The social lives of 'trauma':
Vernacularizing psychiatric discourse in post-conflict northern Uganda

Summary

People around the world are not passive recipients of mental health interventions. They reframe mental health activities within local worlds, and they adopt and use the psychiatric language from mental health intervention for new purposes. At the same time, experiences of distress exist before the entrance of psychiatric terminology, and these experiences live in their own local and complex worlds and are part of local power relations and markets of healing.

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Background

Since the 1990s, humanitarian intervention programs have taken a 'psychological turn' by focusing more on 'trauma', 'psychosocial support' and 'mental health' as core elements. However, these interventions are not deployed into a vacuum, nor are they a-cultural.

Anthropologists working in different parts of the world (Liberia, Haiti, Indonesia) have shown how psychological interventions create new cultural practices and how psychiatric concepts become part of local terminology and understandings of the world[1]. In northern Uganda there has been a massive influx of mental health interventions since the end of the recent war in the region in 2006. Here mental health interventions range broadly from trauma-focused psychotherapy to a variety of psychosocial activities.

This research set out to examine how people understand and use the psychiatric language and practices that came with the many interventions. The fieldwork was conducted under the Trajectories of Displacement grant hosted at Firoz Lalji Centre for Africa at the London School of Economics and Political Science, where formal ethical approval was obtained.

Methods

The research builds on ethnographic fieldwork in northern Uganda between 2015 and 2019. During this period, interviews were conducted with employees from four different NGOs who work with mental health interventions in several ways, both psychotherapeutically and through broader psychosocial activities; with local leadership; and with practitioners from NGOs (who were often from the local area). Interviews and participant observations were conducted in two small villages in northern Uganda including Gulu Town. Furthermore, archival material of videos of cleansing rituals framed as psychosocial activities arranged by NGOs in the region were studied systematically.

[1] Behrouzan, 2016; Abramowitz, 2010; James, 2010; 2004; Bubandt, 2015; 2008.

Findings

1. Symptoms of mental disorder, e.g. psychosis, hearing voices, intrusive memories, sleep deprivation, visions of dead people, wandering around without purpose, lack of emotional control – can be interpreted in a series of different ways. These include spiritual pollution caused by breaking moral rules (e.g. handling dead bodies in incorrect manner); as possession by the Devil; as psychological trauma originating in experiences of violence during the war – or in different *combinations* of all of these. Explanatory models for understanding symptoms are not separate and static, but continuously evolve and mix together traditional, Christian, Muslim and biomedical ideas, understandings and terminology.
2. Languages and practices around 'trauma' are adopted and transformed in a series of ways. 'Trauma' is used to refer to (at least) the following; (1) symptoms relating to atrocious experience of violence in the past; (2) uncertainties about the future; (3) something the spirits can bring onto you as a state of disorder, either by misfortune or through moral trespass, (4) as an illness-phase on a continuum ranging from mentally healthy, over disordered states of 'pre-madness' – which are often referred to as 'trauma' – to finally (5) a state of full-blown madness, from which there is usually no return. This implies a fluidity in language and concepts used when something is not the way it is supposed to be – not unlike how 'trauma' or 'depression' are used in everyday-English by non-clinicians to express all sorts of malaises.
3. NGOs working in northern Uganda use different strategies when dealing with local understanding of mental health symptoms as connected to spirits or spiritual pollution. Some dissuade local people from these interpretations e.g. through psychoeducation, others go along with local understandings and support – financially and organizationally – cleansing rituals of people or areas. These opposing strategies are based on different understandings of the importance of local interpretations. Cleansing rituals may be beneficial – but evaluating their effectiveness is complex in Northern Uganda due to (1) local power relations in terms of who has the authority and resources to execute the cleansing rituals, and (2) the sometimes fierce disagreements over whether 'traditional ways' are a good path for healing or not.

Recommendations

1. Mental health program designers and implementers/practitioners must make an effort to understand local interpretations of symptoms before, but also *during* and *after*, implementation in order to prevent misunderstandings around the purpose of the intervention. This understanding by beneficiaries is important, because part of the success of a mental health intervention is that beneficiaries and practitioners have common goals for the intervention. Particularly, after the intervention there are often no follow-ups on how the intervention was *understood by beneficiaries* (only on how beneficiaries score on symptom-scales).
2. Be aware of the power of language and terminology; Psychiatric language and concepts – like 'trauma' – might already exist locally but have different (and perhaps more nuanced) meanings than in clinical usage. Particularly consider this if the intervention involves 'psychoeducation' and the introduction of new knowledge. Consider if there are local words

that could be used as part of the intervention and/or if the idea you are trying to convey exists in a different form locally.

3. In-line with the IASC guidelines for MHPSS in Emergencies[2], there is a need to understand which existing local resources serve the purpose of 'mental health services' (e.g. traditional healers, churches, local psychiatric services, etc.). Consider if mental health interventions can or should *build on* these existing 'mental health services'. This could prevent both misunderstanding of interventions and make them more relevant by helping to identify core mental health problems instead of assumed problems. If this is done, there is a need to understand that local/traditional methods are complex and always embedded within local power relations – this is important, but not emphasized in the guidelines. A local market of healing often exists, in which people compete with one another. Implementers must carefully consider who the recipients of resources are, who might be missing out, and what the consequences might be.
4. There is a broader need to include anthropological knowledge and cultural experts on/from the region throughout mental health and psychosocial support interventions. Particularly, long-term qualitative follow-up evaluation of any intervention, which lets beneficiaries themselves express concerns or improvements, is necessary for interventions to be both ethical and effective.

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[2] Inter-Agency Standing Committee. (2007). *IASC guidelines on mental health and psychosocial support in emergency settings.* Geneva, Switzerland: https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf