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Summary Article

War and women mental health

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The two publications deal with the important interactions between war, the consequences for the mental health of the women involved and the gender specific aspects of treatment hereof. War is increasingly touching civilians, and has consequences for the health of all involved, but many aspects of war affect the health of women disproportionately. Thus, wars have brought immense sexual violence and pervasive social changes into the lives of women (Arcel & Kastrup, 2004). Life is often marked by loss of family members, of social network, and of social position due to e.g. widowhood or unemployment. Together with the economic effects of war and the difficult access to basic supplies, this places women in a vulnerable social position. It is a fact that violence in wartime permeates the entire society but – and this is particularly the case in patriarchal societies - as long as women are true to their gender roles they are seen as valuable, performing functions as nurses, wives, mothers or prostitutes. Due to the absence of men who are at war, or killed, the female gender role changes as women get greater responsibility as breadwinners. In such situations women may develop a new autonomy and new skills.

Adequate medical care in post-war countries is rarely available, and women may suffer from war-induced health problems without receiving adequate medical care (Arcel et al., 2003). Further we may observe gender discrimination in the distribution of emergency relief, and food supplies often fail to reach women survivors of armed conflicts (Fitzpatrick, 1994).

Sexualised violence against women during war

Sexual violence against women during armed conflict is a clear example of gender discrimination. The particular problems of displaced or refugee women receive increasing attention by international organisation (UNHCR Global consultations, 25.4.2002). Sexual violence may take many forms and includes e.g. rape, forced pregnancy, of sexual mutilation, forced abortions, forced prostitution, the exchange of sexual services for food or access to health services.

Rape is a weapon of war that spreads terror and humiliates and silences women and their families, and it may result in the development of social outcasts, as raped women in some societies are marginalized. Further, life in exile may be full of risks and not providing personal security to women (Arcel, 2002). They risk sexual exploitation in settings such as detention camps, and refugee camps (Gardam & Jarvis 2001; Arcel 1998).

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Psychological consequences

The psychological consequences of war are well documented and frequently persistent and invalidating. Among the prevailing manifestations are anxiety, depression, irritability, emotional instability, cognitive disturbances, personality changes, behavioural disturbances, neuro-vegetative symptoms, such as lack of energy, sleep disturbances, and sexual dysfunction (Holtz, 1998). Sexually violated women complain of fear, betrayal, and guilt, and feelings of shame may prevent them from reporting sexual violence. It is important to analyse the manifested symptoms bearing in mind that such behaviour may represent pathology attached to the traumatic experiences themselves or be situation -specific responses to current stresses, racial discrimination or lack of personal control in the new settings (Arcel et al., 1995). If properly investigated, sexually traumatised women will often be given the diagnosis of post-traumatic stress disorder.

Reactions to psychological and sexual trauma seem of a universal nature. However, the severity and cultural interpretations of symptoms, and the coping strategies may vary from culture to culture (Kastrup & Arcel, 2004).

Sexual abuse of women has traditionally been seen as a "by-product of war". First the rapes of women in former Yugoslavia gave rise to an international outcry of women's organisations and brought the UN in action. It remains to be proved whether it will have any effect in future wars. There are many reasons to focus on gender specific problems in relation to refugees and war victims as women and men face different life situations and have different social roles. Information on gender is essential in planning and evaluating interventions for refugees.

Despite the fact that we have guidelines for protecting the rights of refugee women they may not be implemented. Furthermore women may have no access to legal aid, and the perpetrators of violence may receive no punishment. There is an increasing recognition that gender aspects are important when considering refugee laws as women may have special reasons for applying for asylum but also that women may receive no protection from authorities for their abusive partners.

Marital roles

Inadequate attention has been paid to the relation between marital adjustment and post-traumatic symptoms among refugees. Women fulfill the role of nurturers and providers of emotional support. Consequently, exposure to disaster for the household may overload their capacity to cope. Women tend to have the main responsibility for care giving and they frequently have little time to consider their own needs due to their preoccupation with the needs of their immediate family.

It is well established that gender role conflicts and adverse life events may precipitate anxious and depressive disorders in women with young children. Refugee women may be particularly vulnerable to such stress and consequently have a heightened risk of affective disorders (Matthey et al., 1999).

THERAPEUTIC ASPECTS Refugee women in mental health settings of a host-country often share common traits that challenge therapeutic systems including (Kastrup & Arcel, 2004):

a) *Polytraumatisation*
   Many women will have experienced numerous traumatic experiences, and conditions for women in war and refugee camps may be harmful for both physical and mental health (Arcel et al., 1998). Consequently they will suffer from traumatic experiences acting cumulatively.
b) *Referred by third persons after chronic somatic and psychological problems*
   Frequently, a third party refers the woman after it is revealed that her problems are mainly of a psychological nature. There is often a discrepancy between the problems as perceived by

the professional and the referred person herself. Her concern may focus on her somatic symptoms seeking a relief for them and she may have an unclear expectation regarding the psychological aspects.

The woman may have little knowledge about psychotherapy and show a certain resistance in talking with a psychiatrist/psychologist. The woman may be impatient and often hope for a rapid improvement of her symptoms. If this is not the case, she may question the credibility of the therapist and may lead to her breaking the contact. Whereas the Western therapist is trained on working with self-disclosure, the woman may prefer, at least initially, to be silent about her traumatic experiences.

c) *The woman's social context may question psychotherapy as a legitimate method and increase social control of her*

The physical mobility and social independence of the refugee woman will often be restricted by her social network which may view treatment for psychological problems as a non - legitimate method of treatment. Working with traumatised women from many different nationalities reveal how the social control of women in refugee groups is frequently more prominent in the host than the home country. Males may feel threatened in their new social role and focus on correct female behaviour, maybe due to a fear that women become westernised.

d) *Cultural and social distance between therapist and client*

Therapist and client may differ in language, education, socio-economic status. Religious, educational and cultural differences can be a challenge for the professional.

e) *Current stresses are in the foreground*

Immigration places a lot of stress on life as a refugee. Insecurity in refugee status, housing, separated families, unemployment, poverty, lack of integration in society and work, all contribute to the reactivation of traumatic symptoms, or may even create new ones. The client may hope that the therapist will be able to solve her acute material and practical problems rather than talking about trauma.

All the above conditions put challenges on therapeutic systems to cover the primary needs of traumatised clients: physical and emotional safety, predictability of relationships, and reduction of symptoms and re-establishment of social relationships. Assessment and therapy begin by taking seriously the women's own problem definitions and supporting their own proposals to solutions. Frequently, we will not be able to comply with their wishes but we can discuss their solutions in a therapeutic manner and build a bridge over cultural incongruence.

On the other hand, it is of great importance not to leave the clients without tools for them to get integrated in the new host culture. Therapists have a significant task in helping to empower refugee women. This may be done in many ways but always taking into consideration the cultural and educational background of the client. The understanding of what sufferings women are exposed to may not be present in all members of a given cultural group but it will depend among other things upon the roles ascribed to education, social class, and gender.

There is evidence to suggest that sexual trauma after rape in individuals from the same culture can be reduced by a tolerant family relationship of a well-educated middle-class family but on the other hand be perpetuated in an uneducated traditional family that consciously or unconsciously may stigmatise the woman. Thus, although both women may come from the same country, they do not share the same "culture." This calls for an assessment of the woman's cultural self-concept in the therapeutic situation.

In conclusion, the female refugee brings with her, in treatment, her traumatic experiences, her current stresses, and symptoms of PTSD as well as the whole context of her social relationships. All aspects contribute to the conditions of her expressing trauma and her coping with trauma.

As therapists we must differentiate between suffering from the original trauma and suffering as the result of gender discrimination that this context of social relationships exerts on this particular woman in her attempts to overcome trauma.

DISCUSSION AND CONCLUSIONS Over the last few years we have been experiencing in Europe an increasing animosity towards refugees and asylum seekers, and several countries have passed legislation in order to drastically reduce the numbers of new asylum seekers. Such an atmosphere does not facilitate the integration of refugees already present in the country, and may on the contrary aggravate their mental health conditions. Simultaneously, we experience in the same countries a focus on differences in gender roles and gender expectations between the host population and the migrant groups. Migrant and refugee women - especially those wearing traditional dress, or covering their heads - frequently report harassment and discrimination. Prior to arriving in the host country, these women may have been subject to gender discrimination as regards emergency relief and access to health care. In some countries, as was the case in Afghanistan, there was discrimination against women's access to medical care. Isolated or overcrowded camps and unsafe sleeping premises facilitate sexual violence. Further, lack of police protection and a general lawlessness leave women in such camps without any real protection (Arcel, 2002).

It is of concern that in the extensive literature on consequences of trauma, fairly little is written on the particular problems refugee women face acknowledging that they have been exposed to trauma, but also very often been exposed to insecurity, even sexual abuse in refugee settings. There is ample evidence that women may seek refuge from armed conflicts and war and nevertheless be exposed to further harassments in what was supposed to be a secure environment. The vulnerability of women further increases when they are faced with an unknown life situation as single providers and new responsibilities are placed upon them. Whereas violence towards men tends to take place outside the home, interpersonal violence directed towards women is frequently hidden from the public eye. It permeates the life of a large proportion of women, and is one of the most frequent traumatic stressors for displaced, migrant and refugee women. There is little research about this doubly traumatic life situation. It is to be welcomed that increasingly UNHCR focuses on women's safety as refugees and the consequent challenges to their mental health.

In the new setting the refugee woman and her family are confronted with a new culture that may differ in gender role expectations, marital habits, gender socializations, etc. But the family has to survive and integrate in this new and sometimes unfriendly setting. Due to lack of means to support themselves, their children or elderly relatives, women may in some situations end up with no alternatives than rendering their sexual services. Education about the implications of role change or about the interpretation of the strange, unknown life styles and patterns of the host society may facilitate the integrative process and help us in our understanding of the individual refugee.

The debate related to refugees is frequently colored by preconceived ideas about what is acceptable behavior of certain ethnic groups of women, their lack of freedom to choose a partner according to their wishes, their limited access to employment, their lack of education, etc. Frequently few attempts are made to validate these ideas.

Western women take little interest in reaching out to women from other ethnic backgrounds. By socializing with these women, they could help in creating friendships across cultures; form networks and mentor initiatives in order to facilitate their integration into the host country. We have to keep in mind that the cultural context may aggravate the consequences of violence, but cultural traditions may also be protective (WHO World report, 2002). Resolving the extensive public health problems of interpersonal and sexual violence in refugee women requires the

collaboration of many agencies and the commitment of societies, and governments (WHO World Report, 2002).

Refugee women have experienced several losses, and will typically feel disempowered, and the acculturation process may add to that. Empowerment is (here) understood as the process by which a marginalized person becomes aware of the power structures and dynamics of society, and develops skills to gain control over her life without infringing on the rights of others (McWhirter, 1994). There is an increasing recognition that gender aspects are important when considering refugee laws as women may have special reasons for applying for asylum, but also because women may receive no protection from authorities for their abusive partners.

Many countries and communities have started to take up this challenge and work for improving the conditions of female asylum seekers in terms of their claims, availability of interpreters, etc. Such initiatives are welcome but should always show due respect for the cultural realities of the women concerned. We have to encourage authorities to ensure that women are provided possibilities to use their capacities in a culture sensitive manner as empowerment may benefit them by contributing to their own protection and thereby preventing violations of their rights, and ultimately the need for the treatment of mental health problems.

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