (1908-1962)', *American Journal of Psychiatry*, 119(11)(1963).

community. Mental health work would become preventive as well as curative, and new subfields of psychiatry emerged, such as ‘community psychiatry’, ‘preventive psychiatry’, and ‘social psychiatry’. It is difficult to draw distinct boundaries between them. They all involved the extension of the application of psychiatric theory beyond the individual to groups and communities and the promotion of harmonious social relations through promoting positive mental health. WHO decided that the best way to go about pursuing its mental health agenda was the application of public health methods to psychiatry.[12] This held the promise of expanding the reach of psychiatry, promoting sound mental health, and preventing mental illness, in addition to psychiatry’s traditional focus on curative services. Influenced by the idealism and pacifism of men like Chisholm, the conceptualisation of ‘mental health’ in the first decade of WHO was similarly idealistic, focusing more on the promotion of sound mental health rather than identifying disorder.[13] This would continue until 1957, when WHO’s psychiatric epidemiology program started.[14]

The changing nature of the European refugee problem

In the atmosphere of postwar optimism with which Allied psychiatrists of UNRRA’s psychological study group were imbued in 1945, it is unlikely that they would have imagined the DP camps remaining open and continuing to house refugees of the Second World War for another fourteen years. Yet by 1950, as the life of IRO was ending, it was increasingly obvious that the thousands remaining in the camps were unlikely to leave soon and that there would continue to be great difficulty in finding them new homes. This was through no fault of their own, but an outcome of how countries of resettlement selected DPs from the camps for emigration. The young, fit, healthy, single, and those with no dependants were given priority, while the old, infirm, physically or mentally disabled, and those with criminal records were left behind. Those left behind came to be known disparagingly as the ‘hardcore’. ‘Minus refugees’ was another term.[15] They would remain

[12] WHO Expert Committee on Mental Health & World Health Organization, Expert Committee on Mental Health: report on the first session, Geneva, 29 August - 2 September 1949, WHO technical report series no. 9 (1950), p.7 [https://apps.who.int/iris/handle/10665/37979].

[13] Anne Lovell, ‘The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands’ *International Journal of Epidemiology*, *43*(suppl_1) (2014), pp.i6-i18.

[14] Wu, ‘World Citizenship’.

[15] Odd Nansen, ‘Nansen Medal Award Ceremony’, *World Mental Health,* 10(1)(1958), p.6.

a persistent problem until UNHCR decided to tackle the issue in 1959. We will encounter the 'hardcore' in more detail later in this chapter, but first we must examine the conditions under which this population came to be.

In 1945 and 1946, the preferred solution to the European refugee problem for both the Western Allies and the Soviets was repatriation to the country of origin. The mandate of UNRRA was the relief and rehabilitation of DPs and, in cooperation with the military, their repatriation as soon as possible. In the spring and summer of 1945, six to seven million DPs were repatriated, but by mid-1946 it was clear that a 'last million' would not return to their countries in Eastern Europe, which were now under Soviet domination. Others, like the Jews of Europe, felt that they had no homeland to return to. UNRRA was taken over by IRO, which was active in the camps by mid-1947. This new organisation would tackle the refugee problem through another solution, resettlement in a third country, a 'far cry from the situation in 1945 when Allied governments and military officers envisaged offloading them by means of rapid and often brutal repatriation'.[16] Many anticommunist East Europeans began to join the DPs from 1948, and IRO took charge of them too and classed them as DPs[17]. With the Iron Curtain now dividing Europe in two and a Cold War between East and West, the purpose of the new organisation led to disagreements between the USSR, which insisted on the repatriation of its citizens, and Western states. The USSR insisted that it did not want to forcibly repatriate refugees, but alleged that refugees' continued refusal to return was the outcome of Fascist propaganda spread in the camps by war criminals, Western pressure on them not to return, and the desire of Western states to recruit cheap labour from among the DPs.[18] The Soviet Union and its satellites did not join IRO, and only 18 of the 54 UN member states eventually did. According to one French diplomat, this meant that IRO was 'crippled at birth', and an organisation whose very purpose 'should have been enough to gain unanimity took on a political character which was to become even more marked as a stream of refugees continued to arrive from Eastern Europe'.[19] On the other hand, the official historian of IRO, Louise Holborn, claimed that this was the very secret to the success of IRO. Its

---

[16] Peter Gatrell, *The Making of the Modern Refugee* (Oxford University Press: 2013), p.115.

[17] H.B.M. Murphy, 'The camps', in H.B.M. Murphy (ed.), *Flight and resettlement* (UNESCO: 1955), p.19.

[18] George Ginsburgs, 'The Soviet Union and the problem of refugees and displaced persons 1917-1956', *American Journal of International Law,* 51(2)(1957), p. 352.

[19] Rene Ristelheuber in 1951, quoted in Ben Shephard, *The Long Road Home; The Aftermath of the Second World War* (Bodley Head: 2011), p.334.

'amazing achievement', she wrote in 1956, was 'chiefly due to the extraordinary unity of purpose prevailing in its policy and administrative organs, partly because of the absence of the Soviet Union and its satellites and partly because of the objectivity of the IRO's General Council, whose policies were dictated by the needs of the refugee'.[20]

From the outset, then, there was little chance of 'world citizenship' making any significant inroads where refugees were concerned, not only in legal and political matters but also in seemingly non-political issues such as the mental health of refugees. The recommendation given by a WFMH working group on mental health problems of refugees that there be a 'supranational authority to watch over the interests of all immigrants' – a role for which WFMH was well suited for due to its 'multiprofessional character' - was mere wishful thinking.[21] IRO was certainly not 'objective' in H.B.M. Murphy's view. Murphy joined IRO after UNRRA and was responsible for conducting medical examinations of prospective emigrants. In 1950, he represented IRO at the third annual meeting of WFMH in Paris. IRO, he told the audience, was very different from other 'officially non-political' organisations like WHO and UNESCO. It was very difficult, and 'perhaps wrong', to think of IRO without realising its political implications:

> IRO assists refugees who are regarded as becoming refugees because of the Second World War or Hitlerism. Today it protects and assists refugees who are regarded as having become refugees because of Communism or communistic type politics in Eastern Europe. It does not, as far as I know, assist anybody who does not get on with Western type democracy to go over to the East, it is a one way organisation so I cannot honestly claim that we are even in intent completely international.[22]

All the sources I examine in this chapter are therefore concerned with European refugees in Western countries of transit and resettlement. There is not, as far as I can tell, any information in the English language on the mental health of those who repatriated and how they settled down behind the Iron Curtain. The intensely political sphere of international refugee policy and the postwar international refugee regime had far reaching effects on

---

[20] Louise Holborn, quoted in Shephard, *The Long Road Home,* p.334.

[21] 'Mental health of transplanted and homeless persons', *Bulletin of the World Federation for Mental Health,* 2(6)(1950), pp.17-18.

[22] Oskar Diethlem Library (hereafter ODL), Weill Cornell Medical College, New York City, WFMH US Committee, Box 31 Folder 15, H.B.M. Murphy, 'Remarks of Dr. H.B.M. Murphy, Observer, IRO, at the Third Annual Meeting, Paris 1950', p.1.

mental health professionals' work with refugees, influencing which refugees received psychiatric attention and which went ignored. The clearest example of this was the millions of ethnic German refugees expelled from the East, a situation of the Allies' making. After the Potsdam agreement in February 1945, Poland 'recovered' the territories of East Prussia, Pomerania, and Silesia from Germany, and proceeded to expel ethnic Germans who had lived there for generations into occupied Germany and Austria. The same happened in Czechoslovakia, from which Sudeten Germans were expelled. Hungary and Romania also expelled ethnic Germans from their lands. None of these millions were classed as DPs, nor were they part of UNRRA or IRO's mandate.

The tensions resulting from the political decision to exclude ethnic Germans from the care of UNRRA and IRO were manifest at the same 1950 WFMH meeting that Murphy addressed, in a talk by psychiatrist Rolph C. Jech of the Austrian Society for Mental Health (*Österreichische Gesellschaft für Psychische Hygiene*). Rech divided the refugee population in Austria in two groups: those under the care of IRO, and those 'so-called German-speaking refugees and German-speaking expellees'. 'It must be said frankly', he told the audience, that the exclusion of the latter from IRO care had 'brought a feeling of deception and has developed an attitude of distrust in the United Nations as an organisation' among them.[23] He did not neglect to mention that the German-speaking expellees from Poland, Czechoslovakia, Hungary, Romania, and Yugoslavia had lived for centuries in these countries and helped build and develop them.[24]

The *Volksdeutches* were materially worse off than the DPs, Jech pointed out. According to government statistics, there were 57,867 IRO-eligible refugees in Austria, under 17,000 of those in camps and almost 40,000 living in flats as renters or subtenants.[25] In contrast, there were 293,875 expellees in Austria, 31,267 of them in camps. Denied support from the UN and its organisations, they could only rely on relief from international religious welfare organisations, the Austrian government, and Austrian voluntary societies.[26] Austria, overburdened with displaced people and now enduring a military

---

[23] ODL, WFMH US Committee, Box 31 Folder 14, RC Jech, 'The situation of the transplanted and homeless persons in Austria under mental health aspect; A report delivered to the WFMH at the Paris meeting, 1950' p.2.

[24] Jech, 'The situation', p.1.

[25] Jech, 'The situation', p.2.

[26] Jech, 'The situation', p.3.

occupation, was in no position to be generous, and the expellees suffered greatly as a result of food shortages between 1945-7. They also had little hope of expecting to emigrate to a country with better living conditions, except for the few who secured contracts to go to Sweden.[27] The important psychological fact about the expellee was that 'he still believes in only a temporary stay in Austria, and has a strong and unquenchable desire to return to his former home'. 'Enormously homesick', some South Moravians sought a job near the Austrian border with Czechoslovakia, and every evening would 'look towards the other side of the river on the frontier of their former villages and fields, not fully recognising their fate and always thinking that there will be hope of returning someday'.[28] Jech raised the spectre of the most recent dictator Austria had given the world, warning that in these conditions of 'deception, hopelessness, fear, sadness and demoralisation', it was certain that 'some leaders of the world of tomorrow are today growing up in this situation, and will, in consequence, be driven into abnormal and neurotic reactions'. He reminded his audience that responsibility for the expellees did not rest with Austria alone and that 'the responsibility must be shared by all people', for 'it is not alone the fault of Austria that this situation has developed'.[29]

As the preferred durable solution changed from repatriation to resettlement in a third country, psychiatric thinking about refugees also changed. An example of this is to be found in the career of H.B.M. Murphy, whose activities and interests illustrate the intellectual trajectory of the field of refugee mental health. When IRO replaced UNRRA in 1947, Murphy thought it most regrettable that the new organisation did not include the word 'rehabilitation' in its title. It seemed to him at the time that IRO was no longer going to attempt to rehabilitate refugees, but simply to get rid of them. Looking back in 1950, he told his audience at the WFMH meeting, he had changed his mind. The approach of UNRRA towards refugee rehabilitation had in fact been 'wrong', and the IRO attitude 'the correct one'. UNRRA had tried to rehabilitate refugees in the DP camps, a process which was ultimately 'falsely directed' because of the shortage of trained personnel and leaders to carry it out. He personally felt that 'we did some damage to our refugees through trying to do such work on lines which were scientifically unsound'. IRO changed this tactic, and adopted the view that the first step towards refugee rehabilitation was to find them a new

---

[27] Jech, 'The situation', p.3.

[28] Jech, 'The situation'. p.4.

[29] Jech, 'The situation', p.6.

permanent home. In Murphy's assessment, from a mental health viewpoint, 'this simple straightforward question of getting people into countries where they can be permanently accepted is the biggest step that we could have done for refugees'. 'In considering the work that IRO has or has not done', he continued, 'I would like you to remember that point, that the best thing to do for a refugee is to get him to a place he can call a permanent home.'[30]

There were economic motives for this shift from a repatriation to a resettlement orientation. A committee of American experts reported in 1947 that the European Displaced Persons were 'a dead weight on the ailing economy of Europe'.[31] These uprooted millions had to be relocated so that they would produce at least as much as they consumed. The problem of feeding and integrating millions of expellees from the East in Germany could only be addressed when the DPs had left. The committee recommended that DPs be distributed in areas of labour shortage in Europe.[32] About 170,000 DPs - a fifth of the total - were taken in by the nations of Western Europe, but by 1947 it became clear that the solution had to involve resettlement overseas - in the Americas and the British Commonwealth.[33] By the summer of 1950, IRO had resettled 733,000 people, and was sending DPs out of the camps at a rate of 16-17,000 a month.[34]

Despite the success at resettling hundreds of thousands, it was already apparent that IRO's mandate would expire before thousands of refugees had been found new homes. The recruitment of DPs for resettlement was an economic, not humanitarian, process. Relief worker Marvin Klemme called the British recruitment of DPs a 'cold-blooded labour recruiting programme'.[35] The same could be said of other countries. The unemployable and undesirables would continue to live in the camps for the foreseeable future. One relief worker with the American Friends Service Committee in Germany called them 'the dregs left after UNRRA, IRO, ICEM, and all the voluntary agencies and

---

[30] Murphy, 'Remarks', p.2.

[31] Jane Perry and Clark Carey, *The Role of Uprooted People in European Recovery,* National Planning Association Planning Pamphlet 64 (1948), p.vii [retrieved from https://catalog.hathitrust.org/Record/002092415].

[32] Shephard, *The Long Road Home,* pp.333-4.

[33] Shephard, *The Long Road Home,* p.335.

[34] Murphy, 'Remarks', p.2.

[35] Quoted in Shephard, *The Long Road Home,* p.325.

National Commissions had done their utmost to transplant them to new worlds'.[36] Social worker Gwen Gardner recalled being told 'There's no one worth saving among that rabble.'[37] Odd Nansen, son of the first High Commissioner under the League of Nations Fritdjof Nansen, said in a speech at UNHCR in 1958 that all countries recruiting from the DP camps did

> was to take their fill of a commodity for which there was a shortage. And it was done in a heartless, cynical manner. Some years ago I was personally present at one of these modern slave-markets, and I still blush with shame and indignation at what I saw there.[38]

In Murphy's words, 'As we are always saying, the cream has been skimmed off, the good milk is going and we are being left with the sediment, the very difficult cases to handle from a mental, social, and physical point of view.' In attempts to rehabilitate some of this residual population - 'tuberculotics, amputation cases, asthmatics, and old people' - Murphy found the results depressing. In his personal opinion, there was very little that IRO could do for these people in terms of mental health work 'until we can tell them that this work will get them to a permanent home'. He gave the example of 600 DPs in southern Italy, all 'tuberculotics and amputees' who were 'completely resistant to any attempts that were made to give them a new mentality because they could see no use in it' and no future, as long as countries refused to admit people with even a past history of tuberculosis. Murphy implored his audience to raise awareness of the plight and potential of these people with their governments upon their return home. 'Properly handled', such people would become 'useful' to countries accepting them, and government representatives recruiting from the camps needed to be made aware as to what constituted a chronic condition and what was 'a purely temporary effect of bad environmental pressure'. The other reason for exclusion - criminal records - was also unnecessary in his opinion. Most of the sentences received were handed down by courts under very strict military rules to people who had had a clean record before. He gave the example of many Poles in Germany receiving prison sentences for carrying revolvers, 'although from personal investigation I know that some did not even know how to use them'.[39]

---

[36] Gwen Gardner, 'Employment and integration project for foreign refugees', *World Mental Health,* 10(1)(1958), p. 22.

[37] Gardner, 'Employment and integration', p.23.

[38] Nansen, 'Nansen Medal Award Ceremony', p.7.

[39] Murphy, 'Remarks', pp.3-4.

At the same meeting, a WFMH working group on the 'mental health of transplanted and homeless persons' expressed its dismay at the imminent closure of IRO in 1951, even though, they acknowledged, it was responsible for only a small proportion of refugees in the world. It stressed that 'the mental health of refugees and immigrants has been seriously neglected' and that this was 'a very serious problem, hiding widespread misery and capable of producing dangerous social and political tensions'. 'If steps are not taken to provide all these people with new homes', the Working Group warned, 'their mental unrest can spread from their immediate surroundings and thence affect the whole world'. A series of unheeded preventive mental health recommendations were made. These had to start before resettlement in the form of 'thorough preparation prior to migration: full information, selection, vocational guidance, training and education towards adjustment'. The faster resettlement was processed and the refugee was in a new home, the better for their mental health. The group warned against the separation of family groups or segregation of the sexes upon resettlement. The receiving population needed to be educated too, especially to draw their attention to 'undesirable attitudes such as unconscious hostility, excessive pity and overprotection'.[40] Mental health workers of all stripes had no power to affect the conditions of selection and resettlement laid down by governments, and though they did agree that rapid resettlement and integration in the host society was necessary for sound mental health, they disagreed with how this process was implemented.

From uprooting to striking new roots: DPs as cheap labour

In addition to changes in ideas about the proper setting of refugee rehabilitation, the other obvious way in which psychiatric thinking about refugees changed was through a change in focus from looking backwards to lost roots to looking forwards to striking new roots. During the 1940s, the major mental health focus had been on observing and understanding the effects of 'uprooting' and camp life. By the start of the next decade, new questions were being asked and new concerns raised. Arriving in a country of resettlement was not the end point, and new mental health problems would become apparent. These

---

[40] 'Mental health of transplanted and homeless persons', *Bulletin of the World Federation for Mental Health*, 2(6)(1950), pp.17-18.

revolved around the social and cultural adaptation of the refugee to the new land. Murphy told his WFMH audience that personal communications with professionals in Britain, the USA, Canada, Australia, and Israel indicated an increased rate of mental breakdowns in arriving refugees, that 'the impact of freedom after they reach a new country often produces mental illness of a temporary nature' which was not apparent in the protected atmosphere of the camps.

> I am afraid IRO cannot help here, but this is a very important thing that *you* can do for our refugees after IRO has got them resettled in new countries; it is essential that some organisation watches them and assists them in their adaptation and eventual amalgamation in their new country. National organisations must take over our work. I would ask you to make a special note of that and when you get home to do something active about it [emphasis in original].[41]

What did successful resettlement entail? 'Resettlement', Murphy wrote in 1955, 'cannot be taken to have succeeded only because the transplanted refugees stay till their death in their new lands.'[42] Resettlement could only be said to have begun when the refugee 'ceases to regard his state of life as a purely temporary one and begins to plan for a future based on his present environment'. A 'mental gesture of acceptance of current conditions' had to be made. Without this, a person's mind could remain wholly in the past and their day-to-day life would be an asocial one, with resettlement never really taking place. Successful resettlement implied 'a pushing out of new roots, and an acceptance and nourishing of these roots by the new environment'.[43] These roots could only grow if adequate social relations developed between the newcomers and the host population, 'for roots only grow where the soil is prepared to receive and nourish them'. Of course, refugees had no control over the 'soil' receiving them, and the conditions and manner under which refugees were selected conspired to frustrate the process of root growing. Murphy does not seem to have been a political man, often confining himself to commenting on the psychological impact of government policies without ever recommending a major change to such policy. Commenting on the restrictions placed by immigration recruiters, he wrote

---

[41] Murphy, 'Remarks', p.3.

[42] H.B.M. Murphy, 'The conditions of resettlement', in H.B.M. Murphy (ed.), *Flight and Resettlement*, (UNESCO: 1955), p.97.

[43] Murphy, 'The conditions of resettlement', p.91.

> I do not know of an objective evaluation of such measures and I do not believe that such can be made, except in the most extreme cases. Humanitarian feeling and economic profits are not commensurable, and in the question of refugees they must both be taken into account. All that it is appropriate to remark on here is the psychological result of such restrictions.[44]

The manner of recruitment of DPs had an important influence on the mental health of the refugee in resettlement and their adaptation prospects. The more a refugee saw themselves regarded as 'a unit of manpower, or as a cipher in some great scheme, or as an *Untermensch* unfit to be permitted more than the simplest form of labour', the more they would be alienated from their new society and have difficulty in adjusting there. Another major factor responsible for the disillusionment of refugees was the 'discrepancy between the vague principles put out by their prospective country of resettlement and the way in which they are actually treated by it'. Murphy lamented that in the ideological clash taking place in the Cold War 'this correspondence between principles and practice is often ignored, and refugees are among the chief sufferers'.[45] Practical problems upon arrival in the new country were the continuation of camp living in the form of temporary transit or resettlement camps, where arrivals often stayed for months because of postwar housing shortages, and, for those with dependants, the separation of families so that the breadwinner lived in a camp near his place of work while the rest of the family was far away in the countryside. This was especially a problem in a country as large as Australia, where a worker's family could be hundreds of miles away, forcing him to choose between spending most of his paycheck on transportation costs and not seeing his family in order to save money and take up a second job.[46]

Murphy resigned from his position at IRO in 1950 to explore the question of mental health in resettlement in more depth. In the summer of that year he visited the young state of Israel and in the end of the same year he visited Australia. In both countries he spoke to mental health workers, employment officers, and refugees, and published his impressions. Anticipating his lifelong interest in cross-cultural comparisons of mental health, it was the

---

[44] Murphy, 'The conditions of resettlement', p.92.

[45] Murphy, 'The conditions of resettlement', p.92.

[46] H.B.M. Murphy, 'The assimilation of refugee immigrants in Australia', *Population Studies,* 5(3)(1952), pp.184-5.

cultural and social assimilation of refugees and immigrants in resettlement that concerned him most. Conditions of refugee reception in Australia were conducive to social and cultural isolation. There was no sponsorship scheme under which those in Australia could bring over their DP relatives, and consequently most of the 155,000 DPs who had arrived by 1950 under mass resettlement schemes had no personal contacts in the country.[47]

The Australian government had a policy of rapid Australianization of the DPs within a single generation, and preferably within a single decade. Official policy was thus geared towards high speed assimilation and this found its expression in public attitudes that the new arrivals should adopt Australian labour habits, speak English, and not form colonies of their own.[48] The distance between the Central European culture the DPs hailed from and the new Australian culture was quite wide. By culture, Murphy meant 'the body of habits, attitudes and values which are held more or less permanently by a group of people and are inculcated in their children'.[49] DPs arriving in Australia were in danger of experiencing what earlier generations of migrants to the United States had gone through: the removal of their old European culture without its substitution by a new one, resulting in 'a mass of incomplete, unstable, and potentially asocial individuals who, having lost contact with their old society and being unable to make contact with the new, tended to produce a special culture of their own, the antisocial culture of the gangs'. This would be further complicated in Australia by the pressure on arrivals to rapidly assimilate in a country where they had few contacts, unlike the situation in the US where immigrants often linked up with contacts from their own national group. Murphy observed that the pressure to assimilate placed great mental strain on the DPs, and concluded that it would have been better to allow them a much more gradual assimilation where they could draw on more support from their 'old life'.[50]

Despite superficial cultural similarities between Europe and Australia, the gulf between the two was quite large, Murphy stressed. Australia was 'too close to its pioneering tradition to have developed a complex social structure' like that of Europe. People in small towns did not have local loyalties springing from tradition. Instead, there

---

[47] Murphy, 'Refugee immigrants in Australia', p.189.

[48] H.B.M. Murphy, 'Assimilating the displaced person', *The Australian Quarterly,* 24(1)(1952), p.46.

[49] Murphy, 'Assimilating the DP', p.47.

[50] Murphy, 'Assimilating the DP', pp 47-8.

was an ethos of self-sufficiency accompanied by 'a certain scorn for social functions which attempt to do for the individual what he might be capable of doing for himself, and a mistrust of entangling oneself too deeply in a local society'. What social groupings existed were for purposes of defence or aggression, but not social contact.[51] The arriving DP was therefore quite isolated. Accustomed to the gregariousness of European social life, which had been amplified by years of camp living in close quarters, he or she would realise upon arrival in Australia that they were 'still very far from being able to fit into the Australian ideal of self-sufficiency or to face the quite remarkable emptiness which greets one as soon as one gets out of the cities'.[52]

Government planning for the migration of DPs seemed to be a success in economic terms, but in social matters 'the real problems have either not been realised or are being tackled very inadequately, existing voluntary agency set-ups being used in place of scientifically planned assimilation projects'. The 'real problem' Murphy was referring to was social isolation, a situation which was neglected by welfare agencies in favour of language classes. In his opinion, the apparent difficulty with which DPs were learning English was a not a cause but a side effect of their social isolation. This necessitated a 'switch of expenditure from language teaching to social welfare, the use of more university trained social workers (if they can be found), more explanatory propaganda to both sides, more opportunities for the immigrant to contribute to Australian life, and reorientated national organisations'.[53]

There was no dedicated service for the mental rehabilitation of DPs in Australia. Part of this was down to 'the pioneering self-sufficiency tradition' that only recognised full health or full weakness, with anything in between, like the neuroses, 'mere weakness'.[54] After an initial nine month period of euphoria at having been resettled, many DPs slid into a period of depression with exacerbation of their past neuroses. At the time of Murphy's

---

[51] Murphy, 'Refugee immigrants in Australia', p.197.

[52] Murphy, 'Refugee immigrants in Australia', p.198.

[53] Murphy, 'Refugee immigrants in Australia', p.203.

[54] Murphy, 'Refugee immigrants in Australia', p.202. Loosely speaking, neurotic disorders (e.g. depression, anxiety) were those in which the patient did not suffer a break with reality in the form of hallucinations and delusions, the hallmarks of psychotic disorders (e.g. schizophrenia). In the more strict psychoanalytic sense, neuroses could be categorised into 'psychoneuroses' that were the result of unconscious conflicts that the patient was not entirely aware of, while those behaviours and disorders associated with obvious and known stressors were simply termed 'neurosis'.

visit in 1950, it was still very much in evidence (the recruitment of DPs for immigration to Australia had happened between 1947 and 1949).[55] Australian psychiatry was 'backward' in its recognition of this fact,[56] and the only way a DP could get psychiatric attention was by 'making a nuisance of himself'. Then he could be certified insane and hospitalised, receiving only electroconvulsive therapy as treatment - enough to temporarily 'relieve him of some of his capacity for worrying about life'.[57]

From uprooting to striking new roots: DPs as fulfilment of ideology

Ideas of social adaptation and assimilation of immigrants took on a decidedly political and politicised character in the new state of Israel. Founded in fulfilment of Zionist ideology on the land and homes from which 700,000 Palestinians were expelled in the Arab-Israeli war of 1948, the only criterion for immigration to Israel was being a Jew, the very *raison d'être* of the state. During the first four years of its existence, there were no restrictions on immigrants regarding age or health, and the new state took in many survivors of the Nazi concentration camps. In the four years from May 1948, the Jewish population doubled from 650,939 to 1,596,000.[58] Unlike Australia, in Israel there were professionals ready to take up the cause of mental rehabilitation of arriving refugees. Psychiatrist Abraham Weinberg from the Netherlands had been in Palestine since at least the early 1940s.[59] Through his work at the Israel Mental Health Foundation, he investigated the adjustment problems of arrivals to Israel and how to integrate them quickly and smoothly.

At the 1950 WFMH meeting, Weinberg outlined his ideas on immigrant adaptation, which were clearly influenced by the recent experience of European Jewry. He offered the following definitions: 'Assimilation' was the outcome of successful resettlement, a term he

---

[55] Murphy, 'Refugee immigrants in Australia', p.203.

[56] Murphy, 'Refugee immigrants in Australia', p.204.

[57] Murphy, 'Refugee immigrants in Australia', p.202.

[58] United Nations Library Geneva, World Federation for Mental Health, Practical Measures for dealing with the Mental Health Problems of Refugees and Displaced Persons 1952, in UNHCR collection (CDR HEA/MEN/182 D): Abraham Weinberg, 'Care for new immigrants in Israel: a summarising report on mental health work'.

[59] I have not been able to ascertain when he arrived in Palestine, but he may have arrived with a group of Dutch Jews who arrived prior to 1939. In 1941 and 1942, he conducted a study of this group's adaptation to life and society in Palestine.

proposed be used in a lay or overall sense only. Assimilation to particular conditions of life in the new country was termed 'adjustment'. There was an active, creative adjustment as well as a passive, automatic adjustment, the latter termed 'adaptation'. In adjusting to life in a new country, a refugee or immigrant passed through several stages: 'acculturation…the identification of the immigrant with the culture of his new environment', 'integration…where the immigrant becomes an integral part of the group', and 'amalgamation…established where immigrants and receiving population become a homogeneous group'.[60]

In the process towards amalgamation, a stage could be reached where there was no further identification possible between the incoming and receiving group, at which they had to 'live together while maintaining their own way of life'. This state, termed 'symbiosis', could be a successful and acceptable compromise, but needed to be watched closely, since it could be rendered unstable by changing economic or political conditions under which inter-group tensions would (re)emerge. The ultimate aim of mental health work, in Weinberg's words, was 'as rapid and smooth a passage as possible…towards complete amalgamation, and the attempt to avert development of minority groups as a consequence of more or less successful symbiosis'. In the process of adjustment of immigrants to a new society, psychiatry had to reckon not only with the 'psychological or physical makeup of the immigrants' but also with the 'adjustability and flexibility of the receiving population'. This was not so much a matter of adjustment of an individual immigrant to a new society, but the adjustment of groups of immigrants to groups of natives (or, in the case of Israel, established settlers). For this reason, Weinberg wondered if it would be possible to resettle immigrants in smaller groups to reduce the possibility of inter-group tensions in the new country. Even if this happened, however, it was 'a well-known fact that immigrants tend to flock together, to adhere to old behaviour patterns and to find amidst their country folk a substitute for the fatherland they have lost'. This was a double edged sword: on the one hand the support of people from the same background, who spoke the immigrant's native tongue and could understand them well, could be conducive to smooth integration. On the other hand, a tightly-knit group could become closed to outsiders and raised the danger of insufficient adjustment and the development of minority groups. Even if groups of immigrants and natives lived in peace in a form of

---

[60] Weinberg, 'Mental health of transplanted and homeless persons', p. 173.

symbiosis, there was always the danger that changing sociopolitical conditions could cause tensions between them that could lead to strife, persecution and war.[61]

Adjustment possibilities for those who had suffered the hardships of persecution were ‘decidedly reduced, the most so in those cases where the choice of the country of resettlement [was] not their own’. Weinberg observed that those who migrated forcibly and were in a new country against their will would ‘often sabotage unconsciously, if not consciously, their integration into the new society’. This did not mean that it would be plain sailing for voluntary immigrants. Even those who had not suffered persecution and internment and had migrated more or less of their own free will still had to contend with the break in their life line, and adjust to a new way of life, another culture and society, another climate, and sometimes a lower standard of living. The conditions under which an immigrant was received by the native population, or its representatives in the form of immigration authorities, could be decisive of an immigrant’s future.[62]

That all immigrants to Israel were Jewish did not mean that there would not be adaptation problems. One major issue immigrants to Israel had to contend with was the discrepancy between their expectations of the country and the reality, which often fell short. Weinberg noted that many prospective immigrants to Israel did not have a clear idea of the conditions awaiting them, often having ‘too rose-coloured a picture of the country’. Expecting to find the same kind of Jews they had known back home, ‘many of them were surprised to find themselves in Israel amongst a strange kind of people’, so much so that the new immigrant was ‘inclined to see the Israeli as a stranger or even as a kind of Gentile’. This attitude hampered successful adjustment. The surprise of immigrants upon arriving in Israel was, in Weinberg’s formulation, down to the fact that Jews, among their own people, became cured of their ‘diaspora neurosis’. In their countries of origin they had been self-conscious, shy, and attached to a warm family life. By contrast, the Jew in Israel was more independent, self-assured, bold, cool and stubborn. Though not indifferent to his family, he was more interested in friends and society as a whole. People in Israel ‘work[ed] hard and very often [had] no time and patience to listen to the troubles of new immigrants who wanted to unburden the sorrow of the past and anxiety of the present’. Israeli youths did ‘not like the complex-ridden Jews of the diaspora whom they [could] not easily

---

[61] Weinberg, ‘Mental health of transplanted and homeless persons’, pp.173, 175-6

[62] Weinberg, ‘Mental health of homeless and transplanted persons’, pp.174-5.

understand, being themselves rather uncomplicated'.[63] That the Israeli Jew was referred to by Weinberg as a 'he' is in line with the contemporary ideals of Zionist masculinity in Israel, which represented the imagined transformation from the weak, feminized diaspora Jew to the rugged, muscular, robust Israeli.[64]

Murphy thought certain features of the Israeli response were commendable and worth copying, especially the social work service 'for both the ordinary and the handicapped immigrant' that followed them up for a year or more.[65] In 1951, he would recommend at a WFMH meeting that all refugee receiving countries have a Refugee Social Welfare Service to aid the newcomer's adjustment and take measures to prevent mental and social unrest. This service needed to have a special 'follow-up post-immigration service' of a preventive nature that had 'a means of reaching the most lonely refugee', since the persons most likely to break down were those who remained solitary and did not seek help in time.[66] He was less impressed with what he saw as a neglect of rehabilitation of adult DPs in favour of children. Child welfare organisations, especially the *Youth Aliyah,* were doing remarkable work, 'possibly the best in the world'. The *Youth Aliyah* had rescued and retrained morally and practically over 50,000 children, placing them in kibbutzim or other settlements. Even new immigrants to Israel would try to get their children adopted by the *Youth Aliyah,* 'despite the strong family loyalties which all Jews have', because of its good reputation. By contrast, the Israeli authorities seemed passive on the question of adult rehabilitation and assimilation. Among the earlier settlers, Murphy found the sentiment that the adult DP was useless, and that the pioneers had to bear their burden until the younger generation came of age. The attitude was 'not one of resentment because of this alleged uselessness but [was] rather that of a son towards his retired or disabled father'. This seemed 'only explainable as the effect of an unconscious hostility' towards them.[67] The DP immigrant needed retraining and his attitudes and behaviour were sometimes irritating. While the prewar settlers had been more adaptable, the DPs were

---

[63] Abraham Weinberg, 'Problems of adjustment of new immigrants to Israel, part 2', *Bulletin of WFMH,* 5(3)(1953), pp.129-135.

[64] Philip Hollander, *From Schlemiel to Sabra: Zionist Masculinity and Palestinian Hebrew Literature* (Indiana University Press: 2019).

[65] H.B.M. Murphy, 'The resettlement of Jewish refugees in Israel, with special reference to those known as displaced persons', *Population Studies,* 5(2)(1951), p.172.

[66] World Federation for Mental Health, 'The problems of refugees', *Bulletin of the World Federation for Mental Health*, 4(2) (1952), pp.97-98.

[67] Murphy, 'The resettlement of Jewish refugees', p.169.

made insecure and dependent by their history, unable to stand on their own feet or 'emulate the high moral tone of the earlier settlers'. They were unable to make decisions, and jealous of the status they still possessed as 'the persecuted'. They were spiritually unable to participate in Kibbutz life because they needed to be independent and rebuild themselves as individuals first.[68] On the part of the settled, there were feelings of guilt over what had happened to European Jewry, that complicated interactions with DPs.[69] On the whole, Murphy found interpersonal relations between DPs and settlers in Israel 'poor'.[70] The unconscious hostility seemed difficult to tackle because it was unrecognised by those who bore it.

Murphy noted these findings in 1951. That there were no special programs for concentration camp survivors at this time is confirmed by Israeli historian Rakefet Zalashnik, who writes that in the 1950s, mental health problems of survivors were explained by the difficulties of migration rather than the sequelae of persecution. At this time, patient notes written by psychiatrists in Israel often referred to a patient's recent persecution and war experiences in only a couple of sentences. It was commonly claimed that Jewish survivors in Israel suffered fewer mental health problems than those in other countries. For example, psychiatrist Mark Dvorjetski, a Lithuanian Jew and survivor of the Vilna ghetto and concentration camps, argued in 1955 that the psychic complexes of survivors disappeared when they became rooted in the new State of Israel, in which a 'process of reintegration of the personality' took place.[71] The first article in Israel on mentally ill survivors as a distinct group appeared only in 1956. Its author, psychiatrist Greda Barag, believed Jews to be 'more resistant' than any other race.[72]

The end of IRO

---

[68] Murphy, 'The resettlement of Jewish refugees', p.170.

[69] Murphy, 'The resettlement of Jewish refugees', p.168.

[70] Murphy, 'The resettlement of Jewish refugees', p.174.

[71] Quoted in Rakefet Zalashnik, 'The psychiatrically hospitalised survivors in Israel', in Dori Laub and Andreas Hamburger (eds.), *Psychoanalysis and Holocaust Testimony: Unwanted Memories of Social Trauma* (Routledge: 2017), p. 185; Michael Dorland, *Cadaverland: Inventing a Pathology of Catastrophe for Holocaust Survival [The Limits of Medical Knowledge and Historical Memory in France]* (Brandeis University Press: 2009), p. 110; Dvorjetski's name has also been spelled 'Dworzecki'.

[72] Quoted in Zalashnik, 'The psychiatrically hospitalised survivors in Israel', p. 186

Though IRO's activities had resettled hundreds of thousands of DPs, Murphy still had his regrets, which he expressed at the 1950 WFMH meeting. He mentioned that WFMH had approached IRO a year earlier and invited it to join the Federation, but because of its shaky and uncertain future IRO had either responded negatively or not at all. This was 'a great mistake', for IRO 'could have become a life size laboratory for the testing of mental health principles'.[73] IRO itself was due to expire at the end of March in 1951 (its mandate was later extended to the end of 1951). Responding to questions on the future of the organisation, Murphy said that all he knew was that there would be a new High Commissioner who would have only powers of liaison but no budget or staff.

> All I can tell you at the moment is that IRO is due to die at the end of March and that after that there will be a High Commissioner who will try and look after the interests of refugees but will have very little power to do anything about it.[74]

The new organisation was the United Nations High Commissioner for Refugees. Murphy did not join it; he became director of student mental health services at the University of Malaya in then-British Malaya. He would spend the rest of his life researching transcultural issues in mental health. In 1958 he wrote his MD thesis at the University of Edinburgh on 'Culture, society and mental disorder in Southeast Asia'. In 1959 he wrote his PhD thesis at the New School of Social Research in New York on 'Ethnic variations in juvenile delinquency'. In 1959, he emigrated to Canada to join the new Transcultural Psychiatry Unit at McGill University, where he would become a renowned transcultural psychiatrist and psychiatric epidemiologist. H.B.M. Murphy's postwar career, from the confines of the DP camps in Europe to a global interest in culture and mental health, is a case study in how refugee movements served as a catalyst for the creation of new knowledge and directions in psychiatry. Five years before his death, he would write in the preface to his 1982 textbook *Comparative Psychiatry:*

> The history of this book dates back to 1946, when I was put in charge of the medical services for a group of refugee camps in Germany. Each camp tended to be occupied by people of a particular cultural origin - Estonian, Jewish, Latvian, Lithuanian, Polish - and as I sat with the camp doctors seeing patients or discussing cases it became apparent that some syndromes, particularly the more psychiatric, could be common across the camps of

---

[73] Murphy, 'Remarks', p.5.

[74] Murphy, 'Remarks', p.5.

> one cultural group while uncommon in the camps of another. My clinical teachers had said nothing about such variance, and when I sought to learn more about it I found that very little had been written. In due course that led me to search out employment in some location where I would be able to investigate the phenomenon systematically, and this has become my prime interest ever since.[75]

When the refugee is a 'freedom fighter'

In November 1956, a Hungarian uprising against the Communist government was crushed by the Soviet Union. As a result, about 200,000 Hungarians fled across the border into Austria in late 1956 and early 1957. A further 20,000 fled to Yugoslavia. The Hungarian refugee crisis was the first post-war refugee crisis in Europe. It was also first post-war crisis that UNHCR, founded in 1951, got involved in.[76] Like IRO, the post-1951 international refugee regime and UNHCR were both closely intertwined with the Cold War. According to Frank and Reinisch, it was because, rather than in spite of, deepening East-West divisions that an international refugee regime was able to survive into the 1950s - the Soviet Union and its satellites having boycotted the relevant UN discussions. In the polarised environment of the Cold War, the meaning of a refugee was greatly simplified. Rather than war displaced ethnic or national groups, refugees in the Cold War were political and ideological dissidents fleeing persecution and Communist tyranny.[77] The US organized an evacuation program called 'Operation Safe Haven', and 27,000 Hungarians were evacuated and resettled to the US in ninety days.[78]

The definition of refugee adopted at the 1951 Geneva Convention focused on one sole aspect: fear of persecution. A refugee was someone who 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality' and, owing to

---

[75] H.B.M. Murphy, *Comparative Psychiatry: The International and Intercultural distribution of Mental Illness* (Springer-Verlag: 1982), preface.

[76] Gil Loescher, *The UNHCR and World Politics: A Perilous Path* (Oxford University Press: 2001).

[77] Matthew Frank and Jessica Reinisch, 'Refugees and the nation-state in Europe, 1919–59', *Journal of Contemporary History*, 49(3)(2014), 477-490.

[78] Arthur A. Markowitz, 'Humanitarianism versus restrictionism: The United States and the Hungarian refugees', *International Migration Review,* 7(1)(1973), 46-59.

such fear, unable or unwilling to return.[79] Hungarian refugees fit the spirit, if not the letter, of the 1951 Convention 'like a glove'.[80] Though UNHCR's mandate was limited to refugees who were displaced as a result of events in Europe before 1951, it acted on legal advice that argued that the events that led to Hungarians' fleeing could in fact be traced to 1947-8, when a Communist government took hold.[81] The Convention definition, a legal one, was implicitly adopted by psychiatrists who sought to document and treat the mental health problems of Hungarian refugees in resettlement. The Cold War would frame interactions between psychiatrists and their refugee patients. Though the meaning of a refugee was simplified in the Cold War, interactions between psychiatrists and refugees were complicated as the taken-for-granted link between uprooting and mental ill-health came under scrutiny.

The Hungarian refugee crisis offered a valuable opportunity for UNHCR to demonstrate that it was the only agency capable of undertaking large scale international action on behalf of refugees. UNHCR successfully passed this test, winning international acceptance and recognition. In Gil Loescher's words, 'for the first time in its history, UNHCR was specifically designated by the international community as the "lead agency" to direct a large scale emergency operation'. The US and other Western states were concerned that the refugees would have a destabilising effect on Austria if left there.[82] According to Austrian psychiatrist Hans Hoff, the Austrian government had no intention of letting the refugees settle, but only to improve camp living conditions and getting the refugees out of Austria as soon as possible.[83] Consequently, one of the most striking aspects of the international response to the Hungarian refugee crisis was the speed with which the resettlement process began.[84] For psychiatry this raised a new issue not really seen with the DPs: the rapid process of transit caused persistent anxiety and uncertainty in the camps, and the rapid resettlement contributed to a sense of identity confusion in the

---

[79] UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 152, available at: https://www.refworld.org/docid/3be01b964.html [accessed 22 January 2020].

[80] Frank and Reinisch, 'Refugees and the nation-state', p.484.

[81] Loescher, *The UNHCR and World Politics,* p.86.

[82] Loescher, *The UNHCR and World Politics,* p.84.

[83] Hans Hoff, 'Survey of mental health activities in Austria in connection with the Hungarian refugees', *World Mental Health*, 9(1)(1957), pp.9-14.

[84] Loescher, *The UNHCR and World Politics.*

new country. Unlike the DPs of World War II, the Hungarians would not languish in camps for extended and indefinite periods of time as they waited for countries to offer them resettlement. Eagerness to avoid the precedent set by the 'hardcore' DPs contributed to speedy resettlement in Western Europe and the US, so much so that Elfan Rees, advisor on refugee affairs to the World Council of Churches, declared 'No group of refugees has ever been treated so well and so quickly.'[85] Western states and publics saw the Hungarians as heroes, freedom fighters against Communism, who deserved their help. This was helped by the fact that this was the first televised refugee crisis. The Soviet repression of the uprising 'symbolised the brutality of the Soviet Union and vindicated Western descriptions of life behind the Iron Curtain'.[86] Instead of apathy, laziness and dependency, Hungarians were regarded as possessing the capacity to adapt successfully to new lives in resettlement, having made an active and conscious choice to flee Communist tyranny.[87]

Austrian psychiatrists observed this new refugee situation closely, not only as disinterested scientific observers, but as Austrians. Even before WFMH had managed to raise funds for the Austrian Society for Mental Health (ASMH) to send psychiatrists into refugee camps, Austrian psychiatrists like Hans Hoff, Walter Spiel, and Hans Strotzka were observing the reaction of the Austrian public to the influx of Hungarians and commenting on emerging psychological patterns in interactions between Hungarian refugees and their hosts. The Hungarian exodus represented an opportunity for the newly independent Austrian republic. Tainted by the association with Nazism, and having just regained its independence only a year earlier, this was a chance for Austria to prove the solidity of its democratic institutions, army, and press. Its readiness to host Hungarian refugees and defy Soviet and Communist criticism was testament to its endorsement of the status of 'permanent neutrality' adopted in 1955, and showed that neutrality did not mean abandoning Western values. The Austrian government joined the worldwide condemnation of Soviet actions. The Austrian help to Hungarians was also seen as a validation of the Austrian national character and Austrian nationhood itself.[88] Austrian psychiatrists saw a chance to contribute this validation, while also raising the status of Austrian psychiatry. in

---

[85] Quoted in Cohen, *In War's Wake,* p.158.

[86] Loescher, *The UNHCR and World Politics*, p.85.

[87] Gatrell, *The Making of the Modern Refugee,* p.115.

[88] Robert Knight, 'National construction work and hierarchies of empathy in postwar Austria', *Journal of Contemporary History*, 49(3)(2014), 491-513.

a letter to WFMH Director J.R. Rees in December 1958 discussing the activities of ASMH, Dr Walter Spiel wrote

> We few people could never have managed this task if not the whole country - and here especially Vienna - would have given an example to the whole Western world. You can't imagine the psychic atmosphere - free of anxiety - in these critical days in this country, an atmosphere of love for one's fellow man. Austria would really deserve the Nobel award for peace.[89]

Spiel may have been overstating the situation, or at least affected by the initial enthusiastic Austrian response, which would dampen as time went on. Hans Hoff described in February 1957 how the outbreak of revolution in Hungary had triggered a 'great outpouring of sympathy and solidarity from Austrians', in the form of 'full-hearted and unanimous', albeit disorganised, help. Memories of their own occupation by the Nazis (albeit after effectively inviting Hitler in) and then the Allies were fresh, and there were still feelings of solidarity stemming from old ties dating back to the time of the Austro-Hungarian empire. The desire of Austrians and the international community to help was marred by 'many selfish reactions'. Austrian women hoped to recruit domestic servants from the camps, foreign missions wanted only able bodied men, or only women and children, for resettlement. Once again, this would lead to family separation and did not bear well for mental health, something that was not taken into official policy consideration at first. Subsequent discussions between psychiatrists of the ASMH and the Austrian government led to the issuance of a formal decree banning family separation, a rare example of policy change that Austrian psychiatrists could take credit for.[90]

Interactions between Hungarians and Austrians were structured by the initial expectations each had of the other. The Austrians expected to see poor and starving masses, and prepared large quantities of food, oranges, and gulyás, a popular Hungarian dish. Hungarians expected to find a 'paradise' in the free Western world, as had been promised to them by the broadcasts of Radio Free Europe. A 'complicated sociopsychological pattern' of mutual disappointment between refugees and hosts soon appeared. Hungarians did not find a paradise in Austria, and Austrians did not necessarily

---

[89] ODL, WFMH US Committee, Box 33 Folder 1, Walter Spiel, 'Extract of letter from Dr Spiel, Oesterreichische Gesellschaft fur Psychische Hygiene, December 18th 1956'.

[90] Hoff, 'Survey of mental health activities in Austria', pp.9-10.

find the poorly dressed starving people they expected. After overcoming their initial shock of loss of home and identity, the Hungarians wanted to get on with their lives. Hungarians did not, Hoff stressed, cross the border to fill in gaps in the social and cultural patterns of Austrian society, but to raise their own standard of living. After the initial welcome, rising hostility from Austrians became apparent when Hungarians did not embody the ideal of the grateful, accepting refugee. They resented seeing the Hungarians well dressed, not realising that the refugees had taken only their best clothes with them. They also resented seeing them sitting in groups and chatting in cafes, not understanding that it was a feeling of homesickness that brought them together.[91]

The atmosphere was certainly not one 'free of anxiety' as Walter Spiel said, at least for the refugees. The major cause of anxiety, and one that psychiatrists could do nothing about, was a lack of reliable information as to the fate of the refugees. After the initial warm welcome, they were sent to refugee camps that were felt (wrongly) to be like concentration camps. With a lack of accurate information, rumours spread in the camps and contributed to the anxiety and uncertainty. They did not want to go to France, fearing they would be pressed into the French Foreign Legion. They did not want to go to Belgium either, having heard about the poor conditions in the coal mines there. Many wanted to join relatives in the US, Canada or Australia. Because the US decreed that it would only accept refugees from Austria, since it had the best information on who was a Communist, Hungarians were resistant to any attempt to make them leave Austria. This problem of lack of information for the refugees was consistently brought up in reports of the ASMH's refugee working group.[92]

The international mental health community was also ready to take up the cause of the Hungarians. Maria Pfister-Ammende, a mental health officer at WHO since 1955, visited the refugee camps soon after the Hungarians started arriving. She issued a set of recommendations to governments accepting Hungarian refugees.[93] Reflecting the different circumstances of this refugee movement from those of WW2, she devoted little attention to the perils of 'uprooting' and camp confinement, focusing instead on their emigration

---

[91] Hoff, 'Survey of mental health activities in Austria', pp.11-14.

[92] Hoff, 'Survey of mental health activities in Austria'.

[93] ODL, WFMH US Committee, Box 33 Folder 1, Maria Pfister, 'Suggestions to the governments concerning the reception of Hungarian refugees'.

prospects. She emphasised considerations such as how refugees were chosen for emigration, the role of the refugees themselves in the choice of country, and the circumstances under which such a choice was made. The more refugees were free to make their choices, the better for their mental health. She also drew attention to the actual conditions of transport to their new country, insisting that they not be organized under strict military lines. Conditions in the reception camps upon arrival were just as important. Social workers had a role to play in helping to establish adequate contact between the arrivals and the host community. She raised problems that the refugees themselves could present, namely their high expectations and 'wishful thinking' about conditions in the new country, and the 'inexplicable' refugee behaviour that could foster resentment but which had to be understood as part of an increased drive towards self-preservation that was the result of their flight and uprooting.[94]

The first response of the Austrian Society for Mental Health to the refugee influx was to hold discussions with policymakers and government officials to persuade them of the importance of mental health work forming a part of the response. By December 1956, they started advising camp administrators and personnel on mental health. With the help of WFMH, the ASMH raised funds that enabled it to start a program in the camps, aimed at 'reactivating tendencies to social readaptation'.[95] By the end of March 1957, there were still 41,000 Hungarian refugees in Austria, 26,500 of them in camps.[96] The purpose of this program was to counteract the negative effects of camp life on Hungarians until they received a chance to emigrate. With the 'time of quick transit' over, a 'systematic and detailed service' could start. This service was led by Dr. Hans Strotzka. Through the networks and meetings organised by the World Federation for Mental Health, Hans Strotzka was influenced by the work and ideas of Maria Pfister-Ammende in planning mental health care for refugees in Switzerland in the 1940s. Strotzka set out to initiate a preventive mental health effort in the 250 camps for Hungarians in Austria, with colleagues from the Working Group for Refugees of the Austrian Society for Mental Health. The acute refugee situation in Austria 'proved to be a favourable test case for the introduction' of ideas of prevention in mental health, both 'on theoretical grounds [that]

---

[94] Pfister, 'Suggestions to governments', p.5.

[95] Walter Spiel, 'Report on the work done for Hungarian refugees by the Austrian society for mental health', *World Mental Health,* 9(1)(1957), p.15.

[96] 'Report of activity of the working team for Hungarian refugees of the Austrian society for mental health', *World Mental Health,* 9(2)(1957), pp.83-86.

any group of refugees was known to be a possible source of mental and social danger for the country sheltering them', and because experience with WW2 refugees 'was still sufficiently remembered by authorities and public opinion to prevent any strenuous resistance' to the proposal.[97]

Knowing full well that further emigration was their intention, any systematic treatment of refugees in mental hospitals was discouraged in favour of 'casual treatment by suitable care or psychotherapy', for it was known that mental hospitalisation would hurt the emigration prospects of the refugees.[98] In this sense, psychiatrists were not just treating symptoms of mental ill-health, but took the side of the refugees, helping them to achieve their own goals. With the help of Hungarian refugees who were enlisted as translators, Strotzka's team undertook visits to camps and hostels all over Austria, regularly and on request. During these visits, consultation was provided to camp commandants, physicians, and staff, and treatment given to any patients in the camp. During the peak months of the exodus a permanent mental advice bureau and occupational therapy centre was established in the main transit camp. A 'casual ward' was organised to give short courses of psychotherapeutic treatment to refugees needing it. Data was collected and shared with other relief and welfare organisations. In February 1958 a seminar was arranged by Strotzka's team for camp commandants, in collaboration with the Austrian Home Office. By this time, however, the urgency of the refugee crisis had subsided.

Strotzka's experience in the camps revealed similar problems in mental health work inherent to camp living that recalled the experience of the DP camps. Echoing H.B.M. Murphy's observations about DP camps, Strotzka noted that the institution of large camps, 'justified and unavoidable during the transitory stage', later became an obstacle to rehabilitation because the location and size of the camps rendered adequate employment difficult. Camps had seemed a very logical temporary measure since most refugees wanted to emigrate and their future possibilities were still uncertain, but the longer they stayed in the camps the more apathetic they became. As for the camp staff, Strotzka echoed Murphy once again in his observation that 'the greatest difficulties in the everyday life of refugees arose from faulty training and selection of the personnel caring for them'. It would have been desirable to have personnel familiar with the social and psychological aspects 'of

---

[97] Hans Strotzka, 'Observations on the mental health of refugees', in *Uprooting and Resettlement* (World Federation for Mental Health: 1960), pp.58-59.

[98] Strotzka, 'Observations on the mental health of refugees', pp.59, 62.

such catastrophic situations', and Strotzka hoped that his team's work in the camps as well as small seminar groups could contribute to a better calibre of personnel in the future.[99] Strotzka also drew attention to the regularly recurring problem of a lack of reliable information for the refugees. Because of constantly changing circumstances in what was an emergency situation, anyone who tried to supply refugees with information 'usually soon had cause to regret it, when he found that quite innocently he had caused mischief because for some reason or other the situation had changed, and the information given proved to be incorrect and only produced all the more mistrust'.[100] Strotzka recounted the experience of the Working Group for Refugees of the Austrian Society for Mental Health at the 1958 meeting of WFMH, held in Vienna on the theme of 'uprooting and resettlement'. In discussing the effect of the program he said:

> It is extremely difficult to prove any material effect of preventive work in the psychological field, but we might point out, as an example, that our psychiatric welfare service in one large camp succeeded in the admission of almost all those who had made suicidal attempts to the casual ward, without inflicting on them the stigma of hospitalisation.[101]

Whether or not refugees benefited from this work, he was not in doubt that psychiatry had.

> I think this experience is important, not only because we did something which was very much worthwhile, but because it was the first time that our Federation, the World Federation for Mental Health, was able to organise financial and expert help in an emergency situation very quickly and sufficiently, and it proved that we are not only interested in theory but also in practical international health if there is a real need.[102]

Deserving and undeserving refugees: the reception of Hungarian refugees in Britain

---

[99] Strotzka, 'Observations on the mental health of refugees', pp.61-63.

[100] Strotzka, 'Observations on the mental health of refugees', p. 61.

[101] Strotzka, 'Observations on the mental health of refugees', p. 63.

[102] Hans Strotzka, 'Action for mental health in refugee camps', in *Planning and Action for Mental Health*, (World Federation for Mental Health: 1961), p. 246.

Though Hungarians were celebrated by the West as ‘freedom fighters’ and speedily resettled as refugees under the 1951 Convention, the discourse around their reception was one of charity and benevolence of the host country as opposed to one of rights guaranteed by the Convention that the host state was signatory to. Becky Taylor has written about how this process played out in Britain, where Hungarians were expected to justify the generosity shown them by Britain by assimilating in society, learning English, and becoming industrious, hard working citizens. Ideas about deserving and undeserving refugees intersected with local ideas in Britain about the deserving and undeserving poor under the postwar welfare state.[103] When refugees did not conform to expectations they were problematised, morally and medically. While there was no blanket moral problematisation of refugees as idle and lacking in drive, those Hungarians who failed to conform to hosts’ expectations were promptly problematised and marginalised. In other words, while Hungarian refugees were not automatically seen as inactive and lacking a work ethic, they were all in danger of becoming so. This process of categorisation as deserving or undeserving began in the reception camps in Britain, as shown by a June 1957 paper in the *Lancet* by Thomas Dormandy and CA Milner of the RAMC and GP William Eldon.[104] The first author, Dormandy, was born in Hungary in 1926, and went into hiding with his family in 1944 when the Germans occupied Hungary because of his family’s Jewish background. When the Russians arrived, the family went to Geneva and Paris before settling in Britain in 1948. Dormandy sat his medical exams three times, first in Hungary, then in Switzerland, and finally in Britain.[105]

In the experience of Dr. Dormandy and his colleagues, the first few weeks of reception of Hungarians in Britain ‘saw such an extraordinary surge of human kindness that - hard as it is to recall its immediate effect even from the distance of a few months - they could not but leave a happy and exhilarating memory’. One of the first patients was a 21 year old factory worker who presented to the medical centre in the Aldershot reception camp eight hours after arriving in Britain. He had been injured by a hand grenade during a demonstration in Hungary. Once in Austria, he declared himself fit despite his injuries and

---

[103] Becky Taylor, ‘Their Only Words of English Were ‘Thank You’: Rights, Gratitude and ‘Deserving’ Hungarian Refugees to Britain in 1956’, *Journal of British Studies*, 55(1)(2016).

[104] Thomas Dormandy, W Eldon, and CA Milner, ‘Medical care of Hungarian refugees’, *The Lancet*, 269(6980)(1957), 1183-7.

[105] Anne Gulland, ‘Thomas Dormandy’, *British Medical Journal* (2013). [Retrieved from https://www.bmj.com/bmj/section-pdf/187880?path=/bmj/346/7906/Obituaries.full.pdf]

was allowed to board a plane at Linz that would take him to Britain, avoiding a stay in the camps in Austria. At the camp medical centre, doctors found that the left side of his chest and his left arm were extensively scarred with muscle wasting and reduced mobility. His face was also scarred and his left eye inflamed. Radiographs showed multiple metallic foreign bodies and splinters in his chest wall, as well as in his left eye. Despite treatment, vision in his left eye remained very poor and was unlikely to improve.[106]

Despite his injuries, doctors thought this patient was 'fortunate in many respects'; 'not only was he among the first arrivals, thus receiving the first wave of public sympathy, but he also escaped, through his illness, the inevitable demoralising effects of transit camps'. Though he was miserable in hospital and frequently found in tears, nurses and fellow patients (usually young soldiers evacuated from the Middle East) took turns teaching him English, brought him presents, and made him part of their community. During a brief stay in the transit camp in February 1957 before he was employed, 'the difference between his outlook and that of many of his able-bodied fellow refugees, who had spent the preceding weeks (and the Christmas festivities) in the camp was striking'.[107] Anxious to start employment, work was soon found for him as a nursing orderly in a London teaching hospital. There, by all accounts, he was 'acquitting himself well'.[108] This patient embodied the grateful and deserving refugee, by accepting the help and employment offered, trying to learn the local language, and getting on with life. Because the welcoming attitude Britons offered to Hungarians was conditional on their conforming to certain expectations of behaviour and gratitude, it could not be sustained when they tried to assert themselves, make themselves heard, or simply did not act in the prescribed manner. These became problem patients who came to medical attention through their hosts or employer, like the following patient.

A 29 year old Hungarian man was brought to the medical centre by his employer, a British farmer in Devon. This young man was taken with three others from the transit camp in Aldershot soon after arrival in Britain to work on his new employer's farm, and was given a cottage to live in. After a week, he started having vague digestive complaints. A

---

[106] 'Medical care of Hungarian refugees', p. 1183.

[107] This recalls Eduard Bakis' descriptions of the circumstances in which 'DP apathy' arose in Baltic DP camps in Germany. He evoked the monotonous passage of time in the DP camps, as Christmas of 1945 and then 1946 saw them still in the camps with still not prospect for resettlement.

[108] 'Medical care of Hungarian refugees', p. 1183.

doctor in Devon was unable to make sense of his complaints or convey instructions to him because of the language barrier. In Aldershot, the patient was ‘emphatic about liking his new work and his employers; and he seemed distressed that he might be taken for the Hungarian equivalent of a “skiver.”’ But closer questioning revealed he was resentful on several counts, and had problems other than indigestion. He was paid two pounds less per week than English farm workers, something he did not consider unreasonable because of the language barrier but which he resented not being told about earlier. His wife was also made to do housework, without extra pay. He also felt that he should have been taken to hospital from the outset of his complaints. More generally, he was critical of many features of English life, including the weather.[109]

From the doctors’ point of view, cases with vague (medical) complaints such as this one were often ‘troublesome and medically unrewarding’ even in the best of circumstances. Whereas a British patient with similar complaints could be advised against time consuming and unnecessary lengthy investigations while the doctor remained secure in the ‘comforting thought at the back of one’s mind that they are left with an almost unlimited choice of alternative doctors whose counsel they can seek’, this wasn’t possible with this Hungarian patient, who would not ‘get another chance for a long time even to voice his discontent’. Even the ‘slight benefit of superficial psychotherapy would be denied to him as soon as he had left’ the consulting room. There was also the fear that discussing his grievances with his British employer might cause ill-feeling, and his doctors were ‘far more aware than many of the refugees themselves how much of their future welfare depended on public good will’. In addition, ‘one’s loyalty to the individual patient was strongly assailed by the knowledge that there were many other young men in the camp who, hardworking and dependable, would have been anxious to take on his job and would have done far better in his place’. In this case, the patient was reassured about his symptoms and a discussion with his employer proved the latter to be more understanding than expected. Three days later, the patient was seen for follow up. He looked cheerful and felt perfectly fit - ‘thanks to your tablets, doctor’ - and there was no medical reason against his returning to his job. Later, however, upon getting in touch with the British employer, the doctors learned that he had left his job without notice ‘at a most awkward time’, and

---

[109] ‘Medical care of Hungarian refugees’, p. 1183.

persuaded three other refugees at the farm to go with him. His employer told the doctors that 'in no circumstances would he or any of his friends employ Hungarians again'.[110]

The outbreak of the revolution in Hungary, Dormandy wrote, had disturbed the country's social and political order and upset all conventions of behaviour, so that even for the least adventurous, the open border with Austria was a powerful attraction. Hungarians had arrived in the West in this unsettled state of mind. Only there did they begin to realise that they 'had exchanged the hardships and insecurities of a political regime for the equally crippling, if more transient, hardships and insecurities of life in a foreign country'. In the 'intoxicating atmosphere' of the revolution, many had left behind sick parents or young children without, it seemed, pausing to consider that this might be permanent.[111] Much of the mental illness in the transit camps in Britain was seen among 'the emotionally unstable, the perpetual drifters, the chronic failures - in whose catastrophic lives revolution and escape were but passing episodes - [who] often reacted violently to the growing stresses of refugee life: friends of nobody and their own worst enemies'. It was hard to imagine these people settling down in a 'normal life' in Britain, and they also ran the risk of being mistaken for psychotic when they could not express themselves because of the language barrier, and certified and taken to a mental hospital. Even a brief period in a mental hospital 'could have a disastrous effect on them'.[112]

It was the height of the Cold War, and Western policy makers did not seriously 'consider that Hungarians would be motivated to leave for any reason other than a desire to escape genuine political persecution'. It was also administratively impossible, in such a mass exodus, to actually judge each individual's motive for flight.[113] But that was precisely what doctors tried to do in working with Hungarian refugees. The reason that the actual motivations for flight assumed such relevance for psychiatrists was that many Hungarians were having adaptational difficulties once in resettlement, and it was concluded that many of these had left for reasons that had nothing to do with politics, and were anything but 'freedom fighters'. And it was apparently easier to be a freedom fighter than to learn English and settle down in Britain. In the words of one Women's Voluntary

---

[110] 'Medical care of Hungarian refugees', p. 1186.

[111] 'Medical care of Hungarian refugees', p. 1186-7.

[112] 'Medical care of Hungarian refugees', p. 1185.

[113] Loescher, *The UNHCR and World Politics,* p. 86.

Service relief worker, ‘when we began this work we prepared to receive twenty thousand heroes, but we soon discovered that we had to deal with ordinary human beings, made up of all types, good, bad and indifferent’.[114] The implication was that some of these refugees, having left for reasons other than persecution, were less than genuine. This had two consequences: first, it implied that some refugees were less deserving of assistance and charity than others, especially when they did not conform to the host population’s expectations of gratitude and hard work. Second, it led psychiatrists to ponder how much of a patient’s adaptive difficulties in resettlement were in fact due to the stresses of migration and leaving the homeland, as opposed to manifestations of disturbance and maladaptation that had been long present in Hungary. In trying to uncover the actual motivations for each refugee’s flight, the taken for granted link between uprooting and mental ill-health was uncoupled.

Alexander Goldfeder Mezey, a senior registrar in psychiatry at the Maudsley Hospital in London, and a Hungarian speaker, set out to study the personal background and reasons for emigration in the Hungarian refugees that came to his attention. Mezey was born in Romania, but left in 1940 when Jews were barred from entering the medical profession. He moved to Switzerland, where he qualified in medicine and remained till 1950, moving to Britain in 1951. When he applied for a job at the Maudlsey, he was still stateless, pending naturalisation procedures. Mezey had only two years of experience in psychiatry under his belt when the British Council for Aid to Refugees approached the Maudsley about the possibility of establishing of a temporary clinic staffed by a Hungarian speaking psychiatrist.[115] Cases were often seen first by a BCAR psychiatric social worker, followed by Mezey. Initially, almost all of them were seen through BCAR, and later through voluntary aid agencies or government departments like the National Assistance Board or the Prison Commission. Mezey saw 82 refugees in the two years starting February 1, 1957. Four fifths of them had arrived in Britain under bulk resettlement schemes organised by BCAR, the remainder as mining recruits engaged by the National Coal Board.[116]

---

[114] Quoted in Taylor, ‘Their Only Words of English Were ‘Thank You’ p.135.

[115] G. Russell, ‘Alexander Goldfeder Mezey’, *Psychiatric Bulletin*, 32(10)(2008), 397-398.

[116] AG Mezey, ‘Psychiatric Illness in Hungarian refugees’, *Journal of Mental Science*, 106(443)(1960), 628-637.

Mezey was interested in distinguishing between refugees whose mental distress in Britain was related to the stresses of emigration, and those who had simply brought their troubles with them from Hungary. To Mezey, the Hungarian influx offered the chance to study a relatively homogeneous group of people in a way not possible with the refugees of World War II. The DPs and refugees of WW2 had come from diverse cultural backgrounds, spent varying times in concentration and DP camps, and spent varying times in the UK before coming to a mental hospital. By contrast, the Hungarians 'were rather suddenly immersed from one cultural environment into another and it was possible to examine a relatively large number of cases of all forms and degrees of severity, breaking down in the first two years following their emigration'.[117] Like Strotzka in camps in Austria, Mezey saw the influx of Hungarian refugees to Britain as an opportunity to further knowledge on mental health, migration, and the relationship between them. Here again is an example of the generative potential of refugee movements for medical and psychiatric knowledge.

Mezey concluded that the flight of many Hungarians in 1956 was simply a continued manifestation of a trend of westward migration that had never really stopped, the open border suddenly removing local hindrances to emigration. Over half of his patients had left for entirely non-political reasons, like to escape a bullying father, to avoid paying maintenance to an estranged wife, or to abandon an intolerable marriage. Other reasons were adventure seeking, a desire to see the world, or even medical treatment. Sometimes it was 'purely chance decisions without forethought or apparent reason'. Even those who had left for political reasons had not necessarily taken part in the revolution. Some had lived in a part of the country not even touched by the uprising but had political or economic objections to the regime. Or they were Jews alarmed at a rise in antisemitism in the revolutionary period. Only 22% had previously considered, even vaguely, leaving Hungary before the revolution.[118] Mezey was particularly interested in whether they had taken an active part in the uprising because of the possibility that 'taking part in an active uprising gives you some sort of resistance and resilience against difficulties' later on, the implication being that many of those who did break down in Britain were *not* resilient

---

[117] Mezey, 'Psychiatric Illness in Hungarian refugees', p. 628.

[118] AG Mezey, 'Personal background, emigration and mental disorder in Hungarian refugees', *Journal of Mental Science*, 106(443)(1960), 618-627.

because they had *not* taken part in the revolution - the main pretext on which Hungarians were being admitted to the UK in the first place.[119]

Mezey examined the previous migratory record of the patients and found that patients with schizophrenia had been (statistically) significantly more likely to have previously migrated within Hungary than any other diagnostic group. They were also more likely to have left for non-political reasons. The overall picture suggested that schizophrenics had already been 'marginal' and maladapted people in Hungarian society, moving from place to place in search of better circumstances. Their history of earlier migration to Budapest, and their non-political motivations for leaving, coupled with an entire lack of any prior planning 'indicated in fact that their maladaptation had been the major reason for leaving Hungary'. Any difficulties they had in conforming to 'normative social expectations' in Britain e.g. partner, parent, worker, were therefore unlikely to be related primarily to the circumstance of uprooting and emigration. The picture differed for those with mood disorders. Those suffering from, for example, depression, appeared to have been satisfactorily adapted in Hungary, suffering a decline in social adaptation once in Britain, which could be traced to the stress of emigration. Apart from mood disorders, though, it was difficult to 'ascribe aetiological importance to the stresses of emigration in the causation of the psychiatric disorders'.[120]

Adaptational difficulties and host expectations in Canada

The picture was not much different in Canada. Dr. Anthony Meszaros of Ste. Anne's Hospital, Montreal and one of only three Hungarian speaking psychiatrists in the city, studied the reactions of Hungarians to displacement and arrival in Canada. His research was sponsored by the Transcultural Psychiatry Unit at McGill University, founded in 1955. Meszaros suggested that the acclaim and sympathy with which Canadians had initially received Hungarians served to complicate the latter's adaptation to life in Canada. Canadians and Hungarians had had little prior knowledge of each other, and in 1956 the enthusiastic help given to Hungarians meant that, for Hungarians, Canadians 'suddenly became people from whom they could expect safety and support'. Initial stereotypes of Hungarians as heroes or as impoverished and uprooted victims 'matched quite closely the

---

[119] Mezey, 'Discussion' following Strotzka, 'Observations on the mental health of refugees', p. 71.

[120] Mezey, 'Personal background, emigration and mental disorder', pp.625-6.

current self concepts of the delocalised Hungarians themselves'. Thus, 'a disinterested and remote knowledge of each other was suddenly transformed into an emotionally charged, giving and receiving, relationship'. Initial contacts between Hungarians and Canadians were 'dominated by these idealised, general concepts'.

But these images of each other were impersonal and not based on any actual interaction. As the two groups interacted more 'the intense early emotions faded, [and] a revision of the images was called for, a revision which led to renewed uncertainty and confusion about identity' for Hungarians. This revision was 'as extreme as the original had been, and considerable tension and suspicion now developed between the two groups'. After this phase also faded, 'there remained a great deal of questioning by Canadians of the image which they should hold of the Hungarian immigrants, a question which did not help the latter to establish any more secure a self-identity for themselves'. An interest in roles of rebel and victim gave way to 'expectations of integration and assimilation'. Hungarians now had to demonstrate an adjustment in behaviour to meet these expectations. The criterion for acceptance in Canadian society changed from heroism and suffering to learning the local language, working hard, and conforming to local customs.[121] The language barrier only heightened their sense of being different. One refugee said 'I am just like a five year old child, perhaps even less, here. I have to learn everything anew.'[122] One psychiatrist urged Canadians to think of newcomers to Canada as adopted children who had been previously mistreated and could not be expected to always act reasonably, but who would eventually learn to accept their new country.[123]

For some Hungarians, this change in expectations caused a confusion about their sense of identity, and required that they give up some of their earlier self-concepts and acquire new ones in order to fit in the new society. This only added to the identity confusion many Hungarians had experienced as a result of Second World War and its aftermath and then the 1956 revolution. Meszaros' patients often reported feeling that the whole period of revolution and emigration 'does not seem real to me', 'as if it were a dream'. They would often have dreams of being back in their homeland and meeting

---

[121] AF Meszaros, 'Types of displacement reactions among the post revolution Hungarian immigrants', *Canadian Psychiatric Association Journal*, 6(1)(1961), 9-19.

[122] Meszaros, 'Types of displacement reactions'.

[123] Franca Iacovetta, *Gatekeepers: Reshaping Immigrant Lives in Cold War Canada*. (Between the Lines: 2006). [Chapter 8: 'From newcomers to dangerous foreigners']

familiar people and scenes but without any emotion, upon which they would be 'seized by the strangeness of the situation and by the sudden realisation of having nothing to do there, of not belonging there'. At this point in the dream the patient would remember his new country and try to go back there, experiencing 'considerable anxiety while attempting to reach the place where he is in reality'.[124]

Three psychiatrists of the Jewish General Hospital in Montreal and the McGill Transcultural Psychiatry unit, EK Koranyi, AB Kerenyi and GJ Sarwer-Foner, studied difficulties of Hungarians in the process of adaptation and acculturation. Koranyi and Kerenyi were the other two Hungarian speaking psychiatrists in Montreal. The first author, Erwin Koranyi, was of Hungarian Jewish background. He narrowly survived the Nazi occupation of Hungary, and in January 1945 was rescued from certain death through the efforts of the Swedish diplomat Raoul Wallenberg. In 1949 he crossed the Iron Curtain and never returned to Hungary. He made *Aliyah* to Israel, but in 1952 moved to Canada. He practiced psychiatry at the Jewish General Hospital in Montreal until 1970, when he moved to Toronto.[125] Koranyi and colleagues defined acculturation as 'those processes whereby the culture of a group of Hungarian immigrants was modified as a result of contact with Canadian culture, specifically that form of Canadian culture existing in the Montreal area'. Because there had been no time to plan the move to Canada and become accustomed to the idea of emigration, the sudden change in life circumstances provoked feelings of foreignness and alienation in their patients. Their adaptation to Canada was like an adaptation to a new 'familial' situation, with Canada as a surrogate of the old family, symbolically reenacting difficulties in the formative years of childhood. Adaptation was assessed clinically by asking the refugees if they were happy to be in Canada, if they were gainfully employed and content or, if unemployed, cared for by a social agency, if they felt a sense of freedom and belonging in Canada, and if they had made friends and social contacts among the local population.[126]

---

[124] Meszaros, 'Types of displacement reactions'.

[125] Letter from EK Koranyi to Yad Vashem dated 2010, in Tamas Szabo, *Who was the man in the leather coat?* (Munich: 2011), p.48. [Retrieved from http://mek.oszk.hu/09600/09621/pdf/who_was_the_man_in_the_leather_coat.pdf]

[126] EK Koranyi, AB Kerenyi, and GJ Sarwer-Foner, 'Adaptive difficulties of some Hungarian immigrants—IV. The process of adaptation and acculturation', *Comprehensive Psychiatry*, 4(1)(1963), 47-57.

Mirroring Mezey's findings in London, Koranyi and colleagues found that the few 'hardcore, chronic, passive-dependent, or psychotic patients who do not adapt are those who never functioned adequately in Hungary, i.e. they never worked, were markedly ill, psychotic'. They suggested that 'a certain proportion of disturbed people were among the many who escaped from Hungary during the revolution'. These people did no better in Canada and became a problem for medical treatment services and immigration authorities, forming 'a group whose passivity knows no bounds, and whose great secondary gain derived from satisfying these needs renders treatment difficult'.[127] They formed a 'sort of quasi-permanent relationship' with hospitals and social service agencies, remaining 'chronically in touch with' doctors and 'chronically unemployed, or chronically dependent, hospitalised, or borderline-functioning patients who must be looked after'. Partly because of people like these, Koranyi's sample of patients appeared to show greater unemployment in Canada than they had in Hungary. This was not a poor reflection on Canada, but on the unemployed. In Communist Hungary, they reasoned, the state provided employment and only those who were productive were deserving of rations, but in Canada those who did not want to or could not work could 'depend on welfare agencies' and remain unemployed.[128]

According to Loescher, the relative success in the resettlement of thousands of Hungarians in a short period of time was not entirely down to their utility for Western geopolitical interests and the anti-Communist sentiment of the time. The new home countries for the refugees happened to be in favourable economic conditions with low rates of unemployment.[129] It also helped that the refugee numbers were relatively small.[130] Many of the refugees were young, skilled, and educated, and they happened to be predominantly able-bodied young men.[131] Even though Hungarians were usually celebrated by the West as active and courageous, as opposed to the passive and idle DPs, and even though they were characterised as possessing desirable physical and political traits, those of them who did not conform to expectations were morally problematised in

---

[127] 'Secondary gain is defined as the advantage that occurs secondary to stated or real illness. Transition into the sick role may have some incidental secondary gains for patients.' R. Davidhizar, 'The pursuit of illness for secondary gain', *The Health care supervisor*, *13*(1) (1994).

[128] 'Koranyi, Kerenyi, and Sarwer-Foner, 'Adaptive difficulties of some Hungarian immigrants', p.49.

[129] Loescher, *The UNHCR and World Politics,* p.87.

[130] Frank and Reinisch, 'Refugees and the nation-state', p.484.

[131] Taylor, 'Their Only Words of English Were 'Thank You', p.142.

terms similar to the DPs.[132] The medical and psychiatric professions took on the task of categorising and managing them.

The clearance of the DP camp 'hardcore' (1959-60)

The speed and initiative with which the Hungarian refugee exodus was addressed stood in marked contrast to the attitudes of governments towards the remaining DPs of World War II still in DP camps. The worldwide publicity given to the Hungarians drew international attention to the 'shameful conditions' in which these people were still living. UNHCR was due for redundancy in 1958, but in 1957 the UN General Assembly passed resolutions authorising UNHCR to appeal for funding from governments and the UN specialised agencies to clear the refugee camps. The Office was extended for another five years.[133] The Hungarian emergency changed global popular perceptions of refugee issues, and UN High Commissioner August Lindt hoped that the successful resettlement pattern established with Hungarians could be used to solve the problem of residual refugees in Europe.[134] By the mid-1950s there were still over 200 DP camps in Germany, Austria, Italy and Greece, housing over 70,000 refugees.[135] These were known disparagingly as the 'hardcore', a term in circulation since 1946, and which referred to those whose resettlement claims had been denied for physical or mental disability, a criminal record, or other reasons. While this term implied that there was something defective about the refugees themselves, it only meant that they simply did not fit the profile of immigrants that countries of resettlement were looking for. Because many families wanted to stay together - as psychiatrists recommended - a 'black mark' against one of them damaged the resettlement chances of an entire family.[136] This was 'the most serious and embarrassing residual social and humanitarian problem of the Second World War'.[137]

At the 1957 Nansen Medal award ceremony, which was awarded to the UN High Commissioner, Odd Nansen gave a speech at the request of the High Commissioner. He

---

[132] Cohen, *In War's Wake,* p.158

[133] Loescher, *The UNHCR and World Politics,* p. 89.

[134] Loescher, *The UNHCR and World Politics,* p. 90.

[135] Loescher, *The UNHCR and World Politics,* p. 89.

[136] Gatrell, *The Making of the Modern Refugee,* p.113.

[137] Loescher, *The UNHCR and World Politics,* p.89.

referred to the 'spirit of charity' which characterised the world response to the Hungarian crisis: 'a spontaneous wave of sympathy and fellow feeling, sweeping across the Western World, produced organised relief on a scale hitherto unknow'. Yet this aid was neither large enough nor enduring enough to solve the whole problem: there were still thousands of Hungarian refugees waiting in camps in Austria. Even more scandalous was that there were refugees in DP camps now in their twelfth year.

> Of the approximately 200,000 refugees in Europe that come under the mandate of the United Nations' High Commissioner, over 50,000 are still living in camps. How long must they continue to live there? How many of them must rot away before we have time to see that they are offered conditions of life worthy of human beings? … Isn't it high time we removed this greatest stain of all on the face of our century, so that we can once more look one another in the eye without blushing for shame?[138]

One initiative to address this problem was 'World Refugee Year' (WRY), an initiative begun by three young Conservative politicians in Britain to raise international awareness of the plight of the world's refugees, with particular emphasis on the hardcore. UNHCR went on fully endorse WRY, to be held from 1959-60. WRY was conceived as a non-political initiative to draw attention to the social and humanitarian problems of refugees that would raise funds and encourage third countries to overcome their resistance to accepting sick and elderly refugees. The emphasis was on 'generating public goodwill, loosening purse strings, and, where possible, finding solutions' to the problem. In truth, Peter Gatrell says, the campaign was 'driven by a strong sense of Western guilt and a willingness to atone for failing to prevent the creation of the hardcore'.[139] While WRY did succeed in resettling a small number, UNHCR took on the task of integrating the majority of the remaining refugees in the countries they were currently in. Local integration in the country of asylum was the third of the 'durable solutions'. At the same time, WFMH organised concurrently a 'World Mental Health Year'. The five 'general international objectives' for WMHY were: the needs of children, national field surveys on mental health and illness, teaching principles of mental health, mental health aspects of industrialization, and the psychological problems of migration. One major aim of this final objective was to produce a manual on the social and psychological problems of refugees and immigrants that could be distributed to all refugee receiving countries for a 'wider handling of immigrants and

---

[138] Nansen, 'Nansen Medal Award Ceremony', pp.7-8.

[139] Gatrell, *The Making of the Modern Refugee,* p.114

the diminution of stresses'.[140] I have not found evidence that this manual was produced. The coordinator for this objective of WMHY was the Austrian psychiatrist Hans Strotzka, who had come to prominence during his work in the reception of Hungarians in Austria, as we have already seen.[141]

In May 1959, after consultation with WHO and Maria Pfister-Ammende, the High Commissioner convened a workshop in Geneva to discuss the problem of refugees requiring 'special services'. These were refugees with whom usual integration methods - finding homes and jobs for them, a task for the regular staff of refugee organisations - would 'probably fail'. A 'special case' was a family or household in which at least one member had a 'mental or social handicap that could be expected to render integration difficult or even impossible'. The workshop participants recommended that UNHCR appoint a social psychiatrist experienced in refugee affairs.[142] Social psychiatry was a subfield of psychiatry that coalesced in the 1950s under the leadership of WHO, and whose aim was 'to provide for the mentally ill, and for those in danger of becoming so, opportunities for making contacts with society which are favourable to the maintenance or reestablishment of social adequacy'.[143] If the clearance of the DP camps and integration of their last inhabitants in German society was to be a success, assisting them to develop adequate social relationships was paramount.

The person chosen for this job was Hans Strotzka. Strotzka was appointed as Mental Health Adviser to the High Commissioner's Office, the first of only two ever appointed by the Office. It was, he said, 'the first occasion on which a psychiatrist had had the opportunity to cooperate in a very broad scale social planning system and influence this whole social planning concept to a considerable extent'.[144] Strotzka's task would be to

---

[140] ODL, WFMH US Committee, Box 35 Folder 4, 'World Mental Health Year international objectives', July 1958.

[141] World Health Organisation Archives (WHOA) Geneva, 'Coordination with World Federation for Mental Health', Letter from Maria Pfister to Hans Strotzka, 1 Mar 1959.

[142] Hans Strotzka, 'Mental health aspects of camp clearance: The Activities of the Mental Health Advisor to the UN High Commissioner for Refugees (1959/1960)', in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After ...* (Springer: 1973).

[143] WHO Expert Committee on Mental Health & World Health Organization, 'Social psychiatry and community attitudes: seventh report of the Expert Committee on Mental Health [meeting held in Geneva from 20 to 25 October 1958]', WHO technical report series no. 177 (1959), p.3. [https://apps.who.int/iris/handle/10665/37997].

[144] Strotzka, 'Action for mental health in refugee camps', p. 248.

'assist in camp clearance in Europe, because the residual group of uprooted people in camps is steadily becoming more difficult to integrate, as the number of those who are mentally and socially handicapped increases'.[145] When work began in October 1959, there were 18,000 refugees left in the DP camps, the rest having been able to secure resettlement or spontaneously integrated in the country of asylum.[146] They came from nearly all countries in Eastern Europe. In Germany, Poles, Balts and Russians predominated, while in Austria, Greece and Italy there were various Balkan nationalities. From the outset, there were grave doubts as to whether any positive outcome was possible at all. The experience of many competent refugee relief workers suggested it was not, and 'there was the general impression that social disintegration in many of the camps had progressed to such an extent that all efforts at rehabilitation would be hopeless'. A survey in two camps in Germany suggested that for many cases the only solution was psychiatric hospitalisation. Even this, however, would be difficult, for 'local authorities did not dare to start such an action for fear of national and international complications', and international agencies felt that judgement was too pessimistic.[147]

The first task was case finding 'to make clear how many refugees needed specialised help for integration because of psychological handicap'. Strotzka also expected that there would be a high percentage of 'social and mental handicaps' in the camps because 'this was the group that had remained after a process of negative selection. There had been a long process of spontaneous integration and positive selection of the more healthy elements for emigration.'[148] In cooperation with the Mental Health Adviser, the local Branch Offices of the High Commissioner selected a number of camps in Germany and Austria, where discussions were held with staff of relief organisations and one hundred refugees interviewed.[149] This caseload consisted of 'psychosis, post-psychotic handicap, psychopathic personality, neurosis, and mental subnormality', and from 'a social point of view, the majority…were alcoholics and persons who had lost their ability to work, or at

[145] Strotzka, 'Action for mental health in refugee camps', p. 240.
[146] Strotzka, 'Action for mental health in refugee camps', p. 241.
[147] Strotzka, 'Mental health aspects of camp clearance', p. 283.
[148] Strotzka, 'Action for mental health in refugee camps', p. 242.
[149] Strotzka, 'Mental health aspects of camp clearance', p. 284.

least trust in their own ability'.[150] To Strotzka's surprise, only 10-15% of camp populations seemed to require special rehabilitation methods, a far cry from the 50% at minimum that experts had estimated.[151]

Two possible reasons for this unexpectedly low percentage were offered. First, and for the first time, it was suggested that refugee camps could have positive effects that would counterbalance the well known negative effects. A 'very strong in-group cohesion' was found in many camps, which offered 'a kind of pseudo-security which protects the camp inhabitants but which makes it extremely difficult for them to come back to normal social situations'. This could also explain the 'general resistance to leaving camps' that was found.[152] Second, Strotzka stressed that 'it had not been our task to make an epidemiological study on the basis of psychiatric phenomenology, but that we had to select families where we could not hope for integration with normal methods'. The methods of case finding used were not psychiatric, but sociological, meaning that they were looking for cases that integration counsellors had identified as unlikely to be helped by the current social work system. So, while not all the cases identified had psychiatric problems, they all had integration difficulties. Even after a more comprehensive examination, however, there was no appreciable rise in the number of psychiatric cases. The prognosis of need for additional care was determined not by clinical criteria, but by 'the social history before the displacement and on the general behaviour during camp life.' The result was therefore not a psychiatric study, but 'a social prognostic assessment on social-psychiatric grounds'.[153]

Well acquainted with the potential for refugee camps to serve as laboratories for new ideas and methods, Strotzka would seek to apply the methods of social psychiatry in clearing the camps. In light of conceptions of promoting positive mental health, Strotzka

---

150 Strotzka, 'Action for mental health in refugee camps', p. 242.; Psychopathic personality: 'evidenced by five main characteristics which are; poorly motivated antisocial behaviour, absent or weak superego or conscience, lack of sympathy with individuals and society, marked egocentricity, and at present is unmodifiable.'; John Fotheringham, 'Psychopathic personality - a review', *Canadian psychiatric association journal* 2(1)(1957), p.52; 'Mental subnormality' was a term used to refer to the 'incomplete or insufficient general development of the mental capacities.' This could take the form of 'mental deficiency', the diminution of mental capacity as a result of pathological processes, and 'mental retardation', when 'the social and educational performance is lower than that expected from a knowledge of intellectual abilities.' (Hilda Knobloch, 'Teaching about mental subnormality to the medical student and physician: a conference report', *Pediatrics* 31(1)(1963), pp.146-150.

151 Strotzka, 'Mental health aspects of camp clearance', p. 284.

152 Strotzka, 'Action for mental health in refugee camps', p. 243.

153 Strotzka, 'Mental health aspects of camp clearance', p. 285.

also directed action 'towards influencing the general atmosphere in the offices and the attitude of refugee workers'.[154] The impressions of the first camp survey were encouraging, but he faced a problem: 'in line with the general situation of social work and social psychiatry in Central Europe, one could not expect that the necessary level of sophistication, especially in psychiatric casework and modern industrial rehabilitation techniques, had been reached everywhere'. For this reason, he said, UNHCR decided to temporarily abandon its principle at that time of avoidance of direct operations in the field - these were usually done by partner NGOs - 'and the Mental Health Adviser operated in part *directly* from the branch offices'.[155] Delivering this program through UNHCR could help 'demonstrate the advantages of the new concepts we are following'. It would also help to address well known objections, such as accusations of 'initiating a kind of social perfectionism which could create difficulties for the more traditional type of social work', or that this kind of social care could have a 'spoiling influence' on its recipients.[156]

Strotzka promoted a rehabilitation plan that involved the introduction of group work into social work methods via in-service training and seminars, the enlistment of highly trained personnel like psychiatric social workers, drawing on other fields like social science and public health, and, if all these failed to help integrate a refugee, institutional rehabilitation and sheltered workshops in the community.[157] Institutions would not be simply custodial, but based on the principles of rehabilitation for industrial working conditions, with pay and closely resembling actual factories, but with the necessary care and flexible workloads and hours.[158] Another principle was the integration of psychiatric and social rehabilitation with physical rehabilitation, a procedure that was surprisingly 'unknown to many rehabilitation experts working with specific groups such as amputees, the blind, deaf-mute, or psychiatric patients'.[159] This would be cheaper than separate facilities, and could, it was hoped, challenge the stigma of mental illness.[160] To Strotzka's

[154] Strotzka, 'Action for mental health in refugee camps', p. 244.

[155] Strotzka, 'Mental health aspects of camp clearance', p. 287. Emphasis in original.

[156] Strotzka, 'Action for mental health in refugee camps', p. 245-6.

[157] Strotzka, 'Action for mental health in refugee camps', p. 243.

[158] Strotzka, 'Mental health aspects of camp clearance', pp.287-8.

[159] Strotzka, 'Action for mental health in refugee camps', p. 244.

[160] Strotzka, 'Mental health aspects of camp clearance', p. 288

surprise, and unlike the Hungarian crisis, there were few demands for individual psychotherapy.[161]

Because these refugees would not do well in the sort of accommodation normally provided by refugee welfare agencies, it was necessary to develop sheltered homes with some level of supervision. The concept was to help refugees 'reach a maximum of independence with only as much assistance as was necessary, to cope with physical handicaps, perceptual defects or deficiencies in the mastering of reality, aggressive or inhibited behaviour in social contact, alcoholism, inability to budget, etc'. An example of such an arrangement was where 'a married couple or a single person with training in social work became responsible to the agencies for the inhabitants of a certain number of flats. When problems arose beyond their competence they could call on professional help'. Though Strotzka's team was aware of the danger of 'becoming overprotective' and perpetuating 'social assistance for reasons not so much rooted in the needs of the client but in those of the worker and agency', it was tried whenever possible to arrange social assistance and follow up for a period of 2-3 years after leaving the camp.[162]

The project 'suffered from a lack of scientific evaluation and documentation' because of the orientation towards action and the lack of funds and personnel earmarked for scientific activities, but there were reasons to believe that many refugees had a good prognosis. Strotzka and his team gained the impression that the social prognosis of the mentally and socially handicapped camp refugees was better than that of comparable individuals in the general population, the reason being that many of refugees' problems were caused by environmental circumstances, such as living in a camp.[163] Taking them out of the camp would therefore lead to improvement. Incomplete follow up measures suggested a low failure rate of integration, about 10%.[164] Paradoxically, these refugees who had spent the longest time in DP camps were now not considered irreversibly damaged by the apathy, idleness, and dependency of over a decade of camp life. Psychiatry had come a long way from the perception of the infantile DPs of 1945 who had only a

---

[161] Strotzka, 'Mental health aspects of camp clearance', p. 289.

[162] Strotzka, 'Mental health aspects of camp clearance', pp.288-9.

[163] Strotzka, 'Action for mental health in refugee camps', p. 245.

[164] Strotzka, 'Mental health aspects of camp clearance', p. 289.

vestige of humanity left in them and had regressed so much that they needed to be retaught all civilised norms before leaving the camp.

Conclusion

The use of the botanical, naturalising metaphor of roots in describing the effects of displacement - 'uprooting' - on the refugee's mind may have been a relatively straightforward matter. Being uprooted was conceived as a passive process that resulted from events outside one's control, a violent wrenching, as if a tree, from the motherland. Given how taken for granted the metaphor of roots and uprooting was, as we encountered in the last chapter, psychiatrists' use of this widely prevalent trope to make sense of the effects of displacement is unsurprising.

But it is one thing to compare displaced people to an uprooted tree, and quite another to envision the process of resettlement as striking and growing new roots. In this chapter I have shown how the usage and expression of the metaphor of roots shifted from the former to the latter as the 'Golden Age' of European refugees progressed. The (former) refugee's new roots were expected to be nourished by and be responsive to the country of resettlement. And psychiatrists were there to facilitate this process, sometimes assuming the role of disinterested scientific observer, like H.B.M. Murphy, and sometimes explicitly politicising their work, like Abraham Weinberg. Though the root-striking metaphor acknowledged that the receiving society had a role to play in the integration of refugees, it seemed to place most of the responsibility for successful resettlement on the refugees themselves, who had been displaced through no fault of their own. It was therefore a problematic and unhelpful metaphor.

The Hungarian refugee crisis exposed how untenable the root metaphor was in the new Cold War context. Rather than being passively uprooted by the events of war, Hungarians were portrayed in Western societies as having made a brave, conscious decision to cross a border, ostensibly to flee Communist persecution. When some of them did not conform to the ideal expectations of the receiving society, they could come to the attention of psychiatrists, who examined their actual motivations for fleeing. The reason for this was a belief that there had been something of a selection bias in the circumstances of the refugee crisis that allowed among the refugees a disproportionately large number of people who had already been disturbed and maladapted in Hungary, often with a history of

internal migration. If this was the case, then their current adaptational difficulties did not stem from loss of homeland. This was a new way of looking at refugees' adaptational difficulties that was not in operation with the DPs.

I have argued that psychiatry in the Golden Age adopted states' conception of refugees as a problem to be solved. When, by the 1960s, the European refugee problem had receded from view, psychiatric interest in refugees waned. For this reason, a decade and a half of research and practice with refugees did not lead to the institutionalisation of refugee mental health as a discrete domain of inquiry in psychiatry or medical humanitarianism. This helps to explain a discrepancy I alluded to in the first chapter, that psychiatrists on the Thai-Cambodian border in the 1980s seem to have been unaware of the post-WW2 efforts in refugee mental health. That these fifteen years of work were largely ignored speaks to both the Eurocentrism of the psychiatric knowledge produced through work with refugees and how intricately connected with sociopolitical context this seemingly objective scientific knowledge. The Eurocentrism of this knowledge will become clearer by examining the 1960s, when refugee crises multiplied across Asia and Africa with little humanitarian attention to mental health. Throughout the 1960s, the metaphor of uprooting was still prevalent in psychiatry, but in a very different context: social change, industrialisation and urbanisation in the decolonizing and postcolonial Third World.

Chapter 4
Decolonisation and Development

Introduction

Humanitarian crises in Europe in the 1940s and 1950s helped to drive the generation of new knowledge in psychiatry, with refugee camps serving as the laboratories. By the 1960s, Western Europe was stabilized. Cold War refugees continued to cross the Iron Curtain, but in smaller numbers, and there was no repeat of the Hungarian refugee crisis. East-West tensions eased in Europe and the Cold War moved to Africa and Asia.[1] Refugee crises became a Third World phenomenon, and little knowledge was generated on refugees' mental health throughout the 1960s and 1970s. Doctors who had concerned themselves with the mental health of refugees, like H.B.M. Murphy and Maria Pfister-Ammende, moved on to other research interests that had been first kindled during their work with refugees and which would define their careers: transcultural psychiatry and public mental health. They themselves ceased to contribute to the refugee mental health field, but the concepts and tools of transcultural psychiatry and public mental health were valuable to psychiatrists in newly independent states in Africa who pondered the consequences of migration, urbanisation, and social change.

Uprooting went from being a refugee condition to a condition of modernity, the inevitable corollary of rapid social change. Liisa Malkki has written that 'examining how refugees become an object of knowledge and management suggests that the displacement of refugees is constituted differently from other kinds of deterritorialisation by those states, organisations, and scholars who are concerned with refugees'.[2] The narrative I present in this chapter provides empirical evidence for Malkki's argument, and builds on it by suggesting that not only is refugee displacement constituted differently from other kinds of deterritorialisation, but also that different situations of refugee displacement are constituted differently across time and space. By examining the divorcing of uprooting from its specific association with refugees in psychiatric discourse and its expansion to encompass processes of urbanisation and social change, it becomes apparent how the displacement of refugees in the Third World was constituted differently from European displacement, while

---

[1] Gil Loescher, *The UNHCR and World Politics: A Perilous Path,* (Oxford University Press: 2001), p.105

[2] Liisa Malkki, 'National geographic: The rooting of peoples and the territorialization of national identity among scholars and refugees', *Cultural anthropology,* 7(1)(1992), p.25.

being subsumed within a larger discourse of population mobility and rural-urban migration.

By charting intellectual history of psychiatrists' interest in refugees throughout the previous three chapters, I have shown how psychiatric work with European refugees made far-reaching contributions to the development of new areas in psychiatry in the postwar decades. But intellectual history does not explain why, after the European refugee problem receded from view, two decades of psychiatric work with European refugees went ignored and contributed nothing to medical humanitarianism and refugee relief practices throughout the 1960s and 1970s in Africa. This absence speaks to the new context of humanitarianism in the decolonizing Third World, the assumptions that Western humanitarians harboured about Africans in general and African refugees in particular, and the context of psychiatric practice in newly independent African states.

That Western humanitarian organisations and international institutions did not pay attention to refugee mental health in this period does not mean that it was completely ignored. Other local actors in African host countries did focus attention on refugee mental health, but it was conceptualized in terms of post-independence nation building and social change rather than an issue of humanitarian relief. In this chapter I will explore these themes through the case study of Uganda.

Though there was no role for mental health in medical humanitarianism in the 1960s and 1970s, the language of mental health continued to be used by humanitarians as a vehicle for enduring stereotypes about purportedly typical refugee pathologies like apathy and dependency, as it had in Europe. Such was the endurance of the stereotype of the apathetic refugee that it came to be known by the pseudo-medical term of 'refugee dependency syndrome', recalling the 'DP apathy' of the 1940s.[3] But unlike the situation in 1945 when UNRRA had sought the advice of psychiatrists on the psychological rehabilitation of apathetic DPs - 'for man does not live by bread alone'[4] - there were no psychiatrists advising UNHCR in Africa.

---

[3] Lance Clark, 'The Refugee Dependency Syndrome: Physicians, Heal Thyself!', *Refugee Policy Group,* 1985. <http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:204> [Retrieved October 2019]

[4] United Nations Archives New York, 'Psychological problems of displaced persons; a report prepared for the Welfare Division of the European Regional Office of UNRRA by an Inter-Allied Psychological Study Group', June 1945, p.1.

Given that this chapter is somewhat a case study of an absence, the question of why have a 1960s case study at all must be addressed. First, the question of why mental health was not a feature of humanitarianism in African refugee crises despite the availability of recent experience in Europe and a substantial literature on the subject is worth investigating. This is all the more so when the available explanations are insufficient: either racial bias by Europeans against Africans, or that the sheer scale of poverty and physical deprivation precluded the diversion of any resources to mental health. While racial biases harbored by European and American humanitarians would have been a contributing factor, as I discuss in this chapter, similar racial biases against Southeast Asians and rural Cambodians were also harbored by them as the next chapter shows. Racism on its own is an insufficient explanation for absence of mental health services. As for physical needs taking precedence over mental ones – an explanation alluded to in chapter one – there was also dire poverty and starvation in the Cambodian border humanitarian crisis discussed in chapter five. Neither of these factors prevented the institution of humanitarian mental health services for Cambodian refugees. The answer must be found elsewhere. I argue that the reason is a lack of demand for such services on the part of humanitarian organisations, who were more concerned with promoting industrial development and rural agricultural self-settlement policies, neither of which were conducive to thinking in terms of mental health. As for the few local psychiatrists in African countries, they had greater national priorities such as the rapid social change brought on by modernization and urbanization in their countries. In a larger context of rural-urban displacement, refugees were only a small part of the problem.

The changing nature of the refugee problem globally

For the historian, to attempt to understand humanitarianism in 1960s Africa, as Peter Gatrell writes, means 'tracing both the process of decolonization and the manifestations of the Cold War in different sites, tracking political and geo-political economic changes, and analyzing the dynamic institutional matrix' constituted by UN organisations and their interactions with non-state actors.[5] While this chapter is not a comprehensive history of decolonization or Cold War rivalries, it traces what is relevant to

[5] Peter Gatrell, 'The world-wide web of humanitarianism: NGOs and population displacement in the third quarter of the twentieth century', *European Review of History,* 23(1-2)(2016), p.101.

understanding the context of medical humanitarianism and the place of mental health (or lack thereof) in it.

By the 1960s many humanitarian organisations had shifted their theatres of operation to Africa, where wars of decolonisation and the emergence of independent nation states were generating new refugee movements. UNHCR packed up in Europe and by the mid-1960s a major share of its human and financial resources were diverted to Africa.[6] Voices within UNHCR and many NGOs began to suggest that the nature of the 'refugee problem' had changed.[7] As Louise Holborn wrote in the official history of UNHCR in 1975, 'African refugee movements…proved to be very different [from] those in Europe in size, character and needs', occurring 'in an entirely different political, economic, social and cultural context' than Europe. African refugees were 'for the most part, subsistence farmers or herdsmen', usually illiterate and having had 'little contact with modern society'.[8] The very different political context and nature of the refugee problems demanded of UNHCR 'new and original approaches'. Unlike in Europe, where there had been 'well developed infrastructures and well established government services' to cooperate with UNHCR, refugee programs in Africa 'entailed starting from scratch in terms of program techniques, organisation, and administration, and demanded a new pragmatism regarding the very nature of permanent solutions for refugees'.[9] Peter Gatrell has pointed out that such interpretations 'exaggerate the difference of scale and obscure similarities in policies over time', but the fact remains that refugees of the developing world were seen as very different from European refugees by those (Western) humanitarian organisations engaged in planning and delivering aid to refugees and formulating policies on their behalf.[10] There was also a bigger gap between humanitarians and their beneficiaries than there had been in Europe. In Europe, European humanitarians had provided assistance to European refugees, whereas in the developing world it was a

---

[6] Louise Holborn, *Refugees, A Problem of Our Time: The Work of the United Nations High Commissioner for Refugees, 1951-1972* (Vol. 2). (Scarecrow Press: 1975), p.825.

[7] Peter Gatrell, *The Making of the Modern Refugee* (Oxford University Press: 2013), p.201.

[8] Holborn, *Refugees, A Problem of Our Time,* pp.825-6.

[9] Holborn, *Refugees, A Problem of Our Time,* pp.826-7.

[10] Gatrell, *The Making of the Modern Refugee,* p. 201.

case of Western humanitarians helping destitute peoples of the Third World. This gap was only further widened by the continuing professionalisation of humanitarian NGOs.[11]

How differently the situations of African and European refugees were seen by Western humanitarians was explicated by Dr. Cato Aall. Aall qualified in medicine at the University of Oslo and was active in the Norwegian anti-apartheid movement. From 1965-67 he was secretary of the Refugee Managing Committee of the International Refugee Council of Zambia.[12] Soon after, he became Deputy Field Coordinator and Medical Advisor to the Joint Nigerian Red Cross/International Committee of the Red Cross humanitarian relief operation in Biafra.[13] From 1974-78 he was Food and Nutrition Adviser to the Food and Agriculture Organisation, a specialised UN agency.[14] At a symposium on 'refugee problems in Africa' held at Uppsala University, Sweden in 1966, Aall contrasted what he considered to be two vastly different refugee situations: the flight of Hungarians into Austria in 1956, and the flight of Mozambicans into Zambia in 1965. With regards to Hungarians

> The world was kept informed by hour-to-hour reports of what was going on. When, therefore, the refugees poured into Austria, it did not come as a surprise, and there was an overall good response to appeals for help. People had fled from a situation which was well defined, understood and known. The refugees belonged to one nation: they were Hungarian-speaking people who fled to another country, Austria, which has a German-speaking population. They crossed a well-defined and well-marked border.[15]

As for the flight of several thousand Mozambicans into Zambia in December 1965 following the eruption of violence between the Mozambique Liberation Front and the Portuguese colonial occupation, 'They came quite unexpectedly, and it was very difficult to get a clear picture of what had happened, except that some kind of violence had taken

---

[11] Gatrell, *The Making of the Modern Refugee,* p. 202.

[12] Sven Hamrell, *Refugee Problems in Africa* (Scandinavian Institute of African Studies: 1967), p.122.

[13] Cato Aall, 'Relief, nutrition and health problems in the Nigerian/Biafran War' in *Journal of Tropical Pediatrics,* 16(2)(1970), 70-90.

[14] Cato Aall, 'Disastrous international relief failure a report on Burmese refugees in Bangladesh from May to December 1978', in *Disasters,* 3(4)(1978), 429-34.

[15] Cato Aall, 'Refugee problems in southern Africa', in *Refugee Problems in Africa,* p.29.

place'. Apart from the Luangwa River, there was 'no well-defined border'.[16] According to Aall, a long history of movement and migration across the border meant that 'the border between the two countries is a fiction to them' and the 'concept of a refugee [was] very difficult to establish'.[17] Because of tribal kinship ties on both sides of the border, relationships between the host population and incoming refugees were reportedly good, with 'no signs of jealousy towards the refugees on account of the assistance they received'. Unlike in Europe, the refugees were 'not regarded as aliens, but as unfortunate fellow men'.[18] Also unlike in Europe, where refugees often arrived in densely populated areas with an infrastructure, the refugees from Mozambique

> were spread over an area of more than 150 square miles in which many places are inaccessible by road. These refugees were villagers in every sense of the word. They had little, if any, contact with modern society; few of them had ever been to a hospital or seen a doctor; and hardly any of them knew how to write or read. When it was decided that the refugees were to be transferred to one place for the sake of proper administration and food distribution, many were unwilling to go.[19]

In Aall's view, because of this difficulty in establishing the concept of a 'refugee', and that in many parts of Africa an administration was still 'in the process of being built up and communications are poor or nonexistent', new kinds of solutions needed to be imagined.[20] The experience gained in Europe could not 'be directly transplanted to Africa'. Problems had to be 'attacked at the very base' and little would be accomplished by 'vainglorious prestige projects'. What was needed was 'broad-based projects closely connected with local development and yet established in such a way that refugees may fit in'.[21] The integration of refugee relief programs into local development schemes became a cornerstone of humanitarian aid in Africa. What had been the durable solution of last resort in Europe, local settlement in the country of asylum, became the preferred solution to refugee problems in the Global South.

---

[16] Aall, 'Refugee problems', p.29.
[17] Aall, 'Refugee problems', p.30.
[18] Aall, 'Refugee problems', pp.31-2.
[19] Aall, 'Refugee problems', p.29.
[20] Aall, 'Refugee problems', p.27.
[21] Aall, 'Refugee problems', p.28.

The development turn in humanitarianism

As Ashley Brooke Rockenbach writes, the idea of the ‘African refugee’ came to denote political insecurity, disease, and economic underdevelopment, so that solving the refugee problem came to take on a civilizing dimension, ‘with government and international observers readily inserting refugees into the “savage slot” as people who needed to be molded into productive members of society through socio-economic and moral development schemes.’[22] It is here that ‘development’ came to be seen as a crucial part of responding to refugee problems.

Decolonisation coincided with a reconfiguration of North-South relations from the paternalism of colonialism to an equally paternalistic developed/developing dichotomy, in which aid flowed from Western developed nations and humanitarian organisations to less developed countries in the Third World. As Silvia Salvatici has written, ‘development was the field where there was an attempt to redefine the relationship between colonised and colonisers while the empires were starting to creak’.[23] In the postwar era, the logic of a ‘civilising mission’ was no longer tenable. Development programs ‘absorbed and reprocessed past convictions, techniques and aims’ that had their antecedents in the long tradition of “colonial humanitarianism”’.[24] What made development in the postwar order different from earlier efforts was a ‘shift from the national scale, from colonial policies or regional development, to the transnational scale’. The social and economic advancement of ‘backward’, underdeveloped countries became a question of global order that took on a precise ideological meaning in the Cold War - assistance to underdeveloped countries could help stem the tide of Communism. Improvement of economic conditions in the new postcolonial states was seen as a necessary condition for global peace and stability.[25] Though northern countries did not respond to pressure from the growing numbers of

---

[22] Ashley Brooke Rockenbach, ‘Accounting for the past: a history of refugee management in Uganda, 1959-64’ in (eds.) Kristin Bergtora Sandvik and Katja Lindskov Jacobsen, *UNHCR and the Struggle for Accountability: Technology, law, and results-based management* (Routledge:2016), p.123.

[23] Silvia Salvatici, *A History of Humanitarianism, 1755–1989: In the Name of Others* (Manchester University Press: 2019), p. 147.

[24] Salvatici, *A History of Humanitarianism,* p.157.

[25] Salvatici, *A History of Humanitarianism,* p.148.

postcolonial UN member states for reforms of the international economic system and redistribution of wealth, development aid was one area in which concessions were made.[26]

Development programs became an integral part of international humanitarian relief, and went hand in hand with the promotion of industrialisation and mechanisation of agriculture. Humanitarian programs became a crucial component in the restatement of political, economic and cultural relations between North and South. In the 1950s the UN placed development at the heart of its agenda and in the 1960s private NGOs became intensely involved. Some of these were missionary societies that had a long history of involvement in areas like health and education in the former colonies, others were organisations that had been founded to assist postwar Europe and were now expanding their remit from post-war relief to development.[27] The motto of UNRRA, 'help the people to help themselves', was rebranded and relaunched through the new lexicon of human rights, which had been affirmed by the UN through the Universal Declaration of Human Rights in 1948.[28] Salvatici identifies the commitment to the economic advancement of poor nations as an important stepping stone in the history of humanitarianism that encouraged the reformulation of the experience gained in postwar rehabilitation into a new framework.[29] Alongside the encouragement of industrialisation and mechanisation, humanitarian organisations sought the improvement of living conditions in the Global South through projects of public health, nutrition, and professional training that relied on knowledge and technology transfer. Collaboration with the specialist agencies of the UN like WHO, UNICEF and the ILO provided a significant boost to NGOs that raised their international profile and global projection.[30]

During the 1960s, amounts spend on development aid increased dramatically and refugee problems became increasingly linked to claims by developing countries for greater aid. In his history of UNHCR, Gil Loescher writes that the agency took advantage of these developments to expand its African programs and enhance its own institutional growth. UN High Commissioner Felix Schnyder saw the agency's work in Africa as part of the

---

[26] Loescher, *The UNHCR and World Politics,* p.120.
[27] Salvatici, *A History of Humanitarianism,* p.142.
[28] Salvatici, *A History of Humanitarianism,* p.146.
[29] Salvatici, *A History of Humanitarianism,* p.149.
[30] Salvatici, *A History of Humanitarianism*, pp.148-9.

larger UN effort towards the development and modernisation of African nations. Newly independent nations were interested more in the relief and economic assistance UNHCR could provide them with rather than ensuring refugee protection, and so aid became one of the ways that UNHCR hoped to disseminate and institutionalise international refugee norms globally.[31] In this process UNHCR operations underwent a shift from a previous emphasis on legal protection and determination of eligibility for refugee status, as in Europe, to primarily material assistance for refugees. In any case, most countries that Africans sought refuge in lacked the administrative apparatus to carry out individual determinations, and UNHCR did not have sufficient staff in Africa for this purpose.[32] For the most part, initial emergency assistance to refugees was focused on preventing them from starving to death. Despite protests from the UNHCR Legal Division, the Assistance Division argued that the best way to improve refugees' legal position in the host country was through improving their economic position. As Loescher writes

> In Africa, the normalisation of the legal and social position of refugees was seen to be largely dependent on the possibilities of settlement and assimilation into the host culture. In the best circumstances, protection in Africa meant obtaining access for refugees to local health care and education.[33]

This new emphasis on material assistance led to the elaboration of the concept of 'zonal development'. Schnyder believed that assistance had to target more than refugees' basic needs. It needed to help them become self-sufficient while also benefitting the host population, who were often as poor as the refugees. The blueprint by which to achieve this was 'zonal development': a rural settlement scheme that would allow refugees to re-establish their way of life while also contributing to the host country's economy. Services would be provided to the refugees to enable them to become self-sufficient and achieve a standard of living comparable to that of the surrounding population, without so being markedly better as to arouse resentment among locals. In a report to UNHCR's Executive Committee, Schnyder encouraged 'a wider basis for the solution of refugee problems within the framework of the social development of the country' whereby 'international efforts for assistance to refugees could be regarded as a useful element in the field of

---

[31] Loescher, *The UNHCR and World Politics,* p.120.

[32] Loescher, *The UNHCR and World Politics,* p.110.

[33] Loescher, *The UNHCR and World Politics,* p.118.

international development aid'.[34] UNHCR drew inspiration from World Bank-guided 'integrated rural development land settlement schemes'. Collaborating with other international organisations like the International Labour Organisation and the UN Development Program, UNHCR sought to integrate its assistance programs into the broader rural development strategies taking place throughout postcolonial Africa. Strategies of 'integrated zonal development' were first promoted in Burundi for Rwandan refugees and in the Central African Republic for Sudanese refugees in the 1960s, and later in Uganda, Tanzania, and other states. Within this vogue for development, Rockenbach writes, 'it is not surprising that the Uganda government … reached for a model that the colonial state had used before with other supposedly underdeveloped populations: the agricultural settlement.'[35]

Such was the confidence in these schemes that one political scientist declared in 1967 that 'the solution to the problem of massive rural refugee groups seems to have been found. It consists of rural settlement in the country of asylum, i.e. in the creation of entirely new rural communities'.[36] Many of these schemes were ultimately unsuccessful. Many host countries lacked the social and political stability necessary for such programs to succeed, and most refugees settled on their own anyway.[37] A further problem with the planned settlements was that such development initiatives reflected the demands of the Northern countries providing the development aid. Refugees were expected to grow cash crops for export, which was to be done through block, monoculture farming, which created practical and social problems. In some cases the choice of area to settle was made by someone who had not been in the country or seen the landscape, and land proved unsuitable for cultivation. Even in these cases, development officials sometimes encouraged refugees going hungry to continue growing cash crops like tobacco.[38]

Rwanda's first refugees

---

[34] Felix Schnyder, quoted in Loescher, *The UNHCR and World Politics,* p.121.

[35] Rockenbach, 'Accounting for the past: a history of refugee management in Uganda, 1959-64', p.123.

[36] Hamrell, *Refugee Problems in Africa,* p.10.

[37] Loescher, *The UNHCR and World Politics,* p.122.

[38] Leah Zamore, 'Refugees, development, debt and austerity: a selected history', *Journal on Migration and Human Security,*6(1)(2018), 26-60.

When Tutsi Rwandans first fled into neighbouring Uganda in 1959, Rwanda and Uganda were still Belgian and British colonies, respectively. As pressures for decolonisation intensified in the 1950s, continued Tutsi rule and their monopolisation of Rwandan domestic power - which the Belgians had promoted - were no longer guaranteed. A Hutu Revolution began in November 1959 as a small-scale peasant revolt, prompting the first wave of Rwandan refugees. 7000 Rwandans fled to Uganda, Zaire, Tanzania, and Burundi, with 2000 going to Uganda. Viewed through the interests of colonial rule, Britain's primary concern in Uganda was to manage an orderly transition to Ugandan home rule and independence. Rwandan refugees were seen as a potential threat to this process. Thus their main concern was not to offer these refugees protection, but to prevent their entry and, once they had entered, to push for their repatriation. The insistence on Tutsi return reflected Britain's primary interest in security over humanitarian concern.[39] Unlike the tens of thousands of seasonal migrant workers who came and left in predictable cycles, those displaced into Uganda by the revolution in Rwanda had no sense of when they might return. The British regarded the '59-ers, as they came to be called, as dangerous ideologues that had the potential to destabilise and radicalise the Ugandan Protectorate's own complicated royalist politics.[40]

As Katy Long has written, 'Until independence had been secured, supporting Tutsi claims to asylum was useful political strategy for Ugandan nationalists intent on exposing the injustices of British rule.' Milton Obote, leader of the Uganda Peoples' Congress (UPC) and future Prime Minister of independent Uganda drew attention to the distinction between treatment of European and African refugees and demanded that the colonial government 'treat these people as Hungarians were treated by the rest of Europe when Russia invaded their country'.[41] Despite Obote's future well-documented enmity toward the Banyarwanda, before independence a 'sympathy of political convenience' meant that it made sense for Uganda's politicians to view the Tutsi exile as a problem of colonial rule and to appeal to co-ethnic affinity between Banyarwanda on both sides of the border.[42] In 1964, under Obote, Uganda threatened to close off the border with Rwanda, in what

---

[39] Katy Long, 'Rwanda's first refugees: Tutsi exile and international response 1959–64', *Journal of Eastern African Studies* 6(2)(2012), 211-229.

[40] Rockenbach, 'Accounting for the past: a history of refugee management in Uganda, 1959-64', p.123.

[41] Quoted in Long, 'Rwanda's first refugees', p.215.

[42] Long, 'Rwanda's first refugees', p.216; Banyarwanda refers to people from Rwanda, the prefix 'Ba-' meaning 'people'.

Isabella Soi has described as ‘a radical effort to obtain funds from UNHCR and the international community’.[43]

At the time of the 1959 Tutsi refugee movements, contemporary observers framed them as a ‘temporary response to the painful political processes of political decolonisation’.[44] By the time of Rwandan and Ugandan independence in 1962, some 150,000 Rwandans had fled their country, with 35,000 of them seeking refuge in Uganda. With independence a change in the regional and international community’s attitude towards the appropriate solution to the exile of Tutsis was afoot: from repatriation to local settlement. In an independent Rwanda, ‘peace and stability, far from being a basis for Tutsi return, were in fact dependent on continued Tutsi exclusion from Rwandan territory’.[45] The international community did not shift away from repatriation because of any new concerns about the ethics of forced repatriation, but as a ‘pragmatic response intended to secure regional stability by removing the Tutsi from Rwandan politics’.[46] The obstacle to Tutsi resettlement in neighbouring countries was not so much a lack of land or resources, but what donors and former colonial powers characterised as Tutsi recalcitrance and a refusal to accept that Tutsi power would not be restored in Rwanda. The Tutsi monarchist party UNAR (*Union nationale rwandaise*) looked to prevent any settlement that was not linked to a restoration of Tutsi power.

The response of the international community was to depoliticise the refugees. Long writes that the conflict between UNAR and the international community can be characterised as ‘a dispute about the nature of refugee exile’.[47] UNAR saw the problem in political terms, while the international community, led by UNHCR, framed it as a humanitarian, non-political, problem. Western actors sought to limit the refugees’ identity as political actors, hoping that robust economic and social programs could solve the refugee problem, as long as they abandoned their political ambitions. This coincided neatly with the Ugandan Peoples Congress’s new overriding interest in preserving state

---

[43] Isabella Soi, ‘Uganda-Rwanda Relations: Crossing the Border into Politics’, *Afriche e Orienti,* 1(2020), p.33.

[44] Long, ‘Rwanda's first refugees’, p217.

[45] Long, ‘Rwanda's first refugees’, p218.

[46] Long, ‘Rwanda's first refugees’, p.219.

[47] Long, ‘Rwanda's first refugees’, p.219.

sovereignty and preventing strife and disruption rather than pan-African solidarity against colonial rule. UPC's position on refugees hardened as the Ugandan government became concerned with preventing military and political agitation among refugee populations. Resettlement of Rwandans became 'inextricably connected to containment strategies'.[48] With neither the Ugandan state nor the international community having any interest in facilitating Tusti refugees' role as political actors, development became a substitute for politics. The UN was determined to avoid 'recreating the Middle East's problem of professional refugees'.[49] An acceptable solution to Tutsi exile became linked with economic development and self-sufficiency rather than political citizenship or refugee rights. Yet, as Long reminds us, this was in itself a highly political strategy, aimed at preserving regional African stability above all. In the words of then UNHCR regional representative in Africa south of the Sahara, Jacques Cuenod:

> The government of Rwanda realised that, if the Rwandese refugees could be settled under a UNHCR program, i.e. that their living conditions were at least as good as those they had enjoyed in Rwanda, the risk of seeing these refugees taking arms against their country of origin might decrease and even disappear. And when a climate of peace and confidence is restored, then negotiation on possible voluntary repatriation can start.[50]

Yet this separation of exile from political discourse would lay the foundation for a protracted and intractable Tutsi refugee exile, and there was insufficient political will among UN member states to solve the problem. At the time, the UN was focused on a civil war in Congo. Not enough attention was devoted to finding an acceptable political settlement between Tutsi and Hutu that would have permitted repatriation. But also, not enough funds were provided to host countries to promote the settlement of refugees. Calls for humanitarian aid in Rwanda resulted in little action - an expensive and heavily politicised intervention in the Congo had left little appetite among Western states for intervention in Central Africa, particularly when there was little threat to Western expatriates. This inaction on Rwanda and the refugee crisis in the Great Lakes region was,

---

[48] Long, 'Rwanda's first refugees', p.220.

[49] Long, 'Rwanda's first refugees', p.223.

[50] Jacques Cuenod, 'The problem of Rwandese and Sudanese refugees', in *Refugee Problems in Africa,* p.53.

Gil Loescher writes, a ‘costly political mistake which, at least indirectly, would lead to renewed genocide in the Great Lakes region of Africa 30 years later’.[51]

In the humanitarian response to both the post-WW2 and Rwandan refugee crises, there was an effort to neutralise the threat to social and political order that refugees were seen to represent. And in both cases, the approaches taken to solve the refugee problem were contingent on the particular sociopolitical context and changed with it. Just as the intensification of the Cold War led to a change in orientation from repatriation to resettlement in Europe, the transition from colonial to home rule in the Great Lakes region also led to a shift from repatriation to resettlement being the preferred solution. The key difference, with respect to mental health, is that the social, political, and moral problematisation of ‘uprooting’ in Europe led policymakers and humanitarians to envision solutions that allowed refugees to regain their roots or establish new roots elsewhere. The successful striking of new roots in resettlement was seen as necessary to prevent the social ills that could arise from isolated and alienated refugees. The framing of refugee exile around ‘uprooting’ - though also potentially depoliticising - was nonetheless conducive to engagement with refugee mental illness and health. Ideas about uprooting had a long history to draw on: transatlantic migrations of Europeans in the late 19th and early 20th centuries and, for an even longer period, the framework of ‘nostalgia’ as a way of making sense of the emotional difficulties of those who were far away from home.

This focus on uprooting was not replicated with Rwandan refugees. Viewed as a problem of political instability to be solved purely through economic development and self-sufficiency, as opposed to enabling refugees to become socially and morally ‘rooted’ in the values of a new society, humanitarian discourse around Rwandan - and more generally African - refugees was less conducive to the inclusion of mental health. Economic development was less conducive to a specific psychological concern with refugees. Development, urbanisation, and modernisation were seen as affecting all Africans, refugees included. The mental health needs of refugees were consequently seen as part of the mental health needs of their host populations which were also undergoing rapid social change, not as something unique to their displacement. It was therefore not doctors working for humanitarian organisations that investigated these developments, but psychiatrists in the host states concerned with nation building and modernization after

---

[51] Loescher, *The UNCHR and World Politics,* p.118.

independence. I will examine this by exploring the limited inquiry into the mental health of Rwandan refugees in Uganda below, but first we must explore the global and local contexts in which psychiatry, and psychiatrists in Africa, were operating.

International mental health, transcultural psychiatry, and the search for a global psyche

In 1961, Maria Pfister-Ammende, a Medical Officer for Mental Health at WHO since 1955, addressed an audience at a meeting of the World Federation for Mental Health (WFMH) in Paris gathered for a plenary session entitled 'The United Nations, the specialised agencies, and the future'. She spoke about the international mental health work of WHO and the primary role of public health in WHO's mental health vision. Invoking the recent past and reflecting the mood of optimism among psychiatrists since the end of the Second World War, she triumphantly reminded the audience how

> the proposal to set up a mental hygiene unit within the Health Organisation of the League of Nations did not appeal to the authorities of the League and was consequently turned down, only nine years before the World Health Organisation was given a Constitution that included the well known definition that 'health is not only the absence of disease or infirmity, but a state of complete physical, *mental*, and social well-being' [emphasis in original].[52]

WHO's public health and preventive approaches to mental health were attractive to Maria Pfister-Ammende, who had become convinced during her refugee camp work that the efforts of psychiatry needed to be 'expanded in a social direction'. In the 1940s, she had concluded that a mental health service for refugees should be staffed by 'socially oriented mental health specialists', whose main task should be the primary prevention of mental ill-health among refugees, and not treatment. Any therapeutic duties would consist mainly of case detection, referrals, and 'watching from the "protective therapy" angle, until such time as a proper solution for the individual and his surroundings has been achieved'.[53] She invoked her refugee work in her 1961 address not to indicate any relevance it had to

---

[52] World Health Organisation Archives (hereafter WHOA) Geneva, M4-86-12(B) jacket 1, 'International Congresses of World Federation of Mental Health', Maria Pfister, 'Mental health as a public health responsibility', 1961, pp.1-2.

[53] Maria Pfister-Ammende, 'Mental hygiene in refugee camps', in Charles Zwingmann and Maria Pfister-Ammende (eds.), *Uprooting and After...* (Springer: 1973), p.250.

contemporary refugee situations, but to show that it pointed 'in a similar direction as the recommendation of a WHO Expert Committee with regard to a kind of public health/mental health worker', one which called for 'a new outlook, free from rigid professional exclusiveness' to adequately respond to the challenges of building community mental health care.[54] These challenges were not limited to one area of the world. 'Indeed', she said, 'with respect to mental health, we can make no clear distinction between developed and underdeveloped countries. All nations share positive as well as negative mental health features.'[55] She made particular reference to the sixteen new (mainly African) member states welcomed by WHO since 1958, and described the contemporary movement of deinstitutionalisation of mental hospital patients in Western countries as, in effect, 'taking up the attitudes of other societies - in Africa and elsewhere - that have never given up the care of their mentally ill within and by their family and community'.[56] But - and this was one of the major concerns of psychiatrists at WHO - these ways of life in the developing world were being upset by modernisation and urbanisation.

It had become evident, she continued, that a growing incidence of mental disorders, 'characteristic of our times', was associated with changes in social structures, and in particular with 'the increasing density and mobility of populations undergoing industrialisation and urbanisation'. The stresses of life in the second half of the twentieth century were partly behind the increasing attention to mental health in public health since the Second World War. In her opinion, the main mental health responsibility of the public health worker was the 'prevention of psychoneurotic and psychosomatic disorders that are certainly provoked by social circumstances to a far larger degree than the psychoses'.[57] To meet the challenges facing the world, 'continuous human effort [would] be necessary in politics and in science - including psychiatry, social sciences and psychology'.[58] Processes of urbanisation and modernisation, she would write in 1971, were upsetting traditional ways of life and yanking people from their long established roots into the world of modernity. People in the developing world had hitherto been 'rooted in an extensive family

---

[54] WHOA, M4-86-12(B) jacket 1, 'International Congresses of World Federation of Mental Health', Maria Pfister, 'Features and trends in the mental health work of WHO', 1961, p.5.

[55] Maria Pfister, 'Features and trends', p.3.

[56] Maria Pfister, 'Features and trends', p.6.

[57] Maria Pfister, 'Mental health as a public health responsibility', pp.2-3.

[58] Maria Pfister, 'Features and trends', p.9.

system and in a tribal structure now in the throes of an upheaval caused by rapid socioeconomic change. The tribal structure is breaking down and the ancient ways of caring for the ill, including the mentally sick, are no longer adequate.' Developing countries such as those of Africa, she saw, were places in which great social stress prevailed, just like the rural areas of Switzerland she had worked in during the early days of the war and the refugee camps she would work in by the end of the war. While in the 1940s Pfister-Ammende had seen 'uprooting' as a characteristic of forced migration, by the 1960s she saw it as a metaphor for modernisation. Just as she had concluded in her refugee work, individual one-to-one therapy was of limited use as long as a person was forced to struggle to survive. The task of psychiatrists in these countries, and of WHO, was to provide 'appropriate community psychiatric care to masses of people undergoing periods of rapid change', rather than 'to introduce refined methods of individual psychotherapy as used in certain parts of the Western world'. She saw many commonalities between the 'extreme situations' of flight and persecution she had been confronted with in the 1940s and the 'permanent social stress' of poverty and deprivation that characterised many developing countries, justifying similar approaches to them.[59]

One key area identified by WHO through which to improve the health of the world was technical assistance, which became 'the instrument and end of international cooperation' in healthcare. Standardised practices and notions were the major focus of technical assistance programs. WHO aimed to disseminate specific knowledge and procedures along with the tools needed to put them in practice. The transfer of knowledge, skills, practices and instruments already in possession of the developed countries would, it was believed, reverse the needs of vast regions of the world at a decidedly low cost.[60] For this strategy to succeed in psychiatry and mental health, research in two areas needed to be developed: psychiatric epidemiology and transcultural psychiatry. Epidemiological approaches were needed to identify and quantify mental disorder across increasingly diverse contexts so that public health services could be planned, and transcultural research was necessary to delineate the effects of culture on the genesis and presentation of mental illness. As Anne Lovell has written, there was in WHO an 'acute awareness of the need for uniform definitions [of disorder] if comparable data were to be produced in

---

[59] Maria Pfister-Ammende, 'The Doctor as a Community Agent', *Bulletin of the Menninger Clinic*, 35(5)(1971), pp.356-7.

[60] Salvatici, *A History of Humanitarianism,* p.161.

epidemiological studies worldwide'.[61] This signalled a break from the 'idealist, collectivist, and pacifist' mental health approach of WHO's first decade to a more disease-oriented approach.[62] Underdeveloped countries became 'laboratories for understanding the universality of mental health categories and the mental health effects of rapid social change'.[63] Psychiatrists, physicians and anthropologists engaged in the production of what Lovell calls an 'epidemiological primitivism', searching for 'pristine conditions' to understand the causation of mental and physical disorders. Such conditions were to be found among tribes in Africa, 'traditional' societies, kibbutzim, and situations of rural-urban migration. Standardised and comprehensive diagnoses that were also culturally relevant and acceptable were central to this process.

The comparison of mental disorders across cultures had its roots in colonial medicine and the 'comparative psychiatry' of German psychiatrist Emil Kraepelin that arose out of his trip to Java in 1904.[64] The first transcultural psychiatry department opened at McGill University, Montreal, in 1956. The new element in this iteration that distinguished it from Kraepelin's comparative psychiatry was the use of epidemiological concepts. Culture was conceived as 'a series of variations that can be evaluated using the tools of epidemiology'.[65] In other words, culture was another epidemiological variable to be accounted for in research. Rather than simply conducting cross-cultural comparisons of mental disorder, transcultural psychiatry sought to uncover the relationship between the nature, incidence, and prevalence of mental illness and the cultural environment, transcending the boundaries of any one culture and focusing on differences and processes observed in many cultures. The scholarship and clinical data with which the field began was derived from both colonial medicine and the academic institutions of newly independent countries.[66] Emmanuel Delille has suggested that transcultural psychiatry may be interpreted as a 'literature of exile', for 'not only was it the result of a specialised

---

[61] Anne M. Lovell, 'The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands', *International Journal of Epidemiology*, 43(suppl_1)(2014), i6-i18, pi13.

[62] Lovell, 'The World Health Organization', p. i11.

[63] Lovell, 'The World Health Organization', p. i14.

[64] Emmanuel Delille, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry Research Unit after World War II', *History of psychiatry,* 29(3)(2018), p. 285.

[65] Delille, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry', p. 286.

[66] Delille, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry', p. 286.

therapeutic practice for patients coming from non-Western cultures, as well as migrants and refugees, but also its practitioners were in large part exiled physicians'.[67] These physicians had their own transcultural experiences stemming from the displacement of the Second World War. We have already encountered one of them: the Scot H.B.M. Murphy, who emigrated to Canada and joined the new department in 1959. Another key figure was Eric Wittkower, who was born in Berlin into an atheist Jewish family that held both German and British citizenship. Hitler's ascendancy brought Wittkower's career in Germany to an end. He went to Switzerland and then London, where he joined the Tavistock Clinic. In 1951 he emigrated to Canada. Yet another member of the department at McGill was Henri Ellenberger, who fled Vichy France in 1941 and held French, British, and US citizenship.

But transcultural psychiatry was not solely a Western endeavour. Through international scientific networks fostered by WHO and WFMH, psychiatrists from the developing world participated in research activities and decision making, and contributed to the emerging canon of transcultural psychiatric knowledge while also working to cleanse it of the scientific racism inherited from colonial medicine. A crucial step was to dispel the notion that the African psyche was any different from the Western psyche. The consensus among psychiatrists, H.B.M. Murphy stated in 1956, was that mental illnesses were universal, having the same form everywhere with their contents and specific expressions shaped by culture.[68] Like Western psychiatrists, African psychiatrists also promoted the idea of a universal human psyche, which served to challenge the racist legacies of colonial psychiatry and its ideas about the peculiarity and inferiority of the African mind.[69] In the transition from colonialism to independence, Alice Bullard writes, colonial psychiatry 'transformed into a diverse range of practices, ranging from collaborations with traditional healing to biomedical, pharmaceutical-based psychiatry', with transcultural psychiatry in the middle of this spectrum.[70] While colonial psychiatry had 'produced knowledge while intentionally ignoring or dismissing local beliefs and

---

[67] Delille, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry', p. 284.

[68] Jatinder Bains, 'Race, culture and psychiatry: a history of transcultural psychiatry', *History of Psychiatry,* (16)(2)(2005), p.143.

[69] Matthew Heaton, 'The politics and practice of Thomas Adeoye Lambo: towards a post-colonial history of transcultural psychiatry' *History of psychiatry,* 29(3)(2018), 1-16.

[70] Alice Bullard, 'Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry', in *Psychiatry and Empire*, eds. Sloan Mahome and Megan Vaughan, (Great Britain: Palgrave Macmillan 2007), p. 197.

practices', transcultural psychiatry reversed this 'so that local beliefs and practices including culturally specific healing practices' informed and guided therapeutic practices.[71]

As Matthew Heaton has written, psychiatrists in postcolonial states, such as Thomas Adeoye Lambo from Nigeria, emphasised the universality of mental illness in an attempt to challenge 'the more blatantly racist elements of existing knowledge about "African minds" created in colonial contexts by European experts'. Lambo's work stressed and assumed 'basic principles of human psychology and psychological disorder, emphasising cross-cultural similarity where previous scholarship had fetishised difference'. Lambo thus used the premise of universality of mental illness to decolonize knowledge about the African mind through 'incorporat[ing] Nigerians (and all Africans) into European psychiatry more fully, in effect making European psychiatry more universally applicable'.[72] Lambo was one of the most eminent African psychiatrists of his generation, and the first European trained psychiatrist from Nigeria.[73] Expressing his belief in a universal psyche, he wrote in his 1954 MD thesis on 'the role of cultural factors in paranoid psychosis among the Yoruba tribe'

> it is important to emphasise that the result of this thesis has shown that while the specific psychogenic factors engendered by different cultures may vary and the psychopathology of individuals may reflect the traditions of their society, generally speaking, psychotics will remain comparable insofar as we can account for their behaviour in terms of common psychodynamic formulations. It is only through the study of mental diseases in a number of human societies that the role of cultural variables can be thoroughly understood.[74]

Development, migration, and social change in Uganda

In the age of development, there was little room for mental health in humanitarianism. The notion of mental health as a component and priority of development

---

[71] Bullard, 'Imperial Networks and Postcolonial Independence', p.198.

[72] Heaton, 'The politics and practice of Thomas Adeoye Lambo', p. 6.

[73] Femi Oyeode, 'Thomas Adeoye Lambo O.B.E.', *Psychiatric Bulletin,* 28(12)(2004), 469-469; Heaton, 'The politics and practice of Thomas Adeoye Lambo'

[74] Thomas Adeoye Lambo, 'Observations on the role of cultural factors in paranoid psychosis among the Yoruba tribe, A study in comparative psychiatry', 1954, MD thesis, University of Birmingham [https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.606852, retrieved October 2020], p.44.

was still decades into the future.[75] In the 1960s, (poor) mental health featured mainly as a side effect of development that needed to be mitigated and prevented. It was in this context of decolonisation and development that a postcolonial psychiatry emerged in Africa. The limited work done on refugees' mental health during this period must be seen in this context. It was not directed at a humanitarian cause, but framed within the bigger picture of national development. Whereas Maria Pfister-Ammende had conducted her refugee work in the context of the Swiss government's desire to manage their refugee problem, and H.B.M. Murphy began his refugee work as a doctor in an international humanitarian organisation, the limited investigations by psychiatrists into refugee problems in Africa occurred against the backdrop of anxieties about social change and rural-urban migration. As Yolana Pringle writes, postcolonial histories of psychiatry cannot be told in isolation through the lens of metropole or former colony, but must be situated within the recognition of psychiatry as a transnational and global phenomenon while simultaneously not losing sight of the local social, cultural, and professional contexts that shaped psychiatrists' aim and priorities.[76]

When Makerere Medical School was founded in Kampala in 1923, there were very few other medical schools training Africans in Western medicine on the continent.[77] One of the defining features of the Ugandan Colonial Medical Service was the medical training of Ugandans as well as Europeans. European doctors did not see African colleagues as their equals, but they believed that the training programs in Uganda were distinctive from, and more liberal than, those of other European colonies. In the 1940s and 1950s, Makerere Medical School responded to concerns raised by medical practitioners in Eastern and Southern Africa about the capacity of Europeans to understand and provide care to African patients, the reasoning being that Africans had superior cultural insight into mental illness in Africa. This fed into the first calls for the training of Ugandans in psychiatry. In 1966, a Department of Psychiatry opened at Makerere. It invited psychiatrists from abroad to serve on its faculty and featured WHO-funded lectureships. By the late 1960s, Uganda had developed the capacity to train psychiatrists and psychiatric nurses locally, without the need to send them abroad.[78]

---

[75] Yolana Pringle, *Psychiatry and Decolonisation in Uganda* (Springer Nature: 2019), p.117.

[76] Pringle, *Psychiatry and Decolonisation,* p.16.

[77] In Dakar, Senegal and Cairo, Egypt.

[78] Pringle, *Psychiatry and Decolonisation*

As in the West, psychiatrists at the new department identified a need to extend the reach of psychiatry beyond the walls of the mental hospital to provide mental health care in the community. Efforts to expand and reorganise mental health services, in the context of development and nation building, were framed as a 'psychiatry of poverty'.[79] Limited resources and personnel in Uganda - and other African nations - distinguished psychiatry in Africa from that practiced in the West and demanded new ways of thinking about the incorporation of non-specialists into mental health care. Though innovations in community mental health care in Uganda had little impact on the reach of psychiatry in the country throughout the 1960s and 1970s, local experiments in mental health care involving training and delegation would provide the basis of WHO's policy of encouraging the integration of mental health into primary care. As the WHO African Mental Health Action Group said in 1987, Ugandan mental health services were 'once the best in the region'.[80]

In addition to being part of a broad transnational endeavour to show that mental illness in Africa was no different than anywhere else, research into mental health in Uganda was also driven by concern about two key features of economic and social change: education and urbanisation. Education provision in East Africa expanded rapidly in the final years of colonisation and continued to do so after independence. It was not only seen as necessary for economic growth, but also for the well-being of the young nations. Urbanisation also accelerated and growing cities attracted rural migrants searching for employment, creating an informal sector and posing challenges to municipal order. Students and urban migrants were at the forefront of psychiatric attention, and provided psychiatrists with a new way of demonstrating the relevance of their profession and what it had to offer in the post-independence sociopolitical context. Psychiatric research 'presented a coherent view of how social and economic changes were shaping present and future mental health needs'.[81] Refugees were largely tangential to this vision.

If humanitarian organisations had thought to investigate the mental health of Rwandan refugees in Uganda, they would have encountered similar findings to those found among European refugees two decades earlier. This is what primary care physician Francis

[79] G. A. German, 'The Psychiatry of Poverty', *Psychopathologie Africaine,* 7(1)(1971), pp.113-7.
[80] Quoted in Pringle, *Psychiatry and Decolonisation,* p.18.
[81] Pringle, *Psychiatry and Decolonisation,* p.124.

John Bennett and psychiatrist Marcel Assael found. Both Bennett and Assael held faculty positions at Makerere in the departments of preventive medicine and psychiatry, respectively. Bennett was born in Barotseland (now Zambia) in 1927 and qualified in medicine at the University of Cape Town in 1950. He would come to be regarded as the 'father of primary health care in Africa'.[82] He was professor of community medicine at Makerere University, and later at the University of Dar-es-Salaam, Tanzania and the University of Nairobi, Kenya. Marcel Assael was an Israeli psychiatrist, serving on the faculty of the department of psychiatry at Makerere as well as consultant to the Ugandan government. Bennett and Assael conducted a survey of Rwandan refugees and immigrants in Kasangati, a densely populated rural farming area situated nine miles from the capital city of Kampala. Identifying a gap in the services provided by Kasangati Health Centre, which provided a range of maternal and child health, communicable disease, and environmental sanitation services but no mental health services, a weekly mental health clinic staffed by Assael was set up. This was also prompted by psychiatrists' observations that there was an excess of Rwandan and other immigrant patient admissions to Butabika Mental Hospital relative to their population. For example, 36% of admissions from Kampala were Rwandan, though they formed only 4.5% of the city's population and 2.7% of its workforce.[83] Bennett and Assael published their findings in *Psychopathologie Africaine,* a transcultural psychiatry journal founded in 1965 by the Senegal-based French psychiatrist Henri Collomb.[84] Uganda was, they wrote, 'one of the few countries in the world where international immigration constitutes a substantial proportion of the annual increase in population', with immigrants from Rwanda and Burundi accounting for 11% of the increase in the decade up to 1959, and even more coming to Uganda after independence. By 1966, 4.5% of inhabitants of Kampala were Rwandan, while in Kasangati the proportion was 2%. Many had come to Kasangati to work as labourers on local farms, to live there and seek work in Kampala, or to obtain land for themselves.[85] In Kasangati, 'the big houses of the Baganda landlords contrast[ed] with the humble homes of the immigrant labourers' that were made of mud and pole or grass structures. Rwandans

---

[82] Jennifer Bennett, and Jian Farhoumand, 'Francis John Bennett', *BMJ* (365:l4191) (2019).

[83] FJ Bennett and MI Assael, 'The mental health of immigrants and refugees from Rwanda at Kasangati, Uganda', *Psychopathologie africaine*, 6(3)(1970), p.329.

[84] Alice Bullard, 'L'Œdipe africain, a retrospective', *Transcultural Psychiatry*, 42(2)(2005), 171-203.

[85] Bennett and Assael, 'The mental health of immigrants and refugees', p.321.

formed a ‘very definite minority group who have also been categorised as having the lowest status of all people there’.[86]

The most common diagnoses seen in the clinic at Kasangati were alcoholism, depression with or without somatic symptoms, hypochondriasis, psychopathic personalities,[87] and delinquency and antisocial behaviour. Admissions to Butabika Hospital comprised mainly schizophrenia, manic depression, organic psychoses, and alcoholism. These diagnoses are similar to those that were observed in European refugees and immigrants. But in contrast to Europeans, Bennett and Assael found little evidence of anxiety and neurotic illnesses. Some symptoms that could be due to anxiety, such as insomnia and impotence, were better explained by depression. Their explanation for this absence was that Rwandan immigrants’ ‘social isolation, insecurity, and cultural disorientation’ formed an environment more conducive to ‘excessive drinking and “acting out” frustration in crimes’ rather than anxiety, or that drinking and criminal behaviour in themselves functioned as anxiety reducing mechanisms.[88]

Mental health problems of Rwandans in Uganda were framed not as refugee problems, but as problems of rapid social change. For example, Rwandan households at Kasangati were disproportionately comprised of a single inhabitant, and when there were married couples households were often limited to nuclear families. This contrasted with the wide variety of local family patterns, such as extended and polygynous families.[89] This made their situation similar to that of Ugandans who migrated on their own from rural to urban areas in search of work, or students who left rural backgrounds to go to university in the city, and lived on their own. Like whole societies undergoing social change, Rwandan migrants were at risk of losing the integrity of their social connections, traditions, way of life, culture, and moral values, all protective factors that could serve to minimise the stress of adaptation and acculturation in a new country and which needed to be preserved through

---

[86] Bennett and Assael, ‘The mental health of immigrants and refugees’, p.322.

[87] Psychopathic personality: ‘evidenced by five main characteristics which are; poorly motivated antisocial behaviour, absent or weak superego or conscience, lack of sympathy with individuals and society, marked egocentricity, and at present is unmodifiable.’; John Fotheringham, ‘Psychopathic personality - a review’, *Canadian psychiatric association journal* 2(1)(1957), p.52.

[88] Bennett and Assael, ‘The mental health of immigrants and refugees’, pp.328-9.

[89] Bennett and Assael, ‘The mental health of immigrants and refugees’, pp.330-331.

community mental health work with the input of the migrants themselves.[90] Bennett and Assael expressed concern for the children of these migrants who would struggle for survival in a poor environment in which their parents were 'caught in a web of depression, alcoholism, and isolation'. Their poverty meant that 'school, the one institution which would help in fitting them in a new society' was out of their reach. All these factors would conspire to ensure that 'a frustrated and delinquent second generation might evolve'.[91] Such a generation could pose a threat to the stability of Ugandan society.

Bennett and Assael's paper is a rare example of a study conducted in postcolonial Africa on the relationship between being an immigrant or refugee and mental health. In Yolana Pringle's reading, that no explicit link was made between the violence experienced by Rwandan refugees - which is not mentioned save a reference to 'political persecution' - and their mental health is telling.

> Despite the refugee background of some of these immigrants, no link was made between violence and psychological health. Indeed…the notion that refugees might have unique mental and psychological needs as a result of their exposure to violence, and ongoing uncertainty about their futures, was rarely considered in Africa before the 1980s…Instead, their presence in the psychiatric system was due to a 'changing society' that not only made mental health problems more visible, but was leaving increasing numbers of individuals without adequate social support networks.[92]

Pringle contrasts this contextually appropriate, locally relevant focus on refugees as symptoms of a larger process of social change, with what she considers an imposition of trauma-focused interventions brought by Westerners with their own interests in trauma and victimhood in the 1980s.[93] However, the work of Bennett and Assael needs to be seen in context of not only what came later, but also the tradition of refugee mental health work that had grown in Europe and Western countries of resettlement since the 1940s. Seen in this light, Bennett and Assael's findings are not all that different from what European doctors had written about 'uprooting' two decades earlier. By this I mean that the picture

---

[90] Bennett and Assael, 'The mental health of immigrants and refugees', p.333.

[91] Bennett and Assael, 'The mental health of immigrants and refugees', p.332.

[92] Pringle, *Psychiatry and Decolonisation,* p.123.

[93] Pringle, *Psychiatry and Decolonisation,* p.180.

changes from one of apparent neo-colonial imposition of Western-centric frameworks to supplant local methods, to one in which even the apparently local frameworks of Bennett and Assael are themselves a continuation of Western derived knowledge, applied to a non-Western context.

'The basis for the severity and variety of the immigrants reactions', Bennett and Assael wrote, were related to four factors, all of which hearkened back to the psychic reactions to uprooting described in Europe in the 1940s. The first two factors were related to the processes of uprooting and flight from the homeland. First was the 'loss of complex object relationships',[94] the 'main factor' in the genesis of the resulting severe, chronic depression. Because one's relationship to the homeland was established simultaneously with one's relationship to the mother, the loss of the former mimicked the loss of the latter.[95] This psychoanalytic explanation is similar to Austrian emigre psychoanalyst Editha Sterba's 1940 characterisation of uprooting from the homeland as a reliving of the trauma of weaning from the mother's breast, or Hungarian psychiatrist Erwin Koranyi's description of Hungarians' early days among Canadians as symbolically reenacting the difficulties of the formative years of childhood. The second factor was the process of flight from the homeland itself, 'often accompanied by a serious disappointment in his national home because of political persecution and economic deprivation'.[96] This is similar to Swedish psychoanalyst Stefi Pedersen's characterisation of the process of flight as setting in motion a 'refugee neurosis'; a 'psychopathological reaction to extreme social displacement' which to her was reminiscent of the reactions to combat seen in soldiers.

The third and fourth factors were related to the sense of disorientation and confusion that followed arrival in a new, alien environment. For example, the 'discrepancy between the ideals, moral values, and codes of the new environment and of [the refugee's] country of origin' coupled with the 'loss of support from stimuli arising from a familiar environment and a warm and protective atmosphere in his own native society' led to states

---

[94] The concept of object relations in psychoanalysis refers to 'relations with significant others and their internal representations, starting with infancy and the mother ("object" in psychoanalytic writings always refers to another person). Primitive, early, object relations are the starting point for personality development…The pattern taken by the individual's relationship with others, internalised during early childhood, structures the adult personality'. Benjamin Beit-Hallahmi, 'Object relations theory' in David Leeming, Kathryn Madden, Stanton Marlan (eds.), *Encyclopaedia of psychology and religion* (Springer: 2010)

[95] Bennett and Assael, 'The mental health of immigrants and refugees', p.330.

[96] Bennett and Assael, 'The mental health of immigrants and refugees', p.330.

of paranoia, depersonalisation, and 'acting out' behaviour in which the refugee projected their own problems on to the new environment.[97] This is reminiscent of Eitinger's observations of refugees in Norway in the 1950s, in which they developed a paranoid state from the onslaught of new sensory impressions that could not be made sense of. With the disorientation and lack of familiarity came a sense of isolation not different to that expressed by European refugees in new countries. Rwandans at Kasangati told Bennet and Assael's team that 'No one will help if something happened to me', that 'when you are sick no one will take you to hospital', and that they were 'disappointed with friendship here where no one will help unless you pay - this is not Rwanda'.[98] Such statements are a stark contrast to the romanticised view provided by Dr Cato Aall we encountered above, namely that borders were a fiction to Africans and that that the refugees were 'not regarded as aliens, but as unfortunate fellow men'.

Another study to come out of the department of psychiatry at Makerere also placed refugees firmly within the context of a rapidly urbanising independent nation where old ways of living were breaking down. Marcel Assael collaborated with G. Allen German, a Scottish psychiatrist who was a registrar at the Maudsley in London before being invited to join the faculty at Makerere, on a study of 'changing society and mental health in East Africa'. Their findings were published in 1970 in the pages of the *Israeli Annals of Psychiatry and Related Disciplines.* It was not so much migrant mental health that interested them, but the place migrants occupied in a changing postcolonial society. Africa was, they said, going through 'social stresses and traumas beyond anything experienced previously'. Traditional values and ways of life, what they called 'the natural process', were being interfered with. The 'way back to the traditional society [was] confused and broken, while the way to the new [had] not yet opened up', leaving the individual 'alone and defenseless', lacking 'any cohesive society to flee to'. The most important question facing psychiatrists in a developing society was 'how can desirable social and cultural changes be implemented without the traumatic destruction of the structure, value systems, and morality of the original culture?'[99] These concerns were in line with contemporary European ethnopsychiatric thinking about Africans, who called the social processes by

---

[97] Bennett and Assael, 'The mental health of immigrants and refugees', p.330.

[98] Bennett and Assael, 'The mental health of immigrants and refugees', p.330.

[99] M Assael and GA German, 'Changing society and mental health in eastern Africa', *The Israeli Annals of Psychiatry and Related Disciplines* 8(1)(1970), p. 53.

which Africans were forced to adopt 'modern' European ways of life 'detribalisation'. This was allegedly a process in which education, literacy, and urbanisation exposed Africans to new ideas and cultures that would put a strain on their 'traditional' way of life and threatened the stability of the 'African mind'. Even moving to an urban center in search of employment was enough to cause detribalization. This remained a prevalent theory throughout the colonial period and after independence, despite inconclusive data.[100]

Refugees and immigrants were therefore a symptom of the rapid changes Ugandan society was undergoing. Immigrants tended to have the poorest jobs, were the least well fed, shouldered the greatest disease burden, and lived alone more often than locals.[101] Population mobility, along with urbanisation and industrialisation, was 'an indicator of disintegration in the traditional, more stable society'.[102] Apart from the political upheavals in Rwanda in the early 1960s, there had already been a trend of migration into Uganda, where 'the rich fertile plains and busy cities…exert a powerful attraction'.[103] Most of the new arrivals were employed as unskilled labourers or lowly paid servants. Migrants from Rwanda who were living alone were 'a group of the population who represent a disintegrated society'.[104] The social evils of a rapidly changing society were, Assael and German wrote, exacerbated by the presence of refugees. In a gross mischaracterisation, they contrasted refugees in Western countries who had been successfully 'absorbed and add[ed] their voice to the political forces which control social growth' with the African refugee 'who continues to wander, fails to integrate with society and has no opportunity to organise himself as a political or economic force…not tied emotionally to the society he finds himself in and…ambivalent towards his place of origin'.[105]

They were presuming that European refugees had *not* wandered rootless and aimless, whereas in fact the moral problematisation of African refugees Assael and German were engaging in had a long history and precedent in Europe. We saw this in

---

[100] Matthew Heaton, *Black Skin, White Coats: Decolonisation and Psychiatry in Nigeria* (Ohio University Press: 2013), pp.47-48, 206 footnote 66.

[101] Assael and German, 'Changing society and mental health', p.52.

[102] Assael and German, 'Changing society and mental health', p.61.

[103] Assael and German, 'Changing society and mental health', p.62.

[104] Assael and German, 'Changing society and mental health', p.68.

[105] Assael and German, 'Changing society and mental health', p.74.

Maria Pfister-Ammende's comments on the uprooted person's deterioration in moral values when forced to focus on self-preservation, in H.B.M. Murphy's warnings that unassimilated and isolated European refugees in Australia could be drawn into gangs and crime, and in concerns in Israel about the doubtful potential of concentration camp survivors to contribute anything valuable to the new Jewish state. As discussed in the previous chapter, that refugees in Western countries managed to become integrated in the workforce should not be seen in isolation from the fact that DPs were often selected from the camps based on their youth, good health, and their labor value rather than out of humanitarian concerns, leaving the 'hardcore' of old, sick, and disabled. The same goes for the Hungarian refugees, who happened to be young, able-bodied men in a favourable ideological climate and a postwar economic boom. The final sentence in Assael and German's paper suggests that it was not so much that refugees were exacerbating social evils because they were refugees, but because they were poor: 'If the impoverished cannot organise themselves to better their conditions, then other groups must assume this responsibility, including medical personnel who are particularly well placed to be aware of the dangers and evils of social disintegration.'[106] To some degree, it can be said that Assael and German were pathologizing an economic phenomenon and discursively constructing a problem that only they and their colleagues, medical personnel, could effectively respond to. This is an example of what Michel Foucault has called 'problematisation'.[107]

Against a backdrop of concern with the mental health effects of social change, urbanisation, and industrialisation that preoccupied psychiatrists in Africa in the 1960s, the sources cited in this section are the only examples I have been able to find that explicitly mention the mental health of refugees and immigrants and focus on the role of the migration process in their mental distress. The knowledge of psychopathological processes Assael and Bennett identified among Rwandans at Kasangati - not at all different from psychopathology in European refugees - did not transfer to humanitarian organisations in Africa the way earlier psychological knowledge about European DPs had had a place in UNRRA planning. Apart from the vastly different contextual and political factors operating at play here, the main reason in particular that this knowledge did not transfer to

---

[106] Assael and German, 'Changing society and mental health', p.74.

[107] Michel Foucault, Interview with Francois Ewald, "Le Souci de la verité", *Magazine litteraire* 207 (May 1984): 18, quoted in Gary Gutting (ed.), *The Cambridge Companion to Foucault* (Cambridge University Press: 2005), p.38.

humanitarian practice was the different conceptualisation of the 'refugee problem'. In Europe the very existence of DPs after the war was the problem: these displaced had to replaced elsewhere through repatriation or resettlement, and until they were, they would be a drain on the economy of postwar Europe. In Africa, refugees and immigrants were just one manifestation of a much larger process of decolonisation, urbanisation, and social change. They were one symptom of a bigger problem of social 'disintegration' rather than its cause. These different conceptualisations led practitioners and researchers to imagine the very notion of 'refugee' differently. Different sociopolitical contexts in Europe and Africa produced different understandings of refugeedom. The cultural, popular, and scholarly representation of refugees in the Third World was different. As Barbara Harrell-Bond put it in 1999, describing how humanitarian organisations raised funds for refugee relief

> In the case of the Hungarians in 1956 and even the Czech refugees in 1968 humanitarian organisations were able to base their appeals for funds on anti-Communist sentiments, but once refugees were originating from the South, what else was left besides human misery to trade upon to raise funds?[108]

We can now turn to another factor that contributed to the lack of attention to refugee mental health in Africa in the 1960s and 1970s: the racialist assumptions about Africa, and African refugees, that Western humanitarians brought with them.

'Africans do not suffer like us' and other convenient stereotypes

The dearth of mentions of mental health in humanitarianism in the 1960s/70s suggests that the idea that Africans suffered from mental distress just like Europeans barely occurred to humanitarians, despite transcultural psychiatrists' attempts to prove so. Why was this the case? Fieldwork conducted in the 1980s among Ugandan refugees in southern Sudan (now South Sudan) by Barbara Harrell-Bond, anthropologist and founder of the Refugee Studies Centre at Oxford University, offers some answers. One answer has already been alluded to above: the notion that Africans suffered less from 'uprooting' because the state borders they crossed supposedly meant nothing to them. As Harrell-Bond has written 'it is usually regarded that the culture and landscape of the countries in which

---

[108] Barbara Harrell-Bond, 'The experience of refugees as recipients of aid' in Alistair Ager (ed.), *Refugees: Perspectives on the Experience of Forced Migration* (Cassell: 1999).

most African refugees find asylum is more familiar to them than is the case for most refugees'.[109] As I have shown this was certainly not the case for many Rwandans in Uganda. Harrell-Bond also found in her fieldwork with Ugandan refugees that this naive belief was unwarranted: for her participants, Sudan represented 'a wrenching change from the familiar'. Only a minority of them shared a common mother tongue with local Sudanese, and most had never crossed the border into Sudan before being forced to in 1979, even those just on the other side of the Kaya river. The belief that ethnic kinsfolk on the other side of a border would come to refugees' aid was also overstated. Louise Holborn wrote in her 1975 history of UNHCR that local host populations in Africa were 'generally friendly, helpful and generous to the point where they have sometimes suffered equally when food shortages have resulted'.[110] UNHCR publications often commended Africans' 'traditional hospitality toward refugees', but as Harrell-Bond found many African officials were cynical about such praise, believing 'it has simply excused neglect of the problem they face' as countries faced with economic problems on the domestic front who could 'ill afford the luxury of hospitality'.[111]

Another reason was a presumption of cultural difference that manifested as a crude cultural reductionism bordering on dehumanisation. That African psychiatrists since decolonisation had striven to prove that the African psyche was no different than the European speaks to how pervasive the belief in an essential 'African' identity and psyche was. According to Harrell-Bond, it was very common for humanitarians to conveniently believe certain dehumanizing stereotypes like 'Africans do not suffer as "we" do', and she lost 'count [of] how many times such reassurances were repeated by colleagues in the field." According to them, Africans did not suffer physical and psychological pain in the same manner as 'white' people, exemplified by statements such as 'they are used to death and suffering' and 'Africans are used to this. They don't feel the same way as we do when they lose a child.' Such attitudes, Harrell-Bond said, were a 'mechanism for dealing with scenes of death and misery'.[112] Presumptions of cultural difference also allowed Westerners to ignore distressed and psychotic behaviour in refugees, by assuming they

---

[109] Barbara Harrell-Bond, *Imposing Aid: Emergency Assistance to Refugees* (Oxford University Press:1986), p.290.

[110] Holborn*, Refugees: A Problem of Our Time,* p.826.

[111] Harrell-Bond, *Imposing Aid,* p.1.

[112] Harrell-Bond, *Imposing Aid,* p.205.

were engaged in some culturally specific behaviour rather than suffering from a mental illness. In Harrell-Bond's words

> No one could deny that there were individuals who were clearly psychotic; perhaps because agency personnel had little or no experience in Africa, there was a tendency for them to view the bizarre behaviour of some Ugandans as simply a manifestation of the cultural trappings which they all carried into the Sudan, along with their school certificates.[113]

Yet another manifestation of this cultural reductionism was the assumption that African refugees were more interested in seeking help from local indigenous healers than Western medicine. While it is true that indigenous and vernacular healing methods - 'traditional medicine' - played an important role in non-Western cultures, refugees or not, this did not mean that they were averse to trying Western medicine. As Harrell-Bond writes, 'the size of the queues at any clinic anywhere in Africa contradicts the notion that Africans are unconcerned about their health or resist Western therapy'. Some of these views can be characterised as 'racist', but this would be insufficient and simplistic. What is more important is, as Harrell-Bond writes, 'to note the ways in which unexamined beliefs about non-Western societies are important in shaping the actions of individuals in the field'.[114] The point is not so much whether individual humanitarians adhered to or rejected racialist beliefs reminiscent of colonial thinking about Africans, but that Western humanitarian outsiders

> are part of a society which believes that ours is the most highly evolved, that our values are superior, and that our technical knowledge is the most efficient. Even those who are the most liberal and open to different ways of behaving are, under the stress of a refugee situation, likely to fall back on such assumptions.[115]

In the 1960s and 1970s, assumptions of cultural difference between Europeans and Africans were to blame for the lack of attention to mental health in humanitarianism. This chimes with the findings of Fassin and Rechtman for the 1990s and 2000s, and extends their argument backwards in time. For example, plans by Médecins sans Frontières (MSF) to institute a mental health program in post-conflict Sierra Leone in 2000 were abandoned

---

[113] Harrell-Bond, *Imposing Aid*, p.285.

[114] Harrell-Bond, *Imposing Aid*, p.206.

[115] Harrell-Bond, *Imposing Aid,* p.20.

after discussion. MSF psychiatrist Christian Lachal explained to Fassin and Rechtman that it was thought that 'there was doubt as to the possibility of constructing a new program of psychological care among a population whose traditions and system of thought were so different from ours.' Marie-Rose Moro was coordinator of mental health programs for MSF in 2000. Commenting on the failure of exploratory missions to establish mental health services in Rwanda, Sierra Leone, and Mozambique, she explained that 'I think there are different reasons, which are related to the particular situations, but maybe there is also something structural', meaning cultural. In a 1998 interview, another MSF nurse expressed a similar sentiment: 'We don't have mental health programs in the refugee camps in Africa. We should. But everyone thinks that it's too complicated – that it's cultural.'[116]

That some Western relief workers held racialist beliefs about Africans, however, does not satisfactorily explain the neglect of mental health in humanitarianism in Africa in the 1960s and 1970s, but merely points to how the context of decolonisation and 'development' reinforced beliefs about Africans as backward and underdeveloped. As the next chapter will show, some Western relief workers held similar beliefs about Cambodians, yet this manifested not as an absence of mental health services but as deeply condescending views about the 'fatalistic' and 'inefficient' thought process of Cambodians, while simultaneously working to provide them with mental health care that was culturally familiar. The issue, then, is not the alien culture of Africans or Southeast Asians vis-à-vis Europeans, but in the very *culture of humanitarianism*. That the most enduring stereotypes about refugees harboured by relief workers - whether in Europe, Africa, or Asia - were not about refugees' purported cultural backwardness, but their supposed apathy, laziness, and dependency, lends support to this observation. That such stereotypes were remarkably durable across decades and continents suggests that something institutional, more than personal prejudice, is responsible. In fact, despite an almost total neglect of mental health by humanitarians in Africa in the 1960s and 1970s, the language of mental health nevertheless provided a readily available vocabulary for pathologising refugees who attempted to exercise their agency.

Apathy and dependency revisited

[116] Didier Fassin, and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood,* (Princeton University Press: 2009), pp.185-186.

UNRRA had been advised by the Inter-Allied Psychological Study Group in 1945 that DPs would make unreasonable demands of relief workers, that they had to be dealt with patiently as they were encouraged to develop their own initiative, and that prolonged camp living would lead to a dreaded and potentially irreversible state of apathy. As mental health faded from humanitarianism and refugee care in the 1960s, stereotypes of apathy and dependency persisted. That refugees were apathetic and indolent became a fact in its own right; an unfortunate foregone conclusion that accompanied refugee status. The language of mental health continued to be used to describe undesirable refugee behaviour, though no psychiatric solutions were devised to address it. Apathy and dependency had been described in refugees in the First World War. After the Second World War, observations of apathy were endorsed and legitimated by mental health professionals. In postcolonial Africa, the identification of apathy by doctors continued in the absence of sustained attention to refugee mental health. This suggests that apathy as described by relief workers across time and space has more roots in the structures of aid rather than refugees' psyche, and that it was an external attribution by relief workers at least as much as it was a clinical observation.

Cato Aall, the Norwegian doctor and anti-apartheid activist, believed the most problematic behaviour, and potentially the most threatening from a security point of view, came from 'the qualified, educated refugee', or the 'sophisticated' refugee. Though much smaller in number than rural, villager refugees, recent experience had shown 'that a group of, say, a hundred well disciplined and organised men under certain circumstances can do wonders in independent Africa'.[117] An example of such refugees and the 'kind of mentality some refugees may develop' could be found, he said at Uppsala University in 1966, in a group of refugee students who left South West Africa (present day Namibia) and South Africa to further their education.[118] They all went through Botswana and 'had the experience of waiting and waiting and waiting in uncertainty as to what their future might be - but all the time hoping for some kind of scholarship'. During their wait, 'unable to participate in any positive and constructive activity', many got into trouble with the law over fights in hotel bars or quarrels in the transit centre about their food. 'Had they not been sent onwards, they would have had to go to prison.' They endured more waiting at Kazungula, on the Botswana side of the Zambezi river separating it from Zambia. There

[117] Aall, 'Refugee problems', p.39.

[118] Aall, 'Refugee problems', pp.33-4.

was even more waiting at a transit centre in Lusaka before they were finally admitted to school at the Nkumbi International College.

The refugee students, according to Aall, were unsatisfied with their school placements. They were ‘difficult to deal with all the way through’, with any help offered assumed to have a ‘secret and ill-meaning motive in the background’. Some thought they were overqualified for the school - ‘it is not an unusual thing for refugees, like many other people, to greatly overestimate their qualifications and abilities’ - and it looked like they felt they were being punished by having to go to the College. They ‘continued to take everything the wrong way’ and made demands that were seen to be unreasonable, such as an improved menu even though their food was ‘much better than most Zambians could dream of’, servants to do their laundry, and transport to visit the cinema in the nearest town on Saturdays. When the College did not acquiesce to their demands, they staged a walk-out. These students ‘made everybody furious’ and ‘set an extremely bad example, which may jeopardise the prospects of future applicants’. Aall acknowledged that this behaviour was not ‘typical’.

> Obviously, at the time they left South Africa, they could not have imagined that at a later stage they would be complaining about food or not wanting to wash their shorts - so one must hope! Something must have happened to them. Admittedly they have had an unpleasant time, but indeed it was nothing compared with what others have suffered, many of whom have grown maturer in fighting against the difficulties, instead of developing an attitude that nothing is good enough and “the world owes me a living”.

Aall did not offer much in the way of solutions to this ‘mentality’, except that refugees had to be settled quickly and adequately before they went into a state of ‘mental deadlock’ in which they felt that they were ‘manoeuvred into a position in which they are not able to take advantage of whatever chances may be offered to them’.[119]

Educated refugees were presumably ‘difficult’ because they attempted to exercise their own agency. This did not mean that rural refugees were not also problematised. But their problematisation and stigmatisation suggested that, rather than being difficult by trying to exercise their agency, they lacked any agency at all. They would rather, according to the stereotype, live on aid than work for a living, defeating the very purpose of refugee

---

[119] Aall, ‘Refugee problems’, p.36.

settlement programs that aimed to encourage self sufficiency. So widespread was this stereotype that it was known by the pseudo-medical name of ‘refugee dependency syndrome’. Relief worker Lance Clark called it ‘a metaphor from the mental health field’ in a 1985 article in which he railed against the term. It implied, he said, that dependency was something that existed in refugees’ minds, and was often paired with the related term of ‘welfare mentality’. The symptoms of this ‘syndrome’ were: lethargy, lack of initiative, acceptance of handouts with little attempt at self-sufficiency, and frequent complaints about the lack of generous outside help. For Clark, this term was not only misleading but harmful. It could worsen relations between relief workers and refugees since it encouraged what was ‘in essence, blaming the victim’. In addition, it implied maladaptive thinking and behaviour on the part of the refugee, whereas ‘such thinking and behaviour might alternatively be viewed as a rational, adaptive behaviour in the face of a powerful system which rewards dependency’. The answer, he said, was not to locate the problem in the thought processes of refugees, but to design the assistance system to promote self-reliance and participation.[120]

A period of relative stability in Uganda came to an end in 1971 with the overthrow of Milton Obote’s regime by General Idi Amin and his army. Initially welcomed as an alternative to the increasingly violent and authoritarian Obote regime, optimism faded quickly as the realities of Amin’s rule became clear. Thousands of soldiers suspected of disloyalty were murdered in the first year of his rule. In 1972, he launched an ‘economic war’ against the 50,000 Ugandan Asians in the country, descendants of migrants that had been brought over by the British from the Indian subcontinent, and expelled them. In the following months, the security situation in the country deteriorated and Amin’s army and security services were allowed to kill with impunity. Amin was ousted from power in 1979 following a Tanzanian invasion of the country. Also in 1979, Ugandan refugees began crossing into southern Sudan. Milton Obote returned to power in 1980 in elections widely believed to have been rigged, and he pushed Uganda into a civil war with the insurgent National Resistance Army, likely more brutal and causing more deaths than had been the case under Amin. Obote was overthrown in 1985 and in 1986, the National Resistance Army captured Kampala. In the fifteen years from 1971 to 1986, 600,000 Ugandans died or ‘disappeared’ and over a million were now refugees in neighbouring countries, with

---

[120] Lance Clark, ‘The Refugee Dependency Syndrome: Physicians, Heal Thyself!’, *Refugee Policy Group,* 1985, pp.2-3. <http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:204> [Retrieved October 2019].

over 200,000 in southern Sudan. But the installation of a National Resistance Movement government under Yoweri Museveni - who remains president of Uganda to this day - did not end internal conflict. Up to the early 2000s, violence continued in northern Uganda as Museveni's forces attempted to pacify other resistance and guerrilla groups.[121]

During Amin's dictatorship, health services, including psychiatric services, fell into disarray. Ministry of health expenditure per head of population fell by 85%. As working conditions deteriorated and salaries declined, medical staff fled the country or went into private practice. Expatriate psychiatrists who were on the faculty of the department of psychiatry at Makerere left the country, and the department lost its internationally funded lectureship positions. A decade of political and economic insecurity pushed psychiatric services to the brink of collapse. Ugandan psychiatrists were largely absent from assessments of the psychological effects of violence and conflict their country had been through.[122] One lecturer in the department of psychiatry, GGC Rwegellera, remarked in 1986 that 'what is left now is nothing but a shadow of what was once a reasonably good and growing psychiatric care delivery system'.[123]

Barbara Harrell-Bond went to a Ugandan refugee settlement in southern Sudan in the early 1980s to investigate the economics of refugee aid. She published her findings in her seminal 1986 book *Imposing Aid: Emergency Assistance to Refugees.* Though she set out to question assumptions that blamed refugees for their lack of economic self-sufficiency, she did not actually question the 'stereotyped view that refugees everywhere are excessively and unreasonably demanding', since it was 'too widely accepted for one not to be tempted to believe that it [had] some basis in fact'.[124] Nor did she question the prevailing view of aid organisations that the organisation of refugees into rural settlements was the right way to assist them. Though she 'knew that only a fraction of refugees in the Sudan were recipients of aid, [she] believed that all refugees *should* have access to an assistance program'.[125] She had initially planned to conduct fieldwork only in refugee settlements, but it was her 'discovery that there are refugees who do not accept the view

---

[121] Pringle, *Psychiatry and Decolonisation,* pp.177-8.

[122] Pringle, *Psychiatry and Decolonisation*, pp.180-1.

[123] Quoted in Pringle, *Psychiatry and Decolonisation.* p.182.

[124] Harrell-Bond, *Imposing Aid*, p.2.

[125] Harrell-Bond, *Imposing Aid*, p.4.

that rural settlements are the best for them' that led her to question her initial assumptions and directed her to the self-settled, non-assisted refugees on the Uganda-Sudan border.[126] Many of these had actively rejected aid, sometimes to the point of starvation. It was often dire need that eventually led them to seek assistance and live in a settlement, and this was what marked the start of being a 'refugee' for them. As one Ugandan refugee told her:

> …our people believe that to be a refugee is to be taken care of by UNHCR. But people on the border, they believe that since they are still self-supporting, they are not refugees. When they see you pack to come to the settlement, they say 'so you have accepted to be a refugees'. They use the 's' on the word 'refugee' even if you are a single person, without knowing the connotation, even when they are actually refugees in the Sudan![127]

At the root of the dependency stereotype was humanitarians' 'fundamental belief…that material aid in and of itself has the power to move populations…to attract people from point a to point b and back again to point a'.[128] Harrell-Bond concluded that a major reason for the many reported antisocial and abnormal behaviours in camps subsumed under 'dependency syndrome' was 'the manner which relief is given and the supplicatory role which the refugee is forced to assume in the initial period of the emergency'.[129] An assumption of humanitarian agencies was that in the period of emergency assistance and fulfilment of basic needs 'refugees adopt attitudes and behaviours which impede their progress towards self-sufficiency'. The prevalent theory was that by the time it was possible to move beyond relief to long term solutions 'dependent behaviour has already become entrenched'. A working hypothesis of sorts developed among relief organisations and aid workers: 'the more you give, the more dependent people become'.[130] Harrell-Bond argued that it was the basic political and economic characteristics of the refugee experience that produced and encouraged seemingly inexplicable behaviour that impeded progress towards self-sufficiency and was characterised by aid workers as chronic dependency. This was because the manner in which aid and assistance were provided and controlled by outside agencies did not go

---

[126] Harrell-Bond, *Imposing Aid*, p.5.
[127] Harrell-Bond, *Imposing Aid*, p.6.
[128] Harrell-Bond, *Imposing Aid*, p.18.
[129] Harrell-Bond, *Imposing Aid*, p.2.
[130] Harrell-Bond, *Imposing Aid*, p.10.

toward rebuilding lost social structures and developing and maintaining new community supports. Thus refugees could not act in a socially appropriate and beneficial manner as they had in their intact community back home, and the aid system actively worked against the refugees behaving in a manner conducive to building social structures. It forced them into the position of the passive, dependent aid recipient. Harrell-Bond did not collect empirical evidence to support the hypothesis that unassisted refugees were psychologically better off than camp residents, but 'there was no doubt that they were spared the near total loss of autonomy suffered by assisted refugees'.[131] Her visits to the compounds of self-settled refugees revealed that many were proud at having managed to survive despite everything. Only 20% of those who entered Sudan between 1979 and 1983 had immediately sought assistance on arrival. Less than one fifth of camp residents actually wanted to be there, and some reported that they had been forced to move there.[132]

Allison Umar, a Ugandan doctor who spent two years as a refugee in Sudan, did a MSc at the London School of Hygiene and Tropical Medicine and wrote his thesis on refugee mental health, focusing specifically on his fellow Ugandan refugees.[133] He too was concerned with the notorious 'dependency syndrome' and its causes, and was particularly concerned with the domination of the relief effort by international staff. He objected to the very term, because using it failed 'to acknowledge the role of the outsider in creating the so-called dependency syndrome'. It was predicated on an assumption 'held by outsiders…that refugees cross international borders and move to camps because they find receiving "handouts" easier than their previous lives', an assumption inconsistent with the fact 'that these people now described as unmotivated and lacking initiative had previously led active and independent lives'. To Umar, three issues needed to be acknowledged when discussing the role of aid workers in promoting dependent behaviour: their 'inability to address the "actual needs" of the refugees as seen by themselves', the 'control and high profile of expatriates in the relief programs, especially the over-control of resources', and the deficiencies in provision of basic services.[134]

---

[131] Harrell-Bond, *Imposing Aid*, p.301.

[132] Harrell-Bond, *Imposing Aid*, p.53.

[133] UN Library Geneva, UNHCR collection (CDR HEA/MEN/62 D), Allison Umar, 'Refugee mental health: a comprehensive literature review and case study', MSc thesis, London School of Hygiene and Tropical Medicine, 1986.

[134] Umar, 'Refugee mental health', pp.34-5.

Another factor that Umar saw as relevant to the mental health of refugees, was the mental health of the relief workers themselves:

> Although hardly mentioned and reported in the refugee literature, there can be no doubt that relief personnel working with refugees whose conditions are nothing other than disturbing, do experience psychological problems, and this may reflect on their relationship with refugees.[135]

Some ways in which this could happen were when the psychological reactions and attitudes of aid workers caused them to 'fail to acknowledge needs, or not consider refugee mental health a priority because of not knowing what to do'. It was possible for relief workers to experience a sense of heightened helplessness in overwhelming situations 'and under such circumstances…become more of a liability than an asset'. For example, they could engage in psychological strategies that dehumanised the suffering of refugees in order to shield themselves from their own reactions to suffering and misery. 'If the suffering persons are different from one's self (in size, shape, or colour)', Umar said, 'the tendency to dehumanise is further enhanced'. He saw this to be most common among inadequately orientated aid workers.[136] For this reason, it was essential to adequately orient aid workers to the 'attitudes, practices, and cultural values' of a group before designing health services for them. Adequate orientation would help 'avoid or minimise the sense of the "lost identity" a refugee finds himself in'. Umar lamented the 'too frequent changes in health personnel especially amongst the expatriates' as it meant that 'some degree of "distance" always exists' between aid worker and refugees. It was even worse when changes in personnel brought in '"personality traits" unsuitable for the prevailing circumstances'. Addressing a conference at Oxford on 'Assistance to Refugees: Alternative Viewpoints', he reminded the audience 'it is not always true that a refugee "has no other choice" but to accept the "offered hand" of assistance' in whatever form it was presented in.[137]

The arrival of humanitarian psychiatry in Africa

---

[135] Umar, 'Refugee mental health', p.22.

[136] Umar, 'Refugee mental health', p.22.

[137] Allison Umar, 'Health care to Ugandan refugees in west bank - south Sudan', Paper presented at a symposium on 'Assistance to Refugees: Alternative Viewpoints', 1984 [http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:160], p.6.

In the mid 1970s, Christian Potholm, a political scientist with a special interest in refugee problems in Africa, undertook an 'extensive field trip dealing with refugee resettlement in East and Southern Africa'.[138] In March of 1976, he published his impressions in *Africa Report*. To him, 'the single most overlooked feature of the present refugee situation in Africa' was mental health.

> Occasionally this concern may appear at an international conference, but it is a most minor and overlooked theme in the discussions of refugee problems and solutions. If the past decade has seen considerable progress with regard to refugees' physical well-being in Africa, then the present need is to refocus on the refugees' mental health.[139]

According to Potholm, every humanitarian field worker he spoke to 'insisted that the number of [mentally] disturbed refugees was far greater than anyone has realised', yet whenever he raised the concern at the headquarters of international organisations he was told 'it wasn't a serious problem'. He believed that 'many church organisations have shied away from this dimension for fear of being charged with "missionary" activities' and that therefore the best vehicle through which to investigate mental health concerns was the World Health Organisation (WHO) since it could provide 'neutral' experts. But, he cautioned, 'until the major relief organisations are prepared to admit this is a serious problem, there will continue to be considerable opposition and resistance'.[140]

Bruce Dick, professor at the London School of Hygiene and Tropical Medicine (LSHTM) and member of the School's Refugee Health Group, arrived at conclusions similar to Potholm. In 1984, he noted that 'although there are a number of reports concerning mental health of refugees in industrialised countries and a growing awareness of the association between mental illness and both life events and "uprooting", there is very little information, even at anecdotal levels, about mental illness in refugee camps'. It was 'surprising' that

---

[138] Christian Potholm, 'Africa's Persistent Problem', *Africa Report*, 21(2)(1976), p.12.
[139] Potholm, 'Africa's Persistent Problem', p.15.
[140] Potholm, 'Africa's Persistent Problem', p.15.

> in view of the inevitability of such problems, so little is done to alleviate the situation. One wonders what happened to the UNHCR mental health adviser who was so active with the refugees in Europe following World War II.[141]

Thus far, I have attempted to show how and why this work was forgotten. For the remainder of this chapter and the next I explore how refugee mental health returned once again to the agendas of psychiatry and humanitarianism. Uganda was the first place where this happened in Africa.

When Barbara Harrell-Bond arrived in southern Sudan to conduct research in Ugandan refugee settlements in the early 1980s, she found little appetite among humanitarians for mental health work. 'It was not possible', she wrote in 2000

> to convince NGOs working there that special attention should be paid to the mental health of African refugees, much less to designing interventions to mitigate the stresses associated with their experiences. Indeed, up to the late 1980s, calls for basic socio-psychological research to be conducted - beginning with refugee children, encountered stiff resistance. An emphasis on research was interpreted by humanitarians as implying they were neglecting their duties.[142]

Harrell-Bond came to study economics, not psychology. She persisted 'in looking for the economical explanations for the abnormal social behaviour which [she] observed and resist[ed] the notion that the solution, expect for a minority of cases, [lay] in psychiatric medicine or counselling therapy'. She confessed that she had had a naive belief in the power of the family and traditional community supports to buffer the effects of social stress on the individual, but soon discovered that she had underestimated 'the extent to which the demands of individual survival undermined social values and the time that it takes for new supportive social units to establish themselves in the absence of kinsfolk'.[143]

---

[141] Bruce Dick, Diseases of refugees - causes, effects and control', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 78(6)(1984), 738.

[142] Barbara Harrell-Bond, 'Foreword', in Frederick Ahearn (ed.), *Psychosocial Wellness of Refugees* (Bergahn Books: 2000), p. xii.

[143] Harrell-Bond, *Imposing Aid,* p.283.

Her research revealed 'indirect evidence' of psychological distress that went beyond economics and necessitated further research. For example, 'always looking for new ways to collect expressions of culture' she sponsored a drawing competition among refugee children. Teachers were asked to instruct children to draw their impressions of 'refugee life'. Contrary to her expectations of drawings depicting lorries delivering food and schools under trees, the children saw refugee life in terms of violence. Their drawings depicted 'soldiers shooting their mothers, infants lying bleeding to death, houses burning…men tied to trees, decapitations [and] dogs eating human corpses'. 'More disturbing' to Harrell-Bond than the drawings were the interviews she conducted with 'very young children who all too frequently responded to questions about their future aspirations with statements about how they would return to Uganda to kill "the Acholi"'. Other cultural expressions that indicated psychological distress were the songs composed by the refugees in exile and sung during performances, which 'revealed a preoccupation with death, suffering, hunger, and violent revenge'.

Such indirect evidence prompted Harrell-Bond and her Oxford colleagues to investigate mental health further. In 1984 Alex de Waal and Alula Pankhust, together with three Ugandan colleagues, administered a modified version of a scale known as the Present State Examination (PSE) to two groups of randomly selected adults among assisted and self-settled refugees. The PSE is a 'semi-structured interview, intended to provide an objective evaluation of symptoms associated with mental disorders' consisting of 140 items scored on a 3 or 4 point scale. It was developed by English psychiatrist John Wing in the late 1960s with the aim of facilitating the standardised identification of psychiatric cases. De Waal and Pankhurt's version was modified to probe for mainly anxiety and depression. They found a high prevalence of symptoms of anxiety, depression, or a combination of both in the refugees - only 13 of the 57 did not show any signs of psychological problems. Despite the small sample size and inexperience of the interviewers that cast some reservations on the validity of the results, they concluded that there was 'a strong justification for presenting these results in order to stimulate further work'.[144] Harrell-Bond's team did not use the language of trauma, focusing more on the anxiety, depression, and stress that arose from experiencing conflict and from being a refugee. Yolana Pringle sees in the survey led by Harrell-Bond not so much a call for psychiatric services and counselling, but a 'wider point about the failure of relief workers

---

[144] Harrell-Bond, *Imposing Aid*, pp.286-7.

to consider refugees as individuals with their own social and political histories, or even to consult assisted refugees about the kinds of assistance that would be most beneficial to them'.[145] But it was the language of trauma that galvanised Western interest in humanitarian mental health programming in Africa.

As Yolana Pringle writes, 'at a time when research on trauma was still in its infancy internationally, Uganda and Ugandan refugees became the subject of some of the earliest research of the psychological effects of war and violence in Africa'. Rather than focus on broad populations, the first iterations of this research focused on children and refugees, 'two groups who could be regarded unambiguously as "victims" in a conflict in which there were no clear "sides"'.[146] Two European groups conducted the first research in war trauma in Uganda in the 1980s. One of these was a team led by Cole P. Dodge, UNICEF representative in Uganda since 1981. From 1985 to 1986, Dodge led investigations into 'child stress' aimed at developing intervention strategies for child protection in times of war and stress. He was joined by Magne Raundalen, a Norwegian psychologist, James Lwanga, a lecturer in psychiatry at Makerere, Charles Mugisha, a paediatrician at Makerere, and Atle Dyregrove, a psychologist with experience in stress, grief, and disaster research. These were the first investigations into childrens' reactions to war in Africa. They were limited to Kampala due the unfavourable security situation in most of the country.[147] Another initiative came from the London based Medical Foundation for the Care of Victims of Torture (now Freedom From Torture), who asked Patrick Bracken, a psychiatrist, and Joan Giller, a gynecologist who was working with Karen refugees on the Thai-Burmese border, to set up a centre for physical and psychological support for torture victims in Kampala.[148] A Ugandan social worker, Stella Kabaganda, was involved in the outreach work. Pringle writes

> While psychiatric services continued to be underfunded and of little relevance to most in the face of war and violence, psychosocial activities, driven primarily by international agencies and specialists, attracted significant amounts of attention and money. And while many of these activities have increasingly been appropriated by the Ugandans who were

---

[145] Pringle, *Psychiatry and Decolonisation,* p.188.

[146] Pringle, *Psychiatry and Decolonisation,* p.180.

[147] Pringle, *Psychiatry and Decolonisation*, p.189.

[148] Pringle, *Psychiatry and Decolonisation,* p.190.

> trained to run them, the creation of knowledge about trauma was driven for a long time by expatriate psychiatrists, with their own interests in culture, suffering and victimhood.

Pringle argues that this prioritisation of Western interests in mental health research in Uganda indicates that, thirty years after independence, the decolonisation of psychiatry in Uganda was still incomplete.[149] These activities were appropriated by a new generation of Ugandan psychiatrists only in the 1990s. The first Ugandan psychiatrist to study trauma and post-traumatic stress disorder was James Walugembe, when he was doing his Master of Medicine degree at Makerere. Walugembe continued to research the traumatic effects of war and violence in Uganda till his death in 2009.[150]

Conclusion

This chapter has been a study of an absence. This absence, and my attempt to explain it, constitutes a case study in the political contingency of knowledge creation and the necessary preconditions for the wider dissemination of locally produced medical knowledge. Psychiatrists in Europe made sense of the uprooting, encampment, and resettlement of Europeans after World War II through their understandings of earlier waves of transatlantic migration, of nostalgia as a consequence of social displacement, and of their own military experiences with POWs. In turn, this process of making sense of refugees' experiences in psychological terms often occurred in the context of humanitarian practice dedicated explicitly to refugee aid. Psychiatrists in Uganda, like their counterparts in Europe, were also political actors who were not only aware of the political implications of their work, but also actively sought to tailor their research and practice to be relevant to the local and national political context. They were not working for humanitarian organisations. The institutions they were working for, whether Makerere Medical School, Butabika Mental Hospital, or the Ugandan Ministry of Health, had far more pressing concerns than the influx of Rwandan refugees. When they did broach the topic of refugees, and immigrants more generally, it was subsumed within a larger context of anxieties about population mobility. Psychiatric research and practice were thus instrumentalised to serve the interests of the practitioners wielding them and the institutions they were a part of.

---

[149] Pringle, *Psychiatry and Decolonisation,* p.180.

[150] James Walugembe (posthumous), 'A pioneer's look at psychotrauma in Uganda:"Post-traumatic stress disorder as seen in Mulago Hospital Mental Health Clinic (1992)"', *African Journal Of Traumatic Stress,* (1)(1)(2010), 6-18.

Knowledge that is scientific and objective is not value-neutral, for it is imbued with the values of those producing and wielding it.

Knowledge produced on Rwandan refugees' psychological state remained confined to the universities and clinics it was produced in, and never made its way into humanitarian organisations operating in Uganda or elsewhere in Africa. I draw from this that it is not sufficient for knowledge to be simply produced by practitioners and published in academic journals for it to gain mainstream acceptance. It needs to be adopted by those who have the resources to make said knowledge and its subjects visible; in this specific case, humanitarian organisations. I have not been able to find any record of a mental health practitioner employed by a humanitarian organisation in Africa during this period - as late as 1979, a psychiatrist from Juba offered his services to UNHCR when it began assisting refugees arriving from Uganda and was turned down[151] - nor do I know if the physicians whose work I have examined in this chapter ever approached a humanitarian organisation with the suggestion that they should focus on refugee mental health. That an absence of input from humanitarian agencies contributed to the low or non-existent profile of refugee mental health issues in Africa highlights the role of humanitarian agencies in creating authoritative knowledge about the populations they assist. In the next chapter, I will explore the vital role of humanitarianism and humanitarian agencies in creating a 'modern' science of refugee mental health. In the 1980s, on the Thai-Cambodian border, humanitarians would (re)learn that victims of war and displacement suffered mentally as well as physically - this time around not as 'uprooted' individuals and societies, but as traumatised victims.

[151] Harrell-Bond, *Imposing Aid*, p.323.

Chapter 5
Culture, Trauma, and Confinement

Introduction

The 'notion of "trauma"', Fassin and Rechtman write, 'has become a general way of expressing the suffering of contemporary society, whether the events it derives from are individual (rape, torture, illness) or collective (genocide, war, disaster)'.[1] Trauma, a notion inherited from clinical psychiatry, via psychoanalysis, was from the 1970s able to infiltrate social discourse. The construction of this 'empire of trauma', they write, 'is the product not only of scientific developments, as is commonly suggested, but also of social history'. It owes 'less to advances in knowledge than to changes in the moral climate.'[2] In this chapter I explore one part of this story of the infiltration of 'trauma' into social discourse by focusing on the development and emergence of 'refugee trauma'.

This chapter explores the beginnings of the 'modern era' of research in refugee mental health.[3] It examines how and why psychiatry resumed an interest in refugees in the late 1970s after a hiatus of two decades. Decades after the European refugees of the 1940s and 1950s had grown new roots and integrated in their new lands, Western psychiatrists would find themselves confronted with substantial numbers of refugees once again; this time hundreds of thousands of Indochinese refugees. At the same time as they were arriving in Western countries of resettlement in the 1980s, a humanitarian crisis was brewing on the Thai-Cambodian border. These two stories cannot be examined in isolation, for developments in the diaspora informed and were informed by events in the border camps, as well as camps located inside Thailand that housed Vietnamese and Laotians as well as Cambodians.

The arrival of Indochinese refugees happened at a time of great change in American psychiatry. A new standardised diagnostic manual that eschewed inner drives and dynamics and theoretical orientations in favour of observable criteria was published by the American Psychiatric Association in 1980. This manual introduced the diagnosis of

---

[1] Didier Fassin, and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood,* (Princeton University Press: 2009), pp.19-20.
[2] Fassin and Rechtman, *The Empire of Trauma,* pp.22-23
[3] Derrick Silove, Peter Ventevogel, and Susan Rees, 'The contemporary refugee crisis: an overview of mental health challenges', *World Psychiatry,* 16(2)(2017); Silove et. al. identify this as starting from the 1970s.

post-traumatic stress disorder (PTSD), a reformulation of the familiar traumatic neurosis but in a new context where victims of trauma won the right to be legitimised rather than viewed with suspicion. This itself was an outcome of advocacy by American Vietnam War veterans and mental health practitioners sympathetic to them, who formed an alliance with doctors working with Holocaust survivors; both groups demanded recognition and compensation for the suffering they had endured. When refugees began arriving in the US, seeing their mental health in terms of trauma was an obvious choice, and the field of 'refugee trauma' was born.

But trauma was not the only psychiatric response to the arriving refugees. This was also a moment of change for transcultural psychiatry, and the efforts of this discipline to respond to the psychological distress of refugees reveal the paradigmatic changes the field was undergoing. Whereas throughout the 1950s and 1960s the dominant view in transcultural psychiatry was that patterns of mental illness were universally applicable and could be identified in all cultures, an anthropologically minded 'new cross-cultural psychiatry' was coming into being. In this new view, psychiatric diagnoses were not independent disease entities that could be compared across cultures, but explanations for disease rooted in Western culture. Culture began to be seen not as something that merely influenced the expression and manifestation of mental illness, but as something that determined the very manner in which people conceive of illness.[4] This renewed, relativist, understanding of culture will be explored through examining the work of psychiatrists working with Cambodian refugees both on the Thai-Cambodian border and in resettlement.

In 1979, the genocidal Khmer Rouge regime of Cambodia was brought down by a Vietnamese invasion and occupation. According to some estimates, two million people, a quarter of the Cambodian population, died in the Khmer Rouge's four years.[5] When the regime fell, hundreds of thousands of Cambodians fled the conditions of famine and the advancing Vietnamese army and moved west to Thailand. Not allowed to go any further by the Thai government, who did not recognise them as refugees, they sought refuge in camps on the border. An 'international Cambodian "refugee problem"' was born, and it would

---

[4] Arthur Kleinman, 'Depression, somatization and the "new cross-cultural psychiatry"', *Social Science and Medicine,* 11(1)(1977), 3-9.

[5] National Research Council (US) Roundtable on the Demography of Forced Migration; Reed HE, Keely CB, editors. Forced Migration & Mortality. Washington (DC): National Academies Press (US); 2001. 5, The Demographic Analysis of Mortality Crises: The Case of Cambodia, 1970-1979. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223346/

last until the final camp closed in 1993.[6] Bertrand Taithe has described humanitarian activity in the border camps as forming the cradle of a new international humanitarian system at the end of the Cold War. The border camps provided 'a relatively stable environment where knowledge was co-produced by European and American academics and humanitarians'.[7] The knowledge that was produced and disseminated in the camps 'has since reached deep and far in the nascent international humanitarian networks', and 'the empirical knowledge embodied in practices, manuals and guidelines was transmitted from one organisation to the next'.[8] It was the 'specific features of a closed environment' that made the humanitarian space of the camps so attractive for researchers.[9] The camps 'shaped a specific culture of scientific knowledge which enabled university academics to develop projects sustained by humanitarian aid practices'.[10] In this environment, medical and social science practices were 'defined as both banal and urgent, as an opportunity to redress and correct as well as an epidemiological testing ground'.[11] Taithe has argued that 'among the scores of victims at the end of the Cold War, displaced Cambodians had a particular aura which referred to the extraordinary brutality of the Vietnam Wars and the Cambodian "self-genocide"'. Western encounters with Cambodians, whether in camps or resettlement, '[were] made more complex by the growing conviction that their story was uniquely "traumatized"'.[12] Humanitarians who worked with Cambodians had come of age at a time when the Western world was reckoning with the legacy of the Holocaust, and it was very much on their minds when they encountered the victims of the 'Asian Hitler', Pol Pot.

In responding to the mental health challenges of displacement in the 1970s and 1980s, the volumes of research produced in the aftermath of World War II seem to have been forgotten. In 1980 American political scientist Barry Stein noted that although postwar displacement in Europe had 'led to many excellent refugee studies there and in the

---

[6] Peter Gatrell, *The Making of the Modern Refugee,* (OUP, Oxford: 2013), pp.213-4.

[7] Bertrand Taithe, 'The Cradle of the New Humanitarian System? International Work and European Volunteers at the Cambodian Border Camps, 1979–1993', *Contemporary European History*, 25(2)(2016), p.338.

[8] Taithe, 'The Cradle of the New Humanitarian System?', p.343.

[9] Taithe, 'The Cradle of the New Humanitarian System?', p.349.

[10] Taithe, 'The Cradle of the New Humanitarian System?', p.351.

[11] Taithe, 'The Cradle of the New Humanitarian System?', p.352.

[12] Taithe, 'The Cradle of the New Humanitarian System?' p.338.

countries of resettlement', interest in them waned as the 'problem receded from view and many of the studies gathered dust for a quarter of a century'.[13] In 1987, an article on Vietnamese refugees in a transit camp in Hong Kong in *International Migration Review* would cite Maria Pfister-Ammende's 'classic paper on mental hygiene in Swiss camps' only to lament that since her studies had been conducted, 'little systematic attempt at either theory construction or research has been done to examine the relationship between the conditions of the camp and the emotional and psychological life of the refugees', and that 'for a wide variety of reasons, the advice of Pfister-Ammende regarding camp organization and administration has gone largely unheeded, ignored or forgotten for more than two decades'.[14] I argue that there are two main reasons for this omission: first, humanitarian practitioners in the 1980s had absorbed the legacy of the Holocaust in a way that would have been impossible in the post-war years, and this influenced their outlook and their interactions with Indochinese refugees. Second, that Indochinese refugees were 'new' refugees, far removed from the figure of the 'traditional' European refugee of the 1940s and 1950s, leading practitioners to believe that new solutions and approaches were needed. Despite this, there was a striking similarity between the social and mental health problems humanitarians encountered on the Thai-Cambodian border and those encountered by an earlier generation of humanitarians in DP camps in Germany.

The 'new' refugees

Beginning in the 1970s, refugees from the Third World began to be resettled in the West in substantial numbers, especially in the United States. After the American defeat in the Vietnam War in 1975, the United States began to accept, for the first time, 'substantial numbers of nonwhite refugees', breaking 'decades-old racial barriers in American refugee affairs'.[15] These nonwhite refugees hailed from the Indochinese peninsula: Vietnam, Laos and Cambodia. That they were not white may be one of the most significant differences between this wave of refugees and previous waves of European refugees in the 1940s and 1950s. The mental health and social work, discussed in chapter 3, which aimed at

---

[13] Barry Stein, 'The experience of being a refugee: Insights from the research literature', in *Refugee Mental Health in Resettlement Countries,* eds. C Williams and J Westermeyer (Hemisphere Publishing Corp, 1986), pp.5-23.

[14] Kwok Chan, and David Loveridge, 'Refugees "in transit": Vietnamese in a refugee camp in Hong Kong', *International Migration Review,* 21(3)(1987), p.745.

[15] Carl J. Bon. Tempo, *Americans at the gate: The United States and Refugees During the Cold War* (Princeton University Press: 2008), p.147.

facilitating refugees' growing of new roots and a speedy adaptation in their new country was based on an assumption that these refugees would be visually indistinguishable from the local (white) host population. This was not possible for refugees from the Global South.

Accordingly, scholars in refugee studies and practitioners in the refugee aid sector began to distinguish between these 'new' refugees and earlier arrivals of 'traditional refugees'. This difference was spelled out by Barry Stein at a 1980 London conference on the theme of 'the refugee experience'.[16] In his paper, which focused on the mental health aspects of the refugee experience, Stein articulated the Western world's changing notion of who a 'refugee' was. Until the 1960s, refugees resettled in the West, the 'traditional refugees', were of European origin, first as a result of the Second World War and then the Cold War. By the 1970s, the 'weight of concern and interest' had shifted to 'new refugees' from Asia, Africa, and Latin America. These 'new' refugees were displaced within, and by, a postcolonial order of nation-states. But the 'new' element Stein was focusing on was that they were now an immediate problem for Western countries, as they were 'no longer solely dealt with within those regions but in Europe and North America'. The difference between them was spelled out starkly by Stein.

> New refugees are culturally, racially and ethnically vastly different from their hosts, they come from less-developed countries, at a greatly different stage of development than the host, and they are likely to lack kin, potential support groups, in their country of resettlement. Traditional refugees, on the contrary, are culturally and ethnically similar to their host, come from societies whose levels of development are similar, and are likely to be welcomed and assisted by well-established kinfolk who know their language and can cushion their adjustment.[17]

For Stein, the 'new refugee [was] typified in the extreme' by the Hmong of Laos, who were 'mountain tribesmen' lacking in any formal education, to whom the 'behavioural and material aspects of Western culture [were] strange and alien'.[18] The differences between

---

[16] Stein, 'The experience of being a refugee'.

[17] Stein, 'The experience of being a refugee'.

[18] Stein, 'The experience of being a refugee'.

the new and traditional refugees, Stein said, needed to ‘be included in the resettlement research, particularly mental health research’.[19]

A major feature distinguishing the new refugees from the old ones that was not mentioned by Stein had nothing to do with the refugees per se, but the economic conditions of the Western countries of resettlement in the 1980s. Earlier waves of refugees coming to the West had arrived in the postwar economic boom, when there was almost full employment and a strong welfare state. The dismantling of the welfare state and the dawn of the neoliberal agenda defined the economic climate in which Indochinese refugees arrived. No one offered Southeast Asian refugees a stable job with benefits, they had to find their own way. State programs were being dismantled, unions were downsized, funding for public schools was cut, and standard employment was becoming more and more of a vanishing ideal. As Anna Lowenhaupt Tsing has written, ‘even if they had managed to become perfect copies of white Americans, there would be few rewards’.[20]

Psychiatry resumes an interest in refugees

Refugees from Southeast Asia arrived in the United States in two waves.[21] The first comprised mostly young, well educated professionals who had worked with the Americans in Vietnam, and who came to the US after the fall of Saigon in 1975. Jackie Bong Wright was one such refugee. A mental health paraprofessional, she fled three days before the fall of Saigon.[22] The second wave began to arrive after 1980, and consisted of two major groups: Cambodian and Laotian peasants who found refuge in camps on the border with Thailand, and the ‘boat people’, ethnic Chinese who fled Vietnam on boats, such as Le Thing Hong, who made the 800 mile journey to a refugee camp in the Philippines with her two year old child, braving the high seas and pirate attacks along the way.[23] Jackie Bong Wright was at the airport along with Hong’s family to welcome her, and she was

[19] Stein, ‘The experience of being a refugee’.

[20] Anna Lowenhaupt Tsing, *The Mushroom at the End of the World: On the Possibility of Life in Capitalist Ruins* (Princeton University Press: 2015), p.102.

[21] Aihwa Ong, *Buddha is Hiding: Refugees, Citizenship, the New America* (University of California Press: 2003), p.84

[22] Ronald D. White and Jane Freundel, ‘After a Traumatic Journey, Refugees Get Help Adjusting to U.S.’, *The Washington Post*, 16 August 1979, p.MD3.

[23] White and Freunde, ‘After a Traumatic Journey, Refugees Get Help’.

determined to 'combat the emotional traumas and cultural shock' of boat people like Hong. In an August 1979 article in the *Washington Post* titled 'After a Traumatic Journey, Refugees Get Help Adjusting to US' that featured Wright and Hong, Wright is quoted as warning that the incoming boat people carried 'time bombs of latent stress and grief from the "extraordinary traumas" of the boat passage from Vietnam'. The same article reported warnings by experts that, without appropriate help, many Indochinese refugees were expected to 'experience acute depression, withdrawal from society, suicide, alcoholism, the destruction of vital family relationships and child abuse, all within two years of their arrival in America'.[24]

From the moment of their arrival, then, Indochinese refugees were seen as harbouring a psychological threat to themselves and to their new countries. Mental health practitioners warned not only of the potential problems they could suffer in resettlement, but also that refugees were not seeking the mental health services on offer. Dr. Tran Minh Tung, a Vietnamese psychiatrist who settled in Fairfax County in Virginia, felt, along with other Indochinese counsellors and administrators of local programs, that 'existing federal, religious and private programs [were] insufficient to solve the emotional problems of new refugees'.[25] New, culturally sensitive, programs geared to the needs of refugees were needed, he argued. The main reason for such special projects, Dr. Tung told a conference audience in 1979, was that 'in spite of their problems, the refugees have not utilised the existing mental health resources, so that one is faced with a paradoxical situation of people crying for help and not getting the help they need'.[26]

When refugees did seek help, they often did not get better. Resettlement officers were acutely aware of this problem, and it was not limited to the United States. Mary Petevi, a resettlement officer with UNHCR, noted in a memo to UNHCR representatives in several Western countries that the last months of 1981 had seen a considerable increase in 'suicide attempts and delinquency' among Indochinese refugees in Switzerland and West

---

[24] White and Freunde, 'After a Traumatic Journey, Refugees Get Help'.

[25] White and Freunde, 'After a Traumatic Journey, Refugees Get Help'; 'Voices: Remembering the War', *The Washington Post,* 15 April 1985, p.A18.

[26] UN Library Geneva, UNHCR collection, (CDR SER/CHOMI REPRINTS), 'The Indochinese Refugee Mental Health Problem', T.M. Tung, October 1979, p.2.

Germany.[27] Those involved in their treatment and rehabilitation had 'expressed serious doubts as to whether traditional [Western] psychiatric and psychological methods of treatment were adequate in treating Indochinese refugees, as the results of their efforts were not those expected'. It seemed, she speculated, 'that the historical, cultural, linguistic and other differences often constitute obstacles to psychiatric treatment'. A survey of experts found two tendencies, the first 'insist[ing] that treatment can be provided in the context of traditional, institutional psychiatry' and the second believing that conventional psychiatry was 'neither adequate nor efficient' and that special programs tailored to the needs of refugees were therefore needed. Attached to the memo, she included a report on a reportedly successful refugee mental health project at a community mental health centre in Florida, that had employed 'trained ethnic mental health field technicians' of the same background as the refugees to provide outreach services to overcome low rates of utilisation of existing mental health services.[28] It was hoped, Petevi wrote in her cover letter, that 'through exchange of information of this type, an appropriate therapeutic model could gradually be defined and would eventually lead to a decrease of the resettlement resistance observed with third countries vis-a-vis the mentally disturbed refugees'. This resistance, she continued, was justified by the resettlement countries by 'the lack of an appropriate treatment model, and the fear to be obliged to institutionalise a case forever, with all the deontological and financial implications that such a "therapeutic" act would mean'.[29]

Mental illness was used as a justification to delay or deny resettlement of Indochinese refugees in the West. A history of hospitalisation or psychotic episode would mean an automatic one year hold on resettlement, after which resettlement would be granted if the refugee could demonstrate 'stability'. Refugees knew that 'biting one's tongue might be a means of self-preservation'.[30] Vietnamese refugees in PRPC knew that if they approached Community Mental Health and Family Services (CMHS), a Philippines

---

[27] UNHCR Archives Geneva, Records of the Central Registry, Assistance - Mental Health, REF 11/2/57-571, Fonds 11/Series 2/Box 901 ARC-2/A47 (hereafter UNHCR Archives, Assistance - Mental Health), 'Note for the File, Psychiatric Treatment/Psychological Support to Indochinese Mentally Disabled Refugees in Switzerland and in the Federal Republic of Germany', Mary Petevi, March 1982.

[28] UNHCR Archives, Assistance - Mental Health, 'Mental Health Services for Indochinese: Some Helping and Hindering Forces', Diovelis D. Stone and Charles G. Ray, p.1.

[29] UNHCR Archives, Assistance - Mental Health, 'Mental Health Services for Indochinese Refugees', Mary Petevi, 26 October 1984.

[30] Peter Gatrell, *The Making of the Modern Refugee* (Oxford University Press: 2013), pp.218-9.

based social work and mental health NGO operating in the camp, for help, their smooth passage to the USA could be hindered, and voluntary agency staff 'implicitly encouraged [them] to do what they had done in Vietnam, which is to try to conceal the problem and manage it with the help of family and friends'. The staff of CMHS felt to be in a difficult position, recognising 'that they had to work with the contradiction of offering a service that might produce an outcome that is not in the best interests of the client'. Perhaps to assuage their conflicted feelings, some staff said they felt 'that there was an argument for saying that the one year medical hold condition was a way in which people who would never be accepted by the USA would eventually be allowed to go', and that they 'believed that they provided better services than might be available in downtown Chicago or Detroit'.[31]

The Indochinese refugees' culture, unproblematic in their own countries, became an obstacle to successful treatment outcomes and satisfactory adaptation. This was a consistent theme in mental health work with this population. Psychiatry, and medicine more generally, were not just scientific tools used to alleviate refugee patients' suffering, but also a mode of socialisation into Western culture, as anthropologist Aihwa Ong has shown in her study of resettled Cambodians in California, *Buddha is Hiding.* The arrival of Southeast Asian refugees in the United States in the 1970s and 1980s, Ong writes, 'spurred the invention of a field called Southeast Asian mental health that, though the systematic naming and ordering of refugee illnesses…sought to discipline the behaviour, beliefs, and grief of Cambodian patients according to the self-evident truths of biomedicine'.[32] In practice, Southeast Asian mental health was 'a set of concepts dedicated to the naming, classifying, and treatment of illness in the target population, as well as to the mobilisation of resettlement agents, social workers, and academic and medical experts to assist refugees and relieve their suffering'.[33] Invoking the 'depressed Cambodian refugee' was a strategy to attract funding: 'It was invoked when the public became upset about the refugee drain on the health care system' and also 'became the justification for state and local health clinics to obtain much needed funding from the federal government, especially when they could furnish charts showing Cambodians and Hmongs scaling the depression stratosphere'.[34] Ong has critiqued this model for not considering how 'the power dynamics

---

[31] Linda Hitchcox, *Vietnamese Refugees in Southeast Asian Camps* (Macmillan: 1990), p.139.

[32] Ong, *Buddha is Hiding,* p.93.

[33] Ong, *Buddha is Hiding,* p.98.

[34] Ong, *Buddha is Hiding,* p.96.

of acculturation and the complex micropolitics and consequences of encounters with the health profession may have affected social adjustment', and for assuming 'that the sufferings of diverse populations follow generic patterns, and that mental-health constructs are universally applicable'.[35]

The idea that mental health constructs and diagnoses were universally applicable had been around since the 1950s, but it was given renewed impetus with the publication of new, standardised diagnostic manuals by the World Health Organisation (WHO) and the American Psychiatric Association (APA). Since the early 1970s, WHO had been engaged in international studies that sought to establish the cross-cultural validity of psychiatric diagnoses, such as its international studies on schizophrenia.[36] These were part of a larger program of research that contributed to 'the creation of a systematised, universal language for mental health diagnosis and treatment'.[37] Such work ultimately contributed to classificatory systems like the WHO's 9th edition of the *International Classification of Diseases* (ICD-9) in 1979 and the American Psychiatric Association's third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980, institutionalising and universalising a symptom based, descriptive, standardised approach that facilitated cross-cultural comparisons.[38] This was helped by the discovery of psychotropic drugs which spurred the search for the specific disease entities that responded to them.[39] Prior to the DSM-III there was no standardised psychiatric nosology or common language between various clinical and theoretical orientations in psychiatry, what the APA sought to rectify. The DSM-III was, in anthropologist Allan Young's words, 'a system of classification based on lists of criterial features and Aristotelian principles of inclusion and exclusion'. The new manual claimed to provide what Young has called a 'diagnostic metalanguage' for talking about mental disorders that was not 'particular to any theoretical

---

[35] Ong, *Buddha is Hiding,* p.98.

[36] World Health Organization, 'Report of the international pilot study of schizophrenia', (1973)

[37] Alice Bullard, 'Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry', in Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (Palgrave Macmillan: 2007), p.205.

[38] Jatinder Bains, 'Race, culture and psychiatry: a history of transcultural psychiatry', *History of Psychiatry,* 16(2)(2005), p.144.

[39] Bains, 'Race, culture and psychiatry', p.144

orientation because it is based on features - overt behaviours, biochemical markers, cognitive deficits…that should be visible to any competent observer'.[40]

It was this standardised system of classification and diagnosis that Ong found in operation during her ethnographic fieldwork in refugee clinics in California that prided themselves on 'cultural sensitivity'. Southeast Asian refugees, like other poor newcomers to the United States, 'were said to suffer from something called immigrant psychology', taken to be 'a thing that exists among (non-European) immigrants who enter this country, rather than an attribution by sociologists and health experts, whose discourses play a key role in identifying deviance and proposing rational techniques to reform the other'.[41] Ong found that much of the discourse around culture and refugees 'seemed used only to bolster the normalising strategy of introducing scientific and rational thinking about illness and of treating diseases rather than persons'. The claim of cultural sensitivity simply 'suggested social skills at dealing with the impenetrable other, but not a modification of their basic faith in Western medicine and rationality'.[42] The trappings of cultural sensitivity were used 'in a limited, strategic fashion to win patients' cooperation, facilitate diagnosis, and buttress the doctors' authority, rather than to give equal time to alternative points of view or to relativize biomedical knowledge'.[43] Health workers deployed 'stereotypical cultural concepts' to 'construct an intersubjective reality that sought to manipulate, incorporate and supplant Cambodian notions of healing, body care and family'.[44] Ultimately, 'cultural sensitivity became a strategy that used cultural difference not so much to understand particular experiences of illness as to read symptoms that confirmed universalised states of biomedicine', and 'cultural material was appropriated only to be incorporated within the medical framework'.[45] It can be argued that the medicalization of refugees was part of a larger trend in the neoliberal consumer society of the 1980s in which economic phenomena

---

[40] Allan Young, '*The Harmony of Illusions: Inventing Post-traumatic Stress Disorder*' (Princeton University Press: 1995), p.94.

[41] Ong, *Buddha is Hiding,* p.98.

[42] Ong, *Buddha is Hiding,* p.102.

[43] Ong, *Buddha is Hiding,* p.102.

[44] Ong, *Buddha is Hiding,* p.103

[45] Ong, *Buddha is Hiding,* p.104.

and poverty were individualized and repackaged as individual problems amenable to a psychiatric solution.[46]

This universalist approach did not go unchallenged. Psychiatrist and anthropologist Arthur Kleinman attacked it in a seminal 1977 article titled 'Depression, somatisation and the "new cross-cultural psychiatry"', in which he argued that it was not disease entities that were being compared in cross-cultural comparisons, but culturally determined explanations.[47] The main failing of the 'old transcultural psychiatry', he wrote, was 'its total reliance on external, Western psychiatric categories which are applied by clinicians and epidemiologists as if they were "independent" of cultural bias, but which in fact are culture specific categories'. The 'new cross-cultural psychiatry' he called for would have new methodological foundations in medical anthropology, and Kleinman encouraged psychiatry to 'learn from anthropology that culture does considerably more than shape illness as experience; it shapes the very way we conceive illness'.[48] According to Emmanuel Delille, Kleinman's intervention identified the 'residues of colonial medicine' in the unilateral application of epidemiological categories developed in the West to non-Western populations.[49]

Improvisational mental health relief efforts in Southeast Asian camps

The concerns about resettled refugees having difficulty adapting to their new environment and suffering mental health problems filtered back to refugee camps in Southeast Asia, where many refugees were destined for resettlement. In 1981, David Drucker, a mental health consultant with UNHCR and the Sovereign Order of Malta (SOM) in Thailand, echoed Jackie Bong Wright's warning in the *Post* about refugees harbouring a latent 'time bomb'. In a report on the 'mental health component of a programme of assistance to Indochina refugees in Thailand', he referred to the 'dangerously dammed up disturbance' which constituted 'a massive "at-risk" incidence in

---

[46] Joanna Moncrieff, 'Neoliberalism and biopsychiatry: a marriage of convenience', in Carl I. Cohen and Sami Timimi (eds.), *Liberatory Psychiatry: Philosophy, Politics, and Mental Health* (Cambridge University Press: 2008), pp.235-255.

[47] Kleinman, 'Depression, somatization and the "new cross-cultural psychiatry"'

[48] Kleinman, 'Depression, somatization and the "new cross-cultural psychiatry"', p.4.

[49] Emmanuel Delille, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry Research Unit after World War II', *History of psychiatry,* 29(3)(2018), p.292.

the camp population' and was 'the latent explosive in the so-called "psychological time bomb" that is being experienced and reported in the receiving countries and the professional literature'.[50] In 1984, this sense of urgency was echoed again by another mental health consultant, Steven Muncy, the director of a Philippines based NGO providing social and mental health services in camps, Community Mental Health and Family Services (CMHS). He warned, after visiting various camps in Thailand, that 'the seriousness of the mental health situation at Phanat Nikhom [camp] should not be overlooked', for 'everything seem[ed] to indicate an emotional climate of a most explosive nature'. If appropriate action was not taken soon, it was 'quite possible violent and/or seriously problematic behaviours, both on an individual or group basis, [would] result'.[51] It was in this context that a regime of psychiatric screening existed in transit camps for the purpose of weeding out those with mental illnesses that were deemed a threat or burden to countries of resettlement. According to the Director of Refugee Health Services of the United States Public Health Service, 'the priority area to be addressed for resettling Indochinese refugees was their mental health needs'.[52]

In the early 1980s, mental health service delivery in the camps in Thailand was poorly coordinated and disjointed, as Dr. Rangaraj, a senior health coordinator with UNHCR, remarked at a workshop in Bangkok in 1982.[53] David Drucker described mental health and emotional disturbances as a 'not-anyone's-specific-responsibility situation', that needed good coordination and communication between different actors and agencies.[54] It was not even obvious to what extent a problem existed or what sort of mental health services were needed. Dr. Rangaraj lamented that no screening or surveys had been carried out 'to find out, or assess the nature of the psychiatric disorders, if they exist', and that nothing had been done to train relief workers in this field.[55] Drucker commented that it

---

[50] United Nations Geneva Library, UNHCR Collection, CDR HEA/MEN/26 D, 'Recommendations related to the mental health component of a programme of assistance to the Indo-China refugees in Thailand', David Drucker, 14 October 1981, p.5.

[51] UNHCR Archives, Assistance - Mental Health, Report on Thailand Mission, Steven Muncy, 12 April 1984, p.7.

[52] UNHCR Archives, Assistance - Mental Health, 'Note for the File, Status of Mental Health Services in Phanat Nikhom', Ailsa Holloway, 11 June 1984, p.3.

[53] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', Address by Dr. Rangaraj, UNHCR Senior Health Coordinator, Feb 1982, p.2.

[54] Drucker, 'Recommendations related to the mental health component', p.9.

[55] Rangaraj, Address to 'Mental Health in the Primary Health Care Setting Workshop', p.1.

was not clear what to make of the 'consistently reported impression that the incidence of psychiatric illness and emotional disorder in the refugee camps is on the increase', speculating that it could simply be a function of higher demand following introduction of services by SOM, a consequence of greater diagnosis by doctors after the emergency relief phase had passed, a greater number of people "breaking down", or the effects of prolonged living in a refugee camp'.[56]

In this context, relief workers had much leeway to improvise and experiment in the area of mental health. How they acted was based on their assumptions, orientations, backgrounds, and own understandings of refugees' needs. Some were inclined to use medications, others talking therapies, and still others would try to pragmatically address the source of a refugee's distress, if that was possible. Some tried to get refugees to talk about traumatic experiences they had been through, or at least expected them to do so. Some would encourage refugees to speak about whatever they felt like in an atmosphere of empathy. Many strove to help refugees identify coping mechanisms they could rely on, or orient them towards available services that could help them, or encourage them to take part in activities that could make them feel productive and overcome what they saw as refugees' apathy and idleness. Ultimately they were open to trying whatever they thought could bring about a modest improvement in their patients' situations, or referring them to others when their own efforts fell short.

Of the mental health issues encountered by relief workers in the refugee camps, anxiety seems to have been one of the most common. One cause, Drucker suggested, was 'the lack of flow of authoritative information which is available to the refugees', allowing rumours to 'fill the vacuum'.[57] One suggestion by Drucker, that does not seem to have materialized, was to set up a 'do-it-yourself information facility to disperse some of the tensions and generalised anxiety in the camps', that would be staffed by refugees who would be trained to be 'information workers' and who would regularly meet NGO personnel and relay common questions to them, such as about available resources within

---

[56] Drucker, 'Recommendations related to the mental health component', p.4.

[57] UN Geneva Library, UNHCR Collection, CDR HEA/MEN/26 D, 'Recommendations related to the mental health component of a programme of assistance to the Indo-China refugees in Thailand' - Attachment: 'A do-it-yourself information facility to disperse some of the tensions and generalised anxiety in the refugee camps', p.2.

the camp.[58] A record of all questions asked by refugees would be kept that would eventually build up a 'card index resource' from which information could be looked up when needed.[59] In a best case scenario, such a facility would come to be 'thought of as "a friendly place where our own kind will help us find out what we need to know"', but also, for the relief workers, 'a source for keeping one's finger on the pulse of what is currently of concern to them'.[60] Another suggestion for disseminating information to help orient the refugees was to organise regular tours of the refugee camp, 'maybe with a few picture leaflets just like any tourist agency might provide'.[61] Robin Ray, a psychiatric nurse with the American Refugee Committee (ARC) in Phanat Nikhom found that a common source of anxiety for her patients was lack of information about their resettlement status: 'Perhaps they have been waiting in the camp for a long time and do not know why; or do not understand the whole business of applications, waiting, interviews and so forth'. 'A very simple solution' that relieved a lot of anxiety, she claimed, was to find out 'what [was] taking so long'.[62] If the anxiety was of a 'tremendously overwhelming' nature, a psychiatrist told the workshop audience in 1982, 'Valium, Librium, Oxazepam', anti-anxiety drugs, could be used temporarily to relieve symptoms.[63]

Apart from cases where anxiety was related to the lack of some specific information or guidance about services, however, there was very little that could be done for anxious refugees apart from providing some psychological and emotional support till the anxiety temporarily subsided. Miriam Gilday, a relief worker with the International Rescue Committee (IRC), who was a coordinator of medical training at Khao-I-Dang camp, spoke of a talking therapeutic technique she used called 'crisis intervention' for a

---

[58] Drucker, 'Recommendations related to the mental health component - A do-it-yourself information facility'.

[59] Drucker, 'Recommendations related to the mental health component - A do-it-yourself information facility', p.2.

[60] Drucker, 'Recommendations related to the mental health component - A do-it-yourself information facility', p.4.

[61] Drucker, 'Recommendations related to the mental health component - A do-it-yourself information facility', p.3.

[62] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', 'Address by Robin Ray, RN, Psychiatric Nurse/ARC, Phanat Nikhom Transit Centre', Feb 1982, p.3.

[63] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', 'Address by Dr. James S. Eaton Jr., MD, Chief, Psychiatry Education Branch, National Institute of Mental Health (USA)', Feb 1982, p.2. Dr. Eaton was also the chairman of the workshop.

variety of issues that she saw as 'not mental illness…but a kind of normal response to overwhelming stress': 'anxiety related problems, anxiety attacks, different somatic complaints, family problems and a lot of suicide attempts'.[64] She would listen to patients, try to put the issues or events they described in order, help them identify resources and make a plan of action, and then follow them up. None of this was to ultimately relieve stress: 'we cannot actually remove the stresses', she said. 'The people themselves cannot remove the stresses. They have to live with them'.[65] In many situations, she continued, 'we cannot do anything about them anyway - in a curative way'. The goal of this approach was to 'take away the feeling of being overwhelmed and get him [the refugee] back in control', and to 'mobilize the person's ability to cope with his situation', so that they could 'learn to live with it'.[66]

Gilday recounted a case with whom she had successfully used this approach, a 37 year old woman who presented to the admissions ward in a state of anxiety. A physical examination found no problems - though she was convinced she had heart disease - and since she was complaining of feeling weak and tired, she was sent home with vitamins. Gilday paid her a visit at home where she observed her 'lying on her bed, and she really looked quite sick'. Through the steps of the crisis intervention technique, her patient eventually spoke of all the stresses she had been under for many years, such as the death of her husband and parents, murder of her child, and responsibility to support seven children and three younger siblings. By the end, 'she became aware of her own problems' and 'started to laugh' about all the stresses she was under, and about how 'of course she was in a state of collapse because all of this'. Gilday reported her 'looking physically much better' just by helping to see her situation 'in better perspective'.[67]

Suicide attempts presented another problem to which there were varied responses. Robin Ray said that a depressed patient could be reached before a 'suicide attempt or gesture', though this was not always possible. In any doubt about the safety of a suicidal patient, where there were no friends or relatives to whom their care could be entrusted, the

---

[64] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', 'Address by Ms. Miriam Gilday, MSN/IRC, Coordinator of Medical Training, Khao-I-Dang', Feb 1982, p.1.

[65] Gilday, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.1.

[66] Gilday, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.2.

[67] Gilday, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.4.

safer option was hospitalization. It is reasonable to assume that placing them in the care of friends or relatives was the preferred option since this avoided the consequences that a psychiatric hospitalisation could have on resettlement chances. Sometimes, antipsychotic drugs were prescribed if the suicidal patient showed signs of psychosis. Ray was not above sending her patients to the *Krou Khmer,* Cambodian Buddhist monks versed in the indigenous healing methods, if they were 'difficult' to deal with and 'get very far with'.[68]

Brenda Grimwade, a coordinator of social work services with World Vision Foundation Thailand (WVFT), perceived the mental health problems she saw to be clustered around depression, about either the past (for example, holidays, weddings and anniversaries would trigger memories of lost family members), the present (confinement in the camp bred a feeling of isolation from the outside world) or the future ('what is going to happen to us?'), all 'reactive depression brought about in the main by circumstances beyond their control'.[69] She was also an advocate of talk therapy, but very much against 'encouraging people to relive the terrible things that had happened to them' and reviving 'memories so close in time to traumatic events', an 'extremely manipulative' practice she often observed with newly appointed relief workers coming to work in the camps. In her view, this was only permissible if it was at the refugee's instigation. Rather, she advocated active, empathetic listening, picking up on cues provided by her patients until they would themselves bring up a particular event or memory that was the cause of some of their troubles. For example, one refugee woman took note of someone's wristwatch that had an alarm on the hour, and this reminded her about a clock she had in Phnom Penh which chimed on the hour and which she was forced to sell to buy rice for her sick son who could not eat corn, the only food provided by the Khmer Rouge, and who eventually died of malnutrition.[70]

Ray, when confronted with a depressed refugee ('whenever I think of how terrible things were under Pol Pot, I feel so sad that all I do is sit in my house all day, and smoke cigarettes or sleep'[71]), believed there was value in letting a refugee know that 'it is

---

[68] Ray, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.3.

[69] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', Address by Ms. Brenda Grimwade, Coordinator of Social Work Services/WVFT/Bankaeng, Feb 1982, Address to 'Mental Health in Primary Health Care Setting Workshop', p.2.

[70] Ray, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.3.

[71] Ray, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.3.

appropriate to feel sad about what has happened to him…let him know that it is okay to cry and talk about his feelings'.[72] A supportive environment and 'assistance in dealing with the here and now', and distinguishing between what a refugee could do nothing about, and those things one had some control over, were also therapeutic techniques. To help the refugee overcome the feeling of being 'non productive and useless', which was recognised as a negative effect of camp life, she recommended encouraging them to participate in activities, such as learning a skill, getting a part time job in the camp, taking classes, going to the library, and cultural and recreational activities.[73] Finally, the more medically inclined had the option of prescribing tricyclic antidepressants, and a psychiatrist told his colleagues that even electroconvulsive therapy in a provincial hospital for resistant cases should not be discounted as a possibility.[74]

Transcultural psychiatry and the Traditional Medicine Centres

Among all these piecemeal, improvisational approaches, one effort at providing mental health care stands out from among the rest. The treatment strategies described above were all based on Western systems of knowledge. The only approach that attempted to relativise Western knowledge, and the most significant and systematic of the mental health programs in the border camps, was that of the Traditional Medicine Centres.set up by the International Committee of the Red Cross (ICRC) in the Cambodian border camps. Here, the bulk of health care was provided by *Krou Khmer* (literally, 'teacher of the Khmer') with Western staff assuming an organisational and administrative role. The *Krou* were themselves refugees. The TMCs were the brainchild of Jean-Pierre Hiegel, a French psychiatrist and psychoanalyst with an interest in transcultural psychiatry. Hiegel's conceptualisation of culture was very much in tune with Arthur Kleinman's 'new cross-cultural psychiatry'. Hiegel believed that Western medicine had turned physicians 'into technicians for the restitution of the organ's functions while disregarding the fundamental human oneness'. These established ways of thinking, he wrote, 'could be adequate in university hospitals but [were] unrealistic when directly transposed in another context'.[75]

---

[72] Ray, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.3.

[73] Ray, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.3.

[74] Eaton, Address to 'Mental Health in the Primary Health Care Setting Workshop', p.5.

[75] University of Melbourne Archives (hereafter UoM Archives), Australian Red Cross (hereafter ARC) International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1),

He was also a critic of the application of Western psychiatric diagnoses to refugee patients. In a 1982 workshop in Bangkok on refugees and mental health, he told participants

> Symptoms, attitudes and behaviours of people are of course the expression of psychological suffering. But they are also relevant, to a certain extent, to social codes which differ from one culture to another. That is why we can easily make a wrong diagnosis with people belonging to another culture. A wrong diagnosis may lead to inappropriate treatments but a diagnosis is also a prognostication, i.e., that, more or less consciously, we make our opinion about what the future of the patient will be. In some cases this may be detrimental for the patient. I do not mean that a diagnosis in psychiatry is useless but that it is a serious matter. Sometimes it is better to describe what we can hear and observe, rather than making a diagnosis.[76]

Among the medical services provided by ICRC and local Red Cross Societies in Cambodian border camps, there were no formal mental health services or programs in the way that there were paediatric and obstetric services, or vaccination and nutrition programs. Hiegel, tasked with responding to the suggestion of some doctors in refugee camp hospitals that a psychiatric service be set up to help refugees with mental health issues, thought it more appropriate and beneficial if such services were provided according to local and indigenous healing methods of the Khmer culture, by the *Krou Khmer*, rather than through psychiatry as practiced in the West.[77] Hiegel's position with the ICRC in Thailand was that of medical coordinator for traditional medicine, an unusual area for ICRC medical humanitarian relief work.[78]

In a March 1980 internal report for ICRC, written partly to address the skepticism of Western staff about working with practitioners of 'traditional medicine', Hiegel illustrated the utility of this approach through the case of Vicheka, an 8 year old

---

'The Role of Traditional Medicine in Relief Operations, Introduction to Khmer Traditional Medicine based on Experience in the Refugee Camps in Thailand, Jean-Pierre Hiegel, Mar 1980, p.1.

[76] UNHCR Archives, Assistance - Mental Health, 'Mental Health in the Primary Health Care Setting Workshop', Address by Dr J.P. Hiegel, MD, Neuropsychiatrist-Psychoanalyst/Coordinator of Traditional Medicine Centres/SOM/Khao-I-Dang, Ban Kaeng, Kamput', 'Psychological Needs of Refugees, Western Psychiatric Care and Kru Khmer's Approach to the Problems, Caring Role of Traditional Medicine Centres in the Khmer Holding Camps, Feb 1982, pp 5-6.

[77] Jean-Pierre Hiegel, 'The ICRC and traditional Khmer medicine', *International Review of the Red Cross Archive*, 21(224)(1981), pp.251-252.

[78] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel.

Cambodian boy and refugee in the border camp of Sa Kaeo. Vicheka was considered by his mother a problem child, and she was ready to abandon him. Separated at the age of three from his father, who used to take care of him, he engaged in aggressive and destructive behaviour, would destroy what few belongings his family possessed, and often was aggressive to his mother and two younger brothers. He frequently tried to escape from his mother's shelter, not wanting to stay with her.[79] Soon after arriving in Thailand, Vicheka's mother took him to an unaccompanied minors centre with the intention of abandoning him, though it is not clear why she did not end up doing so. Eventually, Vicheka came to the attention of personnel at Traditional Medicine Centre at Sa Kaeo camp.

At the TMC, several methods were tried to treat him, but without success. One *Krou Khmer* ordered a fifteen day separation of boy and mother during which time lustral water was provided to the boy.[80] After these fifteen days, a member of the 'mental health unit' accompanied Vicheka to his mother's shelter every day and engaged in a form of talk therapy. Psychological issues such as Vicheka's jealousy of his brothers and his separation from his father were addressed, but with little success. At this point the *Krou Khmer* asked for a young banana tree. He fixed incense sticks, candles and nuts to its upper part, and tied the whole figure with white thread. This figure was a '*Sla Thor'*, which symbolised the child's body. This intervention was based on information about Vicheka's 'obstetric' history: he was born with his umbilical cord circling his neck, a condition which can affect the newborn's breathing and cause neonatal asphyxia, depriving the brain of oxygen and potentially causing brain damage. Indigenous beliefs dictated that a child born with its umbilical cord circling the neck (or being born en caul, inside the amniotic sac) was predestined with a 'double sign': on the one hand, the child would have a skin impervious to wounds if a certain rite was respected, and on the other, the child would be madness and headache prone if the rite was not respected. This rite was the making of the aforementioned *Sla Thor*, and placing it next to the figure of the Buddha. This rite was to be performed in childhood and adulthood whenever psychological problems arose. The *Sla Thor* made for Vicheka was left where he lived. The next morning, his behaviour reverted

[79] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, Mar 1980, p.13.

[80] 'Lustral water' is holy water. Incidentally, Lustral is also the trade name of the antidepressant sertraline, marketed by Pfizer.

to one that was ‘perfectly normal’, and he was smiling and happily staying with his family.[81]

There were, Hiegel said, many interpretations for Vicheka’s symptoms and recovery to satisfy physicians of various orientations: organicists could point to cerebral injury at birth as a consequence of asphyxiation from the encircled umbilical cord as the cause of his behaviour, psychoanalysts could point to the boy’s separation from his father at the Oedipal stage as the cause of psychopathology, and those who favoured the unconscious processes and conflicts of psychodynamic explanations could point to the change in family dynamics that was made possible only with the construction of the Sla Thor as the cause of improvement.[82] The alternative explanation, more familiar to the *Krou* and Vicheka’s mother, was that of spirit possession. The recovery, in the local cultural context, was due to pacification of the child’s *Krou Komneut* (guardian angel) with the offering of the Sla Thor. Whatever the causes of Vicheka’s behavioural disturbances and his recovery, it was clear that until the making and offering of the Sla Thor, ‘the child was regarded as being insane and possessed by those around him, and he was unconsciously playing this role because of a cultural determinism’, with nothing being expected from him but maintaining the role attributed to him by his family.[83] Other psychological mechanisms also came into play, allowing Vicheka ‘to feel that he was loved by his mother and to show her his affection’. This, in turn ‘helped the mother to give him the signs of her love he was expecting’. To Hiegel, this was an example of a local therapeutic method that was ‘efficient when linked to the culture of the person and of the social group’.[84]

To Hiegel, the mental health needs of the Khmer were not best served by Western medicine and psychiatry, systems of knowledge elaborated outside their local belief system and which did not acknowledge the supernatural, making them ‘not only foreign but

---

[81] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.13.

[82] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.13.

[83] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.13.

[84] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.14.

strange' to the Khmer.[85] The diagnostic criteria of Western psychiatry were inadequate for the Khmer culture, he observed, and there had been cases of Khmer patients being misdiagnosed with psychosis or schizophrenia by Western doctors 'who analysed the symptoms according to their own criteria'. Some of these patients, however, were actually suffering from painful organic diseases without directly complaining about it. Others were indeed suffering psychologically, but to them, 'only a spirit could be responsible', an opinion reinforced by other Khmers who would avoid them for fear of being possessed as well. Symptoms in these cases were both 'the expression of a somatic or psychological pain' as well as part of the relationship between the affected person and their community. This relationship would only be restored when all were convinced that the spirit had departed, and that could only be effected by 'by the one who has the power to do so and knows the ways according to the culture concerned. Only a traditional healer was 'in the position of being able to satisfy the causality need of the man who comes to him because he speaks a significant language which is rooted in the common cultural background'.[86] Western doctors wishing to work with the Khmer therefore had to 'enter a transcultural field and give credence to a kind of medicine which does not come under the usual scientific discourse'.[87]

Hiegel's philosophy is well illustrated in the following case studies he recounted at a Bangkok workshop on refugees and mental health. In the case of psychosis, such as schizophrenia, he said 'We cannot be too ambitious with refugees suffering from schizophrenia', and have 'to be careful in cutting down their delusion, if they can get nothing to replace it'. His modest aim in the camps was to promote a social recovery, allowing a refugee to have 'normal behaviour among other refugees'. If even that was not possible, his aim was 'just to accept, that they remain "*tchkuot'*" ('tchkuot' is the Khmer word for mad).[88] Two cases of schizophrenia recounted by Hiegel show how these ideas were translated in practice. In the first case, he went, accompanied by a *Krou,* to a Thai military prison to visit a Khmer who was *tchkuot* and had been detained after he was found

---

[85] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.3.

[86] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.3.

[87] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.2.

[88] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.10..

wandering aimlessly in a Thai border village. The *Krou* declared that his condition could be cured by long term treatment with lustral water (holy water) and magic, and he was released from the jail and taken back to the camp. He found accommodation with a Cambodian midwife who shared her home with him, and employment at the Traditional Medicine Centre. His work was irregular, but he was 'able to establish social relationships' and could be said to have achieved a social recovery. Hiegel believed that one day, when time came to repatriate, the midwife would take this man with her, where he would live with her family in a village in Cambodia.[89] This may have been unduly optimistic, but even if he did not believe this to be the case, it would not have made any difference in the treatment plan. The *Krou* were initially reluctant to work with patients who had chronic schizophrenia, knowing that they would not be able to achieve good results and feared jeopardising their reputation as healers. In this case, antipsychotic medication was useful, helping to reduce psychotic symptoms and thus offering more opportunities to the *Krou* to try to heal them.[90] Even the traditional healers themselves were not averse to using modern Western psychiatric methods if it furthered their ends and seemed to produce an improvement in the condition.

The second case of schizophrenia recounted by Hiegel seemed to have had an even poorer prognosis: a young girl's family had been accepted for resettlement in a third country and left her behind (presumably because her condition disqualified her from resettlement), upon which she became 'withdrawn, incoherent, and occasionally agitated'. For a long time, she stayed in a medical ward before being referred to the Traditional Medicine Centre. Now living with a midwife in the camp who took care of her, she would go to the TMC for treatment by the *Krou.* She did not improve, Hiegel said, 'but what reason would she have to improve? When her withdrawal is not too deep, when she is more coherent, she remembers her family, cries, is sad and depressed. Her withdrawal and delusions protect her from painful feelings and thoughts'. Talking before the audience of the workshop on mental health in Bangkok, Hiegel had no happy ending to this case: 'What will be her destiny? I do not know. A psychiatric hospital, or will she have the right to be "tchkuot", but free, in a village in her country with this midwife…I do not know, but anyway, she has time to enter a psychiatric hospital and end her life there. The

---

[89] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.8.

[90] Jean-Pierre Hiegel, 'Collaboration with Traditional Healers: Experiences in Refugees' Mental Care', *International Journal of Mental Health,* 12(3)(1983), p.34.

schizophrenic drama still exists behind the walls even if we feel more comfortable because we do not see it'.[91]

In cases of attempted suicide, Hiegel believed treatment by the *Krou* offered the best prognosis. When a suicidal patient was referred from the hospital admissions ward to the Traditional Medicine Centre, the *Krou* would speak to them and refer to Buddha's teachings about the respect for life. A shower with lustral water was given to the patient by the *Krou* to help them clear their mind, and the patient would be required to make a promise to the *Krou* to not attempt to take their life again. Hiegel reported that the *Krou* believed this promise to be effective at dissuading a patient from another attempt, because it 'represent[ed] a link with a person that he respects'. In fact, Hiegel declared, 'this promise is actually more effective in preventing further attempts than any other method available to us'.[92] For patients who presented with what psychiatrists would call psychosomatic symptoms - psychological disturbances manifested as somatic pain in the absence of a physical lesion - Hiegel's advice was 'modern medical people should admit, without feeling that they lose their prestige, that they cannot do much for these patients, especially when cultural and linguistic barriers prevent them from providing these patients with an adequate psychological aid. They should encourage them to seek help and treatment from their traditional healers'.[93] He admonished his colleagues to avoid adhering to certain attitudes and ways of healing that were familiar to them, and to 'not forget the patients themselves. They try to find help from various sources. This is understandable. They should always be allowed to make their own choice. They should also be allowed not to make a choice, because some of them cannot choose'.[94]

The rationale for ICRC's involvement in 'traditional medicine' did not stem solely from Jean-Pierre Hiegel's philosophy. There were practical and economic reasons too. The medical team reports of the Australian Red Cross Society (ARCS), which was heavily involved in the administration of the TMCs, suggest that involvement in this area was motivated by considerations of culture, cost, and the fear of creating a dependency on Western aid among the refugees. Margaret Robinson, Chief Nursing Adviser to the ARCs,

---

[91] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.10.
[92] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.8.
[93] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.7.
[94] Hiegel, Address to 'Mental Health in the Primary Health Care Setting Workshop', Feb 1982, p.11.

advised against 'over-medication, especially in regard to mental disorders', for in this particular area it was 'often proved that traditional healers are the most successful in dealing with these disorders'.[95] She also cautioned against 'creating new problems', 'making professional beggars' and offering any interventions that 'are not generally available to the surrounding Thai population'. She also advised 'working closely with the Khmers so as to preserve their health infrastructure, and, ultimately, hand over the health care back to them'.[96] Midwife Anne Margetts described how, during the initial briefing upon arrival in Thailand, she and her colleagues were reminded that 'the refugee camps were a temporary arrangement', that they should 'avoid the use of sophisticated medical equipment that would not be available to the Khmers if and when they would return to Kampuchea', and that they should maintain 'a basic standard regarding the use of drugs and the forms of treatment given'.[97] ARCS nurse Joy Nicholls, who worked at one of the TMCs, wrote that she found 'traditional medicine an effective and most interesting form of medicine which dealt successfully with most of the refugees' medical needs, relating as it does to their cultural beliefs as well as physical illnesses'. This did not mean that modern medicine did not have a place – it was also 'needed in the camps but should be available in a backup capacity rather than as the primary form of medicine. Economics alone justify this'.[98] Laurie Warfe, a ARCS doctor and medical coordinator for one of the border camps, thought it 'worth considering that the automatic assumption that Western medicine is the overall best alternative as a basis for health care in third world countries may not be valid'. A better route, he thought, was to use 'those aspects of Western medicine which are socially and culturally acceptable to the people and which can be best utilized in a practical sense', with attempts made to 'rationalise' the differences between Western and traditional medicine.[99]

---

[95] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), 'Mission to Thailand Nov 79-Feb 80', Margaret L Robinson, Apr 1980, p.7.

[96] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Margaret L Robinson, p. 7.

[97] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), 'Report to ARC Society on 12 week contract (Feb-May 1980) with Australian Medical Team 11 in Khao-I-Dang Holding Centre for Kampuchean Refugees, Anne Marie Margetts, Jan 1981, p. 2.

[98] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), 'Report of 12 Week Assignment in Thailand', Joy Nicholls, Jan 1981, p.1.

[99] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 66, Kampuchea/Thailand Medical Team Reports (2), 'Final Report, Dr Laurie Warfe, ARC Society, Medical Coordinator – Nong Samet', Feb 1981, p.5.

By March 1981, there were Traditional Medicine Centres in the three camps of Sa Kaeo, Kamput and Khao-I-Dang. The first of these was established in Sa Kaeo in February 1980 on an experimental basis, with its success leading to the establishment of other TMCs.[100] Western staff undertook the administration of the Traditional Medicine Centres, in a role was 'more that of organization than medical'.[101] Duties involved procuring supplies and herbs for the clinic, liaison with medical staff of 'western orientated medical centres' whenever it was felt that a patient would be better served by 'modern medicine', training *Krou Khmer* and their helpers to eventually take charge of the clinic, and addressing resistance of some groups, particularly Christian religious groups, to the use of traditional medicine.[102] They also liaised between the TMCs and camp hospitals as patients were referred from one to the other. Many who showed up at the TMCs were referred there by the hospital, for what the Western doctors considered to be psychosomatic problems. ARCS nurse Rosemary Brewin wrote that 'personnel at the hospital have come to realize the value of traditional healing in relation to psychological problems, where delirium is frequently associated with belief of spiritual possession, entrenched in phenomena we cannot pretend to understand'.[103] Liaising with the hospitals also involved *Krou Khmer* going to the hospital at the request of 'volags' (voluntary agencies) to treat patients with psychological problems, or allay fears and anxieties of patients hospitalized for organic diseases. One outcome of working with traditional healers, 'perhaps of greatest value', Brewin thought, was 'the establishment of regular daily visits, by two *Krou Khmers*, to the paediatric ward – this has proved invaluable in many cases where mothers have been unwilling to keep their dangerously ill babies in the much needed care of Western medicine'. The additional treatment offered by the *Krou Khmer* helped to 'quieten the expressed doubts and fears of these Khmers in a relatively unknown environment'.[104] In other cases, *Krou Khmer* accompanied patients who needed

---

[100] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), 'Final Report, Traditional Medicine – Kamput', Rosemary Brewin, Jul 1981, p.1.

[101] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Joy Nicholls, p.1.

[102] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Joy Nicholls, p.1.

[103] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.12.

[104] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.12.

modern medical procedures such as radiological investigations or reduction of a fracture under anaesthesia. Again, their presence would allay fears and anxieties among a people who had a 'fear and distrust of 'modern medicine' and a profound faith in traditional healing'.[105] In Brewin's telling, it seems that one of the main values and uses of traditional medicine and healers was to more effectively manage those refugee patients who needed medical care that they didn't want, understand, or know they needed.

Opposition to the use of traditional medicine, Brewin wrote, ranged from scepticism to accusations of practicing black magic. While the more permanent medical personnel at the centres readily accepted traditional medicine, new arrivals and those on short term contracts viewed it as 'a new, rather 'novel' experience and while indicating a polite interest frequently reveal[ed] their scepticism, invariably with the query 'Does it work?''.[106] The most significant opposition to the use of traditional healing methods came from Christian missionaries and religious groups involved in the relief effort. Conflicts arose because of the different religious beliefs of the Khmer and the humanitarian helpers. ARCS Nurse Anne Carswell singled out the staff of organisations World Vision and Carma as particularly problematic: 'Whilst outwardly they appeared to or said they understood the role of traditional medicine their behaviour certainly did not convey that. There were many problems related to religion, customs and tradition and the only polite way I can sum this up is by asking such people: Whose needs are you here to provide for? Yours? Or the Khmers?'.[107] Those who opposed traditional healing on such religious grounds were motivated by strong evangelistic desires to convert the refugees they helped. Nurse Maureen Neilson noted that at Kamput refugee camp the only literature available in Khmer in the camp was religious literature, and that 'Christian religious instruction was given to unaccompanied minors in the camp'.[108] In Khao-I-Dang camp, many American NGOs were run by church groups whose main task was to find local sponsors for refugees

---

[105] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.15.

[106] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.15.

[107] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 66, Kampuchea/Thailand Medical Team Reports (2), 'Report from ICRC Thailand Operation as a Nurse, Jul-Sep 1980', Anne Carswell, p.2.

[108] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 66, Kampuchea/Thailand Medical Team Reports (2), Report for ARC, Kamput Refugee Camp, Thailand, Nov 1979-Feb 1980, Miss Maureen Neilson, p.2.

who wished to be resettled.[109] Refugees found church workers to be 'less intimidating than other camp officials', and Cambodian refugee women found that by attending church services, they could 'compel different kinds of assistance'. As one refugee told Aihwa Ong, 'when I was in Khao-I-Dang, I went to church. The church people helped us: they gave us things and clothes. I didn't know which church it was, but it was American. They came to help us in our homes, giving us food and clothing. They brought them to our homes. Sometimes they even gave us money'[110]. Hiegel reported how Christian religious groups accused Western staff of the TMCs of practicing black magic, and of seeking to 'force the Khmers to use traditional medicine'. Taking a swipe at zealous Christian missionaries, he wrote in his ICRC report 'It is easy to understand the projective origin of the psychological violence [of] which they accuse us of when we know that they are motivated by a strong missionary desire through their evangelistic activity'.[111] The Khmer belief in the power of certain talismans or tattoos to make one invisible to one's enemies or spirited was, he said, no different to the protective power Christians attribute to certain pious medals or a crucifix.[112]

Opposition was not limited to zealous Christians. Western staff also had problems giving credence to a process that seemed so unfamiliar and 'unscientific'. In Joy Nicholls' words, the medical workings were admittedly a subject that the 'Australian Red Cross had little feedback on'.[113] Rosemary Brewin felt that one of the most difficult aspects of her mission was 'orientating and adjusting oneself' to the unexplored and unfamiliar terrain of traditional medicine, 'an area hitherto exclusively Kampuchean'.[114] She had difficulty reconciling traditional medicine with the 'rational, acceptable Western scientific way' because her own understanding of it was 'extremely limited'.[115] She also complained that

---

[109] Ong, *Buddha is Hiding*, p.52.

[110] Ong, *Buddha is Hiding,* p.62.

[111] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.7.

[112] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Jean-Pierre Hiegel, p.10.

[113] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1), Joy Nicholls, Cover Note.

[114] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.1.

[115] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.5.

the Khmer had a ‘different attitude and approach towards the methodology of working’, which was ‘slower, fatalistic and strongly biased toward an immediate need/supply system as traditionally practiced by the *Krou Khmer* in their native environment’, as opposed to the Western methodology which was ‘governed by our training in organization, expectations of efficiency and an overall longer term viewpoint’.[116] Nurse Mary Perkins commented that the ‘Western work ethic, with its associated demand for organizational skills, hyperefficiency, maximum output, logistics and budgeting’ did not ‘generally feature in the thought process of Cambodians’. Western staff thus had to have ‘the right mental approach to this particular problem in order to avoid personal frustrations and interpersonal tensions’ which could jeopardise the whole working of the TMC.[117] These deeply condescending views illustrate a tension inherent in Western-led projects premised on the notion of ‘cultural sensitivity’. There is an implicit premise of superiority in such sensitivity, requiring the more sensitive agent to stoop down to the level of the recipients’ culture. These comments by Brewin and Perkins are an example of what psychiatrist Suman Fernando calls ‘culturizing the problem of racism’, a common manoeuvre by which psychiatry ‘conceals, defends and maintains racism’ by allowing ‘injustices and disadvantages suffered by…minorities’ to be ‘attributed to *their* culture which causes *them* to distort patterns of illness, to make unreasonable demands, or, to not benefit from treatment’.[118] Accordingly, it is possible to argue that there is little difference between the condescending views of those providing purportedly culturally appropriate care to Cambodians and the racist views encountered in the last chapter that suggested that signs of psychosis were just a manifestation of bizarre African behaviour.

What could have motivated the *Krou Khmer* to agree to participate in such an arrangement? Almost nothing is written about how the *Krou* were persuaded to practice their medicine in the open among Western staff in Traditional Medicine Centres established and administered by ICRC. None of the *Krou* are even mentioned by name. This absence of refugee voices is not limited to the *Krou*. As Peter Gatrell has written, the voices of Cambodian refugees are ‘mostly hidden from history, except insofar as they

---

[116] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.13.

[117] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), ‘Final Report: Leaving Report Combined with a Six Months Summary of Work Within the Traditional Medicine Center, KID, by Mary Perkins to J-P Hiegel, July 1981, p.1.

[118] Suman Fernando, *Mental Health, Race and Culture* (Palgrave: 2002), p.123.

emerge in the record of relief organisations'.[119] The impression from the archive is that the *Krou* were ready, eager, and willing participants in the efforts of a Western humanitarian medical organisation to integrate their healing methods alongside modern medicine, with a few reservations and anxieties that were allayed and overcome to produce a successful program, thanks to the 'personal qualities, the motivation and courage of those [at ICRC] who ha[d] participated from the start' in this effort.[120] Hiegel offered his own view of why the *Krou* were motivated to collaborate and 'not to guard their knowledge jealously for themselves, but to pool it'[121].

The *Krou* were concerned about the risks of collaborating with Westerners and practicing their medicine in their full view and under their administration, especially with a camp hospital nearby that offered modern, Western care. This was, Hiegel wrote, a 'new situation for the *Krou*, accustomed as they [were] to practicing as individuals'.[122] It exposed them to the criticism and scepticism of Western doctors and nurses, many of whom condemned traditional medicine 'without trial'.[123] The *Krou* ran the risk of being undermined and their reputations as healers damaged if they were forced to compete with the technologies and techniques of Western medicine, something they were acutely aware of: 'The traditional healers were uneasy in the beginning and hesitant to join in the project. They realized that there were certain risks involved in practicing their medicine in broad daylight among the many Western doctors and nurses present in the camps'.[124] In Hiegel's telling, the ICRC, sensitive to this issue, strove to 'understand and respect the spirit of traditional medicine as far as possible',[125] assuring the *Krou* that they were 'convinced of the value of their medicine'[126] and making sure that it was a program of cooperation rather than competition, where Western and traditional Khmer medicine were 'complementary

---

[119] Gatrell, *The making of the modern refugee*, p.205.
[120] Hiegel, 'The ICRC and traditional Khmer medicine', p.254.
[121] Hiegel, 'The ICRC and traditional Khmer medicine', p. 255
[122] Hiegel, 'The ICRC and traditional Khmer medicine', p.255.
[123] Hiegel, 'The ICRC and traditional Khmer medicine', p.254.
[124] Hiegel, 'The ICRC and traditional Khmer medicine', p.257.
[125] Hiegel, 'The ICRC and traditional Khmer medicine', p.256.
[126] Hiegel, 'The ICRC and traditional Khmer medicine', p.257.

and not competitive'.[127] As if trying to prove their sincerity, Western doctors did not supervise the *Krou*, and traditional and Western medical treatment were given in separate locations.[128] Patients were not examined by a Western doctor either before or after their consultation with the *Krou*, for this would have indicated a lack of confidence in the *Krou*, which in turn would have undermined the patient's sense of security.[129] These measures, however, could not have been very effective: Rosemary Brewin reported that despite efforts by Western staff to assume a secondary role, many *Krou* would often stand back and let the doctors take over, which she interpreted as a feeling of inferiority on the part of the *Krou*.[130] Clearly the *Krou* were not blind to her impression of them as having a slow, fatalistic, thought process.

In addition to 'safeguard[ing] the good reputation of their medicine', Hiegel wrote, the *Krou* also felt that they were 'working to help other refugees' and 'to preserve part of their cultural heritage. Therein lies their commitment to cooperation with ICRC'.[131] Hiegel believed that the work of the *Krou* at the TMCs gave them 'a means of affirming their personal merits, which in turn helps them to endure their situation'.[132] He felt that it was useful for the *Krou* to 'have an ideal' to work towards, since being a refugee dependent on aid put them in a 'humiliating and demoralizing situation'.[133] The *Krou* were in need of such affirmation and an ideal, because, being themselves refugees, 'it was naive to think that…they could easily function alone, as they used to in their natural setting'.[134] Once again, he had no doubt about who was responsible and able to help sustain this ideal, or restore it 'when it is gradually fading': the personal qualities, attitudes and motivation of ICRC staff at the TMCs.[135]

---

[127] Hiegel, 'The ICRC and traditional Khmer medicine', p.257.

[128] Hiegel, 'The ICRC and traditional Khmer medicine', p.257.

[129] Hiegel, 'The ICRC and traditional Khmer medicine', p.255-6.

[130] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.16.

[131] Hiegel, 'The ICRC and traditional Khmer medicine', pp.257-258.

[132] Hiegel, 'The ICRC and traditional Khmer medicine', p.258.

[133] Hiegel, 'The ICRC and traditional Khmer medicine', p.257.

[134] Hiegel, 'Psychosocial and mental health needs of refugees – experience from SE Asia', *Tropical doctor*, *21,* (supplement 1), (1991), p.66

[135] Hiegel, 'The ICRC and traditional Khmer medicine', p.258.

Sometimes 'collaborating' with the *Krou* meant intervening and overriding their authority, such as when it was believed that a patient would be better served by lifesaving drugs or treatment at a hospital (such as for cerebral malaria, eye conditions, fractures, and cases complicated by peritonitis). In such cases, Western staff cautioned that if harm or death befell such a patient, it would constitute a reputational blow to the *Krou* and their medicine.[136] Mary Perkins wrote that part of their role in the TMCs was to ensure that the centres and the *Krou Khmer* sustained a good reputation.[137] In practice this meant that TMCs regulated the *Krou Khmer* and the provision of traditional medicinal services, and it was stressed that traditional medicine should be practiced only through the *Krou* at the centres, who were genuine, and not by anyone else in the camp practicing independently. Brewin wrote that in the infrequent cases where hospital personnel complained to her about patients who had 'undergone traditional healing to their detriment', investigations would reveal that the healing had been done by an independent practitioner in the camp, and not the *Krou* at the TMC.[138] These limits, Hiegel wrote, were justified to the *Krou* by explaining to them that he and the rest of the Western staff were concerned for them and their reputation as well as for their patients, and emphasising that this did not reflect a lack of confidence in them.[139] Given the opposition of some Western personnel to the very idea of using traditional medicine, it is also (or more) plausible that Hiegel was concerned about his own reputation as the ICRC coordinator for traditional medicine. The limits put on the *Krou*, and his qualification of ICRC's commitment to understanding and respecting traditional medicine with the words 'as far as possible'[140], show that there were indeed situations when it was not possible or pragmatic to respect it, if it conflicted with the larger structure of Western, conventional medicine with which it was supposed to conform.

Didier Fassin has commented on how this 'formalization of "traditional" healing transforms the characteristic authority of healers into routinised 'status'' attested by a

---

[136] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.15.

[137] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Mary Perkins, p.9.

[138] UoM Archives, ARC International Project Files, 2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3), Rosemary Brewin, p.4.

[139] Hiegel, 'The ICRC and traditional Khmer medicine', p.257

[140] Hiegel, 'The ICRC and traditional Khmer medicine', p.256.

higher authority.[141] More than a collaboration between equals, as Hiegel sought to present it, the TMCs were an appropriation of indigenous Khmer medicine by Western medical practice, a process complicated by what Alice Bullard describes as 'hijacking "tradition" from its own meanings and agendas to those of Western bio-medicine', and which 'deliberately appropriates' traditional methods to effect healing. This collaboration 'does not participate fully in the rituals and beliefs of the healers', and 'the healers' art is instrumentalized and shorn of its much deeper meanings and broader repercussions' and their role 'as a mediator of social tensions is especially attenuated in Western medical practice that locates disease within an individual body'.[142] Bullard has observed that during the transition from colonial to transcultural psychiatry, the incorporation of traditional healers and the building a body of knowledge on their methods involved 'a problematic project of determining what constitutes tradition and who can claim to speak for it'.[143] That was certainly the case here: it is striking that in the archival documents I consulted for this chapter, there is no mention of what Cambodian refugees, including the *Krou,* thought of this collaboration. Like the strategic use of 'cultural sensitivity' to win patients cooperation that Ong described in refugee clinics in California, a similar strategy was in operation in the TMCs. Tradition was supervised, regulated, and demarcated by the superior authority of Western medicine.

By the middle of 1981 the TMCs administration was handed over from ICRC to the Sovereign Order of Malta, which ran them for the rest of the decade. When a team of mental health practitioners led by Dr Richard Mollica, founder of the Harvard Program in Refugee Trauma, arrived on the Thai-Cambodian border in late 1988 to conduct a mental health survey, they found the capacity of traditional healing systems to respond to what they termed a 'mental health crisis' in the border camps fragmented and lacking.

The birth of 'refugee trauma'

In the end, it was not anthropologically informed approaches such as Hiegel's that captured the imagination of humanitarian organisations, but the concept of trauma. The

---

[141] Didier Fassin, *Les enjeux politiques de la santé: études sénégalaises, équatoriennes et françaises* (Karthala Editions: 2000), p.93; Quoted in Bullard, 'Imperial Networks and Postcolonial Independence', p.209.

[142] Bullard, 'Imperial Networks and Postcolonial Independence', p.207.

[143] Bullard, 'Imperial Networks and Postcolonial Independence', p.208.

story of how trauma came to become the primary framework for conceptualising refugee mental health begins not in Southeast Asia, but in the United States. When Indochinese refugees began arriving in the US in the late 1970s, the notion of 'trauma' was available and at hand for clinicians to deploy and develop with resettled refugees. It was an opportune moment: the new diagnosis of post-traumatic stress disorder (PTSD) had recently come into being in 1980. PTSD has been heralded as ushering in the 'modern era of research in the refugee field, the first studies being conducted amongst Southeast Asian refugees'. The 'formative period of the refugee mental health field', identified by Silove, Ventevogel and Rees as 'broadly the 1970s to 2000', began with the arrival of Southeast Asian refugees in the West who were designated as traumatised by clinicians.[144]

A discourse of refugee trauma and victimisation was enabled, and legitimated, because of contemporary developments in the US and Western Europe that created the moral, social, and political climate that allowed the diagnosis of PTSD to come into being in 1980. This climate was a product of a confluence of circumstances and political movements that, together, joined forces to make 'trauma' an unassailable moral category. These were the legacy of the Vietnam War with its psychically wounded US servicemen and the anti-war movement; the feminist movement of the 1970s and the political advocacy for a recognition of rape and sexual abuse as trauma, and the traumatic legacy of the Holocaust personified in second generation survivors.[145] Psychiatrist Patrick Bracken, who worked in early 1990s in Uganda with the Medical Foundation for the Care of Victims of Torture (now Freedom From Torture), wrote in 2002 that 'many of the people who are currently involved in PTSD research and treatment have a background in the feminist, anti-war and human rights struggles of the past few decades. Often their involvement in the science of trauma stems from an effort to provide legitimacy to political struggles'.[146]

Despite modifications to the diagnostic criteria of PTSD in subsequent revisions and editions of the DSM, 'the characteristic symptoms of PTSD are now widely accepted as defining the essential elements of human reactions to trauma'. There is a 'consensus

---

[144] Derrick Silove, Peter Ventevogel, and Susan Rees, 'The contemporary refugee crisis: an overview of mental health challenges', *World Psychiatry,* 16(2)(2017), pp.131,133.

[145] Fassin and Rechtman, *The Empire of Trauma*.

[146] Patrick Bracken, *Trauma: Culture, Meaning and Philosophy* (Whurr Publishers: 2002), p.64.

about the formulation of post-traumatic reactions in terms of intrusive, constrictive, and hyperarousal symptoms', which are held to be universal, seen in children as well as adults, and are 'expressive of conflicts and disturbances happening within individual minds'.[147] Didier Fassin and Richard Rechtman have argued that in the formulation of trauma as PTSD, trauma had not undergone any semiological modification since it first appeared a century earlier as traumatic neurosis, but what had changed were social sensibilities that meant society was more willing to listen to the experience of the victim, whose trauma became simultaneously witness to the cruel inhumanity suffered at the hands of perpetrators, and proof that a vestige of humanity still existed in the victim.[148]

For psychiatrist Judith Herman, it was the 'moral legitimacy of the anti-war movement and the national experience of defeat in a discredited war [that] had made it possible to recognise psychological trauma as a lasting and inevitable legacy of war', allowing it to become 'for the first time…a "real" diagnosis'. The 1970s had witnessed the proliferation of hundreds of veterans' groups that, with anti-war activists, put political pressure on the Veterans Administration (VA) to take the trauma of servicemen seriously. Consistent pressure of veterans organisations provided the impetus for the VA to undertake systematic psychiatric research, and after the war the VA commissioned studies into the effect of combat on returning veterans. This led to a five-volume study that 'delineated the syndrome of post-traumatic stress disorder and demonstrated beyond any reasonable doubt its direct relationship to combat exposure'.[149] Allan Young has analysed this historical episode more critically, and argued that PTSD was not waiting to be discovered or recognized, but created, in a particular historical moment and according to a particular moral and political agenda: '…the advocates were able to make a compelling moral argument for PTSD…The failure to make a place for PTSD would be equivalent to blaming the victim for his misfortunes…It would mean denying medical care and compensation to men who had been obliged or induced to sacrifice their youths in a dirty and meaningless war. Acknowledging PTSD would be a small step toward repaying a debt'.[150] For Young, PTSD 'is not timeless, nor does it possess an intrinsic unity. Rather, it

---

[147] Bracken, *Trauma: Culture, Meaning and Philosophy,* p.49.

[148] Fassin and Rechtman, *The Empire of Trauma.*

[149] Judith Herman, *Trauma and Recovery: The Aftermath of Violence - from Domestic Abuse to Political Terror* (Basic Books: 1992), p.56.

[150] Allan Young, *The Harmony of Illusions; Inventing Post-traumatic Stress Disorder* (Princeton University Press: 1995), p114.

is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources'.[151]

Contemporaneous with the anti-war movements in the US, on the other side of the Atlantic, a battle was being waged, since the 1950s, in the German courts, press, and medical journals over the thorny issue of reparations for survivors of the Nazi Holocaust and concentration camps. One view held that the psychological sequelae seen in some of the survivors of concentration camps was not the result of the Nazi persecution per se, but of preexisting dispositions and personality characteristics in the individual. Further suspicion was cast on claimants by pointing to the fact that their symptom presentations had been delayed for years or decades after the war, and some suggested that it was the desire for pensions and reparations that had precipitated the symptoms. The opposing point of view was sympathetic to the survivors and argued that the symptoms seen were in fact the result of Nazi persecution. It took the Vietnam War to ultimately put the traumatic legacy of the Holocaust into focus, as Dagmar Herzog has shown. Psychiatrists working to get the trauma of Vietnam veterans recognised found common cause with those who were sympathetic to Holocaust survivors. US based psychiatrist Henry Krystal, in an attempt to get the trauma of Holocaust survivors to be taken seriously in the medical community and wider US public, drew comparisons between concentration camp survivors and Vietnam veterans who had been captured and imprisoned in POW camps. US military psychiatrist Robert Lifton, who joined the military after the war and studied the effects of trauma in survivors of the atomic blast in Hiroshima, saw commonalities between his work and that of William Niederland, a New York based psychiatrist who had worked with concentration camp survivors and developed and explicated the concert of survivor guilt and 'survivor syndrome'. Lifton was to become a key figure in the development of growing collaboration between experts working with Holocaust survivors such as Krystal and Niederland, and those working with Vietnam veterans to legitimise PTSD.[152]

In Herzog's words, 'the growth of passionate activism against the USA's involvement in and escalation of the war in Vietnam turned out to be a decisive factor in bringing traumas experienced by survivors of Nazi persecution and concentration and

[151] Young, *The Harmony of Illusions,* p.5.

[152] Dagmar Herzog, *Cold War Freud; Psychoanalysis in An Age of Catastrophes,* (Cambridge University Press: 2017).

death camps into both public consciousness and scientific legitimacy'.[153] It was a 'twist of historical fate' that allowed a combination of the decline in the international moral authority of the US because of the Vietnam War and a passionate anti-war movement to 'bring not just soldiers' but survivors' traumas into Americans' public consciousness and into official medical nomenclature and professional policy'.[154] Nancy Andreasen, the American psychiatrist charged with heading the workgroup that ushered PTSD into the DSM-III, was familiar with Niederland's work and she was determined to include the survivors of concentration and death camps into a definition of PTSD that went beyond what veterans' advocates called 'Post-Vietnam syndrome'. She circulated a draft memo on 'Post-traumatic disorder' in 1976 to colleagues in which she listed a variety of traumatic experiences that could precipitate post-traumatic symptoms, which included rape, combat trauma, natural disasters, accidents such as plane crashes, and, crucially, 'mass catastrophes…of human origin (Hiroshima, torture, death camps)'.[155] Almost thirty years later she would write 'The concept of PTSD took off like a rocket, and in ways that had not initially been anticipated'.[156]

The inclusion of PTSD in the DSM-III not only reflected the increasing interest of clinicians in psychological trauma, but also spurred further interest and research.[157] In the 1980s, a new patient group began arriving in the US that was highly suitable for investigating and furthering the science of trauma: Indochinese refugees. Already in 1977, a California based psychologist named J. Donald Cohon wrote of a 'trauma syndrome' that had been observed among resettled refugees in California. A Vietnamese and Mandarin speaker, in the 1960s, Cohon had taught English in Vietnam and served as a Chinese Mandarin interpreter for the US Army in Taiwan. In 1981, in a sign of things to come, he wrote in an article for International Migration Review: 'Although this article has cautioned against the use of diagnostic terms for refugees, one category in the DSM-III may have

---

[153] Herzog, *Cold War Freud,* p.111.

[154] Herzog, *Cold War Freud,* p.113.

[155] Herzog, *Cold War Freud,* p.112.

[156] Nancy Andreasen, 'Acute and Delayed Posttraumatic Stress Disorders: A History and Some Issues', *American Journal of Psychiatry*, 161(8)(2004), p.1321.

[157] Bracken, *Trauma: Culture, Meaning and Philosophy,* p.45.

general applicability for a refugee population. The category, grouped under Anxiety Disorders, is Post-traumatic Stress Disorder, Chronic or Delayed'.[158]

In this 'empire of trauma', designating refugees as traumatised became a thinkable, obvious, and readily available choice. But it was made practicable, and practical, because of the fit between refugee trauma and other research agendas and priorities in the science of trauma in the United States. For example, one way in which the importance of studying trauma in refugees was justified was by drawing links between the trauma of refugees and that of other groups of contemporary relevance in the United States. One of the earliest psychiatric efforts to respond to the influx of traumatised refugees to the US was the Harvard Program in Refugee Trauma (HPRT), founded in Boston as the Indochinese Psychiatry Clinic in 1981. Richard Mollica, founder of HPRT, wrote 'the Indochinese refugee serves as a unique model for understanding other highly traumatized groups, such as Vietnam veterans and victims of rape trauma and child abuse' and that 'the experience of the Indochinese refugee can serve as a model for furthering our understanding of cognition and social functioning in other traumatised populations'.[159] James Lavelle, a clinical social worker and co-founder with Mollica of HPRT described a 'refugee trauma' approach as follows

> it says something to all of us because this is what happens to human beings when you put them through catastrophic events. That teaches a lot about the woman who is the victim of a hit and run rape, about the child who was a victim of incest with their dad for three years. If you keep it minority focused, you have a serious problem. It has to be looked at in terms of its broadest implications.[160]

In its broadest implications, Lavelle continued

> …this is the kind of mental health problem that the normal guy can relate to. It's not as if you're sitting on a couch talking about your lack of self esteem and such garbage that a lot

---

[158] JD Cohon Jr, 'Psychological adaptation and dysfunction among refugees', *International Migration Review,* 15(1-2)(1981), p.271.

[159] Schlesinger Library, Harvard University, Cambodian American Women and Youth Oral History Project (CAWYOHP), MC 814 # 1.13, NIMH Research Scientist Development Application, pp.35, 45.

[160] World Health Organisation (hereafter WHO) Archives Geneva, M4-86-12(B) 'International Congresses of the World Federation for Mental Health, jacket 5, 'Mental Health News', August/September 1988, p.15.

> of white middle class Americans spend millions of dollars on every year. We're not talking about that game.[161]

Refugee trauma did not simply appear and make itself obvious, nor was it 'discovered'. Rather, it was consciously made, framed, and defined. Describing their initial reaction to the arrival of Indochinese refugees in the US and the stories of what they had been through, Lavelle said

> We were hearing about this on the streets of Boston for a couple of years but at first there was a lot of denial, part of our collective guilt for messing up South East Asia in the first place. Was this an Asian problem, a migration problem, a mental health problem? It was transcending all the constructs we had, but then we started looking at it through the lens of trauma. We started to systematically collect information about what people had gone through.[162]

Looking through the lens of trauma had consequences for the transcultural dimension of refugee work. Lavelle mentioned the dream of a Cambodian woman in the US who had lost her whole family in the Pol Pot era and was so depressed she could not perform basic tasks. She reported God appearing to her in a dream and telling her to build a temple in memory of the family she had lost, and told her doctors, 'Please help me to make my dream come true. If not, I don't think I can live anymore'. What she 'was really saying', in Lavelle's interpretation, was 'can you reconstruct my culture?'[163] This notion of a decimated culture needing saving was carried to the border camps.

In the naming and defining of refugees' experiences and histories, and the systematic collection of data on them, refugee trauma was made. It represented an opportunity to create a new domain of medical science and expertise around the minds of refugees. In Mollica's words

> We do not have a science developed around trauma-related disorders, so physicians, social workers, psychologists and so on have had no formal training in how to treat or diagnose

---

[161] WHO Archives Geneva, 'Mental Health News', p.14.

[162] WHO Archives Geneva, 'Mental Health News', p.14.

[163] Diane E. Lewis, 'Refugees find no refuge from memories, advocates say', *Boston Globe,* March 1989, p.21.

> these disorders. The field of resettlement is usually based around social work rather than medicine.[164]

> Through a scientific approach we can shift away from exclusively political concerns about highly traumatised populations to a fact-oriented public health perspective. This shift provides public health specialists and physicians a new, unique role for improving the well-being of traumatised populations worldwide.[165]

Responding to a question about the existence of models for refugee care developed in earlier waves of resettlement in the US, Mollica strategically placed trauma at the heart of refugee care and refugee care at the heart of medicine, and suggested that work done with earlier waves of refugees was not clinically useful for this new group of refugees.

> In the USA most of the interest in this area has been primarily from anthropology or from cross-cultural psychiatry, which is far to the margins of mainstream American medicine. The main academic emphasis in psychiatry has been on issues to do with acculturation and resettlement. We have found these models not very useful in working with highly traumatised patient groups. I'm not aware of a single clinical intervention arising from those models that could be used to treat patients.[166]

In working to establish a generalisable and transferable knowledge base for the science of refugee trauma, academics and practitioners saw themselves as innovating and experimenting. A 1990 article in the *Harvard Public Health Review* called the psychosocial care of refugees 'the fastest growing field in public health psychiatry. As a field in its infancy, however, psychiatric care of highly traumatised refugee populations is largely a battle in the dark'.[167] This is certainly how it was conceptualised by the professionals shaping it. In 1991, Mollica recalled the first hundred patients they saw at the Indochinese Psychiatry Clinic, which he founded at a public health clinic in Boston in 1981 to improve the access of Asian patients to psychiatric services, which they were not seeking out.

---

[164] WHO Archives Geneva, 'Mental Health News', p.14.

[165] Schlesinger Library, CAWYOHP, MC 814 # 7.1, 'Giving Refugees a Voice: New HSPH psychiatric program aids refugee trauma victims', *Harvard Public Health Review*, Spring 1990, p.11.

[166] WHO Archives Geneva, 'Mental Health News', p.14.

[167] Schlesinger Library, 'Giving Refugees a Voice', p.10.

> We've been treating refugee patients from Southeast Asia in the psychiatric clinic for about ten years now…One of the things that I was very interested in, is that when we first started treating these patients ten years ago, we had absolutely no idea what we were doing. In other words it was a complete mystery to us, their culture, their problems…In those initial interviews, a lot of information came out around the trauma story, and the terrible things that had happened, but we really didn't know how to deal with that. We didn't know how to deal with that; we didn't know how to understand it, what to think about how to deal with it.[168]

Marguerita Reczyck, a psychiatric nurse who joined the clinic in 1988, recalled Mollica's words to her about how, given the new state of the field, they were 'breaking all the rules' of psychiatry and needed to innovate: 'no one has ever done this before. So no one can say that whatever you're doing is right or wrong. So experiment'.[169]

Refugee trauma in the border camps: the 'mental health crisis' in Site 2

Dr David Ratnavale was an American psychiatrist who headed the US National Institute of Mental Health Task Force on Refugee Mental Health from 1979-81, and arrived in the Cambodian border camps in 1983. Writing in 1986, he wondered how, despite

> what we know about post-traumatic stress disorders - reactions to victimisation and stress that may occur immediately or as much as 20 years after the trauma … this diagnosis was relatively rare in refugee health statistics. Was it because of poor data collection or the difficulty in distinguishing emotional disorder from the array of confusing signs and symptoms presented to the physician? Is the same mistake that was made with the United States veterans of the Vietnam War being repeated? Could it be that in the refugee context, because of ethnic variations in perception and experience, manifestations of stress and their diagnosis and treatment were delayed?[170]

---

[168] Schlesinger Library, CAWYOHP, MC 814 # 7.4, Interview w/Richard Mollica, 1991.

[169] Schlesinger Library, CAWYOHP, MC 814 # 7.3, Interview w/Marguerita Reczyck, August 1991.

[170] David Ratnavale, 'Mental Health of Refugees and Relief Workers', in Barry Levy and Daniel Susott (ed.), *Years of Horror, Days of Hope; Responding to the Cambodian Refugee Crisis* (Associated Faculty Press: 1986), p.154.

This would change very soon, when a team of researchers led by Richard Mollica arrived in Site 2, the largest camp on the border, to conduct a mental health survey. The study was sponsored by the World Federation for Mental Health (WFMH), and the Harvard School of Public Health (HSPH). In collaboration with Russell Jalbert, a consultant in public policy planning and senior program officer for the refugee resettlement program in the US, Mollica authored what HPRT calls the 'first mental health survey of a refugee camp'.[171] A more apt description would be to call it the first mental health survey in a refugee camp in the Third World.

Titled *Community of Confinement: The mental health crisis in Site 2*, Mollica's study and survey was influenced by almost a decade of experience with resettled refugees in the US. This makes its vantage point quite different from Jean-Pierre Hiegel's work, whose starting point was in the border camps among refugees expected to return to Cambodia one day. The Site 2 study's conceptualisation of 'culture' was also quite different.

> Traditional Khmer society especially in the Cambodian countryside has been organised around the Buddhist temple. Although 340 monks live in Site Two, they provide very little psychological counselling. The majority are young and poorly educated as to Buddhist scriptures and rituals. The temple, therefore, has been incapable of establishing healing programs to assist the mentally ill. In addition, many of the monks have suffered from the Pol Pot genocide and are, themselves, suffering from serious emotional distress…Finally, the traditional role of the monk as cultural and moral educators to the Khmer community has been stripped away from them…Nor can the monastery meet any of the real material needs of the Khmer population. The latter must look to Western non-Buddhist providers for protection and material comfort. In effect, the monastery has been relegated to a limited cultural role and an almost non consequential mental health care role.[172]

Culturally appropriate healing could not occur in the presence of trauma, and in the case of camp residents, the trauma was 'ongoing and unremitting'. The danger and extensive violence in Site 2, following the traumas that Cambodians had already experienced before

---

[171] Methodology – More', *Harvard Program in Refugee Trauma* <http://hprt-cambridge.org/about/methodology/methodology-more/> [accessed 14 August 2019].

[172] MC 814 # 1.14, Richard Mollica and Russell Jalbert, *Community of Confinement: The Mental Health Crisis in Site Two (Displaced Persons Camps on the Thai-Kampuchean Border)* (World Federation for Mental Health, Committee on Refugees and Migrants,1989), p.32.

becoming refugees, constituted a 'second wound': a 'retraumatization of individuals who [had] already suffered from severe victimisation prior to entering Site Two'. Revictimization and retraumatization precluded any possibility of a culturally appropriate healing and bereavement process. A 20% prevalence of major depression, and 16% prevalence of PTSD, were estimated.[173]

Case reports served to highlight the tragedy in the border camps and make a case for the introduction of better mental health services rather than to highlight successful outcomes or share experiences. Consider the case of 'Mr M, the Crying Man'. A married man in his early thirties, Mr M was known in his local community as someone with 'mental problems' and 'seizures'. Always tearful, he would visit the outpatient department (OPD) in Site 2 when the stress became unbearable. The staff dubbed him 'the crying man'. Presenting in a fetal position, sometimes he would talk and other times he would fall silent or go into a seizure. The medics in the OPD diagnosed him as a case of chronic depression and PTSD with a possible association with psychosis. Since the Western staff could not speak Khmer, the presence of psychotic thought processes could not be assessed (no attempt to find an interpreter is mentioned). Mr M had previously sought help from the inpatient hospital as well as the *Krou* and monks, all of which failed. OPD staff obtained some herbs from the TMC which provided partial relief, and after a relatively asymptomatic year he presented again in severe distress. No psychiatric referral was made because there was no comprehensive psychiatric system in Site 2. He was referred this time to a new TMC in Site 2 to be evaluated by the *Krou*. This proved ineffective and he subsequently tried to hang himself, but the rope broke and his spine was fractured, leaving him alive but now also 'paraplegic, with urinary and bowel incontinence; seriously psychotic, still without psychiatric care'.[174]

In assessing the capacity of the community based programs of Site 2, which constituted the de facto mental health system, consisting of religious and cultural institutions such as temples, and the *Krou Khmer,* the Site 2 study found that in contrast to what front line camp administrators 'believed [about] an extensive community based mental health system' in Site 2, the traditional healing system was in fact 'fragmented and

---

[173] Mollica and Jalbert, *Community of Confinement*, pp.14-15.

[174] Mollica and Jalbert, *Community of Confinement*, pp.29-30.

disintegrated'.[175] It observed that many of the eldest and most experienced *Krou Khmer* had already died, that the educated Khmer in Site 2 did not respect the healing abilities of the *Krou*, that the healers 'practiced their craft without standards or a system of accountability', and that the camp conditions did not foster the training and development of the healers' skills.[176] In assessing the existing medical services in Site 2, the authors castigated the outpatient departments for their 'failure' to give psychiatric diagnosis. Since no psychiatric treatment was available in the OPD, psychiatric diagnoses were not given, although the Chief Medical Officer of the major OPD in Site 2 'estimated the percentage of illness associated with a primary psychiatric diagnosis in the OPD to be as high as 50% of all adult cases'. Conditions considered to be psychosomatic disorders by the medics were assigned a diagnosis of 'fatigue', the most common diagnosis in the OPD in 1987. Why was psychiatric illness not being identified? Surveys of Khmer and Western practitioners 'indicated that although their knowledge of traditional symptoms and Khmer health seeking behaviour for emotional illness was incomplete, this lack of cultural information was not the major barrier to identifying psychiatric illness'. Rather, the problem was 'a lack of psychiatric guidelines, procedures, and pharmacy in the health care system and a lack of community programs for referral'. Granted, there was a 'lack of systematic training of the medical staff in all aspects of Khmer mental health beliefs', but this was mainly a problem insofar as it 'exacerbated' the 'lack of a formal psychiatric system, correct diagnosis and adequate support through medication'.[177]

The Site 2 study was not only a scientific document, but also a political one. Mollica and his colleagues were aware of their role as political actors in advocating on behalf of the Cambodian people. This advocacy was not only for the introduction of better mental health services, but also for a peaceful solution to the armed border conflict that had held them hostage for a decade. In Mollica's words: 'This is a complete paradigmatic shift. The key is to start with the outcome, and the great problem in psychiatry has been that our outcomes are vaguely defined. In Site Two, there's no question: people need to return home and they need to work. They've been through a genocide, and they've been sitting in a camp for ten years doing nothing'.[178] Mental health services were not only to alleviate

---

[175] Mollica and Jalbert, *Community of Confinement*, p.31.

[176] Mollica and Jalbert, *Community of Confinement*, p.33.

[177] Mollica and Jalbert, *Community of Confinement*, pp.28-29.

[178] 'Giving Refugees a Voice', p.13.

the suffering of refugees in camps, but to begin healing their trauma so that they could start rebuilding their country upon repatriation. Here, a link was made between mental health and development in a way unthinkable two decades earlier.

As political advocates, Mollica and colleagues merged the language of human rights with psychiatry. 'The impetus for this new field [refugee trauma]', the *Harvard Public Health Review* proclaimed, 'reaches beyond medicine' into human rights. In Mollica's words, 'Psychiatric care for the disadvantaged and displaced is ultimately an issue of human rights'.[179] Human rights violations caused medical and psychiatric problems, and a scientific approach to them was crucial to determine the appropriate response. Human rights based talk was extensively employed in advocating for better mental health services for the border camp refugees. The Community of Confinement study began with an invocation of the Universal Declaration of Human Rights, which 'asserts among other rights a number which bear directly on the mentally ill', and went on to invoke a number of articles of the UDHR, in addition to the 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment, and the 1985 Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.[180] It both affirmed the human right to health and necessary medical and psychological care, and highlighted the deleterious impact of human rights violations on the mental health of the inhabitants of the militarized and unsafe border camps. This constituted an early example of 'the convergence of health and human rights in academic and public discourse' which would continue and expand in the post-Cold War era.[181] According to Bertrand Taithe, among the various conflicts occurring at the end of the Cold War, the border camps were 'a prime example of converging practices and consensual analyses within a "human rights framework"'.[182]

Reactions to the declaration of a mental health crisis affirmed the emergent link between mental health and human rights. 'It's time for the world to recognise that in this camp, mental health and human rights are as much a problem as food, water, and shelter',

---

[179] 'Giving Refugees a Voice', p.11.

[180] Mollica and Jalbert, *Community of Confinement,* pp.1-2.

[181] Daniel Tarantola, 'A perspective on the history of health and human rights: from the Cold War to the Gold War', *Journal of Public Health Policy,* 29(1) (2008).

[182] Taithe, 'The Cradle of the New Humanitarian System?', p.339.

said Andy Pendleton, a senior camp officer with UNBRO. Roger Fordham, executive director of the Committee for Coordination of Services for Displaced Persons in Thailand (CCSDPT), believed that action on mental health in the camps had been delayed because of the 'uncomfortable link' between mental health and human rights. Speaking to the LA Times, he said "this [mental health] is a touchy matter, because it leads you to tough political questions…Why isn't the camp moved to a safer place, away from the shelling? Why isn't there a higher level of security?' To others, such as Mary Skully, a psychiatric nurse who worked with resettled Cambodian refugees in the US, the link between mental health and human rights was not so obvious. Skully thought that the UN had to focus more on human rights abuses than mental health: 'I just don't think it's possible to provide effective mental health services in the middle of a war zone…Even the army takes its own people off the front line when it offers them counselling. Until we provide more security for these people, the idea of mental health is beside the point. It may even be a hoax'.[183]

The globalisation of refugee trauma

The data and experience obtained from a decade of working with traumatised Cambodian refugees in the US directly informed the Community of Confinement study in Site 2, where encamped Cambodian refugees were assumed to be at least as traumatised as those who had resettled, with the difference that the trauma in the camps was ongoing and unremitting. While those in the US had to face the stresses of acculturation and adaptation to a new society, they no longer experienced the traumas and deprivations of the border camps.[184] Elaborated in clinics in the US, refugee trauma and PTSD were ready to be exported into the context of a humanitarian crisis and refugee camps. The introduction of mental health and psychosocial support into medical humanitarian relief is often traced to the conflict in the Balkans in the 1990s, but this was actually a phase of professionalisation that had its antecedents in the Cambodian border camps where it was initially elaborated in a post-Vietnam, late Cold War context.[185]

---

[183] Josh Getlin, 'Treating the Tormented: In an Asian Refugee Camp, Pilot Mental Health Program Seeks to Ease the Despair', *LA Times,* Jan 1990. <https://www.latimes.com/archives/la-xpm-1990-01-04-vw-486-story.html> [Accessed Nov 2020].

[184] Mollica and Jalbert, *Community of Confinement,* p.13.

[185] Vanessa Pupavac, 'Psychosocial interventions and the demoralization of humanitarianism', *Journal of Biosocial Science,* 36(4)(2004).

Joshua Breslau has suggested that PTSD was able to 'expand the discourse of humanitarian crises by providing a means for discussion and comparison of psychological dimensions of suffering that carry the full legitimacy of scientific knowledge'.[186] He sees that the expansion of PTSD and trauma into global arena within humanitarian organisations and medical institutions as having been made possible 'because of the fit that exists between this diagnosis and the agendas existing within global institutions', for it is a 'clinical concept that directly engages the kinds of events that are of interest to governments and humanitarian agencies, such as natural disasters, political violence, and mass displacement'.[187] It provides a language for the 'expression of psychological suffering in terms that are consistent with the chartering motivation of much work in international health', while the 'narrative connection' between real world events and individual suffering gives the disorder 'a special ability to stand as hard evidence of suffering backed with the credibility of medical science'.[188]

The emergence of (trauma-focused) mental health in humanitarian relief took place in the time and space that it did because of contextual factors rooted in the social and political context of the late Cold War. The end of the Cold War in the early 1990s was associated with a humanitarianism that was more explicitly on the side of the victims, and increasingly associated with peacebuilding, human rights, advocacy and protection of victims.[189] The beginnings of this approach can be located in the practices employed by humanitarians concerned with the mental health of Cambodian refugees in the camps. 'As individuals begin to reconsider the violations of human rights in relation to the changing world concept of democracy', Mollica said, 'I think there will be a surge of interest in resolving social problems that impact health'.[190] The rights based discourse that served as a practical tool to disseminate and legitimise refugee trauma was a feature of the late Cold War.

---

[186] Joshua Breslau, 'Cultures of Trauma: Anthropological Views of Post-traumatic Stress Disorder in International Health', *Culture, Medicine and Psychiatry,* 28(2)(2004), p.114.

[187] Breslau, 'Cultures of Trauma', p.114.

[188] Breslau, 'Cultures of Trauma', p.116.

[189] Costanza Torre, 'Psychosocial support (PSS) in war-affected countries: a literature review', Politics of Return Working Papers (3), Conflict Research Group, London School of Economics, 2019. <http://eprints.lse.ac.uk/100199/> [Accessed 5 Aug 2019].

[190] 'Giving Refugees a Voice', p.17.

Vanessa Pupavac has drawn attention to how a renewed consciousness of refugees' plight in the post-Cold War era has been associated with a change in the Western conception of the refugee from political hero and freedom fighter to traumatised victim.[191] Though Pupavac starts her analysis in the 1990s and traces the emergence of mental health and psychosocial support in humanitarianism to the conflict in the Balkans, her analysis is relevant to the late Cold War context of the border camps. The archetypal figure of the refugee in the Cold War was the political dissident and exile. Their lives 'were not viewed by Western audiences through the paradigm of trauma, but politics', and their ordeals in terms of political suffering as opposed to psychological trauma.[192] Human rights advocacy in the Cold War also had a different dimension, revolving around the human rights subject as political actor, heroic figures struggling for freedom and justice. They were embraced by the Western world, demonstrating the superiority of the Free World to the Communist bloc, and Westerners could 'vicariously bask in the nobility of their struggles and have [their] way of life affirmed for [them] because they had sought refuge in [their] society'.[193] This cultural image of the refugee as political exile eroded and was displaced by that of the traumatised and depoliticised victim within a health paradigm and a medicalised representation.

This renewed identification with the cause of the traumatised refugee, Pupavac says, was 'linked to political disenchantment and a demoralised sense of political subjectivity following the end of the Cold War', and can be traced to contemporaneous changes in Western societies.[194] Images of traumatized post-Cold War refugees (and, I contend, certain late Cold War refugees in a post-Vietnam context) 'embod[ied] the West's own diminished sense of self'.[195] This 'professional idealisation of the refugee fits with cultural attraction toward self-identities based on diagnosis or wounded attachments to a traumatic past'.[196] Seen from this angle, 'identifying with refugees is not unconnected to the contemporary narcissistic cult of victimization, in which refugee advocacy invites us to

---

[191] Vanessa Pupavac, 'Refugees in the 'sick role': stereotyping refugees and eroding refugee rights', *New Issues in Refugee Research,* Research Paper No. 128, 2006. <https://www.unhcr.org/44e198712.pdf> [Accessed Aug 15, 2019]

[192] Pupavac, 'Refugees in the 'sick role', p.1.

[193] Pupavac, 'Refugees in the 'sick role', p.2

[194] Pupavac, 'Refugees in the 'sick role', p.2.

[195] Pupavac, 'Refugees in the 'sick role', p.13.

[196] Pupavac, 'Refugees in the 'sick role', p.14.

feel good about ourselves by identifying with their pain'. Identifying with traumatised refugees as 'ethical subjects who are passive, politically innocent, untainted by communal ties or economic self-interest' became a symptom and expression of a wider disillusion with the political subject.[197]

The demise of the old alliances and ideological blocs of the Cold War, and the demise of an industrialisation model of development, allowed Western conflict management approaches to dominate international policy, and there was a proliferation of international initiatives based on psychosocial risk management strategies.[198] This, in turn, has been linked to the emergence of the concept of human security which displaced concepts of state and international security, giving rise to what Pupavac calls 'therapeutic governance': 'the management of populations' psychology, and its significance for security'. Positing a link between psychosocial wellbeing and security, therapeutic governance seeks to 'foster personalities able to cope with risk and security', making the individual's sense of psychosocial wellbeing not a personal matter but a feature of good governance.[199]

Pupavac argues that the emergence of a global therapeutic paradigm followed the 'demoralization of humanitarianism' in the 1990s. A crisis of legitimacy, prompted by a fundamental questioning of humanitarian organizations' nature and work that cast doubt over their principles and efficacy of material aid, led to much soul searching and introspection over their mission and motivations. It contributed to a perception of humanitarianism as alienating rather than humanising. This, in turn, encouraged humanitarians to adopt psychosocial work, an attractive option that would 'bring back the human in the face of the bureaucratisation of aid' and foreground how communities personally experienced war and conflict, while allowing Western aid workers to simultaneously project their own sense of vulnerability and crisis of meaning onto war affected populations.[200] How Western relief workers reacted psychologically to the situations they encountered is something barely mentioned in the sources I have examined.

---

[197] Pupavac, 'Refugees in the 'sick role', p.14.

[198] Vanessa Pupavac, 'Therapeutic governance: psycho-social intervention and trauma risk management' *Disasters,* 25(4) (2001).

[199] Vanessa Pupavac, 'Human security and the rise of global therapeutic governance: analysis', *Conflict, Security and Development,* 5(2)(2005), pp.161-162.

[200] Pupavac, 'Psychosocial interventions'.

I have found only one reference to this, by American psychiatrist David Ratnavale, who worked in the border camps in the early 1980s. He reported that relief workers experienced 'exaggerated psychological stress' that led to 'breakdown or seriously handicapped functioning'. Faced with violence, starvation, and death, some of them broke down and required hospitalization in Bangkok or were sent home. They suffered stress, nightmares, and stomach aches, which they ignored as they 'worked feverishly, sometimes mobilized by guilt feelings from within or induced by co-workers. Some came to believe that their work had greater meaning if they themselves suffered a bit, just like the refugees they had come to serve.' They had fits of irritability, temper tantrums, moodiness and a desire to run away from it all. It was 'not unusual for relief workers to vent their anger even on the refugees'.

The isolation they felt led some to identify with the refugees, feeling that, like them, they too were displaced. There were 'blatantly inappropriate liaisons with fellow co-workers and even refugees'.[201]

Though Pupavac's analysis starts in the 1990s, I argue that the precursor to the psychosocial work of the 1990s in the Balkans was in the Cambodian border camps. Then, too, humanitarians experienced a crisis, and had to come to terms with how aid had been manipulated to maintain the political and military structure that had enabled the survival of the Khmer Rouge in the 1980s.[202]

Local Cambodian solutions

The Site 2 study featured refugees as patients and as traumatised victims, but it did not examine the local solutions devised by refugees to address their plight. Some of these solutions were chronicled by Sister Joan Healy, an Australian nun, humanitarian, social worker, and mental health consultant who arrived at the Thai-Cambodian border in 1989 and was intimately involved with and witness to some of them. She chronicled them in her memoir *Writing for Raksmey; A Story of Cambodia*.[203] Meas Nee, the father of the Raksmey in the title of Healy's memoir, wanted to set up a healing facility in the north of

---

[201] David Ratnavale, 'Mental Health of Refugees and Relief Workers', pp.158-9.

[202] William Shawcross, *The Quality of Mercy: Cambodia, Holocaust and Modern Conscience* (Fontana Press: 1985)

[203] Joan Healy, *Writing for Raksmey; A Story of Cambodia* (Monash University Publishing: 2016).

Site 2. Nee told Healy that some of his father's last words before he died at the hands of the Khmer Rouge were 'Be a healer, son. When this is over our people will need healers'. In the border camps, he studied every course Western medical specialist volunteers had to offer, and studying with the American Refugee Committee convinced him that Western drugs and treatments could be used alongside traditional treatments. To Healy, he said 'you will need to teach us about Western ways of healing the spirit'.[204]

Nee worked side by side with traditional healers and counsellors, measuring, cutting and tying bamboo, to build the new facility in 1989, which he called 'Mental Health and Traditional Healing' (MHTH). It was built across from a Medecins Sans Frontieres (MSF) hospital, and the close proximity surely facilitated referrals between the two.[205] Funding and support from this initiative was provided by a Thai NGO, the Catholic Office for Emergency Relief and Refugees (COERR). On returning to Cambodia in 1992, Meas Nee wanted to help rebuild the villages of rural Cambodia, where he found 'that the relationship between people in the rural areas was socially fragile, very fragile', especially when he saw how development money poured in by Western NGOs according to their own priorities could breed the same 'dehumanizing dependence' he had seen in the border camps. This led to a career in community development, and after obtaining a masters in social work and a doctorate in philosophy from Australia, he returned to Cambodia in 2002 to work on rectifying the social and economic issues plaguing his country, engaging in consultancy, community development and political analysis.[206]

One problem that the MHTH counsellors often dealt with was violence against women, and specifically domestic violence. Over lunch in a bamboo-partitioned staff area in the centre, midwives told Joan Healy about the many ways in which they had seen women suffer in the camp. It was not only the detention in the camp, but also 'women beaten by their husbands, women who have been raped, women who are destitute, "taxi" girls who sleep with men for money and are vulnerable to STDs'.[207] Thavy, a Cambodian counsellor and refugee, told Healy that there was no effective law to protect women, and

---

[204] Healy, *Writing for Raksmey,* pp.16-17.

[205] Healy, *Writing for Raksmey,* p.20.

[206] Ben Paviour, 'Tough Truths', *The Cambodia Daily,* Feb. 2017 <https://www.cambodiadaily.com/news/tough-truths-125294>, [Accessed 14 August 2019].

[207] Healy, *Writing for Raksmey,* p.50.

daring to seek a divorce required extraordinary courage.[208] This concurs with the Site 2 study, which also found domestic violence and other forms of violence against women to be a problem, describing the camp as a lawless place where family members could be 'shot, beaten or injured at anytime or harmed over any incident no matter how small'. It quoted a report from March 1988 from the American Refugee Committee hospital, which declared violence to be the major public health problem in Site 2 and surmised that this seemingly unnatural violence, 'on a closer look', was 'the natural product of an overcrowded society, provided with barely enough of the basic commodities of life, such as water, with few educational or occupational opportunities, and no hope'. The report lamented that the violence would only stop when social conditions improved. In the meantime, the hospital medics, could only 'patch the wounds of violent injury'.[209]

How did those actually living in these conditions go about addressing this problem? The solution was fundamentally social. Thavy of the MHTH, as part of her role as a counsellor, worked with a group of eleven vulnerable women who needed to protect themselves from abuse. They devised a plan of action to be implemented when it was suspected that a woman was being or about to be beaten. Because of the overcrowding of crammed bamboo and blue plastic shelters, no conversation was truly private. If a woman heard what sounded like the start of a violent incident, she would raise the alarm: a loud noise made by beating on her cooking pot. Then, 'each other woman, as she hears the beating of a cooking pot, will find a cooking pot and beat it. They will run to the place of the violence, beating and beating at their cooking pots. The violent man will lose face in front of ten or eleven women standing together making a great noise'.[210]

Another Khmer mental health initiative was a centre in the south of Site 2 founded by a Cambodian refugee woman named Nuon Phaly. Phaly came from a middle class family in Phnom Penh and her parents had worked for the Cambodian Royal Family before the Khmer Rouge takeover. She fled to Thailand after the fall of the Khmer Rouge and joined her countrymen and women in the border camps.[211] In 1987, she set up a 'Centre

---

[208] Healy, *Writing for Raksmey,* p.47.

[209] Mollica and Jalbert, *Community of Confinement,* pp.17-18.

[210] Healy, *Writing for Raksmey,* p.47.

[211] Phaly's Story (FLO founder), *eGlobal Family,* <http://www.eglobalfamily.org/phaly-story.html> [Accessed 14 August 2019]

for Healing of Heart and Spirit' across from a hospital run by the American Refugee Committee (ARC), with support from COERR. The official name that it was known to Westerners by, however, was 'Khmer People's Depression Relief' (KPDR).[212] Among the clients were many orphans, or children whose parents could not care for them, who came to the centre and were taken into her care. When she left Site 2 in 1992, she had 91 orphans in her care. She managed to secure funding from UNHCR and World Food Programme (WFP) to transport them to Cambodia, where they formed the core of her new project, the Future Life Orphanage in Phnom Penh. Phaly received distinctions and human rights awards for her humanitarian work.[213] She died in 2012.

The Centre for Healing of Heart and Spirit was built of bamboo and had a garden Phaly planted herself on a hectare of land given by camp authorities. To Phaly, the 'garden [was] good for the soul, it reminds you there is beauty in the world'. Phaly recalled that Western visitors to the centre were particularly fascinated by a phenomenon called 'tiing moong' in Khmer, or 'dummy personality'. It was a 'state of psychological withdrawal or hibernation that can seem like stoicism, callousness or dishonesty', adopted 'during the Khmer Rouge years, and continued in the camps as a defence against the violence and hopelessness of living in limbo at the border. I think it can still be seen in Cambodia today'.[214] This centre blended Western style counselling in groups or individual meetings with traditional treatments through its subcomponent Traditional Herbal Center (THC). Most (85%) of the clients were women, and 95% of all clients received treatment from the Herbal Center. Though there were international volunteers, including Sister Joan Healy, the initiative remained Khmer-led. The most common symptom seen was 'weakness', indicative of emotional distress. Most of the clients were seen on an outpatient basis, sometimes staying at the centre for a short time. Patients who seemed to be a risk to themselves or others were referred to psychiatrists in the UNHCR camp of Khao-I-Dang where they could receive antidepressant and antipsychotic medication. Mollica and the Site 2 team observed that only 7% of clients had a primary psychiatric diagnosis, though they estimated that 'at a minimum, one third of the THC clients were experiencing major emotional distress as expressed through weakness, gynaecological complaints, and others

---

[212] Healy, *Writing for Raksmey,* p.5.

[213] Phaly's Story (FLO founder), *eGlobal Family,* <http://www.eglobalfamily.org/phaly-story.html> [Accessed 14 August 2019]

[214] Phaly's Story (FLO founder), *eGlobal Family,* <http://www.eglobalfamily.org/phaly-story.html> [Accessed 14 August 2019].

complaints'. They observed that very few rape victims were reported, but speculated that many of the cases 'concealed their rape trauma behind more acceptable physical complaints'.[215]

Healy had strong words of criticism for what she saw as the biomedical, Western psychiatric approach advocated by Richard Mollica. She wrote of a four day visit by Mollica to Site 2 in late 1989, a follow up visit to that of 1988 from which the Community of Confinement study had materialised. During those four days, he did some teaching with staff of the two initiatives set up by Meas Nee and Nuon Phaly, and consulted with officials from the UN Border Relief Operation (UNBRO) which was managing Site 2. A second report was produced, 'Turning Point in Khmer Mental Health: Immediate Steps to Solve the Mental Health Crisis in the Khmer Border Camps', which Healy described as recommending an urgent appeal to donor countries for funding and for more psychiatric training and services in the camps and the appointment of an UNBRO mental health coordinator, as well as advocacy on behalf of the Khmer to bring about greater acknowledgement of the mental health crisis.[216] The recommendations did not sit well with Healy, who wrote

> I believe that this report was written in real compassion for the Khmer people. But it joins a long line of similar endeavours which ask, from various professional perspectives, several basic questions. What is the problem that we address? What ought we do to address this problem? This approach began when starved asylum seekers first crossed the border. Answers to these questions have been at best incomplete and at worst arrogant or self-serving. The ensuing debate can easily distract us all from grasping the real nature of the situation. The writers of reports come and go but the suffering of the Khmer people intensifies.[217]

The problem was 'not firstly a mental health problem', but an 'immense problem of human evil and injustice', a 'vast human tragedy'. The problem was 'the continued

---

[215] Mollica and Jalbert, *Community of Confinement,* pp.34-35.

[216] Schlesinger Library, CAWYOHP, MC 814 # 1.4, Richard Mollica, et al. *Turning Point in Khmer Mental Health: Immediate Steps to Resolve the Mental health Crisis in the Khmer Border Camps* (World Federation for Mental Health, Committee on Refugees and Migrants: 1989).

[217] Refugee Studies Centre, Forced Migration Online, RSC/EK-61 HEA, Joan Healy, 'A Dialogue on Khmer Mental Health from Site 2/Thai-Cambodian Border (January 18th, 1990)', p.2. <http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:563>, [Accessed 14 Aug 2019].

existence of the border camps'. Though psychiatrists could 'easily call this a mental health problem because we have experienced that such suffering can well lead to depression and post-traumatic stress', this was 'not the whole truth and certainly not the central truth. We must name the problem accurately'. Referrals to the Khmer led healing centres 'more frequently indicate[d] social problems and human rights violations than psychiatric problems'. She maintained that those with frank psychiatric illnesses were 'by far the smallest' category, and saw Mollica's recommendations of a 'specific psychiatric service with the addition of various Khmer components' as misguided. In Healy's view, declaring a mental health crisis in the camps would do more harm than good and bring 'serious and unintended consequences'. It would, by necessity, manipulate public opinion and the image of the Khmer people: 'If we name the aftermath of grief, trauma, rape and violence as mental illness and then say that mental illness is widespread, yet another misleading and unfortunate image of the Khmer people is created'. Western experts had the power to project this image internationally because of their expertise and professional knowledge. If the media exploited this image of a mentally ill population, 'basic human rights [were] again violated'. Healy also took issue with what she saw as the imposition of conventional Western psychiatric methods via Cambodians who had resettled in the US and trained in Western methods. While they had much to contribute to their fellow Cambodians on the border, the 'task of sharing this experience need[ed] to be approached cautiously', rather than simply importing the methods of the 'psychiatric clinic' to the 'centre for healing of heart and spirit'. Healy quoted a Cambodian in Site 2 who, after listening to a Khmer mental health worker resettled in a Western country and trained in a psychiatric clinic, said 'Your people suffer in paradise. Our people suffer in hell'.[218]

PTSD: A 'universalist solution to a relativist problem'

It was not only humanitarians in the field who took issue with what they saw as the biomedical Western approach of 'refugee trauma' and PTSD. A major critique was mounted by Australian anthropologist and psychiatrist Maurice Eisenbruch, who conducted fieldwork with Cambodian refugees in the border camps, in the US, and in Australia. Eisenbruch described PTSD as a diagnosis 'based on an ethnocentric view of health that prescribes how refugees should express their distress, how their disorders should be classified, and how the distress should be ameliorated'. It offered a checklist of

---

[218] Healy, 'A Dialogue on Khmer Mental Health'.

symptom criteria, many of them physiological, that were 'easy to elicit and presumed to occur as a universal reaction to stress, without regard to the nature of the stressor or the individual's cultural background'.[219] This 'universalist understanding of post-traumatic stress disorder' made the diagnosis (and other Western diagnostic categories) attractive to clinicians 'because they provide[d] convergent and relevant categories into which a traumatized immigrant – of any stripe – can be funnelled'.[220] In effect, PTSD offered a 'universalist solution to a relativist problem', and risked diagnosing a refugee's distress, which could very well be a 'normal, even constructive, existential response rather than a psychiatric illness, and treat[ing] it with Western medicine'. This in turn risked 'treatment (and creation) of an illness the refugee does not have and confusion in the mind of the refugee about what this medical encounter means'.[221]

A superior approach, according to Eisenbruch, that could contribute to better mental heath outcomes was to ensure the survival and continuation of cultural traditions in exile, which would help address feelings of bereavement and loss. In turn, preservation of traditional healing, as an important element of culture, would help in the preservation of Cambodian cultural heritage from perceived loss and death. Therefore, the preservation and application of traditional cultural and religious beliefs, and healing rituals, were highly appropriate to address the symptoms and experience of what Eisenbruch called 'cultural bereavement'[222] – which he developed from his fieldwork in response to the inadequacy of DSM-III diagnoses, chiefly PTSD, to address mental distress and illness in Cambodian refugees. Cultural bereavement, Eisenbruch explained, was a 'culturally determined clinical complex'[223] that would avoid the pitfalls of a PTSD diagnosis and help in mapping 'the subjective experience of refugees', giving 'meaning to the refugee's distress', clarifying 'the structure of the person's reaction to loss', framing 'psychiatric disorder in some refugees' and complementing psychiatric diagnostic categories.[224] He defined it as

---

[219] Maurice Eisenbruch, 'Toward a culturally sensitive DSM: Cultural bereavement in Cambodian refugees and the traditional healer as taxonomist', *Journal of Nervous and Mental Disease*, 180(1)(1992), p.8.

[220] Maurice Eisenbruch, 'From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees', *Social Science and Medicine*, 33(6)(1991), p.678.

[221] Eisenbruch, 'From post-traumatic stress disorder to cultural bereavement', p.673.

[222] M. Eisenbruch, 'From PTSD to cultural bereavement', p.673.

[223] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.10.

[224] M. Eisenbruch, 'From PTSD to cultural bereavement', p.673.

> 'the experience of the uprooted person - or group - resulting from loss of social structures, cultural values and self-identity: the person - or group - continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life'.[225]

Unlike DSM categories, which he contended could 'minimize or ignore the refugees' suffering, their distress and its cultural context', and 'even delegitimize the relation of suffering to disease',[226] Eisenbruch believed that cultural bereavement took account of what the refugees' trauma meant to them, their cultural recipes for signalling distress and strategies to overcome it, and the 'cultural interpretation of symptoms commonly found among refugees that resemble post-traumatic stress disorder'[227] (emphasis added). It therefore allowed a refinement of the PTSD diagnosis to 'allow for greater recognition of the refugee's existential predicament' and could 'contribute to proper outcomes of refugee mental health'.[228] It could also help to reduce the chances of misdiagnosis of a refugee experiencing distress, 'separate signs of pathology – reliving the past, for example - from signs of a consistent and culturally normal relationship between the person's past and present', and help in the early detection and prevention of distress by detecting 'disorder in refugees who exhibit no clinical symptoms in Western terms'.[229] If doctors only treated the disabling symptoms that mimicked PTSD in refugees 'entrapped and suspended from their past', this would not ameliorate their suffering.[230] It could, in fact, prove 'counterproductive because the patient returns to a community that is in itself in a state of collective grief and the patient become more estranged from the parent culture', the result being to 'prolong the trauma'.[231]

To illustrate how the notion of cultural bereavement can improve mental health care for refugees, Eisenbruch recounted the case of a young Cambodian woman named

---

[225] M. Eisenbruch, 'From PTSD to cultural bereavement', p.674.
[226] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.10.
[227] M. Eisenbruch, 'From PTSD to cultural bereavement', p.673.
[228] M. Eisenbruch, 'From PTSD to cultural bereavement', p.678.
[229] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.9.
[230] M. Eisenbruch, 'From PTSD to cultural bereavement', p.677.
[231] M. Eisenbruch, 'From PTSD to cultural bereavement', p.678.

Ros who had been resettled in Australia. Since the birth of Ouk, her third and youngest child, in Australia, she had felt 'worried, depressed and troubled by dreams in which she saw horrifying figures that told her to harm her son, and she was frightened when she was alone in her flat'. She missed her family in Cambodia, and experienced visitations from ancestral spirits, which would be interpreted in Western psychiatric terms as visual hallucinations She cried often, and complained of 'blackouts, shortness of breath and tingling extremities'. She was diagnosed with PTSD and postnatal depression with psychotic features. It was feared that there was a risk she would abuse her child and that therefore he should be taken away from her.

Upon further examination by Eisenbruch, who spoke Khmer, it was found that she was troubled by spirits coming through the ceiling of her fourth floor flat and worried that the flat was dangerous to her son. Her son was vulnerable, Ros thought, because he had been born on the wrong day due to induction of labour by the obstetrician – 'If they hadn't given me an injection, Ouk would have been born on the same day as me' – and because the placenta had been thrown out, according to Western obstetric routine, rather than buried according to her cultural tradition. She recalled how, at the age of seven, she had seen a 'disembodied female skull with entrails dangling behind it flying through the trees', and was told by her father that it could smell the blood of a placenta if it was not buried, and would devour it, kill the baby, and make the mother ill. After Ouk's birth, she saw a bright green light of the same creature flying through the neighbourhood she lived in, and since then 'had been overcome with an icy feeling'. She wanted a *Krou Khmer* to visit her home and make it safe.[232] Eisenbruch took her to a *Krou* who recognized her symptoms. The *Krou's* wife, well versed in astrology, found that 'Ros's birth date and astrological cycle were in decline'. The *Krou* performed several ritual ceremonies in which he used a 'magic amulet to expel the evil spirits' and set up a 'protective marker around her house to repel further attacks'. After this treatment, her nightmares and physical symptoms began to subside, she felt her home to be safe, and her baby Ouk began to thrive.[233]

According to Eisenbruch, the *Krou's* intervention had 'turned an unhealthy contact with the past (borne out of Ros's cultural bereavement) into a mastery of the separation from home, and the symptoms of PTSD abated'. The DSM diagnoses of PTSD and depression had to be 'dismantled and then reassembled in the patient's terms'. The

---

[232] M. Eisenbruch, 'From PTSD to cultural bereavement', p.675.

[233] M. Eisenbruch, 'From PTSD to cultural bereavement', p.676.

collaboration with the *Krou* had thereby allowed the treatment of 'the patient's fundamental suffering rather than dealing only with the symptoms'.[234] The *Krou*, being the 'multidisciplinary mental health worker of Cambodia', could 'apply a consistent template based firmly on Cambodian cosmology' and draw on 'its entire biological, psychological, social and ecological canvas', to diagnose and classify *tchkuot,* the Khmer term that 'encompasses mental illness, behavioural difficulties, and social and community disorders'. Although a traditional healer would be consistent in the kinds of *tchkuot* he described and classified, these were not separate diagnostic categories. Rather, there was a 'seamless connection across the supernatural, moral, and physical realms, and an underlying connection across the various diagnostic groups'.[235] This logic was 'so different from the linear causal thought of Western taxonomists that diagnoses such as PTSD [had] little meaning' to the *Krou*.[236] In this taxonomy where 'etiology and phenomenology are inextricably woven'. The healer did not diagnose by grouping symptoms or affected organs, but by 'metaphorically entering the world of the patient's terror or distress, identifying the whole spiritual and somatic mechanisms by which the patients feel their afflictions, and dealing promptly with the cause', each type of *tchkuot* linked to 'the intent attributed to it'. The treatment took on 'its meaning according to the idea of the underlying spirit cause'.[237]

In fact, 'cultural bereavement' was old wine in new bottles. It was structurally very similar to the language of uprooting and nostalgia of the 1940s and 1950s. But there was a difference: the proposed remedy. Throughout the 'Golden Age' of European refugees, the satisfactory solution to the problem of uprooting was re-rooting in a new country and the task of mental health practitioners was to facilitate and expedite the root growing. The faster the refugee was acculturated into the new land, the better for them, their families, and the host society. Cultural bereavement recognised that this was not a straightforward process for Cambodian refugees. Visually distinguishable from their host population, their acculturation to host societies could not be taken for granted. In Eisenbruch's view, a crucial step in beginning a life in resettlement was to allow refugees to mourn the loss of their culture and facilitate access to familiar modes of healing.

---

[234] M. Eisenbruch, 'From PTSD to cultural bereavement', p.676.

[235] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.9.

[236] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.10.

[237] M. Eisenbruch, 'Toward a culturally sensitive DSM', p.9-10.

Conclusion

Liisa Malkki has examined how disciplines that work with or study refugees harbour an ‘assumption that the homeland or country of origin is not only the normal, but the ideal habitat for any person, the place where one fits in, lives in peace, and has an unproblematic culture and identity’.[238] Rather than a group of varied people with a common legal status, refugees come to be seen as ‘an essentialized anthropological “tribe”’, a community with an exotic culture and identity.[239] That the culture and identity of Cambodians was rendered problematic when they became refugees, and especially so when they were accepted for resettlement in the West, is apparent in the fixation of mental health practitioners on the culture of their refugee patients as something to be deciphered, managed, and tailored to fit into a Western biomedical framework. Culture was the source of explanations for symptoms, beliefs and behaviour indecipherable by the Western observer and a repository of indigenous knowledge to be appropriated and repackaged under Western authority. For the mentally ill who were denied resettlement, their culture, deemed incompatible with existing Western treatment methods, was the justification by resettlement countries. Once resettled, culture became the responsible factor for refugees’ failure to seek available treatment and to respond to the treatment they received. Ultimately, their culture would be pointed to as the reason they failed to adapt to their new societies. Such processes are an outcome of what Malkki calls ‘the uncritical use of the concepts “adaptation” and “acculturation” to analyse processes of transformation in identity, culture and cultural tradition’, which in turn is connected to ‘yet another thematic tendency in refugee studies: the prominence of psychological interpretations of displacement’.[240] The outcome of this for psychiatry when practiced with non-Western populations is a cultural reductionism in the guise being ‘sensitive’ to other cultures.

---

[238] Liisa Malkki, ‘Refugees and Exile; From “Refugee Studies” to the National Order of Things’, *Annual Review of Anthropology*, 24(1)(1995), p.509.

[239] Malkki, ‘Refugees and Exile’, p.511.

[240] Malkki, ‘Refugees and Exile’, p.509.

Western professionals' concern with refugees' culture, whether through encouraging cooperation with traditional healers, or attempting to exercise cultural sensitivity, served to reinforce the dominance and superiority of Western medicine. There is an implicit premise of superiority in 'cultural sensitivity': the more powerful agent endeavours to be sensitive and aware of the culture of the other, in a way that the other cannot. The culturally sensitive agent is presumed to be the one capable of rising above the trappings of his or her own culture in a way that the particular, local, ethnic 'other' cannot. The flexible, culturally sensitive, global agent is thus the one capable of coming down to the other's level. He or she is free to decide how to utilise and respond to the cultural information elicited from the refugee patient. Once the patient's cultural resources are named as 'traditional', vis-a-vis the modern, they are being used in the service of something other than tradition.

The contribution of 'refugee trauma' to refugee mental health research and practice was to pull the rug from under anthropological and transcultural models, and debates over culture, and place refugee mental health firmly within the domain of biomedicine. The concept of trauma enabled a medicalisation of refugees' minds. There is a crucial difference between the refugee mental health research and practice explored in this chapter and that of the post-World War II years; the lack of any common background between humanitarians and refugees, and the lack of refugee voices. In the 1940s and 1950s, European practitioners were working with European refugees, and many practitioners had themselves experienced displacement or internment. In the 1980s the rhetoric was one of saving and rescuing wretched and miserable people in far flung destinations. While the motto of the first UN agency, the United Nations Relief and Rehabilitation Administration was 'help the people to help themselves', the Site 2 study explicitly made a call to help people who were so traumatised they could *not* help themselves.

Conclusion

In the period under study from 1945 to 1993, psychiatrists conceptualized and problematised refugees along three axes: uprooting, confinement, and trauma. As a subfield of psychiatry, refugee mental health first arose as a reaction to population displacement after the Second World War, but only became professionalised in the form we know it today in the 1980s and 1990s. Cutting across colonial, transcultural, humanitarian, global health, and military settings, psychiatric work with refugees has been as varied and international as the global institutional and humanitarian responses that are mounted in response to population displacement. I approached this topic as a physician and public health researcher as well as a historian-in-training. My research suggests that refugee mental health has been more than an area of psychiatric and psychological inquiry. What have we learned from my research?

In the decades from the end of the Second World War to the end of the Cold war, psychiatrists conceptualized and problematized refugees along three axes: uprooting, confinement, and trauma. In addition to being a driver of knowledge generation in psychiatry and a site of interventions and therapeutics, refugee mental health - or to be more precise, the discursive and rhetorical employment of the language of mental health and illness when discussing refugees - has had implications beyond medicine and psychiatry. It has allowed scholars and practitioners concerned with refuges to imagine and make sense of the 'refugee experience' in psychological terms, one consequence of which has been the individualization and psychologisation of sociopolitical phenomena. It has also provided a vehicle for the expression of concerns and anxieties harbored by those who care for and control refugees, inscribing the failures of humanitarian governance and political settlements into the minds of the refugees. Finally, it has been an expression of how humanitarians understand and relate to refugees.

My purpose in this thesis was two-fold: to write a history of psychiatry through the lens of refugees and a history of refugees and medical humanitarianism through the lens of psychiatry. For the former, the case studies I have chosen and weaved together constitute a rich and varied history of psychiatry over a half century. The refugee mental health writings and practices I have explored illustrate several narratives in the history of psychiatry: from the dominance of psychoanalysis in mid-twentieth century central Europe to its decline and replacement by a phenomenological, symptom based, Americanised psychiatry in the form of DSM-III; from the racist assumptions of colonial psychiatry

through postcolonial and transcultural psychiatry's attempts to overcome this legacy by appealing to universalism, and culminating in the 'new cross-cultural psychiatry' that sought to decolonise itself by appealing to cultural relativism; the shift in the legacy and significance of trauma from one of suspicion and weakness to one of unassailable victimhood and moral injury. I have attempted to illustrate these transitions through an examination of diagnostic categories: from 'uprooting neurosis' to 'PTSD', from 'detribalisation' to the rapid social change of modernisation and urbanisation, and from 'social displacement syndrome' and 'displacement trauma' to 'cultural bereavement'.

As for a history of refugees and humanitarianism through the lens of psychiatry, I have tried to show how developments in refugee mental health have been used to make sense of, and inform, popular understandings of refugeedom and population displacement. The sociopolitical contextual influences on refugee mental health diagnosis and discourse illustrate changes and continuities in the international refugee regime and the institutions tasked with responding to population displacement. So, the diagnosis of 'DP apathy' made sense in a postwar context where European displaced persons were seen as a deadweight on an ailing European economy, but it was not a major theme in psychiatric discourse on Hungarian refugees who were, by contrast, active and industrious individuals who had made a choice to reject Communism. While DP apathy reflected the prolonged nature of refugee encampment, the rapid transit time of Hungarians, their speedy resettlement, and the host expectations placed on them were conducive to identity confusion and disorientation. The adoption of trauma in the 1970s reflected the rise of a new discourse of 'human rights' for which it was particularly well suited, allowing trauma to be fashioned as a tool of advocacy on behalf of refugees. I hope to have shown the merits of studying refugee history for history of medicine, and conversely the merits of studying history of medicine for refugee history.

What of practitioners' own sense of history and their place in it? Shifts in diagnostic categories serve to illustrate changes in societal ways of remembering. If the historical reference point for mid-twentieth century practitioners was the transatlantic migration of Europeans to the New World, for practitioners of the 1970s onwards, it was the Holocaust. In the case studies that this thesis begins and ends with, I have argued that different ways of remembering have been applied by psychiatrists to refugees. These psychiatrists drew on the frameworks available to them in their time and context, based on an awareness of their *own* place in history as opposed to that of the refugees they worked

with. As for a sense of the history of their own profession, this seems to have been marginal at best, with massive lacunae in institutional memories and each generation reinventing the wheel while unaware of a previous generation's work. Given these gaps, is it even possible to speak of a 'refugee mental health' field over the second half of the twentieth century? I argue that it is. Though my application of the term 'refugee mental health' to refer to an expanding body of knowledge since the 1940s is somewhat retrospective, I have shown beyond a doubt that psychiatrists developed a substantial interest in refugees and displaced populations as a discrete category beginning in the mid-1940s. Practitioners at the time considered this a novel area of research occasioned by an unprecedented world war and its aftermath, making it distinct from but still drawing on the 'nostalgia' of earlier centuries. That this body of knowledge went on to gather dust when Europe's refugee problems receded from view can be contrasted with the formative contribution it made to other subfields of psychiatry. In this sense, then, I have extended the assumed starting point of refugee mental health as a field back to the mid-twentieth century.

There are potential avenues for following up this research to include the voices of refugees. This could take the form of oral history interviews with refugees who have been through mental health services in camps or resettlement, and with refugees who have gone on to become medical practitioners trained in Western medicine. Interviews with medical practitioners from the Global South, who are well versed in both Western medicine and their own culture, could add another layer of complexity to this research. For example, Cambodian psychiatrist Sotheara Chhim has elaborated a trauma-based cultural syndrome in Cambodia called *baksbat,* or 'broken courage', which he calls a 'Cambodian idiom of distress with sufficient characteristics to be recognized as a formal cultural trauma syndrome distinct from PTSD.'[1]

Our understanding of the history of refugee mental health would benefit from more research into specific case studies. There is scope for further research into the history of refugee mental health in Africa, such as the work Yolana Pringle is currently doing on the origins, development, and impact of MHPSS from the 1970s to the 1990s in African countries. Research into mental health practices in Palestinian refugee camps would complement my research on Jewish Displaced Persons in Israel. Different refugee contexts

---

[1] Sotheara Chhim, 'Baksbat (broken courage): A trauma-based cultural syndrome in Cambodia', *Medical Anthropology,* (32)(2)(2013), 160-173.

would also allow for comparative studies. For example, while Indochinese refugees were given asylum in the United States, funding was made available for programs addressing their integration and mental health, and they were seen as traumatized victims, refugees from El Salvador and Guatemala got quite a different reception. With the US a supporter of the regimes they fled from, refugees from these countries were not granted asylum and lived in hiding and constant fear of discovery US immigration authorities, or 'La Migra' as the refugees called them. Fear of being betrayed to the Migra was one factor responsible for their low utilization of mental health services. The nature of stressors differed too. Sometimes, the most traumatic of experiences was discovery by the Migra. According to Adrianne Aron, a clinical psychologist in California, 'migraphobia' was endemic in Latino neighborhoods. When discovered and brought before a judge, they were treated not as victims deserving of sanctuary, but as criminals. In Aron's words 'All those problems that preoccupy new immigrants and are thought by some to constitute a "migration trauma" immediately pale before the single, overwhelming preoccupation: "Will I be sent back?"'[2] Yet another avenue of research is the intersection of human rights activism and psychoanalysis in the Latin American dictatorships, such as the work of the Chilean Elisabeth Lira and the Austrian-born Argentine Mimi Langer, which have been explored by Nancy Caro Hollander.[3]

My research points to assumptions and narratives in humanitarianism that need to be revisited. One such narrative is that of the assumed beginning of the science of refugee mental health in the 1970s and 1980s. What began in the 1970s/1980s was the refugee trauma approach, a hugely influential and globalized paradigm, but not the first time that psychiatrists, states, and international organisations fashioned mental health responses to population displacement. It is not so much when it actually started that is of interest, but the lack of institutional memory that has led to a forgetting of past experiences in different political contexts and diagnostic paradigms. I have already shown how a UNHCR policy report from 2013 on mental health and psychosocial support for refugees fails to mention that the agency had mental health advisers Hans Strotzka and Peter Berner in the late

---

[2] Adrianne Aron 'Refugees without sanctuary: Salvadorans in the United States', in Adrianne Aron (ed.), *Flight, Exile and Return: Mental Health and the Refugee* (21st Congress of the Interamerican Psychological Society: Havana, 1987), p.38.

[3] Nancy Caro Hollander, *Uprooted Minds: Surviving the Politics of Terror in the Americas* (Routledge: 2010).

1950s and early 1960s.[4] But it is not the only such institution. The International Committee of the Red Cross (ICRC) guidelines on MHPSS from 2016 describe mental health and psychosocial support as receiving 'increasing attention from public health actors in the past 15 years', with ICRC only extending its involvement in the area beyond a handful of teams in 2010.[5] Yet, as I have shown, refugee mental health was a concern to ICRC since the influx of Cambodians to the Thai border in 1979, with an effort led by Jean-Pierre Hiegel.[6] The point is not so much to correct understandings about when an agency's involvement in the field started, but that we can uncover and learn from experiences that happened before mental health in humanitarian relief became 'mainstream'.

The continued use of refugee camps as a response to population displacement needs to be scrutinized. Camps are a distinct policy choice, and one that makes those who live in them sick. Maria Pfister-Ammende wrote as far back as 1949 that camps' effect on mental health was 'frequently deeply pathological. The only satisfactory measure would be to abolish refugee camps'.[7] Richard Mollica told me as much in 2017. 'Should we, from a public health point of view be sponsoring, supporting and creating environments that make people sick? … We are, every day, these camps make people sick.'[8] UNHCR has belatedly recognized this, and recently released updated policy guidance on 'refugee protection and solutions in urban areas' in 2009 and on 'alternatives to camps' in 2014.[9] Refugees living in urban areas will have different mental health needs than those in camps. The urbanization of global refugee crises poses new challenges for refugees and those who care for them. Extra protection risks arise when refugees live in substandard or overcrowded housing, among the urban poor, and in places limited water and sanitation. There are

---

[4] Sarah Meyer, 'UNHCR's Mental Health and Psychosocial Support for Persons of Concern', *United Nations High Commissioner for Refugees*, 2013, [https://www.unhcr.org/51bec3359.pdf, accessed September 2019]

[5] International Committee of the Red Cross, 'Mental health and psychosocial support', 2016, [https://www.icrc.org/sites/default/files/topic/file_plus_list/4174_002_mental-health_web.pdf], pp. 1, 16.

[6] Two psychological practitioners I spoke to at ICRC in Geneva were not familiar with Hiegel's work. The archivist was.

[7] Maria Pfister-Ammende, 'Mental hygiene in refugee camps', in *Uprooting and After ...*, eds. Charles Zwingmann and Maria Pfister-Ammende (Springer: 1973), pp.241-251'.

[8] Interview with Richard Mollica, October 2017.

[9] UNHCR, 'UNHCR policy on refugee protection and solutions in urban areas', 2009 [Retrieved from https://www.unhcr.org/uk/protection/hcdialogue%20/4ab356ab6/unhcr-policy-refugee-protection-solutions-urban-areas.html]; 'Policy on alternative to camps', 2014 [Retrieved from https://cms.emergency.unhcr.org/documents/11982/45535/UNHCR+-+Policy+on+alternatives+to+camps/005c0217-7d1e-47c9-865a-c0098cfdda62]

increased risks of eviction and further displacement, and difficulties in securing employment.[10]

Certain assumptions in clinical practice with refugees deserve also deserve scrutiny, for example the assumption that refugees are traumatised. Peter Ventevogel, psychiatrist, anthropologist, and senior mental health expert at UNHCR acknowledges that 'mistakes were often made in mental health and psychosocial support programs', such as in assuming that all people in a crisis were traumatized and would need psychological help, in focusing on the traumatic events of their initial displacement rather than ongoing stressors of their situation in exile, using a 'service' model that emphasized pathology and victimhood over 'resilience and community self-help', in creating parallel service structures, and in directing scarce resources to identification of symptoms and provision of trauma counseling.[11] In my view, what needs to be drawn attention to is the very specific political context in which trauma and post-traumatic stress disorder were fashioned in the 1970s and 1980s in the United States. For Vietnam War veterans, medical recognition of psychological trauma served to provide political legitimacy to their struggles and suffering and entitled them to compensation. Similarly, asylum lawyers in Western countries have employed their refugee clients' psychological trauma stories with the aim of securing a tangible benefit for the client, approval of an asylum claim.[12] There is no comparable tangible benefit bestowed upon displaced populations in the Global South when they are designated as traumatized victims.

A related assumption is the universal applicability of 'trauma', which has been critiqued since the globalization of refugee trauma programs in the 1990s. For example, psychiatrist and philosopher Patrick Bracken, who worked with the Medical Foundation for the Care of Victims of Torture in Uganda, has questioned the wisdom of privileging the category of 'torture survivors' in a post-conflict situation where deprivation is

---

[10] UNHCR, 'Global Trends: Forced Displacement in 2019', 2019 [Retrieved from https://www.unhcr.org/5ee200e37.pdf], p.33

[11] Peter Ventevogel, 'Mental health of refugees in urban settings: a new challenge?', Mental Health Innovation Network Webinar, 2015, minute 04:00 [Retrieved from https://www.mhinnovation.net/mental-health-refugees-urban-settings-new-challenge-0].

[12] Didier Fassin and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood* (Princeton University Press: 2009).

widespread.[13] Derek Summerfield has questioned the applicability of a trauma in non-Western contexts.[14]

The relevance of nostalgia to clinical practice today also merits another look. I have argued that 'uprooting' related diagnoses of the postwar period and the 'cultural bereavement' of the 1980s retained within them what Jean Starobinski has called 'the idea of nostalgia' even though they did not use nostalgia as a diagnostic category.[15] There are clinicians today who hold on to the idea and see value in it for refugee mental health practice. For example, psychoanalyst Renos Papadopolous, who has worked with UNHCR, has written 'Whenever one thinks of refugees, from a psychological perspective, the first association is to trauma rather than to home … Yet, loss of home is the only condition that all refugees share, not trauma.' He uses the term 'nostalgic disorientation' to describe the 'multidimensional, deep and pervasive loss' refugees feel, akin to a sense of existential angst, or ontological insecurity.[16] This opens up an avenue for further research on the history of nostalgia by examining its persistence as an 'idea' in medicine.

The implications of this research for transcultural psychiatry and psychiatric practice with migrant and minority populations remain to be explored. Are patients well served by the selective appropriation of indigenous cultural concepts by Western psychiatry? Is there scope for an approach that harnesses the strengths of Western and indigenous understandings without subordinating the latter to the former? In particular, the assumed status of 'traditional' knowledge as frozen in time needs to be questioned. Who decides what concepts and practices are 'traditional', and do they remain 'traditional' or evolve after incorporation into Western biomedical thought? I plan to explore some of these questions and others raised by this research through training in psychiatry and doing a postdoctoral fellowship alongside my clinical practice.

---

[13] Patrick Bracken and Celia Petty (eds.), *Rethinking the Trauma of War* (Free Association Books: London, 1998).

[14] Derek Summerfield, 'A critique of seven assumptions behind psychological trauma programmes in war-affected areas, *Social Science and Medicine* 48(10)(1999), 1449-1462.

[15] Jean Starobinski and William S. Kemp (trans.), 'The idea of nostalgia', *Diogenes,* 14(54)(1966), 81-103

[16] Renos Papadopolous, 'Refugees, Home and Trauma' in Renos Papadopolous (ed.) *Therapeutic Care for Refugees: No Place Like Home* (Karnac Books: 2002), pp. 9, 16.

Bibliography

Archival sources

- **Australian Red Cross International Project Files, Australian Red Cross Society Archives, University of Melbourne**

2016.0057, Unit 5, Item 65, Kampuchea/Thailand Medical Team Reports (1)

Mission to Thailand Nov 79-Feb 80, Margaret L Robinson, April 1980

Report of 12 Week Assignment in Thailand, Joy Nicholls, January 1981

Report to Australian Red Cross Society on 12 week contract (February-May 1980) with Australian Medical Team 11 in Khao-I-Dang Holding Centre for Kampuchean Refugees, Anne Marie Margetts, January 1981

The Role of Traditional Medicine in Relief Operations, Introduction to Khmer Traditional Medicine based on Experience in the Refugee Camps in Thailand, Jean-Pierre Hiegel, March, 1980

2016.0057, Unit 5, Item 66, Kampuchea/Thailand Medical Team Reports (2)

Report for Australian Red Cross, Kamput Refugee Camp, Thailand, November 1979- February 1980, Miss Maureen Neilson

Report from ICRC Thailand Operation as a Nurse, July-September 1980', Anne Carswell

Final Report, Dr Laurie Warfe, ARC Society, Medical Coordinator – Nong Samet, February 1981

2016.0057, Unit 5, Item 67, Kampuchea/Thailand Medical Team Reports (3)

Final Report: Leaving Report Combined with a Six Months Summary of Work Within the Traditional Medicine Center, KID, by Mary Perkins to J-P Hiegel, July 1981

Final Report, Traditional Medicine – Kamput, Rosemary Brewin, July 1981

- **Cambodian American Women and Youth Oral History Program papers, Schlesinger Library, Harvard University, Cambridge, MA**

MC 814 # 1.4, Richard Mollica, et al., 'Turning point in Khmer mental health: Immediate steps to resolve the mental health crisis in the Khmer border camps', World Federation for Mental Health, Committee on Refugees and Migrants, 1989

MC 814 # 1.13, National Institute of Mental Health Research Scientist Development Application, not dated

MC 814 # 1.14, Richard Mollica and Russell Jalbert, 'Community of confinement: The mental health crisis in Site Two (displaced persons camps on the Thai-Kampuchean border)', World Federation for Mental Health, Committee on Refugees and Migrants, 1989

MC 814 # 7.1, 'Giving Refugees a Voice: New HSPH psychiatric program aids refugee trauma victims', Harvard Public Health Review, Spring 1990

MC 814 # 7.3, Interview w/Marguerita Reczyck, August 1991

MC 814 # 7.4, Interview w/Richard Mollica, 1991

- **UNHCR Archives Geneva, Records of the Central Registry, Assistance - Mental Health, REF 11/2/57-571, Fonds 11/Series 2/Box 901 ARC-2/A47**

Mental Health in the Primary Health Care Setting Workshop, Address by Ms. Brenda Grimwade, Coordinator of Social Work Services/WVFT/Bankaeng, February 1982

Mental Health in the Primary Health Care Setting Workshop, Address by Dr. Rangaraj, UNHCR Senior Health Coordinator, February 1982

Mental Health in the Primary Health Care Setting Workshop, Address by Dr. James S. Eaton Jr., MD, Chief, Psychiatry Education Branch, National Institute of Mental Health (USA), February 1982

Mental Health in the Primary Health Care Setting Workshop', Address by Dr J.P. Hiegel, MD, Neuropsychiatrist-Psychoanalyst/Coordinator of Traditional Medicine Centres/SOM/Khao-I-Dang, Ban Kaeng, Kamput', 'Psychological Needs of Refugees, Western Psychiatric Care and Kru Khmer's Approach to the Problems, Caring Role of Traditional Medicine Centres in the Khmer Holding Camps, February 1982

Mental Health in the Primary Health Care Setting Workshop, Address by Ms. Miriam Gilday, MSN/IRC, Coordinator of Medical Training, Khao-I-Dang, February 1982

Mental Health in the Primary Health Care Setting Workshop, Address by Robin Ray, RN, Psychiatric Nurse/ARC, Phanat Nikhom Transit Centre, February 1982

Mental Health Services for Indochinese Refugees, Mary Petevi, 26 October 1984

Note for the File, Psychiatric Treatment/Psychological Support to Indochinese Mentally Disabled Refugees in Switzerland and in the Federal Republic of Germany, Mary Petevi, March 1982

Report on Thailand Mission, Steven Muncy, 12 April 1984

Services for Indochinese: Some Helping and Hindering Forces', Diovelis D. Stone and Charles G. Ray

- **United Nations Archives New York**

S-1304-0000-0257, 'Psychological problems of displaced persons: a report prepared for the Welfare Division of the European Regional Office of UNRRA by the Inter-Allied Psychological Study Group'

S-1449-0000-0100, Assembly Centres Vol 1, Letter from Chairman of Welfare Committee of UNRRA to the British Undersecretary of State for War, September 1944

- **United Nations Library Geneva, UNHCR Collection**

CDR HEA/MEN/26 D, 'Recommendations related to the mental health component of a programme of assistance to the Indo-China refugees in Thailand', David Drucker, 14 October 1981; Attachment: 'A do-it-yourself information facility to disperse some of the tensions and generalised anxiety in the refugee camps'

CDR HEA/MEN/62 D, Dr Allison Umar, 'Refugee mental health: a comprehensive literature review and case study', MSc thesis, London School of Hygiene and Tropical Medicine, 1986

CDR HEA/MEN/182 D World Federation for Mental Health, Practical Measures for dealing with the Mental Health Problems of Refugees and Displaced Persons, 'Abraham Weinberg, 'Care for new immigrants in Israel: a summarising report on mental health work', 1952

CDR SER/CHOMI REPRINTS, 'The Indochinese Refugee Mental Health Problem', T.M. Tung, October 1979

- **World Federation for Mental Health US Committee papers, Oskar Diethlem Library, Cornell University, New York**

Box 31 Folder 14, RC Jech, 'The situation of the transplanted and homeless persons in Austria under mental health aspect; A report delivered to the WFMH at the Paris meeting, 1950'

Box 31 Folder 15, HBM Murphy, 'Remarks of Dr. HBM Murphy, Observer, IRO, at the Third Annual Meeting, Paris 1950'

Box 33 Folder 1, Walter Spiel, Extract of letter from Dr Spiel, Oesterreichische Gesellschaft fur Psychische Hygiene, December 18th, 1956

Box 33 Folder 1, Maria Pfister, 'Suggestions to the governments concerning the reception of Hungarian refugees'

Box 35 Folder 4, 'World Mental Health Year international objectives', July 1958

- **World Health Organisation Archives, Geneva**

M4-86-12(B) jacket 1, 'International Congresses of World Federation of Mental Health', Maria Pfister, 'Features and trends in the mental health work of WHO', 1961

M4-86-12(B) jacket 1, 'International Congresses of World Federation of Mental Health', Maria Pfister, 'Mental health as a public health responsibility', 1961

M4-86-12(B) jacket 5, 'International Congresses of the World Federation for Mental Health', 'Mental Health News', August/September 1988

M4-372-8 jacket 1, 'Coordination with World Federation for Mental Health', Letter from Maria Pfister to Hans Strotzka, 1 March 1959

Oral history interviews

Dr. Richard Mollica, October 2017

Published primary sources

Aall, Cato, 'Disastrous international relief failure a report on Burmese refugees in Bangladesh from May to December 1978', *Disasters,* 3(4)(1978), 429-34

Aall, Cato, 'Refugee problems in southern Africa', in *Refugee Problems in Africa,* (ed.) Sven Hamrell (Scandinavian Institute of African Studies: Uppsala, 1967), pp.26-44

Aall, Cato, 'Relief, nutrition and health problems in the Nigerian/Biafran War', *Journal of Tropical Pediatrics,* 16(2)(1970), 70-90

Anspach, C.K., 'Medical dissertation on nostalgia by Johannes Hofer, 1688', *Bulletin of the Institute of the History of Medicine* 2(6)(1934), 376-391

Arendt, Hannah, 'The Stateless People', *Contemporary Jewish Record,* 8(2)(1945), 137-153

Arendt, Hannah, 'We Refugees', in *Altogether Elsewhere: Writers on Exile,* (ed.) Robinson, Marc (Faber and Faber: Boston, 1994), pp. 110-119

Aron, Adrianne, 'Refugees without sanctuary: Salvadorans in the United States', in Adrianne Aron (ed.), *Flight, Exile and Return: Mental Health and the Refugee* (21st Congress of the Interamerican Psychological Society: Havana, 1987), pp. 23-53.

Assael, M and German, GA, 'Changing society and mental health in eastern Africa', *The Israeli Annals of Psychiatry and Related Disciplines* 8(1)(1970), 52-74

Austrian Society for Mental Health, 'Report of activity of the working team for Hungarian refugees of the Austrian society for mental health', *World Mental Health,* 9(2)(1957), 83-86

Bakis, Eduard, 'The so-called DP-apathy in Germany's DP camps', *Transactions of the Kansas*
§ Academy of Science (1903-), 55(1)(1952), 62-86

Bavin, Margaret, 'A contribution towards the understanding of the repatriated prisoner of war', *British Journal of Psychiatric Social Work,* 1(1)(1947), 29-35

Bennett, FJ, and Assael, MI, 'The mental health of immigrants and refugees from Rwanda at Kasangati, Uganda', *Psychopathologie Africaine,* 6(3)(1970), 321-344

Bracken, Patrick, and Petty, Celia, (eds.), *Rethinking the Trauma of War* (Free Association Books: London, 1998)

Chan, Kwok, and Loveridge, David, 'Refugees "in transit"': Vietnamese in a refugee camp in Hong Kong', *International Migration Review,* 21(3)(1987), 745-759

Chesters, Gwen, 'Social Services for Children and Their Families', *International Social Work*
5(3)(1962), 9-12

Chhim, Sotheara, 'Baksbat (broken courage): A trauma-based cultural syndrome in Cambodia', *Medical Anthropology,* (32)(2)(2013), 160-173

Coles, Harry L, and Weinberg, Albert K, *Civil Affairs: soldiers become governors* (Center of Military History United States Army, Washington DC: 1986)

Clark, Lance, 'The Refugee Dependency Syndrome: Physicians, Heal Thyself!', *Refugee Policy Group,* 1985 [http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:204, accessed October 2019]

Cuenod, Jacques, 'The problem of Rwandese and Sudanese refugees', in *Refugee Problems in*
Africa, (ed.) Sven Hamrell (Uppsala: Scandinavian Institute of African Studies, 1967), pp.45-53.

Davis, Matt, 'Giving Refugees a Voice: New HSPH psychiatric program aids refugee trauma victims', *Harvard Public Health Review,* Spring 1990, pp.10-17

Dick, Bruce, 'Diseases of refugees - causes, effects and control', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 78(6)(1984), 734-741

Dicks, Henry V, *Fifty Years of the Tavistock Clinic* (Routledge & Kegan Paul: London, 1970)

Dormandy, Thomas, Eldon, W, and Milner, CA, 'Medical care of Hungarian refugees', *The Lancet*, 269(6980)(1957), 1183-7

Duchesne-Cripps, Audrey, *The mental outlook of displaced persons as seen through welfare work in*
displaced persons camps (No named publisher: Cambridge, UK,1955)

Eisenbruch, Maurice, 'From post-traumatic stress disorder to cultural bereavement:

Diagnosis of Southeast Asian refugees', *Social Science and Medicine*, 33(6)(1991), 673-
760

Eisenbruch, Maurice, 'Toward a culturally sensitive DSM: Cultural bereavement in

Cambodian refugees and the traditional healer as taxonomist', *Journal of Nervous and Mental Disease*, 180(1) (1992), 8-10

Eitinger, Leo, 'A Clinical and Social Psychiatric Investigation of a 'Hard-Core' Refugee Transport in Norway', *International Journal of Social Psychiatry, 5*(4)(1960), 261-275

Eitinger, Leo, *Concentration Camp Survivors in Norway and Israel* (Universitetsforlaget: Oslo 1965
and Allen and Unwin: London, 1965)

Eitinger, Leo, 'Concentation camp survivors in Norway and Israel', in *Uprooting and After …*,
(eds.) Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp. 78-192

Eitinger, Leo, 'Mental diseases among refugees in Norway after World War II', in *Uprooting*
and After …, (eds.) Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp.193-203 (Condensed translation of Eitinger, Leo, 'Psykiatriske Undersokelser Blant Flyktninger I. Norge', Universitetsforlaget Oslo, 1958)

Eitinger, Leo, 'The symptomatology of mental disease among refugees in Norway', *Journal of Mental Science*, 106(444)(1960), 947-966

Flugel, JC, (ed.), *International Congress on Mental Health London 1948 Vol IV* (HK Lewis: London, 1948)

Friedman, Paul, 'The road back for the DPs: healing the psychological scars of Nazism', *Commentary,* December 1948 [https://www.commentarymagazine.com/articles/paul-friedman/the-road-back-for-the-dpshealing-the-psychological-scars-of-nazism/, accessed March 2020]

Future Life Orphanage, 'Phaly's Story (FLO founder)', eGlobal Family, [http://www.eglobalfamily.org/phaly-story.html, accessed 14 August 2019]

Gardner, Gwen, 'Employment and integration project for foreign refugees', *World Mental Health,* 10(1)(1958), 21-34

Ginsburgs, George, 'The Soviet Union and the problem of refugees and displaced persons 1917-1956', *American Journal of International Law,* 51(2)(1957), 325-361

Getlin, Josh, 'Treating the Tormented: In an Asian Refugee Camp, Pilot Mental Health Program Seeks to Ease the Despair', *LA Times,* January 1990. [https://www.latimes.com/archives/la-xpm-1990-01-04-vw-486-story.html, accessed Nov 2020]

German, GA, 'The Psychiatry of Poverty', *Psychopathologie Africaine* 7(1)(1971), pp.113-7

Hamrell, Sven, 'The problem of African refugees' in *Refugee Problems in Africa,* (ed.) Sven Hamrell (Scandinavian Institute of African Studies: Uppsala, 1967), pp. 9-25.

Harrell-Bond, Barbara, 'Foreword', in *Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research,* (ed.) Frederick Ahearn (Bergahn Books: New York, Oxford, 2000), pp. xii-xiii

Harrell-Bond, Barbara, *Imposing Aid: Emergency assistance to refugees* (Oxford University Press: Oxford, 1986)

Harvard Program in Refugee Trauma, 'Methodology - More', [http://hprt-cambridge.org/about/methodology/methodology-more/, accessed November 2020]

Healy, Joan, 'A Dialogue on Khmer Mental Health from Site 2/Thai-Cambodian Border (January 18th, 1990)', Refugee Studies Centre, Forced Migration Online, RSC/EK-61 HEA <http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:563>, [Accessed 14 Aug 2019]

Healy, Joan, *Writing for Raksmey: A Story of Cambodia* (Monash University Publishing: 2016)

Hoff, Hans, 'Survey of mental health activities in Austria in connection with the Hungarian refugees', *World Mental Health,* 9(1)(1957), 9-14

Hiegel, Jean Pierre, 'Collaboration with Traditional Healers: Experiences in Refugees' Mental Care', *International Journal of Mental Health,* 12(3)(1983), 30-43

Hiegel, Jean Pierre, 'Psychosocial and mental health needs of refugees – experience from SE Asia', *Tropical Doctor* (21)(supplement 1)(1991), pp.63-66

Hiegel, Jean Pierre, 'The ICRC and traditional Khmer medicine', *International Review of the*

Red Cross Archive, 21(224)(1981), 251-262

Hitchcox, Linda, *Vietnamese Refugees in Southeast Asian Camps* (Macmillan: Basingstoke, London, 1990)

Ingleby, David, 'Editor's Introduction', in *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced persons*, (ed.) David Ingleby (Springer: New York, 2005), pp.1-28

International Committee of the Red Cross, 'Mental health and psychosocial support', 2016, [https://www.icrc.org/sites/default/files/topic/file_plus_list/4174_002_mental-health_web.pdf, accessed December 2020]

Kleinman, Arthur, 'Depression, somatization and the "new cross-cultural psychiatry"', *Social Science and Medicine,*11(1)(1977), 3-9

Koranyi, EK, Kerenyi, AB, and Sarwer-Foner, GJ, 'Adaptive difficulties of some Hungarian immigrants - IV. The process of adaptation and acculturation', *Comprehensive Psychiatry*, 4(1) (1963), 47-57

Koranyi, EK, Letter to Yad Vashem dated 2010, in Tamas Szabo, *Who Was the Man in the Leather Coat?* (No named publisher: Munich, 2011), p.48. [Retrieved from http://mek.oszk.hu/09600/09621/pdf/who_was_the_man_in_the_leather_coat.pdf

Korwin, Marta, 'Mr. Matthew in Foster Home: A Study in Cultural Factors', *Social Work* 4(3) (1959), pp.104-108

Lambo, Thomas Adeoye, 'Observations on the role of cultural factors in paranoid psychosis among the Yoruba tribe, A study in comparative psychiatry', 1954, MD thesis University of Birmingham [https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.606852, retrieved October 2020]

Lewis, Diane E., 'Refugees find no refuge from memories, advocates say', *Boston Globe,* March 1989

Meerloo, Joost AM, *The Rape of the Mind: the psychology of thought control, menticide and brainwashing* (Grosset & Dunlap, New York: 1956)

Meszaros, AF, 'Types of displacement reactions among the post revolution Hungarian immigrants', *Canadian Psychiatric Association Journal*, 6(1)(1961), 9-19

Meyer, Sarah, 'UNHCR's Mental Health and Psychosocial Support for Persons of Concern', *United Nations High Commissioner for Refugees,* 2013 [https://www.unhcr.org/51bec3359.pdf, accessed September 2019]

Mezey, AG, 'Psychiatric Illness in Hungarian refugees', *Journal of Mental Science*, 106(443) (1960), pp. 628-637

Murphy, HBM, 'Assimilating the displaced person', *The Australian Quarterly,* 24(1)(1952), pp.46-59

Murphy, HBM, *Comparative Psychiatry: The International and Intercultural distribution of Mental Illness* (Springer-Verlag: Berlin, Heidelberg, 1982)

Murphy, HBM, 'The assimilation of refugee immigrants in Australia', *Population Studies,* 5(3)(1952), 179-206

Murphy, HBM, 'The camps', in *Flight and resettlement,* (ed.) HBM Murphy (UNESCO: Paris, 1955), pp.58-65

Murphy, HBM, 'The conditions of resettlement', in *Flight and Resettlement,* (ed.) HBM Murphy, (UNESCO: Paris, 1955), pp.91-98

Murphy, HBM, 'The extent of the problem', in *Flight and resettlement,* (ed.) HBM Murphy (UNESCO: Paris, 1955), pp.11-24

Murphy, HBM, 'The resettlement of Jewish refugees in Israel, with special reference to those known as displaced persons', *Population Studies,* 5(2)(1951), 153-174

Nansen, Odd, 'Nansen Medal Award Ceremony', *World Mental Health,* 10(1)(1958), 3-8

Niremberski, M, 'Psychological investigation of a group of internees at Belsen camp', *Journal of Mental Science,* 92(386)(1946), 60-74

Papadopolous, Renos, 'Refugees, Home and Trauma' in Renos Papadopolous (ed.) *Therapeutic Care for Refugees: No Place Like Home* (Karnac Books: London, 2002)

Pedersen, Stefi, 'Psychopathological reactions to extreme social displacements (refugee neuroses)', *The Psychoanalytic Review (1913-1957),* 36(4)(1949), 344-354

Pedersen, Stefi, 'Reaching safety', in *Flight and Resettlement* (1955), (ed.) HBM Murphy (UNESCO: Paris, 1955), pp.33-46

Perry, Jane, and Carey, Clark, *The Role of Uprooted People in European Recovery,* National
Planning Association Planning Pamphlet 64(1948), p.vii [retrieved from https://catalog.hathitrust.org/Record/002092415]

Pfister-Ammende, Maria, 'Displaced Soviet Russians in Switzerland', in *Uprooting and After …,* (eds.) Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp.73-102 (Translation from German of Pfister Ammende, Maria, 'Psychologische Erfahrungen mit sowjetrussischen Flüchtlingen' in *Die Psychohygiene*, (ed.) Pfister (Bern 1949)

Pfister-Ammende, Maria, 'Mental hygiene in refugee camps', in *Uprooting and After …*, (eds.)
Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp.241-251 (Revised translation from German of Pfister-Ammende, Maria, 'Psychohygiene und Psychotherapie bei der Flüchtlingsbetreuung', in *Die Psychohygiene*, (ed.) Pfister (Bern 1949) and Pfister-Ammede, Maria, Gedanken und Anregungen zur Situation in deutschen Flüchtlingslagern. Deutsches Jugendaufbauwerk 5 (1955) und Caritas 1955)

Pfister-Ammende, Maria, 'The Doctor as a Community Agent', *Bulletin of the Menninger Clinic*, 35(5)(1971), 353-362

Pfister-Ammende, Maria, 'The Long Term Sequelae of Uprooting: Conceptual and Practical Issues', in *Uprooting and Development; Dilemmas of Coping With Modernization*,
(eds.) George V. Coelho and Paul I. Ahmed (New York, London: Plenum Press, 1980), pp.153-173

Pfister-Ammende, 'The symptomatology, treatment, and prognosis in mentally ill refugees and repatriates in Switzerland, in *Flight and Resettlement,* (ed.) HBM Murphy (UNESCO: Paris, 1955), pp.147-172

Pfister-Ammende, Maria, 'The problem of uprooting', in *Uprooting and After …,* (eds.) Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp.7-18 (Translation from German of Pfister-Ammende, Maria, 'Zur Psychopathologie der Entwurzelung', *Bull. Schweiz. Akad. Wiss*, (8)(4)(1952), 338-345)

Pfister-Ammende, Maria, 'Uprooting and Resettlement as a Sociological Problem', in *Uprooting and Resettlement* (World Federation for Mental Health: London, 1960), pp.18-30

Potholm, Christian, 'Africa's Persistent Problem', *Africa Report,* 21(2)(1976), 12-15

Prins, Sal A, 'The individual in flight', in *Flight and resettlement,* (ed.) HBM Murphy (UNESCO: Paris, 1955), pp.25-32

Ratnavale, David, 'Mental Health of Refugees and Relief Workers', in *Years of Horror, Days of Hope: Responding to the Cambodian Refugee Crisis,* (eds). Barry Levy and Daniel Susott (Associated Faculty Press: Millwood, NY, New York City, London, 1986), pp.152-161

Rees, 'Foreword', in *Flight and Resettlement,* (ed.) HBM Murphy (UNESCO: Paris, 1955)

Rodd, Peter, 'The psychology of refugees', *Horizon*, 10(59)(1944), 312-319

Shils, Edward A, 'Social and psychological aspects of displacement and repatriation', *Journal of Social Issues,* 2(3)(1946), pp.3-18

Silove, Derrick, Ventevogel, Peter, and Rees, Susan, 'The contemporary refugee crisis: an overview of mental health challenges', *World Psychiatry* 16(2)(2017), 130-139

Spiel, Walter, 'Report on the work done for Hungarian refugees by the Austrian society for mental health', *World Mental Health,* 9(1)(1957), 15-18

Sterba, Editha, 'Homesickness and the mother's breast', *Psychiatric Quarterly,* 14(4)(1940), 701-707

Strotzka, Hans, 'Action for mental health in refugee camps', in *Planning and Action for Mental Health* (World Federation for Mental Health: London, 1961), pp. 240-258

Strotzka, Hans, 'Observations on the mental health of refugees', in *Uprooting and Resettlement* (World Federation for Mental Health: London, 1960), pp.58-76

Strotzka, Hans, 'Mental health aspects of camp clearance: The Activities of the Mental Health Advisor to the UN High Commissioner for Refugees (1959/1960)', in *Uprooting and After...,* (eds.) Charles Zwingmann and Maria Pfister-Ammende (Springer: Berlin, Heidelberg, 1973), pp. 282-290

Summerfield, Derek, 'A critique of seven assumptions behind psychological trauma programmes in war-affected areas, *Social Science and Medicine* 48(10)(1999), 1449-1462

Tyhurst, Libuse, 'Displacement and migration: a study in social psychiatry', *American Journal*

of Psychiatry 107(8)(1951), 561-568

Vernant, Jacques, *The Refugee in the Post-war World* (New Haven: Yale University Press, 1953)

Umar, Allison, 'Health care to Ugandan refugees in west bank - south Sudan', Paper presented at a symposium on 'Assistance to Refugees: Alternative Viewpoints', 1984 [http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:160]

UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 152, available at: https://www.refworld.org/docid/3be01b964.html [accessed 22 January 2020]

UNHCR, 'Global Trends: Forced Displacement in 2019', 2019 [Retrieved from https://www.unhcr.org/5ee200e37.pdf, accessed December 2020]

UNHCR, 'Policy on alternative to camps', 2014 [Retrieved from https://cms.emergency.unhcr.org/documents/11982/45535/UNHCR+-+Policy+on+alternatives+to+camps/005c0217-7d1e-47c9-865a-c0098cfdda62, accessed December 2020]

UNHCR, 'UNHCR policy on refugee protection and solutions in urban areas', 2009 [Retrieved from https://www.unhcr.org/uk/protection/hcdialogue%20/4ab356ab6/unhcr-policy-refugee-protection-solutions-urban-areas.html, accessed December 2020]

Ventevogel, Peter, 'Mental health of refugees in urban settings: a new challenge?', Mental Health Innovation Network Webinar, 2015 [https://www.mhinnovation.net/mental-health-refugees-urban-settings-new-challenge-0, accessed December 2020]

'Voices: Remembering the War', *The Washington Post,* 15 April 1985, p. A18

Weinberg, Abraham, 'Mental health of homeless and transplanted persons', *Bulletin of World Federation for Mental Health,* 3(4)(1951), 172-181

Weinberg, Abraham, 'Problems of adjustment of new immigrants to Israel, part 2', *Bulletin of World Federation for Mental Health,* 5(3) (1953), 129-134

Weintraub, Phillip, 'UNRRA: An Experiment in International Welfare Planning', *The Journal of Politics*, 7(1)(1945), 1-24

White, Ronald D., and Freundel, Jane, 'After a Traumatic Journey, Refugees Get Help Adjusting to U.S.', *The Washington Post*, 16 August 1979, p.MD3

World Federation for Mental Health, 'Mental health of transplanted and homeless persons', *Bulletin of World Federation for Mental Health,* 2(6)(1950), 17-18

World Federation for Mental Health, 'The problems of refugees', *Bulletin of World Federation for Mental Health*, 4(2)(1952), 96-98

World Health Organisation Expert Committee on Mental Health & World Health Organization, 'Expert Committee on Mental Health: report on the first session, Geneva, 29 August - 2 September 1949', WHO technical report series no. 9 (1950), [https://apps.who.int/iris/handle/10665/37979]

World Health Organisation Expert Committee on Mental Health & World Health Organization, 'Social psychiatry and community attitudes: seventh report of the Expert Committee on Mental Health [meeting held in Geneva from 20 to 25 October 1958]', WHO technical report series no. 177 (1959), [https://apps.who.int/iris/handle/10665/37997]

Secondary Sources

Alexander, Jeffrey C, *Trauma: A Social Theory* (Polity Press: Cambridge, UK, 2012)

American Psychiatric Association, 'Anxiety Disorders', in *Diagnostic and Statistical Manual of Mental Disorders, 3rd edition* (American Psychiatric Association: 1980), p.236.

Armstrong-Reid, Susan, and Murray, David R., *Armies of peace: Canada and the UNRRA years* (University of Toronto Press: Toronto, 2008)

Andreasen, Nancy, 'Acute and Delayed Posttraumatic Stress Disorders: A History and Some Issues', *American Journal of Psychiatry*, 161(8)(2004), 1321-1323

Bains, Jatinder, 'Race, culture and psychiatry: a history of transcultural psychiatry', *History of Psychiatry* (16)(2) (2005), 139-154

Balkelis, Thomas, 'Living in the Displaced Persons Camp: Lithuanian War Refugees in the West, 1944–54' in *Warlands: Population Resettlement and State Reconstruction in the Soviet-East European Borderlands, 1945-50*, (eds.) Peter Gatrell and Nick Baron (Palgrave Macmillan: Basingstoke, New York, 2009), pp.25-47

Beit-Hallahmi, Benjamin, 'Object relations theory' in *Encyclopaedia of psychology and religion,* (eds.) David Leeming, Kathryn Madden, Stanton Marlan (Springer: Boston, MA, 2010)

Bennett, Jennifer, and Farhoumand, Jian, 'Francis John Bennett', *British Medical Journal* (365:l4191) (2019)

Bracken, Patrick, *Trauma: Culture, Meaning and Philosophy* (Whurr Publishers: London, Philadephia, 2002)

Bon Tempo, Carl J., *Americans at the Gate: The United States and Refugees during the Cold War*

(Princeton: Princeton University Press, 2008)

Breslau, Joshua, 'Cultures of Trauma: Anthropological Views of Post-traumatic Stress Disorder in International Health', *Culture, Medicine and Psychiatry,* 28(2)(2004), 211-220

Brody, EB, 'Harry Stack Sullivan, Brock Chisholm, Psychiatry, and the World Federation for Mental Health', *Psychiatry: Interpersonal and Biological Processes,* 67(1)(2004), 38-42

Brody, EB, 'The World Federation for Mental Health: its origins and contemporary relevance to WHO and WPA policies', *World Psychiatry,* 3(1)(2004), 54-55

Bullard, Alice, 'Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry', in *Psychiatry and Empire*, (eds.) Sloan Mahone and Megan Vaughan (Palgrave Macmillan: London, 2007), pp.197-219

Bullard, Alice, 'L'Œdipe africain, a retrospective', *Transcultural Psychiatry*, 42(2)(2005), 171-203

Bynum, Bill, 'Railway Spine', *the Lancet,* 358(9278)(2001), p.339

Cohen, Gerard Daniel, *In War's Wake: Europe's Displaced Persons in the Postwar Order* (Oxford
University Press: New York, 2012)

Crouthamel, Jason and Leese, Peter (eds.), *Psychological Trauma and the Legacies of the First
World War* (Palgrave Macmillan: Basingstoke, 2017)

Davidhizar, R., 'The pursuit of illness for secondary gain', *The Health Care Supervisor*, 13(1)
(1994), 10-15

Deblinger, Rachel B., *'In a world still trembling': American Jewish philanthropy and the shaping of
Holocaust survivor narratives in postwar America (1945-1953*), Doctoral dissertation, UCLA, 2014

De Diego, Filiberto Fuentenebro and Ots, Carmen Valiente, 'Nostalgia: a conceptual history', *History of psychiatry,* 25(4)(2014), 404-411

Delille, Emmanuel, 'Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry Research Unit after World War II', *History of psychiatry,* 29(3)(2018), 282-296

Dodman, Thomas, *What Nostalgia Was; War, Empire and the Time of A Deadly Emotion* (The
University of Chicago Press: Chicago, London, 2018)

Dorland, Michael, *Cadaverland: Inventing a Pathology of Catastrophe for Holocaust Survival [The*

Limits of Medical Knowledge and Historical Memory in France] (Brandeis University Press: Waltham, MA, 2009)

Dudman, Paul, 'Oral History and Collective Memory: Documenting Refugee Voices and the Challenges of Archival Representation', *Atlanti*, (29)(2)(2019), 33-43

Editorial, 'Nostalgia: a vanished disease', *British Medical Journal,* 1(6024)(1976), 857-858

Fassin, Didier, and Rechtman, Richard, trans. Rachel Gomme, *The Empire of Trauma: An Inquiry into the Condition of Victimhood* (Princeton University Press: Princeton, 2009)

Fassin, Didier, *Les enjeux politiques de la santé: études sénégalaises, équatoriennes et françaises* (Karthala Editions: Paris, 2000), p.93; Quoted in Bullard, Alice, 'Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry', in *Psychiatry and Empire,* (eds.) Sloan Mahone and Megan Vaughan (Palgrave Macmillan: Basingstoke, New York, 2007)

Feinstein, Margarete Myers, 'All Under One Roof: Persecutees, DPs, Expellees, and the Housing Shortage in Occupied Germany', *Holocaust and Genocide Studies,* (32)(1)(2018), 29-48

Fernando, Suman, *Mental Health, Race and Culture* (Palgrave: Basingstoke, 2002)

Fotheringham, John, 'Psychopathic personality - a review', *Canadian Psychiatric Association Journal,* 2(1)(1957), 52-75

Frank, Matthew, and Reinisch, Jessica, 'Refugees and the nation-state in Europe, 1919–59', *Journal of Contemporary History*, 49(3)(2014), 477-490

Foucault, Michel, Interview with Francois Ewald, "Le Souci de la verite ́", *Magazine litteraire,* 207(May 1984), p. 18, quoted in Gary Gutting, (ed.), *The Cambridge Companion to Foucault* (Cambridge University Press: Cambridge, UK, 2005).

Freis, David, *Psycho-politics between the World Wars: Psychiatry and Society in Germany, Austria, and Switzerland* (Palgrave Macmillan: 2019)

Freud, Sigmund and Breuer, Josef, *Studies in Hysteria* (1893), cited in (ed.) Caroline Garland, *Understanding Trauma* (Karnac: 2002)

Futselar, Ralf, 'From camp to claim' in *The Politics of War Trauma: The Aftermath of World War II in Eleven European Countries,* (eds.) Jolande Withuis and Annet Mooij (Aksant: Amsterdam, 2010)

Galatzer-Levy, Robert M., 'Psychoanalysis, Memory and Trauma', in (eds.) Paul] Appelbaum, Lisa Uyehara and Mark, *Trauma and Memory: Clinical and Legal Controversies* (Oxford University Press: New York Cirty, 1997), 138-157.

Garland, Caroline (ed.), *Understanding Trauma: A Psychoanalytic Approach* (Karnac: 2002)

Gatrell, Peter, 'Population displacement in the Baltic region in the twentieth century: from "refugee studies" to refugee history', *Journal of Baltic Studies,* 38(1)(2007), 43-60

Gatrell, Peter, 'Refugees - What's wrong with history?', *Journal of Refugee Studies,* 30(2)(2017), 170-189

Gatrell, Peter, *The Making of the Modern Refugee* (Oxford University Press: Oxford, 2013)

Gatrell, Peter, 'The world-wide web of humanitarianism: NGOs and population displacement in the third quarter of the twentieth century', *European Review of History,* 23(1-2)(2016), 101-115

Goffman, Erving, *Asylums: Essays on the social situation of mental patients and other inmates* (Anchor Books: New York, 1961)

Gramaglia, Letizia, 'Migration and Mental Illness in the British West Indies 1838–1900: The Cases of Trinidad and British Guiana Letizia Gramaglia' in Catherine Cox and Hilary Marland, *Migration, Health and Ethnicity in the Modern World* (Palgrave Macmillan: London, 2013), pp.61-82

Gulland, Anne, 'Thomas Dormandy', *British Medical Journal* (2013). [Retrieved from https://www.bmj.com/bmj/section-pdf/187880?path=/bmj/346/7906/Obituaries.full.pdf]

Hansen, Randall, 'State controls: borders, refugees, and citizenship', in *Oxford Handbook of Refugee and Forced Migration Studies,* (eds.) Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona (Oxford University Press: Oxford, 2014), pp.253-264

Harper, Marjory (ed.), *Migration and mental health: past and present* (Palgrave Macmillan: London, 2016)

Harrell-Bond, Barbara, 'The experience of refugees as recipients of aid' in *Refugees: Perspectives on the Experience of Forced Migration,* (ed.) Alistair Ager (Cassell: 1999)

Heaton, Matthew, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonisation and the Globalisation of Psychiatry* (Ohio University Press: Athens, 2013)

Heaton, Matthew, 'The politics and practice of Thomas Adeoye Lambo: towards a post-colonial history of transcultural psychiatry', *History of psychiatry,* 29(3)(2018), 1-16

Herman, Judith, *Trauma and Recovery: The Aftermath of Violence - from Domestic Abuse to Political Terror* (Basic Books: New York, 1992)

Herzog, Dagmar, *Cold War Freud: Psychoanalysis in an Age of Catastrophe* (Cambridge University Press: Cambridge, UK, 2017)

Holborn, Louise, *Refugees, a problem of our time: the work of the United Nations High Commissioner for Refugees, 1951-1972 (Vol. 2),* (Scarecrow Press: Metuchen, NJ, 1975)

Hollander, Nancy Caro, *Uprooted Minds: Surviving the Politics of Terror in the Americas* (Routledge: New York, London, 2010)

Hollander, Philip *From Schlemiel to Sabra: Zionist Masculinity and Palestinian Hebrew Literature* (Indiana University Press: Bloomington, 2019)

Iacovetta, Franca, *Gatekeepers: Reshaping immigrant lives in Cold War Canada* (Between the Lines: Toronto, 2006)

International Pilot Study of Schizophrenia and World Health Organization, 'Report of the International Pilot Study of Schizophrenia' (Geneva: World Health Organisation, 1973) [https://apps.who.int/iris/handle/10665/39405]

Johnson, Alexander and Pahor, Daša, 'Magdalena Lipkowska a.k.a. Marta Korwin', Antiquariat Daša Pahor, 2019 [http://antiquariat-pahor.de/korwinny2.pdf, accessed March 2020]

Kain, Jennifer S, *Insanity and Immigration Control in New Zealand and Australia, 1860–1930* (Palgrave Macmillan: Basingstoke, 2019)

Keller, Stephen, *Uprooting and Social Change: The Role of Refugees in Development* (Manohar Book Service: New Delhi, 1975)

Kienzler, Hanna and Pedersen, Duncan, 'Strange but common bedfellows: The relationship between humanitarians and the military in developing psychosocial interventions for civilian populations affected by armed conflict', *Transcultural Psychiatry,* (49)(3-4) (2012), 492-518

Knight, Robert, 'National construction work and hierarchies of empathy in postwar Austria', *Journal of Contemporary History,* 49(3)(2014), 491-513

Knobloch, Hilda, 'Teaching about mental subnormality to the medical student and physician: a conference report', *Pediatrics,* 31(1)(1963), 146-150

Kunz, Egon F., 'The refugee in flight: Kinetic models and forms of displacement', *International Migration Review,* (7)(2)(1973), 125-146

Leese, Peter and Crouthamel, Jason (eds.), *Traumatic Memories of the Second World War and After* (Palgrave Macmillan: Basingstoke, 2016)

Leys, Ruth, *Trauma: A Genealogy* (University of Chicago Press: Chicago, 2010)

Loescher, Gil, *The UNHCR and World Politics: A perilious path* (Oxford University Press: Oxford, 2001)

Long, 'Rethinking "durable" solutions', in *Oxford Handbook of Refugee and Forced Migration Studies,* (eds.) Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona (Oxford University Press: Oxford, 2014), pp.475-85

Long, Katy, 'Rwanda's first refugees: Tutsi exile and international response 1959–64', *Journal of Eastern African Studies,* (6)(2)(2012), 211-229

Lovell, Anne, 'The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands' *International journal of epidemiology*, 43(suppl_1)(2014), i6-i18

Madokoro, Laura, *Unwanted Refugees: Chinese Migration and the Making of a Global Humanitarian Agenda,* PhD thesis, University of British Columbia, Vancouver, 2012 [Retrieved from https://www.collectionscanada.gc.ca/obj/thesescanada/vol2/BVAU/TC-BVAU-43061.pdf, accessed December 2020]

Malkki, Liisa, 'National geographic: The rooting of peoples and the territorialization of national identity among scholars and refugees', *Cultural anthropology,* 7(1)(1992), 24-44

Malkki, Liisa, 'Refugees and Exile; From "Refugee Studies" to the National Order of Things', *Annual Review of Anthropology,* 24(1)(1995), 495-523

Marfleet, Philip, 'Refugees and history: why we must address the past', *Refugee Survey Quarterly,* (26)(3)(2007), 136-148

Markowitz, Arthur A., 'Humanitarianism versus restrictionism: The United States and the Hungarian refugees', *International Migration Review,* 7(1)(1973), 46-59

McCarthy, Angela, and Coleborne, Catharine (eds.), *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010* (Routledge: New York, London, 2012)

McConnachie, Kirsten, 'Camps of containment: A genealogy of the refugee camp', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 7(3)(2016), 397-412

Micale, Mark, and Lerner, Paul (eds.), *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge University Press: New York, 2001)

Moncrieff, Joanna, 'Neoliberalism and biopsychiatry: a marriage of convenience', in *Liberatory Psychiatry: Philosophy, Politics, and Mental Health,* (eds.) Carl I. Cohen and Sami Timimi (Cambridge University Press: New York, 2008), pp. 235-255

National Research Council (US) Roundtable on the Demography of Forced Migration; Reed HE, Keely CB, editors. Forced Migration & Mortality. Washington (DC): National Academies Press (US); 2001. 5, The Demographic Analysis of Mortality Crises: The Case of Cambodia, 1970-1979 [https://www.ncbi.nlm.nih.gov/books/NBK223346/]

Novick, Peter, *The Holocaust in American Life* (Houghton Mifflin: Boston, 1999)

Ong, Aihwa, *Buddha is hiding: Refugees, citizenship, the new America* (University of California
Press: Berkeley, Los Angeles, 2003)

Oyeode, Femi, 'Thomas Adeoye Lambo O.B.E.', *Psychiatric Bulletin,* 28(12)(2004), 469

Paviour, Ben, 'Tough Truths', *The Cambodia Daily,* February 2017
[https://www.cambodiadaily.com/news/tough-truths-125294, accessed 14 August 2019]

Persson, Sune, 'Folke Bernadotte and the White Buses', *The Journal of Holocaust Education,*
9(2)(2009), 237-268

Porter, Roy, 'The patient's view: Doing medical history from below', *Theory and Society,*
14(2)(1985), 175-198.

Prince, Raymond, 'In Memoriam: Henry BM Murphy 1915-1987, *Transcultural Psychiatric Research Review,* 24(3)(1987), 247-254

Pringle, Yolana, *Psychiatry and Decolonisation in Uganda* (Palgrave Macmillan: London, 2019)

Punzi, Elisabeth, 'Ellen Stephanie (Stefi) Pedersen', Svenskt kvinnobiografiskt lexikon,
[https://skbl.se/en/article/StefiPedersen, accessed September 2019]

Pupavac, Vanessa, 'Human security and the rise of global therapeutic governance: analysis', *Conflict, Security and Development,* 5(2)(2005), 161-181

Pupavac, Vanessa, 'Psychosocial interventions and the demoralization of humanitarianism', *Journal of Biosocial Science,* 36(4)(2004), 491-504

Pupavac, Vanessa, 'Refugees in the 'sick role': stereotyping refugees and eroding refugee rights', *New Issues in Refugee Research,* Research Paper No. 128, 2006.
[https://www.unhcr.org/44e198712.pdf, accessed August 15, 2019]

Pupavac, Vanessa, 'Therapeutic governance: psychosocial intervention and trauma risk management', *Disasters,* 25(4)(2001), pp.358-372

Rees, J.R., 'George Ronald Hargreaves, OBE, M. Sc.(Leeds), FRCP (Edin.) (1908-1962)', *American Journal of Psychiatry,* 119(11)(1963), 1117

Reinisch, Jessica, '"Auntie UNRRA" at the Crossroads', *Past and Present,* 218(suppl_8)(2013), 70-97

Reinisch, Jessica, 'Internationalism in Relief: The Birth (and Death) of UNRRA, *Past and Present,* 210(suppl_6)(2011), 258-289

Robinson, Douglas, *Displacement and the Somatics of Postcolonial Culture* (Ohio State University

Press, Columbus: 2013)

Rockenbach, Ashley Brooke, 'Accounting for the past: a history of refugee management in Uganda, 1959-64' in (eds.) Kristin Bergtora Sandvik and Katja Lindskov Jacobsen, *UNHCR and the Struggle for Accountability: Technology, law, and results-based management* (Routledge: 2016), 119-137

Rosen, George, 'Nostalgia: a "forgotten" psychological disorder', *Psychological Medicine,* 5(4)(1975), 29-51

Russell, G., 'Alexander Goldfeder Mezey', *Psychiatric Bulletin*, 32(10)(2008), 397-398

Salvatici, Silvia, *A history of humanitarianism, 1755–1989: In the name of others* (Manchester University Press: Manchester, 2019)

Salvatici, Silvia, '"Help the people to help themselves": UNRRA Relief Workers and European Displaced Persons', *Journal of Refugee Studies,* 25(3)(2012), 428-451

Silvia Salvatici, '"Fighters without guns": humanitarianism and military action in the aftermath of the Second World War', *European Review of History,* 25(6)(2018), 957-976.

Schwartz, J.M., and Cook, T., 'Archives, records, and power: The making of modern memory', *Archival Science*, 2(1–2)(2002), 1-19

Shawcross, William, *The Quality of Mercy: Cambodia, Holocaust and Modern Conscience* (Fontana Press: Great Britain, 1985)

Shephard, Ben, *After Daybreak: The Liberation of Belsen, 1945* (Schocken Books: New York, 2005)

Shephard, Ben, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Harvard University Press: Cambridge, MA, 2003)

Shephard, Ben, *The Long Road Home: The Aftermath of the Second World War* (Bodley Head: London, 2010)

Soi, Isabella, 'Uganda-Rwanda Relations: Crossing the Border into Politics', *Afriche e Orienti,* 1(2020), 29-47

Starobinski, Jean and Kemp, William S. (trans.), 'The idea of nostalgia', *Diogenes,*14(54)(1966), 81-103

Stein, Barry, 'The experience of being a refugee: Insights from the research literature', in *Refugee mental health in resettlement countries,* (eds.) C Williams and J Westermeyer (Hemisphere Publishing Corp: Australia, 1986), pp.5-23

Taithe, Bertrand, 'The Cradle of the New Humanitarian System? International Work and

European Volunteers at the Cambodian Border Camps, 1979–1993', *Contemporary European History*, 25(2)(2016), 335-358

Tarantola, Daniel, 'A perspective on the history of health and human rights: from the Cold War to the Gold War', *Journal of Public Health Policy,* 29(1)(2008), 42-53

Taylor, Becky, '"Their Only Words of English Were 'Thank You'": Rights, Gratitude and "Deserving" Hungarian Refugees to Britain in 1956', *Journal of British Studies* 55(1)(2016), 120-144

Torre, Costanza, 'Psychosocial support (PSS) in war-affected countries: a literature review', Politics of Return Working Papers (3), Conflict Research Group, LSE, London, UK, 2019 [http://eprints.lse.ac.uk/100199/, accessed 5 Aug 2019]

Torre, Costanza, et al., 'Is promoting war trauma such a good idea?', *Anthropology Today* (35)(6) (2019), 3-6

Tsing, Anna Lowenhaupt, *The Mushroom at the End of the World: On the Possibility of Life in Capitalist Ruins* (Princeton University Press: Princeton, 2015)

University of Oslo, 'About Leo Eitinger', [https://www.uio.no/english/about/facts/awards/human-rights/leo-eitinger/, accessed September 2019]

Walugembe, James, 'A pioneer's look at psychotrauma in Uganda: "Post-traumatic stress disorder as seen in Mulago Hospital Mental Health Clinic (1992)"', *African Journal Of Traumatic Stress* (1)(1)(2010), 6-18

Weindling, Paul, '"Belsenitis": Liberating Belsen, Its Hospitals, UNRRA, and Selection for Re-emigration, 1945–1948', *Science in Context,* (19)(3)(2006), 401-418

White, Benjamin Thomas, *The Emergence of Minorities in the Modern Middle East: The Politics of Community in French Mandate Syria* (Edinburgh University Press, Edinburgh, 2011)

Wu, Harry, 'World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948–c. 1965', *History of Psychiatry,* 26(2)(2015), pp.166-181

Young, Allan, *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder* (Princeton University Press: Princeton, 1995)

Zahra, Tara, '"The Psychological Marshall Plan": Displacement, gender, and human rights after World War II', *Central European History,* 44(1)(2011), 37-62

Zalashnik, Rakefet, 'The psychiatrically hospitalised survivors in Israel', in Dori Laub and Andreas Hamburger (eds.), *Psychoanalysis and Holocaust Testimony: Unwanted Memories of Social Trauma* (Routledge: New York, 2017), pp.185-194

Zalashik, Rakefet and Davidovitch, Nadav, 'Measuring Adaptability: Psychological

Examinations of Jewish Detainees in Cyprus Internment Camps', *Science in context,* 19(3)(2006), 419-41

Zamore, Leah, 'Refugees, development, debt and austerity: a selected history', *Journal on Migration and Human Security,* 6(1)(2018), 26-60